



# IDSAs

Infectious Diseases Society of America

## 2010-2011 BOARD OF DIRECTORS

President  
**James M. Hughes, MD, FIDSA**  
EMORY UNIVERSITY  
ATLANTA, GA

President-Elect  
**Thomas G. Slama, MD, FIDSA**  
INDIANA UNIVERSITY SCHOOL OF MEDICINE  
INDIANAPOLIS, IN

Vice President  
**David A. Relman, MD, FIDSA**  
STANFORD UNIVERSITY SCHOOL OF MEDICINE  
PALO ALTO, CA

Secretary  
**Kathryn M. Edwards, MD, FIDSA**  
VANDERBILT UNIVERSITY MEDICAL CENTER  
NASHVILLE, TN

Treasurer  
**Cynthia L. Sears, MD, FIDSA**  
JOHNS HOPKINS UNIVERSITY SCHOOL OF MEDICINE  
BALTIMORE, MD

Immediate Past President  
**Richard J. Whitley, MD, FIDSA**  
UNIVERSITY OF ALABAMA AT BIRMINGHAM  
BIRMINGHAM, AL

**Paul G. Auwaerter, MD, FIDSA**  
JOHNS HOPKINS UNIVERSITY SCHOOL OF MEDICINE  
BALTIMORE, MD

**Johan S. Bakken, MD, PhD, FIDSA**  
ST. LUKE'S ID ASSOCIATES  
DULUTH, MN

**Michael L. Butera, MD**  
PULMONARY MEDICINE AND INFECTIOUS DISEASES  
MEDICAL GROUP  
SAN DIEGO, CA

**Carlos del Rio, MD, FIDSA**  
EMORY UNIVERSITY  
ATLANTA, GA

**Thomas M. File, Jr., MD, FIDSA**  
SUMMA HEALTH SYSTEM  
AKRON, OH

**Carol A. Kauffman, MD, FIDSA**  
UNIVERSITY OF MICHIGAN MEDICAL SCHOOL  
ANN ARBOR, MI

**Andrew T. Pavia, MD, FIDSA**  
UNIVERSITY OF UTAH  
SALT LAKE CITY, UT

**William G. Powderly, MD, FIDSA**  
UNIVERSITY COLLEGE DUBLIN  
DUBLIN, IRELAND

**Wesley C. Van Voorhis, MD,  
PhD, FIDSA**  
UNIVERSITY OF WASHINGTON  
SEATTLE, WA

Chief Executive Officer  
**Mark A. Leasure**

### IDSAs Headquarters

1300 Wilson Boulevard  
Suite 300

Arlington, VA 22209

TEL: (703) 299-0200

FAX: (703) 299-0204

E-MAIL ADDRESS:

info@idsociety.org

WEBSITE:

www.idsociety.org

August 30, 2011

BY ELECTRONIC SUBMISSION: [HTTP://WWW.REGULATIONS.GOV](http://www.regulations.gov)

Donald Berwick, MD, Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1524-P  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

### Re: Comments on Proposed Rule [Docket No. CMS-1524-P]: Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2012

Dear Dr. Berwick:

The Infectious Diseases Society of America (IDSAs) writes to address several issues raised by the Centers for Medicare and Medicaid Services (CMS) Physician Fee Schedule (PFS) Proposed Rule for Calendar Year (CY) 2012.

IDSAs represents more than 9,300 infectious diseases physicians and scientists devoted to patient care, prevention, public health, education, and research in the area of infectious diseases (ID). The Society's members focus on the epidemiology, diagnosis, investigation, prevention and treatment of infectious diseases in the United States and abroad. Our members care for patients of all ages with serious infections, including meningitis, pneumonia, tuberculosis, surgical infections, those with cancer or transplants who have life-threatening infections caused by unusual or drug-resistant microorganisms, and new and emerging infections, such as severe acute respiratory syndrome (SARS) and H1N1 influenza.

Before addressing specific concerns, we would like to recognize CMS staff for their efforts in developing this proposed rule. The rule continues implementation of many provisions that were mandated by the Patient Protection and Affordable Care Act (ACA). Ongoing identification of potentially misvalued codes under the PFS, proposed changes to the Physician Quality Reporting System (PQRS), efforts to include more robust quality and cost of care information on the Physician Compare Website, and plans to implement a Value-Based Payment Modifier are among the many issues discussed in the Proposed Rule. IDSAs's comments will address these challenges but also will focus attention on persistent access problems caused by Medicare's lack of coverage for home infusion therapy services and the decision to not to cover all preventive vaccines under Part B. However, more than any other issue, steep payments cuts called for by the Medicare physician payment formula pose the most immediate challenge to physicians and their patients.

