August 15, 1997

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, D.C. 20201

Attention: BPD-884-P

Dear Dr. Vladeck:

On behalf of the American Society of Internal Medicine (ASIM), representing the nation's largest medical specialty, I am pleased to submit the enclosed comments on the Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Other Part B Payment Policies, and Establishment of the Clinical Psychologist Fee Schedule for Calendar Year 1998; Proposed Rule, published in the June 18, 1997 Federal Register.

Thank you for full consideration of these comments.

Sincerely,

Alan Nelson, MD
Executive Vice President
I. Resource-Based Practice Expense Relative Value Unit System

The American Society of Internal Medicine (ASIM) understands that legislative developments have delayed implementation of a final rule on a resource-based practice expense (RBPE) relative value unit (RVU) system until January 1, 1999. Nevertheless, we understand that the Health Care Financing Administration (HCFA) still intends to review comments on this proposed rule. These comments will assist HCFA in refining the proposed RBPE RVU system. We encourage HCFA to use these comments in developing a second proposed rule on RBPEs with a 90 day comment period, as mandated by the Balanced Budget Act of 1997.

1. CPEP Data Should Be Used to Develop Direct PE RVUs

ASIM believes that the data from the Clinical Practice Expert Panels (CPEP) should be considered as a principal and valid source that may be used to develop direct practice expense (PE) RVUs. We strongly believe, however, that HCFA must provide sufficient opportunity to further refine CPEP data and make modifications in the proposed direct PE RVUs as appropriate. Additional data from specialty societies and other sources should also be considered as appropriate.

In general, ASIM determined that the CPEP data on direct practice expenses represent a valid basis for beginning to construct direct PE RVUs, pending further refinement. We base this conclusion on the following:

A. ASIM conducted a representative survey of members regarding the CPEP 7 clinical and administrative staff times of evaluation and management (E/M) services. 185 members were surveyed, and 44 responded (a response rate of 23.8%). The number of respondents exceeded the number that the American Medical Association RVS Update Committee (RUC) requires for surveys on the physician work of new and revised codes. The survey respondents’ median and mode staff time responses for each E/M codes were the same as the CPEP estimate, except for the prolonged services codes 99356 and 99357, which the respondents suggested had higher administrative times (7.5 minutes and 10 minutes vs. 5 minutes). Although these survey responses are not by themselves conclusive, they do suggest that the CPEP estimates are reasonable.

B. Several ASIM members conducted their own informal "reality check" by comparing the CPEP estimates with actual internists’ practices. They did this by adding the CPEP estimates of
administrative and clinical staff times for E/M services, multiplied by the actual number of visits over a period of months and compared this with the actual staff hours recorded over this time period in these practices and found a very close correlation. This analysis, although also not conclusive by itself, supported the validity of the CPEP estimates for E/M services.

C. ASIM’s CPT/RBRVS Committee, composed of ASIM members that represent various practice types and the subspecialties of general internal medicine, nephrology, neurology, rheumatology, pulmonology, oncology, and gastroenterology, reviewed and determined that the direct PE RVUs do increase with the required amount of physician time for each level visit, albeit not in a one-to-one ratio (the direct costs are higher per unit of time for the lower level visits than for the higher ones). Because indirect practice expense RVUs are also imputed based on the direct practice expenses, physician work, and malpractice insurance expense, visits with more physician work--and more direct practice expense RVUs--have more indirect RBPE RVUs. These results at least partially address the concerns that ASIM raised in a February letter to HCFA that addressed the preliminary data released in January. Our review of the preliminary data suggested that the direct and indirect practice expense of higher level E/M services may have been undervalued in HCFA’s preliminary analysis. (As noted later in these comments, ASIM has some suggestions on modifying the formula for indirect RBPE RVUs). The committee also concurs that the direct RBPEs of out-of-office visits, such as initial and subsequent hospital visits, should be lower than for in-office visits. The proposed rule provides for very modest direct RBPE RVUs for hospital visits, hospital consultations, and hospital discharge day services, with substantially higher indirect PE-RVUs for those same services--which also makes sense, since one would expect that the indirect costs of running an office while a hospital visit or other out-of-hospital service is being provided would be substantially higher than the direct equipment, supplies, and clinical and administrative staff associated with those services.

