



January 29, 2021

Elizabeth Richter
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1734-IFC
P.O. Box 8016
Baltimore, MD 21244-8016

Re: CMS-1734-IFC; Medicare Program; CY 2021 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Coding and Payment for Virtual Check-in Services Interim Final Rule Policy; Coding and Payment for Personal Protective Equipment (PPE) Interim Final Rule Policy

Dear Acting Administrator Richter:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 136,700 family physicians and medical students across the country, I appreciate the opportunity to provide comments on the CY 2021 Medicare Physician Fee Schedule interim final rules, as published in the December 28, 2020 version of the *Federal Register*.

The AAFP commends CMS for the agency's ongoing efforts to improve access to high-quality, comprehensive, and coordinated primary care for Medicare beneficiaries. We deeply appreciate CMS taking action to more appropriately value office/outpatient Evaluation and Management (E/M) services and we look forward to working with you to ensure that the Medicare Physician Fee Schedule and Quality Payment Program (QPP) facilitate access to primary care services.

Coding and Payment for Virtual Check-in Services

Summary

For CY 2021, on an interim basis, CMS is establishing code G2252 (Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion.). To value this code, CMS is finalizing a direct crosswalk to code 99442, the value of which CMS believes most accurately reflects the resources associated with a longer service delivered via synchronous communication technology, which can include audio-only communication.

In support of its valuation, CMS notes both G2252 and 99442 describe 11-20 minutes of medical discussion when the physician or other qualified healthcare professional (QHP) may not be able to visualize the patient, and is used when the acuity of the patient's problem is not likely to warrant a visit, but when the needs of the patient require more assessment time from the physician or QHP. In

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the case of code G2252, the additional time would be used to determine the necessity of an in-person visit and result in a work time/intensity like the crosswalk code. CMS is finalizing a work RVU of 0.50, direct PE inputs of 3 minutes of clinical labor code L037D, and 1 minute, 15 minutes, and 5 minutes of pre, intra and post service physician/QHP time, respectively.

Because CMS does not view this service as a substitute for an in-person visit, but rather an assessment to determine the need for one, CMS finds the telehealth restrictions in section 1834(m) of the Act do not apply and the only technological requirement is that the communication technology must be synchronous. CMS considers this service to be a communications technology-based service (CTBS).

Consistent with the code descriptor, if this service originates from a related E/M service provided within the previous 7 days or leads to an E/M service or procedure within the next 24 hours or soonest available appointment, CMS would consider it bundled into that in-person service and therefore it would not be separately payable.

AAFP Response

In response to the COVID-19 pandemic, CMS took the critical step of establishing separate payment for audio-only evaluation and management services (CPT codes 99441-99443). This change enabled family physicians to quickly pivot from caring for their patients in-person to caring for them remotely, regardless of whether those patients had interactive audio-visual technology. Audio-only evaluation and management services are especially critical for caring for patients who lack access to high-speed broadband, who lack the technology or technological literacy to utilize audio-video technology, or who are uncomfortable with video visits. According to a May 2020 survey of AAFP members, audio-only was the most popular modality for family physicians to delivery virtual care to their patients. The AAFP has received feedback from members that the audio-only codes were invaluable in allowing them to care for their patients, and they are eager for them to continue beyond the COVID-19 public health emergency.

As such, we are disappointed that CMS opted against maintaining Medicare payment for CPT codes 99441-99443 and instead created the duplicative code G2252, which we note has a very similar descriptor and the same value as 99442.

In our [response](#) to the proposed rule on the 2021 Medicare physician fee schedule, we urged CMS to work through the CPT and RUC processes to develop and value a code(s) to allow all beneficiaries, regardless of geography or location, to access audio-only visits. We appreciate that CMS interprets G2252 as CTBS and therefore does not apply geographic, originating site, and other restrictions. The AAFP also supports limiting the use of this service to established patients.

However, the AAFP is concerned that instead of modifying the descriptors for audio-only E/M services, CMS has opted for a solution that does not adequately capture the physician work performed during audio-only visits and will add to physicians' administrative burden by creating a new code.

The value of G2252 fails to cover the cost of delivering audio-only services. Family physicians report that audio-only visits require the same level of medical decision making as audio-video and in-person evaluation and management visits. Just as CMS has been paying for codes 99441-99443 at

levels comparable to office visits of similar length during the PHE, so we believe CMS should pay for G2252 comparable to an in-person visit of similar length to account for the complexity and physician/QHP time involved.

