The American College of Physicians–American Society of Internal Medicine (ACP–ASIM), representing over 115,000 members, is pleased to provide testimony to the Practicing Physicians Advisory Council (PPAC) regarding Physician Regulatory Issues Team (PRIT) Initiatives and Medicare Evaluation and Management (E/M) Services Documentation Guidelines.

1. Physician Regulatory Issues Team Initiatives

A. Medicare & You 2002 Physician Insert

ACP–ASIM commends the Centers for Medicare and Medicaid Services (CMS) for planning to include an insert in its Medicare & You 2002 beneficiary guide that is aimed at physicians. CMS should take advantage of the opportunity to communicate directly with the physicians treating Medicare beneficiaries by including the following physician-specific information in the insert.

Preventive Benefits

CMS should highlight newly covered preventive benefits (those effective July 1, 2001 and January 1, 2002) even though they will be mentioned in the text of the publication. Ordering information for the recently completed Women in Medicare guide, which describes Medicare coverage of screening Pap tests and pelvic/breast exams, and any other CMS preventive benefit-related guide should be included. It is important that CMS try to eliminate barriers that prevent beneficiaries from receiving Medicare covered screening benefits.

Payment Policy Information

The Medicare & You handbook informs beneficiaries and physicians broadly as to what Medicare covers. Physicians need guidance as to where to find Medicare payment policy information. CMS should include the following in the payment policy section of the insert:

- The PRIT project designed to make payment policy information available electronically (and eventually CD ROM) through a single source, e.g. a compilation of Medicare Carrier Manual instructions, program memoranda, etc.

- Where physicians can find national Correct Coding Initiative (CCI) edits. We believe that HCFA should make CCI edits available on the Internet so that physicians can easily access them instead of purchasing voluminous quarterly manuals through the Commerce
department. CCI edits also complicate physician billing of Medicare covered preventive services.

- Physicians should be aware of carrier-specific local medical review policies (LMRPs) available through the carrier’s website as CMS required when it instructed its carriers to open the CAC process to accommodate information from the public. Physicians should also be directed to the national compilation of LMRPs at [http://www.lmrp.net/](http://www.lmrp.net/).

- An explanation that physicians can review proposed local policies on the website and provide input before they are implemented by the carrier.

**CMS Regulatory Relief Effort: Understanding Physician Practice Environment and Hearing Physician Concerns**

Equally important as informing physicians that CMS is working to make Medicare regulations more accessible so they know the rules is notifying them that the agency is interested in resolving their concerns. Efforts to address physician concerns go unnoticed because initiatives and their reporting are fragmented.

CMS should include the following in the regulatory relief section of the insert:

- Inform physicians that CMS instructed carriers to implement Progressive Corrective Action to improve the audit process.

- Reference the PRIT list of 15 issues slated for immediate action. The recent PRIT document detailing initiatives underway and identifying those designated for action provides a summary of the agency’s efforts.

- Mention the CMS initiative to visit a hospital or spend a day in a physician’s office if the agency is ready to ask who has such a preceptor program in such a national forum. CMS officials have mentioned this initiative to the physician organizations that participate in the monthly provider conference call. We agree with CMS that it will give agency officials a window into the day-to-day issues and hassles faced by practicing physicians.

- A fax back sheet that allows physicians to submit their concerns to CMS. While potentially cumbersome and time consuming, this would serve as a way to supplement what the agency hears from medical organizations. It would serve a purpose similar to what the agency has planned under its Sentinel Clinicians proposal. HCFA could track concerns for trends. Also, it would convey a message to physicians that CMS is interested in their feedback.

