

December 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-FC

Re: Medicare Program: Revisions to Payment Policies and Five-Year Review of and
Adjustments to the Physician Fee Schedule for Calendar Year 2002; Final Rule

Dear Mr. Scully:

On behalf of the American College of Physicians-American Society of Internal Medicine (ACP-ASIM), representing more than 115,000 doctors of internal medicine and medical students, and the nation's largest medical specialty society, I am writing to comment on the Centers for Medicare and Medicaid Services' (CMS) final rule on revisions to payment policies and adjustments to the physician fee schedule for calendar year 2002; published in the November 1, 2001 *Federal Register* (55,246).

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

The American College of Physicians-American Society of Internal Medicine (ACP-ASIM) believes 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. We are 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 and we are disappointed that CMS has not yet taken the opportunity to address these problems. Improvements must be made to both the Medicare Economic Index (MEI) and the sustainable growth rate (SGR) as soon as possible because errors in the MEI and SGR estimates artificially deflate the conversion factor for physician services.

We encourage CMS to re-look at our comments on the proposed rule regarding the MEI and the SGR. 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.

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.

2. Refinement of Resource Based Practice Expenses (RBPE)

AMA SMS Data: We are disappointed that CMS decided to add the 1999 American Medical Association (AMA) Socioeconomic Monitoring Survey (SMS) data to the four year sample despite ACP-ASIM comments that the new data created new problems. It is our understanding that that 1999 survey was greatly scaled back in the number of surveys and respondents and that typically, the AMA would not provide or publish data with so few responses for some specialties, however the net result of CMS using this data could be significant. We understand 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. A letter from the AMA to Terry Kay of CMS on April 5, 2001 describes the overall sample size of the 1999 SMS data as about half of the sample that the AMA used in previous survey years. The 1999 data looks rather suspect as we note that specialties costs went up less than 5%, but others increased 35% in a single year. Additionally, as the CMS is well aware, there was a real opportunity 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.

Supplemental Practice Expense Survey Data: ACP-ASIM is pleased that CMS has agreed to allow specialties to submit supplementary practice expense data to CMS for an additional two years—This is consistent with ACP-ASIM's recommendations to extend the refinement period in order to consider more scientifically valid practice expense data.

Repricing of CPEP Inputs: ACP-ASIM is pleased that CMS has revised the salary and cost estimates with the most current pricing data available. ACP-ASIM also agrees with the CMS decision to collapse several of the clinical staff wage categories due to lack of more current data and to accept several wage studies for medical technicians employed by various physician specialties in areas where the data CMS utilized was less robust.

Physician Time: ACP-ASIM agrees with the decision to update the physician time data used in creating the specialty-specific practice expense pools with the RUC verified physician time database. This is consistent with a previous ACP-ASIM recommendation.

3. Nurse Practitioners (NPs), Physician Assistants (PAs), and Clinical Nurse Specialists (CNS) Performing Screening Sigmoidoscopies

ACP-ASIM agrees with the CMS decision to implement its proposal to allow Nurse Practitioners (NPs), Physician Assistants (PAs), and Clinical Nurse Specialists (CNS) Performing Screening Sigmoidoscopies. However, we are concerned that CMS has not committed to ensure quality of care and safety for Medicare patients by requiring that:

- 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.

ACP-ASIM again urges CMS to promote quality of care and patient safety by implementing the criteria stated above.

4. Medical Nutrition Therapy—Coverage and Payment

ACP-ASIM is pleased that CMS finalized its proposal to cover and pay for medical nutrition therapy to conform with the Medicare, Medicaid, and SCHIP benefits Improvement and Protection Act of 2000 (BIPA). We agree with the CMS decision to expand the definition of renal disease to include beneficiaries with end-stage renal disease who are not receiving dialysis and to expand the time period in which it cover medical nutrition therapy for beneficiaries who have received a kidney transplant, to bring the coverage into conformance with the Medicare eligibility period. We are also pleased that CMS clarified that it did not intend to exclude primary care physicians from the term “treating physician,” and it has redefined this term to mean “the primary care physician or specialist coordinating care for the beneficiary with diabetes or renal disease.” However, as we stated in our comments on the proposed rule, the definition of renal disease should be “either chronic renal insufficiency or post-transplant care provided after discharge from the hospital.” Currently, CMS plans to define renal disease as requiring both, which is a much narrower definition than is medically appropriate.

5. Five Year Review

Critical Care Services in a Global Period

In the proposed rule, CMS mentioned that global surgery includes critical care management and asked for comments. In the final rule, CMS indicated that they intend to finalize the proposed work RVUs for the pulmonary medicine and critical care codes. ACP-ASIM and the critical care/pulmonary community are concerned that the current Medicare policy can be interpreted by individual Medicare carriers in a way that will not allow physicians to bill legitimate critical care services because of concurrent care concerns. We encourage CMS to clarify its policy to allow physicians to bill for the legitimate critical care/pulmonary services that they provide to a patient during the global surgery billing period are reimbursed by Medicare.

