Interim Position Statement on the Medical Direction ob Residents by Teaching Physicians in Academic Settings Based on Recommendations of the AAMC Ad-HOC committee on Physician Payment Reform

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September 1993



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AAMC Interim Position Statement On The Medical Direction Of Residents By Teaching Physicians In Academic Settings

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Approved as an Interim Position Statement by the AAMC Executive Council on September 23, 1993

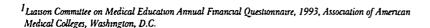
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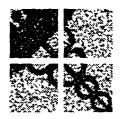
Introduction

Since 1969, the Association of American Medical Colleges (AAMC) has supported the general intent and philosophy of Intermediary Letter 372 (IL-372) Guidelines which delineate the broad criteria for payment to physicians in teaching settings under Medicare Part B. Overall, the AAMC believes that the historical interpretation of the Guidelines has served the academic medical community and the nation well. While there has been substantial variation in the interpretation of the Guidelines by local carriers, problems relating to interpretation, application, or compliance have typically been resolved at the local carrier level without major national policy change or compromise to the teaching and patient care activities of faculty physicians. However, the AAMC recognizes that continuing ambiguities and a recent interpretation of IL-372 Guidelines are causing serious problems for clinical faculty, medical schools and teaching hospitals.

The AAMC and its membership are concerned with assuring high quality patient care and the best possible teaching environment. To achieve these goals, the Association takes a strong interest in Medicare payment policy and provisions which assure equitable payment to teaching physicians for their professional services. Over the past 25 years, medical schools have become increasingly dependent upon the professional service income generated by the clinical faculty as a revenue source due to reductions (in relative terms) of more traditional sources of revenue, such as federal and state funding and research grants. Although the largest share of medical practice income is used to supplement the base salaries paid to the faculty by the school, a significant portion is contributed to the medical school in support of basic science and other essential medical school programs. Medical practice income now accounts for an average of 32.4% of total medical school revenues for 1991-92. At some medical schools, this percentage is much higher. Depending upon the percentage of Medicare patients, many practice plans are experiencing reductions in medical practice income due to implementation of the Medicare Fee Schedule and other policies which disadvantage specialty and procedure-oriented services. Changes in Medicare payment policy will only exacerbate a rather uncertain financial situation at most medical schools and could upset the research and educational missions that have allowed U.S. medical schools to set the standards for the rest of the world.

Medicare supports its proportionate share of costs for physicians in teaching settings to teach and supervise residents under Part A, the direct medical education payment. Allowable costs reimbursed to the hospital through the direct medical education payment include teaching physicians' salaries, teaching physician support costs, and related medical school costs.







Educational support and supervision are often intertwined and not easily separable or distinct from the patient's medical care services. Where these activities are predominantly education, reimbursement of educational support and supervision of the resident by the faculty physician under Part A is appropriate and reasonable.

In testimony before the Health and the Environment Subcommittee of the House Interstate and Foreign Commerce Committee on October 22, 1979 regarding the proposed HCFA regulation to implement Section 227 of the 1972 Social Security Act Amendments, the AAMC stated that:

"The subtle and sometimes elusive question which is causing the controversy should be stated as: How can one be reasonably certain that time and effort devoted to and reimbursed under Medicare Part A for administration, supervision, and teaching does not <u>simultaneously</u> include professional medical services which are billed under Part B?"

The Association is opposed to circumstances leading to double billing in which a single service is reimbursed under both Part A and Part B. However, where the faculty physician provides medical management of the patient, in connection with educational support and supervision, reimbursement of the faculty physician for professional services under Part B is appropriate and reasonable.

Prompted by the issuance of a December 30, 1992 memorandum by HCFA stating that the "physical presence" of the attending physician is a requirement when billing for a professional service performed by a resident, the AAMC believes it is appropriate to reexamine the Guidelines in light of current health care delivery and graduate medical education requirements. The requirement for the "physical presence" of the attending physician is not clearly understood or accepted either by local carriers or providers.

The AAMC is concerned that this narrow interpretation of the physical presence condition by HCFA will not accommodate either the existing graduate medical education (GME) environment or changing GME requirements. It is essential that any change in interpretation or regulation should serve to improve the teaching and training opportunities in ambulatory settings. Many specialties will be adversely affected by the physical presence requirement. For example, family practice, internal medicine, ob-gyn, pediatrics, emergency medicine and psychiatry need more supportive regulations to encourage the provision of ambulatory care experiences.

In this AAMC position statement, the Association comments on when, and under what conditions, a professional fee for medical services is appropriate for a teaching physician when residents are involved in the care of the patient. The AAMC encourages the Secretary of Health and Human

Services and the Administrator of the Health Care Financing Administration to consider these comments when reconsidering current interpretations and future proposed regulations on this subject.

I. Medical Direction and Medical Education

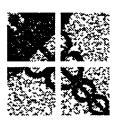
In many instances, medical direction and medical education/supervision of residents occurs simultaneously and synergistically within the academic patient care environment. While this type of joint activity is essential for education, and is beneficial to patient care, it sometimes makes it difficult for outside parties to distinguish which of these activities predominates for any specific interaction of the student and attending physician with the patient. A precise, crystalline distinction is not always possible.

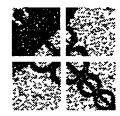
Medicare payment policy, while recognizing the joint nature of these activities, attempts to distinguish between the activities of education and medical direction. Within the Medicare program the educational and teaching activities of attending physicians are paid under Medicare Part A and the activities of medical direction of residents, under Part B. To support and guide these payment policies the Medicare program requires specific criteria which permit both Medicare and the provider to determine when payment under Part A or Part B is appropriate. These criteria, or 'markers,' tend to focus on when medical direction is occurring with a de facto assumption that other activity—supported by documentation such as time studies—is attributable to education not reimbursable under Part B.

The AAMC believes that the medical direction of residents by attending physicians is, in general, distinguishable from education since it is typically patient-specific, is documented in the patient's medical record, and is an integral component of the overall management of the patient's care. While medical direction is usually distinguishable, it is also recognized that this activity is blurred by the very nature of the academic clinical setting in which education occurs side-by-side with the delivery of patient care. Nevertheless, when it can be determined that medical direction is the dominant activity, it should be viewed—in and of itself—as a legitimate, billable service under Part B, as defined within the framework for establishing an "attending physician relationship." This framework is appropriately stated in IL-372 Guidelines, which the AAMC believes have historically recognized the distinction between education and medical direction activities of residents since 1969.

II. The Framework for Establishing an Inpatient "Attending Physician" Relationship

The AAMC supports the basic tenets expressed in IL-372 Guidelines regarding the establishment of an <u>inpatient</u> attending physician relationship. HCFA should recognize, however, that IL-372 Guidelines address only the nature of the attending physician relationship as it has historically





been structured for the inpatient teaching setting. The AAMC supports updating the basic tenets of IL-372 Guidelines so that they encompass inpatient, outpatient and other ambulatory care teaching settings being developed to train residents today. The Association makes specific recommendations for updating the Guidelines later in this document.

Existing IL-372 Guidelines state that to be the "attending physician" for an entire period of hospital care, the teaching physician must, at a minimum:

- A. review the patient's history, the record of examinations and tests in the institution, and make frequent reviews of the patient's progress; and
- **B.** personally examine the patient; and
- C. confirm or revise the diagnosis and determine the course of treatment to be followed; and
- **D.** either perform the physician's services required by the patient or supervise the treatment so as to assure that appropriate services are provided by interns, residents, or others and that the care meets a proper quality level; and
- **E.** be present and ready to perform any service that would be performed by an attending physician in a non-teaching setting when a major surgical procedure or a complex or dangerous medical procedure is performed. For the physician to be an "attending physician" his presence as an attending physician must be necessary (not superfluous as where, for example, the resident performing the procedure is fully qualified to do so) from the medical standpoint; and
- **F.** be recognized by the patient as his personal physician and be personally responsible for the continuity of the patient's care, at least throughout the period of hospitalization.

The AAMC believes these Guidelines are consistent with the AAMC's interpretation that in order to bill for a medically directed service, and in particular evaluation and management services, an attending physician must provide personal, identifiable service to the patient which may or may not be contemporaneous with the directed service furnished by the resident. For major surgical or other complex medical procedures, the attending physician must be immediately available to assist the resident who is under the attending physician's direction.

The AAMC also believes that the current Guidelines should be updated to reflect the fact that medical care teams frequently are involved in the management of complex patients. The Guidelines should recognize that many different physicians may act as the "attending physician" at different times during the course of the patient's illness. However, within the medical care team, the faculty-attending physician must provide personal and identifiable service to the patient and/or appropriate medical direction of the resident when the resident performs the service as part of the training program experience.

