



September 18, 2020

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services, Department
of Health and Human Services,
Attention: CMS-1734-P,
P.O. Box 8016,
Baltimore, MD 21244-8016.

Re: File Code CMS-1734-P; CY 2021 Revisions to Payment Policies under the Physician Payment Schedule and Other Changes to Part B Payment Policies

Dear Administrator Verma:

As the organization representing over 9,000 oral and maxillofacial surgeons in the United States, the AAOMS appreciates the opportunity to comment on the Proposed 2021 Revisions to the Medicare Physician Fee Schedule and other Part B payment policies. The AAOMS commends CMS on efforts to reduce physician burden and efforts to expand telehealth services and licensing flexibilities to preserve Medicare beneficiaries' access to care during the pandemic and thereafter. The AAOMS, however, has concerns with several proposals outlined in the proposed rule.

Physician Practice Expense Data Collection

The AAOMS is pleased that CMS is committed to ensuring that updated practice expense data is collected and attributed to the value of physician services. OMSs are the surgical specialists of dentistry and perform a wide range of procedures in their offices such as extractions, dental implant placement, corrective jaw surgery, facial trauma, and diagnosis and surgical treatment of cancers of the head, neck, and mouth. Unlike medical providers rendering services to Medicare beneficiaries in the non-facility setting, the specialty of OMS is unique whereas the supplies and specialized equipment used by OMS to carry out these procedures and anesthesia services in their offices are very similar to that used in hospital outpatient departments and ambulatory surgical centers. Rendering such services in the office provides Medicare beneficiaries with a safe and cost-efficient

option for receiving treatment for their oral health concerns. For this reason, AAOMS urges CMS to work directly with the AAOMS with collecting specialty specific practice expense rather than apply standard practice expenses that are also applied across a broad range of specialties. The AAOMS also urges CMS to work directly with the AMA and the RUC to initiate a new data collection process and future changes to the methodology for determining practice expense values. Failure to collect practice expense data from the specialists personally rendering covered Medicare procedures could result in an inaccurate representation of the resources used and result in further reductions in reimbursement that could potentially drive more Medicare providers to opt out and privately contract with Medicare beneficiaries, leaving Medicare patients with higher out-of-pocket costs.

Evaluation and Management – Office Visits

The AAOMS commends CMS for accepting the E/M office visit changes and framework as recommended by the CPT Editorial Panel and the RUC. While these changes are a positive step toward reducing provider burden, simplifying code selection, and more adequately compensating physicians for their time, work and resources associated with evaluating Medicare beneficiaries, the increased office visit payment will result in payment reductions to other covered services. Projected pay cuts could be as high as -11% for some specialties, with OMS specifically facing a potential -5% cut in overall Medicare reimbursement. This proposed cut is in addition to other payment reductions associated with a many OMS' inability to participate in MIPS due to lack of certified EHRs and limited Medicare coverage of OMS procedures. Additionally, because of the PHE, many OMS have experienced financial stress this year due to temporary closures, reduced patient appointments, and additional practice expenses for added measures to mitigate the spread of infection. For this reason, the AAOMS urges CMS/HHS to use its authority under the public health declaration to waive budget neutrality for the new office visit policy. Reimbursement cuts of up to -11% could be detrimental to some providers which could potentially result in disruptions to beneficiary access to care.

Furthermore, while the AAOMS is appreciative of CMS' acceptance the RUC's relative value recommendations for E/M office visits, the AAOMS is disappointed that CMS has decided not to recognize the increased value of postoperative E/M services included within the global period of surgical procedures as they have historically done in the past. With CMS proposing to increase payments for E/M codes in the maternity bundle, some therapy services and emergency department codes, overlooking the increase with surgical bundles is deemed discriminatory to surgery and undermines the foundation of a relative value system. The AAOMS echoes AMA and RUC comments and recommends that CMS apply the office visit increases uniformly across all services and specialties by increasing the relative values of surgical procedures accordingly for all post-operative E/M services within a surgical global period to retain relativity within the RBRVS. If CMS is concerned about the accuracy of the number of post-operative visits included in global

surgical packages, CMS is encouraged to work with the RUC and affected specialty societies to confirm and/or make new recommendations rather than work with an independent contractor. Surgical specialty societies are well equipped to collaborate with the RUC in representing the actual resources, work and time associated with rendering surgical procedures.

Supervision of Residents in Teaching Settings Through Audio/Video Real-Time Communications Technology

The AAOMS commends CMS for adopting an interim policy during the pandemic to allow for direct supervision using interactive audio/video, real-time communication technology in efforts to reduce risk of infection in the healthcare setting. In response to CMS' request for comments as to whether audio-only services should be considered after the PHE ends, through all of 2021 or beyond, the AAOMS wishes to express its support in continuing the option for direct physician supervision via audio/video technology indefinitely as it has proven to be effective with the delivery of patient care. However, the AAOMS believes that real-time, direct physician supervision is only required for the supervision of interns and/or medical students and of residents only when they are evaluating and treating complex medical conditions. Otherwise, indirect supervision of residents may suffice. Residents may independently treat simple conditions requiring straight-forward decision making in which the supervising/attending physician may simply review and approve the resident's documentation of diagnosis and overall treatment plan after the fact.

The AAOMS appreciates the opportunity to submit these comments. If you should have any questions or concerns, please do not hesitate to contact Patricia Serpico, AAOMS Health Policy, Quality & Reimbursement at 800- 822-6637 or pserpico@aaoms.org.

Sincerely,



John J. Hillgen, IV, DMD, MBA
Chair, AAOMS Committee on Health Policy, Coding, and Reimbursement

CC:

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AAOMS Committee on Health Policy, Coding and Reimbursement

AAOMS Coding and Reimbursement Department