September 7, 2018

Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-5522-P  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

Re: CMS-1676-P; Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program

Dear Administrator Verma,

On behalf of the 13,500 U.S.-based members of the American Academy of Dermatology Association (AADA), we are writing to provide comments on the Centers for Medicare and Medicaid Services (CMS) proposed rule *Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program*. The AADA is committed to excellence in the medical and surgical treatment of skin disease; advocating high standards in clinical practice, education, and research in dermatology and dermatopathology; and supporting and enhancing patient care to reduce the burden of disease. We appreciate the opportunity to provide comments on the proposed rule and urge CMS to take these recommendations and concerns into consideration when developing the final rule and formulating future policy.

**Proposed Valuation of Specific Codes**

**Technical Corrections to Direct PE Input Database**

In effort to update the direct PE database, CMS proposed to refine PE inputs to address discrepancies found. We are not sure how CMS arrived at the conclusion that there are
discrepancies of the direct PE inputs for the identified codes in Table 5\(^1\) of the proposed rule. **We would like CMS to clarify the method used to determine the discrepancies of the direct PE inputs.**

CMS proposed to switch the microtome blade (SF0004) to surgical super-sharp blade (SF044) for Mohs surgical code 17313. Dermatologists use microtome blade (SF004) to perform the frozen section histology inherent to this procedure. We know of no dermatologists who employ the super sharp blade for this purpose. **We ask CMS to maintain the use of microtome blade for all Mohs surgery codes.**

CMS proposed to remove the sterile gauze (SG056) from Mohs codes 17313 and 17314. The sterile gauze is used intraoperatively to remove blood from the surgical field. For the Mohs Procedure, the three ten packs of gauze for 17313 and two ten packs of gauze for 17314 currently in the practice expense are the intraoperative gauze in the surgical portion of the procedure. The additional single piece of gauze in these codes is utilized in the laboratory portion of the Mohs procedure in preparing the tissue for processing. Both gauze inputs are necessary and always employed. **We ask CMS to maintain the current inputs for gauze in all Mohs surgery codes.**

CMS proposed to reduce the volume of OCT tissue-Tek (SL097) in Mohs codes 17312 and 17314 from 8 to 6. It is not clear to us the reason why CMS is proposing this change. No alteration in the procedure has occurred. **The current volume of (SL097) of 8 in 17312 and 17314 should be maintained.**

CMS proposed to reduce the number of 2in units of Microfoam tape (SL088) from 10 to 8 in Mohs code 17313. It is not clear to us the reason why CMS is proposing the change. No alteration in the procedure has occurred. **CMS should maintain the current value of 10 for (SG088) in 17313.**

**Methodology for Proposing Work RVUs**

In the proposed rule, CMS states that there is an overlap in time and work between the E/M code that is reported on the same day and the service that is being rendered. CMS proposes to remove two minutes pre and post times from codes that are typically reported with E/M services on the same day to account for the overlap. CMS also proposes to remove work Relative Value Unit (RVU) of 0.09 (4 minutes multiplied by 0.0224 Intra Work Per Unit Time (IWPUT)). These adjustments have been made on many of the recently RUC reviewed services already. In doing this, CMS is making refinements to RVU Update Committee (RUC) recommended values where the RUC didn’t make the adjustments.\(^2\)

\(^1\) 82 Fed Reg 33963.

\(^2\) 82 Fed Reg 33985.
CMS adjusts work RVUs to account for significant changes in times to reconcile the recommended work RVUs with the recommended time values. CMS points out that there are many codes with significant time changes that do not accurately reflect the work RVUs. CMS makes the adjustments using many methodologies, including survey data, building block, cross walking to key reference code(s), and comparison of old times and new times. The RUC has objected to such adjustments. CMS is soliciting information on potential alternatives.  

The AADA recommends CMS accept RUC recommended times and RVUs. The RUC thoroughly vets the times and the values of the procedures it reviews. In some circumstances, such as with changing technology and practice patterns, performance times may decrease with increasing levels of intensity. The RUC applies the right valuation methodology to appropriately value the procedures that are being reviewed. The RUC also usually adjusts the times identified by the survey if the times seem unreasonable or if overlap with other services exists. CMS should depend on the RUC recommended values instead of trying to create arbitrary, new methodology that lacks reliability.

The AADA urges CMS to educate Medicare Advantage Organizations (MAOs) about the reductions that have already been made to account for the overlapping work. Many payers are reducing payments for typically procedures reported with an E/M, not realizing that the values have been already reduced by the RUC and CMS. CMS needs to make this policy clear to payers in order to assure that the reimbursement of services is not inappropriately reduced twice. AADA also recommends CMS have a mechanism that restores the value of a procedure if concurrent Evaluation and Management (E/M) billing declines. When E/M billing along with a procedure declines to less than 50% of the time for two consecutive years, the procedural value should be automatically restored.

