AMA
AMERICAN MEDICAL ASSOCIATION

American Medical Association
515 N. State Street
Chicago, Illinois 60654

ama-assn.org
312.464.5000

August 29, 2013

Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1600-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: File Code-CMS-1600-P; Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2014; Proposed Rule; (July 19, 2013).

Dear Administrator Tavenner:

The American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) Notice of Proposed Rule Making (NPRM) on the revisions to Medicare payment policies under the Physician Payment Schedule for calendar year 2014, published in the July 19, 2013 *Federal Register*.

The Proposed Rule includes a number of policy proposals, as well as recommended technical modifications within the Resource-Based Relative Value Scale (RBRVS). This letter includes RUC recommendations and comments regarding the following provisions:

- Resource-Based Practice Expense (PE) Relative Value Units (RVUs)
- Potentially Misvalued Codes under the Physician Fee Schedule
- Complex Chronic Care Management Services
- Chiropractors Billing for Evaluation and Management Services

Resource-Based Practice Expense (PE) Relative Value Units (RVUs)

Practice Expense Relative Value Methodology

In 2010, CMS completed a transition to a "bottom-up" practice expense (PE) RVU methodology, where direct practice expense costs are first determined within the method. According to the CMS PE formula (Table 5, 78 FR 43292) to obtain the direct PE RVU, the actual labor, supply and equipment costs accepted by CMS are first multiplied by a direct budget neutrality adjustment resulting in adjusted labor, adjusted supplies and adjusted equipment costs which are then converted into RVUs by dividing them by the current conversion factor. The RUC has repeatedly expressed concern that this method means that

CMS is only reimbursing a percentage of the actual PE direct costs to provide a service. CMS has responded that the purpose of the resource-based PE methodology is to develop RVUs within the overall Physician Payment Schedule budget neutrality requirements, and prefers to refer to the direct adjustment in their methodology as a scaling factor. The RUC maintains this concern, while acknowledging that the percent of direct PE costs covered has improved since 2010. In 2009, the direct costs covered were 62.5% and then dropped to 50.8% in 2010, under the new "bottom-up" PE RVU methodology. In 2011, that percentage dropped further to 50% and then in 2012 increased to 55% and again in 2013 to 60%. The RUC is disappointed that the percentage of direct costs covered by CMS has dropped again this year and has been proposed at less than 55% for 2014. **CMS should revise their method to reimburse the actual PE direct costs to provide a service.**

Direct PE Inputs for Stereotactic Radiosurgery (SRS) Services (CPT Codes 77372 and 77373)

The RUC appreciates the opportunity to comment on the direct PE inputs for Stereotactic Radiosurgery (SRS) Services prior to implementing the proposed policy to eliminate the contractor-priced G-codes for SRS/SBRT, as outlined in the CY 2014 Proposed Rule. The RUC agrees that there is no reason to distinguish robotic versus non-robotic linac-based SRS through the HCPCS G-codes and we agree that SRS and SBRT treatments are appropriately captured with CPT codes 77372 and 77373. These codes have been recently reviewed by the RUC, CPT code 77372 in April 2013 and CPT code 77373 in January 2013. As part of this review of direct PE inputs, all technologies (including robotic functionality) were included. In addition, equipment invoices for all these technologies were included with the RUC's submission to CMS. The price for the SRS system, CMS equipment code ER083, is the result of weighting six different treatment systems. **As such, the direct PE inputs used to develop PE RVUs for CPT codes 77372 and 77373 accurately reflect the typical resources used when furnishing these services in the office setting and the RUC supports eliminating the G-codes. The RUC encourages CMS to accept the PE recommendations as submitted for CY 2014.**

Ultrasound Equipment Recommendations

In the CY 2012 Proposed Rule, CMS asked the RUC to review the ultrasound equipment described in the direct PE input database. This involved reviewing 17 different ultrasound and ultrasound related pieces of equipment associated with 110 CPT codes. CMS requested that the RUC review the clinical necessity of the ultrasound equipment as well as the way the equipment is described for individual codes. The RUC convened a workgroup of the PE Subcommittee and the Ultrasound Equipment Workgroup submitted its recommendation following the January 2012 RUC meeting. Part of the recommendation was a review of the ultrasound equipment rooms, including the *room, ultrasound, general*, EL015 and the *room, ultrasound, vascular*, EL016. The RUC also recommended creating a new equipment room for cardiovascular studies called *room, ultrasound, cardiovascular*.

CMS states in the Proposed Rule that, "Ordinarily under the PFS, direct PE input packages for "rooms" include only equipment items that are typically used in furnishing every service in that room". This definition is not consistent with the precedent established by CMS in past rulemaking and the RUC disagrees with this definition because not all of the equipment in the room will be used for every service in the room, but if it is used for a typical service furnished in that room it should remain. Although the equipment rooms are packages, including a number of equipment items, they remain direct PE equipment inputs and as such the PE Subcommittee follows the same guidelines as established by CMS to attribute equipment time. These guidelines state that equipment time is comprised of any time that a labor category is using the piece of equipment, plus any additional time the piece of equipment is not available for use with another patient due to its use during the procedure in question. CMS has asked for comment on which of the following three definitions of rooms is appropriate for what should be included in equipment packages called rooms:

- All of the items that might be included in an actual room?
- Just the items typically used for every service in such a room?
- All items typically used in typical services furnished in the room?

The RUC has determined that based on CMS' own guidelines none of these definitions are appropriate and is proposing that the language read, "Equipment packages called rooms should include all items that are typically in the room and cannot be used for another patient, in order to furnish all typical services performed in that room."

