

Submitter : Dr. Robert Hermann
Organization : Northwest Georgia Oncology Centers, PC
Category : Physician

Date: 12/30/2005

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment regarding the 2006 Oncology Demonstration Project.

CMS-1502-FC-49-Attach-1.DOC

Submitter : Dr. Nina Antoniotti
Organization : Marshfield Clinic, TeleHealth Network
Category : Other Health Care Provider

Date: 12/30/2005

Issue Areas/Comments

GENERAL

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This request for additions to the list of approved Medicare TeleHealth services is submitted according to the CMS published guide in the Federal Register Vol 67, No 251, Tuesday, Dec 31, 2003, s410.78(f), and on the CMS website www.cms.hhh.gov accessed 10/21/03. "See attachment"

Interim Relative Value Units

Interim Relative Value Units

none

CMS-1502-FC-50-Attach-1.DOC

**CENTERS FOR MEDICARE AND MEDICAID SERVICES
MEDICARE TELEHEALTH SERVICES
2005 REQUEST FOR ADDTION OF CPT CODES**

This request for additions to the list of approved Medicare TeleHealth services is submitted according to the CMS published guide in the Federal Register Vol 67, No 251, Tuesday, Dec 31, 2003, s410.78(f), and on the CMS website www.cms.hhh.gov accessed 10/21/03.

Marshfield Clinic's TeleHealth Network requests that the following CPT codes be added to the approved list of TeleHealth CPT codes for 2007. This request is being submitted prior to December 31, 2005, for consideration in the 2006 physician fee schedule process.

1. CONTACT INFORMATION:

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2. HCPCS(s) CODES FOR SERVICES PROPOSED FOR ADDITION:

The following requested codes for addition to the approved list of CPT codes are grouped together as a range due to the AMA CPT Code 2004 Manual grouping these codes as like codes with the differences being only the amount of time spent and the complexity of the decision-making by the physician; for specialty testing that is similar in nature; and for other sequential codes representing specific services. We believe these CPT code services to be similar to an office visit and therefore are Category 1 requests.

3. CPT CODE REQUESTS

Speech Pathology/Therapy

- 92506** Evaluation of speech, language, voice, communication, auditory processing disorder (includes aural rehabilitation); individual
- 92507** Treatment of speech, language, voice, communication, auditory processing disorder (includes aural rehabilitation); individual
- 92526** Treatment of swallowing dysfunction and/or oral function for feeding
- 92610** Evaluation of oral and pharyngeal swallowing function
- 92611** Motion fluoroscopy/swallowing function by cine or video recording
- 92607** Evaluation for prescription for speech-generating augmentation and alternative communication device, first hour
- 92608** Evaluation for prescription for speech-generating augmentation and alternative communication device, additional thirty minutes

- 92609 Therapeutic services for use of speech-generating device service including programming and modification
96105 Assessment of aphasia, with interpretation and report, per hour

4. **MEDICAL PROFESSIONAL(S) PROVIDING THE SERVICE:**
Medicare reimbursement-eligible providers include speech pathologists for in-person care. Although speech pathologists are not currently on the approved list of eligible providers for Medicare TeleHealth reimbursement, we would encourage CMS to use the 2005 process of adding eligible providers. CMS added Medical Nutrition Therapists (MNT) to the list of eligible providers in the 2005 physician fee schedule in order to validate the use of the additional approved MNT codes. The same process would need to occur in order to move forward with the use of the speech pathology codes. We would ask that CMS approve Speech Pathologists as eligible TeleHealth providers for 2007 through the physician fee scheduling process (Fed Reg, Vol 70(218) p. 70156-8).
5. **EXPLANATION OF WHY CURRENT APPROVED HCPCS CODES FOR TELEHEALTH CANNOT BE USED:** Diagnostic or treatment procedures usually included in a comprehensive otorhinolaryngologic (speech) evaluation or office visits, are reported as an integrated medical service, using appropriate descriptors from the 99201 series. Itemization of component procedures (eg. Otoscopy, rhinoscopy, tuning fork test) does not apply. Special otorhinolaryngologic services are those diagnostic and treatment services not usually included in a comprehensive otorhinolaryngologic evaluation or office visit. These services are reported separately, using codes 92505-92700 (AMA, *CPT 2006, Current Procedural Terminology*, AMA Press, p. 374). In addition, Therapeutic Procedures 97110-97546, represent services that comprise a manner of effecting change through the application of clinical skills and/or services that attempt to improve function (CPT 2006, p. 403). The current list of approved CPT codes for TeleHealth do not include the appropriate codes and cannot substitute for the appropriate codes, as defined in the 2006 AMA CPT code manual.
6. **REASONS FOR ADDITION OF THE PROPOSED SERVICES:**
Telerehabilitation (telerehab) is the method of using technology to provide rehabilitation services at a distance. The concept of delivering remote speech-language pathology (SLP) services using telerehab tools and techniques has been acknowledged for more than 25 years. As early as 1994, Medicare itself supported the use of TeleHealth in providing speech language services through The Medicare home health initiative (Vladeck, B.C., and Miller, N.A. *Health Care Financing Review* 16(1): 7-16).

A recent report prepared by ASHA (2001, *Telepractices and ASHA: Report of the Telepractices Team* (December) reveals that the most common speech-language pathology treatment services delivered via telehealth are for aphasia, voice, cognitive-communication, articulation, and motor speech disorders. However,

literally all types of speech-language pathology treatment have been provided via telehealth. In addition to treatment, telehealth permits patient/family follow-up and counseling without dependence on transportation.

As with most services delivered via TeleHealth technologies, there is a critical shortage of speech-language professionals, both pathologists and therapists, in remote, rural, and disparate areas. Many large physician clinics of 500+ physicians have only four to five speech-language professionals available to provide services to large geographic areas. The Marshfield Clinic system, with over 45 regional centers, 90 percent of which are located in rural and underserved, disparate areas, has only eight speech pathologists to serve our geographic and referral service area. There are other speech pathologists located in hospitals in the service area, however, these professionals do not have the expertise and specialty practice, ie. stuttering or facial paresis, that the clinicians in the Marshfield Clinic system practice on a regular basis. Additionally, there is a critical shortage of speech pathology services in schools. The American Speech-Language and Hearing Association (ASHA) has determined a national shortage and has a focus initiative to recruit and retain speech pathologists and audiologists. Nationally, the numbers speak for themselves with

7. DATA SHOWING THAT TELECOMMUNICATIONS TECHNOLOGIES DO NOT CHANGE THE DIAGNOSIS OR TREATMENT AS COMPARED TO IN-PERSON CARE:

Speech and language disorders have been diagnosed via satellite since 1987 by speech-language pathologists at the Mayo Clinic. Between 1987 and 1994, 150 speech-language pathology consultations were conducted by Mayo Clinic speech-language pathologists for patients in Arizona and Florida. The purpose of the consultations was to diagnose and provide management recommendations for patients with speech, voice, or language problems. The study concluded that "Telemedicine evaluations can be reliable, beneficial, and acceptable to patients with a variety of acquired speech and language disorders, both in rural settings and within large multidisciplinary medical settings." (Duffy, J.R., et al. (1997, December. Telemedicine and the diagnosis of speech and language disorders. *Mayo Clinic Proceedings*, 1116-1122).

At least one urban rehabilitation hospital has successfully implemented a program to provide follow-up services to patients who use augmentative and assistive communication (AAC) devices. The hospital has a telehealth grant from the federal government for providing services to people with spinal cord injuries. The development of AAC follow-up services became a 2-year subpart of the grant because:

- Limited AAC expertise was available in rural areas.
- Travel and fatigue were lessened for patients receiving AAC services.
- Consultation with speech-language pathologists with acknowledged AAC expertise was possible regardless of location.

Integrus Health Services completed a telehealth service project that provided speech-language pathology services from April 1999 and March 31, 2002, through a HRSA funded grant. Integrus rendered over 48,000 minutes of speech-language pathology treatment (1,300 interventions) compared to 22,000 minutes of physical therapy (430 interventions) and 1,200 minutes of occupational therapy (40 interventions). Integrus administers the largest rehabilitation center in Oklahoma and has three rural satellite outpatient clinics, continuing to provide telerehab services, including speech pathology services.

The evaluation of swallowing disorders has been successfully demonstrated by the remote direction and interpretation of videofluoroscopic swallow studies, also known as modified barium swallow (MBS) assessments (Perlman, A. 2002. Real-time remote telefluoroscopic assessment of patients with dysphagia. *Dysphagia*, 162-167). The telehealth service is applicable to all ages irrespective of disease. Such instrumental assessments are often necessary to develop a treatment plan. In fact, many Medicare intermediaries require some type of instrumental assessment before dysphagia treatment. For each MBS procedure, a hospital radiology department only need switch on a personal computer. The speech-language pathologist's computer handles the interface from that point forward. The procedure is beneficial from a telehealth perspective for at least three reasons:

- It enables the speech-language pathologist most familiar with the patient to participate in the direction of the MBS. This is in contrast to the typical scenario of using the speech-language pathologist employed by the hospital outpatient department.
- The clinical value of the MBS is not compromised by an inordinately long ambulance trip that is fatiguing and distracting to the patient.

The MBS telehealth development has been funded by a grant from the National Center for Supercomputing Applications (University of Illinois at Urbana-Champaign).

Brennan et al. (2004) conducted a study designed to measure performance by brain-injured subjects, with medical diagnoses of stroke or traumatic brain injury, on a standardized Speech-Language Pathology evaluation conducted in both face-to-face and videoconference-based telerehabilitation settings. The Story Retelling Procedure (SRP), which measures connected language production and comprehension of spoken narratives, was administered to each subject in both settings. The primary objectives of this study were to: (1) compare communication as measured by the SRP between experimental settings, and (2) determine if subject variables (such as age, education, technology experience or gender) had an effect on performance differences between settings. The rationale was that any difference in this aspect of performance must be identified and characterized before this mode of intervention can be used clinically. Across all subjects ($n = 40$), no significant difference ($p < 0.05$) was found between SRP performance measured in the two settings. Additionally, variables including age,

education, technology experience, and gender did not significantly affect the difference between performance in the two settings (Brennan, D.M., Georgeadis, A.C., Baron, C.R., and Barker, L.M., 2004. *The effect of videoconferencing-based telerehabilitation on story retelling performance by brain-injured subjects and its implications for remote speech-language therapy* Telemedicine Journal and e-Health Summer 10(2): 147-54).

The purpose of a study by Georgeadis et al.(2004), was to measure performance of adults with acquired brain injury on a standardised SLP assessment conducted in both face-to-face (FF) and videoconference-based telerehab (T) settings. The objective was to determine if performance on the assessment, or subjective feedback from the participants, differed between settings. A total of 40 participants with a recent onset of brain injury--12 with traumatic brain injury (TBI), 14 with a left cerebrovascular accident (LCVA), and 14 with a right cerebrovascular accident (RCVA), were enrolled in the study. Participants were asked to retell stories from the Story Retell Procedure (Doyle, McNeil, Spencer, Goda, Cotrell, & Lustig, 1998) in both FF and T settings. Responses from the stories were scored by the clinician using the percent information unit scoring metric (McNeil, Doyle, Fossett, Park, & Goda, 2001). Additionally, a survey tool was used to probe each participant's level of satisfaction and willingness to use telerehab services in the future. Across all participants, and within the TBI, LCVA, and RCVA groups, no significant difference in performance between the FF and T settings was found. Feedback from survey data demonstrated a high level of acceptance of the T setting. Story-retelling performance by brain-injured adults was not affected by setting. Additionally, participants expressed a high level of interest in using videoconferencing in the future. These findings offer additional support for telerehab as a viable alternative mode of SLP treatment for survivors of stroke and TBI. (Georgeadis, A.C., Brennan, D.M., Barker, L.M., and Baron, C.R. 2004. *Telerehabilitation and its effect on story retelling by adults with neurogenic communication disorders. Aphasiology* May-Jul 18(5-7): 639-52).

The Institute for Stuttering Treatment and Research at the University of Alberta has used videoconferencing to provide follow-up support to geographically remote adults who have undergone intensive treatment on site. The potential value of telecommunications systems in treating communication disorders is being increasingly recognized. This mode of service delivery shows particular promise in giving patients access to specialist services for problems like stuttering, which are difficult to manage and often require long-term follow-up support (Kully, D. 2000. *Telehealth in speech pathology: Applications to the treatment of stuttering. Journal of Telemedicine and Telecare* 6(Suppl 2): S2:39-41). In another evaluative study regarding dysfluency, Sicotte et al. assessed the feasibility and outcome of delivering speech-language services from a distance to children and adolescents who stutter. All six patients who formed the first cohort seen in the telespeech program were included in the study. The results demonstrated that interactive videoconferencing can provide a feasible and

effective care delivery model. Patient attendance was maintained throughout the intervention. All participants showed improved fluency. Stuttering ranged from 13% to 36% before treatment and 2% to 26% after treatment. All participants maintained at least part of their improved fluency during the six-month follow-up, when stuttering ranged from 4% to 32%. The study demonstrates that full assessment and treatment of stuttering in children and adolescents can be accomplished successfully via telemedicine (Sicotte, C., Lehoux, P., Fortier-Blanc, J., and Leblanc, Y. 2003. Feasibility and outcome evaluation of a telemedicine application in speech: language pathology. *Journal of Telemedicine and Telecare* 9(5): 253-8)

Rose et al., (2000) implemented a project between BT and Adastral Park to provide specialist speech and language therapy for pre-school age children. The TeachSpeech project successfully demonstrated that modern videoconferencing technology can be used to support the delivery of speech and language therapy services into schools (Rose E, Furner S, Hall A, Montgomery K, Katsavras E. and Clarke P. 2000. Videoconferencing for speech and language therapy in schools. *BT Technol J*, Vol 18, No 1, p 1001-4).

8. **PATIENT SATISFACTION WITH TELEHEALTH TELECOMMUNICATIONS SYSTEMS:**

Brennan et al.'s earlier quoted study (2004) indicated that "overall, subjects reported a high level of acceptance of videoconferencing with 34 subjects responding "yes," 4 responding "no," and 2 responding "maybe" when asked if they would use videoconferencing again to talk to a clinician. Results of this study confirm the potential for SLP treatment using videoconferencing and indicate a need for continued research in the field."

The study by Georgeadis et. al (2004) as quoted above, also indicates a high level of patient acceptance of and willingness to use videoconferencing in the future.