Acne Surgery (10040)

CMS accepted the RUC recommended work RVU of 0.91, as well as the RUC recommended direct Practice Expense (PE) inputs and times for Current Procedural Technology (CPT) code 10040. However, CMS is considering using the current number of a half post procedure office visit instead of the RUC recommended one post procedure office visit in the follow-up period. CMS also is considering reducing the clinical labor time for assisting the physician performing the procedure from 10 minutes to 3 minutes. CMS explained that the recommended 10 minutes increased the time to cover the entire intra service work time instead of it being one third of the intra service time; therefore; CMS is seeking an explanation of the additional time.  

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3 82 Fed Reg 33985.  
4 82 Fed Reg 33989.
The AADA recommends CMS keep the post procedure office visit that the RUC recommended in reviewing the service. The one post-operative visit is medically necessary for this procedure. The typical patient is a teenager who will often need to return due to the management of medication, including changing topical treatment and/or adjusting retinoid dosage. Patients also may have new lesions that need to be treated within the global period. Furthermore, even though the survey respondents indicated a 99213 office visit was typical, the RUC reduced the visit to a 99212 to better align with clinical appropriateness during the review process.

The AADA recommends CMS not decrease the clinical labor time for assisting the physician performing the procedure. The clinical staff is present for the entire procedure assisting the physician by stabilizing the patient’s head, holding pressure to bleeding areas, and passing instruments. The assistant is gloved the whole time with no opportunity for overlapping responsibilities or multitasking.

Photochemotherapy (96910)

CMS proposed reducing the clinical labor time for “provide preservice education/obtain consent” from 3 minutes to 1 minute. CMS believes 1 minute should be adequate for patient education and there is no need to obtain consent since this would be a repeat procedure. Even though CMS has accepted the RUC recommended times for “prepare and position patient/monitor patient/setup IV” (15 minutes), “monitor patient during procedure” (16 minutes), and “clean room/equipment by physician staff” (15 minutes); CMS is seeking additional comments to justify the consideration of 7 minutes for “prepare and position patient/monitor patient/setup IV”, 4 minutes for “monitor patient during procedure”, and 10 minutes for “clean room/equipment by physician staff”.

Under PE refinement, CMS reduced the equipment times of “Exam table”, “Light”, and “Phototherapy unit” from 67 minutes to 65 minutes. CMS removed the 2 minutes of the clinical staff time for completing diagnostic forms and documentations. CMS also updated the price of the UV protective goggles from $2.30 to $4.10.

The reduction of the clinical labor times for pre-service education is not appropriate. Despite the fact that 96910 is a repeat procedure, significant pre-service education is needed prior to every treatment due to the complex and prolonged nature of the procedure. The staff needs to provide very specific instructions to ensure the safety and comfort of patients while they are in the ultraviolet treatment unit receiving treatment.

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5 82 Fed Reg 34007.
The pre-service period takes 15 minutes, consistent with RUC recommendations. The nurse reviews the chart and the medications especially for new photosensitizing medications and previous treatment protocol and reviews physician orders. The nurse interviews and examines the patient. The nurse evaluates the response to therapy as well as any UV burn from previous treatment and any history of UV exposure in the last 48 hours. A plan for current treatment is determined. The nurse applies a topical tar product, typically over a large proportion of the patient’s body surface area. Occlusive dressings (i.e. impermeable sauna suit, non-latex impermeable gloves and saran wrap) are applied over the tar. The tar product is allowed to penetrate for 4 hours while the patient is in the office, and the patient has to be monitored once every half hour and assisted with using a restroom, as needed. After incubation, the tar is removed. UV protective topicals are applied to areas that the physician doesn’t want exposed to UV.

The intraservice portion of the procedure is 16 minutes, consistent with RUC recommendations. During the intraservice portion of the treatment, the nurse positions the patient in the whole body UV machine and then starts the exposure. After first exposure, the nurse moves the patient to the hand/foot UV machine, positions the patient properly and activates the second UV exposure. The patient must be monitored during the entire time in the ultraviolet treatment unit. The narrow band ultraviolet treatment unit is loud and hot and the patient is naked and has petroleum/tar fumes generated from their body. The patient may become lightheaded or disoriented. The patient has no way to communicate with staff in a closed room and no way to stop treatment if they have a problem. The nurse has to be in the room with the ultraviolet unit wearing ultraviolet blocking goggles looking in the small monitoring window with no ability to multitask.

