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January 25, 2023

Gift Tee

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

**RE: Request for Addition to the Medicare Telehealth List – CPT Codes
99221-99223 and 99234-99236**

Dear Mr. Tee,

The American Academy of Neurology (AAN) is the world’s largest neurology specialty society representing more than 38,000 neurologists and clinical neuroscience professionals. The AAN is dedicated to promoting the highest quality patient-centered neurologic care. A neurologist is a physician with specialized training in diagnosing, treating, and managing disorders of the brain and nervous system. These disorders affect one in six people and include conditions such as multiple sclerosis, Alzheimer’s disease, Parkinson’s disease, headache, stroke, migraine, epilepsy, traumatic brain injury, ALS, and spinal muscular atrophy.

CPT Codes 99221-99223 and 99234-99236

| CPT Code | Code Descriptor |
|---|---|
| 99221: Initial Hospital Inpatient or Observation Care | Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low-level medical decision-making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded. |
| 99222: Initial Hospital Inpatient or Observation Care | Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision-making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded. |
| 99223: Initial Hospital Inpatient or Observation Care | Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision-making. When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded. |

| CPT Code | Code Descriptor |
|---------------------------|--|
| 99234: Same Day Discharge | Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded. |
| 99235: Same Day Discharge | Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 70 minutes must be met or exceeded. |
| 99236: Same Day Discharge | Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 85 minutes must be met or exceeded. |

The AAN requests that CMS consider adding CPT Codes 99221-99223 and 99234-99236 to the Medicare Telehealth list on a Category 1 basis in the 2024 Medicare Physician Fee Schedule (MPFS). These codes describe visits that are furnished to patients who are ill enough to require hospital evaluation and management services. More specifically, 99221-99223 describes hospital and observation care and 99234-99236 are same day discharge codes. These services are commonly provided by a wide variety of clinicians including neurologists, non-neurologist physicians, and non-physician practitioners. The AAN believes that a reconsideration is appropriate given changes finalized in the 2023 MPFS to the relevant code descriptors, as well as recent findings indicating substantial confusion associated with correct billing practices for telestroke services. We believe adding these codes to the Medicare telehealth list will improve patient access to high-quality stroke care by promoting adequate and more intuitive reimbursement for telestroke services.

Stakeholders and regulators have been engaged in extensive discussions about the proper roles of telehealth services after the regulatory flexibilities associated with the Covid-19 Public Health Emergency are terminated. The AAN strongly believes that new telehealth policies must be evidence based and should support patient access to high-quality care. Telestroke in particular is supported by a robust evidence base and is the first condition for which Medicare payment for telehealth services in urban areas was expanded prior to the emergence of Covid-19. While the AAN is highly appreciative of the existing flexibilities, a paper published in Health Affairs in March 2022 indicated that “only a minority of hospitals with known telestroke capacity had ever billed Medicare for that service, and there was substantial billing inconsistent with Medicare requirements.”¹ The authors conclude that “our findings suggest that in shaping the future of Medicare telemedicine payment, simplifying payment rules would help ensure that expanded reimbursement improves access to timely effective care.”²

The paper demonstrates the insufficiency of the current Medicare-specific telemedicine HCPCS codes (G0406-G0408, G0425-G0427, and G0508-G0509), noting that “only about

¹ Wilcock, Andrew D., et al. “Legislation Increased Medicare Telestroke & Billing, but Underbilling and Erroneous Billing Remain Common: Health Affairs Journal.” Health Affairs, 1 Mar. 2022, <https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.00791>.

