



# Statement

of the

American Medical Association

to the

Practicing Physicians Advisory Council

RE: Proposed Physician Fee Schedule Rule  
Durable Medical Equipment

August 18, 2008

**Division of Legislative Counsel**  
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**Statement**  
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The American Medical Association (AMA) appreciates the opportunity to submit this statement to the Practicing Physicians Advisory Council (PPAC or the Council) concerning the proposed physician fee schedule rule and durable medical equipment (DME).

We would also like to advise the Council concerning the status of the Medicare physician payment rate. A 10.6 percent cut in the Medicare physician payment rates became effective on July 1, 2008. Shortly after July 1, however, Congress enacted the *Medicare Improvements for Patients and Providers Act of 2008* (MIPPA), which contained a provision to avert the 10.6 percent cut retroactively by extending the current 0.5 percent payment rate through December 31, 2008, and MIPPA also provides a 1.1 percent payment rate update for 2009. We greatly appreciate the support of PPAC in our efforts to avert steep cuts and ensure positive updates in Medicare physician payment rates. We further urge PPAC to continue to support our efforts as we move forward to resolve the flawed Medicare physician payment formula – the sustainable growth rate (SGR).

Congress' efforts in enacting MIPPA and averting cuts for 18 months allows time to address the steep cuts that are projected to occur under the flawed SGR. Physicians face a 21 percent cut in Medicare payment rates in 2010, with cuts totaling 40 percent in the coming decade. As we work with Congress to develop a long-term solution to the SGR, we will continue to keep PPAC apprised of these developments and look forward to working with the Council to help achieve our shared goals.

**MEDICARE PHYSICIAN FEE SCHEDULE PROPOSED RULE**

The Centers for Medicare & Medicaid Services ("CMS") recently issued the physician fee schedule for calendar year 2009 and the AMA is currently in the process of developing

comments on the proposed rule. Below are some key issues and concerns that we will include in our comment letter to the Centers for Medicare and Medicaid Services (CMS).

### PHYSICIAN QUALITY REPORTING INITIATIVE (PQRI)

In the proposed rule, CMS sets forth a number of proposals relating to implementation of the PQRI for 2007 through 2009. The AMA strongly supports the quality improvement goals envisioned by such programs as the PQRI, along with many specific aspects of this program. We have several serious concerns, however, with various aspects of the PQRI, as discussed further below, and we look forward to working with CMS to resolve these concerns in an effort to improve the PQRI.

#### Barriers to Participation in the PQRI

**Moving forward with the 2009 PQRI, the AMA urges PPAC to recommend that CMS work with the physician community to evaluate and address continued barriers to participation in the program.** Key barriers to participation that remain include such factors as the lack of applicable measures to certain physician specialties and confusion concerning the requirements for participation in the PQRI. **The AMA, along with the Physician Consortium for Performance Improvement (PCPI) is committed to working with CMS to develop appropriate measures so that all physicians have an opportunity to participate. We also look forward to working with CMS to ensure that physicians have the proper education and training concerning how to participate in the PQRI.** There are many opportunities for broadening the potential to participate in the PQRI as well as for educating physicians who wish to participate, and such opportunities are discussed more specifically below.

#### PQRI Transparency

The AMA strongly encourages CMS to ensure greater transparency in all aspects of developing the PQRI program, and especially with respect to the process of measure selection. Many of our physician members have expressed concern that a rigorous, systemic process is not in place to determine which measures will be included in the program. For example, in March of this year, CMS solicited measure topics from the physician community for inclusion in the 2009 PQRI. This was a very broad solicitation, and it remains unclear how and why certain measures are (or are not) included in the list of proposed measures for the 2009 PQRI. In fact, the PCPI submitted to CMS numerous performance measures for consideration for 2009, but many of these measures were not included in the proposed rule and thus will not be part of the 2009 PQRI. Various measures on the list would have provided the only opportunity to participate in the PQRI with respect to certain physicians for whom no other PQRI measures are applicable to their practice. **Inclusion of such measures in the PQRI would increase opportunities for participation in the PQRI. Further, in an effort to increase transparency, we urge PPAC to recommend that CMS provide in the final rule a thorough explanation of why these measures were not included in the list of measures proposed for the 2009 PQRI.**

