September 12, 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-1120-P
RIN 0938-AK11

Comments on Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2001

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) proposed rule regarding revisions to payment policies under the Medicare physician fee schedule for calendar year 2001, published in the July 17, 2000 Federal Register (44,176).

Our comments can be found in the attached document. ACP-ASIM strongly supports the concept of a resource-based relative value system for Medicare and has developed the attached comments to assist HCFA in proper implementation of the Medicare physician fee schedule for calendar year 2001. Please contact John P. DuMoulin, ACP-ASIM’s Director of Managed Care and Regulatory Affairs, at phone 202-261-4535, if you have any questions regarding these comments. Thank you for full consideration of these comments.

Sincerely,

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

Attachment
Comments are listed under the headings as they appear in the Health Care Financing Administration (HCFA) Medicare physician fee schedule (MFS) Notice of Proposed Rulemaking (NPRM).

II. Specific Proposals for Calendar Year 2001

A. Resource-Based Practice Expense Relative Value Units

Clinical Staff Costs

ACP-ASIM commends HCFA for reinstating the clinical staff costs allotted to the use of clinical staff for zero-day global services. The data reported for Pre- and Post- service work performed by clinical office staff in the office in conjunction with a zero-day global service are legitimate practice expenses that never should have been edited out of the fee schedule in the first place. ACP-ASIM is pleased that HCFA has accepted this ACP-ASIM recommendation.

SMS Data

ACP-ASIM is pleased that HCFA has also added 1998 American Medical Association Socioeconomic Monitoring Survey (AMA SMS) data to the 3 year sample that has been used for the past two years of practice expense implementation (1995-1997), so now the SMS data is based on a 4 year sample. ACP-ASIM is pleased that HCFA has accepted this ACP-ASIM recommendation. We believe that the additional data should provide greater assurance as to the quality of data in the sample. We urge that HCFA also use the 1999 SMS data when it becomes available.

PEAC Recommendations

ACP-ASIM notes that none of the Spring AMA Practice Expense Advisory Committee (PEAC) refinements were discussed in the proposed rule. ACP-ASIM believes that these code-specific refinements to the direct practice expenses of numerous services should be included in the final rule for the 2001 Medicare physician fee schedule. This issue is discussed further later in these comments.

Equipment Utilization

ACP-ASIM agrees with HCFA’s proposal to eliminate the distinction between “procedure specific equipment” and “overhead equipment” and to assume a 50% utilization rate for all equipment. We agree that this proposal will remove the subjective equipment distinction that
has been an unnecessary impediment to refining direct practice expense estimates. ACP-ASIM has long-standing policy that indicates that a 50% utilization rate should be assumed in the absence of other data.

ACP-ASIM also agrees with HCFA’s proposal to eliminate all “standby” equipment such as crash carts, defibrillators, wheelchairs, stretchers, and ECG machines. We also agree with the proposal to eliminate all multiple service equipment costs such as cabinets, refrigerators, and autoclaves. We agree that no major specialty-specific impact will occur due to these policy changes and that this proposal should serve to simplify the specific equipment component of practice expenses.

**Mid-level practitioners**

ACP-ASIM agrees with the HCFA proposal to remove mid-level practitioner services from the practice expense pools. We agree that this will make the methodology more consistent with the statutory requirement and that no major impact is anticipated due to this change.

**Definition of site of service**

ACP-ASIM agrees with HCFA’s clarified definition of facility and non-facility. Hospitals, skilled nursing facilities, community mental health centers, and ambulatory surgical centers are facilities. All other sites-of-service are non-facilities. Outpatient therapy (PT, OT, and SLT) services are considered non-facility regardless of site-of-service.

**Additional ACP-ASIM Practice Expense Refinement Recommendations**

ACP-ASIM recognizes that HCFA has made some practice expense methodology refinements that are consistent with previous ACP-ASIM recommendations, namely updating the AMA SMS data and including clinical staff costs in zero day global procedures. However, there are several ACP-ASIM recommendations that have not yet been addressed. ACP-ASIM continues to recommend the following refinements to the practice expense methodology.