For example, included in the equipment inputs for all evaluation and management service such as CPT codes 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214 and 99215 is an *otoscope-ophthalmoscope (wall unit)*, *EQ189*. The otoscope-ophthalmoscope is not used for every evaluation and management service, but it is part of the room and cannot be removed, therefore it cannot be used for any other patient. The RUC contends that the items included in the ultrasound equipment rooms are in the same category as the otoscope-ophthalmoscope in that they must be included in the room to provide the range of typical services.

CMS also questions the need for "…five different transducers, two probe starter kits, two printers, a table, and various other items…" in the general ultrasound room. The Ultrasound Equipment Workgroup thoroughly reviewed these inputs and determined that to provide a range of typical services in the general ultrasound room these items are needed. Specifically, although all five transducers may not be used for every service furnished in the room, all five transducers need to be available for every service furnished in the room. The RUC agrees with CMS that the ultrasound rooms include multiple transducers and any given study may not use all of them. However, this determination is influenced by the patient's clinical presentation and body habitus. Often, the technologist and physician do not know beforehand what varied supplies, including transducers, may be necessary. Accordingly, to provide the typical range of ultrasound services and obtain quality images for each patient, all of the supplies are necessary. **The Ultrasound Equipment Workgroup maintains its recommendation for the general and vascular ultrasound rooms and recommends the**

addition of the cardiovascular ultrasound room as submitted, with only a few minor changes as noted with the attachments to this comment letter.

Lastly, it is very challenging for specialty societies to obtain paid invoices for equipment and supplies, especially for large equipment items that are bought very infrequently due to the large investment cost. However, the RUC shares CMS' concerns about pricing information submitted as supporting documentation for the ultrasound room packages and will work with the specialties to provide paid invoices as soon as possible. In addition, the RUC will work with the specialties to ensure that paid invoices, rather than quotes, are submitted to CMS.

Ultrasound Equipment Input Recommendations for Particular Services

The RUC recommended typical ultrasound items used in furnishing 110 CPT codes (Table 10, 78 FR 43300). CMS agrees with many of the recommendations of the RUC and we appreciate your thoughtful review. For a series of cardiovascular services that include ultrasound technology, the RUC recommended a new PE direct equipment input, *room, ultrasound, cardiovascular*. Rather than create the room, CMS has proposed using the existing *room, ultrasound, vascular* (EL016) as a proxy for resource costs for these services, as they consider the broader issue of ultrasound room equipment packages. The RUC maintains that the *room, ultrasound, cardiovascular*, is an appropriate equipment input to be added to the CMS direct inputs equipment list, as it is significantly different than the current vascular room. The RUC appreciates CMS' reevaluation of this room when paid invoices can be provided as supporting documentation.

The RUC appreciates CMS's review and agreement with our recommendation to replace the current equipment input of *room, ultrasound, general,* EL015 with the *ultrasound unit, portable,* EQ250 for CPT code 76942 *Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation*. The RUC disagrees that this change in equipment constitutes a change in the typical type of procedure reported with this image guidance service. The type of equipment has no bearing on the codes that this service is billed with. Furthermore, CMS states that the CPT code 20610 *Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)* is the code most frequently reported with 76942. CPT code 20610 is a surgical procedure and 76942 is an imaging supervision and interpretation (S&I) service. For S&I codes, activities occur in addition to the base surgical codes. Many of the clinical staff activities included in the S&I code do not occur with the surgical code and the PE subcommittee is purposeful in separating all clinical staff activities between surgical and S&I codes, so no duplication in PE occurs. Reducing the direct PE inputs for clinical staff and equipment minutes associated with 76942 from 58 to 23 based on an altered intra-service time assumption is not based on sound analysis. In addition, a CPT coding proposal has been prepared by the specialty societies for the October 2013 CPT Editorial Panel meeting to bundle CPT codes 20610 and 76942 and these bundled codes will be reviewed for both work and practice expense at the April 2014 RUC meeting. All aspects of the services, including intra-service time and PE inputs will be reviewed at that time. **The RUC requests that CMS delay implementation of changes to the work intra service time and PE clinical staff**

time and equipment time of 76942, until the RUC has had an opportunity to review the code and account for any efficiencies that have developed since the code was last reviewed.

SPECT/CT

The RUC noted that CPT code 78072 *Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization* is currently carrier priced in addendum B. On July 19, 2013, four paid invoices were submitted to CMS and we are again including those invoices. **The RUC encourages CMS to use these invoices along with the detailed PE information to set a practice expense RVU in the Final Rule.**

Using OPPS and ASC Rate in Developing PE RVUs

The RUC strongly opposes the CY 2014 PFS proposal to cap payment rates for 211 physician services at Hospital Outpatient Prospective Payment System (OPPS) or ambulatory surgical center (ASC) rates. The proposal will reduce payments for some services by 50 percent or more, potentially driving them out of physician offices altogether and requiring patients to obtain these services in a more costly, less convenient facility setting. We urge CMS to withdraw this proposal.

CMS proposes to begin capping payments to services performed in the non-facility setting when those payments are greater than what is paid when the same service is performed in either the hospital outpatient or ASC facility setting. The agency offers two arguments to support the appropriateness of this proposal. First, the proposed policy is premised on the idea that there are significantly greater indirect resource costs when a service is performed in a facility compared to the non-facility setting. Second, CMS assumes that the cost data is more reliable in the OPPS and ASC compared to cost data collected under the resource-based relative value scale (RBRVS). Therefore, the agency concludes:

> "We believe that this proposal provides a reliable means for Medicare to set upper payment limits for office-based procedures based on relatively more reliable cost information available for the same procedures when furnished in a facility setting where the cost structure would be expected to be somewhat, if not significantly, higher than the office setting."