## PQRI 2007

Under the Tax Relief and Health Care Act of 2006 (TRHCA), CMS initially implemented the PQRI for the reporting period of July 1, 2007 through December 31, 2007, with a bonus payment for participation in the PQRI. CMS recently provided the first data on interim participation and reporting statistics related to the 2007 PQRI. According to this initial report, approximately 16 percent of physicians and eligible professionals participated in the 2007 program, but nearly 50 percent of participants did not receive any bonus payment. It is clear from this alarming statistic that there is significant confusion among physicians about how to successfully meet the requirements of the PQRI. This strongly points out the need for CMS to undertake an aggressive education and outreach program for physicians and eligible professionals on how to successfully participate in the PQRI. This educational program must include detailed confidential interim feedback and compliance reports that clearly inform physicians of any reporting errors and how to correct these errors. Confidential final feedback reports must be issued as well. This will assist in increasing the number of eligible professionals that successfully report in the PQRI. **Accordingly, we urge PPAC to recommend that CMS, as it moves forward with the 2008 and 2009 PQRI (and beyond), develop a more effective educational and outreach program that clearly informs physicians and eligible professionals who wish to participate in the PQRI of the requirements that must be met to successfully participate in the program.**

Further, the AMA looks forward to working with CMS in an effort to glean additional information from the 2007 PQRI data set file to help improve physician quality measure design. The AMA would also like to conduct a more detailed review of the 2007 data to better understand possible barriers and stimuli to physician reporting. **We, therefore, urge PPAC to recommend that CMS provide the appropriate data so that the AMA may immediately undertake such review.**

## Uses of PQRI Information

The *Medicare Improvements for Patients and Providers Act of 2008* (MIPPA), which became Public Law No. 110-275 on July 15, 2008, authorizes CMS to post on the Internet, in an easily understandable format, a list of the names of the eligible professionals or group practices that satisfactorily submit data on quality measures (as well as with respect to those that are successful electronic prescribers). As discussed further below, we urge CMS to comply with its statutory authority, as directed under MIPPA, and make available to the public only the names of the eligible professionals or group practices that satisfactorily submit data on quality measures (as well as with respect to those that are successful electronic prescribers). **In implementing this provision, we urge PPAC to recommend that CMS inform physicians and eligible professionals who participate in the PQRI well in advance whether they will be listed on the Internet as an eligible professional that satisfactorily submitted data under the PQRI. CMS should also inform those who participate, but who will not be listed as a successful participant, of the reasons why they will not be listed and allow such physicians an opportunity to correct any errors and/or provide a written explanation for such lack of success. Physicians should be**

**able to elect whether this explanation may be available to the public through the CMS web site.**

Further, CMS discusses in the proposed rule its intent to make information on the quality of care for services provided by physicians to Medicare beneficiaries publicly available in future years through a “Physician Compare” Web site. As part of this initiative, CMS proposes to explore using information collected from the PQRI, including performance results, for this purpose. CMS is requesting public comment on a number of issues related to public reporting of PQRI performance information. **These plans to publicly report PQRI performance results further underscores the importance of removing the barriers to successful participation in the program through improved physician education and expansion of the measure set to cover a broader array of specialties.**

The AMA is committed to the development of quality improvement initiatives that increase the quality of care provided to patients. The AMA-convened PCPI has adopted a transparent, consensus-based process for developing physician-level measures and has worked aggressively in developing to date more than 200 physician performance measures and specifications for over 34 clinical topics and conditions. These measures are available for implementation and are designed to help achieve the important goal of quality improvement. In fact, many of these measures have been adopted by CMS for use in the PQRI as well as in other CMS quality improvement demonstration projects.

