September 7, 2018

Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1693-P  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

Re: CMS-1693-P; 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

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 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability 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.

These are some of the highlights of the proposed rule, and the AADA response to those proposals:

- This proposed rule ambitiously reaches toward the goal of Patients over Paperwork by recommending significant changes in the structure and payment of the office based Evaluation and Management (E/M) codes. Unfortunately, the proposed changes are not an improvement over the current documentation requirements and payment structure. The structure is flawed, and the proposal to reduce payments when E/M services are reported with procedures fails to account for fee schedule reductions that have already been taken on these codes. We recommend that CMS work with the physician community, especially the CPT Editorial Panel and the RVS Update Committee (RUC) to develop better alternatives.

- CMS continues to struggle with evaluating the number of visits associated with codes that have 10- and 90-day global periods. Attempts to measure these visits have suffered from significant methodology failures. Our comments include recommendations to help CMS improve on efforts to evaluate these codes.
CMS updated the prices of many supplies and pieces of equipment in the database, based on market research. The AADA applauds efforts to correctly value Practice Expenses (PE), but ask that CMS remain receptive to input from specialties as we review those corrections.

We appreciate the proposals to increase access for Medicare beneficiaries to physicians' services that are routinely furnished via communication technology. Our comments offer recommendations based on the AADA position statement on telemedicine.

We describe the areas where we differ with CMS on some of the proposed valuation specific codes, and include detailed explanations of the rationale for our objections.

CMS is not recommending significant changes to the Quality Payment Program. We identify many areas of agreement.

We encourage CMS to increase QPP scoring credit for physician use of a Qualified Clinical Data Registry (QCDR).

CMS proposes that a condition of acceptance of a QCDR's measure is unconditional sharing of that measure with entities that do not contribute to measure development. This is unacceptable, and will reduce physician community support for the QPP program.

We object to the increased weighting of the cost category in the QPP.

We appreciate the efforts to reduce regulatory burden and to work with stakeholders to improve the Fee Schedule and the Quality Payment Program. Our more detailed analysis and comments are described below.

I. PROVISIONS OF THE PROPOSED RULE FOR PHYSICIAN FEE SCHEDULE (PFS)

A. Update on the Global Surgery Data Collection

CMS reported on the results of its 2017 efforts to determine the number of post-procedure visits that occur during 10- and 90-day global periods. CMS required use of 99024 for reporting post-operative visits associated with 10- and 90-day global services in certain states by physicians in practices with 10 or more practitioners. Post-procedure visits during 10-day global periods were reported 4% of the time, and there was 67% reporting of at least one visit during 90-day global periods. ¹

The AADA was surprised at the low response rate among those who billed for procedures with 10- and 90-day global periods. The reporting clearly does not accurately reflect the number of post-procedure visits. Surveys of physicians conducted for valuation of the services at the Relative Value Scale (RVS) Update Committee (RUC) indicate that 10-day global codes typically include at least one post-procedure visit. In our members’ experience, 90-day global services are nearly always provided with multiple post-procedure visits, so even the 67% reporting of post op visits for this set of services seems unbelievably low. The discordance between the 2017 post-op reporting using 99024, the RUC survey data, and our member physician experience are mainly due to underreporting and inadequacies in the reporting mechanisms.

The 99024 post-op codes were dramatically under-reported to CMS for numerous reasons including increased reporting and documentation burden, lack of incentive for reporting,

¹ 83 FR 35733
clearinghouse procedural issues with billing a non-valued service, confusion on both whether to report as well as what counted as a reportable service, and simple lack of attention coupled with lack of targeted reinforcing messages. To encourage better participation, the AADA offers these responses to the questions posed in the proposed rule:

1. **How can CMS encourage reporting to ensure the validity of the data without imposing undue burden?**

   The AADA recommends providing incentives for reporting. This could be done in at least one of two ways. A nominal payment, such as $10, could be made when 99024 is reported. This incentive would motivate reporting and would defray administrative costs associated with the requirement, at a relatively low cost to CMS. A second option would be to offer a MIPS scoring bonus for meeting a defined reporting threshold. This would demonstrate to providers the importance that CMS places on the activity. Complying with CMS mandates should result in a quality related scoring bonus.

   In addition, CMS could identify when providers are not consistently reporting and try to correct that situation. For example, if physicians frequently reported several 99024 visits during the first month or two of the reporting period, then reported nothing, that would indicate the need for follow-up reminders and encouragement.

2. **Does CMS need to do more to make practitioners aware of their reporting obligation? Should CMS consider implementing an enforcement mechanism?**

   CMS and medical societies such as the AADA need to do more to notify physicians of the reporting requirement. Since this is an ongoing effort, frequent reminders should be sent. CMS has apparently identified physicians in practices for which reporting is expected, yet there was no proactive targeted messaging directed to those individuals. Anecdotally, we know that many physicians are unaware that they are expected to continue reporting until CMS gives notice that the requirement is ending. CMS can also identify practitioners or practices that reported once or twice, then ceased. These could also receive targeted messaging. The AADA made efforts to publicize the participation requirements before and as reporting was beginning, but would be happy to provide additional encouragement. If CMS could identify dermatologists who are expected to report, the AADA could contact them directly with messages approved by CMS to emphasize the importance of reporting 99024.

   Penalties for not reporting visits is obviously an unworkable idea. Doing so could force providers to schedule unneeded visits to meet the requirement.

3. **Might it be reasonable to assume that many visits included in the valuation of 10-day global packages are not being furnished, or are there alternative explanations for what could be a significant level of underreporting of postoperative visits? For example, it is likely that in many cases the practitioner reporting the procedure code is not performing the postoperative visit, or the postoperative visit is being furnished by a different practitioner.**
It is not reasonable to assume that post-operative visits included in the valuation of 10-day global packages are not being furnished. There has been no validation that there is any correlation between post op visit furnished and 99024 reported. Moreover, directly comparing rates of 99024 reporting for 90- and 10-day code rates of 99024 is like comparing apples to oranges because 90 day codes typically include 4 or 5 visits, making the chance of a successful transfer of 99024 to CMS much higher. Many 90-day codes are performed in a facility, increasing likelihood of reporting additional visits.

As noted above, there are multiple reasons why 99024 may be underreported. Beyond the structural issues previously discussed, for many practices such reporting requires a conceptual shift in billing practice that is challenging. Suture removal after a procedure has never been payable or reportable, so practices may not have reported this “routine” visit, which is bundled into the valuation of the procedure. The work and burden of reporting 99024 has not been in historical workflows. Changing workflows to accommodate reporting 99024 requires medical practices to invest in training staff to do their work differently.

Furthermore, it is unclear whether practices were required to report every follow-up visit in the global period with 99024, or report it only once. Given that fewer than 70% of 90-day global codes had an associated 99024, it seems likely that physicians were unaware that each visit is reportable. With advances in technology, some follow-up services may now be performed via telemedicine or telephonic communications platforms. Discussions within the specialty indicate confusion as to whether these interactions should be accounted for by reporting 99024. Greater clarification and education is required from CMS.

