8735 W. Higgins Rd. Ste. 300
Chicago, IL 60631
Phone 847/375-4714
Fax 847/375-6424
Web site: www.neuromodulation.org

September 10, 2018

SUBMITTED ELECTRONCIALLY VIA
http://www.regulations.gov

Seema Verma
Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1693-P
Mail Stop C4-26-05,
7500 Security Boulevard,
Baltimore, MD 21244-1850

Re: Medicare Program; Revision to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program

Dear Administrator Verma:

The North American Neuromodulation Society (NANS) greatly appreciates the opportunity to comment on the Physician Fee Schedule (PFS) and Quality Payment Program Proposed Rule for Calendar Year 2019 (CMS-1693-P). NANS is a non-profit organization devoted to the pursuit of excellence in the application of all neuromodulation therapies. Neuromodulation is often defined as the application of targeted electrical, chemical and biological technologies to the nervous system in order to improve function and quality of life and can be an alternative therapy to treatment with opioids. Our current membership consists of more than 1,000 members, the majority of which are working in pain related disciplines. NANS membership currently includes practitioners from anesthesiology, neurosurgery, neurology, physical medicine and rehabilitation, and other specialties.

Our comments focus on three elements of the proposed rule: CMS proposals related to documentation and payment for evaluation and management (E/M) services; proposed relative value units (RVUs) for the neurostimulator services codes, and the solicitation of comments on the global surgery data collection effort. NANS recommends that CMS adopt the following recommendations with regard to the 2019 PFS proposed rule:

(1) Finalize several of its proposals to reduce documentation burden for CY 2019 including:

- Allow physicians the option to document visits based solely on the level of medical decision-making or the face-to-face time of the visit as an alternative to the current guidelines.

- If physicians choose to continue using the current guidelines, limit required documentation of the patient's history to the interval history since the previous visit (for established patients).

- Eliminate the requirement for physicians to re-document information that has already been documented in the patient's record by practice staff or by the patient.

- Eliminate the prohibition on billing same-day visits by practitioners of the same group and specialty.

(2) Withdraw all of its payment proposals and work closely with interested stakeholders over the next year to develop a refined approach that will achieve CMS's goal of burden reduction while also ensuring the best possible outcome for patients.

(3) Not finalize the proposed work relative value units (RVUs) for the neurostimulator procedures (95970, 95X83, 95X84, 95X85, and 95X86) and should instead assign the work RVUs recommended by the Relative Value Scale Update Committee (RUC).

(4) Not take any action based on the global surgery data presented in the proposed rule and should undertake further data collection and more robust analysis before proposing any changes to the global periods.

I. Evaluation & Management ("E/M") Payment and Documentation Requirements

NANS strongly support the "Patients Over Paperwork" initiative. We appreciate that CMS understands the administrative burden attributable to the current documentation guidelines for the new and established outpatient Evaluation and Management ("E/M") service codes and applaud CMS for its desire to address these issues. We strongly urge the agency to finalize several of its proposals to reduce that burden. However, NANS has significant concerns with the specific payment changes that CMS proposes for 2019 and believes that the payment changes should not be finalized in the CY 2019 Final Rule.

NANS is part of the Patient-Centered Evaluation and Management Services Coalition, a multi-specialty coalition, group of diverse medical societies, that provided separate detailed comments in response to CMS's E/M proposals. Those comments reflect NANS concerns with the proposals and we incorporate them by reference into this letter (see Appendix A). As described in greater detail in those comments, NANS and the coalition urge CMS to not finalize any of its E/M payment proposals, including the proposed modifier 25 reimbursement reduction policy and to withdraw any changes in outpatient visit coding or payment until a consensus on an equitable new coding structure is achieved. We believe that a step-wise and open approach that includes a sophisticated data analysis and involves all stakeholders will help CMS achieve an E/M payment structure that allows accurate reporting of physician work and practice expenses for office visits. By accurately capturing the breadth and depth of current E/M work, we can assure appropriate payment is in accord with the current statute while minimizing unintended consequences.

II. Neurostimulator Services (CPT codes 95970, 95X83, 95X84, 95X85, and 95X86)

In 2017, the CPT Editorial Panel reviewed codes related to neurostimulator services and revised and deleted certain codes. The Editorial Panel also created four new CPT codes for analysis and programming of implanted cranial nerve neurostimulator pulse generator, analysis, and programming of brain neurostimulator pulse generator systems and analysis of stored neurophysiology recording data.

The RUC thoroughly analyzed this family of neurostimulator services, including reviewing the history, survey data and magnitude estimation to other similar services. The RUC **unanimously approved** the work RVUs for all services in this family. In setting work RVUs for the new and one of the revised codes, CMS proposed to reduce the work RVUs as shown below.

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
95970	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group(s), interleaving, amplitude, pulse width, frequency (Hz), on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve neurostimulator pulse generator/transmitter, without programming	**0.35**	**0.45**
95X83	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group(s), interleaving, amplitude, pulse width, frequency (Hz), on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple cranial nerve neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional	**0.73**	**0.95**
95X84	95X84 Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group(s), interleaving, amplitude, pulse width, frequency (Hz), on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with complex cranial nerve neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional	**0.97**	**1.19**
95X85	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group(s), interleaving, amplitude, pulse width, frequency (Hz), on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator /transmitter programming, first 15 minutes face-to-face time with physician or other qualified health care professional	**0.91**	**1.25**
95X86	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group(s), interleaving, amplitude, pulse width, frequency (Hz), on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/transmitter programming, each additional 15 minutes face-to-face time with physician or other qualified health care professional	**0.80**	**1.00**

NANS urges CMS not to finalize the proposed work RVUs and to assign the RUC recommended values instead. For all of these codes, CMS disagreed with the RUCs selection of reference codes to use

as the basis for their work recommendations and selected alternative codes based solely on the relative time involved. CMS does not consider other elements that contribute to work RVUs and the selection of a reference code such as physician work and the intensity and complexity of the service. The RUC examines the services based on clinical relativity of all measures compared to other services. CMS should not review one element, physician intra-service time, and disregard the relativity between reference services. CMS should not finalize the proposed work RVUs for these codes and should instead assign the work RVUs recommended by the RUC.

