ALLIANCE OF
WOUND CARE
STAKEHOLDERS
POWER THROUGH COLLECTIVE ADVOCACY

September 10, 2018

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

Comments Submitted Electronically to **http://www.regulations.gov**

Re: CMS-1693-P, Comments on 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 (RIN 0938-AT31)

Dear Administrator Verma:

On behalf of the Alliance of Wound Care Stakeholders ("Alliance"), I am pleased to submit comments in response to the proposed CY 2019 Physician Fee Schedule. The Alliance is a nonprofit multidisciplinary trade association of physician specialty societies, clinical and patient associations whose mission is to promote evidence-based quality care and access to products and services for people with chronic wounds (diabetic foot ulcers, venous stasis ulcers, pressure ulcers and arterial ulcers) through effective advocacy and educational outreach in the regulatory, legislative, and public arenas. These comments were written with the advice of Alliance clinical specialty societies and organizations who not only possess expert knowledge in treating complex chronic wounds, but also in wound care research. A list of our members can be found on our website: http://www.woundcarestakeholders.org/about/members.

The Alliance appreciates and applauds CMS's efforts in trying to achieve its goal of "Patients Over Paperwork." The Alliance supports the following provisions in the proposed regulations which will help to ensure that the paperwork burden is eased:

- Changing the required documentation of the patient's history to focus only on the interval history since the previous visit;

- Eliminating 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;

- Allowing physicians to choose between current documentation guidelines, documenting by time only, or documenting by medical decision making only;

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- Removing the need to justify providing a home visit instead of an office visit.

The Alliance recommends moving forward in finalizing those provisions. We also offer the following specific comments:

SPECIFIC COMMENTS

Evaluation and Management Code Consolidation

While the Alliance does support the documentation proposals above, CMS, in the hopes of easing documentation requirements, proposes to consolidate Evaluation and Management (E/M) Codes and simultaneously proposes significant reduction in reimbursement for these services for many providers. However, the Alliance submits that neither the consolidation of E/M codes nor the proposed reduction in reimbursement will ease documentation requirements. CMS has itself stated that the amount of documentation that is required for other payers, medical-legal and State Board purposes is not going to be reduced. Therefore, the promise that clinicians will have a lesser burden in documentation, which is how CMS is justifying the significant decrease in reimbursement, is a fallacy. What is real and of significant concern to the Alliance are the *unintended consequences* that this proposal will create including but certainly not limited to: harming patient care, limiting patient access, decreasing the amount of time a physician can spend with a patient, increasing the number of visits required to visit a doctor which results in increasing the number of copayments that a patient will be required to pay, thus potentially creating an exodus of Medicare providers resulting in a shortage of providers.

Therefore, the Alliance strongly opposes the consolidation of Evaluation and Management codes and the corresponding reduction in payment for E/M services for those that provide the most complex care and urges CMS not to move forward with this proposal.

In order to have context to our comments, it is helpful for the Agency to understand more about chronic wound care.

- Most wound care patients have serious multifaceted and/or chronic comorbid medical conditions. Non-healing wounds occur among patients with diabetes, peripheral vascular disease (nearly as common as coronary artery disease and stroke), or as a result of unique medical problems (e.g., sickle cell anemia, vasculitis), or in association with immunosuppression (e.g., AIDS, steroid use or transplantation medications).
- Chronic wounds are clinically devastating and have an extraordinary impact on Medicare beneficiaries.
- Wound healing is a complicated process directly influenced by the status of medical comorbidities, the local wound environment and also by the overall physical condition of the individual. The process of wound healing involves metabolic, structural, biochemical, and patient factors in a unique way. Wound healing is not a single event; it is a result of intricate overlapping processes.
- There are guideline-suggested interventions but there are many combinations of individual wound characteristics which contribute to the challenges of healing a wound.
- The order and combinations of treatments used are varied and may be directed anywhere along the wound healing cascade.

Our members treat very complex patients. The consolidation of E/M codes and the corresponding reduction in reimbursement does not take this into consideration. In this proposal, CMS simply believes that all patient care is created equal and should be compensated accordingly. The Alliance disagrees.

