September 20, 2019


Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1715-P
P.O. Box 8016
Baltimore, MD 21244-8016

Dear Administrator Verma:

On behalf of the Missouri Academy of Family Physicians, I write in response to the CY 2020 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies as published by the Centers for Medicare & Medicaid Services (CMS) in the August 14, 2019 Federal Register.

The Missouri Academy of Family Physicians continues to commend CMS’ leadership and commitment to improving the Medicare program for all beneficiaries—and in improving access to high-quality, comprehensive, and coordinated care, especially your efforts to support family medicine and primary care. We look forward to working with CMS on designing and implementing policies that support these shared goals through both the Medicare Physician Fee Schedule (MPFS) and the Quality Payment Program (QPP).

The recommendations we offer in this letter reflect our members’ experiences caring for patients across the country and our goal to build a health system founded in family medicine and primary care that improves health and reduces system costs.

The Missouri Academy of Family Physicians respectfully offers comments on the following high-level issues for your consideration.

- **Office/Outpatient Evaluation and Management (E/M) Coding.** The Missouri Academy of Family Physicians supports the adoption of the work relative value units (RVUs) recommended by the RVU Update Committee (RUC) for all the office/outpatient E/M codes, the new prolonged services add-on code, and CMS’ proposal to maintain separate values for levels two through four visits rather than implement its plan for a
blended payment rate for those services. However, since most family medicine practices already operate on extremely thin margins and these services have been undervalued for decades, we implore CMS to implement these changes in 2020 rather than 2021 as proposed.

- **Global Surgical Packages.** Based upon analysis available from RAND and the Medicare Payment Advisory Commission, we believe the proposed recommendations put forth by CMS are the appropriate policy. Therefore, we strongly support CMS’ proposal to not adjust the office/outpatient E/M visits for codes with a global period to reflect the changes made to the values for office/outpatient E/M visits.

- **Chronic Care Management.** The Missouri Academy of Family Physicians is concerned the addition of new principal care management (PCM) codes would move away from the continuous, comprehensive, and coordinated value-based care and primary care CMS has otherwise been encouraging as a cost-effective way to care for Medicare patients. We offer alternative recommendations in the body of the letter to strengthen care for beneficiaries with chronic conditions and urge CMS to use the existing Current Procedural Terminology (CPT) coding process to make changes to these codes.

### II.J. Review and Verification of Medical Record Documentation

**Summary**

Building on medical record documentation relief it implemented in 2019, CMS proposes to establish a general principle to allow the physician, the physician assistant (PA), or the advanced practice registered nurse (APRN) who furnishes and bills for their professional services to review and verify, rather than re-document, information included in the medical record by physicians, residents, nurses, students, or other members of the medical team. This principle would apply across the spectrum of all Medicare-covered services paid under the physician fee schedule. Because this proposal is intended to apply broadly, CMS proposes to amend regulations for teaching physicians, physicians, PAs, and APRNs to add this new flexibility for medical record documentation requirements for professional services furnished by teaching physicians, physicians, PAs, and APRNs in all settings.

Specifically, CMS proposes to amend relevant sections of its regulations to add a new paragraph entitled, “Medical record documentation.” This paragraph would specify that, when furnishing their professional services, the clinician may review and verify (sign/date) notes in a patient’s medical record made by other physicians, residents, nurses, students, or other members of the medical team, including notes documenting the practitioner’s presence and participation in the services, rather than fully re-documenting the information. CMS notes that, while the proposed change addresses who may document services in the medical record, subject to review and verification by the furnishing and billing clinician, it does not modify the scope of, or standards for, the documentation that is needed in the medical record to demonstrate medical necessity of services, or otherwise for purposes of appropriate medical recordkeeping.
CMS also proposes to make conforming amendments to its regulations to also allow physicians, residents, nurses, students, or other members of the medical team to enter information in the medical record that can then be reviewed and verified by a teaching physician without the need for re-documentation.

**Missouri Academy of Family Physicians Response**
The Missouri Academy of Family Physicians strongly supports CMS’ proposals in this regard as it is long overdue. The proposed principle and related regulatory changes are consistent with prior CMS efforts to reduce the administrative burden associated with medical record documentation. They are also consistent with the team-based model of care used in family medicine practices and residencies. However, we urge CMS to clarify that multiple students and residents can enter patient information into the medical record even on the same day and during the same office visit. We encourage CMS to finalize this proposal as clarified per our recommendation in the final rule this fall.

