The American Society of Internal Medicine (ASIM), representing the nation’s largest medical specialty, is pleased to provide the following testimony to the Practicing Physicians Advisory Council (PPAC) on the revised Documentation Guidelines for Evaluation and Management (E/M) services, Resource-Based Practice Expenses (RBPE), private contracting, physician self-referral rules, privacy and confidentiality, and regional laboratory carriers.

Documentation Guidelines for Evaluation and Management Services

ASIM’s Position on the New Guidelines

ASIM believes that proper documentation is a mutual interest of Medicare and physicians, and that it is appropriate for the medical community to participate in the development of the standard to which they will be held accountable. However, ASIM has not endorsed the revised documentation guidelines for E/M services that were developed jointly by the Health Care Financing Administration (HCFA) and the American Medical Association (AMA), in conjunction with medical specialty societies. Although ASIM believes that the guidelines are better because of our involvement, we remain concerned that complying with these comprehensive and complex guidelines will be so time consuming that it will detract from the time a physician has available to actually treat patients. ASIM has asked its members to bring specific problems with the guidelines to our attention. ASIM fully expects HCFA to revise the guidelines if specific, valid problems are identified.

Lack of Education on Content of Guidelines

ASIM understands that documentation guidelines for single system examinations were adopted to alert physicians as to what they are expected to document when performing such an exam. ASIM is concerned, however, with the ramifications of HCFA’s decision to play a secondary role in educating physicians on the content of the guidelines. HCFA’s decision to shift the primary responsibility for educating physicians as to the standard they will be held accountable to under the guidelines on specialty societies is inappropriate. ASIM believes that specialty societies should supplement HCFA’s educational efforts and not replace them.

Incorporation of Guidelines into HCFA’s Medical Review Audit Process

HCFA’s decision to hastily incorporate the guidelines into its medical review audit process at a time when it will increase post-payment audits and initiate prepayment reviews would have further exacerbated the situation. Holding physicians accountable to the revised guidelines on January 1, 1998, after just a three month “grace period,” would have created substantial problems as many physicians are still not aware of their existence. ASIM is encouraged by HCFA’s decision to extend the grace period an addition six month and to refrain from having the revised guidelines be the sole standard for medical review audits until July 1, 1998. ASIM recommends to HCFA that it increase its educational activities related to the revised guidelines during the extended grace period.
ASIM strongly opposes HCFA’s decision to initiate prepayment review and is skeptical of the decision to increase post-payment review, and we believe that these activities will fail to strike at the root of the problem. Prepayment review is costly and time consuming for both physicians and Medicare carriers. ASIM doubts that savings generated by prepayment review will justify the resources that must be put into it. We are also skeptical of a systematic increase in the number of claims subjected to post-payment review. While an increase in the number of aberrant billing patterns or beneficiary complaints would be appropriate mechanisms to trigger a rise in the frequency of post-payment review, simply mandating an increase in the number of reviews is unlikely to bring positive results.

Effect of Reaction to Health and Human Services Office of Inspector General’s Audit of HCFA

ASIM is aware that HCFA’s planned expansion of its auditing activities are a direct result of the Department of Health and Human (HHS) Services Office of Inspector General’s (OIG) financial audit that revealed that the agency made $23 billion dollars in “improper” Medicare payments in 1996. ASIM questioned the accuracy and the reporting of the OIG’s findings in our testimony before PPAC at its September 1997 meeting. In that testimony, ASIM specifically recommended that PPAC advise HHS to: (1) use the audit’s results as a starting point for identifying and improving problems associated with Medicare billing; (2) refrain from conducting prepayment review and additional post-payment review of claims; (3) provide clarification for the contentious billing issues currently facing physicians; and (4) resist Congressional pressure to take action that will increase physician hassles and decrease morale. ASIM also recommended that PPAC advise HHS to: (1) acknowledge that the OIG’s estimated improper payment total is not scientifically valid and fails to account for claims under appeal; and (2) ensure that the OIG’s forthcoming annual audits of HCFA are conducted and reported in a more judicious manner. ASIM believes that the need for HHS to act upon these recommendations regarding the OIG’s audit of HCFA is magnified by HCFA’s plans for incorporating the revised documentation guidelines for E/M services into its medical review auditing process.

How the Guidelines Should Be Used

ASIM believes that the guidelines should be used as an educational tool to help physicians better document their E/M services. They should not be used in a punitive fashion by carriers. The guidelines should be used principally as an educational tool used to review only physicians whose utilization (patterns of care) indicates that they are outliers. For example, a carrier would first have to identify, based on statistical profiles, that a physician has an unusual pattern of utilization of the E/M codes (e.g. a physician who bills level 5 visits more than half the time, or who never varies in the level of care billed); for such “outlier” physicians, the carrier could request documentation and compare them with the guidelines. If the physician’s documentation does not comply with the guidelines, the physician should be advised of this and be offered educational assistance on how to document better, but no claims would be denied based on this initial review. If the documentation guidelines are used in this manner, the only instance where claims would be denied would be in cases of fraud (when the documentation conclusively shows that the service was billed fraudulently) and in cases where the physician repeatedly fails to take action to improve his or her documentation.