The room cleaning needed for this procedure is more extensive than the standard room cleaning. The room has to be cleaned multiple times due to the difficult-to-remove tar, which has carcinogenic property. The room needs to be cleaned after the application of tar and then another cleaning is required after removing the tar with mineral oil 4 hours later. In addition, the room is also cleaned after the treatment is done. It takes a long time due to the bulky equipment being cleaned, which requires cleaning skin debris off of the bulbs and the ultraviolet treatment unit.

The AADA disagrees with the removal the clinical labor time that resulted in the equipment time reduction from 67 minutes to 65 minutes. The subjective, objective, assessment, and plan (SOAP) notes needs to be completed for each patient. This documentation is also necessary for reimbursement of the service.

The price of PE input SJ027 should be corrected. We appreciate CMS updating the price of the UV goggles (supply code SJ027) from $2.30 to $4.10. However, we are concerned by the methodology CMS used to calculate the proposed price. The blended price of ultraviolet blocking goggles and monochromatic visible light blocking goggles used during photodynamic therapy is
inappropriate. We believe the current market price of SJ027 is actually higher than $4.10. We have attached copies of paid invoices that show the prices that our physicians are paying for them so CMS may update the price of SJ027.

Photodynamic Therapy (96567, 96X73, 96X74)

CMS accepted the RUC recommended work values for Photodynamic therapy codes 96X73 and 96X74. CMS accepted the PE values with some refinement. However, CMS reduced the post service time from 35 minutes to 17 minutes based on the work description that AAD provided. The equipment times of the Power Table and Exam Light were also adjusted according to the standard formula. The price of the LMX 4% cream was significantly reduced (from $1.60 to $0.78). Furthermore, there was an additional reduction in price of the safety goggles from $6.00 to $4.10.\(^6\)

\textit{The times for code 96567 should mirror the times in code 96X73, with additional time (10 minutes) for applying the photosensitizing agent, as the two procedures are similarly performed.} There was miscommunication during the RUC process regarding the PE inputs for CPT code 96567. We disagree with the reduction of the value of the existing Photodynamic Therapy code 96567. Code 96567 and 96X73 describe the same procedure with the main difference being the physician involvement in same day evaluation of the patient and application of the photosensitizing agent. The proposed valuation does not provide sufficient staff time to provide the service. The staff time for 96567 should be the same as for 96X73 with additional time for the application of the photosensitizing agent and to check dressings & wound/home care instructions/coordinate office visits/prescriptions.

Currently, the following necessary, common and performed clinical activities are missing from the proposed 96567 value: Greet patient (3 minutes), Obtain vital signs (5 minutes), Provide pre-service education (2 Minutes), Prepare room/obtain consent (2 minutes), Monitor patient following procedure (35 minutes) and Clean room (3 minutes).

\textit{We request CMS reassign values for times that are missing but needed to perform the procedure by the staff (RN/LPN).}

\textit{The post service time reduction is inappropriate and does not account for the multitude of clinical activities performed during photodynamic therapy.}

The activities during the post service period heading of “Monitor patient following procedure” (35 minutes) include:

\(^6\) 82 Fed Reg 34007.
• Prepare room for patient to incubate with previously applied topical product in dark room for the period of time determined by the physician.
• Monitor patient intermittently during incubation period. The patient is in a dark room with occlusive dressing and light blocking shielding over face. The patient must be monitored for safety and comfort and for needs such as help to bathroom.
• Review treatment requirements and discuss any reactions or complaints regarding photosensitizing agent.
• Use pre-illumination topical skin scrub for removal of topical products.
• Position patient for illumination and proper monochromatic eye protection applied.
• The patient receives irradiation of the affected area with the BLU-U Photodynamic Therapy Illuminator for approximately 17 minutes.
• Position cooling fan used to minimize patient pain during procedure
• Patient must be observed during irradiation, and this process must be continuously monitored to provide intervention to any adverse reaction. The nurse has monochromatic goggle eye protection on, has to be in the room the whole time with frequent application of interventions for discomfort. This procedure is continuously painful for the patient, and there is no opportunity for nurse to multitask.
• Monitor treatment breaks.
• Once illumination is complete, a photoprotective topical product and dressing are applied.
• The patient receives instructions regarding post procedure skin care, continued duration of photosensitivity, functional risks, and potential complications.
• Post-procedural care and prescriptions are explained to the patient and family.
• A follow up visit is scheduled.

We recommend that CMS maintain the equipment time for the power table. The patient has to stay on the table during the illumination period, and the room isn't available for other patients' use.