**As the AMA continues in our ongoing efforts to enhance quality improvement, we urge CMS to ensure the development of a quality reporting program that physicians are confident will improve quality of care. In doing so, CMS should work with Congress before establishing a program to make available to the public PQRI performance information.** CMS currently does not have the statutory authority to publicly report performance data gathered under the PQRI. MIPPA, as recently enacted, only authorizes CMS to post on the Internet, in an easily understandable format, a list of the names of the eligible professionals or group practices that satisfactorily submit data on quality measures (as well as with respect to those that are successful electronic prescribers). This provision shows Congress’ intent that only limited information can be made public under the PQRI.

Further, in establishing a quality reporting program for hospitals and ambulatory surgery centers (ASCs) under TRHCA, Congress specifically granted the Secretary of HHS the authority to “establish procedures for making data submitted under [the quality reporting program] available to the public.” Congress did not provide such authority for the PQRI.

Public reporting of quality data, if not approached thoughtfully, can have unintentional adverse consequences for patients. For example, patient de-selection can occur for individuals at higher-risk for illness due to age, diagnosis, severity of illness, multiple co-morbidities, or economic and cultural characteristics that make them less adherent with established protocols. Further, health literacy may not be adequate to comprehend basic medical information. Programs must be designed so that appropriate information is available to patients to enable them to make educated decisions about their health care needs.

If done correctly, public reporting has the potential to help provide such appropriate information to patients. There remain, however, several critical issues that must be resolved before public reporting provisions can be implemented. There must be a method for ensuring that any publicly reported information is: (i) correctly attributed to those involved in the care; (ii) appropriately risk-adjusted; and (iii) accurate, user-friendly, relevant, and helpful to the consumer/patient. Moreover, as CMS acknowledges in the proposed rule, an important aspect of a quality reporting program is that physicians (and other eligible professionals) have the opportunity to review their data on reporting rates on PQRI quality measures. We adamantly agree. This is necessary to give an accurate and complete picture of what is otherwise only a snapshot, and possibly skewed, view of the patient care provided by physicians and other professionals or providers involved in the patient's care. In fact, when establishing the quality reporting program for hospitals and ASCs under TRHCA, Congress signaled its agreement with this concept by requiring that CMS procedures to make quality data available to the public "shall ensure that a hospital [or ASC] has the opportunity to review the data that are to be made public with respect to the hospital [or ASC] prior to such data being made public." **Accordingly, physicians and other providers involved in the treatment of a patient must have the opportunity for prior review and comment and the right to appeal with regard to any data that is part of the public review process. Any such comments should also be included with any publicly reported data.**

#### APPLICATION OF "HEALTHCARE ASSOCIATED CONDITIONS" TO OTHER PAYMENT SETTINGS

In the proposed rule, CMS discusses that the Medicare non-payment policy for healthcare associated conditions (HACs) in the hospital inpatient setting could be applied more broadly to other Medicare payment systems, including the OPPS, ambulatory surgical centers, skilled nursing facilities, home health care, end-stage renal disease facilities, and physicians' practices. CMS specifically requests comments about the application of this policy to other Medicare payment systems.

Under the Deficit Reduction Act of 2005, Congress specifically provided CMS with the authority to begin applying the HAC policy to the hospital inpatient setting. If CMS were to extend this policy to other settings, it would likewise need similar statutory authority granted by Congress. **Thus, without this statutory authority, CMS cannot extend the inpatient HAC policy to the OPPS, nor to other settings such as physician office practices.**

Further, the AMA strongly opposes non-payment for HACs in the inpatient or in any payment setting that are not reasonably preventable through the application of evidence-based guidelines, developed by appropriate medical specialty organizations based on non-biased, well-designed, prospective, randomized studies. Thus, we have grave concerns about extending the Medicare HAC payment policy in the inpatient setting more broadly to Medicare payment settings, including physician practices.

It is unacceptable that the inpatient HAC policy is being expanded beyond the original eight conditions identified last year for non-payment in the inpatient setting when the first phase of the program has not even begun. CMS has not yet conducted any analysis of: (i) the impact of the current HAC inpatient policy with regard to such concerns as the: impact on the quality of care delivered to patients, especially in proportion to the additional costs to the Medicare program required to comply with the HAC requirements; (ii) the need for appropriate risk adjustment techniques; (iv) how to determine attribution issues with respect to when, where, and why a condition has occurred; and (iii) the reasonable number of expected incidences in which these conditions will occur in individual hospitals, especially with regard to high-risk patients, when evidence-based guidelines are followed.

