

September 11, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services

Submitted electronically via regulations.gov

RE: [CMS-1784-P] Medicare and Medicaid Programs; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program

Dear Administrator Brooks-LaSure,

The American College of Rheumatology (ACR), representing over 7,700 rheumatologists and rheumatology interprofessional team members, appreciates the opportunity to respond to the CY 2024 Physician Fee Schedule and Quality Payment Program proposed rule published in the *Federal Register* on July 13, 2023. We welcome the opportunity to share our comments regarding the impact of these policies on our ability to provide quality care to the 50 million Americans living with rheumatic diseases.

Rheumatologists and rheumatology healthcare professionals provide ongoing care for Medicare beneficiaries with complex chronic and acute conditions that require specialized expertise. They provide primarily non-procedure-based care to patients with severe conditions that can be difficult to diagnose and treat, including rheumatoid arthritis and other forms of inflammatory arthritis, vasculitis, systemic lupus erythematosus, and multiple other debilitating diseases that require complex diagnosis and treatments. Rheumatologists and rheumatology professionals also work closely with physical and occupational therapists to maximize the ability of patients to achieve and maintain independence outside of healthcare settings. Early and appropriate treatment by rheumatologists and rheumatology professionals can control disease activity and prevent or slow disease progression, improve patient outcomes, and reduce the need for costly surgical or interventional procedures. The improved outcome enables our patients to continue to be more productive than they would have been without timely or effective treatment.

The ACR thanks the Centers for Medicare and Medicaid Services (CMS) for its continued recognition of the value of complex medical decision-making provided by rheumatologists and cognitive care specialists in treating their patients by continuing to operationalize and fine-tune the Evaluation and Management (E/M) code revaluation and documentation requirements. We appreciate the policies and flexibilities set forth by CMS to help alleviate these challenges while we all work to provide quality patient care. The ACR offers the following comments on policies regarding the decreased conversion factor, Medicare Economic Index, E/M split visits, telehealth flexibilities, complex drug administration coding, self-administered drugs, and Quality Payment Program (QPP).

Proposed Provisions in the CY24 Physician Fee Schedule

Conversion Factor

CMS proposes adjusting the CY2024 conversion factor (CF) to \$32.75 from \$33.06. This represents a 3.34% decrease amid a US inflation rate increase. While the public health emergency has expired, there continues to be a significant strain on healthcare professionals and care teams, including staggering inflation costs and a significant workforce shortage. **The ACR strongly urges CMS not to proceed with this damaging adjustment that will further harm an already strained payment system, impact the financial solvency and stability of practices, and exacerbate the ongoing workforce shortage within the healthcare system.**

Rebasing and Revising the Medicare Economic Index (MEI)

In the CY23 proposed rule, CMS proposed to rebase the Medicare Economic Index (MEI) to “reflect current market conditions” for care teams. In the CY23 finalized rule, CMS delayed the implementation of the rebased MEI weights, citing the significant impact on the Fees Schedule and the American Medical Association’s upcoming Physician Practice Information Survey (PPI). The ACR appreciates the agency’s proposal to update the MEI to reflect current economic considerations better and understand the need to ensure the most up-to-date data is used to accurately capture the high market costs impacting our rheumatology care teams. As CMS considers implementation in future rulemaking, **we encourage the agency to collaborate with stakeholders during sub-regulatory guidance to ensure payment accuracy and stability for rheumatology practices.**

Telehealth

Following statutory guidance in the Consolidated Appropriations Act (CAA), CMS proposes to continue all telehealth flexibilities through December 31, 2024. The ACR appreciates the extension as this will allow our rheumatology care teams time to 1) prepare their practices to account for potentially limited telehealth capacities in their care delivery and 2) allow CMS to establish telehealth regulations post-pandemic. **The ACR has been and continues to be supportive of the extension.**

In the proposed rule, CMS proposes a new process for determining if a telehealth service will qualify for the permanent coverage list. The ACR appreciates that the proposed process is transparent to all stakeholders and provides guidance on evaluating telehealth services. The ACR notes that allowing many of the flexibilities to expire will negatively impact rheumatology practices as patients highly value the flexibility afforded by telehealth in their care delivery. These services include telephone E/M visits, audio-only visits, and real-time audio/video technology, as direct supervision requirements are set to expire five months following the expiration of the public health emergency. These services will revert to a physical presence requirement, which is particularly challenging for immunocompromised patients, economically disadvantaged patients, and patients living in geographic areas with prolonged travel times to see their rheumatologist.