The RUC strongly disagrees with the fundamental premise behind this proposal. Specifically, that when a service is more expensive in the non-facility setting it is not because of appropriate payment differentials between the separate provider settings, but rather due to anomalies in the data. This assumption is without basis and leads the agency to the false

conclusion that payment for the affected services must be arbitrarily reduced. While the RUC generally agrees with CMS that the indirect costs for a hospital to provide a service typically should be greater than when the same service is provided in the non-facility setting, we disagree that the correct measurement to identify potentially misvalued services in the non-facility setting should be to compare the costs generated by two vastly different payment systems. Any comparison of the costs between the OPPS and the RBRVS represents a fundamental misunderstanding of the differences in how resource costs are generated in each payment system.

Resource costs in the Medicare physician payment schedule are developed through an extremely thorough "bottom-up" methodology in which the necessary resource costs are added line by line to achieve the actual costs for the physician to provide the care. In contrast, payment to facilities under the OPPS is calculated on the geometric mean of the costs of services in the same ambulatory payment classification (APC). To equate the rigorously developed line item costs associated with services performed in the non-facility setting, with charges that are intended to be an average of "similar" services when performed in the facility is severely flawed because the two systems are making payments under vastly different assumptions. Therefore, whether expressly intentional or not, this capitation proposal undermines not only the fundamental concept behind the RBRVS, but also the significant time and resources spent by medical specialty societies who provide expert analysis to recommend accurate resource data for each service reviewed by the RUC.

Given this distinction, the RUC disagrees with the CMS claim that OPPS payment rates are more reliable than RBRVS rates because they are based on auditable hospital data and are updated annually. While it is correct that hospital charge information is updated on a rolling basis, it does not mean that the cost data are more accurate. Under the OPPS, each APC is assigned a cost weight based on the geometric mean costs of all the procedures assigned to that APC. These estimated costs are derived from hospital charges adjusted to costs using each hospital's cost to charge ratio (CCR). Rather than estimating the costs of each resource on a per line item basis, this ratio is an average at the hospital department level. Since the creation of the OPPS, this averaging mechanism has consistently resulted in charge compression. CMS defines charge compression as the "practice of applying a lower charge markup to higher cost services and a higher charge markup to lower cost services." As a result, the cost-based weights may reflect some aggregation bias, undervaluing high-cost items and overvaluing low-cost items when an estimate of average markup, embodied in a single CCR, is applied to items of widely varying costs in the same cost center. While the agency has worked to mitigate the effects of charge compression, it is clear that the affected codes under this proposal suffer from this bias. Therefore, if CMS were to finalize this

proposal, it would effectively undercut any of the agency's previous attempts at mitigating the negative effects of charge compression.

Given this analysis, the RUC would argue that resource cost data collected under the RBRVS is actually more reliable for two primary reasons. First, pricing in the RBRVS reflects actual costs, while the OPPS/ASC payment system reflects charges that are mathematically manipulated into costs. Second, in the RBRVS, direct resource costs are calculated on a line item basis. This process is extremely thorough and takes into account the clinical intricacies of each service.

Outlined below are several key areas of concern in relation to the proposal.

Services with high cost supplies/equipment

After analyzing the 211 codes affected by this policy, it is clear that services with high direct practice costs are disproportionally disadvantaged. Inexplicably, for 82% of the codes the direct practice expenses alone exceed the proposed payment cap rate. This means that for the vast majority of codes, CMS will not even consider all the clinical labor, supplies and equipment, much less the indirect costs, which are essential in determining the PE RVUs. This is simply illogical and greatly undermines the efficacy of the agency's proposal. Below are three examples of services with high cost supplies, in which specialty societies have provided current paid invoices, which are affected by the proposal.

CPT code 91120 *Rectal sensation test* is a procedure almost entirely performed in the physician's office (99.77%). This service requires a custom barostat catheter (CMS supply code SD216) with a price point of $217. The specialty societies have provided a recent invoice of $237 (attached), confirming the high cost of the supply. The current total payment for this code in the non-facility setting is $427. The procedure is rarely performed in the facility setting and would receive a total payment of $138, a 68% cut in payment under this proposal. With no rationale, CMS has proposed paying less for this service in 2014 than the current cost of one supply item necessary to perform this procedure.

CPT code 65778 *Placement of amniotic membrane on the ocular surface for wound healing; self-retaining* further illustrates the proposal's inability to capture the correct costs. Since the description of CPT code 65778 includes "placement of amniotic membrane," and the supply of the membrane is considered bundled into the APC for this code, one would expect that every claim submitted for this code would also include the V2790 code used to bill for amniotic membrane products. However, examination of the 2011 hospital outpatient claims data reveals that only 39% of the relevant claims included V2790. With the supply code for

amniotic membrane (SD248) being quite expensive, $895, the fact that over 60% of hospital claims did not include the device means that CMS was missing a considerable amount of cost information when it set the 2013 payment rate for this service. Therefore, the 14% payment reduction this code would receive in 2014 is completely unwarranted.

CPT code 88367 *Insitu Hybridization Auto* is a procedure commonly performed in the non-facility setting (65%). This service requires CMS supply code SL196 *HER-2/neu DNA probe kit* costing $157. The specialty societies have provided a recent invoice of $145 (attached), confirming high cost of the supply. The total payment for this code in the non-facility setting is $258.23. However, despite the fact that this code is rarely performed in the outpatient hospital setting, the proposed cap payment of $103, representing a 60% cut in payment. The direct PE costs for this code alone are $240.

