February 11, 1997

Lauren Leroy, PhD
Executive Director
Physician Payment Review Commission
2120 L St., N.W., Ste. 200,
Washington, DC 20037.

Dear Lauren:

On behalf of the American Society of Internal Medicine (ASIM), I am writing to share with you our comments on draft Chapter 15, Medicare Fee Schedule issues. We may be providing you with comments on additional chapters in the near future.

Resource Based Practice Expenses

ASIM agrees with the Commission that there is no reason to conclude now that implementation of methodologically sound resource based practice expenses (RBPEs) should be delayed. A final determination on whether or not the methodology that will be proposed by HCFA will meet the standards of face validity and soundness necessarily must await review of the proposed rule, and following publication of the proposed rule, the practice expense RVUs as further refined by HCFA. Only if the proposed practice expense RVUs, and the methodology used to develop them, are found to lack face validity should any reconsideration be given to the current timetable for implementation. There is no reason to conclude now that the methodology that HCFA is in the process of developing will lack face validity, however.

We concur with the Commission's view that it would be a mistake to abandon the current timetable or process by seeking a legislative delay from Congress. As the Commission appropriately notes, there are no data that are likely to be obtained by further delay, and it is essential to remedy the long-standing inequities created by the flawed charge-based RVUs.

ASIM is currently in the process of reviewing the CPEP data and the methodological options released by HCFA in January. We do have concerns that some of the methodological options presented by HCFA appear to produce problematic results. Under some of the options, practice expense RVUs would not increase in a linear fashion with the duration of the visit. We believe that visits that require more physician time incur higher overhead costs, particularly clinical and administrative staff costs. Some of the CPEP estimates also seem to undervalue the clinical staff time associated with in-hospital visits and consultations. Despite these concerns, ASIM intends to work constructively with HCFA to refine the methodology and data to make improvements within the current timetable established by law. We are providing HCFA with detailed comments on the CPEP data, on methods of linking the CPEPs, and on ways to allocate indirect costs.

It would be helpful for the Commission to comment on some of the methodological options presented by HCFA. 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. HCFA project 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. Conceptually, ASIM agrees with this 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 ASIM believes that it is essential that HCFA share for public comment the different mathematical models for linking the CPEP data before determining precisely which is the best approach. Since the method of linking will be critical to the validity of the entire resource based practice expense relative value scale, ASIM urges that the Commission address this issue in its report to Congress and provide recommendations on appropriate models for linking the direct cost estimates from each CPEP.

HCFA is also considering allocating indirect costs by staff time, physician time, or a blend of the two. ASIM concurs with the Commission's view that physician time appears to be a valid approach for allocating indirect costs, although some blend of physician and staff time may be appropriate. If a blended approach is used, we believe that more weight should be assigned to physician time. Physician time has the advantage of not only being a good surrogate for indirect costs, but of having been validated through the Harvard study and the five year review of the RBRVS. By comparison, staff time was derived from the CPEP data and therefore has not been subject to review and validation.

ASIM also concurs with the Commission's view that a refinement process must be established. We believe that the RVUs that are implemented on 1/1/98 should be interim RVUs subject to further refinement. Since the interim RVUs will benefit from further refinement, it would be appropriate for HCFA to be conservative in its interim RVUs to avoid the problems that would be created by "overshooting" (implementing interim practice expense RVUs that upon further refinement may be found to be too low) or "undershooting" (implementing interim RVUs that upon refinement may be found to be too high). The Commission should consider making a similar recommendation in the report to Congress.

ASIM is not yet persuaded that a transition will be necessary as the Commission recommends. If a transition is provided, and if Congress also decides to delay implementation for another year, then we agree with the Commission's view that the transition should be shortened by the duration of the delay. We also recommend that the Commission provide a more detailed set of options on how a transition might occur--i.e. what would be the blend of historical and resource-based practice expenses; would all RVUs be transitioned over three years or would some that fall within a specified range of the final RVUs (e.g. within 90-110% of the final RVUs) be fully implemented on 1/1/98; how should problems of an asymmetrical transition be avoided, etc. The Commission will recall that the asymmetrical transition that occurred when the work RVUs first were implemented in 1992 resulted in a much larger budget neutrality adjustment than otherwise would have been necessary, since more services received higher RVUs in 1992 than saw lower RVUs. It is essential that the Commission provide HCFA and Congress with some guidance so that such a problem does not recur with implementation of practice expense RVUs.