95970

For CPT code 95970, the code descriptor was revised slightly from the current descriptor but as CMS notes in the proposed rule, "the specialty societies affirmed that the work itself has not changed."[1] In proposing work RVUs, the RUC recommended a work RVU of 0.45 (which is the same as the current work RVU) and 3 minutes pre-service, 7 minutes intra-service and 5 minutes post-service time developed from physician survey data. The RUC compared code 95970 to the top key reference service 62368 *Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming* (work RVU = 0.67 and 27 minutes total time).

CMS disagreed with the RUC's recommendation because CMS does not believe that maintaining the work RVU is appropriate, given a decrease of four minutes in total time from the current estimate of 19 minutes. CMS' concerns are unfounded. The current time estimate is based on Harvard time, which is less accurate than the survey used to estimate time for the revised code. In addition, the survey pre-service time was reduced to account for the fact that this service typically reported with an E/M service. The current time estimate most likely did not take this situation into account.

CMS also notes that the reference CPT codes chosen by the survey respondents have much higher intra-service and total times than CPT code 95970, and also have higher work RVUs, making them poor comparisons. The survey respondents chose these reference services as a comparison, not recommending direct crosswalks. The respondents and the RUC agreed that CPT code 95970 requires less physician time and work and thus valued it lower than the reference codes.

CMS recommends that code 95970 be directly crosswalked to CPT code 95930 *Visual evoked potential (VEP) checkerboard or flash testing, central nervous system except glaucoma, with interpretation and report* (work RVU = 0.35, 10 minutes intra-service time and 14 minutes total time). CPT code 95930 describes the service of reviewing and interpreting ophthalmological results of brain electrical activity measurements. CPT code 95970 requires more physician work and is more intense than 95930 because the physician is performing the electronic analysis of the implanted neurostimulator pulse generator/transmitter and documenting the diagnostic analysis, including the battery state, current program settings, and impedances of electrodes, as well as any event logs from the programming equipment and patient device interrogation. Therefore, 95930 is an inappropriate comparison for 95970. **NANS urges CMS to accept the RUC recommended work RVU of 0.45 for CPT code 95970.**

95X83

For CPT code 95X83, the RUC recommended a work RVU of 0.95 and 3 minutes pre-service, 11 minutes intra-service and 10 minutes post-service time. CMS noted that this new code does not exactly replace the deleted CPT code 95974 *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex*

[1] 83 Fed. Reg. 35768.

cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, with or without nerve interface testing, first hour (work RVU = 3.00 and 30 minutes pre-time, 60 minutes intra-service time and 20 minutes post-service time) which includes a time parameter that is not included in 95X83. In addition, the new CPT code refers to simple rather than complex programming. Despite these differences, CMS is still comparing the physician work and time of these two services. The physician work and times should be different and CMS should not compare these two vastly different services.

CMS states that the top key reference service 95816 *Electroencephalogram (EEG); including recording awake and drowsy* (work RVU = 1.08, 15 minutes intra-service time and 26 minutes total time) is not an appropriate crosswalk. Again, the survey respondents are not recommending code 95X83 be crosswalked to code 95816, but notes that CPT code 95816 was chosen to assess the relativity and to establish a work RVU and physician time recommendation. Clearly, services performed by the same physician, intra-service time differences of 4 minutes, total time differences of 2 minutes, overall intensity and complexity measures indicated as 60 percent identical and 40 percent somewhat more for the key reference code, all support the RUC recommended work RVU of 0.95 and physician time relative to another similar service.

CMS recommends code 95X83 be crosswalked to CPT code 76641 *Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete* (work RVU = 0.73 and 12 minutes of intra-service time and 22 minutes of total time). The RUC disagrees with referencing a service furnished by a different specialty when a valid survey was conducted using reference services provided the same specialty. CPT code 76641 is not a good reference code for 95X83 because, although the physician time may be similar, CPT code 95X83 requires more physician work to interact with the patient and make programming adjustments to multiple parameters which result in real time changes in patient behavior, including but not limited to speech, breathing patterns, heartrate, and seizure activity. Potential side effects and risks of parameter adjustments are significant, and considerations must be weighed carefully, including identifying the correct parameter to manipulate. The identification of and adjustment of the correct parameter(s) requires considerable decision-making effort and concern for patient safety that is not involved in 76641. **NANS urges CMS to accept the work recommended RVU of 0.95 for CPT code 95X83.**

95X84

The RUC recommended the survey 25th percentile work RVU of 1.19 for 95X83. The specialty societies reduced the pre-service time to recognize that this service is typically reported with an E/M service. The RUC recommended 3 minutes pre-service, 17 minutes intra-service and 10 minutes post-service time. The specialty societies indicated and the RUC agreed that the 10 minutes required for the post-time include reviewing all the parameters, documenting final program measurements and any other relevant clinical information obtained during the programming session, reducing side effects and making treatment adjustments. The physician will also address patient and family questions about planned therapy and re-educate the patient and family on the use of the patient device. The RUC confirmed that the physician times appropriately mirror other similar services.

CMS states that the RUC compared CPT code 95X84 with deleted CPT code 95975 *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial nerve neurostimulator pulse generator / transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour* (work RVU = 1.70, ZZZ global period and 30 minutes total time). The RUC recommendation ***did not*** compare code 95X84 to deleted code 95975. The RUC noted that the top two key reference services were disparate compared to this service. Therefore, as a better reference, the RUC compared code 95X84 to

MPC codes 99308 *Subsequent nursing facility care, per day, for the evaluation and management of a patient* (work RVU = 1.16, 15 minutes of intra-service time and 31 minutes total time) and 12013 *Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm* (work RVU = 1.22, 15 minutes of intra-service time and 27 minutes total time), which support the recommended work RVU as the survey code involves somewhat more intra-service and total time and a comparable amount of physician work. For additional support, the RUC referenced codes 93975 *Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study* (work RVU = 1.16, 20 minutes of intra-service time and 30 minutes total time) and 67810 *Incisional biopsy of eyelid skin including lid margin* (work RVU = 1.18, 13 minutes of intra-service time and 27 minutes total time). Thus, the survey 25th percentile work RVU appropriately places CPT code 95X84 relative to the top key reference service and other similar services.

