ADVOCACY UPDATE

July 14, 2011

2012 Medicare physician payment proposed rule

On July 1, the Centers for Medicare and Medicaid Services (CMS) published a proposed regulation detailing Medicare physician payment policies for 2012. The rule, which is open for comment until close of business on Aug. 30, 2011, confirms that unless Congress intervenes, Medicare's physician conversion factor will fall next January by 29.5%--from the current $34.01 to $23.96.

In a statement accompanying the release, CMS Administrator Don Berwick, MD, acknowledged that a cut "would have serious consequences," and expressed the Administration's determination to pass "a permanent SGR fix to solve this problem once and for all." The rule provides no information on how the Administration intends to accomplish this though it does reassert last year's promise to look at potentially helpful changes in the Medicare Economic Index (MEI) used to calculate physician cost inflation.

In response to primary care physicians' continued concerns regarding payments for their services, the proposed rule calls on the AMA/Specialty Society RVS Update Committee (RUC) to review 91 evaluation and management (E/M) codes that CMS thinks may be undervalued and 70 high volume, high dollar services the agency believes may be over-valued. The rule also would impose new payment cuts on advanced imaging services, modify the way geographic practice cost indexes (GPCIs) are calculated, make the electronic prescribing incentive program more flexible, align quality measures in the electronic health record incentive program and the physician quality reporting system, and establish 2013 as the base year for determining value-based payment modifiers in 2015.

Potentially Misvalued Codes

As noted in the proposed rule, "in recent years CMS and the RUC have taken increasingly significant steps to address potentially misvalued codes" and since 2009 have reviewed over 700 such codes identified through the use of objective screens such as whether a service is now typically done on an outpatient rather than an inpatient basis. All told, the AMA estimates that about $1.5 billion has been redistributed among services as a result of these reviews, which have been conducted in addition to four comprehensive five-year reviews.

While values for the major (E/M) codes were increased significantly in the 2006 five-year review, CMS says a new review is warranted due to primary care's evolution to a more comprehensive care management focus. At the same time, the agency is calling on the

RUC to review a "select list of high expenditure procedural codes" that may have dropped in value since the last review. Half of each category would be reviewed in 2012 and half in 2013 and some either have been or are scheduled for review as part of the RUC's misvalued code initiative. In addition, CMS wants to eliminate future five-year reviews and incorporate the publically nominated reviews normally handled through that process into the annual reviews.

AMA supports legislation to repeal the IPAB

On July 6, the AMA sent letters of support to Senator John Cornyn (R-TX) and Rep. Phil Roe, MD (R-TN) for their bills to eliminate the Independent Payment Advisory Board (IPAB), introduced as S. 668 and H.R. 452, respectively. Throughout the health system reform debate, the AMA continually expressed its opposition to the IPAB. Chief among our concerns are its lack of accountability and the fact that physicians would be subject to double jeopardy under both the IPAB and the sustainable growth rate (SGR) targets. The AMA believes that cost containment under Medicare can be best achieved through bipartisan approaches to reform health care delivery and payment systems in ways that promote quality, access, and efficiency. Copies of the letters sent to Senator Cornyn and Rep. Roe can be viewed at **http://www.ama-assn.org/resources/doc/washington/s668-support-letter.pdf** and **http://www.ama-assn.org/resources/doc/washington/hr452-support-letter.pdf.**

AMA works to prevent Medicare cuts to imaging services

The Senate Finance Committee held a mock-mark up (a non-binding action) of the South Korea, Panama, and Columbia free trade agreements, along with legislation reauthorizing the Trade Adjustment Assistance (TAA) program, on July 7. The initial legislative package included a $400 million cut over 10 years in Medicare payments for advanced imaging and other diagnostic procedures to partially offset the costs of the TAA reauthorization. Following strong opposition from the AMA, the American College of Radiology, industry and other groups, the legislation was modified and the imaging cuts were removed prior to passage in the Finance Committee. The House Ways and Means Committee also held a mock-mark up of the free trade agreements on July 7, but it did not include legislation reauthorizing the TAA program.