III. Updating the Guidelines to Promote Graduate Medical Education in Ambulatory Settings

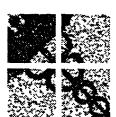
The Guidelines, and any future national policy for the payment of physician services in teaching settings, should acknowledge the complexities of graduate medical education process. They should permit a degree of flexibility and latitude in order for teaching physicians to fulfill their dual responsibilities for providing patient care and medical direction of residents. Furthermore, the policy should provide a framework that is supportive of the medical education goals of residency training. In particular, the criteria should serve to promote, not constrict, the Administration's goal of expanding patient care and residency training in ambulatory settings.

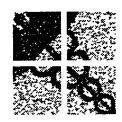
Section 415.178 "Special Attending Physician Requirements: Outpatient Services" of a proposed rule on "Payment of Physician Services Furnished in Teaching Settings" issued for comment on February 7, 1989 by HCFA addressed this issue in a realistic and positive manner. It stated that:

- A. To qualify as a beneficiary's attending physician for physician services furnished in an outpatient setting, including an emergency department or a family practice program in a hospital outpatient department, the physician must: 1) direct interns or residents who furnish services to the beneficiary from such proximity as to constitute immediate availability; 2) assure that these services are appropriate; and 3) review the beneficiary's medical history, physical examination, and record of tests and therapies that are received in the hospital outpatient department.
- **B.** Documentation must include notes signed by the physician that reflect the extent of his participation in services furnished.

This draft provision acknowledges a reasonable approach to updating the current framework and requirements for the attending physician, in that it proposes that the attending physician should "direct interns or residents who furnish services to the beneficiary from such proximity as to constitute immediate availability" when the resident is performing a service. The philosophy expressed in this provision is consistent with a position as stated above that the contemporaneous "physical presence" of the attending physician for the duration of a service being performed by a resident should not be the primary test upon which to determine a billable situation by the attending. The draft provision allows for the extent and duration of the attending's physical presence to be variable—depending upon the nature of the patient care situation, the type and complexity of the service, and the individual skill level of the resident involved in the patient's care.

The AAMC strongly supports the concepts proposed in §415.178 and believes that the proposed text should be expanded to include both inpatient as well as outpatient practice settings and be included in any future proposed regulation on teaching physician requirements. Further, the AAMC





believes this approach: 1) addresses the inherent realities of residency training and medical direction both in inpatient and in ambulatory care settings; 2) is consistent with current health care reform efforts of the Administration; and 3) is good social policy.

IV. Assumption of Risk and Liability by the Attending Physician

In their role as attending physicians, faculty physicians share in the liability for all services performed by residents or other members of the care team under their medical direction. The assumption of this responsibility and liability constitutes an inherent value to Medicare patients, to the graduate medical education process, and to society. It also serves to distinguish further the special and unique role of the teaching physician in the health care delivery system. This degree of responsibility and liability for the patient's care, which is routinely assumed by teaching physicians, should be recognized as it has been by most carriers, and acknowledged by the Medicare program when defining payment policy for the physicians in teaching settings.

Conclusion

The AAMC supports the development of a responsible and equitable national policy for the payment of physicians in teaching settings. Thus far, the historical interpretation of IL-372 Guidelines has reimbursed teaching physicians for providing direct patient care services to millions of Medicare beneficiaries while training new physicians. The comments outlined in this report embrace the original philosophy and intent of IL-372 Guidelines. They suggest a socially responsible Medicare payment policy which recognizes that service and teaching in academic settings are intimately intertwined.

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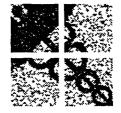
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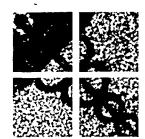
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Position Statement On Physician Payment

Based on Recommendations of the AAMC Ad-Hoc Committee on Physician Payment Reform

September 1993



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Introduction

This position statement on physician payment reform issues is the result of the Ad-Hoc Committee on Physician Payment Reform's deliberations at a meeting held April 8, 1993 in Washington, D.C. The report is intended to address selected Medicare fee schedule payment issues discussed by the Ad-Hoc Committee and not the full range of associated concerns the Committee and the Association may have with respect to payment of physicians in teaching settings.

Congress enacted physician payment reform as part of OBRA 1989 intending to reduce Medicare expenditures to physicians and to redistribute payments among the specialties. To slow the growth in Part B Medicare expenditures, the federal government moved from a payment system based on "customary, prevailing and reasonable charges" (CPR) to a resource-based, relative value fee schedule system. It also adopted a policy of establishing annual Medicare volume performance standards (expenditure targets) to govern the acceptable rates of increase in the volume of surgical and nonsurgical services delivered to Medicare beneficiaries. Other policies were aimed at maintaining beneficiary access by limiting beneficiary financial liability and improving quality of care

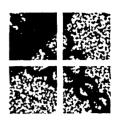
Although the transition to the fee schedule has begun shifting payments toward evaluation and management (EM) services, and those specialties that provide them, primary care specialties have not experienced the anticipated (and promised) gains in payment rates which were anticipated. Instead of the projected increase of up to 18% in family/general practice, payments have increased only by 6 percent in 1992. For surgical specialties, payment per physician decreased by 2 percent.

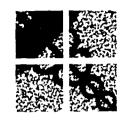
The Physician Payment Review Commission (PPRC) has made a number of important recommendations in areas where refinements in Medicare physician payment policies and the fee schedule which would serve to improve payment to primary care physicians and which would ensure equitable payment to physicians in teaching settings. These recommendations have been discussed and considered by the Ad-Hoc Committee on Physician Payment Reform and are described where appropriate in the body of this report.

Issues

Issue 1: Special provisions to boost payment to generalist physicians for primary care evaluation/management services

Background. The AAMC Task Force on the Generalist Physician and other medical associations have called for a nationwide effort to increase the number of physicians practicing in generalist specialties, that is, family practice, general





internal medicine and general pediatrics. The AAMC Task Force identified several strategies to achieve this goal, a number of which were directed at improving the practice environment. In particular, the Task Force recommended accelerated transition to the Medicare fee schedule as a way to boost payment for the core services provided by generalist physicians. It further recommended that a resource-based system be adopted by private payers as a means of compensating generalist physicians more equitably.

Position. The AAMC supports the goal of increasing payment to generalist physicians. Therefore, the Ad-hoc Committee supports a recommendation already adopted by the AAMC Task Force on the Generalist Physician which states "The Medicare program and other third-party payers should accelerate the transition to a resource-based fee schedule and should adopt other reforms in physician payment designed to compensate generalist physicians more equitably."

Issue 2: Improving the Medicare Volume Performance Standards (MVPS)

Background. The MVPS can play three very different roles. It can serve as a budgeting tool for the federal government and as a financial incentive for more appropriate medical practice. In addition, it can be used purposefully to adjust relative payments across broad classes of services.

Since the setting of the first performance standard for FY 1990, a number of issues have arisen concerning both the design of the current system and the accuracy of the information used to set the standards. OBRA 1989 permits the secretary of HHS to make conversion factor update recommendations for up to five categories of services. In addition, OBRA 1989 called for both the secretary and the Physician Payment Review Commission (PPRC) to make recommendations independently for separate performance standards for surgical and nonsurgical services. These performance standards, in turn, result in separate and different updates in the conversion factors for these two categories of services.

Many specialty societies and the PPRC for a number of reasons, are opposed to multiple performance standards and conversion factor updates. First, multiple performance standards may adversely affect incentives for more effective medical practice. Second, separate standards run the risk of distorting the relative payment rates established by the Medicare Fee Schedule. Distortions would be created by differential conversion factors affecting the baseline growth rate used to set performance standards in future years. Moreover, the accuracy in setting the performance standards depends on the ability to measure accurately all the factors upon which they are based. These factors include. growth in the number of Medicare enrollees, changes in payment policy and benefits coverage, and advances in technology which

impact treatment practices. Measuring the impact of new technology on volume, for example, is extremely difficult. Finally, other concerns have been raised by the PPRC and physician associations as to whether the current MVPS system provides a strong enough incentive for the physician community to act collectively to control volume growth.

Despite these concerns, the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993), passed into law on August 10, contains a provision which not only continues separate MVPS for surgical and nonsurgical services, but establishes a third performance standard for primary care services. Congress, it seems, was swayed by arguments that evaluation and management (EM) services required special treatment under the law to maintain and improve current payment levels to physicians providing these primary care services.

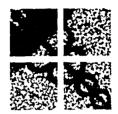
Position. The Association, like the PPRC, continues to prefer the simplicity of one overall MVPS. However, in absence of this policy the committee supports the OBRA 1993 provision to protect payment updates to primary care services by creating a separate MVPS for this service class

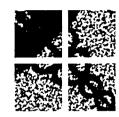
Issue 3: A resource-based methodology for calculating practice expense and malpractice expense relative value units (RVUs) under the Medicare Fee Schedule (MFS)

Background. According to statute, Congress has mandated that HCFA must move from a methodology based on historical charges to a resource-based methodology for measuring both the practice costs and malpractice expenses incurred by physicians and partially reimburse under the Medicare program. As originally planned, Congress intended the transition to a resource-based methodology to occur in 1997, the end of the transition period, allowing HCFA adequate time to study and refine the new methodology. The PPRC has studied the impact of a resource-based methodology on physician payments and has determined that it will result in another significant reallocation of payments away from surgical services toward evaluation and management services.

