August 10, 1999

Eugene Ogrod, MD, JD, Chair
Practice Expense Advisory Committee
Relative Value Systems
American Medical Association
515 North State Street
Chicago, IL 60610

Re: Consensus Statement on Refinement of Practice Expense Data

Dear Dr. Ogrod:

The goal of the undersigned organizations is to provide a fair and credible process for moving ahead with refinements of practice expense relative value units (PE-RVUs). We recognize that a fair and credible process requires:

- Consistency in the definitions and processes used; and
- A refinement methodology that it is driven by objective data inputs, rather than subjective judgments.

Accordingly, the undersigned organizations urge the PEAC to adopt the following process for refining practice expense direct cost inputs:

1. Develop a priorit y list for reviewing the direct practice expense cost inputs for all CPT codes, using CPEP data as the starting point.

   The highest priority services for which practice expense inputs should be reviewed and commented upon by the PEAC are services that are commonly performed and whose expenses are stable over time. All CPT codes should be evaluated using these criteria. The first set of services considered would then serve as reference services for subsequent practice expense comparisons.

2. Adopt standards for considering direct cost practice expense data.

   A. The highest standard is data collected using a standardized validation survey instrument (such as the one attached) that is adopted by the PEAC for use in validating CPEP data.

   The standardized CPEP data validation survey should meet certain standard requirements similar to those for RUC work surveys, such as:

   1. Minimum response rates (30 should be required);
   2. Standard data reporting (such as mean and median responses); and

3. Standard data collection of direct costs typically provided with the service (such as the time and type of clinical staff labor, frequency and type of equipment, and the frequency and type of supplies utilized).

B. The second highest standard is other supporting data collected by third parties on direct practice costs, such as the annual survey data collected by the Medical Group Management Association.

C. The third highest standard is consensus panel data developed by specialty societies.

Specialty societies may use any data source that they choose to develop direct practice cost recommendations, however data collected using a standardized CPEP data validation survey instrument will be considered more favorably than data collected using other supporting data or a consensus panel.

In addition, similar to the CPEP process where certain services were designated as reference services within a family of services. PEAC-approved reference services can be used as anchor codes for other services within the same family of codes that have similar practice expenses.

D. In considering direct cost practice expense data, standard definitions of non-physician work should be established as follows to properly distinguish between physician work and practice expenses. These definitions are as follows:

4. **Physician-equivalent/professional work** --work that substitutes for physician work (work the physician would otherwise have to do him/herself. Such labor should be included in the work RVUs, not PE-RVUs. Work that is being billed separately by NPs, CNSs, or PAs should not be included in the PE-RVUs;
5. **Specialized clinical labor** --clinical labor that is separate and distinct from physician work (for instance, services of licensed practical nurses, lab technicians, etc). Specialized clinical labor would be considered a direct practice expense;
6. **General office staff labor** --labor that does not require specialized training and skills, such as those provided by front office staff. General office staff labor would be considered an indirect practice expense.

E. Standard definitions of non-physician (specialized clinical labor and office staff labor) pre-, intra-, and post-service time should be established. These definitions are as follows:

7. Pre-Service Staff Time: starts after office visit that determines surgery/procedure is needed and ends with admission.
8. Intra-Service Staff Time: starts with hospital admission and ends at discharge.

9. Post -Service Staff Time: starts with hospital discharge and ends with last office visit for global period.

3. Utilize a prefacilitation process. Prefacilitation teams of PEAC members appointed by the PEAC Chair should consider recommendations brought before the PEAC. The goal of the prefacilitation teams is to include the clinical specialties that are familiar with the service in question, generalist physicians, and non-physician practitioners, including non-clinician experts. Such a process should expedite the PEAC review process. The model for the PEAC prefacilitation process should be the prefacilitation process utilized by the RUC for the initial five year review of the Medicare Physician Fee Schedule.
4. Validate the prefacilitation recommendation by reviewing the prefacilitation recommendation before the full PEAC and taking a formal vote (following the RUC procedure for voting).
5. Present the PEAC recommendation to the RUC on a consent calendar, with the RUC having the ability to extract items that merit discussion, for final approval and formal recommendation to HCFA.

In conclusion, the undersigned organizations wish to assist the PEAC in its efforts to produce valid direct practice expense cost estimates and will continue to work with the PEAC to do so.

Sincerely,

American Academy of Family Physicians
American Academy of Neurology
American Academy of Pediatrics
American Academy of Physician Assistants
American College of Physicians-American Society of Internal Medicine
American College of Rheumatology
American Geriatrics Society
American Medical Directors Association
American Nurses Association
American Osteopathic Association
American Society of Clinical Oncology
Renal Physicians Association