June 30, 2000

Nancy-Ann DeParle, Administrator
Health Care Financing Administration
Department of Health and Human Services
Hubert H. Humphrey Building, Room 443-G
200 Independence Avenue, SW
Washington, DC 20201

Attention: HCFA-1111-IFC
(Criteria for Submitting Supplemental Practice Expense Survey Data)

Dear Ms. DeParle:

On behalf of the American College of Physicians-American Society of Internal Medicine (ACP-ASIM), the nation's largest medical specialty society representing more than 115,000 doctors of internal medicine and medical students, I am writing to comment on the Health Care Financing Administration's (HCFA) interim final rule regarding criteria for submitting supplemental practice expense survey data, published in the May 3, 2000 *Federal Register (25,664*), and additional practice expense refinement issues.

Supplemental Practice Expense Survey Data

ACP-ASIM generally concurs with HCFA's proposed method and standards for accepting supplemental practice expense survey data submitted by August 1, 2000. ACP-ASIM supports the following HCFA standards:

- Physician groups must draw their sample from the American Medical Association (AMA) Physician Masterfile. Physician groups must arrange to have AMA send the sample directly to the survey contractor to ensure confidentiality of the sample.
- Non-physician specialties not included in the AMA Socioeconomic Monitoring Survey (SMS) must develop a method to draw a nationally represented sample of members and non-members.
- A group (or its survey contractor) must conduct the survey based on the SMS survey instrument and protocols. Any cover letter or other information furnished to survey sample participants must be consistent with information previously supplied by the SMS contractor.
- A group must use a contractor that has experience with the SMS or a survey firm with experience successfully conducting national, multi-specialty physician surveys using a nationally representative random sample.
- A group must submit all raw survey data, including complete and incomplete survey responses, along with any cover letter or other information that accompanied the survey to HCFA by August 1, 2000.
- Survey data must include data on the six categories that HCFA uses to develop code-specific practice expense RVUs—clinical labor, medical supplies, medical equipment, administrative labor, office overhead, and other.

- General principles to ensure the supplementary data is reliable (coefficient of variation standard of 10% or less or 95% confidence interval) must be met; nationally representative survey sample should be demonstrated; and documentation of potential deviation from national representation must be provided.
- HCFA will use methods to standardize supplemental data to the SMS data by using the Medicare Economic Index and a weight average with existing SMS data.

Practice Expense Refinement Recommendations

ACP-ASIM has developed seven recommendations to assist in the refinement of the practice expense methodology and data inputs. The recommendations are as follows:

Recommendation 1: HCFA should update the practice expense survey data using data from the 1997 and 1998 SMS surveys and use such data for refining the practice expense relative value units (PE-RVUs) for the calendar year (CY) 2001 updates.
Rationale: ACP-ASIM and other medical specialty societies have previously expressed concern that the SMS data used for the development of PE-RVUs is 4-6 years old. More recent SMS data is available to HCFA and it should be utilized.

Recommendation 2: HCFA should establish a modifier to allow for documentation of non-physician clinical staff that provide services in a facility setting, for implementation on January 1, 2001. This modifier would allow for additional payment for such expenses that are documented based on established criteria. The criteria would include documenting that the service provided is a not a substitute for physician work and that it is not duplicating services already provided by the facility.
Rationale: For several years there has been on-going dialogue between HCFA and members of the physician community regarding the use of physician clinical staff in the facility setting. Because the issue is still unresolved, ACP-ASIM believes the best way to determine the utilization rate of physician clinical staff in the facility setting is to develop a coding modifier that specifically identifies this practice expense. This modifier could also be used to provide payment for these practice expenses.

Recommendation 3: HCFA should incorporate any reasonable code level refinements that come through the AMA RUC/PEAC process, or directly in comments to HCFA, for the CY 2001 updates.
Rationale: ACP-ASIM is somewhat concerned at the slow rate of modification to the practice expense components of individual procedure codes and strongly encourages HCFA to consider reasonable code refinement recommendations.

