AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

December 20, 2011

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1524–FC
P.O. Box 8013
Baltimore, MD 21244–8013

Re: Medicare Program; Payment Policies Under the Physician Fee Schedule, Five-Year Review of Work Relative Value Units, Clinical Laboratory Fee Schedule: Signature on Requisition, and Other Revisions to Part B for CY 2012

Dear Ms. Tavenner:

On behalf of the American Academy of Family Physicians (AAFP), which represents more than 100,300 family physicians and medical students nationwide, I write in response to the Centers for Medicare & Medicaid Services' (CMS) final Medicare Program; Payment Policies Under the Physician Fee Schedule, Five-Year Review of Work Relative Value Units, Clinical Laboratory Fee Schedule: Signature on Requisition, and Other Revisions to Part B for CY 2012 as published in the November 28, 2011, *Federal Register*.

Effective January 1, 2012, this final rule with comment period addresses changes to the 2012 physician fee schedule and other Medicare Part B payment policies. The AAFP extensively responded to the proposed 2012 fee schedule in an August letter to CMS and created a summary of the final 2012 fee schedule to help prepare members.

Family physicians often care for children and are concerned that CMS changed the status indicator on code 96110 from "A" (Active) to "X" (Statutory Exclusion) and removed the previously-published relative value units (RVUs) from inclusion on the 2012 Medicare physician fee schedule. The AAFP finds it troubling that CMS did not provide a full explanation for these changes in either the proposed or final 2012 fee schedules.

We understand that the CPT Editorial Panel revised the descriptor for code 96110 from "developmental testing; limited," to "developmental screening." We assume that the revised descriptor's inclusion of the term "screening" resulted in CMS's decision to consider this code statutorily excluded from payment. This assumption seems supported by the fact that CMS has also created a supplemental HCPCS Level II "G" code (G0451), which it has valued on the 2012 RBRVS physician fee schedule based on a crosswalk from the previously-published values of code 96110 and which has a descriptor that is the same as 96110 prior to 2012.

2021 Massachusetts Ave., N.W. • Washington, DC 20036-1011 • 888.794.7481 • 202.232.9033 • Fax: 202.232.9044 • capitol@aafp.org

However, this decision may be based on a misunderstanding of the term "screening" in this context. Developmental screening asks a child's observer to provide his/her observations of the child's skills, and these are recorded on a standardized and validated screening instrument. Developmental screening is subjective and only reports the assessment of the patient's skills through the observation of a caregiver, whereas developmental testing actually measures what the patient is able to do on a standardized psychometric instrument. As such, unlike other screening services, where the result of screening does not result in a specific diagnostic path, developmental screening is more specific and results in formal assessment of specific domains, forming the foundation for identification of treatable developmental conditions. Screening for autism using the Modified Checklist for Autism in Toddlers (M-CHAT, Robins, Fein, & Barton, 1999) is an example of screening leading to targeted assessment.

We acknowledge that CMS does not have authority to provide payment for screening services unless a specific benefit category is authorized by Congress. However, as noted, we believe the editorial revision for CPT code 96110 from "developmental testing; limited" to "developmental screening" should not preclude payment for this specific service since it is more diagnostic than screening as those terms are commonly understood.

Based on the foregoing analysis, the AAFP strongly advises CMS to change the status indicator of code 96110, back to status indicator "A" if possible and refrain from implementing the new G code, G0451. The change in status and publication of the new G code will unnecessarily confuse physicians who provide this service, especially if other payers do not adopt a similar policy.

At a minimum, we would advocate that CMS change the status indicator for code 96110 to "N" (non-covered) and publish the RVUs for this code on the Medicare physician fee schedule. There is a long-standing precedent established by the preventive medicine services codes (99381-99397) and other screening tests such as hearing screening (92551), which are status indicator "N," yet have had their RVUs published on the Medicare physician fee schedule since their inception. CMS established this precedent and should continue to follow it with code 96110. It is a viable solution since it allows CMS to publish the RVUs on the Medicare physician fee schedule while maintaining the Medicare payment policy that does not cover "screenings." This approach also recognizes that Medicaid and many private payers who do cover 96110 rely on the RVUs in the Medicare physician fee schedule to help set their payment levels. Publication of the RVUs for 96110, regardless of its status indicator, will facilitate private insurers and state Medicaid agencies to update their respective fee schedules accordingly.

We appreciate the opportunity to provide these comments and make ourselves available for any questions you might have or clarifications you might need. Please contact Robert Bennett, Federal Regulatory Manager, at 202-232-9033 or rbennett@aafp.org.

Sincerely,

Roland A. Goertz, MD, MBA, FAAFP
Board Chair