## **SUSTAINABLE GROWTH RATE**

Due to the flawed Medicare payment formula, the Sustainable Growth Rate (SGR), physicians face the threat of a 29.5 percent payment cut in 2012. The magnitude of the problem was caused in part by past Congressional actions that merely shifted payment cuts to future years rather than permanently adjusting the cumulative spending targets upward to account for the additional spending. However, the underlying problem remains how the SGR physician payment formula calculates yearly payment updates. The SGR is linked to the Gross Domestic Product and penalizes physicians and other practitioners for volume increases that they cannot control and that the government actively promotes through new coverage decisions and other initiatives. Medicare's practice expense (PE) adjustments, which reduce per service payments downward to a level that accounts for little more than half the PE costs, are further evidence of the payment challenges facing physicians in a budget neutral environment.

**IDSA urges CMS to work with Congress to enact long-term reform of the physician payment formula at the first available opportunity. Immediate action on this problem is especially necessary given ongoing concern over the nation's debt and the possibility of an additional 2 percent Medicare payment cut if the Joint Congressional Committee does not reach agreement on \$1.2 trillion in debt relief by November 23.** At a minimum, Congress should enact a multi-year physician payment update that accounts for actual annual medical practice cost increases and which does not add to the SGR problem in future years.

## **REVIEW OF POTENTIALLY MISVALUED CODES**

In the Proposed Rule, CMS requests that the AMA's Relative Value Update Committee (RUC) review a number of Current Procedural Terminology (CPT) codes as part the ongoing effort to review potentially misvalued services under the PFS. Specifically, all 91 Evaluation and Management (E&M) service codes and 70 procedural codes were proposed for review.

### *Proposal to Review E&M Services*

Table 6 of the Proposed Rule identifies all 91 E&M service codes for which the Agency requests review. CMS cites primary care's evolving focus on comprehensive chronic disease management and prevention as its justification for requesting a review of these codes. ID physicians provide a larger percentage of their services as E&M than perhaps any other specialty and, as such, IDSA members would potentially benefit from a review of these codes by the RUC.<sup>1</sup> However, IDSA also is cognizant of the work that the RUC already has done in identifying and reviewing potentially misvalued codes, which has resulted in the redistributions of approximately \$1.5 billion across the PFS, and of the limited long-term impact of these reviews in a budget neutral environment.

The underlying problems facing primary care go well beyond the relative values of the existing E&M codes. First and foremost, the current E&M coding structure was constructed a quarter century ago, reflecting a bygone, paper-based era that emphasized documentation of episodic acute care management rather than recognizing the critical role of chronic disease management

---

<sup>1</sup> American Medical Association's Relative Value Scale Update Committee. Medicare charges by specialty: comparison by type of service. RUC analysis, 2007.

and care coordination. But no less problematic are E&M documentation guidelines that bear no relation to the complexity of medical decision making, the high cost of medical education, and previous Medicare PFS decisions to not cover care management CPT codes that were valued by the RUC. These problems were neither created by the RUC nor can they realistically be solved by a revaluation of the existing E&M service codes.

**CMS should undertake a comprehensive review of the existing E&M service codes in collaboration with the RUC and the CPT Editorial Panel. Such a review must focus not only on the valuation of these codes but, perhaps more importantly, must consider revisions to these codes that will better recognize the work of primary care physicians and cognitive specialists who provide care for patients with acute and chronic conditions. CMS also should review and reconsider past coverage policies in light of the current focus on primary care and chronic disease management. As an example, the 2008 PFS decision to not cover anticoagulation management services (CPT codes 96363 & 96364) should be reassessed. Finally, any review must also consider appropriate changes to the 1995 and 1997 Documentation Guidelines for E&M Services. Revised Guidelines should reduce the documentation burden while at the same time encouraging documentation that accurately describes disease management services and the complexity of medical decision making.**

*Proposal to Review Outpatient Infusion Codes*

Additionally, Table 7 of the Proposed Rule identifies a 'select list of 70 potentially misvalued procedural codes for which it requests AMA RUC review.' This list includes the following infusion codes: 96413, 96367, and 96365. These codes were first valued by the RUC in 2004. Given that these codes would not have been identified using previous CMS/RUC screens or through the six specific categories of potentially misvalued codes specified in the ACA, the Agency used the seventh category, "other codes determined to be appropriate by the Secretary," to justify review of these codes.

