July 1, 1996

Bruce Vladeck, PhD., Administrator
Health Care Financing Administration
Department of Health and Human Services
Room 309-G Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201
Attn: BPD-846-PN

Dear Dr. Vladeck:

On behalf of the American Society of Internal Medicine (ASIM), I am writing to express our overall support for the notice of proposed rulemaking regarding the five year review of the Medicare physician fee schedule. ASIM appreciates the reliance that the Health Care Financing Administration (HCFA) places on the American Medical Association RVS Update Committee (RUC), as evidenced by the fact that HCFA accepted 93 percent of the RUC recommendations for work value adjustments on twelve hundred codes. ASIM urges HCFA to accept the RUC's recent comments that accept HCFA's proposals regarding evaluation and management services and global surgical services as well.

ASIM supports HCFA's decision to increase the work relative value units (RVUs) for evaluation and management (E/M) services. We applaud HCFA for recognizing that E/M services are currently undervalued in comparison to other services in the Medicare physician fee schedule and that the pre- and post-service work for E/M services has increased over the past five years. Since the proposed increases in work RVUs are relatively modest and are far less than the increases recommended by the RUC for many categories of E/M services, we must emphasize that ASIM's support for HCFA's proposal assumes that the work RVUs for E/M services that will be implemented on January 1, 1997, are no lower than those proposed. Specific comments on the proposal affecting E/M services follow below.

ASIM also strongly supports HCFA's proposal not to increase the work relative values of surgical services with global periods. ASIM agrees with HCFA's rationale that these services should not be increased to reflect the increases in the E/M work relative values because such a change would undermine the proper reevaluation of E/M services. If HCFA were to agree to changes that would erode the proposed increase in E/M services, such as would be the result if HCFA agreed to increase global surgery fees, then ASIM would likely conclude that we could no longer support HCFA's proposal. Specific comments on HCFA's consideration of surgical services with global periods follows on page 2 of these comments.

I. Evaluation and Management Services

ASIM strongly supports HCFA's recommendations relating to evaluation and management services. ASIM believes however, that such increases represent a modest step forward in correcting the historical undervaluation of E/M services given the extensive evidence presented by ASIM, the RUC, and other commenters that the work RVUs for many E/M services should be increased by much more than HCFA is now proposing. We are encouraged by HCFA's acknowledgment that intra-service work intensities of evaluation and management services have been undervalued and should be increased by at least 10 percent (except for the level one established patient visit) to bring them closer to the intraservice work intensities of the procedural services; and post-service physician work involved in providing evaluation and management services has increased over the past five years and the percentage of pre-service and post-service work should be increased by at least 25 percent (except for office consults). However, there are several actions that ASIM suggests HCFA take in order to improve the proposed changes to E/M services: (1) increase the pre- and post-service work for office consultations by at least 25 percent rather than 10 percent; and (2) recognize that the data the RUC presented HCFA is sufficient evidence to remain open to receiving further information that shows the relationships between some families of E/M services have changed.
ASIM does not accept HCFA's rationale that pre- and post-service work for office consultations should only be increased by 10 percent because the consulting physician does not assume on-going

management of the patient until the next face-to-face visit. As managed care has increased, greater emphasis on communication and documentation justifying the referrals between the primary care physician and the consulting physician have greatly increased the pre- and post-service work associated with office consults. Similar to other E/M services, the pre- and post-service work for office consultation services have increased because of the following factors: (1) increased documentation requirements; (2) increased time and effort required for obtaining and providing referrals for tests; (3) increased coordination with other health professionals and family members; (4) and increased patient education. In addition, the referring physician often relies on the consulting physician to assist in the on-going management of the patient. Commonly, telephone follow-up with patients regarding responses to new therapies started, results of tests stemming from the consultation, and patients' concerns regarding flare-ups or relapses in their condition are necessary. Oversight of patients' high risk medication in conjunction with the referring or primary physician providing other face to face visits with the patients are commonly done via periodic phone calls and review of pertinent lab tests. Thus, an office consult rarely involves simply the examination of a patient and transcription of a consulting report. We argue that HCFA should recognize this fact and increase the pre- and post-service work for office consultations by at least 25 percent rather than 10 percent.

