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December 18, 2014

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1612-FC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: File Code-CMS-1612-FC; Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2015 Final Rule; (November 13, 2014).

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) Final Rule on the revisions to Medicare payment policies under the Physician Payment Schedule for calendar year 2015, published in the November 13, 2014 *Federal Register*.

RUC Work Value Recommendations Not Addressed in Final Rule

The RUC is concerned that some of the codes that were submitted to CMS for the 2015 Medicare Fee Schedule were not reviewed by the Agency. As you are aware the RUC makes submissions on an ongoing basis and in this case we were under the impression that these codes would be reviewed in time for values to be published for CY 2015. In light of this omission, we have attached the recommendations and request the Agency conduct a full review as soon as possible.

The RUC recommendations submitted to CMS in October 2014 for CY 2015 are for CPT codes **37215** *Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous including angioplasty, when performed, and radiological supervision and interpretation; with distal embolic protection* and **91200** *Liver elastography, mechanically induced shear wave (eg, vibration), without imaging, with interpretation and report.*

Establishing 2015 Interim Work Relative Values

The RUC appreciates that CMS accepted 86% of the RUC's work on submitted work relative value recommendations submitted for 2015. In preparing the RUC comments, specialties were provided with the opportunity to share additional information for CMS consideration. It is our intention that the following comments will provide enough clarity to persuade the Agency to reconsider the interim recommendations that differ from the RUC recommendations and instead affirm the RUC's recommended values in final rulemaking next year.

Subcutaneous Implantable Defibrilator Services (SICD): 33270, 33271, 33272, 33273, 93260, 93261, 93644

CPT code	Descriptor	RUC Rec RVU	CMS Proposed Interim RVU	CMS Work RVU Decision
33270	Insertion or replacement of permanent subcutaneous implantable defibrillator system, with subcutaneous electrode, including defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters, when performed	9.10	9.10	Agree
33271	Insertion of subcutaneous implantable defibrillator electrode	7.50	7.50	Agree
33272	Removal of subcutaneous implantable defibrillator electrode	5.42	5.42	Agree
33273	Repositioning of previously implanted subcutaneous implantable defibrillator electrode	6.50	6.50	Agree
93260	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; implantable subcutaneous lead defibrillator system	0.85	0.85	Agree
93261	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; implantable subcutaneous lead defibrillator system	0.74	0.74	Agree
93644	Electrophysiologic evaluation of subcutaneous implantable defibrillator (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters)	3.65	3.29	Disagree

The RUC is disappointed that CMS did not accept the RUC recommendation for CPT code 96344 listed in the table above.

To facilitate appropriate payment to physicians for SICD services new Category I codes were added for 2015. These codes replace existing Category III CPT codes. While CMS accepted the RUC recommendations for the other codes in this family, it did not for CPT code 93644. However, the decision to crosswalk 93644 to 32551 is not appropriate. As CMS noted, 32551 includes 20 minutes of intraservice time and 83 minutes of total time, similar to the recommended times for 93644 of 20 minutes of intraservce time and 84 minutes of total time. The similarities stop there. During 93644, after ventricular fibrillation is induced, cardiac arrest is induced to determine if the ICD generator and

subcutaneous lead are positioned adequately to ensure successful defibrillation and resuscitation of the patient. To determine an appropriate work value, the RUC compared CPT code 93644 to CPT code 15002 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children* (work RVU= 3.65) and noted that while the reference code has greater pre-service time, the codes have identical intra-service times and should thus be valued identically. The RUC recommends a direct crosswalk of work RVUs between 15002 and 93644. To justify a value of 3.65, the RUC also reviewed CPT code 16035 *Escharotomy; initial incision* (work RVU= 3.74, intra time= 20 minutes) and noted that both services have identical intra-service time and should be valued similarly. The RUC believed that the work intensity of the service negated the differences in service times between 93644 and 15002.

The RUC urges CMS to accept its original recommendation of 3.65 work RVUs for CPT Code 93644 and to revert to the RUC recommendation of a crosswalk to 15002. In addition, the RUC requests that this code be referred to the Refinement Panel for reconsideration.

Transesophageal Echocardiography (TEE): 93312, 93313, 93314, 93315, 93316, 93317, 93318, 93355

CPT code	Descriptor	RUC Rec RVU	CMS Proposed Interim RVU	CMS Work RVU Decision
93312	Echocardiography, transesophageal, real-time with image documentation (2d) (with or without m-mode recording); including probe placement, image acquisition, interpretation and report	3.18	2.55	Disagree
93313	Echocardiography, transesophageal, real-time with image documentation (2d) (with or without m-mode recording); placement of transesophageal probe only	1.00	0.51	Disagree
93314	Echocardiography, transesophageal, real-time with image documentation (2d) (with or without m-mode recording); image acquisition, interpretation and report only	2.80	2.10	Disagree
93315	Transesophageal echocardiography for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report	3.29	2.94	Disagree
93316	Transesophageal echocardiography for congenital cardiac anomalies; placement of transesophageal probe only	1.50	0.85	Disagree
93317	Transesophageal echocardiography for congenital cardiac anomalies; image acquisition, interpretation and report only	3.00	2.09	Disagree
93318	Echocardiography, transesophageal (tee) for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis	2.40	2.40	Agree

93355	Echocardiography, transesophageal (tee) for guidance of a transcatheter intracardiac or great vessel(s) structural intervention(s) (eg,tavr, transcathether pulmonary valve replacement, mitral valve repair, paravalvular regurgitation repair, left atrial appendage occlusion/closure, ventricular septal defect closure) (peri-and intra-procedural), real-time image acquisition and documentation, guidance with quantitative measurements, probe manipulation, interpretation, and report, including diagnostic transesophageal echocardiography and, when performed, administration of ultrasound contrast, doppler, color flow, and 3d	4.66	4.66	Agree

The RUC is disappointed that CMS did not accept the RUC recommendations for CPT codes 93312, 93313, 93314, 93315, 93316, 93317, and 93318 listed in the table above.

Code 93312 is the main diagnostic TEE code in the family. It describes the work of placing the probe, acquiring/interpreting images, interpreting the results, and creating a report. Therefore, in order to value this service the RUC reviewed CPT code 43247 *Esophagogastroduodenoscopy, flexible, transoral; with removal of foreign body* (work RVU=3.18, 30 minutes intra-service time) and noted that both services have identical intra-service time and comparable total time. The RUC agreed to directly crosswalk the work RVUs of 43247 to the surveyed code 93312. To justify a work value of 3.18, the RUC reviewed CPT code 32557 *Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance* (work RVU=3.12, intra-service time= 30 minutes) and agreed that since both codes have identical intra-service time and comparable physician work, the recommended value is appropriately valued relative to other services across the RBRVS.. Perhaps even more important, all three services require placement and manipulation of a probe into the body for imaging. Additionally, the discrepancy in total time can be attributed to the fact that the comparator codes are 0-day global services that allow for positioning and scrub/dress/wait time in the standardized preservice package. These services are fundamentally similar and appropriately grouped in a relative value system. CMS's proposal to crosswalk to a work RVU of 2.55 from code 75573 is based entirely on the service times with no consideration given to clinical differences.

The RUC urges CMS to accept its original recommendation of 3.18 work RVUs for CPT Code 93312 and to revert to the RUC recommendation of a crosswalk to 43247. In addition, the RUC requests that this code be referred to the Refinement Panel for reconsideration.

Code 93313 separately describes the work of placing the probe while code 93314 separately describes the work of acquiring/interpreting images, interpreting the results, and creating a report. CMS indicates that the services saw a significant drop in intraservice time, prompting it to propose work RVUs at the 25^{th}-percentile of 0.51 and 2.10, respectively. However, these services did not undergo a significant reduction in time. The existing times were derived from CMS/Other sources dating back to 1996. No distinction was made about the division of service times into preservice, intraservice, or postservice time. The physician time file simply assigned a total time of 25 minutes to both services. These service times are largely meaningless in 2014, which is why societies undertook reviews of these services.

Code 93313 had a CMS/Other time of 25 minutes. Specifically, the RUC reviewed the survey respondents' estimated work values and agreed that the median work RVU of 1.00 is an accurate value for this service. To justify this value, the RUC compared the surveyed code to CPT code 78472

Cardiac blood pool imaging, gated equilibrium; planar, single study at rest or stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without additional quantitative processing (work RVU= 0.98) and agreed that since both codes have the same time components, they should both be valued similarly. In addition, the RUC reviewed CPT code 72192 *Computed tomography, pelvis; without contrast material* (work RVU= 1.09) and MPC code 23350 *Injection procedure for shoulder arthrography or enhanced CT/MRI shoulder arthrography* (work RVU= 1.00) and agreed that both these services provide justification for the RUC recommended value for 93313.

