

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 6 - I-04
(December 2004)

Subject: Status Report on Medicare Review Activities

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Referred to: Reference Committee J
(Brooks F. Bock, MD, Chair)

1 Since 1997, the Council on Medical Service has presented an annual report to the House of
2 Delegates on the status of Medicare review activities. This report details the regulatory relief
3 provisions that were included in the Medicare Prescription Drug, Improvement and Modernization
4 Act of 2003 (P.L. 108-173); provides an update on the status of contractor reform activities being
5 undertaken by the Centers for Medicare and Medicaid Services (CMS); summarizes developments
6 in resolving Medicare enrollment issues; and discusses the provisions in the 8th Quality
7 Improvement Organization (QIO) Statement of Work.
8

9 MEDICARE REGULATORY RELIEF

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11 The AMA has established extensive policy in support of regulatory relief for physicians.
12 Accordingly, the Council was pleased that the Medicare Modernization Act included many
13 regulatory relief provisions for which the AMA had strongly advocated over the past few years.
14 Key provisions of the new law are listed below, along with relevant AMA policy citations:
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- 16 • Limits the use of extrapolation to only those cases where there is a sustained or high payment
17 error rate or documented education efforts have failed. (Policy H-335.975, AMA Policy
18 Database)
19
- 20 • Emphasizes education of physicians about incorrect billing practices, and allows an
21 opportunity to correct errors before repayment demands are made. (Policy H-335.976[3])
22
- 23 • Prohibits repayment demands until after physician appeals have been considered. (Policy
24 H-335.976[5])
25
- 26 • Mandates HHS to study alternative, simplified systems of documentation for physician claims.
27 (Policy H-330.920[1])
28
- 29 • Ensures that any new documentation guidelines for evaluation and management codes are
30 thoroughly pilot-tested before they can be implemented as national policy. (Policy
31 H-330.920[5])

- 1 • Ensures that services furnished under the prudent layperson standard and according to
2 EMTALA requirements are covered by Medicare. (Policy H-130.970[5])
3
- 4 • Establishes an EMTALA Advisory Group to “review issues related to EMTALA and its
5 implementation.” (Policy D-130.982[4])
6

7 The AMA spent several years working with members of Congress to ensure that legislation was
8 passed that would provide meaningful regulatory relief to physicians. The inclusion of these
9 provisions in the Medicare Modernization Act represents a major victory for the AMA on behalf of
10 its members.

11 Regulatory Guidance

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13
14 The AMA strongly supports ensuring that physicians have access to reliable and timely information
15 related to the proper interpretation of Medicare regulations, and has advocated forcefully for
16 accountability by CMS and its contractors for actions taken as a result of their guidance. The
17 Medicare Modernization Act requires carriers to provide physicians with clear, concise, and
18 accurate answers to their billing questions within 45 business days, and eliminates penalties and
19 interest for physicians faced with alleged overpayments who have relied on written guidance from
20 Medicare.

21
22 In addition, the Act mandated that the Government Accounting Office (GAO) conduct a study to
23 determine the feasibility and appropriateness of giving the Department of Health and Human
24 Services (HHS) the authority to provide legally binding advisory opinions on appropriate
25 interpretation and application of Medicare regulations. The GAO met with AMA representatives
26 in August 2004, to get input for its study, and the AMA expressed its strong support for a legally
27 binding process by which physicians could obtain guidance on Medicare procedures. The AMA
28 urged GAO to address the following issues in its study:

- 29
30 • Advisory opinions should be provided by the agency responsible for enforcing the specific
31 regulation.
32
- 33 • Advisory opinions should be available free to physicians (or medical societies on behalf of a
34 group of physicians).
35
- 36 • Responses should be furnished in writing within 60 days.
37
- 38 • Physicians should be able to bill for services while waiting for guidance, and to correct errors
39 without penalty if necessary.
40
- 41 • In considering ways to structure the advisory opinion process so as to minimize costs to the
42 government, explore making advisory opinions applicable to groups (where appropriate) as
43 well as individuals, and utilizing medical societies as a means to centralize physician inquiries.
44
- 45 • The advisory opinion process should not be limited to specific topics, but limits may be set on
46 the number of opinions issued.

