***ACP policy originating from ACP sponsored resolution introduced to the AMA House of Delegates**

CODING AND NOMENCLATURE

Payment for Physician Services*

ACP advocates and will take steps to ensure that public and private payers do not bundle services inappropriately by encompassing individually coded services under other separately codes services unless the actual description of the codes under which bundling is placed clearly states that the bundled service(s) is part and parcel to the service code for which payment is allowed. (HoD 97; reaffirmed BoR 08)

Changes in "Index of Diseases" to Allow Coding for Diseases Due to, or Aggravated by, Use of Tobacco*

ACP recommends to the agencies and personnel writing and publishing the "Index of Diseases" that changes and additions be made to the "Index of Diseases" in order to permit physicians and other persons involved in coding to be able to indicate the causative or contributory role of tobacco use whenever applicable. (HoD 95; reaffirmed BoR 06)

Coding for Lab Services*

1. ACP supports a CPT coding change in which the codes for automated, multichannel tests (80002-80019) are replaced by a small, well defined number of organ-, disease-, or condition-oriented panels to which physicians would be encouraged to add or delete specific tests as guided by medical appropriateness. (HoD 95; reaffirmed BoR 06)
2. Some organ-oriented laboratory panels should be maintained in the CPT Code Manual, and should be reconstructed through the use of consultants who have extensive experience utilizing such laboratory studies for the evaluation of disease states. (HoD 92; reaffirmed BoR 04)

Cognitive/Evaluation and Management Services*

1. ACP continues to work with the AMA to improve the current Evaluation and Management CPT codes to be clearer for interpretation, clinically relevant, and more easily applicable in the day-to-day medical practice setting. ACP continues to provide an ongoing mechanism to assist its members with CPT coding issues. (HoD 94; reaffirmed BoR 04)
2. ACP promotes uniform interpretation and appropriate consideration of evaluation and management CPT codes by Medicare fiscal intermediaries and other third-party payers. (HoD 89; reaffirmed BoR 04)
3. ACP opposes the compression of codes for cognitive services. (HoD 89; reaffirmed BoR 04)
4. ACP continues to aggressively work with all appropriate parties to achieve adequate recognition and reimbursement for comprehensive evaluations of complex, established patients by internists. ACP works with component societies to ensure that local carriers do not improperly downcode complex services provided by internists to patients with multiple, complex medical problems. (HoD 92; reaffirmed BoR 04)

Reimbursement

1. ACP recommends that Congress, as the next order of priority, restore hospital outpatient and home-based service funding to pre-BBA levels.
2. Redirect DSH payments for Medicare Advantage enrollees from managed care plans directly to eligible hospitals.
3. Establish a payment floor to limit losses for hospitals that incur large payment reductions under BBA. (BoR 02)

Resolving Payment and Practice Hassles

Recommendations To Properly Fund the Medicare Physician Fee Schedule

1. The Medicare physician fee schedule payment rate (conversion factor) should be restored to the 2001 level until a suitable replacement to the existing payment update formula is developed and implemented, as recommended below.
2. Consistent with the recommendation of the Medicare Payment Advisory Commission (MedPAC), the current flawed Medicare physician payment update formula, known as the Sustainable Growth Rate (SGR) system, which erroneously links updates to changes in the nation's gross domestic product, should be replaced with a new method that will allow for predictable increases based on inflation in the costs of providing services.
3. The Medicare funding that was lost due to previous errors in the SGR system should be immediately restored.

Recommendations To Rationalize the Medicare Physician Payment System Further

1. The Centers for Medicare and Medicaid Services (CMS) should recognize that they did not fully implement the Evaluation and Management (E/M) recommendations of the Relative Value Scale Update Committee (RUC) during the first 5-year review of the Medicare physician fee schedule (1997) and did not review the issue during the second 5-year review of the Medicare physician fee schedule (2002).
2. The CMS should review the relative value of E/M services during the next 5-year review of the Medicare physician fee schedule (2007).
3. The CMS should fund an independent analysis of the extent by which the top-down practice expense allocation methodology perpetuates historical inequities in physician payment.
4. The CMS should develop and implement a method to correct the Medicare physician fee schedule problems that are identified by the independent analysis of the top-down practice expense allocation methodology.
5. Medicare and other payers should provide reimbursement for health-related communication, consultations, and other appropriate services via the Internet, subject to guidelines on the level of work required for the service to be reimbursed as a separate service outside of the usual E/M service.
6. Changes in coding and the relative value units (RVUs) that reflect new medical technologies and new Medicare benefits should not be subjected to Medicare budget neutrality adjustments and should be specifically identified in the conversion factor update formula.
7. Congress should establish a process to authorize coverage of appropriate and cost-effective preventive care and screening services in an ongoing fashion, based on expert evaluation of, and consensus on, the medical evidence of their effectiveness. Medicare payment levels to physicians for covered preventive benefits must be adequate to assure that beneficiaries have access to such services.

