August 3, 2006

Mark B. McClellan, M.D., Ph.D.
Administrator, Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS-1512-PN
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Dr. McClellan:

I am writing on behalf of the American Academy of Family Physicians, which represents more than 94,000 family physicians and medical students nationwide. Specifically, I am writing to offer our comments on the proposed notice regarding "Medicare Program: Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology," as published in the *Federal Register* on June 29, 2006.

Discussion of Comments – Evaluation and Management Services

In the proposed notice, CMS states, "We are in agreement with these RUC recommended work RVUs for E/M services." As participants in the RUC process and as proponents of the work RVUs recommended by the RUC, we deeply appreciate and strongly support CMS's proposal to accept the RUC's recommendations related to E/M services. As CMS is aware, the RUC and the national specialty societies put an unbelievably tremendous amount of effort into reaching agreement on these values. The RUC was very careful to make sure that these codes went through the standard survey process and that the data supporting the changes was very strong. The RUC approval of these recommendations, which requires support from at least two-thirds of the RUC members, indicates wide recognition of the work changes in E/M services in the ten years since CMS last reviewed the codes. We appreciate CMS's validation of the RUC's effort, and we strongly urge CMS to finalize its proposal in the final rule this fall.

Other Issues - Budget Neutrality

In the proposed notice, CMS proposes to make the statutorily required budget-neutrality adjustments by establishing a budget neutrality adjustor that would reduce all work RVUs by an estimated 10 percent. As we understand it, this means CMS would add a factor of 0.9 to the formula for calculating Medicare allowances as follows:

$$((0.9)(RVU_w)(GPCI_w) + (RVU_{PE})(GPCI_{PE}) + (RVU_{PLI})(GPCI_{PLI})) \times \text{Conversion Factor}$$

CMS proposes to adjust for budget neutrality in this way because the need for a budget neutrality adjustment would be largely due to changes proposed as a result of the five-year review of work RVUs and because CMS believes it is more equitable to apply the adjustment across services that have work RVUs.

We strongly disagree with CMS's proposed approach to budget neutrality. We believe that CMS should implement any statutory budget neutrality adjustments through an adjustment to the conversion factor. We believe this option is preferable for at least five reasons.

First, adjusting the conversion factor does not affect the relativity of services reflected in the total RVUs. Adjusting the work RVUs has the potential to inappropriately affect that relativity. For example, if Service A has 0.50 work RVUs and 1.00 total RVUs, while Service B has 1.00 work RVUs and 1.50 total RVUs, then the relative value of Service B to Service A is 1.50 (i.e., 1.50/1.00). Effectively reducing the work RVUs of both services by 10%, as proposed, would mean Service A would have 0.45 work RVUs and 0.95 total RVUs, while Service B would have 0.90 work RVUs and 1.40 total RVUs. After this adjustment, the relative value of Service B to Service A would be 1.47 (i.e., 1.40/0.95). Thus, the proposed adjustment to the work RVUs can inappropriately affect the relativity among services, whereas an adjustment to the conversion factor would not. This impact on relativity seems most acute on those services for which the RUC and CMS agreed that work has not changed. Adjusting the work RVUs for these services effectively reduces their relative value, contrary to RUC and CMS intent in maintaining the current value. This gets to the very heart of the Medicare physician fee schedule as a resource-based relative value scale.

Second, if the RVUs are adjusted as proposed, it will obfuscate the recommended changes and obscure the hard work done by the RUC. The RUC went through a very detailed and difficult process to arrive at its recommended changes in work RVUs, most of which CMS accepted. Adjusting the conversion factor will leave the recommended changes in work RVUs unscathed.

Thirdly, an adjustment in the Medicare conversion factor is preferable because it has less impact on other payers who use the Medicare RVUs. That is, an adjustment in the Medicare conversion factor will not necessarily affect the payment rates of other payers who use the Medicare RVUs and their own conversion factors. However, any adjustment in the RVUs will impact the payment rates of such payers. The payment rates of payers who peg their rates to a percentage of Medicare will be affected regardless. We believe that CMS must consider such "ripple effects" as it decides how to adjust for budget neutrality.

Fourth, CMS has attempted this approach in the past and found it to be problematic. Following the first five-year review, CMS implemented a similar work adjustor in 1997. Two years later, CMS eliminated it, noting that:

> [W]e did not find the work adjustor to be desirable. It added an extra element to the physician fee schedule payment calculation and created confusion and questions among the public who had difficulty using the RVUs to determine a payment amount that matched the amount actually paid by Medicare" (*Federal Register*, Vol. 68, No. 216, Pg. 63246).