1 MEDICARE CONTRACTOR REFORM

2
3 The Medicare Modernization Act also establishes a new process for selecting Medicare contractors.
4 Over the next several years, Medicare Administrative Contractors (MACs) will replace existing
5 Medicare carriers and fiscal intermediaries. The MACs will be selected competitively, and will be
6 subject to annual contract renewals based on specific performance requirements. However,
7 beginning with contracts set to begin on October 1, 2005, all MAC contracts must be completely
8 “re-competed” every five years. CMS hopes that the introduction of competition to the Medicare
9 contracting process will provide a mechanism for offering incentives for MACs to provide higher
10 quality and more efficient services.

11
12 MACs will be expected to perform essentially the same functions that current fiscal intermediaries
13 and carriers perform, including provider consultation and education, beneficiary education, claims
14 processing, and technical assistance. However, under the new law, CMS will have the authority to
15 assign and transfer functions among individual MACs, which has the potential to result in a
16 fragmentation of services. For example, CMS could opt to contract with one MAC to handle
17 beneficiary inquiries, another to handle claims processing, and a third to handle physician payment.
18 Contractor work could be further segmented by geographic region, with certain MACs responsible
19 for certain geographic regions.

20
21 Although it is still unclear exactly how the MACs are going to be organized, it is anticipated that
22 the transition to MACs will result in a consolidation of work being done by the current Medicare
23 carriers and fiscal intermediaries, and a likely reduction in the number of carrier medical directors.
24 The AMA has strong policy supporting the availability of carrier medical directors at the local level
25 (Policies H-335.970, D-330.974, and D-335.992), and has raised concern that proposed changes in
26 the Medicare contracting process may compromise this availability.

27
28 To help ensure that the contractor reform process does not result in fragmented services for
29 physicians or reduced access to medical directors, the AMA presented the following suggestions to
30 CMS in April 2004:

- 31
- 32 • Any transition between old and new contractors should be closely monitored by CMS to assure
33 no disruption in claims processing capabilities.
 - 34
 - 35 • CMS should use existing performance standards to assure that claims are paid accurately and
36 on a timely basis.
 - 37
 - 38 • CMS should provide a dedicated and stable level of funding for physician education that is not
39 transferable to other contractor functions.
 - 40
 - 41 • The new MACs should continue to provide a carrier advisory committee at the state level.
 - 42
 - 43 • The new MACs should continue to provide a carrier medical director for each state.
 - 44
 - 45 • Funding for the carrier medical directors should provide for travel funds to allow them to
46 regularly participate and attend physician functions in the state.

- 1 • Any consolidation of local medical review policies should continue to provide for input from
2 physicians at the local level.
3
- 4 • CMS should avoid fragmentation of the contractor functions so that physicians have a single
5 point of contact for the Medicare program. Should CMS not provide this single point of
6 contact, any communication from program safeguard contractors, durable medical equipment
7 contractors, or others should clearly be identified by logo on the letterhead that it is from the
8 MAC and the other CMS contractor. CMS should work to prevent the confusion that multiple
9 contractors create for the physician community.

10 MEDICARE ENROLLMENT PROCESSING DELAYS

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13 The length of time and complexity of the process associated with establishing Medicare billing
14 privileges have been ongoing concerns for physicians. The AMA has strong policy advocating for
15 a more streamlined enrollment process and the issuance of temporary identification numbers so
16 physicians can bill for services while their enrollment applications are pending (Policies H-330.911
17 and D-330.962).

18
19 Over the past year, Medicare provider enrollment delays have been exacerbated by the introduction
20 of a new system for enrollment/re-enrollment processing. In July 2002, CMS implemented a new
21 national enrollment system for Medicare fiscal intermediaries called the Provider Enrollment and
22 Chain/Ownership System (PECOS), with the goal of improving the overall infrastructure for the
23 systems supporting the provider enrollment function. Although the system appeared to work
24 smoothly for the fiscal intermediaries, it created overwhelming system problems and delays when
25 its use was extended in November 2003 to physicians and other providers who interact with
26 Medicare carriers. For much of 2004, the PECOS system was unable to handle the volume of
27 applications carriers process, initially because of technical difficulties, and then because of a
28 massive backlog of applications and an inadequate level of staffing to handle them. Processing
29 times increased dramatically, and physicians were unable to bill for services while they wait for
30 their applications to be processed.

