THE AMERICAN GERIATRICS SOCIETY
350 FIFTH AVENUE, SUITE 801, NEW YORK, NEW YORK 10118 TEL: 212-308-1414 FAX: 212-832-8646
www.americangeriatrics.org

JENNIE CHIN HANSEN
Chief Executive Officer

COMMENTS SUBMITTED ELECTRONICALLY
VIA www.regulations.gov

January 3, 2011

Donald M. Berwick, MD
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Mail Stop C4-26-05
Baltimore, MD 21244-1850

Re: CMS-1503-FC, Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011, 75 Fed. Reg. 73170 *(November 29, 2010)*

Sec. V. Addressing Interim Final Relative Value Units from CY 2011 and Establishing Interim Relative Value Units for CY 2011

Dear Dr. Berwick:

The American Geriatrics Society (AGS) greatly appreciates the opportunity to comment on the above-referenced CY 2011 physician fee schedule final rule with comment period.

The AGS is a not-for-profit organization comprised of more than 6,000 health professionals who are devoted to improving the health, independence and quality of life of all older people. The Society provides leadership to healthcare professionals, policy makers and the public by implementing and advocating for programs in patient care, research, professional and public education and public policy. Our mission is to advance efforts that promote high quality of care, quality improvement, and increased payment accuracy, and we support many of the provisions that were finalized in the rule.

Our comments are limited to CMS' decision not to accept the AMA Relative-Value Update Committee's ("RUC") recommendation to value subsequent observation care codes (CPT codes 99224, 99225 and 99226) at the level of subsequent inpatient hospital care services.

We disagree with CMS' decision for the reasons set forth below and we request that CMS accept the RUCs recommendations for these codes.

AGS understands that, as an interim final rule, the scope of comments to which CMS can respond regarding the subsequent observation is limited to physician work values for those codes. However, AGS wishes to point out that the issue of admission to observation care as opposed to admission to inpatient care has potentially significant consequences to care of the frail elderly. Even though CMS states that physicians are responsible for writing the orders for placing patients in observation or admitting them as inpatients, the reality is that all hospitals have policies on this issue, to which they require adherence from all staff physicians. Furthermore, these policies can impact patient care because they may result in patients who require a stay in a Skilled Nursing Facility ("SNF") being denied Medicare payment for the SNF stay because they did not have the required three day inpatient hospital stay before transfer to the SNF. This, in spite of the fact that they were treated identically to inpatients with equivalent conditions (e.g., they occupied beds on inpatient units, were treated by the same nurses who treat inpatients, shared rooms with inpatients). There are also beneficiary coinsurance issues because outpatient care has a 20% coinsurance and inpatient care does not. However, as we discuss in this letter, the physician work involved in caring for observation and inpatients is the same and should be paid the same. These policy issues do not impact physician work and CMS should not reduce payment to physicians on the basis of inequitable hospital policies that are beyond their control.

Usually when CMS disagrees with the RUC it does so based on disagreements with the survey data, the RUC process, how the RUC analyzed the survey data or because it believes the RUC recommendation is based on comparison to less than optimal reference services. However, in this case, the CMS disagreement appears to be based on clinical and policy concerns related to observation care in general and on a disagreement over the physician work. More specifically CMS stated the following:

> Observation services are outpatient services ordered by a patient's treating practitioner. Admission of the patient to the hospital as an inpatient or the ending of observation services must also be ordered by the treating practitioner. CMS has stated that in only rare and exceptional cases would reasonable and necessary outpatient observation services span more than 48 hours. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours. Consequently, we believe that the acuity level of the typical patient receiving outpatient observation services would generally be lower than that of the inpatient level. We believe that if the patient's acuity level is determined to be at the level of the inpatient, the patient should be admitted to the hospital as an inpatient. We note that CMS has publicly stated in a recent letter to the AHA that ''it is not in the hospital's or the beneficiary's interest to extend observation care rather than either releasing the patient from the hospital or admitting the patient as an inpatient…"

