Panel Endorses MedPAC's 2.7% Positive Update

Only Congress, not CMS, has the statutory authority to fix the flawed sustainable growth rate formula.

BY JENNIFER SILVERMAN
Associate Editor, Practice Trends

WASHINGTON — The Centers for Medicare and Medicaid Services should not institute the 4.3% decrease proposed in the 2006 physician fee schedule, a federal advisory panel recommended.

As it works to fix the sustainable growth rate, CMS should, instead, adopt the Medicare Payment Advisory Commission's recent recommendation to increase payments by 2.7% to keep pace with the cost of care, the Practicing Physicians Advisory Council recommended.

The council meets quarterly to advise the Department of Health and Human Services on proposed changes in Medicare regulations and carrier manual instructions related to physicians' services.

MedPAC advises Congress in a similar manner.

Physician reimbursements under Medicare will be cut 26% over the next 6 years unless the sustainable growth rate (SGR) formula is changed. Although the PPAC recommendation calls on CMS to take action, only Congress has the statutory authority to fix the formula.

The average physician facing these cuts "is stuck" Ronald Castellanos, M.D., PPAC chairman, told CMS officials who presented a summary of the proposed fee schedule at the meeting. Reductions in Medicare payments have forced some physicians to do ancillary procedures in their offices to make up for the lost income, he said.

Leroy Sprang, M.D., an ob.gyn. who was recently named to the panel, said he's seen at least a dozen ob.gyns. in his area of Evanston, Ill., leave the profession due to the pressures of medical malpractice combined with reduced Medicare payments. While they don't deal with older patients as much as other primary care physicians do, some ob.gyn. practices have stopped seeing Medicare patients, he said.

In another avenue for addressing low physician reimbursement, the PPAC asked CMS for a report on whether Medicare Part B drugs could be removed retrospectively, using an administrative methodology. The council asked that the report be ready in time for its December meeting.

"We've been talking about this for the past 2 years," said PPAC member Gregory Przybylski, M.D. The question is whether CMS could do this administratively by a certain date, he said.

Testifying before the panel, Ardis Hoven, M.D., who spoke on behalf of the American Medical Association, said the AMA was confident of CMS' authority to remove the drugs. "Drugs are not paid under the Medicare physician fee schedule, and it is illogical to include them in calculating the SGR," Dr. Hoven said in her testimony. If CMS adopted a revised definition of "physicians' services" that excludes drugs, it could revise its SGR calculations going back to 1996 using its revised definition, although the revisions would affect payment updates in future years, she said.

Leslie Norwalk, CMS deputy administrator, conceded that Congress needed to institute a more rational approach to determining physician payments. Addressing other possible options, HHS' Office of Inspector General may take another look at "gainsharing," an arrangement where physicians could make suggestions on ways to improve care, and in return receive a portion of the cost savings achieved when their ideas are implemented. "The OIG has permitted physicians to engage in this, but only with respect to supplies, not specifically to medical savings," Ms. Norwalk said.

To her knowledge, Congress has engaged in some ideas where physicians would be able to share in hospital savings for instance, "without it being a kickback violation," she told the advisory panel.

CMS also has the ability to change payment systems statutorily through its practice group demonstration projects, Ms. Norwalk said. Several projects are currently testing pay-for-performance systems.

For the first time, Congress, MedPAC, CMS, PPAC, and all of the medical specialties are in agreement about something: that the SGR is flawed, Dr. Castellanos said. For that reason, "maybe something constructive can come out of this." ■

Medicare's Revised Payment Rules Cut Red Tape for Power Wheelchairs

BY JOYCE FRIEDEN
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WASHINGTON — The Centers for Medicare and Medicaid Services has revised its rules for reimbursement for power wheelchairs and scooters.

This interim final rule is a critical step in ensuring that people with Medicare have access to appropriate technology to assist them with mobility, CMS Administrator Mark McClellan, M.D., said in a statement.

The rule is part of a comprehensive strategy to help Medicare beneficiaries get the mobility assistance equipment they need while avoiding unnecessary administrative burdens and inappropriate Medicare spending.