**Immunization Administration Services (90460, 90471, and 90470)**

**Summary**
In Addendum B of the proposed rule, CMS proposes to reduce the practice expense RVUs for each of these codes from 0.29 to 0.22, due to the continued crosswalk from 96372 (Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular) to 90460, 90471, and 90473. Code 96372 was reviewed by the RUC in January 2017, at which time its practice expense inputs were significantly reduced to remove overlap with E/M codes. CMS further refined the RUC-recommended direct practice expense inputs for code 96372 in the 2018 proposed rule, resulting in nine minutes of clinical staff time rather than 12 as the RUC recommended. CMS also made reductions in the RUC-recommended medical supplies and equipment. That reduction, which CMS is phasing in for 96372, is also being applied to the vaccine administration codes noted, since their values are crosswalked to 96372.

**Missouri Academy of Family Physicians Response**
The Missouri Academy of Family Physicians respectfully requests that CMS utilize the RUC-recommended direct PE inputs to publish practice expense RVUs for CPT immunization administration codes 90460, 90471, and 90473, each of which has been reviewed by the RUC. For instance, CPT code 90460 was reviewed by the RUC in October 2009. Rather than accepting the RUC recommendations, CMS crosswalked 90460 from CPT code 90471, which, in turn, is crosswalked from CPT code 96372.

The recent measles crisis spotlights the importance of immunization administration being appropriately valued. Appropriate payment for immunization administration is essential to ensure access to vaccines provided in the medical home, where studies have shown immunization rates are higher.
The crosswalk from CPT code 96372 to these codes has brought about a 60% reduction in practice expense RVUs, resulting in substantially lower payments under Medicare and other payers that use the Medicare physician fee schedule in setting their own fees. The impact to bottom line of a family medicine practice can cause some practices to stop offering vaccines.

Historically, CMS typically only uses a crosswalk for work values, not practice expense values. Additionally, when the RUC makes crosswalks, it disconnects the codes after the initial crosswalk, so changes to the source code no longer affect the crosswalked code. CMS also has this option.

Finally, it should be noted that CMS has already validated the RUC-recommended values for CPT code 90460. CMS used the RUC-recommended values for CPT code 90460 to value the fast-tracked H1N1 immunization administration code (90470) for 2010—as both codes were reviewed during the same RUC meeting (October 2009).

II. P. Payment for Evaluation and Management (E/M) Visits

*Summary - Office/Outpatient E/M Visit Coding and Documentation*

For calendar year 2021, for office/outpatient E/M visits (CPT codes 99201-99215), CMS proposes to adopt the new coding, prefatory language, and interpretive guidance framework adopted by the CPT Editorial Panel for CPT 2021. This includes deletion of code 99201 and acceptance of a new, single add-on CPT code for prolonged office/outpatient E/M visits (code 99XXX) that would only be reported when time is used for code-level selection and the time for a level five office/outpatient visit (the floor of the level five time range) is exceeded by 15 minutes or more on the date of service. This new add-on code would obviate the need for code GPRO1 (extended office/outpatient E/M time), which CMS had planned to implement in 2021, but now proposes to delete instead.

The one variance from CPT in this regard is that, for Medicare, CPT codes 99358 and 99359 (Prolonged E/M without direct patient contact) would no longer be reportable in association or “conjunction” with office/outpatient E/M visits. New CPT prefatory language specifies 99358 and 99359 may be reported for prolonged services on a date other than the date of a face-to-face encounter. CMS believes its proposed policy regarding 99358 and 99359 would be consistent with the way the office/outpatient E/M visit codes were resurveyed, where the RUC instructed those surveyed to consider all time spent three days prior to, or seven days after, the office/outpatient E/M visit. CMS finds the CPT language and reporting instructions related to 99358 and 99359 to be unclear and circular and believes CPT codes 99358 and 99359 may need to be redefined, resurveyed, and revalued. In the meantime, CMS seeks public input on its proposal and whether it would be appropriate to interpret the CPT reporting instructions for CPT codes 99358 and 99359 as proposed, as well as how this interpretation may impact valuation.

*Missouri Academy of Family Physicians Response - Office/Outpatient E/M Visit Coding and Documentation*
The Missouri Academy of Family Physicians appreciates and strongly supports CMS’ proposal to adopt the new coding, prefatory language, and interpretive guidance framework adopted by the CPT Editorial Panel for CPT 2021. This includes deletion of code 99201 and acceptance of a new, single add-on CPT code for prolonged office/outpatient E/M visits (code 99XXX) in lieu of the code (GPRO1) CMS previously planned to use.

