January 20, 2021

The Honorable Seema Verma
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1734-IFC
Mail Stop C4-26-05
7500 Security Blvd
Baltimore, MD 21244-1850

Re: File Code-CMS-1734-IFC; Interim Final Rule for Coding and Payment of Virtual Check-in Services and Interim Final Rule for Coding and Payment for Personal Protective Equipment

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) Interim Final Rule with Comment Period (IFC) on Coding and Payment of Virtual Check-in Services and Coding and Payment for Personal Protective Equipment (PPE) released on December 1st, 2020. 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.

Coding and Payment for Personal Protective Equipment (PPE)

To address the financial impact of the additional supplies and new staff activities required to provide safe patient care during the COVID-19 public health emergency (PHE), the CPT Editorial Panel approved CPT code 99072 (Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a Public Health Emergency, as defined by law, due to respiratory-transmitted infectious disease) and the RUC submitted extensive research and analysis describing the direct costs for the code. Organized medicine advocated that CMS immediately implement and pay for CPT code 99072 with no patient cost-sharing during the PHE and fully fund these codes using remaining money from the CARES Act Provider Relief Fund or by recognizing the decreased expenditures during the early months of the PHE to waive budget neutrality.
In the IFC, CMS is finalizing CPT code 99072 as a bundled service on an interim basis. Rather than recognizing the increased expenses due to intensive infection control practices by implementing CPT code 99072, CMS instead finalized, on an interim basis, medical supply pricing increases (e.g., an increase in the price of surgical masks and surgical masks with face shields that are bundled into few office-based procedure codes).

The Academy strongly recommends that CMS implement separate payment for CPT code 99072 during the PHE for the following reasons:

- CPT code 99072 is intended to address not only increased PPE expenses but also increased supplies and clinical staff time incurred during the PHE. These increased supplies include not only items necessary for revised cleaning protocols but also items necessary to redesign and reorient office structure and workflow to accommodate physical distancing and modified scheduling. CMS’ medical supply pricing increases for surgical masks and surgical masks with face shields do not address these additional expenses.
- CPT code 99072 service is appropriately restricted to the PHE, which provides CMS the opportunity to project the increased costs incurred by active coverage of the code for a restricted period of time.
- Even though CMS states that 99072 resources are typically bundled into payment for other services, it is clear that during the PHE, these increased expenses are not incorporated into existing practice expense relative value units (PE RVUs) and rather than permanently modify PE RVUs, 99072 offers CMS the opportunity to temporarily accommodate these increased expenses during the PHE.

**Coding and Payment of Virtual Check-in Services**

CMS has requested comments regarding provision of lengthier audio-only services outside of the COVID-19 PHE, if not as substitutes for in-person services, then as a tool to determine whether an in-person visit is needed, particularly as patients may still be cautious about exposure risks associated with in-person services. In the interim, CMS has established a new code, G2252 (Brief communication technology-based service, eg, 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; 11-20 minutes of medical discussion), for which it has established a 60-day comment period.

The PHE has demonstrated that audio-only telephone services are valid not only in assessing whether an in-person visit is necessary but also in managing certain types of conditions and scenarios—especially those where there is strong familiarity between physician and patient. It has also demonstrated that a digital divide exists whereby some types of patients (e.g., elderly, rural, indigent) may not have access to the technology or knowledge to access real-time audio plus visual health care—but who can otherwise access health care via audio-only communication.

For these reasons, the Academy recommends that CMS permanently recognize and value the CPT codes for Telephone Care (99441-99443). CMS need not view these codes as telemedicine services in that they do not meet CMS criteria that define telemedicine services as real-time audio plus visual services. Telephone Care services are better aligned with other types of non-in-person services such as online digital evaluation and management eVisits (99421-99423).
The conceptual perspective established by CMS regarding the virtual check-in is misleading in that it delegates the role of virtual check-in communication to assess whether an in-person visit is necessary. While we do not suggest that an audio-only visit is equivalent to or a replacement for an in-person visit, we recognize that just as with eVisits, the audio-only visit represents another type of visit communication that can accomplish assessment and management goals with many types of scenarios. We view audio-only visits within a continuum of evaluation and management (E/M) that does not replace office E/M but rather expands the scope of care available to patients and physicians. Audio-only visits also increase access for those who may have limited access to care due to broadband limitations.