Different practitioners in the same group, especially in large groups, may be performing many post-operative visits. Claims are not normally submitted for these visits, but the persons performing these postoperative visits may not have been aware that they are also required to report using 99024. Again, CMS could provide better guidance on which visits are to be reported and by whom.

CMS is also engaged in these additional activities to determine the number of post procedure visits:

- A survey of a representative sample of practitioners about the activities involved in and the resources used in providing a number of pre- and post-operative visits during a specified, recent period of time, such as two weeks. CMS recognized that the initial survey effort was too burdensome and did not yield useful results. CMS is attempting this process again with a simplified survey, focusing the effort with a targeted survey on a small number of codes.
- A more in-depth study, including direct observation of the pre- and post-operative care delivered in a small number of sites, and a separate survey module for practitioners practicing in ACOs. CMS apparently has not completed this work.

These additional efforts to collect data should be completed and the results included in the rule making process, for comment, before drawing any conclusions.
4. Is it possible that some or all of the postoperative visits are occurring after the global period ends and are therefore reported and paid separately?

Some of the visits associated with the 10-day global period are likely occurring outside the global period. For example, it is not uncommon for dermatologic surgeons to remove sutures in areas of high skin tension at 11 to 21 days after an excision with a 10-day global period. The AAD has consistently educated members that post-op visits associated with typical care for 10-day global codes, such as suture removal, should not be reported and should not be billed even if they take place after the global period has ended. CMS is not paying dermatologists separately for these services. However, evaluating non-billed post-operative visits outside the 10-day global period will be critical to accurately assessing rates of surgical follow up care.

We appreciate and support CMS efforts to correctly value codes that have 10- and 90-day global periods. However, due to weaknesses in the application and structure of the post-op visit data collection project as well as lack of validation of 99024 reporting, the result of few reported post-op visits is not surprising. Additional efforts and more sophisticated methodology will be required to collect accurate data needed to determine the number and intensity of the visits that are occurring.

B. Evaluation and Management (E/M) Services

CMS has concluded that the E/M code set is outdated and needs revision. The E/M documentation guidelines are perceived as administratively burdensome and confusing. CMS has concluded that the guidelines are too complex and ambiguous, they fail to meaningfully distinguish differences among code levels, and have not been updated to account for changes in technology, especially electronic health record (EHR) use.

CMS is therefore proposing several changes to E/M visit documentation and payment.

Documentation Reduction

As part of the effort to reduce documentation burden, CMS seeks comments on a proposal to eliminate the prohibition on same-day E/M visits billed by physicians in the same group or medical specialty. Dermatologists sometimes refer a patient to another dermatologist within their group practice for same day evaluation, when the first dermatologist lacks expertise to deal with an emergent problem. For example, a general medical dermatologist might refer a patient to a dermatologic surgeon for same-day excision of a melanoma. Similarly, a primary care provider might refer to a dermatologist in the same multispecialty group. Currently, in that situation, patients are expected to return on a separate day. Eliminating the prohibition could encourage quicker access to specialists when patients are seeing different specialties in the same group. The AADA supports the proposal to allow billing for same-day EM visits by physicians of the same specialty or by physicians in the same group.

CMS is proposing to create a single rate under the PFS that would be paid for services billed using the current CPT codes for levels 2 through 5 E/M visits, so it would not be material to Medicare’s payment decision which CPT code (of levels 2 through 5) is reported on the claim.

2 83 FR 35835
except to justify billing a level 2 or higher visit. CMS still expects practitioners to report all 5 levels of office E/M service, but would allow practitioners to choose, as an alternative to the current framework specified under the 1995 or 1997 guidelines, either medical decision making (MDM) or time as a basis to determine the appropriate level of E/M visit. The Agency would like to retain the current CPT coding structure for E/M visits, along with creating new replacement codes for podiatry office/outpatient E/M visits.

CMS also proposes to simplify the documentation of history and physical exam for established patients such that, for both of these key components, practitioners would only be required to document only what has changed since the last visit or on pertinent items that have not changed, rather than re-documenting a defined list of required elements such as review of a specified number of systems and family/social history.

*The AADA supports allowing physicians to choose between current documentation guidelines, documenting by time only, or documenting by medical decision making only. We also support eliminating the redundant documentation requirements for history and exam. The AADA recommends CMS adopt the reduced documentation requirements immediately (i.e. calendar year 2019), since documentation burden is often listed as the greatest deterrent to “putting patients first,” a paramount CMS priority. This part of the proposal can be implemented while the outpatient visit codes and the fee structure are being reviewed and revised by the CPT Editorial Panel and the RVS Update Committee.*

**E/M Payment Consolidation**

The AADA agrees that the current office E/M coding structure, fees, and documentation requirements are outdated and need revision. Simplified codes with simplified reporting requirements would meet the goal of putting Patients before Paperwork. The fee structure should accurately compensate physicians for the extra work involved with caring for patients with more complex or multiple conditions. The AADA commends CMS for appreciating this issue and taking steps toward correction. However, the proposed E/M structures are deeply flawed. The collapsed fee structure is not resource-based and does not provide fees that are relative to the work and practice expenses involved.

Finalizing such changes in November for implementation on January 1 is very problematic. Practice Management and EHR billing systems will need to be able to distinguish the new billing schemes to appropriately code for visits. Considering that some electronic systems are presently set up to extract levels of E/M from the entered medical record data, they will be unable to do so for the proposed time and medical decision-making criteria. The present proposed implementation timeline will not provide sufficient time for the electronic billing systems to be modified to meet the demands of the new coding paradigms or to appropriately educate and prepare all physicians in the United States.

The PFS must appropriately compensate physicians, regardless of specialty, for extra work associated with evaluation and management of more complex patients. Dermatologists often treat patients with very complex conditions and systemic disease with severity of illness on par with other specialties. *The codes and the reimbursement in this proposed rule do not meet the goal of establishing a reasonable, relative, and equitable coding and fee structure. The AADA recommends that CMS work closely with the CPT Editorial Panel to achieve the objective of revising the E/M code set and establish reasonable reporting requirements for those codes.*
Payment reductions when E/M visits are reported with procedures

CMS proposed a reimbursement reduction of 50% to the lowest cost service when an E/M and a procedure occur on the same day. CMS indicates it is recognizing gained efficiencies when both an E/M and procedure occur during the same encounter, though there is no indication of the calculations used to arrive at the 50% figure. The reduced reimbursement would be re-allocated to increase reimbursement for add-on codes that are proposed for E/M visit for primary care encounters and other specific specialty visits. CMS compares this reduction to the Multiple Procedure Payment Reduction (MPPR), which is a reduction in reimbursement by 50 percent for each additional procedure when multiple procedures occur during the same appointment. This concept is erroneous and the proposed payment reduction should be withdrawn immediately.

Modifier 25 is used to indicate that a separate and identifiable E/M service has been performed at the same visit as a minor procedure. A typical example in dermatology would be a patient who presents for a scheduled excision and at the same time is experiencing a flare of psoriasis that requires history, exam and medication adjustment. The resources used for providing the separately identifiable E/M service, as indicated by use of the 25-modifier, are significantly different from those used in performing the procedure. Areas of overlap and “efficiencies gained” when procedures are typically billed with an E/M have long been addressed during code valuation by the RUC and by CMS, with reductions taken in all three major portions of the code value, namely physician work/time, direct PE and indirect PE. It is important to note that these reductions occur even when the procedure code is billed without a concurrent E/M service.

