American Society of Pediatric Nephrology

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October 5, 2020

Seema Verma
Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1715-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

SUBMITTED ELECTRONICALLY VIA http://www.regulations.gov

Re: CMS-1734-P - Medicare Program; CY 2021 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Updates to the Quality Payment Program; Medicare Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs; Medicare Enrollment of Opioid Treatment Programs; Requirement for Electronic Prescribing for Controlled Substances for a Covered Part D Drug under a Prescription Drug Plan or MA-PA plan; Payment for Office/Outpatient Evaluation and Management Services; Hospital IQR Program; Proposal to Establish New Code Categories; and Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy Proposed Rule

Dear Administrator Verma,

On behalf of the American Society of Pediatric Nephrology (ASPN), thank you for the opportunity to comment on the CY 2021 Medicare Physician Fee Schedule (MPFS) proposed rule. As the voice for pediatric kidney disease, our members strive to ensure that infants, children, adolescents and young adults they care for receive appropriate and high-quality care. Approximately one third of our patients with end-stage renal disease (ESRD) are covered by Medicare making the proposals in this rule critical to the pediatric nephrologists.

Founded in 1969, ASPN is a professional society composed of pediatric nephrologists whose goal is to promote optimal care for children with kidney disease and to disseminate advances in the clinical practice and basic science of pediatric nephrology. ASPN currently has over 700 members, making it the primary representative of the Pediatric Nephrology community in North America.

ASPN is pleased to offer the following comments to the proposed rule:

Refinements to Values for Certain Services to Reflect Revisions to Payment for Office/Outpatient Evaluation and Management (E/M) Visits and Promote Payment Stability during the COVID-19 Pandemic

ASPN submitted detailed comments on CMS' proposal to reduce the documentation requirements and improve the values of the outpatient E/M services in last year's MPFS. The children with ESRD that we treat are medically complex, and pediatric ESRD care requires supporting a child's growth and development such that dialysis serves a bridge to kidney transplantation, which differs from the goal of adult ESRD in many ways. Our members typically bill level 4 and 5 outpatient E/M codes for care delivered outside of the ESRD bundle, and as such, strongly support the changes CMS has implemented to the outpatient E/M code family. We urge CMS to implement this policy as finalized on January 1, 2021.

Prolonged Office/Outpatient E/M Visits (CPT code 99XXX)

The changes made to the documentation requirements for the outpatient E/M services allow physicians to document these services either based on medical decision making or total time spent on the date of service beginning January 1, 2021. ASPN continues to support the implementation of CPT add-on code 99XXX (*Prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each additional 15 minutes*) to capture additional time spent on the date of service above that for a level 5 visit, as well as the change CMS proposed: CPT code 99XXX would only be available once a physician has exceeded the maximum, rather than the minimum, time associated with a new or established patient level 5 visit. ASPN agrees this policy would prevent the double counting of time.

ASPN, however, urges CMS to reconsider its policy that requires a provider to spend a full 15 minutes beyond the maximum level 5 time before CPT code 99XXX can be billed, as this contradicts CPT's guidance for other time-based codes that considers a unit of time to be attained when the midpoint is passed (e.g., a code requiring 15 minutes can be reported when 8 minutes have elapsed). To be consistent with existing CPT coding conventions and reduce confusion, we recommend that CMS align its reporting rules for 99XXX with CPT's coding conventions for other time-based services.

Comment Solicitation on the Definition of HCPCS Code GPC1X

CMS finalized the HCPCS add-on code GPC1X to describe the "visit complexity inherent to evaluation and management associated with the 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 condition," as the agency believed the revised outpatient E/M codes still did not reflect all of the work required to deliver certain types of E/M care. ASPN supported this add-on code in last year's comments and continues to do since much of the care delivered by our members typically falls into the second part of the code's definition.

ASPN agrees that this service requires further clarification to support its adoption by providers and reduce their concerns about audits. We appreciate the agency's desire to work with stakeholders to better define the code, as this will help the Society educate its members on its proper use, and as such,

we have considered how it could be applied to care our members deliver to pediatric kidney disease patients. This service would be particularly applicable to patients with a challenging condition, like poorly controlled hypertension that requires additional care management, those who do not adhere to their care instructions, those with complex needs for which medication reconciliation could take significant extra time, and patients with ESRD who require counseling about their dialysis and transplant options. ASPN also requests that CMS consider how this add-on code recognizes the expertise of certain physicians, like pediatric nephrologists, as this has never been factored into a service's valuation, but is a key component of delivering this specialized care.

Services that are Analogous to Outpatient E/M – ESRD Monthly Capitation Payment (MCP) Services

CMS recognized that there are a number of MPFS services whose values are tied to the outpatient E/M services, including those that use these services as building blocks in their valuation. ASPN thanks CMS for recognizing that the ESRD MCP services were valued in this manner and for proposing to increase their values accordingly. We urge you to finalize the policy as proposed with the exception of the value of CPT code 90954 (ESRD related svc monthly 2-11 yr old 4/> visits), which the agency did not propose to increase because it was valued by a crosswalk to CPT code 99471 (Initial ped critical care 29 days thru 24 months) rather than using outpatient E/M services as building blocks.

