AMERICAN COLLEGE OF PHYSICIANS–AMERICAN SOCIETY OF INTERNAL MEDICINE

STATEMENT TO THE PRACTICING PHYSICIANS ADVISORY COUNCIL

September 23-24, 2002

The American College of Physicians–American Society of Internal Medicine (ACP–ASIM), the nation's largest medical specialty society, representing over 115,000 physicians and medical students, is pleased to provide testimony to the Practicing Physicians Advisory Council (PPAC) regarding: Physicians Regulatory Issues Team Initiative; Update on Physician Fee Schedule; Beneficiary Access; Evaluation and Management Guidelines; and Local Medical Review Variation.

1. Physicians Regulatory Issues Team Initiative

ACP–ASIM commends the Centers for Medicare and Medicaid Services (CMS) for its Physicians Regulatory Issues Team (PRIT) initiative and looks forward to working with the agency to implement solutions to the issues on the current PRIT list, as well as new issues that arise.

A. Teaching Physician Documentation Requirements

ACP–ASIM asks CMS to provide an update on its effort to revise the documentation guidelines that pertain to teaching physician claims for evaluation and management (E/M) services that involve a resident. We are surprised that CMS has yet to implement this change, originally proposed in October 2001. The Deputy Administrator indicated this past April that the proposed change would be implemented shortly, and yet five months later, we are still waiting. The proposed change better reflects the teaching environment and eliminates the need for the teaching physician to duplicate resident documentation. **We encourage CMS to implement this change immediately and urge PPAC to also encourage CMS to implement the revised documentation guidelines for teaching physician claims.**

B. Correct Coding Initiative

ACP–ASIM requests that CMS add "Correct Coding Initiative (CCI) Access" to its list of issues on which the PRIT will take action. Physicians have inadequate access to the Medicare CCI process. Physicians have a difficult time monitoring the CCI because the updates are frequent and costly to obtain. Further, a number of CCI edits have been retracted after implementation. This causes confusion and frequently puts the burden on physicians to resubmit inappropriately denied claims.

CMS should make CCI edits available through its website, in a form that is searchable by Current Procedural Terminology (CPT) code. Further, ACP–ASIM urges the PRIT to work to improve the process by which proposed CCI edits are reviewed by the American Medical Association and specialty societies. ACP-ASIM formally requested this change over a year ago and has not yet received a formal response to our proposal. **We recommend that PPAC also**

encourage CMS to add "Correct Coding Initiative (CCI) Access" to its list of issues on which the PRIT will take action.

2. Update on Physician Fee Schedule

ACP–ASIM submitted comments in response to the CMS-proposed revisions to payment policies under the physician fee schedule for calendar year 2003 in an August 23, 2002 letter to Administrator Scully.

The full text of the ACP–ASIM comment letter on proposed 2003 physician fee schedule appears at the end of this statement. One issue of particular concern to ACP–ASIM is that CMS should adequately reimburse influenza immunizations provided to Medicare beneficiaries. The following is an excerpt from our proposed 2003 fee schedule letter:

> **Immunization CPT Codes 90471 and 90472**
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> ACP-ASIM supports the CMS proposal to remove vaccine administration codes, 90471 and 90472, from the zero work pool. The proposal, however, is far too limited. CMS should adopt the Relative Value Scale Update Committee (RUC) recommendation that physician work RVUs be assigned to these codes. The service typically involves physician labor comparable to the work involved in a level one established patient office visit (99211), which has a 0.17 work value. In February 2001, the RUC reaffirmed its May 1999 decision on this issue and recommended a 0.17 work value for 90471 and 0.15 for 90472. We urge CMS to review this methodology, make the correct adjustments, and appropriately reimburse immunization administrations.
>
> CMS should also make this change to implement the Department of Health and Human Services (HHS) Workgroup on Adult Immunization Action Plan outlining five goals the United States should accomplish to improve immunization rates. The third goal of the HHS Action Plan is to expand financing mechanisms to support the increased delivery of vaccines to adults. Inadequate reimbursement rates have been identified as one of the top barriers toward increasing immunization rates in this country. CMS is the lead government agency for this portion of the DHHS plan and is expected to: "Provide adequate reimbursement to providers for the cost of vaccine and vaccine administration by all publicly funded and private health insurance programs."
>
> In addition, the scope of the proposal is far too limited. CMS has not proposed to increase the payment allowance of its own vaccine administration codes (i.e., G0008, G0009, and G0010) to match that of 90471. Instead, it appears that CMS will continue to pay these codes at a rate comparable to that of a therapeutic injection (i.e., 90782), which has only 0.11 practice expense RVUs. CMS should not pay less for giving a Medicare-covered vaccine than 90471. We strongly

