



THE AMERICAN GERIATRICS SOCIETY

Geriatrics Health Professionals.

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July 25, 2011

Donald Berwick, M.D.
Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1582-PN
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare Program; Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule; Proposed Notice (CMS-1582-PN)

Dear Dr. Berwick:

The American Geriatrics Society (AGS) greatly appreciates the opportunity to comment on the above-referenced proposed notice.¹

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.

Our comments are limited to CMS' proposal regarding work relative value units (RVUs) for the initial observation care codes (CPT codes 99218, 99219, 99220) and the codes for Observation or Inpatient Care Services, including admission and discharge Services on the same date of service (CPT codes 99234, 99235, 99236).

We believe that CMS is attempting to apply, through this proposal, a new payment policy, i.e., an "acuity policy," to these observation care codes. Specifically, we find:

¹ 76 Federal Register 32410 (June 6, 2011).

- the “acuity policy” is arbitrary and capricious and should have gone through notice and comment rulemaking;
- acuity is not a key component (or any other component) used for determining the physician work of these codes; and
- the concept of acuity in the hospital setting is not relevant to physician work or to physician care.

Therefore, we disagree with CMS’ proposed work RVUs for these codes and we request that CMS accept the AMA/Specialty Society Relative Value Update Committee’s (RUC) recommendations regarding the work RVUs for these codes.

I. Background

In the proposed rule the only basis articulated for CMS’ disagreement with the RUC over the work values for these observation codes is that the acuity of observation patients is less than the acuity of hospital inpatients and, therefore, the physician work for initial observation services and same day admission/discharge observation or hospital inpatient services should be less than the work of the initial hospital inpatient service codes - even though the initial observation service codes have the exact same descriptors and work requirements as the initial hospital inpatient service codes.

A. CY 2011 Interim Final Rule

This “acuity policy” was first announced in the CY 2011 interim final rule in connection with CMS disagreement with the RUC over the work RVUS for the subsequent observation care codes.

In the CY 2011 interim final rule discussion of the subsequent observation services codes², CMS stated:

The AMA RUC reviewed the survey data for CPT code 99224 and accepted the following physician times: 5 minutes of pre-service, 10 minutes of intra-service, and 5 minutes of post-service time. The AMA RUC believed this code was comparable in physician time and intensity to CPT code 99231 (Level 1 subsequent hospital care, per day, for the evaluation and management of a patient), and recommended work RVUs of 0.76. Similarly, the AMA RUC reviewed the survey data for CPT code 99225 and accepted the following physician times: 9 minutes of pre-service, 20 minutes of

² At the June 2009 CPT Editorial Panel meeting, three new codes were approved to report subsequent observation services in a facility setting. These codes are CPT code 99224 (Level 1 subsequent observation care, per day); CPT code 99225 (Level 2 subsequent observation care, per day); and CPT code 99226 (Level 3 subsequent observation care, per day).

intra-service, and 10 minutes of post-service time. The AMA RUC believed this code was comparable in physician time and intensity to CPT code 99232 (Level 2 subsequent hospital care, per day, for the evaluation and management of a patient), and recommended work RVUs of 1.39. Finally, the AMA RUC reviewed the survey data for CPT code 99226 and accepted the following physician times: 10 minutes of pre-service, 30 minutes of intra-service, and 15 minutes of post-service time. The AMA RUC believed this code was comparable in physician time and intensity to CPT code 99233 (Level 3 subsequent hospital care, per day, for the evaluation and management of a patient), and recommended work RVUs of 2.00.

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 2011.³

B. CY 2012 Proposed Rule

In this year's proposed rule, CMS makes essentially the same argument with respect to the initial observation services and the same day admission/discharge observation/inpatient hospital service codes.

³ Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011, 75 Federal Register 73334 (November 29, 2010).

The initial observation services (99218-99220) and the same day admission/discharge observation/inpatient hospital service codes (99234-99236) were reviewed by the RUC in the fourth five-year review of physician work because CMS identified them as potentially misvalued.

As a threshold matter, before the RUC would agree to review these codes, the specialty societies who perform the service, had to present convincing evidence that the work of observation care has increased significantly since the codes were last reviewed (1992 for the initial observation codes and 1997 for the same day admission/discharge codes). The performing specialties presented such evidence and the RUC agreed to review the codes. The evidence presented demonstrated that the work of these codes had increased. For example, (a) the work of obtaining a history is greater because patients have more medical problems and take more medications, and (b) “high” complexity decision making in 2011 is much more complex than “high” complexity decision making was in 1992 or 1997 because patients have more comorbidities that must be taken into account when making a diagnosis or developing treatment plan.

In the case of the initial observation service codes, the AMA RUC recommended work RVUs that were based on physician survey data and which were very similar, or identical in the case of 99218, to the work RVUs for the corresponding initial inpatient service code (i.e., 99221-99223). CMS disagreed with this determination, stating it did not believe that the work RVUs of the initial observation care codes should be equivalent (or close) to the initial hospital care codes.

