December 7, 2016

Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1654-F
Mail Stop C4-26-05
7500 Security Blvd
Baltimore, MD 21244-1850

Re: File Code-CMS-1654-F; Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Final Rule;
(November 15, 2016)

Dear Administrator Slavitt:

The American Academy of Pediatrics (AAP) appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid Services (CMS) Final Rule on the Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017, published in the November 15, 2016 Federal Register. Although very few pediatric services are included in the Medicare program, payment policies introduced in Medicare are frequently adopted by the Medicaid program and eventually by private payers. Given that Medicaid and CHIP cover over 45 million US children, CMS has an obligation to consider the impact of policies on pediatrics. Therefore, the Academy offers these comments on the final rule to ensure that new policies appropriately accommodate the unique aspects of health care services delivered by primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists.

Health Risk Assessment (CPT Codes 96160-96161)

The Academy is very appreciative of the attentive consideration CMS gave to the proposed rule comments regarding codes 96160-96161 and its decision to reverse its ruling and publish the RUC-recommended values for this rule.

96160 (Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument)
96161 (Administration of caregiver focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument)

In the final rule, CMS notes, ‘After considering comments, we believe that CPT codes 96160 and 96161 describe services that, in particular cases, can be necessary components of services furnished to Medicare beneficiaries. While we recognize that in many cases we have previously assigned non-payment indicators to codes that describe interactions with caregivers, we also note that we have also recognized that in current medical practice, practitioner interaction with caregivers is an integral part of treatment for some patients.’
The Academy agrees with CMS that codes 96160 and 96161 should be designated as ‘add-on’ codes (ie, ZZZ global period) as we cannot envision a situation in which a patient/caregiver will present to the pediatrician solely for the purpose of having a health risk assessment administered. While codes 96160 and 96161 will typically be performed in conjunction with an evaluation and management (E/M) service, this should not impact the RVUs for the codes since all of the RUC-recommended clinical staff time and medical supplies are subsumed by the intra-service period (consistent with an add-on code) and, therefore, do not duplicate E/M inputs.

The same holds true for the professional liability insurance (PLI) recommended for these codes. However, CMS failed to publish PLI RVUs for codes 96160 and 96161.

This runs contrary to CMS’ comments, that ‘…as add-on codes, CPT codes 96160 and 96161 describe additional resource components [emphasis added] of a broader service furnished to the patient that are not accounted for in the valuation of the base code.’

It also conflicts with precedents established by other ‘ZZZ’ global period codes that do include PLI RVUs, such as:

90472 Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid)

96375 Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug

Therefore, the Academy respectfully requests that codes 96160 and 96161 include PLI RVUs as part of their total valuations for 2017.

**CMS Policy on Noncovered Medicare Services**

While the Resource-Based Relative Value Scale (RBRVS) was initially developed as the Medicare physician fee schedule, CMS had come to understand that the majority of non-Medicare payers (ie, Medicaid and private payers) utilize RBRVS values in setting their own fee schedules. Until very recently, CMS published American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC)-recommended values on RBRVS, even when those services were assigned status indicator “N” (noncovered) or “I” (invalid for Medicare purposes) under the Medicare program.

Given the consequence of this issue to pediatrics, the Academy reiterates its comments emanating from the 2016 RBRVS final rule.

In the 2016 RBRVS final rule, CMS failed to publish the RUC-recommended values for two new/revised ocular screening codes (99174 and 99177), offering the following explanation:

*We continue to believe CPT codes 99174 and 99177 are screening services and are therefore non-covered services under the Medicare program. Therefore, for CY 2016, we are finalizing our proposed assignment of a PFS status indicator of N (non-covered service) for CPT codes 99174 and 99177. Because we have not reviewed the recommended values for these services, we do not believe that we...*
should develop or display RVUs for these services. In some cases in the past, we have developed and
displayed RVUs for codes not separately payable by Medicare. However, we note that this practice has
not been consistently applied and we have concerns about this practice since it is not apparent in the
display itself that the resulting RVUs do not reflect our review or assessment of the recommendations nor
do they reflect the influence of updated Medicare claims data. However, we understand that, for PFS
nonpayable services, displaying RVUs that are based solely on recommendations may serve an interest
for the public. Therefore, we will consider for the future how we might reconcile that interest with our
interest in maintaining a clear distinction between the RVUs that result from our established
methodology and RVUs that result solely from recommended input values [emphasis added].