> Consequently, we are not accepting the AMA RUC's recommendation to value the subsequent observation care codes at the level of subsequent inpatient hospital care services. Instead, to recognize the differences in patient acuity between the two settings, we removed the pre- and post-services times from the AMA RUC-recommended values for subsequent observation care, reducing the values to approximately 75 percent of the values for the subsequent hospital care codes. Therefore, we are assigning alternative work RVUs of 0.54 to CPT code 99224, 0.96 to CPT code 99225, and 1.44 to CPT code 99226 on an interim final basis for CY 2011.[1]

The CMS Decision Appears to be a New Policy; Not a Disagreement with the RUC

In addition to AGS being disappointed that CMS did not accept the specialty survey results, we are particularly dismayed that the agency has apparently disregarded those survey results, the RUC process and the magnitude estimation methodology that CMS has accepted, since the inception of the physician fee schedule, as the most appropriate way to value physician work. These factors make this CMS "disagreement" with the RUC recommendations entirely different from its other "disagreements" which are related to disagreements with the manner in which the RUC conducted the valuation process. We reach this conclusion in part because CMS itself states in the Final Rule, as part of a comprehensive discussion on the shortcomings of the RUC methodology, "we found the weakest and least convincing valuations occurred in cases where the AMA RUC either deviated significantly or disregarded the survey results."[2] In fact, CMS discusses three methodological issues which, if present, cause concern over the validity of a RUC recommendation. These three issues are (1) work values recommended in the absence of survey data, (2) basing a recommendation for maintaining the valuation of a current code on survey data that "is predictable" and supports the existing valuation, and (3) recommendations that disregard or deviate significantly from survey data.[3] AGS does not believe any of these three scenarios apply to the RUC recommendations for the subsequent observation codes.

Specifically, the subsequent observation codes are <u>new</u> CPT codes, not preexisting CPT codes and the RUC recommendations are supported by robust survey data. Survey respondents were given the opportunity to choose from a wide range of reference services upon which to compare the time and work of subsequent observation care and the results of the survey demonstrated that the work of subsequent observation care is similar to the work of subsequent inpatient hospital care. As discussed below, this is a reasonable result given the way observation care is provided by hospitals in 2010. Furthermore, CMS did not analyze the RUC recommendation at all, offer an alternate reference or comparison code to support the value it imputed for subsequent observation care or provide any sort of "work" analysis in the manner CMS requires of the RUC when analyzing survey data and performing magnitude estimation.

---

[1] 75 Fed. Reg. 73334

[2] 75 Fed. Reg. 73329

[3] 75 Fed. Reg. 73328

Instead, as discussed extensively below, CMS offers an entirely new, heretofore unannounced policy concerning the "acuity" of patients in observation care to justify its "disagreement with the RUC." Therefore, if appears that CMS is not adhering to its well-established process and touchstones for analyzing RUC recommendations and that if CMS had adhered to its own established policy, its conclusions would not have been supportable.

Instead, in this case the CMS decision appears to be implementing a previously unannounced policy that the value of observation care is 75% of the value of inpatient care. This policy appears to be based on a previously unannounced finding that observation patients have less "acuity" than inpatients. CMS states that, "…we believe that the acuity level of the typical patient receiving outpatient observation services would generally be lower than that of the inpatient level. We believe that if the patient's acuity level is determined to be at the level of the inpatient, the patient should be admitted to the hospital as an inpatient." We point out that CMS never explains how the reduced "acuity" is connected to or justifies a 25% payment reduction as opposed to a 10% payment reduction or a 50% payment reduction. This lack of explanation makes it appear that the 25% payment reduction implemented by CMS is arbitrary.

Further, aside from the lack of connection between the 25% payment reduction and the assumed "acuity" difference between observation patients and inpatient, there is no articulated basis for this new policy other than two unsupported judgments that observation care is rarely necessary for more than 48 hours and that the decision to discharge to home or admit a patient to inpatient status can be made "in the majority of cases" in less than 48 hours. This appears to be a medical necessity/coverage issue and not a payment issue and certainly not an issue related to physician work. Whether a service is medically necessary in a given case is not related to the work of the service.