In the case of the same day admission/discharge observation or inpatient hospital care codes, the RUC recommended work RVUs that were the sum of the recommended work value for the corresponding initial observation service code and one-half of the work RVU of 99238 (Hospital discharge day management, 30 minutes or less), 0.64. For example, the RUC recommended a work RVU for 99234 that is the sum of the work RVU for 99218 and 0.64 work RVUs (half the value of 99238)

While CMS agreed with this building block methodology for 99234-99236 (i.e., the sum of the corresponding initial observation care code and half the value of 99238), CMS disagreed with using the RUC-recommended work values for the initial observation care codes as the starting point, and instead proposed to use the CY 2011 work RVUs for initial observation care as the starting point. See the table below for the current, RUC recommended, and CMS proposed values:

CPT Code	Short Descriptor	CY 2011 Work RVU	AMA RUC Recommended WRVU	CMS Recommended WRVU	CMS Work RVU Decision	CMS Refinements to Time
99218	Observation care	1.28	1.92	1.28	Disagree	x
99219	Observation care	2.14	2.60	2.14	Disagree	x
99220	Observation care	2.99	3.56	2.99	Disagree	x
99234	Observ/hosp same date	2.56	2.56	1.92	Disagree	x
99235	Observ/hosp same date	3.41	3.24	2.78	Disagree	x
99236	Observ/hosp same date	4.26	4.20	3.63	Disagree	x

In the proposed rule, CMS stated that a physician's decision as to whether a patient should be admitted to the hospital or discharged following resolution of the reason for observation care can usually be made in 24-48 hours, and that patients who are kept under observation (without being admitted) must necessarily be less "acute." Therefore, CMS reached a determination that all observation patients must be less acute than inpatients, and as such, the value of the observation codes should be lower than the comparable inpatient codes.

CMS did not provide any rationale for applying the "acuity policy" (which it developed to address the subsequent observation services codes) to the initial or same day admission/discharge codes. In addition, CMS did not cite any published literature, clinical data or offer any rationale in support of its statement that the "acuity level of the typical patient receiving outpatient services would generally be lower than that of the inpatient level."⁴ Furthermore, CMS offered no basis for the proposed work RVUs. For example, why did the difference in patient acuity support the proposed work RVU of 1.28 for 99218 instead of 1.48 or 1.58?

We further understand, after meeting with CMS staff during the comment period, that CMS believes that patients treated in the observation setting are less acute than hospital inpatients because hospital inpatients must meet an "inpatient level of care" acuity in order to be admitted and receive inpatient services.

II. AGS Position

We disagree with the CMS proposal and particularly disagree with the validity of the "acuity policy" in general and with how CMS is applying this policy to observation codes. We discuss our disagreement in detail below.

A. Overview

AGS has several sets of concerns related to the CMS "acuity policy".

Legal Concerns with the CMS Rationale. It appears that the CMS "acuity policy" is a new payment policy that is used to determine reimbursement amounts under the physician fee schedule. Therefore, AGS believes that the policy should have been subject to notice and comment rulemaking before becoming effective. Furthermore, the "acuity policy" does not contain any rationale for supporting any particular proposed RVU (e.g., a work RVU of 1.28 vs. 1.48). Therefore, any proposal based on this policy is arbitrary and capricious. In addition, it is so broad and ill-defined that it can be used at the whim of CMS to justify payment policy proposals or specific RVUs for any service, not just observation care, thereby potentially undermining the entire relative value system. These sorts of issues are the essence of an arbitrary and capricious policy.

⁴ 76 Federal Register 32458.

Acuity is not a key component (or any component) used for determining physician work. We disagree with the CMS assertion that patient acuity so substantially defines physician work so as to make it possible to disregard the Evaluation and Management guidelines and descriptors. Patient acuity, in itself, is not a relevant concept for physician work. Patient acuity is not part of the descriptors or work requirements for E/M services. In fact, the work requirements (i.e., the three key components) for the initial observation care and inpatient hospital care codes are identical. Most significantly, the work of observation and inpatient same day admission/discharge care (99234-99236) is also identical because only one CPT code describes both types of services.

The concept of acuity when used in the hospital setting is not relevant to physician work or physician care. It appears that CMS is confused by the use of the word “acute” or “acuity” in the hospital setting or in relation to the Inpatient Prospective Payment System (IPPS). Even, if the terms “acute” or “acuity” have some meaning in those settings, they are not relevant when it comes to physician care or physician work. When the IPPS was developed in the 1960s, it was implemented in what was then termed “acute” care hospitals. However, this is an outdated term of art used to classify a set of hospitals that, in the 1960s, took care of patients with acute (sudden onset) problems. The word “acute” was also used to differentiate them from other hospitals (e.g., psychiatric hospitals, long term care hospitals) which were paid under systems other than the IPPS.