With respect to patient satisfaction, early results indicated that patients who received care via TeleHealth technologies were extremely satisfied with receiving health care services in this manner. Current patient satisfaction with services delivered by TeleHealth, regardless of the specialty, can be found in a large study conducted by the University of Arizona. The Arizona Telemedicine Program (ATP) is a large, multidisciplinary, university-based program that provides telemedicine services, distance learning, informatics training, and telemedicine technology assessment capabilities to communities throughout Arizona. The types of teleconsultation services available include real-time and store-forward consultations, continuing medical education, and patient information sessions. Since the inception of the ATP, there have been 97,722 telemedicine events. The most frequently used telemedicine service is teleradiology, comprising 85,728 teleconsults. Next in frequency are teledermatology and telepsychiatry consultations. Results of patient satisfaction surveys indicate high levels of patient satisfaction with both real-time and store-forward consultations. Three studies of

the efficacy of telemedicine services are discussed. One study of the efficacy and diagnostic accuracy of utilizing telecolposcopy, revealed a positive predictive value of the telecolposcopic impression of between 81% and 82%, while the positive predictive value of an in-person impression was 80%. (Lopez, A.M., Avery, D., Krupinski, E., Lazarus, S., and Weinstein, R.S. 2005. Increasing access to care via tele-health: the Arizona experience. *Journal of Ambulatory Care Management*, Jan/Mar 28(1): 16-23). An early landmark study by Gustke et al., (Gustke, S.S., Balch, D.C., West, V.L., and Rogers, L.O. 2000. Patient satisfaction with telemedicine. *Telemedicine Journal Spring* 6(1): 5-13), patient satisfaction was examined in relation to patient age, gender, race, income, education, and insurance. Overall patient satisfaction was found to be 98.3%.

Degrees of satisfaction may vary slightly with the specialty accessed through TeleHealth, but overall satisfaction remains high. The source of satisfaction for most patients is the ability to see a specialist trained in the area most closely related to the patient's condition, the feeling of getting personalized care from a provider who has the patient's interest in mind, and the ability to communicate with the provider in a very personal and intimate manner over the telecommunications technologies. The current peer reviewed literature on patient satisfaction with accessing health care via telecommunications technologies including interactive video over high and low bandwidths, store-and-forward teleconsultations, remote monitoring, and telephone consultations, should undisputable evidence that patients are very satisfied with care provided via telecommunications technologies.

Many other peer reviewed medical journals indicate the same results from empirical studies. A few are listed below:

Arizona telepsychiatry project gains national attention, patient approval, 1998. *Mental Health Weekly*, Jan 19, 8(3): 4.

Main purpose for facilitating mental health in the region with the use of TeleHealth technology – role of simplifying case management and prior authorization. Program instituted by the Northern Arizona Regional Behavioral Health Authority.

Craig J, et. al. 2000. The cost-effectiveness of teleneurology consultations for patients admitted to hospitals without neurologists on site. *Journ of Telemedicine and Telecare* 6 (suppl 1): S1: 46-9.

Comparison of outcomes of patients admitted to two small. One hospital received neurological services by TeleHealth, the other in-person . Neurological services were provided via Telemedicine. Comparing case-mix, process of management, and outcomes for all patients using ICD-10 codes with a final diagnosis of neurological condition there were no appreciable differences noted between the clinical outcomes and the length of stay between patients receiving services in-person and those who received services via TeleHealth.

Janca, 2000. Telepsychiatry: an update on technology and its implications. *Curr Op in Psych* 13: 591-7.

This study/article concluded that even “early research demonstrated that the psychiatric interview conducted over videoconferencing is reliable for diagnostic assessment and treatment recommendations.” In addition, a retrospective review of medical records comparing clinical outcomes of patients seen by [interactive TV] (IATV) and those in-person showed no significant difference found in the percentage of change in Global Assessment of Functioning (GAF) between the two groups suggesting clinical outcomes were not affected by the use of IATV.

Young TL, Ireson C. Effectiveness of school-based telehealth care in urban and rural elementary schools. *Pediatrics*. 2003 Nov;112(5):1088-94.

Telehealth technology was effective in delivering pediatric acute care to children in [these] schools. Pediatric providers, nurses, parents, and children reported primary care school-based telehealth as an acceptable alternative to traditional health care delivery systems.

Ermer D.J., 1999. Child and adolescent telepsychiatry clinics. *Psych Services* Jul 29(7): 409-14.

This study concluded that severely disturbed children can be adequately assessed and treated, the range of expressed emotion and the quality of clinical interaction appear similar in TelePsychiatry and [in-person] interactions, and children in crisis can be safely assessed and treated [via telepsychiatry].

DATE SUBMITTED: December 30, 2005

1. Speech Pathology/Therapy

MEDICAL PROFESSIONAL(S) PROVIDING THE SERVICE:

EXPLANATION OF WHY CURRENT APPROVED HCPCS CODES FOR TELEHEALTH CANNOT BE USED: Diagnostic or treatment procedures usually included in a comprehensive otorhinolaryngologic evaluation or office visits, are reported as an integrated medical service, using appropriate descriptors from the 99201 series. Itemization of component procedures (eg. Otoscopy, rhinoscopy, tuning fork test) does not apply. Special otorhinolaryngologic services are those diagnostic and treatment services not usually included in a comprehensive otorhinolaryngologic evaluation or office visit. These services are reported separately, using codes 92505-92700 (AMA, *CPT 2006, Current Procedural Terminology*, AMA Press, p. 374). The current list of approved CPT codes for TeleHealth do not include the appropriate codes and cannot substitute for the appropriate codes, as defined in the 2006 AMA CPT code manual.

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- It enables the speech-language pathologist most familiar with the patient to participate in the direction of the MBS. This is in contrast to the typical scenario of using the speech-language pathologist employed by the hospital outpatient department.
- The clinical value of the MBS is not compromised by an inordinately long ambulance trip that is fatiguing and distracting to the patient.
- The technology used for telepractice MBS is also applicable to the Fiberoptic Endoscopic Evaluation of Swallowing (FEES) as well as other imaging procedures.

The MBS telehealth development has been funded by a grant from the National Center for Supercomputing Applications (University of Illinois at Urbana-Champaign). The principal investigator believes that this telepractice technique will be a cost-saving and appropriate service to beneficiaries when Medicare initiates coverage.

Brennan et al. (2004) conducted a study designed to measure performance by brain-injured subjects, with medical diagnoses of stroke or traumatic brain injury, on a standardized Speech-Language Pathology evaluation conducted in both face-to-face and videoconference-based telerehabilitation settings. The Story Retelling

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PATIENT SATISFACTION WITH TELEHEALTH TELECOMMUNICATIONS SYSTEMS:

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With respect to patient satisfaction, early results indicated that patients who received care via TeleHealth technologies were extremely satisfied with receiving health care services in this manner. Current patient satisfaction with services delivered by TeleHealth, regardless of the specialty, can be found in a large study conducted by the University of Arizona. The Arizona Telemedicine Program (ATP) is a large, multidisciplinary, university-based program that provides

telemedicine services, distance learning, informatics training, and telemedicine technology assessment capabilities to communities throughout Arizona. The types of teleconsultation services available include real-time and store-forward consultations, continuing medical education, and patient information sessions. Since the inception of the ATP, there have been 97,722 telemedicine events. The most frequently used telemedicine service is teleradiology, comprising 85,728 teleconsults. Next in frequency are teledermatology and telepsychiatry consultations. Results of patient satisfaction surveys indicate high levels of patient satisfaction with both real-time and store-forward consultations. Three studies of the efficacy of telemedicine services are discussed. One study of the efficacy and diagnostic accuracy of utilizing telecolposcopy, revealed a positive predictive value of the telecolposcopic impression of between 81% and 82%, while the positive predictive value of an in-person impression was 80%. (Lopez, A.M., Avery, D., Krupinski, E., Lazarus, S., and Weinstein, R.S. 2005. Increasing access to care via tele-health: the Arizona experience. *Journal of Ambulatory Care Management*, Jan/Mar 28(1): 16-23). An early landmark study by Gustke et al., (Gustke, S.S., Balch, D.C., West, V.L., and Rogers, L.O. 2000. Patient satisfaction with telemedicine. *Telemedicine Journal* Spring 6(1): 5-13), patient satisfaction was examined in relation to patient age, gender, race, income, education, and insurance. Overall patient satisfaction was found to be 98.3%.

Degrees of satisfaction may vary slightly with the specialty accessed through TeleHealth, but overall satisfaction remains high. The source of satisfaction for most patients is the ability to see a specialist trained in the area most closely related to the patient's condition, the feeling of getting personalized care from a provider who has the patient's interest in mind, and the ability to communicate with the provider in a very personal and intimate manner over the telecommunications technologies. The current peer reviewed literature on patient satisfaction with accessing health care via telecommunications technologies including interactive video over high and low bandwidths, store-and-forward teleconsultations, remote monitoring, and telephone consultations, should undisputable evidence that patients are very satisfied with care provided via telecommunications technologies.

Submitter : Dr. Fremont Wirth
Organization : American Association of Neurological Surgeons
Category : Physician

Date: 12/30/2005

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-FC-51-Attach-1.DOC

December 30, 2005

Mark McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8017
Baltimore, Maryland 21244

Attention: CMS-1502-FC; Medicare Program: Revisions to the Payment Policies Under the Physician Fee Schedule for Calendar Year 2006

Dear Dr. McClellan:

On behalf of the American Association of Neurological Surgeons (AANS) and Congress of Neurological Surgeons (CNS), we appreciate the opportunity to comment on the above referenced final rule with comment published in the *Federal Register* on November 21, 2005.

In the Final Rule on Page 70281, CMS explains that a status indicator of "N" indicating a non-covered service would be assigned to five Intracranial Angioplasty and Stenting procedures, CPT codes 61630, 61635, 61640, 61641, and 61642, valued by the RUC in April 2005. We have several concerns about the "N" indicator for these procedures.

Background

In February 2005, the AANS and CNS joined several other societies in submitting a coding proposal for intracranial angioplasty and stenting procedures. The AMA CPT Editorial Panel recommended that the codes be separated into two families differentiated by balloon angioplasty and stenting for the treatment of intracranial atherosclerotic stenosis and balloon dilatation for the treatment of vasospasm. This separation was important because a national non-coverage policy existed for the balloon angioplasty and stenting procedures but not for the treatment of vasospasm.

Intracranial Angioplasty for Vasospasm

Intracranial angioplasty for vasospasm secondary to subarachnoid hemorrhage has been shown to be an effective treatment in symptomatic patients who are refractory to aggressive medical management. Data from California Blue Shield as well as a national review of medical practice indicate conclusively that access to endovascular therapy for vasospasm utilizing angioplasty improves patient outcomes.

Intracranial angioplasty of cerebral vasospasm in the treatment of medically refractory patients has become the standard of care in institutions where neuro-endovascular is delivered. The importance of this treatment to these patients is highlighted by the following excerpt:

Recommendations for Comprehensive Stroke Centers: A Consensus Statement From the Brain Attack Coalition

Stroke. 2005 Jul;36(7):1597-616.

Vasospasm is a frequent and deadly complication of an SAH.¹⁰¹ Medical management such as hemodynamic therapy often fails to reverse the clinical effects of the vasospasm.^{102,103} Catheter-directed intracerebral IA infusion of vasodilators is an important therapeutic option used routinely in some cases of vasospasm with mixed results (grade IIIC).¹⁰⁴⁻¹⁰⁸ Intracranial angioplasty for vasospasm has a success rate of >90% in correcting the angiographically visible vasospasm, with clinical improvement in 60% to 80% of patients (grade IIIC)^{106,109,110} and a complication rate of 2% to 4%.¹¹¹ Although angioplasty for vasospasm has not been subjected to rigorous clinical study, it is considered very effective and is a standard therapy for severe vasospasm.¹¹⁰⁻¹¹² Because the other therapeutic options for symptomatic vasospasm are limited and often ineffective, the ability to perform intracranial angioplasty or IA infusions of vasodilators is recommended for a CSC. If a CSC is temporarily unable to offer this therapy, it is recommended that protocols be developed for the rapid transfer of patients needing these treatments to a nearby facility that does offer this therapy.

The procedures described in CPT Code 61640, *Balloon dilatation of intracranial vasospasm, percutaneous; initial vessel*, CPT Code 61641, *Balloon dilatation of intracranial vasospasm, percutaneous; each additional vessel in the same vascular family* and CPT Code 61642, *Balloon dilatation of intracranial vasospasm, percutaneous; each additional vessel indifferent vascular family* should not be considered part of the non-coverage decision for intracranial stenting. These procedures are utilized to treat an entirely different disease process than the codes for angioplasty and stenting to which the non-coverage decision pertains. We feel these procedures have been designated as non-covered in error and request that CMS change to status indicated to an "A" for covered, or at a minimum, to a "C" for carrier-priced.

Angioplasty and Stenting for Medical Failures of Intracranial Atherosclerotic Stenosis

Medicare currently has a non-coverage policy for the angioplasty and stenting codes 61630 *Balloon angioplasty, intracranial (e.g., atherosclerotic stenosis), percutaneous* and 61635, *Transcatheter placement of intravascular stent(s), intracranial (e.g., atherosclerotic stenosis), including balloon angioplasty, if performed*. These codes describe interventions that are considered only for patients for whom all other options have been exhausted. Patients for whom these procedures are indicated have no other treatment options available to them and clinical trial data shows that these procedures have a very strong success rate. We believe that these procedures should be covered for those Medicare patients who are appropriate candidates. Again, we would like to see an "A" status or at least a "C," carrier-priced indication for these codes. At a minimum the RUC-approved values should be published.

Publication of RUC-approved RVUs

More generally, the AANS and CNS support the publication of RUC-approved values for all codes that Medicare does not cover and therefore has a coverage indicator of "N" listed in the Medicare Fee Schedule. The values approved by the RUC are not publicly available except upon publication by CMS as part of the Medicare Fee Schedule. As you know, many private payors, Medicaid, and workers compensation plans determine physician payment based on the Medicare RBRVS. We ask

that these values be published in any correction notice that CMS anticipates publishing for the 2006 Medicare Fee Schedule.

Conclusion

Thank you for your time and consideration in this matter. We would appreciate a review of the payment policy surrounding CPT Codes 61630, 61635, 61640, 61641, and 61642. We object to the inclusion of the codes for the treatment of vasospasm, CPT Codes 61640, 61641, and 61642, in the non-coverage decision for the intracranial stenting codes and ask that CMS change the payment indicator for these codes in the correction notice that it anticipates publishing for the 2006 Medicare Fee Schedule. In addition, we feel that the non-coverage decision for CPT Codes 61630 and 61635 should be revisited. Finally, we ask that CMS publish RUC-approved values for codes even in the case of codes for which it does not provide coverage.

Sincerely,

Fremont P. Wirth, MD, President
American Association of Neurological Surgeons

Richard G. Ellenbogen, MD, President
Congress of Neurological Surgeons

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Submitter : Dr. Nina Antoniotti
Organization : Marshfield Clinic TeleHealth Network
Category : Other Health Care Professional

Date: 12/30/2005

Issue Areas/Comments

GENERAL

GENERAL

This request for additions to the list of approved Medicare TeleHealth services is submitted according to the CMS published guide in the Federal Register Vol 67, No 251, Tuesday, Dec 31, 2003, s410.78(f), and on the CMS website www.cms.hhh.gov accessed 10/21/03.