CMS is proposing to use a reverse building block in developing the work RVU for code 95X84. The RUC has long stated that codes that are not developed using building block should not be manipulated with a reverse building block methodology. CMS is proposing a work RVU of 0.97 for CPT code 95X84 without the use of survey data or a direct crosswalk to another similar code. CMS is taking the difference in work RVUs from the RUC recommended values of 0.24. This approach inaccurately treats all components of physician time as having identical intensity and is incorrect. NANS strongly disagrees with valuing a service by increment and recommends that CMS use valid survey data to develop work RVUs. **NANS recommends CMS assign the RUC recommended work RVU of 1.19 for CPT code 95X84.**

95X85

For CPT code 95X85, CMS states that the RUC's recommendation of 1.25 work RVUs is based on codes 12013 *Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm* (work RVU = 1.22, intra-service time of 15 minutes and 27 minutes total time) and 70470 *Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections* (work RVU = 1.27, 15 minutes of intra-service time and 25 minutes total time). The RUC actually based its recommendation on the survey 25th percentile work RVU of 1.25. Then to support the valid survey data, the RUC referenced similar services from the Multi-Specialty Points of Comparison (MPC) list. The RUC recommended 3 minutes pre-service, 15 minutes intra-service and 10 minutes post-service time for CPT code 95X85, which are comparable in relativity for physician work and time to CPT codes 12013 and 70470.

CMS applies the use of a reverse building block in developing the work RVU for code 95X85. The RUC has long stated that codes that are not developed using building block should not be manipulated with a reverse building block methodology. CMS is proposing a work RVU of 0.91 for CPT code 95X85 by directly crosswalking CPT Code 95X85 to CPT code 93886 *Transcranial Doppler study of the intracranial arteries; complete study* (work RVU = 0.91, intra-service time of 17 minutes, and total time of 27 minutes). Although, CPT code 95X85 requires similar physician time as code 93886, code 95X85 is more intense and complex and requires more physician work because it entails programming adjustments to multiple parameters which result in real time patient behavior. This work includes monitoring for changes in the patient's speech, mobility, strength, voice, and activities of daily living (ADLs), (as they can be assessed on an immediate basis). Potential side effects and risks of parameter adjustments are significant, and considerations must be weighed carefully to consider the benefits of clinical improvement with minimal negative side effects. The service includes observations based on adjustments made, a review of the results, and further adjustments as needed. Therefore 93886 is not an appropriate reference code for 95X85. **NANS urges CMS to accept the RUC recommended work RVU of 1.25 for CPT 95X85.**

95X86

For CPT code 95X86, CMS states that the RUC's recommendation of 1.00 work RVUs is based on the key reference service CPT code 64645 *Chemodenervation of one extremity; each additional extremity, 5 or more muscles (List separately in addition to code for primary procedure)* (work RVU = 1.39 and 15 minutes of intra-service time). The RUC actually based its recommendation on the survey 25th percentile work RVU of 1.00. To support the valid survey data, the RUC indicated that the survey respondents chose code 64645 as the key reference service for comparison for what they thought was the most similar services. The RUC noted that the survey respondents indicated 95X86 is more intense and complex to perform but CPT code 64645 requires more technical skill. Therefore, CPT code 64645 appropriately requires slightly more work than code 95X86.

NANS does not understand why CMS is not relying on survey data and is portraying the RUC's comparison to key reference services and MPC codes as a direct crosswalk, instead of as a consideration in establishing the appropriate relativity of services.

CMS is proposing a work RVU of 0.80 for CPT code 95X86, which is a random value found by calculating RVUs using two methodologies: the incremental difference between codes 95X85 and 95X86 which produces RVUs of 0.75; and the building block methodology which produces RVUs of 0.82. CMS then chose to propose an RVU of 0.80 because it falls between those calculations. CMS then indicates that a work RVU of 0.80 is supported by crosswalking code 95X86 to code 51797 *Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal)* (work RVU = 0.80 and 15 minutes intra-service/total time).

NANS strongly disagrees with the approach of valuing a service by increment and then selecting a reference code to mirror the incremental value. NANS recommends that CMS use valid survey data and review the actual relativity for all elements (physician work, time, intensity and complexity) when developing the work RVU for services. Additionally, CPT code 51797 is not a good crosswalk for CPT code 95X86. CPT code 95X86 require more physician work to perform the programming adjustments to multiple parameters which result in real time patient behavior. This work includes monitoring for changes in the patient's speech, mobility, strength, voice, and ADLs (as they can be assessed on an immediate basis). Potential side effects and risks of parameter adjustments are significant, and considerations must be weighed carefully to consider the benefits of clinical improvement with minimal negative side effects. The service also includes observations based on adjustments made, review of the results and further adjustments as needed. Therefore, 51797 is not an appropriate reference code 95X86. **NANS urges CMS to accept the RUC recommended work RVU of 1.00 for CPT code 95X86.**

III. Global Surgery Data Collection

Since July 1, 2017, CMS has been requiring reporting of the no-pay CPT code 99024 (Postoperative follow-up visit, normally included in the surgical package, to indicate that an E/M service was performed during a postoperative period for a reason(s) related to the original procedure) by practitioners in nine states (FL, KY, LA, NV, NJ, ND, OH, OR, and RI). Only practitioner in practices of 10 or more practitioners are required to report the code when providing follow-up care and only when providing such care for surgeries described by one of approximately 300 CPT codes.

In the proposed rule, CMS provides summary data on six months of experience from July 1, 2017 through December 31, 2017. CMS presents data at the specialty level and does not provide data for individual codes. Overall, 45 percent of practitioners report 99024 with significant variation in reporting rates by specialty. CMS solicits comments on how to encourage reporting of 99024 to ensure the validity of the data without imposing undue burden; whether it is reasonable to assume that many visits included

in the valuation of 10-day global packages are not being furnished or whether there are alternative explanations; and whether CMS should consider changing the global period and reviewing the code valuation. NANS strongly urges CMS not to assume that visits included in the 10-day global period are not provided based on the data presented in the proposed rule. We note that the data collected is based on reporting requirements that only applied to certain providers in certain states and for certain services. The reporting requirements were finalized in November 2016 and began on a voluntary basis January 1, 2017 before becoming mandatory on July 1, 2017. This quick implementation provided little advance notice for physicians to change their billing practice to begin reporting services that provide no additional Medicare payment. It is just as likely that the relatively small percentage of services matched with post-operative visits reflects a lack of understanding of these obligations and confusion about who must report 99024 and under what circumstances as it is that the services were not provided.

