AMERICAN ACADEMY OF FAMILY PHYSICIANS

February 7, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

The Honorable Meena Seshamani, MD, Ph.D.
Deputy Administrator and Director
Center for Medicare
Centers for Medicare & Medicaid Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: Recommendations for the Calendar Year (CY) 2025 Medicare Physician Fee Schedule (MPFS)

Dear Administrator Brooks-LaSure and Deputy Administrator Seshamani:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 129,600 family physicians and medical students across the country, I write to share recommendations for consideration as the Centers for Medicare and Medicaid Services (CMS) begins work on the calendar year (CY) 2025 Medicare Physician Fee Schedule (MPFS) proposed rule. In this letter, **we offer recommendations and rationale for modifications to the G2211 add-on code, telehealth services, and requirements for the supervision of resident physicians in primary care.**

G2211 Improvements

The AAFP greatly appreciates CMS finalizing the G2211 add-on code in the CY 2024 MPFS. Family physicians provide continuous, comprehensive, and coordinated services in a primary care visit, which add to the complexity of the visit. The complexity and comprehensiveness of primary care are undervalued in the current Evaluation and Management (E/M) code system. The G2211 code is an incremental but meaningful step in appropriately valuing primary care and supporting longitudinal, holistic patient-physician relationships, relative to other services in the fee schedule. We applaud CMS for implementing the G2211 code, and we have additional suggestions to ensure the code achieves its aims. Below, we offer rationale for the following recommendations:

- **Eliminate restrictions on the payment of G2211 when modifier 25 is attached to the E/M code to ensure family physicians can continue to offer Medicare beneficiaries comprehensive services in a single visit, and**
- **Allow G2211 to be applied to home and residence E/M services to more accurately reflect the value provided by comprehensive primary care home visits.**

Modifier 25 Policy

In the 2024 MPFS, CMS finalized the proposal to not pay for G2211 when the associated E/M code has modifier 25 appended to it.

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We understand that this policy was primarily aimed at prohibiting use of G2211 in conjunction with E/M services done on the same date as minor procedures, as CMS believes visits with minor procedures provide additional resources not available in stand-alone office E/M visits. However, E/M services are often provided with other, non-procedural services that require use of modifier 25. The current restriction that prohibits use of G2211 with any service requiring a modifier 25 means there are many primary care visits that reflect the complexity and ongoing relationship that G2211 is otherwise intended to address but do not benefit from it.

The blanket prohibition on G2211 payment whenever modifier 25 is attached to the accompanying E/M service results in denial of G2211 even when the E/M service is entirely consistent with the intent of G2211. For instance, when an annual wellness visit (AWV) is reported in addition to an office/outpatient E/M code, Medicare requires modifier 25 to be appended to the E/M code to indicate the E/M service was significantly and separately identifiable from the AWV. The AWV is provided more than 75% of the time by family physicians and internists—physicians who serve as the continuing focal point for all needed health care services for the patient, which is consistent with the expectation for using G2211. Medicare beneficiaries often rely on their physician to address other needs that are separate and distinct from the original intent of the scheduled visit. In fact, Medicare's initial AWV (G0438) is reported with either 99213 or 99214 almost 40% of the time. The subsequent AWV (G0439) is reported with either 99213 or 99214 approximately 47% of the time. To deny payment for G2211 unfairly penalizes physicians who provide comprehensive care alongside an AWV or other preventive services, which runs counter to the intent of G2211.

Another example involves immunization administration. Immunization administration (including percutaneous, intradermal, subcutaneous, or intramuscular injections) involving one vaccine (single or combination vaccine/toxoid - 90471) is reported in addition to an office/outpatient E/M service more than 60% of the time. When it is, Medicare's National Correct Coding Initiative requires physicians to report the E/M with modifier 25 appended to ensure appropriate payment of both services. Immunization administration is typically reported by family physicians and internists—physicians who serve as the continuing focal point for all needed health care services for the patient, which is consistent with the expectation for using G2211—and there is value to patients receiving their immunizations from their usual source of care. Blocking payment for G2211 when modifier 25 is reported unfairly penalizes a physician providing continuous, comprehensive care (in this case, a physician vaccinating a patient visiting the office for a separate E/M service). The additional immunization payment provides resources to cover the cost of furnishing the vaccine; it does not offer supplemental resources to account for the additional complexity associated with an office E/M visit. Allowing G2211 payment in examples like this is necessary to ensure family physicians receive payment that more accurately reflects the resources required for an office E/M visit.