The price reduction of the LMX 4% cream is inappropriate. There may be online suppliers that promise to sell LMX 4% cream at a cheaper price. However, our physicians purchase drugs from reputable medical suppliers in order to ensure the safety of their patients. We have included invoices (attached) from recent purchases of the LMX cream to show the current market price.

The safety goggles used in PDT are different from the UV blocking goggles that are listed in CMS supply list. The PDT goggles cover a different and necessary range of the electromagnetic spectrum than do the ultraviolet goggles. The goggles used during PDT block monochromatic high intensity visible light and not ultraviolet light. These PDT goggles (invoices attached) are proprietary to the company that produces aminolevulinic acid and are not available through other sources. The price is $6 per pair. The goggles used in treatments and procedures employing ultraviolet light are
described by practice expense input SJ027 as described in our above comment for photochemotherapy.

**Superficial Radiation Treatment Planning and Management (HCPCS Code GRRR1)**

In 2015 changes were made to the CPT prefatory language, limiting the codes that could be reported when describing services associated with superficial radiation treatment (SRT) delivery, described by CPT code 77401 (radiation treatment delivery, superficial and/or orthovoltage, per day). Neither CMS nor the RUC has reviewed the inputs for superficial radiation therapy procedures, and neither has determined whether changes in its valuation are appropriate in light of the bundling of associated services.

CMS is proposing to make separate payment for the professional planning and management associated with SRT using HCPCS code GRRR1 (Superficial radiation treatment planning and management related services, including but not limited to, when performed, clinical treatment planning (for example, 77261, 77262, 77263), therapeutic radiology simulation-aided field setting (for example, 77280, 77285, 77290, 77293), basic radiation dosimetry calculation (for example, 77300), treatment devices (for example, 77332, 77333, 77334), isodose planning (for example, 77306, 77307, 77316, 77317, 77318), radiation treatment management (for example, 77427, 77431, 77432, 77435, 77469, 77470, 77499), and associated evaluation and management per course of treatment). CMS intends for this code to describe the range of professional services associated with a course of SRT, including services similar to those not otherwise separately reportable under CPT guidance and the NCCI manual. GRRR1 is valued to include most of the physician work associated with these additional services. There have been some adjustments to the practice expenses associated with the additional services.

There is physician work associated with Superficial Radiation Therapy that is not included in the valuation of CPT code 77401. The AADA has consistently advocated that CMS adopt temporary G codes until new values or codes can be assigned for activities associated with CPT code 77401. However, we do not know whether all of the additional services described as part of GRRR1 are consistently performed with 77401, or whether the list is complete. Dermatologists, who are the dominant specialty providing superficial radiation therapy, rarely employ radiation physicists. It may be better to adopt multiple G codes for the separate activities involved. For example, separate G codes may be needed for planning, management, and for design and construction of blocks or shielding devices. **We recommend that CMS adopt one or more G codes after meeting with individuals who provide 77401 service to determine what additional uncompensated services are being provided with Superficial Radiation Therapy.**

7 82 Fed Reg 34013.
77401 is currently reported once per day per patient regardless of the number of separate lesions treated. However, it is clear that multiple lesions treated on the same date of service require additional work. *In the final rule, CMS should clarify that the G codes may be reported with multiple units for additional sites that are treated in addition to the primary site.*

**Evaluation and Management (E/M) Services**

CMS revised the guidelines for E/M documentation requirements in an effort to reduce physician burden and clarify the guidelines in order to reduce audits. CMS is seeking comments on whether to remove the documentation requirement for history and physical exam for all E/M visits at all levels. CMS believes that decision making and time are the important factors in distinguishing the level of visits. CMS also stated that medical decision making guidelines need to be revised as well. CMS is seeking comments on the effects of such guideline changes, both clinically and legally.\(^8\)

We applaud CMS effort in reducing physician reporting burden. However, *we advise CMS against creating specialty specific E/M codes because activities of primary care and specialties overlap.* We recommend that CMS consider both the legal and clinical implications of the proposed changes before making changes to the documentation requirements of E/M visits.

**Payment for Biosimilar Biological Products**

The AADA appreciates CMS requesting comments concerning Medicare Part B biosimilar biological product payment policy. CMS asks about the impact of changing the current policy of using one HCPCS code per set of biosimilar that have the same reference biologic to a policy of having individual HCPCS codes for each biosimilar.\(^9\) They request comments on the impact this will have on the biosimilar market, including innovation, the number of biosimilar products introduced to the market, patient access, and drug spending.

