AGS Geriatrics Healthcare Professionals
Leading Change. Improving Care for Older Adults.

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February 20, 2024

Gift Tee
Director, Division of Practitioner Services
Hospital and Ambulatory Policy Group
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
7500 Security Blvd.
Baltimore, MD 21244-1850

Re: Medicare CY 2025 Payment Policies Under the Physician Fee Schedule

Dear Mr. Tee:

The American Geriatrics Society ("AGS") greatly appreciates the opportunity to provide input on issues that we hope the Centers for Medicare & Medicaid Services (CMS) will address in the Physician Fee Schedule (PFS) proposed rule for 2025. The AGS is a not-for-profit organization comprised of nearly 6,000 physician and non-physician practitioners (NPPs) who are devoted to improving the health, independence, and quality of life of all older adults. Our mission is to advance efforts that promote high quality of care, quality improvement, and increased payment accuracy for physicians and other professionals paid under the PFS and through the Quality Payment Program (QPP).

We recommend that CMS include the following items in the 2025 PFS proposed rule:

- Extend use of G2211 to Home or Residence Evaluation and Management services (CPT Codes 99341-99350) that meet the requirements of the add-on code.
- Eliminate the requirement under the National Correct Coding Initiative that a -25 modifier must be appended to an office visit (CPT codes 99202-99205, 99212-99215) when it is billed with a code for administration of the influenza, pneumococcal, Hepatitis B, and COVID vaccines. Because these vaccine codes are XXX globals, use of the -25 modifier is unnecessary. Eliminating this requirement will also allow practitioners to bill G2211 for an office visit furnished when a vaccine is administered.
- Develop an indirect allocation methodology that appropriately reflects the Practice Expense (PE) cost for both cognitive and procedural services and specialties.
- Maintain payment parity for telemedicine visits and in-person visits in 2025 and beyond.
- Clarify and define what a mental or behavioral health telemedicine visit consists of because those visits will continue to be payable when the beneficiary is in their home in 2025 under current law.

We describe these recommendations in greater detail below.

G2211 for Home Visits

AGS appreciates CMS's support of G2211 and for recognizing the importance of supporting the 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 condition or a complex condition. We greatly appreciate that CMS implemented the visit complexity add-on code for 2024 to better recognize the resources of furnishing such care in the office/outpatient setting. **For 2025, we strongly urge CMS to extend use of G2211 to Home or Residence E/M services that meet the requirements of the add-on code.** The principles that resulted in the appropriate recognition of the additional work and other resources related to a longitudinal care relationship in primary care or in the care of a patient with a serious or complex condition are identical whether the care is in the office or the home of the patient.

Patients receiving care in the home are generally more complex and have more chronic illnesses than patients seen in the office. They are typically underserved and more dependent on continuity relationships. In other words, home visits have the same inherent complexity, if not more, than office visits. In principle and policy, these vulnerable beneficiaries should be supported by accurate payment to those who serve them.

Application of G2211 to the home or residence services will have a minimal impact on Medicare spending. In 2022, Medicare paid for 5.6M home visits (excluding podiatry and visits billed with the -25 modifier). If all 5.6M services were billed with G2211, it would have 0.1% impact on the conversion factor.

G2211 and Modifier -25

AGS generally agrees that G2211 should not be billed with office visit codes that are billed with the -25 modifier, which is used when an office visit is billed with a minor procedure. Minor procedures have zero or 10 day global periods and the work and practice expense for minor procedure codes include all the procedure related work and practice expense furnished on the day of the procedure. The Medicare National Correct Coding Initiative (NCCI) Manual states that "In general, E&M services on the same date of service as the minor surgical procedure are included in the payment for the procedure." If a significant and separate E/M service is furnished on the same day as a minor procedure, the visit is reported with the -25 modifier to identify it as distinct from the minor procedure. The global surgery concept does not apply to codes assigned an XXX global period.