**B. Physicians Issues Project.**

ACP–ASIM commends CMS for its commitment to address issues that are of concern to physicians. We commend the PRIT for initiating action to begin resolving these concerns. We applaud CMS for implementing a reasonable, effective policy that allows physicians to be
reimbursed for performing preoperative evaluations for patients facing surgery. This enables the PRIT to remove the preoperative clearance for surgery problem from its list of 15 physician concerns. We look forward to continuing to work with CMS to formulate and implement workable solutions to the PRIT-identified problems that will enable physicians to spend less time completing paperwork and more time with patients. Accordingly, we offer the following comments regarding: existing CMS initiatives, the agency’s “current work”; and PRIT characterization of identified areas of concern, with recommendations for potential solutions.

The Centers for Medicare and Medicaid Services’ Current Work

ACP–ASIM offers comments on the followings PRIT-identified issues on which CMS efforts are already underway.

**Enrollment.** We appreciate CMS’s outreach to the physician community and are encouraged by the revised enrollment form. However, the revised form’s benefit is diminished unless the form is supported by an enrollment process that is quick and reliable. Some ACP–ASIM members complain that enrollment takes too long. In some cases, carrier requests for missing information are not issued in a timely manner, which further delays the process.

Carriers should dedicate a staff person to handle enrollment inquiries. Although we do not expect carriers to assign a full-time staff person to handle enrollment matters exclusively, it would be helpful if a physician could contact a single, trusted source for information regarding his or her enrollment application.

**Women’s Health Exam.** ACP–ASIM commends CMS for developing the *Women in Medicare* guide to help female beneficiaries understand that they often incur financial responsibility for a portion of a preventive health exam as this is an on-going area of confusion for patients. An easily searchable database that includes all relevant information (e.g. regulations, program memoranda, and local policies) is needed to supplement the beneficiary guide.

Further, CMS should work to promote the use and understanding of all its covered screening benefits. The agency should ensure that its Correct Coding Initiative payment bundling edits do not discourage beneficiaries from receiving covered screening benefits. For example, CMS currently maintains a CCI edit that prohibits payment for a prostate cancer screening digital rectal examination unless it is the only service furnished on that date. Physicians should be paid separately for this service when performed during a Medicare-covered, medically necessary visit (for an acute problem or monitoring of a chronic condition) as the screening DRE requires distinct counseling and documentation. As one can imagine, it is difficult for physicians to persuade beneficiaries to make a visit for the sole purpose of receiving a screening DRE.

**Medical Review.** We commend CMS for implementing improvements to the Medicare medical review process through its corrective progressive action program. However, we encourage the agency to make further reforms to enhance the fairness of the medical review process; physicians must be considered innocent until the carrier demonstrates that the physician is at fault. CMS should eliminate extrapolation of findings when a physician is audited for the first time, unless the carrier suspects fraud. The current process coerces physicians into accepting a settlement
even if they believe their billing is correct. Physicians settle to avoid further audits, which are disruptive to their practice, and because they can accrue legal expenses that rival the amount in question. In addition, physicians should not be expected to repay overpayment amounts until their appeal rights are exhausted.

**Reassignment.** In addition to the specific aspect of reassignment rules that CMS is currently reviewing, the agency should modify its locum tenens regulations to allow a physician who takes a leave of absence to bill for the work of a substituting physician for 120 continuous days as opposed to the 60 days that are currently allowed. The period of time should be increased in recognition of the enactment of the Family and Medical Leave Act, the federal law that requires employers to permit employees to take time off to attend to family and other issues (e.g. pregnancy, taking care of a sick family member). CMS should propose a legislative change if necessary.

**Focus on Physicians’ Issues Project**

We applaud CMS for its willingness to address these issues and commend it for capturing the essence of the physician concerns communicated to PPAC through testimony at past meetings. We offer the following comments to further assist in the characterization of the issues and to promote workable solutions.

**Carrier Bulletins.** We welcome the CMS initiatives aimed at helping physicians understand Medicare rules (some of which are described under the heading of “Medicare Rules” in the “CMS Current Work” section of the “PRIT Physicians’ Issues Project” document). We also appreciate the CMS effort underway to assess physician education needs.

