September 10, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1751-P
Mail Stop C4-26-05
7500 Security Blvd
Baltimore, MD 21244-1850

Re: File Code CMS-1751-P; CY 2022 Payment Policies under the Physician Payment Schedule and Other Changes to Part B Payment Policies (July 23, 2021)

Dear Administrator Brooks-LaSure:

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 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies published in the July 23rd, 2021 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

The Academy surveyed the Immunization Administration codes (90460, 90461, 90471, 90472, 90473, 90474, G0008, G0009 and G0010) for RUC consideration in April 2021. RUC recommendations were then forwarded to CMS in May 2021. We urge CMS to use the RUC recommendations to value these services based on the RBRVS principles.

We object to the reliance on data from the Outpatient Prospective Payment System (OPPS) in establishing relative values for the Medicare Physician Fee Schedule. Section 4505 of the Balanced Budget Act of 1997 requires CMS to (1) utilize, to the maximum extent practicable, generally accepted cost accounting principles which recognize all staff, equipment, supplies,
expenses, not just those which can be tied to specific procedures and use actual data on equipment utilization and other key assumptions, (2) consult with organizations representing physicians regarding methodology. Any proposal to use the relativity of hospital charge data to determine the relativity of practice costs within a physician office is not consistent with these statutory provisions.

Immunization of children has been and continues to be the most cost effective medical intervention of the past century and maintaining adequate immunization rates is critical to continuing this success. Vaccination has dramatically reduced disease burden, particularly in the pediatric population, not only improving the health of our nation’s children (and other groups due to herd immunity), but also in substantially reducing the cost of care. By failing to utilize resources to assign an appropriate value to this service, CMS is inadvertently placing a barrier to arguably one of the most effective preventive health interventions available.

Because immunization rates among the nation’s Medicaid population correlate with the level of payment for immunization administration¹, the Academy looks to CMS to be a partner in efforts to improve national immunization rates.

**Telehealth**

The Academy appreciates the opportunity to comment on certain services granted interim telehealth eligibility which CMS is now proposing to withdraw from telehealth eligibility upon termination of the Public Health Emergency (PHE).

Medicare recognizes the following categories of telehealth-eligible services:

1) Category 1: Services that are similar to professional consultations, office visits, and office psychiatry services that are currently on the Medicare telehealth services list. Such services demonstrate similarities between the requested and existing telehealth services for the roles and interactions between the originating site patient and distant site clinician.

2) Category 2: Services that are not similar to those on the current Medicare telehealth services list, but which otherwise are accurately described by the corresponding code when rendered via telehealth and which produce demonstrated clinical benefit to the patient along with evidence of clinical effectiveness and relevance.

3) Category 3: Services that were added to the Medicare telehealth services list during the PHE for which there is likely to be clinical benefit when furnished via telehealth but for which there is not yet sufficient evidence available to consider the services for permanent addition under the Category 1 or Category 2. Services added on a temporary, Category 3 basis would ultimately need to meet the criteria under Category 1 or 2 to be permanently added to the Medicare telehealth services list.

¹ PEDIATRICS Vol. 126 No. 5 November 2010, pp. e998-e1010 (doi:10.1542/peds.2009-3514)
(http://pediatrics.aappublications.org/cgi/content/abstract/126/5/e998)
Regarding Category 3 telehealth services, we appreciate CMS’ proposal to retain these services as Category 3 until the end of CY2023 to allow time to collect more information regarding utilization of these services during the PHE and provide stakeholders the opportunity to continue to develop support for the permanent addition of appropriate services to the Categories 1 and 2 telehealth lists.

We herein comment on certain services in Table 11 of the proposed rule, which represent services that were added to the Medicare telehealth services list on an interim basis to respond to the COVID-19 PHE but were otherwise not extended on a temporary Category 3 basis in the CY2021 Physician Fee Schedule final rule. CMS proposes to remove these Table 11 services from the telehealth list upon the termination date of the PHE. We respectfully request additional time to compile evidence of clinical benefit for certain of these interim services and request that the following services be added to the Medicare Category 3 list to allow continued data collection in acknowledgement of the possibility that they could eventually reach Category 1 or 2 status:

1) **99477**, initial intensive care for neonate ≤ 28 days age

   We appreciate that CMS has designated Category 3 status for the subsequent day Intensive Care codes 99478, 99479, and 99480 which thus remain telehealth-eligible through CY2023 under the CMS proposed rule, but CMS has proposed that 99477 remain interim and thus deleted upon termination of the PHE. We request that CMS place 99477 on the Category 3 telehealth list based on our evolving experience with its effective use in telehealth scenarios. While we understand that CMS has had reluctance to grant extended telehealth eligibility to such initial day codes, our experience suggests that initial day telehealth care can occur effectively and safely (Jagarapu et al, A brief history of telemedicine and the evolution of tele-neonatology, Seminars in Perinatology 2021; 151416, in press). For example, we have found that remote physician telehealth participation in initial day intensive care coupled with a qualified healthcare professional such as an advanced practice nurse who is physically on-site in the NICU during the provision of this initial day service allows the remote physician to not only proceed through a remote physical assessment using the skills of the advanced practice nurse but also to rely on the advanced practice nurse to alert the remote physician to significant clinical events throughout the midnight-to-midnight intensive care period and thus allow the physician to fulfill the evaluative, decision-making, and documentation elements of the service. This collaboration of the remote telehealth physician and the on-site, physically present qualified healthcare professional not only provides exceptional care for the patient but also designates the physician as the rendering rather than simply as supervising provider. While we anticipate that this situation will not be typical outside of the PHE, Medicare policy must continue to allow appropriate payment when it does occur.

2) **99468, 99471, 99475**, initial day neonatal/pediatric critical care

   Similar to the above comments related to the 99477 initial day intensive care service, we appreciate that CMS has designated Category 3 status for the subsequent day neonatal/pediatric critical care codes 99469, 99472, and 99476 which thus remain telehealth-eligible through CY2023 based on the proposed rule, and in addition, CMS has also designated Category 3 status to the time-based critical care codes 99291/99292. CMS has proposed that the initial day critical care
codes 99468, 99471, 99475 remain interim and thus deleted upon termination of the PHE. We request that CMS place 99468, 99471, 99475 on the Category 3 telehealth list based on our evolving experience with their appropriate use in telehealth scenarios ([Jagarapu et al, Development and implementation of a tele-neonatology program: Opportunities and challenges, Seminars in Perinatology 2021; 151428, in press](#)). While we understand that CMS has had reluctance to grant extended telehealth eligibility to such initial day codes, our experience suggests that initial day telehealth care for these services can occur effectively and safely. For example, we have found that remote physician telehealth participation in initial day critical care coupled with a qualified healthcare professional such as an advanced practice nurse who is physically on-site in the NICU during the provision of this initial day service allows the remote physician to not only proceed through a remote physical assessment using the skills of the advanced practice nurse but also to rely on the advanced practice nurse to alert the remote physician to significant clinical events throughout the midnight-to-midnight critical care period and thus allow the physician to fulfill the evaluative, decision-making, and documentation tenets of the service. This collaboration of the remote telehealth physician and the on-site, physically present advanced practice nurse not only provides exceptional care for the patient but also designates the physician as the rendering rather than simply a supervising.

3) **99221, 99222, 99223**, initial hospital care

Similar to the above comments related to other initial services, we appreciate that CMS has designated Category 3 status for the subsequent hospital care services 99231, 99232, 99233 which thus remain telehealth-eligible through 2023 under the CMS proposed rule. CMS has proposed that the initial hospital care codes 99221, 99222, 99223 remain interim and thus deleted upon termination of the PHE. We request that CMS place 99221, 99222, 99223 on the Category 3 telehealth list based on our evolving experience with their appropriate use in telehealth scenarios. While we understand that CMS has been reluctant to grant extended telehealth eligibility to such initial day codes, our experience suggests that initial day telehealth care for these services can occur effectively and safely. Pediatric hospitalists and intensivists are using telehealth to provide equitable access to care for inpatient children while optimizing infection control exposure and maintaining high care quality ([Curfman et al Pediatric telehealth in the COVID-19 pandemic era and beyond, Pediatrics 2021, doi: 10.1542/peds.2020-047795](#)). As noted above with other initial day services, remote physician telehealth performance of these initial day services can proceed effectively especially when qualified healthcare professionals are physically on-site with the patient to assist with physical exam and other evaluative elements of care. This collaboration of the remote telehealth physician and the on-site, physically present advanced practice nurse not only provides exceptional care for the patient but also designates the physician as the rendering rather than simply a supervising provider. We've also noted that when providing telehealth consultation on an inpatient, clinicians may use one of these initial hospital care codes in lieu of a telehealth consultation code in cases where the patient's payer denies all other consultation service options. While this particular scenario may not directly impact Medicare which has created unique telehealth consultation codes, this scenario is relevant to many Medicaid and other payers who rely on these initial hospital care codes for inpatient consultation services.
4) **99218, 99219, 99220**, initial observation care

