National Centre for Classification in Health

PROFESSIONAL RELATIVITIES STUDY

RESOURCE MATERIAL T

Clarification of AMA proposals on the relativities of consultations

AMA document presented to the MSRB at its meeting of 4 July 2000 providing clarification of the AMA's approach in formulating their working assumptions for the new attendance item relativities.

prepared for

Medicare Schedule Review Board
December 2000

For consideration at MSRB meeting 4 July 2000

CLARIFICATION OF AMA PROPOSALS ON THE RELATIVITIES OF CONSULTATIONS

At its meeting on 29/30 May 2000 the Board considered the paper attached. The paper summarised the interim position reached by AMA Board members in developing draft proposals for the mandating of consultations.

It was agreed that the Department would review the Australian and overseas sources of information considered by AMA members in formulating the proposed ratios of direct to indirect times and that the AMA would provide further elaboration of its development of other key variables such as:

- referral status of the patient.

- patient type (new versus existing).

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This paper is intended to provide further clarification of the AMA members' approach in formulating their draft proposals for mandating relativities of consultations. A separate paper is being prepared in relation to the use of US work RVUs to link consultations and procedures.

It should be noted that the views expressed in this paper and the proposals developed by AMA members of the Board have not been formally approved by the AMA and craft groups at this stage.

Human capital indexation is not a work relativity issue

The position of AMA members is that human capital indexation is only intended to establish a 'level playing field' between GPs and specialists in terms of income foregone during training, CME etc.

Human capital indexation factors arising from the Remuneration Rates Study are therefore irrelevant to the process of determining differences in the relativities of work and are not a factor in the mandating of consultations.

Peak intensities by different groups

AMA members noted that the Hsiao studies identified patient encounter time as the major predictor of consultative work. In keeping with this position, the relativities of Evaluation and Management items under US Medicare bear a simple linear relationship with encounter times. It was also noted that the US relativities were consistent with HCFA's policy parameters which effectively rule out any differentials in relativities between classes of providers of E and M services. The averaging approach would seem to be the only appropriate way to deal with the open access US system but is not compatible with the

Australian referral system which relies on differential fees and benefits and the GP gatekeeper to operate efficiently and effectively.

AMA members also noted the findings in the NEJM article in the attachment which confirmed that encounter time was the major predictor of E and M work but also found that intensity of work tended to decline as encounter times increased. This phenomenon was examined in the Australian context. It would appear that the Australian referral system is a major differentiating factor, as it is clear that in Australia different categories of provider reach their peak work intensities at different times. For example, the peak work intensity for GP work would occur in the 15-20 minutes area whereas for the bulk of referred services peak intensities would be reached in later encounter times. It is therefore important that the rise and decline in intensity levels be taken in account in establishing work differentials between provider groups.

The application of peak intensity levels was also considered to be important in encouraging quality, efficient practice whilst discouraging unnecessarily long consultations. It was also noted that anaesthetists have short, highly intensive pre operative consultations and this factor should be addressed in the formulation of their consultations. At the other end of the spectrum, psychiatrists tend to have relatively long consultations of fairly even intensity levels and this factor would need to be addressed in a fair and equitable manner.

Referral status of the patient

The central AMA policy position is that the action of referral is acknowledgment by the referring practitioner that the condition of the patient requires the application of specialised knowledge and higher levels of professional skill and expertise than he or she is able to efficiently and effectively provide.

Other relevant policy considerations are:

- The gatekeeper role of the GP in terms of the efficient delivery of health care is predicated on the assumption of appropriate financial and other barriers to access to specialist care. This means that there should be sufficient incentive for GPs to continue to treat patients not requiring specialist care whilst ensuring a relatively higher return to specialists who rely on referrals for their existence. Simply put, there must be a significantly higher return to the specialist per unit of encounter time or the system will not work.

- It is accepted that some referrals arise to meet the structural and administrative requirements of the health care system but this factor is extremely difficult to address in any meaningful way. It should not unduly impact on the specialist who must rely on the referring doctor to differentiate the patient prior to referral. However, some discounting of intensity for referred patients may be appropriate in recognition of this factor.

In considering this matter AMA members concluded that there must be a minimum differential established between referred and non-referred consultations of the same duration. Anything less than 10% is likely to be ineffective in addressing the policy and other considerations identified above.

It was noted that the NEJM article in the attachment (Table 3) identified a work differential of 7% between a 'Follow-up consultation' of 15 minutes duration and an 'Established patient in office' and 19% between an 'Initial consultation' and 'New patient in office' of the same duration.

Although somewhat arbitrary, it was felt that a minimum 12% differential provided a reasonable balance between the two.

Patient type (new versus existing)

AMA members reviewed the discussions at various meetings of the CGAI and concluded that there was strong evidence to support the application of new over existing patient differentials from 30 minutes. No change is recommended to the position reached by the Board when the draft new consultation item structure was proposed in 1998. The draft structure assumes that averaging of new and existing patient differentials will apply up to 30 minutes.

As a general point, it was felt that in the interests of having a practical and workable Schedule the extent of differentiation should be minimised as much as possible.

In reaching their position members noted that in respect of 15 minute encounters the NEJM article had identified a 23% differential between a 'New patient in office' and an 'Established patient in office' and 36% between an 'Initial consultation' and a 'Follow-up consultation'. The article also confirmed that "for longer encounters, the differences in total work among these visit types were somewhat larger".

The AMA members concluded that from 30 minutes encounter time new patients should attract higher (peak) intensity ratings than existing patients. The new to existing work intensity rating for a 30 minute GP consultation was set at 11% for GPs, 21% for specialists and 31% for consultant physicians.

The higher intensity ratings are proposed to continue to 45 minutes for specialists and to 60 minutes for consultant physicians. Extended differentials for consultant physicians are considered necessary to reflect the higher consultative and cognitive skills being applied in consultant physician practice as manifested by their longer consultations with new patients.