recommend that CMS set the payment allowance for G0008, G0009, and G0010 to match that of 90471.

ACP-ASIM recommends that PPAC urge CMS to adequately reimburse influenza immunizations provided to Medicare beneficiaries.

3. Beneficiary Access

A. CMS Efforts to Assess Beneficiary Access

ACP–ASIM supports the recommendation PPAC made to CMS at its March 2002 meeting that the CMS study access issues by working with physician organizations and surveying relevant parties (e.g. physicians, beneficiaries, state departments of health). Specifically, ACP–ASIM supports the PPAC recommendation that CMS assess the time it takes beneficiaries to get appointments and other access-related measures. The current access measures that Medicare uses are inadequate and do not portray a true picture of timely beneficiary access to health services. ACP–ASIM is concerned that payment cuts—the 5.4% reduction this year and the expected future reductions under the current payment system—will exacerbate access problems. Although CMS publicly stated its intent to partner with physician organizations to obtain this information, ACP-ASIM has yet to hear directly from CMS. **We recommend that PPAC ask CMS for an update regarding this effort.**

B. Existing Evidence Identifying Access Problems

While ACP–ASIM encourages CMS to expand its effort to study beneficiary access issues, numerous studies exist demonstrating the acuity of the problem and the need for immediate action. **We recommend that PPAC urge CMS to support a Congressional payment update fix and convey to the agency the urgent need for action.** Seven recently released reports provide compelling evidence that these Medicare cuts are threatening access to care, and if continued as planned, will further harm beneficiaries.[1-7] The following compilation of statistics from these reports demonstrates this impact.

Evidence of Decreased Access

<u>More Doctors Dropping Medicare Patients</u>

- The number of physicians indicating that they plan on continuing to participate in the Medicare program in 2003 (83%) is down from the previous year (92%).[1]
- 24% of physicians have either decreased the number or type of Medicare patients they treat, or plan to do so in the next six months.[1]
- Medicare HMOs are having trouble finding doctors to accept their rates.[2]

<u>More Doctors Refuse to Accept New Medicare Patients</u>

- The number of family physicians that is no longer taking new Medicare patients is 28% higher than one year ago.[3]
- 30% of family physicians did not accept new Medicare patients in 2001.[4]

- 40% of primary care respondents are not accepting new Medicare patients.[4]
- 15% of doctors concerned over cuts said this concern led to limiting new Medicare patients.[5]

Medicare Patients Wait Longer For Care

- In 2001, over a third of Medicare beneficiaries waited more than three weeks for a checkup. A similar percentage waited a week or more for an appointment concerning a specific illness.[6]
- 23.6% of Medicare seniors who put off or delayed care did so because they could not get an appointment soon enough, up from only 13.9% in 1997. [6]
- Although the increases in the amount of time required to get an appointment and delays in getting needed care were evident even before the 5.4% cut in 2002 payment levels, continued payment cuts are likely to further reduce access, especially in areas where private payers pay more than Medicare. [6]
- 11.2% of physicians report that time spent on the telephone with Medicare patients has decreased.[5]
- 23% of physicians report that time spent with Medicare patients during visits has decreased.[5]