It is inappropriate for HCFA to drastically reduce its educational efforts associated with the new, more comprehensive guidelines. Introducing new guidelines without the support of educational efforts, while expanding audits and planning stricter enforcement is not the answer. An educational approach aimed at improving physician documentation that only penalizes physicians who repeatedly fail to cooperate is likely to foster a more cooperative relationship between the Medicare program and the physicians that provide care to its beneficiaries.

Conclusion

ASIM urges PPAC to recommend that HHS: (1) be willing to revise the guidelines when specific valid concerns are brought to its attention; (2) increase educational activities on the content and use of the
guidelines; (3) refrain from conducting prepayment review and increased post-payment review of claims; (4) act upon ASIM’s September 1997 recommendations to PPAC regarding the OIG’s audit of HCFA; (5) use the revised guidelines to educate physicians in a non-punitive manner how to improve their documentation; and (6) recognize that simply expanding on the original documentation guidelines, which the government reports indicate have yet to be fully grasped by physicians, and using them in an antagonistic manner is not in the best interests of the Medicare program.

Resource-Based Practice Expenses

ASIM’s perspective on the Resource-Based Practice Expense (RBPE) project, presented at HCFA’s November 21, 1997 RBPE Conference, appears at the end of our testimony under “ATTACHMENT A.”

Private Contracting

ASIM’s policy on Medicare private contracting reads:

A. ASIM reaffirms its support for the right of physicians and Medicare patients to choose freely to enter into a private contract for professional services, provided that the law provides sufficient protections to assure that the patient who enters into such a contract has the information needed to make a free and informed choice, and that they have the opportunity to choose another physician should they not wish to enter into such a contract. ASIM calls on Congress to repeal the two-year ban on Medicare payments to physicians who enter into a private contract with a patient, provided that the protections identified below are included in the repeal legislation.

B. ASIM specifically believes that any legislation on private contracting should include:

1. A requirement that physicians disclose their specific fee for professional services covered by the private contract in advance of rendering such services, with beneficiaries being held harmless for any subsequent charge per service in excess of the agreed upon amount;

2. A prohibition on private contracting in cases where a physician is the “sole community provider” for those professional services that would covered by a private contract;

3. A prohibition on private contracts in other cases where the patient is not able to exercise free choice of physician;

4. A prohibition on private contracting for dual Medicare-Medicaid eligible patients.

ASIM urges PPAC to advise HHS to work with Congress to incorporate these changes into the private contracting provision of the law.

Physician Self Referral Rules

ASIM expects HCFA to publish the implementing regulations for the Stark II Physician Self-Referral amendments during the week proceeding today’s PPAC meeting. ASIM continues to believe that in order to make the law workable it is necessary to: (1) include a shared facility exemption; (2) change the physician supervision requirement language for in-office ancillary services from “direct supervision” to “general supervision;” and (3) repeal the group compensation requirement prohibiting physician compensation based on volume or value of referrals. ASIM will review the Stark II regulations and provide its comments to HCFA.
Privacy and Confidentiality

Secretary of Health and Human Services Recommendations on Confidentiality of Medical Records

ASIM reviewed the “confidentiality of individually-identifiable health information” recommendations, released by the Secretary of the Department of Health and Human Services (HHS), pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). ASIM finds the vast majority of the Secretary’s recommendations to be generally acceptable and consistent with ASIM policy. It is appropriate that the Secretary’s recommendations build upon existing patient privacy protection law, regulation, and commonly accepted research and ethical standards.

ASIM policy regarding the Secretary’s recommendations on confidentiality of medical records reads:

A. Entities that request patient health information from physicians must retain patient education materials regarding the patient’s right to review the requested health information when this information has been disclosed without the patient’s authorization. Such patient education materials must be provided to the patient upon their request rather than placing the disclosure burden on the physician from which the patient health information was requested;

B. The entity that denied a patient health care services and/or insurance coverage must provide the clinically relevant information to the patient regarding the denial of care and/or insurance coverage upon request rather than placing the disclosure burden on the physician;

C. Peer review and quality assurance activity data should not be required to be made available for patient inspection;

D. Patients’ ability to request that information in their record be corrected should be limited to clinically significant information or information relevant to correctly identifying the patient (such as name, date of birth, and insurance number);

E. Law enforcement agencies should only have the right to review medical records in criminal and/or fraud and abuse investigations without the patient’s authorization if the law enforcement agency has “probable cause.”