8. Congress should authorize coverage for physician-directed geriatric assessments and care coordination of frail elderly patients, as defined in S. 775, the Geriatric Care Act of 2001.
9. Medicare should revise its reimbursement system so that outpatient volume increases associated with changes in Medicare Part A do not penalize reimbursement under Medicare Part B.

Recommendations To Reduce Unnecessary Practice Hassles

1. Claims Payment Issues. All payers in all health care payment systems:
    a. Must pay clean claims promptly within 30 days of receipt of the clean claims and not delay payment for all services if one service on an otherwise clean claim needs additional information.
    b. Must make "black box" coding edits for code bundling and claims editing available to physicians at no cost, for the purpose of education.
    c. Should give practicing physicians the opportunity to review coding edits before implementation in claims processing systems.
    d. Should not require that office visit claims be submitted with copies of the chart, unless there is ample suspicion of fraud.
    e. Should not down-code services and procedures without appropriate individual medical review.
    f. Should request for repayment of claims based on audits, not billing profiles. Billing profiles should be used to identify subjects for possible audits, not repayment without further investigation.
    g. Must make detailed information on compensation arrangements readily available to physicians, including fee schedules; relative values and conversion factors of services; capitation arrangements; percent of premium; and other physician incentive plans, such as withholds and bonuses.
    h. Must eliminate extending negotiated discounted fee schedules to other payers without the consent of the physician with whom the original agreement was made (e.g., eliminate silent preferred provider organization [PPO] arrangements).
2. All payers in all health care payment systems should eliminate the use of contract "all-products clauses," which force physicians to participate in health insurance plans against their will.
3. All payers in all health care payment systems must maintain a 24- hour-a-day telephone line or other confidential electronic means of communication to provide information about specific coverage of and benefits available to any patient presenting for medical care or agree to pay for services provided when such a system is unavailable.
4. Paperwork Reduction and Administrative Uniformity:
    a. One standard physician credentialing and recredentialing form should be used for health care plans and hospitals, with the input of practicing physicians in the development of the form. The universal credentialing form should be linked to an electronic database so the recredentialing form can be prepopulated with previously submitted data from the physician.
    b. Physicians should only have to be recredentialed and required to undergo a site visit once every 3 years, unless quality issues indicate more immediate attention. Insurers should be able to share credentialing and site visit information upon approval of the physician.
    c. The health insurance industry should standardize the fields of information required so

that there is a single uniform encounter form, single uniform durable medical equipment approval form, single formulary request form, single uniform referral form, etc. All health insurance industry forms should be uniform, with one form per task rather than a different form from every insurer for the same task. The development of the uniform forms should involve practicing physicians.

5. The health insurance and pharmaceutical industries should develop technology to make formulary databases accessible and easier to utilize and provide these databases in electronic formats that can be imported into practice systems. Practicing physicians should be involved in the design and pretesting of these technologies.
6. Health insurance carve-out entities, such as managed behavioral health organizations (MBHOs), should share their disease management protocols with primary care and other treating physicians. When a patient's health is managed and/or administered by a carve out entity, the primary care and other treating physicians should be immediately notified and kept apprised of the patient's treatment, progress, and medications, so that the primary care and other treating physician can coordinate the patient's health care needs in an optimal fashion.
7. Health insurance plans should allow consulting physicians or primary treating physicians to make referrals for tests, radiologic procedures, and therapy rather than requiring "gatekeeper" physicians to manage all referrals. (BoR 03)

Reimbursing Physicians for Telephone Care

Recommendation 1:

The American College of Physicians (ACP) supports reimbursement by Medicare and other payers for health-related communications, consultations, and other appropriate services by telephone, subject to guidelines on the level of work required for the service to be reimbursed as a separate service outside of the usual evaluation and management (E/M) service.

