

Undervaluing Evaluation and Management (E/M) Codes Impacts Patient and Public Health

ID physicians make significant contributions to patient care, biomedical research, and public health which lead to lower rates of mortality, shorter hospital stays, and lower Medicare charges and payments.

The Future of Infectious Diseases Care: ID Physicians Talk About the Need to Value ID

ID physicians care for patients with life-threatening infections such as HIV, infections caused by antibiotic resistant bacteria, *Clostridium difficile*, and hepatitis C. ID doctors lead vital public health activities, including preventing and responding to public health emergencies such as outbreaks, bioterrorism attacks, and pandemic influenza.

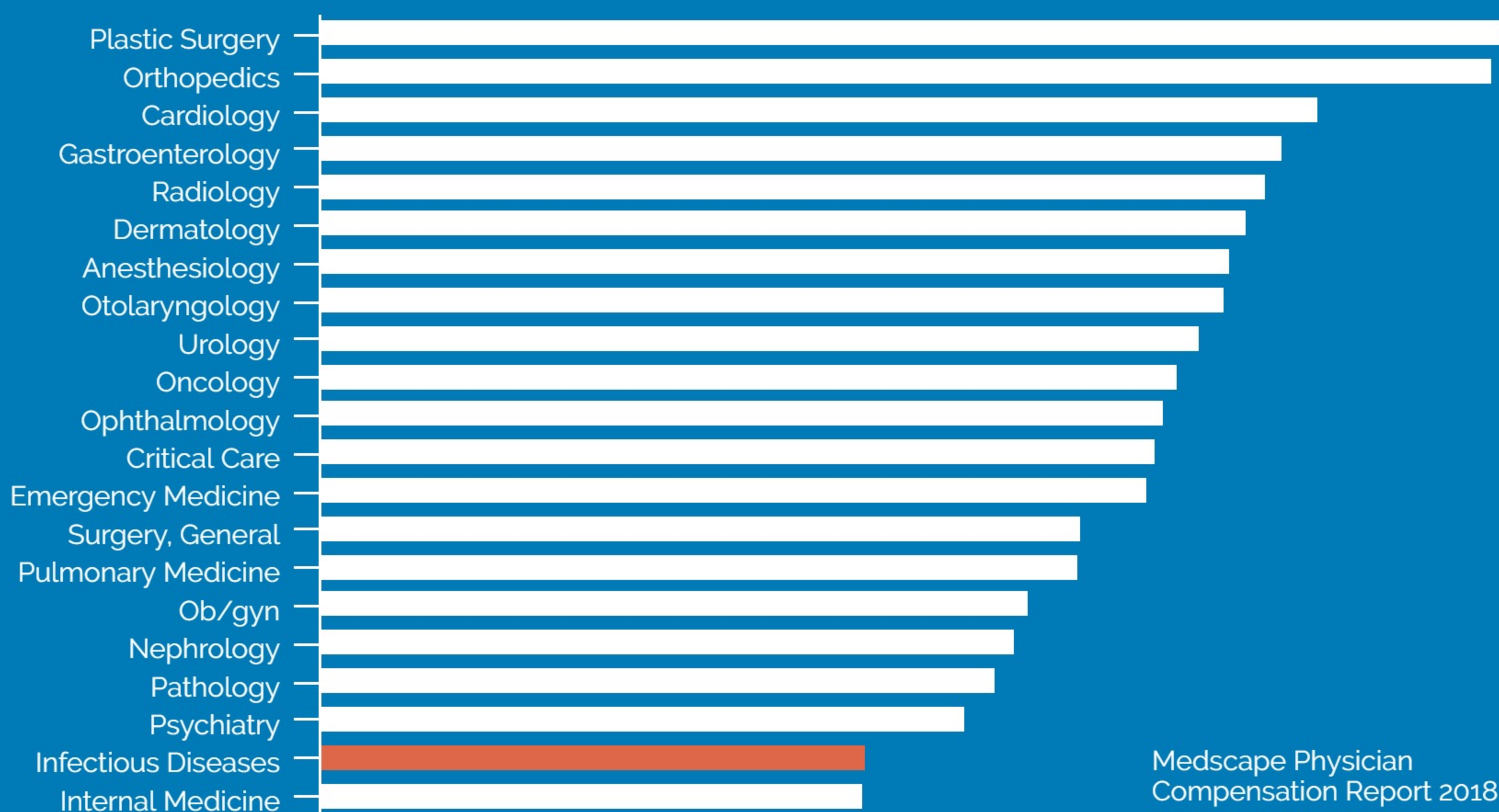
The number of residents applying for ID fellowships declined steadily from 2013 to 2016, and open training positions rose during the same period; the data indicate a problem in the workforce pipeline.