We are encouraged that CMS plans to implement a Quarterly Compendium of Medicare regulations and instructions that affect physicians. The Quarterly Compendium will be effective in preparing physicians to comply with Medicare regulations. However, physicians need to be able to access pertinent regulations when a specific question arises to which they need an immediate answer.

**Potential Solution:** All Medicare regulations should be available electronically. The regulations need to be indexed and cross-referenced by topic. For example, a search for rules pertaining to “critical care” should provide: the CPT description, the Medicare Carriers Manual (MCM) policy; relevant CMS Program Memoranda; relevant Correct Coding Initiative bundling edits; recent Office of Inspector General reports; and any local medical review policies (LMRPs).

**Certificates of Medical Necessity.** We agree with the essence of the problem as captured by the PRIT. Frequent certification for supplies the beneficiary will require for the rest of his or her life is excessive and simply wastes time, generates more paper, and increases costs.

**Potential Solution:** Physicians would only have to complete a Certificate of Medical Necessity once for lifetime needs. The DME supplier would need to notify the DME Regional Carrier if a beneficiary determined to have a lifetime need ceased to need an supply, item, or service (e.g. no longer needed home oxygen therapy).
**Claims Resubmission.** The following example illustrates the problem as defined by the PRIT. The New Mexico carrier was denying payment for joint aspiration billed by a rheumatologist for the same patient on the same date as an E/M service even though the E/M service was appended with modifier –25. The rheumatologist investigated the denial and found out that the aspiration was not paid because the carrier determined that rheumatologists are not qualified to perform the procedure. Although the mistake was rectified, it required a time consuming effort on behalf of the rheumatologist’s office.

**Potential Solution:** If a carrier makes an error or updates a fee during the course of the year that is made retroactive to an earlier date, the carrier should be expected to make the correction to prior payments without the physician having to request such an adjustment. The carrier should inform physicians (e.g. through an insert included with a remittance notice and special notice on its website).

CMS should keep a log of carrier errors for quality improvement purposes. Tracking frequency and severity of errors will enable CMS and its carriers to look for systemic flaws and process problems. It will also allow CMS to better track carrier performance, an area where outside auditing entities, such as the General Accounting Office, have identified the agency as being deficient. Accountability will increase physician confidence in carriers and the Medicare program.

**Coverage of follow-up visits for cancer patients.** Patients who have been treated for cancer typically require long-term medical follow-up. Therefore, it is inappropriate for carriers to deny medically necessary follow-up visits as “screening” services. Follow-up cancer care is similar to physician monitoring of patients with controlled hypertension—patients that also require long-term monitoring even without a complaint to prompt a visit.

**Potential Solution:** CMS should work with physician organizations and the medical community to develop reasonable billing standards—such as when International Classification of Diseases (ICD-9) “V” codes are acceptable medical necessity justification—that can be implemented nationally.

**Prior Hospitalization for Skilled Nursing Facility Placement.** We are encouraged that PRIT intends to re-consider the requirement that a beneficiary must have a three-day hospital stay to be eligible for nursing facility benefits. The three-day inpatient stay requirement is a long-outdated requirement that only drives up program costs. For example, a patient with a CVA does not always need three days of inpatient treatment but should begin intensive rehabilitation immediately.

**Potential Solution:** CMS should work with physician organizations and the medical community to facilitate direct beneficiary nursing facility admissions.

**C. Potential to Reduce Physician Input into Medicare Local Policies**
ACP–ASIM is concerned that changes CMS is considering will reduce the number of Medicare carrier Medical Directors (CMDs). Currently, each state has a physician CMD who oversees its Part B operations. CMDs serve as a vital liaison to the physician community and it is essential that the Medicare program retain a CMD in each state.