For example, this is from the RUC Rationale on the recommendations for eyelid biopsy (67810), reviewed in September 2011:

"The RUC agreed with the specialty society recommended pre-service time of 11 minutes and intra-service time of 13 minutes. The RUC acknowledged that the specialty society survey of 20 minutes and the standard of 23 minutes is too high due to the reporting of Evaluation and Management on the same date. The recommended pre-service time of 11 minutes addresses the issue. However, the RUC reduced the post-service time from 10 minutes to 5 minutes, as this service is typically performed with an Evaluation and Management service…"

Similarly, in previous PFS rules CMS has described how adjustments are made to the values of procedures that are usually done on the same day that an E/M service is provided to account for efficiencies and redundancy in physician work and PE. From the 2018 PFS final rule, regarding the work RVU adjustments:

“In cases where a service is typically furnished to a beneficiary on the same day as an evaluation and management (E/M) service, we believe that there is overlap between the two services in some of the activities furnished during the preservice evaluation and post-service time. Our longstanding adjustments have reflected a broad assumption that at least one-third of the work time in both the preservice evaluation and post-service period is duplicative of work furnished during the E/M visit.”

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3 83 FR 35841
Accordingly, in cases where we have believed that the RUC has not adequately accounted for the overlapping activities in the recommended work RVU and/or times, we have adjusted the work RVU and/or times to account for the overlap. The work RVU for a service is the product of the time involved in furnishing the service multiplied by the intensity of the work. Preservice evaluation time and post-service time both have a long-established intensity of work per unit of time (IWPUT) of 0.0224, which means that 1 minute of preservice evaluation or post-service time equates to 0.0224 of a work RVU.

Therefore, in many cases when we have removed 2 minutes of preservice time and 2 minutes of post-service time from a procedure to account for the overlap with the same day E/M service, we have also removed a work RVU of 0.09 (4 minutes × 0.0224 IWPUT) if we have not believed the overlap in time had already been accounted for in the work RVU. The RUC has recognized this valuation policy and, in many cases, now addresses the overlap in time and work when a service is typically furnished on the same day as an E/M service.\textsuperscript{4}

Regarding the PE adjustments:

"In addition, in cases when a service is typically billed with an E/M service, we remove the preservice clinical labor tasks to avoid duplicative inputs and to reflect the resource costs of furnishing the typical service."\textsuperscript{5}

Procedure codes already have reductions in indirect PE to account for reporting with E/M. CMS calculates indirect PE based on a number of variables, but the most important inputs are physician work/time and direct PE. Given that both physician work/time and direct PE have been reduced in procedure codes typically billed with a concurrent E/M, indirect PE has been reduced and any overlap is eliminated.

The value corrections continue in this proposed rule, where CMS is reducing the quantity of minimum multi-specialty visit packs, SA048, of 165 codes that are typically billed with an E/M service.\textsuperscript{6}

The MPPR policy that CMS previously implemented applies to procedural services furnished together where duplication of time/expense is evident. A reduction to payment when E/M codes are reported with Modifier 25 reduction is not equivalent and not comparable to the MPPR. In this proposed policy, \textit{CMS provides no valid rationale for any value reduction. CMS does not account for the processes already in place to reduce reimbursement when a procedure and E/M occurs during the same encounter. This policy is a misguided attempt to find a way to pay for the add-on G codes that are intended to correct payment inequities created by the proposal to provide a single payment for E/M level 2 to level 5 office visits. CMS is proposing to fix fee schedule flaws created by the flat E/M payment by creating flaws elsewhere in the fee schedule.}

CMS is charged with establishing payments based on the work, practice expense, and professional liability relative value associated with physician services. The work component must be based on the physician time and intensity.\textsuperscript{7} We are aware that Section 3134 of The

\textsuperscript{4} 82 FR 53032
\textsuperscript{5} 82 FR 53036
\textsuperscript{6} 83 FR 35716
\textsuperscript{7} Pub. L. 101-239. 103 Stat. 2171
Affordable Care Act (ACA) added section 1848(c)(2)(K)(ii)(IV) of The Social Security Act specifies that the Secretary of Health and Human Services shall identify potentially misvalued codes by *examining multiple codes that are frequently billed in conjunction with furnishing a single service* (emphasis added). Procedures frequently billed with E/M services have already been reviewed and revalued. By definition, procedures and E/M services reported with modifier 25 on the same day for the same patient are not a single service. They are distinct services. **The proposed 50% reduction is arbitrary and meets neither the original charge associated with establishing physician fees nor the requirements added by the ACA.**

Other E/M associated coding revisions
CMS is proposing separate E/M codes for new and existing patients for podiatry. While we are concerned with the consolidation of payment rates for all E/M codes, we are also troubled that podiatry is targeted under this proposal. CMS’ proposals would effectively serve to provide differential payment for the same evaluation and management services based on specialty, singling out podiatry for reduced payment. Section 1848(c)(6) of the Social Security Act expressly prohibits differential valuation (and thereby payment) of services paid under the Physician Fee Schedule based on specialty. CMS does not provide any rationale for why the evaluation and management required for patients seeking care from podiatrists is distinct from that provided to patients seeking medical care from other physicians, for patients with similarly complex care needs. Therefore, we recommend CMS not finalize its proposal to provide differential payment to podiatrists by requiring them to utilize separate E/M codes.

CMS is also proposing three new add-on HCPCS G-codes:
- **GPC1X** for visit complexity inherent to evaluation and management associated with primary medical care services, with payment of about $5 (0.15 RVUs), for ongoing care of existing patients when procedures are not reported.
- **GCG0X** for office visits performed by certain specialties, with payment of about $12 (0.33 RVUs).
- **New prolonged service code GPR01**, with payment of about $67, for any office visit lasting more than 30 minutes beyond the typical office visit time. A visit would need to exceed 45 minutes for that code to be applicable.

There are a number of unanswered questions associated with the proposed G-codes. Would they be specialty or service based? Would they be linked to ICD-10 diagnostic codes? For example, if a primary care physician treats a patient with acne could the GPC1X modifier be used? If a dermatologist prescribes birth control, could the GPC1X modifier be used? If a dermatologist prescribes a biologic immune modifier to treat psoriasis and psoriatic arthritis or a systemic immunosuppressant for systemic vasculitis, could GCG0X be used?

By selecting particular specialties, services, or diseases for special consideration, two physicians providing the same service may be reimbursed at different rates, with the provider most equipped to provide appropriate care receiving the lesser payment. This disrupts the process that has been fundamental to establishing relative values of services since 1992.

There is no justification for the payment increase for existing patient E/M visits that are not billed with procedures, and payments should not be reduced when procedures are performed during the same visit as an unrelated E/M service is provided. Same day care ensures prompt access to necessary care, and increases patient satisfaction and convenience. Fees should not encourage separation of work.
It is never appropriate to identify specialties when defining a code, whether for increased payments (GCG0X) or the decreases associated with the podiatry codes.