ASPN strongly recommends that 4-visit CPT code 90954 be updated to reflect the increase in the other 13 codes in this family, since not increasing the value of this service will create a rank order anomaly in the ESRD MCP code family. As currently proposed, RVUs for the 4-visit code 90954 for ages 2-11 years (RVU 15.98) would be almost equivalent to 4-visit code 90957 for ages 12-19 years (RVU 15.46), which does not reflect the added work and intensity of providing service for the younger age group. The Society participated in the RUC valuation of the pediatric ESRD MCP services and knows that the RUC had a difficult time appropriately valuing the differences in pediatric ESRD care requirements by age group. Even though the RUC was able to relate work RVUs to E/M outpatient code building blocks for all the other codes in this family, work and intensity for 4-visit code 90954 was difficult for the RUC to value without a crosswalk to CPT code 99471, initial pediatric intensive care for ages 23 days-24 months, tying the value of these two services together. Despite this crosswalk, it is a flaw in the valuation process not to increase the value of CPT code 90954 in relation to the rest of this code family, as the relative work for this age group has not changed. We respectfully request the value for code 90954 be increased proportionally to the rest of the pediatric ESRD MCP code family.

Telehealth Services

ASPN thanks CMS for moving quickly to expand access to telehealth services in response to the COVID-19 public health emergency. Our patients with chronic kidney disease are particularly vulnerable to COVID-19 infection and require continued management by their pediatric nephrologists. Ensuring they have continued access to specialized care has been critical to treating their chronic kidney disease. We are appreciative of the agency's proposed policies and comment solicitations to expand telehealth policies post-pandemic, as they have the potential to transform pediatric chronic kidney disease care.

Additional of Services to the Permanent and Telehealth Services Lists

CMS proposed to add eight services, including CPT code 99XXX and HCPCS code GPC1X, to the permanent telehealth list. ASPN urges the agency to finalize this policy as proposed; this flexibility will provide our patients and their family more options to receive the care they need while limiting disruptions to children's attendance at school and their caregivers at work.

Early in the pandemic, CMS exercised its enforcement discretion to waive the requirement that individuals receiving home dialysis receive a face-to-face visit without the use of telehealth at least once every three consecutive months after the initial three months for the duration of the public health emergency. This policy applies to CPT codes 90951-55 and 90957-70. ASPN respectfully requests that these services remain on the temporary telehealth list through the end of the calendar year in which the public health emergency concludes. We anticipate that it may take time for medically complex and vulnerable patients, including those our members treat, to travel for face-to-face care. Determining when a patient should return to a physician's office should be left to the patient and the physician.

Audio-only Services

ASPN appreciates the additional flexibility CMS has provided by allowing physicians to bill the telephone E/M codes (99441-3) during the pandemic as they have allowed patients who have not been able to access a simultaneous audio/visual connection to continue to receive necessary care. We recognize that the agency's telehealth regulations would prohibit these services to be billed once the public health emergency concludes since these regulations require telehealth services to be provided with a simultaneous audio/visual connection. ASPN, therefore, respectfully requests that CMS revise this regulation to continue to allow telephone E/M services to be delivered after the public health emergency.

During the pandemic, telephone E/M services have proven to be a meaningful tool for patients to access care. ASPN supports the agency's goals of increasing the use of telehealth services under normal circumstances, and precluding the use of the telephone E/M services will limit access unnecessarily. Our members have encountered patients who cannot establish a simultaneous audio/visual connection for many reasons, including technological problems associated with the video platform employed by practices; patients living in areas where they cannot get a strong internet connection; and families having limited data plans who are unable to afford the overage charges. By prohibiting access to phone visits, CMS may be exacerbating disparities in access to care. ASPN urges the agency to work with stakeholders to revise its regulations to ensure patients can continue to participate in telephone visits post-pandemic in a manner that will limit potential fraud and abuse in this area. As this policy has been particularly meaningful for our patients and families, ASPN stands ready to work with the agency to determine how to most appropriately move forward in this area.

Direct Supervision

Our members have utilized the flexibilities provided by CMS to provide direct supervision remotely during the pandemic. It is becoming a regular part of the training of new residents and fellows, and as such, ASPN supports the agency's proposal to allow this policy to be made permanent. We believe continuing to allow remote supervision will encourage the expansion of telehealth after the public

health emergency concludes. ASPN recognizes the agency's concerns related to patient safety and fraud and urges the agency to work with stakeholders, like ASPN, to develop appropriate safeguards.

ASPN appreciates the opportunity to offer comments on CMS's CY 2021 MPFS proposed rule. Please contact our Washington representative, Erika Miller, at (202) 484-1100 or emiller@dc-crd.com, if we can provide additional information or clarification regarding these comments.

Sincerely,

Michael JG Somers, MD
President