

## Senate and House of Representatives Approve 12-Month Medicare Payment Patch

Both houses of Congress recently passed a yearlong Medicare payment patch that effectively blocks an impending 25 percent reduction in the Medicare payment rate called for by the sustainable growth rate (SGR) formula. The legislation marks the fifth and longest physician payment patch enacted in 2010. American Academy of Family Physicians (AAFP) President Roland Goertz, MD, MBA, of Waco, Tex., said the vote will temporarily end the series of short-term patches that occurred throughout 2010, but that it is only one step toward a permanent solution to the flawed SGR formula “that threatens deep Medicare payment cuts and the financial viability of primary care physician practices.” During the next year, the physician community and Congress must work together to put an SGR patch in place for three to five years that will include a differential payment for primary care physicians, Goertz said, noting that this will give payment reform demonstrations enough time to produce the evidence that should underlie any permanent replacement to the current poorly structured formula. Goertz warned that “family physicians cannot sustain practices in an environment with both stagnated Medicare payment and monthly or semi-monthly threats of deep cuts in Medicare (payment).” For more information, visit <http://www.aafp.org/news-now/government-medicine/20101209finalpatch.html>.

## Positive Changes in CPT Codes for Childhood Vaccinations, Medicare Allowances

The annual revision of the American Medical Association’s (AMA’s) Current Procedural Terminology (CPT) manual holds some positive changes for family physicians. Specifically, the AMA’s *CPT 2011* says that as of January 1, 2011, physicians can use CPT code 90460 for administration of immunizations to children via any route of administration, with counseling provided by a physician for the first vaccine or toxoid component; and CPT code 90461 for each additional vaccine or toxoid component that is listed separately and is in addition to the code for the primary procedure. The updated codes for childhood vaccines take into account the professional time required to counsel parents or caregivers of children receiving the vaccine. That counseling includes an explanation of each component of a multiple-component vaccine. In other news related to CPT codes, recent data show that Medicare allowances for CPT codes 99213 and 99214 have seen a slow but steady cumulative rise of 42 and 35 percent, respectively, over

the past six years. The increase in payment for these two CPT codes is important to family physicians because these codes represent basic office visits. AAFP Director Thomas Felger, MD, of Granger, Ind., pointed out that family physicians take care of a majority of the country’s older patients, estimating that Medicare patients account for 20 to 30 percent of the average family physician’s patient panel. “If these payment increases flow over into the private sector—and that’s what usually happens—that means family physicians will see better payment across the board for the cognitive work that we’re doing,” said Felger. For more information, visit <http://www.aafp.org/news-now/practice-management/20101201cptcodesrise.html> and <http://www.aafp.org/news-now/practice-management/20101130pedvaccinecodes.html>.

## Primary Care Benefits from GME Training Provision in Health Care Reform Law

One provision of the new health care reform law specifies that hospitals’ unused graduate medical education (GME) slots be redistributed to hospitals in regions with health professional shortages that want to expand or establish primary care or general surgery residency programs. The Centers for Medicare and Medicaid Services’ (CMS’) final rule implementing GME redistribution was published November 24, 2010, in the *Federal Register* and went into effect January 1, 2011. According to an analysis of the rule by the Council of Academic Family Medicine (CAFM), CMS has set up processes to determine which hospitals are subject to reductions in their caps and how large those reductions will be, how hospitals that want to obtain increases in their caps can apply to do so, and what criteria will be used to determine which hospitals will receive increases. To receive additional slots, hospitals must demonstrate that they can fill the slots, and then they will be evaluated according to certain other criteria to determine their priority ranking to receive the increases. The analysis by the CAFM outlines the preference categories identified by CMS in descending order: urban hospitals that have an accredited rural training track, hospitals located in areas that have resident physician-to-population ratios in the lowest quartile, hospitals located in areas that are among the top 10 in numbers of persons living in primary care health professional shortage areas (HPSAs), and hospitals located in rural areas. In addition to geographically based preferences, CMS will give preference to hospitals that will use the additional slots to establish a new or expand an existing primary care program with a demonstrated focus on training residents

to pursue true primary care careers; establish a new or expand an existing geriatric medicine program; expand an existing program for which the hospital can demonstrate that more than 50 percent of residents completing it go on to practice in rural areas, primary care HPSAs, or federally designated medically underserved areas; or expand an existing emergency medicine program in which residents train in primary care HPSAs. For more information, visit <http://www.aafp.org/news-now/resident-student-focus/20101201hcreform-gmeredistrib.html>, <http://edocket.access.gpo.gov/2010/2010-27926.htm>, and <http://stfm.org/Summary%20Final%20GME%20regulation%2011-10.pdf>.