The time threshold for the third G-code is extremely difficult to achieve, and the payment is small for the time. All of these codes are contingent on the flawed proposed flat payment for physician office visit E/M levels 2 to 5. All of the G-code proposals associated with E/M services are very flawed. None should be implemented. Again, the AADA encourages CMS to work more closely with the physician community, especially the CPT Editorial Panel, to develop a workable E/M coding structure. The RUC should be relied on for developing valuation recommendations.

C. Determination of Practice Expense (PE) Relative Value Units (RVUs)

Market-Based Supply and Equipment Pricing Update

CMS updated the prices of 1300 supplies and 750 pieces of equipment in the database. CMS conducted market research using vendor telephone surveys, data from aggregate health system buyers database, vendor resources (Amazon and Cardinal Health), physician panel substantiation to validate current prices of the medical equipment and supplies. Given the impact on reimbursement CMS is proposing to phase in the updates over 4 years using a 25/75 percent (CY 2019), 50/50 percent (CY 2020), 75/25 percent (CY 2021), and 100/0 percent (CY 2022) split between new and old pricing.

We commend CMS for updating the Practice Expense Database with the most current pricing information. We recommend that CMS obtain prices on medical supplies only from reputable suppliers. Online searches can result in inappropriately low pricing from suppliers that may not actually have inventory or be selling counterfeit supplies. There may be problems with some of the prices that were obtained through this process. For example, here are two example of supplies with questionable pricing:

1. SF040 (Vicryl suture). The agency proposes reducing the supply cost from $7.85 to $4.31. This pricing is not consistent with the current cost from the dominant medical supplier in the USA. We have included invoices with this letter (Attachment 1) indicating a per unit cost of $12.25 to $12.67 for Vicryl sutures.
2. SG056 (sterile gauze). The agency proposes reducing this supply cost from $0.80 to $0.03. This appears to be changing the price of sterile gauze to match that of non-sterile gauze (SG055). Sterile gauze is clearly more costly to produce than non-sterile gauze and the acquisition cost reflects that fact.

In order to validate the updated prices of the supplies that dermatologists commonly use, the AADA requests the opportunity to provide additional invoices after reviewing the changes.

D. Communication Technology-Based Services

CMS is aiming to increase access for Medicare beneficiaries to physicians’ services that are routinely furnished via communication technology. They are proposing new HCPCS codes to meet that goal: brief, non-face-to-face appointments via communications technology (virtual
check-ins); evaluation of patient submitted photos; and the foregoing codes bundled together for use by federally qualified health centers and rural health clinics.

These are the proposed descriptions:

GVCI1: Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5–10 minutes of medical discussion.

GRAS1: Remote evaluation of recorded video and/or images submitted by the patient (e.g., store and forward)\(^9\)

The AADA supports adoption of these G codes, which are consistent with codes under development by the CPT Editorial Panel. We have concerns about the CMS valuation of these codes based on the resources, time, and effort involved. The AADA recommends that CMS go through the RUC/CPT process to appropriately value these services.

The AADA supports adoption of the GVCI1, and concurs that a prior patient-physician relationship is required for high quality care. The AADA’s telemedicine position statement articulates that the consulting dermatologist must either: i. Have an existing physician-patient relationship (having previously seen the patient in-person), or ii. Create a physician-patient relationship through the use of a live-interactive face-to-face consultation before the use of store-and-forward technology, or iii. Be a part of an integrated health delivery system where the patient already receives care, in which the consulting dermatologist has access to the patient’s existing medical record and can coordinate follow-up care. We also urge CMS to consider the importance of appropriate technology in facilitating high quality telemedicine. The AAD’s telemedicine position statement states, “A high resolution video camera is required at the originating site, and a monitor with resolution matched to the camera resolution is required at the distant site. Videoconferencing systems work optimally when a connection speed of >384 kbps is used. Slower connection speeds may necessitate that the individual presenting the patient perform either still image capture or freeze frame to render a quality image. For most diagnostic images, a minimum resolution of 800 x 600 pixels (480,000) is required, but higher resolution may increase diagnostic fidelity.”\(^10\)

We also recommend that CMS add additional clarity around the technology requirements for store and forward technology (GRAS1) to ensure high quality teledermatology patient care. Physicians cannot provide high quality care when patients share pictures on sub-par technology, such as old flip phones. The AADA’s position statement requires the following technology for store and forward telemedicine, “A digital camera, whether integrated in a mobile handheld device or comprehensive telecommunications system or a stand-alone product, with a minimum of 800 x 600 pixel (480,000) resolution is required; however, higher resolutions may increase diagnostic fidelity. For systems that transmit over the Internet, a minimum 128-bit encryption and password-level authentication are recommended.”\(^11\)

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\(^9\) 83 FR 35724


\(^11\) Id.
Finally, the AADA encourages CMS to consider the importance of access to medical records, of documentation, and coordination of care in the provision of teledermatology. The AADA telemedicine position statement requires, “The patient’s relevant medical history must be collected as part of the provision of teledermatology services. For tele triage and teleconsultation, appropriate medical records should be available to the consulting dermatologist prior to or at the time of the telemedicine encounter. Consulting dermatologists should have a good understanding of the culture, health care infrastructure, and patient resources available at the site from which consults are originating. The provision of teledermatology services must be properly documented. These medical records should be available at the consultant site, and for tele triage and teleconsultation services, should also be available at the referral site. The provision of teledermatology services should include care coordination with the patient’s existing primary care physician or medical home, and existing dermatologist if one exists. This should include, at a minimum, identifying the patient’s existing primary care physician and dermatologist in the teledermatology record, and providing a copy of the medical record to those existing members of the treatment team who do not have electronic access to it. This is especially important so that information about diagnoses, test results, and medication changes are available to the existing care team.”

CMS also proposes to value new CPT codes for Interprofessional Internet Consultation (CPT codes 994X6, 994X0) consistent with RUC recommendations while also proposing to unbundle and cover existing time based CPT codes for remote consultation (99446, 99447, 99448, and 99449).

994X0: Interprofessional telephone/internet/electronic health record referral service(s) provided by a treating/requesting physician or qualified health care professional, 30 minutes

994X6: Interprofessional telephone/internet/electronic health record assessment and management service provided by a consultative physician including a written report to the patient’s treating/requesting physician or other qualified health care professional, 5 or more minutes of medical consultative time

We are pleased that CMS is adopting these new codes.

E. Valuation of Specific Codes

1) Skin Biopsy (CPT Codes 11X02, 11X03, 11X04, 11X05, 11X06, and 11X07)

CMS accepted the RUC recommended work values for 5 of the 6 new codes. CMS lowered the RUC recommended value for 11X03 (tangential biopsy) from 0.38 to 0.29 work RVUs, stating that it would have a higher work value in comparison to other similar add-on codes.

