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IDSAs Headquarters
1300 Wilson Boulevard
Suite 300
Arlington, VA 22209
TEL: (703) 299-0200
FAX: (703) 299-0204
EMAIL ADDRESS:
info@idsociety.org
WEBSITE:
www.idsociety.org

September 11, 2017

Ms. Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: CMS-1676-P, Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program

Submitted electronically via Regulations.gov

Dear Ms. Verma,

The Infectious Diseases Society of America (IDSAs) appreciates the opportunity to provide comments on the Medicare Physician Fee Schedule (MPFS) proposed rule for calendar year 2018. IDSAs represents more than 11,000 infectious diseases physicians and scientists devoted to patient care, prevention, public health, education, and research in the area of infectious diseases (ID). The Society's members focus on the epidemiology, diagnosis, investigation, prevention, and treatment of infectious diseases in the United States and abroad. Our members care for patients of all ages with serious infections, including meningitis, pneumonia, tuberculosis, HIV/AIDS, serious health care acquired infections, antibiotic resistant bacterial infections, as well as emerging infections such as the Middle East Respiratory Syndrome coronavirus (MERS-CoV), Ebola virus, and Zika virus diseases.

IDSAs members are committed to improving the quality and the safety of patient care in all healthcare settings and in health systems across the nation. A significant portion of our members in clinical practice are hospital-based, and many lead the "on the ground" efforts to combat healthcare associated infections and antimicrobial resistance. The specialty of infectious diseases is unique in that it is the only specialty whose training routinely emphasizes the linkage between individual patient care and the impact on the larger patient population. "Bedside-to-population" system-based awareness is what distinguishes the critical role of the ID physician within the healthcare system. This especially applies to quality improvement related to healthcare associated infections and antimicrobial stewardship. It is with this perspective that we offer our comments on the proposed rule for 2018 MPFS.

Evaluation and Management (E/M) Guidelines:

We appreciate the Agency requesting comments from stakeholders regarding the revision of E/M guidelines. Including stakeholders in the revision process will provide the Agency with perspectives from all sides and will allow for robust discussions and refinements of the E/M guidelines and associated E/M services, which are fundamental to the practice of medicine.

Out of all physician services billed by ID physicians, E/M codes represent the overwhelming majority; so much so that approximately 93% of ID physicians' 2016 Medicare utilization (designated by specialty code 44) is comprised of E/M codes, totaling \$626 million of the approximately \$670 million in Medicare utilization for all services reported. We also note that the majority of ID physicians practice within a hospital setting, and therefore as the Agency moves forward with revisions of the E/M guidelines, we ask that the Agency not focus exclusively on the burden of the E/M documentation guidelines as they relate to site-of-care. The importance of inpatient E/M services to the practice of infectious diseases cannot be underestimated. Of the \$626 million in E/M Medicare utilization for ID physicians, nearly \$490 million can be attributed to just four inpatient E/M codes: 99232, 99233, 99223, and 99222.

The development of new E/M guidelines will be a difficult undertaking and therefore IDSA would like to recommend that the Agency create a task force, comprised of relevant stakeholders including medical specialty societies, private insurance carriers, and others to assist the Agency moving forward. We understand that creating new E/M guidelines will be a time consuming and resource intensive effort for the Agency and suggest the development of the task force to not only help alleviate the burden to the Agency, but to ensure that all stakeholders are actively involved in the project.

We continue to believe the current E/M codes and their associated work values do not fully capture the value of our work. ID physicians are cognitive physicians that treat extremely complicated, immunocompromised patients, often with multiple co-morbidities. The time, effort, and medical expertise required to treat these patients are substantial; therefore, we support the Agency's premise that medical decision making (MDM) and time are important factors when choosing an appropriate CPT code to report for our services. IDSA has been and continues to be at the forefront of understanding appropriate E/M coding, given its importance to our specialty. More than ten years ago, IDSA developed coding guidance where we emphasized that MDM is critical in assigning the appropriate E/M code to a patient encounter.

However, we believe that MDM guidelines are outdated and do not appropriately enumerate the work of MDM, resulting in under-emphasis on and under-valuation of MDM. The current E/M guidelines are more than 20 years old and in that time the complexity of patients' illnesses and comorbidities as well as the practice of medicine have changed considerably. Because of this, focusing on just the revision of the history and physical exam guidelines would perpetuate the flaws in the current system. To correct this, we submit that a holistic review of the E/M guidelines is called for at this time. We note that, for the ID physician, the history and physical exam components of an E/M encounter remain essential in appropriate diagnosis and treatment. Indeed, the careful accounting of the history of present illness and review of systems, identifying information critical to the care of the patient buried deep within the record, are what often distinguish the high quality care offered by ID physicians. We recognize the premise that the history and physical exam often create electronic health records (EHR) that are cumbersome and bloated due to the functions of copy and paste within the EHR. This problem is particularly acute for patients

with complex and prolonged clinical courses, who often require the detailed evaluation of an ID physician. To appropriately recognize the work of performing a medical record review, we would argue that the time reviewing those records should be adequately accounted and valued for its contribution to patient care.

Finally, we read with concern that CMS will defer on developing an extensive research project that would revise and revalue the E/M code set. The existing E/M codes are one of the fundamental building blocks of the Medicare Physician Fee Schedule, dramatically impacting a broad swath of medical specialties. Given that you have acknowledged “the limitations of the current E/M code set,” we are unsure how the Agency plans to address these limitations if the research project is not considered within the near future. As we have stated in past comment letters, IDSA welcomes the opportunity to work with CMS regarding revising and revaluing the current E/M code set.