Interim Relative Value Units

Interim Relative Value Units

none

CMS-1502-FC-52-Attach-1.DOC

**CENTERS FOR MEDICARE AND MEDICAID SERVICES
MEDICARE TELEHEALTH SERVICES
2005 REQUEST FOR ADDTION OF CPT CODES**

This request for additions to the list of approved Medicare TeleHealth services is submitted according to the CMS published guide in the Federal Register Vol 67, No 251, Tuesday, Dec 31, 2003, s410.78(f), and on the CMS website www.cms.hhh.gov accessed 10/21/03.

Marshfield Clinic's TeleHealth Network requests that the following CPT codes be added to the approved list of TeleHealth CPT codes for 2007. This request is being submitted prior to December 31, 2005, for consideration in the 2006 physician fee schedule process.

1. CONTACT INFORMATION:

Name: Nina M. Antoniotti, RN, MBA, Ph.D
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2. HCPCS(s) CODES FOR SERVICES PROPOSED FOR ADDITION:

The following codes are grouped together as a range due to the AMA CPT Code 2004 Manual grouping these codes as like codes with the differences being only the amount of time spent and the complexity of the decision-making by the physician.

Physical Therapy

97001-97006 Evaluation – therapy and training
97010-97028 Supervision not requiring direct contact
97110 Therapeutic procedure, one or more areas, each 15 minutes
97112 Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97530 Therapeutic activities to improve functional performance, each 15 minutes
97532 Development of cognitive skills to improve attention, memory, problem solving, each 15 minutes

3. MEDICAL PROFESSIONAL(S) PROVIDING THE SERVICE:

Medicare reimbursement-eligible providers include licensed physical therapists and other physical therapy professionals for in-person care. Although physical therapists are not currently on the approved list of eligible providers for Medicare TeleHealth reimbursement, we would encourage CMS to add Physical therapists to the list of approved eligible TeleHealth providers. We would request that CMS

use the same process used to add Medical Nutrition Therapists (MNT) to the list of eligible providers in 2005, through the physician fee schedule process (Fed Reg, Vol 70(218) p. 70156-8).

4. EXPLANATION OF WHY CURRENT APPROVED HCPCS CODES FOR TELEHEALTH CANNOT BE USED:

Physical Medicine and Rehabilitation codes 97001-97755 are used to report each distinct procedure performed and do not use modifier 51. According to the CPT 2006 AMA manual, none of the currently approved TeleHealth CPT codes can be used in place of 97001-97006, 977010-97028, 97110, 97530, or 97532. In addition, Therapeutic Procedures 97110-97546, represent services that comprise a manner of effecting change through the application of clinical skills and/or services that attempt to improve function (CPT 2006, p. 403). None of the currently approved TeleHealth codes include the activities described and represented by the codes listed above.

5. REASONS FOR ADDITION OF THE PROPOSED SERVICES:

The 2000 Census indicated that approximately 37 percent of the population over the age of 65 has a sensory, physical, mental, or self-care disability, with approximately 16 percent having a physical disability (www.census.gov/population/www/cen2000, accessed December 29, 2005). Falls are a significant risk factor in persons over the age of 65 who have declining mobility and proprioception. Traumatic brain injury (TBI) patients have extensive rehabilitation and recovery periods and require intensive physical therapy assessments and therapies in order to restore function. Stroke survivors, a group that consumes a significant portion of the SSI and Medicare expenditures each year, also require assessment, evaluation, and supportive services by physical therapists. Although there is not a shortage of physical therapists in practice today, like many health professionals, physical therapists are often not found in remote, rural, or disparate areas. Services are typically found in larger urban areas, and near secondary and tertiary care facilities. Expanding the codes to include physical therapy codes would allow Medicare beneficiaries to stabilize and improve their physical condition post medical/surgical emergency or as a result of the aging process.

The Marshfield Clinic system conducts an Orthopedic TeleHealth Service, specializing in Spine surgery. Patients often come from the Upper Peninsula of Michigan to obtain the necessary surgery to ambulate, stand upright, or become pain free. Our spine orthopedic specialist is located in the Marshfield Center, more than six hours away from the Upper Peninsula. Most of our patients in our service area will travel more than three hours for follow-up appointments, which include a visit with a nurse practitioner and a physical therapist. This trip, made one week post-op, is very difficult for patients. Many times patients make the entire trip to and from the Marshfield campus, laying down in the back seat of the car. We have been providing physical therapy services via TeleHealth to this population for approximately a year with excellent results. The patient has a

TeleHealth nurse clinician with them at all times. The physical therapist watches the patient as the patient moves through the series of exercises and therapies that are being done at home. If the physical therapist needs to modify or add additional exercises, he or she demonstrates those exercises by panning out the camera and doing them on the traditional physical therapy platform, or uses the PT room for walking, bending, stretching demonstrations. All of this activity occurs in the same manner as if the patient were in the room. None of the services provided (and requested in the listed codes) requires hands-on care by the physical therapist. The services requested are education, demonstration, support and evaluation services.

6. DATA SHOWING THAT TELECOMMUNICATIONS TECHNOLOGIES DO NOT CHANGE THE DIAGNOSIS OR TREATMENT AS COMPARED TO IN-PERSON CARE:

Cooper, Fitzgerald, Boninger, Cooper, Shapcott, Cohen et al. (2002) and Shaw, Dreyer, and Wittman (2001) found that low-cost, "dial-up" methods of Internet connection may be effective for conducting interview assessments. Low-speed Internet connections also have been found to be adequate for observation of performance of daily living tasks (Shaw et al., 2001), overall assessment of sitting posture (Cooper et al., 2002), and collaboration regarding goal setting and intervention planning (Cooper et al., 2002). However, high-speed connections, specific assessment protocols, and clinicians experienced in the use of telerehabilitation technology are recommended for evaluations that require detailed observations of occupational performance or motor performance skills (Allegretti, Fitzgerald, Schmeler, Cooper, Boninger, & Shapcott, 2004; Shaw et al., 2001). Assessments conducted using telerehabilitation methods are often low-cost for clients, particularly when they eliminate long-distance travel. Massman, Dodge, Fortman, Schwartz, and Salem (1999) suggest that as remote sites become more familiar with preparing clients for teleconsultations, telerehabilitation will become more efficient and cost-effective for clinicians and consumers.

Multi-point Internet videoconferencing has been used by the Tel Ability Project (www.telability.org) in Chapel Hill, North Carolina, to provide evidence-based continuing education for physical and occupational therapy practitioners on topics such as constraint induced movement therapy, music therapy interventions, and the use of specific standardized assessment tools in telerehabilitation.

A study by Palsbo et al. determined the equivalence of mode of administration on assessment of physical function (2005) Subjects were simultaneously scored by both the in-person and videoconferenced physical therapist on two physical scales with visual measures and robust psychometric properties. Percentage agreement exceeded 90% for 6 items and within one scoring level for 90% of 13 items on the tests. Overall, the study demonstrated equivalence of videoconference assessment of physical function for post-stroke patients who can follow instructions (Palsbo S, Dawson S, Savard L, Goldstein A. Comparison of

fact-to-face and videoconference administration of the ESS and functional reach for post-stroke patients. *Telemed Journ and e-health*, Vol 11(2), p. 195).

7. PATIENT SATISFACTION WITH TELEHEALTH TELECOMMUNICATIONS SYSTEMS:

With respect to patient satisfaction, early results indicated that patients who received care via TeleHealth technologies were extremely satisfied with receiving health care services in this manner. Current patient satisfaction with services delivered by TeleHealth, regardless of the specialty, can be found in a large study conducted by the University of Arizona. The Arizona Telemedicine Program (ATP) is a large, multidisciplinary, university-based program that provides telemedicine services, distance learning, informatics training, and telemedicine technology assessment capabilities to communities throughout Arizona. The types of teleconsultation services available include real-time and store-forward consultations, continuing medical education, and patient information sessions. Since the inception of the ATP, there have been 97,722 telemedicine events. The most frequently used telemedicine service is teleradiology, comprising 85,728 teleconsults. Next in frequency are teledermatology and telepsychiatry consultations. Results of patient satisfaction surveys indicate high levels of patient satisfaction with both real-time and store-forward consultations. Three studies of the efficacy of telemedicine services are discussed. One study of the efficacy and diagnostic accuracy of utilizing telecolposcopy, revealed a positive predictive value of the telecolposcopic impression of between 81% and 82%, while the positive predictive value of an in-person impression was 80%. (Lopez, A.M., Avery, D., Krupinski, E., Lazarus, S., and Weinstein, R.S. 2005. Increasing access to care via tele-health: the Arizona experience. *Journal of Ambulatory Care Management*, Jan/Mar 28(1): 16-23). An early landmark study by Gustke et al., (Gustke, S.S., Balch, D.C., West, V.L., and Rogers, L.O. 2000. Patient satisfaction with telemedicine. *Telemedicine Journal* Spring 6(1): 5-13), patient satisfaction was examined in relation to patient age, gender, race, income, education, and insurance. Overall patient satisfaction was found to be 98.3%.

Degrees of satisfaction may vary slightly with the specialty accessed through TeleHealth, but overall satisfaction remains high. The source of satisfaction for most patients is the ability to see a specialist trained in the area most closely related to the patient's condition, the feeling of getting personalized care from a provider who has the patient's interest in mind, and the ability to communicate with the provider in a very personal and intimate manner over the telecommunications technologies. The current peer reviewed literature on patient satisfaction with accessing health care via telecommunications technologies including interactive video over high and low bandwidths, store-and-forward teleconsultations, remote monitoring, and telephone consultations, should undisputable evidence that patients are very satisfied with care provided via telecommunications technologies.

Additional references to patient satisfaction are listed below:

Janca, 2000. Telepsychiatry: an update on technology and its implications. *Curr Op in Psych* 13: 591-7.

In this study, results indicated that “most consumers found that a video link with a psychiatrist moderately or greatly helped them in managing their treatment, with 98% of the preferring to be offered videoconferencing in combination with local services.”

Brodey et al, 2000. Satisfaction of forensic psychiatry patients with remote telepsychiatric evaluation. *Psych Services*: Oct 51(10): 1305-7.

This study indicated that satisfaction did not differ significantly between video and in-person consultations for incarcerated patients.

Brown-Connolly N. 2002. Patient satisfaction with telemedicine access to specialty services in rural California. *Journ of Telemedicine and TeleCare* 8 (suppl 2): S2:7-10.

793 (61%) patients responded to a written survey measuring patient satisfaction. Results indicated that patients believed that telemedicine made it easier for patients to receive care (90%), general satisfaction with telemedicine (87%), were willing to continue with receiving services via telemedicine (90%), received the necessary information from specialists (85%), and [was as good as in-person care] (61%). Results indicate that “telemedicine is an acceptable to patients as a method of improving access to specialty expertise, and compares favourably with fact-to-face care.”

Allen A and Hayes J. 1995. Patient satisfaction with teleoncology: a pilot study. *Telemedicine Journ* Spring 1(1): 41-6.

A study to assess the satisfaction of rural cancer patients with interactive videoconferencing, results indicated that ...patient acceptance was high for cancer patients with limited access to cancer specialists.

Huston JI and Burton DC. 1997. Patient satisfaction with multispecialty interactive telecommunications. *Journ of Telemedicine and Telecare* 3(4): 205-8.

Results of a study on patient satisfaction using Kentucky TeleCare telemedicine network to access specialists indicate that of 96 patients surveyed, “the majority of patients were satisfied with the telemedicine encounter although a minority, 16%, would have preferred to have seen the specialist in person.”

DATE SUBMITTED: December 30, 2005

Submitter : Dr. Richard Ellenbogen
Organization : Congress of Neurological Surgeons
Category : Physician

Date: 12/30/2005

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-FC-53-Attach-1.DOC

December 30, 2005

Mark McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8017
Baltimore, Maryland 21244

Attention: CMS-1502-FC; Medicare Program: Revisions to the Payment Policies Under the Physician Fee Schedule for Calendar Year 2006

Dear Dr. McClellan:

On behalf of the American Association of Neurological Surgeons (AANS) and Congress of Neurological Surgeons (CNS), we appreciate the opportunity to comment on the above referenced final rule with comment published in the *Federal Register* on November 21, 2005.

In the Final Rule on Page 70281, CMS explains that a status indicator of "N" indicating a non-covered service would be assigned to five Intracranial Angioplasty and Stenting procedures, CPT codes 61630, 61635, 61640, 61641, and 61642, valued by the RUC in April 2005. We have several concerns about the "N" indicator for these procedures.

Background

In February 2005, the AANS and CNS joined several other societies in submitting a coding proposal for intracranial angioplasty and stenting procedures. The AMA CPT Editorial Panel recommended that the codes be separated into two families differentiated by balloon angioplasty and stenting for the treatment of intracranial atherosclerotic stenosis and balloon dilatation for the treatment of vasospasm. This separation was important because a national non-coverage policy existed for the balloon angioplasty and stenting procedures but not for the treatment of vasospasm.

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Intracranial angioplasty for vasospasm secondary to subarachnoid hemorrhage has been shown to be an effective treatment in symptomatic patients who are refractory to aggressive medical management. Data from California Blue Shield as well as a national review of medical practice indicate conclusively that access to endovascular therapy for vasospasm utilizing angioplasty improves patient outcomes.

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Recommendations for Comprehensive Stroke Centers: A Consensus Statement From the Brain Attack Coalition

Stroke. 2005 Jul;36(7):1597-616.

Vasospasm is a frequent and deadly complication of an SAH.¹⁰¹ Medical management such as hemodynamic therapy often fails to reverse the clinical effects of the vasospasm.^{102,103} Catheter-directed intracerebral IA infusion of vasodilators is an important therapeutic option used routinely in some cases of vasospasm with mixed results (grade IIIC).¹⁰⁴⁻¹⁰⁸ Intracranial angioplasty for vasospasm has a success rate of >90% in correcting the angiographically visible vasospasm, with clinical improvement in 60% to 80% of patients (grade IIIC)^{106,109,110} and a complication rate of 2% to 4%.¹¹¹ Although angioplasty for vasospasm has not been subjected to rigorous clinical study, it is considered very effective and is a standard therapy for severe vasospasm.¹¹⁰⁻¹¹² Because the other therapeutic options for symptomatic vasospasm are limited and often ineffective, the ability to perform intracranial angioplasty or IA infusions of vasodilators is recommended for a CSC. If a CSC is temporarily unable to offer this therapy, it is recommended that protocols be developed for the rapid transfer of patients needing these treatments to a nearby facility that does offer this therapy.