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12 Id.
13 83 FR 35725
14 83 FR 35748
A. Physician Work

CMS compared code 11X03 with other add-on codes instead of the comparator codes used by the RUC. The total number of add-on codes CMS identified with total time 7 minutes or less is 18. Only five of these services have total time of 6 or 7 minutes; the rest are lower. Thus, the work RVUs of the majority of example add-on codes are not comparable to 11X03 because they have lower times. The example codes with 6 or 7 minutes of intraservice time are for immunization administration, intravenous infusion and chemotherapy administration. The physician work associated with these add-on codes is described as an additional injection or as providing “direct supervision.” However, 11X03 is actually an entirely new procedure, performed on a separate site and lesion than the base code, frequently involving an entirely different technique than the primary code. The additional procedure involves performing all the work elements of the base code from scratch, including re-positioning the patient, prepping and anesthetizing the new site, performing the biopsy, collecting the specimen, achieving hemostasis, and bandaging the surgical site. Everything that is done for the primary procedure is also done for the add-on procedure at a different site. As a separate and distinct procedure, the work value of 11X03 is higher than CMS’ comparator codes.

In terms of intensity of service, the cross-walk to code 11732 (which describes a procedure with significant physician effort in removing a nail plate with its anesthesia and hemostasis challenges) is a much better comparator code to 11X03, which involves biopsying a vascular tumor, typically on the face. CMS’ proposed cross-walk code 11201 involves snipping barely vascularized skin tags in areas of little cosmetic concern. CPT code 11732 is a much better cross-walk for 11X03 than 11201.

Furthermore, the ratio of work RVUs of the add-on codes to base codes (calculated by dividing the wRVU of the add on code by the wRVU of the associated base code) should be consistent across the skin biopsy code set to ensure relativity. Using the CMS proposed values for the tangential biopsy codes (11X02 and 11X03), the wRVU ratio is 0.44, which is not proportional to the RUC approved wRVU values with ratios of 0.54 for the punch biopsy codes (11X04 and 11X05) and 0.53 for the incisional biopsy codes (11X06 and 11X07). Of note, the RUC approved wRVU ratio for the tangential biopsy codes is 0.57. Therefore, the proposed wRVU of 0.29 for the shave biopsy add-on code 11X03 is too low to maintain relativity within the family. The RUC-approved wRVU of 0.38 does maintain relativity.

The AADA recommends that CMS compare 11X03 to the appropriate codes and maintain the RUC recommended RVU of 0.38.
B. Practice Expense

CMS lowered a number of Practice Expense (PE) components from the RUC recommended values of the skin biopsy codes. It is not appropriate to only include equipment and supply items in the new biopsy add on codes that are included in the old add-on code (11101). The old codes are not specific enough to accurately distinguish between the 3 types of biopsies. Accordingly, the RUC and CPT created new codes and accurately valued them to allow the reporting of biopsies using the different techniques. The supplies and equipment needed for the 3 types of biopsies are different and because the new codes are valued for specific procedures, they will contain practice expense items not included in the older non-specific biopsy codes. For instance, the old code 11101 does not supply items that are necessary for the performance of the incisional biopsy.

*We strongly recommend that CMS include all clinically needed and RUC recommended equipment and supply items for the new skin biopsy codes.*

The table in Attachment 2, with this letter, addresses the practice expense items that CMS proposed to remove and decrease. The last column explains the clinical reasons why they items are essential to perform the procedures. The PE inputs for 11101 should not be used for establishing PE for the new add-on codes.

2) Shaving of Epidermal or Dermal Lesions code family 11310-11313

CMS reported that there is a rank order anomaly in the shave code family (CPT11310-11313). CMS stated that there were clerical inconsistencies in direct PE inputs for code 11311 that happened after the codes were reviewed by the RUC in CY 2013. CMS found that the PE RVU for 11311 is lower than 11310, suggesting rank order anomaly. Therefore, CMS revised the direct PE inputs for code 11311.

We agree that clearly a significant clerical error occurred after the valuation of 11311 by the RUC and final acceptance of value by CMS. With comparison to the bookend codes 11310 and 11312, it is clear that many elements necessary to the performance of 11311 are not included in the PE supplies as listed in the CMS database.

*The AADA recommends that PE inputs of code 11310 be replicated for code 11311 as shown in the table below to restore rank order.*

### 11310, 11311, 11312 Supply List

<table>
<thead>
<tr>
<th>Supply Code</th>
<th>Description</th>
<th>11310 Quantity</th>
<th>11311 Quantity</th>
<th>11312 Quantity</th>
<th>AADA Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>SA043</td>
<td>pack, cleaning, surgical instruments</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>SA048</td>
<td>pack, minimum multi-specialty visit</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

15 83 FR 35718
| SB001 | cap, surgical | 2 | 0 | 2 | 2 |
| SB007 | drape, sterile barrier 16in x 29in | 0 | 1 | 0 | 1 |
| SB010 | drape, sterile, fenestrated 16in x 16in (eye) | 1 | 0 | 1 | 1 |
| SB011 | drape, sterile, fenestrated 16in x 29in | 0 | 1 | 0 | 1 |
| SB012 | drape, sterile, for Mayo stand | 1 | 0 | 1 | 1 |
| SB016 | drape-cover, sterile, OR light handle | 1 | 0 | 1 | 1 |
| SB020 | drape-towel, sterile OR blue (2 pk uou) | 2 | 0 | 2 | 2 |
| SB023 | gloves, non-sterile, nitrile | 1 | 0 | 1 | 1 |
| SB024 | gloves, sterile | 2 | 1 | 2 | 2 |
| SB027 | gown, staff, impervious | 1 | 1 | 1 | 1 |
| SB033 | mask, surgical | 1 | 1 | 1 | 1 |
| SC031 | needle, 30g | 1 | 0 | 2 | 1 |
| SC064 | syringe-needle 3ml 22-26g | 1 | 1 | 2 | 1 |
| SF033 | scalpel with blade, surgical (#10-20) | 1 | 1 | 2 | 1 |
| SF040 | suture, vicryl, 3-0 to 6-0, p, ps | 1 | 0 | 1 | 1 |
| SG004 | adhesive liquid (Mastisol) (0.67ml uou) | 1 | 0 | 1 | 1 |
| SG030 | cotton balls, non-sterile | 4 | 0 | 4 | 4 |
| SG035 | dressing, 3in x 4in (Telfa, Release) | 1 | 1 | 1 | 1 |
| SG038 | dressing, 4in x 4in (Vigilon) | 0 | 0 | 1 | 0 |
| SG056 | gauze, sterile 4in x 4in (10 pack uou) | 1 | 2 | 3 | 2 |
| SG079 | tape, surgical paper 1in (Micropore) | 6 | 12 | 18 | 12 |
| SG081 | applicator, cotton-tipped, sterile, 6in | 6 | 0 | 10 | 8 |
| SH046 | lidocaine 1% w-epi inj (Xylocaine w-epi) | 4 | 4 | 8 | 4 |
| SJ007 | bacitracin oint (0.9gm uou) | 1 | 1 | 1 | 1 |
| SJ041 | povidone soln (Betadine) | 10 | 10 | 10 | 10 |
| SJ053 | swab-pad, alcohol | 2 | 0 | 2 | 2 |

3. **Superficial Radiation Treatment (SRT) Planning and Management**

We agree with CMS that there are coding gaps for SRT-related professional services that are not included in 77401 and that SRT users are prohibited from reporting. CMS seeks comments on the possibility of creating multiple G-codes specific to services associated with SRT.¹⁶

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¹⁶ 83 FR 35775
There clearly is physician work associated with SRT that is not included in the valuation of CPT code 77401. The AADA supports development of temporary G codes to describe additional services associated with 77401. Carrier pricing would be appropriate. We agree that appropriate CPT codes should be developed and that the RUC should recommend valuation that could be addressed in future rulemaking.

