AMERICAN ACADEMY OF FAMILY PHYSICIANS

March 22, 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

Submitted electronically

Re: Additional information regarding 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 130,000 family physicians and medical students across the country, I write with additional information related to the recommendations we shared with the Centers for Medicare and Medicaid Services (CMS) in February regarding the calendar year (CY) 2025 Medicare Physician Fee Schedule (MPFS) proposed rule. In this letter, we offer additional rationale and data in support of

- modifications to the G2211 add-on code, and
- additional services allowed under the primary care exception for the supervision of resident physicians in primary care.

Modifications to the G2211 add-on code

As noted in our prior recommendations, the AAFP applauds CMS for recognizing the additional complexity required to deliver continuous, comprehensive, and longitudinal primary care and taking steps to improve the value of an outpatient primary care evaluation and management (E/M) visit through the implementation of G2211. However, family physicians have noted they are frequently unable to code G2211 because of the policy that prohibits payment for G2211 when the outpatient/office E/M visit is reported with modifier 25. When a primary care physician serves as the focal point of care for a patient, a primary care office visit often involves other, non-procedural services that require the use of modifier 25. As result, 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.

We therefore urge CMS to consider modification to the current policy which prohibits payment of G2211 when used with an E/M visit reported with modifier 25, specifically, allowing payment when modifier 25 is reported for preventive services provided on the same day as a primary care E/M visit.

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Below, we provide additional data on the impact of the current modifier 25 policy to help estimate the impact to G2211 utilization if the modifier 25 policy is changed.

Estimated utilization of modifier 25 with outpatient E/M visits

The Robert Graham Center used CMS Medicare and Medicaid data from CY 2018, based on a 5 percent random sample of primary care clinicians, to estimate the use of modifier 25 with office/outpatient E/M services by those clinicians. These data included line item-details (e.g., National Provider Identifier (NPI)) that allowed researchers to identify the relevant physician specialty type. Researchers counted how many E/M claims were submitted with and without modifier 25 and used this ratio to estimate the percent of Part B claims submitted by primary care specialties with modifier 25 attached.

The analysis found that for family physicians, 24.1 percent of outpatient/office E/M claims (99202-99215) were submitted with modifier 25. The percentage of E/M visits with modifier 25 for other primary care specialties was very similar: 22.6 percent for general practice, 23.7 percent for general internal medicine, and 13.6 percent for geriatrics. A full summary of the data is available in Appendix A of this letter.

Based on these estimates, approximately 25 percent of primary care E/M visits are provided with other services requiring modifier 25, making them ineligible for G2211 payment**. Our recommendation is to allow G2211 payment for only a subset of this estimated 25 percent of O/O E/M visits—specifically, when the E/M code has modifier 25 appended to report the following additional, separately identifiable preventive services:**

- Medicare AWV **(G0438, G0439)** or "Welcome to Medicare" visit **(G0402);**
- Immunization administration **(90460, 90461, 90471-90474)**;
- Medicare-recommended screening and counseling services, such as:
    - **Q0091** (Screening, Papanicolaou smear)
    - **G0101** (Cervical or vaginal cancer screening)
    - **G0442** (Annual alcohol misuse screening, 5 to 15 minutes)
    - **G0443** (Behavioral counseling for alcohol misuse)
    - **G0444** (Annual depression screening, 5 to 15 minutes)
    - **G0446** (Intensive Behavioral Therapy for cardiovascular disease)
    - **G0447** (Behavioral counseling for obesity)

Changing the modifier 25 policy for G2211 will help ensure CMS succeeds in improving the value of a primary care office visit to more accurately reflect the additional complexity and resources required. Further, changes to the modifier 25 policy will allow primary care physicians to provide a broad range of comprehensive services during an office visit, consistent with being the ongoing, focal point of care for their patients, which is likely to improve patient outcomes. Research suggests Medicare expenditures are reduced when patients receive comprehensive primary care that includes a range of services.[1] We believe allowing payment for G2211 when modifier 25 is used with certain services will improve beneficiary outcomes and reduce Medicare expenditures when the effects of reductions in acute care or emergency department visits are considered.

Information on private payer uptake of G2211

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.