Changes of this magnitude may have an impact on EHRs, since most are built around the current CPT structure and 1995/1997 E/M documentation guidelines. If CMS finalizes this proposal, it must provide this updated framework to EHR vendors as soon as possible and work with the American Medical Association (AMA) and specialty societies on the physician communications and educational efforts that will be needed between now and 2021.

Regarding codes 99358 and 99359 (Prolonged E/M without direct patient contact), we acknowledge the points of confusion in the CPT guidance for use of these codes in conjunction with office/outpatient visit codes vis-à-vis the parameters in which the latter codes were surveyed for the RUC. However, we would encourage CMS to work with the CPT Editorial Panel to resolve these points of confusion between now and 2021 rather than unilaterally making 99358 and 99359 no longer reportable in conjunction with office/outpatient E/M visits for Medicare.

Part of the administrative complexity and burden that hampers our members’ ability to care for their patients is variability in payment policy among payers and payment policy at odds with guidance otherwise included in CPT. CMS’ proposal to unilaterally change its payment policy in this regard, and in conflict with CPT would add to our members’ administrative complexity and burden. This is why we oppose CMS’ proposal and instead urge CMS to work through the CPT process so any changes apply to more than just Medicare. As noted in the AAFP’s policy on “Coding and Payment,” the AAFP supports CPT and the coding principles it contains. Thus, the Missouri Academy of Family Physicians believes it is important for both physicians and health plans to abide by the principles of CPT.

**Summary - Office/Outpatient E/M Visit Revaluation (CPT codes 99201 through 99215)**

CMS proposes to adopt the RUC-recommended work RVUs for all the office/outpatient E/M codes and the new prolonged services add-on code, effective for dates of service on or after January 1, 2021. CMS proposes to maintain separate values for levels two through four visits rather than implement its plan for a blended rate for those services.

Regarding the RUC recommendations for PE inputs for these codes, CMS proposes to remove equipment item ED021 (computer, desktop with monitor), as CMS does not believe that this item would be allocated to the use of an individual patient for an individual service. Instead, CMS believes this item is better characterized as part of indirect costs like office rent or administrative expenses.
The one point of confusion or concern for CMS in valuing these codes concerns the total physician time to be assigned to each code. As CMS notes, the RUC separately averaged the survey results for pre-service, day of service, and post-service times, and the survey results for total time, with the result that, for some of the codes, the sum of the average times associated with the three service periods does not match the RUC-recommended total time, which was the average of the respondents’ total time. A simple example illustrates how this might occur:

<table>
<thead>
<tr>
<th></th>
<th>Pre-Service Time</th>
<th>Intra-Service Time</th>
<th>Post-Service Time</th>
<th>Total Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respondent A</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Respondent B</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Respondent C</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Median</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>

CMS is concerned by the fact that if one adds up the medians of the individual time components (which is 5 [2+2+1] in the illustration above), the total does not equal the median of total time among all respondents (which is 4 in this illustration).

CMS proposes to adopt the RUC-recommended times, in which total time reflects the median of total time among all respondents rather than the sum of the medians for the three components of total time. However, CMS seeks comment on how it should address the discrepancies in median total times versus sum of the median component times. CMS believes this has implications both for valuation of individual codes and for MPFS rate setting in general, as the intra-service times and total times are used as references for valuing many other services under the MPFS and the programming used for MPFS rate setting requires that the component times sum to the total time. Specifically, CMS requests comment on which times it should use, and how it should resolve differences between the sum of the components and median total times when they conflict.

Missouri Academy of Family Physicians Response - Office/Outpatient E/M Visit Revaluation (CPT codes 99201 through 99215)

The Missouri Academy of Family Physicians appreciates and strongly supports CMS’ proposal to adopt the RUC-recommended work RVUs for all the office/outpatient E/M codes and the new prolonged services add-on code, effective for dates of service on or after January 1, 2021. However, since most family medicine practices already operate on extremely thin margins and these services have been undervalued for decades, we implore CMS to implement these changes in 2020. We also appreciate and support the CMS proposal to maintain separate values and payment for levels two through four visits rather than implement its plan for a blended rate for those services.

However, we respectfully disagree with the CMS proposal to remove equipment item ED021 (computer, desktop with monitor) from the direct PE inputs for these codes. According to the
Centers for Disease Control and Prevention (CDC), 85.9% of office-based physicians are using an EHR. Medication and problem lists must be accurately maintained by physicians during a visit using their EHRs. Furthermore, with the multiple medications now required by many patients, monitoring for drug-drug interactions becomes an essential component for patient safety and quality care. All of this makes a computer a typical, indispensable part of the medical equipment used during an office visit. Whether it’s a desktop computer with monitor or a laptop, some computer is typically being used during an office visit, and contrary to CMS’ belief, is allocated to the use of an individual patient for an individual service, just like the exam table in the room.