Physicians and other providers criticized the old reimbursement criteria as too burdensome, because they required physicians to provide a certificate of medical necessity before the wheelchair could be covered.

But CMS officials were wary of loosening coverage requirements because of a rash of fraudulent wheelchair and scooter claims. The fraud reached such a high level that CMS launched its Operator Wheeler Dealer campaign to stop it.

Under the new regulations, the medical necessity certificate has been eliminated, but in its place, the agency is requiring certain clinical documentation items from the patient's medical record, along with a written prescription—given within 30 days of the evaluation—issued to the supplier. And the rules continue to require that physicians must conduct a face-to-face examination of the patient before they can prescribe a mobility device.

Medicare already pays for this evaluation visit. However, because of the additional documentation required under the new regulations, Medicare is authorizing an additional payment to physicians for preparing the paperwork.

Physicians must include a special billing code on the office visit claim in order to receive this extra payment.

The agency also is removing the requirement that only certain specialists—physiatrists, orthopedic surgeons, neurologists, and rheumatologists—are allowed to prescribe power scooters. Instead, all physicians and treating practitioners will be able to prescribe scooters and power wheelchairs.

The Power Mobility Coalition (PMC), a group of mobility-device manufacturers, expressed concern that the new rules would make it tougher for physicians to comply.

The PMC agrees with CMS that the treating physician is in the best position to assess the need for power mobility devices, but is concerned that, in order to fully succeed, CMS and its contractors will have to conduct a comprehensive review of the benefit for physicians, the organization said in a statement. Physicians may not be fully aware of the analytical standard that will be applied to claims, let alone which of the 49 new product codes most appropriately meets beneficiary needs.

The PMC also has concerns over the 30-day time frame for submission of a [mobility device] claim after a physician face-to-face visit, the statement continued. Given the extensive documentation requirement, suppliers, especially those in rural areas, may find the 30-day time frame too tight to obtain and submit all relevant parts of the medical record, as well as the necessary supporting documentation.

The new rules, which were published in the Aug. 26 Federal Register, will take effect Oct. 25. CMS will accept comments on the rules until Nov. 25, and a final rule will be published at a later date, according to the agency. ■

The interim final rule and accompanying fact sheet can be found online at www.cms.hhs.gov/coverage/wheelchairs.asp.

Hurricane Causes Delay In Vote on Medicaid Cuts

A planned vote in Congress on $10 billion in cuts to Medicaid and other changes to the program has become another casualty of Hurricane Katrina.

"There's no doubt that Hurricane Katrina has made it necessary to provide additional resources for the Medicaid program, and we're going to do that apart from reconciliation in the Katrina relief package that's being put together," Sen. Chuck Grassley (R-Iowa), chair of the Senate Finance Committee, said when announcing an indefinite delay.

"There's broad agreement that some changes need to be made in order to preserve and sustain this vital health care program for the poor and disabled," he said.

"It's important to understand that the Medicaid reform effort is about fixing loopholes and stopping abusive spending so that more money is available to help states reach those in need both in the short- and long-term."

In the House of Representatives, 113 Democratic members signed a letter to House Speaker J. Dennis Hastert (R-Ill.) urging him to abandon the proposed spending cuts.

Referring to areas affected by the hurricane, the letter noted, "The health care safety net in these states will be strained to the breaking point by these events. Many of the victims of this tragedy will be left without health care coverage for months if not longer, just when they need it the most. … And they deserve our help."

—Joyce Frieden

42 Million in U.S. Not Insured

The ranks of the uninsured have leveled off, according to a survey by the Centers for Disease Control and Prevention's National Center for Health Statistics.

In 2004, 42 million Americans of all ages lacked health insurance, about the same level as in 1997, the first year this survey began tracking these statistics. One in five adults (aged 18-64 years) were without health insurance last year; this also leveled off in 2004. Coverage for children improved: 7 million children under 18 years lacked health insurance in 2004, compared with 10 million children in 1997.

—Joyce Frieden