Medicare and Medicare Advantage make up roughly 36 percent of family physicians' patient panels,[2] while private insurance makes up about 35 percent of their panels. 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. Therefore, any changes CMS makes to the modifier 25 policy for G2211 are likely to be adopted by private payers.

We anticipate private payers are likely to adopt payment for G2211 and have conducted internal research to assess current private payer adoption. As of March 2024, four national payers have confirmed coverage of G2211, including Aetna (Medicare Advantage only), Cigna (Medicare Advantage only), Humana (commercial and Medicare Advantage), and United Healthcare (commercial and Medicare Advantage). The AAFP continues to monitor private payer coverage of G2211 and maintains a list of private payer policies on G2211 for members (National G2211 Private Payer Coverage Matrix). This resource will be updated as the AAFP receives additional information.

Expansion of services allowed under the primary care exception

The Primary Care Exception (PCE) permits a teaching physician to bill for certain lower and mid-level E/M 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;
- direct the care from such proximity as to constitute immediate availability;
- review with each resident (during or immediately after each visit) the patient's medical history, physical examination, diagnosis, and record of tests and therapies;
- have no other responsibilities at the time;
- assume management responsibility for the patient seen by the resident;
- ensure the services furnished are appropriate.

Our members report the absence of high-value services on the PCE list discourages their integration in residency training, which has a negative impact on physician training, patient access, and longer-term outcomes. **The AAFP strongly recommends CMS to expand the list of services allowed under the PCE.** Below we detail our request rationale for expansion of these codes, including:

- **By allowing all levels of E/M services under the primary care exception, CMS will support primary care workforce development and improve patient continuity of care without compromising patient safety.**
- **Including additional preventive services in the PCE services list will increase utilization of high-value services.**

Allowing residents to bill more complex E/M visits without personal supervision during the visit

Under the PCE, medical decision-making (MDM) (not time) is used to select the level of the visit. This ensures that residents' inefficiencies do not result in inappropriate coding based on the potentially longer time spent on a visit compared to time typically used by a physician after residency. Only lower complexity E/M visits (levels 1 to 3) are eligible for residents to use under the PCE; a teaching physician must be physically present during the visit to use higher complexity (level 4 or 5) codes. Residents with less than 6 months of residency experience must have personal supervision during all services.

Residency programs regularly evaluate resident physicians to determine the level of supervision required by teaching physicians. In 2023, the Accreditation Council for Graduate Medical Education (ACGME) updated core residency program requirements. The updated requirements state that every residency curriculum must include "competency-based goals and objectives for each educational experience designed to promote progress on a trajectory toward autonomous practice."[3] The emphasis on competency-based assessments enables residency programs to adjust resident supervision based on their individualized progression and needs. ACGME core requirements state, "The trajectory to autonomous practice is documented by Milestones evaluations…" Residents must demonstrate their competency against a set of requisite goals and objectives to decrease their level of supervision. **This requirement ensures residency programs have proper guardrails in place to ensure patient safety while allowing the resident the autonomy necessary to practice independently once the program is complete**.

In addition to the core program requirements, the AGCME program requirements for Family Medicine note, "The program must demonstrate that the appropriate level of supervision is in place for all residents is based on each resident's level of training and ability, as well as complexity and acuity." The requirements further state, "Appropriate supervision is essential for patient safety and high-quality teaching. Supervision is also contextual....The level of supervision for each resident is commensurate with that resident's level of independence in practice; this level of supervision may be enhanced based on factors such as patient safety, complexity, acuity, urgency, risk of serious safety events, or other pertinent variables."[4]

Members tell us that some residents nearing program completion have the experience to furnish a level 4 or 5 E/M visit without personal supervision. In many cases, more senior residents are licensed to practice in other settings independently, and they do so in their free time. While moonlighting, these residents independently make complex evaluation and management decisions on par with a level 4 or 5 E/M visit. This type of resident is capable of independently furnishing more complex E/M visits in the residency setting without direct supervision, which would increase patient access. Some non-physician practitioners, such as Nurse Practitioners or Physician Associates, have fewer years of clinical experience than a third-year resident yet provide Level 4 and 5 visits without personal supervision.