There is precedent for including a computer as a direct PE. There are 52 CPT codes that include equipment item ED021. For office visits, the work being performed using the computer is not administrative in nature. Rather, it is used to record, analyze, and communicate to the physician about every element of data that the clinical staff collects from the individual patient for the individual service.

In sum, the computer is dedicated solely to each patient throughout the visit to collect history, share and discuss lab and test results, and document the visit. It is an essential tool in conducting today’s office visits, and CMS should recognize it as a direct medical equipment cost. We encourage CMS to accept the RUC’s recommendation to include item ED021 (computer, desktop with monitor) among the direct PE inputs for these codes.

We appreciate and support that CMS proposes to adopt the RUC-recommended times in which total time reflects the median of total time among all respondents, rather than the sum of the medians for the three components of total time. As the RUC noted in its rationale, “total time is the appropriate measurement of time and each individual survey respondent’s total time response should be used in determining the median total time.” Like the RUC, we think that approach makes the most sense and best honors the robust survey data that CMS acknowledges in the proposed rule.

We understand this approach differs from the way in which CMS usually approaches total time. That said, for these codes, we believe it’s important to use, as the RUC did and as CMS proposes to do, the median total time among all respondents. We are happy to work with the RUC and CMS to sort out any implications both for valuation of individual codes and for MPFS rate setting in general, as well as how CMS should resolve differences between the sum of the components and median total times when they conflict.

Summary - Simplification, Consolidation, and Revaluation of HCPCS codes GCG0X and GPC1X

In the final rule on the 2019 fee schedule, CMS stated its intent in 2021 to implement two G-codes, GCG0X (Visit complexity inherent to E/M associated with non-procedural specialty care) and GPC1X (Visit complexity inherent to evaluation and management associated with primary medical care services that serve as the continuing focal point for all needed health care services). CMS said it would value both codes via a crosswalk to 75% of the work and time value
of code 90785 (Interactive complexity [List separately in addition to the code for primary procedure]).

In the current proposed rule, CMS states the typical visit described by the revised office/outpatient E/M visit code set still does not adequately describe or reflect the resources associated with primary care and certain types of specialty visits. Thus, CMS proposes to simplify the coding by consolidating the two add-on codes into a single add-on code and revising the single code descriptor to better describe the work associated with visits that are part of ongoing, comprehensive primary care and/or visits that are part of ongoing care related to a patient’s single, serious, or complex chronic condition.

Specifically, CMS proposes to revise the descriptor for code GPC1X and delete code GCG0X. The proposed descriptor for GPC1X would read: Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient’s single, serious, or complex chronic condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established).

Lastly, CMS proposes to value code GPC1X at 100% of the work and time values for code 90785, which would yield a proposed work RVU of 0.33 and a physician time of 11 minutes. CMS also proposes that this add-on G-code could be billed as applicable with every level of office and outpatient E/M visit.

Missouri Academy of Family Physicians Response - Simplification, Consolidation and Revaluation of HCPCS codes GCG0X and GPC1X
The Missouri Academy of Family Physicians appreciates and supports CMS’ intent to simplify the potential add-on codes associated with the revised office/outpatient visit E/M codes. Like CMS, we believe the typical visit described by the revised code set still does not adequately describe or reflect the resources associated with primary care visits. Accordingly, we support CMS’ proposal to maintain an add-on G-code (GPC1X) that could be reported in conjunction with a primary care office visit.

The AAFP defines “primary care” as:
Primary care is that care provided by physicians specifically trained for and skilled in comprehensive first contact and continuing care for persons with any undiagnosed sign, symptom, or health concern (the "undiifferentiated" patient) not limited by problem origin (biological, behavioral, or social), organ system, or diagnosis.

Primary care includes health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings (e.g., office, inpatient, critical care, long-term care, home care, day care, etc.). Primary care is performed and managed by a personal physician often collaborating with other health professionals and utilizing consultation
or referral as appropriate. Primary care provides patient advocacy in the health care system to accomplish cost-effective care by coordination of health care services. Primary care promotes effective communication with patients and encourages the role of the patient as a partner in health care.

Given this definition, we would encourage CMS to consider revising its description of GPC1X as follows (language to be added is underlined):

Visit complexity inherent to evaluation and management associated with medical care services that serve as the first contact and continuing focal point for all needed health care services in coordination with others as needed and/or with medical care services that are part of ongoing care related to a patient’s single, serious, or complex chronic condition(s). (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new, or established).

