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IDSA
Infectious Diseases Society of America

February 10, 2023

Chiquita Brooks-LaSure
CMS Administrator
Centers for Medicare & Medicaid Services
ATTN: Division of Practitioner Services, Potentially Misvalued Codes
7500 Security Blvd.
Baltimore, MD 21244

Re: Potentially Misvalued Codes: Hospital Inpatient and Observation Care visit codes (CPT 99221 – 99223)

Submitted electronically via MedicarePhysicianFeeSchedule@cms.hhs.gov.

Dear Administrator Brooks-LaSure,

IDSA represents more than 12,000 infectious diseases (ID) physicians, scientists and other health care professionals devoted to patient care, prevention, public health, education, and research in infectious diseases. Our members care for patients of all ages with serious infections, including meningitis, pneumonia, tuberculosis, HIV/AIDS, health care-associated infections, and antibiotic-resistant bacterial infections, as well responding to infectious disease pandemics and outbreaks including Ebola virus, Zika virus, and most recently SARS-CoV-2 and mpox.

Today, we write to nominate the aforementioned codes as "potentially misvalued" and ask the agency to revisit the valuation of these services with due consideration of the rationale provided. The impact of the misvaluation has a profound impact on ID physicians, as approximately 90% of their revenues are generated based on the delivery of inpatient evaluation and management (E/M) codes.

Background

In 2018, CMS began an effort to ensure accuracy in the valuation of E/M services. This initiative resulted in significant improvements in relative values ("RVUs") for office and outpatient E/M services (CY 2021), and modest improvements in RVUs for certain inpatient, observation, and other E/M services (CY 2023). Mandatory budget neutrality requirements associated with these RVU changes caused a massive shift in Medicare funding across physician fee schedule (PFS) services and the specialties who deliver them, and steep reductions in the annual PFS conversion factor (i.e., -10.2% in CY 2021; -1.6% in CY 2023). The impact of these changes on ID physicians' overall Medicare funding pool was considerable: approximately -4.0% in CY 2021, and approximately 4.0% in CY 2023. These figures pertain only to the policy itself, and not the impact of the budget neutrality adjustment, which exacerbated the impact.

CY 2023 Valuation of Hospital Inpatient and Observation Care visit codes

Based on recommendations from the American Medical Association (AMA) Relative Value System Update Committee (RUC), CMS proposed and finalized reductions to initial inpatient E/M services (see table below).

CPT Code	2023 wRVU	*Cf. 2022*	***IDSA Request[1]***
Initial Visits			
CPT 99221	1.63	*-15.1% (1.92)*	***1.92***
CPT 99222	2.60	*0% (2.61)*	***2.79***
CPT 99223	3.50	*- 9.3% (3.86)*	***4.25***

CMS justified these low values by highlighting the reduced "total time" in delivering of these services, as reflected in RUC surveys. It also disputed assertions from negatively affected stakeholders that "facility-based codes are always inherently (or proportionately) more intense than E/M services provided in other settings," arguing that "…practitioners furnishing visits in the office setting face particular uncertainties in their estimates of illness and treatment courses, and the office settings have fewer resources close at hand," while "…those practicing in institutional settings generally have ready availability of diagnostic equipment (for example, imaging and other advanced services), allowing for more immediate access to clinical information and reducing the amount of time needed to manage a given case."

Rationale for Identifying Inpatient E/M Services as Misvalued

In response to CMS' proposed RVUs for inpatient E/M services, IDSA urged CMS to restore relativity across its E/M codes sets by finalizing the IDSA-requested RVUs for the initial inpatient E/M services (see table above). CMS declined, disagreeing with IDSA that "facility-based codes are always inherently (or proportionately) more intense than E/M services provided in other settings." This response is frustrating given the AMA RUC made it clear that inpatient services are, indeed, more complex. Specifically, in the Summary of Recommendations from the April 2019 AMA RUC, the Committee specifically acknowledged that inpatient and observation E/M services were more intensive and of higher value than office and outpatient services (see excerpt below):