The RUC urges CMS to accept its original recommendation of 1.00 work RVUs for CPT Code 93313. In addition, the RUC requests that this code be referred to the Refinement Panel for reconsideration.

Code 93314 had a CMS/Other time of 25 minutes. The RUC recommended 15 minutes preservice time, 30 minutes intraservice, and 15 minutes postservice for a total service time of 60 minutes. CMS chose to arbitrarily reduce the service times to 10 minutes preservice, 20 minutes intraservice, and 15 minutes postservice. Specifically, The RUC reviewed the survey respondents' estimated work values and agreed that the median work RVU of 2.80 is an accurate value for this service. To justify this value, the RUC compared the surveyed code to CPT code 75573 *Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3D image postprocessing, assessment of LV cardiac function, RV structure and function and evaluation of venous structures, if performed)* (work RVU= 2.55) and agreed that while both services have identical intra-service time, 30 minutes, 93314 is a more intense procedure and is accurately valued higher than this reference code. In addition, the RUC reviewed CPT code 10030 *Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst), soft tissue (eg, extremity, abdominal wall, neck), percutaneous* (work RVU= 3.00) and noted that both services have identical intra-service time, but the reference code has more total time and should thus be valued slightly higher than 93314. The recommended times for this code are somewhat counterintuitive, since one may expect 93314 to take less time than 93312. However, the typical patient that receives 93314 is different than one undergoing 93312. A patient that undergoes 93314 has upper airway complications that warrant separate placement of the probe (93313) by a more experienced physician, often an anesthesiologist. The same difficulties that necessitate probe placement by a physician with expertise in the upper airway also lengthen the duration of 93314. Finally, a value at the 25th-percentile, fails to account for the changes in technique, technology, and knowledge that were previously cited.

The RUC urges CMS to accept its original recommendation of 2.80 work RVUs for CPT Code 93314. In addition, the RUC requests that this code be referred to the Refinement Panel for reconsideration.

CMS used a building block method to derive a work RVU for 93315, recommending a value of 2.94. However, this method fails to correctly incorporate updated service times and changes in technique, technology, and knowledge. The RUC stands by its original recommendation which compared the surveyed code to CPT code 36147 *Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); initial access with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report* (work RVU= 3.72) and agreed that since the reference code has more total time compared to 93315, 80 minutes and 70 minutes, respectively, 36147 should be valued higher than the surveyed code. The RUC also reviewed CPT code 95953 *Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG, electroencephalographic (EEG) recording and interpretation, each 24 hours,*

unattended (work RVU= 3.08) and agreed while both services have identical total times, this reference code is slightly less intense than the surveyed code and is correctly valued less. Finally, the RUC compared 93315 to 93312 and noted that this service is more complex because this service is performed on pediatric patients with complex anatomy and should be valued slightly higher than the adult service.

The RUC urges CMS to accept its original recommendation of 3.29 work RVUs for CPT Code 93315. In addition, the RUC requests that this code be referred to the Refinement Panel for reconsideration.

The arbitrary nature of these intraservice time changes is further demonstrated with code 93316, which separately describes the work of placing the probe for congenital anomalies, generally in children. CMS has increased some times, proposing 15 minutes preservice time, 20 minutes intraservice, and 5 minutes postservice. In this instance, It is uncertain how these times were derived. The existing service time for 93316 was derived from CMS/Other sources dating back to 1996 and is of little relevance in 2014 when compared to a valid survey. A value at the 25th-percentile also fails to account for the changes in technique, technology, and knowledge. The RUC stands by its original recommendation based on the survey results for CPT code 93316 that the following physician time components are appropriate: pre-service time of 5 minutes and intra-service time of 20 minutes. The RUC agreed to lower the pre-service time from the median survey time of 15 minutes because the physician is waiting for the second operator to place the probe.

The RUC reviewed the survey respondents' estimated work values and agreed that the median work RVU of 1.50 is an accruate value for this service. To justify this value, the RUC compared the surveyed code to CPT codes 72148 *Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material* (work RVU= 1.48, intra-service time= 20 minutes) and 93350 *Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report* (work RVU= 1.46, intra-service time= 20 minutes) and noted that both reference codes have identical intra-service and comparable physician work relative to 93316. Furthermore, the RUC noted that this value fits into appropriate rank order compared to 93313 as it is a more intense and longer procedure.

The RUC urges CMS to accept its original recommendation of 1.50 work RVUs for CPT Code 93316. In addition, the RUC requests that this code be referred to the Refinement Panel for reconsideration.

The existing time of 48 minutes for code 93317 was derived from CMS/Other sources dating back to 1996, again making comparison with a valid survey difficult. CMS reduced the service times to 10 minutes preservice, 20 minutes intraservice, and 15 minutes postservice. As with 93314, the recommended times for this code are somewhat counterintuitive. One may expect 93317 to take less time than 93315. However, the typical patient that receives 93317 is different than one undergoing 93315. A patient that undergoes 93317 has upper airway complications that warrant separate placement of the probe (93316) by a more experienced physician, often an anesthesiologist. The same difficulties that necessitate probe placement by a physician with more expertise in the upper airway also lengthen the duration of 93317. The RU C stands by its original recommendation based on survey results for CPT code 93317 that the following physician time components are appropriate: pre-service time of 15 minutes, intra-service time of 30 minutes and immediate post-service time of 15 minutes.

The RUC reviewed the survey respondents' estimated work values and agreed that the median work RVU of 3.00 is an accruate value for this service. To justify this value, the RUC compared the surveyed code to CPT code 10030 *Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst), soft tissue (eg, extremity, abdominal wall, neck), percutaneous* (work RVU= 3.00) and noted that both services have identical intra-service time, 30 minutes, and should thus be valued the same. The RUC also compared this service to the comparable 93314 service and agreed that while both codes have the same time components, the increased intensity for 93317 justifies a slightly higher work value.

The RUC urges CMS to accept its original recommendation of 3.00 work RVUs for CPT Code 93317. In addition, the RUC requests that this code be referred to the Refinement Panel for reconsideration.

Maxillofacial Computed Tomography: 70487 and 70488

CPT code	Descriptor	RUC Rec RVU	CMS Proposed Interim RVU	CMS Work RVU Decision
70487	Computed tomography, maxillofacial area; with contrast material(s)	1.17	1.13	Disagree
70488	Computed tomography, maxillofacial area; without contrast material, followed by contrast material(s) and further sections	1.30	1.27	Disagree

The RUC is disappointed that CMS did not accept the RUC recommendations for CPT codes 70487 and 70488 listed in the table above.

The RUC recommendation for code 70487 was based on 22 minutes of physician work (5 pre-service, 12 intra-service, and 5 post-service) and the 25th percentile RVU from a survey of 62 radiologists and neuroradiologists. The RUC compared the surveyed code to key reference service 70460 *Computed tomography, head or brain; with contrast material(s)* (work RVU = 1.13) and determined that both services require the same physician time and similar intensity and complexity to perform and therefore should be valued similarly. For additional support, the RUC referenced MPC code 70470 *Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections* (work RVU = 1.27). These comparisons were not meant to imply that the work involved in these codes is identical however; CMS reduced the values of 70487 to equal the comparable head CT code, 70460. While these codes are comparable in service period times, the maxillofacial CT is more complex and intense, as was described in the specialty society SORs as follows:

The surveyed code 70487 is comparable to MPC code 70460 *Computed tomography, head or brain; with contrast material(s)* (work RVU = 1.13). These two codes have similar times and image similar regions of the body. They both deal with regions of compact and complex anatomy requiring the interpreter to have a broad-based knowledge of anatomic variants, as well as a keen sense of the dangerous conduits leading to disease spread between these two vital compartments. The volume of images one must review when interpreting 70487 is higher than 70460 because of the thinner CT slice technique required when analyzing the maxillofacial region. This hold true even though the chosen MPC is without and with contrast administration, while the surveyed code only involves post contrast imaging. While 70460 is arguably examining a more vital organ system, 70487 is evaluating the

anatomy immediately adjacent to this region, and is irreplaceable as the imaging study of choice in assuring that these "dangerous conduits" between the two compartments are not involved with, or threatened by, maxillofacial disease processes such as infection, trauma, or tumor.

The RUC urges CMS to accept its original recommendation of 1.17 work RVUs for CPT Code 70487. In addition, the RUC requests that this code be referred to the Refinement Panel for reconsideration.