We are particularly concerned about the general statement: "if the patient's acuity level is determined to be at the level of the inpatient, the patient should be admitted to the hospital as an inpatient."[4] This unsupported conclusion has ramifications for the valuation of services other than subsequent observation care. For example, it is not supported by research that demonstrates elderly patients can often be effectively cared for at home for conditions that are more commonly treated as inpatients nationally.[5] Additionally, as is well established by the requirements for reporting various levels of Evaluation & Management (E/M) services, acuity is not the only determinant of work. E/M services are reported based on the amount of history taken, the extent of the physical examination performed and the complexity of the medical decision making. To the extent that patient acuity plays a role in determining the level of E/M to report (and we would argue that role is unclear) it is taken into account by the fact that "levels of service" exist and that more work is required to care for patients who are more severely ill (i.e., acuity would be a proxy for severity and complexity of medical decision making). Therefore, care of lower "acuity"

[4] 75 Fed. Reg. 73334

[5] Leff et al, JAGS 57:273-278, 2009 "Comparison of Functional Outcomes Associated with Hospital at Home Care and Traditional Acute Hospital Care"

patients would more likely be reported using 99224 than 99226. The E/M service reported and the work value for that E/M is based on the three components listed above. Therefore, the amount of work for 99224-99226 depends solely on the amount of history, extent of examination and complexity of decision making performed. The RUC surveys supported the RUC recommendations and CMS offered no data or alternative analysis to show otherwise.

In summary, we believe CMS has gone off track in its thinking. In particular, CMS appears to have drawn incorrect conclusions about the "acuity" of observation patients from its unsupported judgment that patients should be discharged or admitted to inpatient care after less than 48 hours of observation care. These are two unrelated concepts. The medical necessity of the length of a stay in "observation" is related to the potential for rapid recovery, not to patient acuity. If there is any connection, then the connection might be through billing CPT code 99226 day after day instead of admitting a patient to the hospital and that issue is one that should be addressed through medical review and provider education. In addition, CMS has arbitrarily established a 25% reduction in work RVUs (as compared to the RUC survey) based on its assumption that patients in observation care have less "acuity" than inpatients. Again, if there is any connection between "acuity" and work RVUs then it is taken into account by the level of E/M service reported and the appropriate solution is to review cases of billing 99226 day after day. AGS believes that the judgments made by CMS that appear to form the basis for the CMS decision show a lack of understanding of how E/M services are constructed and in how observation care is provided.

How Observation Care is Provided

When patients are admitted to observation care they receive the same level of physician care as patients admitted to "inpatient care." In fact, "observation beds" are usually in the same units and even the same rooms as inpatient beds and these patients share the same nurses.

The basis for placing patients in observation as opposed to inpatient care is less related to the acuity level of the patient than it is to diagnostic uncertainty (e.g., is the patient's abdominal pain due to a surgical condition) or the possibility for a rapid recovery and potential discharge. In the case of observation care, the physician has made a judgment that the patient's condition, however severe, might improve rapidly enough to allow the patient to be discharged quickly. Typical conditions where the acuity level of observation patients and inpatients is the same, but where some patients may rapidly and unpredictably improve include: congestive heart failure, asthma exacerbations, volume depletion and associated electrolyte abnormalities and transient ischemic attacks. Patients with these conditions can improve rapidly and physicians must make judgments about whether they need to be admitted as inpatients or observation patients. The care rendered by the physician in all these cases is identical.

With this in mind, the AGS thinks that, arguably, medical decision making for observation patients is more difficult than for inpatients because physicians need to make a determination as to whether the patient can go home and be in an uncontrolled environment at a point where they have been treated for less than two days and may have only been "stable" for a

few hours, whereas an inpatient with a similar condition is likely to have been treated for several days and been "stable" for more than 24 hours.

In this connection it is important to remember that patients for whom subsequent observation care is reported are not post-surgical patients receiving postoperative care within the global period of the procedure. Elsewhere in the final rule CMS has articulated concerns it has about the valuation of post-surgical care. We share those concerns. CMS may wish to review options for the proper valuation of post-surgical care. However, CMS should not devalue subsequent day observation care because it is concerned about post-operative care valuations within a global period; they are entirely different issues and should be subject to entirely different payment policies.

