

September 28, 2001

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-1169-P

Comments on Revisions to Payment Policies Under the Physician Fee Schedule
for Calendar Year 2002.

Dear Mr. Scully:

On behalf of the American College of Physicians-American Society of Internal Medicine (ACP-ASIM), the nation's largest medical specialty society representing more than 115,000 doctors of internal medicine and medical students, I am writing to comment on the proposed "Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2002" as published in the *Federal Register* on August 2, 2001.

Our comments can be found in the attached document. 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 2002. Please contact John P. DuMoulin, ACP-ASIM's Director of Managed Care and Regulatory Affairs, 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

Attachment

American College of Physicians-American Society of Internal Medicine (ACP-ASIM)

Comments on the

Medicare 2002 Physician Fee Schedule Proposed Rule

September 28, 2001

1. Medicare Formula for Updating Payments for Physician's Services

The American College of Physicians-American Society of Internal Medicine (ACP-ASIM) is concerned that the Medicare formula for updating payments for physician's services does not fully account for increases in physician practice costs brought on by changes in the healthcare delivery environment and other external events. Improvements must be made to both the Medicare Economic Index (MEI) and the sustainable growth rate (SGR) as soon as possible. We believe that the Centers for Medicare and Medicaid Services (CMS) has the authority to correct flaws in the physician payment update calculations without further Congressional action.

A. Medicare Economic Index

The productivity adjustment in physician services in the MEI is clearly overstated. Productivity gains in physician services are lower than the overall economy. First, because physician services fall under the service sector economy, which has lower productivity gains than the manufacturing sector; and second, because of the increasing regulatory burden paperwork placed on physicians, which is a drain on productivity. In addition, physician office practices faced additional costs associated with upgrading office computer systems to comply with the Y2K problem. We note that the payment formula was adjusted to account for these costs in the hospital sector, but not in the physician sector. These costs must be accounted for in the update formula. To address these issues, ACP-ASIM recommends that at a minimum, CMS: (1) consider reducing the productivity adjustment to the level proposed by the Medicare Payment Advisory Committee (MedPAC) for hospitals (0.5%); and (2) seek methodological avenues that will account for unrecognized expenses incurred by physician practices such as compliance with increased regulatory burdens.

B. Sustainable Growth Rate

Three critical factors in the sustainable growth rate (SGR) formula must be adjusted as soon as possible: (1) unaccounted enrollment growth for the Medicare program, (2) expense of statutory provisions included as part of the Balanced Budget Act of 1997 (BBA '97), and (3) impact of national coverage decisions in the Medicare program in recent years. Because these factors are not properly accounted-for in the SGR, the SGR does not accurately reflect the actual growth of

the Medicare program. ACP-ASIM urges CMS to administratively address these flaws in the SGR.

ACP-ASIM is concerned that errors in the MEI and SGR estimates artificially deflate the conversion factor for physician services. The suggestions on the previous page should serve to guide CMS to create a more accurate update formula.

2. Resource Based Practice Expenses (RBPE)

A. **Use of 1999 Socioeconomic Monitoring System (SMS) Survey Data**

The Center for Medicare and Medicaid Services (CMS) proposes to add 1999 American Medical Association (AMA) Socioeconomic Monitoring Survey (SMS) survey data to the current 1995 through 1998 SMS survey data to calculate specialty-specific practice expense per hour as part of its resource based practice expense methodology. ACP-ASIM is generally supportive of incorporating the most current SMS data in CMS's resource based practice expense methodology, so the practice expense relative value units (RVUs) reflect the most current practice expenses of physicians. We are concerned, however, that the small sample size and apparently skewed results from the 1999 SMS data preclude these data from being included in the sample.

Addition of the 1999 AMA SMS data to the four-year sample creates some new problems. It is our understanding that that 1999 survey was greatly scaled back in the number of surveys and respondents. Furthermore, we understand that the AMA typically would not provide or publish data with so few responses for some specialties, but were compelled to share the data with CMS for the purpose of refining the RBPE system. We are concerned that the net result of CMS using this incomplete data source could have a significant impact on some physician specialties. Our members that practice cardiology suggest that the SMS practice expense data drops for cardiology by 15% in just one year. We think that such a one-year drop is highly unlikely. We simply can't accept the new data. The sample is simply too small and we don't have confidence in the numbers. Additionally, as the CMS is well aware, a real opportunity existed to game the SMS data collection process as the 1999 data was collected after the RBPE system was put in place by Medicare and the public was aware that the SMS data was used to calculate Medicare payments. ACP-ASIM recommends that the 1999 SMS data be excluded from the practice expense refinement.

