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House starts looking at payment reform options

On September 11, the House Ways and Means Health Subcommittee held a hearing on Medicare's physician payment system. Testimony focused on changes Congress should consider next year in order to avert the cut of more than 20 percent in Medicare reimbursement scheduled to take effect in 2010. Witnesses included two former administrators of the agency now known as the Centers for Medicare & Medicaid Services (CMS): Bruce Vladeck, PhD, and Gail Wilensky, PhD. Dr. Vladeck expressed support for reforms similar to those that the American College of Surgeons has proposed, which would replace the current sustainable growth rate (SGR) methodology with a reimbursement formula composed of separate spending targets for specific types of services. This new payment structure would include a distinct category for major surgical procedures and, consequently, spare surgery from the across-the-board, blunt payment cuts caused by the SGR. Dr. Wilensky also expressed interest in this proposal. For more information regarding this hearing, go to <http://waysandmeans.house.gov/hearings.asp?formmode=detail&hearing=645>.

ACS comments on fee schedule

On August 29, the College submitted comments to CMS regarding the proposed rule for the 2009 Medicare physician fee schedule. The letter addresses the following provisions of concern to surgeons: a requirement that physicians who furnish diagnostic testing services enroll as independent diagnostic testing facilities, changes to the effective date for Medicare billing privileges for physicians, an incentive payment and shared savings program, and updates to the Physician Quality Reporting Initiative. In addition, the proposal calls for developing means to address potentially "misvalued" services. To view the College's comments, go to <http://www.facs.org/ahp/views/medicare2009.html>.

ACS comments on OPPS/ASC proposed rule

The College submitted comments on September 2 regarding the outpatient prospective payment system and ambulatory surgical center (OPPS/ASC) proposed rule. In this letter to CMS, the College addresses the following issues: a plan to extend payment policies for hospital-acquired conditions to outpatient settings, a proposal to add imaging efficiency measures using 2008 Medicare administrative claims data, and suggested changes to the list of covered surgical procedures designated as device intensive. To view this correspondence, go to <http://www.facs.org/ahp/views/ambulatory.html>.

New code for noncompliance with Stark law

A new CMS claim adjustment reason code (CARC #213) becomes effective January 1, 2009, for use in denying claims that are noncompliant with the Stark self-referral law. This legislation prohibits physicians from referring Medicare patients needing certain designated health services (DHS) to facilities in which the physicians or an immediate family member have a financial relationship. Penalties for violations of the law include denial of payment, refund of amounts collected for DHS payment, and civil monetary fines. CARC #213 is the first specific code to describe claims denials resulting from violation of the Stark law. For more information, go to <http://www.cms.hhs.gov/transmittals/downloads/R1578CP.pdf>.