D. The impact of HCFA’s methodology on each specialty is very consistent with what would have been expected based on previous studies (Harvard, Physician Payment Review Commission, Health Economics Research, Pope and Burge), even though each used different methodologies.

E. The CPEP process itself was designed to assume that the estimates were derived from a representative sample of physicians and other experts (nominated by specialty societies) who had knowledge of the practice expenses involved with the services that they reviewed. Small group decision-making is a well-established and accepted approach to developing resource-based RVUs. The latter phases of the Hsiao study, the process used by the RUC in developing recommendations on work RVUs, and HCFA’s own work RVUs refinement panels have all demonstrated that small group decision-making, supplemented by other data, can develop valid work RVUs. It is reasonable to conclude that small group decision-making, as represented by the CPEPs, is an equally valid approach to developing direct resource-based practice expense RVUs.

F. ASIM also conducted a survey of the direct practice expense RVUs of the 75 procedures most commonly billed by internists using the ASIM-validated E/M direct practice expense RVUs as a baseline comparison. The survey of over 30 members that are very knowledgeable on practice expenses (ASIM’s Board of Trustees, CPT/RBRVS Committee, and RBPE Validation Panel nominees) concluded that, in general, the direct RBPEs were correct. However, they have uncovered what appears to be some anomalies and errors in the PE RVUs for certain services that should be corrected in future refinements of this proposal. These services are described in the following section.
2. Recommendations for Changes in Direct PE RVUs for Specific Codes

ASIM believes that HCFA should re-examine the direct PE RVUs for the following codes:

31625 Bronchoscopy with biopsy should have a higher practice expense RVU than diagnostic bronchoscopy (31622) because biopsies use more equipment and supplies. In addition, sending a biopsy out for a pathology report and receiving that information will increase administrative staff costs. For many colonoscopy procedures, the difference in PE RVUs due to a biopsy is 0.06 RVUs. For this procedure there is no difference at all.

43239 Upper GI endoscopy with biopsy should have a higher practice expense RVU than diagnostic upper GI endoscopy (43235) because biopsies use more equipment and supplies. In addition, sending a biopsy out for a pathology report and receiving that information will increase administrative staff costs. For many colonoscopy procedures, the difference in PE RVUs due to a biopsy is 0.06 RVUs. For this procedure there is no difference at all.

45378 There are two listings for a diagnostic colonoscopy in the proposed rule and they are not clearly differentiated. We believe the second listing with the lower work values is for a discontinued procedure and should be listed with a modifier -53. The in-office PE RVUs are consistent with other colonoscopy procedures, but the out-of-office PE RVUs for this service are much lower than other colonoscopy codes. We believe this must be a typographical error that needs to be corrected. For example, 45380 (colonoscopy and biopsy) has a work value of 4.01 RVUs, direct practice expense of 3.66 RVUs, malpractice expense of 0.40 RVUs, a direct out-of-office practice expense of 0.14 RVUs, and a total out-of-office practice expense of 1.14 RVUs. These values are all very similar to 45378 except for the total out-of-office practice expense value. 45378 has a work value of 3.70 RVUs, direct practice expense of 3.55 RVUs, malpractice expense of 0.39 RVUs, a direct out-of-office practice expense of 0.14 RVUs, and a total out-of-office practice expense value of only 0.41 RVUs. If the other values for 45378 are correct, then the resulting out-of-office practice expense value should be 1.08 RVUs, not 0.41 RVUs.

62270 It is our understanding that the American Academy of Neurology has presented information regarding diagnostic spinal fluid tap to correct the CPEP information regarding supplies used and equipment utilization in the procedure. We encourage HCFA to consider this new information.

71010 Chest X-ray, single view, has the same proposed direct practice expenses in and out of the office. CPEP data indicates that labor and supplies are substantially less in the out-of-office setting and therefore the out-of-office direct practice expense RVUs should be reduced.