Medicare Telehealth Services:

IDSA supports the development of policies that allow for greater flexibility in reporting and reimbursement for telehealth services. We believe the Agency should approve and add more services to the telehealth code list. These incremental changes may signal to Congress that the Agency continues to support telehealth services and signals that the Agency may be willing to work with Congress to expand the provisions of telehealth.

For example, CMS proposed to not add initial hospital care (codes 99221-99223) to the approved-for-telehealth code list. We disagree with this and believe that initial hospital care may be delivered via telemedicine. We note that in developing the work RVUs for the HCPCS G codes used to report inpatient tele-consults, CMS used the same RVUs as for the initial hospital care codes. Therefore, CMS must believe that these codes represent essentially the same service, comprised of the same work, including the history and physical and medical decision making. We would appreciate CMS’s reconsideration of their decision.

Remote Patient Monitoring:

IDSA supports unbundling of the services reported by code 99091 - collection and interpretation of physiological data (e.g. ECG, blood pressure) from existing services. We believe there should be separate reimbursement for the work involved in reviewing and interpreting physiological data that is stored and transmitted digitally. IDSA would also support the valuation of code 99090 (analysis of clinical data stored on computers). Again the work involved in this service and in 99091 should be considered separate and distinct services.

MACRA Patient Relationship Categories and Codes:

CMS proposes to allow voluntary submission of patient relationship codes on or after January 1, 2018. It is our understanding that these codes would be used to assign cost and resource use to eligible clinicians under the Cost performance category of the Merit-Based Incentive Payment System (MIPS). We believe adding patient relationship codes to the requirements for claims submission will add an additional layer of complexity and burden while adding nothing for the improvement of patient care. We understand that episode-based cost and resource use measures remain under development at this time and without a better understanding of these new episode cost measures and the impact on our members, we believe it is

inappropriate for clinicians to begin reporting them, even on a voluntary basis. IDSA urges CMS to delay the implementation of the patient relationship codes until episode-based measures are available for review and comment by stakeholders.

Section 1848(r) requires CMS to collaborate with physicians and other stakeholders to improve resource use measurement and part of this process is the creation and use of classification codes that indicate the physician/patient relationship during an episode of care. CMS has asked for comments as to whether stakeholders support the proposal of converting the patient relationship codes currently denoted with HCPCS modifiers to CPT modifiers. IDSA would support this change. The modifiers will be used to classify and attribute costs to the clinician who is responsible for a patient's care. IDSA believes that the development of appropriate patient relationship categories which are easy to understand and use will be an important step in assigning patient attribution. IDSA would also suggest that a patient relationship code or modifier should be reported only once per episode of care. This would alleviate some of the administrative burden when the patient relationship codes become operational.

The Agency also requested comments on the patient relationship codes in general. We ask that CMS provide clarification as to how multiple physicians involved in a time-limited treatment event (i.e. knee replacement surgery) would classify the patient relationship. For example, an ID physician may be called upon to assist with treating a prosthetic joint infection after knee replacement surgery. The ID physician would therefore indicate an episodic/focused relationship on the claim form for the services provided as result of the prosthetic joint infection; however the orthopedic surgeon who performed the surgical procedure will also likely indicate the same episodic/focused relationship. We ask CMS to evaluate allowing multiple physicians to report the same patient relationship code on a claim for the same Medicare beneficiary under the same episode of care as each physician provides distinct and unique services to the patient.

IDSA supports CMS's supposition that the five categories represent most doctor-patient relationships. However, we assume that the patient relationship categories are fluid and therefore no single specialty will be confined to a certain patient relationship category. For example, there may be times when an ID physician may be in a continuous/focused relationship with a patient, such as when treating and directing care for an HIV positive patient. We also believe the patient relationship may change over the course of an episode. ID physicians are often asked to care for patients during an acute episode, with the care continuing into a chronic phase. For instance, the care of an acute episode of prosthetic joint infection, which includes elements of care thought of as the domain of primary care, may stretch into a chronic phase of months or even years. IDSA seeks clarity as to how CMS would want this type of relationship defined. IDSA also requests CMS to provide clarity as to how frequently physicians will be expected to define a patient relationship. We also ask for clarity as to the time period for which the patient relationship is to be defined.

Understanding that patient relationships are fluid and may change over time, IDSA suggests CMS develop default patient relationship codes that a particular physician would assume with a patient unless the physician specifically identifies a different relationship. CMS already collects information on a physician's site of service, specialty, CPT code and ICD-10 codes used to identify a service on a claim form. Therefore, it may be possible, using this information, to determine a physician's typical relationship with patients.

IDSA Comments – CMS Proposed Rule for 2018 Physician Fee Schedule

IDSA appreciates the efforts put forth by CMS to improve the Medicare Physician Schedule. We look forward to further engagement with CMS and other stakeholders as we work toward meeting the goals of this proposed rule. If you have any questions, please feel free to contact Andrés Rodríguez, Vice President, Clinical Affairs and Practice Guidelines at 703-299-5146 or arodriguez@idsociety.org.

Respectfully,

A handwritten signature in cursive script that reads "Bill Powderly". The signature is written in black ink on a white background.

William G. Powderly, MD, FIDSA

President