Beneficiary cost and access issues

Implementing this proposal will assuredly have consequences on beneficiary cost and access for the affected procedures. It is important to note that many of the services identified are low volume. Therefore, it is quite reasonable to assume that hospitals could cover lower payment for these services. Since APCs are designed to over pay some services and under pay others, hospitals accept that the cost of services will average out over time. However, physicians who are not paid the hospital rate for other services within the same APC cannot offset their losses. This will undoubtedly force physicians to perform these procedures in a more cost sustainable setting. Moving services to the facility has two undesirable effects.

First, it increases both costs to the patient and the Medicare program. While patients will generally pay 20% of the Medicare-approved amount for the physician service in either setting, services performed in the outpatient setting also require the patient to make a copayment. This could negatively impact the ability of fixed-income patients to afford medically necessary care. Furthermore, moving services to the facility increases total costs to Medicare, as the additional APC/ASC payment rate must be paid on top of the physician rate. It is important to note that these higher costs would be subsumed by all parties not because of improved patient care, but because of an arbitrary reduction. For example, CPT code 96910 *Photochemotherapy; tar and ultraviolet B (Goeckerman treatment) or petrolatum and ultraviolet B,* and 96912 *Photochemotherapy; psoralens and ultraviolet A (PUVA)* is one of the safest and least expensive ways to treat conditions like psoriasis, vitiligo, cutaneous lymphoma and eczema. There is already a shortage of phototherapy units in the country, and these cuts would likely lead to additional closures of phototherapy units and decreased availability of these treatments, adversely affecting millions of patients. Additionally, a series of treatment delivery CPT codes (77412, 77413, and 77414) are experiencing cuts from 25 to

31 percent under this proposal. These services are key treatments for breast cancer and other sites. Cuts at this level would be devastating and unsustainable for community based cancer centers.

Second, there are real concerns that by forcing these services to be shifted into hospital facilities, patients in rural and low-income areas may have access issues. For example, there are eight EEG services that are due to receive an average reduction of 54% in the non-facility PE RVUs. Reductions of this level will force many physicians to direct patients to an outpatient hospital for these procedures, which, especially in a rural area, could add significant travel time for the patient. Since patients who receive this procedure are often at risk of seizures, driving is often not an option. Because these patients have to rely on family or public transportation, they are especially vulnerable to shifting sites of care.

Use of the Ambulatory Surgical Center (ASC) Payment Rates

CMS offers several exclusions to the proposal. For one of these exclusions, CMS states, "We are proposing to exclude any service for which 5% percent or less of the total number of service are furnished in the OPPS setting relative to the total number of PFS/OPPS allowed services." However, the agency provides no data or discussion about whether or not an exemption should also be included for services rarely performed in the ASC. Only nine of the 112 codes that are being tied to the ASC payment rate are actually provided in an ASC at least 5 percent of the time, and only 34 of these codes would have hit the OPPS payment cap. In other words, 78 of the 211 services for which CMS proposes to reduce payments to the ASC level are already paid less under the PFS than the OPPS rate, meaning that Medicare and patients will actually pay more, not less, if these services are driven out of physician offices and into hospital outpatient departments.

Recently reviewed services

Another major flaw in the proposal is the agency's failure to differentiate services that have had a comprehensive PE review which have been accepted by both the RUC and CMS within the last three years. There are 28 codes on the list which meet this criterion. For example, CPT code 77301 *Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications* was just reviewed and approved at the May 2013 RUC meeting. This was the third RUC review of practice expense since 2010. The RUC cannot stress enough how costly and time consuming it is for specialty societies to generate direct practice expense, and the RUC and Practice Expense Subcommittee to review, line-by-line the submissions for each code. The RUC also recognizes the great efforts CMS staff takes reviewing the submissions prior, during and after

each face-to-face RUC meeting. **Given this, CMS should remove any service in which the agency has approved direct practice expense inputs within the last three years.**

Use of disparate years to determine payment rates

CMS proposes to compare the 2014 non-facility PE RVUs to the 2013 OPPS/ASC payment rates. This means that the policy will ignore anticipated conversion factor increases of 1.8% in the hospital outpatient departments (HOPD) and 0.9% in the ASC payment rates as well as any APC weight changes that CMS has proposed. In some cases, this will result in significant disparities between the OPPS/ASC cap and the actual rate that is being paid in these settings in 2014. For example, CPT code 95928 *Central motor evoked potential study* would sustain a reduction of 57% based on a cap of $79.83 using the 2013 APC rate. The technical payment for the practice expense for this service is $218. However, the APC rate affecting this code is being increased by over 50% ($121.86) in 2014, but will be ignored by this proposal. This flaw in the agency's assumptions is another example of the irrationality of this capitation proposal, and again provides evidence that CMS hastily conceived this proposal without thoroughly vetting its reasonableness. **If CMS implements this proposal, the agency should use the most current 2014 OPPS/ASC payment rates in their analysis.**

