American Academy of Pediatrics
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345 Park Blvd
Itasca, IL 60143
Phone: 630/626-6000
Fax: 847/434-8000
www.aap.org

May 28, 2020

The Honorable Seema Verma
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1744-IFC
Mail Stop C4-26-05
7500 Security Blvd
Baltimore, MD 21244-1850

Re: File Code-CMS-1744-IFC; Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency (April 6, 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) Interim Final Rule with Comment Period (IFC) on the Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency published in the April 6, 2020 *Federal Register*.

The Academy applauds the actions taken by CMS to date to facilitate and enhance the ability of our health care workforce to focus on COVID-19 treatment and relief by providing regulatory flexibilities through the duration of this public health emergency (PHE). The actions taken by CMS have provided relief to physicians in the form of temporary enrollment flexibilities, guidance about advanced payments in Medicaid managed care, payment of audio-only telephone calls in Medicare, the addition and expansion of telehealth benefits in both Medicaid and Medicare, and the waiver of some existing documentation requirements, among other important actions. We believe that these actions will be instrumental in providing a pathway for our physicians and other clinicians to focus on patient care during this PHE.

Telehealth needs to support and enhance the continuity demonstrated in the primary care patient-centered medical home or in reinforcing access to care such as with subspecialists who may not otherwise be readily accessible. As such, we write to you at this time regarding additional PHE actions that we urge CMS to take as soon as possible. We believe these actions will complement those taken to date by CMS and will further enable physicians to provide necessary care to those suffering from COVID-19, as well as their broader patient populations as needed and appropriate.

Respectfully, we strongly urge CMS to take the following actions:

1) Further expand the CMS Telehealth List

We recommend adding the following codes to the CMS Telehealth List:

Pediatric Preventive Medicine Services
99381-99385
99391-99395

Developmental Screening
G0451/96110

Emotional/Behavioral Assessment
96127

The health of children is at risk if Preventive Medicine Services (99381-99395) and their *Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents* recommended screenings are further delayed. Enabling these Preventive Medicine Services within a virtual context will reinforce the strength of the medical home and ensure that children and families can continue to access necessary and time-sensitive services from a trusted physician, even when the COVID-19 pandemic proscribes in-person visits. Therefore, given that CMS represents both Medicare and Medicaid, we request that such services be reportable as telemedicine services.

2) Adjust the Immunization Administration Codes

The COVID-19 pandemic has illuminated the serious consequences of an uncontrolled infectious disease. It is paramount that pediatricians remain able to deliver vaccines against preventable diseases during and after the PHE; the health care system and society at large cannot accommodate an outbreak of measles or whooping cough while the COVID-19 pandemic continues.

One of the most commonly used codes in pediatric care is CPT code 90460, for immunization administration and counseling for patients through 18 years of age. Its companion adult administration code, 90471, is used by pediatricians, family physicians, and other frontline physicians. These codes recognize that pediatricians not only physically administer vaccines, but also hold vital conversations with patients and parents to explain the importance of vaccines and combat vaccine hesitancy.

In 2010 CMS hard coded the pediatric immunization codes (90460 and 90471) to a separate code for therapeutic injections in adults (96372). That hard coding has been maintained, and in 2018 CMS cut payment for therapeutic injections by more than half, inadvertently cutting payment for immunization administration. Medicaid and private payers rely on the Medicare Physician Fee Schedule (MPFS) to set their rates, and the codes affected by the cut are the most commonly reported codes in pediatric practices.

In the 2020 MPFS final rule, CMS acknowledged the cuts were problematic and decided to keep payment at the higher 2019 level:

We recognize that it is in the public interest to ensure appropriate payment to physicians and other practitioners for provision of the immunization administration services that are used to deliver vaccines and plan to review the valuations for these services to ensure appropriate payment. In the interim, given our concern about public access to vaccines and in light of recent public health events, we are maintaining the CY 2019 national payment amount for immunization administration services for CY 2020.

We strongly agree with this conclusion given our shared concern about public access to vaccines and in light of recent public health events.

However, CMS applied this policy only to three immunization administration codes commonly used for services provided to Medicare beneficiaries (HCPCS codes G0008, G0009, and 00010 for administration of influenza, pneumococcal, and hepatitis B vaccines, respectively,) and not to immunization administration codes widely used for pediatric and adult populations outside the Medicare program.