To highlight this, our members have provided us with their own experiences in treating patients with chronic wounds which clearly identifies the distinction between a Level 2 E/M visit versus a more complex Level 4 or 5 E/M visit. These distinctions should be recognized and adequately reimbursed. Examples include:

EXAMPLE 1:

In both Level 2 and Level 4, the patient being treated has Chronic Venous Insufficiency with ulcers, and the complexity of care may vary from visit to visit with the same patient:

***Level 2 visit**:*

Follow up visit, the wound is progressing with measured dimensions improving by about 20%, no evidence of systemic infection and the wound bed is clean, no significant slough to require a debridement, the current regimen has been in place for 2 weeks, no need to change therapies at this time.

The visit includes – unwrapping and removing dressings, cleansing with a wound wash by the nursing staff, measurements of all wounds, photos and documentation in the EHR by the nursing staff. The provider will then evaluate the wound, review the records including past measurements in prior photos compared to the current exam, discuss any changes over the past week with the patient and review any other pertinent past medical history then give orders to the nursing staff. The nursing staff then applies any topical medications ordered, read dresses the wound and may reapply compression wraps or compression stockings as ordered.

Total face to face time with this provider maybe as little as 10 to 15 minutes.

***Level 4 or 5 visit**:*

Venous Insufficiency with ulcer, only the ulcer is larger with this visit – has a strong odor and has eroded into deeper structures (tendon/capsule). Further interview with the patient reveals no fever and chills, however, there is some increased tenderness and an increase in the drainage from the wound to the point that the patient removed dressings and wraps and reapplied an ace wrap from his own supplies. The patient is morbidly obese, has poorly controlled diabetes, hypertension and smokes two packs a day. He is on renal dialysis three days a week. He also has congestive heart failure but does not have increased shortness of breath or nocturnal dyspnea however there has been some increased ankle edema. A review of medical records with past calf circumference measurements indicates there is a bilateral 2 cm. increase in edema. In addition to the extra time obtaining past history since the last visit, the provider must review pharmacy records because the patient doesn't recall allergies to medications and he must contact both the patient's cardiologist and nephrologist to determine the right medication course that will not interfere with either cardiac medications and be accurately renal dosed, in light of his dialysis. Extra time is spent with the patient to go over instructions, reinforce dressing and offloading care, nutritional management, smoking cessation instructions, and how to take his new medications. Total face-to-face time with the provider is now 30 to 60 minutes and additional time may have been spent if he entertained having the patient hospitalized to

control medications only to discover he doesn't fit criteria for sepsis and neither at the hospitalist or family practitioner will accept the patient for admission. Then orders must be placed for the new medications with coordination through IV services, and the provider will spend extra time looking for a surgeon to do an operative debridement. Total time spent by the nursing staff may also be increased with more complicated dressings, instructions and follow-up care provided. If in addition to this, negative pressure wound therapy is ordered, the staff will be tasked with additional measurements and coordination of care with the ordering supplies.

EXAMPLE 2:

In both Level 2 and Level 4, the patient has venous insufficiency ulcers, congestive heart failure and diabetes (all common diagnosis for a wound care patient). The type of care received in a Level 2 versus a Level 4 or 5 visit includes the following:

*In a **Level 2 E/M visit**, the doctor obtains the patient history and conducts a review of systems. In the exam, the doctor focuses on VS, measures the leg circumference, edema, pulses and looks to see if there are any open lesions. Upon seeing no open lesions, the doctor. recommends that the patient elevate their leg, use a compression hose, and follow up with the doctor in 4-8 weeks or sooner if there are any significant change in symptoms. This is very straightforward.*

*However, **a Level 4 E/M visit** is significantly more complex and detailed. For example: the patient conducts a detailed history of the patient who complains of chronic swelling of the lower legs which have been much worse over the past 10 days, the right leg worse than left. There has been a change in blood pressure medications and has open wounds that have been weepy and saturating the socks. In their evaluation of the patient, the doctor discovers that the patient has had low grade fever, no chills, no increase in shortness of breath, but had gained 5 lbs since the last visit, increased edema of lower extremities and skin breakdown, no chest pain, blood sugars have been higher than normal. During the exam, the doctor looks for jugular venous distension in neck, listens to lungs for rales or wheezing, listens to the heart, examines the lower extremities for edema and pulses, then examines the skin for the ulcer, measures and evaluates the ulcer for drainage, erythema, smell, periwound skin for dermatitis, etc. This patient requires moderate complexity decision making: - the patient needs a culture of the ulcer, review whether the patient has had recent arterial studies, if not, the patient needs to be sent for arterial Dopplers, the doctor writes a prescription for antibiotics to address the drainage. The doctor might also have to address the change in blood pressure meds (ie, they removed the diuretic) and discuss with the primary care physician(PCP), or the doctor could double their diuretic for a couple of days, and then refer to PCP for longer term management. Patient is to follow up with the doctor in 1 week.*