IDSA is committed to proceeding with RUC review of the infusion codes but notes that the ACA specifies a number of validation methodologies, many of which do not involve surveys. In 2003, several of the relevant specialty societies that provide infusion services (rheumatology, gastroenterology, and infectious diseases) arranged for an outside contractor to prepare an analysis of high-complexity monoclonal antibody pharmaceuticals such as rituximab and infliximab when infused in the non-facility (office) setting. This study was designed as a time and motion study to address resource (practice expense) consumption. In addition, the study was designed to determine whether practice expense differed when the monoclonal antibody was infused by hematology, oncology, or other specialty practice setting. It did not, and this data was used by the societies to provide input to the RUC and the Practice Expense Advisory Committee (the predecessor of the Practice Expense Subcommittee) for consideration when these codes were first surveyed. Since that time, there has been little to no change in the procedures or techniques employed for providing infusion services.

**IDSA believes that this study remains valid today and, more to the point, is consistent with the validation approach favored by the Agency given that the last two PFS Proposed Rules have specifically mentioned time and motion studies. As such, we plan on joining the other affected specialties in submitting this study when the infusion codes are reviewed by the RUC.**

## **PHYSICIAN QUALITY REPORTING SYSTEM AND E-PRESCRIBING PROGRAM**

Launched in 2006, the Physician Voluntary Reporting Program (PVRP) was the predecessor to the Physician Quality Reporting Initiative (PQRI) and later the Physician Quality Reporting System (PQRS). These programs collectively have gone through a multi-year journey that began as voluntary claims-based reporting of a few rudimentary measures and grew to include many more measures, reporting options, and higher incentive payments. The E-Prescribing (eRx) Incentive Program was added as a further inducement in 2009.

Participation in both the PQRS and eRx Incentive Program has risen steadily as evidenced by the 2009 PQRS and eRx Incentive Program Experience Report. While overall participation remains low, this is likely caused by the quantity and complexity of reporting options. This is in part a problem of our own making in that, when physician specialty societies requested more measures and reporting options, CMS responded by adding more of both. We now face the impossible task of helping small, private practices, that are already struggling, decipher this information so that they can avoid payment penalties and stay afloat financially. As such, **IDSA believes that CMS should take a serious look at the long-term value of many PQRS measures and reporting options. Additionally, for purposes of avoiding the 2013 and 2014 eRx payment penalties, IDSA strongly supports the Agency's proposal to allow eligible providers to report the eRx measure regardless of whether the action is associated with a denominator eligible encounter.**

Moreover, incentive payments under both programs are beginning to decline and soon will transition to payment penalties as required by the ACA. The PQRS will fully transition to payment penalties just as CMS begins to implement performance-based payments under the Value-Based Payment modifier. This could potentially expose physicians to double jeopardy whereby they are unfairly penalized under both programs, possibly for failure to report and perform on the same measures. **IDSA has previously made this point and reiterates that it is critical that CMS clarify how these two programs will interact.**

Pay-for-reporting was intended as an interim step towards pay-for-performance that allowed physicians to gain experience with reporting quality measures. **IDSA believes that this goal has largely been accomplished and urges CMS to establish a clear roadmap that transitions from the PQRS to the Value-Based Payment Modifier. Similar to the role of the Hospital Inpatient Quality Reporting (Hospital IQR) program in relation to the Hospital Value-Based Purchasing Program, CMS may wish to maintain the PQRS as a means to test candidate measures for the Value-Based Payment Modifier. However, maintaining both programs as coequals would only serve to compound the confusion caused by the PQRS reporting options and lead to numerous questions about how to fairly apply both payment adjustments. As an alternative, IDSA believes that a much smaller PQRS pilot project that offers pay-for-reporting incentives to a limited number of providers would be sufficient to test candidate measures.**

## **VALUE-BASED PAYMENT MODIFIER AND PHYSICIAN FEEDBACK REPORTS**

The Value-Based Payment modifier offers CMS the opportunity to implement a pay-for-performance program that takes the lessons learned from pay-for-reporting and capitalizes on

Electronic Health Records (EHR) implementation. These include the application of more meaningful measures that assess the continuum of patient care, reducing the number of reporting options, minimizing the reporting burden, providing timely feedback to physicians, and establishing health information technology as the conduit through which all performance data flows.