**We, therefore, urge PPAC to recommend that CMS conduct an analysis of the current HAC policy, in consultation with technical experts, physician organizations, hospitals and other impacted providers. Such analysis must also occur before considering extension of this approach to other settings.** It would defy any logical rationale to extend an approach to other settings when it is not clear that the approach achieves its quality improvement goals and, in fact, may cost significantly more money in proportion to overall program benefits and delay or deny access to needed care for patients.

In addition, in the AMA's June 13, 2008, comments to CMS on the hospital inpatient prospective payment system proposed rule for fiscal year 2009, we stated that many provisions proposed for the inpatient HAC policy would present confusion and many unintended consequences for both the individual beneficiary and Medicare program as a whole. We further stated unequivocally that the conditions that CMS proposed for the HAC non-payment policy in the inpatient setting presume that medical conditions and complications are "reasonably preventable" when there is strong, broad disagreement with CMS throughout the medical community that these conditions are reasonably preventable. Subsequent to our June 13 comments, CMS finalized a list of conditions subject to the inpatient HAC non-payment policy, and we continue to stand by our comments in our June 13 letter.

The AMA continues to work aggressively to improve quality and efficiency for patients, but simply not paying for complications or conditions that—are not entirely preventable—is not an effective mechanism to improve patient care. In the race to improve health care quality, HHS is confusing events that should never happen in a hospital, like wrong-site surgery, with often unavoidable conditions, like surgical site infections. To be reasonably preventable, there should be solid evidence that following guidelines will reduce the occurrences of an event zero or near zero. This is not the case for many of the now-banned conditions. Focusing on determining whether or not medical conditions exist when the patient enters the hospital will increase Medicare spending on tests and screenings with questionable benefit to patients.

Finally, we emphasize that expanding the inpatient HAC nonpayment to other settings would be extremely problematic, especially in physician offices, because the payment approach is completely different from the hospital setting. Under the hospital prospective payment system, the HAC nonpayment policy applies only to the additional payments that

would be made to treat the complications caused by the acquired condition; payment for treatment of the initial diagnosis is still provided. Reduced payments under the procedure based physician payment system would be far more difficult to operationalize. For example, the appropriate level of an evaluation and management service is based on the conditions managed at a given encounter and the time and intensity of the work associated with those conditions. Because the presence and severity of additional conditions that are present during the visit will vary greatly among patients, identifying and valuing the work attributable to a preventable condition managed by the physician at a visit would be very difficult. In addition, the lack of adequate risk adjusters is an even greater problem in physician practices than in hospitals because some physicians specialize in treating the riskiest patients and do not have the ability to make up for losses on these patients through care of patients with below-average risks. Further, patient compliance outside of the physician office setting would be extremely difficult to assess and monitor, which also could seriously hamper any risk adjustment techniques. Many factors outside of a physicians' control could cause a patient to acquire various conditions while under a physician's care.

We are pleased that CMS recognizes in the proposed rule that the implications of applying the inpatient HAC payment policy approach “would be different for each setting, as each payment system is different and the reasonable preventability through the application of evidence-based guidelines would vary for candidate conditions over the different settings.”

**In considering any similar approach for physician practices, we urge PPAC to recommend that CMS instead focus its efforts on encouraging compliance with evidence-based guidelines by health care professionals.**

#### INDEPENDENT DIAGNOSTIC TESTING FACILITY (IDTF) ISSUES

CMS has proposed requiring physician offices that provide diagnostic testing to enroll as IDTFs and comply with most of the standards now required of these stand-alone testing facilities. Under the most onerous version of this plan, use of even basic tests such as ultrasound and electrocardiograms would subject the physician to completion of a very lengthy application, on-site inspections, and proof of competency for each type of test that is performed. Both primary care and specialist physicians would be caught in the net.

