

CMS Rule Would Kick “Problematic” Doctors Out of Medicare/Medicaid

Last week CMS announced that beginning January 1, 2020, they assumed a new power to bar clinicians' participation if agency officials can cite potential harm to patients based on specific incidents (1). CMS created this new authority through the 2020 Medicare physician fee schedule. CMS claimed that it had no pathway to address "demonstrated cases of patient harm" in cases where clinicians maintain their licenses (2).

The rule drew criticism from multiple physician groups with none supporting it. The Alliance of Specialty Medicine said CMS has been using "vague and subjective" criteria to evaluate physicians for some time. The new revocation authority "just compounds the problem," the Alliance told Medscape Medical News (2).

In drafting the final version of the rule, CMS rejected many suggestions offered in comments about the revocation authority. The AMA pointed out that CMS hid such a major change in the annual physician fee schedule under the opioid treatment program section (2). The Association of American Medical Colleges (AAMC) said CMS should defer to state medical boards and other state oversight entities regarding issues associated with protecting beneficiaries from patient harm (2). In the final rule, CMS argued that it needs the new revocation authority due to cases where "problematic" behavior persists despite detection by state boards.

During the past week two examples of CMS' bureaucratic nature were observed in my practice. First, I was told from a durable medical equipment provider that a new CMS requirement was that when reordering patient continuous positive airway pressure (CPAP) supplies that I would need to check, initial and date each item from a long list of supplies whether it was ordered or not. Second, an asthma patient was referred to me that was using daily albuterol. I recommended a long-acting beta agonist/corticosteroid combination but was told that the patient must fail corticosteroids alone before prescribing the more expensive combination therapy. Nearly every physician and many patients have seen some nameless and faceless clerk at CMS give them the "ol' run around". CMS' argument that they are improving quality and protecting patients would be more believable if these and the many other instances of bureaucratic overreach were rare rather than common.

Many "quality" programs have been thrust on clinicians in the past without any demonstrable improvement in healthcare for patients (3). Rather quickly these programs morph from a quality program to a hammer used to control clinicians and suppress dissent. It seems likely that CMS' new self-assumed authority will be the same. If CMS wishes to improve care, they should deal with examples such as those above and many more instances of time wasting paper work and poor care that they mandate. Two recommendations to reduce these poor decisions are: 1. List the name of the licensed practitioner responsible for each CMS decision; and 2. Establish an efficient appeals process not controlled by CMS. These would reduce the instances of

poor, anonymous decision makers hiding behind the anonymity of the CMS bureaucracy and could go a long way in improving patient care.

Richard A. Robbins, MD
Editor, SWJPCC

References

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