asim
american society of internal medicine

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Project Officer, RBPE Study
Health Care Financing Administration
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Baltimore, Maryland 21244

Dear Dr. Levy:

On behalf of the American Society of Internal Medicine (ASIM), I am writing this letter to provide the Health Care Financing Administration (HCFA) with ASIM's observations on the clinical practice expert panel (CPEP) direct cost data and resource-based practice expense (RBPE) methodologies. These comments were drafted based upon the input of the ASIM CPT/RBRVS Refinement committee, which has representatives from the following specialities: general internal medicine, gastroenterology, pulmonology, rheumatology, cardiology, nephrology, oncology, and neurology.

Discussion of CPEP Data

The ASIM CPT/RBRVS Refinement committee reviewed the CPEP direct cost data in detail for the evaluation and management (E/M) services CPEP 7 and the miscellaneous internal medicine CPEP 10.

Compression of Administrative Time Estimates

ASIM is concerned that the E/M CPEP concluded that direct administrative staff time was uniform for all levels of services within each family of evaluation and management services. For example, the CPEP found that new office visits all incurred 60 minutes of direct administrative staff time and that established office visits all incurred 30 minutes of direct administrative staff time. While we concur that billing and initial scheduling administrative time is essentially the same across levels of service within an E/M family of services, other administrative tasks such as transcription of records, writing out referrals and coordinating referrals with managed care entities, scheduling follow-up visits, and other administrative follow-up regarding the patient's chart will increase as the level of visit increases.

Clearly, there is more administrative work involved with handling the medical records for a more complex level five patient encounter than a simple routine level two patient encounter, because there will be more records to handle. For example, lab reports, procedure and consultant reports, pharmacy interactions, and ancillary service reports all must be coordinated with the patient record. This comment pertains to the direct administrative staff time estimates for new office visits, established office visits, office consults, hospital consults, follow-up hospital consults, confirmatory consults, emergency department visits, nursing home visits, rest home visits, and home visits. The only place in the CPEP estimates that this concept is followed is under the initial hospital visit codes, to some extent, but we argue that even here the ratio of direct administrative staff time

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between the level three visit and the level one visit should be higher. The direct staff administrative costs should not be compressed into a single estimate for all levels of services within an E/M family, but should increase in an incremental fashion from the lowest level of service to the highest level of service.

Compression of Clinical Time Estimates

While we have less of a concern with the compression of direct clinical staff time estimates for E/M services because there is some incremental increase from the low level services to the high level services within a family of E/M codes, we do believe that the estimates for the higher level E/M services are undervalued compared to the lower level services within the same family of codes. For example, the typical face-to-face physician time for new office visits are 10 minutes for level one, 20 minutes for level two, 30 minutes for level three, 45 minutes for level four, and 60 minutes for level five. The CPEP direct clinical staff time for these services are 30 minutes for level one, 40 minutes for level two, 50 minutes for level three, 55 minutes for level for level four, and 60 minutes for level five. The ratio of direct clinical staff time to face-to-face physician time for these services is 3 to 1 for level one, 2 to 1 for level two, 1.67 to 1 for level three, 1.22 to 1 for level 4, and 1 to 1 for level five. While we don't expect the ratio to remain 3 to 1 for all levels of service within the family, this ratio should not fall from 3 to 1 for the lowest level service to 1 to 1 for the highest level service. We believe that this estimate undervalues the amount of direct clinical staff time provided to the patient on the higher level E/M codes and is evidence that the CPEP estimates compress the true relative direct clinical staff time relationship for E/M services.

This compression between the low and high levels of service is worse for the established patient office visit codes where the ratio of direct clinical staff time to physicians face-to-face time is 3.6 to 1 for level one and falls to 0.95 to 1 for level five. More complex services in any setting lead to disproportionate procedure scheduling with instructions to nursing staff, patient education, injections, patient phone calls, referral calls by nurses to other providers, and interaction with the patient's family. This problem also occurs for the direct clinical staff time estimates for office consults, hospital consults, follow-up hospital consults, confirmatory consults, emergency department visits, nursing home visits, rest home visits, and home visits.

Subsequent Hospital Visits and Hospital Discharge Day Services

ASIM is particularly concerned with the zero time estimates for direct clinical staff time for subsequent hospital visits and the hospital discharge day service. While it is clear that the estimates for the subsequent hospital visits should be lower than the initial hospital visit, they are certainly higher than zero. Clinical staff provide service to hospital patients when they answer phone calls from the patient's family, often educating the patient family regarding the patient's continuing medical needs, and coordinate clinical care with the family and other providers that will be working with the patient once the patient is released from the hospital to the home or to another setting. The clinical staff also often spends time discussing that patient's care with the patient's insurance company or the hospital, which wants to discharge the patient as soon as possible. This is particularly true on the day of discharge. While the physician determines the subsequent hospital care and discharge orders and indicates the continuing care that the patient needs, the physician relies upon his/her clinical staff to carry out those orders. These services are legitimate, commonly provided, and should be recognized.

