November 30, 2009

Charlene Frizzera
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1413-FC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Ms. Frizzera:

I am writing on behalf of the American Academy of Family Physicians (AAFP), which represents over 94,000 physicians and medical students nationwide. Specifically, I am writing to offer our comments on the final rule regarding payment policies under the Medicare physician fee schedule and other revisions to Medicare Part B for calendar year 2010. The Centers for Medicare and Medicaid Services (CMS) published the final rule in the *Federal Register* on November 25, 2009, and invited comments on several issues, including the following:

- Interim relative value units (RVUs) for selected codes identified in Addendum C of the final rule
- Services for consideration for the Five-Year Review of work RVUs

We will make some general comments on decisions made by CMS in response to comments on provisions in the proposed rule and then comment on issues for which CMS has solicited comments in the final rule, including the issues noted above. We will close with some additional comments on the physician fee schedule update for 2010 and sustainable growth rate.

Comments on CMS Decisions on Provisions of the Proposed Rule

Upon review of CMS's decisions on provisions of the proposed rule, we very much appreciate the recognition of and support for the value of primary care represented by several key policy changes this rule. Specifically, we support that CMS has:

- Finalized its proposal to use the Physician Practice Information Survey (PPIS) data in its practice expense methodology, albeit with a four-year transition from the current practice expense RVUs.
- Finalized its proposal to increase the utilization rate to 90 percent for expensive diagnostic equipment priced at more than $1 million (i.e., computed tomography and magnetic resonance imaging), albeit with a four-year transition.
- Finalized most of its proposals to make its malpractice RVU methodology even more current and resource-based.
- Finalized its proposal to increase the work RVUs for the Initial Preventive Physical Examination (i.e., the Welcome to Medicare Visit) to 2.30 effective for services furnished beginning January 1, 2010.
- Finalized its proposal to eliminate the use of all consultation codes (except for telehealth consultation G-codes) and, in a budget neutral manner, increase the work RVUs for new and established office visits,

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initial hospital and initial nursing facility visits, and the evaluation and management (E/M) component of 10-day and 90-day global surgical services.

These policies will improve payment for primary care physicians. Indeed, as a result of these and other decisions in the final rule, CMS estimates that family physicians will experience, on average, a 4% increase in their Medicare allowed charges in 2010. This will help ensure that all Americans have access to a personal physician who can ensure they get the right care at the right time in the right place.

The AAFP also commends CMS for revising the incentives for e-prescribing and the Physician Quality Reporting Initiative (PQRI). These will encourage more physicians to adopt electronic health records and e-prescribing, which will help improve efficiency in the system and reduce the potential for medical errors, duplication of services and fragmentation of care.

However, it is crucial that CMS continue to monitor the application of these programs and correct their shortcomings rapidly. As previously communicated, AAFP has serious concerns about PQRI's technical effectiveness and data accuracies. The CMS Acting Administrator committed to programmatic improvements. We are hopeful for advancements in the PQRI.

Regarding the e-prescribing bonus, we continue to encourage CMS to derive the data for this bonus directly from Part D claims and hope that CMS will be able to do so in 2011. In the meantime, reporting through PQRI-qualified registries, reducing the number of G-codes and prescriptions required, and adding additional nursing home and home visit codes to the denominator will make qualifying for the e-prescribing bonus much easier for 2010.

Future Practice Expense RVU Considerations

Concerning the PPIS, CMS noted in its comments that it agrees with the Medicare Payment Advisory Commission (MedPAC) that it is appropriate to consider the future of the practice expense RVUs moving forward. Thus, CMS seeks comments from other stakeholders on these issues raised by MedPAC. In particular, CMS seeks comments regarding MedPAC's suggestion that CMS consider alternatives for collecting specialty-specific cost data or options to decrease the reliance on such data. For example, MedPAC stated that "CMS should consider if Medicare or provider groups should sponsor future data collection efforts, if participation should be voluntary (such as surveys) or mandatory (such as cost reports), and whether a nationally representative sample of practitioners would be sufficient for either a survey or cost reports."

We believe that the American Medical Association (AMA) did an excellent job sponsoring and coordinating the PPIS with national medical specialty societies. The results, which CMS accepted with very few exceptions, are a testament to that fact. Accordingly, we would have no qualms with the AMA and the national medical specialty societies sponsoring future data collection efforts.

That said, we are not opposed to CMS undertaking its own data collection efforts, provided it did so under the same or similar conditions to the PPIS, namely:

- Voluntary physician participation
- Professional survey expertise
- Input from and collaboration with organized medicine
- Survey and sample methodology leading to statistically valid results

We do not favor mandatory participation, such as in the form of cost reports. The AAFP supports practice expense RVUs that are based on the actual resources, both direct and indirect, which physicians use to provide

services and that are adjusted in a timely and understandable manner. However, unless CMS is prepared to pay physicians on the basis of their actual practice costs, we see no reason to require physicians to submit cost reports to Medicare.

