



August 30, 2011

Donald Berwick, MD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for
CY 2012; Proposed Rule; 76 Fed. Reg. 42,772 (July 19, 2011); CMS-1524-P.

Dear Administrator Berwick:

The American College of Rheumatology, representing over 8000 rheumatologists and health professionals, appreciates the opportunity to comment on the proposed 2012 Medicare Physician Fee Schedule Proposed Rule. After careful review of the fee schedule, the ACR has great concern that patient access to necessary care will be compromised if certain draft rule proposals are implemented.

Evaluation and Management RUC Review

The ACR is concerned about issues in the proposed rule that relate to the AMA/Specialty Society RVS Update Committee (RUC).

Recent stories in the popular press have criticized the transparency and composition of the RUC. In addition, legislation has been introduced by Representative McDermott and a federal lawsuit accusing the Centers for Medicare and Medicaid Services for relying on RUC recommendations. The ACR encourages CMS to address the issues that are being discussed with specialty societies.

The ACR agrees that there are some concerns with the RUC process. The Medicare Payment Advisory Commission, in its June 2011, report concluded that Congress should act to ensure that patients will continue to have access to cognitive specialists and notes that the validation of physician service time can be improved. Specifically the MedPAC report suggested that CMS should, “realign payments for physician and other health professionals to help ensure an adequate supply of practitioners in cognitive (nonprocedural) specialists who focus on managing patients with chronic conditions.” Difficulty attracting physicians into cognitive specialties already has influenced the cognitive care workforce. Cognitive physician shortages are seen in the mean wait times for non-urgent new patient appointments. For a new arthritis patient, the mean wait time is 38 days (Lewin Group 2006). One way to improve access to cognitive specialists would be to revalue evaluation and management services as suggested in the proposed rule.

However, the current survey process and valuation for evaluation and management services is flawed. The current system neglects to include the complexity of a specialty consultation for a patient with chronic diseases. By definition, patients are sent to a specialist because the physician has expertise dealing with the complex disease(s) presented; namely, completed extra training in order to treat and diagnose the patient. The system needs to have an adjustment for patients seen by

cognitive specialists who treat patients and prevent the patient from having costly procedures such as hip replacements. The current system has artificially inflated the reimbursement for physicians who perform procedures while lowering (in the balance neutral system) reimbursement for physicians who perform primarily cognitive services. Therefore, physicians that perform surgeries achieve higher reimbursement than physicians that are able to prevent the patient from having a costly surgery.

The ACR agrees with CMS that evaluation and management codes do not accurately reflect the work done by physicians. However, the ACR requests modifications to the survey instrument to better capture the work being performed; namely the time spent determining the diagnosis and the time spent developing individualized treatment plans for patients with coexisting conditions. If CMS suggests the codes be re-evaluated using the old system, the flawed valuation system will continue with no benefit.

Misvalued Services – RUC

One initiative in the proposed rule is to review all codes based on the highest physician expenditure services by specialty, and identify the services that have not been reviewed since 2006. This includes evaluation and management services along with many other codes.

It's a flawed assumption that because the codes are frequently performed they may be misvalued. Several of the procedures rheumatologists perform are appropriately valued, and they are performed frequently because of the nature of rheumatology care. Two codes slated to be reviewed are CPT codes 96413, *Chemo, IV infusion, 1 hr*, and 20610 *Drain/Inject, Joint, Bursa*. These procedures are frequently performed by rheumatologists as patients need complex biologic infusions to ease systems and aspirations or injections to relieve joint pain. Physicians are not over-utilizing these procedures to increase their bottom line, and should not be expected to complete numerous surveys to value codes that most likely are appropriately valued (or possibly undervalued). CMS should find another approach to identify over-valued or abused codes.

Furthermore, it is challenging for societies to survey a large group of codes like evaluation and management codes during a single survey process and receive a good response rate. Adding additional codes will overwhelm physicians, leading to poor response rates and an inaccurate survey response. This is on top of other administrative burdens that are now facing physicians such as meaningful use, e-prescribing, and moving to ICD-10.

The ACR respectfully requests that physicians not be asked to re-survey codes solely because they are highly utilized codes. This is especially important as physicians are now trying to complete meaningful use and preparing to move to the ICD-10 coding system.

Payment for Bone Density (DXA)

Payment for bone density studies, dual energy x-ray densitometry or DXA, has been modified several times in the past years. Reimbursement for DXA studies decreased drastically when CMS transitioned practice expense payments. When the Affordable Care Act was passed in 2010, section 3111 provided relief to physicians who perform the studies and patients who need access to this important study. The ACA provided a temporary reimbursement increase to 70% of the 2006 Medicare reimbursement level for two years while a study was performed by the Institute of

Medicine. To date, the IOM has not completed the study. It would be unfair to decrease reimbursement when the study has not been submitted.

DXA reimbursement should remain at the ACA levels (70% of the 2006 Medicare reimbursement rates) until the IOM study is completed and submitted to the Secretary and Congress.

Physician Quality Reporting System and e-Prescribing

The ACR remains supportive of PQRS as a method to collect data and promote quality of care.

The ACR is, however, disappointed that CMS did not alter the timeline for imposing financial penalties against physicians based for PQRS and e-prescribing. CMS is still identifying and addressing the difficulties physicians have with implementing these programs, and should not impose penalties until major difficulties can be resolved.

In addition, the ACR is concerned with the reporting periods outlined in the proposed rule for assessing penalties for both e-prescribing and PQRS. In particular, the reporting period of 2013 for PQRS penalties that will be assessed in 2015 is especially concerning. Physicians have been operating under a different timeline for PQRS penalty assessments. There has not been adequate communication to the physician community that, while the penalties will not be assessed until 2015, physicians need to be fully operative with PQRS reporting in 2013 to avoid those penalties. While we understand time is required to analyze PQRS data, two years is excessive and physicians should not be unduly penalized based on a reporting period that is two years earlier than previously communicated. Additionally, there should be standardization of reporting periods both between programs and for assessment of incentives versus penalties to eliminate confusion and unnecessary administrative burden.

The ACR also asks that CMS consider addressing improvements in the process for PQRS feedback reports. Providers have had difficulty accessing the reports in a timely manner and have had insufficient time for review of these reports.

CMS needs to re-evaluate the penalty timeline for physicians to report. It is unduly burdensome to require physicians to participate two years in advance – and two years sooner than previously communicated by CMS – in order to avoid penalties.

Physician Compare Website

The proposed rule was not clear about certain aspects of the Physicians Compare Website. For example, it states CMS will be reporting on patient health outcomes, but it is not clear how those outcomes will be assessed; it is also unclear how measures of efficiency will be assessed. In addition, the review and appeals process lacks sufficient description necessary in order to knowledgeably comment on whether it is adequate. Since many important details of the plan for the Physician Compare Website are unclear, CMS should further define how they are planning to report physician information, as well as their plan for collecting data, and provide time for comments on the details of the plan before the program is launched. The ACR does support establishing a minimum set of patients seen by the provider before the criteria is reported.

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Physicians should receive and have an opportunity to comment on more descriptive plans on how the Physician Compare Website will be implemented before the site is made “live.”

The ACR appreciates the opportunity to work with CMS to provide appropriate care to beneficiaries. Please feel free to contact ACR VP of Socioeconomic Affairs, Tiffany Schmidt, JD, MBA (tschmidt@rheumatology.org) if you have any questions or concerns.

Sincerely,

A handwritten signature in cursive script that reads "David Borenstein MD". The signature is written in black ink and is positioned above the typed name.

David Borenstein, MD
President, American College of Rheumatology