The administration codes for influenza, pneumococcal, Hepatitis B, and COVID vaccines are XXX globals meaning that the only work and practice expense included in the code is for the vaccine administration – nothing else. This means, by definition, that the work and PE of any E/M visit furnished on the same day as the vaccine administration are not included in the vaccine code. Vaccine administration is usually done in conjunction with a medically necessary office visit where the reason for the service is the E/M visit – not the vaccine administration. Put another way, there is no need to append the -25 modifier to the E/M visit to identify a separate E/M service when a vaccine code is also billed because the vaccine codes do not include work or practice expense related to the E/M service.

AGS believes CMS should remove the NCCI requirement to use the -25 modifier for E/M services furnished on the same day as the administration of a Part B vaccine. As described above the modifier is not needed to identify a separate E/M service and it has the effect of limiting the ability of physicians

who provide vaccines in conjunction with an E/M service from being able to report G2211. If CMS stops requiring a -25 modifier to be appended to an office visit when a vaccine is also administered, physicians will be allowed to report G2211 and have the additional complexity of the E/M service recognized by Medicare. This is important because, as stated above, the primary reason for these visits is the E/M during which, in the case of geriatrics, longitudinal comprehensive care is being furnished – the type of care for which G2211 was created. Timely administration of Part B covered vaccines is an important part of the longitudinal care of a patient.

CMS should implement this policy by eliminating the requirement to report modifier-25 for E/M services furnished with the following vaccine codes:

- Influenza (G0008)
- Pneumococcal (G0009)
- Hepatitis B (G0010)
- COVID-19 (90480, M0201, 0001A – 0174A)

Practice Expense Methodology

AGS appreciates CMS' continued engagement with the provider community as it works to update the practice expense (PE) methodology. We agree with CMS that the data used in the PE calculation should be updated and we urge CMS to ensure that the updated data accurately captures the costs involved in operating a practice. We would like to reiterate our recommendations regarding the PE data and methodology:

- **CMS should conduct PE surveys not more frequently than every 5 years.** We suggest this frequency given that the surveys are time-consuming and expensive. Any shorter time frame would be administratively burdensome and may make it likely that the survey results are inaccurate or not appropriately representative of relative costs across specialties.
- **CMS should refine the PE allocation methodology to reflect PE costs more appropriately for cognitive and procedural services.** More specifically, **we urge CMS to discontinue use of facility physician work, disposable supplies, and equipment to allocate indirect PE**.
    - Physician work outside of the office (e.g., for procedures performed in a facility) does not increase indirect PE (e.g., rent, utilities) for any service.
    - Disposable supplies (e.g., laser fibers, catheters, bandages), irrespective of their cost, do not increase indirect PE for any service.
    - Equipment, irrespective of cost, does not increase indirect PE.

AGS does agree with using non-facility clinical staff time to allocate indirect PE because clinical staff time corresponds to time an office is open and incurring indirect PE.

Telemedicine Services

Maintaining payment parity for telemedicine visits, audiovisual and audio only, and in-person visits is a top priority for AGS to ensure clinician practices can continue providing vital care via telemedicine. **We**

strongly urge CMS to continue to pay for telemedicine at the office visit non-facility rate in 2025 and thereafter. CMS has acknowledged that physician work and practice expenses for telemedicine visits is similar to the work for in-person visits. The physician work, time, intensity, and stress for telemedicine visits are all similar or greater than that required for office visits. For practice expense, telemedicine visits are scheduled services (not brief follow-up calls) and are the same as in-person office visits with respect to staff activities required to accomplish the service. For example, clinical staff time spent preparing for the visit, welcoming the patient, educating the patient, and following up with the patient is identical to that of an in-person office visit in the aggregate. Exam rooms typically go unused during a telemedicine visit because the physician, or other health professional, is in his or her office and the equipment cannot be used for that period of time. In Appendix A, we compare the current clinical staff inputs for a 99214 to similar activities during a telemedicine encounter.