Telehealth Services

We believe that CMS's approach to determining whether or not to add certain services as Medicare telehealth services is fundamentally flawed. Specifically, the technology used to deliver the services should not be the primary consideration in determining whether or not to pay for telehealth services. The critical test is whether the service is medically reasonable and necessary. Medical necessity, not the technology involved, should be the determining factor.

We continue to believe that care provided via telemedicine should be paid as other physician services and can be a win-win-win for Medicare, patients, and physicians. By creating ready access to information, telemedicine can provide rural physicians in particular with current medical information that may not be available in an isolated setting. Regrettably, CMS's approach to decisions on Medicare telehealth services works against such access. Indeed, CMS's approach essentially applies a comparative-effectiveness standard to telehealth services requests that is not applied to any other services (of which we are aware) for which Medicare pays. We fail to see how CMS can justify this double-standard.

Potentially Misvalued Codes under the Physician Fee Schedule

In its discussion of valuing services under the physician fee schedule, CMS states:

> We also share some [of] the concerns expressed by the commenter with regards to IWPUT, which is a calculation that was used as the primary tool to value physician services for some codes during the third Five-Year Review. This calculation poorly assesses intensity for services that are short in time duration and also services that are short in time duration and of high intensity. The IWPUT has also been used to align procedures within a family of codes. It has value in some instances, such as in validating the RVUs for a given procedure using the building block methodology. However, the IWPUT has not proven to be a valuable tool in evaluating or validating cognitive services. The building block methodology is the accepted methodology used by the AMA RUC and CMS for valuing all physician procedures and services. We believe that the building block methodology should be consistently used when the AMA RUC considers valuation of physician services for its recommendations.

We appreciate CMS's recognition that IWPUT has limits to its utility. Unfortunately, those limits often seem to be overlooked within the AMA/Specialty Society Relative Value Scale Update Committee (RUC) process, on which CMS relies so heavily. We are heartened to know that CMS is cognizant of IWPUT's limitations and would encourage the agency to keep them in mind as it reviews recommendations from the RUC.

Five-Year Refinement of RVUs

In the final rule, CMS solicits comments only on services for which the currently assigned work RVUs may be inappropriate. CMS notes that it is implementing the second review and update of malpractice RVUs in this final rule. CMS also notes that a comprehensive review of practice expense was undertaken prior to the four-year transition period for the practice expense methodology from the top-down to the bottom-up methodology, which will be complete in 2010. According to CMS, the next five-year review of practice expense RVUs will be addressed in calendar year 2014, and CMS solicits comments on approaches to take for that five-year review of practice expense RVUs.

With respect to services for which the currently assigned work RVUs may be inappropriate, the AAFP's 2009 Congress of Delegates has instructed the AAFP's representative to the RUC to ask for the revaluation of the RVUs for the E/M codes for home visits. The resolution to the Congress of Delegates noted that many home-bound patients would benefit from home visits by their physicians and that many physicians are willing to make home visits and still find making them a valuable part of their practice. However, it is the opinion of our Congress of Delegates that the current payment for such services is often below the cost of providing the service. Pursuant to this direction from our Congress of Delegates, we would respectively request that CMS review the work RVUs of the E/M codes for home visits (i.e., Current Procedural Terminology (CPT) codes 99341 through 99345 and 99347 through 99350) as part of the upcoming five-year review of work values.

Regarding approaches to the next five-year review of practice expense RVUs in 2014, we do not have any specific suggestions to offer at this time. We would observe that, to date, physician input to the practice expense RVU methodology has been limited primarily to recommendations regarding direct practice expense inputs and that these recommendations have come primarily through the RUC process. We would also observe that those recommendations have typically come from expert panels of the affected national medical specialty societies and not any sort of survey process. If CMS expects a more rigorous process in the next five-year review of practice expense RVUs in 2014, we would encourage it to work with the national medical specialty societies now to clarify expectations and identify a process that is both satisfactory to CMS and manageable for the national medical specialty societies.

Establishment of Interim Work RVUs for New and Revised Codes in 2010 – CPT 95905

We have reviewed the list of new and revised codes in Addendum C for which CMS has established interim work RVUs for 2010. Upon review, we would like to comment on code 95905, "Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study; each limb, includes F-wave study when performed, with interpretation and report." Specifically, we believe that CMS should subject this code to a refinement panel. As explained below, we believe that the RUC erred in its recommendation to CMS in regard to the physician work involved.

As to the physician work involved, we and the other specialty societies that presented this code to the RUC recommended that it should be assigned 0.15 work RVUs. This was less than the 0.17 work RVUs currently assigned to an electrocardiogram (e.g., CPT code 93000), another diagnostic, physiologic test that involves physician interpretation and report of electronically-produced data. It was also substantially less than the 0.42 work RVUs currently assigned to CPT code 95900, "Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study," even though both codes involve physician interpretation and report of the same data. Ironically, code 95900 does not include an F-wave study, while the new code does, when performed, and code 95900 is reported on a per nerve basis, while the new code is reported only once per limb.