In the AMA's view, this proposal is unnecessary and unwise. CMS has provided no data to support the need for yet another regulatory burden. The agency also acknowledges that it is “unable to determine” how many physicians and groups currently providing diagnostic testing “will be unable to meet these requirements and therefore have their billing privileges revoked.” It then suggests that the requirement might be extended only to advanced imaging or to “more costly testing and equipment.”

Even this narrower application is unwarranted, however, because subsequent to the rule's publication, Congress enacted legislation that will require all physicians providing the technical component of advanced imaging services to meet rigid new accreditation standards. Neither CMS nor physicians' offices have the resources to deal with the largely overlapping goals and requirements of a more rigorous enrollment process and the new accreditation program. As a result, **we urge PPAC to recommend to CMS that it should**



**abandon this proposal to treat physicians' offices as IDTFs and focus on ensuring a smooth implementation of the new accreditation standards mandated by Congress.**

### ENROLLMENT

CMS has made a number of sweeping proposed changes to enrollment. As we have communicated to CMS, we continue to receive reports from physicians that the enrollment process is unduly confusing, time intensive, and bureaucratic. We are concerned about changes to the effective date of billing privileges, eligibility to participate in the program, enrollment processing, and revocation of billing privileges. We are generally concerned about these proposed changes because we believe they are: 1) unjustified; 2) provide marginal benefits; 3) overlap with Medicare Administrative Contractor (MAC) transitions; 4) are too voluminous; and 5) feel no further changes should be implemented until the internet-based enrollment system is available and running smoothly.

### Retroactive Billing

While physicians are currently prohibited from billing Medicare prior to their enrollment date, the program has long permitted physicians to retroactively file for claims for services delivered to Medicare patients during the time they were awaiting approval of their Medicare application up to 27 months prior to enrollment. CMS has proposed removing physicians' ability to retroactively bill citing, "it is possible that physicians...who meet our program requirements prior to the date of enrollment may not have met those same requirements prior to the date of enrollment..." or other program requirements. The AMA is strongly opposed to removing a physician's ability to retroactively bill. Given that physicians must have a medical degree and a license to practice medicine in the state where they see patients, it is entirely unclear what Medicare enrollment requirements a physician would not meet prior to enrollment in the program. **The AMA urges PPAC to urge CMS not to adopt the proposed changes to billing retroactively and to retain a physician's ability to retroactively bill up to 27 months as currently allowed.**

### PECOS Web

CMS asserts that the new internet-based Provider Enrollment, Chain, and Ownership System (PECOS) enrollment system will be available to most states in early 2009, a long anticipated system that is expected to help streamline the enrollment process. Aside from reducing the application processing timeframes which are expected to be reduced to 45 days under the new system, the AMA sees no reason for requiring massive policy changes at a time when this program is about to become operational. **AMA urges PPAC to urge CMS not to make any further policy changes to the enrollment system, with the exception of reduced processing timelines, until the new system is up and running smoothly.**

### Medicare Tax Delinquency

CMS indicates in its notice of proposed rulemaking that it will utilize the Federal Payment Levy System (FPLS) process starting in fiscal year 2009 for Medicare payments made under

Part A and Part B. This will allow the government to recover a physician's tax debt from his or her Medicare payments. Nonetheless, the agency then indicates that it is considering changes to enrollment eligibility that would bar any physician with a tax debt from participating in the Medicare program. These proposed changes are not in the best interest of the government nor in the interest of a physician who may want to participate in the Medicare program (and who may not have the financial reserves to pay the tax debt all at once) to implement such a program. CMS indicates that it may, in the future, offer two separate proposals that would apply to physicians who have an existing federal tax delinquency. One proposed change would allow CMS to deny enrollment to a physician with a Federal tax delinquency. This is inconsistent with the government's interest because when it denies a physician participation in the Medicare program, the government may never recover the tax debt if the physician is unsuccessful in securing employment or making a livelihood until he or she retires the whole tax debt. **The AMA urges PPAC to recommend that CMS not exclude physicians with tax delinquencies from the Medicare program as this is inconsistent with the government's interest.**