CMS outlined the argument for parity in CY 2024 final rule in their rationale for supporting payment parity for behavioral telehealth services:

> Now that behavioral health telehealth services may be furnished in a patient's home, which now may serve as an originating site, **we believe these behavioral health services are most accurately valued the way they would have been valued without the use of telecommunications technology, namely in an office setting.** There was an increase in utilization of these mental health services during the PHE that has persisted throughout and after expiration of the PHE for COVID–19. It appears that practice patterns for many mental health practitioners have evolved, and they are now seeing patients in office settings, as well as via telehealth. **As a result, these practitioners continue to maintain their office presence even as a significant proportion of their practice's utilization may be comprised of telehealth visits. As such, we stated that we believe their practice expense (PE) costs are more accurately reflected by the non-facility rate.**

We acknowledge that specific elements of the care delivery by these different modalities (in person, audiovisual and audio only) may be different, but the total resources needed to furnish the care are comparable. More importantly, any of these modalities are superior to no care. Clinicians carefully select the appropriate service for each patient. Evaluation and Management services of the same medical decision making level or duration are the same whether in-office or via telemedicine.

We have provided additional details in the multispecialty society letter supported by AGS and sent to CMS on February 9th. We have attached the letter as Appendix B.

Definition of a Mental Health or Substance Use Disorder Telemedicine Visit

CMS stated in the CY 2024 final rule that

> **"**Under current law, beginning on January 1, 2025, the beneficiary's home can be an originating site only for Medicare telehealth services furnished for: (1) the diagnosis, evaluation, or treatment of a mental health disorder; or (2) a beneficiary with a diagnosed substance use disorder (SUD) for purposes of treatment of the SUD or a co-occurring mental health disorder; or (3) monthly ESRD-related clinical assessments furnished to a beneficiary who is receiving home dialysis, beginning January 1, 2025."

However, there is no definition as to what constitutes a telemedicine visit for the diagnosis, evaluation, or treatment of a mental health disorder, or what constitutes a telemedicine visit that is for the purpose of treatment of an SUD or a co-occurring mental health disorder.

Geriatricians commonly perform telemedicine visits where a purpose of the visit is to address mental health or SUDs. For example, patients with dementia are often depressed and telemedicine visits are used to address depression as well as dementia. Similarly, mental health issues such as depression and anxiety commonly occur in older patients with multiple chronic illnesses such as heart failure and diabetes.

We recommend that CMS clarify that any telemedicine visit where one of the issues addressed is a mental health disorder or an SUD is covered under the law in 2025, irrespective of the specialty of the practitioner, procedure code, or whether other issues (e.g., dementia, heart failure) are also discussed and that the mental health or SUD need not be the primary diagnosis. We recommend that CMS clarify that the determination as to whether a mental health condition or SUD was addressed during a telemedicine visit will be based solely on the ICD-10 diagnosis codes included on the claim. Obviously, the medical record will need to support that such a condition was addressed in case of audit.

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The AGS appreciates the opportunity to provide the above comments and recommendations.

Sincerely,

Nancy E. Lundebjerg, MPA
Chief Executive Officer

Appendix A

Comparison of current Clinical Staff inputs for a 99214 to similar activities during a telemedicine (TM) encounter

Activity Code (99214)	Activity	TM equivalent	99214 Minutes	TM minutes
CA009	Greet, provide gown, ensure records available	Greet, ensure records available	3	3 (lack of gown trivial time)
CA010	Obtain Vital Signs	Obtain VS from patient	5	3
CA013	Prep room, supplies	Establish connection	2	2
CA016	Prepare, set-up and start IV, initial positioning and monitoring	Establish and test connection, hand off to physician	2	2
CA020	Assist physician/QHP intra	Assist physician/QHP intra	1	1 (sharing info obtained, same as in person)
CA024	Clean Room	none	3	0
CA037	Conduct patient communications	Conduct patient communications	6	8 (typically longer as patient needs to be contacted again immediately after visit (atypical that patient stays on-line)
CA048	Identify need for imaging etc. and ensure obtained	Identical tasks, as pre-date of service	5	5
CA050	Review and document hx, systems, meds	Identical tasks performed AV or A-only	13	13
CA051	Education/instructions	Education/instructions	5	6 (takes longer to do when not in-person)
CA052	Coordinate care	identical	3	3 (both involve tasks where patient may not be present)
Net difference vs in-person				-2 min