The impact of the current or the proposed policy is unclear. We have concerns about the impact on patients who are stable on a biologic product but could be switched for non-medical reasons. Pharmacovigilance continues to be extremely important given the relatively new introduction of biosimilars into the healthcare system in the United States. A biosimilar payment policy should support access for patients with moderate to severe disease who are stable on current therapy. *Patients must be able to remain on their current treatment without penalty, including in Medicare Advantage plans. Forced switching of therapy poses a significant*

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\(^8\) 82 Fed Reg 34078.
\(^9\) 82 Fed Reg 34090.
risk to the patient of flaring of disease, immunogenicity (negative immune response), adverse effects and secondary nonresponse. Additionally, the physician should always be informed of the specific product, by brand name and chemical name, dispensed to a patient so they may be able to determine if a product correlates with an adverse event.

**Physician Quality Reporting System (PQRS)**

Prior to the final reporting period for PQRS in 2016, for the payment adjustment to be made in 2018, CMS had established requirements to report 9 quality measures across 3 National Quality Standard (NQS) domains. As the result of requests from the AADA and a few other specialties, CMS is proposing to reduce the number of required measures to 6, with no domain or cross-cutting measurement requirements, to achieve full credit for PQRS reporting. This will mean that more individuals will avoid the payment reductions associated with underreporting. *The AADA fully supports the reduced 2016 PQRS reporting requirement.*

CMS previously finalized a decision to publicly report data in the Physician Compare downloadable file in late 2017 quality tiers for quality, based on the 2016 data, for the 2018 Value Modifier (VM). However, because the proposed policies for PQRS and VM in this rule would change the nature of how the PQRS data will be used under the VM, CMS is now proposing not to report this data specific to the VM. *The AADA supports the proposal to not report the quality component of the 2018 VM.* We do not believe that reporting this information would be useful to the public.

**Clinical Quality Measurement for Eligible Professionals Participating in the Electronic Health Record (EHR) Incentive Program for 2016**

CMS is proposing to change the reporting criteria for Eligible Providers (EPs) and groups who chose to electronically report Clinical Quality Measures (CQMs) through the PQRS Portal for purposes of the Medicare EHR Incentive Program in 2016. CMS is proposing to change the reporting criteria from 9 CQMs covering at least 3 National Quality Strategy (NQS) domains to 6 CQMs with no domain requirement. CMS is proposing this change so that the reporting criteria for the Medicare EHR Incentive Program would be in alignment with the modified requirement that they are proposing for PQRS. *The AADA has advocated for and supports the reduced EHR CQM reporting requirement.*

**Value-Based Payment Modifier (VM) and Physician Feedback Program**

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10 82 Fed Reg 34099.
11 82 Fed Reg 34103.
12 82 Fed Reg 34103.
CMS is proposing modifications to the VM policies for the CY 2018 payment adjustment period.\textsuperscript{13} CMS is proposing to reduce the downward adjustment for groups and solo practitioners who do not meet the criteria to avoid the 2018 PQRS payment adjustment as individual solo practitioners, as a group practice, or groups that have at least 50 percent of the group’s Eligible Practitioners (EPs) meet the criteria as individuals to negative 2 percent (-2\%) for groups with 10 or more EPs and at least one physician, and negative 1 percent (-1\%) for groups with 1 to 9 EPs. This is a reduction of the maximum VM penalties that had been previously set at -4\% for groups of 10 or more and -2\% for groups of 9 or fewer EPs.

CMS would hold all groups and solo practitioners who meet the criteria to avoid the 2018 PQRS payment adjustment as individual solo practitioners, as a group practice, or groups that have at least 50 percent of the group’s EPs meet the criteria as individuals harmless from downward payment adjustments under quality tiering in 2018.

CMS will reduce the maximum upward adjustment under the quality-tiering methodology to two times an adjustment factor (+2.0x) for groups with 10 or more EPs. This is the same maximum upward adjustment under the quality-tiering methodology that they previously finalized and will maintain for groups with between 1 to 9 EPs.

\textit{These changes to the VM policies have been advocated by the AADA. We are pleased that CMS is proposing to accept our recommendations.}

\textbf{MACRA Patient Relationship Categories and Codes}

CMS is proposing the Level II HCPCS modifiers listed below as the patient relationship codes, which they would add to the operational list if they are adopted in the final rule.