71015 Chest X-ray, stereo frontal view, has the same proposed direct practice expenses in and out of the office. CPEP data indicates that labor and supplies are substantially less in the out-of-office setting and therefore the out-of-office direct practice expense RVUs should be reduced.

71020 Chest X-ray, two views, has the same proposed direct practice expenses in and out of the office. CPEP data indicates that labor and supplies are substantially less in the out-of-office setting and therefore the out-of-office direct practice expense RVUs should be reduced.

90918-The Renal Physicians Association has indicated to us, and we concur, that the Monthly 90922 Capitated Payment (MCP) for End-Stage Renal Disease (ESRD) services is undervalued in the proposed rule. The services indicated by the MCP for ESRD services do not represent a single procedure but rather a series of evaluation and management (E/M)
services provided over a month’s time in conjunction with the administration of the patient’s dialysis prescription. Every E/M service that has historically represented a "building block" component code of the MCP experienced an increase in the proposed rule, therefore the PE RVUs for the MCP should be adjusted upward as well.

93350 Echo transthoracic has the same proposed direct practice expenses in and out of the office. CPEP data indicates that labor and supplies are substantially less in the out-of-office setting and therefore the out-of-office direct practice expense RVUs should be reduced.

95819 It is our understanding that the American Academy of Neurology has presented information regarding incorrect CPEP information regarding supplies used and equipment utilization in this procedure. We encourage HCFA to consider this new information.

95925 It is our understanding that the American Academy of Neurology has presented information regarding incorrect CPEP information regarding supplies used and equipment utilization in this procedure. We encourage HCFA to consider this new information.

99239 Hospital discharge day services should not have an in-office practice expense value. This appears to be a typographical error, the other hospital discharge day code (99238) and hospital visit codes do not have in-office practice expense RVUs.

We also note that many procedures have the same direct in-office PE RVUs and out-of-office RVUs. We encourage HCFA to revisit these procedures to determine if indeed the in-office and out-of-office RVUs should be the same.

3. Most Data Editing Rules are Appropriate

ASIM reviewed HCFA’s proposed edits to the CPEP data, and believe that most of the edits are defensible. However, ASIM does not concur with the edit which eliminates the administrative staff costs associated with procedures that include a “ZZZ” indicator. While it is true that these services are always billed with another procedure, this does not mean that there is not an additional administrative expense for billing the procedure. This situation is similar to the proposed reduction in administrative staff time for multiple E/M and procedural services billed on the same day, which we object to later in these comments.

4. Linking is Appropriate, but More Information is Needed

ASIM agrees with HCFA that the relative relationships within CPEPs are correct, but the relationships between CPEPs need to be normalized to bring the relative estimates to a single scale otherwise the proposed RBPE RVU system would not truly contain “relative” values. We agree with the methodology of separately linking clinical and administrative cost estimates using CPEP data on services that were evaluated by multiple CPEPs (redundant codes). We agree that it is appropriate to use CPEP 7 (evaluation and management services) as the linking base because (1) E/M services are billed by more physician specialties than any other family of services (2) E/M services were included in the services evaluated by each CPEP; and (3) the direct PEs RVUs for E/M services as determined by CPEP 7 have face value validity, and therefore represent a reliable basis for linking all of the CPEPs on a common scale. Because the linking methodology has a major impact on the redistribution of practice expense relative values we request that HCFA provide more information regarding the mathematical model used in making the linkages. We also encourage HCFA to consider other approaches to linking if presented by other commenters. These alternative approaches could be offered for comment in a proposed rule next Spring.
We strongly urge HCFA not to accede to any recommendation to eliminate the links between CPEPs. A relative value scale requires that all services be placed on a common scale. If the direct PE RVUs of each CPEP are not linked, the result would be separate and distinct relative value scales for each family of services, as rated by their own CPEP, rather than a common scale. Further, if the CPEPs are not linked, the PE RVUs that result would not be truly resource based, as the law mandates. Depending on which CPEP rated the service, some services would receive more direct PEs RVUs than another set of services that involve the same relative practice expense costs, simply because the experts on one CPEP uniformly applied higher estimates of direct PE costs than their colleagues in another CPEP.

