ACP
American College of Physicians
Internal Medicine | Doctors for Adults®

December 29, 2009

Charlene Frizzera
Acting Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-8013

Attention: CMS-1413-FC

Dear Ms. Frizzera:

The American College of Physicians (ACP), representing 130,000 internists and medical students, appreciates the opportunity to comment on Centers for Medicare and Medicaid Services' (CMS) *Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2010; Final Rule with Comment Period; CMS-1413-FC.*

Practice Expense Proposals for CY 2010
Physician Practice Information Survey (PPIS)

ACP continues to support use of Physician Practice Information Survey (PPIS) data to update specialty practice expense per hour (PE/hr) figures. The College appreciates the additional analyses CMS has made available; the agency's efforts provide a more complete understanding of the action taken and increase confidence in the results.

ACP notes that use of the PPIS-derived PE/hr figures accounts for much, but not all, of the change in the practice expense relative value unit (RVU) assigned to individual services that drive the CMS specialty impact estimates. Accordingly, College recommends that CMS explicitly indicate the amount of change that resulted from each practice expense adjustment, e.g., PPIS, or the imaging assumed use rate increase. The agency should at least provide this more detailed impact estimate for the specialties for which multiple factors make a significant contribution.

ACP recommends that CMS be transparent if it considers future changes based on its analysis and/or requests from specialty organizations or other stakeholders.

Practice Expense Relative Value Methodology; Adequate Recognition of Direct Practice Expenses

ACP is concerned that the CMS adjustment to direct practice expense input costs to maintain budget neutrality may result in inadequate recognition of those costs. CMS attempted to address proposed rule comments that the budget neutrality adjustment results in Medicare paying only 51% of direct practice expense costs in the final rule. The agency's explanation, however, failed to dispel the contention that Medicare systematically underpays direct expenses. The College urges CMS to open a dialogue with stakeholders regarding how the practice expense methodology may best recognize actual physician direct costs.

Equipment Utilization Rate
ACP commends CMS for finalizing its proposal to increase the assumed utilization rate for equipment priced over $1 million. The College has long advocated a rate increase that more accurately reflects the utilization of services involving expensive equipment. In addition, ACP urges CMS to work with Congress, which is pursuing a similar course through health reform legislation, to ensure that any "savings" that result from an increase in the assumed use rate stay in the physician payment pool.

Consultations Services
ACP continues to urge CMS to delay implementation of the policy change that entails Medicare no longer recognizing the Current Procedural Terminology (CPT) consultation service codes for payment purposes. The College supported the concept of using the CPT codes for office, initial hospital, and initial nursing facility visits to report consultations contingent on CMS taking certain actions and clarifying specific issues. ACP was disappointed that CMS was dismissive of these and other proposed rule comments that pointed the complexity of the policy change in the final rule. The College does appreciate that the agency has since worked with stakeholders to provide guidance regarding billing and payment issues. The intensive effort required, however, resulted in CMS first providing notice and guidance pertaining to the change to Medicare contractors and physicians on December 14, 2009. A delay is needed, as the slightly more than two-week period before the change is effective is insufficient for physicians to adjust their billing practices. In addition, it is likely that CMS will need to clarify issues beyond those addressed in the December 14, 2009 release.

ACP recommends that CMS provide more information regarding the crosswalks that map the distribution of CPT consultation service codes to the substitute office, initial hospital, and initial nursing facility visit codes that the agency used to ensure the consultation policy change is budget neutral in 2010. We question whether CMS first determined the amount of money that Medicare paid for CPT consultation codes and then distributed it across the substitute service codes using its mapping to allocate the money available to distribute. This approach would appropriately ensure that no money left the physician payment pool. An approach that first did the mapping and then distributed money to substitute codes based on that mapping has the potential to fail to expend all of the funds CMS previously paid for CPT consultation service codes. In its mapping spreadsheet, available at http://www.cms.hhs.gov/PhysicianFeeSched/PFSFRN/itemdetail.asp?filterType=none&filterByDID=99&sortByDID=4&sortOrder=descending&itemID=CMS1230135&intNumPerPage=10, CMS states that the lowest level inpatient consultation service code, CPT 99251, will be billed as the lowest level initial hospital care service code, CPT 99221, 70% of the time. We question this

assertion as the history, examination, and medical-decision making requirements for billing 99221 are equal to the mid-level inpatient consultation service, CPT 99253, and not 99221.