The procedures described in CPT Code 61640, *Balloon dilatation of intracranial vasospasm, percutaneous; initial vessel*, CPT Code 61641, *Balloon dilatation of intracranial vasospasm, percutaneous; each additional vessel in the same vascular family* and CPT Code 61642, *Balloon dilatation of intracranial vasospasm, percutaneous; each additional vessel indifferent vascular family* should not be considered part of the non-coverage decision for intracranial stenting. These procedures are utilized to treat an entirely different disease process than the codes for angioplasty and stenting to which the non-coverage decision pertains. We feel these procedures have been designated as non-covered in error and request that CMS change to status indicated to an "A" for covered, or at a minimum, to a "C" for carrier-priced.

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Medicare currently has a non-coverage policy for the angioplasty and stenting codes 61630 *Balloon angioplasty, intracranial (e.g., atherosclerotic stenosis), percutaneous* and 61635, *Transcatheter placement of intravascular stent(s), intracranial (e.g., atherosclerotic stenosis), including balloon angioplasty, if performed*. These codes describe interventions that are considered only for patients for whom all other options have been exhausted. Patients for whom these procedures are indicated have no other treatment options available to them and clinical trial data shows that these procedures have a very strong success rate. We believe that these procedures should be covered for those Medicare patients who are appropriate candidates. Again, we would like to see an "A" status or at least a "C," carrier-priced indication for these codes. At a minimum the RUC-approved values should be published.

Publication of RUC-approved RVUs

More generally, the AANS and CNS support the publication of RUC-approved values for all codes that Medicare does not cover and therefore has a coverage indicator of "N" listed in the Medicare Fee Schedule. The values approved by the RUC are not publicly available except upon publication by CMS as part of the Medicare Fee Schedule. As you know, many private payors, Medicaid, and workers compensation plans determine physician payment based on the Medicare RBRVS. We ask

that these values be published in any correction notice that CMS anticipates publishing for the 2006 Medicare Fee Schedule.

Conclusion

Thank you for your time and consideration in this matter. We would appreciate a review of the payment policy surrounding CPT Codes 61630, 61635, 61640, 61641, and 61642. We object to the inclusion of the codes for the treatment of vasospasm, CPT Codes 61640, 61641, and 61642, in the non-coverage decision for the intracranial stenting codes and ask that CMS change the payment indicator for these codes in the correction notice that it anticipates publishing for the 2006 Medicare Fee Schedule. In addition, we feel that the non-coverage decision for CPT Codes 61630 and 61635 should be revisited. Finally, we ask that CMS publish RUC-approved values for codes even in the case of codes for which it does not provide coverage.

Sincerely,

Fremont P. Wirth, MD, President
American Association of Neurological Surgeons

Richard G. Ellenbogen, MD, President
Congress of Neurological Surgeons

Washington Office Contact:

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Submitter : Dr. Nina Antoniotti
Organization : Marshfield Clinic TeleHealth Network
Category : Other Health Care Provider

Date: 12/30/2005

Issue Areas/Comments

GENERAL

GENERAL

This request for additions to the list of approved Medicare TeleHealth services is submitted according to the CMS published guide in the Federal Register Vol 67, No 251, Tuesday, Dec 31, 2003, s410.78(f), and on the CMS website www.cms.hhh.gov accessed 10/21/03.

Interim Relative Value Units

Interim Relative Value Units

none

CMS-1502-FC-54-Attach-1.DOC

**CENTERS FOR MEDICARE AND MEDICAID SERVICES
MEDICARE TELEHEALTH SERVICES
2005 REQUEST FOR ADDITION OF CPT CODES**

This request for additions to the list of approved Medicare TeleHealth services is submitted according to the CMS published guide in the Federal Register Vol 67, No 251, Tuesday, Dec 31, 2003, s410.78(f), and on the CMS website www.cms.hhh.gov accessed 10/21/03.

Marshfield Clinic's TeleHealth Network requests that the following CPT codes be added to the approved list of TeleHealth CPT codes for 2007. This request is being submitted prior to December 31, 2005, for consideration in the 2006 physician fee schedule process.

1. CONTACT INFORMATION:

Name: Nina M. Antoniotti, RN, MBA, Ph.D
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1000 North Oak Avenue
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Fax: 715-387-5733
Email: antoniotti.nina@marshfieldclinic.org

2. HCPCS(s) CODES FOR SERVICES PROPOSED FOR ADDITION:

The following codes are grouped together as a range due to the AMA CPT Code 2004 Manual grouping these codes as like codes with the differences being only the amount of time spent and the complexity of the decision-making by the physician.

Nursing Facility Care (SNF)

99304-99306 Initial Nursing Facility Care
99307-99310 Subsequent nursing facility care per day
99315-99316 Discharge Services
99318 Other Nursing Facility Services

3. MEDICAL PROFESSIONAL(S) PROVIDING THE SERVICE:

Medicare reimbursement-eligible providers including physicians, nurse practitioners, physician assistants, certified nurse anesthetists, and clinical psychologists (Fed Reg, Vol 63(211), p. 58886) and any other Medicare eligible practitioner or physician.

4. EXPLANATION OF WHY CURRENT APPROVED HCPCS CODES FOR TELEHEALTH CANNOT BE USED:

The current list of Evaluation and Management CPT codes that are approved for TeleHealth services are approved for office or other outpatient services, Emergency Services, or for Hospital Observation or Inpatient Services. These codes are used to report evaluation and management services provided in the

physician's office or in an outpatient or other ambulatory facility (AMA, CPT Code 2006, p. 9); to patients in an outpatient status in an emergency department (p. 17); to patients designated/admitted as observation status in a hospital (p. 10); or for patients admitted to an inpatient status (p.12). Initial nursing facility care and subsequent nursing facility care are separate codes 99304-6, 99307-10, 99315-16, and 99318 cannot be interchanged with other evaluation and management codes as they are restricted to the Medicare designation of skilled nursing facilities.

Nursing Facility Services use codes to report evaluation and management services to patients in Nursing Facilities (formerly called Skilled Nursing Facilities, Intermediate Care Facilities, or Long Term Care Facilities). The codes are also used to report evaluation and management services provided to a patients in a psychiatric residential treatment facility. A key determination in the use of an appropriate code is the site or place of service (AMA, CPT 2006, p. 23). Codes are not interchangeable when distinctive sites of service have been identified and coded by the AMA. The current list of approved codes for TeleHealth do not include codes used in the site of nursing facility and therefore are not interchangeable or applicable to services provided to residents in a nursing facility.

5. REASONS FOR ADDITION OF THE PROPOSED SERVICES:

As a HRSA grantee since 1997, Marshfield Clinic has implemented a telemedicine network that includes two nursing homes (skilled nursing facilities). The purpose of the telemedicine connections to our Internal Medicine Department geriatricians is to provide urgent consultations for changes in patient conditions that need to be reported to the primary care physician. In addition, the purpose of the program is to provide services through telemedicine on the days when no physicians are present in the nursing home. Physicians make mandatory Medicare rounds several days a month, but are not present everyday on the nursing home campus. The telemedicine linkage allows physicians to see patients on days that they cannot travel to the nursing home, on days they are not scheduled to be there, on days that family members are present but the physician is not, etc. When consultations are provided for a resident who has a sudden change in their condition, the potential to avoid transfer and the resulting transfer trauma increases significantly. Transfer costs for Medi-Vans and staff to care for the resident are avoided. The resultant transfer trauma, which staff indicate takes about three days for the resident to return to baseline cognitive and emotional stability, is also avoided. Currently, there are many nursing home telemedicine linkages in the United States, and none of them are in place to replace on-site care or act as a substitute for on-site care. The telemedicine linkages with skilled nursing facilities at Marshfield Clinic and across the nation are adjuncts to the on-site care, providing in many cases, 24 hour availability to primary care and specialty care, which would not be available without the use of telemedicine.

CMS has commissioned, conducted, and completed an extensive report on adding skilled nursing facilities (now called nursing facilities) to the list of originating sites for the purposes of reimbursement for services delivered to Medicare beneficiaries via TeleHealth technologies. In addition, CMS solicited and received many comments from the TeleHealth community regarding the addition of SNFs to the list of originating sites in the request for comments on the proposed Physician Fee Schedule and Request for Additional TeleHealth codes in August of 2005 (Fed Reg, Vol 70(151), p.). As CMS is moving forward with their recommendation, we would suggest that the codes for services are already justified in the report.

We would request that the codes for Skilled Nursing Facility services be approved at this time pending the decision by the Secretary to approve skilled nursing facilities as originating sites. Again, the argument exists that without the codes, the originating site designation is meaningless. As we are close to authorization of skilled nursing facilities as originating sites, the 2006 final physician fee schedule, including these codes as approved for TeleHealth services, would be timely for implementation in January of 2007.

6. DATA SHOWING THAT TELECOMMUNICATIONS TECHNOLOGIES DO NOT CHANGE THE DIAGNOSIS OR TREATMENT AS COMPARED TO IN-PERSON CARE:

Marshfield Clinic, being one of only a few organizations that have been billing Medicare for services provided via TeleHealth since 2001, was requested by the CMS contracted agencies, to participate in the data collection for the report. The report is currently under review at HHS with regards to adding skilled nursing facilities to the list of approved originating sites for TeleHealth reimbursement. Marshfield Clinic's TeleHealth Network submitted comments to the request by CMS in the August 8, 2005, Federal Register, regarding additional input into adding SNFs to the list of originating sites.

Since that time, two other important studies have been published with regards to the usefulness, value, cost-savings, and improvement in quality, of care for residents of nursing facilities when TeleHealth is available. In a study by Weiner et al., (2004), TeleHealth was implemented in a nursing home of a county-managed facilities through the use of a portable system, connecting to seven on-call physicians between the hours of 5:00pm and 1:00 am. A total of 461 video-eligible patients were evaluated, 361 who generated 1,399 calls from nursing staff to physicians after business hours. Physicians made 99 video consultations. Calls regarded questions about orders (25%), admission to the facility (14%), worrisome examination findings (11%) were handled over the telephone. Calls regarding lab values and questions about orders (8%), falls or injuries (11%), and pain or dyspnea (16%) resulted in video consultations. The study concluded that nighttime videoconferencing between nursing-home residents and physicians leads to easier medical decision-making when the alternative is no direct contact with residents. Video conferencing was useful in evaluating falls, injuries, pain, and

dyspnea. Physicians indicated that decision making was easier in 71% of the cases when video conferencing was used (Weiner M, Schadow G, Lindbergh D, Warvel J, Abernathy G, Perkins S, Daggy J, Dexter P, McDonald C. 2004. Impact of videoconferencing on nighttime on-call medical decision-making in the nursing home. *Journal of General Internal Medicine*, Vol 19, Supplement 1, p. 165)

In another study conducted by Laflamme et al., three clinicians conducted 69 videoconferences with 36 residents of a skilled nursing facility. Wound therapy accounted for 71% of the consultations. Clinicians generated orders in 30 percent of the encounters, with 75 percent of the orders being made only after a physical exam was performed over videoconferencing, indicating the clinician's reliance on the examination provided by video. Clinicians reported that, compared to no contact at all, videoconferencing facilitated their clinical assessments in 73% of the encounters (Laflamme M, Weiner M, Wilcox D, Sullivan J, Schadow G, Lindbergh D, Warvel J, Abernathy G, Perkins S, Daggy J, Dexter P, McDonald C. 2004. Usefulness of videoconferencing for medical decision in the nursing home, *Journal of General internal Medicine*, Vol 19, Supp 1, p. 233).

In another study by the same authors (Laflamme et al. 2004), participants in a nursing home were evaluated over videoconferencing and then immediately thereafter by the same clinician in-person. After both examinations, the clinicians rated the encounters and generated order necessary for the nursing home residents. Orders were categorized and counted according to timing. Clinician-patient interactions were assessed using coding videos with a 31 item instrument. Clinicians stated that in 71% of the encounters, videoconferencing facilitated their assessment. Videoconferencing was judged to be valuable, especially for wound care (Laflamme M, Wilcox D, Sullivan J, Schadow G, Gunther M, Lindbergh D, Warvel J, Buchanoan H, Ising T, Abernathy G, Perkins S, Daggy J, Frankel R, Dexter P, McDonald C, Weiner M. 2004. A pilot study of usefulness of clinician-patient videoconferencing for making routine medical decisions in the nursing home, *Journal of General internal Medicine*, Vol 19, Supp 1, p. 1380-1385).

We would respectfully refer CMS to the report for further scientific and case study data on diagnostic accuracy, treatment decision making, and patient/family satisfaction.

7. PATIENT SATISFACTION WITH TELEHEALTH TELECOMMUNICATIONS SYSTEMS:

Patient satisfaction with TeleHealth access to care and the use of telecommunications technologies to connect with specialists and other health care providers in order to meet unmet medical needs has always been very high. Degrees of satisfaction may vary slightly with the specialty accessed through TeleHealth, but overall satisfaction remains high. The source of satisfaction for most patients is the ability to see a specialist trained in the area most closely related to the patient's condition, the feeling of getting personalized care from a provider who has the patient's interest in mind, and the ability to communicate

with the provider in a very personal and intimate manner over the telecommunications technologies. The current peer reviewed literature on patient satisfaction with accessing health care via telecommunications technologies including interactive video over high and low bandwidths, store-and-forward teleconsultations, remote monitoring, and telephone consultations, should undisputable evidence that patients are very satisfied with care provided via telecommunications technologies. When patients would have preferred to see a health care provider in person, the services are typically not available locally. A few of the peer reviewed scientific studies are listed below:

Janca, 2000. Telepsychiatry: an update on technology and its implications. *Curr Op in Psych* 13: 591-7.

In this study, results indicated that "most consumers found that a video link with a psychiatrist moderately or greatly helped them in managing their treatment, with 98% of the preferring to be offered videoconferencing in combination with local services."

Brodey et al, 2000. Satisfaction of forensic psychiatry patients with remote telepsychiatric evaluation. *Psych Services: Oct* 51(10): 1305-7.

This study indicated that satisfaction did not differ significantly between video and in-person consultations for incarcerated patients.

Brown-Connolly N. 2002. Patient satisfaction with telemedicine access to specialty services in rural California. *Journ of Telemedicine and TeleCare* 8 (suppl 2): S2:7-10.

793 (61%) patients responded to a written survey measuring patient satisfaction. Results indicated that patients believed that telemedicine made it easier for patients to receive care (90%), general satisfaction with telemedicine (87%), were willing to continue with receiving services via telemedicine (90%), received the necessary information from specialists (85%), and [was as good as in-person care] (61%). Results indicate that "telemedicine is an acceptable to patients as a method of improving access to specialty expertise, and compares favourably with fact-to-face care."

Gustke, S.S., Balch, D.C., West, V.L., and Rogers, L.O. 2000. Patient satisfaction with telemedicine. *Telemedicine Journal Spring* 6(1): 5-13.