Most PQRS measures are process measures that only measure a particular aspect of care attributable to a single physician with no correlation to the cost of the entire episode or the final outcome. There is broad consensus that a pay-for-performance program, such as the Value-Based Payment Modifier, must include robust outcomes and composite measures that correctly describe each provider's role, including inpatient consultants, during an episode of care that may span multiple facilities. However, even the best measures will be of limited value without the ability to interconnect the disparate pieces into an episode that not only captures the physician services but also captures (and accurately attributes) every relevant test, treatment, and procedure from the admission to 30 days post discharge. Capturing this amount and type of data through claims-based measures is impossible. **Going forward, all measures should be designed with electronic entry specifications that render them easily captured via multiple available EHRs linked by an interoperable health information technology infrastructure. Only then will it be possible to consistently capture, attribute, and connect all relevant data into a single episode that accurately assesses each provider's impact on the quality and cost of care.**

The PQRS includes numerous reporting options in an effort to maximize participation by physicians. While the claim-based reporting option has been the most popular, it also is the least reliable in terms of successful participation because of its dependence on manual data entry at the time the service is billed. This shortcoming combined with the aforementioned limitations in the amount and type of data that can be collected through claims makes this reporting option unsuitable for pay-for-performance programs in which the ability to accurately capture, attribute and connect all aspects of an episode is critical to ensure accurate provider payments and comparisons. **IDSA believes that reporting options for the Value-Based Payment Modifier should be limited to those that allow for seamless and accurate exchange of all relevant data across multiple settings of care. These options include reporting directly to CMS through "qualified" EHR products and indirectly to CMS through an EHR data submission vendor. Registries also could be used in so far as they pull their data directly from EHRs.**

Excluding the claims-based reporting option from the Value-Based Payment Modifier should also reduce the reporting burden. This is because, unlike the claims-based reporting option which requires someone to manually input the correct quality data code every time a claim is submitted for the process being measured, EHR-based reporting options should enable programming the quality reporting process to automatically occur each time the appropriate ICD/CPT code combination occurs. As such, reporting on 20 measures 100 percent of the time should be no more burdensome than reporting on 3 measures 50 percent of the time. That said, **while the number of measures will not, in and of themselves, pose a burden under EHR reporting, CMS must be careful to only include valid measures so that feedback to physicians is credible and actionable. Preexisting process measures should be bundled into composite measures when possible and more focus should be given to developing outcome measures as well as to developing consultative measures and physician-level antimicrobial stewardship and infection prevention measures for specialties like infectious diseases.**

Related to the development of specialty-specific and care coordination measures, CMS requested comments on possible measures to include in the Value-Based Payment modifier that will foster care coordination in situations when services are ordered by one physician but furnished by another. CMS's 2010 decision to eliminate payments for the consultation codes, which included a built-in reporting requirement that fostered care coordination between the referring and consulting physicians, has reduced coordination between physicians as evidenced by the results of a 2010 Survey. **IDSA will no longer devote resources to advocate for reinstatement of the consultation codes under Medicare but continues to believe that this was a poorly thought out political decision that continues to have negative policy ramifications.**

Under the PQRS, feedback reports were not distributed to physicians until 7-8 months after the end of the Calendar Year. This time lag was widely criticized by the physician community due to the fact that it made it impossible for physicians to address problems in their PQRS reporting prior to the end of the reporting period. Under the Value-Based Payment Modifier in which performance scores will not only impact physicians' payments but also will be publicly reported on the Physician Compare Website, **it is essential that physicians receive confidential feedback on their performance at least mid-way through the performance period and preferably every quarter.**

Finally, the ACA gives CMS the authority to "coordinate the value-based payment modifier with the Physician Feedback Program and, as the Secretary determines appropriate, other similar provisions of Title III."<sup>2</sup> As alluded to in the preceding section, **IDSA strongly believes that CMS should not maintain the PQRS as a national pay-for-reporting program while also implementing differential payments under the Value-Based Payment modifier.** The statutory language described above appears to give the Agency the necessary authority to establish the Value-Based Payment modifier in lieu of the PQRS.

The preceding recommendations may be controversial in so far as they look several years ahead to where measurement and technological capabilities should be once ICD-10 has been fully implemented and the EHR "meaningful use" incentive payments are winding down. However, given that current law requires performance-based payments starting in 2015 and publicly reported physician comparisons over the next few years, it is critical that we make a realistic assessment of the value of the existing PQRS measures and reporting options prior to establishing the Value-Based Payment Modifier. Such an assessment is especially important for ID and other predominantly hospital-based and consultative specialties that have few measures to report.