Payment for an Initial Preventive Physical Examination
ACP commends CMS for finalizing the increase in the work RVU for HCPCS code G0402 to 2.30, the equivalent of CPT code 99204.

Potentially Misvalued Codes Under the Physician Fee Schedule
High Cost Supplies
ACP recommends that CMS use an annual review of the prices for high-cost supplies and urges the agency to include such an annual review in future rulemaking. The College also urges the agency to explore the supply pricing methodology currently used by the Veterans Administration.

Site of Service Anomalies
ACP disagrees with the CMS final rule decision to reverse its proposed rule proposal to account for the recognized physician work changes in procedures for which the typical site of service has changed. However, we appreciate CMS conveying its future expectation that the American Medical Association (AMA)/Specialty Society Relative-Value Scale Update Committee (RUC) use its established survey process and, when appropriate, the building-block method to adjust service RVUs when there are changes to pre-/post-service times, hospital days, office visits, and/or discharge day management services.

Establishing Appropriate Relative Values for Physician Fee Schedule Services
ACP continues to urge CMS to establish a panel of independent experts who would supplement the advice provided by the RUC and would generally counsel CMS on the maintenance of the Resource Based Relative Value Scale (RBRVS). The College agrees with the Medicare Payment Advisory Commission (MedPAC) that such an expert panel would enhance the agency's ability to maintain accurate RVUs for the complete set of physician services, which is especially important as overvalued services can distort incentives and influence the delivery of health care services. ACP continues to believe that an expert panel could contribute on the range of activities described in our proposed rule comments, including data source and methodology issues.

Further, the manner by which CMS addresses many of the specific issues in the "Potentially Misvalued Services Under the Physician Fee Schedule" section of the final rule reinforces the need for an expert panel. Specifically, on the:

- "Valuing Services Under the Physician Fee Schedule" issue, CMS states that more can be done and it urges the RUC to use the building block methodology consistently.
- "High Cost Supplies" issue, CMS does not make a proposal despite noting broad support for improved pricing and ideas for how to accomplish it.
- "Review of Services Often Billed Together and the Possibility of Expanding the Multiple Procedure Payment Reduction (MPPR) to Additional Nonsurgical Procedures" issue, CMS appears content to move forward gradually on a concept it first discussed in its

2009 fee schedule final rule, stating that it will consider comments and that any changes will be proposed through future rulemaking.

- "AMA RUC Review of Potentially Misvalued Codes" issue, CMS reversed its decision not to accept the RUC recommendations for "site of service anomaly" codes, refrained from implementing its proposal to address concern about overpayment for services involving a "23-hour" hospital stay, and expressed concern about the RUC method for addressing site of service anomaly codes, while it accepted the great majority of the RUC recommendations pertaining to misvalued codes from its April 2009 meeting.

An expert panel that supplements the RUC would help CMS address these labor-intensive, technical issues more thoroughly and promptly.

Issues Related to the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)

Section 131(b): Physician Payment, Efficiency, and Quality Improvements – Physician Quality Reporting Initiative (PQRI)

2010 Reporting Periods

ACP supports the final rule provision that establishes the 6-month and 12-month reporting periods for 2010 for claims-based reporting.

2010 PQRI Reporting Mechanisms

ACP supports the CMS decision to proceed with electronic health record (EHR)-based reporting for 2010. EHR-based reporting must be a necessary component of meaningful use and CMS must be prepared to support it in 2010, as a way of preparing for the 2011 beginning of EHR incentive payments.

Regarding the dissemination of results data to the public, ACP is pleased that the final rule states that disclaimers will accompany the data. The College urges the agency to word these disclaimers carefully so that the public will clearly understand the purpose of the data.

Requirements for Individual Eligible Professionals Who Choose the Registry-based Reporting Mechanism

ACP supports the decision to continue registry-based reporting. ACP recommends that CMS implement a transparent process for registry selection to improve the viability of this option. Specifically, ACP recommends that the PQRI measures and acceptable registries be published at the start of each reporting year to give physicians ample time to consider their reporting options.

