September 8, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1631-P
PO Box 8013
Baltimore MD, 21244-8013

Dear Mr. Slavitt:

The American Society of Hematology (ASH) is pleased to offer comments on the 2016 Proposed Rule covering Revisions to the Medicare Physician Fee Schedule for 2016 (CMS-1631-P). ASH represents more than 15,000 clinicians and scientists worldwide committed to the study and treatment of blood and blood-related diseases. These diseases encompass malignant hematologic disorders such as leukemia, lymphoma, and multiple myeloma and non-malignant conditions such as sickle cell anemia, thalassemia, aplastic anemia, venous thromboembolism, hemophilia, and iron deficiency anemia. In addition, hematologists have been pioneers in the fields of stem cell biology, regenerative medicine, bone marrow transplantation, transfusion medicine, gene therapy, and the development of many drugs for the prevention and treatment of heart attacks and strokes. The Society is also committed to improving the nation’s health through public health initiatives. ASH membership is comprised of basic scientists, physician scientists, PhD researchers, and physicians working in diverse settings, including universities, hospitals and private practices.

Potentially Misvalued Services Under the Physician Fee Schedule

In the proposed rule, the Centers for Medicare & Medicaid Services (CMS) note that code 36516 (Therapeutic apheresis; with extracorporeal selective adsorption or selective filtration and plasma reinfusion) was nominated for review as potentially misvalued by an unnamed stakeholder. 36516 is not commonly provided by hematologists, but other codes in the apheresis family are primarily provided by hematologists and hematopathologists. ASH does not have access to this stakeholder’s original request, but CMS indicates that the stakeholder believes both the work relative value unit (RVU) and practice expense inputs to be incorrect. ASH does not believe that code 36516 is misvalued and recommends that CMS not take the time and energy to investigate a service that is provided fewer than 2,000 times per year in the Medicare program. ASH membership is comprised of basic scientists, physician scientists, PhD researchers, and physicians working in diverse settings, including universities, hospitals and private practices.

In the proposed rule, the Centers for Medicare & Medicaid Services (CMS) note that code 36516 (Therapeutic apheresis; with extracorporeal selective adsorption or selective filtration and plasma reinfusion) was nominated for review as potentially misvalued by an unnamed stakeholder. 36516 is not commonly provided by hematologists, but other codes in the apheresis family are primarily provided by hematologists and hematopathologists. ASH does not have access to this stakeholder’s original request, but CMS indicates that the stakeholder believes both the work relative value unit (RVU) and practice expense inputs to be incorrect. ASH does not believe that code 36516 is misvalued and recommends that CMS not take the time and energy to investigate a service that is provided fewer than 2,000 times per year in the Medicare program. ASH notes that the requester’s comments focused on two practice expense supply inputs used to dispose of biohazards and CMS indicates that these items would not be considered direct practice inputs under current standards. Since the stakeholder may be misinformed, the service is extremely low volume, and other individuals have not identified this service as being misvalued, ASH urges CMS to not review this service and focus on items which have a greater impact on the fee schedule.
CMS has also proposed to review the top 20 codes for each specialty as had been proposed and not finalized in last year’s rule. This list includes nine services commonly provided by hematologists:

- Bone marrow biopsy, needle or trocar (38221)
- Hydration, IV infusion (96360)
- Therapeutic, prophylactic, or diagnostic injection; subcutaneous or intramuscular (96372)
- Therapeutic, prophylactic, or diagnostic injection; intravenous push, single or initial substance/drug (96374)
- Therapeutic, prophylactic, or diagnostic injection; each additional sequential intravenous push of a new substance/drug (96375)
- Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic (96401)
- Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic (96402)
- Chemotherapy administration; intravenous, push technique, single or initial substance/drug (96409)
- Chemotherapy administration; intravenous, push technique, each additional substance/drug (96411)

ASH understands the desire by CMS to maintain relativity within the system but is concerned about the Society’s ability to meaningfully survey and analyze nine different services and their associated families in the short timeline that is required by the interaction of the Relative Value Update Committee (RUC) and the new rulemaking structure. ASH urges CMS to consider reviewing these services over a multi-year period rather than requiring all be reviewed in a single year.

**Improving Payment Accuracy for Primary Care and Care Management Services**

ASH has long believed that the existing evaluation and management code structure does not fully capture the level of work associated with diagnosing and treating patients with difficult hematologic conditions. Such work can require extensive time both with the patient and in review of laboratory data. The Society is encouraged by the number of proposals and requests for comments that CMS makes in this rule to help to address this issue.

First, CMS requests comments on the existing transitional care management and chronic care management codes. ASH members provide treatment for patients leaving the hospital as well as patients with ongoing chronic disease and hematologists would seem to be appropriate candidates to provide these services. However, burdensome documentation requirements for modest payment mean that the service is often not billed. In the particular case of chronic care management, ASH believes that CMS needs to reexamine the decision to not pay for the complex care management codes (CPT 99487 and 99489) that were created for 2013. These codes better describe the types of services required by patients treated by hematologists and better account for the associated level of work. ASH also encourages CMS to consider new methods to look at the breadth of work associated with chronic care management. A CPT book that includes more than 7,000 codes and describes various surgeries and imaging in minute detail now lumps all chronic disease management into a single code.