**Recommendation 1:** HCFA should establish a modifier to allow for documentation of non-physician clinical staff who 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. The modifier should also indicate if this is a physician practice expense or a hospital practice expense that has been transferred to the physician practice.

**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. ACP-ASIM recognizes that there is concern regarding whether the funds to pay for these expenses should come from Medicare Part A or Medicare Part
B. Therefore, the modifier should be created to track the original responsible party for the practice expense (either the hospital or the physician practice).

**Recommendation 2**: 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 3**: HCFA should consider appointing facilitation panels, consisting of physicians who 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 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 2 above. This process is not designed to replace the AMA RUC/PEAC, but instead to serve as the government’s independent validation process as is done with the refinement of work RVUs.

**Recommendation 4**: 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 5**: 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 6:** 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.

**D. Critical Care Relative Value Units**

ACP-ASIM strongly supports the HCFA proposal to restore the critical care work relative value units (RVUs) to 4.00 for Current Procedural Terminology (CPT) code 99291 and 2.0 for CPT code 99292. We also support the revised CPT definition of critical care that will appear in the introductory text to the codes in CPT 2001. ACP-ASIM strongly opposed HCFA’s decision last year to reduce the work RVUs for critical care services. We found problems with HCFA’s rationale for reducing the work RVUs and with the process for implementing the reduction. We are pleased that HCFA implemented ACP-ASIM’s recommendation to re-establish the original values for the critical care codes.

ACP-ASIM was particularly concerned when HCFA lowered the values of the critical care codes because that change created anomalies within the family of evaluation and management (E/M) services and anomalies between critical care codes and non-E/M services. The May 3, 1996 physician fee schedule proposed rule states that code 99291 was selected as the anchor for all the E/M services. The rule states that "we have an established relationship between CPT code 99291 and CPT code 99213…CPT code 99291 represents an hour of service. We believe that four times the value for CPT code 99213 plus the work RVUs for ventilation management (1.22) and the interpretation of a single view chest x-ray (0.18) should be about equivalent to the work RVUs for critical care. We selected ventilation management and interpretation of a chest x-ray because they are the commonly performed items in critical care that are bundled into the critical care work RVUs." HCFA then scaled the rest of the E/M codes to the critical care anchor code by assigning intensity values and comparing the ratio of pre/post work to intraservice work. HCFA adjusted the key anchor code in the entire set of E/M services, which altered the entire relative relationships of E/M services. Similarly, changing the work RVUs for critical care services arbitrarily changed the relative relationship between critical care services and non-E/M services. We are pleased that HCFA reinstated the proper relative value units for critical care services and put the critical care codes back into proper alignment with the rest of E/M services.

**E. Care Plan Oversight and Physician Certification/Re-certification**

**Care Plan Oversight Codes**

ACP–ASIM strongly opposes the HCFA proposal to create new “G” codes for care plan oversight (CPO) services and urges the agency to adopt the revised CPO codes that will appear in CPT 2001.
We recommend that HCFA clearly explain the reason it proposes to create new G codes to physician organizations before it activates these new codes. HCFA cites a discrepancy between its CPO payment policy and the revised CPT 2001 CPO codes as its rationale for creating G codes. HCFA must provide a rationale on which individuals and organizations can base their comments before it finalizes any proposal.

ACP–ASIM disagrees with HCFA that the physician time spent discussing care decisions with non-health professionals, i.e. family members and other caregivers, is adequately captured in the post-service work portion of the payment for a previous patient visit to the physician’s office or through another E/M service.

