February 6, 1996

Bruce Vladeck, PhD, Administrator
Health Care Financing Administration
Department of Health and Human Services
Room 309-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

Attention: BPD-827-FC

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 and Adjustments to the Relative Value Units Under the Physician Fee Schedule for Calendar Year 1996; Final Rule, published in the December 8, 1995 Federal Register.

Thank you for full consideration of these comments.

Sincerely,

Alan R. Nelson, MD
Executive Vice President

AMERICAN SOCIETY OF INTERNAL MEDICINE (ASIM)

COMMENTS

ON THE

MEDICARE FEE SCHEDULE CALENDAR YEAR 1996 FINAL RULE

Full Title: Medicare Program: Revisions to Payment Policies and Adjustments to the Relative Value Units Under the Physician Fee Schedule for Calendar Year 1996

I. Final Relative Value Units for 1996

The American Society of Internal Medicine (ASIM) is pleased with the adjustments in work relative value units (RVUs) for care plan oversight services (CPT code 99375) and the monthly capitation rate for end-stage renal disease services (CPT codes 90918-90921). The decision to increase the work RVUs from 1.06 to 1.73 for care plan oversight CPT code 99375 is appropriate and consistent with the original American Medical Association RVS Update Committee (RUC) recommendation. As we stated in our comments on the 1995 Medicare fee schedule, 1.06 work RVUs was far too low for
this important service. However, we continue to be concerned that Medicare does not recognize extensive care plan oversight services (CPT code 99376) or care plan oversight services in the nursing home setting. For more information on ASIM’s recommendations on care plan oversight and case management services, please see our discussion of “Primary Care Case Management and Other Managed Care Approaches” below.

Moving the monthly capitation payment (MCP) for end-stage renal disease (ESRD) services to the Medicare physician fee schedule so that it would receive annual updates is appropriate. The adjustments made to the MCP work RVUs are also appropriate. The interim RVUs developed last year were too low. ASIM continues to support the efforts of the Renal Physicians Association (RPA) in developing the definition of the bundle of services included in the MCP and developing the relative value recommendations to HCFA.

II. Interim Relative Value Units for 1996

ASIM is pleased that Health Care Financing Administration (HCFA) accepted approximately 90 percent the work relative value recommendations of the RUC and only decreased 10 percent of the RUC recommendations, principally to maintain budget neutrality within families of services. ASIM is an active participant in the RUC process and supports HCFA’s increased reliance on the RUC.

ASIM believes that the work relative value for the new CPT code 99239, Hospital Discharge Day Services, is appropriate. HCFA’s acceptance of 1.75 work RVUs recommended by the RUC for 99239 is consistent with the RUC survey recommendations that ASIM developed. We also agree with HCFA that the work RVUs for the lower-level hospital discharge day codes (99238) should remain the same (1.06).

III. Primary Care Case Management and Other Managed Care Approaches

In the past decade, rapid advancements have occurred in the way medical care is provided for many acutely ill patients in the U.S. The types of services provided by physicians in the nursing home, hospice and home settings are quickly evolving toward the types of more complex care previously provided solely in the hospital setting. A number of factors have contributed to these practice changes, including pressures to curb the escalating costs of health care, advances in medical and information technology, patient and family preferences, and publication of numerous scientific studies showing that outpatient, hospice and home care can be high quality, cost-effective alternatives to inpatient care. Many hospitalizations now can be avoided entirely and handled on an outpatient basis. Patients requiring an inpatient stay tend to be discharged earlier and usually without total and complete recovery from their illness. They require a more intense, but shorter inpatient stay, followed by continued medical care and management at a greater intensity than previously provided in the outpatient setting. These changes in the practice of medicine have created an urgent demand for active physician direction and supervision of medical care to patients in the nursing home, home, and hospice settings.

Current Medicare Policy Discourages Active Physician Involvement

The longstanding--and current--Medicare policy regarding physician case management fails to fully recognize the fundamental evolution in patient care from inpatient to outpatient settings that is taking place. It is no longer appropriate in today’s medical practice environment to focus exclusively on reimbursement for face-to-face encounters. Instead, appropriate financial incentives should be provided for physicians to practice high quality, cost-effective medical care across a continuum of care settings. The current lack of physician reimbursement for extensive case management is contributing to perverse financial incentives for provision of inpatient care rather than more cost-efficient outpatient treatment.
With HCFA's recent change in policy to reimburse for care plan oversight services provided for those patients in the home health or hospice settings, there is greater incentive for physicians to be more involved in the management of patient care. This policy change encourages physicians to provide these services beyond the basic level that patients require. Yet while this policy established an important precedent by finally providing recognition for these services, we are concerned that it is much too narrow. Physicians providing case management services should also be appropriately reimbursed for performing the additional management/administrative functions associated with the "care manager" role required of them by the Medicare program. It is for these reasons that ASIM strongly advocates proper reimbursement for care plan oversight services in settings other than those covered by current Medicare policy, as well as for medical telephone services provided by physicians. In addition, as discussed below, HCFA should modify the "direct supervision" requirement for "incident to" physician services in order to recognize the ability of physicians to provide extensive case management through their employed mid-level practitioners.