Patient satisfaction was examined in relation to patient age, gender, race, income, education, and insurance. Overall patient satisfaction was found to be 98.3%.

Allen A and Hayes J. 1995. patient satisfaction with teleoncology: a pilot study. *Telemedicine Journ* Spring 1(1): 41-6.

A study to assess the satisfaction of rural cancer patients with interactive videoconferencing, results indicated that ...patient acceptance was high for cancer patients with limited access to cancer specialists.

Huston JI and Burton DC. 1997. Patient satisfaction with multispecialty interactive telecommunications. *Journ of Telemedicine and Telecare* 3(4): 205-8. Results of a study on patient satisfaction using Kentucky TeleCare telemedicine network to access specialists indicate that of 96 patients surveyed, “ the majority of patients were satisfied with the telemedicine encounter although a minority, 16%, would have preferred to have seen the specialist in person.”

DATE SUBMITTED: December 30, 2005

Submitter : Mr. Jonathan Linkous
Organization : American Telemedicine Association
Category : Health Care Provider/Association

Date: 12/30/2005

Issue Areas/Comments

GENERAL

GENERAL

see attached file

CMS-1502-FC-55-Attach-1.DOC

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CPT CODE REQUESTS

The American Telemedicine Association requests that the following CPT codes be added to the approved list of telehealth related CPT codes for 2007. This request is being submitted prior to December 31, 2005, for consideration in the 2006 physician fee schedule process.

The requested codes are grouped together as a range following the AMA CPT Code 2004 Manual. These codes are grouped as like code, the differences being only for the amount of time spent and the complexity of the decision-making by the physician; for specialty testing that is similar in nature; and for other sequential codes representing specific services. We believe these CPT code services to be similar to an office visit and therefore are Category 1 requests.

1. Speech Pathology/Therapy

- 92506** Evaluation of speech, language, voice, communication, auditory processing disorder (includes aural rehabilitation); individual
- 92507** Treatment of speech, language, voice, communication, auditory processing disorder (includes aural rehabilitation); individual
- 92526** Treatment of swallowing dysfunction and/or oral function for feeding
- 92610** Evaluation of oral and pharyngeal swallowing function
- 92611** Motion fluoroscopy/swallowing function by cine or video recording
- 92607** Evaluation for prescription for speech-generating augmentation and alternative communication device, first hour
- 92608** Evaluation for prescription for speech-generating augmentation and alternative communication device, additional thirty minutes
- 92609** Therapeutic services for use of speech-generating device service including programming and modification
- 96105** Assessment of aphasia, with interpretation and report, per hour

MEDICAL PROFESSIONAL(S) PROVIDING THE SERVICE:

Medicare reimbursement-eligible providers include speech pathologists for in-person care. Although speech pathologists are not currently on the approved list of eligible providers for Medicare Telehealth reimbursement, we would encourage CMS to use the 2005 process of adding eligible providers. CMS added Medical Nutrition Therapists (MNT) to the list of eligible providers in the 2005 physician fee schedule in order to validate the use of the additional approved MNT codes (Fed Reg, Vol 70(218) p. 70156-

8). We would ask that CMS approve Speech Pathologists as eligible Telehealth providers for 2007 through the physician fee scheduling process.

EXPLANATION OF WHY CURRENT APPROVED HCPCS CODES FOR TELEHEALTH CANNOT BE USED:

Diagnostic or treatment procedures usually included in a comprehensive otorhinolaryngologic evaluation or office visits, are reported as an integrated medical service, using appropriate descriptors from the 99201 series. Itemization of component procedures (e.g., Otoscopy, rhinoscopy, tuning fork test) does not apply. Special otorhinolaryngologic services are those diagnostic and treatment services not usually included in a comprehensive otorhinolaryngologic evaluation or office visit. These services are reported separately, using codes 92505-92700 (AMA, *CPT 2006, Current Procedural Terminology*, AMA Press, p. 374). The current list of approved CPT codes for Telehealth does not include the appropriate codes and cannot substitute for the appropriate codes, as defined in the 2006 AMA CPT code manual.

REASONS FOR ADDITION OF THE PROPOSED SERVICES:

Telerehabilitation (telerehab) is the method of using technology to provide rehabilitation services at a distance. The concept of delivering remote speech-language pathology (SLP) services using telerehabilitation tools and techniques has been acknowledged for more than 25 years. As early as 1994, Medicare itself supported the use of Telehealth in providing speech language services through the Medicare home health initiative (Vladeck, B.C., and Miller, N.A. *Health Care Financing Review* 16(1): 7-16).

A recent report prepared by ASHA (2001, *Telepractices and ASHA: Report of the Telepractices Team* (December) reveals that the most common speech-language pathology treatment services delivered via telehealth are for aphasia, voice, cognitive-communication, articulation, and motor speech disorders. However, literally all types of speech-language pathology treatment have been provided via telehealth. In addition to treatment, telehealth permits patient/family follow-up and counseling without dependence on transportation.

As with most services delivered via Telehealth technologies, there is a critical shortage of speech-language professionals, both pathologists and therapists, in remote, rural, and disparate areas. Many large physician clinics of 500+ physicians have only four to five speech-language professionals available to provide services to large geographic areas.

DATA SHOWING THAT TELECOMMUNICATIONS TECHNOLOGIES DO NOT CHANGE THE DIAGNOSIS OR TREATMENT AS COMPARED TO IN-PERSON CARE:

Speech-language pathologists at the Mayo Clinic have diagnosed speech and language disorders via satellite since 1987. Between 1987 and 1994, Mayo Clinic speech-language pathologists conducted 150 speech-language pathology consultations for patients in Arizona and Florida. The purpose of the consultations was to diagnose and provide management recommendations for patients with speech, voice, or language problems. The study concluded "Telemedicine evaluations can be reliable, beneficial, and

acceptable to patients with a variety of acquired speech and language disorders, both in rural settings and within large multidisciplinary medical settings.” (Duffy, J.R., et al. (1997, December). Telemedicine and the diagnosis of speech and language disorders. *Mayo Clinic Proceedings*, 1116-1122).

At least one urban rehabilitation hospital has successfully implemented a program to provide follow-up services to patients who use augmentative and assistive communication (AAC) devices. The hospital has a telehealth grant from the federal government for providing services to people with spinal cord injuries. The development of AAC follow-up services became a 2-year subpart of the grant because:

- Limited AAC expertise was available in rural areas.
- Travel and fatigue were lessened for patients receiving AAC services.
- Consultation with speech-language pathologists with acknowledged AAC expertise was possible regardless of location.

Integris Health Services completed a telehealth service project that provided speech-language pathology services from April 1999 and March 31, 2002, through a HRSA funded grant. Integris rendered over 48,000 minutes of speech-language pathology treatment (1,300 interventions) compared to 22,000 minutes of physical therapy (430 interventions) and 1,200 minutes of occupational therapy (40 interventions). Integris administers the largest rehabilitation center in Oklahoma and has three rural satellite outpatient clinics, continuing to provide telerehab services, including speech pathology services.

The evaluation of swallowing disorders has been successfully demonstrated by the remote direction and interpretation of videofluoroscopic swallow studies, also known as modified barium swallow (MBS) assessments (Perlman, A. 2002. Real-time remote telefluoroscopic assessment of patients with dysphagia. *Dysphagia*, 162-167). The telehealth service is applicable to all ages irrespective of disease. Such instrumental assessments are often necessary to develop a treatment plan. In fact, many Medicare intermediaries require some type of instrumental assessment before dysphagia treatment. For each MBS procedure, a hospital radiology department only need switch on a personal computer. The speech-language pathologist's computer handles the interface from that point forward. The procedure is beneficial from a telehealth perspective for at least three reasons:

- It enables the speech-language pathologist most familiar with the patient to participate in the direction of the MBS. This is in contrast to the typical scenario of using the speech-language pathologist employed by the hospital outpatient department.
- The clinical value of the MBS is not compromised by an inordinately long ambulance trip that is fatiguing and distracting to the patient.
- The technology used for telepractice MBS is also applicable to the Fiberoptic Endoscopic Evaluation of Swallowing (FEES) as well as other imaging procedures.

The MBS telehealth development has been funded by a grant from the National Center for Supercomputing Applications (University of Illinois at Urbana-Champaign). The principal investigator believes that this telepractice technique will be a cost-saving and appropriate service to beneficiaries when Medicare initiates coverage.

Brennan et al. (2004) conducted a study designed to measure performance by brain-injured subjects, with medical diagnoses of stroke or traumatic brain injury, on a standardized Speech-Language Pathology evaluation conducted in both face-to-face and videoconference-based telerehabilitation settings. The Story Retelling Procedure (SRP), which measures connected language production and comprehension of spoken narratives, was administered to each subject in both settings. The primary objectives of this study were to: (1) compare communication as measured by the SRP between experimental settings, and (2) determine if subject variables (such as age, education, technology experience or gender) had an effect on performance differences between settings. The rationale was that any difference in this aspect of performance must be identified and characterized before this mode of intervention can be used clinically. Across all subjects ($n = 40$), no significant difference ($p < 0.05$) was found between SRP performance measured in the two settings. Additionally, variables including age, education, technology experience, and gender did not significantly affect the difference between performance in the two settings (Brennan, D.M., Georgeadis, A.C., Baron, C.R., and Barker, L.M., 2004. *The effect of videoconferencing-based telerehabilitation on story retelling performance by brain-injured subjects and its implications for remote speech-language therapy* Telemedicine Journal and e-Health Summer 10(2): 147-54).

The purpose of a study by Georgeadis et al. (2004) was to measure performance of adults with acquired brain injury on a standardised SLP assessment conducted in both face-to-face (FF) and videoconference-based telerehab (T) settings. The objective was to determine if performance on the assessment, or subjective feedback from the participants, differed between settings. Forty participants with a recent onset of brain injury -- 12 with traumatic brain injury (TBI), 14 with a left cerebrovascular accident (LCVA), and 14 with a right cerebrovascular accident (RCVA) -- were enrolled in the study. Participants were asked to retell stories from the Story Retell Procedure (Doyle, McNeil, Spencer, Goda, Cotrell, & Lustig, 1998) in both FF and T settings. Responses from the stories were scored by the clinician using the percent information unit scoring metric (McNeil, Doyle, Fossett, Park, & Goda, 2001). Additionally, a survey tool was used to probe each participant's level of satisfaction and willingness to use telerehab services in the future. Across all participants, and within the TBI, LCVA and RCVA groups, no significant difference in performance between the FF and T settings was found. Feedback from survey data demonstrated a high level of acceptance of the T setting. Story-retelling performance by brain-injured adults was not affected by setting. Additionally, participants expressed a high level of interest in using videoconferencing in the future. These findings offer additional support for telerehab as a viable alternative mode of SLP treatment for survivors of stroke and TBI (Georgeadis, A.C., Brennan, D.M., Barker, L.M., and Baron, C.R. 2004. *Telerehabilitation and its effect on story retelling by adults with neurogenic communication disorders.* *Aphasiology* May-Jul 18(5-7): 639-52).

The Institute for Stuttering Treatment and Research at the University of Alberta has used videoconferencing to provide follow-up support to geographically remote adults who have undergone intensive treatment on site. The potential value of telecommunications systems in treating communication disorders is being increasingly recognized. This mode of service delivery shows particular promise in giving patients access to specialist services for problems like stuttering, which are difficult to manage and often require long-term follow-up support (Kully, D. 2000. Telehealth in speech pathology: Applications to the treatment of stuttering. *Journal of Telemedicine and Telecare* 6(Suppl 2): S2:39-41). In another evaluative study regarding dysfluency, Sicotte et al. assessed the feasibility and outcome of delivering speech-language services from a distance to children and adolescents who stutter. All six patients who formed the first cohort seen in the telespeech program were included in the study. The results demonstrated that interactive videoconferencing can provide a feasible and effective care delivery model. Patient attendance was maintained throughout the intervention. All participants showed improved fluency. Stuttering ranged from 13% to 36% before treatment and 2% to 26% after treatment. All participants maintained at least part of their improved fluency during the six-month follow-up, when stuttering ranged from 4% to 32%. The study demonstrates that full assessment and treatment of stuttering in children and adolescents can be accomplished successfully via telemedicine (Sicotte, C., Lehoux, P., Fortier-Blanc, J., and Leblanc, Y. 2003. Feasibility and outcome evaluation of a telemedicine application in speech: language pathology. *Journal of Telemedicine and Telecare* 9(5): 253-8).

Rose et al. (2000) implemented a project between BT and Adastral Park to provide specialist speech and language therapy for pre-school age children. The TeachSpeech project successfully demonstrated that modern videoconferencing technology can be used to support the delivery of speech and language therapy services into schools (Rose E., Furner S., Hall A., Montgomery K., Katsavras E. and Clarke P. 2000. Videoconferencing for speech and language therapy in schools. *BT Technol J*, Vol 18, No 1, p 1001-4).

PATIENT SATISFACTION WITH TELEHEALTH TELECOMMUNICATIONS SYSTEMS:

Brennan et al.'s earlier quoted study (2004) indicated that "overall, subjects reported a high level of acceptance of videoconferencing with 34 subjects responding "yes," 4 responding "no," and 2 responding "maybe" when asked if they would use videoconferencing again to talk to a clinician. Results of this study confirm the potential for SLP treatment using videoconferencing and indicate a need for continued research in the field."

The study by Georgeadis et al. (2004) as quoted above, also indicates a high level of patient acceptance of and willingness to use videoconferencing in the future.

With respect to patient satisfaction, early results indicated that patients who received care via Telehealth technologies were extremely satisfied with receiving health care services in this manner. Current patient satisfaction with services delivered by Telehealth, regardless of the specialty, can be found in a large study conducted by the University of Arizona. The Arizona Telemedicine Program (ATP) is a large, multidisciplinary,

university-based program that provides telemedicine services, distance learning, informatics training, and telemedicine technology assessment capabilities to communities throughout Arizona. The types of teleconsultation services available include real-time and store-forward consultations, continuing medical education, and patient information sessions. Since the inception of the ATP, there have been 97,722 telemedicine events. The most frequently used telemedicine service is teleradiology, comprising 85,728 teleconsults. Next in frequency are teledermatology and telepsychiatry consultations. Results of patient satisfaction surveys indicate high levels of patient satisfaction with both real-time and store-forward consultations. Three studies of the efficacy of telemedicine services are discussed. One study of the efficacy and diagnostic accuracy of utilizing telecolposcopy, revealed a positive predictive value of the telecolposcopic impression of between 81% and 82%, while the positive predictive value of an in-person impression was 80%. (Lopez, A.M., Avery, D., Krupinski, E., Lazarus, S., and Weinstein, R.S. 2005. Increasing access to care via tele-health: the Arizona experience. *Journal of Ambulatory Care Management*, Jan/Mar 28(1): 16-23). In an early landmark study by Gustke et al., (Gustke, S.S., Balch, D.C., West, V.L., and Rogers, L.O. 2000. Patient satisfaction with telemedicine. *Telemedicine Journal* Spring 6(1): 5-13), patient satisfaction was examined in relation to patient age, gender, race, income, education, and insurance. Overall, patient satisfaction was 98.3%.

