September 11, 2017

Submitted Electronically at
www.regulations.gov

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

Re: Comments on Medicare Program 2018 Physician Fee Schedule Proposed Rule (CMS 1676-P)

Dear Administrator Verma:

The American College of Allergy, Asthma and Immunology (ACAAI) and its Advocacy Council appreciate this opportunity to submit comments on the proposed 2018 Medicare physician fee schedule rule. The ACAAI and its Advocacy Council represent the interests of over 6,000 allergists-immunologists and allied health professionals. Our members provide patient care services across a variety of settings ranging from small or solo physician offices to large academic medical centers. Our comments address the following issues:

- Revaluation of CPT Code 95004
- Evaluation and Management Documentation Requirements
- Patient Relationship Codes
- Easing of PQRS and Value Modifier penalties

1. Revaluation of CPT Code 95004- Allergy Skin Testing

This code was reviewed by the AMA's Relative Value Update Committee (RUC) as a potentially misvalued code. The RUC recommended that physician work RVUs of 0.01 be maintained. It also reviewed practice expense and recommended changes to supply items and, in particular, the quantity of antigen used in furnishing a single skin test. The RUC recommendations are consistent with the recommendations the ACAAI, together with the American Academy of Allergy, Asthma and Immunology and the American Academy of Otolaryngic Allergy, made to the RUC. Therefore, we support CMS' proposal to adopt the RUC recommendations for this service.

It is our understanding that where revaluation of an existing code results in payment reductions of 20% or more, applicable law and regulations require that the reduction be phased in over two years. Therefore, we would expect that CMS will phase in the reductions for this service.

2. Documentation of Evaluation and Management Services

We appreciate CMS's willingness to reconsider the Evaluation and Management (E&M) guidelines which were flawed at inception and which have become increasingly outdated with the use of EHR and changes in how medicine is practiced. Overall, we believe the role of time and the complexity of medical decision-making are the critical elements in determining the level of visit. Our specific comments and recommendations are below:

- **Importance of Physician Time:** Cognitive specialties, such as allergy, require the taking of probing and penetrating patient histories. Much of what we do is detective work that often takes a significant amount of face-to-face time talking to the patient. The E&M guidelines penalize this type of work because the History of Present Illness (HPI) is only one of three elements for assigning the visit level and does not take physician time into consideration. For new allergy patients, the HPI is usually critical to developing a diagnosis. For example, one of our members reports a patient with a complicated history of a disease that had eluded at least five other physicians over the course of a number of years. Only after sixty minutes of history taking did the cause of the patient's condition become clear and was managed by a simple course of oral corticosteroids. This visit was paid as a level two new patient visit.

  Allergists also spend considerable amounts of time with patients teaching them how to cope with their illnesses through behaviors such as proper medication use, avoidance measures, environmental controls and peak flow monitoring. The E&M guidelines need to do a better job of capturing time (not just counseling time) and rewarding it appropriately even if it does not amount to 50% of the total patient encounter. We recognize the potential for abuse, but we believe documented encounter time can be compared with a physician's schedule of total visits for the day as a curb on abuse.

  Recommendation: *E&M guidelines should be revised to recognize the importance of physician time. At the very least, use of time should not be limited to counseling time and should include time spent on other activities such as obtaining a complete history.*

- **Documenting the History and Physical:** CMS seeks comments on whether it is appropriate to eliminate the history and physical documentation requirements for all visit levels. We agree with CMS that the E&M guidelines for history and physical exam are outdated and create additional burdensome recordkeeping. We would

support eliminating these requirements if there are other factors that are recognized as supporting a higher level of visit such as physician time coupled with medical-decision-making. If CMS decides to maintain history and exam documentation requirements, we urge that they be modified to require reporting of only what is pertinent to the patient's diagnosis or presenting symptoms. Requiring specialists to perform a specific number of elements of a physical examination is of little value to the patient and is often done simply for the purpose of justifying a higher code, with no corresponding patient care benefit. A complicated patient may have only one issue and may need only two or three areas examined. The simpler and less burdensome the documentation requirements are, the more time physicians will have for face-to-face conversations with the patient. This is what will result in better patient care; not checking boxes in an EHR.

Recommendation: *Eliminate requirements for documentation of history and physical and focus instead on physician time and medical-decision-making or, at the least, eliminate all numeric elements for history and physical in the documentation guidelines and allow physicians to document only what is relevant to the patient's specific diagnosis.*

3. Patient Relationship Codes

CMS has proposed five categories of patient relationship codes that would be reported as modifiers on claims. CMS is also proposing that the use of modifiers would be voluntary during an initial period while clinicians gain familiarity. It is seeking comments both on the modifiers themselves and on whether they should be voluntary at first.

CMS has proposed the following five patient relationship categories:

- Continuous/broad services
- Continuous/focused services
- Episodic/broad services
- Episodic/focused services
- Only as ordered by another clinician

We appreciate CMS' effort to keep this as simple as possible and we agree that these five categories would capture most types of physician/patient relationships. However, it is not clear whether they capture the situation in which a specialist provides services in a consultative or diagnostic role only. For example, an allergist may, at the request of the patient's primary care physician, see a patient once or twice and provide a report to the referring physician but would not initiate treatment. This type of care does not seem to fit clearly into any of the five categories. Either a sixth category is needed or CMS should clarify how this type of patient relationship should be reported.

We also support CMS' proposal to make patient relationship reporting voluntary during an initial period. We believe this is necessary to give physicians and their staff time to understand and implement the new modifiers before they have an impact on the physician's MIPS score.

Recommendation: CMS should add a patient relationship category to describe cases in which a specialist sees a patient in a consultant relationship and reports back to the referring physician but does not provide treatment.

4. Easing of PQRS and VM Penalties

CMS is proposing to reduce the number of quality measures required under the Physician Quality Reporting System (PQRS) and the Value Modifier (VM) program from nine to six for the 2018 payment year. It is also proposing to reduce the 2018 VM automatic penalty for those clinicians that do not meet minimum quality reporting requirements from 4 percent to 2 percent for groups of ten or more clinicians and from 2 percent to 1 percent for solo physicians and those in groups of nine or fewer. In addition, all physicians would be held harmless with respect to reductions based on performance in the quality-tiering portion of the VM program. Finally, CMS is proposing that it would not publish VM data on the Physician Compare Website. We strongly support these proposals. They will help ease the transition from the legacy PQRS and VM programs to MIPS and provide needed consistency.

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We thank you for consideration of our views. If you have questions, please contact Susan Grupe, Director of Advocacy Administration at suegrupe@acaai.org.

Sincerely,

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