The proposed definition includes the continuing and comprehensive (“all needed health care services”) elements of primary care. However, it lacks the “first contact” and “coordination” elements that are otherwise essential in distinguishing primary care visits from other types of office/outpatient E/M visits.

There is inherent administrative burden associated with use of an add-on code, and regardless of how CMS defines the new add-on code, we recognize CMS will need to issue documentation guidance to support its appropriate use. That said, we urge CMS to ensure its documentation guidance is clear and minimizes the burden of using the new code.

If revised as we suggest, we support CMS’ proposal to value code GPC1X at 100% of the work and time values for code 90785, which would yield a proposed work RVU of 0.33 and a physician time of 11 minutes.

Summary - Valuation of CPT Code 99XXX (Prolonged Office/Outpatient E/M)
CMS proposes to delete the planned add-on code for extended visits (GPRO1) it finalized last year for calendar year 2021 and instead adopt the new CPT code 99XXX. Further, CMS proposes to accept the RUC recommended values for CPT code 99XXX without refinement.

Missouri Academy of Family Physicians Response - Valuation of CPT Code 99XXX (Prolonged Office/Outpatient E/M)
The Missouri Academy of Family Physicians appreciates and strongly supports CMS’ proposal to adopt the RUC-recommended work RVUs for the new prolonged services add-on code, effective for dates of service on or after January 1, 2021. However, since most family medicine practices already operate on extremely thin margins, we implore CMS to implement these changes in 2020.
Summary - Global Surgical Packages
Considering three RAND reports on the subject and CMS’ understanding that work RVUs for procedures with a global period are generally valued using magnitude estimation, CMS does not state its intent to accept the RUC recommendation to adjust the office/outpatient E/M visits for codes with a global period to reflect the changes made to the values for office/outpatient E/M visits. Instead, CMS states it will give the public and stakeholders time to study the RAND reports (which CMS makes available), along with this rule and consider an appropriate approach to revaluing global surgical procedures. CMS will continue to study and consider alternative ways to address the values for these services.

Missouri Academy of Family Physicians Response - Global Surgical Packages
Based upon analysis available from RAND and the Medicare Payment Advisory Commission, we believe the proposed recommendations put forth by CMS are the appropriate policy. Until such time that verifiable, third-party data provides a clearer justification for the inclusion of E/M codes in the global period we strongly support CMS’ decisions as outlined in the proposed rule. As CMS notes in the proposed rule and as the RUC and the surgical specialties have frequently maintained, work RVUs for procedures with a global period are generally valued using magnitude estimation rather than building blocks.

As noted in the proposed rule and as required by law, CMS is collecting data to validate the number and level of E/M services assumed to be included in global surgical services. The RAND study analyzing data collected through claims supports CMS’ intent not to accept the RUC recommendation to adjust the office/outpatient E/M visits for codes with a global period to reflect the changes made to the values for office/outpatient E/M visits. For instance, during the first 12 months of reporting post-operative visits via claims, RAND found most procedures with 10-day global periods did not have an associated post-operative visit. Further, among procedures with 90-day global periods, the ratio of observed-to-expected post-operative visits provided was only 0.39. Further, in its study of the levels of post-procedure visits, RAND found the reported physician time and work for the post-operative visits in the two 90-day global codes studied (i.e., cataract surgery and hip replacement) were generally similar—but slightly less—than the levels expected based on the E/M visits assumed to typically occur by CMS when valuing these procedures.

The Office of Inspector General and others have questioned the accuracy of current assumptions underlying 10- and 90-day global codes. Until CMS can adequately address those questions, we believe it would be imprudent to adjust the E/M component because of any changes to the values of stand-alone office/outpatient visit codes 99201-99215 and we strongly support CMS’ decision in this regard. We continue to believe the best approach to this issue is to convert all codes with a 10- or 90-day global period to zero-day global periods and revalue the codes accordingly and thereby allow physicians to appropriately code and document necessary pre- and post-operative services using the E/M codes inclusive of their new values and payment amounts. For decades, physicians using these global codes have not been required to follow the E/M documentation guidelines for charting in the medical record.
for such visits which has been blatantly unfair to the rest of the physician community and especially primary care—it is time for the global service codes to be eliminated and level the playing field for all physicians and other clinicians.

We appreciate the opportunity to provide these comments. Please contact Kathy Pabst, Executive Director, at (573) 635-0830 or kpabst@mo-afp.org with any questions.

Sincerely,

Jamie Ulbrich, MD, FAAFP
President