September 13, 2021

Administrator Chiquita Brooks-LaSure
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1751-P
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS–1751–P

Dear Administrator Brooks-LaSure:

On behalf of the Council of Academic Family Medicine (CAFM), including the Society of Teachers of Family Medicine, Association of Departments of Family Medicine, Association of Family Medicine Residency Directors, and the North American Primary Care Research Group, we are pleased to submit comments in response to the proposed rule published in the July 23, 2021 *Federal Register*, titled "Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-Payment Medical Review Requirements."

Our comments today focus solely on issues related to payment for the Services of Teaching Physicians. The proposed rule requests comment on two related issues: 1) When total time is used to determine the office/outpatient E/M visit level, only the time that the teaching physician was present can be included, and 2) Under the primary care exception, only Medical Decision Making (MDM) can be used to select office/outpatient E/M visit level.

Total Time to Determine the Office/Outpatient E/M Visit Level:
CMS proposes that only the teaching physician's time should be used to determine the level of E/M visit if time, rather than medical decision-making is selected for coding purposes. The rationale behind this proposal is that residents' time is paid for separately through the direct graduate medical education (GME) system under Medicare Part A. The statute states that "in the case of physicians' services furnished to a patient in a hospital with a teaching program, the Secretary shall not provide payment for such services unless the physician renders sufficient personal and identifiable physicians' services to the patient to exercise full, personal control over the management of the portion of the case for which payment is sought."

Primary Care Exception Policy:
CMS proposes that only MDM, not time, be used to select office/outpatient E/M levels under the primary care exception. The proposal states CMS's belief that MDM would be more accurate indicator of the complexity of the visit as opposed to time, especially considering the potential need for residents to need more time than is reflected in the code descriptor.

Hope R. Wittenberg
Director, Government Relations 1133 Connecticut Ave. NW, Suite 1100 Washington, DC 20036 Ph: 202.986.3309 hwittenberg@stfm.org

We agree that both these proposals are reasonable. In fact, in our 2018 comments on the CY 2019 proposed fee schedule, we responded to a request for comments on the use of time in a teaching situation. Specifically, we wrote:

> In a teaching situation, particularly in the primary care exception, the concept of using time doesn't work in situations where the resident physician provides most of the care with the teaching physician required to be present for the key portion of the visit. It also doesn't seem an appropriate method to be used in the primary care exception due to the need for resident physicians to potentially require more time while they are learning, than a physician in independent practice would be expected to require. For the purposes of revised coding included in this proposal, we do not believe that time-based billing should be used when resident physicians are providing care.

Based on the reasoning above, we wish to request that CMS include E&M codes 99204 and 99214 in the primary care exception. Historically, CMS has only allowed E&M codes 99201-99203 and 99211-99213 to be included in the primary care exception to the teaching physician rule, except for recently during the public health emergency (PHE) related to the COVID 19 pandemic.

This made sense at the time of the establishment of the exception, back in the mid-90's, as the 99204s and 99214s were considered complex visits often involving patients with acute or unstable chronic conditions requiring the teaching physician to personally examine and assess the patient in order to assure a high standard of care. However, within the Medicare population it is not unusual to find patients with three or more chronic conditions presenting for new and follow-up visits that require a level of time and decision-making consistent with a level 4 code for management of multiple chronic conditions, but do not involve a level of diagnostic complexity that is beyond the resident physician's ability to provide quality care with indirect supervision. In addition, in recent years, medical training has moved further toward competency-based assessment and rigorous standards have been put in place regarding supervision.

In fact, the ACGME has moved toward competency-based education by the development of the common program requirements. (https://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements) These requirements were developed specifically for the purpose of producing independent, well trained physicians in the context of patient safety. This is a concept CMS recognized when it developed regulations in the mid-90s that created the primary care exception. ACGME notes that "combined with gradually increasing authority and independence, supervision and feedback allow resident physicians to make the transition from novice learner to proficient practitioner at the completion of residency training. At the same time, excessive supervision without progressive independence, as resident physicians acquire knowledge and skills, may hamper their progression from learner to competent practitioner in their discipline."(https://www.acgme.org/What-We-Do/Accreditation/Clinical-Experience-and-Education-formerly-Duty-Hours/Research-and-Testimony (Chapter 6 New Supervision Standards: Discussion And Justification))

These Common Program Requirements compel the establishment of Clinical Competency Committee (CCC) in each accredited residency and fellowship. The committee reviews all resident physicians twice a year, evaluating the resident physician's progress. As part of those evaluations, the committee determines whether (and for what purposes) the resident physician is ready for direct vs indirect supervision.

With these internal processes in place, and the experience of residents utilizing these codes during the PHE, we believe it is both safe and advantageous for CMS to include the 99204 and 99214 E&M codes in the primary care exception. Our goal is to reduce unnecessary bureaucracy, not appropriate supervision. In fact, this change would free up preceptors to spend more time with resident physicians on complex and unstable patients, no matter what code is being billed.

In summary, we appreciate continuing the opportunity for the teaching physician to bill for time as that can be significant. We also recognize that time spent by the resident may not be commensurate with the code descriptor for services under the primary care exception. Moreover, we request that CMS consider the inclusion of the 99204 and 99214 codes in the primary care exception, beyond the PHE.

Sincerely,

Aaron Michelfelder, MD
President
Society of Teachers of
Family Medicine

Wendy Barr, MD
President
Association of Family
Medicine Residency Directors

Chelley Alexander, MD
President
Association of Departments
of Family Medicine

Gillian Bartlett, PhD
President
North American Primary Care
Research Group