



AMERICAN ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

December 9, 2014

Marilyn Tavenner, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1612-FC
P.O. Box 8013
Baltimore, MD 21244-8013

Dear Administrator Tavenner:

On behalf of the American Academy of Family Physicians (AAFP), which represents 115,900 family physicians and medical students across the country, I write in response to the “Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015” [final rule](#) as published by the Centers for Medicare & Medicaid Services (CMS) in the November 13, 2014, *Federal Register*. The final rule invited comments on code-specific issues and provided a comprehensive list of all values for which CMS is soliciting public comments in Addendum C to the final rule. Our comments are limited to select code-specific issues.

Topical Application of Fluoride Varnish (Code 99188)

The AAFP is disappointed that CMS did not publish any relative value units (RVUs) for this new code. CMS states, “Since this code describes a service that involves the care of teeth, it is excluded from coverage under Medicare by section 1862(a)(12) of the Act, which provides ‘items and services in connection with the care, treatment, filling, removal, or replacement of teeth, or structures directly supporting the teeth are excluded from coverage.’” Accordingly, CMS assigned code 99188 a status indicator of “N” (Noncovered service).

We understand CMS’ decision to designate this service as noncovered, given the statutory provision cited and the nature of the service. However, CMS should still publish RVUs for it. There is a long-standing precedent for CMS publishing the RVUs of codes with status indicator “N.” CMS established this precedent when it published RVUs for the preventive medicine services codes (99381-99397). CMS should continue to follow this precedent with code 99188. We believe that doing so allows CMS to publish values on the Medicare resource-based relative value scale (RBRVS) while maintaining Medicare payment policy that certain services may not be covered. We encourage CMS to look to the Relative Value Scale Update Committee (RUC) recommendations for 99188 as a starting point for publishing RVUs for this code.

In addition, we note that CMS includes Medicaid, the insurer of a significant portion of this country’s children, for whom this service is important. Further, unlike Medicare, Medicaid may, in fact, cover 99188 in many states. Many private payers also use the RBRVS in setting their fee schedules, and some of them may cover 99188, too. Therefore, CMS has a responsibility to publish RVUs for services included in the

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RBRVS, whether Medicare covers them or not. It is imperative that CMS publish recommended values for code 99188 on the Medicare RBRVS.

Complex Chronic Care (Code 99487) and Chronic Care Management (Code 99490)

In Addendum C of the final rule, CMS shows code 99487 as status "B" (bundled). We understand this decision in light of CMS' plans to pay for code 99490 (chronic care management) in 2015. What we do not understand is why CMS lists zero practice expense RVUs for 99487. CMS has previously published 0.38 practice RVUs for this code as a bundled service. Absent some compelling reason to the contrary, which we did not note in the final rule, we believe that CMS should continue the use of 0.38 practice RVUs.. As noted above, Medicare is not the only payer that uses the RBRVS. For the benefit of other payers that do, especially those that cover and pay for code 99487, CMS should publish the practice expense RVUs for this code, as it has in the past. This service continues to require direct and indirect practice expense inputs, which should be reflected in an appropriate amount of practice expense RVUs for the service.

On a related note, we observe that CMS made two significant and, in our view, inappropriate adjustments to the direct practice expense inputs for code 99490. Specifically, CMS:

- Changed the clinical staff type from "RN" to "RN/LPN/MA" and
- Reduced the clinical staff time from 60 minutes to 20 minutes.

We respectfully disagree with both of these adjustments on the part of CMS.

Regarding the clinical staff type, the RUC and its Practice Expense Subcommittee discussed this aspect specifically at length. In the end, the RUC was persuaded that it would be typical for this service to be provided by a registered nurse rather than the blended staff type substituted by CMS. We urge CMS to review the rationale considered and adopted by the RUC and change the staff type for this service back to "RN."

Regarding the clinical staff time, the specialties that surveyed this code for the RUC actually surveyed this element of practice expense. The survey results supported the 60 minutes recommended by the RUC. Additionally, the code descriptor for 99490 says "at least 20 minutes of clinical staff time." Thus, 20 minutes of clinical staff time, as planned by CMS, is the minimum, not the typical. Indeed, given the open-ended nature of code 99490, it seems reasonable to expect that the typical clinical staff time will be something greater than the minimum of 20 minutes, and we believe that the 60 minutes recommended by the RUC seems a reasonable alternative in terms of valuing the service.

Advance Care Planning (Codes 99497 and 99498)

In the final rule, CMS states that, for 2015, it is assigning a status indicator of "I" (Not valid for Medicare purposes. Medicare uses another code for the reporting and payment of these services.) to codes 99497 and 99498. However, CMS also states that "we will consider whether to pay for CPT codes 99497 and 99498 after we have had the opportunity to go through notice and comment rulemaking."

CMS does not elaborate on what other code Medicare uses for the reporting and payment of these services. It also does not offer any indication as to what issues it must examine or what additional information it needs as it considers whether to pay for these two codes through the notice and comment

Administrator Tavenner
Page 3 of 3
December 9, 2014

rulemaking process. Accordingly, it is difficult to know how to respond to CMS' interim decision in this regard or how to be helpful to CMS in its further consideration of payment for these services.

Therefore, we ask CMS to make known publicly what issues it is considering and what, if any, additional information the agency needs going forward. We believe that these are valuable services that are separately identifiable from other services provided to Medicare beneficiaries. In the meantime, we also respectfully ask CMS to clarify which code(s) it believes Medicare already uses for the reporting and payment of these services.

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

Sincerely,



Reid B. Blackwelder, MD, FAAFP
Board Chair