CMS next asks stakeholders to make recommendations for add-on services that could be reported in addition to existing evaluation and management services, similar to those add-on services reported for
procedural codes. ASH supports the intention behind this request but believes that CMS should instead focus on reviewing the existing evaluation and management codes, which focus too much on documentation and are not properly valued to reflect clinical expertise.

With regard to the issue of interprofessional collaboration among physicians, ASH is very pleased to see that CMS is acknowledging the discussions that take place between physicians in different disciplines can add significant value to the care of patients, even if the patient is not seen in person by one of the physicians. Increasing numbers of hematologists work in consultative roles with internists, general pediatricians, and surgeons in hospitals to avoid complications related to bleeding or other symptoms. For example, in some circumstances related to specific patients, a skilled hematologist can work with a surgeon without seeing the patient to help to avoid deep vein thrombosis. In today’s system, that hematologist must either provide the service without compensation or the patient must unnecessarily make an in-person visit to the hematologist in order for Medicare to pay for the service. ASH strongly encourages CMS to work with medical specialty societies to develop a code that will allow expert physicians to bill for this important work, which would require documentation similar to that found in other non-face-to-face services to provide auditable evidence that the service was provided. The service would also likely require a time minimum to ensure that significant effort was needed for this work. CMS notes that it has concerns that a patient would be billed for 20% of the cost of this service for a physician with whom he or she has not established a relationship. Although ASH supports the notion of the Center for Medicare and Medicaid Innovation (CMMI) establishing a waiver of patient responsibility to address this issue, even if this waiver is not possible, there are other ways to avoid surprising patients with additional costs. ASH would point to examples of patients receiving care from physicians with whom they have not established relationships, such as radiologists and pathologists. ASH would be happy to have further discussions with CMS regarding the typical scenarios in which interprofessional collaboration is able to benefit patients and provide examples of the kind of typical documentation which may be found. The Society recommends that CMS establish a proposal for a paid Medicare code for this service for 2017.

**Physician Quality Reporting System (PQRS)**

ASH supports the CMS proposal to allow for group-based reporting under the Qualified Clinical Data Registry (QCDR) PQRS method. The QCDR option is an excellent opportunity for physicians who focus on less common diseases to be able to meaningfully measure quality. Since many hematologists practice in large groups that are team-focused, individual reporting in QCDRs was often not feasible nor reflective of the care in this setting. This new option will give more opportunity for reporting for these groups and will continue to be useful as CMS transitions to the new Merit-Based Incentive Payment System (MIPS).

The MIPS program, created by the Medicare and CHIP Reauthorization Act of 2015 (MACRA), in effect combines the existing programs of performance measurement (PQRS), pay-for-performance (VBM), and electronic health record usage (EHR meaningful use) into a new consolidated program that will affect individual physician and physician group’s payments. ASH has made extensive comments on these three existing programs that are still relevant as the new MIPS program is implemented. As specialists in relatively uncommon diseases who often practice in large groups, hematologists support the opportunity to report on measures that are meaningful to the specialty even if they affect a relatively small number of Medicare patients overall. In the area of pay-for-performance, ASH supports the use of
resource measures that recognize the differences among specialties of medicine and that are properly risk-adjusted to account for the varying acuity in patients.

The one major addition in the transition to the MIPS program is the requirement of clinical practice improvement activities as a partial determinant of an overall MIPS score. The MACRA legislation includes several examples of potential clinical practice improvement activities but does not mandate the inclusion or exclusion of particular activities on this list. ASH recommends that CMS be as inclusive as possible in considering practice improvement activities. Unlike performance measures which are typically created by large organizations and vetted by the National Quality Forum, performance improvement activities can be local to an individual practice. ASH recommends in the first year of implementation that practices be required to attest to practice improvement activities based on the list which is suggested in the MACRA legislation. ASH believes that anything beyond attestation would be unnecessarily burdensome to physicians without improving the quality of care provided to their patients.

MACRA allows for CMS to establish a standard under which physicians or physician groups with low volumes of Medicare patients may be exempted from MIPS. ASH supports the creation of a low volume standard and believes that it should be based on a standard of total Medicare dollars for an individual physician, as opposed to a standard for a group. This is of particular importance for groups that include pediatric and adult subspecialists as the pediatric subspecialists may see a few Medicare patients but many patients with Medicaid and commercial insurance. Given their low volume, CMS will be unable to calculate performance scores on these pediatric subspecialists so requiring their participation in the MIPS program is needlessly burdensome. ASH also recommends that an absolute minimum be established rather than the standard of a percentage of revenue. Since CMS does not have access to total revenue for a particular physician or group, using a percentage of revenue standard would require additional reporting and documentation by those affected groups. Using an absolute standard avoids this additional burden for those physicians and groups that already have limited interaction with the Medicare system.

ASH appreciates the opportunity to provide comments on this important proposed rule. If you have any questions or comments about this letter, please contact Brian Whitman, Senior Manager of Policy and Practice, at bwhitman@hematology.org.

Sincerely,

David A. Williams, MD
President