Recommendation 4: HCFA should consider appointing facilitation panels, consisting of physicians that provide the service most frequently, physicians in related specialties, primary care physicians, carrier medical directors, nurses, office staff, and other non-physician practice cost experts to make recommendations on code-level refinements that are submitted to HCFA in response to the Notice of Proposed Rulemaking on the CY 2001 updates. Such panels would meet in August-September in order to have their recommendations incorporated into the CY 2001 updates.

Rationale: ACP-ASIM recommends that HCFA establish a multi-specialty panel process to consider code level refinements to practice expense data inputs as a corollary to the historical process that HCFA has used for refinement of work RVUs. This process is necessary to validate the decisions made by HCFA on the practice expense data recommendations provided to HCFA under recommendation 3 above.

Recommendation 5: HCFA should conduct the sensitivity analyses recommended by the U.S. General Accounting Office (GAO) and include the results of such analyses in the CY 2001 updates.
Rationale: ACP-ASIM agrees with the February 1999 GAO report "Medicare Physician Payments: Need to Refine Practice Expense Values During Transition and Long Term," recommendation that sensitivity analysis is needed to determine the effects of various adjustments to the practice expense methodology and data. Without knowing how a particular methodological or data change will effect the physician fee schedule, it is difficult to determine that acceptability of such a change.

Recommendation 6: HCFA should establish a methodology to accept a "j" code for unusual equipment costs associated with a procedure, propose the methodology in the 2001 proposed rule, and allow for payment for such costs beginning on January 1, 2002.
Rationale: Equipment utilization rates have been an ongoing source of confusion throughout the development and refinement of the resource-based practice expense methodology. HCFA should alleviate the concerns of those physicians whose practice expenses are unusually high due to the type of patient they serve. One way to do so would be to allow physicians to bill for atypical, unusual costs that are not properly captured in the practice expense data by billing "j" codes in addition to the regular CPT procedure code.

Recommendation 7: HCFA should make the practice expense RVUs that will be implemented on January 1, 2002 as interim RVUs for a minimum of another three years, during which HCFA will consider comments for further code-level refinements.
Rationale: As is stated above, ACP-ASIM is somewhat concerned at the slow rate of modification to practice expense components of individual procedure codes and therefore recommends that the comment period for individual codes remain open beyond the original refinement deadline established by HCFA.

Conclusion

ACP-ASIM supports HCFA's proposed method and standards for accepting supplemental practice expense survey data and has the following practice expense refinement recommendations:

1. HCFA should update the practice expense survey data using data from the 1997 and 1998 SMS surveys and use such data for refining the practice expense relative value units (PE-RVUs) for the calendar year (CY) 2001 updates.

2. HCFA should establish a modifier to allow for documentation of non-physician clinical staff that provide services in a facility setting, for implementation on January 1, 2001.

3. HCFA should incorporate any reasonable code level refinements that come through the AMA RUC/PEAC process, or directly in comments to HCFA, for the CY 2001 updates.

4. HCFA should consider appointing facilitation panels to make recommendations on code-level refinements that are submitted to HCFA in response to the Notice of Proposed Rulemaking on the CY 2001 updates.

5. HCFA should conduct the sensitivity analyses recommended by the U.S. General Accounting Office and include the results of such analyses in the CY 2001 updates.

6. HCFA should establish a methodology to accept a "j" code for unusual equipment costs associated with a procedure, propose the methodology in the 2001 proposed rule, and allow for payment for such costs beginning on January 1, 2002.

7. HCFA should make the practice expense RVUs that will be implemented on January 1, 2002 as interim RVUs for a minimum of another three years, during which HCFA will consider comments for further code-level refinements.

ACP-ASIM strongly supports the concept of a resource-based relative value system for Medicare and have developed the seven recommendations above in an effort to address practice expense refinement concerns expressed by physicians. ACP-ASIM would like to meet with HCFA to discuss these refinement ideas in greater detail. Please contact John P. DuMoulin, ACP-ASIM's Director of Managed Care and Regulatory Affairs, at phone 202-261-4535, to arrange an appropriate meeting date. Thank you for full consideration of these comments.

Sincerely,

Cecil B. Wilson, MD, FACP, Chair
Medical Services Committee