American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

141 Northwest Point Blvd
Elk Grove Village, IL 60007-1019
Phone: 847/434-4000
Fax: 847/434-8000
E-mail: kidsdocs@aap.org
www.aap.org

September 6, 2017

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1676-P
Mail Stop C4-26-05
7500 Security Blvd
Baltimore, MD 21244-1850

Re: File Code-CMS-1676-P; Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2018 (July 21, 2017)

Dear Administrator Verma:

On behalf of the American Academy of Pediatrics (AAP), a non-profit, professional organization of 66,000 primary care pediatricians, pediatric medical sub-specialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults, I appreciate the opportunity to provide comments on the Centers for Medicare and Medicaid Services (CMS) Notice of Proposed Rule Making (NPRM) on the Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2018 published in the July 21st, 2017 *Federal Register*. Although few pediatric services are included in the Medicare program, payment policies introduced in Medicare are frequently adopted by the Medicaid program and by private payers. Given that Medicaid and CHIP cover over 45 million US children, CMS has an important obligation to children and their providers to consider the impact of every policy on pediatrics. Therefore, the Academy offers these comments on the proposed rule to ensure that all new policies reflect this important principle.

CMS Policy on Noncovered Medicare Services

The Academy applauds CMS for publishing the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC)-recommended values for the three pediatric 'N' (noncovered) status codes on Addendum B as a result of a long-standing partnership between the AAP and CMS:

CPT Code(s)	CPT Description	CPT Publication Year	RUC Recommendations Finalized
99174 99177	Instrument-based ocular screening	2016	September 2014
99188	Application of topical fluoride varnish	2015	April 2014

CMS' action provides a basis for non-Medicare utilization and payment policy without impacting Medicare budget neutrality. This change in policy now allows pediatricians and other child health providers to refer to these CMS-published relative value units (RVUs) for codes in their payment negotiations with other payers (whether in Medicaid, Tricare, or private pay), allowing these essential providers to be able to more efficiently and effectively deliver care to the populations they serve.

RBRVS remains the "gold standard" for valuation and the RUC is the only committee charged with developing valuation recommendations for RBRVS to CMS. The Academy is honored to actively participate in the RUC process, which allows pediatric participation in determining how pediatric services are valued, and we appreciate the partnership we have shared over the past many years.

Even though these services are noncovered by Medicare, they represent covered Medicaid services and, as such, RVU publication by CMS provides supportive value within the broader CMS domain. We look forward to seeing these changes finalized as proposed.

Health Risk Assessment (CPT Codes 96160-96161)

During the April 2016 RUC meeting, the Academy and the American Academy of Family Physicians presented refined direct practice expense (PE) inputs for the Health Risk Assessment (HRA) codes utilizing PE survey data.

The Academy appreciates CMS' proposal to adopt the seven (7) minutes of total clinical staff time as recommended by the RUC and agrees with CMS' designation of all 7 minutes under "administration, scoring, and documenting results of completed standardized instrument" rather than dividing the minutes into four categories.

Interprofessional Telephone/Internet Consultative Services (CPT Codes 99446-99449)

As part of a multispecialty coalition, the Academy presented an Action Plan to the October 2016 RUC Relativity Assessment Workgroup (RAW) for the Interprofessional Telephone/Internet Consultative Services (ITC) codes (99446-99449).

The RAW recommended the following: "Reaffirm previous RUC recommendation (October 2012) and request that CMS pay for the interprofessional telephone consultative services separately."

As such, the Academy is profoundly disappointed that CMS not only continues to bundle these services (ie, status indicator "B") but fails to publish the RUC-recommended values for these codes.

CMS states that it made this decision based on its policy wherein telephone consultations concerning Medicare beneficiaries are bundled into payment for other services, providing the example of a "telephone call from a hospital nurse regarding care of a patient."