Degrees of satisfaction may vary slightly with the specialty accessed through Telehealth, but overall satisfaction remains high. The source of satisfaction for most patients is the ability to see a specialist trained in the area most closely related to the patient's condition, the feeling of getting personalized care from a provider who has the patient's interest in mind, and the ability to communicate with the provider in a very personal and intimate manner over the telecommunications technologies. The current peer reviewed literature on patient satisfaction with accessing health care via telecommunications technologies including interactive video over high and low bandwidths, store-and-forward teleconsultations, remote monitoring, and telephone consultations, should provide undisputable evidence that patients are very satisfied with care provided via telecommunications technologies.

2. Physical Therapy

97001-97006 Evaluation – therapy and training

97010-97028 Supervision not requiring direct contact

97110 Therapeutic procedure, one or more areas, each 15 minutes

97112 Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities

97530 Therapeutic activities to improve functional performance, each 15 minutes

97532 Development of cognitive skills to improve attention, memory, problem solving, each 15 minutes

MEDICAL PROFESSIONAL(S) PROVIDING THE SERVICE:

Medicare reimbursement-eligible providers including licensed physical therapists and other physical therapy professionals. Although physical therapists are not currently on the approved list of eligible providers for Medicare Telehealth reimbursement, we would

encourage CMS to add Physical therapists to the list of approved eligible providers. A precedent for this action was set in 2004 when Medical Nutrition Therapists (MNT) was added to the list of eligible providers in 2005, through the physician fee scheduling process (Fed Reg, Vol 70(218) p. 70156-8).

EXPLANATION OF WHY CURRENT APPROVED HCPCS CODES FOR TELEHEALTH CANNOT BE USED:

Physical Medicine and Rehabilitation codes 97001-97755 are used to report each distinct procedure performed and do not use modifier 51. According to the CPT 2006 AMA manual, none of the currently approved Telehealth CPT codes can be used in place of 97001-97006, 977010-97028, 97110, 97530, or 97532. In addition, Therapeutic Procedures 97110-97546, represent services that comprise a manner of effecting change through the application of clinical skills and/or services that attempt to improve function (CPT 2006, p. 403). None of the currently approved Telehealth codes includes the activities described and represented by the codes listed above.

REASONS FOR ADDITION OF THE PROPOSED SERVICES:

The 2000 Census indicated that approximately 37 percent of the population over the age of 65 has a sensory, physical, mental, or self-care disability, with approximately 16 percent having a physical disability (www.census.gov/population/www/cen2000, accessed December 29, 2005). Falls are a significant risk factor in persons over the age of 65 who have declining mobility and proprioception. Traumatic brain injury (TBI) patients have extensive rehabilitation and recovery periods and require intensive physical therapy assessments and therapies in order to restore function. Stroke survivors, a group that consumes a significant portion of the SSI and Medicare expenditures each year, also require assessment, evaluation, and supportive services by physical therapists. Although there is not a shortage of physical therapists in practice today, like many health professionals, physical therapists often are not found in remote, rural, or disparate areas. Services are typically found in larger urban areas, and near secondary and tertiary care facilities. Expanding the codes to include physical therapy codes would allow Medicare beneficiaries to stabilize and improve their physical condition post medical/surgical emergency or as a result of the aging process.

DATA SHOWING THAT TELECOMMUNICATIONS TECHNOLOGIES DO NOT CHANGE THE DIAGNOSIS OR TREATMENT AS COMPARED TO IN-PERSON CARE:

Cooper, Fitzgerald, Boninger, Cooper, Shapcott, Cohen et al. (2002) and Shaw, Dreyer, and Wittman (2001) found that low-cost, "dial-up" methods of Internet connection may be effective for conducting interview assessments. Low-speed Internet connections also have been found to be adequate for observation of performance of daily living tasks (Shaw et al., 2001), overall assessment of sitting posture (Cooper et al., 2002), and collaboration regarding goal-setting and intervention planning (Cooper et al., 2002). However, high-speed connections, specific assessment protocols, and clinicians experienced in the use of telerehabilitation technology are recommended for evaluations that require detailed observations of occupational performance or motor performance skills (Allegretti, Fitzgerald, Schmeler, Cooper, Boninger, & Shapcott, 2004; Shaw et al.,

2001). Assessments conducted using telerehabilitation methods are often low-cost for clients, particularly when they eliminate long-distance travel. Massman, Dodge, Fortman, Schwartz, and Salem (1999) suggest that as remote sites become more familiar with preparing clients for teleconsultations, telerehabilitation will become more efficient and cost-effective for clinicians and consumers.

Multi-point Internet videoconferencing has been used by the Tel Ability Project (www.telability.org) in Chapel Hill, North Carolina, to provide evidence-based continuing education for physical and occupational therapy practitioners on topics such as constraint induced movement therapy, music therapy interventions, and the use of specific standardized assessment tools in telerehabilitation.

A study by Palsbo et al. determined the equivalence of mode of administration on assessment of physical function (2005). Subjects were simultaneously scored by both the in-person and videoconferenced physical therapist on two physical scales with visual measures and robust psychometric properties. Percentage agreement exceeded 90% for 6 items and within one scoring level for 90% of 13 items on the tests. Overall, the study demonstrated equivalence of videoconference assessment of physical function for post-stroke patients who can follow instructions (Palsbo S., Dawson S., Savard L., Goldstein A. Comparison of fact-to-face and videoconference administration of the ESS and functional reach for post-stroke patients. *Telemed Journ and e-health*, Vol 11(2), p. 195).

PATIENT SATISFACTION WITH TELEHEALTH TELECOMMUNICATIONS SYSTEMS:

With respect to patient satisfaction, early results indicated that patients who received care via Telehealth technologies were extremely satisfied with receiving health care services in this manner. Current patient satisfaction with services delivered by Telehealth, regardless of the specialty, can be found in a large study conducted by the University of Arizona. The Arizona Telemedicine Program (ATP) is a large, multidisciplinary, university-based program that provides telemedicine services, distance learning, informatics training, and telemedicine technology assessment capabilities to communities throughout Arizona. The types of teleconsultation services available include real-time and store-forward consultations, continuing medical education, and patient information sessions. Since the inception of the ATP, there have been 97,722 telemedicine events. The most frequently used telemedicine service is teleradiology, comprising 85,728 teleconsults. Next in frequency are teledermatology and telepsychiatry consultations. Results of patient satisfaction surveys indicate high levels of patient satisfaction with both real-time and store-forward consultations. Three studies of the efficacy of telemedicine services are discussed. One study of the efficacy and diagnostic accuracy of utilizing telecolposcopy revealed a positive predictive value of the telecolposcopic impression of between 81% and 82%, while the positive predictive value of an in-person impression was 80% (Lopez, A.M., Avery, D., Krupinski, E., Lazarus, S., and Weinstein, R.S. 2005. Increasing access to care via tele-health: the Arizona experience. *Journal of Ambulatory Care Management*, Jan/Mar 28(1): 16-23). In an early landmark study by Gustke et al. (Gustke, S.S., Balch, D.C., West, V.L., and Rogers, L.O. 2000. Patient satisfaction with telemedicine. *Telemedicine Journal Spring* 6(1): 5-13), patient

satisfaction was examined in relation to patient age, gender, race, income, education, and insurance. Overall, patient satisfaction was 98.3%.

Degrees of satisfaction may vary slightly with the specialty accessed through Telehealth, but overall satisfaction remains high. The source of satisfaction for most patients is the ability to see a specialist trained in the area most closely related to the patient's condition, the feeling of getting personalized care from a provider who has the patient's interest in mind, and the ability to communicate with the provider in a very personal and intimate manner over the telecommunications technologies. The current peer reviewed literature on patient satisfaction with accessing health care via telecommunications technologies including interactive video over high and low bandwidths, store-and-forward teleconsultations, remote monitoring, and telephone consultations, should undisputable evidence that patients are very satisfied with care provided via telecommunications technologies.

3. Nursing Facility Care (SNF)

- 99304-99306** Initial Nursing Facility Care
- 99307-99310** Subsequent nursing facility care per day
- 99315-99316** Discharge Services
- 99318** Other Nursing Facility Services

MEDICAL PROFESSIONAL(S) PROVIDING THE SERVICE:

Medicare reimbursement-eligible providers including physicians, nurse practitioners, physician assistants, certified nurse anesthetists, and clinical psychologists (Fed Reg, Vol 63(211), p. 58886), and any other Medicare eligible practitioner or physician.

EXPLANATION OF WHY CURRENT APPROVED HCPCS CODES FOR TELEHEALTH CANNOT BE USED:

Nursing Facility Services use codes to report evaluation and management services to patients in Nursing Facilities (formerly called Skilled Nursing Facilities, Intermediate Care Facilities, or Long Term Care Facilities). The codes are also used to report evaluation and management services provided to a patients in a psychiatric residential treatment facility. A key determination in the use of an appropriate code is the site or place of service (AMA, CPT 2006, p. 23). Codes are not interchangeable when distinctive sites of service have been identified and coded by the AMA. The current list of approved codes for Telehealth do not include codes used in the site of nursing facility and therefore are not interchangeable or applicable to services provided to residents in a nursing facility.

REASONS FOR ADDITION OF THE PROPOSED SERVICES:

CMS has commissioned, conducted, and completed an extensive report on adding skilled nursing facilities (now called nursing facilities) to the list of originating sites for the purposes of reimbursement for services delivered to Medicare beneficiaries via Telehealth technologies. In addition, CMS solicited and received many comments from the Telehealth community regarding the addition of SNFs to the list of originating sites in the request for comments on the proposed Physician Fee Schedule and Request for

Additional Telehealth Codes in August of 2005 (Fed Reg, Vol 70(151), p. 45788). As CMS is moving forward with their recommendation, we would request that the codes for services already justified would be added to the list of approved codes for Telehealth. Again, as stated in previous years, the approval of an originating site is moot unless the specific AMA CPT codes for that specific site are also approved.

DATA SHOWING THAT TELECOMMUNICATIONS TECHNOLOGIES DO NOT CHANGE THE DIAGNOSIS OR TREATMENT AS COMPARED TO IN-PERSON CARE:

ATA has participated in the data collection and consideration of the report currently under review at HHS with regards to adding skilled nursing facilities to the list of approved originating sites for Telehealth reimbursement. ATA has also submitted comments to the request by CMS in the August 8, 2005, Federal Register, regarding additional input into adding SNFs to the list of originating sites.

Since that time, two other important studies have been published with regards to the usefulness, value, cost-savings, and improvement in quality of care for residents of nursing facilities when Telehealth is available. In a study by Weiner et al. (2004), Telehealth was implemented in a nursing home of a county-managed facilities using a portable system, connecting to seven on-call physicians between the hours of 5:00pm and 1:00 am. A total of 461 video-eligible patients were evaluated, 361 who generated 1,399 calls from nursing staff to physicians after business hours. Physicians made 99 video consultations. Calls regarded questions about orders (25%), admission to the facility (14%), worrisome examination findings (11%) were handled over the telephone. Calls regarding lab values and questions about orders (8%), falls or injuries (11%), and pain or dyspnea (16%) resulted in video consultations. The study concluded that nighttime videoconferencing between nursing home residents and physicians leads to easier medical decision-making when the alternative is no direct contact with residents. Video conferencing was useful in evaluating falls, injuries, pain, and dyspnea. Physicians indicated that decision making was easier in 71% of the cases when video conferencing was used (Weiner M., Schadow G., Lindbergh D., Warvel J., Abernathy G., Perkins S., Daggy J., Dexter P., McDonald C. 2004. Impact of videoconferencing on nighttime on-call medical decision-making in the nursing home. *Journ of General Internal Medicine*, Vol 19, Supplement 1, p. 165).

In another study conducted by Laflamme et al., three clinicians conducted 69 videoconferences with 36 residents of a skilled nursing facility. Wound therapy accounted for 71% of the consultations. Clinicians generated orders in 30 percent of the encounters; with 75 percent of the orders being made only after a physical exam was performed over videoconferencing, indicating the clinician's reliance on the examination provided by video. Clinicians reported that, compared to no contact at all, videoconferencing facilitated their clinical assessments in 73% of the encounters (Laflamme M., Weiner M., Wilcox D., Sullivan J., Schadow G., Lindbergh D., Warvel J., Abernathy G., Perkins S., Daggy J., Dexter P., McDonald C. 2004. Usefulness of videoconferencing for medical decision in the nursing home, *Journal of General internal Medicine*, Vol 19, Supp 1, p. 233).

In another study by the same authors (Laflemme et al. 2004), participants in a nursing home were evaluated over videoconferencing and then immediately thereafter by the same clinician in-person. After both examinations, the clinicians rated the encounters and generated order necessary for the nursing home residents. Orders were categorized and counted according to timing. Clinician-patient interactions were assessed using coding videos with a 31-item instrument. Clinicians stated that in 71% of the encounters, videoconferencing facilitated their assessment. Videoconferencing was judged to be valuable, especially for wound care (Laflamme M., Wilcox D., Sullivan J., Schadow G., Gunther M. Lindbergh D., Warvel J., Buchanoan H., Ising T., Abernathy G., Perkins S., Daggy J., Frankel R., Dexter P., McDonald C., Weiner M. 2004. A pilot study of usefulness of clinician-patient videoconferencing for making routine medical decisions in the nursing home, *Journal of General internal Medicine*, Vol 19, Supp 1, p. 1380-1385).