31
32 The AMA has been in regular contact with CMS attempting to resolve or minimize the
33 enrollment/re-enrollment problems. Specifically, the AMA advocated that funds be made available
34 to pay for temporary staff or overtime hours to relieve the backlogs; a process be established where
35 carriers can advance payments to physicians still awaiting their enrollment number; and physicians
36 be paid interest on claims that have been delayed because of enrollment processing problems. In
37 June 2004, the House of Delegates adopted Resolution 132, which directed the AMA to continue to
38 pursue these remedies with CMS (Policy D-330.956).

39
40 In May 2004, Medicare released more than \$5 million for use by Medicare carriers to pay overtime
41 and hire additional temporary staff to process backlogged claims. The clean-up process has been
42 slow, but the backlogs were significantly reduced during the summer of 2004. At the time this
43 report was written, CMS anticipated that it would be completely up to date by sometime in the fall
44 of 2004. The AMA continues to advocate for interest payments for physicians who experienced
45 processing delays, and CMS has not ruled this option out.

46
47 Nevertheless, the AMA is very concerned that the problems associated with the transition to the
48 PECOS system could be magnified when all physicians are required to re-enroll in order to obtain a

1 National Provider Identifier. In a final rule published on January 23, 2004 (45 Fed. Reg. 3434),
2 CMS adopted the National Provider Identifier as the standard unique health identifier for
3 physicians and other health care providers. Providers may begin applying for the number in May
4 2005, and all covered entities must comply by May 2007 (2008 for small health plans). Providers
5 must complete an application process in order to be issued the Identifier. The main concern is that
6 the National Provider System which is being created to handle the applications will experience
7 problems similar to the PECOS system, including being overwhelmed by the sheer volume of
8 applications associated with re-enrolling the entire physician/provider population. Policy
9 D-330.956 also calls for the AMA to advise CMS against implementation of the National Provider
10 Identifier until providers are assured that advance payments will be made in the case of delayed
11 enrollment processing.

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13 8th QUALITY IMPROVEMENT ORGANIZATION STATEMENT OF WORK

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15 CMS is currently developing the 8th Quality Improvement Organization (QIO) Statement of Work,
16 which is scheduled to be implemented in the summer of 2005. At the time this report was written,
17 the 8th Statement had not been released; however, CMS had issued preliminary documents in order
18 to facilitate feedback from interested organizations. According to the summary documents, the
19 emphasis of the 8th Statement will be on accelerating improvement in clinical quality measures.
20 Specifically, the program will emphasize giving providers the tools and knowledge to implement
21 changes that will help them achieve excellent outcomes.

22

23 CMS anticipates organizing the 8th Statement of Work around three main areas: creating an
24 environment for quality; assisting providers in developing the capacity for and achieving
25 excellence; and protecting beneficiaries and the Medicare program. The Statement of Work will
26 emphasize the clear and consistent communication of expectations, the use of incentives for
27 delivering higher levels of quality, and the adoption and implementation of new systems and
28 technologies to ensure quality care delivery.

29

30 In January 2004, the AMA submitted comments to CMS based on its preliminary “Framework for
31 the 8th Quality Improvement Organization Statement of Work.” The AMA praised the continued
32 emphasis on internal quality improvement efforts by individual physicians and the proper
33 development of methodologically sound physician level measures designed for this purpose. In
34 addition, the AMA emphasized the importance of increasing the use of information technology,
35 while also recognizing the need for adequate funding to support its expanded use. The AMA plans
36 to issue further comments when the full draft 8th Statement of Work is made available.

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38 DISCUSSION

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40 The AMA spent several years working with members of Congress to develop and pass regulatory
41 relief legislation that would ensure that Medicare rules and their implementation were fair to
42 physicians. The regulatory relief provisions included in the Medicare Modernization Act represent
43 a major victory for the AMA on behalf of its members. The Council on Medical Service believes,
44 however, that the Association will need to closely monitor the implementation of these provisions,
45 to ensure that the intent of the law is preserved when the regulations are developed and
46 implemented.