We have no specific problems with the Secretary’s recommendations on coverage and basic requirements (sections A and B of the recommendations), including safeguards on disclosure. The minimum disclosure requirements (Section B.3)—as currently drafted—shouldn’t impose excessive hassles or costs on internists and their office staffs, but disclosure may prove to be a hassle factor once the recommendations are codified into regulation and are enforced. Therefore, HHS must ensure that implementation of the standards that are eventually included in confidentiality legislation passed by Congress (or in the regulations that it must publish if Congress fails to pass legislation by the date specified in HIPAA) will not unduly burden physicians.

The Secretary’s recommendations on patient awareness and control (section C) will create hassle factor problems for physicians. The recommendations on explanation of information practices (section C.1) require physicians and the entities that request patient information to inform patients of their rights to review health information when the health information had to be disclosed without the patient’s authorization or at least keep the patient rights information on file and provide it to the patient upon request. If the Secretary intends that patient rights information be disclosed to the patient every time health information is transmitted, the disclosure burden should not be placed on both the provider and the other entity; rather, it should be the source that is requesting the health information that should inform the
The requester should inform the patient rather than requiring that the same information be
provided to the patient from two separate sources.

The recommendations on patient inspection and copying of records (section C.2) indicate that patients
will be allowed to inspect and copy health information held by providers and payers. It is likely that
patients will request copies of all their records every time a procedure is denied by a health plan. This
would create a lot of hassle for physicians if it is the physician that is required to provide the information to
the patient. Instead, it should be the entity that denied the care that must provide the clinically relevant
information to the patient regarding the denial of care. This distinction is important because there is a
phrase in the recommendations that indicates that the patient can be denied access to information “if it
duplicates information available for inspection by the patient.” Payers can use this recommendation to
pass all the disclosure burden on to the physician who maintains the patient’s medical record, which is
clearly inappropriate.

The recommendation that allows providers and payers to deny patient inspection of health information if it
is used solely for internal management purposes and is not used in treating the patient or making an
administrative determination about the patient (section C.3) should be strengthened to specifically include
peer review and quality assurance activity data. This information should not be disclosed to patients as it
is relevant only to the physician and the reviewer and because the clinical information is already available
in the patient’s medical record.

The provision allowing patients to request that information in the patient’s record be corrected (section
C.3) should be limited to clinically significant information or information relevant to correctly identifying the
patient (such as name, date of birth, and insurance number). Otherwise, patients may request all sorts
of non-pertinent information be altered in the their charts. For example, the patient may request a change
in their medical record if the patient disagrees with the weight listed in their chart because they were
weighed with their shoes on. The Secretary’s recommendation as it is currently worded would force
physicians to consider all sorts of requests that have nothing to do with patient care.

The requirements that providers and payers maintain a log of disclosure of health information (section
C.4) would not impose an unreasonable burden on internists and their office staffs. The requirements
governing disclosure authorized by patients (Section D) and other disclosures regarding payment for
services (Section E.1) are not unreasonable either.

ASIM supports the contention that law enforcement agencies should only have the right to review medical
records in criminal and/or fraud and abuse investigations without the patient’s authorization (Section E.2)
if the law enforcement agency has probable cause. This will prevent the law enforcement agencies from
undertaking “fishing expeditions” for fraud and abuse, which may be possible under the wider-ranging
recommendation by the Secretary. Additionally, the Secretary’s current recommendation regarding
accreditation, standard-setting, or other voluntary quality review organizations does not require that
records be transmitted in a manner where the patient’s identity is unknown before being reviewed by
these voluntary review entities. These organizations must have the patient’s authorization to review
patient records unless the information is transmitted in a manner where the patient’s identity is unknown.

The disclosure policies regarding public health (section E.3), research (section E.4), emergency purposes
(section E.5), state health data systems (section E.6), next-of-kin (section E.7), directory information
(section E.8), law enforcement (sections E.9-10), judicial proceedings (section E.11-13) and disclosure
policies regarding specialized classes of persons and entities (section F) all seem reasonable.

ASIM agrees with the Secretary’s statement that these recommendations (section G) should preempt
State laws only to the extent that those laws are less stringent or restrictive than the Federal law, but that
the legislation should not modify or supersede other Federal or State law that provides greater
protection. The enforcement and sanction recommendations (section H) appear to be reasonable and
are consistent with current House of Delegates policy. The recommendations on administration and
implementation (section I) also appear to be reasonable. Finally, the proposal that the standards become effective within nine months of issuing regulations is a sufficient period of time for internists to come into compliance with the regulations.

Regional Laboratory Carriers

ASIM strongly urges HHS to exempt physician office labs (POLs) from having to submit claims for laboratory services to one of the regional carriers whose development is mandated by the Balanced Budget Act of 1997 (BBA ‘97). The BBA ‘97 permits HHS to exclude POLs from the requirement that all laboratory service claims be submitted to a regional carrier “if the Secretary determines that such offices would be unduly burdened by the application of billing responsibilities with respect to more than one carrier.”

