

September 10, 2018

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1693-P
P.O. Box 8016,
Baltimore, MD 21244-8016

RE: [CMS-1693-P] RIN 0938-AT31 --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

Submitted electronically via www.regulations.gov

Administrator Verma:

The Heart Failure Society of America (HFSA) is pleased to have the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) Proposed Rule: ***CMS-1693-P --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.*** HFSA represents the first organized forum for all those interested in heart function, heart failure, and congestive heart failure research and patient care.

Practice Expense for Heart Failure and Transplant Specialty

In this proposed rule, CMS outlines an approach to incorporate the new Advanced Heart Failure and Transplant Cardiology specialty into the calculation of Medicare's practice expense relative value units (PE RVUs). This specialty code took effect October 1, 2017.

CMS proposes to crosswalk the cardiology Physician Practice Information Survey (PPIS) practice expense data to the newly designated Heart Failure and Transplant specialty:

- Cardiology direct practice expense per hour \$47.52 (35%)
- Cardiology indirect practice expense per hour \$88.04 (65%)



HFSA notes that CMS also crosswalks interventional cardiology and electrophysiology to the cardiology data. We support CMS' proposal to crosswalk the Advanced Heart Failure and Transplant specialty to the cardiology PPIS data.

Revision of Evaluation and Management (E/M) Services – Payment Structure and Documentation Requirements

Payment Structure

CMS proposes a new payment structure for E/M services. Specifically, CMS proposes that new patient office visits (CPT 99202-99205) would be subject to a single blended payment rate of \$135.00. Established patient office visits (CPT 99212-99215) would be blended and paid at \$93.00. This proposal places the value of work RVUs at 1.69 for new patient office visits and 1.25 for established patient visits, equivalent to a complexity between existing Level 3 and 4.

HFSA has serious concerns about the impact of this proposal on both patients and providers. We urge CMS to halt this proposal. We are very concerned that proposed E/M revisions would impede the provision of care for chronically ill patients, such as heart failure patients, who typically require a substantial amount of time per visit. The delivery of care may be compromised as physicians will have a disincentive to take the required amount of time for patients who require Level 4 and 5 visits. This likely means there will be care interruptions and/or problems in accessing a provider for patients with complex care needs. A potential unintended consequence of this proposal is that physicians will likely have to schedule patients for short visits, thereby requiring repeat visits for patients. This will result not only in a financial hardship for patients, through added copays, but will also impose a significant burden on severely ill patients who often struggle to get to medical appointments. There is the potential for access to care to become an overwhelming burden for patients who may require multiple visits. We urge CMS to take into account the views of Medicare beneficiaries who will be most affected by this proposal.

From a provider perspective, we appreciate the CMS modeling of potential impacts to reimbursement for cardiology services as a result of the proposed E/M restructuring. Under the CMS modeling, CMS suggests a minimal change to overall payment to cardiology services. However, we note that an aggregate analysis is not reflective of the impact on an individual practice, especially when a practice treats a significant number of Medicare beneficiaries with complex and often co-morbid conditions. The impact on providers will inevitably vary by patient mix and services provided.

HFSA notes that CMS has proposed new add on codes for primary care and the provision of specialty care to complex patients. These are:

- GPC1X for primary care services, can also be reported for other forms of face-to-face care management, counseling, or treatment of acute or chronic conditions not accounted for by other coding. This G-code would account for the inherent resource costs associated with furnishing primary care E/M services, CMS

- anticipates that it would be billed with every primary care-focused E/M visit for an established patient. Proposed RVU value 0.11 - \$3.97
- A new HCPCS code GCG0X (Visit complexity inherent to evaluation and management associated with endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, cardiology, or interventional pain management-centered care (Add-on code, list separately in addition to an evaluation and management visit)). Given the billing patterns of the specialties included in the G code language, CMS believes that they apply predominantly non-procedural approaches to complex conditions that are intrinsically diffuse to multi-organ or neurologic diseases. Proposed RVU – 0.38 - \$13.70
 - HCPCS code GPRO1 is the 30-minute prolonged services add on code as time is often an important determining factor in the level of care. This is in response to stakeholder feedback that the “first hour” time threshold in the descriptor for CPT code 99354 is difficult to meet and is an impediment to billing these codes. Proposed RVU 1.87 - \$67.41