ASIM also urges the Commission to advise HCFA that a behavioral offset adjustment should not be applied to the practice expense RVUs. Such an adjustment will increase the reductions and reduce the gains from implementation of RBPEs. As the Commission has noted in the past, HCFA's view that implementation of resource-based work RVUs would result in increased volume from a behavioral offset has not been borne out by the data.

Five Year Review and Global Surgery

ASIM agrees with the Commission's view that a direct translation from the increases in the nonsurgery-related E/M services to the E/M components of global surgery is not necessarily correct. We agree that the work of E/M services in global surgical services is not likely to be identical and equivalent to that of separately billed E/M services. We especially support the Commission's observation that the increased documentation that is required for E/M services is not required for

E/M services that are bundled into global surgery services. We also agree with the observations that there is a lack of precision with which the E/M content of global surgical services was estimated when the fee schedule was first derived and that changes have occurred in the E/M component of surgical services since the inception of the RVS, such as reductions in lengths of stay.

The RUC considered this issue its February 7-9 meeting. After first rejecting the results of an analysis that would have directly increased the E/M component of global surgical services by the non-surgical E/M increases, based on an assumption that the work involved in surgical post-operative codes is exactly equivalent to those of an office visit of comparable intra-service time, the RUC developed a compromise approach. The RUC's approach would reduce the assumed number of post-operative visits in the hospital by CPEP data on reduced lengths of stay; provide the full E/M increase for the remaining in-hospital post-operative visits; increase the work RVUs for post-operative visits provided in the office setting by the full amount of the increase for intra-service work for office visits that involve the same face-to-face time; and provide half of the increase for the post-service work of the post-operative visits provided in the office as was given to to office visits with the same intra-service time (i.e. a 15 minute post-operative visit provided in the office would get the full increase given for the intra-service work of a 99213, but only half of the post-service work increase given to a 99213 under the five year review). The decision to provide only half of the increase for post-service work was in recognition of the fact that surgical post-operative services involved less documentation and other post-service work than office visits.

Although the RUC compromise was an improvement over the original proposal, ASIM does not believe that it meets the "compelling evidence" standard that the RUC used for all other changes recommended during the five year review. Use of unvalidated length-of-stay data from the CPEPs is not a sufficient enough basis for determining how the number of post-operative visits provided in the hospital may have changed over time. We do not believe that it can be assumed that the intra-service work of the post-operative visit is the same as for a subsequent hospital visit that involves the same amount of face-to-face time. We similarly question the decision to increase the post-operative visits in the office by the same amount as the intra-service increase for the office visits, since this assumes (without any data to support this) that the intra-service work is equivalent. Although we agree with the RUC's conclusion that post-operative visits provided in the office involve less post-service work than office visits, we question the basis for determining that the post-service work is as high as half of that for the office visit.

ASIM believes that the Commission should indicate in its report to Congress that the RUC recommendation does not sufficiently address the concerns identified in this draft chapter about changes in lengths of stay, the uncertainty of the original Harvard estimates, and the differences in the post-service work of nonsurgical and surgical E/M services. Simply put, the RUC did not develop compelling evidence that the intra-service work of the E/M component of global surgery is equivalent to that of nonsurgical E/M services, that the post-service work of the post-operative visits provided in the office is half that of office visits that have the same face-to-face time, or that the current number of visits assumed to be included in the global surgery services, based largely on out-dated Harvard data adjusted by unvalidated CPEP estimates, is necessarily correct. The Commission should re-affirm its view that increases in the E/M component of global surgery should be considered only when compelling evidence that takes into account all of these factors is presented to HCFA.

We appreciate the opportunity to comment on these issues as discussed in the draft report. Please call me at 202-466-0283 if you have any questions.

Sincerely,

Robert B. Doherty
Vice President
Governmental Affairs and Public Policy