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February 9, 2022

Mr. Gift Tee
Director
Division of Practitioner Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Attention: Telehealth Review Process

Dear Mr. Tee:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to request that the three CPT codes for telephone visits, 99441, 99442, and 99443, that were added to the Medicare Telehealth List during the COVID-19 Public Health Emergency be added to Category 3 of the Medicare Telehealth List. The AMA strongly supports the policy that the Centers for Medicare & Medicaid Services (CMS) adopted in the 2022 Medicare physician payment rule that codes in Category 3 will continue on the Medicare Telehealth List beyond the COVID-19 Public Health Emergency (PHE) through the end of 2023 to allow evidence to be analyzed that could support their addition to the Medicare Telehealth List on a permanent basis. This same policy should be applied to the telephone visit codes and they should be included in Category 3.

99441	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
99442	11-20 minutes of medical discussion
99443	21-30 minutes of medical discussion

Telephone visit codes are important for health equity

CMS has assigned a high priority to improving equity in the delivery of health care services. Eliminating coverage for the telephone visit codes as soon as the PHE ends would be absolutely counter to the Administration's goals for improving equity for minoritized and marginalized patient populations, as stated in President Biden's day one Executive Order on Advancing Racial Equity and Support for Underserved Communities.

AMA policy calls for "coverage and payment of audio-only services in appropriate circumstances to ensure equitable coverage for patients who need access to telecommunication services but who do not have access to two-way audiovisual technology." A key finding of the COVID-19 Health Coalition

Telehealth Impact Study was that audio-only coverage is important to allow patients to access their physician when audiovisual service is not available. Analysis of the Coalition's patient survey found that 20.6 percent of survey respondents over 65 accessed their most recent telehealth service through audio-only telephone. The AMA's Physician Practice Benchmark Survey looked at use of telehealth services in September 2020, six months into the COVID-19 pandemic. It found that primary care physicians provided 12.5 percent of visits via videoconferencing and 9.4 percent via telephone, and medical specialties provided 12.9 percent of visits via videoconferencing and 9.3 percent via phone. AMA analysis of Medicare claims data for 2020 shows that Medicare spent $736 million on the three CPT codes for audio-only visits over the entire year, which was 18 percent of total 2020 Medicare spending on telehealth services. Office visits for Medicare patients using audiovisual telecommunications accounted for 52 percent of 2020 Medicare telehealth spending. Overall, telehealth services accounted for 4.9 percent of Medicare spending in 2020. An analysis by the Assistant Secretary for Planning and Evaluation found that at least two-thirds of Medicare's telehealth visits were via interactive video-based technology.

While not a high percentage of office visits provided to Medicare patients via telehealth in 2020, access to audio-only services is critical for patients who do not have access to audiovisual telehealth services. Discontinuing payment for these services would exacerbate inequities in health care, particularly for those who lack access to broadband and/or audiovisual capable devices, including seniors in minoritized and marginalized communities where there were significant health disparities before COVID-19 that have become much worse during the pandemic. For example, according to the most recent progress report from the Federal Communications Commission, Tribal lands continue to face significant obstacles to broadband deployment. Likewise, an October 2020 article in Government Technology reported that less than half the population in the parts of Alabama defined as the "Black Belt" have internet access, and two of these Alabama counties have no internet access at all. Marginalized urban communities have also been excluded from broadband service and need to rely on audio-only visits, because even when cities have broadband, many residents of these communities do not have access to it in their homes. A June 2020 report of the National Digital Inclusion Alliance describes data showing that the U.S. has more than three times as many urban as rural households living without home broadband of any kind.

Broadband and audiovisual telehealth services are clearly not accessible by all Medicare patients. We urge CMS to continue covering the CPT codes for audio-only evaluation and management services through 2023 by adding them to Category 3. The AMA has adopted significant policy to address equity in telehealth. We recognize access to broadband internet as a social determinant of health and encourage initiatives to measure and strengthen digital literacy, with an emphasis on programs designed with and for historically marginalized and minoritized populations. We also support efforts to design telehealth technology, including voice-activated technology, with and for those with difficulty accessing technology, such as older adults, individuals with vision impairment and individuals with disabilities.

Telephone visits are important for quality of care

The experience physicians have had providing patient care since Medicare began paying for the CPT codes for audio-only visits demonstrates that these visits enhance quality and improve patient health outcomes. They do not diminish quality relative to audiovisual visits and, because some patients are more comfortable speaking with their physicians without video and the quality of telephone service may be better than they can obtain over the internet for audiovisual services, some patients report better health care experiences with telephone than audiovisual visits. The following are several examples provided to us by practicing physicians which illustrate in their own words that the clinical content of their audio-only patient visits is entirely comparable to in-person and audiovisual visits:

- "We talked about her appetite, which has been failing. She has lost weight and has a good scale to tell me her numbers. We talked about the possibility of depression, asked about her support systems, can she get out for a drive with her daughter? And how is she sleeping, does she have food? We talked about her cats, and which movies she is watching, and what medications she is taking when she was able to come to the clinic, and last year able to see her at home. It was a full visit."

- "Another example is an older gentleman, a veteran, who has been blind in one eye for decades due to a fishing accident. He has a terribly arthritic hip, and would like to have it replaced, but the surgeons say he is too old with too many other illnesses. He takes insulin for diabetes and lives alone ever since his wife died. Despite many ailments, his mind is very sharp. He is able to tell me his blood sugar readings, his blood pressure (on a home blood pressure cuff) and his weight. Over the phone we can have a lot of information exchanged that helps me make decisions with him about his medications, his overall health and his safety at home."

- "Allowing patients to make this choice is important because it gives them a greater sense of autonomy. Using their preferred means of communication increases the connection between provider and patients which is likely to improve outcome."

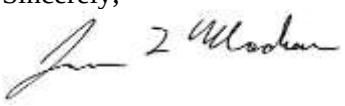
- "As a neurologist, I have done many 99441, 99442, and 99443 audio-only visits. This is essential even after PHE is over, as I serve a rural population of elderly who have no internet or video phone, and live 50-120 miles away with transportation difficulties and need care for their Parkinson's or other progressive movement disorders e.g., PSP, MSA, as well as post stroke rehab follow-ups, headache, epilepsy, and four types of dementia."

Audio-only visits can only be used to manage treatment for patients with chronic conditions like diabetes, hypertension, chronic kidney disease, chronic obstructive pulmonary disease, congestive heart failure, and irritable bowel disease or Crohn's. Physicians can discuss patients' symptoms and behaviors, such as understanding not only quantitative measures such as glucose readings but discussing what patients are typically eating, the amount of pain, and how they feel. For patients with equipment that permits remote monitoring, physicians can listen to their lungs and heart over the phone and get their weight and blood pressure readings. Cancer patients can be followed up over the phone to monitor how they are tolerating therapy.

To conclude, the AMA deeply appreciates the CMS decision to add the CPT codes for telephone visits to the Medicare Telehealth List during the PHE and strongly urges CMS to place these codes in Category 3 so that coverage can continue on an interim basis after the PHE ends. Although few patients would want or be able to receive all of their needed health care services over the phone, it has become clear during the PHE to date that telephone visits play an important role in digitally enabled hybrid models of in-person and virtual care.

Thank you for your consideration. If you have any questions, please contact Margaret Garikes, Vice President for Federal Affairs, at margaret.garikes@ama-assn.org or 202-789-7409.

Sincerely,



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