AMA members believe that the differentials being proposed are well with the limits of reason, are supported by the general findings in the NEJM article and accord with the policy framework of the Australian referral system.

Referred to the Board for further discussion.

John Popplewell

Late paper for consideration by the MSRB at its meeting on 29/30 May 2000

Mandating consultations

AMA members of the Board met on 17 January and 1 and 2 April 2000 to develop proposals for the mandating of consultations.

The meetings considered a range of information from Australia and overseas and confirmed that the key variables for consideration were as identified in meetings of the CGAI:

- ratios of direct to indirect time.
- relationships of times and intensities of work.
- referral status of the patient.
- patient type (new or existing)
- location of service.

Ratios of direct to indirect times

Papers provided by NCCH covering the preliminary ranking and rating of new consultation items from the BGAP process indicated a simple average face to face to total time of 73%.

The preliminary results were in line with overseas and other Australian studies.

The meetings concluded that modelling of the relativities of the professional components of the draft new consultation item structure was required and that the modelling should include the following ratios of face to face to total times for rooms based consultations:

- General practitioners 75%
- Specialists 75%
- Consultant physicians 70%

It was also felt that the ratio for hospital based consultations for GPs should be the same as their rooms but for other specialties a more appropriate rate was 90%. The higher percentage would more accurately the higher ratio that 'floor time' (as a proxy for encounter time) represented of total time for hospital consultations.

Relationships of times and intensities of work

Members noted that the "Harvard studies" in the USA found that the length of the consultation (encounter time) was the major predictor of consultative work. A more recent analysis of a survey of physicians conducted by the US Physician Payment Review Commission in 1989 (but considered to be still relevant today), reported in the New England Journal of Medicine in July 1999, confirmed the key Harvard findings but also found that the intensity of work tended to decline as encounter times increased.

The NEJM article (copy and some analyses at Attachment A) indicated that the intensity of initial consultations (referred consultations for new patients) was significantly higher than other attendances of the same duration.

It was felt that the Australian referral system was significantly different to the USA. A realistic interpretation of available information was that different groups reached peak intensities at different times. The peak for GPs was likely to be between 15 and 20 minutes, for most specialists between 20 and 30 minutes, and consultant physicians between 30 and 45 minutes.

It was also recognised that groups whose consultations tend to fall in fairly tight time bands may need to have a different focus. For example, it may be more practical for psychiatrists to have a flat intensity scale to reflect the great bulk of their consultations occurring at around 60 minutes wheras anaesthetists and dermatologists were more likely to reflect peaks around 10 minutes or less.

Referral status

There was considerable debate around the nature of the Australian referral system including, the policy implications of the 'gatekeeper" role of the GP and the need to maintain an efficient health care delivery system which directs patients to the most cost effective forms of treatment.

It was recognised that some referrals may occur to meet the administrative requirements of the health care system. However, the action of referral should be seen as recognition of the need to apply higher level of knowledge and expertise than the GP could reasonably and efficiently bring to bear on the case.

The meetings concluded that referred consultations by specialists and consultant physicians should carry higher intensity/complexity loadings than consultations of the same duration by GPs.

It was felt that a basic intensity loading of 12% should apply to referred consultations by specialists and consultant physicians.

Also, referred consultations by consultant physicians, psychiatrists and possibly some specialists such as dermatologists whose primary work was consultations should enjoy higher intensity/complexity loadings than consultations of the same duration by procedural specialists.

Patient type (new and existing)

The meetings addressed the strong concerns of some groups about potential inequities arising from the current draft consultation item structure, which only recognised ‘new’ and ‘existing’ differentials from the 30-minute items.

It was felt that many of the concerns arose from a lack of appreciation that averaging of intensity in respect of patient status was intended apply up to 30 minutes and that ‘branching’ should occur from that point. It was intended that from 30 minutes the intensity for new patients would be higher and lower than average for existing.

There was also a requirement to keep the new Schedule as simple as possible.

It was agreed to recommend continuation of the current draft structure, which has the new and existing split occurring from the 30-minute item.

Location status

It was agreed to wait and see if any significant location status differentials could be identified by NCCH from the consensus process. The proposed treatment of the ratios of ‘floor time’ to total time may be sufficient to overcome concerns in this area. It was also recognised that special ’rules of interpretation’ may need to be introduced to assist in dealing with multiple patient visits in locations such as nursing homes but should be avoided wherever possible.

Initial modelling for consideration and discussion

Attachment B is a spreadsheet with charts, which reflects the initial relativities developed by AMA members.

John Popplewell

Analysis of tables provided in the special article in the New England Journal of Medicine THE INTENSITY OF PHYSICIANS' WORK IN PATIENT VISITS Implications for the Coding of Patient Evaluation and Management Services' Vol 341 Number 5 ps 337-341

Table 1- Indexes of Total Work Intensity According to Type of Visit and Encounter Time

	Encounter time(Mins)			
	10	15	25	45
	67	*100*	*167*	*300*
Total work				
Established patient in office	84	100	125	159
New patient in office	80	100	133	186
Follow-up visit in hospital	82	100	128	171
Initial visit in hospital	78	100	137	195
Follow-up consultation	82	100	128	171
Initial consultation	82	100	128	171
Work intensity				
Established patient in office	126	100	78	53
New patient in office	120	100	80	62
Follow-up visit in hospital	123	100	77	57
Initial visit in hospital	117	100	82	65
Follow-up consultation	123	100	77	57
Initial consultation	123	100	77	57

Table 3-Total Work According to Type of Visit or Patient Characteristic for Visits involving a 15 Minute Encounter

