September 13, 2019

The Honorable Seema Verma
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1715-P
Mail Stop C4-26-05
7500 Security Blvd
Baltimore, MD 21244-1850

Re: File Code-CMS-1715-P; CY 2020 Revisions to Payment Policies under the Physician Payment Schedule and Other Changes to Part B Payment Policies (August 14, 2019)

Dear Administrator Verma:

On behalf of the American Academy of Pediatrics (AAP), a non-profit, professional organization of 67,000 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; CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies published in the August 14th, 2019 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 children, their families, and their physicians. Therefore, the Academy offers these comments on the proposed rule to ensure that all new policies reflect this important principle.
**Immunization Administration (CPT Code 90460)**

The Academy respectfully requests that CMS utilize the RUC recommended direct practice expense (PE) inputs to publish PE relative value units (RVUs) for CPT code 90460 *Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered*.

Code 90460 was reviewed by the RUC in October 2009. Rather than accepting the RUC recommendations, CMS crosswalked code 90460 from code 90471 *Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)*, which is crosswalked from code 96372 *Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular* (formerly code 90772 and then 90782).

The recent measles crisis spotlights the importance of immunization administration (IA) being appropriately valued. Since one-third of pediatric visits include immunizations, appropriate IA payment is essential to ensure access to vaccines provided in the medical home, where studies have shown immunization rates are higher.

The crosswalk from code 96372 to codes 90471/90460 is not appropriate as the clinical staff documentation requirements are significantly more robust for IA than they are for the service of therapeutic injection:

*Clinical staff enters vaccine information into the patient medical record to include the vaccine type, lot number, site, date of administration, and date of VIS as required by federal law. A final check of the patient is done to confirm that there are no serious immediate reactions and final questions are answered. Clinical staff enters data into the state online immunization information system (registry) and maintains the vaccine refrigerator/freezer temperature log.*

Furthermore, the crosswalk has brought about a 60% reduction in PE RVUs, resulting in payment substantially lower than current CDC regional maximum charges. Since 90460 is among the most commonly reported codes in pediatrics, the impact to any practice providing childhood immunizations is significant and without adequate payment to offset costs, some practices could be unable to offer vaccines.

Historically, CMS typically only uses a crosswalk for work values, not PE values. Additionally, when the RUC makes crosswalks, it disconnects the codes after the initial crosswalk – so that changes to the source code no longer affect the crosswalked code. CMS also has this option – since once the crosswalk is used, the codes no longer need to stay linked.
Finally, it should be noted that CMS has already validated the RUC-recommended values for code 90460. CMS used the RUC-recommended values for code 90460 to value the fast-tracked H1N1 IA code (90470) for 2010 – as both codes were reviewed during the same RUC meeting (October 2009).

**Office Visits (CPT Codes 99202-99205, 99211-99215, 99XXX)**

The Academy commends CMS for accepting the RUC recommendations for the Office Visit CPT codes (99202-99205, 99211-99215, 99XXX). We respectfully request clarification on two issues as we prepare our members for 2021 implementation.

A. **10-Day ‘Window’ Reference for Office Visit Valuation**

We appreciate the opportunity to respond to CMS request for clarification of the impact of 3-day pre and 7-day post-service periods as relates to Office Visit valuation. CMS reference to a ‘new 10-day window’ (page 40674) is not conceptually different from the current way that CMS views the pre- and post-service periods for the Office Visit codes; therefore, it would not be accurate to refer to it as a “new” 10-day window.

Rather than instructing providers to consider all time spent 3 days prior to or 7 days after the Office Visit, the RUC survey applied conventional pre- and post-period concepts in instructing survey participants to report only time in the 10-day period that was related to the Office Visit encounter itself and to not otherwise include time that was separately reportable. The survey included the statement, “For this survey, your physician time and physician work estimates should also incorporate work and time you typically perform before and after the date of the encounter if the service is not separately reportable.” The survey goes further in instructing the provider to only reference that time that is “related to this procedure” (ie, the Office Visit itself) and requests that the provider “not include time for work related to another service, procedure, or evaluation and management code that is separately reportable.”

The assignment of the 3- and 7-day pre- and post-periods is not conceptually new and is aligned - with existing approach to Office Visit valuation. For previous valuation, the Office Visits were also valued with a post-service period of 7 days. Even though that previous valuation only generically referenced the pre-service period as “days,” the formalization of that pre-service period to 3 days better defines that period without conceptually creating new coding rules and without impeding the ability to report separately billable services that are currently reportable during the Office Visit pre-service period. In further support of this, the Office Visit codes have always been surveyed with a 7-day post-service period and yet the 99358-99359 codes are currently reportable in this time period.
Appropriate understanding of these pre- and post-service periods has important implications in the reporting of non-E/M services during these periods. For example, while certain services acknowledge the existing 7-day post-service period and are explicitly prohibited during that time (such as the telephone care codes 99441-99443, which are not reportable if originating from a related Office Visit provided within the previous 7 days), other services (such as the non-direct prolonged service codes 99358-99359) were created to be independent of the pre- and post-periods based on their minimum time requirement which captures physician work exceeding that related to the E/M service. Further confirming our correct interpretation of these scenarios, CPT states that “prolonged service of less than 30 minutes total duration on a given date is not separately reportable because the work involved is included in the total work of the evaluation and management or psychotherapy codes.” This concept of prolonged service codes 99358 and 99359 capturing work that exceeds the total work of the E/M has not changed with the new code structure. The new CPT language clarifies that only the new prolonged service code 99XXX can be reported on the same date as the E/M service but does not restrict use of 99358-99359 on other dates of service.

