American Podiatric Medical Association

Testimony to the Practicing Physicians Advisory Council

February 10, 2003

My name is Dr. Lloyd Smith and I am a podiatrist in private practice in Newton Centre, Massachusetts. I am here today representing the American Podiatric Medical Association (APMA). The APMA is the national organization representing nearly 11,000 doctors of podiatric medicine. I serve as Vice-President of the association and as Chair of the Health Policy Committee, which has responsibility for all Federal health-related issues.

The APMA appreciates the opportunity to submit testimony to the Practicing Physicians Advisory Council (PPAC) concerning the 2004 proposed rule for the Physician Fee Schedule. First, we wish to commend PPAC and the Centers for Medicare and Medicaid Services (CMS) for inviting comments in advance of the publication of that rule. We believe that this represents a positive step and that by seeking input prior to publication of the proposed rule, areas of potential concern can be more fully identified and addressed.

In general, our concerns today relate to the development of new "G" codes by the Centers for Medicare and Medicaid Services (CMS). We realize that the 2003 Medicare Physician Fee Schedule final rule includes discussion by CMS of its efforts to work cooperatively with CPT staff in transitioning G codes to CPT codes. We believe that this represents a positive step in reducing the number of G codes in existence and we support those efforts.

We remain concerned, however, when new G codes are introduced as part of the final rule, as occurred with the 2003 Medicare Physician Fee Schedule. Specifically, CMS introduced codes G0279 *Extracorporeal shock wave therapy; involving elbow epicondylitis* and G0280 *Extracorporeal shock wave therapy; involving other than elbow epicondylitis or plantar fasciitis*. In our opinion, the introduction of new coding and payment decisions should occur as part of the proposed rule. When these types of decisions do not appear until the final rule, interested parties are deprived of the opportunity to offer comments. We believe this constitutes a serious violation of the Administrative Procedure Act (APA). In order to avoid violations in the future, we believe that CMS should address decisions related to new codes in the proposed rule first.

According to CMS, in the interest of coding standardization, accuracy, and clarity, G codes should only be developed as a last resort and should be temporary. We agree with that premise. The 2003 final rule acknowledges, however, that it is sometimes necessary to develop G codes to accommodate changes in legislation, regulation, coverage and payment policy. We believe that a compelling need must exist before a new G code is considered.

Absent a compelling need, new codes should be introduced through the traditional CPT Editorial Panel process and valued through the traditional Relative Value Update Committee (RUC) process. As an active participant in those processes, the APMA recognizes that careful and thoughtful debate must occur when developing new codes and assigning values to those codes. CPT and RUC allow for input from interested specialty societies as well as from CMS. We believe that those are the forums that should be primarily utilized when new codes are created and valued.

Finally, the APMA is concerned when new G codes are created that describe services or procedures already described by existing CPT codes. In 2002, CPT introduced a new Category III code, 0019T *Extracorporeal shock wave therapy; involving musculoskeletal system*. In our opinion, the services described by codes G0279 and G0280 are already described by CPT code 0019T. We believe that as a result of the introduction of the new G codes, confusion will result. If a compelling need exists to create new G codes, then those codes should be sufficiently different so that confusion with existing CPT codes does not occur.

In summary, the APMA encourages the PPAC to recommend the following:

1) CMS should continue efforts to transition G codes to CPT codes, as appropriate, at least annually.

2) If new coding and payment decisions are made by CMS, they should be addressed in the proposed rule whenever possible so that interested parties have sufficient opportunity to provide comment on suggested changes.

3) CMS should adhere to the Administrative Procedure Act (APA).

4) CMS should continue efforts to achieve coding standardization, accuracy and clarity.

5) CMS should not introduce new G codes absent a compelling need. If a new G code is developed to accommodate changes in legislation, regulation, coverage, and payment policy, its transition to a CPT code should occur as soon as possible.

6) If new G codes are created, they should not duplicate existing CPT codes.

The APMA appreciates the opportunity to offer these comments.