Recommendation 2:

Medicare and other payers should work with the physician community to develop guidelines on reimbursement of health-related communications, consultations, and other appropriate services via the telephone. The guidelines should include examples of both reimbursable and nonreimbursable telephone-related communications.

Recommendation 3:

Payment for health-related telephone communications should not result in a reduction in separate payments for E/M services. (BoR 03)

ACP Recommendations for Achieving an Interoperable National Healthcare Information System

In developing and implementing a national interoperable healthcare information infrastructure, ACP urges the federal government and all sectors of the healthcare market to ensure the following recommendations are addressed:

1. Interoperable health information networks should be created in the United States to ensure the rapid flow of secure, private and digitized information relevant to all facets of patient care.
2. ACP will take a leadership role among the national and state medical societies advocating for public policies and private sector initiatives to create a national electronic health information infrastructure. The American College of Physicians will support this objective by:
    a. Advocating for federal legislative and executive branch initiatives to create an electronic health information infrastructure consistent with the policies described in these recommendations.

b. Participating in public and private sector initiatives to support the development and implementation of interoperable electronic health information systems.

c. Facilitating participation by internists in demonstration projects on interoperable electronic health information systems.

d. Providing practice management assistance to internists to help them make informed decisions on acquiring components compatible with interoperable electronic health information systems.

e. Providing clinical decision support tools, such as the Physicians' Information and Education Resource (PIER), which can be integrated into office-based electronic health information systems.

f. Providing physician and technical input into the development and implementation of voluntary quality performance measures and health information systems industry standards.

3. The creation of interoperable healthcare information networks, electronic health records, electronic prescribing, and other e-health technologies must not become another un-funded regulatory mandate on physician practices.

4. Federal policy should support voluntary standards setting, rather than federal mandates on specific e-health technologies or products.

5. Demonstration projects, which contain usability requirements, should be conducted to test the new e-health technologies to ensure the technology is practical and worthwhile in the clinical setting prior to being implemented nationally.

6. Sufficient time must be allowed for development, implementation, and testing of interoperable healthcare information networks, electronic health records, electronic prescribing, and other e-health technologies, with direct involvement of physicians and other stakeholders in all stages of the design and implementation of the networks.

7. Physicians and other caregivers must be given adequate time and financial resources to acquire the necessary technology, training and skills to incorporate interoperable healthcare information networks, electronic health records, electronic prescribing, and other e-health technologies into their practices. Consideration must be given to the increased personnel costs that will be incurred as a result of these increased technological skill requirements.

8. The physician's responsibility to make patient care decisions and prescribe medications, based on his or her clinical expertise and experience, must be preserved. Electronic health record (EHR), e-prescribing, and other e-health technology must be designed to facilitate access to unbiased and evidence-based decision support tools.

9. Clinicians, researchers, and patients should have access to complete health records available on the interoperable healthcare information network consistent with Health Insurance Portability and Accountability Act (HIPAA) regulations.

10. EHR and e-prescribing systems must dynamically/bi-directionally link to the physician office medical management system, reducing the need for double entry of information such as insurance and demographic information.

11. Insurance companies must place clear formulary codes on insurance cards and e-prescribing systems so that formulary checking can be seamless and accurate.

12. Although EHRs may include certain functions for the collection of data or as reminders, physicians should not be mandated to use each EHR function. For example, physicians should

not be required to screen every patient for a disease condition, such as Lyme disease or all drug/diet interactions, simply because a reminder function for this disease is embedded in the EHR. Ultimately, a clinical encounter should be managed based upon a patient's presenting condition and the physician's training and expertise.

13. E-prescribing systems:
    a. Must provide a patient medication profile that includes prescriptions from all pharmacy sources in a single unified view. The system would provide a list of every individual prescription filled for a given patient by any pharmacy within a specified time frame from most recent to least recent and indicate which prescriptions have been discontinued.
    b. Must be dynamically updated with the most current health plan formularies.
    c. Must interact with the final HIPAA Security standards, due to be implemented in 2005, address issues such as what physical safeguards are necessary to guard data integrity, personal authentication, encryption, and patient confidentiality, and address the impact of e-prescribing on access to DEA-controlled drugs, which in many states can only be provided through a triplicate (or other special paper) prescription order.
    d. Must not be used as a means for payers and pharmacy benefits managers to pressure physicians to prescribe a different therapy or medication than what the physician concludes is best for a particular patient based upon scientific evidence and knowledge of the patient's medical history. (BoR 04)

e-Prescribing

1. The College broadly supports the development and implementation of e- prescribing technology within the healthcare system. It recognizes the potential for benefits in care quality, patient safety, administrative efficiencies and lower costs associated with the introduction of this technology.

