



AMERICAN ACADEMY OF  
FAMILY PHYSICIANS  
STRONG MEDICINE FOR AMERICA

January 23, 2014

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

Re: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014

Dear Administrator Tavenner:

On behalf of the American Academy of Family Physicians (AAFP), which represents 110,600 family physicians and medical students across the country, I write in response to the "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014" [final rule with comment period](#) as published in the December 10, 2014, *Federal Register*.

The AAFP recognizes that only limited portions of the final rule remain open for further comments; however, we wish to take this opportunity to thank CMS for finalizing:

- The revisions to the Medicare Economic Index (MEI) based on the recommendations of the MEI Technical Advisory Panel.
- The proposal to modify the geographic criteria for eligible telehealth originating sites to include health professional shortage areas located in rural census tracts of urban areas as determined by the Office of Rural Health Policy. In addition, we appreciate that CMS updated the list of eligible Medicare telehealth services to include transitional care management services.
- The clarifications that require as a condition of Medicare payment that "incident to" services be furnished in compliance with applicable state law.
- The proposal to allow coverage of Abdominal Aortic Aneurysm screenings for eligible beneficiaries without requiring a referral as part of the Initial Preventive Physical Examination (IPPE).
- The policy that allows an attending physician, physician assistant, nurse practitioner, or clinical nurse specialist to furnish written orders for screening fecal occult blood tests.

Specific to the agency's continuing efforts to develop and establish a separate payment under the physician fee schedule beginning in 2015 for chronic care management (CCM)

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services furnished to certain patients with multiple chronic conditions, the AAFP encourages CMS to continue moving forward, and we appreciate that the agency:

- Adopted a 30-day billing interval for CCM services rather than the proposed 90-day interval.
- Broadened applicability to patients with two or more chronic conditions.
- Dropped the proposed requirement that a physician provide the patient with an Annual Wellness Visit or IPPE as pre-requisite to offering CCM services.

In regard to codes with calendar year 2014 interim relative values in which CMS seeks further public comments, the AAFP reviewed the codes and associated relative value units (RVUs) in Addendum C. In general, we are supportive of the RVUs proposed by CMS. For instance, we appreciate that CMS revised the RVUs for a number of the codes covering psychiatric services and thus eliminated rank order anomalies that existed in the 2013 RVUs.

However, the AAFP is disappointed that CMS did not take the opportunity to correct what we perceive to be a disturbing trend seen in the recommendations of the Relative Value Scale Update Committee (RUC). Specifically, we note that the RUC has recommended dramatically decreased intra-service times for a number of codes while concurrently recommending unchanged or increased work RVUs. Consequently, there is a significant increase in the calculated service intensity (i.e., intra-service work per unit of time) for those codes with no evidence that the service has, in fact, changed.

To illustrate our concern, we provide the following examples.

- In calendar year 2013, code 35301 (Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision) had a work RVU of 19.61 with intra-service time of 144 minutes and total time of 431 minutes. For calendar year 2014, the RUC recommended, and CMS apparently accepted, that the work RVU should be 21.16 with intra-service time of 120 minutes and total time of 349 minutes. Thus, the work assigned to the code increased 8 percent while intra-service time has decreased 17 percent and total time decreased 19 percent.
- In calendar year 2013, the work RVU for code 31240 (Nasal/sinus endoscopy, surgical; with concha bullosa resection) was 2.61; the intra-service time was 30 minutes, and the total time was 90 minutes. For calendar year 2014, it is scheduled to have the same work RVU and less intra-service (20 minutes) and total (73 minutes) time.
- We believe similar examples within Addendum C include 95928 (Central motor evoked potential study (transcranial motor stimulation); upper limbs) and 95929 (Central motor evoked potential study (transcranial motor stimulation); lower limbs).

To address these concerns, we encourage CMS to re-examine the RVUs of all of these codes and any others in Addendum C where the physician work RVU has not decreased in proportion to physician time. Finally, the *Affordable Care Act* provides CMS with the authority to evaluate overvalued and undervalued services provided by physicians. The AAFP urges CMS to continue evaluating overvalued services.

Additionally, the AAFP urges CMS to use its authority to address undervalued services. In particular, we continue to believe that office-based evaluation and management (E/M) codes (99201-99215) are not appropriately valued and do not accurately capture the range of ambulatory E/M work done by physicians. As we argued in a March 27, 2013 [letter](#) to CMS, there is evidence to suggest that the complexity and comprehensiveness of ambulatory E/M services varies widely by physician specialty, with the complexity per unit of time being highest for primary care specialties, such as family medicine and internal medicine. More recent, as yet unpublished, research seems to reaffirm those findings, and we are exploring its implications for the current structure of ambulatory E/M codes and the values assigned to them. The AAFP will share our conclusions with the agency at an appropriate time in the future. In the meantime, we encourage CMS to do its own review of codes 99201-99215 and consider revaluing them in an appropriate manner.

We appreciate the opportunity to provide these comments and make ourselves available for any questions you might have. Please contact Robert Bennett, Federal Regulatory Manager, at 202-232-9033 or [rbennett@aafp.org](mailto:rbennett@aafp.org).

Sincerely,

A handwritten signature in black ink, consisting of a stylized 'J' and 'C' followed by a long horizontal line extending to the right.

Jeffrey J. Cain, MD, FAAFP  
Board Chair