	Relativity
Type of Visit	
Established patient in office	100
New patient in office	123
Follow-up visit in hospital	92
Initial visit in hospital	120
Follow-up consultation	107
Initial consultation	146
Characteristics of patient seen in office	
Initiating treatment for new problem	107
Continuing treatment for new problem	97
Age (yr)<=40	99
Age (yr)41-64	98
Age (yr)65-74	101
Age (yr)>=75	102
Impaired	108
Unimpaired	100

Table 1-Total work in relation to encounter time

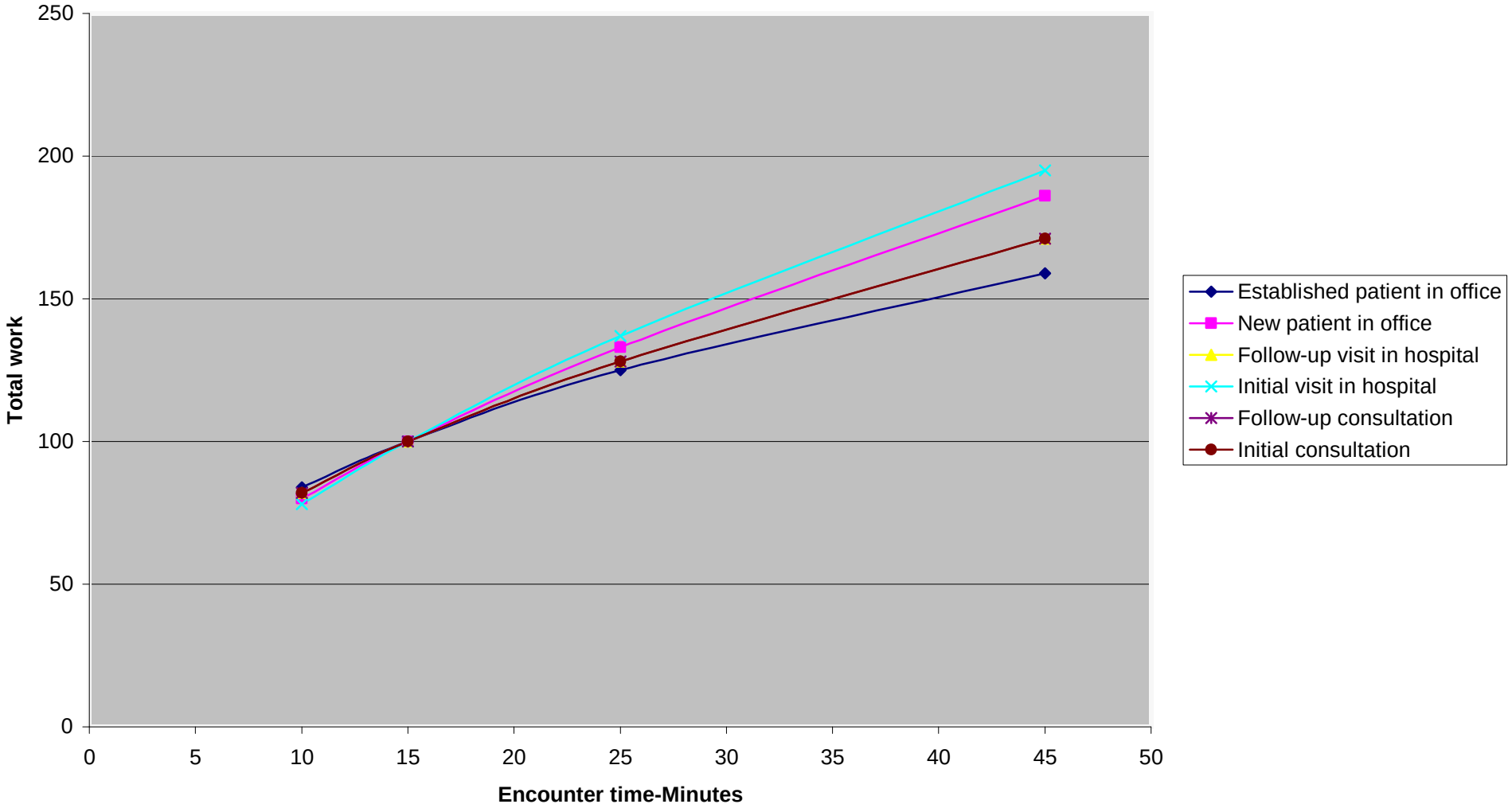


Table 1-Work Intensity in relation to Encounter Time

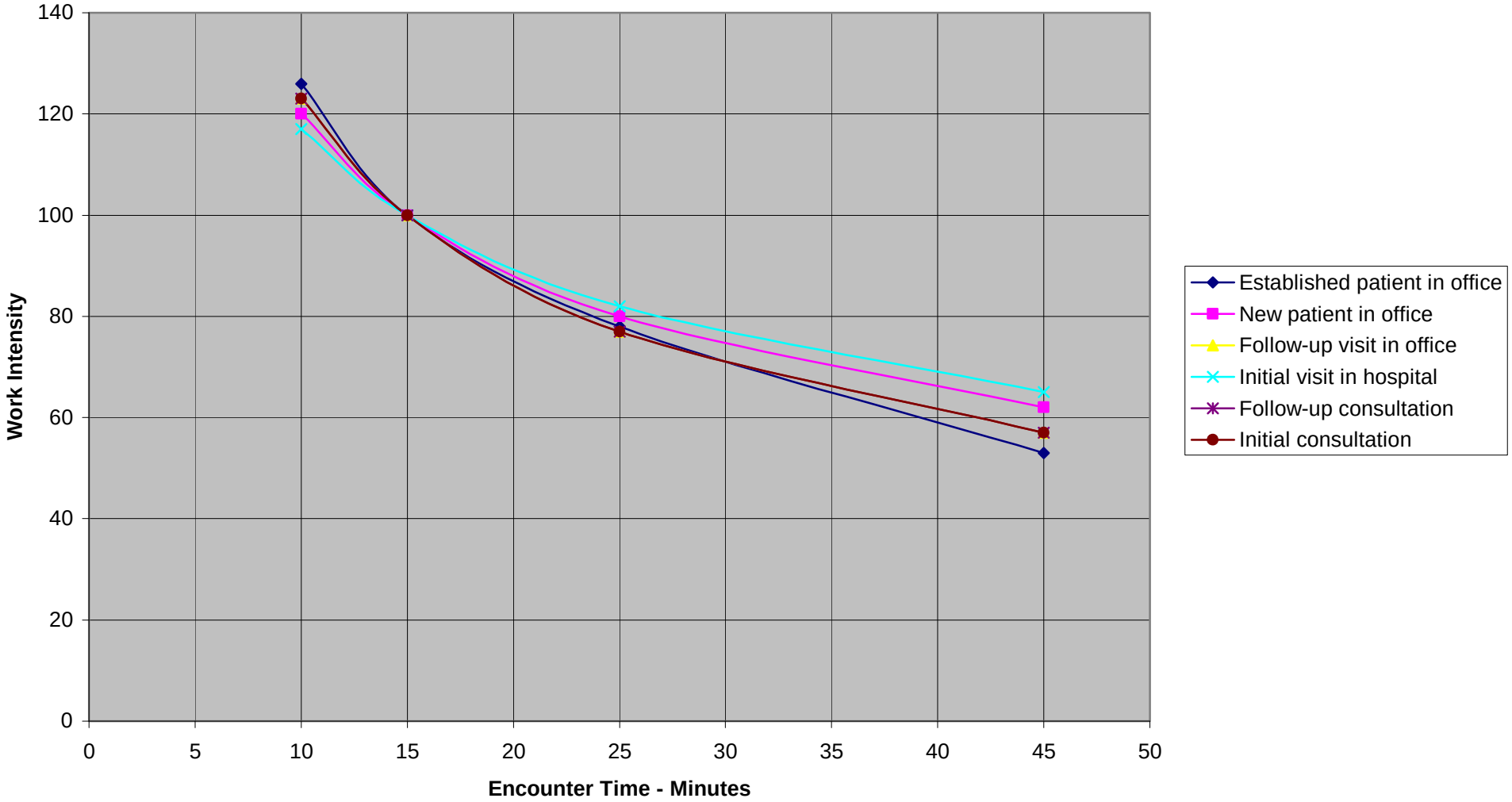


Table 3-Total work according to type of visit-15 minute patient encounters

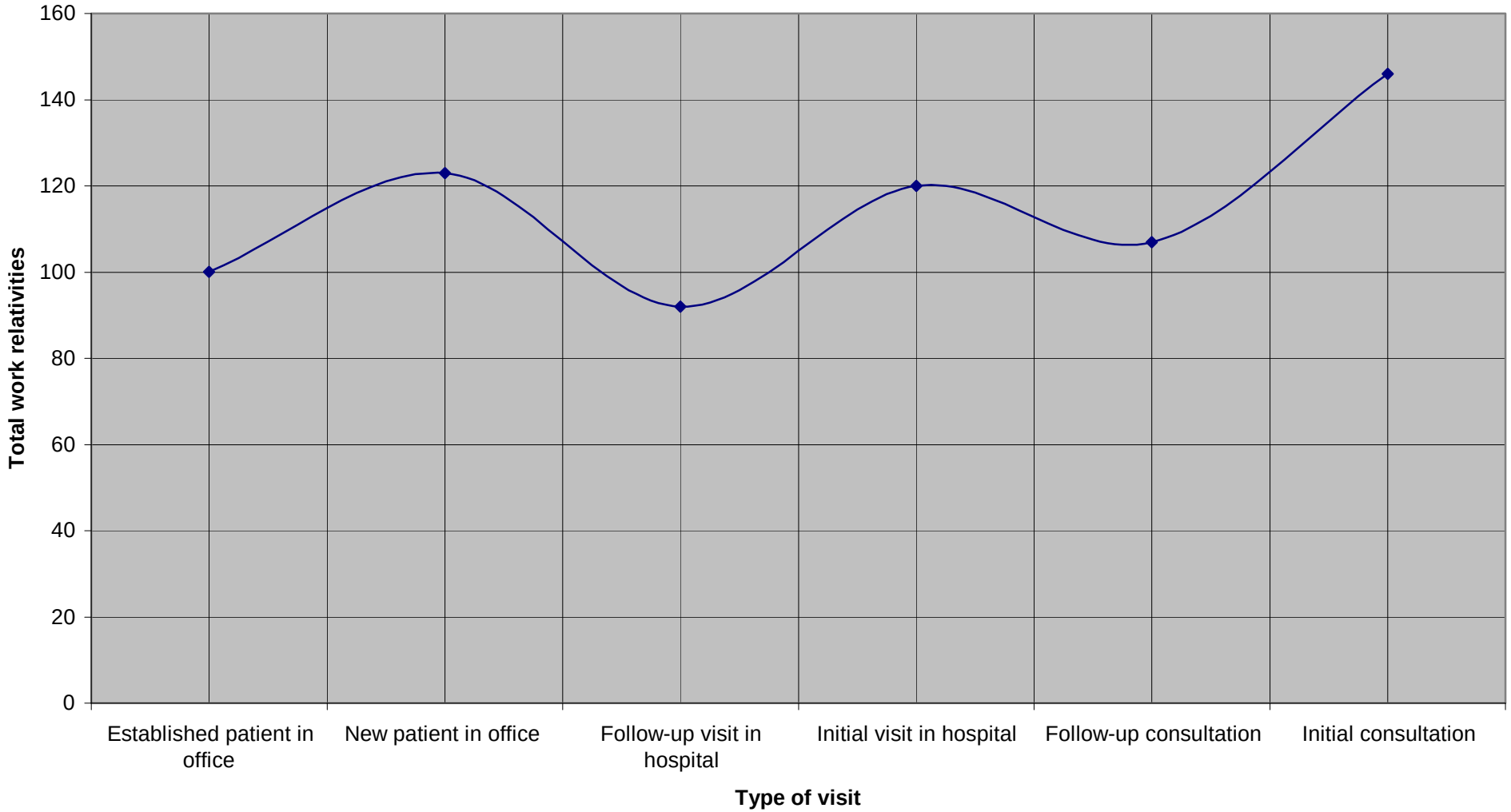
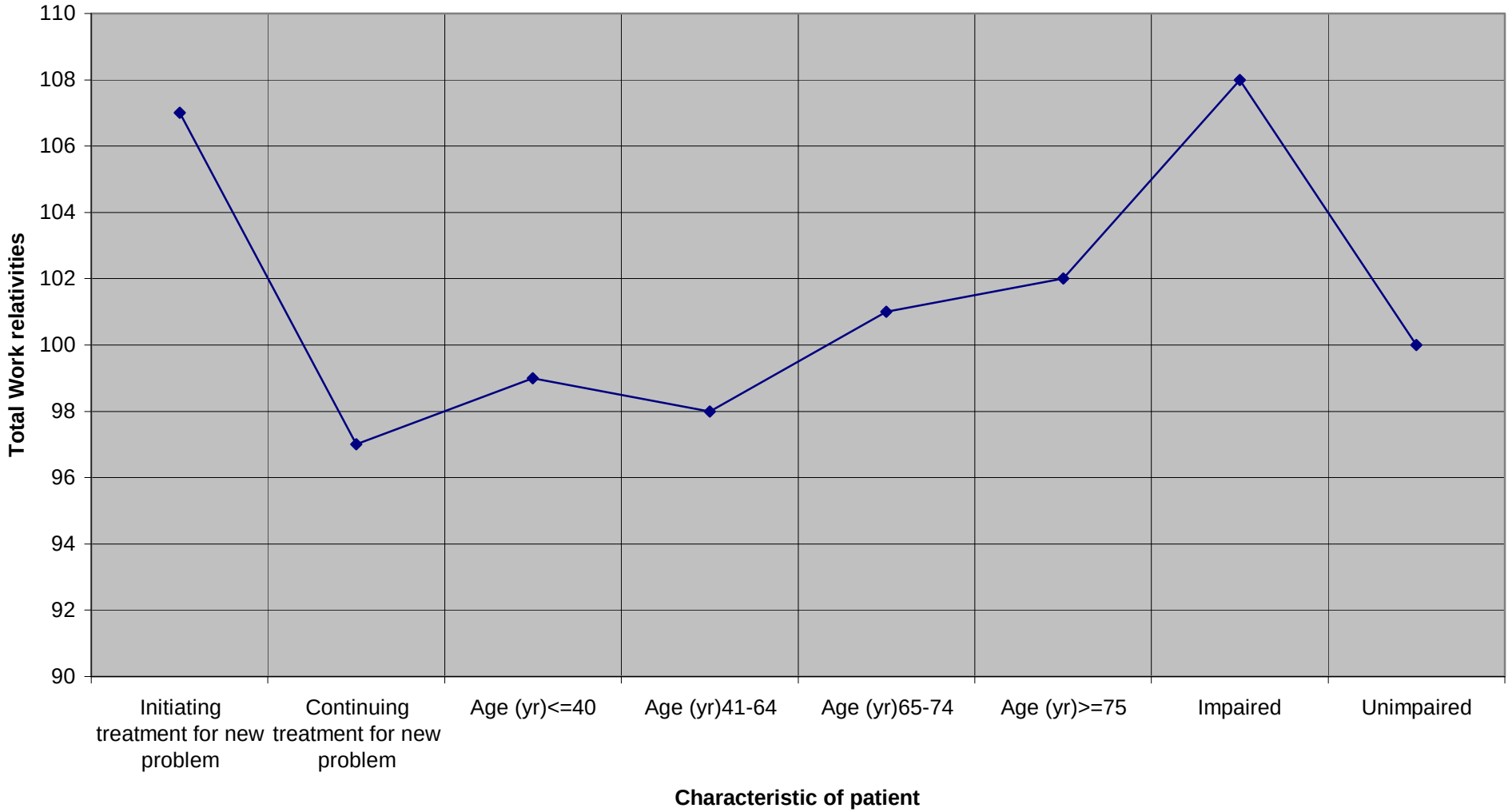


Table 3-Total work according to patient category-15 minute patient encounters