4. Audiology

- 92541 Spontaneous nystagmus, including gaze and fixation nystagmus, with recording
- 92542 Positional nystagmus test, minimum of 4 positions, with recording
- 92543 Caloric vestibular test, each irrigation, with recording
- 92544 Optokinetic nystagmus test, bidirectional, foveal, or peripheral stimulation, with recording
- 92545 Oscillating tracking test, with recording
- 92546 Sinusoidal vertical axis rotational test
- 92547 Use of vertical electrodes
- 92548 Computerized dynamic posturography
- 92551 Screening test, pure tone, air only
- 92552 Pure tone audiometry, air only
- 92553 Pure tone audiometry, air & bone
- 92555 Speech audiometry threshold
- 92556 Speech audiometry threshold, with speech recognition
- 92557 Comprehensive audiometry threshold evaluation and speech recognition
- 92560 Bekesy audiometry, screening
- 92561 Bekesy audiometry, diagnosis
- 92562 Loudness balance test, alternate binaural or monaural
- 92563 Tone decay test
- 92564 Short Incremental Sensitivity test
- 92567 Tympanometry
- 92568 Acoustic reflex test
- 92569 Acoustic reflex test, threshold
- 92571 Filtered speech test
- 92572 Staggered spondaic word test
- 92575 Sensorineural acuity level test
- 92576 Synthetic sentence identification test
- 92577 Stenger test, speech
- 92579 Visual reinforcement audiometry

- 92582 Conditioning play audiometry
- 92583 Select picture audiometry
- 92584 Electrocochleography
- 92625 Assessment of tinnitus
- 92626 Eval of auditory rehabilitation status, first hour
- 92627 Eval of auditory rehabilitation status, each additional 15 minutes
- 92630 Auditory rehab, pre-lingual hearing loss
- 92633 Auditory rehab, post-lingual hearing loss

MEDICAL PROFESSIONAL(S) PROVIDING THE SERVICE:

Medicare reimbursement-eligible providers including licensed audiologists and any other audiology professional. We would again request that CMS add audiologists to the approved list of eligible Telehealth providers through the physician fee schedule in 2006.

EXPLANATION OF WHY CURRENT APPROVED HCPCS CODES FOR TELEHEALTH CANNOT BE USED:

Diagnostic or treatment procedures usually included in a comprehensive otorhinolaryngologic evaluation or office visits, are reported as an integrated medical service, using appropriate descriptors from the 99201 series. Itemization of component procedures (e.g., Otoscopy, rhinoscopy, tuning fork test) does not apply. Special otorhinolaryngologic services are those diagnostic and treatment services not usually included in a comprehensive otorhinolaryngologic evaluation or office visit. These services are reported separately, using codes 92505-92700 (AMA, *CPT 2006, Current Procedural Terminology*, AMA Press, p. 374). In addition, Therapeutic Procedures 97110-97546, represent services that comprise a manner of effecting change through the application of clinical skills and/or services that attempt to improve function (CPT 2006, p. 403).

In addition, the audiometric tests listed imply the use of calibrated electronic equipment. Other hearing tests (such as whispered voice, tuning fork) are considered part of the general otorhinolaryngologic services and are not reported separately. All services include testing of both ears, and apply to testing of individuals (CPT 2006, p. 375). The current list of approved CPT codes for Telehealth do not include the appropriate codes and cannot substitute for the appropriate codes, as defined in the 2006 AMA CPT code manual.

REASONS FOR ADDITION OF THE PROPOSED SERVICES: A 2002 survey conducted by ASHA revealed that the most common audiology services delivered via telehealth were for hearing aid/assistive technology, hearing disorders, and aural rehabilitation. The use of telepractice is a viable way to provide audiology services to rural and underserved areas, and permits the provider to spend more time on rendering services rather than driving from one location to another. In addition, telehealth permits treatment, follow-up and/or counseling without a patient's dependence on family and friends for transportation. Anecdotal information indicates that patients are more willing to continue treatment when they can access the services without relying on family and friends for transportation.

As grant funds and third party payment for audiology telehealth expands, equipment that allows easy adaptation for telehealth purposes become more readily available. Currently, the hardware and software requires considerable alteration and redesign for telehealth tasks. Nevertheless, the following telehealth services by audiologists have been reported: (1) intra-operative monitoring, (2) audiologic diagnostics, (3) fitting of digital hearing aids, (4) aural rehabilitation, and (5) balance (vestibular) testing. A joint effort in Hawaii involving an Army medical center, university school of medicine, and an audiovestibular private practice has been successful in training nurse practitioners over the Internet so they can assist audiologists in remote testing. A university medical center in North Carolina, driven by the needs of an isolated rural population, has developed an Internet-based hearing assessment that accesses an audiometer via an Internet protocol network. The pilot data have been excellent (www.telemed.ecu.edu/2001/telehearing/goals.htm).

DATA SHOWING THAT TELECOMMUNICATIONS TECHNOLOGIES DO NOT CHANGE THE DIAGNOSIS OR TREATMENT AS COMPARED TO IN-PERSON CARE:

EARS, a remote audiology testing service provided via Telehealth technologies, is supported by DHHS Grant No. 2 D36 AH11000. Two rural communities in Washington County, Maine are linked with the Conley Speech and Hearing Center at the University of Maine. All audiologic test data including voice interaction with the patient are transmitted to the speech and hearing center. Results of this pilot project indicate remote hearing evaluations can be conducted with computer technology. (Sechrest, A., Peacock M., & Yonovitz, A. Remote Hearing Diagnosis: Evaluation and Assessment in Remote Settings [EARS]).

In the audiology technician telehealth model, hearing testing is performed under the direction of an audiologist who supervises the technician and observes client/patient responses using interactive video (Audiology technician certified by the state of California). Marincovich successfully practiced audiology using this approach for two years in northern California, in one rural community (Krumm, M., Marincovich, P., Hogarth, B., Martin, L., & Windsor, T. 2001. Providing audiological services through a telemedicine medium. Paper presented at the meeting of the American Academy of Audiology, San Diego, CA).

In a study conducted by Krumm et al., preliminary data analysis shows that little difference exists between face-to-face testing and the screening results obtained via telepractice. Dr. Greg Givens developed technology that permits conventional Audiology equipment (with digital readouts) to be interfaced to a network for remote computing applications (Krumm, M., Lancaster, P. & Ribera, J. East Carolina University, 2003)

Givens and his colleagues (2003) used a tele-audiometric system developed for the application of realtime diagnostic audiometry via the Internet. A pilot study evaluated 31 adult participants in a double-blind study of two different systems (i.e., conventional versus Internet-based) for assessing auditory thresholds. The threshold data show

substantial agreement between the two systems. Mean thresholds varied by no more than 1.3 dB, well within established variability of audiometric testing. The pilot study demonstrated the feasibility of real-time Internet-based assessment of hearing. The system allows for remote assessment of hearing without an audiologist on site (Givens G., Blanarovich A., Murphy T., Simmons S., Blach D., Elangovan S. 2003. Internet based tele-audiometry system for the assessment of hearing: a pilot study. *Telemedicine Journal and e-health*, Winter Vol 9(4), p. 375-8).

The following are examples of audiology telehealth programs and their outcomes.

- In Hawaii, a university school of medicine and an audiovestibular private practice have been successful in training nurse practitioners over the internet so they can assist audiologists testing consumers at a remote site (e.g., audiometry, tympanometry, electronystagmography).
- The Mayo Clinic completed a project in the late 1990's in which hearing aids were programmed successfully on adults at remote sites using internet-based software. In this circumstance, a technician was used to assist the consumer at the remote location while the audiology services originated from the Mayo Clinic.
- A HRSA (OAT) grant supported a project at Santa Rosa California providing virtually all audiology services using a traditional telehealth model. In this project, the audiologist supervised a technician at a remote site who conducted hearing evaluations and hearing aid fittings. In addition to directing these services, the audiologist also provided consumer counseling and aural rehabilitation.

PATIENT SATISFACTION WITH TELEHEALTH TELECOMMUNICATIONS SYSTEMS:

- At the Utah State University, newborn hearing screening is performed using remote control telepractice technology. This technology involves the use of otoacoustic emissions and auditory brainstem response (ABR) measurements. The preliminary results of this project indicate that the services using this technology are efficacious.
- In a recent study, otoacoustic emission recordings were made on subjects approximately 500 miles away from the researcher. The results of the study indicated that similar otoacoustic emission recordings were obtained whether using face to face or via telepractice.
- In a study by Towers, et al., they reported reliability of auditory brainstem response testing using telehealth technology via Internet over 500 miles from the testing center. Results indicated that there were essentially no differences in recordings when face-to-face conditions were compared to telepractice assessments.

Submitter : Mr. William Tierney
Organization : William E Tiereny, CPA
Category : Rural Health Clinic

Date: 01/03/2006

Issue Areas/Comments

GENERAL

GENERAL

See attachments (2) excel file and word document displaying comments and e-mails. I was unable to attach the excel file

Interim Relative Value Units

Interim Relative Value Units

11/22/2005 Federal register MEI % change for CY 2006 is not computed correctly and is not considering annual retroactive changes.

CMS-1502-FC-56-Attach-1.DOC

Federal Register 11/22/2005 Various Paragraphs MEI % Change for .CY 2006

MEI is used 33 times in the 11/20/2005 Federal Register
Page 152 70266 II K For Therapy Cap increase
Page 185 70299 VI B For Physician Fee Update
Page 187 70301 VI C Update Adjustment Ffactor
Page 191 70305 VI C Physician Services Comments about 3.5% MEI

The MEI % change is used for all FQHCs & RHCs as a annual increase to their Medicare and Medicaid (in majority of states) programs.

The CY 2006 2.8% is not correct and should take into consideration the retroactive changes to the MEI indexes in prior and penultimate (2nd prior period) periods. I believe the CY 2006 MEI % change is 3.4%. The other solution is the CY 2004 MEI% change is adjusted to 3.2% from 2.9%, that means a 0.30% retroactive adjustment going two years back. The retroactive/update adjustments are the main concerns and are not included in the current periods MEI % change.

I have been complaining about the MEI computation for sometime but it was not until earlier this year that I understood the current and retroactive computation that takes place. I also found a instructional computation that was incorrect on the CMS website that was immediately corrected. This year, I performed a simple mathematical check on this years MEI % change, by freezing last years MEI 2004 indexes as a denominator. The computation divides the average MEI 2005 index over the average MEI 2004 index. This results in complete MEI % change from one year to another. Please refer to the excel file comparing both methods and a comparison back to the MEI 2001.

Please take a look at my correspondence with BLS official and the very low retroactive CPI changes (twice in 35 years and it is a monthly index).

Please get back to me.

I have already forwarded these e-mails to David Worgo from CMS .

Bill Tierney, CPA
609-263-8052

Below are E-mail correspondence with the CMS Actuary Office during December 2005. Also, I attached the Excel file comparing MEI 2004 and MEI 2005 indexes used to compute the MEI % change in the November 22, 2005 Federal Register.

Steve

CY 2006 MEI % is change more like 3.4% than 2.8%

Steve, I enclosed an MEI excel file where I simply froze last years MEI indexes (2nd QTR 2004 historical data). When I do that, the CY 2006 MEI % change is 3.4% or 0.6% points higher than the published 2.8% CY 2006 change. Please review my analysis including the under and over %s. I can see that the two past years (CY 2005 and CY 2004) are being adjusted but we are still off by 0.3% over the last three years. Please get back to me or Mr. Roger Schwartz before CMS Medicare publishes the CY 2006 FQHC MEI increase.

Thanks for your cooperation.

Bill Tierney, CPA
609-263-8052

Bill,

I'm not sure I follow the logic of freezing last year's MEI index levels. Where did the numbers in bold in your worksheet come from? The 2.8% MEI update for CY06 is based on all historical data available as of the 2nd quarter of 2005. I'm not clear why having updated numbers for 2004:3-2005:2 compared to "frozen" levels is more appropriate.

Steve

Steve

The bold number came from the 3rd quarter 2004 report with historical data up to 2nd quarter 2004. Mary Lee send me the prior year and current year reports.

Steve

My logic is taking a picture in time last year and then taking the same picture again this year and what falls in between is the change. The change is the change in the total index level without adjusting the prior periods. The characteristics of the change could be this years % change and some of change could be prior year or the penultimate year.

Measuring a % change from one period to another, the numerator should becomes denominator in the following years computation. Most MEI users think the MEI as

published in the federal register has a frozen denominator. This is basically because of their accounting and budgetary background. If the MEI denominator is a moving target, then there has to be restatement disclosure. A prior period adjustment should be recorded/recognized in current period to reflect that appropriate impact.

I am taking the prior year MEI indexes freezing them so as to reflect to cumulative % change. That 3.4% cumulative CY 2006 change reflects a current year MEI % change (2.8%) and a prior/penultimate year MEI % change of 0.6%.

I believe there is a difference between the MEI four quarter moving table and MEI accounting. The MEI accounting should provide full disclosure of the prior period adjustment in the current period so that users can make decisions about this year's change and retroactive changes.

I am applying my accounting background logic and that the MEI % change is being used to reflect a inflationary adjustment from one year to another year.

Call me or e-mail me.

Mr. Tierney,

Thank you for the explanation, I now have a clearer understanding of your issue. The MEI update is determined based on all of the available historical information at the time the update is estimated. That way it ensures an apples-to-apples comparison between periods and accurately reflects the price increase associated with that period. The methodology used to determine this calculation is completely consistent with standard price indexing, and is similar to the methodology used by other government agencies (BLS, BEA) when determining price increases.

The methodology you have described could result in apples-to-oranges type comparisons, which would not be acceptable for determining the MEI update. For instance, when we rebase the MEI (as we did in 2003) we had to compare the new index levels for both years to determine the update. It would have been inappropriate to estimate the update using new index levels for one year compared to previously published index levels for the old index for the prior year.

I hope this helps clarify our methodology and why our estimated update of the MEI for CY06 is appropriate.

Steve

Steve,

MEI 2004 to MEI 2005 is apples to apples since CY 2000 is the base weight. The 2003 update covered the transition from the 1996 to the 2000 base weights, that would be

apples to oranges. The present 4 quarter moving average displays a common CY 2000 base weight so everything is apples to apples.

If indexes developed using common base weight (2000) are being adjusted retroactively, the retroactive % change should be accounted either as prior period adjustment or part of the current period. My excel file example shows it (retros) a current year adjustment when I the prior year indexes.

Thanks again for your cooperation

Bill

Steve,

MEI 2004 to MEI 2005 is apples to apples since CY 2000 is the base weight. The 2003 update covered the transition from the 1996 to the 2000 base weights, that would be apples to oranges. The present 4 quarter moving average displays a common CY 2000 base weight so everything is apples to apples.

If indexes developed using common base weight (2000) are being adjusted retroactively, the retroactive % change should be accounted either as prior period adjustment or part of the current period. My excel file example shows it (retros) a current year adjustment when I the prior year indexes.

Thanks again for your cooperation

Bill

Bill Tierney, CPA
609-263-8052

Steve,

Why is there less prior period adjustments with the CPI than the MEI?
Bill Tierney

----- Original Message -----

From: McGettigan, Thomas - BLS
To: Bill Tierney, CPA ; BLSinfoPhiladelphia
Sent: Friday, December 16, 2005 8:50 AM
Subject: RE: CPI Pdf files

Bill:

Could I receive the CPI. pdf files for January 2005 to October 2005 for the Mid-Atlantic region?
Yes. A link to these pdf files is here: <http://www.bls.gov/ro3/home.htm#inflation>

I have a questions? CPI-All urban Consumers (CPI-U) Do you go back an update each month indexes?
No. Each month's CPI is final and are not updated. Only on a couple VERY RARE occasions have they been revised.
(about twice in 35 years.)