It should be noted that a similar linking methodology as has been proposed in this NPRM was used by the Hsiao study in developing the original work RVUs that formed the basis of the Medicare RBRVS. The RUC also uses cross specialty linkages when it develops recommendations to HCFA on work RVUs. It is well-established that an appropriate linking methodology is an essential element of a resource-based relative value scale, and that linkages should be applied in developing both physician work and PE RVUs.

5. Allocation of Indirect Practice Expenses Needs Further Refinement

ASIM supports HCFA’s proposal to allocate indirect costs based on direct costs (nonphysician administrative and clinical labor, medical equipment, and medical supplies), physician work, and malpractice insurance expense. This proposal is similar to the Physician Payment Review Commission model presented in 1993. We agree that using only physician time or staff time as an allocation method results in an incomplete set of practice expense RVUs because such methods fail to consider other variables that can contribute to indirect costs. However, we believe that this proposal should be refined to make allocation of indirect expenses more accurately reflect the specialty variation in indirect practice expenses.

ASIM supports HCFA’s approach of dividing total practice expense RVUs into two pools of RVUs (55% direct and 45% indirect) for all physician services based upon the American Medical Association (AMA) Socioeconomic Monitoring Survey (SMS) data in order to calculate appropriate scales for each pool of RVUs. However, ASIM does not agree with using the 55% direct/45% indirect split to allocate indirect PE-RVUs. Although this may be appropriate in terms of defining the typical proportion of direct and indirect PEs spread across all physician services, it may not be the appropriate proportion for any one specific service because the direct/indirect split varies based upon physician specialty. Rather than using a fixed factor of 0.219 to scale indirect PE RVUs to the available pool of RVUs, this factor should vary based on the percentage of indirect and direct practice expense RVUs billed by each specialty. Using the Medicare BMAD billing data files, HCFA should be able to determine the specialties that predominately bill for each individual service. HCFA could also use the AMA SMS data to determine the direct versus indirect costs for those specialties for each individual service. The common 0.219 scaling factor could be multiplied by a weighted average of indirect practice expenses for those specialties that actually perform the service rather than a generic scaling factor based upon all specialties.

The following example illustrates ASIM’s recommendation: three specialties account for 95% of the Medicare billings for procedure “AA.” According to the BMAD data, specialty 1 accounts for 50% of the billings, specialty 2 accounts for 30% of the billings, specialty 3 accounts for 15% of the billings, and the remaining 5% of billings are not predominately billed by any one specialty. According to the AMA SMS data, specialty 1 has an indirect practice expense of 54%, specialty 2 has an indirect practice expense of 52%, specialty 3 has an indirect practice expense of 44%, and the remaining 5% of billings is calculated using the default indirect practice expense of 45% because the BMAD billing data does not specify a particular specialty for the remaining percentage of the billings. Rather than
using the common 0.219 scaling factor, this methodology results in a 0.25 scaling factor for
procedure AA {[0.5 x 1.2 x 0.219]+[0.3 x 1.1555 x 0.219]+[0.15 x 0.9777 x 0.219]+[0.05 x 1.0 x
0.219]}. We believe that such a methodology is more appropriate than the one proposed because it
captures the overhead costs of those specialties that providing the service rather than a generic
overhead figure.

The use of a common 0.219 multiplicative factor to scale the indirect practice expense RVUs for
each physician service to the total available pool of indirect PE-RVUs could result in inadequate
indirect cost PE-RVUs for services with higher-than-average indirect costs compared to direct costs.
For instance, an E/M service with low direct PE RVUs, but high indirect practice expenses, might
more appropriately be rescaled using a higher multiplicative factor. Other services with higher direct
practice expense RVUs, but lower indirect costs, might appropriately be rescaled using a lower
multiplicative factor.