Physicians as case managers

It is very important to the Medicare program to have physicians act in a "case manager" role. It is through visits to physicians, particularly primary care physicians, that patients obtain appropriate access to initial medical care and other services available from the health care system. As the initial point of contact with the health care system, primary care physicians have a critical role in determining, in consultation with their patients, what care patients will receive. Primary care physicians also keep costs in mind when determining the potential medical benefit to the patient. Physicians that have completed an approved internal medicine training program are well-qualified to be case managers. Internists are uniquely qualified to assess either discrete or undifferentiated complaints of their patients, and to formulate a diagnosis and treatment plan in consultation with the patient, including situations when that plan entails the services of specialists and ancillary service providers. Internal medicine subspecialists--such as endocrinologists for patients with diabetes, pulmonologists for patients with advanced chronic obstructive pulmonary disease or severe asthma, oncologists for cancer patients and rheumatologists for severe rheumatoid arthritis patients--typically act as principal care case managers for patients who require their specialized training.

ASIM suggests that HCFA accept the principal care concept when developing policies to promote primary care case management. ASIM defines "principal care" as:

- Integrated, accessible health care provided by medical subspecialists and neurologists that addresses the large majority of the personal health care needs of patients with chronic conditions requiring the subspecialist's expertise, and for whom the subspecialist assumes care management, developing a sustained physician-patient partnership and practicing within the context of family and community.

Nurse practitioners (NPs), other suitably qualified nursing personnel, and physician assistants (PAs) with appropriate training can also serve in the case manager role, provided that their case management services are provided under the supervision of a primary or principal care physician and that physicians have helped design or approve the case management protocols that the mid-level practitioners follow.

It is unreasonable, however, for the physician to be held totally accountable for the quantity or quality of care delivered by home health agencies, especially with regard to the unnecessary use of non-physician services and supplies, when physicians and their staff are discouraged by Medicare policy from providing direct patient care to patients in the home health setting. Physicians are eager to act as case managers for patients in the home health setting if the physician's office staff were allowed
to provide direct patient care under the physician's direction and supervision. Currently, such an arrangement is prohibited.

Patients that would benefit from case management

Patients with chronic illnesses, catastrophic illnesses following acute in-patient care, multiple concurrent conditions, and medically frail or high-risk individuals benefit most from physician case management services in the home health, hospice, nursing home, and skilled nursing facility settings. Patients without family or community support will also benefit from case management. Case management, particularly telephone case management, is also valuable to patients who require follow-up maintenance services, such as management of insulin-dependent diabetics with multiple blood-sugar checks and insulin changes or patients who are being treated with anticoagulation therapy.

Another example of patients that would benefit from case management are those with chronic severe pulmonary problems requiring supervision by a pulmonary specialist. The physician employs or directly supervises staff—such as respiratory therapists—who can assess the patient in home or skilled nursing facility (SNF) settings, obtain oximetry or spirometric measurements, obtain arterial blood gases if needed, and administer treatments pursuant to consultation with the supervising physician. Programs like this are extremely effective because they prevent repeated emergency room visits and hospital admissions. Equivalent programs for home care management of tenuous cardiac patients, including management of infusions and high dose IV diuretic programs, require close physician case management (for more examples see below). When case management is provided, patient satisfaction is high. Families feel more assured that help is available where and when it is needed. Patients can remain in the more cost effective home environment rather than the more costly inpatient or skilled nursing facility setting.