Having to submit claims for laboratory services to a newly designated regional carrier, while continuing to send all other claims for service to an existing Medicare carrier would certainly unduly burden physicians with POLs. Without an exemption, POLs would be required to submit over 60 million new claims (based on data supplied by HCFA) to the new regional carriers. Aside from the additional resources necessary to prepare and submit these claims, it is simply unnecessary for force physicians to generate identical claims for the same beneficiary to submit to the same federal program. Failing to exempt POLs from this requirement would cause ASIM to question the Administration’s commitment to its frequently stated goal of administrative simplification.

This provision was included in the BBA ‘97 to simplify the billing process for large regional and national clinical laboratories who were required to submit claims to local carriers. Problems occur because local carriers often have vastly different, and sometimes conflicting, lab test coverage and payment policies. POLs experience this problem infrequently under the current setup as they typically only bill a single, local carrier. However, if HHS fails to exempt POLs the legislative intent of this provision in the BBA ‘97 will not fully be recognized; administrative relief will be provided to regional or national laboratories, as POLs will be saddled with a new and even greater administrative burden.

It is our understanding that HHS may seek a legislative repeal of this provision as to avoid designating regional laboratory carriers. ASIM strongly believes that any attempt by the Administration to repeal this BBA ‘97 provision must refrain from interfering with the development of uniform coverage, administrative, and payment policies for clinical laboratory tests, which the BBA mandates must be in place by January 1, 1999. ASIM has already expressed its interest in working with HHS to standardize lab policies and looks forward to assisting the Administration in achieving this task.

ASIM thanks PPAC for the opportunity to comment on the revised Documentation Guidelines for E/M services, RBPEs, private contracting, physician self-referral rules, privacy and confidentiality, and regional laboratory carriers.

ATTACHMENT A

HCFA CONFERENCE ON RESOURCE-BASED PRACTICE EXPENSES

VIEWS AND RECOMMENDATIONS

OF THE

AMERICAN SOCIETY OF INTERNAL MEDICINE

November 21, 1997
The American Society of Internal Medicine (ASIM) appreciates the opportunity to share our perspectives on HCFA’s approach to developing resource-based practice expenses (RBPEs). We understand that HCFA is particularly interested in our views on how indirect practice expense relative value units (RVUs) should be developed. Given the fact that HCFA has proposed that the indirect practice expense RVU be based in part on the direct PE-RVUs, it is important to also discuss today the process and methodology that HCFA proposes be used to develop the direct practice expense inputs.

It seems to us that there are at least seven fundamental questions that HCFA must answer as it refines its proposal:

First, is the objective to develop direct and indirect PE RVUs that pay physicians for the actual costs that they incur—or is the objective to develop PE-RVUs that determine how much more or less each service costs compared to other services on the same scale?

Second, is HCFA’s proposal to divide total PE-RVUs into separate pools of direct and indirect PEs a reasonable one, and do the data specifically support the proposed 55%/45% split between direct and indirect PE RVUs?

Third, should the numerical factor that scales the indirect PEs per service to the aggregate 55/45% split be uniform for all services, or should the factor vary based on specialty-based weighted averages of indirect PEs?

Fourth, should the “pass through” option of basing indirect expenses on the historical charge-based system be considered?

Fifth, is it reasonable to base the indirect PE RVUs on the sum of the direct PE RVUs, physician work RVUs, and medical liability RVUs, scaled to the total pool of indirect PE RVUs?

Sixth, are the process and methodology being used to develop the direct PE RVUs reasonable ones?

Finally, what additional data should HCFA collect on direct and indirect PE RVUs for the purpose of developing a new proposed rule, and new PE-RVUs, for publication by May 1, 1998 as mandated by the Balanced Budget Act of 1997?

ASIM offers the following perspectives on each of these questions.

1. **Is the objective to develop direct and indirect PE RVUs that pay physicians for the actual costs that they incur—or is the objective to develop PE-RVUs that determine relatively how much more or less each service costs compared to other services on the same scale?**

Perhaps the single greatest misconception that many physicians have is that the final RBPE rule should assure that physicians are adequately compensated for the actual costs that they incur in running their practices. But the purpose of a relative value scale is to determine how much more or less each service should be valued compared to all other services on the same scale, not how much each service should be paid in an absolute sense.

Under a resource-based relative value scale, the relative values cannot be based on historical charges. In the case of physician work, they must be based on the relative amount of physician time, mental and physical effort, judgment, and stress due to risk to the patient of each service compared to all others on the same scale. In the case of practice expenses, they must be based on the relative amount of clinical and administrative staff times, equipment, supply, utilities, rent, and
other practice expenses the physician is typically responsible for, compared to all others on the same scale. Therefore, it can be expected that the relativity established by a resource-based relative value scale will be very different from what physicians were accustomed to under the charge-based methodology that is currently used to determine practice expenses.