The RUC recommendation for code 70488 was based on 25 minutes of physician work (5 pre-service, 15 intra-service, and 5 post-service) and the 25th percentile RVU from a survey of 62 radiologists and neuroradiologists. The RUC compared the surveyed code to key reference service 74170 *Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections* (work RVU = 1.40) and noted that 74170 requires slightly more physician time to complete and is appropriately valued higher than 70488. For addtional support, the RUC referenced MPC code 70470 *Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections* (work RVU = 1.27). These comparisons were not meant to imply that the work involved in these codes is identical. However, CMS reduced the values of 70488 to equal the comparable head CT code, 70470. While these codes have comparable intraservice period times, the maxillofacial CT is more complex and intense, as was described in the specialty society SORs as follows:

The surveyed code 70488 is comparable to MPC code 70470 (CT head w/o & w/contrast). These two codes have similar times and image similar regions of the body. They both deal with regions of compact and complex anatomy requiring the interpreter to have a broad-based knowledge of anatomic variants, as well as a keen sense of the dangerous conduits leading to disease spread between these two vital compartments. The volume of images one must review when interpreting 70488 is higher than 70470 because of the thinner CT slice technique required when analyzing the maxillofacial region. This holds true even though the chosen MPC code is without and with contrast administration, while the surveyed code only involves post contrast imaging. While 70470 is arguably examining a more vital organ system, 70488 is evaluating the anatomy immediately adjacent to this region, and is irreplaceable as the imaging study of choice in assuring that these "dangerous conduits" between the two compartments are not involved with, or threatened by, maxillofacial disease processes such as infection, trauma, or tumor. The societies are recommending a net negative 0.10 difference in wRVU for the surveyed code in comparison to the MPC code to account for the total time difference of 3 minutes.

The RUC urges CMS to accept its original recommendation of 1.30 work RVUs for CPT Code 70488. In addition, the RUC requests that this code be referred to the Refinement Panel for reconsideration.

Isodose Planning Codes: 77316

CPT code	Descriptor	RUC Rec RVU	CMS Proposed Interim RVU	CMS Work RVU Decision
77306	Teletherapy isodose plan; simple (1 or 2 unmodified ports directed to a single area of interest), includes basic dosimetry calculation(s)	1.40	1.40	Agree
77307	Teletherapy isodose plan; complex (Multiple treatment areas, tangential ports, the use of wedges, blocking, rotational beam, or special beam considerations), includes basic dosimetry calculation(s)	2.90	2.90	Agree
77316	Brachytherapy isodose plan; simple (calculation[s] made from 1 to 4 sources, or remote afterloading brachytherapy, 1 channel), includes basic dosimetry calculation(s)	1.50	1.40	Disagree
77317	Brachytherapy isodose plan; intermediate (calculation[s] made from 5 to 10 sources or remote afterloading brachytherapy, 2-12 channels), includes basic dosimetry calculation(s)	1.83	1.83	Agree
77318	Brachytherapy isodose plan; complex (calculation[s] made from over 10 sources or remote afterloading brachytherapy, over 12 channels), includes basic dosimetry calculation(s)	2.90	2.90	Agree

The RUC is disappointed that CMS did not accept the RUC recommendation for CPT codes 77316 listed in the table above.

CMS is establishing the RUC recommended work RVUs for CY 2015 for all of the codes in this family except CPT code 77316. CMS disagreed with the RUC-recommended crosswalk for this service because they do not believe it is an appropriate match in work. The RUC crosswalked CPT code 77318 to CPT code 77307, because both codes are complex isodose planning codes and are in the same family. CMS believes that the RUC should have crosswalked CPT code 77316, a simple isodose planning code, to the corresponding simple isodose planning code in the same family, CPT code 77306. Therefore, for CY 2015 they are establishing an interim final work RVU of 1.40 for CPT code 77316.

Although the surveyed physician times are the same for CPT codes 77306 and 77316, the survey respondents believed that the intensity of CPT code 77316 should be slightly more than CPT code

77306. CPT code 77306 captures the work of external beam radiation planning for 1 or 2 unmodified ports, whereas 77316 is typically used for high dose rate brachytherapy planning with a single channel which has multiple dwell positions (typically more than 4) hence significantly higher number of variables that have to be taken into account to create the plan. Thus, there is an incremental increase in the amount of physician work for brachytherapy isodose plans.

The RUC stands by its recommendation, which was based on survey results from 70 radiation oncologists. The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty that the survey 25th percentile work RVU of 1.50 is appropriate. The RUC also agreed that the brachytherapy isodose planning is a more intense service relative to tele therapy isodose planning. The RUC compared the surveyed code to MPC code 88321 *Consultation and report on referred slides prepared elsewhere* (work RVU= 1.63, intra-service time of 50 minutes) and noted that the reference code has a higher intra-service time (50 minutes versus 40 minutes), supporting a lower work RVU of 1.50 for the surveyed code. The RUC also compared the surveyed code to CPT code 88380 *Microdissection (ie, sample preparation of microscopically identified target); laser capture* (work RVU= 1.56, intra-service time of 45 minutes) and noted that with similar total time (46 minutes versus 45 minutes) and similar work intensities, the RUC recommended work value is appropriate for 77316.

The RUC urges CMS to accept its original recommendation of 1.50 work RVUs for CPT Code 77316. In addition, the RUC requests that this code be referred to the Refinement Panel for reconsideration.

Pathology Codes 88341, 88364, 88367, 88369, 88373, 88374, 88375

CPT code	Descriptor	RUC Rec RVU	CMS Proposed Interim RVU	CMS Work RVU Decision
88341	IHC additional	0.65	0.42	Disagree
88364	Qualitative FISH additional	0.88	0.53	Disagree
88367	Quantitative, Computer Assisted FISH initial	0.86	0.73	Disagree
88369	Quantitative, Manual Assisted FISH additional	0.88	0.53	Disagree
88373	Quantitative, Computer Assisted FISH additional	0.86	0.43	Disagree
88374	Quantitative, Computer Assisted FISH multiplex	1.04	0.93	Disagree
88375	Optical Endomicroscopy	1.08 (2014 RUC Recommendation)	0.91	Disagree

The RUC is disappointed that CMS did not accept the RUC recommendations for CPT codes 88341, 88364, 88367, 88369, 88373, 88374, and 88375 listed in the table above.

CMS applied a 40% reduction to the work RVU for new CPT code 88341 based on previous RUC recommendations for pathology add-on codes for CPT codes stating that the agency believes "that the relative resources involved in furnishing an add-on service in this family would be reflected appropriately using the same 60 percent metric." The RUC strongly disagrees with CMS applying a 40% percent reduction and categorizing all pathology add-on services as requiring the same resources as the cited examples. Specifically the codes noted by CMS are services that, when performed as an add-on service are assessment of tumor margins, and the diagnosis of tumor has typically been made prior to that assessment. We strongly believe that all pathology services cannot be generalized in the same manner as may be the case for frozen section services where the add-on service is to check tumor margins for the presence of cancer.

Specifically, for additional Immunohistochemistry services represented by new CPT code 88341, each antibody is evaluated separately on different slides. Each antibody has a specific staining pattern for true positivity as opposed to non-specific staining, and the pattern of cytoplasmic, nuclear, and heterogeneous versus homogenous staining must be individually evaluated for each stain. Each antibody provides specific additional information for the pathologist to interpret in arriving at a diagnosis for the specimen. This is in contrast to the two examples CMS provided, in which the primary diagnoses would typically be known prior to the resection, so that, for each of the margins reviewed with the add-on code, the diagnosis is typically known in advance. This is not the case with the immunohistochemisty add-on services.

In addition, the RUC carefully reviewed the survey data and to ensure relativity of CMS code 88341 to other services on the physician fee schedule. The RUC reviewed the survey results from 206 pathologists for CPT code 88341 and determined that the survey 25th percentile work RVU of 0.65 appropriately accounts for the work required to perform this service. The RUC noted that although this add-on service requires the same time as the base code 88342, the work is slightly less for each additional single antibody. Based on the relativity established by the RUC through its review of this service, as well as the above explanation why all pathology add-on services cannot be presumed to represent a 40% reduction in physician work relative to their corresponding initial services, we urge CMS to adopt the RUC approved work RVU for CPT code 88341 of 0.65 work RVUs. A different valuation would create a rank order anomaly.

The RUC urges CMS to accept its original recommendation of 0.65 work RVUs for CPT Code 88341. In addition, the RUC requests that this code be referred to the Refinement Panel for reconsideration.

Similar to CPT code 88341, CMS again applied a 40% reduction to the work RVU for new CPT code 88364 relative to the corresponding initial service. The RUC strongly disagrees with CMS' 40% percent reduction categorizing all pathology add-on services as requiring the same reduced resources relative to the initial service as the cited examples. It is clear that when pathologists perform in situ hybridization add-on services there is no corresponding interpretive diagnosis previously established when the pathologist's work begins on the additional single probe stain procedure.