NANS is a multi-specialty organization whose members include interventional pain management specialists, anesthesiologists, orthopedic surgeons, physical medicine and others. Our members provide several of the services included in the reporting requirement such as:

CPT	Short Descriptor
63650	Implant neuroelectrodes
63685	Insrt/redo spine n generator
64555	Implant neuroelectrodes
64561	Implant neuroelectrodes
64581	Implant neuroelectrodes

NANS does not understand the results that CMS presents in the proposed rule. Our members confirm that an E/M visit is typically performed with these services and most other services that have a 10 day global period. CMS does not present data on a code-by-code basis and therefore it is not possible to determine whether the low reporting rate CMS observed is specific to particular services.

CMS should not make any policy changes based on the data presented in the proposed rule. CMS should continue to gather additional data on the provision of E/M visits during 10 global period and improve the data collection efforts to ensure that future data is accurate. In particular we urge CMS to better identify and educate which practitioners are subject to the requirement, including reaching out to all relevant specialty societies to help inform their members. NANS pledges to work with CMS to communicate reporting requirements to our members. We also ask that CMS conduct more detailed analysis of visit reporting, including reporting at a service level.

*****

NANS appreciates the opportunity comment on the proposed rule and your attention to our concerns.

Sincerely,

B. Todd Sitzman, MD, MPH
President
North American Neuromodulation Society (NANS)

David Kloth, MD
Sr. Advisor, NANS Advocacy and Policy Committee

David Provenzano, MD
Co-Chair, NANS Advocacy and Policy Committee

Dawood Sayed, MD
NANS Representative, AMA CPT Committee

Appendix A

September 10, 2018

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

Seema Verma
Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1693-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program (CMS–1693–P)

Dear Administrator Verma:

The undersigned members of The Patient-Centered Evaluation and Management Services Coalition [hereinafter "the Coalition"] write to comment on the Centers for Medicare and Medicaid Services' ("CMS") proposed changes to Evaluation and Management ("E/M") documentation guidelines and payment policies as set forth in the above captioned proposed rule,[1] which is intended to update the Physician Fee Schedule ("PFS") for CY 2019. **The Coalition appreciates the intent behind CMS's proposals to reduce documentation burden and we strongly urge the agency to finalize several of its proposals to reduce that burden. However, we are very concerned about the payment proposals and strongly urge CMS to withdraw all of its payment proposals and work closely with the coalition and other stakeholders to consider whether there are alternatives that will improve upon the current structure.**

The Coalition strongly supports the "Patients Over Paperwork" initiative and we appreciate that CMS understands the administrative burden attributable to the current documentation guidelines for the new and established outpatient E/M service codes and applaud CMS for its desire to address these issues. However, the Coalition has significant concerns and believes that waiting at least one year to finalize any payment proposals (e.g., until 2020) will allow CMS to work with the undersigned and other stakeholders to create a coding structure that better meets the agency's goals of improving patient care and reducing burden but without the undesirable consequences described below. In other words, the coalition urges CMS to not finalize any of its E/M payment proposals, including the proposed modifier 25 reimbursement reduction policy and to withdraw any changes in outpatient visit coding or payment until a consensus on an equitable new coding structure is achieved.

We believe that a step-wise and open approach that includes a sophisticated data analysis and involves all stakeholders will help CMS achieve an E/M payment structure that allows accurate reporting of physician work and practice expenses for office visits. By accurately capturing the breadth and depth of current E/M work, we can assure appropriate payment is in accord with the current statute while minimizing unintended consequences.

[1] 83 FR 35704 (July 27, 2018) [Hereinafter, "Proposed Rule"]

To support this effort, the Coalition has engaged an independent consultant to perform additional data analysis of CMS's current proposal and to model alternatives. However, we believe that the limited duration of the comment period does not permit adequate analysis of CMS's proposals or possible alternatives in the context of this year's rule-making cycle and that finalizing these proposals for CY 2019 would be premature. While it is not possible to complete this analysis by the comment period deadline of September 10, 2018, we expect to be able to share our analysis and conclusions with CMS in time to inform discussion among stakeholders so the agency can develop refined proposals for the CY 2020 or 2021 rulemaking cycles.

Summary of Recommendations

Documentation: For CY 2019, the Coalition proposes that CMS finalize the following changes to documentation requirements while retaining the existing five level coding structure:

1. Allow physicians the option to document visits based solely on the level of medical decision-making or the face-to-face time of the visit as an alternative to the current guidelines.

2. If physicians choose to continue using the current guidelines, limit required documentation of the patient's history to the interval history since the previous visit (for established patients).

3. Eliminate the requirement for physicians to re-document information that has already been documented in the patient's record by practice staff or by the patient.

4. Eliminate the prohibition on billing same-day visits by practitioners of the same group and specialty.

5. Remove the need to justify providing a home visit instead of an office visit.

Payment: We request that CMS withdraw finalizing any of its proposals related to payment for outpatient/office visits (i.e., the proposed collapsing of 99202-99205 and 99212-99215, the proposed multiple procedure reduction, and the proposed G codes for primary care and specialty adjustments and prolonged services). Instead, we invite CMS to engage with stakeholders over the next year to develop a refined approach that will achieve CMS's goal of burden reduction while also ensuring the best possible outcome for patients. We believe that this collaborative effort will more effectively address the needs of the agency to have accurate pricing for the outpatient E/M services consistent with the Congressionally mandated "relativity" of service payment based on physician work, practice expense, and malpractice costs. The accurate pricing of outpatient E/M services is integral to all efforts at heath care payment reform, especially those arising from MACRA. In addition, implementation of any new coding structure requires substantial physician and office staff education and changes to our electronic health records systems, as well as changes in the procedures of Medicare contractors, commercial payers, and auditors. CMS must allow ample time for education and implementation.

The proposed changes in CMS' coding structure will not apply to E/M services other than outpatient visits and therefore will not necessarily be followed by commercial payers. With an eye to minimizing confusion, we urge that consideration be given to the role of the CPT editorial process in developing consistent codes for use by all payers.

