December 27, 2000

Robert Berenson, MD, FACP, Acting 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-FC

Re: Medicare Program: Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2001; Final Rule

Dear Dr. Berenson:

On behalf of the American College of Physicians-American Society of Internal Medicine (ACP-ASIM), representing more than 115,000 doctors of internal medicine and medical students, and the nation’s largest medical specialty society, I am writing to comment on the Health Care Financing Administration’s (HCFA) final rule on revisions to Medicare payment policies under the physician fee schedule for calendar year 2001, published in the November 1, 2000 Federal Register (65,376).

**Resource-Based Practice Expense Relative Value Units**

**PEAC Recommendations**

ACP-ASIM agrees with HCFA’s contention that the recommendations received this year from the American Medical Association Practice Expense Advisory Committee (PEAC) for the refinement of the Clinical Practice Expert Panel (CPEP) inputs for existing codes mark a positive step in the CPEP data refinement process. ACP-ASIM agrees that the refinement of 15 major evaluation and management (E/M) codes is crucially important. However, we note that the “rolling” implementation of CPEP refinements creates a temporary anomaly where the E/M practice expense (PE) relative value units (RVUs) are determined by the PEAC estimates and other services that use E/M building blocks, such as global surgery packages are determined by other means, which artificially favors codes that have not had the lower PEAC estimates applied. This anomaly results in lost payments relative to other services where the PEAC estimates should also be applied. We urge HCFA to take prompt action to correct this anomaly. In addition, ACP-ASIM recommends two enhancements to the PEAC recommendation:

1. HCFA should use the RN/LPN clinical staff labor cost mix rather than the RN/LPN/MA staff labor cost mix. ACP-ASIM believes that the RN/LPN labor cost mix is more typical of practice than the RN/LPN/MA mix.
2. HCFA should increase the post-service clinical staff work by twenty percent. ACP-ASIM recommended to the PEAC that the post-service clinical staff times for the E/M
codes were undervalued. In our experience, a higher post-service clinical staff time is more typical than the current PEAC values.

**Staffing Arrangements Between Hospitals and Physicians**

ACP-ASIM is pleased that HCFA has requested that the Office of Inspector General (OIG) make an independent assessment of staffing arrangements between hospitals and physicians that use the hospital because HCFA is interested in receiving data on the cost shifts between hospitals and other providers. However, HCFA did not adequately explain why it believes that the suggested use of a modifier for this purpose would be extremely difficult to implement and also burdensome for the practitioner. ACP-ASIM believes that a modifier to allow for documentation of non-physician clinical staff who provide services in a facility setting would be of benefit. ACP-ASIM asks that HCFA inform the public of its rationale not to develop such a modifier.

**Sensitivity Analysis**

ACP-ASIM notes that HCFA did not respond to our recommendation that HCFA should conduct the sensitivity analyses recommended by the U.S. General Accounting Office (GAO) and publish the analyses. 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 the impact of such a change. ACP-ASIM reiterates this recommendation and requests a response from HCFA.

**Unusual Equipment Costs**

HCFA indicated that it “foresee[s] many policy and operational difficulties in implementing” the recommendations to establish a methodology to accept a "j" code for unusual equipment costs associated with a procedure. ACP-ASIM believes that 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 because the type of patient they serve requires use of unusually costly equipment. HCFA should 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. If HCFA is unwilling to propose use of “j” codes to recognize such costs, HCFA should at least elaborate on its concerns so that we can respond and develop this concept further.

**Interim Values**

ACP-ASIM is pleased that HCFA indicated that “as long as there is a good faith effort on the part of all parties to continue the quality work that the PEAC/RUC has already undertaken, [HCFA does] not plan to close the door on further code-level refinements in 2002.” We agree with HCFA that sufficient time to deal with the CPEP inputs of all services in a thoughtful and
equitable manner should be provided and that is why ACP-ASIM recommended that the practice expense RVUs that will be implemented by January 1, 2002 should remain as interim RVUs for a minimum of another three years, during which HCFA will consider comments for further code-level refinements.

**Hemodialysis Access Study Relative Value Units**

ACP-ASIM is concerned by HCFA’s action to change the American Medical Association RVS Update Committee (RUC) recommendation for CPT code 90940, hemodialysis access study. The RUC determined that there was no physician work associated with the service, but that practice expense RVUs should be assigned to 90940. HCFA does not address this disagreement with the RUC anywhere in the final rule. Further, in Addendum ‘B’ of the final rule 90940 is designated an ‘X’ code, indicating that the service is “not within the definition of ‘physician’s services’ for physician fee schedule payment purposes.” This decision is wholly inappropriate, as this service is provided by the physician’s office, generates legitimate practice costs and are within the definition of ‘physician’s services’ for physician fee schedule payment purposes. ACP-ASIM urges HCFA to accept the RUC recommendations that assigned practice expense RVUs to code 90940, and to change 90940 to an active status.

**Publication Of Relative Value Units For Status N Codes**

HCFA stated in the final rule that it will review and address the publication of N codes in a later rulemaking. ACP-ASIM strongly opposes any proposal by HCFA to discontinue publication of RVUs for non-Medicare covered services (N codes). The American Medical Association RVS Update Committee (RUC) gives equal review to all codes regardless of their Medicare coverage status. Discontinuing publication of RVUs for non-Medicare covered services would be a disservice to Medicaid payers, as well as all other private payers and physicians who depend on the Medicare RBRVS.