Again, the RUC carefully reviewed the survey data to determine relativity of this service and this family. Specifically, the RUC reviewed the survey results for CPT code 88364 and determined that a work RVU of 0.88, the same as the recommended work RVU for CPT code 88365 and 88368, appropriately accounts for the work required to perform this service. The RUC noted that the recommended work RVU is lower than the survey 25th percentile work RVU of 0.95. The RUC determined that since 88365 and the add-on code 88364 require identical time and intensity, these two

services should be valued the same. The RUC noted that the pathologist is looking at a second probe with an entirely different signal than the base code 88365. Again, we urge CMS to value the work RVU for CPT code 88364 based on the RUC's relativity assessment rather than on an incorrect general assumption regarding pathology add-on services and adopt the RUC recommended work RVU of 0.88. A different valuation would create a rank order anomaly.

The RUC urges CMS to accept its original recommendation of 0.88 work RVUs for CPT Code 88364. In addition, the RUC requests that this code be referred to the Refinement Panel for reconsideration.

The Agency notes that CPT code 88367 is the computer assisted version of morphometric analysis, analogous to 88368 which is the manual version. CMS accepted the RUC recommended work RVU of 0.88 for 88368 but the Agency does not believe that the RUC recommended work RVU of 0.86 adequately reflects 25 minutes of intraservice time compared to 30 minutes for CPT code 88368. The RUC concluded that 0.86 work RVUs appropriately accounts for the work required to perform this service and compared this code together with its code family including CPT code 88368 for relativity. In addition, it was noted that the same numbers of cells are evaluated by the pathologist when rendering a diagnosis for CPT code 88367 as in CPT code 88368. Specifically, the RUC compared 88367 to 88368 and noted that CPT code 88368 is manual and requires slightly more physician work and time because the physician is moving between the images from the fluorescent microscope to find the cells of interest that will be counted. In code 88367, the images that the physician evaluates are selected by the computer. CPT code 88367 still requires the physician to independently view, analyze and make decisions as each separate image, and a ratio is calculated for each service.

The RUC urges CMS to accept its original recommendation of 0.87 work RVUs for CPT Code 88367. In addition, the RUC requests that this code be referred to the Refinement Panel for reconsideration.

Similar to other new add-on codes, CMS again applied a 40% reduction to the work RVU for new CPT code 88369. The RUC again strongly disagrees with CMS applying a 40% percent reduction, categorizing all pathology add-on services as requiring the same reduced resources relative to the initial service as the cited examples. It is clear that when pathologists perform in situ hybridization add-on services there is no corresponding interpretive diagnosis previously established when pathologists work begins on the additional single probe stain procedure.

The RUC carefully reviewed the survey data to determine relativity of this service and this family. In addition, the same numbers of cells are evaluated by the pathologist when rendering a diagnosis for CPT code 88369 as in CPT code 88365. Specifically, the RUC reviewed the survey results for CPT code 88369 and determined that a work RVU of 0.88, the same as the recommended work RVU for CPT code 88365 and 88368, appropriately accounts for the work required to perform this service. The RUC compared 88373 to 88369 and noted that CPT code 88369 is manual and requires slightly more physician work and time because the physician is moving the slide with the fluoroscopic microscope around to find the cells of interest that will be counted.

The RUC urges CMS to accept its original recommendation of 0.88 work RVUs for CPT Code 88369. In addition, the RUC requests that this code be referred to the Refinement Panel for reconsideration.

Similar to other new add-on codes, CMS again applied a 40% reduction to the work RVU for new CPT code 88373 based on previous RUC recommendations for pathology add-on codes. The RUC again strongly disagrees with CMS applying a 40% percent reduction and categorizing all pathology add-on services as requiring the same reduced resources relative to the initial service as the cited examples. It is clear that when a pathologist performs in situ hybridization add-on services there is no corresponding interpretive diagnosis previously established when pathologist's work begins on the additional single probe stain procedure.
The RUC carefully reviewed the survey data to determine relativity of this service and this family. The RUC firmly agreed that "using computer-assisted technology" as included in the descriptor, does not replace the physician work. Computer-assisted technology refers to the computer selecting the images for the pathologist to review. The computer does not adequately distinguish between cancer and non-cancer cells. In addition, the American Society of Clinical Oncology (ASCO) guidelines indicate that a minimum of 40 neoplastic cells need to be examined for signal intensity. Specifically, they reviewed the survey results for CPT code 88373 and determined that a work RVU of 0.86, the same as the recommended work RVU for CPT code 88367, appropriately accounts for the work required to perform this service. The RUC compared 88373 to 88369 and noted that CPT code 88369 is manual and requires slightly more physician work and time because the physician is moving the slide with the fluoroscopic microscope around to find the cells of interest that will be counted. In code 88373, the computer selects the images that the physician evaluates, however 88373 still requires the physician to analyze and make decisions.

The RUC urges CMS to accept its original recommendation of 0.86 work RVUs for CPT Code 88373. In addition, the RUC requests that this code be referred to the Refinement Panel for reconsideration.

CMS reduced the RUC recommended value for CPT code 88374 as the code is a computer assisted version of CPT code 88377 with decreased intraservice time from 45 minutes to 30 minutes. The agency applied a similar ratio to the work RUV of 88377 to assign an interim work RVU of 0.93 for 88374. The RUC however, clearly agreed that "using computer-assisted technology" for 88374, as included in the descriptor, does not replace the physician work. Computer-assisted technology refers to the computer selecting the images for the pathologist to review. The computer does not effectively distinguish between cancer and non-cancer cells. In addition, the American Society of Clinical Oncology (ASCO) guidelines indicate that a minimum of 40 neoplastic cells need to be examined for signal intensity. The RUC compared 88374 to 88377 and noted that CPT code 88377 is manual and requires slightly more physician work and time because the physician is moving the fluoroscopic microscope field around to find the cells of interest that will be counted. In code 88374, the images that the physician evaluates are selected by the computer. CPT code 88374 still requires the physician to analyze and make decisions to reach a separate diagnosis. In addition, the pathologist when rendering a diagnosis for CPT code 88374, as in CPT code 88377, evaluates the same numbers of cells. The RUC concluded that based on the survey's 25th percentile work RVU, that 1.04 appropriately accounts for the work required performing this service. The RUC urges CMS to adopt the RUC recommended work RVU of 1.04 for CPT code 88374 and not create a rank order anomaly amongst these services.

The RUC urges CMS to accept its original recommendation of 1.04 work RVUs for CPT Code 88374. In addition, the RUC requests that this code be referred to the Refinement Panel for reconsideration.

In the 2014 Medicare Physician Payment Schedule, CMS assigned a Medicare Status of I (not valid for Medicare purposes) to CPT code 88375. The RUC appreciates the Agency's decision to establish CPT code 88375 as an active code for Medicare purposes. However, we strongly believe that the Agency should utilize the RUC recommended physician work RVUs for this service. In the Final Rule for 2015, CMS stated that "to value this service, we based the RVUs on those assigned to CPT code 88329, adjusted for the difference in intraservice time between the two codes. We are assigning a final work RVU of 0.91 for CPT code 88375 for CY 2015." We question the calculation utilized to determine the 0.91 work RVU based on adjustments for intrasevice time between CPT codes 88375 and 88329. We believe that the RUC's recommended value of 1.08 based on survey data as well as comparison to other physician services determines a relative value that should be adopted by the Agency. In addition, by discounting the RUC survey's intra service intensity data comparisons with the key reference service, CMS has created a rank order anomaly by not accepting the RUC valuation.

To validate the RUC's recommended value, the RUC compared the surveyed code to key reference service 88331 *Pathology consultation during surgery; first tissue block, with frozen section(s), single specimen* (work RVU= 1.19) and agreed that although the pathologist will review more images (in real time) during an optical endomicroscopy session, the intensity and urgency of reviewing frozen sections during surgery accounts for the greater physician work in the reference code. The RUC survey results demonstrate that the complexity and intensity measures of 88375 were identical or greater than those for 88331. The RUC also reviewed CPT codes 11311 *Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm* (work RVU= 1.10) and 88121 *Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; using computer-assisted technology* (work RVU= 1.00) as both codes have identical intra-service time, 25 minutes, as the surveyed code which justifies the recommended work value for 88375.

The RUC urges CMS to accept its original recommendation of 1.08 work RVUs for CPT Code 88375. In addition, the RUC requests that this code be referred to the Refinement Panel for reconsideration.

Caloric Vestibular Test Code: 92543

CPT code	Descriptor	RUC Rec RVU	CMS Proposed Interim RVU	CMS Work RVU Decision
92543	Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes 4 tests), with recording	0.35	0.10	Disagree

The RUC is disappointed that CMS did not accept the RUC recommendation for CPT code 92543 *Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes 4 tests), with recording*, as outlined above.

