American Academy of Pediatrics
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September 29, 2020

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

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 (August 17, 2020)

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 2021 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies published in the August 17th, 2020 *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.

Emergency Department Services

The Academy commends CMS for proposing to increase the wRVUs of codes 99283, 99284, and 99285 to ensure that relativity between the Emergency Department codes and the Office Visit codes is maintained.

Immunization Administration

The Academy applauds CMS for proposing to crosswalk the valuation of the base Immunization Administration (IA) codes (90460, 90471, 90473) to code 36000 (*Introduction of needle or intracatheter, vein*), as the current values of 36000 more accurately reflect the relative resource costs associated with immunization administration. In addition, the Academy strongly supports the CMS proposal to apply the same crosswalk to base IA codes across all populations, including for immunizations most often used in patients who are enrolled in Medicare (ie, HCPCS codes G0008, G0009, and G0010). This approach underscores that immunizations are key in all populations to avoid community outbreaks of vaccine-preventable illness.

As is the nature of crosswalks, the involved codes are disconnected after the initial crosswalk so that changes to the source code (36000) no longer affect the crosswalked code(s) (90460, 90471, 90473, G0008, g0009, G0010). The Academy believes that this is the best possible situation for a service as essential as immunization administration.

The Academy requests that CMS reconsider its proposal to value the add-on Immunization Administration codes (90461, 90472, 90474) at "half the valuation of the base codes." CMS proposes this based on the determination that "the previous valuation methodology set their RVUs at approximately half the value of the base codes." This is inaccurate; the value of the add-on Immunization Administration codes are not half of the base codes for work or practice expense (PE) RVUs. The work RVU for the add-on codes is 88% of the value of the base codes and the PE RVU is 91% of the value of the base codes:

Current IA Base Codes wRVU (90460, 90471, 90473)	Current Add-On IA Codes wRVU (90461, 90472, 90474)	Current wRVU Percentage Difference	Current IA Base Codes PE RVU (90460, 90471, 90473)	Current Add-On IA Codes PE RVU (90461, 90472, 90474)	Current PE RVU Percentage Difference	Proposed IA Base Codes wRVU (90460, 90471, 90473)	Proposed Add-On IA Codes wRVU (90461, 90472, 90474)	Proposed wRVU Percentage Difference	Proposed IA Base Codes PE RVU (90460, 90471, 90473)	Proposed Add-On IA Codes PE RVU (90461, 90472, 90474)	Proposed PE RVU Percentage Difference
0.17	0.15	88%	0.22	0.20	91%	0.18	0.09	50%	0.69	0.35	51%

Therefore, the Academy respectfully requests that CMS apply the same magnitude relationship between the base and add-on codes as in the previous valuation:

Current IA Base Codes wRVU (90460, 90471, 90473)	Current Add-On IA Codes wRVU (90461, 90472, 90474)	Current wRVU Percentage Difference	Current IA Base Codes PE RVU (90460, 90471, 90473)	Current Add-On IA Codes PE RVU (90461, 90472, 90474)	Current PE RVU Percentage Difference	2021 IA Base Codes wRVU (90460, 90471, 90473)	2021 Add-On IA Codes wRVU (90461, 90472, 90474)	2021 wRVU Percentage Difference	2021 IA Base Codes PE RVU (90460, 90471, 90473)	2021 Add-On IA Codes PE RVU (90461, 90472, 90474)	2021 PE RVU Percentage Difference
0.17	0.15	88%	0.22	0.20	91%	0.18	0.16	88%	0.69	0.63	91%

Visit Complexity G Code (GPC1X)
CMS is proposing to implement a new Visit Complexity G code as follows:

GPC1X *Visit complexity inherent to evaluation and management associated with primary medical care services that serve as the continuing focal point for all needed health care services (Add-on code, list separately in addition to an evaluation and management visit)*

While we congratulate CMS on concluding the collaborative process undertaken with the CPT Editorial Panel and the RUC in supporting modifications and valuation of the Office Visit codes, that process has appropriately achieved the desired goals of representative valuation along with reduction in documentation and coding complexity -- without the 2021 addition of the Visit Complexity G code. The CMS recommendation to implement the Visit Complexity G code is now not only unnecessary but also injurious to a balanced MPFS and the resulting conversion factor. While we recognize that CMS highlights the role that longitudinal care plays as the rationale in implementing this Visit Complexity G code, previous work by CMS in valuing many other important, non-procedural services such as care management and remote monitoring services are effectively addressing gaps in care that transpire between patient visits.