The CMS document, "How to Use the Office & Outpatient Evaluation and Management Visit Complexity Add-on Code G2211", provides an example of using the G2211 code for a patient who visits the office for sinus congestion. In this example, the physician provides recommendations and communications to build longitudinal trust with the patient, and G2211 is billed to reflect the additional complexity not otherwise accounted for in the E/M visit. If the physician also persuades the patient to receive a vaccine (to prevent future illness) during the same visit, the physician would be unable to bill for G2211 because modifier 25 is required to report the immunization service on the same day as an E/M visit for sinus congestion.

Family physicians have shared other examples. When a family physician trims the toenails of a patient with diabetes, they are unable to bill G2211 because the additional procedure requires modifier 25 be appended to the office/outpatient E/M visit. The family physician is penalized for offering comprehensive, same-day services to care for their patient—care that reinforces the physician's longitudinal relationship with the patient as their primary source of care. The current policy inadvertently reduces the incentive for physicians to fully address patient needs in a single visit. Returning for a second visit would also unfairly penalize Medicare beneficiaries who face additional out-of-pocket costs and spend additional time visiting the physician's office a second time.

The AAFP urges CMS to allow payment for G2211 when attached to an E/M visit appended with modifier 25. Family physicians provide a wide range of services at every office visit that encompass whole-person primary care. We support the goals of the G2211 add-on code and are very concerned that the restriction on visits with modifier 25 works against those goals by preventing family physicians from receiving the resources needed to account for the complex care that serves as the continuing focal point for all needed health care services they provide to Medicare beneficiaries in office E/M visits. Further, the policy creates incentives to offer fragmented care.

We acknowledge potential budget neutrality-related concerns about allowing payment for G2211 when modifier 25 is used with the accompanying E/M service. **At minimum, CMS should consider modifications that would reduce restrictions on the use of G2211 when preventive services are provided during an office visit for E/M services.**

We specifically urge CMS to change its G2211 policy to allow for its payment with E/M services when modifier 25 is appended in the following situations:

- When the E/M service is reported in addition to a Medicare AWV (G0438, G0439) or "Welcome to Medicare" visit (G0402);
- When the E/M service is reported in addition to an immunization administration (90460, 90461, 90471-90474); and
- When the E/M service is reported in addition to Medicare-recommended screening services, such as G0442 (Annual alcohol misuse screening, 5 to 15 minutes) or G0444 (Annual depression screening, 5 to 15 minutes) or G0443 (behavioral counseling for alcohol misuse).

We conducted our own analysis to estimate the potential impact of eliminating the modifier 25 exclusion for the situations above. Our analysis found the following number of additional visits would be eligible for G2211 payments:

- an estimated five million E/M visits billed alongside an annual wellness visit;
- an estimated 250,000 E/M visits billed when an immunization is also furnished; and
- an estimated two million E/M visits billed with depression screening, alcohol misuse, and/or smoking cessation and counseling services.

We believe making the G2211 changes the AAFP is urging is in the best interest of Medicare beneficiaries and the primary care physicians who provide these valuable services.

Our analysis suggests the total increase in Part B allowed charges as a result of this modification would be approximately $121 million. This estimate assumes 100% of these visits are submitted with

a G2211 code, however. Based on these assumptions, we estimate a potential 0.1 percent reduction in the conversion factor would be necessary to maintain budget neutrality. We urge CMS to examine actual CY 2024 utilization of G2211, which is likely lower than anticipated due to the large number of outpatient/office E/M visits that are ineligible for G2211 payment because of the modifier 25 exclusion.