Similar to the above comments related to other initial day services, we appreciate that CMS has designated Category 3 status for the subsequent observation care services 99224, 99225, 99226 which thus remain telehealth-eligible through 2023 under the CMS proposed Rule. CMS has proposed that the initial observation care codes 99218, 99219, 99220 remain interim and thus deleted upon termination of the PHE. We request that CMS place 99218, 99219, 99220 on the Category 3 telehealth list based on our evolving experience with their appropriate use in telehealth scenarios. While we understand that CMS has had reluctance to grant extended telehealth eligibility to such initial day codes, our experience suggests that initial day telehealth care for these services can occur effectively and safely. As we've noted above with other initial day services, remote physician telehealth performance of these initial day services can proceed effectively especially when qualified healthcare professionals are physically on-site with the patient to assist with physical exam and other evaluative elements of care. This collaboration of the remote telehealth physician and the on-site, physically present advanced practice nurse not only provides exceptional care for the patient but also designates the physician as the rendering rather than simply a supervising provider.

5) **94664**, demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device

Proper inhaler use is central to effective treatment of asthma and other chronic respiratory diseases. Clinicians and their patients are using real-time audio-visual technology to instruct and monitor use of inhalers in these patients, and this use of telehealth technology has been shown to be effective while providing patient access that might otherwise have been compromised ([Locke et al, Using Video Telehealth to Facilitate Inhaler Training in Rural Patients with Obstructive Lung Disease, Telemed J E Health 2019 Mar;25(3):230-236](https://journals.lww.com/telemedjrnl/Fulltext/2019/03000/Using_Video_Telehealth_to_Facilitate_Inhaler.49)). CMS proposes to designate 94664 as an interim service but based on the evolving use of telehealth to effectively render this service, we request that CMS designate 94664 as a Category 3 telehealth service.

**Strabismus Surgery (67311, 67312, 67314, 67316, 67318, 67320, 67331, 67332, 67334, 67335, & 67340)**

These procedures are all designed to correct ocular misalignment by removing one or more extraocular muscles from their insertions, shortening or repositioning them, and re-suturing them to the sclera. We appreciate that CMS has adopted the RUC recommendations for the family of eleven strabismus surgery codes (67311-67340). Seven of these services will be subject to greater than 20% reductions in the allowable from CY 2021 to CY 2022 at the proposed conversion factor of $33.5848. The affected procedures are 67311, 67314, 67320, 67331, 67332, 67334, 67335, and 67340. We note that 67340 is not on the CMS list of “Codes Subject to Phase-In.” It should be because it is subject to a 21% reduction in the allowable. The reductions for all seven of these services should be phased in to reduce the potential impact on access associated with such large reductions.

Even with a phase-in, these represent major cuts to almost all of the surgical codes used by pediatric ophthalmologists, a limited and shrinking group of physicians who are the only providers of these
services. Therefore, we also recommend that the phase-in be implemented over three years, with one third of the total reduction taken annually rather than the typical 19% reduction the first year. We also recommend that the phase-in be applied to 67312 and 67316 as well as the seven services noted above. Although the anticipated reductions for these two services are less than the typical threshold of 20%, they are greater than 10% and represent a significant component of reimbursement for pediatric ophthalmologists.

The CMS budget impact of these prolonged phase-ins and application to nine of the procedures will be minor because of the small Medicare FFS claims volumes. However, it will be significant for the pediatric ophthalmologists who perform these procedures primarily on patients covered by Medicaid and commercial carriers.