ACP supports the CMS final decision to design the 2010 PQRI with neutrality across measure specifications and reporting instructions. The College believes that, regardless of which reporting mechanism a physician chooses for participation in PQRI, measure specifications and instructions for reporting a measure should be consistent across mechanisms. We also believe that reports generated through participation by a registry or EHR, which are dependent on the measure specifications, should be very close or identical to the results from claims-based reporting.

Qualification Requirements for Registries
ACP is hopeful that future versions of PQRI will allow the data for one eligible professional to be "cross-referenced" to the data from other eligible professionals at the individual eligible professional level. This could become one of the benefits of the physician group PQRI reporting option, which starts in 2010. Satisfactory participation in PQRI for individuals looks at reporting rates at the individual TIN/NPI level.

In order to make the program more useful to physicians, ACP recommends that CMS provide feedback more frequently than the current annual basis. The College suggests that physicians receive notification when their data is received successfully and then receive prompt feedback after they are assessed. Ideally, CMS should indicate to physicians whether their data submission appears to meet criteria for PQRI payment incentives or if not, what deficiencies exist. This could be particularly relevant for interim reports when there may be sufficient time for the physician to correct any data submission errors or supplement the data provided for particular measures. Providing this information prior to CMS scoring will assist quality improvement in addition to facilitating successful participation.

Qualification Requirements for EHR Vendors and Their Products
ACP appreciates that CMS re-qualified the 2009 EHR vendors. ACP recommends that CMS continue to provide ongoing qualification processes for new vendors and systems. This would enable inclusion of vendors that did not self-nominate or did not exist during the prior reporting year.

ACP recommends that the complicated reporting criteria and time-periods be simplified for EHR users. We suggest a more streamlined approach, such as allowing EHR users to report on all their patients throughout the year. The current CMS requirement for satisfactory PQRI reporting via a qualified EHR that all PQRI quality data be submitted at one time is less than optimal. Further, ACP urges CMS to complete the necessary infrastructure development to avoid reporting redundancies such as eligible professionals inadvertently submitting previously reported data.

For physicians who are using paper records, ACP recommends that CMS consider providing an option to report via claims or registry for all their patients.

Proposed Reporting Option for Satisfactory Reporting on Quality Measures by Group Practices
ACP thanks CMS for clarifying the limited circumstances under which a group practice may deselect an assigned patient.

ACP believes that data points should not be collected until the patient has sufficient interaction with the physician, e.g., is seen at least twice by the physician.

ACP thanks CMS for clarifying that the reporting grid will be partially pre-populated with data.

ACP recommends that CMS explain the absence of an EHR reporting option for group practices. Given that large groups are more likely than small practices to have sophisticated health information technology, EHR-based reporting would likely be more feasible and less burdensome for group practices.

ACP recommends, for future program years, that CMS provide physician-level data in feedback reports to the practice. This would be useful in facilitating behavior adjustments, which will lead to improvements in care.

Statutory Requirements and Other Considerations for Measures Proposed for Inclusion in the 2010 PQRI

ACP urges CMS to ensure that there are no differences between PQRI reporting methods and those that will be used in 2011 meaningful use. ACP is intensely concerned about any changes in quality reporting that might jeopardize a physician's chances of qualifying for the incentive payment.

Section 131(c): Physician Resource Use Measurement and Reporting Programs

The College continues to have concerns regarding the project but appreciates that CMS is engaging the physician community on an on-going basis. We support the CMS commitment to refine the program benchmarks and note that engagement with the physician community will help the agency better understand the reasons behind resource use. The College anticipates that the agency will pursue further research to refine the attribution rules, especially as it concerns the evaluation and management services contained in surgical global fees.

ACP urges CMS to implement any statutorily required publication of physician resource use information carefully. Public reporting of resource use data—without reliable cost and quality data and appropriate education of all stakeholders about the methodology and program goals—can damage physician reputations and harm patient access to care.