Comments Related to E/M Documentation Reduction Proposals

In an effort to "simplify and change our documentation requirements to better align with the current practice of medicine and eliminate unnecessary aspects of the current documentation framework," CMS proposed to apply a minimum documentation standard under which practitioners would only need to meet documentation requirements currently associated with a level 2 visit for history, exam, and medical decision-making ("MDM"). CMS explains that it "believe[s] [the] proposed documentation changes for E/M visits are intrinsically related to our proposal to alter PFS payment for E/M visits . . ." For that reason, and because the current documentation guidelines have been in effect for so long, CMS suggests that it chose the rulemaking process to create new documentation standards, even though it has done so through sub-regulatory guidance in the past. Finalizing these proposals is consistent with the discussion of the documentation guidelines in the preamble of the proposed rule, where CMS stated, among other things, it would permit practitioners to document E/M services, regardless of the level of service provided based on the CPT code descriptors, by choosing to use either current documentation guidelines, documenting by time only, or documenting by medical decision-making only. We are convinced that this can be done without collapsing the code levels. Since each code descriptor contains an estimated visit time (which is advisory unless more than 50% of the visit is for counseling and coordination of care) and a level of medical decision-making, physicians are already very familiar with how to use time and decision-making to support a level of service. Finalizing these proposals would not require extensive re-education.

In this connection we note that private payers have their own documentation requirements and allowing a specified interval for new code development and vetting would amplify the agency's commitment to burden reduction. If implemented as proposed, physicians will need to juggle between different documentation requirements based on site of service and payer policy. The development interval will also allow electronic health record ("EHR") systems to be updated in an incremental manner. We are very concerned that if CMS finalizes its payment proposal to collapse code levels and establish complexity adjusters, documentation workflows will not mirror the new CMS requirements, commercial insurers will continue existing requirements, meaning practitioners will be relegated to documenting E/M services as they always have because creating two entirely different documentation systems for patients with different insurance is not feasible. Furthermore, the proposed primary care and complexity adjusters are inherently vague and will likely require their own, entirely new documentation guidelines (if so, these must be carefully developed to avoid adding unnecessarily to the burden on providers).

More significantly, although CMS has acknowledged that Recovery Audit Contractors ("RACs") and the Office of Inspector General ("OIG"), which conduct pre- and post-payment documentation audits, will need to be trained on the new proposed documentation guidelines, the Coalition has significant concerns that fear of over-zealous audits could affect whether and how physicians use these (i.e., physicians may not use the complexity adjuster codes or the prolonged service codes due to potential audits and overpayment demands).

Lastly, we wish to note that there are many other important reasons why all visits need to be appropriately documented. These include: (1) providing sufficient information for other healthcare

professionals to care for patients. The amount of documentation required for this purpose will vary based on the acuity and complexity of the patient's medical condition(s), and (2) the need to document in accordance with the standards required for professional liability considerations. CMS's proposals address Medicare's documentation requirements related to claim audits, which are only one reason that documentation is necessary.

Once a consensus new coding structure is in place, additional reduction in E/M documentation burden, consistent with a new simplified coding structure, as well as education of physicians and other qualified health practitioners on the new codes and documentation requirements can be initiated and can be made consistent across all stakeholders.

Comments Related to the Single Payment Level and Adjuster Proposals

We applaud the leadership role CMS has taken in suggesting simplification of the coding structure for office visits. However, we believe the proposed collapsing of levels 2-5 for new and established patient visits along with the proposed multiple procedure reduction, the savings from which would fund two codes for complexity adjustments, could have extremely negative effects on patient care. For the reasons described below, we recommend that CMS not finalize any of these proposals and instead work with us and other stakeholders to come up with a better solution – one that achieves the goals of coding and documentation simplification but does not negatively impact patient care.

CMS proposes a single payment amount for established patients that is a little more than the current payment amount for 99213 and a single payment amount for new patients that is a little more than the current payment amount for 99203. The single level payment amounts were determined by (1) weight averaging the work RVUs based on specialty utilization for levels 2-5 and (2) establishing a new E/M practice expense pool. As expected, this proposal resulted in an extremely negative impact on specialties that predominantly bill level 4 and 5 services and an extremely positive impact on specialties that bill mostly level 2 and 3 services. CMS attempted to mitigate these impacts by creating complexity adjuster codes for primary care and selected specialty care. These payment amounts are $5 and $13.70 respectively and, when billed with the new single payment level, would still pay significantly less than the current payments for 99214 and 99204.

Unfortunately, because the original single payment level proposal was budget neutral to existing payments, CMS had to fund the complexity adjustors in order to not add additional cost to the system. CMS found this money by proposing a reduction to encounters when a procedure is performed on the same day as an E/M visit. (E/M visit codes are only billable on the same day as procedure codes when the billing professional indicates that the visit is separately identifiable from the procedure in which case the visit is paid at the full amount. To indicate that the visit is separately identifiable from the procedure the line item for the E/M is appended with modifier 25.)

CMS proposes to reduce payment for the least expensive service performed during the encounter (the procedure or the E/M visit) by 50% even though a physician uses modifier 25 to identify a visit as separately identifiable from the procedure. Importantly, CMS does not propose to limit the reduction to only those procedures with a 0-day global; as we understand it, the reduction would be tied to all 0, 10, and 90 day global codes. CMS indicates that this proposed modifier 25 reimbursement reduction policy is an extension of the Multiple Procedure Payment Reduction (MPPR). The MPPR is a reduction in

reimbursement by 50% for each additional procedure when multiple procedures occur during the same encounter. The existing MPPR policy recognizes the efficiencies gained when two or more procedures are performed during the same encounter (e.g., there is overlap in the physician work for the procedures). However, the proposed modifier 25 reimbursement reduction policy is unlike the MPPR because the medical community and CMS have worked for several years to remove any overlap in the physician work and practice expense for procedures commonly performed during the same encounter as an office visit. Therefore, the proposal would result in an excessive, unjustified reduction in reimbursement because the overlap in physician work and practice expense has already been accounted for in the valuation of these services.