In the final rule, CMS' basis for maintaining the current value of 0.10 for 92543 was that "survey respondents may not have understood the revised code description for CPT code 92543, and thus the survey data may be unreliable." However, CPT 92543 was subject to a rigorous RUC process during

which the RUC recommended directly crosswalking to CPT code 92550 *Tympanometry and reflex threshold measurements* (work RVU =0.35), which was determined to be a similar service.
The RUC urges CMS to accept its original recommendation of 0.35 work RVUs for CPT Code 92543.

Transcranial Doppler Studies Codes: 93888, 93975 & 93976

CPT code	Descriptor	RUC Rec RVU	CMS Proposed Interim RVU	CMS Work RVU Decision
93888	Transcranial Doppler study of the intracranial arteries; complete study	0.70	0.50	Disagree
93975	Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study	1.30	1.16	Disagree
93976	Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; limited study	1.00	0.80	Disagree

The RUC is disappointed that CMS did not accept the RUC recommendations for CPT codes 93888, 93975, and 93976, as outlined in the table above.

In the Final Rule, CMS noted that the RUC recommended 0.50 RVUs for several codes in this family with 10 minutes intraservice work, which CMS feels is an appropriate relationship between time and intensity. Therefore, codes with 10 minutes intra-service work are being assigned 0.50 RVUs. The RUC rejects this generalization to other codes within this family as each code was carefully reviewed, taking into consideration made the specific services being provided, not just the amount of intraservice time.

The RUC stands by its recommendation which is based on the survey results from 32 neurologists and radiologists who determined that the survey median work RVU of 0.70 for CPT code 93888 appropriately accounts for the work required to perform this service. The RUC recommends the following physician time: 5 minutes of pre-service time, 10 minutes of intra-service time and 5 minutes of post-service time. The RUC compared 93888 to the key reference service 76821 *Doppler velocimetry, fetal; middle cerebral artery* (work RVU= 0.70) and agreed that both services require the same physician work and time and should be valued the same. The RUC also referenced MPC codes76536 *Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation* (work RVU= 0.56) and 99213 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU= 0.97) and determined that the recommended work RVU of 0.70 places this service relative to other similar services. Lastly, the RUC noted that this service is appropriately valued higher than the duplex scan codes, as the typical patient is critically ill, possibly in a coma, therefore it is more challenging to identify the arteries and more difficult to complete the measurements.

The RUC urges CMS to accept its original recommendation of 0.70 work RVUS for CPT Code 93888. In addition, the RUC requests that this code be referred to the Refinement Panel for reconsideration.

In the Final Rule, CMS notes that the RUC recommended the survey 25th percentile for codes in this family with 15 minutes intraservice work which CMS feels appropriately reflects the work. Therefore, codes with 15 minutes intraservice work are being assigned the survey 25th percentile values. However, CPT code 93975 has 20 minutes of intraservice time so that is not an appropriate or valid rationale for this reduction.

The RUC stands by its original recommendation which is based on the survey results from 54 radiologists, cardiologists and vascular surgeons and determined that the survey median work RVU of 1.30 for CPT code 93975, a decrease from the current value, appropriately accounts for the work required to perform this service. The RUC recommends the following physician time: 5 minutes of pre-service time, 20 minutes of intra-service time and 5 minutes of post-service time. The RUC compared 93975 to the key reference service 93306 *Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography* (work RVU= 1.30) and agreed that both services have analogous physician work and time and should be valued the same. The RUC also referenced MPC codes 99238 *Hospital discharge day management; 30 minutes or less* (work RVU= 1.28) and 74170 *Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections* (work RVU= 1.40) and determined that the recommended work RVU of 1.30 places this service relative to other similar services.

The RUC urges CMS to accept its original recommendation of 1.30 work RVUs for CPT Code 93975. In addition, the RUC requests that this code be referred to the Refinement Panel for reconsideration.

In the Final Rule, CMS notes that the RUC recommended the survey 25th percentile for codes in this family with 15 minutes of intraservice time, which CMS feels appropriately, reflects the work. Therefore, codes with 15 minutes of intraservice time are being assigned the survey 25th percentile values. The RUC rejects this generalization to other codes within this family as each code was carefully reviewed taking into consideration the specific services being provided, not just the amount of intraservice time.

The RUC stands by its original recommendation which is based on the survey results from 53 radiologists, cardiologists and vascular surgeons and determined that the survey median work RVU of 1.00 for CPT code 93976, a decrease from the current value, appropriately accounts for the work required to perform this service. The RUC recommends the following physician time: 5 minutes of pre-service time, 15 minutes of intra-service time and 5 minutes of post-service time. The RUC compared 93976 to the key reference service 93970 *Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study* (work RVU= 0.70) and agreed that both services are vascular lab studies. However, there is a difference in the body area and type of blood vessels imaged. CPT code 93976 is a limited study that involves both arterial inflow and venous outflow examination of an organ and is therefore more intense. Likewise, 93976 is more intense than 93880, 93925 and 93930 because it includes a study of both arterial inflow and venous outflow of organ systems and is appropriately valued higher. CPT code 93976 relies more on the interpretation of Doppler wave forms which are non-numerical and use deep Doppler which is more complex; therefore there is an increased complexity to interpret the Doppler spectrum. The RUC also referenced MPC codes 99213 *Office or other outpatient visit for the evaluation and management of*

an established patient (work RVU= 0.97) and 95805 *Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness* (work RVU= 1.20) and determined that the recommended work RVU of 1.00 places this service relative to other similar services.

The RUC urges CMS to accept its original recommendation of 1.00 work RVUs for CPT Code 93976. In addition, the RUC requests that this code be referred to the Refinement Panel for reconsideration.

Application of Topical Fluoride Varnish Code: 99188

CPT code	Descriptor	RUC Rec RVU	CMS Proposed Interim RVU	CMS Work RVU Decision
99188	Application of topical fluoride varnish by a physician or other health care professional	0.20	N	N/A

The RUC is disappointed that CMS did not accept the RUC recommendation for CPT code 99188, and instead assigned a status indicator of "N" for non-covered.

The RUC believes that since CMS covers services provided by Medicaid it is imperative that the Agency publish the RUC recommended values for code 99188 on the Medicare Physician Payment Schedule. There is a long-standing precedent established by the preventive medicine services codes (99381-99397) and other codes, which are status indicator "N," yet have had their RUC recommended values published on the Medicare Physician Payment Schedule since their inception. CMS established this precedent and should continue to follow it with code 99188. This is a viable solution since it allows CMS to publish the RUC-recommended values on the Medicare Physician Payment Schedule while maintaining the Medicare payment policy that may not cover certain services.

Advanced Care Planning Codes

CPT code	Descriptor	RUC Rec RVU	CMS Proposed Interim RVU	CMS Work RVU Decision
99497	Advanced care planning including the explanation and discussion of advanced directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate	1.50	I	N/A
99498	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other	1.40	I	N/A

	qualified health care professional; each additional 30 minutes (list separately in addition to code for primary procedure)			

The RUC is disappointed that CMS did not accept the RUC recommendation for CPT codes 99497 and 99498, and instead assigned a status indicator of "I" for non-covered.

Specifically, CMS states that *"For CY 2015, we are assigning a PFS status indicator of ''I'' (Not valid for Medicare purposes. Medicare uses another code for the reporting and payment of these services.) to CPT codes 99497 and 99498 for CY 2015. However, we will consider whether to pay for CPT codes 99497 and 99498 after we have had the opportunity to go through notice and comment rulemaking."*

The RUC is unclear and CMS does not elaborate on what other codes Medicare uses currently for payment of these services. Further, the RUC is concerned that CMS is suggesting that these codes need an additional level of consideration or review. Finally, the RUC believes that it is imperative that the RVUs be published on an interim basis the way it does for other new and revised codes that appear on the Medicare Fee Schedule.

The RUC urges CMS to publish the RUC recommended RVUs and begin separate payment for advance care planning services.

CY 2015 Identification and Review of Potentially Misvalued Services

The RUC continues to ensure that potentially misvalued services are fairly identified and reviewed. Since 2006, the RUC's efforts have led to the identification of more than 1,700 codes and resulted in $3.5 billion in redistribution within the Medicare Physician Payment Schedule. A report of the RUC's progress in this project is attached to this letter.

In the Final Rule, CMS eliminated the list of codes identified as potentially misvalued in a proposed rulemaking "High Expenditure" screen. The RUC had been prepared to review these services at the January 2015 RUC meeting. The specialties understand the direction provided by CMS and the individual services will no longer be scheduled for review, if they are related only to this specific CMS screen.