We discuss these concerns in detail below.

B. Typical Observation Vignette

As we proceed through our discussion of physician work for observation services, we believe it will helpful to keep a typical patient example in mind. The vignettes below are based on patients with “Respiratory Symptoms” and “General Symptoms” which are the two most common diagnosis codes associated with observation care. As CMS is aware, the RUC uses a brief typical patient description, a “vignette”, in the surveys completed by professionals who provide the services being surveyed. In these examples, we seek to demonstrate that “acuity” and the administratively defined location of care, does not define work. In each case, the site of care is the same - a hospital. We do not assert that the physician work for each of these six vignettes is the same; rather, we assert that the work is not defined by admission status. We believe the details of these vignettes accurately reflect the decision making and work associated with care for patients depicted.

Patients are admitted to the hospital because evaluation and treatment of their condition requires fast access to the rich resources of the inpatient setting, e.g., advanced diagnostic modalities, specialty consultation, IV fluids and drugs. Some patients have well-defined needs (e.g., hip fracture) which require hospital admission but not complex decision-making by the admitting physician, whereas others may have ambiguous conditions where the uncertainty of diagnosis and prognosis increase the difficulty of decision-making while at the same time failing

to clearly fulfill the criteria for admission. Because the need for and appropriateness of admission is unclear, such patients are often placed in “observation status.”

Thus we argue that there is no clear and unequivocal relationship between the patient’s administrative status, or acuity, and the level of physician work required.

General Symptoms Medicare Vignette: *A 75 year old woman with mild dementia is found lying on the floor of her home.*

- a. The fall occurred an hour ago and was observed by her family who brought her to the hospital; the patient is in some pain and is mildly confused. The family notes the confusion is not much different than usual. She can walk but she is a little dehydrated. Lab work is normal. She is given a liter of IV fluid and is discharged to home with her family. In this vignette, even though the medical problem is acute, the medical decision making is of low complexity because of the low risk to the patient and the ease of making the decision to send her home with her family.
- b. The fall was not observed; the patient was found with emesis around her; she is confused; and she is in agony and can’t move her right leg. The family is with her but did not observe the fall. By the history and exam, the fall most likely occurred one day ago. She has a fractured hip and is dehydrated with significant electrolyte abnormalities. In this vignette, the medical problems are acute and the medical decision making is of moderate complexity due to the risk of complications of managing the fracture with comorbid acute and chronic illnesses. This is a very routine and familiar situation for the hospitalist who performs the admission service. Although the problem is very acute and requires inpatient treatment, the needs of the patient are relatively straightforward
- c. The fall was not observed. Her landlady found her on the floor and called 911. She is confused. She can move her leg but refuses to walk, seemingly due to pain. She is mildly dehydrated and has electrolyte abnormalities. When the fall occurred is unknown. She does not have a hip fracture. She says her family is “on vacation.” In this vignette, the medical problems are not as acute as in (b), but the medical decision making and work related to the care of this patient is of higher complexity than the patient in (b) because there is greater difficulty in making a decision to send the patient home where she is at high risk for falling again and where no one is known to be available to assist and monitor her. Even if independently ambulatory in the hospital, a safe discharge from the ER is not possible without further evaluation of her medical condition and living circumstances to resolve any ambiguity in her condition and social situation. It may well be possible to resolve these issues in 24 hours without admitting her to the hospital so that the patient may be able to return home to the familiar environment that is less likely to cause delirium and functional decline (a much preferable option to admission). The patient is admitted to observation

Respiratory Symptoms Medicare Vignette: *A 75 year old man with a cough and fever.*

- a. The symptoms started less than 24 hours ago. Patient is otherwise healthy and has a normal exam and an a chest x-ray that is consistent with early pneumonia. He is febrile and has a normal oxygen saturation. His only risk factor related to indications for hospitalization is his age. He is sent home on an appropriate antibiotic and over the counter medication. This vignette involves moderate physician work due to patient risk and related medical decision making. The problems are acute.
- b. The symptoms started four days ago. The patient is a smoker who has a fever and high white count. The blood oxygen level is low and a chest x-ray shows pneumonia. Antibiotics were administered in the Emergency Department consistent with the community acquired pneumonia hospital patient treatment bundle. The patient is admitted. This vignette also involves moderate complexity decision making because while the patient is acutely ill and at risk for complications of his illness, his problem and the required interventions are both well-defined.
- c. The symptoms started four days earlier and have progressively worsened. The patient is a past smoker with emphysema (COPD) who is wheezing and coughing. He has a low grade fever and a slightly elevated white count with an indeterminate chest x-ray. Blood oxygen is borderline but unchanged from the past. He is in mild distress on arrival to the Emergency Department, but has improved after respiratory treatments, oxygen and intravenous fluids. Antibiotics are administered for possible pneumonia and the chest x-ray is reviewed with radiology. The patient is admitted to observation. This is a patient with acute symptoms but with higher complexity medical decision making due to the difficulty in making a diagnosis, the complexity of the treatment plan (e.g., diagnostic work up and treatment with intravenous and inhaled medications) and the need for ongoing observation and reevaluation of the patient because of the difficulty in making a decision to send the patient home where he is at risk of deteriorating.