Patients with any of the following medical conditions will likely benefit from case management services:

- Dementia
- Chronic congestive heart failure
- Chronic neurological disease
- Chronic obstructive pulmonary disease
- Chronic asthma
- Parkinsons disease
- Rheumatoid arthritis
- Glaucoma
- Polycythemia vera
- Lymphoma
- Patients on chronic anticoagulant therapy with one or more co-morbidities (i.e. prosthetic heart valve patients with diabetes mellitus, severe degenerative joint disease, collagen vascular disease, hypertension)
- Patients with cerebrovascular disease involving posterior circulation and requiring chronic anticoagulant therapy with one or more co-morbidities
- Stroke patients - home bound
- Patients with cerebrovascular disease with CVA and two or more significant residual functional deficits (i.e. marked hemiparesis and aphasia, dysphagia with gastrostomy, severe degenerative joint disease, diabetes mellitus, hypertension)

Please note that some patients with the medical conditions listed previously do not necessarily need more than 30 minutes a month of care plan oversight services. Besides the diagnosis, severity of illness is the critical factor in determining the level of case management that a patient requires.
We have reservations about setting up case management fees for Medicare patients by diagnosis. Our primary concern is that there is marked variability in the intensity of follow up care, including case management that physicians must perform, not simply reflecting the diagnosis and comorbidity of the individual patient. Across thousands of physicians and millions of patients there may be statistically valid medians and standard deviations for developing accurate capitation rates, but for an individual physician with perhaps no more than 800-1200 Medicare patients, the case complexity varies substantially. If capitation were to replace fee for service reimbursement, care may be compromised by some physicians, not improved. A capitated system may also lead to gaming where patients are inappropriately placed into the capitated pool to increase revenue.

It is difficult to assess the effect of bundling payments for physician services for case management. For example, patients with dementia can have very mild diabetes or hypertension which does not require much intervention or they can have major complications that are very time consuming. Diagnosis alone does not indicate how much physician time would be needed to treat the patient. If the case management fee included defined services and additional work could be billed separately on a fee-for-service basis, a capitated case management fee might be reasonable. We prefer however, to see Medicare expand coverage for the existing care plan oversight codes and to permit reimbursement for certain telephone services rather than implementation of a capitated case management fee.

To answer HCFA’s question regarding the appropriate periodicity for a capitated payments, we believe that payment of a monthly basis makes the most sense. Shorter or longer capitated time periods would likely create tracking and billing problems for physicians. Furthermore, the private sector time standard is monthly.

**Payment proposal for Medicare case management services**

As noted earlier, ASIM is pleased with HCFA’s 1994 change in policy to reimburse for care plan oversight services provided for patients in the home health or hospice settings and the recent increase in work RVUs because of the HCFA refinement process. ASIM strongly advocates proper reimbursement for care plan oversight services in settings other than those covered by current Medicare policy, including nursing homes. We urge coverage for extensive case management services of more than one hour in a month. We also recommend that medical telephone services provided by physicians be reimbursed when appropriate, subject to specified coverage guidelines, as discussed later. In each of these circumstances, physicians should be able to receive payment based upon the level of care plan oversight they provide.

Furthermore, not all patients who benefit from care plan oversight services of greater than 30 minutes per month are receiving home health agency care. These patients could be significantly benefitted--and home health agency use reduced--if physician-employed and/or supervised nursing and other mid-level personnel could assess patients in ambulatory or home care settings and provide services such as inhaler treatments, dressing changes, assistance with tube feeding problems, diet counseling, and review of medication compliance.

Discussed in detail below are ASIM’s specific recommendations for expanding Medicare payment policy to allow reimbursement for physician case management of nursing home patients, extensive care plan oversight services, telephone services, and services provided by mid-level practitioners "incident to" a physician service.

In lieu of creating a new monthly capitation rate for case management services based upon patient diagnosis, ASIM believes that HCFA should adopt the following recommendations:
Recommendation # 1: HCFA should expand the current care plan oversight policy to nursing home patients.

ASIM urges HCFA to recognize that physicians do provide care plan oversight services to patients in skilled nursing facilities (SNF) and nursing facilities (NF). We disagree with HCFA's assumption that the RVU increase to SNF and NF evaluation and management codes in 1993 adequately reflect care plan oversight performed in conjunction with those evaluation and management codes. There are circumstances where case management is being provided in the SNF and NF, but not in conjunction with SNF and NF E/M codes. Extensive care plan oversight is provided during the period following a hospital patient discharge to a nursing home. Most of the physician directed care provided to SNF and NF patients is via care plan oversight, rather than face-to-face encounters with the patient. New medical problems such as fever, altered mentation, behavior, pain, minor orthopedic, nutrition, bowel and bladder problems--requiring reevaluation of medical status, new prescriptions, ordering of diagnostic tests, and evaluation of those diagnostic tests--are often treated via the telephonic and facsimile media rather than face-to-face encounters. Much of the care plan oversight that occurs in this setting is totally unrelated to subsequent SNF and NF E/M codes. Physicians should be able to receive payment based upon the level of care plan oversight that they provide.