As part of OBRA 1993, the Congress voted to begin phasing-in a resource-based approach for practice expenses in 1994 as a deficit reduction measure. To achieve this, Congress has authorized that practice expense RVUs which are greater than 128% of physician work value units be reduced. In 1994, the reductions to the RVUs will be 25% of the difference between the practice expense RVUs and the physician work RVUs. In 1995-96 the reduction will equal an additional 25% of the remainder. Practice expense RVUs can not be reduced below 128% of the physician work RVUs for any service.

Position. The AAMC is strongly opposed to an early phase-in of the resource-based methodology which Congress has approved as a deficit reduction mechanism and legislated into law by OBRA 1993. The committee continues





to support a 1997 implementation date of a resource-based methodology to determine the practice expense and malpractice components of the Medicare Fee Schedule.

The Association continues to support a resource-based methodology for determining malpractice expense; in conjunction with medical liability tort reform legislation to be enacted either separately or as a component of comprehensive health care reform.

Issues 4: The time frame for revising the relative value units (RVUs) of the Medicare fee schedule and the refinement process employed to conduct RVU revisions

Background. Both the timeframe and the process for refining the fee schedule's relative value units (RVUs) for service will determine, in large part, whether physicians receive equitable payment under the fee schedule system. Since publication of the 1993 Medicare Fee Schedule, the relative value units (RVUs) for services are now final and are not scheduled to be revised for another five years, until 1998. As an exception to this rule, new services may be added to the fee schedule at any time to accommodate advances in technology and medical care. The Physician Payment Review Commission believes that the five year interval is too long a period and that the refinement process should be accelerated to occur every 2 to 3 years, or that at least a percentage of services should be reviewed and updated each year, possibly on a "rolling" basis.

The PPRC wants to ensure that all specialties are adequately represented in the refinement process. In updating the fee schedule for 1993, HCFA relied heavily on recommendations from the AMA's Relative Value Update Committee (RUC), a private advisory group consisting of representatives from the AMA and 22 major medical specialty societies. According to HCFA, the agency incorporated 55% of the values recommended by the RUC during the refinement process which culminated in July 1992. Since the AMA's RUC is not required to abide by any formal procedures or contractual guidelines in developing its recommendations to HCFA, the PPRC is concerned that the political nature of the RUC's decision-making process may favor specialty services over primary care services. The PPRC has recommended policy options for imposing stricter controls over the RBRVS refinement process to ensure that there is not a specialty-oriented, procedural bias in the process.

Position. The AAMC recognizes the importance of maintaining accurate relative work values for physician services. This is especially important in academic settings where CPT codes and relative values must be established to reflect the additional physician work, time and intensity often required to care for complex patients. Therefore, the Association supports the Physician Payment Review Commission's recommendations that:

- HCFA should continue to develop a small-group process to update the fee schedule for new codes and to conduct the periodic review of the entire fee schedule. Specialty groups participating in this process should include teaching physicians from academic settings
- The process should be developed with public input and clear guidelines and decision rules should be specified in advance.
- The process should include a means to identify overvalued as well as undervalued services to avoid unintentional bias in the revision process.
- Congress should provide HCFA with explicit legislative authority to insulate evaluation and management services from budget-neutral reductions.
- Future changes in relative work values should be directed toward calibrating them as closely as possible to the work required to perform a service, and the experience and training of the provider.

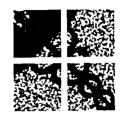
Issues 5: Ensuring equitable payment to teaching physicians under the Medicare Fee Schedule (MFS) for future years

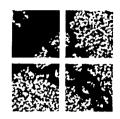
Background. Ensuring equitable payment for teaching physicians in academic settings under the Medicare Fee Schedule system is a paramount concern. Refinements to the MFS are necessary with respect to critical care services, global surgical procedures and trauma services.

Critical Care Services: The present fee schedule has "bundled" 13 commonly performed critical care procedures into the critical care service definitions—and thus into the fee schedule payments for the two most frequently billed critical care codes. Although HCFA increased the relative values for these two critical care codes by 51%, the Ad-hoc Committee felt strongly that procedures should not be bundled into the visit code, but should be billed separately. Bundling procedures in the manner established by HCFA obscures the accuracy of the physician work values assigned to these codes and does not reflect the varying treatment patterns required by these complex, severely ill patients.

Global Surgical Fees: Policies governing the global surgical fee need to be clarified regarding: 1) procedural services for complications occurring within the global fee period of an operation, and 2) payment for multiple operations on trauma patients. Currently, reoperations for complications occurring within the global fee period of an operation are billable separately, i.e., not included in the global surgical fee. However, other procedural services required to treat complications may not be separately billed, but are included in the global fee.

<u>Trauma Services</u>. Trauma care typically requires multiple operations (often by different surgeons) and a team of physicians to stabilize and manage the patient. Currently, global fee policies and reductions in payment for multiple operations apply to trauma patients. This is inappropriate, given the nature





and extent of the multi-system injuries often sustained by trauma patients and the frequent need for multiple operations to be performed on these complex patients.

Position.

<u>Critical Care Services</u>: The AAMC strongly opposes bundling of procedures into the CPT codes for critical care services given the highly variable treatment patterns required of these complex, severely ill patients.

Global Surgical Fees: The AAMC recommends that separate payment be permitted for all procedural services required to treat complications whether or not the patient's condition necessitates a complete reoperation.

<u>Trauma Services</u>. The Association encourages HCFA to continue to work with involved specialty societies to develop broad policies that would make payment for trauma care more equitable while preserving incentives for efficient utilization of services.

Issue 6. Adjustments to fee schedule payments for severityof-illness, cognitive and communication impairments, and other patient characteristics.

Background. More physician work is often required to care for patients who are severely ill or disabled. Physicians have expressed concern that payment under the fee schedule does not adequately reflect such factors. This may cause payment inequities for physicians who treat a disproportionate share of complex patients. Patients who have communication barriers or disabling cognitive or physical impairments, for example, are likely to require more time during a physician visit.

Existing visit codes (and their relative work values) do not recognize adequately this additional work required, as they are based on the "average" patient. For example, the work required to perform a total abdominal hysterectomy may vary substantially depending on whether the patient has cancer. Therefore, gynecological oncologists routinely may be underpaid if they use the same codes as other physicians performing this service. Similarly, if it takes longer to provide the same level of office visits to patients with functional or communication impairments, physicians who regularly provide primary care services to patients with disabilities in a rehabilitation clinic may be underpaid.

Research by the PPRC has concluded that the current CPT coding system for evaluation and management services inherently underpays physicians who routinely utilize higher levels of codes for visits and consultations when seeing complex patients. This is because the average intensity (work per unit of time) for most visits and consultations in virtually identical in the fee schedule. The PPRC believes that a special needs modifier(s), used in

conjunction with the higher level EM codes, would ensure that physicians are paid equitably for patients where more time is required to deliver the same service content.

As a remedy to this problem with CPT, fee schedule payments can be adjusted in two ways: 1) through separate and discrete CPT codes; and 2) through modifiers for unusual circumstances, to account for patient characteristics that affect the extent of physician work and service duration. Currently, using modifiers requires supplementary documentation which can be burdensome.

Position. The Association supports adjusting payment for certain patient characteristics since patients who are severely ill or disabled often require more physician work. A special-needs modifier, which could be used as part of the electronic billing process, would help ensure that physicians who care for functionally impaired patients will be paid more fairly.

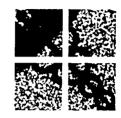
With respect to severity-of-illness, the AAMC supports capturing severity through a variety of ways: 1) refined relative work values, 2) better, more exact coding; and 3) changes in payment policies. In particular, the committee strongly encourages HCFA to develop explicit criteria for broadening the use of Modifier 22—Unusual Procedural Services, as proposed in a rule published July 14, 1993 (58 Federal Register 37994-38019). The criteria for Modifier 22 should specifically recognize and address the additional work required by certain complex patients.

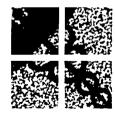
Issue 7: Payment for services of the anesthesia care team (ACT)

Background. Current HCFA payment policy results in an anesthesia care team (ACT) consisting of an anesthesiologist and one or more certified registered nurse anesthetists (CRNAs) being paid more than a solo anesthesiologist providing the same service. For example, in 1992, anesthesia care teams consisting of an anesthesiologist and two CRNAs received between 30% and 35% more for each 90-minute hernia operation than a solo anesthesiologist in most localities.

In studying payments to the anesthesia care team, the PPRC could not find any clinical justification for differences in payment and subsequently recommended a policy by which Medicare would not pay more for services delivered by an anesthesia care team. The PPRC has recommended that the total payment for a procedure would be equivalent to what a solo anesthesiologist would receive under the fee schedule and would be split evenly between the anesthesiologist and the CRNAs. The 50/50 split, according to the PPRC, would preserve use of the ACT and cause the least disruption to current employment patterns.