Finally, underlying this proposal is the agency's continued dissatisfaction with their own methodology of collecting pricing information for certain direct costs, like the price of high-cost disposable supplies and expensive capital equipment. CMS reiterates their position that there is no practical means for the agency or stakeholders to "engage in a complete simultaneous review of the input resource costs for all HCPCS codes paid under the physician payment schedule on an annual or even regular basis." The RUC shares the CMS concern that inaccurate resource input costs may distort the resources used to develop non-facility PE RVUs. This is why the RUC has worked diligently with specialty societies to obtain current, accurate invoices for direct practice equipment and supplies. The RUC remains confident in our ability to collect accurate data and has always considered CMS requests to refine the accuracy of cost information, especially for high cost disposable medical supplies. For CMS to bypass the expertise of the RUC process with arbitrary reductions based off flawed assumptions continues to undermine the hard work all stakeholders, including CMS, have undergone to regularly review potentially misvalued services under the RBRVS. **The RUC requests that CMS <u>not</u> implement this proposal to cap non-facility PE RVUs at either the OPPS or ASC rate and instead allow the RUC's process of evaluating potentially misvalued codes to initiate a review of these services based on the clinical necessity of the associated costs.**

Potentially Misvalued Codes Under the Physician Payment Schedule

RUC Progress in Identifying and Reviewing Potentially Misvalued Codes

CMS recognizes the significant work regarding identification and review of potentially misvalued services, quoting the following statement from the Medicare Payment Advisory Commission (MedPAC) "CMS and the AMA RUC have taken several steps to improve the review process." Since 2006, the RUC has identified over 1,500 potentially misvalued services through objective screening criteria and has completed review of approximately 1,300 of these services. The RUC has recommended that nearly half of the services identified be decreased or deleted (Table 1). The RUC's potentially misvalued codes review project has identified services that account for approximately $38 billion in Medicare allowed charges (Table 2).

Table 1.
RUC Potentially Misvalued Services Project by Total Number of Codes in Project (1,553)

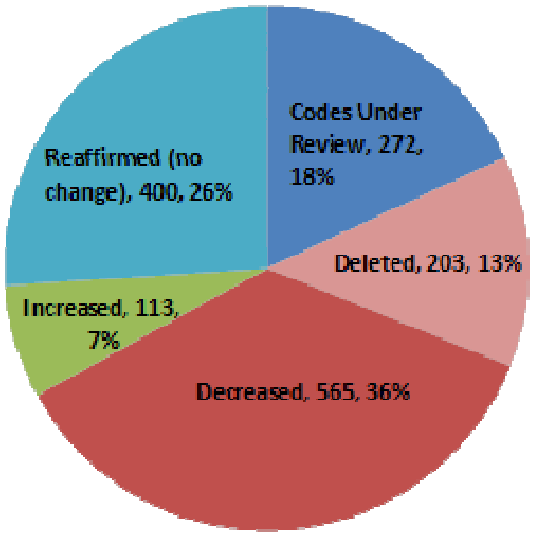
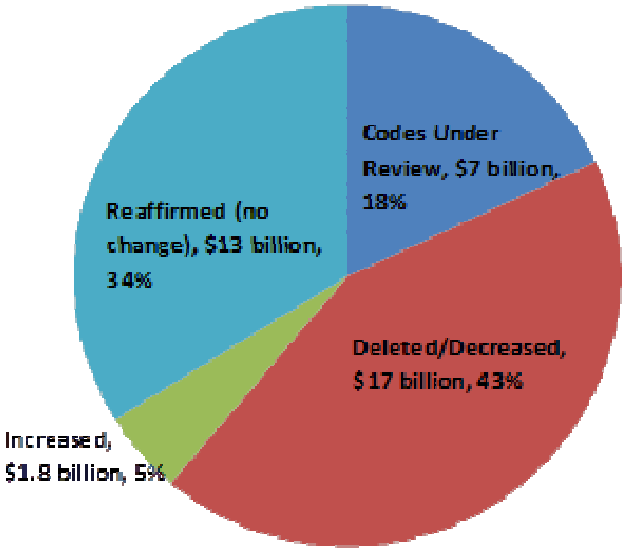


Table. 2
RUC Potentially Misvalued Services Project by Medicare Allowed Charges (2012)



The RUC has worked vigorously over the past several years to identify and address misvaluations in the RBRVS through provision of revised physician time data and resources cost recommendations to CMS. The RUC fully acknowledges that there are services that are now performed more efficiently and these codes have been or will be addressed. For example, the time and valuation for cataract surgery was significantly reduced in 2013. The RUC's efforts for 2009-2013 have resulted in $2.5 billion in redistribution within the Medicare Physician Payment Schedule.

CMS indicated that the agency plans to continue its work in examining potentially misvalued codes with the RUC, and other individuals and stakeholder groups, over the upcoming years. The RUC looks forward to working with CMS on a concerted effort to address potentially misvalued services. A detailed report of the RUC's progress is appended to this letter.

Codes Identified in Consultation with CMDs as Potentially Misvalued

To broaden participation in the process of identifying potentially misvalued codes, CMS sought the input of Medicare contractor medical directors (CMDs). The CMDs have identified approximately one dozen services which CMS is proposing as potentially misvalued (Table 11, 78 FR 43305). The RUC will review specialty society action plans and discuss these services at the October 2013 meeting. However, the RUC would like to comment specifically on CPT codes 17311, 17313 and 76945 identified in Table 11. The RUC recently reviewed the Mohs Surgery code family (CPT codes 17311-17315) and has provided recommendations to CMS for implementation in CY 2014. Regarding CPT code 76942 *Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation*, the RUC will provide recommendations for work and practice expense for CPT 2015. CMS' specific concerns

outlined in the Proposed Rule for CPT code 76942 are addressed in the "Resource-Based Practice Expense (PE)" section of this comment letter.

