

September 6, 2022

Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
7500 Security Boulevard  
Baltimore, MD 21244

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

Re: CMS-1770-P: Medicare Program; CY 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements

Dear Administrator Brooks-LaSure:

On behalf of the Endocrine Society, thank you for the opportunity to provide comments on the Centers for Medicare & Medicaid Services (CMS) Medicare Physician Fee Schedule (MPFS) proposed rule for calendar year (CY) 2023 (CMS-1770-P). Founded in 1916, the Endocrine Society represents approximately 18,000 physicians and scientists engaged in the treatment and research of endocrine disorders, such as diabetes, hypertension, infertility, obesity, osteoporosis, endocrine tumors cancers (i.e., thyroid, adrenal, ovarian, pituitary) and thyroid disease. Many of the patients our members treat are Medicare beneficiaries; consequently, the payment policies and other revisions in the MPFS are of importance to our members.

We welcome the opportunity to work with CMS to address the ongoing needs of Medicare beneficiaries and ask you to consider our comments on the following sections of the proposed rule as you finalize your policies for CY 2023:

- Conversion Factor for 2023
- Evaluation and Management (E/M) Services
- Split/Shared Services
- Insertion, and Removal and Insertion of new 180-Day Implantable Interstitial Glucose Sensor System (HCPCS codes G0308 and G0309)
- Payment for Medicare Telehealth Services Under Section 1834(m) of the Act



- Request for Information: Medicare Potentially Underutilized Services
- Strategies for Updates to Practice Expense Data Collection and Methodology

### **Conversion Factor for 2023**

Understanding that the conversion factor, used to convert relative value units to a monetary value, requires an act of Congress to update, the Endocrine Society urges the agency to work with Congress to mitigate payment cuts to the MPFS. Payment cuts to endocrinology and many other specialties may have a devastating effect on access to care for many Medicare beneficiaries. At a time when endocrinology continues to be one of the lowest paid specialties and there is a shortage of endocrinologists, Medicare physician payment cuts will further impede the size of the endocrinologist workforce. Rising medical education debt continues to plague newly minted physicians, and when those new physicians are making a choice between specialties, they will often choose the more lucrative. Many Medicare beneficiaries suffer from conditions treated by endocrinologists, including diabetes, obesity, and thyroid conditions; and access to care and a deep bench of endocrinologists is vital to their health. Data show that 78.5 percent of counties in the United States have no practicing endocrinologists, forcing patients to travel long distances and endure significant wait times to see an endocrinologist.<sup>1</sup> We believe that payment cuts, whether congressionally mandated or otherwise must be stopped to preserve patient access.

### **Evaluation and Management (E/M) Services**

Working collaboratively with the AMA CPT<sup>®</sup> Editorial Panel, the agency has taken on the task of revising the entire E/M code set culminating in the revision of inpatient E/M services, including same day discharge services, along with nursing home visits, prolonged services, and others. The Endocrine Society appreciates the work involved and has been supportive of the agency's acceptance of the changes as recommended by the AMA. The revised code set was crafted to alleviate administrative burden and ease the ambiguity of code level selection process, resulting in a code set and documentation requirements that are consistent with the outpatient E/M codes. In this rule, the agency has proposed to accept the work RVUs (wRVUs) for inpatient initial and subsequent E/M services. While some of the wRVUs are lower than some of the comparable outpatient services than we

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<sup>1</sup> Goodson JD, Shahbazi S, Song Z. Physician Payment Disparities and Access to Services-a Look Across Specialties. *J Gen Intern Med.* 2019 Nov;34(11):2649-2651. doi: 10.1007/s11606-019-05133-0. Epub 2019 Aug 5. PMID: 31385213; PMCID: PMC6848648.



would like, we still believe that the changes and revisions that result in less administrative burden will make the entire E/M code set easier to use. The Endocrine Society does urge CMS to carefully consider whether the new valuations of these codes disrupt the relativity of the MPFS. Additionally, we strongly agree that the E/M codes, particularly the outpatient family, continue to be undervalued and welcome the opportunity to work with the agency to make improvements to ensure they reflect the work being performed.