C. Discussion of Initial Observation Care Codes

i. Legal Concerns with the CMS Rationale

- a. The “acuity policy” was not subject to notice and comment rulemaking.

AGS is very concerned that CMS has apparently established a new payment policy, the “acuity policy,” that is being used to determine physician payment but which has not been subject to notice and comment rulemaking. As articulated in the CY 2011 interim final rule and CY 2012 proposed rule for revisions to policies under the Medicare Physician Fee Schedule, the “acuity policy” appears to be a judgment made by CMS that physician work is related to patient acuity and that patient acuity is less in the administratively defined setting of observation care than in the administratively defined setting of inpatient care.

The “acuity policy” is not an analytic or technical disagreement over the RUC recommendations. In fact no analytic disagreement with the RUC review was articulated in this proposed rule so AGS is forced to come to the conclusion that CMS has no disagreement with the RUC and that the only basis for its proposed work RVUs for these observation services is based on its “acuity policy.” In justifying the RVU reduction of subsequent observation services CMS illogically adjusted pre- and post-service time, providing some limited basis of analysis. In this proposed rule only the reputed acuity differences are provided as justification. In support of this being a payment policy and not a technical disagreement is the fact that it is being applied to all observation services not just one or two. AGS is even more concerned that this unsupported policy (CMS did not provide any published, or unpublished, data to support its assertion about acuity), which was established without going through notice and comment rulemaking, can be applied to any setting of care (i.e., the physician office setting) and result in a unilateral reduction in work RVUs for services in that setting without explaining why.

Policies that are used by CMS to establish or revise payments under the Medicare Physician Fee Schedule (MPFS) must go through notice and comment rulemaking. The Administrative Procedure Act (APA)⁵ and applicable case law make it clear that substantive rules, that do more than merely clarify or explain what is meant by a statutory or regulatory term, but rather “grant rights, impose obligations, or produce other significant effects on private interests” must go through notice and comment rulemaking.⁶ The newly established “acuity policy” is such a rule.

b. The “acuity policy” is arbitrary and capricious.

CMS has established its “acuity policy” without any supportive data or rationale. Furthermore, this policy is being used to establish, revise, and reduce, payments to physicians for observation care. Not only is the policy without basis but the RVUs established under the policy for initial, subsequent and same day admission/discharge care are without basis. CMS does not explain why the policy supports its proposed RVUs, as opposed to any other RVUs. For example, why does the “acuity policy” support a work RVU of 1.28 for 99218 instead of 1.44? In last year’s interim final rule when discussing the subsequent observation codes. CMS first applied its new “acuity policy” and concluded, without basis, that the pre and post services times for subsequent observation services should be removed resulting in times that are “approximately” 75% of those for subsequent inpatient care codes. CMS then assigned interim work RVUs for subsequent observation services that were 29%, 31% and 28% lower than the work RVUs for the corresponding subsequent inpatient care service codes (e.g. the interim work RVU of 0.54 for 99224 is 29% less than the work RVU for 99231, 0.76). There was no

⁵ Administrative Procedure Act, 5 U.S.C. §551, *et seq.*, and §§701-706.

⁶ *Steinhorst Associates v. Preston*, 572 F. Supp.2d 112, 120 (D.D.C. 2008)(citing *National Family Planning & Reproductive Health Ass’n v. Sullivan*, 979 F.2d 227, 238 (D.C.C. 1992); *Chrysler Corp. v. Brown*, 441 U.S. 281, 302 (1979).

explanation as to why these work RVUs were assigned nor any connection made between the removal of pre- and post-service time to the work RVU assignment.

The table below compares the proposed work RVUs for initial observation care with those of the corresponding initial inpatient care codes:

Inpatient	current work RVU	Observation	proposed work RVU	Reduction Observation/Inpatient
99221	1.92	99218	1.28	33.3%
99222	2.60	99219	2.14	18%
99223	3.56	99220	2.99	16%

The application of the “acuity policy” has resulted in proposed work RVUs for initial observation care that are 33.3%, 18% and 16% lower than the work RVUs for the corresponding initial inpatient care code.