Appendix B

Multispecialty Letter

Gift and CMS Team

Thanks for meeting with our multispecialty group of ten organizations on Jan 29. I apologize for the long email but we are writing to follow up with additional information regarding the questions and comments that were raised by CMS. Maintaining payment parity for telemedicine visits and in-person visits is a top priority for all our organizations to ensure that physician practices can continue providing vital care via telemedicine in 2025 and beyond.

Telemedicine Practices

The unanimous consensus of the societies is that audio-visual (AV) and audio-only telemedicine provide fundamental patient services when in-person access is a challenge. Telemedicine visits dramatically expand access to care and, in our view, have improved care for Medicare beneficiaries. Unfortunately, not everyone with a serious medical condition has reliable transportation or the ability to take time off work to attend in-person visits 100% of the time. For these patients, telehealth services are a lifeline. Additionally, many Medicare beneficiaries lack access to reliable broadband internet and do not have a smart phone, making audio-only the only accessible telehealth modality.

The typical practice that furnishes telemedicine is a hybrid practice that also performs in-person visits. While telemedicine-only practices exist, they are atypical. According to a recent AMA white paper[1] only 10% of physician practices utilize video visits for more than 20% of their visits and only 4.8% of practices utilize video visits for more than 40% of their visits. We believe this supports our contention that telemedicine-only practices are atypical and should not factor into CMS rate setting for telemedicine visits, especially in regard to practice expense.

Literature on Telemedicine Services

Below are summaries and links to several articles and papers we have reviewed on the utilization of telemedicine. The articles highlight that while the volume of telemedicine has been decreasing since the onset of the public health emergency (PHE), telemedicine availability has persisted and greatly increased access to care. Several articles have shown increased use of audio-only visits among marginalized groups including African-Americans, non-English speakers, older patients, those with public insurance as opposed to private insurance and patients living in rural communities and communities with low broadband access. We know that these social determinants of health contribute to complexity and risk and while the underlying causes like limited broadband access need to be addressed, telemedicine can serve as a stopgap to support the health of these communities as progress is made. Any change in

[1] "Policy Research Perspectives, Telehealth in 2022: Availability Remains Strong but Accounts for a Small Share of Patient Visits for Most Physicians

payment parity, for physician work or practice expense reimbursement, risks decreasing access for these populations that are in the greatest need and could further widen existing disparities in access and outcomes. Our societies are committed to promoting public health and working with CMS to ensure widespread access to care.

Payment Parity

For all office-based specialties that provide predominantly cognitive services, the typical telemedicine visit involves seeing a patient located in their home and entails equivalent work and practice expense as an in-person visit. CMS outlined the argument for parity in CY 2024 final rule[2] in their rationale for supporting payment parity for behavioral telehealth services (emphasis added):

> Now that behavioral health telehealth services may be furnished in a patient's home, which now may serve as an originating site, **we believe these behavioral health services are most accurately valued the way they would have been valued without the use of telecommunications technology, namely in an office setting.** There was an increase in utilization of these mental health services during the PHE that has persisted throughout and after expiration of the PHE for COVID–19. It appears that practice patterns for many mental health practitioners have evolved, and they are now seeing patients in office settings, as well as via telehealth. **As a result, these practitioners continue to maintain their office presence even as a significant proportion of their practice's utilization may be comprised of telehealth visits. As such, we stated that we believe their practice expense (PE) costs are more accurately reflected by the non-facility rate.**