Construction of professional component relativities of rooms based consultations

Item No. (draft structure)	**1**	**2**	**3**	**4**	**4A**	**5**	**5A**	**6**	**6A**	**7**	**7A**	**8**	**8A**
Indicative time (Mins)	**5**	**10**	**15**	**20**	**20**	**30**	**30**	**45**	**45**	**60**	**60**	**75**	**75**
Service/patient type	New/Exist	New/Exist	New/Exist	New/Exist	New/Exist	New	Exist	New	Exist	New	Exist	New	Exist
Comments					Extended 3								
% of direct time to total time (required as inputs)													
GPs	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
Specs	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
CPs	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%
Total indic time (Mins)													
GPs	6.7	13.3	20.0	26.7	26.7	40.0	40.0	60.0	60.0	80.0	80.0	100.0	100.0
Specs	6.7	13.3	20.0	26.7	26.7	40.0	40.0	60.0	60.0	80.0	80.0	100.0	100.0
CPs	7.1	14.3	21.4	28.6	28.6	42.9	42.9	64.3	64.3	85.7	85.7	107.1	107.1
Intensity/Complexity (required as inputs)													
GPs	0.80	0.90	**1.00**	**1.00**	**1.00**	**1.00**	0.90	0.95	0.86	0.85	0.77	0.80	0.72
Specs	0.90	1.01	1.12	1.12	1.12	**1.22**	1.01	**1.22**	0.96	1.09	0.86	1.02	0.81
CPs	0.90	1.01	1.12	1.12	1.12	**1.32**	1.01	**1.32**	0.96	**1.32**	0.86	1.25	0.81
Specs relativity to GPs	112%	112%	112%	112%	112%	122%	112%	128%	112%	128%	112%	128%	112%
CPs relativity to GPs	112%	112%	112%	112%	112%	132%	112%	139%	112%	156%	112%	156%	112%
CPs relativity to Specs	100%	100%	100%	100%	100%	109%	100%	109%	100%	122%	100%	122%	100%

Notes:

Bolded values denote peak intensity for group. Some modification will be necessary for groups such as Psychiatrists, Dermatologists, Anaesthetists and Ophthalmologists which tend to work in relatively narrow time bands.