### **ONGOING IMPLEMENTATION OF THE PHYSICIAN COMPARE WEBSITE**

The ACA requires that Medicare, to the extent practicable, include a process to ensure the data published on the Physician Compare Website provides a robust and accurate portrayal of a physician's performance and a process to ensure appropriate attribution of care when multiple and other providers are involved in the care of the patient. In the case of ID, neither of these statutory requirements has been met.

---

<sup>2</sup> Value-Based Payment Modifier Under the PFS. Affordable Care Act, Title III, Subtitle A, Section 3007.

From IDSA's perspective, the single biggest challenge to including meaningful performance information on a Physician Compare Website is the lack of available accountability measures for predominantly hospital-based physicians, including those who primarily serve in consultative roles. Hospital-based physicians provide care to highly complex patients who require more services, more tests, and generally more resources than patients treated in outpatient settings. **The dearth of physician-level inpatient measures must be addressed before CMS can accurately report hospital-based physicians' performance results on the Physician Compare Web Site.**

Additionally, "patients who are hospitalized have little control over care associated with their stay—for example, the professional services of physicians"<sup>3</sup> or the inpatient physicians who treat them for that matter. This is because many inpatient physicians work in small community-based hospitals. In these small to medium sized hospitals, only a single physician or a small number of physicians from a particular specialty have privileges. These physicians typically see all patients who are referred to them, without regard to the patient's complexity, risk of adverse outcome or payer source. Moreover, it is highly unlikely that ID inpatients, who are routinely among the sickest and most complex in the Medicare population, would have the means to access or the ability to compare meaningful performance information from their hospital bed prior to the initiation of consultative care. **Making such data publicly available would serve no purpose other than to provide retrospective and potentially misleading performance information to hospitalized patients and their family members.**

Implementation of the Physician Compare Website is intertwined with Section 3003 of the ACA, which requires Medicare to confidentially report both quality and cost information to individual physicians and groups. IDSA has serious concerns that much of this confidential data may not be appropriate for public dissemination due to unresolved problems associated with risk adjustment and attribution and the likelihood that such data would be misinterpreted by laypeople who do not understand the limitations inherent in the current state of performance measurement. As such, **CMS should specifically clarify what, if any, "confidential" information it plans to make available to the public and carefully consider how to present such information in a manner that is easily understandable by individuals who have no expertise in healthcare performance metrics and measurement or statistics.**

Lastly, CMS is required to issue a report to Congress by January 1, 2015 that describes the Agency's efforts and plans to collect and publish data on physician quality and efficiency and on patient experience through the Physician Compare Website. **IDSA urges CMS to work with measure developers and endorsers to resolve the issues described above prior to drafting and submitting the Report to Congress.**

#### **MEDICARE COVERAGE OF OUTPATIENT INFUSION DRUGS**

Fee-for-service Medicare has long resisted efforts to cover home infusion therapy services, a safe and cost effective alternative to the provision of intravenous therapies in the inpatient setting, by citing payment policy limitations and concerns over fraud and abuse<sup>4</sup>. As a result, many Medicare beneficiaries experience prolonged stays in inpatient facilities (acute care hospital, long term acute

---

<sup>3</sup>Report to the Congress. Aligning Incentives in Medicare. MedPAC, p. 60. June 2010.

<sup>4</sup> Medicare Fraud Strike Force Charges 94 Doctors, Health Care Company Owners, Executives and Others for More Than \$251 Million in Alleged False Billing. [DOJ Press Release](#), July 2010.

care hospital or skilled nursing facility) or must make daily trips to physician offices or other outpatient facilities. These seniors, particularly those that must remain in an inpatient facility, incur increased risks for healthcare-associated infections (and other complications), excess cost, slower recovery, prolonged hospital stays, and more inconvenience than if they were able to receive these treatments at home.