### **CDC Issues Recommendations for Lead Exposure During Pregnancy and In Utero**

The Centers for Disease Control and Prevention (CDC) recently released new guidelines to help physicians identify and manage lead exposure in pregnant and lactating women. The guidelines also address management strategies for infants exposed to lead in utero. According to the guidelines, blood lead levels of 5 mcg per dL (0.24 µmol per L) or higher in pregnant women indicate previous or ongoing lead exposure. The following groups are at increased risk, according to the CDC: recent immigrants from areas with high lead levels in the environment, women who work with lead, certain racial and ethnic groups, and women who practice pica (i.e., eating nonfood items such as pottery, clay, and dirt). Women and children also can be exposed to lead during renovations of older homes. The CDC guidelines will be reviewed by the AAFP's Commission on Health of the Public and Science. In 2006, the AAFP endorsed the U.S. Preventive Services Task Force recommendation against routine screening of pregnant women for elevated blood lead levels. However, the recommendation acknowledged that certain groups of women were at increased risk of lead exposure, including those who have a low income, live in an urban residence, have low educational attainment, use ethnic remedies, use certain cosmetics, have exposure to lead-glazed pottery, use alcohol, and smoke. For more information, visit <http://www.aafp.org/news-now/clinical-care-research/20101208leadguidelines.html> and <http://www.cdc.gov/nceh/lead/publications/LeadandPregnancy2010.pdf>.

### **IOM Updates Vitamin D, Calcium Guidelines, Report Says Deficiency Is Overestimated**

The number of persons in the United States and Canada with vitamin D deficiency may be overestimated because of inconsistent testing methods, according to a report from the Institute of Medicine (IOM). Members of the IOM committee that reviewed dietary reference intakes for the two nutrients said there has been a large and

unnecessary increase in the number of tests for vitamin D levels in recent years, that vitamin D testing should not be part of routine medical care, and physicians should instead assess individual patients for risk factors. The panel's findings confirmed the benefits of calcium and vitamin D related to bone health. However, reviews of about two dozen other health outcomes—including cancer, cardiovascular disease, hypertension, and diabetes mellitus—found insufficient and sometimes conflicting data regarding the nutrients' benefits. The IOM committee determined that the level of serum 25-hydroxyvitamin D that is needed for good bone health in most persons is 20 ng per mL (50 nmol per L), and national surveys in the United States and Canada indicate average blood levels are above that mark. The report said a considerable overestimation of the levels of vitamin D deficiency exists in North America because of the current use of cut-points that exceed 20 ng per mL, including some higher than 50 ng per mL (125 nmol per L). A recommended daily allowance (RDA) of 600 IU was set for patients ranging in age from one to 70 years. For those older than 70 years, an RDA of 800 IU is advisable. RDAs for calcium varied more widely by age group and gender. For more information, visit <http://www.aafp.org/news-now/health-of-the-public/20101201iomrpt-vitdcal.html> and <http://www.iom.edu/Reports/2010/Dietary-Reference-Intakes-for-Calcium-and-Vitamin-D.aspx>.

### **AAFP Makes Minimum Implementation Timeline Change to METRIC Program**

A recent modification in the AAFP's performance improvement program, Measuring, Evaluating and Translating Research Into Care (METRIC), means physician practices will have more flexibility when it comes to implementing practice changes. The required minimum implementation period for METRIC dropped to one month, a change from the previous three-month minimum period. The program combines evidence-based medicine with education, gives physicians the opportunity to evaluate how they manage chronic diseases, and then encourages practices to make systematic changes to improve patient outcomes. Susan Richart, AAFP's manager of performance assessment and improvement, said the change would help physicians "maximize their flexibility." For more information, visit <http://www.aafp.org/news-now/cme-lifelong-learning/20101208metricchange.html> and <http://www.aafp.org/online/en/home/cme/selfstudy/metric.html>.

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