Other Problems Exacerbate Cuts

- National surveys show that up to 80% of physicians over 50, a significant portion of family physicians, were considering leaving or reducing practices before the Medicare cuts announcement.[7]
- Many states link their Medicaid physician payment rates to Medicare rates, which could mean greater access problems for Medicaid patients.[7]
- In some states other payers, including PPOs and HMOs, link their payment levels directly to the Medicare conversion factor.[7]
- Increases in professional liability insurance premiums, in addition to the cuts in Medicare payments, are causing many doctors to leave particular practices or states.[7]
- Physician costs outstripped Medicare payments by 13% over the last 10 years.[4]
- 66% of physicians delayed or reduced expenditures to cut costs.[5]

Additional Cuts Will Lead to Less Participation

- If Medicare payments were cut an additional 5-6% in 2003, 42% of physicians stated that they would not continue to participate in the Medicare program. When asked why, the number one response was, "can't afford to."[1]

Summary

Since physicians must decide whether to participate in Medicare between November 1, and December 31, 2002, the timing and substance of congressional action to replace the cuts with positive updates will be critical in influencing physicians' decisions on their relationship with the Medicare program. The data show that unless Congress prior to November 1 halts the cuts and assures positive updates that keep pace with inflation, Medicare patients' access to services will likely decline and their out-of-pockets costs will increase. Longer waiting times for appointments, delays in receiving needed care, and higher out-of-pocket expenses due to

increases in balanced billing (as physicians shift from participating to nonparticipating status) are the most likely impacts.

References

1. American Medical Association: Research Brief on Medicare Physician Payment Cut Survey. Washington: American Medical Association; 2002; Available at http://www.ama-assn.org/ama1/pub/upload/mm/41/julymedpay.pdf

2. Medicare Rights Center: Have people with Medicare lost access to doctors? Medicare Rights Center: Washington; 2002. Available at http://www.medicarerights.org/FactSheet-AccessDocs.pdf

3. American Academy of Family Physicians: Annual Survey of Members. Washington: American Academy of Family Physicians; 2002.

4. American College of Physicians-American Society of Internal Medicine: Reimbursement Problems Undermine Medicare. Philadelphia: American College of Physicians-American Society of Internal Medicine; 2002: White paper. Available at http://www.acponline.org/hpp/med_reim.pdf

5. Medicare Payment Advisory Council: Results of the Medicare Payment Advisory Commission's 2002 Survey of Physicians. Washington: Medicare Payment Advisory Council; 2002.

6. Center for Studying Health System Change: Growing Physician Access Problems Complicate Medicare Payment Debate. Washington: Center for Studying Health System Change; 2002. Available at http://www.hschange.org/CONTENT/466/

7. American Medical Association: Medicare Physician Payment Update State-by-State Impact. American Medical Association: Washington; 2002. Available at http://www.ama-assn.org/ama/pub/category/6931.html

4. Evaluation and Management Guidelines

The American Medical Association (AMA) Evaluation and Management (E/M) Services Workgroup was created to take a fresh look at documentation guidelines (DGs). The on-going DG problem is predicated on the government's insistence on a standard by which it can determine whether documentation justifies the E/M service billed. Efforts to revise the guidelines after physicians objected to the 1997 DGs have failed, leaving physicians in the untenable situation of using the 1997 (or 1995) DGs. As the Workgroup tries to facilitate DGs acceptable to all parties, CMS must reassess several of its positions to move the issue toward resolution.

A. Assess Effectiveness of Current Medicare Medical Review Process

While we encourage CMS to participate in the E/M Workgroup effort, we believe the agency should take other steps simultaneously to attempt to resolve the documentation issue. **ACP-ASIM has recommended and encourages PPAC to recommend that CMS assess its effectiveness in conducting review of E/M services under its current system by conducting a cost-benefit analysis.** ACP–ASIM is skeptical that the on-going work to develop/refine DGs,

which has spanned nearly a decade, is worth the effort. CMS maintains Part B overpayment data in its Physician/Supplier Overpayment Reporting (PSOR) system. CMS should analyze the database to identify:

- Amount of overpayment requests that pertain to claims for E/M services, in dollars;
- Percentage of E/M overpayment requests arrived at by extrapolation;
- Median amount of initial E/M overpayment requests, in dollars;
- Median amount physicians repaid after all appeals are exhausted; and
- Median cost associated with conducting review at each level (e.g. carrier, Fair Hearing, Administrative Law Judge, etc) to determine a total cost attributed to identifying and recovering overpayments

CMS should ensure that it is not unnecessarily antagonizing physicians by using a medical review audit process that costs more than it recoups. There are numerous examples of cases in which a physician ultimately repaid a small overpayment amount, or no repayment at all, after the carrier initially asked for repayment of a large sum. An internist in the Northeast had an initial carrier overpayment request of over $70,000 reduced to under $500. The carrier arrived at the $70,000+ figure by extrapolating the result of an audit of 15 E/M service claims (the total overpayment amount included some laboratory tests that the carrier identified as routine and, therefore, not medically necessary). The final overpayment amount was under $500 after the physician appealed the carrier decision. The case took over three years and tens of thousands of dollars of physician and Medicare carrier time and effort to resolve. A California oncologist had the carrier requested overpayment amount of over $57,000 reduced to zero on appeal. A November 2000 *American Medical News* article documented the oncologist's experience. Adjudicating these cases results in substantial expenses for the physician and the government while seemingly generating little benefit, only acrimony and ill will.

The medical record is a tool of clinical care, not an accounting document. A physician entry into the medical record should be governed by the patient's interest and not to satisfy government auditors. ACP–ASIM is concerned that the current detailed DGs clutter the medical record with information irrelevant to the on-going care of the patient, obscuring pertinent clinical facts.

B. Review Initiatives that Limit Burden on Physicians

We are not suggesting that CMS discontinue audits or cease its effort to protect Medicare funds. We recognize that CMS must maintain a process or standard by which reviewers can determine whether physicians provided the service billed. CMS must devise a process that makes sense for the physicians, their patients, and the government. CMS should strive to identify initiatives that limit burden on physicians and ensure proper use of the scarce Medicare resources. We offer two suggestions.

<u>Peer Review of Outliers</u>

ACP-ASIM commends CMS for agreeing to design a pilot program to determine whether the outcomes of medical review determinations are substantially different when performed by same-specialty physician reviewers as compared to the current system,

which mainly uses nurse reviewers. CMS previously stated its intent to work with the California Medical Association (CMA) to design the program since the CMA has been the primary advocate for this peer review approach. We encourage CMS to use the CMA outlier approach pilot to determine if it can verify that it is paying appropriately without prescriptive DGs. **CMS should provide an update on status of this pilot project.**

California Pre-manual Review Patient Severity Assessment Project

CMS should use International Classification of Diseases, Ninth Revision (ICD-9) codes and other indicators derived from claims information as a mechanism for carriers to further analyze perceived aberrant billing patterns. A carrier could review the claim history of an outlier physician to determine a pattern of care, specific to the particular patient for which the claim is in question. The claim history will provide insight regarding patient complexity, recent hospital stays, home care status, etc. The carrier may be able to judge the appropriateness of questionable encounters and gain insight regarding apparent aberrant billing patterns without a formal inquiry.

We are aware that this approach was pilot-tested by the Medicare carrier for Southern California. ACP–ASIM subsequently discussed the methodology with the Southern California carrier. The carrier indicated that it developed an algorithm that reduced the need for the carrier to request medical records from physicians by 50%. The carrier identified measures available in its current claims processing system that allows it to assess the severity of the patient before deciding whether to request records from the physician. These measures include but are not limited to: diagnoses (number), recent hospitalizations (Yes or No), recent surgeries (Y or N), emergency room visits (Y or N), current number of treating physicians (1, 2, or 3+), recent nursing facility stay (Y or N), and home health services (Y or N). The carrier assigned points to each measure and then requested records to verify physician claims if the points fail to reach a certain threshold.

