AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

October 9, 2019

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Expanding the "primary care exception" code list

Dear Administrator Verma:

On behalf of the American Academy of Family Physicians (AAFP), which represents 134,600 family physicians and medical students across the country, I write requesting that the Centers for Medicare & Medicaid Services (CMS) expand the "primary care exception" policy for teaching physician services to include additional codes. Doing so would improve the educational training for applicable medical residents, expand patient access to primary care services, and improve the patient-physician relationship of primary care physicians in teaching centers.

Long-standing federal policy allows teaching physicians to bill under the primary care exception for outpatient visits performed by residents beyond their first six months of post-graduate training for specific codes. Current CMS policy requires teaching physician supervision, but not face-to-face presence of the teaching physician with the patient. To document use of this policy, the "GE" modifier is added to a billed code to indicate full primary care exception. The "GC" modifier indicates the service was performed with the teaching physician present. Currently, the following codes are on the primary care exception list:

- 99201, 99202, 99203 – New patient visits
- 99211, 99212, 99213 – Follow-up patient visits
- G0402, G0438, G0439 – Welcome to Medicare and Annual Wellness Visits

With the proliferation of new screening and preventive care services, the AAFP believes more can be done to promote and provide these services in the residency setting. These screening and preventive services are recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B. They are important services provided by primary care physicians. After receiving appropriate training and supervision to assure demonstration of correct application of screening and preventive codes, CMS should allow residents to provide these services with indirect supervision under the "primary care exception" rules. Developing a strong patient-physician relationship is central to the care provided by primary care residents. Inclusion of screening and preventive care services in the "primary care exception" will also enhance both the quality of the patient experience and the learning environment for the resident. CMS should add codes to the primary care exception list to promote the proper teaching and delivery of these services.

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We also request the inclusion of codes 99204 and 99214 in the primary care exception. Historically, CMS has only allowed codes 99201-99203 and 99211-99213 to be included in the primary care exception to the teaching physician rule. This made sense at the time of the establishment of the exception in the mid-1990's, as 99204 and 99214 were considered complex visits often involving patients with acute or unstable chronic conditions requiring the teaching physician to personally examine and assess the patient to assure a high standard of care. However, within the Medicare population, it is not unusual to find patients with three or more chronic conditions presenting for new and follow-up visits that require a level of time and medical decision making consistent with a level 4 code for management of multiple chronic conditions. These do not involve a level of diagnostic complexity that is beyond the resident physician's ability to provide quality care with indirect supervision. In addition, in recent years, medical training has moved further toward competency-based assessment and rigorous standards have been put in place regarding supervision.

In fact, the ACGME has moved toward competency-based education by the development of the common program requirements. These requirements were developed specifically for producing independent, well-trained physicians in the context of patient safety. This is a concept CMS recognized when the primary care exception regulations were developed. The ACGME notes, "combined with gradually increasing authority and independence, supervision and feedback allow resident physicians to make the transition from novice learner to proficient practitioner at the completion of residency training. At the same time, excessive supervision without progressive independence, as resident physicians acquire knowledge and skills, may hamper their progression from learner to competent practitioner in their discipline."

These Common Program Requirements compel the establishment of Clinical Competency Committee (CCC) in each accredited residency and fellowship. The committee reviews all resident physicians twice a year, evaluating the resident physician's progress. As part of those evaluations, the committee determines whether (and for what purposes) the resident physician is ready for direct versus indirect supervision.

With these internal processes in place, we believe it is both safe, appropriate and advantageous for CMS to include the 99204 and 99214 codes in the primary care exception. Our goal is to reduce unnecessary bureaucracy, not appropriate supervision. In fact, this change would free up preceptors to spend more time with resident physicians on complex and unstable patients, regardless of the code billed.

In recent years, CMS has included the Welcome to Medicare and Annual Wellness Visit codes (G0402, G0438, and G0439) to the primary care exception. We request the inclusion of additional codes relating to Chronic Care Management, Transitional Care Management, and home visits be added to these. Transitional Care Management code 99495 includes a face-to-face visit with a medical provider which we believe a resident physician can provide under the primary care exception. Chronic Care Management services are mainly performed by clinical staff in support of the medical provider, and any actual face-to-face visit with a physician is a separately reportable Evaluation and Management (E/M) service that likely falls within the primary care exception, especially if codes 999204 and 99214 are added. Lastly, the home visit codes listed below represent ambulatory E/M services with levels of history, exam, and medical decision making to the office visits already or proposed to be covered under the primary care exception. We do not believe the different site of service (i.e., home rather than office/clinic) is enough to merit their continued exclusion from the exception.

Finally, Advance Care Planning is a valuable service for patients that CMS has previously determined to be appropriately delivered through team-based care. A sufficiently trained resident should be considered a member of that care delivery team. In addition, we believe these services can be delivered through indirect supervision and likewise would be a logical addition to the primary care exception.

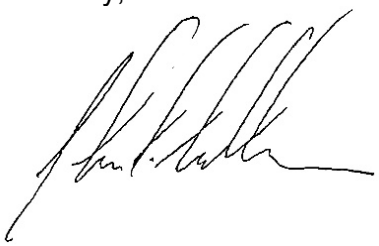
The AAFP strongly encourages CMS to add the following codes to the primary care exception list.

Code	Description
G0444	Annual depression screening, 15 minutes
G0442	Annual alcohol misuse screening, 15 minutes
G0443	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes
99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
99407	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes
G0446	Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes
G0447	Face-to-face behavioral counseling for obesity, 15 minutes
99490	Chronic Care Management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional
99491	Chronic Care Management services provided personally by a physician or other qualified health care professional, at least 30 minutes
99487	Complex Chronic Care Management services; 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
99489	Add-on code for CPT 99487 that pays for each additional 30 minutes of Complex Chronic Care Management services per calendar month
99204	Office or other outpatient visit for the Evaluation and Management of a new patient
99214	Office or other outpatient visit for the Evaluation and Management of an established patient
99497	Advance Care Planning including the explanation and discussion of advance directives; first 30 minutes, face-to-face
99498	Add-on code for CPT 99497 (Advance Care Planning, each additional 30 minutes)
99495	Transitional Care Management services
99341-99344	Home visits, new patient
99347-99349	Home visits, established patient

The AAFP strongly recommends that CMS support these codes as important work that residents should be encouraged to perform without direct supervision and their inclusion in the “primary care exception” will foster high-quality patient care. Through annual rulemaking, we encourage CMS to review the accuracy and appropriateness of this list.

Please contact Robert Bennett, Federal Regulatory Manager, at 202-655-4908 rbennett@aafp.org with any questions or concerns.

Sincerely,



John S. Cullen, MD, FAAFP
Board Chair