AGS believes that the application of any policy that results in work RVU reductions ranging from 16 to 33.3%, without further explanation or analytic discussion, is by definition arbitrary and capricious. Aside from the lack of uniformity to the amount of work RVU reduction, there is no articulated reason why the alleged “lower acuity” of patients in observation care should result in a 28% reduction in work RVUs as opposed to a 50% or a 5% reduction. AGS is at a loss to figure out how a single policy, the “acuity policy,” can support a 33.3% reduction in work RVUs for one initial observation care code and a 16% reduction for another initial observation care code. Therefore, AGS is forced to conclude that not only is the “acuity policy” arbitrary and without basis, but the payment reductions established under that policy are equally as arbitrary.

c. Summary of legal concerns

AGS is very concerned about the manner in which CMS has established its “acuity policy,” the way the policy has been implemented and in the payment reductions resulting from the policy. Given the lack of basis for the policy, the fact that it has never been subject to notice and comment rulemaking and because it is being applied in an inconsistent, arbitrary manner, AGS requests, on the basis of these concerns alone, that CMS withdraw this policy and accept the RUC recommendations for work RVUs for initial and same day admission/discharge observation care services.

AGS believes that the legal concerns discussed above are more than sufficient to provide the basis for withdrawal of the “acuity policy” and acceptance of the RUC recommendations.

ii. Acuity is not a key component (or other component) used for determining physician work.

a. CPT Descriptors

The work of the initial observation care and the initial hospital admission codes is defined by the code descriptors. Those are the only criteria that must be met in order to fulfill the work requirements for each initial observation care code. Below are the “three key components” which make up the work requirements for the initial observation care and initial hospital care codes:

Initial Observation Care (99218-99220)

- 99218
 - A detailed or comprehensive history;
 - A detailed or comprehensive examination; and
 - Medical decision making that is straightforward or of low complexity.
- 99219
 - A comprehensive history;
 - A comprehensive examination; and
 - Medical decision making of moderate complexity.
- 99220
 - A comprehensive history;
 - A comprehensive examination; and
 - Medical decision making of high complexity.

Initial Hospital Care (99221 - 99223)

- 99221
 - A detailed or comprehensive history;
 - A detailed or comprehensive examination; and
 - Medical decision making that is straightforward or of low complexity.
- 99222
 - A comprehensive history;
 - A comprehensive examination; and
 - Medical decision making of moderate complexity.
- 99223
 - A comprehensive history;
 - A comprehensive examination; and
 - Medical decision making of high complexity.

The code descriptors clearly show that the work requirements for initial observation care services are identical to the work requirements for the initial hospital care codes. Importantly,

there is no mention anywhere in the code descriptors or elsewhere in CPT of patient acuity. We acknowledge that the “severity” of the patient’s problems is included in the code descriptors, in the description of the presenting problem. For example, the following statements appear in 99220, 99223 and 99236:

- 99220: “Usually, the problem(s) requiring admission to "observation status" are of high severity.”
- 99223: “Usually, the problem(s) requiring admission are of high severity.”
- 99236: “Usually the presenting problem(s) requiring admission are of high severity.”

Please review the vignettes in Section II.B. above. They clearly show that physician work is related to the complexity of decision making and patient risk and not to the acuity of the illness. It is very important to note that while the “severity” of the patient’s problems is mentioned in the code descriptors, it is not a work requirement; instead it is merely a guideline to assist physicians in choosing the level of service to report. This is demonstrated by the fact that the three requirements, or “key components,” of these services relate to the amount of history obtained, physical examination performed and the complexity of the medical decision making. CPT considers severity to be a marker for the complexity of medical decision making (e.g., codes requiring low level decision making also include the term “low severity”) and therefore, an aid to proper reporting. We do not agree that “severity” and “acuity” are equivalent in meaning, as relates to patient care and medical decision making. In any case, the initial observation care codes have the same level of severity as their corresponding initial hospital care codes. In other words, CPT codes 99220, 99223 and 99236, for example, contain the guideline that patients who require a comprehensive history, a comprehensive physical examination and high level decision making, usually have problems of high severity. It is completely inappropriate for CMS to make an a priori, across the board decision, that the “high complexity decision making” required by 99220 is any different, or lesser, than the “high complexity decision making” required by 99223. It is also inconsistent with CMS’s own Documentation Guidelines. Distinguishing “levels” of “highly complex decision making” has never been done, or even attempted, and is not part of the CPT lexicon. If CMS wishes to attempt to establish different levels of “highly complex” or “moderately complex” decision making then it should only do so in consultation with CPT and proceed through notice and comment rulemaking. However, we believe this would be a task doomed to failure.

In summary, based on the code descriptors, there is no basis for assigning lower work values to initial observation care services than to initial hospital care services. CMS guidance regarding 99234-99236 states:

“The physician shall satisfy the E/M documentation guidelines for furnishing observation care or inpatient hospital care. In addition to meeting the documentation requirements for history, examination, and medical decision making documentation in the medical record shall include:

- Documentation stating the stay for observation care or inpatient hospital care involves 8 hours, but less than 24 hours;
- Documentation identifying the billing physician was present and personally performed the services; and
- Documentation identifying the order for observation services, progress notes, and discharge notes were written by the billing physician.”⁷

Nowhere in the manual is there a reference to patient acuity as an item that needs to be documented in the medical record.