In contrast, the commercial healthcare industry has concluded that it is more cost effective to provide home infusion therapy rather than pay for continued hospitalization for patients who can be safely and effectively treated in the comfort of their home. This was underscored by a June 2010 Government Accountability Office Report (GAO) which found that “all of the health insurers in this study provide comprehensive coverage of home infusion therapy for all members in their commercial health plans, and some do so in their Medicare Advantage plans as well.”<sup>5</sup>

Medicare’s inability or unwillingness to cover home therapy services spurred the GAO to recommend that “the Secretary of HHS should conduct a study of home infusion therapy to inform Congress regarding potential program costs and savings, payment options, quality issues, and program integrity associated with a comprehensive benefit under Medicare.” **IDSA believes that such a study falls within the statutory authority of the Center for Medicare and Medicaid Innovation (CMMI) “to research, develop, test, and expand innovative payment and delivery arrangements to improve the quality and reduce the cost of care.”<sup>6</sup> Accordingly, IDSA urges CMS and CMMI to work with IDSA and other home infusion stakeholders to develop a pilot project that will pave the way for Medicare coverage of these high quality, patient centric, and cost effective services.**

### **ACCESS TO PREVENTIVE VACCINES UNDER MEDICARE PART B**

Currently, CMS’s coverage of preventive immunizations under Medicare Part B is limited to influenza, pneumococcal and a subset of hepatitis B vaccinations. The remaining recommended immunizations are paid for under Medicare Part D, the Prescription Drug Benefit. Often, patients must purchase their vaccines at a retail pharmacy and transport them to a physician’s office for administration. Not only does this practice, which is referred to as “brownbagging,” result in persistent access problems but it exposes the transported vaccine to quality and integrity concerns that may make it unsafe to administer or less effective.

The ACA requires Medicare to waive the Part B deductible and coinsurance for preventive services that have a Grade of A or B from the United States Preventive Services Task Force (USPSTF). At the time of passage, IDSA and other vaccine advocates were hopeful that this provision would provide the justification to finally cover all vaccines under Medicare Part B. Unfortunately, the Agency demurred, citing the fact that USPSTF ceded its authority over vaccines to the CDC’s Advisory Committee on Immunization Practices (ACIP) in 1996. Since that time, USPSTF has declined to grade any of the vaccines recommended by ACIP but, instead, has demonstrated support for ACIP’s recommendations by including them in guidance materials. IDSA believes that Medicare is hiding behind a circular argument to justify an untenable coverage policy, which is made more egregious by the fact that Section 1001 of the ACA requires most

---

<sup>5</sup> Home Infusion Therapy: Differences between Medicare and Private Insurers’ Coverage. [GAO Report](#), June 2010.

<sup>6</sup> Section-by-Section Analysis. The Patient Protection and Affordable Care Act (H.R. 3590) as Passed. March 2010.

private health plans to cover all ACIP-recommended vaccines. This results in reduced access for Medicare beneficiaries even as their privately insured counterparts enjoy the benefits of mandatory coverage of preventive vaccines.

The GAO is expected to publish a report this fall that examines the rates of, and barriers to, immunizations in the Medicare population. This report is likely to confirm what we already know, that Medicare beneficiaries face difficulties in accessing vaccines under Part D. **IDSA urges CMS to carefully consider the GAO's recommendations and to work with stakeholders and with Congress to determine how best to ensure that Medicare beneficiaries have ready and safe access to all ACIP-recommended vaccines for adults 65 years and older.**

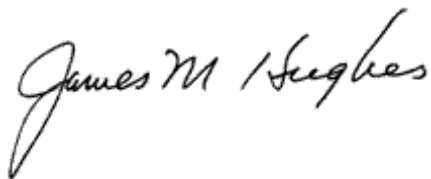
### **MEDICARE'S PROPOSAL TO RETRACT ITS LAB REQUISITION REQUIREMENT**

In addition to issues discussed in the 2012 PFS Proposed Rule, CMS released a separate Proposed Rule that reconsiders the Agency's 2011 PFS Final Rule requirement that all laboratory requisitions must include a physician signature. CMS cited concerns about administrative burden and patient access to care as reasons for its proposal to retract the signature requirement. **IDSA strongly supports Medicare's proposal to retract this requirement given that it would have caused an undue burden on ID practices and offered no value in terms of quality or efficiency.**

### **CONCLUSION**

IDSA appreciates the Agency's consideration of our comments on the 2012 Physician Fee Schedule Proposed Rule. If you have any questions or comments, please feel free to contact Mark Leasure, IDSA's Chief Executive Officer, at (703) 299-0200. We look forward to working with CMS as it finalizes this regulation.

Sincerely,

A handwritten signature in cursive script that reads "James M. Hughes". The signature is written in black ink and is positioned above the typed name and title.

James M. Hughes, MD, FIDSA  
President, IDSA