

# Dateline Washington

prepared by the Division of Advocacy and Health Policy

## Medicare proposes revised enrollment procedures

The Centers for Medicare & Medicaid Services (CMS) announced in April its plans to revise procedures for physicians and suppliers to enroll in Medicare and secure a billing number. The stated goal is to simplify enrollment requirements and ensure that only qualified health care suppliers and providers participate in the program.

Of particular importance, the new rules require physicians and suppliers to recertify the accuracy of their information every three years. In addition, any enrolled provider or supplier that does not bill the program for two consecutive quarters will be automatically “deactivated” until they begin submitting bills again. (Special consideration will be given to pediatricians and others who bill Medicare infrequently.)

In a related move, the *CMS 855 Provider/Supplier Enrollment Application* was revised last November. The CMS 855 is now a set of individualized forms, each geared toward a specific physician or supplier type. The proposed regulation and the revised application may be accessed by going to: <http://www.cms.gov/providers/enrollment/forms/>.

## Medicare updates list of ambulatory procedures

Medicare has updated the list of procedures that may be performed in an ambulatory surgical center (ASC) effective July 1. The list, which was last updated in 1995, has been revised to include 283 new procedures. In addition, 139 services were deleted from the list.

A link to the file containing revisions to the ASC list is available on the College’s Web site at [www.facs.org/newsscope/nso41103.html#1](http://www.facs.org/newsscope/nso41103.html#1).

## Legislation to limit work hours is reintroduced

On April 30, Sen. John Corzine (D-NJ) reintroduced legislation to limit resident work hours. The Patient and Physician Safety & Protection Act, S. 952, places the following limits on resident work hours: 80 hours per week; 24 hours per shift, plus an additional three hours for transferring patient care (12-hour limit for emergency room shifts); and nights on call in the hospital should be no more than every third night. In addition, the bill would require outside work to count against the 80 hours, at least 10 hours off-duty between scheduled shifts, and at least one full day out of every seven days off, and one full weekend off per month.

The bill further provides “whistle-blower protections” and states that any hospital that violates these restrictions is subject to a civil monetary penalty of up to \$100,000 for each residency program in any six-month period.

Senator Corzine’s bill is almost identical to legislation introduced in March by Rep. John Conyers (D-MI). However, Representative Conyers’ bill, H.R. 1228, does not permit an additional three-hour extension of a resident’s shift for the transfer of patient care, nor would it restrict moonlighting or give hospitals an opportunity to submit a corrective action plan in order to avoid paying the monetary penalties. The College opposes both bills.

---

## **New members elected to the RUC**

New members were elected to the AMA/Specialty Society RVS Update Committee (RUC) at the panel's spring meeting in April. Of particular interest, Robert M. Zwolak, MD, FACS, was elected to the RUC. Dr. Zwolak has represented the vascular societies as an advisor to the RUC for several years, and he is a member of the College's General Surgery Coding and Reimbursement Committee.

Also of interest, William L. Rich III, MD, FACS, an ophthalmologist who is also a member of the College's Health Policy Steering Committee, was selected chair of the RUC. The RUC is a broadly representative panel of physicians and surgeons who review and make recommendations to CMS on Medicare fee schedule relative value units for new, revised, and existing procedure codes.

## **College backs plan to avert 4.2 percent cut**

CMS is projecting another cut in physician payment next year. In a March letter to Glenn Hackbrath, chair of the Medicare Payment Advisory Commission (MedPAC), the director of CMS's Center for Medicare Management, Thomas Grissom, projected a -4.2 percent update for 2004. CMS attributes this reduction to the increased volume and intensity of physicians' services and a lower real gross domestic product per capita than previously estimated.

MedPAC's recommendation suggests that the Secretary of Health and Human Services establish an update framework similar to those used for other Medicare services. In addition to changes in the input prices, the framework would include components to reflect changes in all other factors affecting the cost of delivering physician services, including changes in the volume and intensity of physician services due to new technology, site of service shifts, and practice patterns, among others. Physician updates would be based solely on beneficiary needs and the cost of providing physician services.

## **Congressional budget resolution identifies priorities**

On April 11, Congress completed consideration of the fiscal year (FY) 2004 budget resolution that will guide the federal spending decisions made in coming months. While the resolution does not call for spending reductions in Medicare or Medicaid, it does call upon the committees with jurisdiction over these programs to identify by September 2 changes in law that would achieve savings through the elimination of waste, fraud, and abuse. In addition, the General Accounting Office is required to submit a report by August 1 on legislative changes that would allow the committees to "improve the economy, efficiency, and effectiveness of programs" within their jurisdictions.

Also of interest, the resolution:

- Earmarks \$400 billion for Medicare reform with prescription drug coverage.
- Provides a \$50 billion reserve fund over 10 years to increase access to health insurance for the uninsured.
- Increases Medicaid spending by 9 percent in 2004, and earmarks a \$8.9 billion reserve over five years for Medicaid reform.