Finally, whether or not the relative values that are established under a resource based relative value scale result in fee schedule payments that pay physicians for the actual costs that they incur is a function of the dollar conversion factor that converts the RVUs into payment amounts, not the RVUs themselves. If the total payments are insufficient to cover physicians’ costs, then the reason is that Congress has not provided an adequate conversion factor, not that the PE-RVUs themselves are flawed.

All of this may seem obvious to some in this room. But it is apparent that many physicians have a very different impression of what this whole exercise is all about. To them, the litmus test is not whether the relativity is correct, but whether or not the fee schedule payments will cover their actual costs or charges. If the objective instead is to develop a resource-based relative value scale, HCFA only needs to assure that the data and methodology it uses results in a reasonable relationship across all physician services based on the best available data on the resource costs involved in providing each service, not that the PE-RVUs cover the actual costs or charges of any given physician or specialty.

2. Is HCFA’s proposal to divide total PE-RVUs into separate pools of direct and indirect PEs a reasonable one, and do the data specifically support the proposed 55%/45% split between direct and indirect PE RVUs?

According to the October 31 notice of the intent to regulate, HCFA states that "indirect costs are generally defined as those costs not directly allocable to individual services, such as rent, utilities, maintenance, phones, general clerical staff, and office equipment . . . Costs attributable to billing, procedure-specific equipment maintenance, and other direct expenses should not be included since they were captured by the clinical practice expert panels or other means."

ASIM believes that HCFA’s definition of indirect costs is a reasonable one. Some costs, such as billing and clerical costs, are inherently difficult to categorize explicitly as a direct or indirect practice expense. Although we have no conceptual disagreement with including billing costs in the direct cost RVUs for a specific procedure, we do have some concerns, as discussed later in this statement, that some of the clerical and administrative cost estimates from the CPEPs and validation panels are inflated.

Based on an analysis of the AMA’s Socioeconomic Monitoring Survey (SMS) data, HCFA concluded that in aggregate approximately 55 percent of the practice expenses that physicians incur involve direct practice expenses, and 45 percent indirect practice expenses. Based on this finding, HCFA proposed to divide the total pool of PE-RVUs into separate pools of direct and indirect PE-RVUs, with 55% of the total PE-RVUs representing direct PE-RVUs and 45% indirect PE-RVUs.

Based on a review by our own committee of physician experts on practice expenses, ASIM has concluded that HCFA’s percentage allocation of the total pool of direct and indirect PEs is valid and well-supported by existing data on practice expenses. We have yet to see any credible data that suggests that this allocation is fundamentally flawed or inherently unreasonable.

3. Should the numerical factor that scales the indirect PEs per service to the aggregate 55/45% split be uniform for all services, or should the factor vary based on specialty-based weighted averages of indirect PEs?
In our comments on the proposed rule, we asked that HCFA consider varying the percentage allocation of indirect PEs per service based on the weighted average by frequency of the indirect costs of the specialties that provide each service. HCFA proposed to base the indirect PE-RVUs on the sum of the direct practice expense RVUs, the physician work RVUs, and the malpractice RVUs, multiplied by a factor of 0.219 to scale the indirect PEs to the total available pool of indirect PE-RVUs. Under ASIM’s suggested alternative, the multiplicative factor would vary based on the proportion of indirect practice expenses of the specialties that perform each service, weighted by the frequency by which each specialty billed for each service. For specialties for which there are insufficient data on billing frequencies, the 0.219 multiplicative factor would be the default.

ASIM continues to believe that this option deserves consideration by HCFA. If a particular specialty has a higher proportion of indirect practice expenses than is the average for all specialties, and that specialty provides a given service more frequently than any other, it seems only fair that the higher proportion of indirect PEs that typically are involved in providing the service be reflected in the factor used to determine the total number of indirect PE-RVUs.

We suggest that HCFA present this option, along with estimates of its potential impact on payments per specialty and per service, as part of the new proposed rule for public comment that will be published by May 1 of next year. It is premature for ASIM and other interested parties to unequivocally endorse this option without having more information on its potential impact compared to the option of applying the same multiplicative factor to all services, however.

4. Should the "pass through" option be considered?

No. The pass through option, which would base the indirect practice expense RVUs on the current charge-based PE-RVUs (after the new direct practice expense RVUs are subtracted from the total RVUs) is fundamentally inconsistent with resource-based payments and statutory intent.

5. Is it reasonable to base the indirect PE RVUs on the sum of the direct PE RVUs, physician work RVUs, and medical liability RVUs, scaled to the total pool of indirect PE RVUs?

ASIM believes that the basic formula proposed by HCFA for determining indirect practice expense RVUs is fundamentally sound.

A major element of the physician work RVUs is the time a physician spends in providing a service. A major element of the direct practice expense RVUs is the time that clinical and administrative staff spend that is directly related to the performance of a given procedure. In our view, there is a clear relationship between the amount of time that a physician and his or her staff spend in providing a service and the indirect costs associated with the service. Services that take more time to perform typically require more indirect costs--administrative salaries, utilities and rent--than services that take less physician and staff time.