Second, CMS also indicates that it is considering another change to revoke the billing privileges of an already enrolled physician or taking some other type of administrative action when a physician has a tax delinquency that cannot be levied through FPLS because the physician has reassigned his or her Medicare payment to third parties. Since we urge CMS not to bar new physicians with federal tax debts from participating, in part because it will actually allow the government to recover the debt, we think it is reasonable to identify progressive steps that could include revocation of billing privileges to address those physicians who attempt to evade the FPLS levy. **In light of the recommendation above, we urge PPAC to urge CMS to identify and evaluate progressive administrative action prior to revocation of billing privileges in the foregoing scenario before issuing a proposed rule.**

#### Reporting Requirements for Providers and Suppliers

The AMA is extremely concerned with the agency's proposal to establish what it characterizes as more stringent reporting requirements for physicians. Specifically, CMS proposes establishing its authority to revoke Medicare billing privileges if physicians fail to report a change of ownership, "any" adverse legal action, or change in practice location within 30 days. Our overarching concern rests on the unreasonably short period of time that will be afforded to physicians to report this information in light of the persistent and chronic problems that have plagued the enrollment process. We are specifically troubled by the requirement that physicians report "any" adverse legal action. This is unreasonable and overbroad as this would include adverse decisions in divorce proceedings, landlord-tenant disputes, and a host of civil actions that may have no rational basis connection to the physicians' participation in the Medicare program.

#### Revocation of Enrollment and Billing Privileges in the Medicare Program

CMS also proposes to significantly curtail the current amount of time—up to 27 months—physicians whose billing number has been revoked may continue to bill for services

furnished prior to the revocation. CMS now proposes that all outstanding claims not previously submitted must be submitted within 30 calendar days of the revocation effective date. This is patently unreasonable. We are concerned again that CMS is creating a policy for many but aimed at a few even though CMS has not furnished any data to indicate that such a dramatic and burdensome change would have a corresponding positive benefit—of the same magnitude as the burden—to the Medicare program. (This is particularly important in light of CMS proposed changes to the effective date of revocations and the appeals process, as discussed below.) **There is a reasonable period between 27 months and 30 days and we urge the agency to provide physicians with up to 6 months to submit claims for services rendered prior to the revocation.**

The aforementioned proposed changes presented by CMS would financially penalize physicians for an enrollment process that remains unduly fragmented, provides uneven customer service, is marked by slow processing by select poor performing contractors, and is antiquated based on today's technological standards. These proposed changes would confer contractors with an excessive amount of discretion that could impose financial and administrative hardship on individual physicians. More importantly, CMS has not identified the scope and persistence of the problem presented to the Medicare program of the existing practices that these changes are supposed to fix. Unless and until CMS allocates additional resources in order to significantly upgrade the infrastructure—both technological and human resources—to support the enrollment process the changes proposed by CMS to the enrollment process would represent a significant deterrent to participation in the program.

#### REVISIONS TO APPEALS FINAL RULE

CMS proposes to change the appeals process used by physicians to challenge revocations of their billing authority as well as changes to the effective date of the revocation when it is based on a physician no longer being operational at a specific practice location, has a felony conviction, or has been subject to license suspension or revocation. Currently, a revocation is effective 30 days after CMS or its contractor mails notice of its determination to the physician except for federal exclusions or debarments which are effective on the date of the exclusion or debarment. The agency is proposing to add to the list of situations where it does not have to provide actual notice of a revocation before it becomes effective. This proposal is a significant departure from agency policy, would deprive physicians of basic due process, and particularly extreme in the context of revocations based on untimely reporting of practice location. CMS also proposed creating an expedited reconsideration process for revocations based on federal debarment or exclusion, felony conviction, license suspension or revocation, or determination that changed practice location not reported within 30 days. While we strongly oppose adding to the list of situations where a physician would not be provided with actual notice of his or her revocation of billing authority, we believe that, at a minimum, physicians must be provided an expedited reconsideration process. However, we do not believe that the expedited reconsideration diminishes the lack of notice and due process physicians would experience if the agency implemented its other proposed changes. **The AMA urges PPAC to urge CMS to retain the existing revocation effective dates in order to preserve physicians' right to notice and due process.**