Based on the foregoing discussion, AGS is disappointed that CMS would establish a completely new payment policy that appears to be arbitrary and based on insufficient policy analysis. AGS is also concerned that this previously unannounced policy that observation care should be valued at 75% of inpatient care is not the logical outgrowth of any policy in the proposed rule and therefore is procedurally suspect.

The 25% Reduction

The technical discussion as to how CMS arrived at its 25% payment reduction notable for its brevity and, in its reasoning is also perplexing to AGS. CMS states, "…to recognize the differences in patient acuity between the two settings, we removed the pre- and post-services times from the AMA RUC-recommended values for subsequent observation care, reducing the values to approximately 75 percent of the values for the subsequent hospital care codes. Therefore, we are assigning alternative work RVUs of 0.54 to CPT code 99224, 0.96 to CPT code 99225, and 1.44 to CPT code 99226 on an interim final basis for CY 2011."[6]

Nowhere does CMS embark on an analysis or discussion of physician work. Instead, CMS removes pre- and post-service time from the RUC "recommended values" and then translates the "removed time" to a 25% reduction in work. It is not accepted that the time of an E/M service is linearly related to the physician work for that service, much less that there are specific "per-minute" valuation intensities for pre- and post-services times in E/M.

Aside from this, AGS again points out that the subsequent observation care codes are the only E/M service reported on a date of service and it is completely inappropriate to arbitrarily determine that there is no pre- or post-service work performed. This determination flies in the face of the well established concept that all E/M services have pre- and/or post-service work which is included in the physician work RVU for the service.

[6] 75 Fed. Reg. 73334

As discussed above, we reiterate that patient acuity is included in the work of observation care, like it is in the work of any other E/M service, by the establishment of different levels of service.

Summary

AGS disagrees with the interim final values assigned to subsequent observation services (CPT codes 99224, 99225, and 99226) by CMS. We believe that the values determined by the survey process, and later recommended by the RUC, are correct. The collected survey data show that subsequent observation services (CPT codes 99224, 99225, 99226) closely approximate subsequent hospital services (CPT codes 99231, 99232, 99233).

The RUC recommendations are:

CPT CODE	RUC-recommended work RVU	Pre-service time	Intra-service time	Post-service time
99224	0.76	5	10	5
99225	1.39	9	20	10
99226	2.00	10	30	15

The survey results, obtained from randomly chosen physicians, clearly indicate that the subsequent observation services' physician work values are strikingly similar to those of subsequent hospital services (CPT codes 99231, 99232, 99233), and require pre-service, intraservice, and post-service physician time and work. It is important to remember that a subsequent observation code is the only E/M service billed on that date. Therefore, just like any other E/M code, there must be pre- and post-service time and work included in the service.

If CMS is concerned about post-surgical care and how it relates to the valuation of the subsequent observation codes, we ask CMS to refer the issue to the RUC for further discussion or create policy through the rule-making process. We reiterate that the CMS decision to remove the pre-service and post-service times and to reduce the work values by 25% appears to be arbitrary. Nowhere have we found a basis for the 25% reduction nor have we found any language where CMS articulates which services it feels is comparable to the surveyed services.

Lastly, we do not believe this is an issue that should be referred to a refinement panel next summer. This is not a technical disagreement with the RUC issue. This is a policy issue where CMS has articulated a heretofore unannounced policy on valuation of physician services that must be established through notice and comment rulemaking. If CMS wishes to establish a new payment policy for observation services it should do so through notice and comment rulemaking and not through the guise of a disagreement with the RUC. The current articulation and process of adjudicating CMS disagreements with the RUC through a refinement panel is insufficient in this case. If CMS elects to not revise the interim values, at a minimum CMS should send the codes back to the RUC for the purpose of having an open discussion about the

proper valuation of observation services, with this interim final rule as a background and context for such a discussion. This would be in line with CMS' long established policy of working with the RUC on acceptable validation methodologies which add certainty and predictability to the process.

Thank you for the opportunity to provide these comments. Please do not hesitate to contact Susie Sherman, Coordinator Public Affairs & Advocacy at (202) 308-1414/ssherman@americangeriatrics.org if you need any additional information.

Sincerely,

Sharon A. Brangman, MD
President

Jennie Chin Hansen, RN, MS, FAAN
Chief Executive Officer