ASIM urges HCFA to re-examine its decision to use the same multiplicative factor to determine the
indirect PE RVUs, to conduct some modeling based on use of variable factors, and to consider using
such variable factors in the next year’s proposed rule if the modeling suggests that this would result
in more accurate indirect PE-RVUs.

ASIM does not support HCFA’s "pass through" option, which essential allows the current charge-
based indirect costs to be carried over into the proposed payment system. While this option results
in the least redistribution of PE RVUS, it is not completely resource-based and therefore does not
follow the legislative intent of the 1994 law which called for practice expenses to be based upon
relative resource costs. The current PE RVUs are not resource-based, so they should not be
retained as part of the new RBPE RVU scale. The current PE RVUs are based upon the old charge-
based system and bear no resemblance to the resources involved in providing a service.

6. **ASIM Disagrees That There is Duplication Between the CPEP Estimates of the Direct
Costs of E/M Services and the Physician Work Associated With Those Same Services**

ASIM strongly rejects the view that the CPEP estimates of clinical and administrative staff duplicate
the increased physician work associated with coordination of care and documentation of services
that was already accounted for in the five year review. Rather, the increased demands on
physicians and their clinical and administrative staffs associated with coordination of care and
documentation has increased both physician work (as accounted for by the five year review) and
clinical and administrative staffwork associated with these activities. The direct practice expense
RVUs and physician work RVUs therefore are not duplicative, but additive.

The five year review of the physician work RVUs was addressed by the AMA RVS Update
Committee (RUC) at HCFA’s request. The survey that the RUC used for developing the five year
review recommendations was specifically tailored to physician work, not practice expenses. There
were no questions regarding practice expenses in the RUC surveys and no recommendations made
by the RUC to HCFA regarding practice expenses during the five year review. Since they were
independently measuring different inputs, the estimates from the RUC and the CPEPs cannot be
considered to be duplicative.

To cite just one example of the increase on physician work which was captured in the five year
review and the increase in practice expenses which was not captured in the five year review,
coordination of care of homebound patients requires that the physician spend more time
communicating with nurses and family members, reviewing treatment plans and documenting the
services that are rendered. But it also requires that his or her clinical and administrative staff also
spend more time arranging communications between nursing staff, family members and the
physician; responding to routine request and questions; and filling out the paperwork required to
document the services rendered. The physician and his or her staff have distinct, but complementary roles, in carrying out these activities.

7. **HCFA’s Policy of Reducing Payments by 50% for Multiple Surgical Procedures Provided on the Same Day Should Not Be Extended to Non-surgical Services**

ASIM recognizes HCFA’s concern that the method of estimating clinical and administrative times on a code-by-code basis failed to take into account the fact that some clinical and administrative staff furnish services to more than one patient at a time. It is true that for a small percentage of administrative staff time, billing staff may perform one function for a patient while waiting on-hold on the telephone waiting for information on another patient. However, ASIM does not believe that there is any significant disaggregation of tasks and resulting overcounting of administrative staff time in CPEP direct administrative time estimates. Such “overcounting” is even less likely for the direct clinical staff CPEP time estimates. For these reasons, It would be highly inappropriate to extend the 50% discount for multiple procedures to non-surgical services. Multiple diagnostic procedures performed during an office visit or other E/M services are fundamentally different than surgical procedures. When multiple surgical procedures are performed, surgical preparation is not duplicated. For most non-surgical services, the only conceivable savings in physician work or practice expenses is a minor reduction in the administrative time required to schedule another appointment or pull up a record on a computer—which at most would reduce the practice expenses by only a few percentages. The physician and clinical staff time and work required to provide the multiple procedures is no less than if the patient were brought back to the office on another day to have the procedure done. Under a resource-based system, it is inappropriate to mandate an arbitrary percentage discount to the work or practice expenses of any physician service. It is especially inappropriate to assume that whatever savings occur in multiple surgical procedures would apply equally to nonsurgical services.

8. **Additional Data Requirements**

The Balanced Budget Act of 1997 requires that HCFA “develop new resource-based relative value units” that “utilize, to the maximum extent practicable, generally accepted cost accounting principles” which (i) recognize all staff, equipment, supplies and expenses not just those which can be tied to specific procedures and (ii) use actual data on equipment utilization and other key assumptions. HCFA is also required to consult with organizations representing physicians regarding data and methodology to be used.