### **Split/Shared Services**

For CY 2023, CMS is proposing to delay the much-debated split/shared services policy for another year, until 2024. In 2022, CMS finalized, but then delayed a proposal, which stated that the practitioner who billed the split/shared service should be based on substantive time, defined as more than 50% of total time, spent with the patient. While we appreciate the delay in implementation, the Endocrine Society continues to believe that using time, as the deciding factor when determining the provider that bills for a split/shared service, is not the appropriate means to make such a determination. The Endocrine Society supports using either medical decision-making (MDM) or time to determine the substantive portion of a visit consistent with the documentation requirements across E/M code families.

Our members often practice using team-based care when treating patients with diabetes and other endocrine related disorders. Team-based care provides the patient with a well-rounded course of treatment that includes input and care from diabetes educators, nurse practitioners and physician assistants. The members of this team will not be carrying a stopwatch to determine who spent 51 percent of the time with the patient. Instead, what should be the factor in determining the billing provider is the MDM component of the visit in those instances. MDM, not time spent with the patient, is often where the “work” occurs, when the provider is using their mental effort, skill, and experience to develop a plan of action for the patient. We believe the policy, when implemented, is contradictory to the agency’s stated goal of promoting team-based care. In this rule, CMS has requested comments and solutions to increase underutilized services within the Medicare program. These underutilized services include diabetes management, which is team-based by definition. In addition to undermining team-based care, using time alone to determine the substantive portion of an E/M visit for split/shared services will create administrative burden and confusion. Given that the agency allows E/M visit level selection to be based on time **or** MDM, recognizing that MDM will most often be the means used to determine the code level for billing purposes.



In conclusion, the Endocrine Society recommends CMS continue to allow time or MDM in determining the substantive portion of an E/M visit. This will allow providers the flexibility to choose the method that works best for them, while preserving team-based care which is of utmost importance to the successful care and positive outcomes for Medicare beneficiaries.

### **Insertion, and Removal and Insertion of new 180-Day Implantable Interstitial Glucose Sensor System (HCPCS codes G0308 and G0309)**

For CY 2021, CMS established pricing for three Category III CPT codes that describe the services for inserting, removing, and removing and inserting an implantable interstitial glucose sensor from a subcutaneous pocket. The sensor for this system provided 90-days of monitoring. Earlier this year, the Food and Drug Administration approved a 180-day system, increasing the monitoring period from 90- to 180-days to allow for a longer period before replacing the sensor, and CMS established two G-codes, HCPCS codes G0308 and G0309, to apply to the newly approved system.

The Endocrine Society appreciates that CMS made these two new G-codes available as of July 1, 2022, but respectfully requests that CMS to sunset them at the end of calendar year 2022 and revise the national price for the existing Category III CPT codes for these services to reflect the costs of the 180- day sensor as of January 1, 2023. Since the 80-day sensor is no longer on the market, we do not believe that it is necessary to maintain the G-codes in addition to the existing CPT codes. Additionally, we believe that it is imperative to set a national price to support appropriate patient access to this technology. Our members have reported that they have faced challenges with Medicare Administrative Contractors' coverage and reimbursement when using the 90-day product, which would be mitigated by a consistent national payment policy.

The Endocrine Society supports valuing 0446T and 0448T at 94.57 and 94.59 RVUs, respectively. These recommended values represent twice the practice expense value for the 90-day sensor since the supply costs double for the 180-day system.

### **Payment for Medicare Telehealth Services Under Section 1834(m) of the Act**

Endocrinologists are using telehealth services to treat patients and increase access to this specialized care, potentially reducing the burden of health inequities and social determinants of health. The Endocrine Society believes telehealth will continue to be a valuable tool for our members to provide care after the PHE concludes and applauds CMS for proposing policies to expand access to telehealth services, including adding services to



the telehealth list both on a permanent Category 1 or 2 basis and a temporary Category 3 basis. Our members primarily bill E/M services and support the agency's proposal to add the new HCPCS codes for prolonged services associated with certain types of E/M services—GXXX1, GXXX2 and GXXX3—to the telehealth list on a Category 1 basis to replace the existing prolonged service codes, which are currently on this list. Additionally, we support the proposal to allow all services that were added to the telehealth list on a temporary basis during the public health emergency (PHE), including those that have not been converted to Category 1, 2 or 3, to remain available through the 151-day period following the conclusion of the PHE during which certain Medicare telehealth flexibilities will remain in place. This policy will allow the agency to continue to collect data on telehealth utilization to inform permanent policies. As we discussed in our comments on the CY 2022 MPFS proposed rule, the Endocrine Society believes decisions about permanent telehealth policies, including protections against fraud, should be based on the best available data.

