



August 23, 2010

Donald Berwick, M.D.  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1503-P  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

**Re: Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011; Proposed Rule; CMS-1503-P**

Dear Dr. Berwick:

On behalf of The Endocrine Society (Society), representing more than 14,000 physicians and scientists in the field of endocrinology, we appreciate the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) proposed revisions to the payment policies under the Physician Fee Schedule for calendar year 2011. The Society looks forward to working closely with the Agency as this proposed rule moves toward implementation. Founded in 1916, the Society represents physicians and scientists engaged in the treatment and research of endocrine disorders, such as osteoporosis, diabetes, hypertension, infertility, obesity, and thyroid disease.

The following comments focus on these areas of particular importance to our members:

- 1. DMEPOS Competitive Bidding Program Issues (Diabetic Testing Supplies)**
- 2. Diabetes Self-Management Training (DSMT) Services (HCPCS Codes G0108 and G0109)**
- 3. Identifying, Reviewing and Validating the RVU's of Potentially Misvalued Codes**
- 4. Incentive Payments for Primary Care Services**
- 5. Consultation Code Billing Policy**

**DMEPOS Competitive Bidding Program Issues (Diabetic Testing Supplies)**

The Society has concerns about the potential negative impact that the DMEPOS Competitive Bidding Program (CBP) could have on diabetic patients. However, we are supportive of two proposals included in the proposed rule that we feel are necessary to provide adequate patient safeguards during rollout of the CBP.

First, we agree with CMS's decision to exclude retail settings from the CBP. We believe that this is an important step to help ensure that beneficiaries have the ability to access products from a reliable retail source that will be shielded from any unintended consequences of the CBP while the mail order program is being tested. The Society believes that it is vital that endocrinologists' patients have access to the particular testing systems that are prescribed based on a physician's assessment of each patient. Testing needs vary widely patient-by-patient and each diabetic is managed differently, so different patients will need different testing supplies based on their individual medical and lifestyle needs.

As you are aware, the diabetes community has concerns that a CBP for diabetic testing supplies could limit access to a wide variety of testing products. In the Society's assessment, there is a possibility that suppliers could limit the range of diabetes testing supplies options by only offering the lowest cost versions of those supplies in order to be consistent with a low bid initially offered by the supplier in order to win the bid. It remains unclear how CMS intends to ensure that a wide range of testing supplies will remain available under the CBP and the Society feels that a retail exemption should remain in place until that issue is resolved.

Secondly, the Society welcomes CMS's addition of the proposed Anti-Switching Rule that was added to the CBP with regard to diabetes testing supplies for the same reasons as articulated above. One of the most important aspects of managing diabetes, both as a physician and a patient, is maintaining a comfort level with a monitoring system. As such, the Society strongly encourages CMS to follow through on the Anti-Switching Rule to ensure that patients will have the ability to continue to use the same monitoring and testing systems that they currently use to manage their diabetes. The Society applauds CMS for developing this important rule in order to protect Medicare beneficiaries.

### **Diabetes Self-Management Training (DSMT) Services (HCPCS Codes G0108 and G0109)**

In March 2010 the Society wrote in support of a request submitted by the American Association of Diabetes Educators (AADE) and the American Association of Clinical Endocrinologists (AACE) to review and revalue DSMT HCPCS codes G0108 and G0109. At that time the Society expressed concern that while the need for DSMT continues to rise, patient access to these important programs has decreased, due in large part to inadequate reimbursement for these services.

This inadequate reimbursement was undervalued due to the fact that CMS had not assigned any physician work RVUs to these codes because CMS argued that training would be performed by individuals other than a physician. However, as noted by the petitioners, physicians play an active role in DSMT by coordinating DSMT and providing patient instruction. We thank CMS for recognizing the role of the physician in DSMT and including physician work in the value of DSMT.

### **Identifying, Reviewing and Validating the RVU's of Potentially Misvalued Codes**

The Society strongly disagrees with the elimination of consultation codes in order to boost payment for other evaluation and management (E/M) codes. However, should CMS commit to this approach we believe a detailed examination of the value of all E/M services should be

undertaken. Recent physician workforce studies have concluded that the current income gap between cognitive and procedural medicine plays a large role in shaping the physician workforce. It seems evident that the current payment policy, which favors procedural medicine, is a factor in the workforce shortage seen in cognitive specialties such as endocrinology.

The Society, and many other cognitive specialties, remains concerned that E/M services continue to be undervalued. As such, we would encourage CMS to include E/M services in its ongoing effort to identify and review potentially misvalued codes.

### **Incentive Payments for Primary Care Services**

The severe shortage of endocrinologists and primary care physicians in this country must be addressed in order to ensure that all newly insured patients have access to the care that they require. Any effort to provide health coverage for all Americans will have a greatly blunted impact if the increasing numbers of patients are unable to identify a physician to care for them, a hypothesis borne out by the recent experience with healthcare reform in Massachusetts. The endocrinologist shortage across the country has impaired access to care by patients with diabetes, obesity, metabolic syndrome, thyroid cancer, osteoporosis, pituitary disease, and reproductive disorders. According to a recent analysis of the supply of and demand for endocrinologists, it is standard to encounter waits of 3–9 months, and many endocrinology practices are closed to new patients.