Section 132: Incentives for Electronic Prescribing (E-Prescribing)—The E-Prescribing Incentive Program

ACP remains concerned that the incentive program will include a penalty (adjustment), scheduled to begin in 2012. The College urges CMS to offer detailed discussion of these "payment adjustments" in its future rulemaking.

ACP thanks the agency for its response clarifying that CMS does not have the statutory authority to change the calculation on which the incentive payment is based. However, the College does urge CMS to seek the necessary authority to modify the e-prescribing bonus qualification so that it is based on a physician's prescribing volume and other measures, not solely on the physician's total allowable Medicare charges.

ACP continues to recommend that the 25-event minimum for incentive bonus qualification be set at a higher number. We believe that the proposed minimum favors prescribers who typically bill high-cost services, by paying a bonus on allowable charges, rather than a flat-rate bonus, or perhaps a bonus that rewards medication management (of which e-prescribing is a component). That an internist or other primary care provider may reach the 25-event minimum in just a few days supports our contention that the event minimum should be higher.

ACP thanks CMS for its decision to expand the scope of the e-prescribing denominator codes to include the domiciliary, rest home, and custodial care and plan oversight services among the eligible professional services.

ACP recommends that CMS provide prescribers with a sufficiently detailed list of qualifying systems in order to assist them with accurately selecting a system that will meet the e-prescribing criteria.

ACP applauds CMS for reinstating the EHR reporting option for individuals. It is more appropriate for CMS to measure the use of e-prescribing functions to ensure that the prescription is correct for the patient than it is to measure the transmission of prescribing messages through a network.

ACP requests that CMS provide more detail about its plans to overcome accuracy concerns about use of a certain number of Part D prescribing events as the basis for the incentive payment. It is necessary that these concerns be resolved in time for 2011 meaningful use.

Although public comments requested it, the final rule did not clarify the issue of "generation" versus "transmittal." The final rule restates that HCPCS code G8443 means that at least one prescription was "generated and transmitted electronically using a qualified E-Rx system." In its ambiguity, it leaves open to interpretation whether the prescription can be generated by a qualified E-Rx system and then electronically transmitted by the qualified E-Rx system or whether the prescription can be generated by some other means and then transmitted electronically by a qualified E-Rx system.

ACP strongly urges CMS not to create an assumption that the complete benefits of medication safety (drug interactions, allergic reactions, and other safety precautions) can be achieved through e-prescribing alone. The vast majority of the benefits of e-prescribing have already accrued before the e-prescription order is sent.

ACP does not support the change to the e-prescribing numerator. The College's view is that the change provides an unintentional incentive for providers to write more prescriptions with fewer refills—and, thus, generate at least one e-prescription with each visit. This is not only inappropriate and wasteful—it is more costly to pharmacies.

Section 144(a): Payment and Coverage Improvements for Patients with Chronic Obstructive Pulmonary Disease and Other Conditions

Pulmonary Rehabilitation Services

ACP disagrees with the CMS final rule decision against recalculating its proposed payment for HCPCS code G0424. ACP believes that the physician work involved in pulmonary rehabilitation and cardiac rehabilitation are essentially similar and should be valued similarly. ACP strongly urges CMS to review its own calculations for the work RVUs assigned to G0424 and adjust it proportionately to 0.98 work RVUs, in order to create a work value that is analogous to that of cardiac rehabilitation CPT code 93797.

Cardiac Rehabilitation Services

While ACP generally supports CMS implementation of this provision, it recommends that the agency address the concerns below.

ACP is disappointed that CMS did not use the American College of Cardiology (ACC) definition of cardiac rehabilitation medical director. The College urges CMS to use the ACC definition, which states that a medical director should be a licensed board-certified/board eligible cardiologist or a physician with demonstrated expertise in the diagnosis and treatment of cardiovascular disease as well as expertise in exercise physiology, preventive cardiology and in the management of cardiac rehabilitation programs.

ACP continues to recommend that CMS propose a mechanism for separate reporting and payment for the new physician work and staff resources required to perform the outcomes assessment. MIPPA mandates that cardiac rehabilitation programs perform an outcome assessment for each patient every 30 days and at the conclusion of the program. Neither the physician work nor the staff resources required to perform the outcomes assessment are included in the physician work and practice expense RVUs established for CPT codes 93797 and 93798, meaning that the enhanced expectations for this service are not appropriately accounted for in the fee schedule values.