Until recently, CMS has published RUC-recommended values for noncovered services, effectively
providing a basis for non-Medicare utilization without impacting Medicare budget neutrality. This
practice was helpful to children because it allowed pediatricians and other child health providers to refer
to CMS-published relative value units (RVUs) for codes in their negotiations for payments with other
payers (whether in Medicaid, Tricare, or private pay).

RBRVS remains the “gold standard” for valuation and the RUC is the only committee charged with
developing valuation recommendations for RBRVS. Therefore, the Academy actively participates in the
RUC process since it allows pediatrics to provide direct input into how pediatric services are valued and
paid. However, CMS’ policy change no longer affords pediatrics the same opportunities as other medical
specialties -- since a greater number of pediatric services fall into the ‘noncovered’ category. This CMS
policy change has impacted several essential pediatric services, including ocular screening, topical
application of fluoride varnish, and maternal depression screening.

Furthermore, even though these services may be noncovered by Medicare, many represent covered
Medicaid services and, as such, RVU publication provides supportive value within the broader CMS
domain. Without such accommodation by CMS, for children especially, the effect of CMS’ decision will
be severe. Pediatrician experts who focus on coding have stated that the decision not to publish RUC-
recommended RVUs may lead to the creation of an unregulated payment regime in every state as payers
and providers are forced to re-negotiate values for every code not recognized for payment by Medicare (as
opposed to the Medicaid) side of CMS. Pediatricians are severely disappointed by CMS' decision, since
publishing the RVUs for noncovered services in the physician fee schedule does not represent a penny of
cost to Medicare but represents a prejudicial denial of a fully vetted RUC valuation process and negates
the arduous advocacy efforts of pediatricians to assure equal recognition of services to children. CMS’
action, by refusing to publish noncovered codes’ values, undermines highly preventive, cost effective
services and deals a severe blow to children’s health care – most recently maternal depression screening.

We note that rather than increasing CMS resource utilization, such publication of noncovered RVUs
would reduce CMS resource expense by alleviating the continual need to respond and explain the absence
of RVUs for these services. As we have stated, CMS rendered this sweeping seismic shift in practice
based on a rationale (lack of CMS assessment, review, updating) that can be easily addressed through
instructive fee schedule footnoting or detail.

The Academy appreciates the opportunity to assist CMS in accommodating the publication of RVUs for
noncovered services as outlined in the 2016 RBRVS final rule. While CMS states that such publication
might erroneously imply CMS review and assessment of these noncovered service RVUs, we suggest that
CMS can publish these RVUs without such risk through acceptable approaches including any of the following:

- Appending a footnote that informs readers that the RVUs are RUC-recommended only
- Establishing separate columns for publishing RUC-recommended values for noncovered services
- Including an asterisk (*) after the RUC-recommended values of noncovered services
- Explicitly including CMS guidance that although RVUs are published for noncovered services, such publication represents RUC-recommended valuation rather than CMS-established methodology

The Academy is prepared to collaborate with CMS in accommodating this worthwhile pursuit and we welcome the chance to meet with you to discuss it further.

In recognizing our collective responsibility to provide preventive and cost effective care for children and diminishing their burden of disease, we are confident that CMS will restore its previously long-held willingness to publish noncovered RVUs.

The Academy appreciates the opportunity to provide comments on the November 15th final 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, AAP staff, at 847/434-7931 or lwalsh@aap.org.

Thank you.

Sincerely,

[Signature]

Benard P. Dreyer, MD, FAAP
President

BPD/ljw