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Welcome to the first issue of *Endocrine Insider*, a bi-weekly newsletter with a focus on health and science policy affecting the endocrinologist. *Endocrine Insider* is designed to provide you with timely updates on policy matters that are important to you and highlight Society advocacy efforts—all in one place.

The Programs & Policy Affairs Department welcomes your feedback and comments about *Endocrine Insider*. We hope that you will find this newsletter useful and informative. Please let us know what you think, and feel free to pass it along to your colleagues who share your interest in these issues.

### **Federal Funding Levels for Research in FY 2005 Finalized**

Congress approved the FY 2005 Omnibus Appropriations bill on Saturday, November 20<sup>th</sup>. This spending bill included appropriations for all federal agencies that had not been funded by Congress prior to the elections. The omnibus bill totaled \$388 billion, which represents a freeze in domestic discretionary spending from last year. As a result, nearly all programs were flat-funded with only a few priority programs receiving a small increase. The bill also specified that all non-defense and non-homeland security appropriations would be subject to an across the board cut of .83 percent (represented below).

The National Institutes of Health: The final NIH program level appropriation is \$28.4 billion, an increase of \$563 million (two percent increase) over FY 2004. Numerous taps also will be subtracted from this number (the \$28.4 B) including the Global HIV/AIDS transfer (\$100 million) and the funds for program evaluation (.24 percent).

Department of Veterans Affairs: VA received an appropriation of \$28.09 billion (roughly 4.7 percent over FY 2004). Of that, \$405.5 million was allocated for the VA Medical and Prosthetics Research Program. This represented a \$500,000 or .1 percent cut from FY 2004 level of \$406 million.

The National Science Foundation: NSF was allocated \$5.47 billion, \$270 million below the budget request and \$105 million below the FY 2004 level.

The Agency for Healthcare Research and Quality: Received \$318.7 million, which is roughly a five percent increase over FY 2004.

Department of Agriculture: \$85.2 billion in mandatory agriculture spending for FY 2005, of which \$16.9 billion is discretionary. Included in this bill was \$181 million for the USDA National Research Initiative Competitive Grants Program. This was a \$17 million or 10.4 percent increase over FY 2004 levels.

### **1.5% Pay Increase for Medicare Physicians**

The 2005 Physician Fee Schedule Final Rule, published in the *Federal Register* on November 14, sets rates for how Medicare pays more than 875,000 physicians and other health care professionals beginning January 1, 2005. Thanks to a provision in the Medicare Modernization Act (MMA), physician payment rates will increase across the board by 1.5 percent next year, replacing a previously passed payment cut of 3.3 percent.

While physician advocates had hoped the Centers for Medicare and Medicaid Services (CMS) would use the final rule to provide a fix to the flawed Medicare reimbursement formula, Congress is mulling over other options for easing the physician payment crisis. Tying physicians' Medicare reimbursement to their performance is one scenario being considered as a means to fixing the formula, according to sources on the Hill.

Committee staff are currently reviewing private-sector pay-for-performance initiatives for physicians. Sources say that there is interest from both sides of the aisle for this option, which would help alleviate the extensive cost of repealing the payment formula altogether. The cost of this move is estimated at about \$95 billion, according a Congressional aide.

The Endocrine Society is currently coordinating lobbying efforts with the AMA and other specialty societies to ameliorate Medicare's physician payment system.

### Bonus Payments in Health Professional Shortage Areas

An additional 5 percent incentive payment is in store for primary care and specialty physicians furnishing services to beneficiaries in those areas with low ratios of physicians to beneficiaries. A 10 percent bonus will be given to those physicians providing services in "health professional shortage areas." Medicare will make these payments automatically, in most cases, so the physician will not have to take any special action to receive the additional payments.

CMS recently created a Web site for the provider community that addresses the changes to the health professional service areas bonus payment program and describes the new physician scarcity area bonus payment program. The site contains complete instructions on determining eligibility for the automated payments and resources with links to further assist physicians in completing a bonus payment claim. The new procedures are effective for claims submitted with dates of service on and after January 1, 2005. The Web site is <http://www.cms.hhs.gov/providers/bonuspayment>.

### New Medicare Preventive Examination

The Medicare Modernization Act of 2003 (MMA) mandates three new preventive services for beneficiaries: an initial preventive physical examination, cardiovascular screening blood tests, and diabetes screening tests. According to CMS, an estimated 200,000 eligible individuals are expected to enroll in Medicare Part B each month starting in January 2005.