2. The College has specifically supported the Centers for Medicare and Medicaid Services (CMS) efforts to develop foundation standards for the primary e-prescribing functions, the creation of safe harbors to the Medicare Anti-kickback Act and exceptions to the Stark laws promoting donation of e-prescribing technology to practices, and efforts at the federal, state and private sector level to provide increased payment, loans and grants to facilitate e-prescribing adoption at the practice level.

3. The College recognizes that efforts to facilitate e-prescribing adoption at the practice level must address significant barriers. These barriers, which effect all practices, but have the greatest effect on small and medium size practices and rural practices, include:

    a. The significant software, hardware, implementation and maintenance costs to the practice.
    b. The substantial practice workflow changes that are required to effectively implement e-prescribing into the practice.
    c. The limited evidence for a "business case" to implement e-prescribing technology at the practice level. Most benefits and costs savings are received by the patient, the pharmacy benefit manager, the pharmacy and the payer.
    d. The significant technical difficulties being encountered in implementing current e-prescribing products in the market place being reported by our members and in the literature.

e. The lack of a system to certify and ensure that the e-prescribing products available in the market place are functionally effective (BoR 07)

Electronic Prescribing of Controlled Substances

ACP supports an amendment to the Controlled Substance Act to permit electronic transmission of prescriptions of controlled substances using appropriate and reasonable security standards and audit capabilities; and will encourage the Centers of Medicare/Medicaid Services (CMS) and the Drug Enforcement Agency (DEA) to work together to modify the regulation. If this is not feasible, legislation should be passed to allow for a statutory change in the law. (BoR 09)

Downcoding*

ACP continues to assign high priority to monitoring downcoding and documentation problems and continue working with the Health Care Financing Administration, Congress, the Physician Payment Review Commission (PPRC) and others to alleviate these difficulties. ACP believes that component societies should monitor downcoding issues, comment on carrier policy changes and meet regularly with their carriers to resolve difficulties members are experiencing with them. This should include components monitoring with the appeals process and forwarding this information to ACP to enhance ACP's abilities to conduct more meaningful discussions with CMS. ACP believes that a useful and meaningful definition of codes including guidelines for appropriate documentation of services performed should be established. ACP opposes the practice of arbitrary or automatic downcoding of comprehensive hospital admission services and will work with CMS towards this end. ACP believes that the apparently different requirements (in complexity and documentation) for acceptably complete hospital admission history and physical examinations as defined by state licensing authorities, JCAHO and Medicare carriers, particularly as to how these may change with subsequent hospital admissions should be clarified. ACP believes that a simplified, uniform and expeditious process for development and appeals of coding disputes with Medicare carriers should be developed and promoted. (HoD 90; reaffirmed BoR 04)

Coding*

ACP opposes burdensome coding and record-keeping requirements unless patient care benefits result from their implementation. (HoD 89; reaffirmed BoR 04)

Support for AMA/CPT*

ACP approves of the AMA Current Procedural Terminology (CPT) coding and nomenclature, recognizing it will be expanded as medical practice advances. (HoD 70; reaffirmed HoD 87; reaffirmed BoR 04)

ACP supports the Editorial Board of CPT and the AMA Board of Trustees in their effort to implement the nationwide use of CPT by the medical profession, and recognizes that responsibility for formalized nomenclature of professional services and procedures is the clear prerogative of organized medicine. (HoD 73; reaffirmed HoD 87; reaffirmed BoR 04)

Third-Party Manipulation of Terminology*

ACP opposes the modification of procedural descriptions or conversions to different terminologies by third-party employees without appropriate professional medical consultation. The use of any terminology system containing modified data shall be considered invalid and inappropriate for the purposes of reimbursement, measures of practice patterns, peer review, utilization review, or any other related uses. (HoD 76; revised HoD 87; reaffirmed BoR 04)