ASIM is not convinced that collection of additional data on actual costs would materially change the redistribution that would occur under the proposed rule. Nevertheless, ASIM does not object to obtaining additional data on actual costs and utilization of specific equipment, *to the maximum extent practicable*. We note that the committee of the House of Representatives that reported out this provision specifically added the "maximum extent practicable" language to make it clear that HCFA is not required to initiate a data collection activity beyond that which is practicable to achieve within the timeframe mandated by law. Our review of the proposed rule suggests that the proposed practice expense RVUs already recognize all staff, equipment, supplies and expenses, not just those tied to a specific procedure, since those expenses are captured in the indirect PE RVUs. Nevertheless, to the extent that it is practicable to collect additional data on actual costs, ASIM has no objection to HCFA considering such data, provided that:

- It not cause additional delay in implementation, beyond the one-year delay called for by legislation; and
- It not result in a decision to disregard the data it has already collected from the CPEPs. The additional data should supplement, not substitute, for the CPEP data.
We note for the record that the Balanced Budget Act of 1997 does not require that the new proposed practice expense RVUs cover the actual costs incurred by physicians in providing each service, only that HCFA consider data on actual costs and utilization to the maximum extent practicable in developing the new PE RVUs. There is also nothing in the law that requires that HCFA exclude consideration of data from the CPEPs.

ASIM strongly agrees that a refinement process that allows for timely correction of anomalies and errors in specific direct and indirect practice expense RVUs that may have resulted from the CPEP process should be established. This refinement process should consider the specific proposals and comments offered in this statement, as well as the other comments being offered during the proposed rule comment period.

ASIM recommends that the refinement process should include the following:

1. A review, by HCFA, of the comments made on this proposed rule;
2. Establishment of HCFA validation panels, with representation of physicians who provide each service as well as financially-disinterested physicians and other experts, to review the current proposed PE RVUs;
3. Release of a second proposed rule with a 90 day comment period in the Spring of 1998, as mandated by the Balanced Budget Act of 1997, that updates the current proposal based upon these comments and the comments of other interested parties and that incorporates the results of the validation panels, as well as any additional data that may be obtained by HCFA.
4. Consideration of input from the RUC on PE RVUs. It is our understanding that the RUC will be discussing a proposal at its September meeting to assist HCFA in its refinement process.

9. Replacement of the Site-of-Service Policy is Appropriate

ASIM agrees with HCFA’s proposal to replace the current site-of-service policy which reduces practice expense RVUs by 50% if it is a service that is typically performed in the office when it is performed in an out-of-office facility. We agree with using a site specific practice expense RVU (in-office or out-of-office). The proposed site-of-service policy creating different in-office RBPE value for services provided in the office and out-of-office RBPE value for services provided in the out-of-office setting (hospital or ambulatory surgery center) is far superior to the current site-of-service policy because the current policy is not based upon procedure specific information. ASIM has been advocating for this policy change since the creation of the original site-of-service policy.

10. Refinements of Equipment Utilization Inputs are Needed

ASIM agrees with the general methodology for pricing nonphysician labor costs, medical supplies, and medical equipment. However, the equipment capacity assumptions should vary based upon experience. It is our understanding that at least some of the CPEPs collected equipment utilization data. When utilization data on specific procedures is available, it should be used, as mandated by the Balanced Budget Act of 1997. The 50% utilization level for procedure specific equipment and 100% utilization level for overhead equipment should be used as a default figure if HCFA does not have utilization data for equipment for specific procedures.
II. Geographic Practice Cost Index (GPCI) Changes

ASIM continues to urges HCFA to continue to improve and refine the proxies used to construct the Geographic Practice Cost Indices (GPCIs), and to investigate alternative approaches that would collect physician-specific practice cost data by locality, rather than using proxies.

