Dateline Washington

prepared by the Division of Advocacy and Health Policy

House passes Patients' Bill of Rights

On August 2, the House of Representatives passed an amended version of H.R. 2563, the Bipartisan Patient Protection Act of 2001. The original bill was introduced by Reps. Greg Ganske, MD, FACS (R-IA), John Dingell (D-MI), and Charlie Norwood (R-GA), and supported by the College. However, earlier this year President Bush indicated his opposition to the legislation because of provisions pertaining to health plan liability.

During the debate, three amendments to the bill were offered: (1) an expansion of medical savings accounts; (2) the establishment of medical liability reforms for physicians, hospitals, and other health care providers; and (3) a compromise proposal reached between Representative Norwood and the President that placed restrictions on health plan liability. The expansion of medical savings accounts and the Norwood/ Bush compromise both passed on essentially party-line votes, with Republicans supporting both amendments. The medical liability reform amendment, which was strongly supported by the College, lost on a vote of 208-221. The final amended bill passed the House by a vote of 226-203.

The House bill must be reconciled with different legislation that the Senate passed in early July. Most important, the House-Senate conference committee that should begin meeting in the fall will need to find common ground on the health plan liability issue. For example, the House bill limits noneconomic damages to $1.5 million, while the Senate bill contains no cap on noneconomic damages.

ACS comments on Medicare five-year review

On August 7, the College submitted comments to the Center for Medicare and Medicaid Services (or CMS, formerly the Health Care Financing Administration) on the proposed notice giving the results of the five-year review of the physician work values listed in the Medicare fee schedule. The five-year review began in March 2000 when the ACS identified 314 CPT codes in 31 general surgery procedure families as being misvalued. The codes were referred by CMS to the AMA/Specialty Society Relative Value Scale Update Committee (RUC) for revaluing. Ultimately, CMS accepted the RUC's work value recommendations for 278 codes in 25 different procedure families. However, the agency rejected the RUC's recommendations for 36 codes, because the suggested values would have produced rank order anomalies within the six service families involved. Instead, CMS followed the advice of the College and increased the work for all 36 codes. The changes made during the five-year review of physician work translate into a 4 percent average increase in payments to general surgeons in 2002, assuming all else remains constant.

The most controversial issue addressed in the proposed rule involved inclusion of critical care in the valuation of certain procedure codes (in which critical care is a routine part of the postoperative care). CMS questioned whether Medicare might be making duplicate payments for critical care—once to the surgeon and once to another physician assigned to the intensive care unit. The agency made clear that it will not change Medicare's critical care payment policy in 2002, but asked

for comments on various changes that could be made for 2003. The College objected strongly to all the proposed changes because they would violate the ethical standards of the College on postoperative care, as well as Medicare's own global surgery policy. Futhermore, the College was joined by 30 other specialty societies, including most major groups with members who provide critical care, in signing a letter urging that no policy or payment changes be made.

CMS proposes changes in payment policies

CMS published its plans for continuing to refine the resource-based practice expense relative value units in a proposed rule on the 2002 Medicare fee schedule that was issued on August 2. The draft regulation also proposed a number of payment policy changes for 2002, none of which is expected to have a significant impact on surgical services.

The proposed rule did, however, seek information pertaining to payments for co-surgeons (CPT modifier -62); that information could be used to decide whether a policy change for 2003 is necessary. CMS appears to be concerned about two things: (1) the possibility that a surgeon can seek much higher reimbursement as a co-surgeon than as an assistant at surgery; and (2) whether it is possible to set a more precise payment amount for co-surgery. (Currently, both of the co-surgeons are paid 62.5 percent of the Medicare fee schedule amount, as opposed to an assistant at surgery who is paid 16 percent of the primary surgeon's global service amount.)

This proposed rule also projected the changes in payments that would result from the five-year review of work, the changes made to practice expense relative value units, and other miscellaneous changes. The big "winner" is general surgery with a 4 percent increase. Other gains were made by vascular surgery (with a 2 percent increase) and thoracic surgery, urology, and obstetrics/gynecology (with 1 percent increases). Ophthalmology took a 1 percent loss. These estimates must be interpreted with some caution, however, since the annual update that will be applied to the fee schedule conversion factor in 2002 is not yet known (and may, in fact, be a negative number).

PROs ordered to disclose information

In a recent decision, a judge in Washington State ordered the CMS to force peer review organizations (PROs) to give Medicare beneficiaries access to reports on investigations into complaints about substandard care. PROs were created initially to ensure that services provided to Medicare beneficiaries were reasonable and necessary, in addition to investigating beneficiary complaints and violations of the Emergency Medical Treatment and Active Labor Act. Until this recent decision, CMS has barred PROs from disclosing information on investigations, fearing physicians would not cooperate with reviews or speak honestly about events if the results could be used against them in malpractice lawsuits. The agency is currently reviewing the decision to determine whether to appeal or seek a stay of the order.