1 Although the Council is encouraged by CMS' intent to improve service delivery by introducing
2 competition and flexibility into the Medicare contractor process, it is concerned that the transition
3 to MACs may result in reduced access to local carrier medical directors, and subsequently a
4 decrease in physician-carrier interaction. The Council believes that the AMA should continue to
5 monitor this process to ensure that carrier medical directors remain available to physicians, and that
6 services are provided in an accurate and timely manner.

7
8 The Council also remains concerned about the enrollment delays that arose as a result of
9 implementation of the PECOS system, which took CMS nearly a year to resolve. In keeping with
10 Policy D-330.956, the Council believes that the AMA needs to continue to advocate that CMS
11 compensate physicians for delayed payments caused by enrollment or re-enrollment delays. The
12 Council also believes that CMS needs to increase its efforts to ensure that physicians have the
13 option of completing the entire enrollment or re-enrollment process (including the eventual
14 application for the National Provider Identifier) electronically, without the need to submit a printed
15 signature page. For physicians seeking to re-enroll, electronic application fields should be pre-
16 populated with data already supplied to CMS during the initial enrollment process. The electronic
17 process should be thoroughly pilot tested to ensure it can accommodate the timely processing of
18 applications.

19
20 Although the enrollment delays precipitated by the transition to the PECOS system seem to be
21 decreasing, it is unclear if the PECOS system will in fact result in more efficient enrollment
22 processing in the long run. The Council believes that the successful adoption of an electronic
23 application option would minimize enrollment delays, and could facilitate a reduction in processing
24 time. Currently CMS requires its carriers to process 90% of enrollment applications within 60
25 days, and 99% within 120 days. The Council believes that these periods are too long, especially
26 for new physicians who do not yet have billing privileges. The Council believes the AMA should
27 advocate for a reduction in the carrier/contractor standard for enrollment and re-enrollment
28 processing to 90% in 30 days and 99% in 60 days. An additional provision in the Medicare
29 Modernization Act grants physicians the right to appeal in the event that their enrollment
30 applications are denied or their billing privileges are revoked. The Council believes that this is a
31 positive step in ensuring that the enrollment process does not disadvantage physicians.

32
33 Finally, the Council is pleased with the Administration's continued support for the ongoing quality
34 of care focus of the Medicare QIO program. The preliminary information available on the 8th
35 Statement of Work indicates that important issues will be highlighted, including an emphasis on
36 enhancing the infrastructure of physician's offices and practice settings as a means to achieve high
37 quality care delivery. The Council will continue to monitor the ongoing development and
38 implementation of the 8th Statement of Work.

39 40 RECOMMENDATIONS

41
42 The Council on Medical Service recommends that the following be adopted and that the remainder
43 of the report be filed:

- 44
45 1. That the American Medical Association (AMA) closely monitor the Center for Medicare and
46 Medicaid Services' (CMS) transition to the use of Medicare Administrative Contractors to
47 ensure physician access to local-level carrier medical directors, and that contractor services are

- 1 provided in an accurate and timely manner and that these issues are considered in contracting
2 in addition to purely financial issues. (Directive to Take Action)
3
- 4 2. That the AMA continue to advocate that CMS compensate physicians who experience
5 significant delays in the Medicare enrollment and/or re-enrollment processes. (Directive to
6 Take Action)
7
- 8 3. That the AMA urge CMS to increase its efforts to ensure that physicians have the option of
9 completing the entire Medicare enrollment and/or re-enrollment processes (including the
10 eventual application for the National Provider Identifier) electronically. (Directive to Take
11 Action)
12
- 13 4. That the AMA urge CMS to conduct pilot tests to ensure that the electronic enrollment and re-
14 enrollment processes will accommodate the timely processing of physician applications.
15 (Directive to Take Action)
16
- 17 5. That the AMA urge CMS to reduce the carrier/contractor standard for enrollment and/or re-
18 enrollment processing from 90% in 60 days and 99% in 120 days, to 90% in 30 days and 99%
19 in 60 days. (Directive to Take Action)

Fiscal Note: Continue to monitor and advocate to CMS at estimated total staff cost of \$1,645.