Earlier, HCFA had considered basing the indirect PE-RVUs only on physician time or staff time. Basing the indirect practice expense RVUs only on physician time could undervalue services that have involve little physician time but extensive staff time, however. Basing the indirect practice expense RVUs only on staff time could undervalue services that involve substantial physician time, but relatively less staff time. Using physician time, as opposed to physician work, would undervalue highly work intensive services that involve substantial physician work but relatively less direct face-to-face physician time. Therefore, it seems reasonable to base the indirect PE RVUs on both physician work and the direct practice expense RVUs, as proposed by HCFA.
Some have criticized HCFA’s proposal for relying on "proxies" to determine indirect PE-RVUs. Several studies support basing indirect PE-RVUs on formulas derived from extant data on physician time or physician work, however. Dunn and Latimer from Health Economics Research used extant data from the Hsiao study on physician time to develop indirect PE-RVUs. They concluded that:

- The formula-driven approaches employed in this study make use of existing data and can be implemented and updated on a timely basis at relatively low cost. The accuracy of these methods is an empirical question. Our impact simulations suggest that they address the biases perceived by many in the existing MFS practice expense RVUs. They also produce RVUs which are similar to those generated by more extensive accounting-based studies such as that conducted by PPRC. Given their design, these approaches are also likely to be more resistant to potential gaming and undue influence by those most influenced by the study results." (page iii)

Similarly, extensive research by Harvard University, PPRC, and Pope and Burge also support a conclusion that extant data on physician time and/or work can be used to develop direct and indirect PE-RVUs. Attached to this statement is a summary of ten studies that supports the views that (1) extant data can be used to develop resource-based practice expense RVUs, including indirect PE RVUs and (2) existing data support a conclusion that office-based services, particularly E/M services, are undervalued based on the current charge-based formula.

It should be recognized that there are several different approaches that HCFA could take to determining indirect PE RVUs and that no matter what method is used, indirect practice expenses by definition will have to be allocated to specific services using a formula or proxy. If it was possible to directly link the costs to a given service, those costs would be included in the direct practice expense RVUs, not as indirect PE-RVUs. We concur with the views expressed by the Physician Payment Review Commission in its 1997 Annual Report to Congress:

- HCFA must choose among several alternative methods for allocating indirect costs . . . No one correct method exists, and no analytic tools are available that would dictate the choice. Instead, HCFA must consider factors like data availability and reliability, payment incentives, and policy goals. The method should be acceptable to physicians so that the resulting values are credible.

It is also likely that no matter what method is used to determine direct and indirect practice expense RVUs, the results will still likely support a conclusion that office-based services are undervalued and most in-hospital procedures overvalued. In 1991, Dunn and Latimer concluded the following:

- First, whichever one of the four allocation methods is used, the high-intensity services tend to experience significant declines in fees, whereas the low-intensity services experience increases. Fees for office visits in particular increase substantially. This pattern agrees with the PPRC results, which are based on service-specific measures of direct expenses. Any resource-based method for incorporating practice costs into the RBRVS will narrow the gap in fees between high-intensity (primarily invasive) and low-intensity (primarily evaluation and management) services, increasing fees for office visits in particular. Second . . . using time as a basis for allocation results in an even smaller differential in fees between high-intensity and low-intensity services than using work. Third, our sensitivity analysis . . . shows that whether 100% of office expenses are counted as indirect, or
50% as indirect and 50% as direct, makes relatively little difference in the fees. The largest difference between a total fee among the services listed . . . and the corresponding direct and indirect, is about nine percent. The imprecision with which this classification must be made appears not to have great practical importance. Fourth . . . an allocation method which is more resource-based than the current one can be simple.

Given the fact that assignment of indirect costs to direct services is inherently imprecise (Dunn and Latimer) and no one correct method exists (PPRC), we believe that HCFA’s proposal is a reasonable one, considering data availability and reliability, payment incentives, and appropriate policy goals (PPRC).

6. Are the process and methodology being used to develop the direct PE RVUs reasonable ones?

ASIM believes that the process of developing direct PE-RVUs based on the input of the clinical practice expert panels (CPEPS), as recently refined by the validation panels, is likely to result in reasonable estimates of the relative relationships of direct costs within families of similar services. We have less confidence in that this process will by itself produce appropriate direct PE-RVUs across families of services. Inconsistencies in how the CPEPs and the validation panels determined the amount of clinical and administrative costs associated with the services that they evaluated argue for the necessity of the data editing and linking methods proposed by HCFA in the June NPRM.