HCFA should be open to a reexamination of its assumption that the relationships between E/M services have not changed. The RUC did present a persuasive rationale, supported by survey data, that suggests that the work of some categories of E/M services have increased more than some other E/M services. While HCFA did not accept the original RUC data, it should be open to accepting new data and additional persuasive rationale that shows that the relationships between some E/M services have changed.

II. Global Surgery

ASIM agrees with HCFA's decision to maintain the current work RVUs for global surgical packages. No compelling evidence was presented to the RUC or to HCFA that would support a conclusion that these services should be increased simply because the E/M values deserve to be increased. This issue should be studied further before changes in the global surgical values are made. We concur that the underlying philosophical rationale for increasing the work RVUs for evaluation and management services (i.e., their historic undervaluation), by definition makes corresponding across-the-board increases in the work RVUs for all global surgical packages inappropriate.

In addition, the assumption that work RVUs for E/M services and global surgical services are directly related has not been validated. As is stated in the rule, the specific components of post-service work supporting changes in E/M services indicate that pre-operative and post-operative visits are not of equal magnitude and should not be increased across-the-board. ASIM agrees with HCFA's rationale that the documentation requirements for surgical follow-up visits are clearly lower than for an established patient office visit, and that the predictability of post-operative visits reduces the amount of time necessary to provide these services. Therefore, there is no justification to increase the value of global surgical services simply because E/M services have increased in value.

ASIM does support the RUC's proposal to examine this issue further in 1997. We believe that such a reexamination should include the following:

1. HCFA and the RUC should not assume that the work involved in surgical global services has increased or decreased across-the-board. Rather, HCFA should require compelling evidence that the work involved in a specific global service has changed before making any adjustments in the work RVUs for that service code. ASIM believes that it is likely that if the work involved with some surgical global services has increased, for others the work will have decreased over the past five years.

2. HCFA and the RUC should examine changes in practice patterns that may have shifted care of post-operative patients from surgical specialties to general primary care specialties over the past five years. It is likely that some of the pre- and post-operative care that was provided by a surgeon in the past, as part of the global service, is now provided by another physician. Several

examples of this pattern are as follows: (1) management of coronary bypass patients has reduced inpatient lengths of stay from 10-12 days five years ago to 5-7 days today because of the coordination of care provided by cardiologists in conjunction with general internists, case management nurses, and others providing much of the postoperative care for the patient; and (2) hip and other joint replacement surgery where patients are transitioned to skilled nursing or other transitional sites and are seeing greater coordination of care by general internists, physical therapists, and nurse specialists. These are examples ofpost discharge office visits by surgeons not increasing in number or complexity, but actually decreasing.

3. HCFA and the RUC should use external data such as changes in length of stay to validate proposed changes in the work RVUs for global surgery. A reduction in inpatient length of stay, for example, may indicate that the number of post-operative visits has decreased.

4. HCFA and the RUC should reexamine the number of pre- and post-operative visits that are assumed to be included in the global surgery fee.

5. HCFA and the RUC should examine if the complexity level of history, examination, and medical decision-making of the visits that are included in the global surgery services has increased, decreased, or stayed the same.

III. Budget Neutrality

ASIM continues to believe that budget neutrality adjustments made as a result of the annual revision of the Medicare physician fee schedule should be made via a separate budget neutrality factor that will preserve the relationships of the work relative value units. The optimal budget neutrality adjustment methodology would make the budget neutrality adjustments to the work relative values in a manner that does not disrupt actual work values or the integrity of the different pools of physician work, practice expense, and malpractice insurance expense. If such a methodology is not possible, then ASIM agrees with HCFA's proposal to make the budget neutrality adjustments for the purpose of the five year review only to the work values. The five year review resets the work values into proper alignment. Making a budget neutrality adjustment across all the work RVUs will not upset the proper alignment of these values. However, a change in the absolute RVU figure will distort the ultimate payment made when these adjusted RVUs are adopted by other payers. In the future therefore, HCFA should begin using a separate budget neutrality adjustment factor.

ASIM appreciates the opportunity to comment on the five year review of the Medicare fee schedule proposed rule. If you have any questions regarding ASIM's comments, please contact ASIM's Director of Managed Care and Regulatory Affairs, John P. DuMoulin, at (202) 466-0299 or asimdumoulin@mem.po.com.

Sincerely,

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President

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