Complex Chronic Care Management Services

CMS proposes to provide payment for complex chronic care management (CCCM) services beginning January 1, 2015. Payment will be made for services provided to patients with two or more complex chronic conditions that are expected to last at least 12 months or until the death of the patient, and that places the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. CMS will delay implementation to develop standards, through public rulemaking, related to physician office capability to perform these CCCM services.

The CMS proposal is relatively consistent with the model envisioned by the joint workgroup of the CPT Editorial Panel and RUC, the Complex Chronic Care Workgroup (C3W). The C3W has actively urged CMS to pay for non face-to-face services that are critical components of ensuring management of care, including team conferences, patient education, telephone calls and anticoagulant management. Most recently, CMS implemented payment for transitional care management services (TCM). We applaud CMS for the decision to pay for TCM and CCCM services and urge CMS to continue consideration of payment for other non face-to-face services.

Definition of Complex Patient

CMS proposes to utilize the parameters described in the CPT guidelines to identify the patients eligible for the CCCM services. For example, as stated above, CMS will specifically require that payment be made only to patients with two or more chronic conditions. However, the Proposed Rule does not fully discuss the guidelines as described for CPT 2014, including the expectation that the typical adult patients take three or more prescription medications and may be receiving other types of therapeutic interventions (eg, physical therapy). These patients commonly are unable to perform activities of daily living and require the services of a number of different specialists. A specific care plan must be established for these patients. CMS should work closely with the CPT Editorial Panel to align the patient requirements in a final proposal to the CPT guidelines.

Physician Practice Capability

CMS plans to develop and seek public input on practice capabilities required to provide CCCM services. However, this Proposed Rule articulates many of the Agency's thoughts on requirements and we, therefore, provide written comments on statements made in this Rule. Several of the practice requirements are included in the CPT guidelines and we propose that CMS consider these capabilities in the proposal, including:

- provide 24/7 access to care providers or clinical staff;
- use a standardized methodology to identify patients who require chronic complex care coordination services;
- have an internal care coordination process/function whereby a patient identified as meeting the requirements for these services starts receiving them in a timely manner;
- use a form and format in the medical record that is standardized within the practice; and
- be able to engage and educate patients and caregivers as well as coordinate care among all service providers, as appropriate for each patient.

The CMS discussion moves significantly beyond these requirements and we urge the Agency to reconsider this direction. Two specific concerns are noted. First, the Rule includes a statement that practices "must employ one or more advanced practical registered nurse or physician assistant." CMS staff have clarified that this does not impact the level of clinical staff working with the physician to provide the service, but rather is a metric to identify the necessary infrastructure and capability to provide CCCM. We strongly disagree that employment of this level of staff be a consideration in final implementation. There are certainly practices that employ registered nurses who are well qualified to provide care management. Second, we have significant concerns with the discussed Electronic Health Record (EHR) requirements. While physicians look forward to a future when EHR is available with total interoperability of all providers real time 24 hours per day and 7 days a week, this is not yet attainable for too many physicians. Physicians, who would otherwise be qualified to provide CCCM and can demonstrate timely access to a patient's medical records, should be eligible to report CCCM as systems transition to more sophisticated and coordinated EHRs.

CMS indicates that some suggest that practices could be recognized as medical homes by a national organization, such as the National Committee for Quality Assurance (NCQA) or the Joint Commission, to demonstrate met standards to provide CCCM. We argue that any physician practice should be able to qualify for payment of CCCM as long as the individual practice meets the practice requirements established to report these individual codes. We do not support a requirement that physician practices be certified as primary care medical homes in order to receive payment for complex chronic care management. If, however, CMS decides to certify medical homes – be it through accrediting organizations or otherwise – the certification standards should fully reflect the Joint Principles for the Patient-Centered Medical Home (http://tinyurl.com/ccbhvzz).

These Joint Principles, adopted by the AMA and the primary care organizations, require physician leadership of the medical home. However, the current accreditation programs do not require physician leadership and some do not even require the participation of a physician in any capacity. The CCCM services are designed to ensure that (1) each patient having an

ongoing relationship with a personal physician, and (2) the personal physician of the patient lead the medical home interdisciplinary care team. Requirement of accreditation would not be consistent with the model of care described by the CCCM services.

Reporting of Services/Codes

The CPT Editorial Panel developed CCCM codes that are reported per calendar month and are quantified by first hour of clinical staff time, with an add-on code for each additional 30 minutes. CPT code 99487 is reported when no face-to-face visit was performed in a month and 99488 is reported when a face-to-face is performed. The CMS proposed code structure varies in two ways: 1) CMS proposes to pay for all visits independently of the CCCM code. CPT included a code with a face-to-face visit to ensure that pre and post work of the E/M code reported in the same month as care coordination was not duplicated into the payment for care coordination. If CMS is not concerned with this potential duplication and prefers that E/M be reported separately, the Panel may wish to discuss if 99488 should be deleted; 2) CMS proposes a 90 day reporting structure, rather than per calendar month. A 90 day increment is problematic for several reasons and we urge CMS to instead utilize the CPT code structure. A 90 day structure would be difficult to evaluate for both work and practice costs. At a minimum, an add-on code for each additional half-hour provides the level of granularity required to ensure that the services is valued correctly.

In addition, we do not understand the purpose of subsequent versus initial code definition. The reporting will be dependent upon clinical staff time, therefore, direct practice expense inputs will not vary between initial and subsequent.