## **DURABLE MEDICAL EQUIPMENT**

MIPPA contains a provision affecting the administration of Medicare's durable medical equipment, orthotics, prosthetics, and supplies (DMEPOS) program. Under this provision, Congress imposed an 18-month delay to Round 1 of the DMEPOS Competitive Acquisition Program (CAP), with a corresponding 18-24 month delay of Round 2 and subsequent applications of the program. Further, Congress provides increased authority and flexibility to the Secretary of the Department of Health and Human Services in implementing the DMEPOS CAP. Specifically, under MIPPA (and previously under the *Medicare Prescription Drug, Improvement and Modernization Act of 2003* (MMA)), DMEPOS "suppliers" must meet quality standards and accreditation requirements. MIPPA, however, provides the Secretary with the authority to exempt physicians from the accreditation and quality requirements if the Secretary determines that licensing, accreditation, or other mandatory quality requirements apply. Further, in the alternative the Secretary may tailor accreditation or quality standards to physicians.

Congress included this provision in MIPAA because in implementing the DMEPOS CAP originally required under the MMA, CMS took the view that it did not have the authority to exempt DMEPOS office-based "suppliers," such as physicians, from the DMEPOS accreditation requirements and quality standards. The AMA and other organizations representing affected physicians and licensed health care professionals had previously requested that CMS provide such exemption for physicians (and certain other health professionals, e.g., podiatrists, optometrists, physical and occupational therapists) who provide their own patients with DMEPOS. Such an exemption is warranted because physicians and these other practitioners are licensed by their state board to practice in that state, and as such could be "deemed" as qualified to provide patients with DMEPOS.

Further, physicians and these other practitioners generally operate as small businesses (and small suppliers of DMEPOS), and the financial and administrative burden of complying with the DMEPOS CAP, simply to supply DMEPOS to their own patients for the purpose of patient convenience and safety, is too great. Yet, physicians and practitioners must be integrally involved in providing DMEPOS to their patients to ensure that: (i) a particular item of DMEPOS meets the "size and fit" specifications for a particular patient; and (ii) the patient is properly instructed concerning the use of that DMEPOS. This is necessary to provide patients with the highest quality of care, achieve patient compliance, reduce risk of further injury, and avert liability concerns as well. Application of DMEPOS accreditation and quality standards that are tailored toward retail, commercial-based suppliers do not make sense when applied to physicians and other office-based suppliers.

Since CMS did not believe they have the authority to exempt or apply scaled-down requirements tailored toward physicians and other office-based DMEPOS suppliers, Congress provided CMS with such authority under MIPPA. Despite this authority provided under MIPPA, CMS is currently continuing to apply the DMEPOS accreditation requirements and quality standards to certain suppliers, including some physicians that supply DMEPOS in-office to their patients. The cost of meeting such requirements can be up to \$3,000 or more per physician (or other practitioner). Yet, physicians (and other

licensed health care professionals) who are enrolling for the first time with Medicare as a supplier, or are making changes to their enrollment application, are still being required by CMS to become accredited.

Due to CMS' continuing application of the DMEPOS requirements and standards, the AMA, along with various organizations representing physicians and licensed health care professionals integrally involved in the delivery of DMEPOS, sent Secretary Leavitt the attached letter, dated July 24, 2008, with specific inquiries regarding the HHS and CMS plan for implementing the MIPPA DMEPOS provision. **We urge PPAC to urge CMS to grant the requests set forth in the letter, which are stated below.**

In the July 24 letter, the signatory organizations made the following requests of HHS and CMS:

- *That the Secretary of HHS exercise the newly expanded authority to exempt physicians and licensed health care professionals from the quality standards and accreditation requirement considering the licensing, accreditation, and other quality requirements that physicians and licensed health care professionals must meet;*
- *That the Secretary of HHS exempt physicians and licensed health care professionals from DMEPOS accreditation deadlines and acknowledge that the deadline for suppliers, including "new suppliers," who remain subject to accreditation is October 1, 2009 given:*
  - *Clear Congressional concern about how these standards and requirements are being applied to physicians and licensed health care professionals;*
  - *The fact that the only accreditation deadline referenced in the law is October 1, 2009;*
  - *The time needed for the Secretary to make the determination required under MIPPA Section 154(b)(1)(A) regarding the application to and design of the standards and accreditation requirements for physicians and licensed health care professionals; and*
  - *That MIPPA delayed the implementation of the DMEPOS competitive bidding program, therefore giving HHS and CMS greater flexibility to implement the newly revised quality standard and accreditation requirements under 42 U.S.C. 1395(m)(a)(20).*

