



Statement

of the

American Medical Association

to the

Practicing Physicians Advisory Council

RE: Physician-Administered Drugs,
Consultation Services Billing Policy,
Physician Quality Reporting Program, and
Provider Enrollment, Chain and
Ownership System

December 7, 2009

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The American Medical Association (AMA) appreciates the opportunity to submit this statement to the Practicing Physicians Advisory Council (PPAC) concerning physician-administered drugs, consultation services billing policy, the Physician Quality Reporting Program (PQRI) and Provider Enrollment, Chain and Ownership System (PECOS).

MEDICARE PHYSICIAN FEE SCHEDULE RULE

Physician-Administered Drugs in the Sustainable Growth Rate Calculations

Last month, the Centers for Medicare and Medicaid Services (CMS) issued the final Medicare physician fee schedule rule for calendar year 2010 (final rule). **The AMA is extremely pleased and grateful to CMS and the Obama Administration for acknowledging that physician-administered drugs do not belong in calculations of the sustainable growth rate (SGR) formula, and therefore these drugs are being removed from calculations of allowed and actual Medicare physician spending retroactive to the 1996/1997 base year.**

The AMA has advocated for years that physician-administered drugs be removed from SGR calculations. We appreciate that CMS agrees, and we applaud CMS' decision to remove these drugs from SGR calculations. Our nation has a historic opportunity for health reform this year, and fixing the Medicare payment formula once and for all, along with averting a 21.2 percent physician payment cut due January 1, 2010, must be a cornerstone of this effort. Removing drugs from the SGR is a significant step forward in paving the way for Congress to enact a long-term solution to the fatally flawed Medicare physician payment formula and ensuring stable payment rates that reflect increasing medical practice costs, which is fundamental to comprehensive health reform.

Physician Quality Reporting Initiative

CMS has announced the results for the 2008 PQRI program. While participation almost doubled in 2008 (153,000 participants), a mere 56 percent (85,000 eligible professionals) were successful and received an incentive payment. More than \$92 million in 2008 PQRI incentive payments were distributed in the fall of this year, with the average individual payment around \$1,000. (Many have highlighted that the administrative cost for the time and effort required to understand and participate in the PQRI program is far greater than the incentive.) The 2008 PQRI incentive payment was tied to 1.5 percent of Medicare Part B charges (2 percent for 2009).

Reasons why successful participation remained in the 50th percentile are still under review by CMS. The AMA appreciates CMS' past PQRI program improvements. Nevertheless, a 56 percent successful participation rate is troubling and we are disappointed with this result, yet we remain committed to continuing to work CMS to improve the PQRI program. The AMA continues to work with CMS on identifying viable solutions for improving the program. Potential solutions include working to improve the distribution, accessibility, and usability of the PQRI physician feedback reports, along with improvements to Medicare's data systems and algorithms. This requires a significant increase in the financial and staff resources available to CMS. As communicated by physician practices who participated in the 2008 PQRI, timely feedback (at least monthly) reports would have a huge impact on their ability to understand: their participation, where reporting problems exist, and how to fix problems during the reporting period as opposed to discovering ten months later that they were unsuccessful.

Another necessary change is adding an appeals process for those physicians who are found unsuccessful, and feel that a detailed review of their participation is warranted. Further, revising the criteria for determining successful participation is another avenue for exploration. The AMA also appreciates CMS' efforts to correct problems with PQRI software for calculating successful participation. However, the AMA continues to advocate for increased transparency in understanding how participation is deemed successful. Finally, the AMA appreciates CMS' efforts to improve and expand education and outreach regarding the PQRI. These efforts are critical and will need to be continued and significantly expanded.

The 2008 PQRI results underscore the importance of ensuring that reporting programs are effectively constructed and implemented before adopting additional requirements under consideration by Congress and CMS, such as penalties for non-participation, public reporting of performance information, and development of more complex measures as components of a cost/quality index used to modify payment for physician services. Thus, it is imperative that PQRI problems continue to be evaluated along with implementation of improvements to address these problems. We urge PPAC to recommend that CMS continue to work with the AMA and other stakeholders to significantly improve the PQRI.

Consultation Services Billing Policy

Despite numerous objections raised in comments on the proposed rule, CMS has adopted in the final rule a new billing policy for consultations, which has created significant concern in the physician community. Under the new policy, beginning January 1, 2010, CMS will no longer reimburse physicians for consultations using the CPT consultation codes. The consultation codes comprise 99241-99244 for office or other outpatient consults and 99251-99255 for inpatient consultations. CMS has instructed physicians to bill using the new or established patient visit codes instead.