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 additional G codes may be reported with each lesion.

4. Biopsy of Nail (CPT Code 11755)

Code 11755 was reviewed by the RUC in April 2017. CMS did not accept the RUC recommended value of 1.25 work RVUs, but instead recommended 1.08 RVUs. CMS states that this is being done to reflect the reduced survey times.

Code 11755 describes a complex procedure with high work intensity and clinical risk. The anesthesia for 11755 is complex, involving a digital block or wing block and local anesthesia placed along the majority of the affected nail unit. There is the potential for nerve and vascular damage to the underlying structures with the digital block. The nail plate is typically difficult to remove during the process of the biopsy and it can take significant effort to cut through a nail plate if left in place without avulsion. The biopsy must be used with extreme care to avoid a through and through injury to the surgeon or extension of the incision to the underlying bone, giving the potential for an osteomyelitis and significant post-operative pain. There is significant risk of post-operative nail dystrophy and scarring. Post-biopsy hemostasis is also particularly challenging because vasoconstrictors are not used in the anesthesia due to risk of digit tip necrosis and high risk for damage to the sensitive tissues of the nail unit. We urge CMS to accept the RUC recommended values for the nail biopsy code 11755.

II. UPDATES TO THE QUALITY PAYMENT PROGRAM

A. Virtual Groups

CMS is proposing minor technical revisions to the virtual group program so that it is more consistent and better aligned within MIPS. The Academy acknowledges the good progress CMS has made toward establishing more user-friendly requirements for virtual groups. We agree with both proposals—adding the ability to notify CMS of interest in participation as a virtual group through a web-based portal and modifying the eligibility look-back assessment period to a 12-month determination that ends on September 30 of the year prior to the performance period. This will improve alignment between virtual group requirements and MIPS participation. As we have indicated before, we support and encourage CMS to consider future ways to streamline, enhance and incentivize virtual group requirements in order to make this untested model more appealing to solo and small group practices.

B. Cost Performance

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17 83 FR 38748
18 83 FR 35892
CMS recognizes that measuring cost is an integral part of measuring value, and that clinicians often have a significant impact on the costs of patient care. CMS proposes to increase the weight of the cost performance category by 5 percentage points each year until reaching the required 30 percent weight for the 2024 MIPS payment year.

CMS intends to continue to measure clinicians and group practices on the Total Per Capita Cost and Medicare Spending Per Beneficiary measures. The agency intends to add eight episode-based measures to the eight existing measures. The episode-based measures only include items and services that are related to the episode of care for a clinical condition or procedure, as opposed to including all services that are provided to a patient over a given period of time.

The Per Capita Cost and Spending Per Beneficiary measures are not useful for measuring costs associated with dermatologic care, and there are no dermatologic episode-based measures. We are aware of instances where extensive inpatient expenses were assigned to dermatologists because they were the only provider of E/M services to patients during the year. **CMS should simplify the process for clinicians to opt out of the cost category, recognizing that some providers have little control over or impact on inpatient expenses and the behavior of other providers. CMS should also maintain the cost performance category scoring weight at 10% until sufficient episode groups exist to appropriately assign costs to specialties such as dermatology.**

C. Improvement Activities

CMS proposes a few changes to the Improvement Activities (IA) category, including adding six new improvement activities and modifying 5 existing activities.

Two of the new proposed IAs could apply to dermatologists. One is the option to participate in a course that stresses the importance of Relationship-Centered Communication (IA_CC_XX). To receive credit for this activity, MIPS eligible clinicians must participate in a minimum of eight hours of training on relationship-centered care tenets such as making effective open-ended inquiries; eliciting patient stories and perspectives; listening and responding with empathy; using the ART (ask, respond, tell) communication technique to engage patients, and developing a shared care plan.

The other new IA has the potential to reward providers who provide resources and options for their patients regarding the financial side of their care (IA_BE_XX). In order to receive credit for this activity, MIPS eligible clinicians must attest that their practice provides financial counseling to patients or their caregiver about costs of care and an exploration of different payment options.

Of the activities that the AADA recommends to dermatologists, only one (IA_PSPA_8 “Use of Patient Safety Tools”) has any changes. The activity denominator expands to include patient safety tools to address the opioid crisis.

*The AADA approves of all proposed changes.*

D. Promoting Interoperability (previously Advancing Care Information)

*Renaming the Advancing Care Information Performance Category*
Clinicians are frustrated and confused by the continuing changes associated with CMS requirements. Constantly changing metrics, scoring, and names all contribute to the disillusionment that physicians are experiencing. A few years ago, the Electronic Health Record (EHR) Meaningful Use program was established to encourage adoption of EHRs and to encourage interoperability. When CMS implemented MIPS, the name was changed to Advancing Care Information. Now, what is essentially the same program is called Promoting Interoperability (PI). We recommend that CMS do everything in its power to maintain stability within the MIPS program, including putting the brakes on future changes to names associated with the program.

Certification Requirements
Many physician practices remain on the 2014 edition even in 2018, and the costs to upgrade are formidable and impossible for many small practices. CMS has made a concerted effort to reduce burdens on small practices, and mandating the 2015 edition for all practices for performance year 2019 is a burden that many small practices will not be able to overcome. This will reduce participation in the QPP, thus defeating a primary goal of CMS. For this reason, we request that CMS not proceed with the requirement to participate only with the 2015 edition of CEHRT, but instead retain the option to use either the 2014 edition, or the 2015 edition.

Proposed PI Scoring Methodology
CMS proposes elimination of the base, performance and bonus scoring that is required in 2018. CMS proposes to allow physicians to report fewer measures, and adopts a new performance-based scoring methodology. CMS would score physicians on a 100 point scale at the individual measure level. Individuals would be required to report certain measures from each of these four categories:

- e-Prescribing
- Health Information Exchange
- Provider to Patient Exchange
- Public Health and Clinical Data Exchange

If a MIPS eligible clinician fails to report on a required measure or claim an exclusion for a required measure if applicable, the clinician would receive a total score of zero for the Promoting Interoperability performance category.¹⁹

While we support simplification of the 2018 reporting requirements, this should not be an all or nothing approach. The AADA opposes the requirement to report at least four measures, one measure for each category, to earn a score. CMS should encourage participation by giving credit for whatever measures are reported.