> Therefore, we proposed that, beginning in CY 2024, claims billed with POS 10 (Telehealth Provided in Patient's Home) would be paid at the non-facility PFS rate. When considering certain practice situations (such as in behavioral health settings, **where practitioners have been seeing greater numbers of patients via telehealth), practitioners will typically need to maintain both an in-person practice setting and a robust telehealth setting. We expect that these practitioners will be functionally maintaining all of their PEs, while furnishing services via telehealth.** When valuing services, we believe that there are few differences in PE when behavioral health services are furnished to a patient at home via telehealth as opposed to services furnished in-person (that is, behavioral health settings require few supplies relative to other healthcare services). Claims billed with POS 02 (Telehealth Provided Other than in Patient's Home) will continue to be paid at the PFS facility rate beginning on January 1, 2024, as we believe those services will be furnished in originating sites that were typical prior to the PHE for COVID–19, and we continue to believe that, as discussed in the CY 2017 PFS final rule (81 FR

[2] Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies,Vol. 88,F.R., 78875, (Finalized Nov 16, 2023) https://www.federalregister.gov/d/2023-24184

80199 through 80201), the facility rate more accurately reflects the PE of these telehealth services; this applies to non-home originating sites such as physician's offices and hospitals

Physician Work

We believe the CMS rationale above applies to the typical modern medical practice, not just behavioral health. We know that the hybrid model, in which practices see some patients in-person and some patients via telemedicine, is the typical practice. We have also heard overwhelmingly from our members that the work of seeing patients via telemedicine is equivalent to the work of seeing patients in-person; medical decision making is the same irrespective of modality and the time it takes to review records, take a history, formulate a plan, communicate next steps and write a note is the same whether that work is done for an in-person visit or a telemedicine visit.

Practice Expense

Our members who comprise many medical specialties including behavioral health, agree that hybrid practices are typical and that those practices must maintain offices and purchase supplies and equipment. While the clinical staff time, supplies and equipment may not be identical, they are equivalent. More importantly, as CMS agreed was true for behavioral and mental health professionals, most practices must continue to maintain office based-practices and will thus incur the practice expense costs of maintaining these hybrid models. For that reason, parity is needed to ensure that access to telemedicine is sustained.

Clinical Staff

The majority of telemedicine visits are prescheduled and the clinical staff time is the same as for an in-person visit. In the pre-service period, clinical staff must assess the need for imaging, lab or test results and ensure that information has been obtained; that applies to telemedicine as much as to in-person. On the day of the visit, clinical staff must greet the patient, ensure appropriate medical records are available, enter patient reported vital signs, prepare the patient for the visit by ensuring their audio and/or visual connectivity, review and document history and medications, communicate instructions, share education and coordinate home care; again, this applies to both telemedicine and in-person. Clinical work in the post-period occurs after the visit is complete and by definition would be the same for in-person and telemedicine visits because in both circumstances the post-period work occurs after the visit has concluded.

Supplies

While it is true that there is no E/M pack or sanitizing wipes used in a telemedicine visit, the full cost of telemedicine visit equipment and rising cost of cybersecurity, software, and additional licenses are not recognized in the current PE data.

Equipment

Typically, physicians perform telemedicine visits in one of two places: (1) the physician office, or (2) an exam room outfitted for telemedicine visits. Because the exam table and any other equipment cannot be used on another patient while the physician is doing a telemedicine visit in these spaces, it can conceptually be allocated to the patient who is receiving the telemedicine visit.

Malpractice

The malpractice risk is the same for telemedicine visits as it is for in-person visits.

Conclusion

We would like to thank CMS for their work to promote equity and access and for their recent support of expanding telehealth coverage and flexibilities in the CY2024 final rule. We appreciate CMS making the time to meet with us and allowing us to share our experience delivering care via telehealth. We hope that in 2025 CMS will continue its policy of parity based on the evidence and clinical experience we have presented. This is essential to ensuring that patients across the country can continue accessing telemedicine services, especially those whose social determinants of health would otherwise limit their care. Please don't hesitate to follow up with any additional questions you may have.