Telehealth services filled a crucial gap during the COVID pandemic and have remained an essential element in the future healthcare needs in the United States, especially in areas where the shortage of rheumatologists is exacerbated by geographic maldistribution. Many patients travel long distances to

receive the care they need to manage their rheumatic diseases. These chronic, debilitating diseases require continuous follow-up with the rheumatic care team, and telehealth services have allowed patients to receive the care they need without traveling long distances for some follow-ups. Audio-only telehealth has provided necessary care and non-inferior satisfaction to video visits for our patients without the need for complex audio-visual capabilities. Further, patients with low technological literacy or those with limited or no internet connections can benefit from continuous care by audio-only telehealth without worrying about finding ways to satisfy the visual component of telehealth services. **The ACR firmly believes a more comprehensive telehealth service will improve and be a permanent fixture in the future of healthcare but should serve as a supplemental method of care delivery and not as a substitute for in-person care. These expanded telehealth services are vital for our patients, and the ACR encourages discussion and policies that allow for appropriate reimbursement rates for these services.**

Request for Information (RFI): Drugs and Biologicals that are Not Usually Self-Administered by the Patient, and Complex Drug Administration Coding

The ACR applauds CMS's undertaking to conduct a comprehensive review of the administration of biologicals not usually self-administered by the patient and complex drug administration coding, issues that have posed significant challenges to rheumatologists and other specialists in the House of Medicine. The ACR believes the critical components of providing best practice treatments options with biologics and immunomodulatory therapies and protecting the patient and care team relationship are at the highest level of ethical responsibility to our patients and their access to quality healthcare in treating their rheumatologic conditions.

CMS plays a crucial role in working with the specialties affected by these policies to identify long-term solutions to the current issues of down coding for services billed for the administration of biologics and the drugs added to the Self-Administered Drug (SAD) list. **The ACR is concerned that the criteria used for these two policies contradict the proposed nondiscrimination rules created for Medicare Fee-for-Service.**

“Downcoding”

The downcoding of complex chemotherapy services has reached a deep concern as it relates to the billing of biologics for the treatment of most non-oncologic conditions. This is mainly due to flawed billing and coding articles created by the Medicare Administrative Contractors (MAC) that have restricted which complex therapies will be reimbursed using the “chemotherapy” administration codes, forcing rheumatologists and other specialists (except for hematology and oncology) to bill these services with the therapeutic drug administration code. The advent and evolution of biologics and other immunomodulating therapies have revolutionized outcomes for patients with auto-immune diseases such as rheumatoid arthritis (RA), psoriasis, systemic lupus erythematosus, and vasculitis, which carry significant morbidity, mortality, and associated healthcare and societal costs. Despite the up-front costs, adding biologics to other treatment modalities has been cost-effective in appropriate patient populations.¹

¹ American College of Rheumatology. (2023). *The Complexity of Biologics and their Coverage and Payment*. Policy and Position Statements. The Complexity of Biologics and their Coverage and Payment.

The American Medical Association (AMA) Current Procedural Terminology (CPT) states, “Chemotherapy administration codes 96401-96549 apply to parenteral administration of non-radionuclide antineoplastic drugs; and also to anti-neoplastic agents provided for treatment of noncancer diagnoses (e.g., cyclophosphamide for auto-immune conditions) or to substances such as certain monoclonal antibody agents, and other biologic response modifiers.” Yet, the **MACs continue to utilize unsubstantiated criteria to determine which drugs should be defined as complex and warrant the use of complex administration codes.**

In 2013, the American College of Rheumatology released its position outlining the common clinical situations that require the use of intravenous biologics as opposed to self-administered biologics and outlined the FDA indications, appropriate use, safety, and off-label use for biologics, which are far more complicated at the molecular level than traditional chemically synthesized drugs.² Also, based on the evolution of biologics and monoclonal antibody treatments on the market for auto-immune diseases in rheumatology, gastroenterology, infectious disease, dermatology, neurology, and other key areas of medicine, it is appropriate to review the definition of “chemotherapy,” which is no longer a useful term, as indications and toxicity should distinguish drugs.