In order to rectify this situation, we ask CMS to:

1. Issue a technical correction to the Medicare Program; CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule (PFS) and Other Changes to Part B Payment Policies Final Rule, maintaining the CY 2019 national payment amount for CPT codes 90460 and 90471 for CY 2020.
2. Discontinue hard coding the value from 96372 to 90460/90471 in CY 2021 and beyond, instead using the RUC-recommended valuations for the 90460/90471 codes.

3) Further expand the Primary Care Exception Rule (PCER) to include Pediatric Preventive Medicine Services (99381-99385, 99391-99395)

Since CMS has expanded the PCER to now include all levels of Office Visits, we request that CMS include the PMS codes, as well.

The Academy represents 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. A significant portion of Academy members work in academic institutions, often in safety net hospitals. These institutions are responsible for the training of all of the pediatric physicians who will serve families as their medical homes. To allow consistency with current policy and rationale, we are requesting that CMS include the Pediatric Preventive Medicine Services (PMS) codes (99381-99385 and 99391-99395) under the primary care exception rule (PCER).

Background

The PCER in the *Physicians At Teaching Hospitals (PATH)* guidelines (ie, CMS guidelines for health care provided by interns, trainees, and fellows, collectively referred to as 'trainees' in this document) allows teaching physicians to bill for primary care services provided by trainees under their supervision. These trainees must have completed at least 6 months of approved graduate medical education. To qualify for this exception, services must be provided in a teaching hospital or clinic. If the services are provided outside a hospital, there must be a written agreement with the teaching hospital that includes a contract outlining the payment for the teaching services or written documentation that the services will be 'donated.' In general, this exception cannot be applied in a private physician's office.

The teaching physician must be physically present in the setting where the care is taking place, must be immediately available to the trainees, and may not have other responsibilities (including supervising other personnel or seeing patients). No more than 4 trainees can be supervised at a time. The teaching physician must review the care (history, findings on physical examination, assessment, and treatment plan) provided either during or immediately after each visit. The documentation must reflect the teaching physician's participation in the review and direction of the services performed.

This exception allows the teaching physician to report CPT Office or Other Outpatient Services codes 99201-99203 for new patient visits and 99211-99213 for established patient visits when the service is provided by a trainee under the teaching physician's supervision. However, if a higher-level evaluation and management (E/M) service is necessary and performed, the teaching physician must personally participate in the care of the patient. As always, the selection of the code is based on the E/M code descriptions and documentation guidelines.

The PCER does not explicitly address the CPT Preventive Medicine Services (PMS) codes for either new or established patients (99381-99385, 99391-99395). The CPT PMS codes are classified as 'Noncovered' (ie, Status Indicator 'N') on the Medicare Resource-Based Relative Value Scale (RBRVS). However, these services are of primary importance in the training of primary care pediatric physicians.

Importance of the PCER

The PCER grew out of the recognition that trainees training in primary care specialties, unlike other medical/surgical disciplines, require extensive training with graded levels of supervision in the continuous supervision of their own panel of patients throughout their training, both preventive ('well-child care') and acute care visits. Unlike adult preventive care, well-child care comprises repeated and constantly changing content throughout childhood. Trainees in training benefit from this continuous patient interaction as the child grows, matures and developmentally progresses, both as a model of care they will follow in future primary care and a mechanism to excite trainees to the personal fulfillment of watching children and families mature physically, emotionally and developmentally over time.

Primary care physicians follow a panel of patients for the three years of their residency. While the PCER allows the supervising physician to review each patient at the time of or after the encounter with the trainee, it does not require the supervisor to physically see each of the trainee's patients. This helps to encourage the independence of the trainee as well as family attachment to the trainee in training. The trainees must have at least 6 months of completed training and can always ask the supervising physicians to see any patient in which they require confirmation of a finding or help in diagnostic or therapeutic advice.

Because Medicaid plans often follow the Medicare PATH guidelines, pediatric trainees may be denied an important part of their training experience that the PCER intended to help develop by not addressing the pediatric CPT PMS codes.