Over the past several weeks, the physician representatives from our organization that participated in the validation panel meetings early last month reported to us on their observations. With the exception of the validation panel for E/M services, they expressed similar concerns. Specifically:

1. The internists who served on the E/M validation panel felt that it had arrived at recommendations in which they have a high degree of confidence. They particularly felt that the estimates of direct clinical and administrative staff times were reasonable and appropriate. This panel may have been more successful in reaching a consensus on clinical and administrative staff times due to the fact that the composition of the panel assured balanced representation from primary care physicians, medical specialists, and surgical specialists. No one group dominated the panel--there were six primary care physicians, five surgeons (including obstetrics and gynecology), one emergency physician and one internal medicine subspecialty (cardiology) that performs a substantial number of invasive procedures in the hospital setting.

2. There seemed to be a consistent pattern in most, if not all, of the other validation panels inflating clinical and administrative staff times. Billing times, especially the time required to obtain pre-certification approval for surgical procedures, were viewed as excessive by the internist participants. Many surgical specialists also continued to argue that their clinical nursing staff were substantially involved in assisting in the performance of surgical procedures in the hospital setting, which was not supported by the observations of internists who are familiar with the way surgery is performed in
their own hospitals. No independent data have been provided to support the view that the surgeon's own nursing staff are heavily involved in providing inpatient procedures. Primary care physicians and carrier medical directors attempted to challenge these inflated estimates, but the composition of the panels made it difficult for them to do so.

The observations of internists who participated in the validation panels therefore support two key elements of HCFA’s original proposed rule on practice expenses: linking and data editing.

By supporting linking, we do not necessarily argue that the specific mathematical formula proposed by HCFA in the June NPRM is the only way to establish the appropriate relative relationship between the clinical and administrative staff times for E/M services and those for other services. In our formal comments to HCFA, we urged that HCFA solicit comments on other ways to establish appropriate linkages. But we continue to believe that the clinical and administrative staff times developed by the non-E/M CPEPs and validation panels generally are too high compared to those for E/M services, and that HCFA must therefore establish linkages that will result in a more appropriate relative relationship between E/M services and non-E/M services. We also believe that HCFA needs to continue to apply data editing rules to the CPEP data as modified by the validation panels. We base these conclusions on the following:

First, although small group panels can come up with the proper relative relationship within a given family of services, a process of linking all of the clinical and administrative staff estimates to those for E/M services needs to be applied to assure consistency across panels. If all the panels inflated the administrative and clinical staff times by an equal amount, then linking would not be needed. But if some panels’ estimates were consistently inflated compared to the estimates for E/M services, in the absence of linking, procedural services would continue to be overvalued at the expense of E/M services. Physicians who provide E/M services should not be penalized because the E/M panels were more conservative in their estimates of clinical and administrative staff times compared to the estimates from the other panels. The composition and decision-making rules made it impossible for internists and other primary care physicians to lower the time estimates for the other panels, even when they made their concerns known. Therefore, linking is essential to assure a proper relative relationship across families of services.

Second, in the absence of any independent data to support the contention that the nursing staff of surgeons typically accompany and assist the surgeon in providing a surgical procedure in the hospital, HCFA should continue to edit out clinical nursing staff time estimates for services provided in an inpatient setting, as suggested in HCFA’s proposed rule from June. Even if it could be shown that surgeons are bringing their own nurses into the hospital setting, HCFA needs to consider if the nurse is providing patient care services that otherwise would have been performed by the physician. If so, the nurse may be providing services that should be considered a work expense (i.e. checking on patients or doing preliminary information gathering, ordering, etc. that would otherwise have to be done by the physician, not a practice expense.

ASIM understands that HCFA may be giving consideration to dropping the linking formula proposed in the NPRM and replacing it with a multi-specialty panel that would reach consensus on specific codes that were reviewed by more than one CPEP and validation panel and given different clinical and administrative staff times. Given the experience to date with the validation panels, we are highly skeptical that a multi-specialty panel will be able to establish appropriate relative relationships between clinical and administrative staff times for E/M and non-E/M services. If the panel is working with three different estimates from the validation panels, but all three of the estimates are inflated, then it is likely that it would arrive at a “compromise” that would still overvalue the clinical and administrative staff times compared to those for E/M services.
It is also not clear how such a panel could establish appropriate relative relationships for over 7000 CPT codes. The decision-making rules and composition of the panel would also largely dictate the values that it produces. Therefore, we urge HCFA to exercise extreme caution in relying on a cross-specialty panel to determine the appropriate relativity of clinical and administrative staff times. A multi-specialty panel, such as the RUC, could play an important role in refining the PE-RVUs in the future, however.

**7. What additional data should HCFA collect on direct and indirect PE RVUs for the purpose of developing a new proposed rule, and new PE-RVUs, for publication by May 1, 1998 as mandated by the Balanced Budget Act of 1997?**

For all of the reasons presented in this paper, ASIM believes that the process HCFA is following is likely to produce reasonable resource-based practice expenses without the need to initiate a substantial new data collection effort. We specifically believe that a process that principally relies on extant data on direct and indirect practice expense is likely to produce reasonable resource-based practice expense RVUs.

