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BRIEF19

A daily review of covid-19 research and policy.

RESEARCH BRIEFING

Do symptomatic and asymptomatic patients stay positive for SARS-CoV-2 for the same period of time? A new study sheds light and offers other insights.

Do asymptomatic patients clear SARS-CoV-2 faster than symptomatic ones? A new study from South Korea [just published](#) in *JAMA Internal Medicine* followed 303 SARS-CoV-2 infected patients (average age 25) who were kept in isolation for weeks and monitored closely, whether symptomatic or asymptomatic, to assess this. Patients who were presymptomatic—that is, symptom-free initially but who developed symptoms later—were also included in the analysis of symptomatic patients. All participants were tested multiple times, on a strict schedule, to determine when “negative conversion” occurred. Negative conversion refers to when patients who initially test positive for a virus have cleared the infection sufficiently so as to test negative on a repeat test.

The investigators tested patients on days 8, 9, 15, and 16 of isolation. The patients provided both upper (nose or throat swab) and lower (coughed up sputum) respiratory samples. The main findings that will grab headlines is that there was no difference in how quickly symptomatic and asymptomatic patients apparently cleared the virus (though that’s not the same thing as contagiousness, as we’ll discuss). The median time from diagnosis to a negative test was 17 days in asymptomatic patients and 19.5 days in symptomatic persons. On day 14, 34 percent of asymptomatic patients had negative conversion versus 30 percent in the symptomatic patients; the difference was not statistically meaningful. By day 21, 75 percent and 70 percent had negative conversion, which again was not statistically different. By day 28, zero asymptomatic patients had detectable viral genetic material. Meanwhile, around 10 percent of symptomatic patients still did.

But there are two other important findings worthy of substantial note. The study found that presymptomatic patients did not develop symptoms until 15 days after first testing positive on average; the range for most subjects was 13 to 20 days. This is highly concerning. Previous studies have reported that 95 percent of presymptomatic patients develop symptoms by day 11. If the data from this study are accurate, it could mean that individuals might be spreading the virus unknowingly for far longer than we have previously realized and that 14 day quarantines suggested by the Centers for Disease Control and Prevention might be inadequate. Another important finding is that around 36 percent of the infections were asymptomatic at the outset. Of these, around one fifth later developed symptoms.

These data imply that young adults are not unlikely to never develop symptoms. This has implications for safely re-opening economies. While the elderly have the highest risk of serious covid-19 courses, younger adults may be driving contagion of the pandemic. That said, the underlying assumption is that the amount of viral genetic material correlates to contagiousness has not been definitively established. It may be that individuals who are no longer contagious break down high quantities of virus, which these tests detect, but that this reflects destructed viruses, rather than infectious particles.

—Jeremy Samuel Faust, MD MS

POLICY BRIEFING

Pay cuts for heroes? 2021 proposed physician fee schedule published.

As it does each year, the Centers for Medicare and Medicaid Services (CMS) has [opened](#) the comment period for its proposed Physician Fee for the upcoming year, and covid-19 has made a predictable impact. The Physician Fee Schedule, first used in 1992, establishes reimbursement for physicians and other healthcare providers based on the setting of the intervention, equipment available, and a variety of other factors. Termed Relative Value Units (RVUs), the number of units provided determines the rate of reimbursement. As part of “budget neutrality” mandated by law, a conversion factor is modified based on changing RVUs to prevent excessive expenditures each year. Amidst the 1353 pages encompassing this year’s proposal are several significant coronavirus-related [highlights](#).

First, the conversion factor has a negative correction of \$3.83, which if finalized would lead to decreased reimbursements across the board. Seemingly the hardest hit specialties are emergency medicine (-6 percent), critical care (-8 percent), anesthesiology (-8 percent), interventional radiology (-9 percent) and diagnostic radiology (-11 percent). Another questionable proposal is granting permanence of autonomy to “Non-Physician Providers” such as Nurse Practitioners and Physician Assistants that has been enacted during the current covid-19 Public Health Emergency (PHE). With respect to diagnostic testing, this would mean that PAs and NPs could furnish and administer diagnostic tests without physician supervision. The rule also proposes permanent codes for telehealth reimbursement, which would be beneficial in its ability to encourage further practicing socially distanced medicine. Some additional telehealth billables have been added to the temporary list with final determination to come.

Furthermore, in the past, the fee schedule has required direct, in-person supervision of medical residents by attending physicians to allow for billing. But in the proposal, starting in 2021, CMS will change this to allow attendings the ability to conduct this oversight remotely, as long as proper adequate audio/visual equipment is used. While meant to be temporary for the duration of the PHE, the rule seeks feedback in terms of permanence and any restrictions on qualified use.

Aside from the covid-19 related proposals, a long list of other proposed changes are included in next year’s Physician Fee Schedule, including new billing codes and funding for opioid use disorder treatment services, requirements for electronic prescribing for all Schedule II-V medications and delaying MIPS Value Pathways implementations until 2022. *The Center for Medicare and Medicaid Services.*

—Joshua Lesko, MD

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Brief19 is a daily executive summary of covid-19-related medical research, news, and public policy. It was founded and created by frontline emergency medicine physicians with expertise in medical research critique, health policy, and public policy.