We agree with CMS that there is widespread concern about the continuing need for audio-only services to ensure beneficiaries' access to care. We continue to believe that modifying the code descriptors and continuing Medicare payment for CPT codes 99441-99443 would more effectively address those concerns than creating a duplicative code for Medicare purposes. We recognize that implementation of G2252 is an interim measure while CMS considers what to do in 2022 and beyond. **We again urge CMS to work through the CPT and RUC processes to develop and value (or revise and revalue, as appropriate) a code(s) to allow all beneficiaries, regardless of geography or location, to access audio-only visits on a permanent basis.**

Payment for Personal Protective Equipment

Summary

In the final rule, CMS finalized a new policy on an interim basis to address concerns related to payment for PPE amid the COVID-19 pandemic. CMS declined to implement a new CPT code (99072) to account for the added cost of PPE, designating it as "bundled" instead. CMS believes use of additional forms of PPE are inherent to the furnishing of separately paid services. CMS did use the information provided by stakeholders, including the RUC, to update pricing information for some types of PPE and to add N95 masks to its supply database.

AAFP Response

The AAFP appreciates that CMS increased its pricing for some PPE supply items and added N95 masks to its supply database based on the information provided by stakeholders. However, we were disappointed CMS effectively declined to compensate physician practices for the additional clinical staff time and supplies they are consuming to keep their patients and themselves safe during the PHE. The AAFP is concerned about the ramifications of this decision as physician practices continue to report significant financial strains, as well as the added threat of COVID-19 mutations that are more readily transmissible.

A comparison of the practice expense inputs recommended for code 99072 and those already included in other services illustrates why CMS's approach is inadequate. For instance, consider code 99072 in comparison to code 99213, a common office visit:

- Code 99072 includes a three-minute, pre-visit phone call by clinical staff to screen the patient (symptoms check) and provide instructions on social distancing during the visit. Code 99213 does not; the only pre-visit clinical staff time is 4 minutes to identify the need for imaging, lab or other test result(s) and ensure information has been obtained.
- Code 99072 includes 1 minute of clinical staff time to do a temperature check when the patient arrives (often in the parking lot), which was not anticipated when CMS allocated 5 minutes of clinical staff time to code 99213 to obtain vital signs in the exam room.
- Code 99072 includes 2 minutes for clinical staff to don PPE, which was again not anticipated when CMS allocated 2 minutes to 99213 to prepare the room, equipment, and supplies. Saying the 2 minutes allocated to 99213 covers the 2 minutes needed to don PPE means CMS is no longer compensating practices for the other time needed to prepare the room, equipment, and supplies for the visit.

- Code 99072 includes 5 minutes of clinical staff time for cleaning the room and equipment, while code 99213 only includes 3 minutes for that function. How, payment for 3 minutes compensates for 5 minutes (which is, in reality, 5 additional minutes reflecting the extra time needed to disinfect under the PHE) is unclear.
- Code 99072 includes 3 surgical masks, reflecting the fact the physician/QHP, patient, and clinical staff person all need one during the encounter; code 99213 includes none.
- Code 99213 includes one sanitizing cloth-wipe for purposes of cleaning surfaces, instruments, and equipment in the exam room. Recognizing one cloth-wipe is insufficient to clean and disinfect an entire exam room, code 99072 includes additional cleaning supplies.

CMS's approach to this matter will not provide the support family medicine practices need to cover the additional financial costs they are incurring during the PHE for clinical staff time and supplies to keep their patients safe and fight the COVID-19 pandemic. CMS has taken many positive steps to support practices in this regard over the past year. **We urge the agency to reconsider its decision in this case and take another positive step by making code 99072 an active code (Status A) under the Medicare physician fee schedule and paying appropriately for it, based on the recommendations of the RUC and others.**

Payment for Immunization Administration

Summary

CMS finalized a policy to maintain the 2019 payment for all nine of the services in this family, including the add-on codes. CMS will continue to seek additional information that specifically reflects the resource costs and inputs that should be considered to establish payment for these services on a long-term basis and welcomes the results of an updated formal review of these services as well as any additional information that may be helpful for valuation in the immediate future.

AAFP Response

The AAFP is disappointed that CMS is maintaining the value of these immunization administration codes at the 2019 levels and we are deeply concerned that CMS reversed course amid a worsening pandemic.