Finally, we believe an adjustment to the conversion factor is preferable because it recognizes that budget neutrality is a fiscal issue, not an issue of relativity. Budget neutrality is mandated for monetary reasons. Thus, the conversion factor, as the monetary multiplier in the Medicare payment formula, is the most appropriate place to adjust for budget neutrality.

Other Issues - Post-Operative Visits Included in the Global Surgical Period

Based on a recommendation from the RUC, CMS proposes to apply the RUC-recommended new values for the E/M services to all surgical services with a 10 or 90-day global period. As participants in the RUC process, we accepted the RUC's recommendation and appreciate CMS's proposal to adopt this recommendation.

In the proposed notice, CMS notes that there is some question whether the assumptions about the number and level of visits within the global period reflect the actual post-operative work done. Accordingly, CMS invites comments on its current policy of including post-operative visits in the global surgical packages and what advantages or disadvantages might be associated with proposing a change to this policy in the future.

We share CMS's question regarding whether the assumptions about the number and level of visits within the global period reflect the actual post-operative work done. We note that the global surgical concept employed by CMS stems from language in section 1848(c)(1)(A) of the Social Security Act, which states:

> The term "work component" means the portion of the resources used in furnishing the service that reflects physician time and intensity in furnishing the service. Such portion shall—
> (i) include activities before and after direct patient contact, and
> (ii) be defined, with respect to surgical procedures, to reflect a global definition including pre-operative and post-operative physicians' services.

The actual definition is left to the Secretary. In 42 CFR 414.40(b), it states, "CMS establishes uniform national ancillary policies necessary to implement the fee schedule for physician services. These include, but are not limited to, the following policies: (1) Global surgery policy (for example, post- and pre-operative periods and services, and intra-operative services)." Thus, the definition of the global surgical period is neither statutorily nor regulatorily defined, and CMS can change it as needed to meet program needs. We further note that CMS has changed the global period of individual codes in the past. Accordingly, CMS could change the global period of all surgical services from 10 and 90 days to 0 days, if it chose to do so.

There are both advantages and disadvantages to such a change. Among the advantages:

1. Makes valuation of the work of the surgical procedure itself more straightforward

Under the present system, the intra-service work of global surgical services is derived by "backing out" the pre- and post-service work from total work surveyed using the RUC survey. The work value of the procedure itself is not directly surveyed or valued. Global periods of 10 and 90 days add to the amount of post-service work that must be "backed out" and unnecessarily complicates comparison among services. Making all surgical services 0-day global services would facilitate comparison.

2. Reduces errors in practice expense valuation

As noted elsewhere in the proposed notice, the number and level of post-operative visits impacts the clinical staff time, equipment, and supplies assigned to global surgical services for practice

expense purposes. To the extent that CMS incorrectly assigns the number or level of post-operative visits to a particular procedure, this has implications for practice expense as well as physician work. Making all surgical services 0-day global services would reduce the effects of such errors.

3. Facilitates research (e.g., what is the typical length of stay for a particular procedure), quality improvement (e.g., how does post-operative care compare to established clinical guidelines?), and utilization tracking

Under the present system, post-operative care is invisible. Medicare has no way to measure or track it for research, quality improvement, or other purposes. Making all surgical services 0-day global services, thus necessitating separate reporting of post-operative care, would make such care visible again and provide Medicare with a tool that could be used for multiple purposes.

4. Holds all physicians who provide E/M services to the same coding and documentation standards

Under the present system, those who provide and bill E/M services independent of global surgical services must adhere to the CPT and Medicare E/M Documentation Guidelines and are subject to audit on the basis of those guidelines and medical necessity. Those who provide and bill E/M services as part of a global surgical service do not face the same requirements, because, as noted, such services are "invisible" to Medicare. Making all surgical services 0-day global services, thus necessitating separate reporting of post-operative E/M care, would hold everyone who provides E/M services to the same standards.

5. Helps ensure fiscal responsibility in the Medicare program

Under the present system, CMS has no way to ensure that it is actually paying for the services it thinks it is during the post-operative period. As noted in the proposed notice, some patients may not require the "typical" number or level of follow-up visits included in the global period; yet, Medicare pays for those visits anyway. Making all surgical services 0-day global services would all-but-eliminate this scenario and make Medicare payments for surgical services more consistent with a fee-for-service system based on actual resources used.