Applying G2211 to Other Evaluation and Management Visits

In 2024, G2211 may only be reported in addition to office/outpatient E/M services (99202-99215). In comments in the 2021 MPFS final rule, CMS reiterated the intent to use G2211 to adequately reflect the resources required for office/outpatient E/M visit codes, and that if the resources associated with other types of E/M visits are not adequate, it should be considered by the AMA RUC and CMS at a later date. In 2023, CMS revalued the home and residence E/M codes (CPT codes 99341-99350). The revaluation resulted in **decreased** work relative value units (RVUs) for five of the eight codes, with increases for the remaining three codes ranging from 5% to 10%.

We encourage CMS to consider whether there are other families of E/M services with which it may be appropriate to report G2211. Specifically, we ask CMS to consider allowing G2211 to be reported in addition to the home and residence E/M services (99341-99350), since the valuation decreased for some of these codes in 2023. For many Medicare beneficiaries, especially some of the most vulnerable, medical care services that serve as the continuing focal point for all needed health care services typically occur in the home. Family physicians who do home-based primary care maintain the relationship and continuity that G2211 is meant to value but are otherwise prohibited from reporting it because they care for patients in the home rather than the office. We encourage CMS to re-think this limitation on the reporting of G2211 as part of the 2025 rulemaking.

Telehealth

The *Consolidated Appropriations Act of 2023 (CAA 2023)* extended geographic and originating site waivers and coverage of audio-only telehealth services through December 31, 2024. We appreciate the policies finalized in the 2024 MPFS final rule to implement these provisions. CMS noted in the CY 2024 final rule that the agency will be examining more permanent telehealth coding and payment policies in CY 2025 rulemaking. **The AAFP strongly supports permanent coverage of both audio-video and audio-only telehealth services for all beneficiaries regardless of geography, as these continue to be essential modalities that provide beneficiaries access to their primary care physician.**

Telehealth, when implemented thoughtfully in the context of the patient's usual source of primary care, can improve the quality and comprehensiveness of patient care, and expand access to care for under-resourced communities and vulnerable populations. As discussed in our previous comments and outlined in our Joint Principles for Telehealth Policy, the AAFP strongly believes telehealth policies should advance care continuity and the patient-physician relationship. Telehealth should also enable high-quality, personalized care by making care more convenient and accessible for patients. Expanding telehealth services in isolation, without regard for a previous patient-physician relationship, medical history, or the eventual need for a follow-up, hands-on physical examination can undermine the central value offered by a usual source of primary care and a continuous and comprehensive

patient-physician relationship. It can also lead to increases in fragmented care and patients receiving suboptimal care.

Payment policies that do not appropriately recognize the resources used in telehealth visits, including practice expenses and physician time and work, can ultimately serve as a disincentive for practices to continue offering telehealth services and negatively impact patient access to their primary care physician. Medical decision-making and cognitive work does not differ based on modality of care, and existing evidence supports that virtual care is most efficient when provided by a primary care physician with whom a patient already has a relationship. When provided by a patient's usual source of care, telehealth (including audio-only) is another tool for practices that can provide increased access to a trusted member of the medical team. Policies should be designed to support more tools, not less, for primary care physicians, so they can provide the familiar and quality care their patients seek. We urge CMS to work with Congress to enact legislation, such as the *Protecting Rural Telehealth Access Act*, that would expand the definition of a telecommunication system to include audio-only technology.

Our members continue to provide high-quality primary care to patients both in-person and via telehealth. We believe payment policies should appropriately account for the practice expenses associated with offering hybrid options (i.e., telehealth and in-person). **We encourage CMS to revisit its policy that pays telehealth services reported with place of service (POS) 10 at the facility rate and to instead pay telehealth services reported with either POS 10 or 02 at the non-facility rate.** Regardless of the patient's location, the practice expenses remain the same. Furthermore, by providing hybrid options, the patient and physician can decide together which modality is most appropriate. The policies set forth by CMS often impact payment beyond traditional Medicare. Many Medicare Advantage plans and private payers align their policies with CMS. This was evident during the COVID-19 Public Health Emergency (PHE), when payers aligned with CMS' policies to expand coverage and payment for telehealth services. Among the largest national payers, there is still a high degree of alignment with CMS' policies, which signals that payers remain influenced and guided by CMS' actions. Alignment was and remains crucial in reducing burden and supporting practices as they continue leveraging telehealth to meet their patients' needs. According to internally conducted research, Medicare and Medicare Advantage make up roughly 36 percent of family physicians' patient panels[i], while private insurance makes up about 35 percent of their panels. This means CMS policies could influence more than two-thirds of telehealth payments to a family physician. The AAFP encourages CMS to support physicians offering telehealth services by ensuring adequate payment in its programs, which is a key driver to maintaining access for Medicare beneficiaries.