> *There were 1472 respondents, 84% of whom found the vignette to be typical. The survey median times and work RVU were 14/59/15/85/3.5 as compared to the current times and RVU of 7/45/15/67/3.17. The panel noted that the median survey total time of 85 minutes is 27% higher than the current value and the median work RVU of 3.5 is only 10% higher than the current value. The key reference services were 99223, Initial hospital care for patient with problems of high severity, with times and work RVU of 15/55/20/90/3.86, and 99220, Initial observation care for patients with problems of high severity with times and work RVU of 15/45/15/75/3.56. The panel determined that the survey median total time and work RVU place 99205 in proper rank order with both key reference services.* ***While all three services require high complexity medical decision making, 99223 and 99220 are reported for patients in a hospital or observation setting so the RVUs should be higher*** *[emphasis added]. However, the RVU of 99205 should be close to that of 99220 because it is 10 minutes longer. 99223 is only 5 minutes longer than 99205 but the intensity is higher which supports its higher RVU. The panel also reviewed 90792, Psychiatric diagnostic evaluation with medical services that has times and work RVU of 10/60/20/90/3.25. The median survey times and RVU place 99205 in proper rank order to 90792 which has slightly longer time but is less intense. Therefore, the panel recommends the survey median RVU of 3.5 and the survey median time of 85 minutes for 99205.*

CMS' response is even more upsetting to IDSA given the E/M service codes reported by physicians in the office setting, and for which CMS enthusiastically finalized weighty increases, *are exactly the same codes physicians report in the hospital outpatient setting*. Physicians seeing patients in a hospital setting – inpatient or outpatient – would be afforded "ready availability of diagnostic equipment (for example, imaging and other advanced services), allowing for more immediate access to clinical information and reducing the amount of time needed to manage a given case." If CMS truly believes that patients in the inpatient setting are less complex to manage because of readily available resources, would this not apply to the office and outpatient E/M codes?

We understand from conversations with the agency that maintaining relativity – for relativity's sake – is at odds with CMS' charge in updating relative values to reflect current practice. However, neither the AMA RUC process nor CMS' revaluation exercise specifically stated a belief or hypothesis that this relativity between the code sets no longer exists

[1] IDSA's requested values reflect historic relativity across office/outpatient E/M services for new patients and the initial inpatient E/M services, prior to CY 2021.

nor was any information, data, or comment provided as to why practice had changed such that the code sets' historic relativity had shifted. Particularly shocking about CMS' response is that the agency makes no mention of this apparent shift in the intensity or resources of services when increasing the values of the subsequent inpatient visits. In truth, the loss of relativity is simply a coincidental outcome of the valuation process, which IDSA believes suffered from unique challenges, including the timing under which these services were deliberated[2] and issues with the AMA RUC survey and process itself.[3] In contrast to the AMA RUC's evaluation of the outpatient E/M code set, which was conducted prior to the pandemic, presentations and deliberations of the inpatient E/M code set were conducted in a completely virtual environment. This hindered the ability of the multiple presenting societies to respond to RUC challenges regarding proposed values and led to acquiescence to inappropriately valued initial codes, with which not all participating societies fully agreed.

Indeed, CMS has ensured relativity across other E/M codes code sets, including Emergency Department (ED) E/M services. As outlined in the CY 2023 PFS, CMS said:

> *We appreciate commenters' feedback. We disagree with the commenters and continue to believe that CPT code 99284 is more accurately valued at a higher rate than CPT code 99204 at the proposed work RVU of 2.74. As we noted in the proposed rule, the survey conducted for CPT code 99284 maintained - unchanged - a work time of 40 minutes, and the level of medical decision making in the code's descriptor also remains unchanged at "moderate" complexity.* ***We do not agree that the work RVU of CPT code 99284 should be reduced to match the work RVU of CPT code 99204, given that the code remains essentially unchanged. This is especially true, given that this has been the historic relationship between these codes, and that we previously finalized a proposal in the CY 2021 PFS final rule to increase the work RVU from 2.60 to 2.74 for CPT code 99284 specifically so that these codes would not share the same work RVU*** *[emphasis added].*

IDSA's request to restore relativity across the E/M code sets is an attempt to mitigate the misvaluation of initial inpatient E/M services due to these challenges, which is aligned with CMS' prior approach for the ED E/M codes.