The carrier conducted the pilot manually. It assigned staff to pull up screens containing relevant claims data and made notes. It did not develop a software program. We believe that this approach has potential to reduce carrier enforcement costs, improve the recoupment rate for audits, and improve relations with physicians by reducing frivolous audits. **ACP-ASIM encourages PPAC to urge CMS to review the California Medicare Carrier Pre-manual Review Patient Severity Assessment Project and consider investing in developing and piloting software to automate the system.**

5. Local Medical Review Variation

CMS instructed multi-state carriers to begin consolidating Local Medical Review Policies (LMRPs) so that it has a single LMRP for the states it covers. CMS expects carriers to complete the standardization process by 2004. ACP-ASIM is concerned that the CMS plan will result in a dramatic increase in the number of LMRPs that restrict coverage of services, procedures, and tests to specific diagnosis codes. **Therefore, we recommend that CMS reassess its plan to regionalize LMRPs.**

We strongly object to routine regionalization. The Medicare carrier manual (MCM) Section 7501.2, instructs carriers to develop LMRPs to address identified or potential overutilization. Therefore, a LMRP should only pertain to an area where there is evidence of overutilization or legitimate concern about potential abuse. While carriers have latitude to develop an LMRP, routine regionalization of LMRPs violates MCM Section 7501.2. Additionally, we are concerned that carriers will use the "lowest common denominator approach" to regionalizing LMRPs, meaning that existing LMRPs will be combined to be more restrictive for every state in the region.

CMS should review the current LMRPs in place before expanding them on a regional basis. CMS should require carriers to document the reason they have implemented each LMRP and periodically review each LMRP to determine if the demonstrated or perceived overutilization still exists. Although physicians have input into LMRP development through the CAC process, it is typically the carrier that unilaterally determines when to develop an LMRP and the carrier then has sole discretion to decide whether to incorporate physician input after it proposes a LMRP.

In addition to requiring carriers to evaluate LMRPs currently in place, CMS should insist that carriers make the decision to develop and implement LMRPs in accordance with MCM section 7501.2. The process should reflect the often-stated CMS Program Integrity goal to pay claims correctly and not simply seek to limit expenditures.

We recommend that CMS clarify that carriers adhere to the following process and encourage PPAC to do the same:

- **Conduct medical review audits on physician outliers—those whose billing pattern stands out from physicians who practice the same specialty in the same geographic area;**
- **Medical review data should trigger physician education (even while the carrier recoups overpayments from individual physicians), with more dramatic steps, such as the implementation of an LMRP, as needed; and**
- **LMRPs should be assessed periodically against relevant data to determine if overutilization (or other reason for the LMRP implementation) is still a problem.**

6. Summary

ACP–ASIM thanks PPAC for the opportunity to comment. ACP-ASIM's recommendations to PPAC are as follows:

Physicians Regulatory Issues Team Initiative: PPAC should encourage CMS to implement the revised documentation guidelines for teaching physician claims immediately and to add "Correct Coding Initiative (CCI) Access" to its list of issues on which the PRIT will take action.

Physician Fee Schedule: PPAC should urge CMS to adequately reimburse influenza immunizations provided to Medicare beneficiaries.

Beneficiary Access: PPAC should:

- Ask CMS for an update on the March 2002 promise to work with medical societies in gathering more accurate data on Medicare beneficiary access to medical services.
- Urge CMS to support a Congressional payment update fix and convey to the agency the urgent need for action as seven recently released reports provide compelling evidence that these Medicare cuts are threatening access to care, and if continued as planned, will further harm beneficiaries.

Evaluation and Management Guidelines: (1) PPAC should recommend that CMS assess its effectiveness in conducting review of E/M services under its current system by conducting a cost-benefit analysis. (2) PPAC should encourage CMS to review the California Medicare Carrier Pre-manual Review Patient Severity Assessment Project and consider investing in developing and piloting software to automate the system.