Section 152(b): Coverage of Kidney Disease Patient Education Services
CMS adjusted the payment rates for G0420 and G0421 in the final rule—in response to proposed rule comments—to reflect the 1-hour time limit for a single session,. The calculation is based on multiplication of the work RVUs for G0420 by four and the work RVUs for G0421 by two to account for the cross-walk from a 15-minute code to a 60-minute code (CPT code 97802 to G0420) and a 30-minute code to a 60-minute code (CPT code 97804 to G0421). It remains unclear to ACP that the resulting reimbursement level will support the practice expenses involved in providing these services, but we believe that this is an appropriate first step towards appropriately pricing the services.

In 2010, the agency will also adjust the inputs for supplies, even though the CMS calculation for supplies does not involve a straight multiplication of the actual inputs because the agency does not believe the required equipment and supplies will increase directly proportional to the time for the codes. ACP believes that the agency should price the supplies as directly proportional multiple units, in order to reimburse the costs of care.

While CMS decided not to add specific education/experience qualifications for qualified persons, citing a lack of uniformity regarding the need, ACP continues to urge CMS to ensure that kidney disease educators are appropriately qualified to provide the education services. CMS should do this without creating unnecessary requirements or obstacles to the provision of these services. Specifically, we concur with the position of Kidney Care Partners (KCP) that CMS should require that qualified providers be either: board certified in nephrology or have at least two years of experience working with patients with kidney disease. Such a requirement would ensure that educators have the background and experience necessary to meet the needs of patients with kidney disease without imposing unnecessary barriers or administrative complexity.

Establishment of Interim Work Relative Value Units for New and Revised CPT) Codes and New Healthcare Common Procedure Coding System Codes (HCPCS) for 2010

H1N1 Immunization Administration
CMS notes that the CPT Editorial Panel created code 90470, *Immunization administration (intramuscular, intranasal), including counseling when performed,* to assist the public health effort to vaccinate for H1N1. The RUC reviewed this service and recommended 0.20 work RVUs. While CMS will continue to require physicians to bill the agency-established HCPCS code G9141, *Influenza A (H1N1) immunization administration (includes the physician counseling the patient/family,* for this service, ACP urges CMS to assign G9141 the 0.20 work RVU assigned to CPT 90470. This is more appropriate than using the 0.17 work RVU-assignment that is equal to the linked pair of HCPCS G0008/CPT 90471.

Services for Consideration for the Five-Year Review of Work RVUs
ACP requests that CMS include the services listed below—identified by their CPT code—in the fourth Five-Year Review. The College believes that these services have experienced a significant change in physician work in the many years since they were valued through the RUC process. The College looks forward to working with CMS and the RUC to ensure that the work RVUs for these services are valued appropriately.

Initial Observation Care
- 99218 – Initial observation care
- 99219 – Initial observation care
- 99220 – Initial observation care

Preventive Medicine Services
New Patient
- 99384 – Periodic comprehensive preventive medicine evaluation and management…; adolescent (age 12 through 17 years)
- 99385 – Periodic comprehensive preventive medicine evaluation and management…; 18 – 39 years
- 99386 – Periodic comprehensive preventive medicine evaluation and management…; 40 – 64 years
- 99387 – Periodic comprehensive preventive medicine evaluation and management…; 65 years and older

Established Patient
- 99394 – Periodic comprehensive preventive medicine reevaluation and management…; adolescent (age 12 through 17 years)
- 99395 – Periodic comprehensive preventive medicine reevaluation and management…; 18 – 39 years
- 99396 – Periodic comprehensive preventive medicine reevaluation and management…; 40 – 64 years
- 99397 – Periodic comprehensive preventive medicine reevaluation and management…; 65 years and older

ACP appreciates the opportunity to comment on issues addressed in the final rule. If you have questions on any of our recommendations or positions, please contact Debra Lansey, Associate in the Regulatory and Insurer Affairs Department, at dlansey@acponline.org or (202) 261-4544.

Sincerely,

Yul Ejnes, MD, FACP
Chair, Medical Service Committee