As might be expected from the foregoing discussion and as demonstrated by the vignettes above, we believe that the work of initial observation care is at least equivalent to the work of initial hospital care due to the stress and uncertainty of making a decision to send home a patient who may deteriorate - the stress and uncertainty of that decision does not arise in the case of initial inpatient care because the decision to keep the patient in the hospital has already been made. The administratively defined setting (e.g., observation) does not define lower work. Furthermore, a low acuity patient with an uncertain diagnosis or high risk of deteriorating often requires more work than a high acuity patient with a known diagnosis or risk of deterioration. Acuity does not define work.

- b. The “acuity policy” as articulated in the CY 2011 interim final rule is not relevant to initial observation or same day admission/discharge observation or hospital care

The CMS basis for establishing interim work RVUs for subsequent observation care that are lower than the work RVUs for the corresponding subsequent inpatient care codes was that decisions to admit observation patients to inpatient status should be made within 24 or 48 hours of admission to observation. When that decision is made more than 48 hours after admission to observation, which is when the subsequent observation care codes would be reported, CMS believes that the patient is of lower acuity and that there is less physician work required. While AGS disagrees with this “acuity policy” and how it was used by CMS in the case of subsequent observation care, even if the policy had any validity, it is totally irrelevant when it comes to initial observation care or same day admission/discharge observation or inpatient care. The codes at issue are reported for the first day of observation care and, in the case of same day admission/discharge care, for the only day of care. Therefore, the issue of admitting a patient to inpatient status after 24 or 48 hours is irrelevant to work determinations for these codes and the “acuity policy” is also irrelevant.

Even though the foregoing analysis would appear to support assigning higher work values for 99218-99220 than the RUC recommended, AGS is asking only that CMS accept the

⁷ Medicare Claims Processing Manual, Publication 100-04, Chapter 12, Section 30.6.8(C).

RUC recommendations. AGS participated in the physician surveys for these codes and AGS was actively involved in the RUC review of the survey data. AGS believes that the RUC process was fair and that its recommendations reflect the results of the survey. As a threshold matter, AGS and the other specialty societies participating in the RUC process had to demonstrate that the work of initial observation care has increased since the last time the codes were reviewed. The societies demonstrated this by showing that the medical decision making for each level of care required more work (e.g., moderate level decision making requires more work now than it did the last time the codes were reviewed) because patients admitted to observation care have more problems, more complex problems and are taking more medications, resulting in more complex management plans that carry higher risk to the patient.

The survey respondents compared the initial observation service codes to the comparable inpatient care code and the respondents, using the magnitude estimation methodology which has been accepted as a valid way of valuing physicians' services since the origin of the physician fee schedule, valued initial observation care similarly to initial hospital care. CMS offers no alternative methodology or critique of the RUC review and recommendations. All CMS offers in their proposal is a simple, unsubstantiated policy that the acuity of observation patients is less than the acuity of inpatients. The CMS proposal does not include any published methodology, process or basis to support its proposal. This sort of proposal undermines the entire concept of the physician fee schedule because it allows CMS to value services based on vague and broad generalities instead of analytical thinking. Ironically, CMS has criticized the RUC for making recommendations without a firm basis, yet CMS is essentially doing the same thing in this proposed rule. In this case, it may be even more egregious because CMS creates an acuity policy that it uses to justify a certain RVU level, but does not provide analytic support as to what that level must be - at least the RUC provides analytical support for all its recommendations. Dangerously, this sort of ad hoc policy making without analytical support, could be used throughout the physician fee schedule and applied to many services. In other words, the "acuity policy" could be used by CMS to support hidden agendas or unarticulated policies to increase payments for favored services and decrease payments for unfavored services. AGS is very concerned that implementation of this sort of black box process, which cannot be applied fairly, will undermine the entire physician fee schedule and make it impossible to appropriately value physician services going forward.

As discussed in more detail below, AGS would also like to point out that CMS claims data shows that the most common diagnoses reported with the initial observation care codes and the same day admission/discharge codes are the same and that at the time of admission to observation or inpatient care, it is impossible to know when the patient will go home. The timing of discharge is based on how quickly a patient recovers and how quickly the physician is able to make a decision to send a patient home.

- iii. The concept of “acuity” when used in the hospital setting is not relevant to physician work or physician care.

The only place where the concept of patient acuity may have any relevance to payment or care is in the inpatient setting because under the Inpatient Prospective Payment System (IPPS), hospitals are paid under Diagnosis Related Groups (DRGs) where payment is, in part, based on whether patients have major or minor comorbidities and complications. If comorbidities and complications are examples of “acuity” then it could be argued that IPPS DRG payments are based, in part, on acuity and therefore, that acuity is a relevant concept for IPPS payment policy. However, physician payments are not adjusted based on patient comorbidities, complications or anything else. Therefore, this concept is not relevant for determining physician work. Physician work is determined entirely by the requirements of the code descriptor(s), as we discuss below.