It is our understanding that some carriers plan to do away with the CMD position in some states in which they operate because of cuts in contractor budgets. Budget cuts have prompted carriers to change the way they operate. For example: A $2.2 million cut in the Arkansas Blue Cross Blue Shield budget prompted it to shift responsibility for medical review in New Mexico and Oklahoma to Louisiana and from Missouri to Arkansas. The CMD position in New Mexico, Oklahoma, and Missouri will be eliminated as a result. One CMD, possibly located in Arkansas, could potentially cover all five states. The same process of consolidation is likely to take place across the country. This type of consolidation further comprises customer service, an area in which carriers are already judged to be deficient. There are numerous Congressional and administrative proposals aimed at fixing CMS/carrier customer service problems.

Further, we understand that a CMS policy change request (Policy Change Request #186) will give carriers discretion to reduce physician input by eliminating or diluting their state Carrier Advisory Committee (CAC). This proposed policy change is totally unacceptable. This would change restrict physicians' ability to provide input into local medical review policy (LMRP) development. Our understanding is that CMS may delete its instructions requiring carriers to establish a CAC in each state and replace them with a directive to secure physician input through a mechanism of their choosing. The five states in the example above plan to develop a single Local Medical Decision Review Board.

We have concerns regarding the impact of such a decision that would give carriers more autonomy in deciding how to secure physician input. We believe that it would free carriers to effectively do away with the CAC process. It could also allow carriers that process claims in multiple states to apply “local” policies to all the states for which it has jurisdiction. Further, it would allow carriers who operate in multiple states to have a single carrier Medical Director (CMD) as opposed to a CMD in each state. As noted above, this is already inappropriately occurring because of budget constraints.

The proposed policy change is problematic because:

- Eliminating the current CAC process will thwart physician participation in local (i.e. state-level) policies decisions. The CAC process has been successful as it allows the physician community to have meaningful input and facilitates peer-education after local policy implementation. We commend CMS for its November 2000 decision to enhance the CAC process by instructing carriers to put proposed LMRPs on-line to get broader input and to put implemented LMRPs on-line to make them more accessible. These positive strides should not be undone. To many physicians, the carrier is Medicare. Eliminating the mechanism that enables practicing physicians to meaningful input would revive the adversarial relationship the Administration is working to overcome.
• Allowing uniform LMRPs for multiple states (for carriers that operate in multiple states) is counter to the reason CMS and carriers employ local policies. LMRPs are introduced to address a utilization or other perceived problem specific to a local area. Having uniform LMRPs on a carrier-specific, instead of a state-specific basis, would likely result in more rather than less LMRPs. LMRPs should be limited to the areas for which there is a documented need.

• Allowing a single CMD to cover multiple states reduces his or her effectiveness as a liaison; it is important that there be a CMD in each state. The CMD is the liaison to the physician community. One CMD per state permits the CMD to be active and recognizable to physicians in that state.

• Allowing a single physician advisory group for multiple areas would make it difficult for physician advisors to attend meetings.

The concern underlying all of the above is that the change that is being considered, as we understand it, would result in less access for the physician community. We believe the potential change runs counter to the Administration’s stated aim of being more responsive to its constituents—physicians and beneficiaries.

ACP–ASIM urges CMS to take action to remedy this urgent situation. We recommend that CMS: (1) instruct its carriers that they cannot eliminate CMD positions; (2) refrain from implementing the proposed change to give carriers more discretion in receiving physician input on local policies, likely diluting the CAC process; and (3) work with physician organizations and the state CACs to ensure physicians have input into local decisions.

We are grateful for the agency's efforts to be more responsive to the physician community and are impressed that it has been able to accomplish much in a short period of time. We believe that reducing the number of CMDs and less effective physician input into LMRPs are serious steps backward.

D. Physicians Issues Workgroup

ACP–ASIM supports the Administration’s creation of seven stakeholder workgroups to address Medicare issues. We encourage CMS to work with PPAC and physician organizations to proceed with the development of the Physicians Workgroup to realize the Administration’s goal of acting on physician issues of concern within 18 months.