Telephone E/M services play a key role in treating certain Medicare beneficiaries—those who do not have access to high-speed broadband or devices necessary for simultaneous audio-visual connections. Endocrinologists have reported that patients receiving telephone visits may be some of the most vulnerable in terms of access to care and their health and economic status. Retaining access to these telephone visits is crucial to treating these patients for chronic conditions, like diabetes. CMS received requests to add the telephone E/M codes to the telehealth list on a Category 3 basis, and in response, reiterated its position that these services are not analogous to in-person care or a substitute for a face-to-face encounter outside of the PHE. The Endocrine Society has consistently maintained that telephone E/M services serve an important role in patient care; however, we recognize that CMS does not have the statutory authority to cover these services outside of the PHE or the 151-day extension of certain telehealth flexibilities and we will continue to advocate for Congress to provide CMS with this authority to support access and improved health equity.

CMS received a request to add Ambulatory Continuous Glucose Monitoring, CPT code 95251, to the Medicare Telehealth Services List on a Category 3 basis but did not propose to do so. The agency reasoned that the service is inherently non-face-to-face and cannot be substituted for an in-person visit, which are requirements for being added to the list, and requested comments on whether the service should be considered face-to-face. The Endocrine Society urges CMS to reconsider this position and add CPT code 95251 to the list



on a Category 3 basis when it is billed with CPT codes 99213 or 99214 and the appropriate modifier. 2020 claims data show CPT code 95251 is billed with 99213 and 99214 8.2 percent and 62.6 percent of the time respectively, demonstrating that this service is typically performed face-to-face. Making this addition to the telehealth list will allow virtual practice patterns to replicate in-person patterns expanding access to medically necessary diabetes care. Additionally, many private payers allow CPT code 95251 to be billed when delivered via telehealth. Adding this to the Medicare telehealth list will increase consistency across payers.

### ***Virtual Direct Supervision***

CMS' current policy is that virtual direct supervision will be permissible through December 31 of the year the COVID-19 PHE concludes. In preparation, the agency has requested stakeholder feedback on whether virtual direct supervision should be permitted permanently and if it should only apply to a subset of services. The Endocrine Society recommends that CMS develop and implement a permanent virtual supervision policy. According to our members, they have virtually supervised residents and other professionals during the pandemic. This flexibility is a valuable tool to improve patient access to endocrinologists in shortage areas. We look forward to working with CMS to develop a final policy.

### ***Reimbursing Telehealth Services at the Facility Rate***

CMS noted that once the PHE concludes telehealth services will be reimbursed at the facility payment rate in accordance with established policy as the agency believes the facility payment amount best reflects the direct and indirect practice expenses of telehealth services. The Endocrine Society respectfully requests that CMS reconsider this policy and instead continue to reimburse telehealth services at the physician office rate. Since the start of the COVID-19 pandemic, endocrinologists have integrated telehealth services into their practices and reported that virtual visits during which patients are in their homes require significant staff resources that include check in, medication reconciliation, scheduling follow up, and communicating with patients to ensure the physician has adequate data prior to the visit including laboratory test results and assisting patients access and download the data from their diabetes devices for review.

### ***Request for Information: Medicare Potentially Underutilized Services***

The Endocrine Society is appreciative of the opportunity to provide feedback regarding underutilized services within the MPFS. Many of the services our members provide fall



under this request for information, including preventive services, diabetes self-management training (DSMT), screening for diabetes, referral to appropriate education/prevention/training services, intensive behavioral therapy for obesity, and complex/chronic care management. The Endocrine Society agrees that these services are underutilized, including by our members, for many reasons. While they may represent work already being done, practice coding and billing teams are not aware these services are available to be billed. Better provider and practice education would help increase their utilization. However, the practices that are aware of these codes' availability choose not to utilize them and make the calculation that the additional RVUs are not worth the documentation burden. If, and until, the documentation requirements are simplified, we do not anticipate these services will be highly utilized.

