ENDOCRINE SOCIETY
Hormone Science to Health

September 4, 2024

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: Medicare Program; CY 2025 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies (CMS-1807-P)

Dear Administrator Brooks-LaSure:

On behalf of the Endocrine Society, thank you for the opportunity to submit these comments on the Calendar Year (CY) 2025 Medicare Physician Fee Schedule (MPFS) proposed rule. 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, obesity, osteoporosis, endocrine cancers (i.e., thyroid, adrenal, ovarian, pituitary) and thyroid disease. Many of the patients our members treat are Medicare beneficiaries. We also note that there is a shortage of endocrinologists; wait lists to see an endocrinologist can be many months long; diagnosis and treatment can be extremely complex; the amount of work outside of clinic time is increasing; and endocrinologists have some of the lowest salaries of medical subspecialists, yet they have not seen significant increases in Medicare payments in decades. Consequently, the payment policies and other revisions in the MPFS are of great importance to our members.

We are pleased to submit comments on the following policies:

- CY 2025 Conversion Factor
- Office/Outpatient Evaluation and Management Visit Complexity Add-on
- CY 2025 Identification and Review of Potentially Misvalued Services – Fine Needle Aspiration Biopsy
- Request for Information (RFI) for Services Addressing Health-Related Social Needs

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- Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Conditions for Certification and Conditions for Coverage (CfCs) – Provision of Services
- Valuation of Specific Services – Telemedicine Evaluation and Management Services
- Payment for Telehealth Services
- Request for Comment on Dental Services Integral to Specific Covered Services to Treat Diabetes
- Medicare Diabetes Prevention Program

CY 2025 Conversion Factor

The Endocrine Society is concerned about the proposed decrease of 2.8 percent to the CY 2025 conversion factor. While we understand that the Centers for Medicare & Medicaid Services (CMS) does not have the statutory authority to provide a positive update to the conversion factor, the continued downward pressure on the conversion factor threatens patient access to medically necessary services, including those delivered by endocrinologists. While many Americans suffer from chronic conditions, like osteoporosis, obesity, and diabetes, there are many areas of the country where there are no endocrinologists or significant wait times to see an endocrinologist. After three decades of stagnant Medicare reimbursement rates, this situation is unsustainable for endocrinologists, other physicians, and people with Medicare.

We encourage the agency to work with Congress to develop solutions that provide stability and certainty to the MPFS. The Endocrine Society will continue to advocate that Congress craft a legislative solution to end the cycle of cuts to the conversion factor and to create a sustainable reimbursement system for MPFS services that includes regular, positive updates to the conversion factor.

Office/Outpatient (O/O) Evaluation and Management (E/M) Visit Complexity Add-on

In the CY 2024 MPFS final rule, CMS finalized separate payment for the O/O E/M visit complexity add-on code, G2211, to reflect the time and resources required to deliver care when a practitioner has a longitudinal relationship with their patient and has taken responsibility for most of the individual's health care needs over time. For our members, this code can be billed with most of the O/O E/M care that they deliver as they manage the care of individuals with chronic conditions, like diabetes, obesity, osteoporosis, and thyroid conditions.

The implementation of this policy has been pivotal for endocrinologists who primarily bill O/O E/M visits and rarely perform procedures. The specialty's focus on cognitive work, which typically is valued lower than procedures, is evidenced by the average compensation for endocrinologists. According to the 2024 Medscape Physician Compensation Report, endocrinology is one of the lowest compensated specialties with the average endocrinologist earning $256,000 annually below the average compensation for specialists of $394,000.[1] Because of the importance of this service to properly value our members' work, the Endocrine Society has taken steps to educate members about the code's availability and proper use.

CMS proposed to refine its policy regarding G2211 to allow for the add-on to be billed when an O/O E/M service is billed by the same practitioner on the same day as an annual wellness visit, vaccine administration, or any Medicare Part B service using modifier -25 reasoning that this will pay "for previously unaccounted resources inherent to the complexity of all longitudinal primary care office visits" and that "trust-building in the longitudinal relationship is more significant than ever in making decisions about the administration of immunizations and other Medicare Part B preventive services." Based on this rationale, the Endocrine Society respectfully requests that CMS consider allowing G2211 to be billed when an O/O E/M visit is billed by the same practitioner on the same day as CPT code 95251 (*Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report*) using modifier -25.)