In addition to the above, the AMA has the following concern regarding inappropriate uses of physician identifiers in the billing process for DMEPOS and other services. Specifically, we are concerned that physician identifier numbers used for billing are still widely available on the Internet, a method identified by the GAO as one used by some billers to submit fraudulent claims. In fact, the data furnished by physicians during their application for a national provider identifier (NPI) has been made widely available online (with some limited exceptions such as social security number and date of birth). While CMS has said legacy

numbers supplied by a physician (including NSC numbers which permit a physician supplier to bill Medicare for DMEPOS) are among the data elements that a physician can elect not to have released in the public, online NPI registry, Medicare nonetheless has made it very clear that unless a physician supplies their old billing numbers they will not be able to match these legacy numbers to their NPI and thus will not get paid. This has left physicians in the untenable position of having to put this information online, a move that clearly opens them up to identity theft. As the GAO learned through their investigation of Medicare DMEPOS fraud, physicians billing numbers located on the Internet have been stolen to inappropriately bill for DMEPOS. Prior to the widespread release of NPI numbers and related information online last year by CMS in the form of the NPI registry, despite concerted opposition by the AMA that only those with legitimate business needs should have access to this information, CMS made it clear that they had no mechanism for implementing a system with restricted access. The theft of physician identities outlined in the GAO report is disturbing. Furthermore, there is no evidence that requiring physicians to become accredited will reduce DMEPOS fraud given the fact that physician billing numbers are widely available online now as a result of CMS actions. **We urge PPAC to urge CMS to analyze ways to mitigate the risks to physicians of identity theft given that physician identifiers are widely available online and to develop solutions.**

### **CONSULTATIONS**

The AMA would also like to raise before PPAC an issue of ongoing concern regarding reimbursement rules for medical consultations. Given the long-standing concerns and questions we and many other state and medical specialties have raised to CMS on the interpretation of this policy, we strongly urge CMS to instruct its contractors, including Recovery Audit Contractors (RACs), to refrain from conducting any audits of visits that are billed as consultations (CPT codes 99241 - 99255).

Significant and ongoing concerns over CMS' consultations policy, published December 2005 (Transmittal #788), make contractor audits problematic at this time. These concerns were outlined in a letter signed by 51 medical societies and organizations sent to CMS on October 23, 2006. The AMA and others continue to try and work collaboratively with CMS to arrive at a policy that is both workable for physicians and Medicare, and these discussions remain underway.

The portion of the policy, "Consultation Followed by Treatment" (Section 30.60.10 B) involving "transfer of care," in particular is causing significant confusion among physicians. For example, we understand that at least one Medicare contractor currently is informing providers that if the intent of the referral is for the consultant to assume management of the care of the patient for the condition that necessitated the consultation, then the initial service cannot be billed as a consultation. Instead, it is billed as a new patient or established patient office visit. This same contractor also has informed providers that prepayment reviews of consultation services will begin shortly. Until physicians are clear about how consultations involving "transfers of care" should be billed, they should not be audited on these services.

The physician community is committed to correct billing, and over the years has devoted significant time and effort to understanding Medicare requirements and complying with them. It is not reasonable, however, to allow prepayment reviews to begin at a time when providers are struggling to understand Medicare's consultations rules and apply them properly. All stakeholders will benefit by allowing extra time for CPT review, agency clarification and provider education. The AMA is committed to an ongoing dialogue with CMS on the concerns involving billing consultations. **The AMA, therefore, urges PPAC to urge CMS to: 1) prohibit any contractors from auditing physicians on the consultations until a clear policy is in effect; and to 2) continue an open dialogue with Medicine on the above identified concerns in order to arrive a clear, understandable and acceptable policy.**

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

Attachment