Preventive Medicine Services Currently Included Under PCER[1]

CMS created HCPCS Level II PMS codes G0344, G0402, G0438, and G0439 using CPT PMS codes 99387 and 99397 as their foundation, both in terms of their descriptors and their valuation.

For services provided on or after January 1, 2005, the following HCPCS Level II code is included under the PCER:

G0344 Initial preventive physical examination; face-to-face visit services limited to new beneficiary during the first 6 months of Medicare enrollment

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[1] *Transmittal 2159*; Change Request 7079, Department of Health & Human Services, Centers for Medicare & Medicaid Services [2/15/2011] http://www.cms.gov/transmittals/downloads/R2159CP.pdf

[Note: Code G0344 was deleted effective December 31, 2008 and replaced by code G0402.]

For services provided on or after January 1, 2009, the following HCPCS Level II code is included under the PCER:
G0402 Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment

Effective January 1, 2011, the following HCPCS Level II codes are included under the PCER:
G0438 Annual wellness visit, includes a personalized prevention plan of service (PPPS), first visit
G0439 Annual wellness visit, includes a personalized prevention plan of service, subsequent visit

Pediatric Precedent Established

It is clear that CMS now recognizes preventive health care as part of the Medicare mission, as evidenced by the development of the specific HCPCS Level II codes. As with previous legislative initiatives such as the Affordable Care Act (ACA), CMS has chosen to develop new HCPCS Level II codes instead of utilizing CPT codes because the former can be developed with greater expediency than the latter. By including the HCPCS Level II preventive medicine services under PCER, CMS clearly establishes a precedent for *all* CPT PMS codes to be included under the PCER.

Pediatricians following *Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents* provide many preventive medicine service visits for children. The *Bright Future Guidelines* were first developed 25 years ago by a multidisciplinary group of pediatric health care experts and family representatives convened by the Maternal and Child Health Bureau (MCHB), Health Resources and Services Administration (HRSA), and the Medicaid Bureau. All children enrolled in individual and group non-grandfathered health care plans receive, without cost-sharing, the 'standard' of preventive care screenings and services as recommended by the *Bright Futures Guidelines*. In the younger age groups where growth and development are changing rapidly, preventive medicine service visits predominate and represent the most important educational experiences for primary care pediatric trainees in training.

Additionally, under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, Medicaid programs are required to provide comprehensive services and furnish all appropriate and medically necessary services needed to correct and ameliorate health conditions, based on certain federal guidelines.

EPSDT includes the following screening services:

- Comprehensive health and developmental history
- Comprehensive unclothed physical exam
- Appropriate immunizations (according to the Advisory Committee on Immunization Practices)

- Laboratory tests (including lead toxicity screening
- Health Education (anticipatory guidance including child development, healthy lifestyles, and accident and disease prevention)

Unfortunately, CMS has never explicitly communicated that the Pediatric Preventive Medicine Services (PMS) codes (99381-99385 and 99391-99395) are included under the PCER. This creates inconsistencies among non-Medicare payer acceptance of the PMS codes, resulting in inequities in care.

To be consistent with current policy and rationale related to HCPCS Level II preventive service codes, we request that CMS include the pediatric CPT PMS codes under the PCER.

In looking beyond the PHE, we encourage CMS policies that enhance provision of and payment for virtual services.

Coverage and Payment: CMS should continue its expanded coverage of services that can be provided via telehealth and paid at parity with in-person visits. In addition, CMS should continue its recognition and payment for non-face-to-face (NF2F) services, such as telephone calls, online digital services, interprofessional consultations, remote monitoring, care management, and transitional care management. CMS should also maintain its expansion of eligible telehealth nonphysician providers such as nutritionists, social workers, physical and occupational therapists.

Regulatory: While we expect mandated HIPAA-compliant platforms to be re-instituted after the PHE, relaxation of other regulatory barriers can carry forward, such as use of medical decision-making or total time for telehealth Office Visits, accommodation of a wide variety of originating sites include the patient's home, and use of place of service codes which match what would have been reported if physically present.

The Academy appreciates the opportunity to provide comments on the April 6th interim 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.

Sincerely,

Sara Goza

Sara H. Goza, MD, FAAP

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