² Id.

half of telestroke claims in the pandemic period used the G0 modifier code. The telestroke consults that did not use the G0 code used various combinations of inpatient telemedicine HCPCS/CPT codes; the GT modifier code; the place-of-service code for telehealth; and the 95 modifier code, which was recommended by Medicare for telemedicine services during the COVID-19 pandemic period.”³ The AAN believes that the complexity of billing for hospital-based telestroke services is likely contributing to observed ongoing discrepancies in telestroke coding. The AAN encourages CMS to explore necessary reforms to reduce burden and promote more accurate billing and coding for telestroke. Given the need for a more intuitive system of billing and coding for telestroke, we believe it would be appropriate to greatly simplify current policies for telestroke services by adding commonly used codes for inpatient hospital care, observation, and discharge to the Medicare Telehealth list on a permanent basis.

When considering the predecessor CPT codes to 99221-99223 for potential addition to the Medicare Telehealth list in the 2021 MPFS, CMS stated that the agency declined to include them on the Medicare Telehealth list because the agency had concerns that the relevant codes “describe an evaluation for these potentially high acuity patients that is comprehensive and includes an in-person physical examination. Our view that in-person care is necessary to fulfill the requirements of the code is driven by the need for the physician or health provider to fully understand the health status of the person with whom they are establishing a clinical and therapeutic relationship. We also noted that we believe that the need for an in-person interaction would rise above any specific diagnosis, and serves as the foundation upon which any and all clinical decisions are based for these services.”⁴ CMS shared a similar concern when assessing whether to add the predecessor CPT codes for 99234-99236, stating that “without an in-person physical examination, the need for the physician or health care provider to fully understand the health status of the person with whom they are establishing a clinical relationship would be compromised. We noted that we believe the need for an in-person interaction would rise beyond any specific diagnosis, and serves as the foundation upon which any and all clinical decisions are based for these services.”⁵

The above rationale made sense at the time, given specific reference in the code descriptors to typical time spent at the bedside and on the patient’s hospital floor or unit. The AAN believes this language implied that in-person care was typically required to satisfy the elements of the relevant codes. The AAN notes that specific references to bedside or floor time were excluded from the revised code sets finalized in the 2023 MPFS. The revised code sets instead refer to medically appropriate history and/or examination, the relevant level of medical decision-making for the specific code level, as well as total time thresholds on the date of the encounter for code selection. The AAN believes that it would be appropriate to reimburse these services as Medicare telehealth services in cases in which a medically appropriate history and/or examination and the relevant level of medical-decision making can be completed via a real-time two-way audio and video telecommunications system.

³ Id.

⁴ 85 Fed. Reg. at 84517

⁵ Id.

The AAN believes that currently available peer-reviewed medical literature provides strong support for the equivalence between remote and in-person stroke evaluation and care.^{6,7} Remote and in-person stroke evaluation and management services are equivalently depicted by the new 2023 inpatient evaluation and management codes. Therefore, to promote patient access to medically appropriate care, the AAN believes it would be appropriate for CMS to consider adding 99221-99223 and 99234-99236 to the Medicare Telehealth list. The AAN notes that for stroke care specifically, CMS’ previously stated rationale that “the need for an in-person interaction would rise above any specific diagnosis” is not accurate when applied to stroke care, due to the demonstrated efficacy of remote stroke care. Further, we note that all elements of the level selection criteria can easily be satisfied and documented via telehealth. While considering this request for addition, the AAN strongly urges CMS to consider any additional cases in which the newly revised 99221-99223 and 99234-99236 can be provided in a medically appropriate manner using a real-time two-way audio and video telecommunications system. It is very likely that these recommendations are applicable to other medical conditions with the appropriate evidence base supporting the equivalence of remote and in-person evaluation and management.