The only disadvantage we can identify in making all surgical services 0-day global services is that it would likely increase Medicare claims volume, because post-operative visits would have to be separately reported and would likely not all be on the same claim as the procedure itself. Larger claim volume would, in turn, drive up Medicare administrative costs.

We appreciate CMS's willingness to consider changes to its current approach to global surgical packages, and we would strongly encourage CMS to eliminate 10 and 90-day global periods from the Medicare physician fee schedule. Doing so, we believe, would be consistent with and a logical extension of what CMS did a few years ago with the ESRD monthly capitation codes when it created different codes based on the number of visits provided.

<u>Practice Expense</u>

CMS proposes the following changes to its practice expense methodology:

- Use a bottom-up methodology to calculate direct practice expense costs
- Eliminate the non-physician work pool
- Use supplementary practice expense survey data previously accepted by CMS
- Modify the current indirect practice expense RVU methodology

In addition, CMS proposes to transition proposed practice expense changes over a four-year period.

The Academy has historically supported a bottom-up approach to the calculation of direct practice expenses and elimination of the non-physician work pool. As such, we support CMS's proposals in this regard and believe they are long overdue, even though family physicians will benefit only marginally from the proposed changes (i.e., CMS estimates allowed charges by family physicians will only be 1% greater after the proposed changes are fully implemented in 2010).

We agree with CMS that these changes will produce a more accurate, more intuitive, and more stable practice expense methodology. The methodology will be more accurate, because, as CMS notes, the practice expense inputs are better refined and more current than those historically used by CMS. Also as CMS notes, we believe it will be more accurate because the bottom-up methodology assumes that the costs of the clinical staff, supplies and equipment are the same for a given service, regardless of the specialty that is performing it. This assumption does not hold true under the top-down direct cost methodology, where the specialty-specific scaling factors create widely differing costs for the same service.

The bottom-up methodology has always been more intuitive to us than the top-down method employed by CMS, and the elimination of the non-physician work pool will make it even more intuitive. As noted in the proposed notice, under the proposed changes, any revisions made to the direct inputs would now have predictable results, since changes in the direct practice inputs for a service would proportionately change the practice expense RVUs for that service without significantly affecting the practice expense RVUs for unrelated services. Finally, stability should be improved, because direct practice expenses should only change for a service if it is further refined or when prices are updated.

As regards supplemental survey data, we understand CMS's desire to use the supplemental survey data it has received and which has met its previously published criteria for precision. Additionally, we understand that it would be unfair to the specialties that followed CMS's stringent supplemental survey requirements and collected data in good faith to have that data unused for any arbitrary reason. Accordingly, we can accept CMS's proposed use of supplemental practice expense survey data from the identified specialties (i.e., allergy/immunology, cardiology, dermatology, gastroenterology, radiology, radiation oncology, urology, and independent diagnostic testing facilities) in the short run.

However, in the long run, the Academy supports the concept of a multi-specialty survey to ensure that the practice expenses assigned to specific services reflect true resource costs for purposes of CMS's practice expense methodology. We believe that updating the data for all specialties at once is preferable to the piece-meal approach that CMS has taken with supplemental surveys since the last Socioeconomic Monitoring Survey. The AMA is currently coordinating such a survey with the goal of providing CMS with data in time to be used in the 2009 Medicare physician fee schedule. The Academy has committed to contribute $25,000 to the funding of

such a survey. We strongly urge CMS to do what it can to facilitate such a survey of all physician specialties to identify practice costs to include in the practice expense methodology.

With respect to the indirect practice expenses, we continue to question why CMS uses physician work RVUs, rather than physician time, in its formula for allocating indirect expenses. We continue to believe physician time makes more sense than physician work in this regard. By definition, physician work is a product of time and intensity. We would contend that physician time is more likely than physician work to drive indirect expenses since we are not convinced such expenses vary with physician intensity. For example, consider two physician services, done in an office, that involve the same amount of time but different levels of intensity. Does it make sense to say that the cost of the utilities varies with the intensity of the service when, for example, the cost of the electricity is, in fact, a function of the time the lights are on while the services are being done? We do not think so. Therefore, as we did when CMS first proposed its formula for indirect practice expense RVUs, we would recommend that CMS use physician time rather than physician work in the allocation of indirect expenses.