The PPRC recommended a transition period to allow providers to adjust to reduced payment levels and the federal government to monitor any changes in access and quality of care. Under this scenario, Medicare payments for





services provided by the anesthesia care teams would be capped at 120 percent of the payment made to the solo anesthesiologist and for each of the following four years, the cap would be reduced by 5 percent. At the end of the transition period, payments to the ACT would be capped at 100 percent of the payment to the solo anesthesiologist. This policy was passed into law as part of OBRA 1993.

The American Society of Anesthesiologist (ASA) continues to support maintaining the cap on payment to the ACT at 120 percent. ASA points out that lowering the cap to 100 percent will eliminate any incentive for anesthesiologists to supervise CRNAs and may cause many anesthesiologists to go into solo practice, thereby placing the care team mode of practice in jeopardy. Under a worst case scenario, lowering the cap could restrict surgical schedules and access, reduce employment opportunities for CRNAs and lower quality of care.

Position. The Association continues to support the position of the American Society of Anesthesiologists whereby a cap on payment to the anesthesia care team should be maintained at 120 percent. The AAMC is concerned that the OBRA 1993 provision to reduce payment to 100 percent could have a negative impact on quality and access to care in certain manpower shortage areas where anesthesiologists may become unwilling to supervise the anesthesia care team without the financial incentive to assume the liability for care delivered by CRNAs. Further, the AAMC continues to support 1982 TEFRA regulations requiring an anesthesiologist to supervise services provided by CRNAs.

Issue 8: Use of national data to study physician utilization

Background. In a new effort to make Medicare's post-payment review of Part B claims more focused, HCFA has directed local Medicare carriers to use national claims data to identify overutilization and "problem" providers. HCFA's new medical review program requires carriers to compare local claims data with national averages and explain or correct any apparent overutilization. Specifically, HCFA has developed a system for carriers to receive the rankings of the top 500 procedure codes by specialty according to dollars spent per 1,000 Medicare beneficiaries. Carriers are required to investigate and initiate corrective actions for any procedure for which more than 800 claims over six months have been processed and for which the cost per 1,000 beneficiaries is more than twice the national average. Under this new review program, it is likely that teaching physicians at academic medical centers and community teaching hospitals may be identified as "problem" providers when compared to national practice norms due to the residents ordering tests under the name of the attending and a more severely-ill patient mix.

Position. The Association supports utilization standards that recognize that physicians in teaching settings may have practice patterns different and distinct from community physicians, given the influence of teaching and research activities within the academic medical center and the nature of the patient population. The Association encourages its constituents to

work with their specialty societies in developing appropriate "benchmark" utilization standards that reflect the practice patterns of academic physicians and in educating local Medicare carriers to these standards.

Issue 9: Legislative relief to prevent elimination or reduction in payments for assistants-at-surgery

Background. The Health Care Financing Administration (HCFA) favors reducing or eliminating payments for assistants-at-surgery.

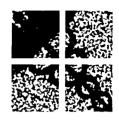
Position. The AAMC recommends that HCFA develop specific criteria to determine when the services of an assistant-at-surgery are medically necessary and an acceptable form of practice. At present, academic medical centers use assistants-at-surgery less than other hospitals. However, the country is beginning to develop care networks that involve partnerships of academic medical centers with community hospitals and ambulatory surgical centers that do utilize assistants-at-surgery. Therefore, it seems prudent that the academic community be involved in developing the criteria for utilization of an assistant-at-surgery. The Association also recommends that eliminating or reducing payment for assistants-at-surgery be delayed until such criteria have been established.

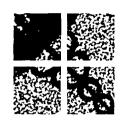
Issue 10: "Attending physician" requirements for physicians in teaching setting

Background. On December 30, HCFA issued a "clarification" to all regional HCFA administrators on the attending physician requirements which were originally stated in IL-372 Guidelines, published in 1969. The clarification represents a more strict interpretation of existing policy. In this memo, HCFA states that: "physicians' fees are payable in teaching hospitals if (1) the physician personally performs an identifiable service; or (2) the chart indicates that the physician has performed those activities necessary to qualify as an "attending physician" and the physician is physically present when the resident performs the identifiable service for which payment is sought."

Many AAMC members have received updated instructions from their local Medicare Part B carriers based on the December 30 memo. Compliance with this change in the interpretation of IL-372 Guidelines may represent a significant problem to many medical schools and teaching hospitals.

Position. The AAMC has addressed this issue in a separate policy statement.





Appendix

AAMC Comment Letter on HCFA Proposed Physician Payment Policy Revisions July 14, 1993

September 9, 1993

Bruce Vladeck
Administrator
Health Care Financing Administration
Attention: BPD-770-P
Room 309
200 Independence Avenue, SW
Washington, D.C. 20201

RE: Medicare Program: Revisions to Payment Policies Under the Physician Fee Schedule

Dear Mr. Vladeck:

The Association of American Medical Colleges (AAMC) is pleased to provide comment on the Health Care Financing Administration's (HCFA's) proposed rule "Medicare Program: Revisions to Payment Policies Under the Physician Fee Schedule" (58 Federal Register, 37994-38019) published July 14, 1993. The AAMC represents the nation's 126 accredited medical schools and their clinical faculty, over 400 teaching hospitals and 90 academic specialty societies.

I. Specific Proposals for Calendar Year (CY) 1994

Establishing Relative Value Units (RVUs) for New Codes and Revised Codes

The AAMC supports HCFA's general approach for establishing RVUs for new and revised Current Procedure Terminology (CPT) codes and recognizes the importance of maintaining accurate work values for physician services. Maintaining accurate RVUs is especially important to physicians in academic settings where new technologies are developed and medical procedures are refined continuously The AAMC is supportive of the AMA's Relative Value Unit Committee review activities and encourages the continuation of the small group process initiated by HCFA in July, 1992.

The AAMC is pleased that HCFA is proposing to "base payments on the relative resource of physicians' services as determined by objective measures of physician work and to redistribute payments in a manner that would provide more equitable payment to primary care services". The Association is a strong advocate of payment policies directed at equitable payment for services provided by generalist physicians.

Establishing National RVUs for Transplant Surgeries

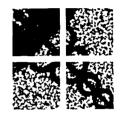
Many AAMC members are providers of transplant services (heart, heart-lung, and liver transplants). While the AAMC supports uniform RVUs and payment for physician services under the fee schedule, the Association is concerned that this particular proposal may cause substantial payment inequities nationally. The extent of physician work involved in performing a transplant procedure is highly variable due to patient-specific conditions and surgical technique. While fee schedule payments for physician services are based on the work required to treat the "average" patient, HCFA cannot ignore the variability in case difficulty in these complex surgical situations. If uniform RVUs are adopted for transplant surgeries, the AAMC believes that it will be essential for HCFA to take additional measures to assure equitable payment. Specifically, HCFA should develop case-specific criteria for the use of modifier 22, "Unusual Services", implement these criteria in concert with national RVUs for transplant surgeries and permit the use of modifier 22 without additional documentation requirements by the surgeon.

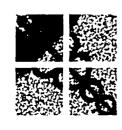
Site-of-Service Payment Differential

HCFA has proposed to expand the site-of-service payment differential to all office and outpatient consultations in addition to all other services which are routinely furnished in physician's offices more than 50% of the time Under current policy, the practice expense RVUs for these services are reduced by 50% when they are performed in the outpatient department of a hospital or other inpatient setting where the physician does not incur the operating costs of the practice site. For office-based services, the practice expense RVUs reflect office practice costs and are calculated using the historical charge data for office settings only.

In the proposed policy, HCFA assumes that the "current office charge data accurately reflects physician practice expenses in the office setting". In fact, studies conducted by both the original Harvard research team and the Physician Payment Review Commission (PPRC) indicate that current practice expense RVUs for office-based, EM services are significantly underestimated by as much as 10 to 20%. (This is in comparison to practice expense RVUs for surgical procedures which are recognized to be overestimated due to the higher historical charge data for these services.) Since practice expense RVUs are already inappropriately low, the proposed policy would further reduce total payments for office services.

The AAMC urges HCFA to reconsider this policy. Since the validity of existing cost data for EM services is questionable, HCFA should proceed by collecting new and improved data on practice expenses and revise the RVUs for office-based services accordingly. Once this is accomplished and the policy implemented, HCFA should channel the savings from the site-of-service reductions back into the payment pool for office-based EM services. These actions will instil a degree of confidence in the physician community, align





HCFA payment policy with Congressional and Administration goals, improve payment of EM services to primary care physicians, and perhaps create new financial incentives for residents to choose careers as generalist physicians.