This new policy has caused a combination of panic and confusion among many physicians. Of even greater concern, however, are the hundreds of thousands of Medicare participating providers who have no idea the change in policy is occurring. A change of this magnitude can not be accomplished under CMS' expedited time frame without creating havoc for patients and physicians. **For the reasons outlined below, the AMA is urging CMS to delay the implementation of this policy for one year, and we urge PPAC to make this same recommendation to CMS.**

Background

In December 2005, CMS issued Transmittal #788 describing CMS' consultations policy. Although CMS considered this a clarification of existing policy, it was perceived by physicians as a significant change and the language in the Transmittal created significant confusion which still persists today. In particular, a number of issues emerged including when a consultation could be billed when there is a transfer of care from one physician to another, and the "dual documentation" requirements that call for both the referring and consulting physician to document the consult.

Following the publication of the policy, the AMA discussed these concerns on several occasions with CMS. CMS communicated to the AMA that they hoped to rewrite the policy to clarify it. Meanwhile, the CPT Panel, a multi-stakeholder body with payer representation, including Medicare, listened to concerns and fielded coding proposal changes during a two-year span from 2006 to 2008. The coding proposal focused on clarifying when a physician can bill for a consult when a transfer of patient care is involved from one physician to another. In October 2008, the CPT Panel voted to change the language in the CPT book to help mitigate this confusion. The changes are effective January 1, 2010.

New Policy Will Create Greater Confusion

Over the summer, we heard from a number of individual physicians, states, and specialty societies about their concerns and confusion over the proposal to begin reimbursing consultations using the new or established patient codes instead. In comments on the proposed rule, the AMA urged CMS not to finalize its proposal and cautioned that proceeding so rapidly would result in a flood of claims denials. Since the final rule was published by CMS in October, the concerns over the new policy have heightened considerably. Furthermore, during the AMA's House of Delegates (HOD) meeting in November, the new

policy generated significant debate and opposition and resulted in the HOD adopting a resolution that calls for repealing the new policy altogether.

CMS says its goal is to reduce confusion and administrative burden regarding consultation codes, but this policy will only increase confusion. We are not convinced that it will ever be possible to resolve all of the issues the new policy has raised and our preference would be to delay its implementation until the effect of the new CPT language can be evaluated. At the very least, the change in consultation billings should be delayed until CMS has worked through a number of technical issues and collaborated with the medical community to ensure that physicians understand and can comply with the new policy. Without such a delay, we anticipate payment denials, re-submissions and appeals that could create claims backlogs, cash flow problems, and increased costs that could lead some physicians to avoid Medicare patients—especially if Congress has not acted to prevent a scheduled 21.2% cut in the conversion factor that is also scheduled to take effect on January 1.

Technical Issues

Within each category of E&M service, there are three to five levels of E&M services available for reporting purposes. In the case of inpatient consult codes there are five levels of codes, while there are only three initial inpatient visit codes. Many physician organizations requested a crosswalk that would allow physicians to easily discern how they should now bill for consultations using the smaller number of initial hospital (or nursing facility care) codes in lieu of consultation codes. A number of issues were raised, including several scenarios where following the CMS billing advice could put the physician in violation of current rules for using the visit billing codes and the CPT coding conventions followed by private payers. Many of these issues were raised by commenters and are mentioned in the final rule. However, CMS responded that the visit billing rules are clear and no crosswalk is needed. **Without clear coding guidance, we fear that physicians will experience claims denials, audits and repayment demands, and conflicts with secondary payers simply for following the rules that CMS has laid out. Increased frustration and costs for physicians, payers and patients seem sure to follow.**

CMS is developing a modifier to distinguish the admitting physician of record who oversees the patient's care from other physicians furnishing specialty care. This may not be sufficient to address all the issues that could arise when multiple physicians all are billing for an initial hospital visit on the same day. In addition, we do not see how physicians can be expected to begin using this new modifier on January 1 when CMS has not yet told them what the modifier is and how to use it.