Thanks to a flurry of comments from concerned specialty societies, including The Endocrine Society, CMS reversed its proposal to limit coding for the new “Welcome to Medicare” exam in the final rule. CMS had originally proposed limiting the level of medically necessary evaluation and management (E/M) visits for the exam to level 2 visit codes only, but reversed this proposal in the final rule and advised that the higher level visits codes (99201 through 99215) “may be used, depending on the circumstances, and appended with CPT modifier –25 identifying the E/M visit as a separately identifiable service from the [preventive exam] code G0344 reported.” In addition, CMS added that they do not believe this scenario will be the typical occurrence, stating that they “will monitor utilization patterns for the level 4/5 new or established office or other outpatient visit codes being reported with the exam. If there are consistent data that demonstrate high usage of level 4/5 E/M codes we may need to revise the policy.”

This new preventive exam is available to new beneficiaries as of January 1, 2005, but only during their first six months in the program. While this in-office payment is \$97.40, it also is subject to a geographic adjustment. This service requires an EKG to accompany it, which can be billed separately for an office payment of \$26.90.

CMS will launch an educational campaign to inform physicians and other providers about these new benefits and direct physicians and patients to resources as they become available.

#### Telemedicine Payments

Pursuant to another MMA provision, CMS will pay physicians who use telecommunications technology to provide monthly management services for rural beneficiaries who are on dialysis. As a result, the agency expects that rural beneficiaries with end stage renal disease will get better support for high-quality care.

#### 90-Day Grace Period Removed

Effective January 1, 2005, Medicare providers will no longer have a 90-day grace period to use discontinued HCPCS codes for services rendered in the first 90 days of the year. Use of discontinued codes will cause your claims to be returned (rejected) and not paid. In essence, HCPCS codes must be valid at the time the service is rendered.

Carriers, Durable Medical Equipment Regional Carriers, and Fiscal Intermediaries will no longer accept discontinued HCPCS codes for dates of service January 1 through March 31 of the current year (beginning in 2005) that are submitted prior to April 1. To ensure prompt and timely payment of claims, use the new HCPCS for 2005 beginning with services rendered on or after January 1, 2005, and stop using discontinued codes at that time. Each year thereafter, be sure to adopt the new codes.

#### **Endocrine Society Members Weigh in on Office Consultation and Visit Values**

A recent physician survey revealed that many higher level evaluation and management (E/M) services for CPT codes 99203 to 99205 and 99213 to 99215 have become more intense and complex since they were initially valued almost ten years ago. The Endocrine Society joined more than 16 “cognitive” medical specialty organizations for a meeting in Washington, DC, last month to discuss the results of a survey that asked physicians if the work that goes into providing E/M services has changed in the past ten years. The purpose

of the November 19 meeting, which was hosted by the American College of Physicians, was to consider which codes should be recommended to the Centers for Medicare and Medicaid Services (CMS) for the agency's Five-Year Review of Codes.

Sent to clinician members on November 10, The Endocrine Society was among the few organizations that had a significant number of respondents complete the survey. Sixty-eight individual endocrinologists had completed the survey at that point, compared to nine responses by the emergency physicians, 34 by hematologists, and 18 from infectious diseases doctors. It appeared that the neurologists had the highest number of respondents at 89.

Results of the endocrinology-specific data indicated that the amount of work for office visit and consultation codes had changed significantly enough to warrant review and possible increases in reimbursement rates by CMS.

As mandated by law, CMS must review CPT codes every five years for possible revaluing and adjustment. CMS will conduct the upcoming Five-Year Review in the spring of 2005. Organizations wishing to have their members' codes reviewed, must submit the list to CMS for consideration by January 3, 2005.

Meeting participants concluded that the best method for recommending codes for review to CMS should be one letter that contains a list of codes and is signed by all participating societies. The meeting chair, Len Lichtenfeld, MD, of the American College of Physicians, emphasized the importance of thousands of physicians signing on to a recommendation letter versus a few organizations submitting lists of their own particular codes.

Specialty societies will complete the review of their survey results during the next week and make a final decision about signing on to the group's letter to CMS by the end of December.

### **NIH Open Access Plan Included in Omnibus Bill**

The final omnibus bill included language regarding open access. According to direction included in the bill "NIH would request investigators to voluntarily submit electronically the final, peer reviewed author's copy of their scientific manuscripts; six months after the publisher's date of publication, NIH would make this copy publicly available through PubMed Central." Further, "NIH is directed to give full and fair consideration to all comments before publishing its final policy. The conferees request NIH to provide the estimated costs of implementing this policy each year in its annual Justification of Estimates to the House and Senate Appropriations Committees. In addition, the conferees direct NIH to continue to work with the publishers of scientific journals to maintain the integrity of the peer review system."