The interprofessional telephone/internet consultative services codes are reported exclusively for *physician to physician* telephone/internet communication – and not for situations where the hospital nurse contacts the patient. An interprofessional telephone/internet consultation is an assessment and management service in which a patient's treating (eg, attending or primary) physician requests the opinion and/or treatment advice of a physician with specific specialty expertise (the consultant) to assist the treating physician in

the diagnosis and/or management of the patient's problem without the need for the patient's face-to-face contact with the consulting physician.

These services are typically provided in complex and/or urgent situations where a timely face-to-face service with the consultant may not be feasible (eg, geographic distance). These codes should not be reported by a consultant who has agreed to accept transfer of care before the telephone/internet assessment, but are appropriate to report if the decision to accept transfer of care cannot be made until after the initial interprofessional telephone/internet consultation.

The patient for whom the interprofessional telephone/internet consultation is requested may be either a new patient to the consulting physician or an established patient with a new problem or an exacerbation of an existing problem. However, the consultant should not have seen the patient in a face to face encounter within the last 14 days. When the telephone/internet consultation leads to an immediate transfer of care or other face-to-face service (eg, a surgery, hospital visit or a scheduled office evaluation of the patient) within the next 14 days or next available appointment date by the consultative physician, these codes are not reported.

This vital service is widespread in the United States and, as such, there are at least two Medicaid programs (North Carolina and Texas) that have considered it important enough to pay for telephone/internet consults with pediatric subspecialists. Furthermore, due to the fact that the United States has far fewer pediatric subspecialists than adult subspecialists – with most located in dense population centers – the use of telephone/internet consultations greatly helps those physicians caring for families located in smaller and more rural areas of the country ensure access to pediatric subspecialists unavailable in their local areas. Especially for vulnerable populations with limited access to specialty care, electronic physician-to-physician consultation programs have been shown to support timely consultative access for underserved patients while decreasing the need for specialist face-to-face visits—as demonstrated for example by Los Angeles County Department of Public Health's eConsult program.[1] Pediatric hematologists found that eConsult systems were viewed highly favorably by referring primary care providers and decreased by 40% the need for face-to-face consultation.[2] And especially relevant to Medicare beneficiaries who suffer from higher than average rates of comorbid disease and mobility issues, eConsult services create excellent value for primary care physicians and their patients 68% of whom did not require a subsequent face-to-face visit.[3]

The Academy strongly advises CMS to change the status indicator of codes 99446-99449 and publish their RUC-recommended values on the Medicare RBRVS physician fee schedule.

Immunization Administration (CPT Codes 90460, 90471, and 90473)

CMS has utilized CPT code 96372 (*Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular*) as a crosswalk for valuing the Immunization Administration (IA) codes (90460, 90471, and 90473).

---

[1] Barnett et al. Los Angeles Safety-Net Program eConsult System Was Rapidly Adopted And Decreased Wait Times To See Specialists. Health Affairs 2017; 36 (3): 492-499.

[2] Johnston et al. Use of Electronic Consultation System to Improve Access to Care in Pediatric Hematology/Oncology. Journal of Pediatric Hematology Oncology. 2017 Apr 21 (ahead of print).

[3] Liddy et al. Improving Access to Specialist Care for an Aging Population. Gerontol Geriatr Med. 2016 Nov 7;2:2333721416677195. doi: 10.1177/2333721416677195. eCollection 2016 Jan-Dec.

While we appreciate CMS' proposed refinement of the direct practice expense (PE) inputs for crosswalk code 96372, we do not believe that similar refinements are needed for the IA codes because we believe that the current IA direct PE inputs are accurate and in no need of refinement. Additionally, if refinement were to occur as a result of the 96372 crosswalk, there would be no rationale for the resulting decrease in PE RVUs for codes 90460, 90471, and 90473. Furthermore, it would contradict CMS' position that espouses the value of vaccines and the critical role they play in disease prevention. Reduction of the PE RVUs and, therefore, reimbursement for these services may reduce vaccine access as providers shift the burden to other settings. The administration of vaccines has shown to reduce the cost of the health care burden.