*In a **Level 5 E/M** all the above occurs plus the doctor notices that the patient has a significant fever, is short of breath, and have pursed lip breathing. The doctor would still conduct the same review of systems, evaluation and treatment as the Level 4 example above but would necessitate calling the PCP, and determining what Emergency Department to send the patient to, possibly by ambulance, and co-ordinate the care for transfer, put them on oxygen, etc*

EXAMPLE 3

***Level 2 Established Visit**:*
A patient is seen in follow up for a dehisced wound which occurred after a laparoscopic appendectomy was performed 6 weeks prior. The wound has been steadily improving with the use of advanced wound dressings. At this visit, the provider evaluated the wound and made a simple change in the dressing management. The new regimen was explained to the patient and their spouse and plans for the next evaluation were discussed. Total time for visit and care coordination- 15 minutes

***Level 4 Established visit**:*
A patient is seen in follow up for a left plantar foot ulcer as well as a right gluteal wound. The patient is an incomplete paraplegic due to a gunshot wound 8 years ago. The patient has had the foot ulcer for approximately 2 years and has been treated for osteomyelitis. They noted pain to the right thigh earlier this year which deteriorated into Fournier's gangrene. The patient underwent multiple surgical debridements as well as a diverting colostomy. The gluteal wound is being managed with negative pressure wound therapy but there are challenges with maintaining a seal due to the wound location. This issue is evaluated and discussed in detail with the patient. The patient has visiting nurses at home and orders were updated to reflect the treatment plan. The foot ulcer is covered in callus and needs a selective debridement to reduce the buildup and treat the wound bed. It was noted during the visit that the patient had removed the insert from their shoe to accommodate the dressing. The patient does not have any other shoewear present. However, a custom brace has been ordered. In addition, the patient is inquiring as to the status of their customized wheelchair. Multiple phone calls to the orthotist, seating specialist, visiting nurse and podiatrist were done before the end of the visit to address these issues. Total time for visit and care coordination- 40 minutes.

***Level 5 Established visit**:*
A patient with uncontrolled type 1 diabetes and autoimmune disease is seen in follow-up for atypical ulcers to the dorsum of their foot as well as the forearm. At the initial visit, a punch biopsy was taken from the foot. The biopsy revealed leukocytoclastic vasculitis. At the return visit, the patient is febrile, tachycardic and hyperglycemic. An interim history, complete physical exam and review of systems was done. The patient now has exposed, grey tendon with purulence on the dorsum of the second toe. The other four wounds on the foot were markedly deteriorated from the previous visit as well. There is erythema and warmth to the foot. The patient requires admission to the hospital to aggressively treat the infection as well as to manage the vasculitis. The reason for admission and the expected hospital course (surgical debridement, rheumatology consult, infectious disease consult, endocrinology consult) was all discussed with the patient. After the patient agreed with the admission plan, coordination of care calls were placed to the on-call podiatrist, admitting hospitalist and emergency room where the patient would board for admission. The results of the biopsy were shared with all treatment teams. The patients wounds were treated during the visit. A note reflecting the outpatient clinic visit is also placed in the hospital EHR to provide closed-loop communication between all teams. Total time for visit and care coordination- 75 minutes.

Despite the significant differences in care and resources, CMS wants to pay the same rate for these very disparate services. Without adequate time and corresponding reimbursement to evaluate and manage these complex patients, there will be significant risk to patients, increased cost on their part as they will need to

come to the office more often thus incurring additional copayments, and significant issues with access to care which will impact patient satisfaction and quality of care.

The current CPT® system recognizes that there are varying levels of categories for care that respresents the history, assessment and medical decision making. Physicians should be compensated fairly for the care of their patients based on the resources needed to provide care and the complexity of the patient. Consolidating the E/M codes and creating blended rates devalues the rigors of medical decision-making as well as the comprehensive care being provided, and ignores the best interests of the patients. Not all patient visits are equal and should not be reimbursed as such.

Thus, the Alliance opposes the CMS proposal to "simplify" E/M coding by blending CPT® codes 99202 – 99205 – codes that cover new patient office visits levels two through five – into a single payment of $135 and to blend established patient office visits Level 2– 5 that are currently covered by CPT® codes 99212-99215 into a single payment rate of $93 and urges CMS to withdraw this proposal.