Regarding diabetes self-management training (DSMT), the Endocrine Society encourages CMS to incorporate the recommendations of the National Clinical Care Commission (NCCC) to improve access to this benefit for people living with diabetes. The NCCC recommended several changes that would improve Medicare beneficiary access to the program.<sup>2</sup> These changes include allowing the initial 10 hours of DSMT to be made available to a beneficiary until fully utilized and allowing for 6 additional hours of DSMT if a beneficiary needs them. The report also recommends expanding the types of physician providers who can refer for DSMT and allowing community-based sites to provide the program. We encourage CMS to act upon these recommendations which will ensure more Medicare beneficiaries with diabetes utilize this important program.

As CMS indicated, the Intensive Behavioral Therapy for Obesity (IBT) program is also underutilized. Recent data has indicated that only 2.16% of the more than 7.6 million Medicare FFS beneficiaries with obesity received IBT for obesity.<sup>3</sup> Under current rules, IBT for Obesity can only be covered if Medicare beneficiaries receive the service from a primary care provider (PCP), or under the supervision of their PCP, in a primary care setting. This means that physician specialties, including endocrinologists, and other providers such as Registered Dietitians, nutrition professionals, and community-based lifestyle programs are limited in their ability to provide this service. We encourage CMS to

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<sup>2</sup> National Clinical Care Commission, Report to Congress on Leveraging Federal Programs to Prevent and Control Diabetes and Its Complications, 2021, Retrieved from: <https://health.gov/sites/default/files/2022-01/NCCC%20Report%20to%20Congress.pdf>

<sup>3</sup> Medicare Provider Utilization and Payment Data: Physician and Other Supplier PUF CY2019. Data.cms.gov. <https://data.cms.gov/provider-summary-by-type-of-service/medicare-physician-other-practitioners/medicare-physician-other-practitioners-by-geography-and-service/data>.



allow these other providers to serve as direct providers for the IBT for Obesity benefit. This would allow them to see patients outside of the primary care setting upon referral from a physician and would improve utilization of this benefit.

### **Strategies for Updates to Practice Expense Data Collection and Methodology**

CMS is seeking comment as to the best approach for updating the indirect practice data inputs within the practice expense methodology that the agency may then consider in future rulemaking.

The Endocrine Society respectfully requests that the agency consider how to capture the costs of providing telehealth services to Medicare beneficiaries in the indirect practice expense. Over the course of the PHE the use of telehealth services to provide care has drastically increased. The Assistant Secretary for Planning and Evaluation (ASPE) found that the number of Medicare fee-for-service beneficiary telehealth visits increased 63-fold in 2020, from approximately 840,000 in 2019 to 52.7 million in 2020.<sup>4</sup> While the number of telehealth services has leveled off since the start of the pandemic, telehealth remains a critical modality to deliver services, increase patient access, and mitigate some health inequities. As such, providers are and will continue to invest in capital equipment needed to provide such services. We believe the telehealth equipment, software and other items should be accounted for in the indirect practice expense.

Additionally, the Endocrine Society urges CMS to use the best available data, which should be updated over regular intervals, when developing a new methodology. We believe this will help mitigate the redistributive effects of these updates and will avoid replicating the challenges created when the agency proposed to update the clinical labor inputs included in the direct practice expense calculations. No matter the methods adopted for updating the indirect costs, we believe a phased approach when incorporating the initial values is most appropriate. CMS has used phased-in methodologies in the past to mitigate potential large swings in payment for physicians' services.

Thank you again for the opportunity to provide comments on this proposed rule. We are committed to working with you on the development of these payment policies. Should you have any questions or require additional information, please direct your correspondence to Rob Goldsmith, Director of Advocacy and Policy, at [rgoldsmith@endocrine.org](mailto:rgoldsmith@endocrine.org).

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<sup>4</sup> <https://aspe.hhs.gov/sites/default/files/documents/a1d5d810fe3433e18b192be42dbf2351/medicare-telehealth-report.pdf>





Sincerely,

*Ursula Kaiser*

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