2. Evaluation and Management Services Documentation Guidelines

A. Development of Workable Documentation Guidelines

ACP–ASIM recommends that CMS develop guidelines that impose minimal burden on physicians. ACP–ASIM encourages CMS to allow the American Medical Association (AMA)

CMS should make the criteria that its carriers use to audit evaluation and management (E/M) service claims according to the 1995 and 1997 documentation guidelines available to physicians. The agency should not wait until new guidelines are developed and tested to release auditing criteria.

B. Pilot Testing Alternatives to Comprehensive Guidelines

Encounter Time as an Alternative

ACP-ASIM recommends that the CMS conduct a pilot test that allows physicians to select a level of E/M service based on encounter time with the patient with documentation of the E/M documentation “basics” as defined in the “general principles of medical record documentation” section of the guidelines. Current Procedural Terminology (CPT) currently states that physicians can use time to select a level of service when patient counseling and/or coordination of care accounts for more than 50% of the encounter. The concept could be expanded to give physicians the option to use time to select a level of service for all E/M services. The concept could be pilot-tested for documentation purposes without changing the actual CPT descriptors. The AMA CPT Editorial Panel could consider incorporating the expanded role of time if the pilot was successful.

Comments made by CMS and others lead us to believe that our proposal is still not clearly understood. Physicians would have the option to select a level of service by comparing the length of the encounter to the “typical times” found in CPT or according to the traditional method using extent of history, exam, and decision making. The proposal would not penalize physician efficiency nor would it require CMS to pay more in the aggregate for E/M services. Physicians have a financial disincentive to extend the length of a service simply to bill a higher level of service. A physician would generate more revenue by furnishing and billing for more frequent lower level services.

We believe it would be relatively inexpensive for CMS to pilot test a time-based approach. It would be unnecessary for CMS to send individuals or instruments to monitor the precise length of services. CMS could use the same audit process it plans for its other pilot tests. Our proposal requires physicians to document relevant clinical information beyond the length of the encounter. Plus, CMS could ask for the charts pertaining to all the services the physician performed in a given day if the reviewer suspected that the physician was misrepresenting the time he or she was spending with patients. Carriers may also be able to detect potential coding abnormalities by looking at physician billing profiles.

Our research indicates that physicians who select the level of E/M service themselves typically consider face-to-face patient encounter time as a surrogate for physician work. Moreover, the Harvard Hsiao study and a Physician Payment Review Commission (PPRC) study demonstrated a very tight statistical correlation between the assessment of physician work and the intra-service time associated with providing an E/M service. Our proposal is consistent with CPT structure as
it allows physicians to cite time as a proxy for the work performed (i.e. history, exam and
decision making).

Further, CMS should provide an update on the status of its comprehensive review of the
encounter time contained in National Ambulatory Medicare Care Survey (NAMCS) data. At the
October 2000 AMA Relative-value Scale Update Committee (RUC) meeting, CMS stated that
the NAMCS data showed a strong correlation between encounter time and work for internal
medicine E/M services. While this statement seems to support our encounter time proposal,
CMS stated that it is working on a more comprehensive analysis of the NAMCS data.

CMS should take advantage of this opportunity to test an idea that would simplify documentation
requirements while ensuring that physicians report a level of service consistent with the work
and effort involved in providing the service.

Outlier Approach

ACP-ASIM commends CMS for agreeing to design a pilot program to determine whether the
outcomes of medical review determinations are substantially different when performed by
specialty physician reviewers as compared to the current system employing nurse reviewers. We
are pleased that CMS intends to work with the California Medical Association (CMA) to design
the program since the CMA has been the primary advocate for this peer review approach.

We encourage CMS to use the CMA outlier approach pilot to determine if it can verify that it is
paying appropriately without prescriptive documentation guidelines. The medical record must
continue to primarily serve as a tool for clinical care. CMS must do everything possible to
ensure that it refrains from turning the medical record into an accounting document. Pilot testing
an outlier approach is a reasonable step toward achieving that goal.

ACP–ASIM thanks PPAC for the opportunity to provide testimony on Physician Regulatory
Issues Team Initiatives and Medicare Evaluation and Management Services Documentation
Guidelines.