CMS chose to maintain the payment rate for these services at the 2019 level even though the 2019 level is based on a crosswalk to CPT code 96372 (Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular), a crosswalk CMS proposed to abandon in the proposed rule on the 2021 MPFS and which results in payment rates substantially lower than current Centers for Disease Control and Prevention regional maximum charges. Further, the 2019 rates reflect two years of reduced payment from the 2017 rates Medicare paid before the revaluation of CPT code 96372 led to the current undervaluation of immunization administration. The 2019 rates are inappropriate, particularly as our nation continues to face a public health crisis and is undertaking a massive vaccination campaign.

In light of this decision in the CY 2021 MFPS final rule, the AAFP strongly urged CMS to use its emergency authority under the PHE to immediately increase payment rates for immunization administration in order to ensure access to these critical services. We maintain that CMS should take action to appropriately value these codes.

After the passage of the Consolidated Appropriations Act of 2021 (the Act), the AAFP also recommended that CMS provide clarifying instruction to Medicare Administrative Contractors indicating that payment amounts set in the CY 2021 MPFS final rule for immunization administration services should be increased by 3.75 percent pursuant to the Act, along with all other payment rates in the MPFS. A plain reading of the legislation clearly indicates that Congress intended to increase payment for all physician services to provide them with much needed relief amid the COVID-19 pandemic. **Accordingly, we recommend that CMS direct MACs to increase the payment rates for the immunization administration codes by 3.75 percent and take any other action needed to ensure these codes are properly valued for the remainder of 2021.**

Our understanding is that the RUC will conduct a formal review of these services at its April 2021 meeting, based on recommendations to be prepared between now and then. We urge CMS to use the results of that review in setting the value for these services in 2022.

Quality Payment Program

The AAFP strongly urges CMS to automatically apply the extreme and uncontrollable (E&U) circumstances to the 2020 MIPS performance year. While vaccination efforts are underway, they are far from complete and eligible clinicians (ECs) will need to remain focused on providing care for the foreseeable future. The US continues to set daily records of COVID-19-related deaths, and the emergence of new, more contagious strains of COVID-19 will place additional stressors on the health care system and physicians.

We understand and appreciate CMS' extension of the application deadline for the E&U exception. However, a practice that is unable to apply or fails to submit data will face a -9 percent payment adjustment, further exacerbating a practice's fragile financial situation. By automatically applying the extreme and uncontrollable circumstances policy, CMS will relieve physicians of the burden of reporting and the stress associated with potential negative payment adjustments. By the end of the MIPS reporting period, the national public health emergency will have been in place for more than a year. CMS should acknowledge the significance of this and provide assistance and relief where it can. We ask that CMS make a determination and announcement as soon as possible.

The AAFP also believes CMS should be ready to automatically apply the extreme and uncontrollable circumstances policy to the 2021 MIPS performance year. The PHE will be in effect through the first quarter of 2021, and many expect it will need to be extended through the calendar year. Additionally, the impact of the COVID-19 pandemic on quality and cost is yet to be determined. Continuing to assess ECs on their performance without fully understanding or accounting for the effects of the pandemic will not lead to accurate or fair measurement.

The AAFP reiterates our concerns with the elimination of the APM Scoring Standard. As we stated in our comments on the 2021 MPFS proposed rule, eliminating the APM Scoring Standard increases confusion and burden for participants that are not in the Medicare Shared Savings Program. By aligning the MSSP quality reporting requirements and removing the APM Scoring Standard, CMS is prioritizing the MSSP over other APMs. We do not believe one APM should receive priority over another. Forcing all MIPS APM participants to report either through the APP or MIPS places them at a disadvantage and holds them to a higher reporting standard as compared to MSSP. Therefore, **we strongly urge CMS to reinstate the APM Scoring Standard.**

Annual Alcohol and Depression Screenings

Summary

In the final rule, CMS noted that some commenters requested that CMS nominate codes G0442 (*Annual alcohol misuse screening, 15 minutes*) and G0444 (*Annual depression screening, 15 minutes*) as potentially misvalued due to the possible misinterpretation of their descriptors. Commenters highlighted that the descriptors may appear to convey that the physician providing the service must provide a full 15 minutes of screening to report either of these services. Per CMS, the commenters stated their understanding of the descriptor to mean “up to 15 minutes” to perform the screenings and suggested CMS adjust the official descriptors to say G0442 (*Annual alcohol misuse screening, up to 15 minutes*) and G0444 (*Annual depression screening, up to 15 minutes*). Commenters also asked CMS to provide an educational announcement to clarify the proposed change.