**Cardiac Catheterization for Congenital Defects (93X1X, 93X2X, 93X3X, 93X4X, 93X5X, & 93X6X)**

<table>
<thead>
<tr>
<th>Code</th>
<th>Long Descriptor</th>
<th>CMS Proposed work RVU</th>
<th>RUC Recommended work RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>93X1X</td>
<td>Right heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone; normal native connections</td>
<td>3.99</td>
<td>3.99</td>
</tr>
<tr>
<td>93X2X</td>
<td>Right heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone; abnormal native connections</td>
<td>6.10</td>
<td>6.10</td>
</tr>
<tr>
<td>93X3X</td>
<td>Left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone, normal or abnormal native connections</td>
<td>5.50</td>
<td>6.00</td>
</tr>
<tr>
<td>93X4X</td>
<td>Right and left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone(s); normal native connections</td>
<td>6.84</td>
<td>7.91</td>
</tr>
<tr>
<td>93X5X</td>
<td>Right and left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone(s); abnormal native connections</td>
<td>8.88</td>
<td>9.99</td>
</tr>
<tr>
<td>93X6X</td>
<td>Cardiac output measurement(s), thermodilution or other indicator dilution method, performed during cardiac catheterization for the evaluation of congenital heart defects (List separately in addition to code for primary procedure)</td>
<td>1.44</td>
<td>1.75</td>
</tr>
</tbody>
</table>

In May 2020, the CPT Editorial Panel replaced a family of four cardiac catheterization codes with five new codes to describe cardiac catheterization for congenital cardiac defect(s). In addition, the CPT
Editorial Panel replaced two cardiac output measurement codes with one new add-on code to report cardiac output measurement(s), performed during cardiac catheterization for congenital cardiac defects.

CMS did not address the compelling evidence for this service. CMS appears to dismiss the fact that services may change due to technological advances, changes in the patient population, shifts in the specialty of physicians providing services or changes in the physician work or intensity required to perform services. CMS appears to only propose blanket reductions instead of considering how a service may have changed or increased. The AAP requests that CMS address the compelling evidence that was submitted with the RUC recommendations when CMS does not accept the RUC recommendation. The AAP urges CMS to consider the following compelling evidence argument:

The RUC reviewed and agreed that there is compelling evidence based on a change in the patient population and a change in technology. The specialty societies noted, and the RUC agreed that the vast majority of diagnostic catheter studies were performed in children who were healthier with simpler cardiac defects when the previous code structure was last valued in 1997; children with more significant cardiac defects had no treatment options, so catheterization was not warranted. Over the past 23 years, as result of improvements in both technique and technology, the specialty has evolved and now performs a substantially larger number of more complex diagnostic evaluations to guide more complex interventional procedures, and the typical patient is now a more complex patient requiring more pathology. The specialties noted that one of the whitepapers that they provided by Nicholson et al. confirms that these procedures were unable to be previously accomplished on the current typical patient with earlier technology/techniques. The specialties provided additional literature to further demonstrate the changes in congenital catheterization over the past two decades.

The societies also noted there are numerous reasons why the original CPT code, 93530, does not work to properly capture the work performed in 2020 and beyond. For instance, the original code was the only right heart only catheterization code designed to capture all possible pathologies for patients with congenital heart disease. Although this was somewhat appropriate in the era where right heart only catheterizations were performed mostly for simple lesions, a far broader use of right heart catheterization had since developed. This brought about a need to divide the code into two; one for those with simple defects, defined in CPT as having normal connections, and a second code for the more complex patients with abnormal connections.

The specialties also noted that, relative to adult patients with normal cardiac anatomy, the pre-service evaluation time for pediatric patients with congenital defects includes additional time to discuss a patient’s procedure with the parent. Similarly, the post-procedure work includes additional time to explain the pathology of the child to the parent. Furthermore, as a national standard, congenital heart programs are now also required to enter hemodynamic data and other procedural details into national registries such as Improving Pediatric and Adult Congenital Treatments (IMPACT), which can also add significant post procedure work time. In addition, the post-service period time typically includes time to diagram the congenital heart defect in the EHR and complete data submission to the registry.
For CPT code 93X3X, CMS disagrees with the unanimously approved RUC recommended work RVU of 6.00 and proposes a work RVU of 5.50, based on a direct work RVU crosswalk to CPT code 32607 Thoracoscopy; with diagnostic biopsy(ies) of lung infiltrate(s) (eg, wedge, incisional), unilateral (work RVU= 5.50, intra-service time= 45 minutes, total time of 178 minutes). Beyond performing a basic search for other services with similar intra-service time, it is unclear what criteria CMS used to reject the RUC recommendation or to select this specific reference code as a direct work value crosswalk. CMS does not provide any clinical foundation for their proposed alternate value, did not seem to consider the compelling evidence provided in the RUC rationale, and makes no acknowledgement that this service is typically for pediatric patients with congenital defects. The AAP requests CMS provide rationale for their recommendations and provide insight for the lack of compelling evidence review.