The CPT manual also states that “The highly complex infusion of chemotherapy or other drug or biologic agents requires a physician or other qualified health care professional work and/or clinical staff monitoring well beyond that of therapeutic drug agents (96360-96379) because the incidence of severe adverse patient reactions are typically greater. These services can be provided by any physician or other qualified health care professional.” Accordingly, the ACR’s position statement indicates that given the complexity associated with the design, manufacturing, and storage of biologics and differences over time in the structure, efficacy, and safety of biologics, these treatments should be supervised and carried out by specially trained physicians and advanced practitioners who have the required knowledge, training, and experience to administer biologic agents and monitor adverse reactions. **The ACR recommends that CPT work with the key stakeholders to change the terminology in the manual from “chemotherapy” to “immunomodulatory” therapies, which is more in line with drug indications.**

As a reminder, the 2003 Medicare Modernization Act (MMA) Congress included language allowing the use of the chemotherapy administration code by physicians who administer non-oncologic medications in their offices. The policy also indicated that the same level of supervision was required, and there are no significant differences between earlier biologics and currently proposed biologics in their level of risk in administration. Another key point in the MMA also outlined that these treatments should cost the same to administer, including clinical labor costs, and that no specialty should be reimbursed more than the other. Unfortunately, this has also caused another issue in how “chemotherapy” is assigned with the J-codes versus monoclonal antibody and biologic therapies through HCPCS. There are more than one example of a particular drug used as cancer therapy and an immunomodulator to treat different types of arthritis and vasculitis. To reimburse differently based on specialty is not consistent with the MMA language. Also, the toxicity issues related to these infusions do not differ based on the indication of use.

There has been a great deal of progress in the use of biologics in many disciplines, with the expectation for continuous advancement in the future. The ACR believes that policies related to access and reimbursement for biologic treatment should be transparent and prioritize the well-being

² American College of Rheumatology. (2013). *Part B Biologic Access and Medical Necessity*.

and health of patients across disease processes with a focus on reducing morbidity and mortality. **We recommend that the agency convene stakeholder roundtables or workgroups to explore regulatory and legislative solutions to these policies to avoid unintended consequences with deleterious impacts on access and coverage for beneficiaries and their healthcare team.**

Self-Administered Drug (SAD) List

Reimbursement is inadequate for drugs and biologics placed on the existing Self-Administered Drug (SAD) exclusion list policy, and the process used to determine if a drug is usually self-administered by the patient lacks transparency. The ACR is deeply concerned about barriers that limit the ability of patients with rheumatoid arthritis or other autoimmune diseases to obtain affordable, high-quality, high-value healthcare, which includes appropriate treatment. Additionally, beneficiaries who lose access to medication by virtue of inclusion on the SAD list are at risk of delay and deprivation of therapeutic benefits. Arthritis is the leading cause of disability in the United States, and modern treatment approaches have revolutionized outcomes for patients with these diseases. Early aggressive therapy with various drugs, including biologics, has been shown to reduce joint damage and deformities and improve function, reducing work absenteeism, disability, death, costly procedures/surgeries, and hospitalizations.

The ACR affirms the ethical responsibility of the healthcare team to place the welfare of the patient above all other considerations, as well as the importance of safeguarding the patient's relationship with their healthcare team. The ACR's goal is to preserve patients' access to care from rheumatology specialty care teams and the therapies necessary to treat their rheumatologic conditions. **The ACR believes this is an important opportunity for CMS to work with the rheumatology community and other key stakeholders as trusted voices on the critical issue of an equitable approach to the criteria for the SAD list and the billing of the complex administration services, especially as it applies to inadvertent harmful consequences related to poor access to future medications.**

Ultrasound Guidance

For CY 2024, CMS accepted the RUC-recommended values for the neuromuscular ultrasound family of codes. The ACR appreciates the work of the RUC as there was a significant increase for 76882, including the practice expense refinements to the limited ultrasound codes.