The Academy regards the current IA inputs as appropriate and, as such, respectfully suggests an alternative crosswalk code:

36000 *Introduction of needle or intracatheter, vein*

Evaluation and Management Documentation Guidelines

The Academy is encouraged by CMS willingness to reconsider the documentation guidelines underlying Evaluation and Management (E/M) visits. AAP agrees with CMS that especially as it relates to pediatric care, the current guidelines are administratively burdensome and outdated, complex and ambiguous. Especially for History and Physical Examination (H&P), the current documentation guidelines are superseded by the fluidity, interconnectivity, and expanded access to electronic health records. This expansion of EHR access has occurred during a time of elevated focus on the role of team-based, multi-disciplinary collaborate care management where contribution to documentation is multi-faceted but remains under the oversight and review of the visit's primary clinician.

The AAP looks forward to collaborating with CMS for this review especially considering the Academy's appreciation for the uniqueness of pediatric care and our expertise in representing general pediatricians and pediatric specialists in characterizing the care they deliver. Because of the role played by evolving childhood growth and development in pediatric patients, guidelines must accommodate unique, discrete episodes in pediatric life such as during the newborn period, childhood, and adolescence. More so than in other fields, pediatric scenarios rely on the collaborative participation of the parent and family in assessing history, considering diagnoses, and rendering management, and this reliance on parents and family not only influences the nature of history taking but also challenges physician decision-making. These complex social interactions inherent in general pediatric care underscore the value cognitive services play in establishing criteria for pediatric medical decision-making.

The Academy is interested in the CMS proposal to abolish H&P requirements in assessing E/M level and instead to focus solely on the role of medical decision-making, but we admit that such removal of H&P requirements must be accompanied by a decision-making or time-based rating system that appropriately and accurately adjudicates pediatric encounters. The removal of H&P documentation guidelines acknowledges that medical decision-making most closely equates to medical necessity and the nature of the presenting problem, but the E/M rating replacement must accommodate the unique encounters performed by pediatricians and pediatric specialists.

We appreciate CMS acknowledgment that the evolving approach to EHR data entry requires a renewed assessment of the role of H&P in E/M level and value assignment. While we recognize that the primary clinician assumes ownership of the medical record's characterization of the patient visit, such ownership must accommodate the expanded contribution allowed through patient portals and patient-submitted H&P elements. In addition to the patient and family, multiple healthcare personnel including ancillary staff make valuable contributions to the record which enhance patient care under the purview of the primary physician. Thus, establishing arcane, arbitrary restrictions on physician use of medical record data and narrative diminishes the value and contribution that EHR and patient portal use allow. In alignment with the physician's medical training, being able to incorporate, review, edit, and modify these important multi-faceted contributions acknowledges the role of clinicians in assessing complex data points, and this multi-sourced contribution to the record need not detract from the physician's ownership and performance of H&P which has been supplemented from multiple sources.

Furthermore, pediatric history especially is unconventional and dependent on patient age, developmental status, and social milieu. For example, the unique aspects of newborn care with its reliance on maternal history and the unnecessary imposition of mandated review-of-systems criteria is but one demonstration of the inappropriateness of current documentation guidelines in pediatric care. We also note current clinical scenarios which demonstrate capacity for robust and meaningful documentation without the imposition of complex H&P guidelines (such as Neonatal/Pediatric Intensive Care, Neonatal/Pediatric Critical Care, Newborn Care, and Discharge services).

If H&P were to be removed from E/M level assessment, we agree with CMS that E/M level and valuation would then primarily focus on time and decision-making. Currently, time plays an important role in level selection when counseling and/or coordination of care dominate the visit. Counseling and care coordination are especially important elements in pediatric care because of the challenges in communicating with pediatric patients and the need to ally parents and family in addressing clinical need. When incorporating time into service valuation, it is essential that either patient as well as parent/family time be included in that assessment.

Because the parent/family play such a central role in delivering pediatric care, guidelines must be clear in allowing time with parent/family to accrue to time-based E/M selection. In addition, the requirement that office-based time be face-to-face with the patient is not practical for pediatric care where face-to-face time with parent/family remains just as relevant and contributory as patient time. Furthermore, as clinician time becomes more central to coordinating multi-disciplinary team care, consideration must be given to extending billable physician office time outside of face-to-face contact to also include non-face-to-face physician office time devoted to managing the encounter.