93X3X is typically somewhat more intense to perform than 93X2X, justifying a somewhat higher assigned physician work intensity. CMS proposed value would produce a rank order anomaly between 93X3X and 93X2X as the difference in intensities between these two services would not be appropriately reflected. For 93X3X, the physician typically accesses the femoral artery after which all of them connect to the aorta; there is no variability with this for the most part. For a normal connection patient, it will be straightforward. Risk of arterial catheterization is always high due to risks of stroke, bleeding into the brain for infants on heparin, femoral artery injury for infants. For an abnormal connection patient, the procedure is more complex, as doctors are now facing crossing arterial shunts or the PDA to evaluate the pulmonary arteries, or evaluating other vascular structures like MAPCAs, which can be multiple. Although the overall structures evaluated are still fewer than from a right heart catheterization (93X2X), when assessing the pulmonary arteries across shunts or a PDA, this is not typically well tolerated by the patient. These shunts are 3 or 3.5mm in diameter with a catheter being ~1.5mm, the procedure involves blocking roughly 50 percent or more of the entire blood flow to the lungs. These procedures require a significantly greater level of diagnostic evaluation, catheter and wire manipulation, and angiography to identify each and every vessel for surgical planning than previously afforded with the non-congenital diagnostic codes. Due to this, the physician work intensity is very high.

The RUC recommendation was based on the median work RVU from robust survey results and favorable comparison to CPT code 93453 Combined right and left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed (work RVU=5.99, intra-service time of 45 minutes, total time of 113 minutes) and CPT code 37248 Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; initial vein (work RVU= 6.00, intra-service time of 50 minutes, total time of 109 minutes). The AAP urges CMS to accept a work RVU of 6.00 for CPT code 93X3X.

For CPT code 93X4X, CMS disagrees with the unanimously approved RUC recommended work RVU of 7.91 and proposes a work RVU of 6.84, based on a direct work RVU crosswalk to CPT code 32608 Thoracoscopy; with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral (work
RVU = 6.84, intra-service time = 60, total time = 195). CMS does not provide any clinical foundation for their proposed alternate value, did not seem to consider the compelling evidence provided in the RUC rationale and makes no acknowledgement that this service is typically for pediatric patients with congenital defects. Furthermore, CMS’ proposed value would assign 93X4X an intensity that is substantially lower than the top two key reference codes, even though 3/4ths of the survey respondents that selected those top reference codes indicated that the survey code was a more intense service than either reference code.

The RUC recommendation was based on the median work RVU from robust survey results and favorable comparison to CPT code 93461 Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization... (work RVU = 7.85, intra-service time of 60 minutes, total time of 143 minutes) and CPT code 52356 Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (eg, Gibbons or double-J type) (work RVU = 8.00, intra-service time of 60 minutes, total time of 133 minutes). The AAP urges CMS to accept a work RVU of 7.91 for CPT code 93X4X.

93X5X
For CPT code 93X5X, CMS disagrees with the unanimously approved RUC recommended work RVU of 9.99 and proposes a work RVU of 8.88, based on the survey median work value. However, following detailed review of the physician work typically involved in this service, had felt that the survey respondents had underestimated the typical work involved. CMS’ proposed value would assign this service a similar intensity to CPT code 93X4X, even though 93X5X is for a more complex patient with an abnormal native connection. CMS does not provide any clinical foundation for their proposed alternate value, did not seem to consider the compelling evidence provided in the RUC rationale and makes no acknowledgement that this service is typically for pediatric patients with congenital defects.

The RUC recommendation was based on the current work RVU for the code currently used to report this service (deleted code 93532) and favorable comparison to CPT code 92920 Percutaneous transluminal coronary angioplasty; single major coronary artery or branch (work RVU = 9.85, intra-service time of 68 minutes, total time of 127 minutes). The AAP urges CMS to accept a work RVU of 9.99 for CPT code 93X5X.