Timely Release of New CPT/CMS Common Procedural Coding System Codes*

ACP believes that the appropriate agencies to release CPT/HCPCS codes on newly accepted medical

treatments, procedures and medications immediately following their acceptance should be petitioned. ACP believes that CMS should fairly and promptly reimburse these newly accepted treatments, procedures and medications. ACP will urge CMS to provide carriers and physicians with timely, clear and uniformly applied conditions if there are limitations on service or special requirements for documentation. (HoD 87; reaffirmed BoR 04)

Reimbursement to Assure Fair Reimbursement for Physician Care Rendered Online

1. ACP supports reimbursement by Medicare and other payers for health-related communication, consultations, and other appropriate services via the Internet, subject to guidelines on the level of work required for the service to be reimbursed as a separate service outside of the usual evaluation and management (E/M) service.
2. Medicare and other payers should work with the physician community to develop guidelines on reimbursement of health-related communication, consultations, and other appropriate services via the Internet. The guidelines should include examples of both reimbursable and non-reimbursable Internet-related communication.
3. Payment for health-related Internet communication should not result in a reduction in separate payments for evaluation and management (E/M) services. Such reimbursement should also not be subject to budget-neutrality offsets under the Medicare fee schedule. (BoR 03)

Controlling Health Care Costs: Options for Controlling Administrative Costs

1. Congress should request that the Institute of Medicine or another appropriate entity conduct a comprehensive assessment of administrative, paperwork, documentation, and medical review requirements imposed on physicians by federal regulatory agencies, public and private health plans and state governments. This study should determine the amount of time typically required by physicians to meet such requirements and identify specific strategies to reduce the time required. Particular attention should be given to the administrative burdens imposed on primary care physicians, such as micromanagement of E&M documentation.
2. Congress should enact legislation to:
    a. Require that any new regulatory requirements that would create added costs to physician practices be accompanied with funding to offset such costs and establish a moratorium on any new regulations that would create additional unfunded costs to physician practices.
    b. Simplify and shorten the physician enrollment process under Medicare by allowing physicians to use external databases to submit demographic and credentialing information required to establish and maintain Medicare participating physician status.
    c. Study "real-time" adjudication of claims for physician services
    d. Study opportunities to collaborate with private sector relief and simplification efforts.
    e. Test models that eliminate documentation requirements for E/M services, pre-authorizations, retrospective medical utilization review, and other regulatory and paperwork requirements for physician practices that qualify as PCMHs or that participate in other designed programs where the performance of such practices are measured based on quality, efficiency, and patient satisfaction metrics.
3. Health insurance forms should be uniform across insurers, (e.g., a single durable medical equipment approval form, a single referral form).
4. An online platform should be established in which all benefit information, forms, formularies, and prior approval information could be accessed and completed online with as little disruption to medical practices as possible.
5. A standard physician credentialing and re-credentialing form should be used, with the input of practicing physicians in the development of the form. The universal credentialing form should be linked to an electronic database so the re-credentialing form can be prepopulated with previously submitted data from the physician.

6. Health insurance companies should be required to disclose fully and uniformly the portion of health care premiums that is spent on administration, including the percentage of premium dollars allocated to marketing, claims processing, other administrative expenses, profits, and reserves as well as the payment for covered benefits. (BoR 10)

Solutions to the Challenges Facing Primary Care Medicine: Quality of Practice Life: Provide Relief from Administrative Burdens

1. Congress should request that the Institute of Medicine or other appropriate entity conduct a comprehensive assessment of administrative, paperwork and medical review requirements imposed on primary care physicians by federal regulatory agencies, public and private health plans and state governments. This study should determine the amount of time typically required by primary care physicians to meet such requirements, and identify specific strategies to reduce the time required.
    a. Based on results of such a study, the federal government should implement reforms to reduce the amount of time required to complete administrative tasks, especially tasks required by the Medicare program, leading to an overall improvement in the practice conditions for primary care physicians and practices and allowing them to better serve patients.
    b. Private payers that participate in programs subsidized, directly or indirectly, with public dollars should be required to implement comparable strategies as a condition of qualifying for such subsidies.
    c. Other private payers should be encouraged to implement comparable strategies. (BoR 09)

Efficiency Benchmarks for Health Insurance Companies

ACP work with the AMA to establish performance, e.g. business practice, benchmarks for health insurance companies and furnish this information to providers, purchasers, patients, and policymakers. (BoR 08)