Prolonged Evaluation and Management (EM) Services

The Association applauds HCFA for proposing to permit billing of modifier 21, with documentation for certain EM codes, when the physician furnishes a high-level visit or consultation service which exceeds the typical time established for the code by Current Procedure Terminology (CPT). It is essential that Medicare payment policy begin to pay physicians appropriately for extensive evaluation and management services. However, the AAMC strongly disagrees with the conditions HCFA has proposed for providers to qualify for the additional payment. In particular the AAMC believes that:

a) The Proposed Incremental Payments Are Inadequate and Provide No Meaningful Incentive. The proposed incremental payment structure is inadequate and provides little, if any, incentive for physicians. The proposed policy continues to disadvantage those physicians routinely per forming extensive EM services. According to HCFA's example cited in the proposed rule, a physician who spends 85 minutes on a code with a typical time of 40 minutes will only be paid an increment of 1.0 RVU for every 15 minute increment after his/her service has exceeded the typical time specified in the code by at least 30 minutes. In this example, the physician will work more than double the typical time specified in the code (45 minutes more than the typical time of 40 minutes), yet be paid for only 15 minutes more. HCFA's rationale for establishing a threshold of 30 minutes for additional payment, like the policy itself, does little to promote or encourage physician confidence in Medicare's payment system.

b) The Proposed Policy Contributes to the Physician "Hassle" Factor By Requiring Additional Documentation. For very little incremental payment, the policy requires the physician to provide additional documentation of his/her extensive services. The documentation is then subject to carrier review and approval. The AAMC believes that HCFA should develop specific criteria for use of modifier 21 (and all other CPT modifiers) and eliminate the additional documentation requirements. The AAMC strongly opposes any proposed policies which perpetuate the administrative burden of practicing physicians and supports the Administration's efforts to reduce these burdens throughout the Medicare payment system.

To improve upon what is a sound concept, the AAMC urges HCFA to eliminate the threshold requirement for extensive services and establish a policy which is simple to understand and administer. The AAMC supports a policy which will pay physicians 1.0 RVU for every 15 minute increment above the typical time of the EM code. The Association also recommends that this policy be implemented without any additional and burdensome documentation requirements. Alternatively, HCFA should establish standard criteria for use of modifier 21, reducing the administrative costs to both physicians and carriers.

Bundling Ventilation Management with a Subsequent Hospital Visit

The AAMC is opposed to bundling ventilation management services with subsequent hospital visits. As with the bundling of commonly performed procedures into critical care codes, the Association believes that this proposed policy is flawed and will lead to further payment reductions to physicians, namely pulmonary specialists, who routinely care for seriously ill patients that are ventilator dependent for all or part of their hospitalization. Further, the proposed policy, like the bundling of EKG interpretation payments with office visits and consultations, pays physicians for work they may rarely perform

Subsequent hospital visits provided to these patients, typically by pulmonary specialists, are intensive in nature. Usually, ventilator patients have serious underlying problems caused by multi-system disease or traumatic injuries that require extensive physician care which often consumes the full duration of the highest level of hospital visit. The AAMC does not agree with HCFA's conclusion that furnishing a separately identifiable service from ventilation management is a "rare circumstance". Although ventilator management may be intertwined in the medical decision-making of the physician it is frequently a separate, identifiable service. Therefore, if the RVUs for ventilator management services are bundled into the subsequent hospital visit codes as proposed, HCFA will reduce payments to physicians inappropriately. For physicians in tertiary care settings the AAMC believes this proposed policy will cause payment inequities.

If HCFA implements the proposed policy, the AAMC recommends that a new or revised modifier be developed to indicate "ventilator management as a separately identifiable service, performed in conjunction with an EM service" Uniform criteria could be established for the modifier which would permit physicians to bill without additional documentation

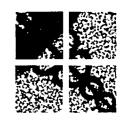
II. Issues for Possible Change After CY 1994

Modifiers for Severity Adjustment

The AAMC is pleased to learn that HCFA is considering a payment policy which would adjust fee schedule payments for severity and unusual patient circumstances through a broadened use of modifiers 22 and 52. The Association strongly supports any policy withthe objective of assuring more equitable payment to physicians treating complex patients. We encourage HCFA to include academic physicians in developing both the specific criteria for expanded use of modifiers 22 and 52 and the uniform physician work values for services identified to be of higher or lower severity.

Global Surgery-Payment for a Visit on the Day of a Minor Procedure

The AAMC continues to support payment for a visit on the same day of a scheduled or emergent minor procedure. The Association believes it is appropriate to unbundle relative values for the visit service added to the RVUs for minor procedures. Again, HCFA should include academic physicians in







the development of standard criteria for when an EM service is a significant, separately identifiable service and is not part of the routine pre- and post-operative care of minor procedures.

Payment for Physician Case Management Services

The Association urges HCFA to develop a payment policy which recognizes comprehensive case management services as a separate, billable service as soon as possible. We are aware that the American Medical Association's CPT Editorial Panel has already approved new CPT codes for case management services for publication in 1994.

As the delivery of more sophisticated health care services moves from inpatient to outpatient, nursing home and home care settings, Medicare payment policy cannot continue to focus exclusively on the physician's face-to-face encounter with the patient. Rather, Medicare policy must recognize the need to create incentives to physicians to coordinate care outside the hospital, in these less costly settings. The Administration has cited that significant health care savings can be realized through expansion of home care services and through the use of non-physician providers, under the direct supervision of a physician. It is both timely and appropriate for HCFA to recognize the legitimacy of defining case management activities as a separate billable physician service. Since the CPT Editorial Panel has officially recognized case management services by establishing new CPT codes for these services, the AAMC is strongly opposed to introducing this policy change in a budget-neutral way as indicated in the proposed rule.

Examples of the changing nature of health services delivery and the critical need for case management services abound. Physician services to AIDS patients is a good case-in-point. As this patient population continues to grow in number and live longer, the need for comprehensive case management services increases exponentially. AIDS patients may require complex home infusion, nutritional feedings, regimens of sophisticated antibiotic therapy, general nursing care, etc. Since there is now greater emphasis and financial incentive to care for AIDS patients on an outpatient basis and in the home, case management needs for these patients alone has placed extraordinary demands on the average internists' time, especially in urban centers where a high percentage of AIDS patients reside. Other types of patients include: insulin dependent diabetes, asthma management, congestive heartfailure, uncontrolled hypertension, and general conditions of the frail elderly and the disabled.

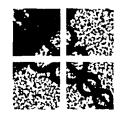
Because of the broad application for expansion of case management services as an alternative way to deliver cost-effective medical care, the Association advises against the development of a restrictive list of diagnoses and types of cases which would qualify for a case management fee. Alternatively, the AAMC strongly recommends that HCFA permit self-selection of the appropriate

cases by the physician. The new CPT codes for case management services offer adequate detail to guide the physician in making a determination as to whether or not his/her services were significant and should be billed separately, or if the services were infrequent and incidental in nature to the care of the patient and should be considered as part of the visit fee. The CPT definitions could be supplemented with clinical vignettes if necessary. If the codes need to be revised, the AAMC urges HCFA to work with the Editorial Panel or to create an independent Technical Advisory Group to study the CPT definitions. The AAMC would be pleased to participate in this process. With respect to implementation, it seems possible that payment for case management services could begin within the next calendar year; therefore, the AAMC encourages HCFA to consider this policy change in 1994.

Thank you for the opportunity to comment on this proposed rule. If you have any questions please contact Robert D'Antuono, Senior Staff Associate, Division of Clinical Services at 202-828-0493 for assistance.

Yours sincerely,

Robert G. Petersdorf, MD
President



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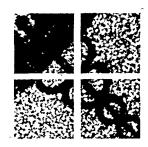
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Position Statement On Physician Payment

Based on Recommendations of the AAMC Ad-Hoc Committee on Physician Payment Reform

September 1993



AAMC Position Statement On Physician Payment

Based on Recommendations of the AAMC Ad-hoc Committee on Physician Payment Reform

Approved by the AAMC Executive Council on September 23,1993.

For Further Information Contact the Division of Clinical Services Association of American Medical Colleges 2450 N Street, NW Washington, DC 20037 202-828-0490

Introduction

This position statement on physician payment reform issues is the result of the Ad-Hoc Committee on Physician Payment Reform's deliberations at a meeting held April 8, 1993 in Washington, D.C. The report is intended to address selected Medicare fee schedule payment issues discussed by the Ad-Hoc Committee and not the full range of associated concerns the Committee and the Association may have with respect to payment of physicians in teaching settings.

Congress enacted physician payment reform as part of OBRA 1989 intending to reduce Medicare expenditures to physicians and to redistribute payments among the specialties. To slow the growth in Part B Medicare expenditures, the federal government moved from a payment system based on "customary, prevailing and reasonable charges" (CPR) to a resource-based, relative value fee schedule system. It also adopted a policy of establishing annual Medicare volume performance standards (expenditure targets) to govern the acceptable rates of increase in the volume of surgical and nonsurgical services delivered to Medicare beneficiaries. Other policies were aimed at maintaining beneficiary access by limiting beneficiary financial liability and improving quality of care.