The Obama Administration will soon submit a package to Congress that includes the trade agreements and perhaps language reauthorizing the TAA program. The trade package will be subject to procedural protections that prohibit amendments, so the House and Senate may only vote to accept or reject the package in its entirety.

Separately, on June 30, the AMA sent a letter to Congress signed by 36 national medical specialty societies conveying objections to three recent Medicare Payment Advisory Commission (MedPAC) recommendations that would cut payments for imaging and a broad array of other ancillary services provided in physicians' offices. The recommendations, which are included in the MedPAC's June 2011 Report, could have a number of unintended consequences, such as reducing payments to primary care physicians, fragmenting care, and driving more services out of physician offices and into more expensive hospital settings. The letter urges that they not be included in any future legislation.

Language with implications for gene patents is removed

On June 14, the AMA sent a letter to the House Judiciary Committee opposing the inclusion of an amendment to H.R. 1249, the "America Invents Act of 2011," which had implications for the legal status of patents on human genes. The amendment was offered by Rep. Debbie Wasserman Schultz (D-FL), and was initially included in the manager's amendment to the legislation. It was intended to permit second opinions on genetic tests covered by a gene patent without triggering a patent infringement claim. The AMA opposed the amendment because it could have been misconstrued as implicitly authorizing the issuance of patents on human genes, and because it would not increase the availability of providers willing to offer a second opinion on tests covered by a gene patent. Additionally, it had the potential to affect ongoing litigation regarding the legality of gene patents under existing law.

The final manager's amendment to H.R. 1249 stripped the flawed amendment and replaced it with a study on the impact of gene patents on patient access to diagnostic tests. H.R. 1249 passed the House of Representatives on June 23, and now moves to the Senate for consideration.

Children's hospital GME bills under consideration

Both the Senate Committee on Health, Education, Labor and Pensions (HELP) and the House Committee on Energy and Commerce will consider legislation to reauthorize the Children's Hospital Graduate Medical Education (CHGME) program. The Senate HELP Committee scheduled a mark-up of S. 958, the "Children's Hospital GME Support Reauthorization Act of 2011," on July 20; the House Energy and Commerce Health Subcommittee held a hearing on July 11 on a companion bill, H.R. 1852. These bills would extend the CHGME program through 2016 at current authorization levels.

The CHGME program was enacted in 1999 as part of the Health Research and Quality Act to provide federal support to freestanding children's hospitals for direct and indirect expenses associated with operating medical residency training programs. Since few children's hospitals receive Medicare funds, the legislation was designed to correct the exclusion of pediatric training in Medicare's GME financing program. CHGME now provides funding for 56 hospitals in 30 states to support pediatric residency training. The current authorization for the CHGME program expires on October 1.

HHS abandons "mystery shopper" survey

The Department of Health and Human Services (HHS) considered hiring surveyors to pose as potential new patients to assess whether primary care physicians are less willing to accept Medicare and Medicaid patients than those with private insurance. The surveyors were to contact more than 4,000 doctors' offices in nine states twice—first posing as patients with private coverage, and then acting as patients in a public plan. The AMA and a number of other groups raised strong concerns about the project and, as a result, HHS decided not to proceed with the survey.

CMS's fraud fighting efforts to include new predictive modeling tool

The AMA met recently with the Centers for Medicare & Medicaid Services (CMS) Center for Program Integrity (CPI) to discuss various initiatives, including a new predictive

modeling tool to identify fraudulent claims, efforts to deter physician identity theft, and the agency's "audit of audits."

Pursuant to the Small Business Jobs Act of 2010, CMS launched a new predictive modeling technology program on July 1 to help target and identify fraudulent Medicare claims nationwide. This tool is not intended to identify improper billing or coding, but rather as a means of identifying truly fraudulent claims. CMS describes the new technology as similar to that used by credit card companies, and it will allow real-time analysis of Medicare Parts A and B claims data. The predictive modeling technology employs risk scores and other data, such as information on stolen provider or beneficiary identifications, to help identify fraudulent claims. For example, It should help identify fraudulent billing for services performed in multiple and geographically distant locations on the same day. The AMA stressed in its meeting with CMI that any physicians whose claims are flagged by this technology through honest mistakes should be informed and have the opportunity to correct any errors. At the AMA's request, CMI will devise a FAQ on this program. The AMA also asked CMS to continue efforts to reduce multiple, burdensome physician audits, and expressed support for CMS's internal "audit of audits". The issue of physician identity theft was also raised, and the AMA renewed its request that CMS create a single ombudsman office to assist physicians whose identities have been stolen and used fraudulently to restore their good name and credit.

