

March 16, 2015

Mr. Sean Cavanaugh
Deputy Administrator and Director
Center for Medicare
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Proposal to redefine and revalue outpatient Evaluation and Management (E&M) service codes

Dear Mr. Cavanaugh:

The undersigned specialty societies request that the Centers for Medicare and Medicaid Services (CMS) engage in a process to create additional outpatient evaluation and management (E&M) codes. We believe that the existing office codes (CPT 99201-5 and 9921-5) no longer accurately or adequately reflect the work currently provided to and required by Medicare beneficiaries.

CMS has initiated a series of payment reforms designed to improve quality and care coordination. These innovations include models being tested by the Innovation Center, including the Comprehensive Primary Care Initiative and Accountable Care Organizations (ACOs), as well as the value-based modifier, the Electronic Health Record Incentive Program, the Physician Quality Reporting System (PQRS), and other programs. CMS has also implemented the Transitional Care Management (TCM) and Chronic Care Management (CCM) service codes to address specific beneficiary needs. However, these new programs and service codes do not eliminate fee-for-service or address the legacy outpatient E&M service code deficiencies. In all cases, the current outpatient E&M service codes remain as fundamental building blocks. E&M valuations are employed within ACO compensation models. The newly implemented service codes have been added to existing E&M codes in order to cover physician work that heretofore has not been covered but do not address the valuation deficiencies of the core outpatient E&M service codes that are fundamental to healthcare delivery.

Over the last twenty-five years, the management expectations for optimal chronic illness care have caused a paradigm shift for Medicare beneficiaries. New and complicated diagnostic and treatment algorithms have emerged for the deep understanding of complex presenting symptoms and disease states as well as the early identification and prevention of disease complications. There has been an explosion in treatment options with increasingly complicated interactions. Our specialties regularly treat patients with multiple coexisting chronic conditions, often utilizing multiple medications for effective care. Physicians spend less of their time treating acute illnesses and more of their time, appropriately, trying to ensure optimal outcomes efficiently. This work involves brief, focused physical exams, the determination of patient goals, medication reconciliation, the assessment and integration of hundreds of data points, the effective coordination of multiple consultants, collaboration with team members, continuous development and modification of care plans, patient or caregiver education, and

constant communication. A byproduct of this transformation in care is that the CPT codes for outpatient E&M services no longer describe the work performed by physicians and their clinical staff.

We believe the following criteria for requesting the reevaluation of service codes, having been met (Fed Reg, 2014:40336), necessitate the addition of new codes:

1. Documentation in the peer reviewed medical literature or other reliable data that there have been changes in physician work due to one or more of the following: technique, knowledge and technology, patient population, site of service, length of hospital stay and work time.
3. Evidence that technology has changed physician work.
5. Evidence that incorrect assumptions were made in the previous evaluation of the service such as a misleading vignette, survey or flawed work assumptions.
7. Analysis of work time, work RVU or direct PE input using other data sources.

We are prepared to provide detailed evidence to support our assertion that the above criteria have been met and that new service codes are needed.

We believe that new codes must be developed from a knowledge-base that reflects the current levels of outpatient E&M physician work based on nationally representative samples and electronically accessible data. Codes must define clear, discrete and graded increments of physician work intensity. New codes should also include documentation expectations that focus on medical decision making. Attached are goals and principles our societies agree are important to guide this work.

We understand that this project will require a significant commitment of time and resources. Our societies are willing and prepared to provide as much assistance as possible. To do this work, we ask that CMS commit to hiring a contractor to work with stakeholders to develop a comprehensive understanding of what physicians and their clinical staff do on a daily basis. This research would 1) describe in detail the full range of intensity for outpatient E&M services, 2) define discrete levels of service intensity based on this observational and electronically stored data combined with expert opinion, 3) develop documentation expectations for each service level that place a premium on the assessment of data and resulting medical decision making, 4) provide efficient and meaningful guidance for documentation and auditing, and 5) ensure accurate relative valuation as part of the Physician Fee Schedule. We hope this work would be completed in time for these services to be proposed and valued for inclusion in the CY 2018 Physician Fee Schedule.

Our proposed timetable for this work would be:

- July through November, 2015: convening a series of conference calls and face-to-face meetings to define the research plan. Participants would include a CMS funded contractor, CMS Medical Officers and administrators, and physician representation from interested specialty societies;
- December, 2015 through October, 2016: collect survey, observational, and other data;
- November, 2016-February, 2017: analyze results and prepare a summary document with recommendations to CMS by March 1, for consideration in the spring 2017 Notice of Proposed Rule Making;

- November 1, 2017: publication of final G codes for incorporation in the 2018 Medicare Physician Fee Schedule and for submission of Code Change Proposals to the AMA CPT Editorial Panel, to convert the G codes to Category I CPT codes.

We look forward to discussing the proposal outlined in this letter with you in more detail. We believe this is the beginning of a productive conversation that will ultimately improve the quality of care being provided to Medicare patients. If you have any questions, please do not hesitate to contact Erika Miller at emiller@dc-crd.com or (202) 484-1100.

Sincerely,

American Academy of Allergy, Asthma and Immunology
American Academy of Family Physicians
American Academy of Neurology
American College of Allergy, Asthma and Immunology
American College of Rheumatology
American Society of Hematology
American Psychiatric Association
Endocrine Society
Joint Council of Allergy Asthma and Immunology on behalf of the Advocacy Council of the ACAAI
Society of General Internal Medicine

cc: Andy Slavitt, Acting Administrator

Goals and principles for the development and valuation of outpatient New and Established Patient Evaluation and Management (E&M) Codes

1. The professional community represented by the societies of this coalition will support the work of CMS and any research contractor. Members from the specialty societies will be available for technical advisory panels as needed.
2. The outpatient E&M codes for new and established patients need to be revised because the current code choices do not adequately capture the range in physician work as it has evolved over the 25 years since RBRVS was implemented. Furthermore, physician work for a post-operative follow-up visit during a global period fundamentally differs from physician work for a cognitive E&M service.
3. The development of new codes must be derived from a knowledge-base that reflects the current levels of E&M physician work based on nationally representative samples and electronically accessible data.
4. New or revised E&M codes must be defined to reflect clear, discrete, and graded increments of physician work intensity.
5. The pre and post visit work of each code must reflect the complexity and interactions of the inputs to the visit and the complexities, interactions and implications of that follow from the visit.
6. There will be only one set of E&M codes for all physicians and other qualified health professionals.
7. While there will not be any practice capability expectations for reporting the revised or new E&M codes, new HCPCS codes or modifiers may be necessary to describe additional practice expenses or other costs associated with certain clinical situations (e.g., the need to report the additional clinical staff time required for patients who cannot gown themselves or be left alone in the exam room) or services (e.g., post-operative visits during the global period requiring special supplies or equipment).
8. The practice expense and professional liability costs will be developed based on specialty specific data.
9. New documentation expectations will be developed focusing on medical decision making (MDM). This will take into account the inputs reviewed, the complexity density of the interactions among inputs, the knowledge and expertise required to maintain the required professional skill set required, the outputs, and the implications of the outputs.

10. Documentation expectations will be based on the ability of EHRs to record and verify that data has been reviewed. Data will not need to be copied into a note except when the physician determines that it is clinically appropriate.
11. At the appropriate time (e.g., when it appears that CMS is willing to adopt the new and/or revised codes) it is the intent of the coalition to submit a coding change proposal for the new and/or revised codes to the CPT Editorial Panel for consideration.