A 2014 IDSA survey of 600 Internal Medicine residents (in-training) found high interest in ID but other fields were chosen instead. **Low salary was the most often cited reason for not choosing ID**, as the average starting salary for an ID physician is less than positions that do not require additional training.

90% of the services provided by ID physicians are reported using E/M codes.

ID physicians use these codes to bill Medicare and other payers for the care they provide. Compared to procedure-based services, cognitive care is often **undervalued despite the life-threatening nature of the disease.**

Average salaries for ID physicians are significantly lower than many other procedure-based specialties and only slightly higher than the average salary of general Internal Medicine physicians, even though ID training and certification requires an additional two to three years of study. Given that the average medical student debt is approximately \$200,000, **many physicians are being driven to more lucrative specialties.**



The undervaluation of E/M codes account for significant compensation disparities between ID physicians and those who provide procedure-based services. In addition, primary care physicians who provide services billing under the exact same E/M codes as ID physicians have received payment increases because their specialty designation is "primary care physician."

Undervalued E/M codes mean that procedure-based specialists are more valuable to a hospital than ID specialists, which can cause hospitals to fail to allocate sufficient resources for the ID staff, even though **ID physician services are proven to improve patient outcomes and save money.**

“ I have been an ID doctor for ten years, we have found it challenging to find trainees to match into ID. After a long search, we finally found a doctor to replace a retired partner. She is a star and we are very grateful, but the recruitment process was not easy. Perhaps **the pipeline is running dry.**

- Dr. Mark Ransake, Assistant Professor and Residency Program Director, University of Tennessee Graduate School of Medicine, Knoxville, Tennessee

ID doesn't bring in money like procedures, so it is more difficult to influence resource allocation.

- Dr. Michael Landrum, Bellin Health, Green Bay, Wisconsin

The work associated with an inpatient E/M service for a patient with a life-threatening infection is **valued much less** than the work associated with an elective knee replacement.

- Dr. Michael Landrum

Each of us should find a way to advocate for a higher relative compensation for the work that we do in ID, as well as work towards **a health system that makes more sense for our patients and our communities.**

- Dr. David Wheeler, Annandale, Virginia



Issue

In its 2019 Physician Fee Schedule Proposed Rule, CMS proposed collapsing outpatient E/M codes for new and existing patients from five levels, which are used in billing for non-physician services (level 1) up to physician services for the most complex patients (level 5), down to just two levels regardless of the complexity of a patient's case, and making reimbursement for complex care equal to payment for more routine, minor conditions. The rule was finalized on November 1, delaying implementation of the E/M changes to 2021, and maintaining level 5 E/M to account for the most complex patients and visits. Unfortunately, beginning in 2021, CMS will create a single payment rate for levels 2 through 4 E/M outpatient visits (one rate for new, and one for established patients), which will result in lower payments for level 4 visits. **While we appreciate that CMS included ID among the specialties that may use a new “complexity adjuster” that may impact payment for the most complex patient visits, the adjuster provides a low payment that is insufficient to value complexity.**



Solution

IDSA is grateful for the support of Congress in urging CMS to develop an improved rule. As CMS continues to work on implementation of the E/M changes finalized in the 2019 MPFS, **we ask Congress to urge the agency to work with IDSA and other medical societies to ensure the appropriate valuation of E/M codes to sustain the ID and HIV workforce.** Specifically, **IDSA has joined with multiple other medical societies to request CMS to establish a technical advisory panel to draw upon external expertise in this effort.** We look forward to continuing dialogue with you regarding the final rule and the value of E/M codes.

IDSA represents over 11,000 infectious diseases physicians and scientists devoted to patient care, disease prevention, public health, education, and research in the area of infectious diseases. Our members care for patients of all ages with serious infections, including meningitis, pneumonia, tuberculosis, HIV/AIDS, antibiotic-resistant bacterial infections such as those caused by methicillin-resistant *Staphylococcus aureus* (MRSA), vancomycin-resistant enterococci (VRE), and Gram-negative bacterial infections such as *Acinetobacter baumannii*, *Klebsiella pneumoniae*, and *Pseudomonas aeruginosa*, emerging infections such as Middle East respiratory syndrome coronavirus (MERS-CoV), Enterovirus D68, and Ebola, and bacteria containing novel resistance mechanisms such as the New Delhi metallo-beta-lactamase (NDM) enzymes and others that make them resistant to a broad range of antibacterial drugs, including one of our most powerful classes of antibiotics, the carbapenems (carbapenem-resistant Enterobacteriaceae, or CRE).