Unfortunately, the RUC recommended that the new code be assigned 0.05 work RVUs, based on a comparison to the physician work of CPT code 76977, "Ultrasound bone density measurement and interpretation, peripheral site(s), any method." We believe that this comparison is erroneous because the output of a bone density machine includes only discrete data (BMD and T Scores) with fully automated, accurate, machine interpretation. We believe the better comparison is to 93010, "Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only," since both include automated collection of electrical physiologic data after electrodes are placed in predetermined locations and a printout with a preliminary machine interpretation. These data and interpretation must be carefully reviewed by the physician, as the machine frequently makes inaccurate assessments or over-interprets faulty data.

Additionally, we believe that the undervaluation of the physician work for 95905 will undermine the ability and viability of physicians providing the service. Ultimately, patients will lose access to this new, less expensive alternate method of providing motor and/or sensory nerve conduction testing.

For all of these reasons, we believe this code would benefit from review by a CMS refinement panel before CMS finalizes the RVUs for it in 2011.

Payment for H1N1 Immunization Administration

In the final rule, CMS notes that the CPT Editorial Panel created CPT code 90470,"Immunization administration (intramuscular, intranasal), including counseling when performed," to assist the public health effort to vaccinate for H1N1. CMS also notes that the AMA RUC reviewed this service and recommended 0.20 work RVUs. However, for Medicare payment purposes, CMS will not recognize this code since it created a specific Healthcare Common Procedure Coding System (HCPCS) code (G9141, Influenza A (H1N1) immunization administration (includes the physician counseling the patient/family) for this service that was effective September 1, 2009. CMS has assigned a status indicator of "N" (Non-covered) to 90470 and will publish the AMA RUC-recommended value in accordance with its practice for non-covered CPT codes.

We appreciate that CMS has accepted the RUC-recommended work RVUs for 90470 and consented to publish them, even though CMS will not recognize this code for Medicare purposes. Unfortunately, we observe that the payment rate for the Medicare code, G9141, is set equal to that of the HCPCS code for seasonal influenza vaccine administration, G0008. The payment rate for G0008, in turn, is set equal to code 90471, which only has 0.17 work RVUs. In essence, CMS is undervaluing its own H1N1 immunization administration code relative to the value it has recognized for the corresponding CPT code.

Ideally, we would like to see CMS delete code G9141 and, instead, cover and pay for code 90470 at the recommended level. From our perspective, duplicate codes make no sense and are an administrative hassle for our members.

If CMS is determined to maintain code G9141 and otherwise not recognize code 90470 for Medicare purposes, then we would encourage CMS to set its payment for G9141 equal to the amount that would otherwise be paid for 90470 if covered under Medicare rather than continuing to set it equal to G0008 (i.e., 90471). If CMS does not adjust the G9141 crosswalk from 90471 to 90470, it will result in a "two tier" payment platform for administration of the identical vaccine.

Physician Fee Schedule Update for Calendar Year 2010

In the final rule, CMS is finalizing its proposal to remove physician-administered drugs from the calculation of allowed and actual expenditures for purposes of setting the 2010 conversion factor and retrospectively to the 1996/1997 base. CMS is also finalizing its proposal to remove drugs from the calculation of the Sustainable Growth Rate (SGR) beginning with 2010.

We commend CMS for finalizing this proposal, which AAFP has supported for a long time. It will help reduce the cost of a permanent fix to the problem posed by the SGR, and as noted in the final rule, it will make a positive update in the fee schedule conversion factor far more likely in the future. It was the right thing to do, and we appreciate that CMS recognized that.

Unfortunately, this action will not solve the more immediate problem of a 21.2% reduction in the Medicare physician fee schedule conversion factor for 2010. Like our counterparts throughout the physician community, family physicians are outraged that the final rule must implement a 21.2 percent Medicare physician pay cut for

2010. This cumulative, enormous reduction demonstrates the urgent need for Congress to implement legislation that permanently addresses the flawed SGR formula on which Medicare physician payment is based. We have separately called on Congress to eliminate the SGR and act on physician payment reform before these drastic payment cuts go into effect on January 1, 2010. CMS should support elimination of the SGR in favor of a system based on the Medicare Economic Index or another fair representation of physicians' costs of delivering care.

Conclusion

In closing, we note that publication of the final rule and associated regulations demonstrates CMS's continued recognition that a high quality, efficient health care system must rest on a foundation of primary medical care. Further, the final rule recognizes the need to improve payment for primary care and help establish a foundation on which meaningful and sustainable health care system reform can be built. We thank CMS for all of its efforts in this regard.

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.

Sincerely,

Ted Epperly, M.D.
Board Chair