Separate E/M Codes and Payment For Podiatric Physicians

CMS has proposed to create separate E/M codes and reimbursement for the services provided within these codes for podiatric physicians. The Alliance strongly opposes these proposals since it appears that the Agency is discriminating against one physician group. Wound care is multidisciplinary. The practice of wound care is not limited to one particular medical specialty recognized by the American Board of Medical Specialties. Instead, there are many different specialists who treat patients with chronic wounds. These practitioners include but are not limited to the following: surgeons (e.g. general surgeons, vascular surgeons, plastic surgeons, and foot and ankle surgeons), vascular medicine physicians, podiatrists, dermatologists, nurse practitioners, infectious disease experts, physical therapists, nurses, registered dieticians, nutritionists, and primary care physicians who are in the full time practice of managing patients with wounds.

Since wound care is multidisciplinary, all our members work very closely with podiatric physicians, and know first-hand how critical a role they play in diagnosing and treating wounds and ulcers of the foot and ankle. A diabetic foot ulcer is an open wound that occurs in approximately 15 percent of patients with diabetes and is commonly located on the bottom of the foot. Of those who develop a foot ulcer, 6 percent will be hospitalized due to infection or other ulcer-related complication. Diabetes is the leading cause of non-traumatic lower extremity amputations in the United States, and approximately 14-24 percent of patients with diabetes who develop a foot ulcer will require an amputation. Foot ulcerations precede 85 percent of diabetes-related amputations.

Wound and ulcer care of the foot is unique, and Doctors of Podiatric Medicine (DPMs) are trained to treat, heal, and ultimately keep these wounds from recurring. Particularly for individuals who are Medicare beneficiaries with diabetes, neuropathy or vascular disease, not properly treating an open wound can put patients at increased risk of developing infection in the skin and bone, and in extreme cases, can lead to limb amputation.

While there are other physicians who also diagnose and treat diabetic wounds and ulcers of the foot and ankle, under CMS's proposed rule, when podiatrists are evaluating and managing such a condition, they will be required to use a different code set and receive less payment than another clinician for performing the same service. This is not only unfair, we believe it is discriminatory and goes against the laws in which

CMS is supposed to adhere. Specifically, Section 1848(c)(6) of the Social Security Act states, "No variation for specialists – The Secretary may not vary the conversion factor or the number of relative value units for a physician's service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician."

The Alliance opposes the singling out of podiatric physicians in the creation of new consolidated E/M codes and the corresponding additional reduction in reimbursement. The Agency should not contain provisions in its regulations that violate the very laws that it is supposed to adhere to. We urge CMS to withdraw this proposal.

Modifier 25 – E/M and Procedure on the Same Day

CMS has proposed when billing for an E/M and a procedure on the same day, the utilization of modifier 25 is required and the payment will be the lower price between the procedure and the E/M visit. The Alliance opposes this proposal and urges CMS not to finalize it. Modifier 25 is used to indicate a significant, separately identifiable, and medically necessary E/M service provided on the same day as a procedure. Modifier 25 is specifically indicated for use when distinct E/M services, distinguishable from any E/M work integral to a procedure's valuation, are performed. As such, a modifier 25 specified E/M service is no less than what would be done if the patient were to be evaluated on a separate day with no overlap of either direct or indirect costs. Therefore, separate and distinct payment, without adjustment, is appropriate. The procedural payment reduction is punishing practitioners for providing more direct, relevant, and efficient services to their patients by reducing payment.

CMS may be concerned about costs when a separately identifiable and medically necessary E/M services is provided on the same day, but we can assure the Agency that the RUC automatically reduces procedure pre-service time estimates and values for all codes typically billed with an E/M visit. Therefore, the value of codes commonly billed with a 25 modifier are already reduced in the RVU to account for the potential overlapping of work performed during an E&M service. If CMS then reduces the payment for a procedure as defined in this proposal, the practice expense portion will not be significant enough to cover the physician product costs. As a result, physicians will not be paid appropriately for the procedure making the provision of these services unsustainable. In addition, many of the codes used in the wound care setting include defined costs of products/dressings, and equipment. The RUC defines cost for the "practice expense" which includes surgical dressings such as compression bandages and then assigns it an RVU value. If CMS reduces the payment for a procedure by 50%, the practice expense portion will no longer cover the physician's product costs. This will impact wound care clinicians significantly. In conclusion, the Alliance believes additional reduction in an appropriately billed, separate and unrelated E&M service is arbitrary, unfair and without merit.