Split/Shared Visits

For CY 2024, CMS is proposing to delay implementation through at least December 31, 2024 of their definition for the "substantive portion" as more than half of the total time, and proposing to maintain the current definition of substantive portion that allows for the use of either one of the three key components (history, exam, or MDM) or more than half of the total time spent to determine which health professional will bill for the visit. **The ACR applauds the agency for maintaining the current definition and encourages CMS to continue working with all stakeholders on defining the "substantive portion" of this service.**

G2211

For implementation on January 1, 2024, CMS finalized the G2211 add-on code, which would be billed with codes for office/outpatient evaluation and management (E/M) visits to better recognize

the inherent resource costs clinicians incur when longitudinally managing a patient's overall health or treating a patient's single, serious, or complex chronic condition. With the estimation that the G2211 code will be reported by specialties that primarily bill E/M services, the ACR supports the reintroduction of this outpatient office code as we believe it will provide a more accurate representation of the resources needed to treat patients with complex rheumatic diseases. The ACR recognizes that this add-on code will have redistributive effects. **The ACR and our members strongly advocate for a comprehensive reform of the Medicare reimbursement program to allow for a more accurate representation of the medical decision-making and resources needed to provide the best and most appropriate treatment for our patients.**

Proposed Policies for the Quality Payment Program

The proposed rule outlines several proposals to implement programmatic changes to the Quality Payment Program to reduce the burden among care teams and allow patients to compare health professional quality and value of care in more streamlined ways. While the ACR supports the overall goal of these proposals to improve the QPP, we are concerned that continual programmatic changes have confused participants and put the added administrative burden on specialty associations trying to help care teams navigate the program effectively. We offer comments on cost measure changes, performance thresholds, and the Advancing Rheumatology Patient Care MVP. We urge CMS to consider the administrative burden on specialty societies and our members as the QPP evolves.

ACR Supports Several Proposed Policies

The ACR supports the change proposed by CMS to the Targeted Review Process timeline as we believe the updated timeline would be more acceptable to our care teams.

CMS proposes to allow truncation of eCQMs to a nine-month reporting period where ICD-10 coding changes cannot be implemented promptly. The ACR supports this change and encourages CMS to create clear and consistent messaging to care teams, reducing confusion around why a measure is being truncated and how it will impact care teams and their performance.

Cost Improvement

The ACR is concerned with the CMS proposal to determine the cost improvement score at the category level instead of the cost measure level. Within the rheumatology specialty and among our Qualified Clinical Data Registry (QCDR) participants, we have seen unpredictable attribution of cost measures over the years. For example, one rheumatology professional was scored on the Total per Capita Cost (TPCC) and performed well. However, they were also unexpectedly attributed a diabetes cost measure outside their specialty and scored poorly, bringing their cost category score down significantly. The inclusion of unexpected cost measures causes significant concern when evaluating improvement at the category level. **We urge CMS to reconsider its proposed policy on evaluating practitioners within the category level. This policy has the potential to amplify the impact of methodological flaws and misattribution of costs, resulting in inaccurate and potentially perverse performance incentives.**

Request for Information: Improvement within the MIPS Program

In the proposed rule, CMS requested information on continuous improvement within the MIPS program. While we appreciate the program's goal to improve quality within the healthcare system, we are concerned that CMS has increased focus on complex all-or-none or weighted measures. We note that use of these measures in the real world is not characterized by the same level of enthusiasm that CMS has for them, as 1) they are difficult to implement without adequate EHR and IT support, 2) the data are challenging to access for quality improvement projects, and 3) solo/small practices with minimal support staff experience disproportionate burden and costs to comply. We agree that changes must be made to encourage care teams to adopt more rigorous measures and activities. To that end, **we strongly encourage CMS to focus on policy changes that would create positive incentives to integrate these complex measures versus adding more requirements to the program.**

In our interactions with rheumatology care teams attempting to understand the program and how it can succeed, we have seen a continually growing frustration and anxiety associated with MIPS reporting. This was especially prominent during the 2022 reporting period when many of our care teams struggled to meet the neutral payment threshold, especially given the lack of cost-related information available. **We urge CMS to introduce a new system of bonus points that will allow for greater participant buy-in and minimize frustration with the program.** For example, when our rheumatology professionals received bonus points for reporting high-priority and outcome quality measures, we saw an increase in those who tracked their performance on those measures and included them in their quality reporting. Instituting similar incentives, such as bonuses for reporting new measures or measures without historical benchmarks, could give encouragement to healthcare professionals who are increasingly disenchanted with the program, increase awareness of and interest in important and new measures or activities, and provide benchmarking data that is more representative of the actual performance range among care teams.

