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April 25, 2022

Dear Ms. Blackford and Dr. Howe,

Thank you and your team for meeting with the Infectious Diseases Society of America (IDSA), Society of Hospital Medicine (SHM) and American College of Emergency Physicians (ACEP) on April 5, 2022, to discuss the valuation of initial inpatient (IP) evaluation and management (E/M) services. We appreciate your time and consideration of the issues we raised during the meeting. These services are central to our members' ability to provide high-quality care to patients, and the CPT codes in question (described below) are at risk of serious undervaluation. IDSA represents over 12,000 infectious diseases (ID) physicians who care for patients with a wide range of serious infections, including COVID-19; infections associated with transplants, cancer chemotherapy and opioid use; and infections caused by antibiotic-resistant pathogens. Securing the ID workforce and improving access to ID care are critical for pandemic preparedness and for the many areas of medicine that rely upon ID.

In the follow-up to our discussion, ***we urge you to propose an increase to the initial IP E/M services, so the work relative value units (wRVUs) continue to reflect the historical relativity with the office/outpatient (O/O) E/M services (prior to those services being revalued in calendar year [CY] 2021), as part of the upcoming CY 2023 Medicare Physician Fee Schedule (MPFS) rulemaking***. While we recognize that in some instances it may be appropriate to change the relativity between code sets, that would not be appropriate in this instance, as IP E/M services are inherently more complex, involving sicker patients, higher risk of adverse outcomes and higher-level medical decision-making as compared to O/O E/M services. Failure to appropriately revalue IP E/M codes will exacerbate existing workforce shortages in our fields and further hamper access to care, particularly for patients already in underserved communities.

Specifically, we urge you to adopt the following wRVUs for the initial IP E/M services:

- CPT 99221: 1.92 wRVUs
- CPT 99222: 2.79 wRVUs
- CPT 99223: 4.25 wRVUs

At a minimum, we urge you to include a discussion of our proposal in the preamble as an alternative considered by the agency.

Rationale

The Centers for Medicare and Medicaid Services (CMS) has long-emphasized the need to improve payment for primary care, care management and patient-centered services. This has been demonstrated for more than a decade through CMS' "*ongoing incremental effort to identify gaps in appropriate coding and payment for care management/coordination, cognitive services and primary care within the MPFS*,"[1] and has resulted in the following new and revised services and associated values:

- Transitional care management (TCM) services (2013)
- Chronic care management services (CCM) (2015, 2017)
- Behavioral health integration (BHI) services (2017)
- Assessment/care planning services for cognitive impairment (2017)
- Prolonged E/M services without direct patient contact (2017)

Beginning in 2018, CMS supported a renewed effort to ensure modernization of the documentation guidelines and accuracy of values for E/M services. The primary focus on office and outpatient E/M visits resulted in the implementation of new policies and values in CY 2021. However, as a result of the statutory budget neutrality requirements, our specialty faced reductions in overall Medicare reimbursements (i.e., -4%). Nevertheless, we registered strong support for these important and necessary improvements, with the expectation that the inpatient-based primary care and cognitive specialty services that our members deliver would soon be addressed and commensurately revalued.

Now that the focus has shifted to the IP E/M services, we are concerned that enthusiasm for improving the values of the remaining E/M code sets will dissipate, particularly if increases put more pressure on the conversion factor. Regardless, we continue to believe the historic relativity between the inpatient hospital and observation E/M code sets must be maintained to ensure that the codes accurately reflect the complexity of care being provided. This sentiment was shared by the American Medical Association (AMA) Relative Value System Update Committee (RUC) in its April 2019 Summary of Recommendations for the increased values for CPT 99205:

> *The key reference services were 99223, Initial hospital care for patient with problems of high severity, with times and work RVU of 15/55/20/90/3.86, and 99220, Initial observation care for patients with problems of high severity with times and work RVU of 15/45/15/75/3.56. The panel determined that the survey median total time and work RVU place 99205 in proper rank order with both key reference services.* ***While all three services require high complexity medical decision making, 99223 and 99220 are reported for patients in a hospital or observation setting so the RVUs should be higher.*** [Emphasis added].

Longstanding undervaluation of IP E/M codes has led to a significant compensation disparity between physicians who primarily provide IP E/M services and those who mainly do procedures. This disparity has driven serious recruitment challenges and workforce shortages. For example, the ID specialty routinely fails to fill about 25% of its training programs each year, making it increasingly difficult for patients to access ID specialty care. In 2021, only 70% of ID fellowship training programs were able to fill their slots.[2] Nearly 80% of counties in the U.S. do not have a single ID physician.[3] While hospitals do

[1] CY 2018 MPFS, p. 53163, https://www.govinfo.gov/content/pkg/FR-2017-11-15/pdf/2017-23953.pdf

[2] https://www.nrmp.org/wp-content/uploads/2022/03/2022-SMS-Results-Data-FINAL.pdf

[3] https://www.acpjournals.org/doi/10.7326/m20-2684

provide crucial support staff to help manage highly complex patients, these valuable support staff cannot duplicate the expertise of specialty physicians to manage the complex diagnosis, treatment and care management of severely ill patients who often have multiple comorbidities.

Again, given that one of the original intents of revisiting the E/M codes sets was to improve the accuracy of the values of E/M code sets, we believe it is imperative that CMS maintain the historic relativity of the inpatient and observation codes with the office and outpatient E/M services by proposing wRVUs for CPT 99221 – 99223 as listed above.

Thank you for your consideration of our request, and we look forward to a favorable outcome in the forthcoming proposed rule. Should you have any questions or wish to discuss our request further, please contact Amanda Jezek, IDSA senior vice president for public policy & government relations, at ajezek@idsociety.org.

Sincerely,

Daniel P. McQuillen, MD, FIDSA
President, IDSA