As we stated in our comments on the 1995 Medicare physician fee schedule proposed rule, we are concerned about the decision to continue to use the “all education” sample, rather than the earnings of professionals with an advanced degree, as a proxy for the physician work GPCI. We also continue to have reservations about the use of apartmental rental data as a proxy for the office rental costs. ASIM recognizes that limitations in the available data on commercial rental costs led to HCFA's decision to continue to rely on apartment rental data. It is our belief that the sooner HCFA is able to revise the GPCIs to base them on data that more closely mirrors the commercial costs of renting physician office space, rather than apartment rental data, the more confident physicians will be in the accuracy of the GPCIs. The use of apartment rental data that HCFA uses is corrupted by rent control policies that may have artificially restrained the growth in apartment rents in certain urban locales. Furthermore, apartment rental data is less relevant a proxy as it once was because of the strong trends toward physicians “grouping up” into centralized group practices and other integrated practice arrangements. A large group practice is more likely to have rental or real estate ownership costs that are comparable to large corporate entities that are located in commercial real estate locations. ASIM also continues to have reservations about HCFA's decision to continue to use a national market price for medical equipment, supplies and other miscellaneous expenses rather than data that differentiates by geographic area. We suspect that the costs of obtaining medical equipment in remote rural areas is higher than in urban areas. Rural areas are likely to incur higher shipping costs, and physicians in those locales are unlikely to enjoy the "volume discounts" available to their colleagues in urban areas.

III. Redefinition of Actual Charges is Inappropriate

ASIM strongly disagrees with HCFA proposed change in the actual charge definition. We do not believe that actual charges should be the lesser of the amount the physician, supplier, or other person charges for the service to a particular beneficiary or the amount the physician, supplier, or other person has voluntarily agreed to accept as payment in full under a particular private plan contract that also covers the beneficiary when Medicare is primary and the private plan is secondary. Fee discounts that physician agree to with private payers on commercial populations should not be transferred to the Medicare population. Medicare beneficiaries typically require more physician work and practice expense per service than commercial patients and therefore such a discount is inappropriate. Furthermore, many private sector fee discounts are not based upon the Medicare RBRVS, so adopting such payment schedules would create unintended payment inequities.

The proposal to require physicians to provide their Medicare carrier with the discount rate that the physician is willing to accept with the secondary insurer is totally unworkable. This would require the physician to identify the secondary carrier and the fee schedule rate prior to submitting the bill. The typical small physician group practice bills over 30 different third-party payers a week and there are more than 1500 different insurers in the U.S. It is simply not possible for a physician’s office to maintain accurate payment schedule information from so many different payers. The statement that physicians may be filing a “false claim” if they do not bill the lower rate is particularly disturbing because physicians often cannot maintain a current fee schedule from the private payer and would not be able to provide such information.

This proposal would be a major hassle factor for physicians, if implemented, and it is not consistent with routine coordination of benefit procedures in the insurance industry. Physicians bill their fee
schedule amount and let the insurers determine if there is a discounted rate. Physicians are unable to maintain accurate information of current payment rates for various insurers because those rates change regularly, often without notification to the physician. Also, for services with withholds or bonuses, the final payment rate is often not determined until well after the calendar year in which the service is provided because these payments are measured against year-end production targets. It is not the physician’s responsibility to adjudicate claims disputes among insurance carriers. The physician should continue to be able to bill his/her charge and let the insurers determine what they will pay. Furthermore, the proposal undermines the physician’s appropriate expectation of receiving the fee schedule payment from a primary, not secondary, payer, when the latter is less than the former. This issue underlies two recent court cases that successfully held states (New York, California Medicaid programs) responsible to pay the 20% copayment and deductible for dual eligible beneficiaries.

This proposal runs counter to the administration’s efforts to re-invent government to reduce bureaucracy and cut through red tape. This proposal simply will not be able to be implemented as proposed and the statement about filing “false claims” is insulting to honest physicians.

IV. Budget Neutrality Adjustments

ASIM supports HCFA’s objective of preserving the work and PE RVUs from budget neutrality adjustments. Implementation of RBPEs would require a 2.4% reduction in the conversion factor (CF). ASIM agrees that this adjustment should be made in the CF, rather than in the RVUs.

