AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

February 20, 2013

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 314-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Improving the Valuation of the Global Surgical Package

Dear Administrator Tavenner:

On behalf of the American Academy of Family Physicians (AAFP), which represents more than 105,900 family physicians and medical students nationwide, I write to offer the AAFP's suggestions regarding CMS's efforts to improve the valuation of the global surgical package.

In the proposed and final rules on the 2013 Medicare physician fee schedule, CMS discussed the concern that current efforts to validate relative value units (RVUs) in the fee schedule do not go far enough to assess whether the valuation of global surgical packages reflects the number and level of post-operative services that are typically furnished. To support its statutory obligation to identify and review potentially misvalued services and to respond to the Office of Inspector General's concern that global surgical package payments are misvalued, CMS believes that it should gather more information on the evaluation and management (E/M) services that are typically furnished with surgical procedures.

As the AAFP noted in our response to the proposed rule on the 2013 Medicare physician fee schedule, the AAFP supports efforts to improve the valuation of the global surgical package. The AAFP has long argued that the global surgical packages are inflated in terms of the number and level of post-operative visits assumed to be included and incorporated in the value of the codes in question. Also at issue is who is providing these services; surgeons may employ nurse practitioners (NPs) and physician assistants (PAs) to perform many of these post-operative visits while the surgeons focus only on the surgery itself. Under current Medicare payment rules, such visits would be paid at a discount rate if reported separately by the NPs and PAs (assuming "incident to" was not

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applicable); however, these visits are valued at the full physician rate in the global surgical package, even when the visits take place in a hospital (where "incident to" does not apply).

The AAFP concurs with CMS that the usual review process does not go far enough to assess whether the valuation of global surgical packages reflects the number and level of post-operative services that are typically furnished. Thus, the AAFP supports CMS's intent to both investigate this area of potentially misvalued codes and to do so outside the process of the American Medical Association (AMA)/Specialty Society Relative Value Scale Update Committee (RUC). The AAFP offered two suggestions regarding how CMS might proceed in our response to the proposed 2013 rule.

Through continued contemplation of the valuation of global surgical packages, the AAFP has identified additional troubling aspects and would like to offer at least one additional suggestion. Recall that when CMS re-valued the stand-alone E/M codes in 2007, CMS also made a concurrent adjustment in the value of all of the 10- and 90-day global codes in existence at the time. These concurrent adjustments were based on the assumed number and level of post-operative visits included in each code. Thus, CMS has de facto valued each of those codes by adding the RVU of the surgical procedure and all pre- and post-operative E/M services included in the global period rather than by magnitude estimation. Accordingly, if CMS reduces the number of post-operative visits for a given code, the AAFP believes CMS should decrease the work RVUs by the exact amount of the corresponding stand-alone E/M codes.

Additionally, the AAFP notes that the work RVU is a direct input to both the practice expense RVU as well as the malpractice RVU in the methodologies that CMS uses for each. Thus, the AAFP believes that if CMS reduces the number of post-operative visits for a given code, it should also adjust the practice expense and malpractice RVUs to account for both the decline in the work RVU as well as the elimination of follow-up clinical labor, supplies, and equipment associated with the E/M services in question.

Currently, E/M services, specifically the practice expense RVU component of these services, in the global period appear to be valued higher than the same services when billed independently. This phenomenon seems to be attributable to three primary factors, each connected to CMS's practice expense methodology:

- Different mix of clinical labor/supplies/equipment: The global period valuation reflects the specific items necessary during these types of follow-up visits. These inputs often slightly differ from the stand-alone E/M inputs.
- Work RVU: As noted, one of the indirect cost inputs for the practice expense RVU methodology is the work RVU; most surgical codes have significantly higher work RVUs than stand-alone E/M codes, resulting in a higher indirect practice valuation that extends to the E/M portion of the global surgical service.
- Specialty mix: The types of physicians performing a specific code dictate the direct and indirect percentages, as well as the indirect practice cost index, in the practice expense methodology. Apparently most surgical specialties have a lower direct

percentage mix, resulting in higher indirect costs that extend to the E/M portion of the global surgical service.
Thirdly, the AAFP observes that post-operative E/M services in the global surgical period that occur post-discharge are assumed to occur in the physician's office. Thus these visits are valued accordingly in the building blocks that comprise the global surgical service. However, the AAFP believes a not insignificant number of these visits actually occur in a hospital outpatient department.

The AAFP commissioned an examination of the 2010 carrier (physician) and hospital outpatient five percent claims files for two codes: 27447 (total knee arthroplasty) and 33235 (removal of pacemaker electrode). The AAFP contractor examined both total E/M billing by hospital outpatient departments for patients with one of these codes within 90 days after the procedure, as well as the number of times a physician-billed E/M on the same day was not reported. The AAFP assumes the latter number is indicative of the frequency of follow-up visits provided in a hospital outpatient department and paid under the global surgical code on the physician fee schedule, as the primary reason a physician would choose not to submit a claim is that he or she was already being paid for the visit under the global surgical service.

The analysis showed that of the 13,048 beneficiaries involved with either code 27447 or 33235 in 2010, 918 (7%) received a post-discharge follow-up visit in a hospital outpatient setting rather than the physician's office. If the assumption is that all post-discharge follow-up visits take place in the surgeon's office, then post-discharge visits taking place in a hospital outpatient setting lead to an overvaluation of the post-discharge E/M services in the global surgical package. A more thorough analysis of codes with 10- and 90-day global periods would be instructive, and the AAFP encourages CMS to conduct such an analysis while exploring the larger issue of improving the valuation of the global surgical package.

Finally, as the AAFP looked at the physician time file that underlies the Medicare physician fee schedule, we observed a number of codes where the total number or level of post-operative visits begs further scrutiny. For instance, there are 30 codes that are assumed to include one or more 99215 office visits in the post-operative period. Such a level of service would be highly unusual in the post-operative period on a single occasion, let alone two or more. In another instance, six codes were identified that are assumed to include a 99204, a code for a new patient office visit. The likelihood of any post-operative visit meeting the definition of a new patient visit is tenuous. Finally, the AAFP found at least 11 codes covering 10 or more post-operative office visits.

As CMS observed in the final rule on the 2013 Medicare physician fee schedule, the use of different methodologies for valuing global surgical packages since 1992 has created payment rates that reflect a wide range of E/M services within the post-operative period, especially among those with 90-day global periods. Recently reviewed codes tend to have fewer E/M services in the global period. The AAFP acknowledges CMS efforts to identify misvalued codes. For example, CMS has placed a priority on the review of potentially misvalued codes that have not been subject to review since the

implementation of the fee schedule (the so-called “Harvard-valued codes”). Beyond those current efforts, as part of CMS’s effort to improve the valuation of the global surgical package, the AAFP encourages CMS to also prioritize global surgical codes with large numbers or questionable levels of post-operative visits.

The AAFP appreciates the opportunity to provide comments and make ourselves available to answer any questions or offer any clarifications. Please direct correspondence to Robert Bennett, Federal Regulatory Manager, at 202-232-9033 or rbennett@aafp.org.

Sincerely,

Glen Stream, MD, MBI, FAAFP
Board Chair