CMS also created a new set of specialty specific codes for podiatrists explaining that the new "consolidated E/M structure" does not accurately represent podiatric E/M visits. The Coalition believes this is a back-end fix to the problem of winners and losers resulting from the proposal to collapse E/M services. In this regard we note that CMS's own impacts showed a positive 12% impact on podiatry based on the code consolidation proposal which became a -4% impact after creation of the new podiatry G codes.

Lastly, CMS, realizing that it was paying the same amount for a 40 minute visit as for a 10 minute visit, proposed to establish a new prolonged services code that could be reported in addition to the underlying visit code if the visit lasted 15 minutes beyond the typical time for the visit. We believe the CMS proposal on the new prolonged services code is very unclear and more information is needed on how the prolonged service code will be used with other codes. We are also concerned that as proposed, the new code may be subject to a lot of miscoding. This is an area that needs further work.

Discussion of Policy and Legal Issues

The Coalition believes CMS should withdraw its payment proposals relating to outpatient E/M service coding and payment for the following reasons:

Patient Care Concerns

- The significant reduction in payment expected for providers of the frail elderly and patients with complex chemotherapies or several concurrent chronic complex and chronic conditions could result in practitioners providing shorter, more frequent visits for these patients resulting in additional coinsurance amounts for the additional visits and additional patient inconvenience. It is not clear that CMS has anticipated this result in this context, but this type of response is well described in documentation prepared by CMS' Office of the Actuary.[2] The single payment rate could create patient access issues because it will incentivize physicians to avoid treating the sickest patients who require additional time and resources that will no longer be recognized by Medicare.

- CMS's proposal will create an incentive for hospitals and health systems employing physicians to reduce the scheduled time for all visits to 5-10 minutes and to instruct practitioners to address

[2] See, https://www.cms.gov/Research-Statistics-Data-and Systems/Research/ActuarialStudies/downloads/PhysicianResponse.pdf

only one medical problem per visit. Physician practice can be heavily influenced by enterprise financial need. Such a pattern would reduce the quality of care, especially for patients with multiple illnesses or those with age-related issues such as dementia. In addition, shorter visits are antithetical to the generally accepted notion that spending more time with patients improves quality of care and helps foster shared decision-making and doctor patient relationships.

- Establishing a single payment irrespective of the code being reported (i.e., the existing outpatient visit codes describe different levels of physician work) will likely result in a disconnect for physician practices where compensation is based on physician work RVUs and it is assumed that payments correlate with work. In other words, because a single payment irrespective of visit length means that high volume providers will generate more income than lower volume providers, practices will need to determine how to value providers whose patient mix allows them to reduce time per visit on the one hand and, on the other hand, providers whose patient mix will not allow them to do that. One unintended consequence could be that providers and medical centers may not be financially able to care for older patients with multiple chronic conditions who require highly intensive team oriented care. It may also discourage physicians in training from entering specialties with older and/or highly complex patients.

- The flat rate will produce beneficiary cost sharing that is the same regardless of the length or content of the visit.

Analytic Concerns and Unintended Consequences

- CMS proposes a poorly explained change in the calculation of practice expense RVUs that will have a significant impact on codes with high practice expense, such as those for oncology. To determine the practice expense RVUs, CMS calculates an indirect practice expense index (IPCI) for most specialties and uses the IPCI to adjust the practice expense costs for a service based on the specialties that perform the service. A percentage reduction in the service-level IPCI for a CPT code would result in the same percentage reduction in the indirect practice expense component of Medicare payment, all else held equal (i.e., a -25% reduction in service-level IPCI would result in a -25% reduction in indirect practice expense payment).

  CMS's proposal to collapse payment for office visits included creating a new IPCI solely for office visits, overriding the current methodology for these services by treating Office E/M as a separate Medicare Designated Specialty. This change also excludes the indirect practice costs for office visits from the derivation of all the other specialty IPCIs. CMS justifies this proposal because in the absence of this adjustment, "establishing a single PFS rate for new and established patient E/M levels 2 through 5 would have a large and unintended effect on many specialties." Significant swings of more than 10% in the IPCI occurred for roughly a quarter of all physician specialties, a result CMS does not explain in the preamble.

  The proposed methodology change would also result in large swings in payment for many services predominantly performed by those specialties. There are 1,100 CPT codes that are proposed to experience a non-facility practice expense payment reduction, which cannot be explained by any other factor other than the change in their service level IPCI predominantly due to the E/M payment collapse. The RUC estimates that the change in the specialty-level IPCI

will result in a redistribution of almost $1 billion between Medicare specialties. For example, the payment rates for chemotherapy administration codes would be reduced by well over 10% solely because the practice expense RVUs for E/M were removed from all specialty pools to create the new E/M pool.

CMS did not isolate the impact of the E/M payment collapse on indirect practice expense for other services in the CY 2019 Proposed Rule and the impact analyses presented do not appear to account for these large changes. Therefore, most stakeholders may not even be aware of the impact of the IPCI policy change and have not been provided with an opportunity to comment. With the additional impact on the indirect practice expense for all services, it is unclear whether the proposed E/M payment collapse and E/M MPPR are even budget neutral.

The Coalition believes the development of an E/M IPCI distorts the relativity of Medicare physician payments. We strongly recommend that this proposal should not be implemented and believe that the need for this methodological change undermines all of CMS's payment proposals. The unintentional consequences of this policy alone are sufficient to demonstrate that all of CMS's payment proposals should be withdrawn.

- In determining how the proposals will impact clinician payment, the Coalition believes that CMS is placing too great reliance on the use of the proposed prolonged services code (GPRO1) to mitigate the financial impact of the single payment proposal. It is unlikely any individual physician will be able to use GPRO1 more than once or twice a day. Patients are seen based on an overall office schedule that does not include prolonged visits – prolonged visits are unexpected; if physicians have a prolonged visit with one patient, other patients are kept waiting. Prolonged visits will only occur when it is completely unavoidable. While GPRO1 might allow practitioners to report occasional outliers with very long visits, it does not address the distribution of usual patients, which includes patients that require longer (e.g., 40-45 minutes) base visits because of the complexity of their condition. The Coalition also notes that discussion of GPRO1 omits any explanation of how it would be billed in conjunction with the single level payment and that CMS offered no projections on utilization and did not include it in the impact analysis, but CMS did use it in its "examples" of what "typical" payment would look like if the payment proposals were finalized. The Coalition finds the "examples" to be extremely optimistic as they make it appear that an outlier case (i.e., use of GPRO1) that would be used perhaps once a day, is really the "typical" case.