In response, CMS thanked the commenters for these suggestions for clarifications on codes G0442 and G0444 descriptors and welcomed comments and continued engagement with stakeholders on all aspects of coding that improves accuracy and promotes clarity.

AAFP Response

The AAFP was one of the commenters on this issue, and we appreciate CMS’s openness to continued engagement. We continue to believe codes G0442 and G0444 are potentially misvalued, given the way Medicare and its contractors are interpreting the codes as compared to how CMS has valued them. We also continue to believe CMS could address this potential misvaluation by simply revising the descriptors for the codes through the addition of “up to” in front of “15 minutes” and clarifying to its staff, MACs, and audit contractors that the 15 minutes specified in the codes is not a threshold or minimum time to report the code but rather the maximum time for a service that would qualify as screening as opposed to a diagnostic and/or management service.

As noted in our original comments, CMS implemented code G0444 in 2012 because of a national coverage determination (NCD) to cover such screenings for adults. We are aware some MACs consider the 15 minutes referenced in the descriptor of code G0444 to be a threshold, meaning the physician providing the service must provide a full 15 minutes of depression screening to report the service. Email correspondence with CMS staff at the regional and national level indicate they share this interpretation. We believe this interpretation is incorrect and the descriptor and interpretation of code G0444 should be revised accordingly.

As we read the NCD in question, we understand that “up to 15 minutes” is indicative of the brief screening described and that beyond 15 minutes would imply management of depression has been provided in lieu of screening alone. Further, we note section 190.A of chapter 18 of the Medicare Claims Processing Manual states, “Effective October 14, 2011, CMS will cover annual screening **up to 15 minutes** for Medicare beneficiaries in primary care settings that have staff-assisted depression care supports in place to assure accurate diagnosis, effective treatment, and follow-up.” (Emphasis added)

When CMS valued code G0444 in the final rule on the 2013 Medicare physician fee schedule, the agency crosswalked the value with CPT code 99211. CMS set the time for G0444 at 15 minutes. However, the crosswalk to code 99211, which has a total physician time of 7 minutes and an intra-

service time of only 5 minutes, indicates CMS viewed the 15 minutes assigned to G0444 not as a threshold but as a maximum beyond which the physician is no longer screening and instead providing additional services (e.g. counseling) reported with other codes.

Considering the crosswalk to code 99211, the service as anticipated in the NCD, and the explicit language in the Medicare Claims Processing Manual, we continue to recommend CMS revise its descriptor for G0444 to read “Annual depression screening, up to 15 minutes.” Further, we recommend CMS clarify to its staff, MACs, and audit contractors that the 15 minutes specified in code G0444 is not a threshold or minimum time to report the code but rather an indication that a service of more than 15 minutes exceeds screening and is reported with other codes. Otherwise, code G0444 appears misvalued by crosswalking a 15-minute service to one with less than half the time, suggesting code G0444 should be valued twice what is now.

For much the same reason, we recommend CMS revise its descriptor for G0442 to read “Annual alcohol misuse screening, up to 15 minutes” and clarify to its staff, MACs, and audit contractors that the 15 minutes specified in code G0442 is not a threshold or minimum time to report the code but rather an indication that a service of more than 15 minutes exceeds screening and is reported with other codes (e.g., G0396 or G0397, Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, dast), and brief intervention, 15 to 30 minutes or greater than 30 minutes, respectively). As with G0444, CMS crosswalked the value of G0442 to code 99211, suggesting similar logic should apply to the understanding of the 15 minutes specified in the descriptor and that, absent such understanding, G0442 is potentially misvalued for the same reason.

Again, we appreciate CMS’s openness to continued engagement on this issue. We would welcome the chance to address any related questions CMS staff may have and discuss with them ways in which the agency might address the matter.

Thank you for the opportunity to provide comments on the interim final rule. The AAFP looks forward to partnering with CMS to ensure Medicare beneficiaries’ access to high-quality care. Should you have any questions or wish to discuss our comments further, please contact Meredith Yinger, Senior Regulatory Strategist, at myinger@aafp.org or 202-235-5126.

Sincerely,



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Board Chair
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