Moreover, it is not always clear when a visit will meet the criteria for a level 4 or 5 visit. As a result, some experienced residents may furnish a visit that meets the MDM criteria of a level 4 or 5 E/M visit, but unless they stop the visit to call in the teaching physician, they are unable to code the visit based on the actual MDM level involved. These visits do not surpass the resident's capabilities or supervision requirements but require a teaching physician's presence to code accurately because the PCE policy does not allow a resident to select higher-complexity codes.

There is evidence to suggest residents may be using lower-complexity codes for more complex visits. During the COVID-19 Public Health Emergency (PHE), CMS allowed office/outpatient E/M visits at any level to be furnished under the PCE.[5] The temporary flexibility allowed experienced residents to use any level E/M visit code, even when a teaching physician was not present. A recent analysis of billing data from one residency program during the COVID-19 PHE found that the use of higher-complexity visit codes increased for residents while coding patterns generally remained the same for teaching physicians.[6] This suggests the overall frequency of higher-complexity visits did not change and lifting the restriction for residents allowed for more accurate coding based on MDM criteria.

A 2019 analysis examining coding accuracy in a family medicine residency observed that 88% of visits coded by residents use a lower complexity code when a higher-level code was more accurate, as judged by a trained observer.[7] A 2016 study compared residency programs that apply the PCE only for Medicare patients and programs that apply the PCE to all patients and found that programs applying the PCE to all patients bill significantly fewer high-complexity visits.[8] Another study compared coding from residency programs across five states against Medical Group Management Association (MGMA) data and found that both residents and attending physicians bill fewer high-complexity codes compared to benchmarks.[9]

These research studies suggest residents are unlikely to use higher level billing codes if the physical presence of a teaching physician is required during the visit, even if the visit merits a higher-level code. This coding pattern results in decreased resources for family medicine programs at a time when CMS is otherwise investing more in primary care (e.g., by implementing code G2211), and over time, impacts the viability of primary care residency training programs. Many residency programs have expenses that exceed their resources and funding, and residency program directors are often pressured by their sponsoring organization to demonstrate a financial benefit (or at minimum, a break-even) to continue the program. With a shortage of primary care physicians, ensuring the sustainability of existing residency programs is crucial. **Adding more complex E/M visits to the PCE will provide investment in primary care residency programs and the development of new graduates who are trained to provide comprehensive primary care to Medicare beneficiaries. Moreover, allowing residents to code more complex E/M visits under the PCE would improve access by freeing up teaching physician time to see additional patients instead of attending other visits where their personal supervision is not medically necessary.**

Residency program requirements for family medicine and internal medicine also include competencies to ensure graduates can provide continuity of care across settings. Primary care physicians must learn to independently build longitudinal relationships with their patients. **Allowing resident physicians to furnish more complex E/M visits without personal supervision will reinforce the resident physician's role as the focal point of care and provide patients with a greater continuity of care.**

We therefore urge CMS to reconsider the inclusion of level 4 E/M visits given recent changes in residency requirements, as these changes would allow only residents qualified to furnish a more complex visit do so without a teaching physician present. We recommend CMS add the following E/M services:

- **99204 New patient office visit, (level 4)**
- **99214 Established patient office visit (level 4)**

Additional high-value services to include under the primary care exception

The PCE also allows residents to bill for the following services without a teaching physician present during the service:

- G0402 – Initial preventive physical examination during first 12 months of Medicare enrollment
- G0448, G0489 – Annual wellness visit (initial visit, subsequent annual visits)

Research suggests residency training imprints certain practice patterns that persist beyond graduate training.[10] Allowing resident physicians to bill for preventive services during residency may improve longer-term utilization of these high-value services, which is particularly important as many patients catch up on preventive care after the COVID-19 PHE. This change would also help residency programs teach and reinforce the behaviors necessary to provide comprehensive primary care and sustain a primary care practice. In recent years, additional HCPCS codes have been implemented to value primary care services more fully and accurately. These codes help to provide the resources necessary to maintain a clinic and support a transition to value-based payment models.