The portion of the payment for a previous office visit devoted to post-service work is inadequate as the physician is likely to have multiple discussions with family members or other care givers before the next face-to-face visit. The CPO codes allow physicians to be reimbursed for directing the care of patients who are ill-equipped to receive on-going care through frequent visits to the physician’s office. HCFA payment policy recognizes that patient office visits will be infrequent as it only requires a single office visit within six months of the first physician bill for CPO services furnished to that patient. Therefore, numerous physician-family discussions are considered to be bundled into the post-service payment for a single office visit.

ACP–ASIM contends that physician discussions with family member represent intra-service work as they are integral to the physician’s medical decision making. An interaction that consists of a physician simply updating the family regarding the patient’s condition is atypical. In fact, it is often the other way around. Family members often provide an array of information pertaining to the patient’s status, such as eating habits, temperature, degree of congestion, sputum, urine color, bowel habits, etc. In turn, physicians often relay instructions for caring for the patient back to the family member.

Family members are effective in ensuring the patient receives adequate care as they typically spend more time with the individual than home health agency (HHA) or hospice personnel. It is illogical to recognize second hand discussions—the HHA or hospice personnel often receive patient information from the family—and not recognize primary communication between the patient caregiver and the physician. While ACP–ASIM recognizes that value of information provided by health professionals and urges its continued recognition, we believe discussion with family can be equally as valuable and should be treated as such.

Further, ACP–ASIM objects to the proposed G codes because:

- Recognizing family discussions is cost-effective as it is likely to encourage closer physician–family interaction that can improve patient care. The patient is more likely to avoid receiving care in high-cost settings, such as the emergency department and the inpatient setting, if physician-patient caregiver interaction is encouraged.

- Discussions with family in the hospice setting can focus on end of life and/or intensity of care issues and are, therefore, important to the physician’s medical decision making process. Also, these discussions must be carefully considered and documented since they involve
potential litigious issues. Again, these are situations in which the family is providing the physician with critical patient status information and not instances of the physician merely updating the family regarding the patient’s care.

- **The new G codes would further complicate billing for CPO services.** The current HCFA payment policy creates barriers that discourage physicians from reporting CPO services. These barriers result from a payment policy that: requires physicians to determine time on a calendar month basis; requires physicians to provide the home health agency provider number; and only counts physician contact with HHA or hospice personnel and not the time the physician may spend instructing a nurse who then makes the actual contact with the entity.

- **Physicians already find CPO billing requirements to be confusing; creation of G codes only exacerbates the situation.** HCFA has alternated use of CPT codes and G codes over the past five years. Implementation of G codes would force physicians to maintain one set of codes for Medicare and another set for other payers. Additionally, Medicaid as well as many secondary payers do not recognize G codes.

**Physician Certification/Re-certification**

ACP–ASIM is encouraged that HCFA proposes to make separate payment for physician certification and re-certification of patient home health care plans. We support the agency’s proposal to assign Gxxx3 a work RVU that equates to that of CPT 99213 and assign Gxxx4 a work RVU that equates to that of a CPT 99212. We also agree with the decision to crosswalk the practice expense RVU to the inputs currently used for CPT 99375. However, ACP-ASIM is concerned that HCFA did not bring the proposal to the CPT Editorial Panel prior to publishing this proposal in the Federal Register.

In addition, HCFA should adopt these new G codes for HHA certification in addition to recognizing the CPT 2001 CPO codes. HCFA adoption of the 2001 CPO codes would not increase expenditures for physician services. In addition, Medicare has never realized the original CPO billing projections of $300 million per year.

Although we support adoption of the certification and re-certification G codes for the 2001 MFS, we recommend that HCFA submit a proposal to the AMA CPT Editorial Panel to establish CPT codes for these services.

**F. Observation Care Codes**

ACP–ASIM recommends that HCFA reconcile its conflicting payment policy by revising its Medicare Carriers Manual (MCM) instructions to allow for payment for observation and inpatient admission and discharge on the same date. Revising the MCM will enable HCFA to refrain from establishing new RVUs for CPT 99234-99236. Three years ago, HCFA accepted the RUC-recommended RVUs for CPT 99234-99236. HCFA agreed with the RUC argument that there is no overlap between admission and discharge work regardless of the date of service. Each service
involves a distinct examination; different paperwork; and divergent counseling and/or coordination of care.