Referred consultations have been allocated an underlying 12% higher differential than non referred consultations.

New patients from 30 minutes reflect higher intensities allocated to that class of work but with reduced intensity for existing patients.

Work units (total time multiplied by intensity)													
GPs	5.33	12.00	20.00	26.67	26.67	40.00	36.00	57.00	51.30	68.00	61.20	80.00	72.00
Specs	5.97	13.44	22.40	29.87	29.87	48.64	40.32	72.96	57.46	87.04	68.54	102.40	80.64
CPs	6.40	14.40	24.00	32.00	32.00	56.74	43.20	85.11	61.56	113.49	73.44	133.51	86.40
Specs relativity to GPs	112%	112%	112%	112%	112%	122%	112%	128%	112%	128%	112%	128%	112%
CPs relativity to GPs	120%	120%	120%	120%	120%	142%	120%	149%	120%	167%	120%	167%	120%
CPs relativity to Specs	107%	107%	107%	107%	107%	117%	107%	117%	107%	130%	107%	130%	107%

Please note that the work units do not include adjustments for human capital remuneration factors such as longer lengths of training by specialists and consultant physicians over GPs estimated to be of the order of . 20%

Intensity charting

	5 N/E	10 N/E	15 N/E	20 N/E	20 N/E-E	30 N	30 E	45 N	45 E	60 N	60 E	75 N	75 E
GPs	0.80	0.90	1.00	1.00	1.00	1.00	0.90	0.95	0.86	0.85	0.77	0.80	0.72
Specs	0.90	1.01	1.12	1.12	1.12	1.22	1.01	1.22	0.96	1.09	0.86	1.02	0.81
CPs	0.90	1.01	1.12	1.12	1.12	1.32	1.01	1.32	0.96	1.32	0.86	1.25	0.81

% direct time charting

	5 N/E	10 N/E	15 N/E	20 N/E	20 N/E-E	30 N	30 E	45 N	45 E	60 N	60 E	75 N	75 E
GPs	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
Specs	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
CPs	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%