Local Medical Review Variation: PPAC should recommend that CMS clarify that carriers adhere to the following process:

- Conduct medical review audits on physician outliers—those whose billing pattern stands out from physicians who practice the same specialty in the same geographic area;
- Medical review data should trigger physician education (even while the carrier recoups overpayments from individual physicians), with more dramatic steps, such as the implementation of an LMRP, as needed; and
- LMRPs should be assessed periodically against relevant data to determine if overutilization (or other reason for the LMRP implementation) is still a problem.

ATTACHMENT

August 23, 2002

Thomas A. Scully, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
Room 443-G
200 Independence Avenue, SW
Washington, DC 20201

Attention: CMS-1204-P

Comments on Revisions to Payment Policies Under the Physician Fee Schedule
For Calendar Year 2003.

Dear Mr. Scully:

On behalf of the American College of Physicians-American Society of Internal Medicine (ACP-ASIM), representing more than 115,000 internal medicine physicians and medical students, I am writing to comment on the proposed "Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2003" as published in the Federal Register on June 28, 2002.

Resource-Based Practice Expenses: Zero Work Pool

Handling of Global, Technical Component, and Professional Component Values

ACP-ASIM supports the Centers for Medicare and Medicaid Services (CMS) proposal to:

- make the technical component value equal to the difference between the global and the professional component for procedure codes that are not included in the zero physician work pool; and to

- make the global value equal to the sum of the professional and the technical component values for procedure codes that remain in the zero physician work pool.

It is important that CMS maintain parity of code administration for similar codes within and outside of the zero physician work pool. We understand that some medical societies wish to provide additional information on this subject and we urge CMS to accept such data.

Removal of Immunization CPT Codes 90471 and 90472

ACP-ASIM supports the CMS proposal to remove vaccine administration codes, 90471 and 90472, from the zero work pool. The proposal, however, is far too limited. CMS should adopt the Relative Value Scale Update Committee (RUC) recommendation that physician work RVUs

be assigned to these codes. The service typically involves physician labor comparable to the work involved in a level one established patient office visit (99211), which has a 0.17 work value. In February 2001, the RUC reaffirmed its May 1999 decision on this issue and recommended a 0.17 work value for 90471 and 0.15 for 90472. We urge CMS to review this methodology, make the correct adjustments, and appropriately reimburse immunization administrations.

CMS should also make this change to implement the Department of Health and Human Services (HHS) Workgroup on Adult Immunization Action Plan outlining five goals the United States should accomplish to improve immunization rates. The third goal of the HHS Action Plan is to expand financing mechanisms to support the increased delivery of vaccines to adults. Inadequate reimbursement rates have been identified as one of the top barriers toward increasing immunization rates in this country. CMS is the lead government agency for this portion of the DHHS plan and is expected to: "Provide adequate reimbursement to providers for the cost of vaccine and vaccine administration by all publicly funded and private health insurance programs."

In addition, the scope of the proposal is far too limited. CMS has not proposed to increase the payment allowance of its own vaccine administration codes (i.e., G0008, G0009, and G0010) to match that of 90471. Instead, it appears that CMS will continue to pay these codes at a rate comparable to that of a therapeutic injection (i.e., 90782), which has only 0.11 practice expense RVUs. CMS should not pay less for giving a Medicare-covered vaccine than 90471. We strongly recommend that CMS set the payment allowance for G0008, G0009, and G0010 to match that of 90471.

Resource-Based Practice Expenses: Utilization Data

ACP-ASIM supports the CMS proposal to combine utilization data from 1997 to 2000 to determine the practice expense values. Medicare utilization is an important data source used in determining the practice expense RVUs.It is imperative that a stable value be established rather than letting these data change significantly from year to year. Currently, CMS uses the most recently available year's Medicare utilization data for resource-based practice expense RVUs. While substituting the latest year's utilization data into the practice expense methodology generally made little difference on total Medicare payments per specialty, it had a larger impact on services that have values affected by the zero physician work pool. The practice expense values for the technical component and other services included in the zero physician work pool declined 4 percent in 2002 as a result of using the most recent Medicare utilization data. Since the technical component is used to derive the global practice expense RVUs for professional and technical component services, there was also a reduction in the practice expense RVU for the global service. The specialties that provide many of the services that are included in the zero physician work pool have expressed concern about the impact of the most recent data on utilization on values for their services. ACP-ASIM echoes these concerns.