Current Medicare policy does not adequately reflect the level of care plan oversight that Medicare beneficiaries residing in SNF and NF receive. The current policy discourages physicians from providing more than the minimum level of care plan oversight necessary, which in turn costs HCFA more in the long run because of emergency room and hospital visits that could have been avoided if HCFA's policies encouraged care plan oversight in the SNF and NF settings.

We also maintain that effective case management by physician-supervised nursing personnel or physician assistants of patients in SNFs would benefit the quality of patient care and save Medicare the costs of avoidable complications, deterioration of function, or subsequent emergency room and hospitalization services. Examples include:

1. Medical-group based nurses or NPs that would be able to follow patients after acute discharge through the SNF and home sites of care.
2. Ambulatory care of high risk geriatric frail patients living in the community and receiving a variety of medical and social services provided by nurses or sometimes with a licensed social worker supervised by a physician.
3. Teams of nurse practitioners that could provide primary care for SNF residents.

Present regulations allow the "routine" or monthly visits to be shared between an MD and a NP or PA, but an extension of this concept should allow and encourage flexibility where the physician-supervised personnel can provide assessment and treatment for acute problems. With this type of flexibility, management of pneumonia, UTIs, minor strokes and cardiac problems can be treated in the SNF or home without need for hospital transfer.

Recommendation # 2: HCFA should expand the current care plan oversight policy to include extensive case management services.

ASIM objects to the fact that HCFA has ignored truly extensive case management services that require more than one hour during a month. Existing Medicare policy sends a negative message to patients that require higher levels of care. Medicare policy should encourage physicians to provide extensive care plan oversight because such a policy could lower the incidences of hospitalizations for patients with more complex medical conditions.
Furthermore, HCFA’s policy to ignore extensive care plan oversight services does not follow HCFA’s own payment policy in regard to reimbursement for services provided in a linear relation to the level of service provided. The 1992 final rule, Medicare Program: Fee Schedule for Physicians’ Services for Calendar Year 1993 states, “RVUs for evaluation and management services should increase in a linear fashion so that the work per unit time is the same for every code within a given class regardless of the duration of the visit [Federal Register, November 25, 1992, Page 55949].” Similarly, extensive care plan oversight should be recognized and reimbursed according to the HCFA policy quoted above.

We believe the frequency of such extended services would be substantially less than the number of services billed under the presently recognized code. Therefore, the fiscal impact of extending coverage would be relatively small.

**Recommendation # 3: HCFA should develop policies that allow physicians to be reimbursed for specific medical telephone services.**

We also continue to believe that extensive--but non-recurrent--physician telephone services that are provided for patients should be separately billed and reimbursed according to the AMA's Current Procedural Terminology. Many professional services can be provided with high quality and efficiency via telephone. Telephone services which are reasonable, properly documented, and of high quality are billable services that merit reimbursement by patients and third parties, including Medicare, Medicaid and private insurers. Many patient telephone calls involve tangible resource costs to the physician including the physician's time and expertise. The physician is responsible for documenting these services and is liable for their medical appropriateness.

ASIM has developed guidelines (attached) on reimbursement for physician telephone services that could serve as a basis for the development of Medicare policy to allow reimbursement for such services under clearly defined circumstances.

**Recommendation # 4: HCFA should modify the direct supervision requirement for "incident to" physician services to allow coverage for services provided by mid-level health professionals who are employed by--and are under the general supervision of--a physician.**

ASIM urges HCFA to revise its 1993 policy that allows coverage and payment for services provided by employed NPs and PAs as long as the nonphysician is acting within the scope of practice allowed by the state and the physician fulfills all of the "incident to" supervision requirements. These requirements specify that the physician employer must have an ongoing relationship with the patient and must be immediately available within the office suite throughout the time the patient is being seen to provide assistance if necessary. The requirement that the physician be physically located within the office suite is referred to as the "direct supervision" requirement. This policy covers visits performed by nonphysician employees as well as other services within their scope of practice such as minor procedures. The requirement that the physician be immediately available within the building whenever services are provided by physician-employed mid-level practitioners is inconsistent with the concept of integrated primary care delivery in the context of a health care team working under a physician's supervision. In the current medical practice environment where patients with complex illnesses are routinely cared for in the home, hospice or nursing facility rather than the inpatient setting, the current "incident to" requirement makes it extremely difficult for physicians to direct and monitor the care provided to their patients. The "incident to" provision should be revised to allow coverage for services provided by physician-employed mid-level practitioners if: 1) the physician-employer has an established, ongoing relationship with the patient; 2) the physician-employed mid-level practitioner is acting within the scope of practice allowed by the state, and 3) the physician-employer, or the physician providing back-up coverage for the physician-employer, is
immediately available to provide assistance *via telephone or in the building* throughout the time the physician-employed mid-level practitioner provides services for the patient. Nonphysician providers should be explicitly identified as such when providing services to patients.