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<th>No.</th>
<th>Proposed HCPCS modifier</th>
<th>Patient relationship categories</th>
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<td>1x</td>
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<td>X1 Continuous/broad services</td>
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\textit{PROPOSED PATIENT RELATIONSHIP HCPCS MODIFIERS AND CATEGORIES}

\textsuperscript{13} 82 Fed Reg 34125.
For at least an initial period while clinicians gain familiarity, CMS is proposing that the HCPCS modifiers may be voluntarily reported on Medicare claims, and the use and selection of the modifiers would not be a condition of payment.14

*While the AADA approves of the plan to make reporting voluntary, we urge CMS to offer a small payment for reporting these modifiers. This would encourage more widespread use. Without a financial incentive, few clinicians will report.*

**Request for Information on CMS Flexibilities and Efficiencies**

CMS included a Request for Information in this proposed rule, seeking ideas about improvements that can be made to the health care delivery system that reduce unnecessary burdens for clinicians, other providers, and patients and their families.15 We appreciate the opportunity to submit our recommendations to CMS on specific regulatory burdens that the agency could lift that would enhance patient care and support the physician-patient relationship in care delivery.

**Modifier 25**

The AADA has seen insurers, including at least one Medicare Advantage (MA) plan, implement reimbursement policies that reduce reimbursement by 50 percent for evaluation and management (E/M) services when modifier 25 is appropriately appended, indicating a significant separately reportable E/M on the same day as a procedure. Payers have indicated that this is in response to the HHS Office of Inspector General report citing modifier 25 for potential abuse. Since the OIG report, specialty societies including the AADA, have made significant and successful efforts to educate member physicians on appropriate use of modifier 25, and the insurers present no evidence of improper reporting of claims with modifier 25. Moreover, payment reductions on E/M services with modifier 25 do not prevent abuse. They are arbitrary cuts that reduce reimbursement below the practice expenses incurred to deliver the additional care to patients, which is unsustainable.

Many procedures performed by dermatologists are typically performed with E/M services, as dermatology patients typically present with more than one complaint. While performing a skin cancer examination or while addressing other dermatologic complaints, one or several lesions may be identified which require a procedural intervention. Patients appreciate a dermatologist’s ability to perform these procedures at the time of the office visit. We are concerned that policies that reduce payment for E/M services with modifier 25 will result in higher patient wait times and greater inconvenience.

14 82 Fed Reg 34129.
15 82 Fed Reg 34172.
Insurers have also used "overlapping overhead" as an explanation for their modifier 25 payment reduction policy. As CMS knows, during valuation at the RVU Update Committee (RUC) and CMS, both work RVUs and practice expense inputs for procedures typically provided with an E/M have been reduced to account for any overlap between the services. A further reduction in payment is therefore inappropriate.

Lastly, payment reform efforts by CMS have focused on paying physicians for delivering high quality, patient-centered care. Providing care for distinct medical conditions during one physician visit is both convenient for patients and expedites care for multiple conditions. Modifier 25 reduction policies clearly discourages high-value care by penalizing those who provide it and ultimately could lead to increased healthcare costs for patients and their employers.

*The AADA recommends that CMS implement policies to require MA plans to adhere to the standard Medicare payment policy of full payment for E/M services reported with modifier 25.*

**Prior Authorization**

Physicians face significant burdens meeting Medicare Part C and D plans' prior authorization requirements for medically necessary medications for their patients. The 2016 AAD Drug Prior Authorization Survey revealed the extent of the prior authorization (PA) burden. Most respondents to the survey reported processing six or more prior authorizations for drugs daily. Physician practices reported it taking at least 30 minutes and often an hour to complete each PA form. Dermatologists reported that they are spending up to 3 hours a day of their time completing PAs. This time could be better spent providing direct care to patients.

Dermatologists and their practices shared that there is a lack of uniformity in PA forms and processes that greatly contributes to the amount of time each PA takes. We recommend CMS alleviate this burden by placing requirements for Medicare Advantage and Medicare Part B participating plans that would shorten the turnaround time for prior authorizations and extend the length of the prior authorization approval period, encourage plans to allow for electronic prior authorization, provide detailed explanations for PA denials, including the clinical rationale, provide the plan's covered alternative treatment and provide details on the provider's appeal rights. CMS could standardize the PA form across all payers as well as the time the payer has to make and inform the provider of the PA decision and of the appeal period. We strongly encourage CMS to enforce the provisions of 42 CRF section 162.1302(c) that requires the development and implementation of a uniform standard for use in electronic PA requests as well as the provisions of 42 CFR 422.568 that require Medicare Advantage plans to standardize timelines for PA decisions. CMS could also streamline PA through sub-regulatory action, that is, by modifying the Medicare Prescription Drug Benefit Manual. We also recommend that CMS review the work of the National Council for Prescription Drug Programs (NCPDP) on electronic transactions for electronic prior authorizations. These standards aim to both
streamline the prior authorization process and provide real-time prescribing and pricing information for physicians.