Also, unique to pediatric care, the extended time incurred in collecting and documenting highly comprehensive developmental histories and exams must be recognized for the developmental pediatric specialist where the complex nature of the developmental history and exam itself represents an elevated type of decision-making that would not conventionally conform to an E/M rating approach devoid of H&P criteria. In order to accommodate such unique scenarios, CMS must expand definition of time beyond conventional counseling and care coordination to also include exceptional time-based physician-patient activities that primarily focus on H&P. For example, since chronic disease may be less prevalent in the primary care pediatric population, a pediatrician may expend extensive diagnostic and evaluative

effort and time for an encounter that may not result in prescriptive therapy and may not score an E/M level sufficiently representative of physician work using current decision-making rating systems.

To best represent pediatric care, CMS should expand the definition of time to go beyond just counseling/care coordination, expand allocation of time to also include office-based non-face-to-face time, and allow the clinician to select E/M to the highest representative level using either time or other components.

If medical decision-making is to play the central prominent role in assessing E/M level and value, the AAP looks forward to participating with CMS to ensure that decision-making guidelines are relevant and reflective of pediatric care. While current elements of diagnostic/management options, data complexity, and risk remain reasonable categories by which to assess physician effort, those categories must be sufficiently expansive and inclusionary to accommodate pediatric care. For example, current approach to diagnostic complexity does not readily capture the higher level of physician effort expended in management of clinical problems that may be stable or changing as expected yet still require a high level of complex physician diagnostic and therapeutic assessment.

As previously noted, many pediatric encounters may require intensive diagnostic, cognitive, and evaluative physician work which may not be result in discharge pharmacologic therapy, and this complex cognitive work is not well-addressed in current decision-making algorithms. Assessment of data complexity does not currently account for the expansion of uploaded data that is now possible and does not acknowledge the complexity of assessing multiple lab and imaging studies derived from the same code family. Especially relevant to pediatrics, the interactive complexity in pediatric care with focus on the dynamics of parent-child-physician interaction could be more fully acknowledged for its role in imposing increased data complexity effort by the physician.

In addition, we recognize the importance that risk plays in assessing medical decision-making, and the AAP looks forward to the opportunity to assist CMS in enhancing its Table of Risk to better align with neonatal, infant, and pediatric clinical scenarios that will apply both to the primary care pediatrician and pediatric medical/surgical subspecialist. Because of the AAP's unique expertise and understanding of primary and specialty pediatric care, we seek the opportunity to collaborate with CMS in creating an approach to coding medical decision-making that uniquely addresses pediatric care.

Currently popular medical decision-making point systems do not fully incorporate these important aspects of pediatric care, and CMS has thus far shied away from authorizing any particular decision-making rating system for medical decision-making. We value the CPT process and recognize the collaborative and professional relationship that CMS has established with CPT. Because CPT currently includes H&P among its key components in selecting E/M level, we anticipate that CPT will play an integral role in representing clinicians in this groundbreaking evolution in E/M coding. If decision-making were to be elevated as the primary means of E/M selection, providers will look to CMS to play an important role in clarifying a decision-making rating approach that accommodates a wide spectrum of clinical scenarios. Because of the unique needs of pediatricians and their patients, contemplating deletion of H&P guidelines will require collaboration with the Academy in structuring an alternative rating system that appropriately accommodates the full spectrum of healthcare including newborns, infants, children, and adolescents. The AAP looks forward to engaging CMS in this discussion.

Medicare Telehealth Services

The Academy appreciates CMS' proposed expansion of the list of Medicare telehealth services, particularly with regard to the Health Risk Assessment codes (96160 and 96161).

The Academy appreciates the opportunity to provide comments on the July 21st proposed rule and looks forward to working with CMS to ensure that the physician fee schedule accurately reflects the work value of physician practice and pediatric care.

Sincerely,

Fernando Stein, MD, FAAP
President

FS/ljw