Lastly, as concerns the four-year transition for these changes, we understand CMS's desire to ameliorate the impact of the other proposed changes, especially for those specialties that will be negatively impacted by the changes. We also appreciate CMS's desire to give everyone affected ample opportunity to identify any anomalies in the practice expense data, to make any further appropriate revisions, and to collect additional data, as needed prior to the full implementation of the proposed changes. However, we would note that Congress enacted the original legislation mandating resource-based practice expenses in 1994 and that CMS delayed its initial implementation by a year before entering a four-year transition to resource-based practice expenses under its current methodology. Thus, it has already been over a decade of delays and transitions since Congress directed CMS to implement resource-based practice expenses, and we find it ironic that CMS proposes to further draw out that transition. We would encourage CMS to shorten or eliminate the transition and finally complete the process of implementing resource-based practice expenses.

<u>Discussion of Comments – Neurosurgery</u>

In its discussion of the proposed valuation of spine surgery codes, CMS notes that it has technical concerns with the recommendation for code 22612, "Arthrodesis, posterior or posterolateral technique, single level; lumbar (with or without lateral transverse technique)." Specifically, CMS states:

> The workgroup recommended the survey's 25th percentile for CPT code 22612 to keep the appropriate rank order with the reference service, CPT code 22595, **which is a more complex procedure**. However there was a typographical error in the information presented by the specialty society that listed the work RVUs for the reference code as 23.36, rather than the correct of value of 19.36 work RVUs. Therefore, the recommended work value of 22.00 RVUs is clearly inappropriate and we are proposing to maintain the current work RVUs of 20.97 for this service. (emphasis added)

We fail to understand why CMS, believing 22595 is a more complex procedure than 22612, decided to maintain the current value of 22612 at 20.97, even though that is greater than the current value of 22595 (19.36). We do not accept that a simple typographical error in the

information presented to the RUC should prevent CMS from correctly valuing a service it clearly believes is overvalued relative to 22595.

The RUC recommended a value of 22.00 for 22612 on the mistaken premise that code 22595 was valued at 23.36. In essence, the RUC thought the ratio (or relativity) of work between 22612 and 22595 was 0.942. Given that relativity and knowing that the correct work value for 22595 is 19.36, CMS could have and should have, in our opinion, recommended a work value of 18.23 for 22612.

It is situations like this one that only add to our frustration with CMS's failure to address overvalued services during the Five-Year Review process. In the proposed notice, CMS states, "However, because there has been little incentive for specialties to bring codes that may be overvalued for review, such services will still need to be identified for the next 5-Year Review." CMS has had 15 years to develop criteria and methodology for identifying and addressing overvalued services. Yet, it has failed to do so. We do not believe CMS should wait another five years to identify and act on overvalued services. Indeed, if CMS had reduced the non-E/M work relative value units for services it deemed overvalued as part of this five-year review, the necessary budget neutrality adjustment could have been less severe. Instead, as recommended by the Medicare Payment Advisory Commission (MedPAC), we believe CMS should proceed immediately to establish a standing panel of experts to help CMS identify overvalued services and to review recommendations from the RUC. As recommended by MedPAC, this panel should include members with expertise in health economics and physician payment, as well as members with clinical expertise. The Academy would be happy to participate in such a panel.

Discussion of Comments – Cardiothoracic Surgery

In its discussion of the proposed valuation of the adult cardiac codes and general thoracic codes, CMS enumerates multiple concerns with the RUC's use of the Society of Thoracic Surgeons (STS) database to propose work values for these codes. Based on those concerns, CMS proposes not to accept the RUC work RVU recommendations for these codes. However, because the RUC did approve the use of the STS database and the specialty societies put forth a substantial effort to present their data to the RUC based on that approval, CMS does not think it would be appropriate to propose maintaining the current values. Instead, CMS proposes to establish new work RVUs for these services based on the calculated IWPUT of the current values for each code multiplied by the time proposed for that code.

We share CMS's concerns with use of the STS database and are glad that CMS chose not to follow the RUC's lead in using it to value these services. That said, we do not understand CMS's decision not to maintain the current values until such time as STS conducted standard RUC surveys as suggested by CMS. As noted, CMS states that because the RUC did approve the use of the STS database and the specialty societies put forth a substantial effort to present their data to the RUC based on that approval, CMS does not think it would be appropriate to propose maintaining the current values. To that, we would respond that every specialty society used a RUC-approved methodology and put forth substantial effort to present their data to the RUC based on that approval. This did not prevent CMS from maintaining current work RVUs for other codes in which it chose not to accept the RUC's recommendations. For instance, CMS did not accept the RUC recommended work RVUs for all the presented codes in the proctoscopy-anoscopy family, because CMS believes the RUC used a flawed method to obtain the work

values. Instead, CMS recommends maintaining the current work values until another standard RUC survey of these codes can be done.