**Drug Pricing**

Physicians face significant challenges prescribing drugs that patients can afford. At this time there is no easy way to determine the price of a drug at the time of prescribing in the medical office. Patients are often unaware of the cost of a drug until they are at the pharmacy. If coverage and costs information was more easily accessible to the provider when making treatment decisions it could help increase price transparency of treatments at the point of prescribing. The AADA supports having the information in the EHR/eRX system to include but not be limited to the following: medications’ formulary status, co-pay tier, out-of-pocket cost, and coverage restrictions (prior authorization, step therapy, and quantity limits).

**Notice of Benefits and Drug Price Tiering**

We share CMS’ concern, articulated in the HHS Notice of Benefit and Payment Parameters for 2017, that the number drugs eligible for specialty tiers continues to increase despite the threshold being modified. We appreciate that the agency will continue to monitor this situation. CMS has stated that it will continue reviewing drug formularies to ensure they are not discriminatory to those with specific chronic conditions. We once again commend CMS’s efforts to survey formularies for adverse tiering and high cost sharing that may discourage enrollees as important in ensuring continued access to necessary medications.

**Treatment for Vitiligo**

Vitiligo is an inflammatory, autoimmune skin disease that causes prominent pigment loss of the skin. Because the most commonly affected areas are the extremities, vitiligo has a profound and permanent impact on patients’ quality of life. However, unlike other inflammatory skin diseases with severe psychological implications such as acne, psoriasis, and atopic dermatitis, vitiligo treatments are routinely denied by insurance carriers.

Although there is no cure for the disease, there are available treatments that can halt the progression and return varying degrees of pigment with acceptable results in many cases.

Vitiligo, like these other conditions, is not cosmetic, and those affected deserve medical treatment for their condition. *The AADA asks that CMS ensure vitiligo patients have access to all treatment options for vitiligo.*

**Conclusion**
The AADA appreciates the opportunity to provide comments on the *Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program* proposed rule. We look forward to additional opportunities to discuss these issues and to provide feedback that may help guide policy development. Please contact James Scroggs, Associate Director of Regulatory and Payment Policy, at (202) 842-3555 or jscroggs@aad.org if you require clarification on any of the comments in this letter or would like more information.

Sincerely,

Henry W. Lim, MD, FAAD
President
American Academy of Dermatology

Attachments:
LMX Invoices (3)
UV eye protection invoices (2)
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The purchase listed on this invoice may be subject to a discount or other promotional consideration that may require you to report the value of such discount or promotional consideration, if any, as a discount. In addition, the prices on this invoice may include fees for services that may not be reimbursable under the Medicare/Medicaid statutes. You can receive an itemized list of any fees included in the prices upon request.

PRICING IS CONFIDENTIAL AND PROPRIETARY.
#BARCODE#EB

Invoive
Page 1 of 2

Shipped From:

MCKESSON MEDICAL-SURGICAL INC
(SUWANEE)
ATLANTA PC
1005 SATELLITE BLVD.
SUWANEE, GA 30024

District License 000001774

Shipped To:

Regulatory License 16626

Payment / Account Balance Inquires 1-800-453-5180

Phone: 1-800-426-0747

Notes: See back for Terms and Conditions.
Please contact us regarding electronic payment options at McKesson.com.

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<td>ETHCON J443H</td>
<td>SUTURE, VICRYL UD BR CT 2-0 2 (1 BX)</td>
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Account Number 54514141
Document Number 96954787
Date 03/27/2017
Amount $688.33

Please contact us regarding electronic payment options at MMS.Treasury@McKesson.com.

Please Remit To:

MCKESSON MEDICAL SURGICAL
PO BOX 634404
CINCINNATI OH 45263-4404
INVOICE

BILL TO: SHIP TO: INVOICE AMOUNT
1098602 1098602 *292.94

INVOICE INVOICE DATE
44279266 8/08/17

CUSTOMER FOR

ORDER DATE ESTIMATED DUE DATE
54718915 08/08/17 09/07/17

This order has been processed by our NORTHEAST D.C.
41 WEAVER ROAD
DENVER, PA 17517

HELLO SUE

THANK YOU FOR YOUR ORDER

HAVE A GREAT SUN SCHEIN DAY

ANY QUESTIONS PLEASE CALL STEPHANIE MAYS
1 800 772 4346 EXT 8752

GO TO YOUR ONLINE ACCOUNT TO RETRIEVE THIS MSDS/SDS. IF YOU CAN'T ACCESS ONLINE OPTIONS, CALL 1-800-472-4346.
** SPECIAL CONTRACT PRICE **

