



Anthony Mader
Vice President, Public Policy
Anthem, Inc.
1121 L Street
Sacramento, CA 95814
(916) 403-0522

Submitted via email: Jessica.Bruton.cms.hhs.gov

February 9, 2018

Jessica Bruton
Health Policy Analyst
Department of Health and Human Services
Centers for Medicare & Medicaid Services
Baltimore, MD

Re: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program Final Rule

Dear Ms. Bruton:

Anthem, Inc. (Anthem) appreciates this opportunity to comment on the Potentially Misvalued Code Initiative established to meet the Misvalued Code Target established through the Achieving a Better Life Experience (ABLE) Act of 2014.

Anthem is one of the nation's leading health benefits companies, serving over 74 million people through its affiliated companies, including more than 40 million within its family of health plans. As a committed participant in the health care markets, including the Medicare, Medicaid managed care, individual (both on and off Exchange), small group, and large group markets, we look forward to working with the Centers for Medicare & Medicaid Services (CMS) to provide feedback on the CY 2018 Medicare Physician Fee Schedule (PFS) final rule (82 FR 52976) annual comment opportunity on the revaluation of certain Fee-for-Service (FFS) codes.

We appreciate CMS's solicitation of comments on the FFS codes that should be considered for revaluation. Based on a number of Government Accountability Office (GAO) and the Medicare Payment Advisory Commission (MedPAC) reports, media reports regarding time inflation of specific services, and the January 19, 2017 Urban Institute [report](https://www.urban.org/sites/default/files/publication/87771/2001123-collecting-empirical-physician-time-data-piloting-approach-for-validating-work-relative-value-units_1.pdf)¹ for CMS, Anthem believes there is systematic overvaluation of work for the Berenson-Eggers Type of Service (BETOS) categories of Major Procedures, Other Procedures, Test Interpretations, and Imaging Interpretations.

The specific reasons for overestimates of time vary by the nature of the service – for Major Procedures and many of the Other Procedures, the problem is with substantial overestimates of pre- and, especially,

¹ https://www.urban.org/sites/default/files/publication/87771/2001123-collecting-empirical-physician-time-data-piloting-approach-for-validating-work-relative-value-units_1.pdf

post-service time, mostly related to follow-up inpatient and outpatient visits that do not take place. For many other procedures and test interpretations, the essential time misvaluation results from overestimates of intra-service time, as documented in the Urban Institute report (which only collected empirical intra-service time data).

As the embedded summary of important data parameters associated with the attached list of our proposed codes with overvalued work units demonstrates, virtually all high cost codes have previously been subject to Relative Value Scale Update Committee (RUC) review – including many in the 2013 and 2014 time frame – as CMS increased its interest in identifying and revaluing overvalued codes. However, although many of the codes which were subject to review did receive reductions in work values, it is apparent that the reductions in most cases were insufficient or limited, such that the new values continue to be excessive and not empirically supported.

A central component of correcting overvaluation of work should be revaluing times in the PFS to more closely track with empirically available data, rather than relying upon specialty society estimates provided to the RUC, in determining times associated with a service. MedPAC has long pointed out that time predicts 70-80 percent of work differences across services. Based partly on the important point made in the Urban Institute report – *that in many cases, time is reduced substantially but work much less* – that this results in implying an increase in the intensity of work that does not pass any tests of face validity, but does create work intensity anomalies that cannot be defended. An example of this would be imaging interpretations having implied work intensity far higher than the physician work associated with performing major procedures.

In accordance with the process finalized in the CY 2017 Medicare PFS (45 CFR Parts 405, 410, 424)², Anthem proposes the accompanying list of overvalued services for CMS’s review (see table below).

Anthem believes the review of the proposed codes will accomplish a few specific objectives:

1. For two years, CMS has not been able to redistribute 0.5 percent of spending under the Medicare PFS, as called for under the ABLE Act of 2014. Anthem believes that overvaluations of work are far greater than this modest threshold amount of 0.5 percent. Accordingly, we have identified seven services drawn from the highest spending 75 codes as presented in the CMS document “[Part B Physician/Supplier National Data – CY2016: Top 200 Level 1 Current Terminology \(HCPCS/CPT\) Codes](#).”³ Many of these high spending codes are in families with similar codes that are comparably overvalued because the families represent relatively small variations of the same service. Examples of such families include colonoscopies and imaging scans with or without contrast. To avoid creating “rank order anomalies” and other internal distortions, review and revision of the index code in our list should also lead to revision of the similar codes by extrapolation. Because the indirect practice expense allocator is partially driven

² <https://www.gpo.gov/fdsys/pkg/FR-2017-11-15/pdf/2017-23953.pdf>

³ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareFeeForSvcPartsAB/Downloads/LEVEL1CHARG16.pdf?agree=yes&next=Accept>

by the work values, the actual code-specific reductions would be greater than that derived only from work values.

2. More importantly, reviewing and revising the work estimates for these high cost services would demonstrate that systematic overvaluation of work plagues the Medicare FPS and leads to a broader initiative to correct misvaluations throughout the fee schedule. Focusing on just seven codes and their families would be manageable and achievable demonstrating processes that CMS could then expand for the greater goal of systematic review and revision, including by extrapolation from specifically reviewed codes.
3. We have included codes in the 4 major BETOS categories other than Evaluation and Management (E&M), i.e., Major Procedures, Other Procedures, Imaging, and Test Interpretations. We specifically selected codes performed primarily by only four specialties to make the review work less complex. We have identified likely overvalued services in the top 200 codes by spending performed by other specialties, but have limited our proposed set of codes to review for feasibility. The specialties are cardiology, orthopedics, radiology, gastroenterology, and ophthalmology, with each specialty having either one or two codes.
4. Below are the codes recommended for review, drawn from the Urban Institute report. The time differences found by researchers are limited only to the intra-time component, but serve as sufficient evidence that the Total Time estimates should be re-evaluated.

HCPCS Code	Description	2016 Charges (m)	2016 Spending Rank	2018 wRVU	2016 wRVU	CMS 2016 Intra-time (min)	CMS 2016 Total Time (min)	External Intra-time Estimates (min)	Time Difference (CMS vs. External)	Primary Impacted Specialty
27130	Total hip arthroplasty	227	67	20.72	20.72	100	407	87	-13%	Orthopedics
27447	Total knee arthroplasty	442	30	20.72	20.72	100	407	83	-17%	Orthopedics
43239	Egd biopsy single/multiple	347	34	2.39	2.49	15	54	6	-60%	Gastroenterology
45385	Colonoscopy w/lesion removal	387	33	4.57	4.67	30	78	22	-27%	Gastroenterology
70450	CT head w/o contrast	244	60	0.85	0.85	10	19	5	-50%	Radiology
93000	Electrocardiogram complete*	202	75	0.17	0.17	5	6	0.1	-98%	Cardiology / PCP
93306	Tte w/doppler complete	892	16	1.50	1.30	20	31.5	5	-75%	Cardiology

We value the partnership that we have developed with CMS and welcome the opportunity to discuss our recommendations for the revaluation of certain FFS codes. Should you have any questions or wish to discuss our comments further, please contact Alison Armstrong at (805) 336-5072, or Alison.Armstrong@anthem.com.

Sincerely,



Anthony Mader
Vice President, Public Policy