ACP-ASIM agrees with the CMS proposal to accept and use any supplemental specialty-specific data for an additional two years that meets the criteria CMS outlined in the November 1, 2000, final rule, until the next five-year review of the Medicare Fee Schedule in 2007. This is consistent with ACP-ASIM's recommendations to extend the refinement period in order to consider more scientifically valid practice expense data.

B. **Repricing of Clinical Practice Expert Panel (CPEP) Inputs**

ACP-ASIM agrees with the CMS proposal to update the clinical staff salary data used to price CPEP inputs for clinical staff time. CMS use of the 1999 Bureau of Labor Statistics (BLS) Occupation Compensation Survey wage data is certainly more current than the 1993 BLS data currently used.

ACP-ASIM does not take issue with the CMS proposal to delete those clinical staff that can bill separately (e.g., nurse practitioners) from the list of CPEP staff types. These staff types are typically used as physician extenders and thus should not be counted for practice expense purposes. ACP-ASIM has supported this approach in the Practice Expense Advisory Committee's (PEAC's) refinement of CPEP inputs.

C. Physician Time

ACP-ASIM is pleased that CMS proposes to use a revised database of physician time per service provided by the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC). As a participant in the RUC process, we support using the revised database, because it is an improvement over the previous data used by CMS.

However, further improvement of the physician time database is needed. We are concerned that the number and level of postoperative visits and the corresponding physician time included in the global surgical period may be overstated in the proposed physician time database. As part of the five-year review, CMS indicated that it would study length of stay data relative to the number of postoperative hospital visits included in the global surgical period. Results of this study, however, have yet to be released. We encourage CMS to focus on this issue and further refine the physician time data that it uses.

3. Services and Supplies Incident to a Physician's Professional Services

ACP-ASIM supports the CMS proposal to allow registered nurses and medical assistants to provide services incident to the services of physicians or nurse practitioners and physician assistants, regardless of the employment relationship involved. ACP-ASIM agrees with CMS that the nature of the employment relationship is no longer critical for purposes of payment for "incident to" services, as long as the auxiliary personnel reports to a physician or practitioner under the required level of supervision. ACP-ASIM also agrees with CMS that there is no clinical reason to exclude independent contractor physicians and practitioners from the class of practitioners who can receive Medicare payment for "incident to" services.

4. Non-physicians Performing Screening Flexible Sigmoidoscopies

CMS is proposing that, in addition to medical doctors and doctors of osteopathy, physician assistants, nurse practitioners, and clinical nurse specialists be allowed to perform screening flexible sigmoidoscopies for a Medicare beneficiary if they meet the applicable Medicare qualification requirements and are authorized to perform this service under state law.

ACP-ASIM supports allowing physician assistants, nurse practitioners, and clinical nurse specialists to perform screening flexible sigmoidoscopies for Medicare beneficiaries, if the following requirements to ensure quality of care and safety for Medicare patients are met:

1. The non-physician provider is authorized to perform this service under state law;
2. The service is provided under physician supervision; and
3. The service is provided in an integrated practice arrangement whereby a licensed physician (MD/DO), jointly with other health care personnel, manages the overall care of a patient or patient population using an integrated approach to health care.

ACP-ASIM also urges CMS to review whether and how the agency and its carriers can ensure that the above-recommended requirements are met when non-physician practitioners perform screening flexible sigmoidoscopies.

5. Performance Measurement and Emerging Technology Codes

ACP-ASIM participated in the development of and strongly supports Current Procedural Terminology-Volume 5 (CPT-5), therefore we are pleased that CMS will recognize new codes for Performance Measures and Emerging Technology. ACP-ASIM agrees with the CMS proposal to allow physicians to list performance measure codes on their Medicare bills to facilitate tracking of these services, and the payment of emerging technology codes on a case-by-case basis. However, category III emerging technology codes should sometimes warrant CMS payment and should be assessed using the current CMS process for assessing new technology. CMS should refrain from categorically denying payment just because CPT chose a category III code. Overall, we appreciate CMS's recognition of these new categories of CPT codes and encourage CMS to continue to actively utilize CPT codes and participate in the CPT process.