93X6X
For CPT add-on code 93X4X, CMS disagrees with the unanimously approved RUC recommended work RVU of 1.75 and proposes a work RVU of 1.44, based on a direct work RVU crosswalk to CPT code 37253 Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (List separately in addition to code for primary procedure) (work RVU = 1.44, intra-service time = 20 minutes, total time = 21 minutes). However, 37253 is a relatively less intense and less risky service typically performed in the lower extremity of an adult patient, making it an inappropriate crosswalk. The survey code is a more intense service typically performed on a more complex pediatric patient, where a Swan Ganz catheter is introduced from the venous sheath, advanced through the right heart, and placed into the pulmonary artery for purpose of assessing cardiac output by thermodilution. CMS does not provide any clinical
foundation for their proposed alternate value, did not seem to consider the compelling evidence provided in the RUC rationale and makes no acknowledgement that this service is typically for pediatric patients with congenital defects.

The RUC recommendation was based on a direct work value crosswalk to CPT code 36483 *Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)* (work RVU= 1.75, intra-service time= 20 min) and favorable comparison to CPT code 20931 *Allograft, structural, for spine surgery only (List separately in addition to code for primary procedure)* (work RVU= 1.81, intra-service time of 20 minutes). The AAP urges CMS to accept a work RVU of 1.75 for CPT code 93X6X.

**Critical Care Services (99291-99292): Guidelines, Global Bundling, and Concurrent Reporting**

The Academy supports CMS’ proposal to adopt the CPT guidelines for the reporting of critical care services. CMS, however, goes on to propose that physicians would no longer be able to report other Evaluation and Management Services (E/M) on the same date as a critical care visit. This is contrary to CPT specific instruction (*CPT 2021 Professional*, page 31) which states, “Critical care and other E/M may be provided on the same patient on the same date by the same individual.” We urge CMS to reconsider this proposal. A patient may be seen on an inpatient floor, emergency department, or even a physician office and then later require critical care services on the same date. These are separate services and should be reported and paid.

The Academy does not agree with CMS’ proposal to bundle critical care services with procedure codes that have a global surgical period. This policy would breach current Medicare policy, which states that critical care services should be unbundled from procedures with global surgical period as long as the critical care service is unrelated to the procedure.

Furthermore, it is essential that CMS clarify and confirm that intensivists, specialists, and other clinicians may report their clinically indicated critical care services when performed during a surgeon’s global period. We believe that CMS agrees with us in their stating that “Thus, we are proposing that critical care services may be furnished as concurrent care (or concurrently) to the same patient on the same day by more than one practitioner in more than one specialty (for example, an internist and a surgeon, allergist and a cardiologist, neurosurgeon and NPP), regardless of group affiliation, if the service meets the definition of critical care and is not duplicative of other services.” Yet, we know that many clinicians and possibly some payers may not clearly appreciate CMS’ intent and instead view CMS comments to imply that no reportable critical care services may be rendered during a surgical global period regardless of the reporting clinician (ie, regardless of whether the reporting clinician is the primary surgeon or instead is a collaborating clinician providing concurrent care for the critical patient). As CMS acknowledges in the proposed rule, clinicians other than the surgeon often participate in the patient’s post-operative care by providing separately billable critical care services that contribute to the patient’s overall care beyond what may be the surgeon’s focus on certain aspects of the surgical procedure. We believe that CMS intends to
maintain this essential contribution to effective post-operative care by acknowledging the value that this concurrent care provides by recognizing that this care is separately billable even during the global period. We respectfully suggest that CMS has an opportunity to further confirm this intent with greater explicit clarity in the final rule such that clinicians and payers assume no misunderstanding regarding CMS intent.

**Split (Or Shared) Services**

CMS is seeking public comment on whether there should be a different listing of qualifying activities for purposes of determining the total time and substantive portion of split (or shared) emergency department visits, since those visits also have a unique construct.

The Academy requests that CMS work with the CPT/RUC Workgroup on E/M to create a proposal to the CPT Editorial Panel to address this issue and to clarify the reporting in CPT guidelines.