We have identified examples in wound care to highlight why this proposal is inappropriate.

1. A new diabetic patient is seen for a non-healing wound on the foot. An E/M is performed that arrives at a complex decision-making treatment plan to include: ordering of x-rays, ordering of vascular studies, and prescribing of empiric antibiotics for the wound based upon a diagnosis of cellulitis to the affected extremity. In addition to those items, the wound is malodorous, with a heavy degree of bioburden/necrotic tissue and copious green exudate. A debridement of the wound is necessary during the same office visit to gain control of the infection.

2. A hyperbaric patient that needs a wound re-evaluated with negative pressure wound therapy changed on the same day as a treatment. Hyperbaric oxygen therapy is a daily treatment which can last for many weeks. However, the wounds need routine evaluation and management during the therapy period and necessitates multiple visits on the same day.
3. A patient is having a right foot diabetic foot ulcer debrided. As the debridement is concluding, and all discussion of the right foot ulcer is coming to an end, the doctor is getting ready to go see the next patient, but the patient says, "Oh, I have an area of discoloration on my left leg I am worried about". The doctor conducts a new, unrelated evaluation related to the left leg discoloration, makes a diagnosis, explains the diagnosis to the patient, and manages the left leg. In this situation, there is no overlap in time, effort, risk, direct cost, or indirect cost between the right foot debridement procedure and the evaluation and management of the left leg discoloration.
4. A patient with venous insufficiency ulcers, congestive heart failure and diabetes (all common diagnosis for a wound care patient) visits the office. During a Level 4 E/M visit the patient complains of chronic swelling of lower legs, much worse over the past 10 days, right worse than left. The patient has had a change in blood pressure medications and has open wounds that have been weepy and saturating the socks. The doctor evaluates the patient - VS, they look for jugular venous distension in neck, listen to lungs for rales or wheezing, listen to heart, exam lower extremities for edema and pulses, then examine the skin for the ulcer, measure, evaluate for drainage, erythema, smell, periwound skin for dermatitis, During the evaluation of the patient, the doctor determines that the patient has edema which needs to be addressed and compression is necessary. The doctor applies compression for edema control. In this situation, there is no overlap in time, effort, risk, direct cost, or indirect cost between the compression procedure and the evaluation and management of the patient.

As highlighted above, it is inappropriate for CMS to reduce payment for an E/M service and procedure when conducted on the same day.

Furthermore, the Alliance would like to point out that the AMA Relative Value Scale Update Committee (RUC) reviews relative value units (RVU) and updates them to reflect changes in physician work, practice expense, and malpractice inputs. The RUC is now automatically reducing procedure pre-service time estimates and value for all codes typically billed with an E/M visit. Therefore, the value of codes commonly billed with a 25 modifier has already been reduced in the RVU to account for the potential overlapping of work performed during an E&M service. Furthermore, additional reduction to an appropriately billed, separate and unrelated E&M service is arbitrary, unfair and without merit.

Billing Same Day Visits By Practitioners in the Same Specialty

CMS has proposed to eliminate the prohibition on billing same day visits by practitioners of the same group and specialty. The Alliance opposes this proposal. It is not uncommon when treating a wound care patient to bill same day visits by a practitioner in the same specialty.

A case in point describes a vascular surgeon seeing a patient in the wound center for a Level 4 Wound Care edema visit. Based on the visit, the surgeon sends the patient for vascular studies, (i.e. Segmental dopplers), and the study is read by the vascular surgeon from the same group that is covering the vascular lab that day. In this case, practitioners from the same specialty/group have both had an encounter which should be billed for and reimbursed which this proposed rule would not allow if it goes into effect.

As such, the Alliance recommends that CMS withdraw this proposal. Clinicians should be able to be reimbursed for the services that they perform.

Establishing Office-Based PE RVUs for Disposable Negative Pressure Wound Therapy

In January 2015, the American Medical Association (AMA) revised the Category 1 CPT codes (97605 and 97606) for negative pressure wound therapy (NPWT) and created two new, permanent Category I CPT codes for disposable NPWT, shown below:

97607 *Negative pressure wound therapy (e.g., vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment, including provision of exudate management collection system, topical application(s), wound assessment, and instruction(s) for ongoing care, per session, total wound(s) surface area less than or equal to 50 square centimeters*

97608 *Negative pressure wound therapy (e.g., vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment, including provision of exudate management collection system, topical application(s), wound assessment, and instruction(s) for ongoing care, per session, total wound(s) surface area greater than 50 square centimeters*

These CPT codes describe NPWT services using a disposable device. Since the implementation of these new CPT codes, there has been confusion among physicians regarding the payment rates for these new CPT codes when performed in the office setting, as CMS opted not to assign national fee schedule amounts for these codes in 2015, and instead allowed the carriers to price these services. This decision was based partly on the heterogeneity of products that were described by the available CPT codes at that time.