Importantly, if CMS' charge is to ensure values reflect current practice, we question CMS' emphasis on the reduction in total time over the patient complexity. In our comments, IDSA explained that the inpatient setting has a predominance of more seriously ill, extraordinarily complex patients with multiple comorbidities – much more so than the office-setting. Persons typically evaluated by ID physicians in the hospital include immunocompromised patients such as organ or bone marrow transplant recipients with critical illness, who have ID problems far more complex than outpatient infections, with multiple organ failure and multiple drug interaction and adverse effects considerations. We further noted that ID inpatient consultations involve rapidly changing clinical presentations that require the expertise of and coordination among many different subspecialties, as well as interpretation of many different diagnostic testing modalities (e.g. radiology, cultures, pathology), which culminates in recommendations for therapy, along with ongoing, evolving management during the patient's hospitalization and post-discharge by the ID-led care team.

Notwithstanding concerns regarding how this survey was conducted and how that might impact survey results, a reduction in time should not automatically result in a reduction in value, because the patients remain extremely complex. Reducing value based on time inappropriately penalizes physicians who can address those challenges more efficiently due to their expertise and training. ***Patient complexity dramatically intensifies physician effort and***

[2] The revaluation of office and outpatient E/M code set resulted in a 10.2 percent reduction in the CY 2021 Medicare physician fee schedule conversion factor. Deliberations were seemingly clouded by concerns about the impact of increased values for a highly utilized code set (i.e., inpatient E/M services) on the overall PFS, thus dampening the final recommended values.

[3] Challenges with the survey of inpatient E/M codes, including a lack of confidence in the validity of the times, hindered deliberations by the AMA RUC and ultimately led the Committee to recommend the 25th percentile, which doesn't match the complexity and intensity of the work involved in the delivery of the initial inpatient E/M services.

commensurately increases medical decision making (MDM), and the finalized RVUs for initial inpatient E/M services fail to appropriately reflect this.

Previously provided clinical vignettes are included below to aid in CMS' appreciation of the increased complexity of delivering inpatient E/M services.

- A patient with recent bilateral total knee arthroplasties, cardiovascular disease and diabetes presents with fever and pain in his low back, right knee and right hip. An ID consultation is requested to review the case, conduct a thorough history and physical examination, and interpret the significance of positive blood cultures. The ID physician consultant must choose appropriate diagnostic testing to confirm infection in all mentioned sites and to identify an underlying source. The ID physician helps discuss appropriate surgical intervention, assess antimicrobial susceptibility and make a therapeutic decision, and a transition from inpatient to outpatient parenteral antibiotic therapy (OPAT). Coordination is required with orthopedic surgery, hospital medicine, pharmacy, physical therapy and case management. Extensive patient and family education are required during hospitalization and post-discharge to appropriately monitor antimicrobial therapy, prevent spread or worsening of infection, promote wound care and identify potential emerging complications of both the infection and the treatment (intravenous line complications and antimicrobial adverse effects). The ID physician is, as is often the case, the first and only physician to interact with and care for the patient post-discharge.
- A recent lung transplant recipient with a history of serious infections presents with tachycardia and hypotension. Urinalysis shows pyuria; CT imaging shows bilateral pulmonary nodules and hepatic nodules. An ID consultation is requested. The ID physician consultant orders further diagnostic evaluation to determine antibiotic choice and duration of therapy. Extensive testing required includes blood and respiratory cultures, blood chemistries, serologies, acute phase reactants, and potentially the need for biopsy – all of which will require ID physician expertise to interpret and manage. Given the need for immunosuppression to prevent organ rejection, extremely close monitoring is required to rapidly identify potential additional infections. The patient's history of serious infections may limit antimicrobial therapy options, heightening the need for complex clinical decision-making, including combination therapy approaches. Coordination is required with the pulmonary transplantation team. Extensive patient and family education is required during hospitalization and post-discharge.
- A patient with prostate cancer diabetes and COPD is admitted for a severe urinary tract infection. He is treated with antibiotics and initially improves, but develops fever and abdominal pain. An ID consultation is requested. The patient requires interpretation of microbiologic studies of stool, urine, and blood, as well as imaging findings. Pre-existing co-morbidities need to be factored into interpretation and clinical decision-making, potentially increasing risks and limiting treatment options. Coordination is required with urology, general surgery, pathology, radiology, pharmacy, and case management. Extensive patient and family education are required during hospitalization and post-discharge.

We urge CMS to deem the initial inpatient E/M services as potentially misvalued, and to restore historic relativity across the E/M code sets, as outlined above. For additional information or to contact IDSA leadership, please contact Amanda Jezek, IDSA senior vice president, public policy and government relations at ajezek@idsociety.org.

Sincerely,

Carlos del Rio, MD, FIDSA
IDSA President