We notice that they have been recognized for hospital consults, which have a direct clinical staff time

estimate of 12 minutes and follow-up hospital consults which have a direct clinical staff time estimate of 6 minutes. The amount of direct clinical staff time provided for the subsequent hospital visits is higher than the estimate for hospital consults and the time associated with discharge services is even greater than that.

Nursing Home Visits

The direct administrative staff time estimates for nursing home visits are also undervalued. Rather than estimates of 20 minutes for assessments and 10 minutes for follow-ups, these estimates should be more of the magnitude of new patient office visits and established patient office visits respectively. Again, we believe that the CPEP considered only billing time and did not consider other administrative tasks such as coordinating frequent phone calls from the nursing facility and the patient's family, and orders that must be presented to the physician for signature and sent back to the nursing facility. These administrative tasks can be more cumbersome when the physician is providing the service out-of-the-office.

Prolonged Visits

The direct clinical staff time for prolonged office visit codes is undervalued. In order for a physician to bill for a prolonged office visit (99354) the physician must, by definition, spend 30 to 74 minutes beyond the typical time for the level of service being billed for the patient encounter. So, by definition, the direct clinical staff time must be more than the 28 minutes estimated. A more reasonable direct staff time estimate is the midpoint of the definitional parameters, 52 minutes. The estimate for the prolonged service add-on code (99355) is more reasonable, but again, should be higher. We also disagree with the zero direct clinical staff time estimates for the prolonged hospital service codes, for the reasons discussed in the comments above regarding subsequent hospital visits.

Discussion of the RBPE methodology

Linking

It is our understanding that HCFA believes that the relativity within the CPEPs appear to be valid, pending further validation, but that there are significant variations in the estimates across CPEPs and that HCFA staff have suggested addressing this problem by linking the CPEPs, which would be done by scaling all the direct costs to clinical and administrative staff costs of codes studied by more than one CPEP. When the ASIM CPT/RBRVS Refinement Committee reviewed the CPEP 10, miscellaneous internal medicine data they found the estimates to be comparatively higher than the estimates in the E/M CPEP 7. This evidence supports a linking process.

Conceptually, ASIM agrees with a linking approach. It is unclear, however, how HCFA would standardize the staff costs of the redundant codes, since the CPEP estimates for the redundant codes also varied across the panels. We do not believe that it would be appropriate to average together all of the clinical and administrative staff times from the various CPEP estimates for each redundant code to create a single standardized time per code estimate, since this would tend to bias the estimates towards the high end. Median staff time estimates, or a weighted average approach that gives more weight to the CPEP estimates from the specialty that provides the redundant services most often, are alternative approaches that should be considered. Since the method of linking will be critical to the validity of the

entire resource based practice expense relative value scale and it will not be possible to evaluate the appropriateness and validity of the proposed practice expense RVUs until more is known about the mathematical models for linking and their potential impact, ASIM urges HCFA to provide more information on the potential mathematical models for linking the direct cost estimates from each CPEP before determining the model that will be selected.

Direct vs. Indirect Expenses

ASIM still questions HCFA's method of determining that the total pool of direct costs is 55% of total practice expense RVUs and that 45% is indirect costs. We would like to see a more specific explanation of this determination, including the data used to determine the overall split between direct and indirect practice expenses. Based upon committee discussion, such a split is not representative of internal medicine practice, the specialty that provides care to more Medicare patients than any other.

Allocation of Indirect Practice Expenses

ASIM believes that physician time should be the primary method of allocation of indirect practice expenses rather than staff time. Physician time estimates have been discussed and validated over many years. Physician time was discussed and refined in the original Harvard relative value data and again during the five year review of the Medicare fee schedule, whereas staff time has only been discussed in the CPEP process and has not been validated. ASIM has concerns with many of the direct staff time estimates and using these estimates to also allocate indirect practice expenses will exacerbate existing anomalies and inconsistencies in the direct cost data. A more practical and conservative method of allocating indirect costs is to use physician time, which has been through a rigorous review and refinement process.

While ASIM understands that HCFA may be favoring a blended approach that takes into account both physician time and staff time to take into account both the services that incur large amounts of staff time without large amounts of physicians time, we believe that such services should be handled separately. Perhaps using physician time will not be the best method to allocate indirect expenses for services provided by certain medical specialties such as pathology and radiology, but we believe that using physician time is the best allocation method for other specialties and the most refined allocation methodology should not be thrown out because it doesn't work as well for a minority of services. If HCFA does decide to use a blended approach, then ASIM would urge HCFA to weight physician time more highly than staff time.

ASIM appreciates full consideration of these comments. If you have any questions regarding these comments, please contact ASIM's Director of Managed Care and Regulatory Affairs, John DuMoulin, at (202) 466-0299 or <jdumoulin@asim.org>.

Sincerely,

Glenn D Littenberg, MD /100

Glenn D. Littenberg, MD, Chair
CPT/RBRVS Refinement Committee