CMS is seeking public comment on whether they should further define “group” for purposes of split (or shared) visit billing. While CMS is not proposing a definition in this proposed rule, they have considered several options, such as requiring that the physician and NPP must be in the same clinical specialty, in which case they would use the approach outlined in the CPT E/M Guidelines; that is the NPP is considered to be in the same specialty and subspecialty as the physician with whom they are working. CMS is also considering an approach under which they would align the definition of “group” with the definition of “physician organization” at §411.351. The term “physician organization” is defined at §411.351 for purposes of section 1877 of the Act and regulations in 42 CFR part 411, subpart J (collectively, the physician self-referral law).

The Academy requests that CMS work with the CPT/RUC Workgroup on E/M to create a proposal to the CPT Editorial Panel to address this issue and to clarify the reporting in CPT guidelines.

CMS is proposing that documentation in the medical record must identify the two individual practitioners who performed the visit. The individual who performed the substantive portion (and therefore bills the visit) would be required to sign and date the medical record. CMS is proposing to revise the regulation at §415.140 to reflect the conditions of payment for split (or shared) visits.

The Academy requests that CMS work with the CPT/RUC Workgroup on E/M to create a proposal to the CPT Editorial Panel to address this issue and to clarify the reporting in CPT guidelines.

Finally, with regard to CMS’ proposal to create a modifier to describe split (or shared) visits that will be appended to claims for split (or shared) visits, the Academy urges CMS not to require a modifier to be reported for split (or shared) visits. Requiring a modifier adds a level of administrative burden that the new E/M coding structure and guidelines were designed to alleviate.
**Clinical Labor Pricing Update**

CY 2022 marks the final year of the 4-year market-based transition for supply and equipment pricing. The clinical labor pricing has not been updated since 2002. CMS proposes to update the clinical labor wage rates according to data from the United States Bureau of Labor Statistics (BLS).

The Academy agrees with CMS that the BLS wage data continues to be the most accurate source to use as a basis for clinical labor pricing and these data will appropriately reflect changes in clinical labor resource inputs for purposes of establishing practice expense relative values. However, we understand that there may be improvements in the methodology used in utilizing these data. For example, CMS utilizes the mean in its analysis, while the majority of the RBRVS data inputs are based on the median. CMS should carefully consider comments regarding the appropriate application of the multiplier to include fringe benefits in the overall clinical labor costs. CMS should also carefully consider comments on specific clinical staff types and their labor rate costs.

The total direct practice expense pool increases by 30 percent under this proposal, resulting in a significant budget neutrality adjustment. Practice expense comprises 44.8% of the physician payment and the pool of this payment is fixed. Therefore, increasing payment for clinical labor shifts funds that were previously directed to supplies and equipment. Since the overall size of the practice expense component is static, a larger proportion of that 44.8% is now clinical labor, relative to before the proposed wage rate update. Due mostly to this proposed update, the practice expense direct scaling adjustment would decrease by 24.4% for CY 2022 (from 0.5916 in CY2021 to 0.4468 in CY2022); in other words, if a supply that is not being repriced had an adjusted direct cost of $100 for CY2021, that same supply would have an adjusted direct cost of $76.60 for CY 2022. By increasing the clinical labor pricing, physician services with high-cost supplies and equipment are disproportionately impacted by the budget neutrality component within the practice expense relative values. The scaling of direct expenses, to 44 cents on every dollar fully recognized as direct costs, puts a huge and unfair burden on specialties that require expensive supplies and other direct costs to care for their patients. While the increase in clinical labor is appropriate, it is not appropriate that physicians and other qualified health care professionals, and notably from a few small specialties, are negatively impacted by the change.

CMS has requested comment on whether to implement a four-year transition to the new clinical labor cost data, much like the transition used in updating the supply and equipment price updates. Such a transition appears reasonable, particularly because individual procedures will experience significant reduction. In the future, CMS should update pricing data on a more frequent basis for all inputs, so adjustments will not be so dramatic. We understand the underlying unfairness that the real increase in clinical labor costs is not recognized through an update to the conversion factor and calls on CMS to urge Congress to provide a positive update to the Medicare conversion factor in 2022 and all future years.

The Academy appreciates the opportunity to provide comments on the July 23rd 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,

/s/

Lee Savio Beers, MD, FAAP
President

LSB/ljw