Performance Threshold

The rule proposes that the CY24 performance period/CY26 payment year threshold payment will be calculated using the median of the CY17 through CY19 performance year. **The ACR has significant concerns about the proposed change in calculating the neutral payment threshold and the proposed 82 performance threshold.** While we understand that the statute requires the QPP to be a budget-neutral program, the burden on care teams to report for MIPS and ongoing frustrations with the program due to the 2022 reporting period increase to 75 performance threshold points are already creating financial stress at a time of extreme uncertainty; rapid increases in performance thresholds may result in unintended consequences, such as further reducing access to care or increasing healthcare disparities, or contributing to practice closures. Many care teams are becoming reacclimated to the program after years of uncertainty due to COVID-19 flexibilities and are still trying to understand the MVP program. The proposed payment threshold increase threatens our care teams' livelihoods and will create a negative reporting experience.

Additionally, frustrations have been exacerbated by identified issues related to measure selection practices. The change would disproportionately impact healthcare professionals in smaller specialties where the number of relevant measures is limited and may be further limited if any of those measures have reached topped-out status or do not have benchmarking data, depriving those specialists of their opportunity to earn full points.

Third-Party Intermediary Support of MVPs

CMS proposes adding an exception to the requirements for supporting measures and activities associated with an MVP, citing that QCDR measures must only be reported by the QCDR measure owner. We strongly support the proposed exception. We also believe that CMS should consider a third exception to the requirement where the care setting associated with the measure or activity does not apply to the participants of the QCDR or QR.

The ACR does have some concerns about two proposed changes to remedial action and termination of third-party intermediaries. First, while we recognize the burden created by organizations not maintaining current contact information, **we do not support the immediate termination proposal for intermediaries who fail to do so.** Advance notice to the remaining contacts and any contacts suggested in automated messages would be most appropriate, as immediate termination without notice would potentially leave some eligible care teams without a means to support QPP reporting for the current year. Second, the ACR has concerns with the proposal that CMS may publicly disclose that CMS took remedial action against or terminated a third-party intermediary. ACR understands the need for transparency so eligible care team members can make informed decisions about their reporting needs. However, suppose a third-party intermediary is actively addressing a concern, especially a newly identified one. In that case, we feel that information should not be disclosed unless the intermediary is unable or unwilling to fix an issue. It is appropriate to alert the public at that point. In the proposal to allow for audits of third-party intermediaries if there is an area of concern, the ACR requested clarification on how CMS defines “a continuing pattern of Quality Payment Program Service Center inquiries or support call questions.”

MIPS Measure Set

CMS proposes multiple changes to the rheumatology MIPS measure set. The ACR offers the following comments on the proposed changes to our specialty’s measure set:

- **QPP111 Pneumococcal Vaccination:**
The ACR recognizes the interest in removing this measure from the MIPS program and the rheumatology measure set. However, our care team has little interest in its replacement, QPP493, while QPP111 remains one of our most popular measures. **Many eligible care team members continue to utilize this measure instead of the complex weighted measure, and we believe there is value in retaining it, at least until care teams gain more experience in implementing the measure and CMS can develop and implement a plan that will incentivize the adoption of the new, more complex measures.**
- **QPP402 Tobacco Use for Adolescents:**
The ACR supports the removal of this measure from the rheumatology measurement set.
- **QPP128 BMI Screening:**
We encourage CMS to retain this measure both in the program and as part of the rheumatology measure set, given its meaningful nature for rheumatologic conditions and musculoskeletal limitations, which are worse in the setting of obesity, and the challenges of implementing replacement measures. Many eligible rheumatology professionals are not adopting composite measures such as the preventive care and wellness composite

measure given the complexity of implementation, which is particularly difficult for solo and small practices, and challenges to meet all components of the numerator for a specialty practice. Furthermore, QPP128 was among the top 10 reported quality measures for CY2021 and 2022 for our QCDR participants, supporting the value of this data for rheumatology. **Given this, the ACR supports the retention of QPP128 for MIPS.**