Throughout the debate on open access the Society has fought to make the voice of the non-profit publishers heard. In addition to submitting its comments in response to Dr. Zerhouni's open access proposal, the Society has, and will continue to, communicate its concerns to the highest levels of Administration officials and Congressional leaders. The Society has joined several coalitions to broaden support on this issue. Representatives from the Society have met with officials at the Administration level including NIH, HHS, and the Office of Information and Regulatory Affairs. In addition, the Society has canvassed the

Hill with more than twenty meetings with House and Senate offices. The Society will continue to press NIH on the unintended consequences of the open access proposal and urge adoption of a policy that will work for all stakeholders.

To view The Endocrine Society's comments to NIH regarding enhanced public access, visit our home page and click on [Comments on NIH's Enhanced Public Access Proposal](#).

### **CMS 'Forums' Provide First-Hand Dialogue on Medicare Policy**

The Centers for Medicare and Medicaid Services will hold its monthly Physician, Nurses & Allied Health Professionals Open Door Forum on December 13, 2004 at 2 p.m. Eastern Standard Time (EST).

Open Door Forums are conference calls that provide a dialogue about the many individual service areas and beneficiary needs within CMS. Each forum is chaired by a senior-level agency official and co-chaired by a CMS Regional Administrator. Senior CMS leadership, including Administrator Dr. Mark McClellan, and Deputy Administrator Leslie Norwalk actively participate in these forums. Rich Lawlor, a senior level policy advisor in the Office of the Administrator, directs the forums. Callers may ask questions and provide comments during the hour-long calls.

There are currently fourteen individual ongoing forums held on a monthly or bimonthly basis. The CMS also continues to pilot new forums as well as hold special forums to meet current and evolving provider and beneficiary needs.

**To participate in the call please dial the following number and use the Conference ID number:**

**Dial: 1-800-837-1935**

**Conference ID: 4369067**

If you are unable to participate in the call but would like to listen to a recording of it, use the CMS Encore service by dialing 1-800-642-1687 and using Conf. ID Number: 4369067.

"Encore" is a recording of this call that can be accessed beginning two hours after the call has ended. The recording expires after three business days.

To sign up for e-mail reminders of monthly forums, schedule updates, Listserv registrations, and Frequently Asked Questions, go to the CMS web site at [www.cms.hhs.gov/opendoor/](http://www.cms.hhs.gov/opendoor/).

### **CA Officials Appoint Stem Cell Research Oversight Board, Includes Endocrinologist**

On November 17, the Institute for Regenerative Medicine, which will dispense \$3 million annually for stem cell research over the next decade, received five new appointments to California's Independent Citizens Oversight Commission (ICOC).

Nominations to the commission were divided among chancellors of five University of California campuses as well as other state officials. As outlined in Proposition 71, passed by California voters Nov. 2, the chancellors of five UC campuses with a medical center each

were to appoint an Executive Officer to the ICOC. In addition, Lt. Gov. Cruz Bustamante appointed UC Berkeley Chancellor Robert Birgeneau to the commission as one of four additional California University representatives.

According to a recent issue of Washington Fax, Birgeneau noted that UC Berkeley researchers are working on a synthetic substance to facilitate the growth of new embryonic stem cell lines. “The few lines that are available are unreliable and cannot be propagated indefinitely,” he said.

Those appointed to the ICOC by UC chancellors were Claire Pomeroy, Vice Chancellor for human health sciences and Dean of the School of Medicine, an expert in infectious diseases and a professor of microbiology and immunology; Susan Bryant, Dean of the School of Biological Sciences and professor of developmental and cell biology; Gerald Levey, Vice Chancellor of medical sciences and Dean of the David Geffen School of Medicine, an internist and endocrinologist who oversees the School of Medicine, UCLA Medical Center and UCLA Neuropsychiatric Institute and Hospital; Edward Holmes, Vice Chancellor for health sciences and Dean of the School of Medicine; and David Kessler, Dean of the School of Medicine and Vice Chancellor for medical affairs, who previously served as dean of the Yale University School of Medicine and as Commissioner of the U.S. Food and Drug Administration from 1990 to 1997.

The term for those appointed to the ICOC by the UC chancellors is eight years. The term for Birgeneau and three other California University representatives appointed to the commission by state constitutional officers is six years.

In addition to California University representatives, remaining members of the ICOC are expected to be drawn from state non-profit research institutions, California disease advocacy groups and the biotechnology industry.

For questions regarding articles listed in *Endocrine Insider* or information on advocacy and policy activities within The Endocrine Society, contact the Programs & Policy Affairs department:

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