While we appreciate the valuation crosswalk of code G2252 to CPT Telephone Care code 99442, use of HCPCS Level II codes to address CMS valuation disadvantages physicians such as pediatricians who have large exposure to Medicaid populations. While HCPCS Level II codes are technically available for use by any payer, the majority of non-Medicare payers such as Medicaid programs do not consistently and reliably incorporate HCPCS Level II codes into their fee schedules, instead focusing predominantly on CPT codes. By addressing the CPT Telephone Care code concepts without active valuation of those CPT codes on the Medicare Physician Fee Schedule essentially creates a void in audio-only service valuation for providers who rely on non-Medicare payers for most of their services.

**Immunization Administration**

The importance of immunization administration (IA) cannot be underestimated and, therefore, warrants comment outside of the IFC. The ongoing COVID-19 PHE highlights the need for a robust and effective vaccine delivery infrastructure to protect individuals and communities from vaccine-preventable diseases. As CMS identifies in its September 2020 preliminary Medicaid & CHIP data snapshot, routine childhood immunization rates among children up to age 2 dropped by more than one-third between January 2020 and May 2020. These declines leave children and their communities susceptible to outbreaks of preventable diseases like measles while their communities continue to grapple with COVID-19 (please see https://www.nejm.org/doi/full/10.1056/NEJMoa1912514).

The declines in service use have also harmed pediatric practices and other primary care providers, who have confronted serious financial challenges and limited financial relief leading to furloughs, layoffs, forgone salaries, schedule reductions, and even temporary or permanent closure. One-third of pediatric visits include immunization administration and counseling, and inadequate payment for this essential service threatens the ongoing viability of pediatric practices. The AAP is deeply concerned that inadequate payment will force pediatric practices to consider choices like permanent closure of practice resulting in decreased access to care, reducing their investment in vaccine counseling and confronting vaccine hesitancy, limiting participation in Medicaid and CHIP, or restricting service hours or days. These outcomes would have long-lasting impacts on children’s timely access to care and on the nation’s vulnerability to outbreaks of vaccine-preventable diseases.

In promulgating the Medicare Physician Fee Schedule (MPFS), CMS must acknowledge the impact that its national policy has outside the traditional Medicare fee-for-service program, including uptake by commercial carriers and Medicaid agencies. CMS has an obligation to address the impact of its MPFS on populations who are not Medicare beneficiaries, and particularly on Medicaid and CHIP enrollees for whom CMS has a direct responsibility. The family of IA codes particularly impact children and the physicians who care for them.
In the 2021 MPFS final rule (CMS-1734-F), CMS notes that it is “finalizing a policy to maintain the CY 2019 payment for all nine of the services in this family.” The AAP has concerns with the final policy for CY 2021:

- CMS’ statement is not accurate. The values published for the IA codes on CY 2021 Addendum B are not consistent with the values published for the IA codes on CY 2019 Addendum B, leading us to question the origin of the CY 2021 IA values.
- The CY 2021 IA values are clearly not consistently resource based. For example, the direct inputs for CPT code 90471 (Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)) are incorrect in the CY 2021 PFS Final Rule Direct PE Inputs and should instead reflect the direct practice expense inputs that are listed for 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). Currently, CPT code 90471 has no supply inputs listed and only 4 minutes clinical staff time.
- CMS offers no justification in its final rule for its ostensible policy of maintaining the CY 2019 payment for all nine IA services rather than for finalizing its initial CY 2021 proposal. The initial CY 2021 proposal to fix the problematic hard coding to the therapeutic injection code (96372 Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular) by linking all base IA codes to CPT code 36000 (Introduction of needle or intracathether, vein) would have addressed the inadequate payment in the CY 2019 rates and would have clearly established equal treatment of essential immunization services regardless of population.

For these reasons, the AAP strongly urges CMS to issue a technical correction to the CY 2021 MPFS to correct the payment for all nine IA services. CMS should finalize its proposed policy to crosswalk the base IA codes to CPT code 36000 and implement a valuation for the add-on codes reflecting that work RVUs should be 88% of the value of the base codes and PE RVUs should be 91% of the base codes. CMS must issue this fix for CY 2021 to ensure appropriate payment for IA services immediately.

CMS will be able to respond to new information for the CY 2023 MPFS. The RUC intends to review all IA codes (90460, 90461, 90471, 90472, 90473, 90474, G0008, G0009 and G0010) in April 2021 with the goal of ensuring that the IA codes are consistently resource-based and valued commensurate with RUC recommendations. However, failure to correct the inadequate payment rates for IA codes for CY 2021 will stunt the public health response to the COVID-19 PHE and leave the nation more vulnerable to outbreaks of vaccine-preventable diseases.

The Academy appreciates the opportunity to provide comments on the December 1st interim final rule with comment period 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 Senior Manager, Health Policy & Coding, at lwalsh@aap.org.

Sincerely,

Lee Savio Beers, MD, FAAP
President

LSB/ljw