CMS did seek public comment for a few other services unrelated to this screen. The tables below provide a status on various items CMS has requested the RUC to review:

Public Nomination of Potentially Misvalued Services

CPT Code	RUC Status
33282 33284	CMS noted that stakeholders who are interested in providing information about the direct practice expense (PE) inputs used in furnishing these services in the non-facility setting may do so in this comment period. The RUC solicited the specialty societies' interest in submitting non-facility inputs. The specialty societies indicated that the services described by these two codes would not be performed in the office. **Therefore the RUC will not be developing PE inputs for the non-facility setting at this time.**
41530	RUC submitted only PE recommendations for 2015. **The RUC will review physician work at the April 2015 meeting.**

Potentially Misvalued Codes

Issue	CPT Code	RUC Status
Epidural Injection and Fluoroscopic Guidance	62310 62311 62318 62319 77001 77002 77003	Referred to CPT 2017 cycle. Services to be revised to include imaging guidance.
Neurostimulator Implantation	64553 64555	RUC to review at the April 2015 meeting.
Mammography	77055 77056 77057	Referred to February 2015 CPT meeting to revise the word "film" in the descriptor and survey for the April 2015 RUC meeting.
Abdominal Aortic Aneurysm Ultrasound Screening	G0389	Referred to February 2015 CPT meeting to transition to a Category I code and survey for the April 2015 RUC meeting.
Prostate Biopsy	G0416	RUC to review at the April 2015 meeting.

Finalizing CY 2014 Interim Direct PE Inputs – Code Specific Comments

Issue	CPT Code	RUC Status
Cytopathology	88108 88112	In the Final Rule for 2015 CMS requests that this service be reviewed as potentially misvalued based on comments that the refinements to the PE inputs for CPT code 88112 resulted in a rank-order anomaly, as CPT code 88108 has higher PE RVUs than CPT code 88112, while CPT code 88108 is a less complex service than CPT code 88112. Specifically, commenters stated that it is illogical for a cytology specimen processing technique that involves an additional step that requires materially more resources to have an RVU that is less than an associated technique that requires fewer resources, and expressed concerns about the potential for misreporting. **The RUC will review the direct PE inputs for 88108 and 88112 at the April 2015 RUC meeting.**

Establishing CY 2015 Interim Final Work RVUs – Code Specific Issues

Issue	CPT Code	RUC Status
Electronic Analysis of Implanted Neurostimulator	95971 95972 95973	In the Final Rule for 2015 CMS notes that the RUC reviewed CPT codes 95971 and 95972 because they were identified by the High Volume Growth Services screen which identifies services in which Medicare utilization increased by at least 100 percent from 2006 to 2011 screen. It is unclear to CMS why CPT code 95973, the add-on code to CPT code 95972, was not also surveyed. Even though the RUC did not survey 95973, CMS believes it should be reviewed as part of this family. The lack of a survey for CPT code 95973 along with the confusing descriptor language and intraservice time suggest the need for this family to be returned to CPT for clarification of the descriptor and then to the RUC for resurvey. **The RUC has referred this issue to CPT for clarification.** The RUC recommended that for CY 2016, the relevant specialties should submit a code change proposal to more definitely address the concern and make the codes more consistent with current practice. The specialties anticipate two separate families; one for peripheral nerve root stimulators and another for spinal cord stimulators.

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

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

Until recently, SRS services furnished using robotic methods were billed using contractor-priced G-Codes G0339 *Image-guided robotic linear accelerator based stereotactic radiosurgery, complete course of therapy in one session or first session of fractionated treatment,* and G0340 *Image-guided robotic linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum five sessions per course of treatment.* Stakeholders have indicated that the CPT codes accurately described both services and the RUC stated that the direct PE inputs for the CPT codes accurately accounted for the resource costs of the described services. CMS proposed to recognize only the CPT codes for payment of SRS services and to delete the G-Codes used to report robotic delivery of SRS. After consideration of the comments regarding the appropriate inputs to use in pricing the SRS services, CMS has concluded that at this time, they lack sufficient information to make a determination about the appropriateness of deleting the G-Codes and paying for all Stereotatic Radiosurgery (SRS) and Stereotatic Body Radiation Therapy (SBRT) services using the CPT codes. Therefore, they will not delete the G-Codes for 2015, but will instead work with stakeholders to identify an alternate approach and reconsider this issue in future rulemaking.

SRS and SBRT are precise and effective types of radiation therapy that use concentrated radiation beams in high doses to destroy tumors in difficult and hard to reach areas, such as the brain or spine, and other sites within the body. These forms of treatment are high-value services that achieve tumor eradication expediently and non-invasively.
The RUC maintains that the CPT codes accurately describe SRS/SBRT services and that the G codes are not needed. However, we recognize the issue is complicated and there is the potential for significant impact on practices if the G-Codes are deleted.

The RUC notes that the direct practice expenses for these services have been reviewed by the RUC's Practice Expense Subcommittee and PE direct inputs accurately capture the resources utilized for all SRS and SBRT services (including robotic) relative to other radiation oncology services. It is unlikely that reviewing the services through the RUC process in the future will yield any significant changes.

The RUC appreciate CMS' attention to this issue and supports their decision to monitor the issue closely and possibly identify an alternate approach to deleting G-Codes.

Review of Direct PE for Codes Identified Under CMS Proposal to Cap PE RVUs at OPPS/ASC Rates

The RUC is disappointed that CMS did not recognize the exhaustive work undertaken by both the RUC and the specialties societies in reviewing the direct practice expense for select services involved in the CMS proposed OPPS/ASC cap.

As part of the 2014 NPRM, CMS proposed to cap 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. While CMS did not finalize this proposal, the RUC took the initiative to solicit feedback from specialty societies regarding CPT codes potentially impacted by the OPPS/ASC payment cap proposal. Specialty societies looked over the list of 211 codes identified by the proposal and indicated which services they have an interest in reviewing. The

RUC recommended developing practice expense (PE) inputs only for the subset of codes identified by specialty societies, grouped by specialty, at the April 2014 RUC meeting.

This review marked a new type of screen for the RUC, whereby specialty societies brought forward codes from a range of services identified by CMS through a policy proposal. Given that the OPPS/ASC cap proposal was to limit the practice expense payment when non-facility payment was greater than in the hospital outpatient or ASC facility setting, the expectation was to review a subset of services to demonstrate that the associated direct PE inputs were clinically appropriate and did not represent distortions. This history is important to note, as the specialty societies who provide the 211 services on the list were not compelled to undergo PE review, but instead chose to conduct a review. Furthermore, as the primary purpose of the review was to confirm the clinical appropriateness of the direct PE already included in these codes, the RUC recommended overall decreases to the PE inputs. While the RUC viewed the policy proposal to be misguided, it did agree that it served as an appropriate screen to determine if the non-facility inputs were appropriate.

As with all CMS screens and proposals, the RUC addresses only direct PE when the CMS concern is solely related to the practice expense. Thus, as is consistent with all past RUC recommendations, these codes were only reviewed for direct PE inputs because that was the agency's area of concern. **Given the amount of work that went into revising the direct PE inputs for numerous codes, the RUC requests that CMS consider the PE recommendations for the four PE only recommendations, which are attached, in the 2016 NPRM.**

2014 RUC Recommandations – Finalizing Direct Practice Expense Refinements

Equipment Time

In the Final Rule, CMS addressed the RUC's repeated request for additional information about the specific rationale used in developing refinements. Specifically, CMS provided the criteria it considers to determine which direct PE equipment inputs are highly technical, as well as some examples. The RUC appreciates CMS' response to our request for this information and we intend to use it to improve our practice expense recommendations. We hope that our efforts will result in fewer CMS refinements to direct PE input recommendations in future rulemaking.

Code-Specific Direct PE Inputs

The RUC appreciates that CMS has specified the clinical staff activities typically included in the calculation of equipment time for highly technical pieces of equipment. Similar to the criteria for identifying highly technical pieces of equipment, the RUC intends to use this information to improve the accuracy of equipment time calculations and we hope that these efforts will result in fewer CMS refinements to direct PE input recommendations in future rulemaking.

Cross-Family Comments

In its response to comments regarding refinements to clinical labor minutes related to film inputs, CMS states:

> "In reviewing the times associated with these clinical labor tasks, we noted that it would be consistent with our policy finalized in this rule to adjust the times associated with

> clinical labor tasks for all interim final codes to be consistent with the RUC recommendations regarding clinical labor tasks for digital technology."

