AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

July 25, 2011

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

Re: Five-Year Review of Work Relative Value Units under the Physician Fee Schedule

Dear Dr. Berwick:

On behalf of the American Academy of Family Physicians, which represents 100,300 physicians and medical students nationwide, I am writing to offer our comments on the proposed notice, "Medicare Program; Five-Year Review of Work Relative Value Units under the Physician Fee Schedule," as published by the Centers for Medicare and Medicaid Services (CMS) in the *Federal Register* on June 6, 2011. We will confine our comments to those codes of most interest to family physicians.

Nursing Facility Discharge Day Services (Codes 99315 and 99316)

In the proposed notice, CMS indicates that it agrees with the Relative Value Scale Update Committee's (RUC's) recommendation to increase the work value of both of these codes. Specifically, CMS proposes to increase the work relative value units (RVUs) of code 99315 from 1.13 to 1.28. Similarly, CMS proposes to increase the work RVUs of code 99316 from 1.50 to 1.90.

We support CMS's proposals for these codes. The proposed new values will put these codes on par with the corresponding codes for hospital discharge day services (codes 99238 and 99239). In our view, this is appropriate, because the physician work involved in discharging a patient from a nursing facility is comparable to that of discharging a patient from a hospital. We appreciate CMS's recognition of this position and its acceptance of the RUC's recommendations in this regard.

Preventive Medicine Services (Codes 99381-99397)

CMS did not review the RUC recommended values for the preventive medicine services codes, because Medicare does not cover these services. However, CMS has published the RUC-recommended RVUs for these codes in Addendum B of the proposed notice, and we appreciate CMS's decision to do so. Although Medicare does not cover these services, many other payers do. The RUC-recommended RVUs represent an increase over the current RVUs in each case, reflecting a more appropriate recognition of the value of

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preventive medicine services. Publication of the new values in Addendum B will provide a basis for other payers to use those values in setting their own fee schedules.

Observation Care (Codes 99218-99220 and 99234-99236)

In the proposed notice, CMS indicates its intent to maintain the current work RVUs for codes 99218-99220 and to decrease the work RVUs for codes 99234-99236. In each case, CMS chose to ignore the RUC's recommended values, which reflected an increase in all but one case. The following table compares CMS's-recommended value with the current and RUC-recommended 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

CMS's rationale, as stated in the proposed notice is that "we [CMS] do not believe the work RVUs of the initial observation care codes (99218, 99219, and 99220) should be equivalent (or close) to the initial hospital care codes (99221, 99222, and 99223)." Instead, CMS believes that "the acuity level of the typical patient receiving outpatient observation services would generally be lower than that of the inpatient level. We [CMS] 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." The CMS recommended values for 99234-99236 are subsequently affected by CMS's recommendations for 99218-99220.

We are extremely disappointed by CMS's proposal in this regard, which parallels its treatment of the subsequent observation care codes that were new in 2011. CMS's perception of what "should be" bears no resemblance to what "is" when it comes to patients' inpatient or observational care status. As we observed in our comments on the final rule on the 2011 Medicare physician fee schedule, CMS's belief that the acuity level of the typical patient receiving outpatient observation services would generally be lower than that of the inpatient level is an assumption, not a documented statement of fact. We have yet to see any evidence from CMS to support its contention in this regard. The criteria for inpatient status versus observational status do not distinguish between severity of illness, acuity or the work required. For example a patient admitted for chest pain or acute blood loss in many cases will be admitted to observational status, but requires the same diagnostic evaluation, professional consideration of risks, potential other diagnoses as if they were admitted as an inpatient. They often go to the same inpatient ward (not to an "observational care" ward), require the same documentation and work from the physician and staff. The only difference is that their definitive diagnosis may become known earlier or they are then converted to an inpatient status. This is a very arbitrary distinction to begin with and to undervalue this work is a disservice to the physicians who are attempting to accurately categorize patients to either inpatient or observational status.

A patient kept in observation as an outpatient for 23 hours may be as sick or sicker, and require as much or more physician work, as a patient admitted as an inpatient for the same time period. Much of the extended observational stays are due to evolving patient issues. When the patient first presented, they did not meet criteria for inpatient care, but during the ensuing time, their condition was further evaluated or they deteriorated and thus the need for continued time until they were either discharged or changed to inpatient status.

If hospitals were not attempting to correctly categorize patients based on the initial admission criteria, there would be no need for CMS to express concern about the increasing incidence of observation stays extending beyond 48 hours, as CMS Acting Administrator and Chief Operating Officer, Marilyn Tavenner, did in a letter to the President and Chief Executive Officer of the American Hospital Association (AHA) on July 7, 2010. In that letter, Tavenner stated that CMS:

> . . . has become increasingly concerned that Medicare beneficiaries are remaining in observation care for longer periods of time, sometimes exceeding 48 hours. Our claims data indicate a modest trend toward proportionally more observation services extending beyond 48 hours, from approximately 3 percent in 2006 to nearly 6 percent in 2008.

Thus, CMS's correspondence with the AHA undermines the validity of the agency's assumptions in this regard. Accordingly, we strongly urge the agency to reverse its position and accept the RUC-recommended values for observation care services, so family physicians and others may be appropriately compensated for the work involved in caring for hospital patients, regardless of the patients' nominal status as inpatient or observational.

In closing, we appreciate this opportunity to comment on matters related to the Medicare Physician Fee Schedule. As always, the AAFP looks forward to working with CMS in its continued efforts to ensure access to appropriate physician services. If you or your staff has any questions about our comments, please contact Robert Bennett, Federal Regulatory Manager at the AAFP, at 1-800-274-2237, extension 2522, or at rbennett@aafp.org.

Sincerely,

Lori J. Heim, MD, FAAFP
Board Chair