We urge CMS to consider the addition of similar preventive HCPCS codes to the PCE list, including:

Screening codes

- **G0442** Annual alcohol misuse screening
- **G0444** Annual depression screening

Standardized screening instruments are frequently used for both services and are often provided by nurses under the direct supervision of a physician. Allowing resident physicians to provide these services with direct rather than personal supervision will likely increase utilization and train resident physicians to embed high-value services in their day-to-day practice.

Behavioral counseling or therapy codes

- **G0443** Brief face-to-face behavioral counseling for alcohol misuse
- **G0446** Annual, face-to-face intensive behavioral therapy for cardiovascular disease
- **G0447** Face-to-face behavioral counseling for obesity
- **99406** Smoking and tobacco use cessation counseling visit; intermediate
- **99407** Smoking and tobacco use cessation counseling visit; intensive

Residents who have established an ongoing relationship with the patient are well-suited to provide these services. In fact, these services may be less effective or declined by the patient if they require the presence of an attending physician who is unfamiliar to the patient. We also note that tobacco cessation counseling may be provided by non-physician practitioners, including Nurse Practitioners or Physician Associates, who in some cases may have less clinical training and experience than a third-year resident. Allowing resident physicians to provide these services without a teaching physician's presence will encourage residents to furnish these high-value services after residency is complete.

Codes related to patient continuity and integration of care

- **99421-99423** Online digital E/M service for an established patient
- **99495** Transitional care management
- **99497** Advance Care Planning, including explanation and discussion of advance directives
- **99498** Add-on code for CPT 99497 (Advance Care Planning, each additional 30 minutes)
- **99490** Chronic Care Management services, first 20 minutes of clinical staff time directed by a physician or other qualified health care professional
- **99439** Add-on code for CPT 99490 for each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional
- **G2211** Office/Outpatient E/M visit complexity add-on code

Residency programs must provide the experiences necessary to develop primary care physicians who can integrate care across settings and serve as a longitudinal source of care. Allowing these services under the PCE will improve utilization and encourage residents to provide these high-value services after graduation. It will also expand access by allowing qualified residents to provide these services to their patient panel without the face-to-face presence of a teaching physician. Teaching physicians could use this time to see additional patients, improving access.

Advance Care Planning and Chronic Care Management services are often provided by other staff under general or direct supervision by the patient's physician. Allowing qualified resident physicians to direct these services would provide residents with experience to become an effective physician leader of a multidisciplinary care team, a skill critical to the adoption of value-based payment models.

We also note that many of these codes help to provide the resources needed to employ appropriate staff for team-based care. Residency programs often have very limited financial resources and may be unable to employ a full team without the additional support these codes offer. Adding these services to the PCE would help to ensure residency programs have the resources to hire sufficient medical assistants, nurses, and other staff, which is critical to teaching resident physicians to work effectively with a multidisciplinary care team.

It is possible residents are furnishing these services during a lower-complexity E/M visit or AWV but are unable to code for these services because a teaching physician is not present. In fact, one member recently reviewed billing data from a residency program and learned that out of 38,777 visits, only three included code G0444 (depression screening) and four included 99406 (smoking cessation counseling) despite his observation that patients often receive these services during a visit. The Calendar Year 1996 MPFS final rule indicates the PCE was established out of concern that physical presence requirements for Part B payment would "unfairly deny reimbursement for the activities of teaching physicians in these programs and endanger the financial viability of these programs."[11] We greatly appreciate CMS' continued investment in primary care and believe allowing certain preventive services under the PCE would support the policy's originally stated aims as well as CMS' current strategy.

In summary, we strongly recommend CMS expand the services allowed under the PCE to improve access, support primary care workforce development, improve continuity of care, and equip graduate physicians with the skills and experiences to sustain a primary care practice after program completion, including the ability to code accurately. Updated residency program

requirements ensure patient safety is not at risk if the list of services is expanded. We ask CMS to include the following codes in the PCE:

- **99204** New patient office visit, (level 4)
- **99214** Established patient office visit (level 4)
- **G0442** Annual alcohol misuse screening
- **G0444** Annual depression screening
- **G0443** Brief face-to-face behavioral counseling for alcohol misuse
- **G0446** Annual, face-to-face intensive behavioral therapy for cardiovascular disease
- **G0447** Face-to-face behavioral counseling for obesity
- **99406** Smoking and tobacco use cessation counseling visit; intermediate
- **99407** Smoking and tobacco use cessation counseling visit; intensive
- **99421-99423** Online digital E/M service for an established patient
- **99495** Transitional care management
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- **99498** Add-on code for CPT 99497 (Advance Care Planning, each additional 30 minutes)
- **99490** Chronic Care Management services, first 20 minutes of clinical staff time directed by a physician or other qualified health care professional
- **99439** Add-on code for CPT 99490 for each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional
- **G2211** Office/Outpatient E/M visit complexity add-on code

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. Expanding the primary care exception will support access and primary care workforce expansion. 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 inside and outside residency programs. 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,

R. Shawn Martin
Executive Vice President & CEO

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[2] 2022 Practice profile (Medicare - 19%, MA 17%, private 35%)
[3] Accreditation Council for Graduate Medical Education (ACGME) Common Program Requirements, available: https://www.acgme.org/globalassets/pfassets/programrequirements/cprresidency_2023.pdf
[4] Family Medicine Program Requirements effective 7/1/2023, available: https://www.acgme.org/globalassets/pfassets/programrequirements/120_familymedicine_2023.pdf
[5] https://www.cms.gov/files/document/teaching-hospitals-physicians-medical-residents-cms-flexibilities-fight-covid-19.pdf
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[11] Medicare program; Revisions to payment policies and adjustments to the relative value units under the physician fee schedule for calendar year 1996, Health Care Financing Administration. Final rule with comment period. Fed Regist. 1995;60:6312463357. Available: https://www.govinfo.gov/content/pkg/FR-1995-12-08/pdf/X95-11208.pdf

Appendix A

E&M Claims (99202 - 99215) with Modifier 25 attached in 2018

Physician Specialty	Number of Unique NPIs in FFS Carrier File	Number of Unique Beneficiaries	Number of E&M Claims	Number of E&M Claims with Modifier 25	Percent E&M Claims with Modifier 25
Family Medicine	5,164	1,196,162	2,560,966	618,427	24.1%
General Practice	291	54,753	134,662	30,433	22.6%
General Internal Medicine	3,931	1,211,761	2,525,764	598,286	23.7%
Geriatrics	116	27,101	50,463	6,849	13.6%

Data and Methods:
Last year, the Graham Center successfully applied for CMS Medicare and Medicaid data, based on a 5% random sample of primary care clinicians. Using that cohort, we were able to obtain the claims, line-detail, encounter data, plan, and enrollment files associated with the beneficiaries these clinicians treated in CY2018 and 2019.

A request for information was made in January regarding the likely impact of the new G2211 code, using the prevalence of Modifier 25 on select office/OP E&M Services as a proxy for impact of CMS' payment exclusion policy.

We began by linking over 14K unique physician NPIs from our analytic cohort to the Part-B FFS Carrier Line-Detail file for 2018. This file contains information such as beneficiary ID, claim ID, billing NPI, procedure code, modifier codes, provider type, and medical specialty, which were necessary for the analysis. Any and all line-details that had that NPI as the billing provider were kept, thus creating a smaller subset of data from which to work. This reduced the count of observations from 215M in the 2018 FFS Carrier Line-Detail file to a more manageable 20.9M.It was then possible to identify the relevant provider type (physicians) and the specialties of interest.

The question posed relates to the frequency of Modifier 25 for select E&M codes (99202 - 99215) in 2018, so it was possible to highlight the line-items within a given claim that contained one of these codes, as well as highlight which of those observations also had a concurrent Modifier 25.

The line-item data was then summarized to the beneficiary-claim (single observation), where we retain information that was created prior, such as the presence of the relevant E&M codes, the presence of Modifier 25, and physician specialty for the claim. The resulting analytic file had 10.1M observations, each observation being a unique beneficiary-claim.

Using the available unique identifiers for both beneficiaries and claims, it was then possible to count how many beneficiaries, E&M claims, and E&M claims with Modifier 25 were accounted for by physician specialty across the analytic file, and of course, what percent of these Part B claims include Modifier 25.