On the other hand, if by “acuity,” CMS means that a patient must “meet a threshold for hospital admission,” this is a purely administrative, post-payment quality review issue for hospitals. In this context, we understand that hospitals are under scrutiny from payers in order to assure payments made for hospital inpatients are medically necessary and that various organizations have developed criteria for determining whether an inpatient admission is medically necessary. However, for the same reasons as cited above, this meaning of “acuity” is also irrelevant for determining physician work. The administrative status of a patient, and determination of medical necessity via a post payment review, has nothing to do with the work for a physician to perform a history, perform a physical exam and make medical decisions.

D. The CMS Proposal for Work RVUs for Observation or Inpatient Care Services (Including Admission and Discharge Services)

CPT Codes 99234, 99235 and 99236 are used to report observation *or inpatient* hospital care services provided to patients that are admitted and discharged on the same date of service. These codes are used irrespective of whether a patient is classified as an observation patient or a hospital inpatient. CPT (and CMS by virtue of using these codes for inpatients) recognizes that the work of admitting and discharging a patient on the same day is the same regardless of the hospital status of the patient. In fact, the descriptors for the admission components of 99234, 99235 and 99236 have identical work requirements as 99221, 99222 and 99223, respectively. In addition, because the code also describes same day discharge of an observation patient or an inpatient - by definition, the work of discharging these two types of patients is the same. The criteria for reporting these codes are listed below:

- 99234
 - A detailed or comprehensive history;
 - A detailed or comprehensive examination; and
 - Medical decision making that is straightforward or of low complexity.

- 99235
 - A comprehensive history;
 - A comprehensive examination; and
 - Medical decision making of moderate complexity.

- 99236
 - A comprehensive history;
 - A comprehensive examination; and
 - Medical decision making of high complexity.

AGS is pleased that CMS has accepted the RUC recommendation to use a building block approach to assigning work RVUs to CPT codes 99234-99236. AGS is also pleased that CMS agrees with the specific building blocks recommended by the RUC - namely, adding the work RVU for the applicable initial observation service CPT code (i.e., 99218, 99219 or 99220) to half the work RVU for 99238, Hospital discharge day management, 30 minutes or less. AGS agrees that the work of discharging a patient from observation or inpatient care who was admitted the same day, is less than the work of discharging a patient that was admitted one or more days earlier. However, AGS strongly disagrees with the CMS not using the RUC recommended work RVUs for 99218-99220 in its first building block approach.

The reasons why AGS disagrees with the CMS proposals for valuing 99218-99220 are set forth above. In addition, to the issues raised for those codes, not using the RUC recommended work values for 99218-99220 results in work values for 99234-99236 that create significant rank order value anomalies in these code families and therefore, the values lack face validity. The proposed work RVUs for 99234-99236 and the comparable inpatient admission codes are in the table below:

CPT Code	Current Work RVU	CMS Proposed Work RVU
99234		1.92
99221	1.92	
99235		2.78
99222	2.61	
99236		3.63
99223	3.86	

We note that the total work value for 99234, which is used for same day admission/discharge for inpatient as well as observation care is the same as the work RVU for 99221 which is the corresponding code for inpatient admission only. As described earlier in this comment letter, 99234 and 99221 have the exact same work requirements (i.e., three key components) with respect to the admission. This means that the CMS proposal values the work of the discharge in 99221 at 0.00 RVUs. As noted above, the work of admission in 99234 is the same as work of admission in 99221. Both require a detailed or comprehensive history and physical examination and involve straightforward or low complexity decision making. Those are

the only work requirements for the admission. In addition to the admission work, 99234 involves ongoing treatment, reevaluation and discharge. Assigning identical work RVUs to 99234 and 99221 has no face validity.

Even more egregious is the proposed work value for 99236 which is lower than the work value for 99223. 99223 describes an admission only and 99236 describes the exact same admission as 99223 with the exact same work requirements (i.e., comprehensive history, comprehensive examination, high complexity medical decision making), and it includes ongoing observation, treatment and discharge of the patient on the same day. This means that not only is there no work included for the discharge component of 99236, but the admission component is valued less than the admission of 99223 which carries identical work requirements. The work of 99236 cannot be less than the work of 99223 and must be higher to take into account the fact that the admission work of 99236 is identical to that of 99223 and the additional work of discharging the patient.

The proposed work RVUs for 99235 have similar problems to those of 99234 and 99236. The concerns AGS has about the proposed work RVUs for 99235 are the same as those articulated for 99234 and 99236.

In this connection we point out that CMS has a long established policy of not allowing physicians to report the observation discharge code if the length of stay is less than eight hours.⁸ This policy affirms our contention, and shows that CMS agrees, that the work of discharge on the same date as admission, is significant and additional to the work of admission. Therefore, the CMS proposed work RVUs are inconsistent with its own longstanding policy on when the work of discharge can be separately reported.