While we appreciate CMS’ recognition that distribution of E/M visits is not uniform across medical specialties, we remain concerned that even with the proposed new add-on codes for primary care and complex patients, the total payment will still fall well short of the current payment for Levels 4 and 5 for patients with complex medical problems and/or multiple comorbidities.

Further, CMS has not set forth detailed requirements for the use of these codes and the documentation required, thereby elevating the risk of an audit for a provider who attempts to include these new codes on a claim. We have also heard anecdotal comments from CMS officials regarding the intended use of these codes, and whether combining the use of these codes for one patient visit is an acceptable practice. Additional guidance would be necessary for providers to better understand and make use of the proposed new add on codes.

HFSA also is concerned about the CMS proposal to apply a multiple procedure payment reduction (MPPR) when a physician (or a physician in the same group practice) reports an E/M service and a procedure on the same date, applicable to the lower paid of the two services. This proposal unfairly removes value from services that do not overlap with E/M services. The American Medical Association (AMA) Specialty Society Relative Value Scale (RVS) Update Committee (RUC) has done extensive work with CMS to remove overlapping physician work and practice expense (e.g., clinical staff time, supplies, and equipment) when E/M services are typically performed on the same date of service as a procedure. In addition, this proposed reduction would apply to separately identifiable E/M visits reported with modifier -25. This is also inappropriate as, in these cases, the E/M visit is unrelated to the procedure performed. This proposal also has the potential to place a burden on patients who may be forced to return for separate appointments to obtain needed care.

Documentation

We thank CMS for its expressed intent to reduce administrative burdens for providers. In this proposal, CMS proposes to ease the burden of documentation by allowing various documentation options. Instead of applying 1995 or 1997 E/M documentation guidelines, CMS' proposed changes include:

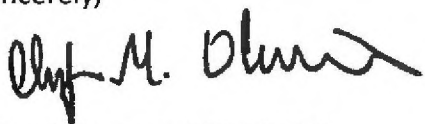
- allowing practitioners to use time as the governing factor in selecting visit level and documenting the E/M visit, regardless of whether counseling or care coordination dominate the visit;
- allowing practitioners to focus their documentation on what has changed since the last visit or on pertinent items that have not changed, rather than re-documenting information, provided they review and update the previous information
- allowing practitioners to simply review and verify certain information in the medical record that is entered by ancillary staff or the beneficiary, rather than re-entering it.

While we believe this was intended as a step in the right direction, we are concerned that this proposal will, in reality, increase administrative burdens on physicians. If Medicare has one set of guidelines and Medicare Advantage or commercial payers have a different set, there will not be an alleviation of burden. This will mean providers will continue to count time and document the level of the E/M service instead of finding relief in proposed documentation changes. We would welcome the opportunity to work with CMS and other stakeholders to identify administrative solutions that would constitute real regulatory relief.

In summary, we urge CMS to halt implementation of this E/M restructuring proposal until the House of Medicine has an opportunity to fully analyze how this proposal would impact the delivery of care to Medicare beneficiaries, many of whom are chronically ill. This analysis cannot be adequately done within the confines of this 60-day public comment period. Furthermore, allowing the meaningful engagement of multiple stakeholders from the House of Medicine will create the opportunity to develop an alternative coding and payment structure to appropriately reflect the complex care needs of chronically ill patients. As you are aware, the AMA has an active working group to develop a proposal for a revised E/M services structure. We hope that CMS will take into account this important work and not implement any changes until the results of this effort can be considered.

Thank you for your consideration of these views.

Sincerely,



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Joseph A. Hill, MD, PhD
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