This is a misrepresentation of the RUC recommendations regarding clinical labor activities for digital technology. The way that the above statement is worded implies that the RUC provided specific time standards for clinical staff activities as part of the Migration from Film to Digital Imaging Workgroup's recommendation, when the Workgroup intentionally only recommended the activities and not the number of minutes that the activities require. There is absolutely no basis for CMS' assertion that the number of minutes that they have specified as typical for digital imaging in Table 20 of the Final Rule is in any way a RUC recommended standard. Additionally, in the Proposed and Final Rule for 2015, CMS accepted the RUC's recommendation to remove the identified supplies and equipment from imaging CPT codes and included no discussion of the number of minutes that would be assigned to the clinical labor tasks. Although it was not included in the proposed rule CMS has now begun to use the "typical minutes" they have determined as appropriate in Table 20 as a practice expense standard implemented to imaging codes accepted, with refinement as interim final in CY2014 (Table 21 in the 2015 Final Rule) and for imaging codes accepted, with refinement for CY 2015 (Table 31). CMS has included the following comment to explain the refinement in Table 31, "standard times for clinical labor tasks associated with digital imaging." In conclusion, the RUC strongly disagrees with the number of minutes that CMS has included as typical for digital imaging clinical labor activities in Table 20 and implemented as interim final for the codes listed in Table 21 and 31. It is clear that CMS determined the range of minutes listed in the RUC PE recommendations submitted for CY2014 and applied the minimum minutes recommended to the digital inputs. This is not a legitimate way to determine the appropriate clinical staff time for these codes. The RUC recommended a range of 5-27 minutes total film clinical staff activities for CY2014. This variation is based on what is needed to perform the service and the time does not suddenly become uniform for all codes simple because of the transition to digital technology. The RUC suggests that CMS maintain the original RUC recommended times and apply them to the new clinical staff activities related to digital imaging. The RUC also takes issue with the times being referenced to as standards in rationale for refinement of Direct PE Input Recommendations for 2015 in Table 31. This is not a RUC standard. **The RUC recommends that no standard time for these clinical staff activities be applied. The RUC recommends that the specialties have an opportunity to determine the appropriate inputs at the individual distinct service level. If CMS insists on development of a standard for these tasks, the RUC asks that you specifically call for comment on the development on these standards and then provide appropriate opportunity for clinical expertise to be utilized in developing any such standards.**

Esophagoscopy/Esophagoscopy Gastroscopy Duodenoscopy (EGD)

In establishing interim final direct PE inputs for CY 2014, CMS refined the RUC's recommendations for CPT codes 43201 by removing needle, micropigmentation (tattoo) (SC079). In response to commenters CMS stated that, "We did not receive an invoice for the tattoo needle and have no information about this item. We are also unable to include this item in the PE calculations without a method to price it. We do not believe that we have a reasonable proxy at this time. If we receive invoices for this item, we will be able to include it in the direct PE input database." We were very surprised to see this explanation as supply direct PE inputs SC079 was already priced at $12.00 and exists as an input in other CPT codes 11920, 11921 and 43236. The RUC's understanding of the invoice process is that an invoice is only needed with the RUC recommendation if the supply or equipment item does not have a code number and price in the CMS direct practice expense inputs lists, provided as addenda to the Final Rule each year. In addition to new items, the RUC can

understand the need for a paid invoice if the specialty is requesting a change in the pricing of the supply or equipment item, but the RUC has never provided invoices for every supply and equipment item included in its recommendations. **We urge CMS not to implement such a requirement if that was the intent as it is extremely difficult for specialty societies to obtain paid invoices for new supply and equipment items and would be near impossible to obtain them for every supply and equipment item for every code that the RUC reviews.**

High Dose Rate Brachytherapy

CMS notes in their response to commenters that the specialty societies should recommend the survey data even if they do not have compelling evidence to "request higher procedure times." The RUC maintains that compelling evidence is an important tool used by the expert panel to evaluate survey data. The RUC agrees that a data-driven approach is important, but that large increases in time would generally be able to be explained with strong compelling evidence. Furthermore the RUC is very concern with CMS' statement that "surveys of technicians have the potential to be more accurate, rather than less accurate, than those of physicians, as the technicians do not have incentive to increase surveyed time." The implication of this statement is that physicians are providing inflated survey times. The RUC has no reason to believe that physicians are any less trustworthy in their survey responses than other health care professional and we are very concerned that CMS would make this statement.

CMS is finalizing the CY2014 interim final direct PE inputs as refined for CPT codes 77785, 77786, and 77787. These services have again been reviewed by the CPT Editorial Panel and will be reviewed by the RUC at the January 2015 RUC meeting. New RUC recommendations will be submitted to CMS for consideration for 2016 rulemaking.

2015 RUC Recommendations – CMS Direct Practice Expense Refinements

In the Final Rule, Table 28 lists the RUC's direct practice expense (PE) recommendations as interim, without refinement and Table 31 lists the AMA RUC's direct practice expense (PE) recommendations as interim, with refinements. Although Table 28 is supposed to be without refinement, the RUC did find refinements that appear to be a different interpretation of the PE Spreadsheets submitted to the Agency with the RUC recommendations. Below are the issues the RUC found for two families of codes, Percutaneous Vertebral Augmentation and Laparoscopic Hysterectomy.

Percutaneous Vertebroplasty and Augmentation

When examining the clinical staff time for CPT codes 22512 and 22515, the RUC found that the clinical staff time for the entire Percutaneous Vertebral Augmentation family, CPT codes 22510, 22511, 22512, 22513, 22514 and 22515, is inaccurate in the CMS Direct Practice Expense Inputs public use files. The clinical staff time for staff type *L041B, radiologic technologist (RT),* is missing in the direct practice expense inputs for labor for all six new percutaneous vertebral augmentation codes and there is no discussion in the regulatory language or in Table 31 indicating that CMS intentionally removed the time. The RT clinical time for 'assist physician' (who is scrubbed in and working side by side with the physician during the procedure) is missing from the file. These minutes were RUC-approved and follow the standard algorithm for interventional procedures. The clinical times for the RN, the RT who acquires images and the RN/LPN/MTA (circulator) are all noted correctly in the file. The following RT (L041B) minutes are missing:

CPT Code	RT (L041B) minutes missing for 'assist physician'
22510	45
22511	45
22512	30
22513	50
22514	45
22515	30

For your reference, please find attached to this letter the PE spreadsheet entitled, *Percutaneous Vertebroplasty and Augmentation PE Spreadsheet*, which was originally submitted to CMS with the RUC recommendation for these services. The RUC hopes that these issues can be corrected prior to January 1, 2015 to ensure that payments are appropriate for these six new percutaneous augmentation procedures.

Laparoscopic Hysterectomy

When examining the clinical staff time for the Laparoscopic Hysterectomy family, CPT codes 58541, 58542, 58543, 58544, 58570, 58571, 58572 and 58573, the RUC found that the clinical staff time is inaccurate in the CMS Direct Practice Expense Inputs public use files. The post-operative clinical time is missing in the file for these recently RUC reviewed procedures. The RUC approved two level 3 office visits (99213) during the global period in the facility setting. We believe this is an error because CMS included these codes in *Table 28: CY 2015 Interim Final Codes with Direct PE Inputs Recommendations Accepted Without Refinement*, and because the CMS direct PE inputs supply file and CMS direct PE inputs equipment file both suggest that CMS accepted the recommendation to include the post-operative visits. There should be 72 minutes for the staff type *L037D, RN/LPN/TA* in the post-service period for CPT codes 58541, 58542, 58543, 58544, 58570, 58571, 58572 and 58573 (in the facility setting).

For your reference, please find attached to this letter the PE spreadsheet entitled, *Laparoscopic Hysterectomy PE Spreadsheet*, which was originally submitted to CMS with the RUC recommendation for these services. The RUC hopes that these issues can be corrected prior to January 1, 2015 to ensure that payments are appropriate for these eight recently reviewed hysterectomy procedures.

Radiology

When examining the clinical staff time for the Ultrasound family, CPT codes 76700, 76705, 76770, 76775, 76856, and 76857, the RUC found that the changes to the direct PE inputs made by the RUC at the October 2013 RUC meeting for codes 76700 and 76705 are not captured in the CMS Direct Practice Expense Inputs public use files. The RUC believes this is an error because the other 4 codes (76770, 76775, 76856, and 76857) surveyed with 76700 and 76705 show a RUC meeting date of November 2013 and are included in the detailed PE direct input labor file.

For your reference, please find attached to this letter the PE spreadsheet entitled, *Ultrasound PE Spreadsheet*, which was originally submitted to CMS with the RUC recommendation for these services. The RUC hopes that these issues can be corrected prior to January 1, 2015 to ensure that payments are appropriate for these two recently reviewed ultrasound services.

Pathology

The RUC recommended including the *diamond milling tool* as a supply item for CPT code 88348. In the Final Rule, CMS reclassified it as an equipment item and assigned it 5 minutes in the direct PE inputs for CPT code 88348. The RUC agrees with the reclassification of the *diamond milling tool* as an equipment item, but recommends 8 minutes of time which is associated with the clinical labor activity (Line 42 of RUC recommendation), *Face off tissue blocks on milling machine. Trim excess polymerized resin from sides of faced block to form pyramidal blocks that can be cut using microtome*. Please note that row 300, added to the end of Table 31, was not originally included in the refinement table and has been added by the specialty society for newly created equipment input EQ365, *diamond milling tool* (affecting CPT code 88348).