6. Implementation of Benefits Improvement and Protection Act (BIPA) 2000

The Benefits Improvement and Protection Act (BIPA) 2000 BIPA made a substantial number of changes to policies applicable to the Medicare physician fee schedule, which ACP-ASIM supports. ACP-ASIM has specific comments on CMS's proposed implementation of screening colonoscopy coverage and payment, medical nutrition therapy, and telehealth services.

A. Screening Colonoscopy

ACP-ASIM agrees with the CMS proposal to alter its screening colonoscopy coverage and payment to conform with the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). We strongly encourage CMS to instruct carriers to identify which International Classification of Diseases volume nine (ICD9) codes are acceptable to use in conjunction with this G0121 code. Failure to do this for screening flexible sigmoidoscopy code G0104 has created problems for beneficiaries, physicians, and carriers because individual carriers adopted a variety of different acceptable ICD9, but refused to inform the public under

which circumstances the benefit was covered or not-covered by Medicare. Failure to inform the public of acceptable coverage conditions is contrary to the intent of the screening benefit.

B. Medical Nutrition Therapy

ACP-ASIM is concerned that the definition of renal disease in the BIPA medical nutrition therapy services benefit may be too restrictive. CMS's proposal to limit the benefit to "chronic renal insufficiency" appears to be more restrictive than intended by the statute. The International Classification of Diseases suggests that there are renal diseases beyond chronic renal insufficiency that do not involve maintenance dialysis, but would benefit from medical nutrition therapy and therefore should be covered under the BIPA statute. Rather than defining renal disease as "as only chronic renal insufficiency and post-transplant care provided after discharge from the hospital" renal disease should be defined as "either chronic renal insufficiency or post-transplant care provided after discharge from the hospital." This clarification would enable all beneficiaries who satisfy either of the criteria to gain access to the medical nutrition therapy benefit.

ACP-ASIM is also concerned by the requirement that the "treating physician" must refer the patient for medical nutrition therapy. CMS's intent to ensure that the physician who establishes the need for medical nutrition therapy is also the physician who treats the beneficiary's chronic disease and to ensure that the therapy is coordinated with the care being provided by the treating physician does not appreciate the fluidity of patient care coordination and referral. Hospital-based physicians and principal care physicians should also be allowed to refer patients for medical nutrition therapy.

7. Summary of Recommendations

In conclusion, ACP-ASIM recommends that CMS:

1. Reduce the productivity adjustment for physician services in the Medicare economic index to the same level as hospitals (0.5%);
2. Seek methodological avenues that will account for unrecognized expenses incurred by physician practices, such as compliance with increased regulatory burdens;
3. Adjust the sustainable growth rate (SGR) formula to account for:
 - a. unaccounted enrollment growth for the Medicare program,
 - b. expense of statutory provisions included as part of the Balanced Budget Act of 1997 (BBA '97), and
 - c. impact of national coverage decisions in the Medicare program in recent years;
4. Do not add the 1999 American Medical Association (AMA) Socioeconomic Monitoring Survey (SMS) survey data to the current 1995 through 1998 SMS survey data to calculate specialty-specific practice expense per hour as part of its resource based practice expense methodology;
5. Update the clinical staff salary data used to price CPEP inputs for clinical staff time;
6. Use a revised database of physician time per service provided by the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC);
7. Study length of stay data relative to the number of postoperative hospital visits included in the global surgical period;

8. Clarify the services and supplies incident to a physician's professional services as proposed;
9. Allowing physician assistants, nurse practitioners, and clinical nurse specialists to perform screening flexible sigmoidoscopies for Medicare beneficiaries, if the following requirements to ensure quality of care and safety for Medicare patients are met:
 - a. The non-physician provider is authorized to perform this service under state law;
 - b. The service is provided under physician supervision; and
 - c. The service is provided in an integrated practice arrangement whereby a licensed physician (MD/DO), jointly with other health care personnel, manages the overall care of a patient or patient population using an integrated approach to health care.
10. Refrain from categorically denying payment just because the service is a category III Current Procedural Terminology-Volume 5 (CPT-5) code;
11. Instruct carriers to identify which International Classification of Diseases volume nine (ICD9) codes are acceptable to use in conjunction with the screening flexible sigmoidoscopy G0121 code.
12. Define renal disease as "either chronic renal insufficiency or post-transplant care provided after discharge from the hospital."