Measure Proposal Summary
The AADA supports the two new measures for the e-Prescribing objective: Query of Prescription Drug Monitoring Program (PDMP) and Verify Opioid Treatment Agreement, for 2019. However, reporting of these measures should not be required in 2020 and future years since many MIPS eligible clinicians do not e-prescribe controlled substances, and not all EHRs may be able to upgrade to tracking this measure by the initiation date.

¹⁹ 83 FR 35915
The AADA does not support renaming the existing Send a Summary of Care measure to Support Electronic Referral Loops by Sending Health Information. Clinicians are accustomed to the current name and changing the name will only contribute to confusion.

We support the Provider to Patient Exchange objective, Provide Patients Electronic Access to their Health Information, at 40 points toward the total PI performance category score in 2019 and 35 points beginning 2020. There should be an exclusion if the clinician’s EHR does not have the ability to have a portal.

E. Quality Performance Category

CMS proposes to maintain 2018 program requirements to submit six measures and continue data completeness requirements.

CMS is seeking comments on the number of measures to require. The 2018 Dermatology Specialty Set has seven Dermatology-specific measures. With the removal of #224, the 2019 Dermatology will be down to six Dermatology-specific measures. Further removal of measures will mean it is less likely Dermatology practices be able to report meaningful measures. It is more important that practices have a small number of relevant measures than to report a larger number of less relevant ones. The AADA recommends requiring fewer measures – five, rather than six.

CMS seeks comment on implementing a system where measures are classified as a particular value (gold, silver or bronze) and points are awarded based on the value of the measure. CMS would define the classification levels as follows:

- Gold: outcome measures, composite measures, or measures that address agency priorities (such as opioids). The CAHPS for MIPS survey, which collects patient experience data, may also be considered a high value measure.
- Silver: directly related to outcomes and have a good gap in performance (there is no high, unwavering performance) and demonstrate room for improvement; or topped out outcome measures.
- Bronze: standard of care process measures or topped out process measures.

AADA recommends the categorization remain the same as 2018. Implementing a new classification system would be confusing and burdensome. Consistency and stability is needed for practices to be able to report efficiently and focus on care improvement. The gold/silver/bronze strategy unfairly disadvantages specialties with small measure sets and few outcome measures. For Dermatology, current high priority measures would be given the lowest tier (bronze) because they are process measures with high (but not topped out) performance. Most dermatologists have only one outcome measure and rely on high priority measures for meeting requirements. This classification system would exclude practices and specialties from higher valued measures. Moreover, assigning higher classifications to measures that pertain to agency priorities segregates medical care inappropriately. This rating system is inherently unfair and should not be implemented.

CMS is proposing that once a measure has reached an extremely topped out status (for example, a measure with an average mean performance within the 98th to 100th percentile range), they may propose the measure for removal in the next rulemaking cycle. CMS would consider retaining the measure if there are compelling reasons as to why it should not be
removed (for example, if the removal would impact the number of measures available to a specialist type or if the measure addressed an area of importance to the Agency).

An accelerated removal process would further restrict Dermatology practices from reporting meaningful measures. The measure development and CMS-acceptance process takes 3-5 years and would not be able to keep up with accelerated removal of measures. **Specialty specific measures should not be removed unless they are being replaced by newer, more meaningful measures. CMS should continue the current staged approach to removal of measures to allow practices time to identify alternative measures and adjust workflows and systems for reporting.**

**CMS proposes not to include a cost improvement score in 2019 for 2021 payment adjustment. The AADA supports this proposal.** As discussed previously, the flawed approach to cost measures disadvantages Dermatology practices.

The AADA strongly recommends that CMS accelerate the release of MIPS program data. CMS continues to model the MIPS program (including assessment of Topped Out Measures) on PQRS data despite the lack of comparability. Without actual data on MIPS quality measures, medical societies and other measure developers cannot plan new measures or modifications to improve existing measures, and practices need accurate data for practice improvement and reporting.

**The AADA appreciates that CMS recommendations regarding changes to Quality measure #410 were consistent with changes requested by the AADA.** The description was revised to read “Percentage of psoriasis vulgaris patients receiving systemic therapy who meet minimal physician- or patient-reported disease activity levels. It is implied that establishment and maintenance of an established minimum level of disease control as measured by physician-and/or patient-reported outcomes will increase patient satisfaction with and adherence to treatment.” The denominator was expanded to include systemic medications rather than just oral systemic or biologic therapy; and the numerator expanded to include the 6-point Physician Global Assessment (PGA) scale.

**F. Qualified Clinical Data Registries (QCDRs)**

**QCDR Definition**

CMS is proposing to change the definition/criteria of QCDR as, “an entity with clinical expertise in medicine and quality measurement development that collects medical or clinical data on behalf of a MIPS eligible clinician for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients.”

The current definition of a QCDR states, “an entity CMS approves that collects clinicians’ clinical data for submission, such as regional collaborative and specialty societies for example. QCDR data submission is different from a qualified registry because it is not limited to MIPS measures. A QCDR may submit at most 30 ‘QCDR’ measures for CMS review and approval.”

**CMS’ QCDR definition modification would support the basis and focus of such entities with clinical expertise in medicine and quality measure development. This will foster a more**

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20 83 FR 36347  
21 83 FR 35982
productive environment for QCDRs in order to learn best processes and practices with other similar entities, as well as assist with providing better collaboration opportunities. The AADA supports the proposed QCDR definition.

Creating an environment where Medical Specialty Societies would exclusively lead the QCDR arena as entities who are clinically and appropriately creating useful QCDR measures, which have as a primary goal the use of clinical data to improve healthcare, would facilitate the best use of QCDR’s abilities for the program, and could help reduce data blocking by third party entities that do not have the interests of the program within their core missions.

Clinical data registries play an essential role in promoting quality of care. QCDRs provide timely and actionable feedback to providers on their performance, enhancing quality improvement opportunities. QCDRs allow for patient-centered, statistically valid and timely inter-practice and national benchmarking and comparisons. The measures developed by QCDRs and other clinical outcomes data registries are meaningful and relevant to participating providers and their patient populations. The AADA and other Medical Specialty Societies have invested considerable resources in QCDRs and in development of measures that can used with the data collected by those QCDRs. Physicians who submit data to QCDRs and who participate in MIPS through a QCDRs are demonstrating their desire to efficiently improve care. MIPS reporting is considered an administrative burden, and much of the program impedes the movement toward high-value care.22 Physicians see involvement with a QCDR differently – meaningful measures and data collection that has real potential for care improvement. CMS should structure MIPS scoring so that clinicians who participate in MIPS through a QCDR at least meet the threshold scoring requirements, avoiding any payment penalty.

We support allowing all entities to apply for the QR designation. However, the QCDR designation should be limited to entities such as Medical Specialty Societies that can prove they are the most beneficial option to clinicians and the Quality Payment Program. QCDR entities must (1) be led by physician and clinical expertise, (2) create and maintain useful QCDR measures, and (3) foster improvement opportunities for the quality of care provided to patients. Entities such as EHR vendors that have participated in data blocking and charging providers to access and submit their data to Registries and to CMS should be prohibited from entering the QCDR space. Large general EHR vendors lack the perspective of care improvement in medical specialties. Small specialty-specific EHR vendors who serve a narrow segment of providers may be collecting skewed data related to certain practice arrangements and patient populations. Therefore, neither small nor large EHR vendors should be allowed to enter the QCDR space. For smaller specialties, multiple QCDRs fragment data collection and prevent the accumulation of meaningful data from a variety of practice settings who serve different patient populations. If a third party entity that is not a Specialty Society would like to become a QCDR for reporting purposes, we recommend that CMS require those entities to collaborate with Specialty Society QCDR(s) in order to align themselves within the program.