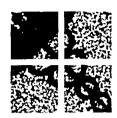
Although the transition to the fee schedule has begun shifting payments toward evaluation and management (EM) services, and those specialties that provide them, primary care specialties have not experienced the anticipated (and promised) gains in payment rates which were anticipated. Instead of the projected increase of up to 18% in family/general practice, payments have increased only by 6 percent in 1992. For surgical specialties, payment per physician decreased by 2 percent.

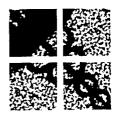
The Physician Payment Review Commission (PPRC) has made a number of important recommendations in areas where refinements in Medicare physician payment policies and the fee schedule which would serve to improve payment to primary care physicians and which would ensure equitable payment to physicians in teaching settings. These recommendations have been discussed and considered by the Ad-Hoc Committee on Physician Payment Reform and are described where appropriate in the body of this report

Issues

Issue 1: Special provisions to boost payment to generalist physicians for primary care evaluation/management services

Background. The AAMC Task Force on the Generalist Physician and other medical associations have called for a nationwide effort to increase the number of physicians practicing in generalist specialties, that is, family practice, general





internal medicine and general pediatrics. The AAMC Task Force identified several strategies to achieve this goal, a number of which were directed at improving the practice environment. In particular, the Task Force recommended accelerated transition to the Medicare fee schedule as a way to boost payment for the core services provided by generalist physicians. It further recommended that a resource-based system be adopted by private payers as a means of compensating generalist physicians more equitably.

Position. The AAMC supports the goal of increasing payment to generalist physicians. Therefore, the Ad-hoc Committee supports a recommendation already adopted by the AAMC Task Force on the Generalist Physician which states "The Medicare program and other third-party payers should accelerate the transition to a resource-based fee schedule and should adopt other reforms in physician payment designed to compensate generalist physicians more equitably."

Issue 2: Improving the Medicare Volume Performance Standards (MVPS)

Background. The MVPS can play three very different roles. It can serve as a budgeting tool for the federal government and as a financial incentive for more appropriate medical practice. In addition, it can be used purposefully to adjust relative payments across broad classes of services.

Since the setting of the first performance standard for FY 1990, a number of issues have arisen concerning both the design of the current system and the accuracy of the information used to set the standards. OBRA 1989 permits the secretary of HHS to make conversion factor update recommendations for up to five categories of services. In addition, OBRA 1989 called for both the secretary and the Physician Payment Review Commission (PPRC) to make recommendations independently for separate performance standards for surgical and nonsurgical services. These performance standards, in turn, result in separate and different updates in the conversion factors for these two categories of services.

Many specialty societies and the PPRC for a number of reasons, are opposed to multiple performance standards and conversion factor updates. First, multiple performance standards may adversely affect incentives for more effective medical practice. Second, separate standards run the risk of distorting the relative payment rates established by the Medicare Fee Schedule. Distortions would be created by differential conversion factors affecting the baseline growth rate used to set performance standards in future years. Moreover, the accuracy in setting the performance standards depends on the ability to measure accurately all the factors upon which they are based. These factors include: growth in the number of Medicare enrollees, changes in payment policy and benefits coverage, and advances in technology which

impact treatment practices. Measuring the impact of new technology on volume, for example, is extremely difficult. Finally, other concerns have been raised by the PPRC and physician associations as to whether the current MVPS system provides a strong enough incentive for the physician community to act collectively to control volume growth.

Despite these concerns, the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993), passed into law on August 10, contains a provision which not only continues separate MVPS for surgical and nonsurgical services, but establishes a third performance standard for primary care services. Congress, it seems, was swayed by arguments that evaluation and management (EM) services required special treatment under the law to maintain and improve current payment levels to physicians providing these primary care services

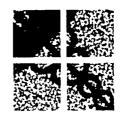
Position. The Association, like the PPRC, continues to prefer the simplicity of one overall MVPS. However, in absence of this policy the committee supports the OBRA 1993 provision to protect payment updates to primary care services by creating a separate MVPS for this service class.

Issue 3: A resource-based methodology for calculating practice expense and malpractice expense relative value units (RVUs) under the Medicare Fee Schedule (MFS)

Background. According to statute, Congress has mandated that HCFA must move from a methodology based on historical charges to a resource-based methodology for measuring both the practice costs and malpractice expenses incurred by physicians and partially reimburse under the Medicare program. As originally planned, Congress intended the transition to a resource-based methodology to occur in 1997, the end of the transition period, allowing HCFA adequate time to study and refine the new methodology. The PPRC has studied the impact of a resource-based methodology on physician payments and has determined that it will result in another significant reallocation of payments away from surgical services toward evaluation and management services.

As part of OBRA 1993, the Congress voted to begin phasing-in a resource-based approach for practice expenses in 1994 as a deficit reduction measure. To achieve this, Congress has authorized that practice expense RVUs which are greater than 128% of physician work value units be reduced. In 1994, the reductions to the RVUs will be 25% of the difference between the practice expense RVUs and the physician work RVUs. In 1995-96 the reduction will equal an additional 25% of the remainder. Practice expense RVUs can not be reduced below 128% of the physician work RVUs for any service.

Position. The AAMC is strongly opposed to an early phase-in of the resourcebased methodology which Congress has approved as a deficit reduction mechanism and legislated into law by OBRA 1993. The committee continues





to support a 1997 implementation date of a resource-based methodology to determine the practice expense and malpractice components of the Medicare Fee Schedule.

The Association continues to support a resource-based methodology for determining malpractice expense; in conjunction with medical liability tort reform legislation to be enacted either separately or as a component of comprehensive health care reform.

Issues 4: The time frame for revising the relative value units (RVUs) of the Medicare fee schedule and the refinement process employed to conduct RVU revisions

Background. Both the timeframe and the process for refining the fee schedule's relative value units (RVUs) for service will determine, in large part, whether physicians receive equitable payment under the fee schedule system. Since publication of the 1993 Medicare Fee Schedule, the relative value units (RVUs) for services are now final and are not scheduled to be revised for another five years, until 1998. As an exception to this rule, new services may be added to the fee schedule at any time to accommodate advances in technology and medical care. The Physician Payment Review Commission believes that the five year interval is too long a period and that the refinement process should be accelerated to occur every 2 to 3 years, or that at least a percentage of services should be reviewed and updated each year, possibly on a "rolling" basis.

The process itself is being questioned by the PPRC and physician associations. The PPRC wants to ensure that all specialties are adequately represented in the refinement process. In updating the fee schedule for 1993, HCFA relied heavily on recommendations from the AMA's Relative Value Update Committee (RUC), a private advisory group consisting of representatives from the AMA and 22 major medical specialty societies. According to HCFA, the agency incorporated 55% of the values recommended by the RUC during the refinement process which culminated in July 1992. Since the AMA's RUC is not required to abide by any formal procedures or contractual guidelines in developing its recommendations to HCFA, the PPRC is concerned that the political nature of the RUC's decision-making process may favor specialty services over primary care services. The PPRC has recommended policy options for imposing stricter controls over the RBRVS refinement process to ensure that there is not a specialty-oriented, procedural bias in the process.

Position. The AAMC recognizes the importance of maintaining accurate relative work values for physician services. This is especially important in academic settings where CPT codes and relative values must be established to reflect the additional physician work, time and intensity often required to care for complex patients. Therefore, the Association supports the Physician Payment Review Commission's recommendations that:

- HCFA should continue to develop a small-group process to update the fee schedule for new codes and to conduct the periodic review of the entire fee schedule. Specialty groups participating in this process should include teaching physicians from academic settings
- The process should be developed with public input and clear guidelines and decision rules should be specified in advance.
- The process should include a means to identify overvalued as well as undervalued services to avoid unintentional bias in the revision process.
- Congress should provide HCFA with explicit legislative authority to insulate evaluation and management services from budget-neutral reductions.
- Future changes in relative work values should be directed toward calibrating them as closely as possible to the work required to perform a service, and the experience and training of the provider.

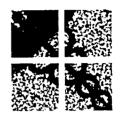
Issues 5: Ensuring equitable payment to teaching physicians under the Medicare Fee Schedule (MFS) for future years

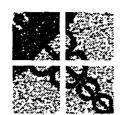
Background. Ensuring equitable payment for teaching physicians in academic settings under the Medicare Fee Schedule system is a paramount concern. Refinements to the MFS are necessary with respect to critical care services, global surgical procedures and trauma services.

Critical Care Services: The present fee schedule has "bundled" 13 commonly performed critical care procedures into the critical care service definitions—and thus into the fee schedule payments for the two most frequently billed critical care codes. Although HCFA increased the relative values for these two critical care codes by 51%, the Ad-hoc Committee felt strongly that procedures should not be bundled into the visit code, but should be billed separately Bundling procedures in the manner established by HCFA obscures the accuracy of the physician work values assigned to these codes and does not reflect the varying treatment patterns required by these complex, severely ill patients.