ACP-ASIM agrees with CMS that the using multiple years of utilization data in the practice expense methodology has merit. This proposal will minimize the effect of year to year case mix changes on practice expense RVUs and improve the stability of CMS payment systems. ACP-

ASIM also agrees with CMS that the utilization data should not change annually until the zero physician work pool is eliminated.

Changes to the Fee Schedule Update Calculation and Sustainable Growth Rate (SGR)

Medicare Economic Index (MEI) Productivity Adjustment

ACP-ASIM supports the CMS proposed to change the Medicare Economic Index (MEI) productivity adjustment. Currently, the productivity adjustment accounts only for growth in the productivity of labor inputs. ACP-ASIM agrees with the proposal to change to an economy-wide multifactor productivity adjustment for purposes of the 2003 update. This is a better measure of input price inflation. The proposal is consistent with a recommendation that the Medicare Payment Advisory Commission made to Congress earlier this year. The MEI ideally should measure changes in the costs of operating a medical practice. Given data constraints, however, this alternative is better than the previous method.

ACP-ASIM continues to be concerned that the productivity adjustment in the MEI overstates productivity gains in the physician services industry for two reasons.

- First, it is widely recognized that productivity growth in service industries is typically lower than that in other types of industries. The productivity data from the Bureau of Labor Statistics bear this out, showing productivity growth in the general non-farm economy of 2% per year from 1991 to 2000, compared to 4% annual productivity growth for manufacturing.

- Second, productivity growth in physician practices is likely to be low in comparison to other service industries due to the massive regulatory burden that physicians face. Physician compliance with evaluation and management guidelines and other documentation requirements, workplace and patient safety requirements, certification (medical necessity) requirements, etc., place demands on physician and staff time, and reduce physician productivity. CMS should develop a mechanism to change the productivity adjustment to account for these factors.

Medical Liability in the MEI

ACP-ASIM is concerned that the rapidly accelerating costs of medical liability insurance are not adequately reflected in the MEI. Table 1 of the proposed rule indicates an 11.3 percent change in calendar year 2003 liability insurance costs. It also indicates that these costs compose 3.2 percent of the MEI. It is unclear if the medical liability factor of the MEI adequately addresses the significant increases in liability costs experienced by physicians in many areas of the country, as well as in a number of specialties. The information provided in the proposed rule does not provide a rational basis for determining whether the MEI appropriately reflects these increases in liability costs.

Sustainable Growth Rate (SGR)

Drug Spending in the Sustainable Growth Rate (SGR)

In the proposed rule, CMS indicates that drugs furnished in a physician's office that are not usually self-administered are generally covered as "incident to" a physician's services and included in the SGR. The payment update for physicians' services under the Medicare Fee Schedule should not be affected by the price growth in drugs, which are not paid under the Medicare Fee Schedule. CMS must not include such drugs in the SGR calculation, given the statutory language creating the SGR. Nowhere in section 1848(f)(2) of the Social Security Act, which defines the SGR, is there a reference to drugs administered incident to a physician's service. There is a reference to "physicians' services," but section 1861(q) defines those as "professional services performed by physicians, including surgery, consultation, and home, office, and institutional calls (but not including services described in subsection (b)(6))." Further, section 1861(s) of the Social Security Act, which defines "medical and other health services," draws a distinction between "physicians' services" (1861(s)(1)) and "services and supplies (including drugs and biologicals which are not usually self-administered by the patient) furnished as an incident to a physician's professional service, of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in the physicians' bills" (1861(s)(2)(A)).

Since the statute states that "physicians' services," not "medical and other health services," should be included in the SGR computation, we believe that CMS cannot consider drugs furnished in a physician's office that are not usually self-administered in the SGR. CMS should adjust its calculations accordingly.