Policy Concerns

As described earlier, this proposal came as a surprise to the medical community because CMS had never raised it during the ongoing attempt to clarify consult coding. Furthermore, it came at a time when the CPT Panel had just adopted new language that was expected to significantly mitigate confusion over how current Medicare policy on consultations should be

applied. CMS apparently is rejecting this effort because there was not “universal agreement” among physicians on what the appropriate policy should be. **Yet, CMS’ substitute policy has far less acceptance among physicians and has not been subjected to the cross-specialty scrutiny that could have identified and avoided some of the confusion and concerns the new policy has engendered among physicians.**

Underlying CMS’ decision to eliminate the consultation codes is an assumption that there is no longer a significant difference between consultations and other visits, because consultant physicians are no longer required to send the referring physician a report on their findings. **A number of organizations, including the AMA and the Medicare Payment Advisory Commission, commented that this decision is inconsistent with Congress’ and the Administration’s desire to encourage coordination among physicians and improve quality of care for the rising numbers of Americans with multiple chronic conditions.** There are two potential unintended consequences. First, consulting physicians may stop accepting Medicare patients referred for consults. Second, more and more consultants may stop interpreting the findings in the medical record in a report back to the referring physician. Each scenario presents significant care coordination concerns and while CMS says it will monitor any unintended impact the new policy could have on care coordination, some real damage to individual patients could occur while CMS is still in monitoring mode.

Practical Concerns

The most pressing concern is timing. With only a month remaining before the new billing policy goes into effect, we are extremely concerned about the negative implications this will have on physicians and patients. A change of this magnitude requires much more time to educate physicians. Unless the January deadline is moved back significantly, we do not see how Medicare will have sufficient time to educate physicians about the new modifier or to develop and widely distribute guidance—including a crosswalk—on how to use the visit codes. Time is also needed to educate secondary payers and provide them with enough time to handle impacted crossover claims.

PROVIDER ENROLLMENT, CHAIN AND OWNERSHIP SYSTEM

The AMA, and a number of other affected organizations recently sent the attached letter to CMS expressing concerns and recommendations to remedy a new Medicare enrollment policy, under which Medicare will not pay claims for services when the referring or ordering physician or health care practitioner is not in the PECOS database. Since October 5, 2009, hundreds of thousands of otherwise acceptable Medicare claims have been marked for nonpayment merely because physicians and other health care practitioners ordering or referring an item or service enrolled in Medicare before 2003 when the PECOS database was developed. Implementing this policy as scheduled will cut off access to care for millions of Medicare beneficiaries, interrupt reimbursement for legitimately provided items and services, interrupt care coordination, and add unfunded administrative mandates on a significant portion of physicians and other health care practitioners who provide care to Medicare beneficiaries.

The impact of this policy has not been adequately considered by CMS or explained to contractors, physicians, other health care practitioners, and beneficiaries. We appreciate that CMS has delayed the implementation date for this new policy until April 5, 2010. However, we believe more time is needed to re-enroll all physicians who refer or order services and who are not yet in PECOS. Further, we are concerned about denial of claims. CMS has stated that if a claim is submitted and the contractor determines that the name of the referring/ordering physician listed is not in PECOS, contractors will then search their own enrollment database files for these physicians. Since this requires a data matching process, however, claims could still be denied. During the transition to the NPI, data matching processes were used and countless physicians saw their claims denied and experienced massive wait times for enrollment application processing.

Therefore, we urge PPAC to recommend that CMS take the following immediate steps:

- 1. Take action to ensure that otherwise acceptable claims are paid without delay or need for appeals;**
- 2. Indefinitely suspend the plan to deny these claims and instead wait at least until all practicing Medicare physicians, other health care practitioners, and residents can be revalidated and reenrolled or enrolled for the first time;**
- 3. Focus its efforts on ensuring a smooth and efficient revalidation process, which will require physicians and other health care practitioners to re-enroll in Medicare if they have not done so since 2003; and,**
- 4. Convene a high-level meeting with stakeholders to discuss concerns about ordering and referring physicians and other health care practitioners, and collaboratively develop a feasible and appropriate plan and timetable for addressing these concerns.**

RECOVERY AUDIT CONTRACTORS

We are very appreciative that CMS has sought our input on the new medical records request limits under the Recovery Audit Contractor (RAC) Program. Under the current policy, RACs may only request up to ten medical records for a RAC audit within a 45 day window. The current policy is also tied to the National Provider Identifier (NPI) number. Under the proposed new system, CMS would apply a percentage rather than a flat number based on practice size. The new formula calls for 1% of the physician's claims submitted to Medicare divided by 8 (# Medicare claims x 1%) / 8. Further, the proposed new policy would be tied to a physician's tax identification number (TIN). We have received feedback that suggests there are strong concerns with the new approach and that the current approach is far more preferable. We look forward to hearing from PPAC members on this matter and continuing to discuss our concerns with CMS.

The AMA appreciates the opportunity to comment on the foregoing, and we look forward to continuing to work with PPAC and CMS to resolve these important matters.