ACP-ASIM is pleased with HCFA’s statements in the final rule supporting the use of CPT codes, as well as HCFA’s assurances to the medical community that the agency will establish G codes only when absolutely necessary and will continue to work with the AMA CPT Editorial Panel to minimize the need for G codes. There were a number of provisions under the proposed rule for which HCFA proposed new coding policies, and, in doing so, bypassed the medical profession’s process for assigning new CPT codes and recommending appropriate RVUs for these codes by establishing HCPCS and G codes. Bypassing the CPT process by creating of new HCPCS and G codes creates an administrative hassle for physician practices.
Critical Care Relative Value Units

ACP-ASIM is pleased that HCFA has finalized its 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 based upon 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.

Care Plan Oversight Codes

ACP-ASIM is disappointed that HCFA has finalized the proposal to create new “G” codes for care plan oversight (CPO) services. ACP-ASIM strongly opposed the creation of new CPO codes. 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 unable, due to their medical conditions, to receive on-going care through frequent visits to the physician’s office. HCFA payment policy recognizes that patient office visits will be infrequent for patients who are eligible for care plan oversight services, since HCFA policy requires that only a single office visit be provided within six months of the first physician bill for CPO services furnished to that patient. Therefore, under current HCFA policy, all physician-family discussions that occur within a six month period can be considered to be bundled into the post-service payment for the 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.
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 and many secondary payers do not recognize G codes. HCFA should use the current CPT codes and CPT definitions for care plan oversight services.

**Physician Certification/Re-certification of Home Health Services**

ACP-ASIM is pleased that HCFA will implement its proposal to make separate payment for certification of home health services. Encouraging physician involvement in these services is critically important. We support the agency’s proposal to assign G0180 a work RVU that equates to that of CPT 99213 and assign G0179 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 care plan oversight. We are pleased that the original proposal has been forwarded to the CPT Editorial Panel for consideration and that the codes will be considered by the AMA RUC/PEAC subsequently.

**Observation Care Codes**

We are pleased that HCFA has revised the proposal to keep the relative work values of CPT codes 99234 through 99236 unchanged. We agree with HCFA’s decision to continue to use a calendar date standard instead of adopting its proposed 24-hour period standard to determine the appropriate billing combination. However, we are concerned that the HCFA policy deviates from CPT by requiring that the discharge must take place at least eight hours after the admission when the services are furnished on the same calendar date. We recommend that HCFA use the CPT standard that allows physicians to report a same day admission and discharge code, CPT 99234-99236, regardless of the total duration of the patient’s stay. The RUC has previously addressed this issue and determined that the work involved with admission and discharge are not the same and are not a function of the amount of time the patient spends in the hospital. The policy specified in the final rule is unnecessarily confusing as the situation that HCFA intends to prevent—physician billing for an admission and discharge for a stay less than eight hours—likely occurs infrequently. It appears that the administrative complexity of this policy change exceeds any potential cost savings.

**Payment for Pulse Oximetry Services**

ACP-ASIM is disappointed that HCFA finalized its proposal to make separate payment for a pulse oximetry service only when it is the only service performed. HCFA rejected comments arguing that pulse oximetry should always be paid separately since the physician incurs practice expense costs and it involves separately identifiable physician work. ACP–ASIM continues to urge 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 will reinstate separate payment for pulse oximetry when it is furnished independent of an E/M service, this 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 policy, 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 service. 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. 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.

**Summary and Conclusion**

ACP-ASIM appreciates the opportunity to comment on the Medicare physician fee schedule final rule for calendar year 2001. To summarize, ACP-ASIM recommends that HCFA take the following actions on practice expense refinement:

1. Do not implement the PEAC recommendations for CPEP data refinement for 15E/M codes until the CPT codes which use these E/M codes as building blocks are also refined.
2. Use the RN/LPN clinical staff labor cost mix rather than the RN/LPN/MA staff labor cost mix for the CPEP data refinement for the 15 E/M codes.
3. Increase the post-service clinical staff work by twenty percent for the CPEP data refinement for the 15 E/M codes.
4. Inform the public why the agency will not develop a modifier to allow for documentation of non-physician clinical staff who provide services in a facility setting.
5. Conduct and publish sensitivity analyses on practice expense methodology refinements.
6. Elaborate the agency’s concerns regarding the proposal use of “j” codes to recognize unusual equipment costs.
8. Accept the RUC recommendation that assigned practice expense RVUs to CPT code 90940 and change 90940 to an active status.

ACP-ASIM recommends that HCFA take the following actions on other issues discussed in the final rule:

1. Continue to publish Medicare non-covered (“N”) codes.
2. Use the CPT editorial process rather than creating new “G” (unassigned CPT) codes.
3. Use the current CPT codes and CPT definitions for care plan oversight services.
4. Use the CPT standard that allows physicians to report a same day admission and discharge code, CPT 99234-99236, regardless of the total duration of the patient’s hospital stay.
5. Allow separate payment for pulse oximetry services when performed on the same date as an E/M service.

ACP-ASIM supports HCFA’s decision to:

1. Reinstate the RVUs for critical care services
2. Pay for physician certification and re-certification of home health services.

If you have any questions about these comments, please contact ACP-ASIM’s Director of Managed Care and Regulatory Affairs, John DuMoulin, at (202) 261-4535. Thank you for full consideration of these comments.

Sincerely,

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