We thank CMS for its interest in seeking support for correct interpretation of Office Visit valuation and separate billing. From the standpoint of CPT, documented time outside of the date of service that conforms to a separately billable service will be billable time (whether through use of prolonged service codes (99358-99359) or with other time-based codes). Neither CPT nor the RUC processes views Office Visits as a “10-day global” service that excludes other time-based coding.

B. **Prolonged E/M without Direct Patient Contact (99358-99359)**

CMS clarifies its interpretation of reporting CPT prolonged service codes 99358 *(Prolonged evaluation and management service before and/or after direct patient care; first hour)* and 99359 *(Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (List separately in addition to code for prolonged service))*), used for reporting prolonged evaluation and management service before and/or after direct patient care. CMS states that “CPT codes 99358, 99359 can be used to report provider time spent on any date (the date of the visit or any other day).” This is not correct. These codes are not reported for time spent on the date of an Office Visit (99202-99205, 99211-99215).

CMS further states that it is unclear if 99358 and 99359 can be reported in addition to or instead of the new 99XXX add-on code to describe extended time. The descriptor and guidelines clearly state that 99XXX should be utilized for the extended time on the date of encounter and that 99358 and 99359 are **not** to be reported for this time.
99XXX  Prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 minutes (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services)

(Use 99XXX in conjunction with 99205, 99215)
(Do not report 99XXX in conjunction with 99354, 99355, 99358, 99359, 99415, 99416)
(Do not report 99XXX for any time unit less than 15 minutes)

We agree that 99XXX describes the add-on code for extended time and that this CPT code is administratively simpler than the original CMS proposal.

Physician Online Digital Evaluation Service (CPT Codes 99421-99423)

The Academy applauds CMS for accepting the RUC recommendations for the physician eVisit codes (99421-99423) and assigning them as status ‘A’ (Active).

With the 2020 implementation of these codes, we encourage CMS to delete codes G2010 (Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, 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) and G2012 (Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, 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). The elimination of codes G2010 and G2012 supports CMS’ goal of reducing administrative burden through the adoption of the HIPAA-compliant CPT code set.

The entirety of services described by codes G2010 and G2012 can be captured by codes 99421-99423 – plus use of code 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). Code 99441 can be reported for physician-patient phone calls subsumed under the virtual check-in service – and will only require that CMS change the status of code 99441 from ‘N’ (Noncovered) to ‘A’ (Active).
Emergency Department Visits (CPT Codes 99281-99285)

As our members include pediatric emergency medicine physicians, AAP joined the American College of Emergency Physicians (ACEP) in the RUC survey for the Emergency Department (ED) Visit CPT codes (99281-99285). While AAP is pleased that CMS accepted the RUC recommendations for those codes, CMS’ proposal to increase the work values of the Office Visit codes (99202-99215) shifts the foundation upon which the RUC considered the ED codes in April 2018.

The RUC has three times (1997, 2007, 2018) recommended that the ED codes be the same value as the new patient Office Visit codes for levels 1-3. The September 2005 RUC rationale for the current work values of the ED codes, which has historically been accepted by CMS, is as follows:

“The RUC agreed that the original assumptions utilized in valuing the Emergency Department visits were flawed. In addition, the RUC’s recommendations on the new patient office visits (99201-99205) would create a rank order problem if the Emergency Department codes were not addressed. In the first Five-Year Review of the RBRVS, the RUC had recommended that the first 3 levels of Emergency Department services should be valued equivalent to the first three levels of new patient office visits. The RUC had further recommended that Emergency Department levels 4 and 5 should be valued higher than the level 4 and 5 new patient office visits. The RUC reaffirms its previous recommendations with this submitted recommendation.”

The ED codes had been undervalued compared to the new patient Office Visit codes since the 2010 increase in those codes due to Medicare elimination of the consultation codes.

The April 2018 increase was intended to bring the two code families back into alignment. Now that the new patient Office Visit codes are proposed to increase in 2021, the inequities will return -- perpetuating a problem even before the current fix is implemented.

We join our ACEP colleagues in requesting that CMS increase the ED code work values to the same levels as the proposed new patient Office Visit codes. If code 99201 is removed from the code set, then there is no direct cross walk to 99281.