Direct Supervision via Use of Two-way Audio/video Communications Technology

The AAFP appreciates CMS finalizing the proposal to define "direct supervision" in such a way as to permit the immediate availability of the supervising physician through real-time audio and video interactive telecommunications through December 31, 2024. **We strongly recommend CMS permanently allow direct supervision of non-physician clinicians by physicians through the use of real-time audio/video technology.** The AAFP believes in the value of physician-led team-based care and clinically integrated teams that allow health professionals to work collaboratively in the best interest of patients, which can be accomplished via real-time audio/video technology. This virtual capability continues to promote patient access, continuity, convenience, and choice; decrease the spread of communicable diseases; and provide critical support to patients and physicians in rural areas.

Supervision of Residents in Teaching Settings

The AAFP applauds the policy finalized in the 2024 MPFS final rule allowing teaching physicians to have a virtual presence in residency training locations where the service is furnished virtually through December 31, 2024. This policy permits teaching physicians to meet supervision requirements through interactive, audio and video telecommunications technology during the key portion of the virtual service for which payment is sought, though not through audio-only technology. However, the AAFP believes that teaching physicians should be allowed to have a virtual presence in all teaching settings, and **we strongly encourage CMS to permit a teaching physician to have a virtual presence, regardless of whether the service is provided in-person or via telehealth**. The virtual presence option promotes patient access, continuity, convenience, and choice, while also decreasing the spread of communicable diseases.

Expanding the Primary Care Exception

The primary care exception permits a teaching physician to bill for certain lower and mid-level complexity physicians' services furnished by residents in certain types of residency training settings, even when the teaching physician is not present with the resident, if certain conditions are met. Regulations require that the teaching physician must not direct the care of more than four residents at a time; must direct the care from such proximity as to constitute immediate availability; and must review with each resident (during or immediately after each visit) the patient's medical history, physical examination, diagnosis, and record of tests and therapies. The teaching physician must have no other responsibilities at the time, assume management responsibility for the patient seen by the resident, and ensure the services furnished are appropriate.

The AAFP strongly supports the permanent expansion of services allowed under the primary care exception to include high-value primary care services, which we detail in Appendix A of our 2024 Medicare Physician Fee Schedule comment letter. The flexibilities authorized during the COVID-19 PHE, which allowed level 4 and 5 E/M visits to be furnished under the primary care exception, benefitted both patients and primary care training programs. Our members report that the absence of high-value services on the primary care exception list discourages their integration in residency training and day-to-day medical practice, negatively impacting physician training and patient outcomes in the long term. Additionally, members across the country have reported a shortage of supervising physicians in their locales, making the requirement that a supervising physician be physically present for a level 4 or 5 visit particularly challenging. **Thus, the AAFP recommends CMS permanently expand the list of services subject to the primary care exception to include all codes listed in Appendix A of our recent letter.** Permanently expanding the primary care exception could help improve utilization of recommended preventive care services, which is particularly important as many patients are still catching up on preventive care they may have forgone throughout the pandemic.

The AAFP greatly appreciates CMS' ongoing work to support comprehensive, longitudinal primary care, and we appreciate this opportunity to offer our recommendations. Implementing G2211 represented a significant step forward in ensuring fair and accurate payment for primary care services in the MPFS, and the AAFP stands ready to partner with CMS to ensure the code's intent is achieved in CY 2025 and beyond. We look forward to continued collaboration with CMS to support equitable access to high-quality, holistic, person-centered primary care. Thank you again for your consideration

of our recommendations. Should you have any questions, please contact Julie Riley, Regulatory and Policy Strategist, at jriley@aafp.org or (202) 655-4934.

Sincerely,

Tochi Iroku-Malize, MD, MPH, MBA, FAAFP
American Academy of Family Physicians, Board Chair

[i] 2022 Practice profile (Medicare - 19%, MA 17%, private 35%)