

# Dateline Washington

*prepared by the Division of Advocacy and Health Policy*

## **Congress adjourns without enacting payment fix**

Just before their holiday recess, both the U.S. House of Representatives and the Senate passed the Deficit Reduction Act of 2005, S. 1932, which included provisions that would have averted the 4.4 percent across-the-board reduction in Medicare reimbursement for physician services. Instead, the legislation would have frozen 2006 physician payment at the same amount paid in 2005. However, the House and Senate versions differed in a number of respects, and Congress adjourned without reconciling these disparities. As a result, the 4.4 percent Medicare payment cut took effect January 1. Failure to gain passage of S. 1932, which addresses a broad range of spending issues, was unrelated to the Medicare physician payment provisions.

At press time, Congress was scheduled to reconvene on January 31, but it was unclear whether or how soon the interim Medicare payment fix would be enacted. Also uncertain was whether any legislation passed early this year would apply retroactively to services provided on or after January 1. The College and its medical and surgical specialty society partners intend to redouble their efforts in 2006 to advocate for true Medicare reforms that will bring financial predictability to surgical practices.

## **Three Fellows testify on Medicare reform**

On November 17, 2005, three ACS Fellows testified at the House Energy and Commerce Committee Health Subcommittee's hearing, Medicare Physician Payment: How to Build a More Efficient Payment System. Frank Opelka, MD, FACS, a member of the College's Health Policy Steering Committee, provided testimony on behalf of this organization.

In his comments, Dr. Opelka expressed the College's concern that the 4.4 percent cut in Medicare payments that took effect January 1 will have a negative impact on surgeons' ability to practice and, in turn, on Medicare beneficiaries' ability to access needed surgical care. He further demonstrated how the Medicare payment system fails to recognize the unique nature of surgery relative to other physician services and how the methodology, which sets a universal volume target for all physician services under the sustainable growth rate, disproportionately cuts surgical reimbursement.

The subcommittee also heard testimony from two other ACS Fellows: Elizabeth Ann Davis, MD, FACS, on behalf of the Alliance of Specialty Medicine, and Duane Cady, MD, FACS, on behalf of the American Medical Association.

## **CMS reduced Medicare overpayments in 2005**

The Centers for Medicare & Medicaid Services (CMS) recently announced that it reduced improper payments in Medicare fee-for-service by \$9.5 billion last year. According to a CMS report released November 10, Medicare paid providers \$234 billion in fiscal year (FY) 2005, with overpayments totaling \$11.2 billion. Combined with underpayments, which were approximately \$900 million in FY 2005, the total improper claims rate was 5.2 percent, or \$12.1 billion, down from a 10.1 percent error rate and \$20.8 billion overpayment amount in 2004.

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## OIG reports on surgical coding issues

Most FY 2005 errors occurred in physician codes, totaling \$4.2 billion in overpayments. With respect to physician services, evaluation and management (E/M) codes accounted for the highest rate of error. Significant problems with billing for surgical dressings also were noted.

On December 12, 2005, the Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services posted two reports pertaining to the incorrect use of procedure code modifiers as specified by Medicare's Correct Coding Initiative.

The first report, *Use of Modifier 59 to Bypass Medicare's National Correct Coding Initiative Edits* (OEI-03-02-00771), shows that the -59 modifier, which indicates distinct and payable procedure or service was provided to a patient on the same day as another procedure service, was used incorrectly 40 percent of the time in FY 2003. Specifically, modifier -59 was used inappropriately with 15 percent of code pairs because the services were indistinct from each other and with 25 percent of code pairs because the services were inadequately documented. The OIG also found that 11 percent of code pairs billed with modifier -59 were paid when the modifier was billed with the incorrect code, resulting in \$27 million in erroneously paid claims. The OIG recommended that CMS: (1) encourage carriers to conduct prepayment and postpayment reviews of the use of modifier -59, and (2) ensure that carriers' claims-processing systems only pay claims with modifier -59 when it is billed with the correct code.

The second report, *Use of Modifier 25* (OEI-07-03-00470), pertains to the modifier used to allow additional payment for E/M services provided on the same day as a procedure. Separate payments are allowed, as long as the E/M services are significant, separately identifiable, and above and beyond the usual preoperative and postoperative care associated with the procedure. The OIG found that 35 percent of claims for E/M services allowed by Medicare in 2002 did not meet program requirements, resulting in \$538 million in improper payments.

## ACS comments on databases in quality improvement

At a meeting hosted by CMS on December 8, R. Scott Jones, MD, FACS, Director of the ACS Division of Research and Optimal Patient Care, presented information about the College's clinical databases and answered questions from participants about their potential use in improving the quality of surgical care. Dr. Jones described the content and uses of information collected by the National Cancer Data Base, the National Trauma Data Bank™, and the ACS National Surgical Quality Improvement Program. Fred Edwards, MD, FACS, also participated in the meeting and provided a similar perspective on the Society of Thoracic Surgeons National Data Base and its evaluation of cardiothoracic procedures.