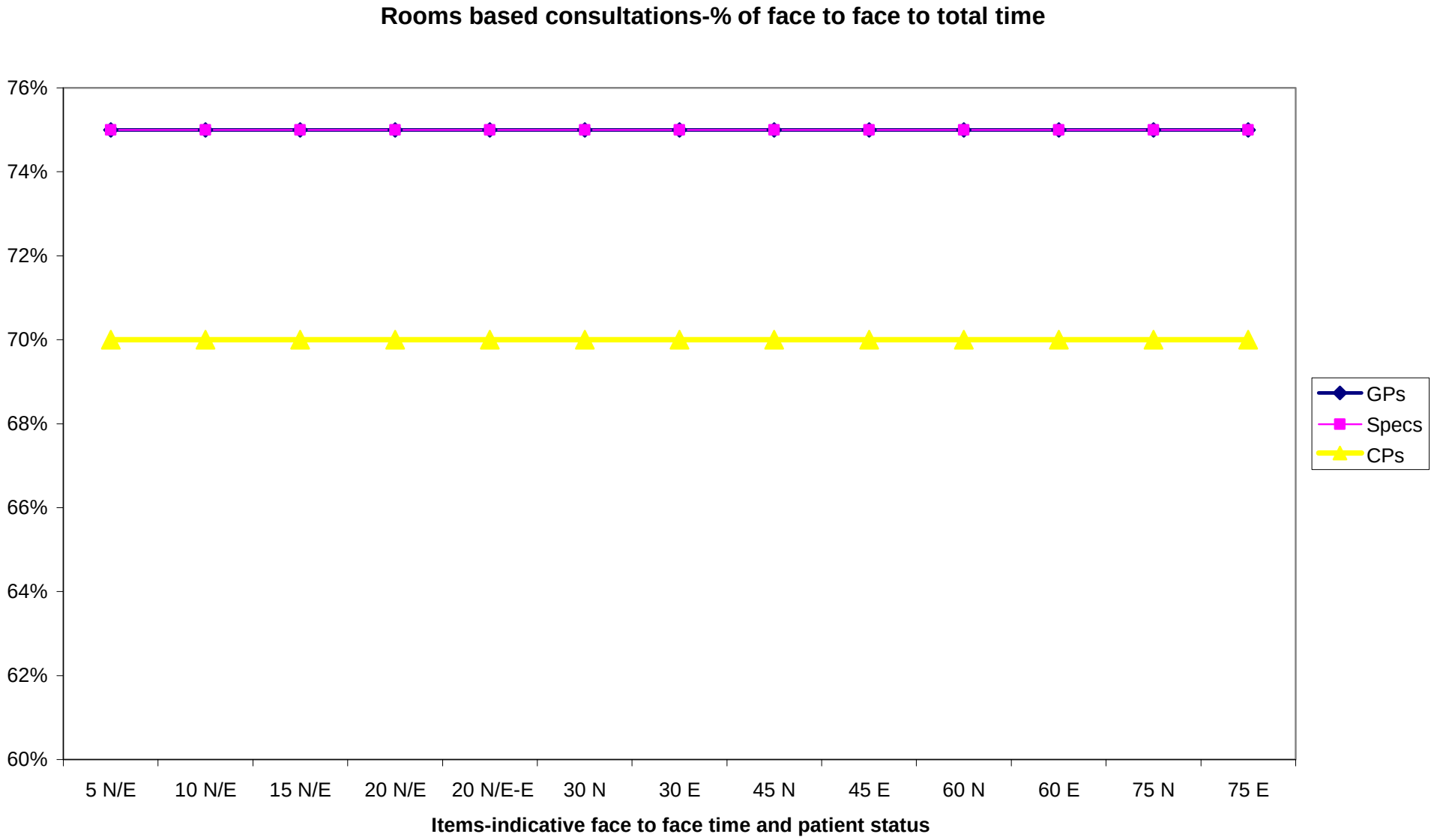
Work units charting

	5 N/E	10 N/E	15 N/E	20 N/E	20 N/E-E	30 N	30 E	45 N	45 E	60 N	60 E	75 N	75 E
GPs	5.33	12.00	20.00	26.67	26.67	40.00	36.00	57.00	51.30	68.00	61.20	80.00	72.00
Specs	5.97	13.44	22.40	29.87	29.87	48.64	40.32	72.96	57.46	87.04	68.54	102.40	80.64
CPs	6.40	14.40	24.00	32.00	32.00	56.74	43.20	85.11	61.56	113.49	73.44	133.51	86.40

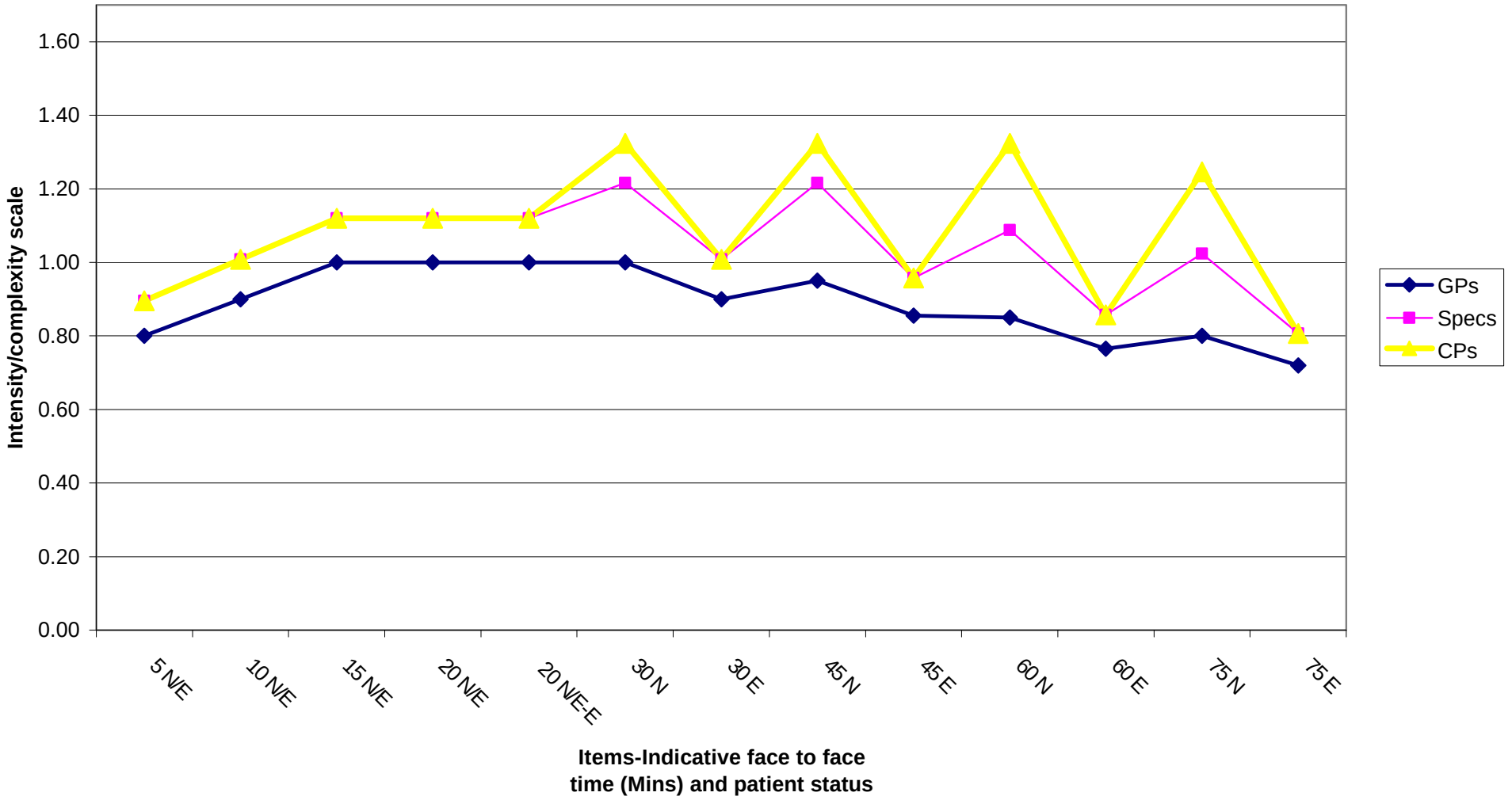
Intensity charting

	5 N/E	10 N/E	15 N/E	20 N/E	20 N/E-E	30 N	45 N	60 N	75 N
GPs	0.80	0.90	1.00	1.00	1.00	1.00	0.95	0.85	0.80
Specs	0.90	1.01	1.12	1.12	1.12	1.22	1.22	1.09	1.02
CPs	0.90	1.01	1.12	1.12	1.12	1.32	1.32	1.32	1.25