6. Refinement of Relative Values Units For Calendar Year 2002

ACP-ASIM is concerned that CMS has not clarified the status of CPT Code 90940, Hemodialysis Access Study. The 2001 fee schedule inappropriately designated 90940 as an ‘X’ code designation. This determination does not follow the AMA/Specialty Society RUC recommendation and could have a potentially harmful impact on patients in the End-Stage Renal Disease (ESRD) program. Appropriate dialysis access management is critically important in ESRD care. ACP-ASIM recommends that CMS accept the RUC practice expense recommendations on CPT code 90940, and to change the coverage designation for 90940 to an active status.

7. CMS Decision on New and Revised Codes for 2002

A. Collection and Interpretation of Physiologic Data

ACP-ASIM objects to the CMS decision to consider payment for CPT 99091, collection and interpretation of physiologic data (e.g. ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health professional, requiring a minimum of 30 minutes of time, to be bundled into the payment for other services. We contend that 99091 represents physician work for which payment is not captured in other services. We urge CMS to identify 99091 as an active code, designating it “A” status in the physician fee schedule, and to accept the RUC recommended work relative value unit of 1.1.

The CMS decision to consider this service bundled presumes that the physician review of data is post- service work associated with E/M service, e.g. an office visit. This rationale is misguided as the 30-minute reporting requirement ensures that the service, which can be comprised of multiple data transmissions, exceeds typical post- service work. It is inappropriate to consider such an extensive service as typical post- service work. For each data transmission, the physician reviews the patient medical record; determines whether the data requires an adjustment to patient care plan; communicates the decision to the patient; and documents a separate entry into the patient medical record. The following example illustrates the complexity of this separate service:

A 67-year old male with labile diabetes is utilizing a home glucose-monitoring device to capture multiple glucose readings during the course of a month in association with diary data of symptoms, medication, exercise, and diet. The data is transmitted from home computer to physician’s office by email, downloaded by physician and data reviewed. Pre-service work includes chart review concerning prior glucose control methods. Intra-service work involves the physician spending 35 minutes during a 30-day period for the review, interpretation and report based on the physiologic data and diary. Separate time spent typically involves at least one contact with patient (e.g. telephone call or e-mail exchange) with further advice about medical management and monitoring recommendations. Post-service work includes associated chart documentation.

CPT 99091 is similar to the codes that describe physician oversight of patient home health and hospice care plans, which are also time based and have a 30-minute in 30-day reporting

requirement. Appropriately, CMS provides separate payment for these care plan oversight codes. CPT 99091 is parallel to care plan oversight as both aim to manage patient care without unnecessary face-to-face visits. While non-traditional, the service of physician review of computer transmitted data from remote monitoring devices and the subsequent care plan adjustments is equally valuable and must also be compensated.

Medicare currently maintains no mechanism to provide reasonable compensation to physicians for extraordinary pre- and post- service work. It is our understanding that CMS has informally stated that physicians can consider selecting a higher level of E/M service for the next face-to-face encounter when their review of data and other information and subsequent communication with patients exceeds typical post –service work. This practice is limited, however, because the CMS failure to codify this determination in regulation leaves physicians vulnerable to overpayment requests determined by Medicare carrier auditors.

The CMS decision to consider 99091 bundled fails to account for an e-service that does not correspond to a face-to-face service. The proliferation of Internet use among patients and physicians makes it increasingly likely that some computer interactions, known as e-health services, will constitute a separate service, independent of on-going treatment for a chronic patient problem. The post-service concept does not apply under this type of scenario since the physician neither performs or bills for a face-to-face service. CMS should compensate physicians for this type of service. The 30-minute requirement for reporting precludes a physician from billing for a routine e-mail exchange with a patient, such as patient statement that he or she is feeling good after experiencing flu-like symptoms.

CMS failure to pay separately for 99091 is likely to discourage the use of existing and emerging technology that facilitate the efficient provision of clinically appropriate care. Physicians currently provide this service to patients with a wide range of illness and disease, especially those afflicted with cardiovascular disease and diabetes. Also, the frequency by which physicians spend time reviewing patient data from remote monitoring devices that exceeds typical pre- and post- E/M service work will increase as technology allows medical care to rely less on face-to-face patient interactions. CPT 99091 recognizes that technology is changing the nature of physician work and allows physicians to report this increasingly prevalent type of work.

Research focused on the cost effectiveness of e-health services documents its potential. The article, “Recent Advances: Telemedicine,” by Richard Wootton, in the September 2001 *British Medical Journal* details the recent advances in e-health. The article, documents that: the first randomized controlled trial of home telenursing showed evidence of cost effectiveness; electronic referrals are a cheaper and more efficient way to handle outpatients; teleconsulting can be cheaper than traditional consulting at least in some circumstances; physician oversight of nurse practitioner minor injury units via real time video links is safe and effective; and that the British public has demonstrated a demand for call centers and on-line health services. CMS needs to adjust its payment system to recognize the increasing prevalence of e-health services. Assigning 99091 active code status in the fee schedule is an important first step.

B. Immunization Administrations

ACP-ASIM is pleased that CMS has activated immunization administration CPT codes 90471 and 90472 in the 2002 Medicare Physician Fee Schedule. However, we have two concerns about this revision.