In May 1994, HCFA announced its intention to conduct a thorough review of the Medicare home health benefit under Medicare Part A. It is ASIM's understanding that HCFA is interested in reorganizing the benefit so it is simpler, results in the greatest benefit for the greatest number of patients, and provides a sensible basis for predicting expenditures. Perhaps the largest problem that has been identified during the discussions relating to Medicare's home health initiative is how to promote physician involvement in home health care. Given that internists frequently have no previous relationship with many home health agency personnel providing surrogate care for their homebound patients (and little opportunity to form such a relationship), they frequently express frustrations about the difficulty of verifying whether the homecare being provided is high quality and medically necessary. The physician often is overburdened with large volumes of administrative work to verify medical necessity of home health agency care and is placed in the position of second-guessing medical decisions of agency personnel rather than directing and participating in the medical decision making process.

Consistent with the movement toward more integrated systems of health care delivery, ASIM believes that physicians could provide better control over the quality of care provided to homebound patients if these services were provided by their own employed mid-level practitioners. In many instances, allowing coverage of such services could avoid an ambulance ride and emergency room visit that would otherwise have been necessary because the physician could not trust, verify or accept legal liability for homecare based on the medical information provided by a home health agency employee with whom the physician had no previous relationship.

It is ironic that HCFA allows coverage, and relatively exorbitant payment levels when compared to physician visits, for services provided under the Medicare Part A home health benefit by home health agency (HHA) personnel. Medicare currently reimburses home health agencies 50 percent more for nursing visits to patients in the home than they reimburse physicians for an established patient home visit. The Medicare reimbursement rate is approximately $95 for a home visit provided by a skilled nurse and only $61.50 for a level two, established patient, home visit provided by a physician.

When home services are provided by home health agency personnel, physician supervision in the overwhelming majority of cases is limited to brief telephone and written interactions between virtual strangers, usually long after the HHA interaction with patient. There is minimal coordination of care plans and little congruence between the preferred practice patterns of the physician and HHA personnel. Meanwhile, HCFA refuses to allow coverage and payment for out-of-office services (except in underserved rural areas) provided by physician employees who have equal training and a close, interactive relationship with the physician and in many cases, a preexisting relationship with the patient and family as well.

Since physicians are intimately familiar with the knowledge base, skills, judgment and capabilities of their own employees, they are much better able to assess what services can and cannot be appropriately provided without the physician's direct supervision in the office. The services provided by physician employees outside the office setting are much more closely coordinated and a truer "extension" of the physician than those provided by home health agency personnel with no previous relationship or employment ties to the physician.

Training of physician employed mid-level practitioners providing care to homebound patients without direct physician supervision should be required to meet the same standards as is currently required of home health agency personnel. Quality of health care would be improved because physicians
would have the opportunity to regularly discuss care of homebound patients during face-to-face meetings with their employed mid-level practitioners, which is a level of interaction that frequently is impossible when working with home health agency personnel.

**Recognizing the Value of Physician Case Management is Good Public Policy**

Home health care, hospice and nursing home reimbursement policies can be improved by providing incentives for cost-efficient use of resources. An important step is to fairly reimburse physicians for their medically necessary case management services that in many instances are instrumental in providing high quality medical care outside of the costly hospital setting. Direct savings to the Medicare program and the patient may include the costs of an ambulance, a hospital room and daily professional services. According to some studies, fewer laboratory and radiological tests are ordered for outpatients than for hospitalized patients with the same diagnosis and receiving the same treatment. One study shows that patients with disabilities can clearly be taken care of in a cost-effective manner at home where overhead is minimal rather than an institutional setting.

There is virtually unanimous agreement among physicians, allied health professionals, nursing home administrators, home health agency administrators, hospice administrators and others that physician case management services are valuable, cost-efficient services that reduce hospitalizations, provide for better continuity of patient care, and merit separate reimbursement. Allowing adequate reimbursement for physician case management services could resolve one of the most universal complaints of primary care physicians and medical subspecialists who are serving as principal care physicians.

**Summary of Recommendations**

In lieu of creating a new monthly capitation rate for case management services based upon patient diagnosis, ASIM recommends that HCFA:

1. expand the current care plan oversight policy to nursing home patients;
2. expand the current care plan oversight policy to include extensive case management services;
3. develop policies that allow physicians to be reimbursed for specific medical telephone services; and
4. modify the direct supervision requirement for "incident to" physician services to allow coverage for services provided by mid-level health professionals who are employed by--and are under the general supervision of--a physician.