The Office Visit codes are now positioned in 2021 to effectively represent physician time expended on the date of service as well as effectively accommodate visit complexity through enhanced medical decision-making guidelines. While acknowledging that CMS has already achieved these important goals through this direct focus on the Office Visit codes, the addition of a supplemental Visit Complexity G code needlessly erodes appropriate valuation in the non-E/M portion of the MPFS, which is especially poignant during a period of financial stress brought about by the COVID-19 pandemic and resulting public health emergency (PHE). Furthermore, the CMS pursuit through application of a HCPCS G code is not as universally effective as working through the CPT process to effect nationally standardized coverage solutions for patients of all ages.

Virtual Check-In (G2012)
CMS is seeking input on whether it should develop coding and payment for a service similar to the virtual check-in but for a longer unit of time and with an accordingly higher value.

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*

We value CMS recognition of the role of audio-only communication in supporting effective care and agree that the historical valuation of the Telephone Care codes underrepresented the role that they have played during the PHE. This has been demonstrated by CMS' temporary increase in their valuation to achieve payment and coverage parity with the Office Visit codes. But CMS' longer-term approach to modify its Virtual Check-In G code rather than actively cover and enhance the Telephone Care CPT codes does not represent the most desirable approach to valuing audio-only, telephone services. Instead, we recommend CMS utilize existing Telephone Care CPT codes and assign appropriate valuation in recognizing the role that these services play in supporting care.

We appreciate the impact that technically challenged Medicare beneficiaries have on the ability to achieve reliable audio plus visual connections and thus CMS' need to offer an audio-only care solution that is appropriately valued and representative of the effective decision-making that can occur via electronic communication. In addition, we acknowledge that at-risk beneficiaries may lack supportive broad-band access that restricts beneficiary access to audio plus visual contact while limiting remote contact to audio-only. Pediatricians are also experienced in those challenges faced by families who lack technical sophistication or limited remote access. The PHE has demonstrated that effective assessment and decision-making can be achieved by telephone; thus, we support permanent increased valuation and recognition of these services beyond the PHE so that pediatric patients can have access to these services.

While a handful of non-Medicare payers started to utilize this code during the COVID-19 PHE, most Medicaid programs and commercial payers do not recognize G codes. This is especially true when there are CPT codes in existence for the same/similar services, as they are the most efficient and specific path to coverage. It is preferable for CMS to recognize the RUC-recommended values for the Telephone Care CPT codes (99441-99443 and 98966-98968) and assign them status "A" (Active) on the MPFS to foster equal access to these services for patients of all ages.

Initial Preventive Physical Examination (IPPE) and Initial and Subsequent Annual Wellness (AWV) Visits
CMS proposes to revise the work, physician time, and direct practice expense inputs for the following codes to maintain their alignment with Office Visit codes 99204 and 99214, on which their values are based:

G0402 *Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment*
G0438 *Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit)*
G0439 *Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit*

CMS' proposal results in a net increase in value for these G codes.

In keeping with CMS' goal of alignment and relativity, the Preventive Medicine Service CPT codes (99381-99397) should also be revised commensurate with the Office Visit codes on which their value is based. Just as the Medicare wellness services are critical to promoting health and reducing overall health care expenses, the pediatric wellness services that incorporate age-specific preventive plans (reported with the Preventive Medicine Service CPT codes) are equally important in this role. The preventive care offered to children should be similarly recognized with revision in the value to maintain alignment with Office Visit codes.

When the Preventive Medicine Service CPT codes were last valued by RUC in 2010, an anomalous relationship was identified because the codes had not been included in the third Five-Year review that included the Office Visit codes. By not aligning the Preventive Medicine Service codes with the Office Visit codes now, an anomalous relationship will again be created. Please see attached Appendix for more information.

Hearing Assessment Services (92X51 -- Recently Assigned 92650)
92650 *Auditory evoked potentials; screening of auditory potential with broadband stimuli, automated analysis*

CMS indicates that 92650 "….is a screening service and is not payable by Medicare. Therefore, we are not proposing a valuation for this code; however, we will display the RUC-recommended work RVU of 0.25."

For services such as 92650 that are essential to both pediatric and adult care, it is always our preference that CMS assign status indicator "A" (active) on the MPFS. Short of that, the Academy strongly urges CMS to at least publish the full complement of RVUs associated with this service – the RUC-recommended work and practice expense RVUs, as well as the professional liability insurance RVU. As we noted in our 2017 MPFS NPRM comment letter, CMS publishing of values for noncovered services 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 RVUs for codes in their negotiations for payments with other payers (whether in Medicaid, Tricare, or private pay).

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 continue to publish the full complement of RVUs associated with all noncovered services, including 92650.

The Academy appreciates the opportunity to provide comments on the August 17th 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, AAP Senior Manager, Health Policy & Coding, at lwalsh@aap.org.

Sincerely,

Sara Goza MD, FAAP

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President

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