Please call if you have other questions or need more information.

Tom McGettigan
Bureau of Labor Statistics
215-597-3282

-----Original Message-----

From: Bill Tierney, CPA [mailto:wet.cpa@comcast.net]
Sent: Friday, December 16, 2005 7:10 AM
To: BLSinfoPhiladelphia
Subject: CPI Pdf files

Could I receive the CPI. pdf files for January 2005 to October 2005 for the Mid-Atlantic region?

I have a questions? CPI-All urban Consumers (CPI-U)

Do you go back an update each month indexes?

If so, are the % changes usually only in the 0.1% range?

I am comparing the as published CPI-U to MEI to show the accuracy of the CPI-U & MEI indexes.

Thanks
Bill Tierney, CPA
609-263-8052

Submitter : Ms. Emily Graham
Organization : ASCRS/OOSS
Category : Health Care Professional or Association

Date: 01/03/2006

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-FC-58-Attach-1.DOC

ASCRS

OUTPATIENT OPHTHALMIC
SURGERY SOCIETY, INC.

AMERICAN SOCIETY OF CATARACT AND REFRACTIVE SURGERY
OUTPATIENT OPHTHALMIC SURGERY SOCIETY

January 3, 2006

Mark McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
ATTN: CMS-1502-FC
200 Independence Avenue
Room 445-G
Washington, DC 20201

**Re: Medicare Programs; Revision to Payment Policies to the Physician Fee
Schedule for Calendar Year 2006; Final Rule.**

Dear Dr. McClellan:

The American Society of Cataract and Refractive Surgery (ASCRS) represents over 9,500 ophthalmologists in the United States and abroad who share a particular interest in cataract and refractive surgical care. ASCRS members perform the vast majority of cataract procedures done annually in the United States.

The Outpatient Ophthalmic Surgery Society (OOSS) is a professional medical association of ophthalmologists, nurses, and administrators who specialize in providing high-quality ophthalmic surgical procedures performed in cost-effective outpatient environments, including ambulatory surgical centers (ASCs).

ASCRS and OOSS appreciate the opportunity to submit comments on the final rule for the 2006 Medicare physician fee schedule.

Sustainable Growth Rate (SGR)

The agency is aware that the current mechanism for updating Medicare physician payments is fatally flawed. In fact, the agency recognizes that the current payment system is "unsustainable" in the long term. As you are aware, the cost of replacing the SGR is currently estimated at \$180 billion dollars. We have offered a suggestion that would help reduce the cost of this estimate, giving Congress greater ability to replace the SGR with a more stable payment

system. We have urged the agency to use its administrative authority and remove physician-administered drugs from the SGR formula retroactively.

As outlined in the final rule, the agency maintains that it lacks the administrative authority to remove physician-administered drugs from the physician payment pool retroactively. We continue to be disappointed that the agency believes that it does not have the authority to make this change; however, we are optimistic that CMS has noted it may have the authority to remove drugs prospectively. We disagree with the agency that a prospective removal of drugs from the SGR formula would not be helpful. Granted, it would not help avert the future pending reductions; however, it would help lower the cost of a permanent solution to the SGR. This action alone would demonstrate to the ophthalmic community CMS' willingness to work with us on a long term solution to the current unsustainable physician payment system.

We, again, urge the agency to use its administrative authority and remove physician administered drugs from the physician payment pool, thereby reducing the cost of a permanent fix to the SGR.

ASCRS and OOSS look forward to working with CMS on the 2006 physician fee schedule and encourage CMS to consider our recommendation. Should you have any further questions or comments, please contact Emily L. Graham, CCS-P, CPC, ASCRS Manager of Regulatory Affairs, at 703-591-2220 or egramham@ascrs.org, or Michael A. Romansky, OOSS Legal Counsel, at MRomansky@SHCare.net or 202-626-6872.

Sincerely,



Roger F. Steinert, MD
President, ASCRS



William Fishkind, MD
President, OOSS

AMERICAN SOCIETY OF CATARACT AND REFRACTIVE SURGERY
4000 Legato Road • Suite 700 • Fairfax, Virginia 22033-4055 • (703) 591-2220 • Facsimile (703) 591-0614

OUTPATIENT OPHTHALMIC SURGERY SOCIETY
P.O. Box 5256 • Johnson City, TN 37602-5256 • 866-246-9880 • Facsimile (423) 282-9712

Submitter : Michael Mabry
Organization : Society of Interventional Radiology
Category : Other Association

Date: 01/03/2006

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-FC-59-Attach-1.PDF



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January 3, 2006

Mark McClellan, MD, PhD
Administrator

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2006 [CMS-1502-FC]

Dear Administrator McClellan:

The Society of Interventional Radiology (SIR) is a physician association with over 4,000 members that represents the majority of practicing vascular and interventional radiologists in the United States.

SIR appreciates the opportunity to comment upon the final rule, Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2006 as published in the November 21, 2005 *Federal Register*.

SIR's comments are directed to:

1. Medicare Non-Coverage of New Intracranial Interventional Procedures
2. Publication of Relative Values for Non-Covered Services
3. Practice Expense Issues
4. Malpractice Relative Values
5. Multiple Procedure Payment Reduction for Diagnostic Imaging
6. Response to Public Comments on Interim Relative Value Units for 2005

**Medicare Non-Coverage of New Intracranial Interventional Procedures
(Page 70281)**

Neurointerventional techniques, such as angioplasty and stenting, expand the therapeutic options for patients with cerebrovascular atherosclerosis and vasospasm. SIR would like to work with CMS in order for Medicare beneficiaries to have access to these life-saving procedures.

Vasospasm is the primary cause of mortality after subarachnoid hemorrhage. While standard therapy for vasospasm is medical management, a sizable number of these patients will develop an ischemic neurological deficit or die from brain damage secondary to vasospasm. Balloon dilatation for vasospasm is not a substitute for medical management, rather a last resort for patients who fail such therapy.

Patients with intracranial atherosclerosis have few medical options. Medical therapy has limited effectiveness and carries with it a high risk of cerebrovascular events and death. No surgical option exists. In the absence of effective medical or surgical therapy for intracranial atherosclerotic stenoses, intracranial angioplasty and stenting offer a second option for patients who have failed medical therapy.

The new codes for intracranial interventions (61630- 61642) are "comprehensive" in that they represent catheterization, imaging, and therapy. Intracranial catheter-based angiography has been a Medicare-covered service for many years. SIR would welcome the opportunity to work with CMS towards separate payment of these services in the context of the non-coverage decision.

Discussion of Codes for Which the RUC Recommendations Were Not Accepted – New and Revised Codes for 2006 [Intracranial Interventions] (Page 70281)

SIR recommends that CMS publish the relative values for non-covered services, but indicate that such values are not used for Medicare purposes.

In the final rule, CMS elected not to publish the relative values for the new codes for intracranial interventions (CPT codes 61630, 61635, 61640, 61641 and 61642) on the basis that these services are noncovered under Medicare.

SIR asks CMS to reconsider this decision and publish the RUC's relative values for these services and others affected at its earliest opportunity. Medicare's resource-based relative value scale (RBRVS) is used by a majority of private insurers in this country. These insurers may cover intracranial interventions and the publication of the RUC's values may serve as a guide for their valuation. These values may serve to benchmark physician productivity and for compensation determination.

CMS' decision not to publish the values for these services is inconsistent with the treatment of other noncovered services. In addition, through the use of the "+" indicator, CMS can readily identify those services whose relative values are not used for Medicare payment. The 2006 RBRVS includes values with the "+" indicator for a range of noncovered (along with "bundled" and "invalid") services such as MR angiography of the spine, MR spectroscopy, various contact lens/spectacle procedures, acupuncture, and various preventive care services.

Additional PE Issues Raised by Commenters – CPT Code 36566 (Page 70148)

SIR appreciates CMS' consideration of our request to replace the Tesio catheter for the LifeSite hemodialysis system in its practice expense database for code 36566. This issue will be taken up by the RUC at its February 2006 meeting.

CPT code 36566 [Insertion of tunneled centrally inserted central venous access device, requiring two catheters via two separate venous access sites; with subcutaneous port(s)] involves the creation of two subcutaneous pockets into which two LifeSite devices are inserted, one in each pocket. Each device costs \$1,750 for a total device cost of \$3,500.

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SIR supports adding a tilt table not only to codes 36475 and 36746, but also to codes 36478 and 36479 – the entire endovenous ablation family. We, however, disagree with the requested 15 minutes of additional clinical labor time. These will be considered by the RUC at its February 2006 meeting.

CMS received a comment from a manufacturer requesting that a tilt table and 15 minutes of clinical labor be added to CPT codes 36475 and 36476. A tilt table is necessary and common to all forms of endovenous ablation – radiofrequency (codes 36475 and 36476) and laser (codes 36478 and 36479) and should be added to each code. However, we believe that the clinical times for these codes take into account the services provided by non-physician clinical staff and, thus, do not support the additional 15 minutes as requested.

Malpractice Relative Value Units (RVUs) – Five Percent Specialty Threshold (Pages 70153 – 70154)

SIR is disappointed by CMS' decision to stay with the 5 percent specialty threshold instead of the 1 percent threshold recommended by SIR. SIR maintains that the five percent threshold will remove specialties that actually provide the service, whereas a 1 percent threshold achieves significant data cleaning and minimize the exclusion of appropriate providers. SIR recommends that CMS continually assess its use of the five percent threshold.

SIR is concerned that the 5 percent threshold would remove appropriate specialties from the calculation of malpractice RVUs. We cited the example of venous angioplasty (code 35476) where vascular surgeons and general surgeons would be dropped from the malpractice methodology despite the fact that each account for approximately 4 percent of the total volume of the code. SIR believes that a 1 percent threshold would better retain those specialties actually providing the service while substantially "weeding out" so called aberrant specialties.

Multiple Procedure Payment Reduction for Diagnostic Imaging (Pages 70261 – 70265)

SIR is disappointed by CMS proceeding with the discounting for multiple imaging services of contiguous body sites. Instead, SIR recommends a delay allowing time to evaluate the imaging families and the proposal's underlying assumptions of "savings".

In the proposed rule, SIR cited concerns over the specific "savings" purported by CMS for certain imaging of contiguous areas and the magnitude of such savings relative to the 50 percent technical component payment reduction. We appreciate CMS' decision not to implement the full 50 percent reduction in 2006. SIR would be supportive of monitoring and continued refinement of the use of the -59 modifier for "same session" circumstances.

Mark McClellan, MD, PhD
January 3, 2006
Page 5

**Response to Public Comments on Interim Relative Value Units for 2005
– Radiofrequency Endovenous Ablation (Page 70275)**

SIR supports the RUC assigned work values for the endovenous family of codes (36475 – 36479).

CMS received a comment expressing concerns over the RVW relationship between radiofrequency (codes 36475 and 36476) and laser (codes 36478 and 36479) endovenous ablation. The commenter called into question the vignette used in the surveys and the surveys themselves.

SIR stands by the survey process used for this family of codes and the RUC's recommended values which were accepted by CMS. The surveys, including the vignettes, were developed through a multispecialty process involving the American College of Radiology, the Society for Vascular Surgery, and SIR. The surveys had a response in excess of the RUC's minimum of 30 respondents for all codes. The results of which concluded that the work associated with both forms of ablation were comparable. The RUC reached its conclusions following a thorough review of the results of the survey, presenters' testimony, and relativity in the context of existing procedures and values. We see no reason to deviate from the RUC's recommended values for these codes at this time.

SIR appreciates the opportunity to comment on the final rule for the 2006 Medicare physicians' fee schedule. If you have any questions or require additional information, please contact Michael R. Mabry, Assistant Executive Director at (703) 460-5561 or mabry@sirweb.org.

Sincerely,



Michael E. Edwards, MD
Counselor, Health Policy & Economics

CC: Kenneth Simon, MD, CMS
Carolyn Mullen, CMS
Pam West, CMS

Submitter : Dr. Robert Provenzano
Organization : Renal Physicians Association
Category : Physician

Date: 01/03/2006

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-FC-60-Attach-1.WPD



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January 3, 2006

Mark McClellan, MD, PhD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2006 [CMS-1502-FC]

Dear Administrator McClellan:

The Society of Interventional Radiology (SIR) is a physician association with over 4,000 members that represents the majority of practicing vascular and interventional radiologists in the United States.

SIR appreciates the opportunity to comment upon the final rule, Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2006 as published in the November 21, 2005 *Federal Register*.

SIR's comments are directed to:

1. Medicare Non-Coverage of New Intracranial Interventional Procedures
2. Publication of Relative Values for Non-Covered Services
3. Practice Expense Issues
4. Malpractice Relative Values
5. Multiple Procedure Payment Reduction for Diagnostic Imaging
6. Response to Public Comments on Interim Relative Value Units for 2005

**Medicare Non-Coverage of New Intracranial Interventional Procedures
(Page 70281)**

Neurointerventional techniques, such as angioplasty and stenting, expand the therapeutic options for patients with cerebrovascular atherosclerosis and vasospasm. SIR would like to work with CMS in order for Medicare beneficiaries to have access to these life-saving procedures.

Vasospasm is the primary cause of mortality after subarachnoid hemorrhage. While standard therapy for vasospasm is medical management, a sizable number of these patients will develop an ischemic neurological deficit or die from brain damage secondary to vasospasm. Balloon dilatation for vasospasm is not a substitute for medical management, rather a last resort for patients who fail such therapy.

Patients with intracranial atherosclerosis have few medical options. Medical therapy has limited effectiveness and carries with it a high risk of cerebrovascular events and death. No surgical option exists. In the absence of effective medical or surgical therapy for intracranial atherosclerotic stenoses, intracranial angioplasty and stenting offer a second option for patients who have failed medical therapy.

The new codes for intracranial interventions (61630- 61642) are “comprehensive” in that they represent catheterization, imaging, and therapy. Intracranial catheter-based angiography has been a Medicare-covered service for many years. SIR would welcome the opportunity to work with CMS towards separate payment of these services in the context of the non-coverage decision.

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SIR asks CMS to reconsider this decision and publish the RUC’s relative values for these services and others affected at its earliest opportunity. Medicare’s resource-based relative value scale (RBRVS) is used by a majority of private insurers in this country. These insurers may cover intracranial interventions and the publication of the RUC’s values may serve as a guide for their valuation. These values may serve to benchmark physician productivity and for compensation determination.

CMS' decision not to publish the values for these services is inconsistent with the treatment of other noncovered services. In addition, through the use of the "+" indicator, CMS can readily identify those services whose relative values are not used for Medicare payment. The 2006 RBRVS includes values with the "+" indicator for a range of noncovered (along with "bundled" and "invalid") services such as MR angiography of the spine, MR spectroscopy, various contact lens/spectacle procedures, acupuncture, and various preventive care services.

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