Under the current policy, endocrinologists must choose between billing G2211 and interpreting the data from an individual's continuous glucose monitor (CGM). Yet, O/O E/M visits where an endocrinologist interprets CGM data are analogous to an O/O E/M visit where a patient also receives a vaccine or other Part B preventive service. Endocrinologists typically see individuals living with well-controlled diabetes every six months and those without good control every three months, more frequently than these individuals see their primary care providers. There is no question that these represent longitudinal relationships over the course of which the individual develops a significant level of trust with the endocrinologist as they work together to develop treatment plans to manage their diabetes outside of the clinic between visits based on the individual's past experiences. The Endocrine Society believes it is inappropriate for its members to choose between billing CPT code 95251 and G2211, and better policy and patient care would

support billing these services together.

CY 2025 Identification and Review of Potentially Misvalued Services – Fine Needle Aspiration Biopsy

CPT codes 10021, 10004, 10005, 10006 for fine needle aspiration biopsies were publicly nominated as misvalued. This is not the first time these services have been nominated. CMS continues to believe that these services are not potentially misvalued but acknowledged "that there could be significant changes to the practice of delivering services described by these codes that were not fully reflected in the current work RVU." In that case, CMS recommended that the codes be referred to the RUC for resurvey.

The Endocrine Society participated in the most recent resurvey of these services and was disappointed when CMS did not accept the RUC-recommended work values. As explained in the RUC's comment letter, CMS double-counted the utilization for the new codes that had image guidance bundled, which resulted in the agency believing that the RUC recommended a 20% increase in physician work for the code family. We do not believe that the codes need to be resurveyed but respectfully request that CMS correct the error with the following RUC recommended work RVUs: 1.63 for CPT code 10005, 2.43 for CPT code 10009, and 1.20 for CPT code 10021.

Request for Information (RFI) for Services Addressing Health-Related Social Needs

During last year's rule making cycle, the agency proposed and finalized payment under the MPFS for services that address the health-related social needs of people with Medicare. In this rulemaking, CMS included an RFI requesting comments on ways to improve new codes used for reporting services like illness navigation and community health integration. Additionally, the agency requested information on fracture care delivery, and if there are programmatic or other policy changes that the agency could implement to improve this care. The Endocrine Society thanks CMS for its interest in how to improve care for people with Medicare who have suffered from fractures. This is a longstanding priority of the Society.

CMS posed a series of questions ranging from how often evidence-based care for beneficiaries with fractures is not adhered to and what barriers to providing evidenced-based care for fractures exist to how codes for principal illness navigation, transitional care management, and other E/M services are appropriately used and reimbursed for fracture code. In our members' experience, people with Medicare who have fractures very rarely

receive the recommended evidence-based care. Following a fracture, only between 10% and 20% of Medicare-aged patients are being treated for osteoporosis.[2] Studies indicate that the one-year mortality rate post hip fracture is 21% in the United States.[3] These individuals are more likely to have a subsequent fracture leading to unnecessary hospitalizations, surgeries, and other related healthcare costs.[4] It is important that patients are diagnosed with osteoporosis and receive appropriate treatment following a fracture. Bisphosphonates, which are used to treat osteoporosis, reduce a patient's long-term risk for fracture by 50%. These medications are generic and have minimal cost to the patient and Medicare.

The primary barrier to appropriate diagnosis of osteoporosis post-fracture is the fragmentation of care people with Medicare and others receive after breaking a bone. Immediately after a fracture, an orthopedic surgeon assumes responsibility for the individual's care, performing the surgical repair and required follow-up before the individual's discharge to the skilled nursing facility for rehabilitation. At no point does the orthopedic surgeon refer the patient to an endocrinologist to address any underlying causes of the fracture, like osteoporosis.

The Endocrine Society recommends a pathway for referral between the orthopedic surgeon and the endocrinologist. A flag for a referral for an endocrinology consultation could be incorporated into the electronic medical record. Some institutions have a fracture liaison service, which ensures that patients receive a bone density evaluation, and a personalized care plan is developed to prevent future fractures. CMS should consider supporting this type of service through appropriate reimbursement.

CMS asked for comments on whether codes like the transitional care management, principal care management, and evaluation and management services are billed for fracture care. With the surgical team's focus on the surgical repair of the fracture and subsequent discharge, these codes are not utilized by endocrinologists because there is no referral to initiate care for the individual's underlying condition. Specifically, the agency asked about the use of GPOC1, which is proposed to report care delivered by a practitioner that did not perform the surgery when there is a transfer of care. As we consider the typical clinical scenario, we do not believe this is an appropriate clinical situation for a transfer to an endocrinologist. The endocrinologist will treat the patient's underlying conditions that may place them at elevated risk of fracture but will not assume their post-surgical care, which may still be most appropriately provided by the orthopedic surgeon.

Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Conditions for Certification and Conditions for Coverage (CfCs) – Provision of Services
To date, CMS has enforced a standard requiring RHCs to primarily deliver primary care services. In this rule, the agency aims to provide RHCs with more flexibility in the services they offer and are proposing changes to the *Provision of services* CfCs by allowing them to provide more outpatient-specialty services within the practitioner's scope of practice. The Endocrine Society thanks the agency for proposing this change. While we fully support the mission of RHCs to deliver primary care services, we believe that RHCs can primarily provide primary care services while offering more outpatient-specialty services. Given the shortage of endocrinologists in many areas of the country, the Endocrine Society believes this change to RHCs' CfCs will allow for more Americans to access care for chronic conditions, like diabetes and obesity, and urges CMS to finalize this policy as proposed.

Valuation of Specific Services – Telemedicine Evaluation and Management Services
The Endocrine Society appreciates the work of the CPT Editorial Panel and RUC to develop and value the new family of telemedicine E/M services to describe audio-video and audio-only visits. We agree with CMS' proposal to assign the code family, except for CPT code 9X091, a Procedure Status indicator of "I" meaning that there is a more specific code that should be used for billing Medicare. The existing E/M code set, the appropriate modifiers, and place of services codes meet practitioners' billing needs for telehealth services, particularly given how the values between the existing E/M codes and new code family were almost identical.

We do recognize that the new code set will be in the CPT book for 2025, potentially creating confusion amongst practitioners and their billing teams about how to appropriately code for telehealth care. Therefore, we urge CMS to take whatever practical actions it can to educate stakeholders about how to bill telehealth services appropriately.

Payment for Telehealth Services
Audio-Only Communication Technology to Meet the Definition of "Telecommunications System"
Since the start of the pandemic, telephone services have played a vital role in ensuring patients have appropriate access to endocrinologists and other practitioners. The Endocrine Society has advocated for continued coverage of audio-only care as an important option to deliver telehealth services, and therefore, we are pleased that CMS has

proposed to revise the definition of “telecommunications system” to include audio-only and urge you to finalize this change.

Our members have reported that telephone visits have played a key role in delivering care to individuals who may not have regular access to care, including those in rural and urban areas without reliable internet connections and unhoused patients who would prefer not to have a medical visit in a place with public internet. When phone visits are not covered, our members report that visits are canceled when patients cannot establish an audio-visual visit, creating unnecessary stress and delaying care. We believe this policy change is a crucial step towards furthering our shared goal of improving health equity.

Distant Site Practitioners
The Endocrine Society thanks CMS for proposing to allow distant site practitioners to use their currently enrolled practice location instead of their home address when providing telehealth services from their home. This is necessary to protect physicians’ privacy. We recommend that it be finalized as proposed.

Request for Comment on Dental Services Integral to Specific Covered Services to Treat Diabetes
In this proposed rule, CMS considers whether to provide coverage for dental services under Part B when they are “inextricably linked to, and substantially related and integral to the clinical success of, other covered services.” Stakeholders nominated dental services as inextricably linked to covered medical services for the treatment of diabetes. However, CMS has reviewed the data and has not identified an extricable link between dental services and certain services in the treatment of diabetes despite the studies submitted by stakeholders.

The data overwhelmingly shows that diabetes and periodontitis negatively affect each other. Routine dental cleanings can lead to improved glycemic control in individuals with periodontitis and type 2 diabetes.[5] Maintaining oral health is a key component of an individual’s diabetes management overseen by an endocrinologist.[6] Better dental care, including treating periodontal infections, will result in improved diabetes management and reduce diabetes’ burden on public health and the Medicare system. However, we recognize that dental cleaning cannot be linked to a specific service to treat diabetes, and therefore, cannot be covered by Medicare at this time. Instead, we urge CMS to work within its authority and with stakeholders to support policies for individuals with diabetes to receive

appropriate dental care.

Medicare Diabetes Prevention Program

We support the changes proposed to the Medicare Diabetes Prevention Program (MDPP) which would align the MDPP standards to the Center for Disease Control and Prevention's (CDC) Diabetes Prevention Recognition Program (DPRP) standards. Aligning the MDPP standards to the DPRP standards will ease administrative burden for suppliers who provide both services through the MDPP and the National Diabetes Prevention Program (National DPP). This alignment could also help with expanding the number of MDPP providers which could improve access to diabetes prevention programs for Medicare beneficiaries. We are also pleased that the agency has recognized the value of providing flexibility to beneficiaries for make-up sessions, which will help for those who do not have transportation to multiple program classes within one week.

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

Sincerely,

Rob Lash, MD
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Endocrine Society