Clinically, as the RUC realized, the only difference between a patient admitted and discharged on the same day and a patient who is discharged one or two days after admission is that a patient discharged on the same day as admission, got better faster. The fact that a patient is discharged from the hospital on the same day as admission, has nothing to do with the work required to admit the patient because the work required is defined in the CPT code that is reported.

If CMS really believes the admission work for a patient who is discharged on the same day is different from the admission work for a patient who is discharged the following day, then CMS should work with the CPT Editorial Panel to develop new CPT codes that have different

⁸ *Medicare Claims Processing Manual*, Publication 100-04, Chapter 12, Section 30.6.8. (“When a patient receives observation care for less than 8 hours on the same calendar date, the Initial Observation Care, from CPT code range 99218-99220, shall be reported by the physician. The Observation Care Discharge Service, CPT code 99217, shall not be reported for this scenario...When a patient receives observation care for a minimum of 8 hours, but less than 24 hours, and is discharged on the same calendar date, Observation or Inpatient Care Services (Including Admission and Discharge Services) from CPT code range 99234-99236 shall be reported. The observation discharge, CPT 99217, cannot also be reported for this scenario.”)

work requirements. For example, CMS would have to argue that the amount of history, physical examination, medical decision making etc. is less for same day discharge patients than it is for patients discharged the following day.

Lastly, the CMS proposals would result in an absurd anomaly because it would value the exact same amount of physician work differently simply because the patient was in observation or inpatient care over the midnight hour. CMS allows physicians to report only one E/M code per patient per calendar day. Therefore, a physician will be able to report an observation or inpatient admission and an observation or inpatient discharge code for a patient admitted on, for example, Monday (admission code) and discharged on Tuesday (discharge code). However, if a patient is admitted and discharged on the same calendar day, in the absence of a single code describing admission and discharge care, a physician will only be able to report the admission or the discharge. Unless the observation/inpatient, same day admission/discharge code is valued identically to the sum of the admission and discharge codes the physician will get paid less for a patient admitted and discharged on the same day, **even though the length of admission and the work is exactly the same.** For example, a patient admitted at 7 AM and discharged at 9 PM will have spent 14 hours in the hospital and a physician can only bill one E/M CPT code for the care rendered - say 99236. However, for a patient admitted at 7 PM and discharged the next day at 9 AM, also 14 hours in the hospital, a physician may report 99223 and 99238 because the admission crossed midnight. AGS believes this is an absurd result that is not based on the physician work but on an arbitrary, unsupportable CMS “acuity policy.” The RUC recommendations for 99234-99236, which include a 50% reduction in the work of the stand alone discharge code 99238, appropriately reflect the total work performed and dramatically reduce any financial incentive for physicians to unnecessarily admit patients to the hospital. If the proposed work RVUs are finalized, the result will be that physicians have a financial incentive to never use observation and to always admit patients to the hospital. This flies in the face of more and more care being furnished in the outpatient setting.

In summary, the application of the CMS “acuity policy” to 99234-99236 results in work values that have no face validity, are not consistent with CPT code descriptors, and create major rank order anomalies in this family of codes. The absurd results of applying the “acuity policy” to these codes is further evidence that the policy itself is arbitrary and should be abandoned. CMS should accept the RUC recommendations. If CMS believes that the work of admitting and discharging a patient on the same day is different from the work of admitting a patient and discharging the patient the following day then CMS should work with CPT to develop new CPT codes with new descriptors.

E. Implications of the Acuity Policy

We believe the use of acuity is a policy decision. We believe it is an adverse policy decision that is counter to accumulating evidence and consensus related to care of patients. The most high cost, complex Medicare beneficiaries have multiple chronic conditions. We have observed a bias in payment valuations that apparently confuse the setting of care and patient acuity for a single condition with the complexity of medical decision making. The new CMS

policy would worsen an already pernicious under recognition of the work of medical decision-making and care coordination in treating individuals with multiple chronic diseases. Additionally, it incentivizes use of inpatient services which are costly, more restrictive and pose greater risk of harm to the beneficiary.

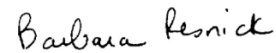
Recommendation:

We urge CMS to reverse its position and accept the RUC recommended values for observation care services, so that geriatricians and other physicians may be compensated appropriately for the work involved in caring for hospital patients, regardless of the patients' administrative status as inpatient or outpatient.

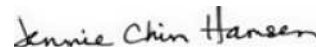
The proposal that CMS has put forth does not achieve this goal, and in fact will have the opposite result of incentivizing physicians to admit patients to the hospital, and discharge them the next day, rather than keeping patients under observation.

Thank you once again for this opportunity to comment on an important issue. We will be happy to work with CMS as the agency finalizes this important policy. If you or your staff has any questions or needs any additional information, please contact Susan Sherman at 212-308-1414.

Sincerely,



Barbara Resnick, PhD, CRNP, FAAN, FAANP
President



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