The HCFA proposal for the CY 2001 MFS states that the work associated with discharging a patient is a function of the length of stay in hours. HCFA, however, fails to explain how it reached this conclusion. Instead, the agency is proposing an adjustment to the work RVUs for CPT 99234-99236 to account for an antiquated MCM policy that it failed to modify when it accepted the RUC recommended work RVUs after the AMA CPT Editorial Panel established these codes. We view this as a case of the tail wagging the dog.

Further, revising the MCM will prevent physicians from having to navigate overly burdensome billing instructions. The HCFA proposal will create as many “inequities” as it purports to resolve. For example, it results in different payment for patients whose stay is 7 hours versus 8 hours or whose stay is 23 hours versus 24 hours. Does HCFA believe that an extra hour in the hospital or observation care makes such a significant difference in the level of work involved? The HCFA proposed eight and 24-hour thresholds are as arbitrary as the midnight threshold it identifies as problematic. The requirement that physicians document and bill according to the time between patient admission and discharge is an undue burden.

ACP–ASIM believes that the HCFA attempt to correct this “inequality” misguided. It will force HCFA to re-examine the entire concept of billing according to calendar date. Attempting to make coding more precise is likely to compromise administrative simplicity to the point that disrupts the entire claims payment system. Medicare expenditures for physician services would remain unchanged if HCFA revised the MCM and retained the current work RVUs for CPT 99234-99236.

I. Global Period for Insertion, Removal, and Replacement of Pacemakers and Cardioverter Defibrillators

ACP–ASIM understands that the organizations representing the cardiology-related specialties that perform insertion, removal, and replacement of pacemakers and cardioverter defibrillators dispute the HCFA notion that the physician who performs the procedure also provides the follow-up care. It is our understanding that electrophysiologists generally provide the follow-up care. We are concerned that HCFA’s proposal to eliminate the current 90-day global period for all CPT codes involving the insertion, removal and replacement of pacemakers or cardioverter defibrillators and the corresponding reduction in RVUs has created unintended policy consequences for physicians that provide those services. We recommend that HCFA work with the affected organizations to arrive at a reasonable Medicare policy as soon as possible. Accordingly, the agency should delay implementation of this proposal until a reasonable solution is found.

III. Other Issues

B. Payment for Pulse Oximetry Services
ACP–ASIM urges HCFA to allow separate payment for pulse oximetry services when performed on the same date as an E/M service. While we are encouraged that HCFA proposes to reinstate separate payment for pulse oximetry when it is furnished independent of an E/M service, the agency policy recommendation does not go far enough. The failure to recognize pulse oximetry as a separate service is especially problematic as the agency requires periodic blood gas measurements to certify a patient’s need for home oxygen therapy. Under the HCFA proposal, physicians are unable to receive payment for the practice expense associated with the service if it is provided on the same day as an E/M. As a result, physicians may be forced to send the patient to a hospital laboratory to receive a blood gas measurement. HCFA should allow separate payment for pulse oximetry on the same day as an E/M service to avoid creating an incentive for patients with respiratory ailments to make an unnecessary trip to the hospital. Other situations when a pulse oximetry should be paid in addition to an E/M services are when a physician needs to assess acute respiratory distress and when a physician suspects a patient has severe hypoxemia.

It is reasonable for HCFA to implement safeguards if it allows separate payment for a pulse oximetry performed on the same date as an E/M service. ACP–ASIM would support HCFA implementation of a national coverage policy for pulse oximetry that would limit coverage on the same date as an E/M service to specific International Classification of Diseases (ICD-9) codes. We would also support implementation of a Correct Coding Initiative (CCI) edit that would require the code for pulse oximetry to be appended with CPT modifier –25.