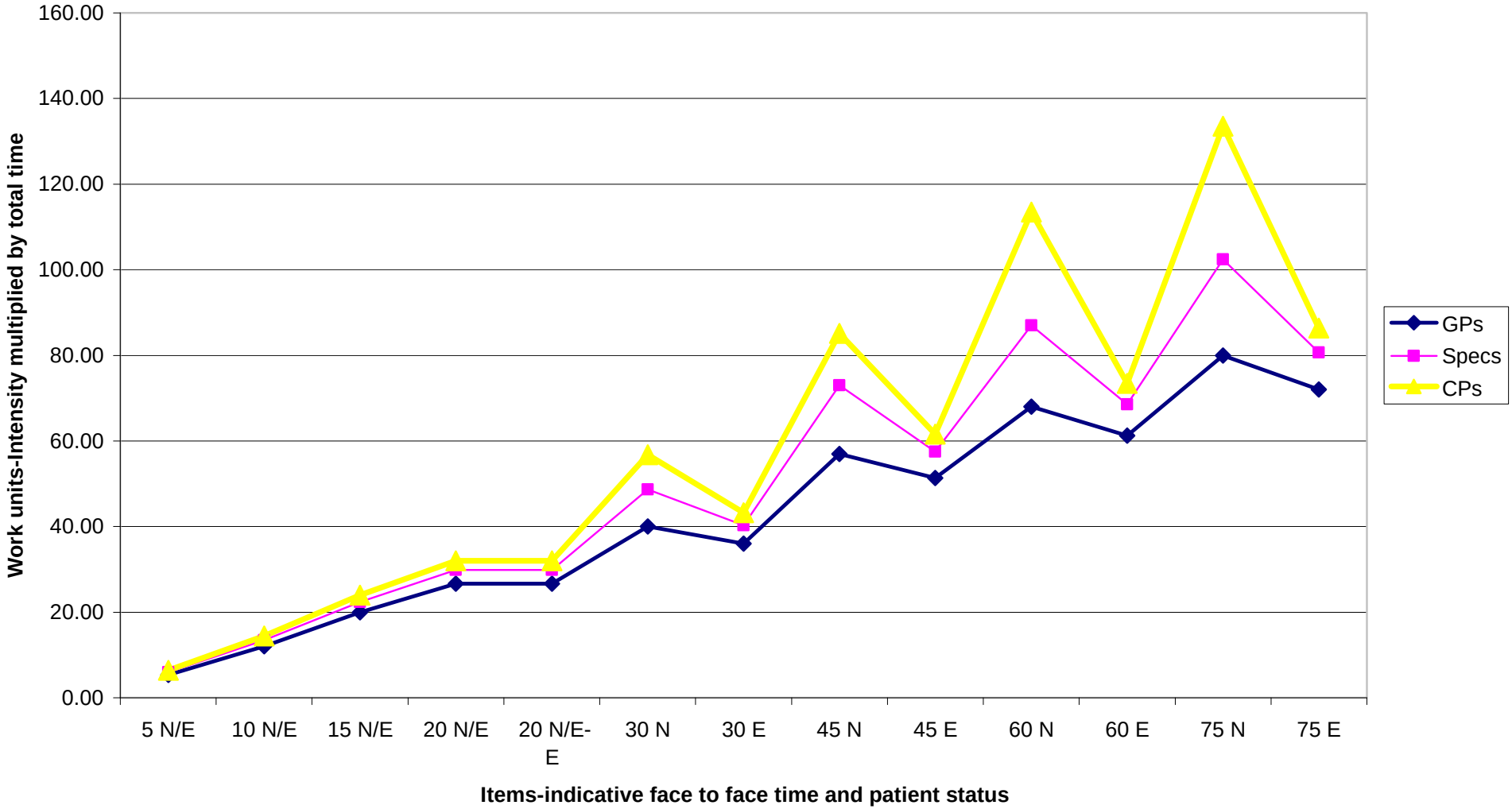
	5 N/E	10 N/E	15 N/E	20 N/E	20 N/E-E	30 E	45 E	60 E	75 E
GPs	0.80	0.90	1.00	1.00	1.00	0.90	0.86	0.77	0.72
Specs	0.90	1.01	1.12	1.12	1.12	1.01	0.96	0.86	0.81
CPs	0.90	1.01	1.12	1.12	1.12	1.01	0.96	0.86	0.81


Rooms based consultations-% of face to face to total time
76%
74%
72%
70%
68%
66%
64%
62%
60%
5 N/E
10 N/E
15 N/E
20 N/E
20 N/E-E
30 N
30 E
45 N
45 E
60 N
60 E
75 N
75 E
Items-indicative face to face time and patient status
GPs
Specs
CPs

Intensity of Rooms based consultations



Relative work values for rooms based consultations



Conversion to US RVU equivalents

Item No.	**1**	**2**	**3**	**4**	**4A**	**5**	**5A**	**6**	**6A**	**7**	**7A**	**8**	**8A**
Indicative time (Mins)	**5**	**10**	**15**	**20**	**20**	**30**	**30**	**45**	**45**	**60**	**60**	**75**	**75**
Service/patient type	New/Exist	New/Exist	New/Exist	New/Exist	New/Exist	New	Exist	New	Exist	New	Exist	New	Exist
Comments					Extended 3								
Work units (total time multiplied by intensity)													
GPs	5.33	12.00	20.00	26.67	26.67	40.00	36.00	57.00	51.30	68.00	61.20	80.00	72.00
Specs	5.97	13.44	22.40	29.87	29.87	48.64	40.32	72.96	57.46	87.04	68.54	102.40	80.64
CPs	6.40	14.40	24.00	32.00	32.00	56.74	43.20	85.11	61.56	113.49	73.44	133.51	86.40

Relativities rebased on a 15 minute GP consultation having **0.64** **RVUs as per US Medicare item number 99241:-**