AMA and specialties continue to urge for flexible meaningful use criteria

The AMA worked with specialty societies to drill down even deeper to depict the overall ability of various specialists to meet the electronic health record incentive program's meaningful use measures. In a labor intensive exercise, 22 specialty societies joined the AMA on a June 29 letter to HHS Secretary Sebelius that detailed specific concerns about the measures, identifying those that are inapplicable to their scope of practice or the services they provide to their respective patient populations. The letter urged the Secretary to consider lessons from Stage 1 before moving forward with future stages. It also recommended that the Administration provide adequate flexibility in the meaningful use incentive program to accommodate all specialists and their varying practice patterns and patient populations. To view the letter, visit: **http://www.ama-assn.org/ama/pub/physician-resources/health-information-technology/incentive-programs/advocacy-efforts.page**

CMS issues proposed rules on home health face-to-face requirements

On July 5, CMS published two proposed rules on home health face-to-face (F2F) encounter requirements. CMS proposed to add flexibility to these requirements by allowing a physician who attended to a home health patient in an acute or post-acute setting to inform the certifying physician of the patient encounter and so satisfy the requirement. CMS also proposed Medicaid home health F2F encounter requirements that are comparable to those applicable to Medicare. Under the Medicare requirements and the proposed Medicaid requirements, the F2F encounter can occur within 90 days prior to, or 30 days after, the start of home health services. The proposed rules are on display at **http://www.ofr.gov/OFRUpload/OFRData/2011-16938_PI.pdf and http://www.ofr.gov/OFRUpload/OFRData/2011-16937_PI.pdf.**

CMS Announces National Version 5010 Testing Week – Mon Aug 22 through Fri Aug 26

The Version 5010 compliance date – Sun Jan 1, 2012 – is fast approaching. Physicians should be taking steps now to get ready, including conducting testing with their payers, either directly or through their clearinghouse and/or billing service, to ensure timely compliance.

The Centers for Medicare & Medicaid Services (CMS), in conjunction with Medicare Fee-for-Service (FFS) Program, will be holding a National 5010 Testing Week Mon Aug 22 through Fri Aug 26. National 5010 Testing Week is an opportunity for physicians, including their clearinghouse and/or billing service, to test the Version 5010 transactions with the added benefit of real-time help desk support and direct and immediate access to the Medicare Administrative Contractors (MACs).

More details concerning transactions to be tested will be forthcoming from the MACs. There are several State Medicaid Agencies that will also be participating in the National 5010 Testing Week; more details on Medicaid testing will become available soon.

Physicians do not need to wait until August. CMS encourages physicians to begin working with their MAC *now* to ensure timely compliance.

Visit the AMA's version 5010 Web page or the CMS Web site, **http://www.CMS.gov/Versions5010andD0**, for more information.

CMS Hosting an ICD-10 Physicians National Provider Call Aug 3, 2011

To assist physicians prepare for a smooth transition to ICD-10 on October 1, 2013, the Centers for Medicare & Medicaid Services (CMS) will host a National Provider Call on "ICD-10 Implementation Strategies for Physicians" on Aug. 3 from 1:00 – 3:00 pm Eastern Time. CMS subject matter experts will discuss ways that physician offices can prepare for the change to ICD-10 for medical diagnosis and inpatient procedure coding. Topics to be discussed on the call include an ICD-10 overview, update on claims spanning the implementation date, national ICD-10 implementation issues, and laboratory conversion process. A question and answer session will follow the presentations. Physicians, medical coders, office staff, billing staff, and health records staff should plan to attend this call.

For registration go to:
http://www.cms.gov/ICD10/Tel10/itemdetail.asp?itemID=CMS1249632 on the CMS website. Registration will close on Tue Aug 2 at 1pm ET or when available space has been filled. No exceptions will be made. Please register early