We believe that CMS should clarify their intent for activating 90471 and 90472 because it is unclear whether providers should use these codes or the existing codes (G0008, G0009, or G0010) to document immunization administrations beginning January 1, 2002. We recommend that CMS require providers to use CPT codes 90471 and 90472 for all immunization administrations because these codes were specifically created to describe these services. In addition, these codes will simplify the coding requirements placed on providers because the majority of private insurance plans already require their use.

ACP-ASIM is also concerned with the CMS decision to ignore the physician work associated with 90471 and 90472. The Relative Value Update Committee (RUC) made physician work and practice expense value recommendations to HCFA in May 1999, and reaffirmed in February 2001, that values be placed in the Medicare Physician Fee Schedule for these codes. These RUC recommendations were ignored by CMS and as a result inaccurate values have been assigned to immunization administration services.

The CMS rationale that 90782 is analogous to 90471 is simply not true. The RUC has not surveyed the work component of 90782, so it is inappropriate to say that 90471 has the same value as a code that has never undergone a full review. The RUC studied the work involved in immunization administrations and concluded that the work is comparable to 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. Utilizing the RUC approved values for CPT codes 90471 and 90472 will ensure vaccine administration services are appropriately valued relative to other services. Therefore, we urge CMS to review this new vaccine administration policy and make the correct adjustments to accurately value these services.

For years physicians and other health care providers have reluctantly accepted payment for immunization services below the actual expenses incurred. Many providers are frustrated with reimbursement rates that do not cover the costs to provide these services and are referring their patients to other sources to receive immunizations. This trend has grown and is now identified as one of the top barriers toward increased immunization rates. Furthermore, Medicaid and private payers are increasingly utilizing the RBRVS physician fee schedule as a basis for setting payment rates and will likely mirror the values arbitrarily assigned to vaccine administrations by CMS. Unless revised, the current policy will only lessen the utilization of these necessary, yet cost efficient services for all Americans. ACP-ASIM strongly encourages CMS to use the RUC recommendations and properly value immunization administrations.

C. Continuous Glucose Monitoring Services (CPT Code 95250)

ACP-ASIM is pleased that CMS recognizes the new CPT Code for continuous glucose monitoring services (CPT code 95250), however we are concerned that the practice expense value for this service is too low. The total RVUs for the service are only 1.45. Comparable services such as cystometograms (CPT codes 51725 and 51726) have non-facility practice expense relative values of 5.92 and 4.65 respectively, more than three times the current relative value for continuous glucose monitoring services. ACP-ASIM recommends that CMS review the practice expense component of continuous glucose monitoring services and revise the relative value for this service as is appropriate.

Summary and Conclusion

ACP-ASIM appreciates the opportunity to comment on the Medicare physician fee schedule final rule for calendar year 2002. To summarize, ACP-ASIM recommends that CMS take the following actions:

- 1) Consider reducing the MEI productivity adjustment to the level proposed by the Medicare Payment Advisory Committee (MedPAC) for hospitals (0.5%);
- 2) Seek methodological avenues in the MEI that will account for unrecognized expenses incurred by physician practices such as compliance with increased regulatory burdens.
- 3) Adjust the SGR formula for:
 - i) unaccounted enrollment growth for the Medicare program,
 - ii) expense of statutory provisions included as part of the Balanced Budget Act of 1997 (BBA '97), and
 - iii) impact of national coverage decisions in the Medicare program in recent years.
- 4) Refine the resource based practice expenses by deleting the 1999 American Medical Association (AMA) Socioeconomic Monitoring Survey (SMS) data from the five year sample.
- 5) Promote quality of care and safety for Medicare patients by requiring that Nurse Practitioners (NPs), Physician Assistants (PAs), and Clinical Nurse Specialists (CNS) performing screening sigmoidoscopies:
 - i) Are authorized to perform this service under state law;
 - ii) The service is provided under physician supervision; and
 - iii) 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.
- 6) Define renal disease as “either chronic renal insufficiency or post-transplant care provided after discharge from the hospital.”
- 7) Clarify policy to allow physicians to bill for the legitimate critical care/pulmonary services that they provide to a patient during the global surgery billing period are reimbursed by Medicare.
- 8) Accept the RUC practice expense recommendations on CPT code 90940 (Hemodialysis Access Study) and to change the coverage designation for 90940 to an active status.

- 9) Identify CPT code 99091 (collection and interpretation of physiologic data) as an active code, designating it “A” status in the physician fee schedule, and to accept the RUC recommended work relative value unit of 1.1.
- 10) Activate immunization administration CPT codes 90471 and 90472 and accept the RUC recommendations of 0.17 work value for 90471 and 0.15 for 90472.
- 11) Review the practice expense component of Continuous Glucose Monitoring Services (CPT Code 95250) and revise the relative value for this service as is appropriate.

If you have any questions about these comments, please contact ACP-ASIM’s Director of Managed Care and Regulatory Affairs, John DuMoulin, at (202) 261-4535. Thank you for full consideration of these comments.

Sincerely,

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