QCDR Self-Nomination Period
CMS is proposing to change the self-nomination period for QCDRs from September 1 through November 1 of the year prior (current), to July 1 through September 1 of the year prior (proposed).23 Instituting an earlier self-nomination period immediately following the end of the

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22 MedPAC Report to the Congress. March 2018. p 456
23 83 FR 35983
previous program year (through March 31), will not provide QCDRs adequate time to obtain necessary responses and/or QCDR data for the self-nomination application. **The AADA opposes this change in the self-nomination period.**

QCDRs Seeking Permission From Another QCDR To Use an Existing, Approved QCDR Measure

CMS is proposing that a condition of a QCDR’s measure approval is the requirement to agree to enter a license agreement with CMS permitting any approved QCDR to submit data on the QCDR measure (without modification) for purposes of MIPS and each applicable payment year. If a QCDR refuses to enter such a license agreement, the QCDR measure would be rejected and another QCDR measure of similar clinical concept or topic may be approved in its place.²⁴

**We strongly oppose CMS mandating that the intellectual property of an entity be provided without the right of remittance, or with threatened expulsion from the QPP program.** The development of valid measures is expensive and time consuming. It would be a major deterrent for QCDRs to continue to include developed measures and data into the QPP program.

By removing the licensing requirement, this proposal would also remove the oversight necessary for correct implementation and calculation of the measures. The collected data would not be usable. The only way that a QCDR supporting organization can protect its investment in creating measures, and continue to provide the most accurate data possible to CMS, is to maintain the current approved licensing process. Allowing all QCDR’s access to QCDR measures, without the support to ensure correct data collection and reporting, would make accurate measure testing and benchmarking impossible.

The proposal that CMS would reject QCDR measures from entities that do not comply with the sharing requirement is frustrating for Societies and QCDRs that are the sole investors in the measures development process. **CMS is proposing that the results of the investment would be taken and given to the entities that are not contributing to the measure development. This is unacceptable, and will reduce physician community support for the QPP program.**

Remedial Action and Termination of Third Party Intermediaries

CMS has proposed they be allowed to terminate (immediately or with advanced notice) an Intermediary’s status if CMS has grounds to impose remedial action.²⁵ The AADA does not support CMS terminating a QCDR’s designation without formal consideration of a Corrective Action Plan, and without a clear and formal process explaining a change in the status of a QCDR. Probationary status allows the QCDR to reconcile any deficiencies. Allowing termination of QCDRs at any time would have undue hardship and impact on Eligible Clinicians when a remediation process may be the best solution. **We strongly oppose the proposal to eliminate the probationary status with the ability to take immediate and terminating action against an Intermediary, without a formal remediation process.**

**G. MIPS Performance Category Weights and Scoring**

CMS is proposing several changes to scoring that are not substantive but which simplify reporting and scoring. The AADA appreciates the effort to balance statutory requirements with

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²⁴ 83 FR 35984
²⁵ 83 FR 35986
ease of use and stability. The scoring is still complex, and the reports that physicians receive offer little information that can be translated into better care or outcomes for patients. **We encourage CMS to continue to work toward improving care, rather than producing scores that have little meaning.**

For 2019 scoring and 2021 payment adjustments, compared to 2018 scoring and 2020 payment, CMS is proposing to reduce the weight of the category Quality from 50% to 45% and increase the Cost category from 10% to 15%. Improvement Activities remain at 15% and Promoting Interoperability stays at 25%. CMS makes adjustments to scoring based on various risk factors. The proposed minimum 2019 score necessary to avoid a penalty in 2021 is 30 points. Eighty points is the minimum required to be eligible for the exceptional score bonus.

As previously noted in this comment letter, clinicians are frustrated and confused by the continuing changes associated with CMS requirements. **We recommend that CMS do everything within its power to maintain stability within the MIPS program, including maintaining as much consistency in scoring as possible within statutory limits.**

Reallocation of category weights puts a greater emphasis on the cost category. The cost category does not yet accurately assess the impact of a provider’s care on the total cost of care. Quality and improvement activities are the categories in which providers engage more willingly and there is room for improvement in those areas. The Bipartisan Budget Act of 2018 authorized CMS to weight cost between 10% and 30% through 2021. **CMS should maintain the CY 2018 weights for all four categories in 2019.**

Recognizing that most of the MIPS program does not really pay for value or move clinicians toward providing better patient care, CMS should do everything possible to minimize the administrative burdens imposed. **The minimum 2019 score necessary to avoid a penalty in 2021 should be maintained at 15 points, as part of the “Patients over Paperwork” initiative.**

### H. Low Volume Threshold

CMS currently excludes certain clinicians from participation in the QPP if they do not exceed certain Medicare Part B payment or patient volume thresholds. The current threshold is $90,000 or less in Medicare Part B charges or 200 or fewer Medicare beneficiaries. CMS proposes to add a third criterion for ECs or groups that provide 200 or fewer covered professional services under the PFS. CMS also proposes to remove Part B drugs from the low-volume threshold determinations.

CMS would allow eligible clinicians and group practices who exceed at least one of the three low volume threshold criteria to opt in to MIPS and be eligible for a corresponding payment bonus or penalty. **The AADA supports the existing threshold criteria and the proposed changes.** We appreciate this continued effort to reduce administrative burden while allowing participation by those who might benefit.

### I. Accommodations for Small Practices under MIPS

We appreciate the continued effort to provide special accommodations and support for small practices, to encourage participation in the QPP and the movement toward payment for value. Small practices are those with 15 or fewer clinicians. These are the proposed accommodations:
• Continue to allow small practices to use Medicare Part B claims for reporting quality.
• Award 3 points per measure for quality measure reporting that does not meet data completeness requirements. Others receive 1 point per incomplete measure.
• Add 3 bonus points to the numerator of quality category instead of the current 5 points added to the total score.
• A hardship exception is still available for the PI category, with score redistribution to quality category.
• Small practices would be exempt from the cost category. With the exemption from PI and Cost categories, the Quality category would be 85% of the MIPS score, Improvement activities remain at 15%.

Changing the bonus point allocation to only the numerator of the quality category puts increased burden on small practices. We understand that reallocation of the points could increase the weight of the quality score to 85% of the total, meaning the 3 point quality bonus would result in a 4.5% impact on the total MIPS score. Nonetheless, a 5 point addition to the total score would simplify scoring for smaller practices and would offer further incentive for their participation. **We recommend that CMS retain the 5 point bonus to small practices in the final score, rather than change to the 3 point quality bonus.**

**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 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability 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,

Suzanne Olbricht, MD
President
American Academy of Dermatology Association

Attachments (2)