Global Surgical Fees: Policies governing the global surgical fee need to be clarified regarding: 1) procedural services for complications occurring within the global fee period of an operation, and 2) payment for multiple operations on trauma patients. Currently, reoperations for complications occurring within the global fee period of an operation are billable separately, i.e., not included in the global surgical fee. However, other procedural services required to treat complications may not be separately billed, but are included in the global fee.

<u>Trauma Services</u>. Trauma care typically requires multiple operations (often by different surgeons) and a team of physicians to stabilize and manage the patient. Currently, global fee policies and reductions in payment for multiple operations apply to trauma patients. This is inappropriate, given the nature





believes this approach: 1) addresses the inherent realities of residency training and medical direction both in inpatient and in ambulatory care settings; 2) is consistent with current health care reform efforts of the Administration; and 3) is good social policy.

IV. Assumption of Risk and Liability by the Attending Physician

In their role as attending physicians, faculty physicians share in the liability for all services performed by residents or other members of the care team under their medical direction. The assumption of this responsibility and liability constitutes an inherent value to Medicare patients, to the graduate medical education process, and to society. It also serves to distinguish further the special and unique role of the teaching physician in the health care delivery system. This degree of responsibility and liability for the patient's care, which is routinely assumed by teaching physicians, should be recognized as it has been by most carriers, and acknowledged by the Medicare program when defining payment policy for the physicians in teaching settings.

Conclusion

The AAMC supports the development of a responsible and equitable national policy for the payment of physicians in teaching settings. Thus far, the historical interpretation of IL-372 Guidelines has reimbursed teaching physicians for providing direct patient care services to millions of Medicare beneficiaries while training new physicians. The comments outlined in this report embrace the original philosophy and intent of IL-372 Guidelines. They suggest a socially responsible Medicare payment policy which recognizes that service and teaching in academic settings are intimately intertwined.



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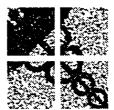
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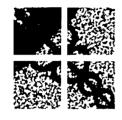
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services provided by the anesthesia care teams would be capped at 120 percent of the payment made to the solo anesthesiologist and for each of the following four years, the cap would be reduced by 5 percent. At the end of the transition period, payments to the ACT would be capped at 100 percent of the payment to the solo anesthesiologist. This policy was passed into law as part of OBRA 1993.

The American Society of Anesthesiologist (ASA) continues to support maintaining the cap on payment to the ACT at 120 percent. ASA points out that lowering the cap to 100 percent will eliminate any incentive for anesthesiologists to supervise CRNAs and may cause many anesthesiologists to go into solo practice, thereby placing the care team mode of practice in jeopardy. Under a worst case scenario, lowering the cap could restrict surgical schedules and access, reduce employment opportunities for CRNAs and lower quality of care.

Position. The Association continues to support the position of the American Society of Anesthesiologists whereby a cap on payment to the anesthesia care team should be maintained at 120 percent. The AAMC is concerned that the OBRA 1993 provision to reduce payment to 100 percent could have a negative impact on quality and access to care in certain manpower shortage areas where anesthesiologists may become unwilling to supervise the anesthesia care team without the financial incentive to assume the liability for care delivered by CRNAs. Further, the AAMC continues to support 1982 TEFRA regulations requiring an anesthesiologist to supervise services provided by CRNAs.

Issue 8: Use of national data to study physician utilization

Background. In a new effort to make Medicare's post-payment review of Part B claims more focused, HCFA has directed local Medicare carriers to use national claims data to identify overutilization and "problem" providers. HCFA's new medical review program requires carriers to compare local claims data with national averages and explain or correct any apparent overutilization. Specifically, HCFA has developed a system for carriers to receive the rankings of the top 500 procedure codes by specialty according to dollars spent per 1,000 Medicare beneficiaries. Carriers are required to investigate and initiate corrective actions for any procedure for which more than 800 claims over six months have been processed and for which the cost per 1,000 beneficiaries is more than twice the national average. Under this new review program, it is likely that teaching physicians at academic medical centers and community teaching hospitals may be identified as "problem" providers when compared to national practice norms due to the residents ordering tests under the name of the attending and a more severely-ill patient mix.

Position. The Association supports utilization standards that recognize that physicians in teaching settings may have practice patterns different and distinct from community physicians, given the influence of teaching and research activities within the academic medical center and the nature of the patient population. The Association encourages its constituents to

work with their specialty societies in developing appropriate "benchmark" utilization standards that reflect the practice patterns of academic physicians and in educating local Medicare carriers to these standards.

Issue 9: Legislative relief to prevent elimination or reduction in payments for assistants-at-surgery

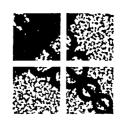
Background. The Health Care Financing Administration (HCFA) favors reducing or eliminating payments for assistants-at-surgery

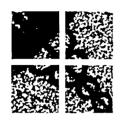
Position. The AAMC recommends that HCFA develop specific criteria to determine when the services of an assistant-at-surgery are medically necessary and an acceptable form of practice. At present, academic medical centers use assistants-at-surgery less than other hospitals. However, the country is beginning to develop care networks that involve partnerships of academic medical centers with community hospitals and ambulatory surgical centers that do utilize assistants-at-surgery. Therefore, it seems prudent that the academic community be involved in developing the criteria for utilization of an assistant-at-surgery. The Association also recommends that eliminating or reducing payment for assistants-at-surgery be delayed until such criteria have been established.

Issue 10: "Attending physician" requirements for physicians in teaching setting

Background. On December 30, HCFA issued a "clarification" to all regional HCFA administrators on the attending physician requirements which were originally stated in IL-372 Guidelines, published in 1969. The clarification represents a more strict interpretation of existing policy. In this memo, HCFA states that: "physicians' fees are payable in teaching hospitals if (1) the physician personally performs an identifiable service; or (2) the chart indicates that the physician has performed those activities necessary to qualify as an "attending physician" and the physician is physically present when the resident performs the identifiable service for which payment is sought." Many AAMC members have received updated instructions from their local Medicare Part B carriers based on the December 30 memo. Compliance with this change in the interpretation of IL-372 Guidelines may represent a significant problem to many medical schools and teaching hospitals.

Position. The AAMC has addressed this issue in a separate policy statement.





Appendix

AAMC Comment Letter on HCFA Proposed Physician Payment Policy Revisions July 14, 1993

September 9, 1993

Bruce Vladeck
Administrator
Health Care Financing Administration
Attention: BPD-770-P
Room 309
200 Independence Avenue, SW
Washington, D.C. 20201

RE: Medicare Program: Revisions to Payment Policies Under the Physician Fee Schedule

Dear Mr. Vladeck:

The Association of American Medical Colleges (AAMC) is pleased to provide comment on the Health Care Financing Administration's (HCFA's) proposed rule "Medicare Program: Revisions to Payment Policies Under the Physician Fee Schedule" (58 Federal Register, 37994-38019) published July 14, 1993. The AAMC represents the nation's 126 accredited medical schools and their clinical faculty, over 400 teaching hospitals and 90 academic specialty societies.

I. Specific Proposals for Calendar Year (CY) 1994

Establishing Relative Value Units (RVUs) for New Codes and Revised Codes

The AAMC supports HCFA's general approach for establishing RVUs for new and revised Current Procedure Terminology (CPT) codes and recognizes the importance of maintaining accurate work values for physician services. Maintaining accurate RVUs is especially important to physicians in academic settings where new technologies are developed and medical procedures are refined continuously. The AAMC is supportive of the AMA's Relative Value Unit Committee review activities and encourages the continuation of the small group process initiated by HCFA in July, 1992.

The AAMC is pleased that HCFA is proposing to "base payments on the relative resource of physicians' services as determined by objective measures of physician work and to redistribute payments in a manner that would provide more equitable payment to primary care services". The Association is a strong advocate of payment policies directed at equitable payment for services provided by generalist physicians.

Establishing National RVUs for Transplant Surgeries

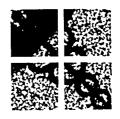
Many AAMC members are providers of transplant services (heart, heart-lung, and liver transplants). While the AAMC supports uniform RVUs and payment for physician services under the fee schedule, the Association is concerned that this particular proposal may cause substantial payment inequities nationally. The extent of physician work involved in performing a transplant procedure is highly variable due to patient-specific conditions and surgical technique. While fee schedule payments for physician services are based on the work required to treat the "average" patient, HCFA cannot ignore the variability in case difficulty in these complex surgical situations. If uniform RVUs are adopted for transplant surgeries, the AAMC believes that it will be essential for HCFA to take additional measures to assure equitable payment. Specifically, HCFA should develop case-specific criteria for the use of modifier 22, "Unusual Services", implement these criteria in concert with national RVUs for transplant surgeries and permit the use of modifier 22 without additional documentation requirements by the surgeon.