CPT Codes		CMS Proposal
99487	Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with no face-to-face visit, per calendar month	Complex chronic care management services furnished to patients with multiple (two or more) complex chronic conditions expected to last at least 12 months, or until the death of the patient, that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; GXXX1, initial services; one or more hours; initial 90 days GXXX2, subsequent services; one or more hours; subsequent 90 days
99488	first hour of clinical staff time directed by a physician or other qualified health care professional with one face-to-face visit, per calendar month	
✚99489	each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)	

Valuation of Services/Budget Impacts

CMS did not propose values to correspond with the proposed 90 day coding structure. If the coding structure varies from the CPT 2014 descriptions, it will be necessary to resurvey and revalue the CCCM services prior to revaluation. We appreciate that CMS recognized that improvements in chronic care management would decrease costs through reductions in hospitalizations, use of post-acute care services and emergency department visits. Budget neutrality assumptions will need to be re-reviewed if coding and valuation change from the current structure.

Patient Consent

We recognize the importance of patient consent and notice. CPT requires that a plan of care must be documented and shared with the patient and caregiver. CMS proposes a more elaborate consent and notification process, with the following elements:

- Beneficiary must provide consent prior to initiation of service and reaffirm every 12 months;
- Practice required to document in the patient's medical record that all CCCM services were explained and patient's acceptance must be noted;
- The patient must be provided with a copy of care plan which is also to be included in electronic medical record; and
- Patient must be notified prior to any claims submission (dates of services; why provided; what was provided); separate notice for each claim must be in medical record.

CMS should carefully consider comments regarding whether the second notice, related to claims submission, is necessary or an unnecessary administrative burden.

Incident to Policy Revisions

CMS proposes that the time spent by the clinical staff outside the practice's normal business hours (with no direct physician supervision) would count toward the one hour requirement even though the services do not meet the direct supervision requirement for "incident to" services. These clinical staff must be directly employed by the physician. Services must relate to the CCCM and general supervision is required (ie, performed under the physician's overall supervision and control). This proposed modification for the intent of the CCCM model as after-hours calls conducted by nurse care manager will be critical to care management.

Individuals Who May Report the Service

The CPT guidelines require that a physician must meet practice capabilities to report CCCM. The physician must be able to engage and educate patients and caregivers; and coordinate care among all service providers, as appropriate for each patient. CMS proposes the following requirements:

- The patient must receive an Annual Wellness Visit (AWV) G0438, G0439 (or Initial Preventive Physical Exam (G0402) for new Medicare Patients) in past 12 months to receive CCCM services.
- AWV must include a list of current practitioners and suppliers involved in the patient's care – CMS views to be essential for CCCM.
- CMS assumes that patient selection of physician to perform AWV indicates which provider he/she would want for CCCM.
- CMS will allow patients to select two different physicians for these services; however the CCCM physician must have a copy of the AWV assessment and care plan prior to billing for CCCM.

While the AWV may not be directly related to the needs of these chronically ill patients, however, we understand that it is one mechanism for CMS to identify the appropriate physician to provide CCCM services. We believe that it is critical that CMS retain the proposal that would allow a different physician to provide the care management if he/she obtains the AWV assessment and care plan.

The CPT Editorial Panel and the RUC are eager to resolve any differences in the structure, valuation and understanding of the CCCM services in over the next several months to allow for successful implementation on January 1, 2015. Accordingly, it will be imperative for CMS to include in the November 2013 Final Rule a clear direction regarding the required structure of coding CCCM.

Chiropractors Billing for Evaluation and Management Services

CMS has requested comments to determine whether or not there are situations when it would be appropriate for doctors of chiropractic (DCs) to furnish and bill for Evaluation and Management (E/M) services with treatment of manual manipulation of the spine (to correct a subluxation) that are not included within the definition of the Chiropractic Manipulative Treatment (CMT) codes (CPT codes 98940-98942).

In October 2012, the RUC HCPAC reviewed CPT codes 98940-98942 with the following pre-, intra- and post-service descriptions. We provide this information to assist CMS to determine if E/M services are described within CMT.

98940: Chiropractic manipulative treatment (CMT); spinal, 1-2 regions

Pre-service: The physician reviews the patient's records and established treatment plan to familiarize himself or herself with the previous treatment. The physician then conceptualizes the range of potential manipulative treatments that may be performed in both body regions for the current date of service. The potential procedures are explained to the patient, verbal consent is obtained, and the physician answers any further questions, comments, and concerns.

Intra-service: A premanipulation patient assessment is performed, including assessment of the patient's pain level using a numerical rating scale, evaluation of interval changes in objective signs, and evaluation of functional changes that may include identifying asymmetry, assessing segmental mobility, and evaluating changes in tissue and tone in both affected regions. The treatment procedure that best fits the patient's condition that day is finalized.

The patient is then placed in the prone position on the treatment table. Static and dynamic palpation is performed, which identifies primary involvement at T3-T4. The physician applies brief soft tissue manual therapy adjacent to spinal skeletal structures. The appropriate segmental level is identified in the adjusting position (T3-T4). The physician makes a pisiform contact on the left transverse process of T3. Breathing instructions are given to the patient. The physician prestresses the periarticular soft tissues to identify the appropriate direction/amplitude of thrust. An articular (osseous) adjustive procedure is applied to the determined spinal lesion at T3-T4 utilizing a short-lever, high-velocity, low-amplitude (HVLA). Postadjustment procedures and interactive reassessments are made. The patient is then assisted in moving to a supine position. Chiropractic manipulative treatment is directed at C5-C6. Postadjustment procedures and interactive reassessments are made.

Post-service: Chart entry and documentation, including documentation of appropriate subjective and objective assessments as well as the procedural components of this patient visit, are completed. The patient is assessed based on the previously formulated treatment plan. The physician provides the patient a clinical care summary and answers any questions pertaining to the document. The physician then reinforces instructions on positions of comfort and previously identified therapeutic home measures.