In light of the legislative change that delays the implementation of the RBPEs one year, we urge HCFA not to eliminate the separate budget neutrality adjustment for the work RVUs that was required to offset the costs of the five year review of the RBRVS. This change is no longer necessary. The Balanced Budget Act of 1997 mandates a special rule for 1998 that requires that HCFA limit the PE RVUs to 110% of the work RVUs, with in-office procedures exempted. An 8.3% increase in the existing practice expense RVUs will create an unintended consequence of increasing the number of procedures--and the amount of reduction that would be required--that will be subjected to the 110% limit (since the 8.3% increase in PE-RVUs would result in more procedures exceeding the cap on PE-RVUs, and by a greater amount). Since neither HCFA nor Congress intended to bring more services under the 110% limit because of an unrelated change in budget neutrality due to last year’s five year review of work RVUs, it is essential that HCFA eliminate or modify this proposal to preclude an unintended increase in the number of procedures and amount of reduction that would be required under the 1998 special rule.

ASIM also urges HCFA to not apply a behavioral offset as a result of the changes in PE-RVUs that will occur under the “special rule” for 1998 and the subsequent transition to RBPEs. The Physician Payment Review Commission has determined that the behavioral offset anticipated by HCFA from implementation of resource-based work RVUs has not occurred. There is no basis therefore for concluding that a behavioral offset to the PE-RVUs is required in order to maintain budget neutrality.

V. Summary/Conclusion

In conclusion, ASIM believes that the new proposed rule that will be published next year, as mandated by the Balanced Budget Act of 1997, should:

1. Build upon--but not replace--the methodology used to develop this notice of proposed rule-making in developing the new PE-RVUs mandated by the Balanced Budget Act of 1997.
2. Continue to use the CPEP data, as refined further by the refinement panels, as a principal source of data in constructing the proposed new practice expense RVUs.

3. Supplement the CPEP data with data on actual costs and utilization of procedures, to the extent that it is practicable to obtain such data within the timeframe mandated by the Balanced Budget Act of 1997. HCFA’s assumptions on utilization should be considered the default estimates should better data not be available.

4. Consider all compelling arguments for correcting errors or anomalies in the CPEP data and make corrections as needed, including consideration of ASIM’s recommendations on the specific codes discussed in these comments.

5. Statistically link the CPEP data, using the CPEP 7 estimates on evaluation and management services as the common link, while being open to consideration of alternative statistical models for achieving appropriate linkages.

6. Publish models of how different linking methodologies would affect the PE RVUs.

7. Modify the indirect PE calculations by using specialty-specific shares of indirect costs.

8. Reject the view that the five year review and the CPEPs resulted in duplication of the physician and non-physician work of E/M services.

9. Desist from implementing the proposed redefinition of actual charges.

10. Maintain the separate budget neutrality adjuster for the work RVUs rather than implementing HCFA’s proposal to replace it with a reduction in the CF that would also require an increase in PE RVUs. HCFA should not implement an across-the-board increase in PE RVUs that would have the unintended consequence of increasing the number of procedures--and the amount of the reduction--required under the 110% (of work RVUs) limit on PE-RVUs mandated by the Balanced Budget Act of 1997.

11. Calculate the new practice expense RVUs and specialty impacts without applying a behavioral offset adjustment. The PE-RVUs that are implemented on 1/1/99 should not be subjected to a behavioral offset adjustment.

ASIM continues to strongly support the concept of resource-based payments for physician services. This proposed rule represents a sound starting point for the development of valid PE-RVUs. The methodology and data can and should be improved and refined, however, and the one-year delay in implementation should provide sufficient opportunity to make the necessary improvements. ASIM strongly rejects the view, however, that the data and methodology presented in the proposed rule are so fundamentally flawed that HCFA needs to start over and use other sources of data. What is needed is a good faith effort on the part of HCFA and physicians to work together to improve the proposed methodology, rather than replacing it entirely with some other untried approach.