Although ASIM has a good deal of confidence in the current process, we support efforts to obtain additional data as appropriate. Independent data should be sought before accepting the contention made by some surgeons that it is a common practice to bring nursing staff into the hospital to assist in performing a surgical procedure. Other data, such as that obtained by MGMA, could be used to compare the clinical and administrative staff times from the CPEPs, as refined by the validation panels, with data on the number of FTEs in a practice, using reasonable volume assumptions.

The BBA '97 requires that HCFA "utilize, to the maximum extent practicable, generally accepted accounting principles that recognize all staff, equipment, supplies and expenses, not solely those that can be linked to specific procedures, and use actual data on equipment utilization and other assumptions." ASIM believes that the Notice of Intent to Regulate, published in the October 31, 1997 Federal Register, represents a good faith effort by the agency to solicit such data to the maximum extent practicable.

By specifying that HCFA utilize generally acceptable accounting principles and actual cost data only to the "maximum extent practicable," Congress made it clear however that it did not intend for HCFA to initiate a major new cost accounting study, since it is not practicable to expect that such a study could be initiated, and reliable data made available, in time to be used in developing the proposed rule that Congress directed must be published by May 1, 1998. Nor, in ASIM’s view, is it necessary that such a study be initiated in order to produce reasonable resource-based practice expense RVUs. It is clear that Congress did not intend that the practice expense RVUs cover actual costs, only that such cost data be considered to the maximum extent practicable in determining the relative relationships between each physician service.

Cost accounting also does not address the issue of resource inputs, only costs which can vary widely from practice to practice. Examples include rent in fancy buildings versus low budget buildings; fancy computers vs. simpler ones that can do the job; expensive nurses vs. less expensive medical technicians, and other such variable costs.

ASIM believes that HCFA should consider verifiable data on the actual utilization rates for equipment. The 50 percent utilization rate should be considered the default estimates in the absence of better data on equipment utilization.
We note that in HCFA’s October 31 notice of intent to regulate, HCFA expresses a willingness to consider special studies conducted by specialty societies to develop or validate resource-based RVUs for physician services. Although ASIM commends HCFA for seeking additional data, we caution the agency to look very critically at studies funded by groups with a vested financial interest in the outcome of the RBPE study.

Conclusions

To summarize, ASIM believes that HCFA’s definition of indirect costs is a reasonable one. We believe that extant data from the AMA Socioeconomic Monitoring Service can reasonably be used to determine the proportion of total practice expense RVUs that represent direct and indirect costs as the agency proposes. We believe that the number of indirect PE RVUs per procedure can reasonably be derived from the physician work RVUs and direct practice expense RVUs, scaled to the total available pool of indirect PE RVUs, possibly using the weighted averages by billing frequency of the indirect costs of the specialties that provide each service. We believe that HCFA must assure that the administrative and clinical staff time estimates from the non-E/M CPEPs and validation panels that are included in the direct cost RVUs are valued properly compared to those for the E/M codes, using a reasonable linking methodology. Finally, we have suggested that the statutory mandate that HCFA use generally accepted accounting principles “to the maximum extent practicable” does not require that HCFA conduct a cost accounting study of actual costs or that the PE RVUs cover the actual costs incurred by physicians.

Throughout our comments today, ASIM has repeatedly suggested that HCFA’s proposal be reviewed using a standard of reasonableness. There simply is no perfect method for determining direct and indirect PEs that will be endorsed by all of the experts in the field and that would enjoy the support of all physicians. The PPRC, in its 1997 report to Congress, said it best:

HCFA must choose among several alternative methods for allocating indirect costs . . No one correct method exists, and no analytic tools are available that would dictate the choice. Instead, HCFA must consider factors like data availability and reliability, payment incentives, and policy goals.

The test ultimately must be whether or not HCFA’s approach is a reasonable one, based on the available data, program policy goals and the statutory requirements. While final judgment must be reserved until a new proposed rule is published in the Spring of 1998, ASIM believes that the process HCFA is following to refine the methodology proposed this past June is more likely than not to produce direct and indirect resource based practice expense RVUs that will meet any reasonable standard of validity. Certainly, we have not heard any proposal that lays out a better process for achieving accurate resource-based relative value units.

Finally, it must be noted that the current charge-based system of allocating practice expenses is inherently unfair. To our knowledge, every independent study (i.e. a study not funded by a group with a financial interest in the outcome) has concluded that office-based services, particularly E/M services, are systematically undervalued, and many invasive procedures overvalued, under the current Medicare fee schedule. The approach that HCFA has taken to develop resource-based practice expenses will almost certainly result in payments that more closely reflect relative differences in practice expense inputs than the current charge-based formula. Refinements of the way that HCFA proposes to define and allocate direct and indirect costs are not likely change that basic conclusion that under a resource-based practice expense system, the total practice expense RVUs--direct and indirect combined--for office-based services will be substantially higher, and those for invasive procedures done in the hospital lower, than under the current Medicare fee schedule.
We’d be pleased to answer any questions.