98941: Chiropractic manipulative treatment (CMT); spinal, 3-4 regions

Pre-service: The physician reviews the patient's records and established treatment plan to familiarize himself or herself with the previous treatment. He or she then conceptualizes the range of potential manipulative treatments that may be performed in all three body regions for the current date of service. The potential procedures are explained to the patient, verbal consent is obtained, and the physician answers any further questions, comments, and concerns.

Intra-service: The patient is then placed in a prone position. Static and dynamic palpation is performed, which identifies involvement at T9, L4, and the left ilium.

For the thoracic involvement, the physician applies brief soft tissue manual therapy adjacent to spinal skeletal structures. Breathing instructions are given to the patient. The physician prestresses the periarticular soft tissues to identify the appropriate direction/amplitude of

thrust. An articular (osseous) adjustive procedure is applied at T9 and T10. Postadjustment procedures and interactive reassessments are made.

For the lumbar involvement, a supportive cushion (half Dutchman's roll) is placed under the patient's pelvis at the appropriate position. The locking levers of the table are released, and the foot piece is adjusted to the proper length. The table is gently extended (axial distraction) to patient tolerance. The physician contact is made on the spinous process of L4. With the other hand, the physician grasps the table or appropriate handle at the caudal end of the table. The patient is advised to take in a deep breath and let it out. A slow, controlled flexion maneuver is applied within patient tolerance and safety to the caudal portion of the table with multiple (five to eight) repetitions. This process is repeated through three cycles. Following this treatment, the locking levers are secured, and the foot piece is returned to its neutral position. Postadjustment procedures and interactive reassessments are made.

For the pelvic region, the patient is turned onto his side, positioned for a side-posture manipulation. A brief stretch is applied to the lumbar-pelvic musculature and a long-lever, low-amplitude, high-velocity thrust is applied to the left ilium. The patient is then returned to a comfortable position for a brief rest. Postadjustment procedures and interactive reassessments are made.

Post-service: Chart entry and documentation, including documentation of appropriate subjective and objective assessments as well as the procedural components of this patient visit, are completed. The patient is assessed based on the previously formulated treatment plan. The physician provides the patient a clinical care summary and answers any questions pertaining to the document. The physician then reinforces instructions on positions of comfort and previously identified therapeutic home measures.

98942: Chiropractic manipulative treatment (CMT); spinal, 5 regions

Pre-service: The physician reviews the patient's records and established treatment plan to familiarize himself or herself with the previous treatment. He or she then conceptualizes the range of potential manipulative treatments that may be performed in all five body regions for the current date of service. The potential procedures are explained to the patient, verbal consent is obtained, and the physician answers any further questions, comments, and concerns.

Intra-service: A premanipulation patient assessment is performed, including assessment of the patient's pain level using a numerical rating scale, evaluation of interval changes in objective signs, and evaluation of functional changes that may include identifying asymmetry, assessing segmental mobility, and evaluating changes in tissue and tone in all five affected regions. The treatment procedure that best fits the patient's condition that day is finalized.

The table is then positioned appropriately for the planned technique. Static and dynamic palpation is performed and identifies involvement at C2, T5-T7, L2, the sacrum, and the right ilium.

For the cervical involvement, the patient is assisted in moving to a supine position. The physician applies brief soft tissue manual therapy adjacent to spinal skeletal structures. Chiropractic manipulative treatment is directed at C2. Postadjustment procedures and interactive reassessments are made.

For the thoracic involvement, the physician assists the patient in moving to a prone position. The physician applies brief soft tissue manual therapy adjacent to spinal skeletal structures. Breathing instructions are given to the patient. The physician prestresses the periarticular soft tissues to identify the appropriate direction/amplitude of thrust. An articular (osseous) adjustive procedure is applied at T5-T7. Postadjustment procedures and interactive reassessments are made.

For the lumbar involvement, the patient is turned onto her side, positioned for a side-posture manipulation. A brief stretch is applied to the lumbar-pelvic musculature and a long-lever, high-velocity, low-amplitude (HVLA) thrust is applied to L2. The patient is then returned to a comfortable position for a brief rest. Postadjustment procedures and interactive reassessments are made.

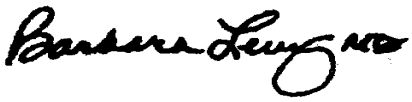
For the pelvic region, the patient is then placed on the contralateral side, positioned for a side-posture manipulation. A long-lever, low-amplitude, high-velocity thrust is applied to the ilium. Postadjustment procedures and interactive reassessments are made.

For the sacral area, the patient is placed again in a prone position. The locking lever of the drop piece of the table is adjusted to the appropriate position and tension. A HVLA thrust is applied to the left superior sacrum. This process is repeated two to three times. The patient is returned to a comfortable position for a brief rest. Postadjustment procedures and interactive reassessments are made.

Post-service: Chart entry and documentation, including documentation of appropriate subjective and objective assessments as well as the procedural components of this patient visit, are completed. The patient is assessed based on the previously formulated treatment plan. The physician provides the patient a clinical care summary and answers any questions pertaining to the document. The physician then reinforces instructions on positions of comfort and previously identified therapeutic home measures.

Thank you for your careful consideration of the RUC's comments on the proposals for the 2014 Medicare Physician Payment Schedule. We look forward to continued opportunities to offer recommendations to improve the RBRVS.

Sincerely,



Barbara S. Levy, MD

cc: RUC Participants