INCLUDED IN THE BELOW FREIGHT CHARGE IS A FUEL/HANDLING SURCHARGE. FOR THE CURRENT TERMS OF SALE GOTO HTTP://WWW.HENRYSHEIN.COM/US-EN/MEDICAL/LEGAL/TERMS.ASPX

PLEASE REFER TO BACK OF PAPERWORK FOR DISCLOSURES/TERMS OF SALE

PLEASE NOTE THAT LATE PAYMENTS ARE SUBJECT TO A 1.5 % MONTHLY FINANCE CHARGE

MERCHANDISE TOTAL
270.20

ITEM STATUS KEY
B - Backordered: item will follow
D - Discontinued: item no longer available
F - Special offer
M - Manufacturer will ship item directly to you
P - Prescription Drug; Return Authorization Required
R - Refrigerated Item; May be shipped separately
S - Special Schein Pricing
T - Taxable Item
U - Temporarily unavailable; please reorder
* - item has SDS

SK - School Kit
NC - No Charge

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Continued on Next Page
**HENRY SCHEIN**

135 Duryea Road, Melville, NY 11747
Questions: 1-800-472-4346

---

**INVOICE**

BILL TO: SHIP TO: INVOICE AMOUNT

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CUSTOMER PO

BILL TO/SOLD TO:

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Please detach here and mail the above with your payment

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<td>08/08/17</td>
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**ITEM STATUS KEY**

B - Backordered: Item will follow
D - Discontinued: Item no longer available
F - Special offer
M - Manufacturer will ship item directly to you
P - Prescription Drug: Return Authorization Required
R - Refrigerated Item; May be shipped separately
S - Special Schein Pricing
T - Taxable Item
U - Temporarily unavailable: please reorder
* - Item has SDS

---

SALES TAX 17.49

FREIGHT CHARGES 5.25

Invoice Date * 30 days 292.94

*Paid by Credit Card 292.94

**Balance Due .00

---

Please remit payment only to the following address:

Henry Schein, Inc.
Box 371952
Pittsburgh, PA 15250-7952

---

**ITEM STATUS KEY**

B - Backordered: Item will follow
D - Discontinued: Item no longer available
F - Special offer
M - Manufacturer will ship item directly to you
P - Prescription Drug: Return Authorization Required
R - Refrigerated Item; May be shipped separately
S - Special Schein Pricing
T - Taxable Item
U - Temporarily unavailable: please reorder
* - Item has SDS

**REM KEY**

SK - School Kit
NC - No Charge
# McKesson

## Invoice #3419459

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## Account

**Ship To**

- **Address**: PO BOX 634404
- **City**: CINCINNATI, OH 45263-4404

**Account Information**

- **PO**: 05172017STK
- **Order**: 86557671
- **Captured**: 5/17/17
- **Invoiced**: 5/17/17
- **Status**: Paid
- **Total**: $445.94

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**MISC CHARGE**  12.00  
**SHIPPING & HANDLING**  107.40  
**SALES TAX**  107.40  
**TOTAL**  107.40CR  
**PAYMENT REC'D**  .00  

**AMOUNT DUE**  .00  

**CODES:**  
NC - NO CHARGE  

**COMMENTS:** THANK YOU FOR YOUR ORDER  

**CUSTOMER #: P95605**  
F.O.B. SHIPPING POINT
# Invoice

**Bill To**

Department: 
Sales Order: SO109517

**Ship To**

Department: 

**Credit Terms**

Net 30 Days

**Order Date**

4/14/2016

**Ship To**

55073

**Ship Via**

55073

**Ship Date**

4/14/2016

**Order**

**Item Number** | **Order Qty** | **Invoice Qty** | **BO Qty** | **Tax** | **List Price** | **Net Price** | **Extended Price**
--- | --- | --- | --- | --- | --- | --- | ---
905GR | 12.0 EA | 12.0 EA | 0.0 EA | Yes | 8.50 | 6.00 | 72.00
Glasses, Fitover-Green L-30

913GR | 12.0 EA | 12.0 EA | 0.0 EA | Yes | 7.50 | 6.00 | 72.00
Goggles, Sperti Green

**Trailer**

**Currency** | USD

**Discount Pct** | 0.00

**Tax Date** | 4/14/2016

**Line Total** | 144.00

**Discount** | (0.00)

**Shipping/Handling** | 14.25

**Total Tax** | 9.50

**Invoice Total** | 167.75

**Payment Summary**

**Balance Due** | 167.75