



Statement

of the

American Medical Association

to the

Practicing Physicians Advisory Council

RE: National Provider Identification
Medically Unlikely Edits
Proposed Physician Fee Schedule Rule

August 27, 2007

Division of Legislative Counsel
202 789-7426

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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: (i) national provider identification; (ii) medically unlikely edits (MUEs); and the proposed physician fee schedule rule.

NATIONAL PROVIDER IDENTIFICATION

CMS is in the process of implementing the national provider identifier (NPI) to replace the multiple existing identifiers used by physicians for billing and other transactions. The purpose is to benefit physicians, their patients, and others in the healthcare sector and lead to administrative efficiencies. Physicians were originally expected to meet a May 23, 2007, NPI compliance deadline. We appreciate that CMS has invoked a "contingency plan" that allows those physicians and other covered entities working toward NPI compliance, an additional year to get ready.

On May 30, 2007, CMS issued a "Data Dissemination" Notice (the Notice), which was intended to articulate who will have access to a physician's NPI numbers and associated data, as well as how these numbers will be accessed. This notice was issued a year and half late. The AMA has argued all along that: 1) no more information than is currently available to the public through the UPIN look-up, should be made available with release of the NPI numbers; 2) a physician's home address should never be included among the information released; and 3) access should be limited to those with a legitimate business need.

Despite the multiple letters, testimony and conversations submitted by the AMA advocating for these protections, CMS has decided to put the majority of information provided by

physicians on their NPI applications, with some exceptions, on a public website. The Notice furthermore provided no comment period, and indicated that within 30 days (by the end of June), this information would be published on a public website. During this same short timeframe, CMS said physicians could update any of their information that was incorrect and delete any information provided which was deemed “optional” on the NPI application, though little physician outreach was done to alert them to this.

Following publication of the Notice, the AMA expressed two overarching and significant concerns. One, it became clear based upon multiple conversations between the AMA and CMS that no comprehensive risk analysis was conducted by CMS to study the implications for posting so much sensitive and personal physician information in the a single place in the public domain. Two, the AMA strongly disagrees with CMS’ interpretation of the Freedom of Information Act (FOIA), the law which CMS has argued requires them to release this information to the public. The AMA in fact retained outside counsel and sent CMS a lengthy legal memo articulating our specific concerns with their flawed interpretations of their responsibilities under FOIA and had several follow-up conversations.

It is also troubling, given the recent widespread identity theft concerns expressed by the Congress and the Government Accountability Office, among others, that CMS chose to move forward with the policies outlined in the Notice. In addition, the way the NPI application is structured could easily lead a layperson to believe the information provided would not be shared with the public. It is also of concern that CMS has refused to withhold from the public information supplied on an application which was provided on an “optional” basis.

After extensive communication with CMS, the agency has postponed making the NPI database available twice. Physicians now have until August 20, 2007, to make any changes/deletions to their NPI application. But, CMS did decide to post all the information in a physician’s NPI application to the website.

The AMA remains concerned about the significant risks and consequences for physicians in making this data public. The stated purpose of the establishment of the NPI is to standardize and simplify the process through which Medicare, Medicaid, other federal health care programs, and private health programs and plans identify physicians and other providers or suppliers of health care services and products. It is not necessary to disclose the majority of information provided on an NPI to the general public in order to achieve the statutory objective. However, CMS continues to insist that their legal obligations under FOIA require them to do so.

Accordingly, the AMA urges PPAC to recommend that CMS postpone implementation of the Data Dissemination Notice until the agency completes an identity theft assessment and legal analysis. We also urge PPAC to recommend that CMS, upon completion of the review, allow for a public comment period and adequate outreach before implementation of any Data Dissemination policy.

MEDICALLY UNLIKELY EDITS

The AMA continues to support CMS efforts to reduce the Medicare paid claims error rate. We recognize that CMS has chosen the MUEs to prevent the payment of obviously erroneous Medicare claims submissions, and have spent the last year working with the national medical specialty societies to provide review of the edits. We are thankful that CMS has responded to initial concerns about lack of modifier usage by permitting the use of some modifiers. We also appreciate information on the group of physicians and coders responsible for creating the edits. **We have serious concerns, however, about the lack of transparency in both the edit development process and the edits themselves.**

A recent letter from the CMS contractor MUE contractor specified the members of the group of physicians and coders that provide input on the creation of edits based on clinical judgment. However, the CMS rationale and supporting frequency data used by this group in developing the prospective units of service still have not been disclosed. As the AMA has indicated previously, this lack of transparency leads to a more time consuming and potentially discordant review process. Organized medicine is forced to speculate on the basis for edit development, which could lead to misinterpretations. The development of MUEs continues to be a “closed” process, which only impedes meaningful comments, making the review process frustrating. **We urge PPAC to recommend that CMS: (i) disclose the frequency data used in developing the MUEs; and (ii) provide rationale for each edit similar to the manner used for the National Correct Coding Initiative (NCCI) edits.**

Complicating the “closed” process used for edit development is the failure to make the edits available to the provider community who are held accountable to them. It is essential to have full disclosure of the MUEs, consistent with the NCCI edits. Despite opinions from CMS that availability of the edits will lead to misuse of the CPT codes by providers and lead to adoption by private third party payers, the AMA does not believe that continuing to withhold the list of edits is feasible. We are confident that only the services that meet the needs of the patient will continue to be provided with documentation reflecting these procedures. Further, the AMA has always promoted correct coding and strongly prohibits fraudulent billing. Releasing the edits can only assist CMS in the purpose of protecting the Medicare program by preventing payment of obvious billing errors. Keeping the edits in a “black box” is reminiscent of the Commercial Off The Shelf Software (COTS) created by CMS years ago. **Just as with the COTS, the AMA’s position on the MUEs remains the same, in that we firmly believe that providers and patients are best served when all Medicare program rules and coding guidelines are public knowledge and not part of a “black box” system. We, therefore, urge PPAC to recommend that CMS make the MUEs available to the public.**

Finally, although we appreciate that modifiers are now allowed, clear examples on their use are needed to appropriately educate the provider community. Education is imperative and necessary to promote correct coding and the correct use of modifiers within the MUE program. We request additional circumstances be given when each modifier

would be appended to the CPT code to bypass the MUEs, when appropriate. **The AMA urges PPAC to make these foregoing recommends to PPAC.**

PROPOSED PHYSICIAN FEE SCHEDULE RULE

On July 12, 2007, the Centers for Medicare and Medicaid Services (CMS) published in the *Federal Register* its proposed physician fee schedule rule 2008, and public comments are due August 31, 2007. Although the AMA has not yet finalized our comments on the proposed rule as of the August 27 PPAC meeting, we will be filing extensive comments concerning many critical proposals in the rule by the August 31 comment deadline. We will be happy to forward our comments to the Members of PPAC when they are finalized.

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.