- The Coalition has been unable to recreate the analytic methodology CMS applied in determining the proposed RVUs for 2019. In this rule, CMS appears to have deviated significantly from the standard methodology it uses to incorporate the most recent available claims data into the practice expense RVU calculation. Since 2007, CMS has provided a detailed step-by-step description of exactly how the practice expense RVUs are calculated and has posted on the CMS website the data files needed to replicate the RVUs by following that methodology. In the proposed rule, CMS provides the same description of the methodology used in previous years and does not explain the substantial adjustments required to implement the proposed E/M policy changes. CMS appears to have made assumptions about utilization of outpatient E/M services under the proposed documentation and payment policies, including utilization by specialty of the proposed adjusters and other G codes, without acknowledging or describing

those assumptions in any way. Nor does CMS describe the assumptions used to create the new "EM" specialty added to the practice expense per hour file nor the impact that the creation of the "EM" specialty has on the practice expense pool. The sum effect of these assumptions can been seen in the data files released with the rule but the origin of and logic behind the assumptions is wholly unclear and it is not possible to isolate the impact of individual elements of the proposal on the RVU calculations or on payments for E/M services for different specialties In addition, as a result of these apparent methodology changes, the IPCI calculated for many specialties is significantly different than the IPCIs used in previous years, as noted above. The change in the IPCIs means that the assumptions related to the outpatient E/M services also affect the practice expense RVU calculation for all other codes under the PFS. There was no discussion in the rule about the IPCI changes or the impact these changes would have on the PFS payment rates.

Because of the lack of transparency about the assumptions and changes in methodology required to implement the proposed payment policies and the scope of the impact that those changes have on RVU calculation for outpatient E/M visits and other services, the Coalition believes that CMS must withdraw those proposals. CMS should also release additional information describing the process and assumptions it used in each step of the rate-setting methodology, as it typically provides, to allow stakeholders to effectively analyze the proposals.

Legal Concerns

- As presented in the proposed rule, it appears the primary care adjuster, the specialty care adjuster, and the podiatry codes violate the legal prohibition on creating specialty specific payment rates. The statute states that "the Secretary may not vary the conversion factor or the number of relative value units for a physicians' service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician."[3] CMS has previously interpreted this language to require the same payment regardless of specialty, stating that it "prohibits the Secretary from making differential payments by physician specialty for the same service."[4] The descriptors for those proposed codes state which specialties are allowed to report the code and would vary the PFS payment rate for the E/M visit based on the type of specialty of the physician.

- The single payment proposal for all established and new patient visits and the payment proposal for the primary care and specialty specific adjuster appear to violate the statutorily mandated requirement that the PFS be based on the relative resources required to furnish a service. The statute requires that for each physician service, the Secretary determine work RVUs based on the "relative resources incorporating physician time and intensity required in furnishing the service"[5] and practice expense RVUs "based on the relative practice expense resources involved in furnishing the service or group of services."[6] Creating a payment rate based on the weighted averaged utilization of a code set eliminates the connection between the resources needed to provide outpatient E/M services relative to those needed to furnish other physician services.

[3] SSA § 1848(c)(6).
[4] 58 Fed. Reg. 63856, 63861 (Dec. 2, 1993)
[5] SSA §1848(c)(2)(C)(i).
[6] SSA §1848(c)(2)(C)(ii)

Because outpatient E/M service comprise such a significant share of physician services, severing the mandated connection to relative resource use for those services undermines the integrity of the entire fee schedule.

- The relativity of the PFS is further weakened by the proposal to establish the primary care and specialty care adjusters based on money from the multiple procedure reduction. The proposed RVUs for the adjusters are not derived from the resources needed to provide specific E/M services but are simply a means of redistributing money to certain specialties.

- The single payment rate for established and new patient office visits results in a payment reduction for level 5 services (99205 and 99215) that is well over 20% and the law prohibits HHS from reducing the payment rate for an existing code by more than 20% in a single year.[7]

Coding and Valuation Concerns

- The proposed multiple procedure reduction is not resource based and not justified. As noted above, the RUC has worked closely with CMS to remove any overlap in physician work, clinical staff time, supplies, and equipment between office procedures and visits. If finalized, this proposal will create an incentive for physicians to perform procedures on days when there is no visit being billed, with resulting inconvenience for patients.

- The Coalition strongly opposes the proposed primary care and complexity adjuster codes for several reasons. The definitions appear arbitrary and are not reasonable from a clinical perspective; the proposed payments for the complexity adjuster codes are far too low to be meaningful and they are not resource based because CMS has designed them to be budget neutral with respect to the savings generated from the multiple procedure reduction proposal.

- CMS does not explain how it determined that 1.75 minutes and 0.07 work RVUs accounts for the "extra" time and effort required to provide GPC1X and why it determined that the adjuster should not be applied to new patient visits. The Coalition believes that the proposal vastly underestimates the actual time and effort required to deliver primary care services and does not understand why it should not be applied to new patient visits where the time and intensity of a primary care visit is even higher.

- The specialty adjuster GCG0X is not clinically reasonable (e.g., there is no basis for excluding psychiatry, infectious disease or nephrology as those patients are just as complex as rheumatologic or urologic patients); use of this code should not be guided by a physician's specialty designation but rather the level of work performed.

- CMS provides no explanation as to how it concluded that GCG0X should be valued at 75% of the psychiatric interactive complexity code (90785). Further, reliance on 90785 appears misplaced because 90785 can only be added on to specific psychiatric services, primarily psychotherapies. E/M services are specifically excluded as the primary service to which 90785 is added. Therefore 90785 describes a completely different type of complexity and psychiatrists should be able to

[7] SSA §1848(c)(7).

report GCG0X. Further, the Coalition opposes the proposal that would prohibit psychiatry from using GCG0X appended to E/M services delivered in the care of complex psychiatric patients.

- The Coalition believes it would not be appropriate to limit use of GCG0X to "stand-alone" E/M services. Why are E/M services provided on the same date as procedures any less complex than those provided on dates without procedures? CMS offers no explanation for this, but the proposal would result in additional incentives to request patients return on a different date for minor procedures.