In the CY 2018 hospital outpatient rule, CMS implemented a national payment rate of $307.39 for both 97607 and 97608. We believe a similar payment rate under the PFS final rule, accounting for differences in costs across these disparate settings of care, will create much needed transparency and predictability for physicians, and allow office-based access to this proven wound care therapy for Medicare beneficiaries.

The Alliance submits that CMS can and should assign direct cost inputs to this service, which would allow the establishment of national payment rates for CPT codes 97607 and 97608 in the final PFS rule for CY 2019. Specifically, we recommend that CMS adopt practice expense (PE) relative value units (RVUs) for CPT codes 97607 and 97608 and to establish national payment rates for these CPT codes.

Provisions Related to the Quality Physician Payment

The proposed rule contains several provisions related to the Quality Physician Payment QPP)—some of which the Alliance supports and some which we do not.

The Alliance supports the following provisions within this proposed regulation:

1. Expanding the types of eligible providers under MIPS to include physical therapists. Physical therapists are one of many providers in the multidisciplinary field of wound care. Since they were

not recognized as eligible providers prior to this proposed rule, they have not been utilized as frequently as they should have to treat patients with wounds. We are pleased that CMS has recognized them as eligible providers and recommend that CMS finalize this provision.

2. Allowing individuals or groups to submit data using multiple collection types (for example, electronic clinical quality measures (eCQMs), Qualified Clinical Data Registry (QCDR) measures, and Medicare Part B claims measures.

3. Modifications to the low-volume threshold and the creation of an opt-in policy for the MIPS program.

4. MIPS eligible clinicians and groups that have fewer than the required number of measures and activities applicable and available under one submission mechanism could be required to submit data on additional measures and activities via one or more additional submission mechanisms.

5. CMS's proposed Qualified Clinical Data Registry (QCDR) measures selection criteria.

6. CMS's alternative proposal for weighting of the quality and improvement activities categories at 70% and 30%, respectively

The Alliance does NOT support that CMS has proposed to eliminate the existing small practice bonus under MIPS and instead fold it into the quality performance score. The Alliance believes that this could harm small and rural providers and therefore supports maintaining the small practice bonus as a 5 MIPS point stand-alone bonus that is added to the final score.

We also encourage CMS to consider ways to include facility-based clinicians, including those within skilled nursing facilities, home health agencies, and rehabilitation agencies in MIPS in the future.

Conclusion

In summary, the Alliance recommends that CMS:

1. Withdraw the current proposal to consolidate E/M codes and the corresponding reduction of payment for those services. The current proposal ignores the wide range of patient visit complexity, time and risk that is addressed by these levels. To pay physicians at a lower rate for all patients without regard to the higher level of care is ill advised.

2. Withdraw the proposal to create separate E/M codes and reimbursement for podiatric physicians. The current proposal is discriminatory and without merit.

3. Withdraw the provision in which CMS will pay the lower price between the procedure and the E/M visit when conducted on the same visit.

4. Finalize changing the required documentation of the patient's history to focus only on the interval history since the previous visit;

5. Finalize eliminating 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;

6. Finalize allowing physicians to choose between current documentation guidelines, documenting by time only, or documenting by medical decision making only

7. Finalize removing the need to justify providing a home visit instead of an office visit.

8. Finalize PE RVU for office based applications of 97607 and 97608.

9. Finalize expanding the types of eligible providers under MIPS to include physical therapists.

10. Finalize allowing individuals or groups to submit data using multiple collection types (for example, electronic clinical quality measures (eCQMs), Qualified Clinical Data Registry (QCDR) measures, and Medicare Part B claims measures.

The Alliance further urges CMS to work together with health care professional associations and societies in order to develop proposals that do not jeopardize access to care for the nation's sickest and most vulnerable elderly patients, which includes those with chronic wounds.

The Alliance appreciates the opportunity to provide our comments. Should you have any questions or require additional information, please do not hesitate to contact me.

Sincerely,

Marcia Nusgart R.Ph.
Executive Director