Sincerely,

American Geriatrics Society
American Academy of Neurology
American College of Gastroenterology
American Gastroenterological Association
American Nurses Association
American Osteopathic Association
American Psychiatric Association
American Society for Gastrointestinal Endoscopy
American Society of Regional Anesthesia- Pain Medicine

Literature on Telemedicine Services

Hughes HK, Hasselfeld BW, Greene JA.
N Engl J Med. 2022 11 17;387(20):1823-1826.
Health Care Access on the Line — Audio-Only Visits and Digitally Inclusive Care | NEJM

Chen J, Li KY, Andino J, Hill CE, Ng S, Steppe E, Ellimoottil C. Predictors of Audio-Only Versus Video Telehealth Visits During the COVID-19 Pandemic. J Gen Intern Med. 2022 Apr;37(5):1138-1144. doi: 10.1007/s11606-021-07172-y. Epub 2021 Nov 17. PMID: 34791589; PMCID: PMC8597874.
Predictors of Audio-Only Versus Video Telehealth Visits During the COVID-19 Pandemic - PubMed (nih.gov)

https://connectwithcare.org/jama-network-open-comparison-of-quality-performance-measures-for-patients-receiving-in-person-vs-telemedicine-primary-care-in-a-large-integrated-health-system/ **JAMA Network Open: Comparison of Quality Performance Measures for Patients Receiving In-Person vs Telemedicine Primary Care in a Large Integrated Health System** A study found that virtual care methods can expand health care capabilities, performing on par or better than in-person care on most quality measures evaluated. Patients with telemedicine exposure in primary care had comparably better performance in 11 of 16 quality measures with statistically significant differences. The study examined whether quality of care among patients exposed to telemedicine differs from patients with only in-person office-based care. Researchers concluded that telehealth could augment care for various conditions, especially chronic diseases. The study also supplies information that could assist providers in determining an ideal ratio of in-person and telehealth visits.

https://pubmed.ncbi.nlm.nih.gov/36085158/. The impact of expanded telehealth availability on primary care utilization. The expanded availability of telehealth due to the COVID-19 pandemic presents a concern that telehealth may result in an unnecessary increase in utilization. We analyzed 4,114,651 primary care encounters (939,134 unique patients) from three healthcare systems between 2019 and 2021 and found little change in utilization as telehealth became widely available. Results suggest telehealth availability is not resulting in additional primary care visits and federal policies should support telehealth use.

https://connectwithcare.org/association-between-telemedicine-use-in-nonmetropolitan-counties-and-quality-of-care-received-by-medicare-beneficiaries-with-serious-mental-illness/ **JAMA Network Open: Association Between Telemedicine Use in Nonmetropolitan Counties and Quality of Care Received by Medicare Beneficiaries With Serious Mental Illness**. A study to assess whether greater telemedicine use in a nonmetropolitan county is associated with quality measures, including use of specialty mental health care and medication adherence, found that greater use of telemental health visits in a county was associated with modest increases in contact with outpatient specialty mental health care professionals and greater likelihood of follow-up after hospitalization. The study suggests that telemental health can improve quality of care for Medicare beneficiaries with serious mental illness.

https://connectwithcare.org/majority-of-physicians-say-telehealth-enables-more-comprehensive-quality-care/ **American Medical Association: Majority of physicians say telehealth enables more comprehensive quality care**. A survey conducted by the American Medical Association found that the vast majority of physician respondents say they're currently using telehealth. The results suggest enduring interest in virtual care among physicians. Among physician respondents, 85 percent indicated they currently use telehealth, with the majority of decreased use attributed to a mix of virtual and in-person visits. There findings are similar to a survey conducted by the **Alliance for Connected Care** in March. An accompanying blog post on this survey from the American Medical Association can be found here.