



January 3, 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: CMS-1503-FC. Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011; Final Rule.

Dear Dr. Berwick:

The American College of Rheumatology appreciates the opportunity to comment on the 2011 Medicare Physician Fee Schedule Final Rule. Through review of the fee schedule, the ACR still has great concern that patient access to necessary specialty care will be compromised when this rule is implemented.

#### **Elimination of Consultation Codes**

*The ACR respectfully requests that CMS recognize the value of specialty care through reinstatement and appropriate reimbursement of consultation service codes.*

Patients referred to rheumatologists require time intensive evaluations of their complex chronic disabling conditions and extensive medical history. Often, patients see several other physicians before receiving the correct diagnosis from a rheumatologist. Specialty physicians, such as rheumatologists, have additional training and expertise in appropriately diagnosing and providing necessary treatment plans for patients with complex chronic conditions, such as rheumatoid arthritis, lupus and ankylosing spondylitis. In many cases, patients are referred back to the original physician for on-going care or, in other situations patients continue to be treated by the rheumatologist.

In the final rule, CMS reiterated its rationale to eliminate consultation codes noting that the reduction appropriately reflects the relative value in the context of the PFS' other services. Additionally, CMS asserted that all physicians benefited from the increase in payment levels for new patients. However, CMS continues to recognize the agencies numerous attempts to educate physicians on appropriate billing for consultation services which makes the overall justification seem disconnected. Is there no substantial difference in physician work between an E/M visit and services that would otherwise be reported as a consult? Is there no value in specialty care? Although CMS initially tried to educate physicians on how to properly code, the agency seemingly gave up and now defends that the reduction in codes as being appropriate of the relative value. The inability for devising an effective coding system does not negate the extra expertise required to care for complicated patients effectively.

The elimination of consultation codes is preventing coordination of care. As the ACR mentioned in our 2011 MPFS Proposed Rule comment letter, a spring 2010 survey recognized that over 20 percent of physicians completing the survey had already reduced the number of new Medicare patient. Almost 75 percent had seen decreases in Medicare reimbursement. The survey results negate CMS' opinion that all physicians benefited in the increase in "new patient" codes. In addition, CMS should recognize that consultations go far beyond a "new patient" visit and must value specialty care by appropriately reimbursing for medical expertise.

#### Definition of new patient

The ACR continues to have concerns with the new patient definition. If a patient is seen within a multi-specialty practice and is referred to another physician in the practice, the physician would be required to report an established patient code which does not recognize the time and expertise put into the evaluation. This visit should be recognized as a consultation code, yet due to CMS' definition, the physician will only be reimbursed at an "established patient" level.

The policy change to eliminate consultation codes has disheartened many specialty and subspecialty physicians, including rheumatologists. **The ACR respectfully requests that CMS reinstate consultation service codes and appropriately reimburse for these services.**

#### **Physician Quality Reporting Initiative and e-Prescribing**

*The ACR respectfully requests that CMS make additional modifications to the PQRI program.*

The ACR remains supportive of PQRI as a method to collect data and promote quality of care. It is important for CMS to provide proper feedback, available assistance and an appeals process so physicians can report appropriately and have the will to participate in the program. The ACR requests that CMS implement a program to instruct physicians on proper reporting and welcomes positive feedback to improve collaboration with specialty organizations to improve the program.

The ACR would like to express our disappointment that CMS did not alter imposing financial penalties against physicians based on e-prescribing in 2012 and 2013. CMS should not impose penalties until determining the success of the program and properly identifying the difficulties physicians have with e-prescribing. Physicians must have an opportunity to determine successful participation in the e-prescribing program. And those who are unsuccessful should be provided an opportunity to resolve the issue. CMS should reconsider this provision in the final rule.

The ACR appreciates the opportunity to provide comments and work with CMS to ensure Medicare beneficiaries receive optimal care. Please feel free to contact ACR Director of Government Affairs, Aiken Hackett, at (404) 633-3777 or at ahackett@rheumatology.org if you have any questions or concerns.

Sincerely,



David Borenstein, MD  
President, American College of Rheumatology