<table>
<thead>
<tr>
<th>ED wRVU</th>
<th>New Office Visit wRVU</th>
<th>Difference</th>
<th>% Difference</th>
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<tbody>
<tr>
<td>99281</td>
<td>0.48</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>99282</td>
<td>0.93</td>
<td>99202</td>
<td>0.00</td>
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<tr>
<td>99285</td>
<td>3.80</td>
<td>99205</td>
<td>0.30</td>
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We ask that the work relative value unit (wRVU) of 99283 be raised to match the new proposed wRVU of 99203 of 1.60.

We ask that the wRVU of 99284 be raised to maintain historic relativity to 99204 by 6.9% to 2.74.

We are proposing a direct crosswalk between 99202 and 99203 and 99282 and 99283 as in the chart above. To maintain relatively and avoid rank order anomalies across both families of codes, for 99284 we propose using the relative difference between 99204's current wRVU and the proposed wRVU for 2021.

For 99204 to 99284:
\[
\frac{(2.43-2.60)}{2.43} = \frac{2.60}{2.43} = 1.099% = 2.74
\]

Applying the same methodology to 99205 and 99285:
\[
\frac{(3.17/3.50)}{3.17} = \frac{3.50}{3.17} = 10.41% = 4.20
\]

However, we ask that the wRVU of 99285 be raised to 4.00. Although the crosswalk suggests a higher wRVU for 99285 (4.20), we ask instead for 4.00, which was the survey median in the 2018 presentation to the RUC based on those that regularly provide the service. That presentation cited numerous peer reviewed journal articles showing the intensity of 99285 had increased significantly over the past decade because of fewer admissions based on more detailed workups in the emergency department setting.

We urge CMS not to let the ED code values slip again to be undervalued when compared to the new patient Office Visit codes.

**Principal Care Management**

CMS proposes to create two new codes for Principal Care Management (PCM) services, which would pay physicians for providing care management to patients with a single high-risk disease. CMS has aligned its proposal with many aspects of the current Chronic Care Management (CCM) codes, which require patients to have two or more chronic conditions. CMS references phrasing such as “lasting at least 3 months” and addresses seriousness of the single disease, such as placing patient at risk of acute exacerbation, decline, or decompensation.

While we support development of PCM codes, we strongly advocate for the creation of CPT codes rather than G codes. Toward that end, the Academy is very interested in partnering with its specialty society colleagues in proposing a CPT code change application for consideration in the near future, with a focus on the following:

- Aligning with CCM so that the initial clinical staff code will be 20 minutes while the physician code will be 30 minutes
Creating an add-on code for additional clinical staff time beyond 20 minutes

- Raising concern about reference to "frequent adjustments to medication regimen," which need not be a criteria to manage serious disease
- Raising concern about reference to complexity dependent on co-morbidities -- since the presence of co-morbidities need not be a factor in identifying serious pediatric disease

**CMS.gov Physician Fee Schedule Search Tool**

The [Physician Fee Schedule Search tool on the CMS.gov web site](https://www.cms.gov) does not currently compute payment levels for codes designed 'N' (Noncovered).

For example, when code 99391 (Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; infant (age younger than 1 year)) is entered, the result is:

“The current Physician Fee Schedule does not price the requested HCPCS Code(s).”

As CMS publishes values for ‘N’ codes on the [Medicare Physician Fee Schedule](https://www.cms.gov), this CMS tool should compute payment levels for codes designated ‘N.’

For services assigned status indicator ‘N,’ CMS has historically published values, which effectively provides a basis for non-Medicare utilization without impacting Medicare budget neutrality. This practice is helpful to children because it allows pediatricians and other child health providers to refer to CMS-published values for codes in their negotiations for payments with other payers (whether in Medicaid, Tricare, or private pay).

Furthermore, even though these services may be noncovered by Medicare, they may in fact represent covered Medicaid services and, as such, payment information provides supportive value within the broader CMS domain.

**Quality Payment Program**

A small minority of pediatricians participate directly in the Quality Payment Program (QPP). Nonetheless, the QPP affects children’s health and the practice of pediatricians because CMS’ Medicare payment programs set the direction for value-based payment by a multitude of payers, integrated health systems, and other stakeholders. It is essential that CMS consider the impact of the QPP and other Medicare-centric payment programs on pediatrics. The inherent differences between children and adults require special consideration when implementing value-based payment models in pediatric
populations. Bundling the care of adults and children into one health care delivery and financing system risks encouraging system transformation that ignores the unique characteristics of children. Innovations toward value-based payment and other alternative payment models, including accountable care organizations, the inclusion of social determinants of health, population health, appropriate quality measurement for the pediatric population, and other initiatives and reforms are not only critically important for pediatrics but must be developed with a pediatric focus, as pediatrics differs in many ways from adult-oriented medical care. The Academy asks CMS to include this consideration in further development of Medicaid-led system transformation as well as in the future directions of the QPP.

The Academy appreciates the opportunity to provide comments on the August 14th 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. If you have any questions, please contact Linda Walsh at lwalsh@aap.org.

Sincerely,

Kyle E. Yasuda, MD, FAAP
President

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