We also do not understand CMS's decision to use the proposed times for valuing these codes. According to the proposed notice, the proposed intra-service times for the cardiac codes were mean times from the STS database, while the proposed intra-service times for the general thoracic codes were median times from the STS database. Despite all of its enumerated concerns with the STS database, we fail to understand why CMS chose to use the proposed times from this database in proposing values for these codes. We especially fail to understand why CMS chose to use the mean times for the adult cardiac codes when it acknowledges that the RUC's standard methodology is based on median values and when it states that it also believes the median is a better estimate of central tendency. Accordingly, we would encourage CMS to maintain the current value for all of these codes until such time as standard RUC surveys can be done for them.

Discussion of Comments – Otolaryngology and Ophthalmology

We note in our review of the proposed valuation of code 69210, "Removal impacted cerumen (separate procedure), one or both ears," that CMS accepted the RUC's recommendation to maintain the current work RVU of 0.61 for this code. The RUC and CMS did so on the basis that 94% of the survey respondents indicated that the work in performing this procedure has not changed in the past five years.

However, CMS expresses concern with this valuation for the use of this code for routine removal of ear wax during a physical examination of a patient. CMS states:

> This code is listed with a "separate procedure" designation in the CPT code book, meaning that it is billed most properly when it is the only service provided for a particular date of service. However, Medicare data used for evaluation of codes in the current 5-Year Review indicate that CPT code 69210 was billed with an E/M service 63 percent of the time. It is our understanding that CPT code 69210 is to be used when there is a substantial amount of cerumen in the external ear canal that is very difficult to remove and that impairs the patient's auditory function. We will continue to monitor the use of this code for the appropriate circumstances.

We appreciate CMS's proposal to maintain the current work RVU of this service. We agree with CMS that, per CPT, code 69210 is to be used when there is a substantial amount of cerumen in the external ear canal that is very difficult to remove and that impairs the patient's auditory function.

However, we are concerned that CMS is misinterpreting the "separate procedure" designation in this instance. Per CPT:

> Some of the procedures or services listed in the CPT codebook that are commonly carried out as an integral component of a total service or procedure have been identified by the inclusion of the term "separate procedure." The codes designated as "separate procedure" should not be reported in addition to the code for the total procedure or service of which it is considered an integral component.

> However, when a procedure or service that is designated as a "separate procedure" is carried out independently or considered to be unrelated or distinct from other procedures/services provided at that time, it may be reported by itself, or in addition to other procedures/services by appending modifier 59 to the specific "separate procedure" code to indicate that the procedure is not considered to be a component of another procedure, but is a distinct, independent procedure. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries).

The designation of "separate procedure" does not mean "that it is billed most properly when it is the only service provided for a particular date of service." As noted, per CPT, it may be reported by itself or in addition to other procedures/services. As such, the fact that 69210 is billed 63% of the time with an E/M service does not violate its "separate procedure" designation. When 69210 is billed with an E/M service on the same date of service, modifier 25 should be appended to the E/M service to indicate that it was significant and separately identifiable from the impacted cerumen removal. Assuming both services are accurately documented in this circumstance, then their use is appropriate.

Other Issues - Anesthesia Services

In its discussion of anesthesia services in the proposed notice, CMS discusses the impact of the revised work values for E/M services and their relationship to the valuation of pre- and post-anesthesia services. Specifically, CMS notes that the pre- and post-anesthesia services derive their work values from the lower level E/M codes for new patients, the subsequent hospital care codes, and the initial inpatient consultation codes. Consequently, CMS proposes to substitute the proposed, revised work values for E/M codes where applicable and recompute the anesthesia work values and their impact on the increase in total anesthesia work.

In reviewing this particular proposal, we note that the RUC did not consider this issue. As such, the RUC has not had an opportunity to discuss this matter as it did with the issue of applying the proposed E/M work values to post-operative visits included in the global surgical packages, discussed below. We note that CMS proposes to refer the valuation of the post-induction time period of anesthesia services to the RUC for its review and consideration. We believe CMS should similarly refer the valuation of pre- and post-anesthesia services to the RUC for review and consideration at the same time and refrain from making any changes in the value of pre- and post-anesthesia services until that time.

We appreciate this opportunity to comment on matters related to the Medicare Fee Schedule. As always, the American Academy of Family Physicians looks forward to working with CMS in its continued efforts to ensure access to appropriate physician services.

Sincerely,

Mary E. Frank, M.D., FAAFP
Board Chair

Bcc: Doug Henley, M.D.
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