The Society applauds CMS' efforts to provide greater incentives for physicians to choose primary care as their focus through increased payments for primary care services. However, the Society encourages CMS to ensure that other subspecialists who provide a significant amount of E/M services, such as endocrinologists, who are also facing a severe workforce shortage benefit from this payment increase. For many endocrinologists, a majority of their time is spent providing direct patient care in the office setting to new and established patients for continued management of a variety of endocrine disorders. The shortage of endocrinologists will significantly impact the care available to individuals with costly and debilitating endocrine conditions such as diabetes and obesity. The Society respectfully asks that bonuses for primary care physicians be extended to other internal medicine specialists facing workforce shortages and the care of an increasing numbers of patients with high cost chronic conditions.

### **Consultation Code Billing Policy**

The Society would like to again express our deep concern with CMS's elimination of payment for consultation codes in 2010 in order to redistribute the work values for those codes to other E/M services. While we recognize that this was done in order to provide an increase to general practitioners, we strongly disagree with the notion that this increase should come at the expense of other cognitive specialists. CMS had argued that increases in other E/M codes would offset the elimination of the consultation codes, but unfortunately this has not been the case.

According to a recent American Medical Association survey of approximately 5,500 physicians, the vast majority of specialists have seen their payments drop following the elimination of consultation codes -- most by more than 5% -- and three out of every 10 already have reduced

services to Medicare patients or are contemplating other cost-cutting steps that will impact care<sup>1</sup>. Furthermore, a separate membership survey conducted by The Endocrine Society and the American Association of Clinical Endocrinologists found that 96% of those endocrinologists surveyed say their total revenue stream has decreased as a result of Medicare's decision to eliminate the use of consultation codes. In addition, 40% say they have had to modify their practice or services. Of those who made modifications, 69% say they reduced the number of new Medicare patients and 32% say they reduced the amount of time spent with Medicare patients. Clearly, the elimination of consultation codes is hurting cognitive specialists, the field of endocrinology, and Medicare patients.

As we have previously expressed in our comments on this issue, office visits and consultations can be vastly different services and should be valued as such. The decision to place similar value on these services intensifies and lends credibility to the criticism that our current health care delivery system benefits procedural medicine over cognitive practice. We urge CMS to revisit the elimination of payment for consultation codes and work with the cognitive specialists to find a more equitable solution. For instance, the Society recommends that CMS modify two policies—involving prolonged services and new patient definitions--that have compounded the problem caused by elimination of the consultation codes.

In determining whether a service meets the prolonged service criteria, CPT stipulates that, for the inpatient setting, in addition to time spent “face-to-face” with patients, physicians can include time spent on the patients’ floor or unit performing other tasks related to their care. Were CMS to apply the same definition as CPT, consulting specialists could use the prolonged services to obtain fairer reimbursement for particularly long and challenging cases they previously would have billed as consultations. CMS only recognizes the face-to-face time, however, and further discourages coordination of care by essentially denying payment for activities such as creating and reviewing charts, communicating with the family and coordinating with other health care professionals.

Cases where it would benefit a physician to use the prolonged service code are relatively limited and their use could be monitored through claims edits. Consequently, it does not appear that conforming to CPT policy on these codes would lead to large increases in Medicare expenditures and the Society is again requesting that CMS modify its interpretation of the prolonged service codes to match the CPT descriptors.

The issue involving new patient definitions occurs because unlike the consultation codes, visit codes distinguish between new and established patients. The difference can be significant--about \$60 for the most complex office visits—and it affects a substantial number of specialists. In the aforementioned AMA survey, for example, 33% of all respondents and more than 70% of some specialties said that more than 25% of their consultations in 2009 were with patients who had been seen previously by another member of the same specialty and group within the past three years.

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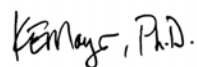
<sup>1</sup> Source: American Medical Association Consultation Codes Survey, June ([www.ama-assn.org/ama1/pub/upload/mm/399/consultation-codes-survey.pdf](http://www.ama-assn.org/ama1/pub/upload/mm/399/consultation-codes-survey.pdf))

In CPT, new patients are defined as those who have not been seen by the same physician or another member of the same group and sub-specialty within the last three years. In Medicare, however, a new patient is one “who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous 3 years. The problem is that physicians often focus on a narrower range of services than are recognized in Medicare’s current list of 42 medical specialties. Thus, for example, if an endocrinologist specializing in diabetes treats a particular patient and two years later, the patient is seen by an endocrinologist specializing in thyroid conditions in the same group, the patient will be viewed as an established patient even though the two endocrinologists have different areas of expertise.

The current situation is inequitable and the Society believes that Medicare should comply with the CPT policy of identifying patients seen by physicians in a different sub-specialty as “new” patients. As pointed out in the June 18 letter signed by the American Medical Association (AMA) and 33 medical specialty organizations, correcting its budget neutrality assumptions would provide some additional funding CMS could use to offset or partially offset any cost associated with this change. We recognize, however, that due to variations in the way that different specialties have dealt with the issue of extended training and focused expertise, setting the criteria for determining Medicare-recognized sub-specialties or equivalent expertise will require some further analysis. The Society would be pleased to assist CMS in identifying endocrinology subspecialties.

The Society appreciates the opportunity to submit these comments regarding CMS' 2011 Physician Fee Schedule. As always, the Society is grateful to CMS staff for the hard work that went into drafting this proposed rule. Please do not hesitate to contact Stephanie Kutler, Director of Government Affairs, at [skulter@endo-society.org](mailto:skulter@endo-society.org), if we may provide any additional information or assistance as CMS moves forward in developing this rule.

Sincerely,



Kelly Mayo, PhD  
President  
The Endocrine Society