CPT Codes 95970, 95983, and 95984

| CPT Code | Code Descriptor |
|---|--|
| 95970: Electronic analysis of implanted neurostimulator pulse generator/transmitter | Electronic analysis of implanted neurostimulator pulse generator/transmitter (e.g., contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without programming. |
| 95983: Electronic analysis of implanted neurostimulator pulse generator/transmitter | Electronic analysis of implanted neurostimulator pulse generator/transmitter (e.g., contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/transmitter programming, first 15 minutes face-to-face time with physician or other qualified health care professional. |
| 95984: Electronic analysis of implanted neurostimulator pulse generator/transmitter | Electronic analysis of implanted neurostimulator pulse generator/transmitter (e.g., contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/transmitter programming, each additional 15 minutes face-to-face time with physician or other qualified health care professional. |

The AAN appreciates CMS’ decision to add CPT codes 95970, 95983, and 95984 to the Medicare Telehealth list on a Category 3 basis. While we are not requesting that CMS add these codes on a Category 2 basis at this time, the AAN would like to make CMS aware of

⁶ Alberts, Mark, et al. “AAN Position: Stroke Care.” AAN, American Academy of Neurology, 15 July 2020, <https://www.aan.com/advocacy/stroke-care-position-statement>.

⁷ Andrew D. Wilcock, PhD. “Reperfusion Treatment and Stroke Outcomes in Hospitals with Telestroke Capacity.” JAMA Neurology, JAMA Network, 1 May 2021, https://jamanetwork.com/journals/jamaneurology/fullarticle/2776793?utm_campaign=articlePDF&utm_medium=articlePDFlink&utm_source=articlePDF&utm_content=jamaneurol.2021.0023.

rapidly developing evidence that may be available prior to the release of the 2024 Medicare Physician Fee Schedule proposed rule. The ongoing Remote Optimization, Adjustment and Measurement for Deep Brain Stimulation (ROAM-DBS) aims to gather evidence directly comparing real world outcomes of remote and traditional in-clinic programming.⁸ The ROAM-DBS trial compares remote and in-clinic programming in the immediate post-operative period. The primary endpoint is the comparison of time required after initial programming for a minimal clinically important difference of 1-point improvement in the Patient's Global Impression of Change (PGI-C) score. The estimated completion date for this study is March 1, 2023 and may provide persuasive evidence in support of adding CPT codes 95970, 95983, and 95984 to the Medicare Telehealth list on a permanent basis. The rapidly developing body of evidence indicates that there may be clinical benefit by allowing for a treatment option for a patient population without access to clinically appropriate in-person treatment options⁹ and through a decreased number of future hospitalizations or physician visits.¹⁰ AAN members report that remote deep brain stimulation has allowed for expanded access and timely delivery of care for those that utilize this technology and is particularly useful for patients with limited mobility and for whom travel has become increasingly difficult.

We strongly urge CMS to stay apprised of the developing body of evidence and are eager to provide support to the agency as it develops policy going forward so that beneficiaries do not lose access to remote care that may provide clinical benefit.

Conclusion

Thank you for the opportunity to provide input on the Medicare Telehealth list. Neurologists have historically been early adopters of telehealth and possess a depth of expertise and knowledge that is critical to ongoing policy discussions. Our members are eager to provide you with our expertise and to provide any additional evidence you may need in support of policy changes to ensure that patients maintain access to telehealth services. If you have any questions regarding these comments or seek further input, please contact Matt Kerschner, the AAN's Director, Regulatory Affairs at mkerschner@aan.com or Michaela Read the AAN's Telehealth and Practice Program Manager at mread@aan.com.

Sincerely,



Orly Avitzur, MD, MBA, FAAN
President, American Academy of Neurology

⁸ Details on ROAM-DBS can be found here: <https://clinicaltrials.gov/ct2/show/NCT05269862>

⁹ Esper, Christine D, et al. "Necessity and Feasibility of Remote Tele-Programming of Deep Brain Stimulation Systems in Parkinson's Disease." *Parkinsonism & Related Disorders*, Elsevier, 24 Jan. 2022, <https://www.sciencedirect.com/science/article/pii/S1353802022000256>.

¹⁰ Pintér, Dávid, et al. "Potential Clinical and Economic Benefits of Remote Deep Brain Stimulation Programming." *Nature News*, Nature Publishing Group, 19 Oct. 2022, <https://www.nature.com/articles/s41598-022-22206-z>.