- Connection to Community Service Provider:
The ACR does not support the inclusion of this measure into the rheumatology quality measurement set, as the numerator actions are outside the scope of a specialty provider's care. Although extremely meaningful for individual patients, addressing and linking to these services is not achievable in a standard office visit where a focus on evaluation and diagnosis or management of chronic, complex conditions is provided. This is especially true for rheumatology practices in rural areas with significant rheumatology access issues and a lack of community resources. The ACR believes the first focus for the measure should instead be on primary and inpatient care.
- Gains in Patient Activation Measure (PAM®) Scores at 12 Months:
The ACR does not support including this PAM measure in the rheumatology quality measurement set, given the costs associated with licensing the tool required to implement this measure. As there is an associated cost with the tool, small and solo practices, which make up most of the practices that participate in our QCDR, would be negatively impacted by even the limited commercial use fee of approximately \$4,500 or \$7,500, which is a significant amount of money to require practice to invest for one quality measure. As there is a low likelihood of adoption across rheumatology practices, the ACR does not support including the measure. If it were to be included, the ACR would anticipate that disparate results would be observed over time by practices adopting the measure in later years, failing to reach performance levels of practices with more significant economic resources, allowing for early adoption and implementation.

Advancing Rheumatology Patient Care MVP

CMS proposed several changes to the Advancing Rheumatology Patient Care MVP. We offer the following feedback on these proposals:

- Adding the Connection to Community Service Provider measure:
We do not support adding this measure to the rheumatology MVP for the reasons previously stated.
- Removing QPP111 and replacing it with QPP493:
As stated in this letter, we are concerned about transitioning from 111 to 493. **We encourage CMS to delay removing 111 from the Rheumatology MVP and replace it with 493 until our care teams are more comfortable with the test and development experience using the tradition MIPS pathway measure 493.**
- Adding the Patient Activation Measure:
We do not support adding this measure to the rheumatology MVP for the reasons previously stated.

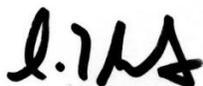
- Adding QPP487 Screening for Social Drivers of Health:
We support including this measure in the rheumatology MVP as we know that social drivers of health can impact outcomes for rheumatology patients and should be considered when rheumatology care teams develop a treatment plan. To be clear, we recognize the importance of collecting and considering this data and, as such, support QPP487. However, we are concerned about the narrow and burdensome action items proposed in the Connection to Community Service Provider measure and believe they are inappropriate for our rheumatology specialty.
- Adding UREQA10 Ankylosing Spondylitis: Controlled Disease Or Improved Disease Function:
While the ACR supports incentivizing outcome measures, we are concerned about adopting a measure that rewards achieving low disease activity without accounting for differences in case mix and social risks/needs across practices. UREQA10 does not adjust for clinical case mix, nor does it acknowledge the complexity of factors impacting disease activity scores as assessed by the BASDAI instrument. Adopting this measure in the MVP has the potential to provide inaccurate performance data, worsen disparities, and increase healthcare costs. **We ask CMS to defer adding this measure to the Advancing Rheumatology Patient Care MVP until further information about its potential for unintended consequences is available, or these concerns have been addressed.**

Quality Measures

The ACR requests that CMS review QPP374 Closing the Referral Loop: Receipt of Specialist Report to determine if it is feasible to create a version of the measure that evaluates whether a specialist has sent a follow-up report. As the measure is currently developed, the onus of meeting the quality action falls on the intended recipient of a report to follow up with the care team member who is expected to send the report. Incorporating into the measure an evaluation of whether the follow-up report is sent or creating a separate measure would benefit rheumatology and similar specialties.

The ACR is dedicated to working with CMS to ensure that rheumatologists and rheumatology interprofessional team members are equipped to provide patients with quality care. As the public health emergency has expired, we must recognize how the pandemic changed the healthcare system. We urge CMS to recognize the value of telehealth in chronic care management, the importance of appropriate reimbursement for our members and the services they provide, and streamlining programs designed to advance quality care. We look forward to serving as a resource to you and working with the agency to explore changes and improvements needed to ensure patients with rheumatic diseases have access to quality care. Please contact Amanda Grimm Wiegrefe, MScHSRA, Director of Regulatory Affairs, at awiegrefe@rheumatology.org or (202) 991-1127 if we can assist or have questions.

Sincerely,



Douglas White, MD, PhD
President, American College of Rheumatology