Account for Law and Regulation Changes in the Sustainable Growth Rate (SGR):

ACP-ASIM is concerned that CMS does not account for any regulatory changes in the SGR unless the change is the direct result of a law change. The SGR has a specific category that is designed to account for these changes and it is not properly administered. Each year CMS develops numerous program memorandum and other regulatory changes that impact utilization of Medicare services and these changes are not accounted for in the SGR as they should. We are concerned that the increase was due to an influx of new regulation, not increased utilization of traditional physician services. New benefits and regulatory changes that increase SGR spending need to be properly accounted for in the SGR law and regulation component to prevent spending for these new initiatives from being funded by across-the-board cuts to all other providers of SGR services. In addition, omission of the impact of these regulatory changes in the calculation of the SGR is a violation of federal law.

Proposed Addition to the Definition of Medicare Telehealth

ACP-ASIM urges CMS to ensure that the CPT Editorial Panel be involved early in the process of adding or deleting services to the definition of telehealth, especially since the outcomes in this process often may result in new HCPCS codes. Reviewing codes and their descriptors and

determining how these services can be furnished to patients is the CPT Editorial Panel's area of expertise. Receiving input from the CPT Panel should be an integral part of CMS' process.

ACP-ASIM agrees with the CMS proposal to add psychiatric diagnostic interviews, as described by code 90801, to the list of Medicare Telehealth services. We support this addition for the reasons described in the proposed rule.

New G-Codes

ACP-ASIM continues to be concerned that CMS develops G-codes rather than working with the CPT to create CPT codes. While we do not have any specific comment regarding the proposal to create a G-code for diabetic foot evaluation, we question the necessity of creating such codes outside of the CPT process. ACP-ASIM recommends that CMS regularly present the CPT Editorial Panel with new codes that may be necessary to accommodate new Medicare payment or coverage policies. CMS should discuss new codes with CPT before CMS develops the spring physician payment fee schedule proposed rule. Ideally CMS should present the codes to CPT in time for CPT to place the items on their agenda for the February CPT meeting so that CPT and the RUC can weigh in on the matter before it is published in the Medicare physician fee schedule.

ACP-ASIM is concerned that CMS is establishing new payment policies without substantial input from the physician groups who are most familiar with the services involved. In addition, intra-specialty review is also important. We believe that the process we have outlined will result in better coding standardization, accuracy, simplicity and clarity, which in turn will ultimately benefit patients.

<u>Ambulatory Blood Pressure Monitoring</u>

ACP-ASIM recommends that CMS issue a corrected Program Memorandum to the carriers that indicates that code 93788 is a covered service. In September 2001, CMS issued a limited national coverage decision for ambulatory blood pressure monitoring for patients with suspected white coat hypertension. There are four CPT codes for ambulatory blood pressure monitoring; the global code is 93784; the two technical component codes are 93786 (recording only) and 93788 (scanning analysis and report) and the professional component only code is 93790. When CMS announced its coverage decision and Program Memorandum to the carriers, it indicated coverage for only one of the two technical component codes, 93786, implying that 93788 is non-covered, which is an error.

ABPM is currently carrier priced. At the request of CMS, this issue will be considered at the September 2002 AMA/Relative Value Update Committee process (RUC) and a survey is currently being conducted by the American College of Cardiology and ACP-ASIM to determine a work RVU recommendation. Practice expense data will also be presented at the September RUC. Because the national payment will not be effective until 2004, our data that will be submitted to the September RUC should be used to set an appropriate interim payment rate for 2003.

Conclusion

ACP-ASIM strongly supports the concept of a resource-based relative value system for Medicare and has developed the attached comments to assist the Centers for Medicare and Medicaid Services (CMS) in proper implementation of the Medicare physician fee schedule for calendar year 2003. Please contact John P. DuMoulin, ACP-ASIM's Director of Practice Advocacy, at phone 202-261-4535 or e-mail jdumoulin@mail.acponline.org, if you have any questions regarding these comments. Thank you for full consideration of these comments.

Sincerely,

C. Anderson Hedberg, MD, FACP, Chair
Medical Services Committee