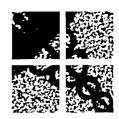
Site-of-Service Payment Differential

HCFA has proposed to expand the site-of-service payment differential to all office and outpatient consultations in addition to all other services which are routinely furnished in physician's offices more than 50% of the time. Under current policy, the practice expense RVUs for these services are reduced by 50% when they are performed in the outpatient department of a hospital or other inpatient setting where the physician does not incur the operating costs of the practice site. For office-based services, the practice expense RVUs reflect office practice costs and are calculated using the historical charge data for office settings only.

In the proposed policy, HCFA assumes that the "current office charge data accurately reflects physician practice expenses in the office setting". In fact, studies conducted by both the original Harvard research team and the Physician Payment Review Commission (PPRC) indicate that current practice expense RVUs for office-based, EM services are significantly underestimated by as much as 10 to 20%. (This is in comparison to practice expense RVUs for surgical procedures which are recognized to be overestimated due to the higher historical charge data for these services.) Since practice expense RVUs are already inappropriately low, the proposed policy would further reduce total payments for office services.

The AAMC urges HCFA to reconsider this policy. Since the validity of existing cost data for EM services is questionable, HCFA should proceed by collecting new and improved data on practice expenses and revise the RVUs for office-based services accordingly. Once this is accomplished and the policy implemented, HCFA should channel the savings from the site-of-service reductions back into the payment pool for office-based EM services. These actions will instil a degree of confidence in the physician community, align





HCFA payment policy with Congressional and Administration goals, improve payment of EM services to primary care physicians, and perhaps create new financial incentives for residents to choose careers as generalist physicians.

Prolonged Evaluation and Management (EM) Services

The Association applauds HCFA for proposing to permit billing of modifier 21, with documentation for certain EM codes, when the physician furnishes a high-level visit or consultation service which exceeds the typical time established for the code by Current Procedure Terminology (CPT). It is essential that Medicare payment policy begin to pay physicians appropriately for extensive evaluation and management services. However, the AAMC strongly disagrees with the conditions HCFA has proposed for providers to qualify for the additional payment. In particular the AAMC believes that:

a) The Proposed Incremental Payments Are Inadequate and Provide No Meaningful Incentive. The proposed incremental payment structure is inadequate and provides little, if any, incentive for physicians. The proposed policy continues to disadvantage those physicians routinely per forming extensive EM services. According to HCFA's example cited in the proposed rule, a physician who spends 85 minutes on a code with a typical time of 40 minutes will only be paid an increment of 1.0 RVU for every 15 minute increment after his/her service has exceeded the typical time specified in the code by at least 30 minutes. In this example, the physician will work more than double the typical time specified in the code (45 minutes more than the typical time of 40 minutes), yet be paid for only 15 minutes more. HCFA's rationale for establishing a threshold of 30 minutes for additional payment, like the policy itself, does little to promote or encourage physician confidence in Medicare's payment system.

b) The Proposed Policy Contributes to the Physician "Hassle" Factor By Requiring Additional Documentation. For very little incremental payment, the policy requires the physician to provide additional documentation of his/her extensive services. The documentation is then subject to carrier review and approval. The AAMC believes that HCFA should develop specific criteria for use of modifier 21 (and all other CPT modifiers) and eliminate the additional documentation requirements. The AAMC strongly opposes any proposed policies which perpetuate the administrative burden of practicing physicians and supports the Administration's efforts to reduce these burdens throughout the Medicare payment system

To improve upon what is a sound concept, the AAMC urges HCFA to eliminate the threshold requirement for extensive services and establish a policy which is simple to understand and administer. The AAMC supports a policy which will pay physicians 1.0 RVU for every 15 minute increment above the typical time of the EM code. The Association also recommends that this policy be implemented without any additional and burdensome documentation requirements. Alternatively, HCFA should establish standard criteria for use of modifier 21, reducing the administrative costs to both physicians and carriers.

Bundling Ventilation Management with a Subsequent Hospital Visit

The AAMC is opposed to bundling ventilation management services with subsequent hospital visits. As with the bundling of commonly performed procedures into critical care codes, the Association believes that this proposed policy is flawed and will lead to further payment reductions to physicians, namely pulmonary specialists, who routinely care for seriously ill patients that are ventilator dependent for all or part of their hospitalization. Further, the proposed policy, like the bundling of EKG interpretation payments with office visits and consultations, pays physicians for work they may rarely perform.

Subsequent hospital visits provided to these patients, typically by pulmonary specialists, are intensive in nature. Usually, ventilator patients have serious underlying problems caused by multi-system disease or traumatic injuries that require extensive physician care which often consumes the full duration of the highest level of hospital visit. The AAMC does not agree with HCFA's conclusion that furnishing a separately identifiable service from ventilation management is a "rare circumstance". Although ventilator management may be intertwined in the medical decision-making of the physician it is frequently a separate, identifiable service. Therefore, if the RVUs for ventilator management services are bundled into the subsequent hospital visit codes as proposed, HCFA will reduce payments to physicians inappropriately. For physicians in tertiary care settings the AAMC believes this proposed policy will cause payment inequities.

If HCFA implements the proposed policy, the AAMC recommends that a new or revised modifier be developed to indicate "ventilator management as a separately identifiable service, performed in conjunction with an EM service". Uniform criteria could be established for the modifier which would permit physicians to bill without additional documentation.

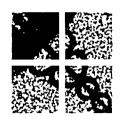
II. Issues for Possible Change After CY 1994

Modifiers for Severity Adjustment

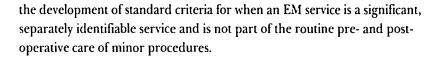
The AAMC is pleased to learn that HCFA is considering a payment policy which would adjust fee schedule payments for severity and unusual patient circumstances through a broadened use of modifiers 22 and 52. The Association strongly supports any policy withthe objective of assuring more equitable payment to physicians treating complex patients. We encourage HCFA to include academic physicians in developing both the specific criteria for expanded use of modifiers 22 and 52 and the uniform physician work values for services identified to be of higher or lower severity

Global Surgery-Payment for a Visit on the Day of a Minor Procedure

The AAMC continues to support payment for a visit on the same day of a scheduled or emergent minor procedure. The Association believes it is appropriate to unbundle relative values for the visit service added to the RVLs for minor procedures. Again, HCFA should include academic physicians in







Payment for Physician Case Management Services

The Association urges HCFA to develop a payment policy which recognizes comprehensive case management services as a separate, billable service as soon as possible. We are aware that the American Medical Association's CPT Editorial Panel has already approved new CPT codes for case management services for publication in 1994

As the delivery of more sophisticated health care services moves from inpatient to outpatient, nursing home and home care settings, Medicare payment policy cannot continue to focus exclusively on the physician's face-to-face encounter with the patient. Rather, Medicare policy must recognize the need to create incentives to physicians to coordinate care outside the hospital, in these less costly settings. The Administration has cited that significant health care savings can be realized through expansion of home care services and through the use of non-physician providers, under the direct supervision of a physician. It is both timely and appropriate for HCFA to recognize the legitimacy of defining case management activities as a separate billable physician service. Since the CPT Editorial Panel has officially recognized case management services by establishing new CPT codes for these services, the AAMC is strongly opposed to introducing this policy change in a budget-neutral way as indicated in the proposed rule.

Examples of the changing nature of health services delivery and the critical need for case management services abound. Physician services to AIDS patients is a good case-in- point. As this patient population continues to grow in number and live longer, the need for comprehensive case management services increases exponentially. AIDS patients may require complex home infusion, nutritional feedings, regimens of sophisticated antibiotic therapy, general nursing care, etc. Since there is now greater emphasis and financial incentive to care for AIDS patients on an outpatient basis and in the home, case management needs for these patients alone has placed extraordinary demands on the average internists' time, especially in urban centers where a high percentage of AIDS patients reside. Other types of patients include: insulin dependent diabetes, asthma management, congestive heartfailure, uncontrolled hypertension, and general conditions of the frail elderly and the disabled.

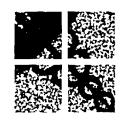
Because of the broad application for expansion of case management services as an alternative way to deliver cost-effective medical care, the Association advises against the development of a restrictive list of diagnoses and types of cases which would qualify for a case management fee. Alternatively, the AAMC strongly recommends that HCFA permit self-selection of the appropriate

cases by the physician. The new CPT codes for case management services offer adequate detail to guide the physician in making a determination as to whether or not his/her services were significant and should be billed separately, or if the services were infrequent and incidental in nature to the care of the patient and should be considered as part of the visit fee. The CPT definitions could be supplemented with clinical vignettes if necessary If the codes need to be revised, the AAMC urges HCFA to work with the Editorial Panel or to create an independent Technical Advisory Group to study the CPT definitions. The AAMC would be pleased to participate in this process. With respect to implementation, it seems possible that payment for case management services could begin within the next calendar year; therefore, the AAMC encourages HCFA to consider this policy change in 1994.

Thank you for the opportunity to comment on this proposed rule. If you have any questions please contact Robert D'Antuono, Senior Staff Associate, Division of Clinical Services at 202-828-0493 for assistance.

Yours sincerely,

Robert G. Petersdorf, MD President



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