- The descriptors proposed for GPC1X and GCG0X are inherently vague. They will necessitate the creation of new documentation guidelines that could undermine this proposals attempt to simplify documentation, and will require extensive education to providers and auditors to assure compliance. We are concerned that the documentation requirements that will be required to assure appropriate reporting of these codes (and the proposed prolonged services code) could actually be more onerous than the current requirements. This concern has been amplified because even though the proposed rule indicates these codes are specialty specific, in meetings CMS has stated that they are not specialty specific and can be billed when any of the "topics" included in the codes are addressed during the visit. Unfortunately, this makes the codes even more problematic. For example, this suggestion could be interpreted as meaning that GCG0X could be reported for any visit in which a patient complains of chest pain or nerve pain. Similarly, GCG0X could be reported if the primary care doctor rewrites a prescription during the office visit for gabapentin, a drug initially prescribed by a neurologist for diabetic neuropathy, or GPCIX could be reported if a provider inquires about a screening mammogram.

The Coalition's Concerns About the Payment Impacts of CMS' Proposal

As we discussed above, the Coalition believes strongly that additional modeling is needed to obtain more accurate estimates of the true payment impacts of the proposals on clinicians because there is a discrepancy between the payment analysis performed by the American Medical Association (AMA) and the impacts that CMS published in the proposed rule. CMS looks at the impact on specialties at a high level, without evaluating the impact on subspecialties or types of physicians that may be more significantly affected by the proposal, such as physicians who see patients in office settings (rather than in facilities) or physicians who practice in academic medical centers and who may specialize in particularly complex cases. The Coalition finds the AMA analysis to be much more useful because it isolates the effects of the E/M proposals, including the effect of the 50% multiple procedure reduction. The AMA analysis shows that there are over 20 specialties that will face unsustainable decreases in payment, including specialties such as geriatrics whose practices are limited to the Medicare population.

In summary, even with the primary care and complexity adjusters, the total payment will still fall well short of the current payment for levels 4 and 5, which are the services billed for visits involving high complexity care and medical decision-making and which are typically needed to treat sicker and the most complicated Medicare beneficiaries.

For all of these reasons, the Coalition strongly opposes CMS's proposals regarding single payment for E/M levels 2 through 5 and the primary care and complexity adjusters, and prolonged services add-on code.

The Coalition's Vision for a Pathway Forward

We propose that CMS collaborate with all stakeholders and as a coalition we will fully engage and support this effort. We believe that the definition, valuation and documentation expectations of the MPFS should be as accurate as possible and reflect the breadth and depth of the services provided across the full range of physician specialties. CMS has powerfully identified longstanding issues with the current coding documentation expectations, now over two decades old. Clearly, updating is an appropriately essential activity, especially as we embark on new and more value focused payment models. We believe that there is a range of changes that must be considered, thoughtfully analyzed and modeled as part of the process of determining whether any are feasible and achieve dependability for the pricing of E/M services in the MPFS.

The Coalition will consider a number of coding options as alternatives to the CMS proposal. Our process will include data and impact analysis and be driven by consensus of all those involved. To the extent possible we will coordinate our efforts with the AMA CPT/RUC workgroup and we intend to meet with CMS to discuss our findings and recommendations. We acknowledge that any options with more levels of service than the CMS proposal, including maintaining the current code set, will need to be accompanied by clear descriptors and/or criteria to use when selecting each code level. Finally, should none of these options be superior to the current system, we would recommend focusing on documentation that does not require coding or payment changes.

Recommendations

We strongly urge CMS to take action on the following:

Finalize several of its proposals to reduce documentation burden for CY 2019 including:

1. Allow physicians the option to document visits based solely on the level of medical decision-making or the face-to-face time of the visit as an alternative to the current guidelines.

2. If physicians choose to continue using the current guidelines, limit required documentation of the patient's history to the interval history since the previous visit (for established patients).

3. Eliminate the requirement for physicians to re-document information that has already been documented in the patient's record by practice staff or by the patient.

4. Eliminate the prohibition on billing same-day visits by practitioners of the same group and specialty.

5. Remove the need to justify providing a home visit instead of an office visit.

Withdraw all of its payment proposals and work closely with the coalition and stakeholders over the next year to develop a refined approach that will achieve CMS's goal of burden reduction while also ensuring the best possible outcome for patients.

* * *

The Patient-Centered Evaluation and Management Services Coalition is a coalition of medical societies across a range of specialties formed in response to the CMS proposal to revise the Evaluation and Management documentation guidelines and payment policies as outlined in the CY 2019 Medicare Physician Fee Schedule Proposed Rule.

We greatly appreciate your attention to our concerns. For additional information or if you have questions, please contact Dr. Paul Rudolf by emailing Paul.Rudolf@arnoldporter.com or by calling 202-942-6426.

Sincerely,

Supporting Organizations within The Patient-Centered Evaluation and Management Services Coalition

American Geriatrics Society
AMDA - The Society for Post-Acute and Long-Term Care Medicine
American Academy of Allergy, Asthma & Immunology
American Academy of Child and Adolescent Psychiatry
American Academy of Dermatology Association
American Academy of Home Care Medicine
American Academy of Hospice and Palliative Medicine
American Academy of Neurology
American Academy of Otolaryngic Allergy
American Academy of Ophthalmology
American Association for Geriatric Psychiatry
American Association for the Study of Liver Diseases
American Association for Thoracic Surgery
American Association of Clinical Endocrinologists
American Association of Neurological Surgeons
American College of Cardiology
American College of Chest Physicians
American College of Physicians
American College of Rheumatology
American Gastroenterological Association
American Osteopathic Association
American Podiatric Medical Association
American Psychiatric Association
American Society for Blood and Marrow Transplantation
American Society for Clinical Pathology
American Society of Addiction Medicine
American Society of Hematology
American Society of Nephrology
American Society of Pediatric Nephrology
American Thoracic Society
American Urological Association

College of American Pathologists
Congress of Neurological Surgeons
Digestive Health Physicians Association
Heart Rhythm Society
Infectious Diseases Society of America
North American Neuromodulation Society
Renal Physicians Association
Society of General Internal Medicine
The Endocrine Society
The Society of Thoracic Surgeons