Refinement Table

CMS accepted roughly the same number of codes without refinement than with refinement for 2015. The reasons for CMS refinement were in many cases different than in previous years, leading the RUC to believe that we have addressed some of the issues leading to refinements in the past. This development is concerning since it indicates that as refinements are addressed, CMS will determine that new types of refinements are needed. Although the RUC appreciates this attention to detail, we maintain that a collaborative relationship aimed at addressing concerns as they develop and thereby reducing the number of refinements published in the Final Rule is preferable. The RUC appreciates CMS' effort to maintain appropriate relativity among PE and work components of PFS payment and in some cases we agree with the refinement of direct PE inputs listed in Table 31, however there are many instances where the RUC disagrees with the refinements. Please see a complete list of the *CY 2015 Interim Final Codes with Direct PE Input Recommendations Accepted with Refinements* with specialty society comments in the attached table.

Improving the Valuation and Coding of the Global Service Package

The RUC is profoundly disappointed with CMS' poorly-justified decision to finalize its proposal to transition away from the 010-day and 090-day global surgical periods without modification. Several of the major flaws and gaps in CMS' vague policy previously pointed out by the AMA and other stakeholders, including the lack of a mechanism to pay for certain necessary physician work, practice expense and PLI resources and the unachievable implementation timeline, were either entirely ignored or refuted without a rationale in the Medicare Physician Payment Schedule Final Rule. We have attached our prior comments regarding CMS' original global surgery proposal in an addendum for CMS' reference, as all of the major gaps and flaws we previously identified still apply to this finalized policy.

We strongly believe that it is critical for organized medicine to play a significant role in the eventual transition of all 010-day and 090-day global surgery codes to 000-day global codes. One of the early steps the RUC will undertake will be to hold a strategy session on Saturday, January 31, 2015 to discuss the implementation of CMS' finalized policy. Following this session, the RUC will submit implementation recommendations to CMS to assist with the transition away from 010-day and 090-day global surgery codes. We strongly recommend for CMS to continue working closely with the RUC on the implementation of this and all other relevant Medicare physician payment policy.

CMS should still account for these additional unique direct PE inputs for the post-operative period of surgical procedures after the transition away from 010-day and 090-day global periods via new and/or

existing CPT/HCPCS codes. Many surgical postoperative Evaluation and Management (E/M) services include additional clinical staff time relative to the clinical staff time in existing CPT/HCPCS codes for separately-reported E/M visits. Examples of physician work and/or clinical labor that will need to be separately reported after the global surgical code transition include: dressing changes; local incision care; removal of operative pack; removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, and nasogastric and rectal tubes; changes and removal of tracheostomy tubes.

In our prior comments, we also shared a list of 181 different types of supplies and 35 types of equipment which are practice expense resources that are used while providing many of the 010-day and 090-day global surgical services during the postoperative period. The RUC is deeply troubled by CMS' assertion that surgical services that involve these unique, necessary, direct practice expense resources should either not be paid at all or paid without taking into account the actual resources utilized.

Furthermore, surgical services typically involve more expensive indirect practice expense and PLI resources. As the Medicare payment system is required by statute to be resource-based, we fail to see how a potential discrepancy exists under the current system, as more expensive resources and additional clinical labor time should be paid at correspondingly higher amounts. **We would again like to remind CMS that it is the Agency's statutory obligation to pay for procedures based on the actual resources expended.**

CMS stated its intention to propose the collection of data on post-operative services through future rulemaking, while at the same time going forward with its unrealistic timeline for the transition of all 010-day by 2017 and all 090-day global surgical codes by 2018. Although we support CMS' stated intention to gather objective data on the number of E/M and other services furnished during the current post-operative periods, we are very disappointed that this was not done prior to the finalization of any proposal that will have such a large and unknown impact on providers, patient care and other stakeholders. Furthermore, it is unsettling that the transition deadlines were seemingly selected arbitrarily and prior to properly weighing the logistics of such a massive undertaking.

The RUC continues to strongly recommend a staggered rollout over the span of several years to provide the necessary time for the full RUC review process and the creation of the many new CPT codes that would be needed to cover unbundled miscellaneous post-operative services. A staggered rollout would also give CMS sufficient time to vet the accurate resource costs for over 4,200 codes.

To provide further context for the logistics involved in this transition, there are 1,143 010-day and 090-day global services with greater than 1,000 Medicare utilization in 2013 and 863 services with Medicare allowed charges greater than $1 million. The vast majority of the services above either of these two thresholds are performed frequently enough to warrant a full RUC survey. On the other hand, regardless of the whether or not a service is infrequently performed, all of these lower volume services would still each need to be individually analyzed and reviewed in detail to either determine their new valuation, or in some instances, to decide to refer them to CPT. The RUC would like to remind CMS that, although relatively infrequent services may individually pale in comparison to the size of the entire Medicare Physician Payment Schedule, a large majority are still critical to segments of the non-Medicare and Medicare populations alike and are also of great importance to certain specialties and subspecialties of Medicine.

We strongly encourage CMS to provide a longer timeline for the transition of 010-day and 090-day global codes to 000-day global codes, so there is sufficient time for CMS to further define its policy and for CMS and the RUC to work together to jointly develop and implement an appropriate strategy to transition these 4,200 global surgical services to 000-day codes. To continue with this unachievable deadline will very likely result in significant and lasting damage to the relativity of the Medicare Physician Payment System.

Professional Liability Insurance Relative Value Units

Dominant Specialty for Low Volume Codes

In the comment letter for the 2015 NPRM, the RUC again expressed concern that In the Medicare claims data for any given year, some services have low enough volume that the dominant provider does not accurately reflect the associated PLI premiums and risk involved. The RUC appreciates the Agency's acknowledgement that services with low volume may have inappropriate PLI RVUs due to the variability in the reporting of low volume services from year to year. Furthermore, the RUC thanks CMS for applying the crosswalk methodology to a subset of procedures which according to CMS had dominant specialties inconsistent with a specialty that could be reasonably expected to furnish the service. While this is a positive first step, the RUC is concerned that CMS has not properly defined what constitutes a large enough difference between the dominant specialty according to Medicare claims and the actual reasonable provider of a given service. For example, as the RUC mentioned in their comments in the 2015 NPRM, CPT code 61576 *Transoral approach to skull base, brain stem or upper spinal cord for biopsy, decompression or excision of lesion; requiring splitting of tongue and/or mandible (including tracheostomy)* has nearly half the PLI RVUs as another code in the family, CPT code 61575 *Transoral approach to skull base, brain stem or upper spinal cord for biopsy, decompression or excision of lesion*. This disparity is a result of 61576 being assigned the Otolaryngology risk factor rather than the Neurosurgery risk factor. Again, it is hard to ascertain the reasoning behind not crosswalking a service like this which has such a great disparity between the actual clinical risks involved and the assigned risks based off the Medicare claims data totaling just three cases in 2013. The RUC maintains that CMS should accept the entire list of 120 services submitted as part of the RUC comments on the 2015 NPRM. Any methodology that arbitrarily picks winners and losers without consideration of the nuances between the work and intensity between specialties who would reasonably provide a service is simply unfair. **Therefore, CMS should accept the entire list of crosswalk specialties for the 120 codes which have an inappropriate dominant specialty according to the clinical review of 2013 Medicare claims data.**

Cardiac Catheterization and Angioplasty Exception

The RUC thanks CMS for not only finalizing their proposal to include the injection procedures used in conjunction with cardiac catheterization and angioplasty services but also accepting six additional cardiac catheterization and angioplasty procedures to be include in the exempt list.

Annual Review of PLI RVUs

In the comment letter for the 2015 NPRM, the RUC noted that while CMS has removed the traditional five-year reviews of physician work and practice expense, instead conducting annual, rolling reviews, CMS has continued to only review and update PLI RVUs every five years. Instituting a yearly review of both PLI RVUs and PLI premium data would provide two clear advantages. First, it would base PLI RVUs on the most current PLI premium data available, increasing the reliability

and accuracy of PLI payments. Second, it would provide additional transparency for stakeholder comments.

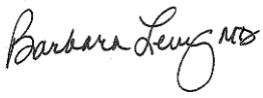
The RUC is pleased that CMS acknowledges these concerns by stating,

> "We will consider the recommendation from stakeholders to conduct annual MP RVU updates to reflect corrections and changes in the mix of practitioners providing services. We will also consider the appropriate frequency for collecting new MP premium data. After reviewing these issues, we would address potential changes regarding the frequency of MP RVU updates in a future proposed rule."

The RUC encourages CMS to institute an annual review of PLI RVUs starting in 2016 and not wait until the next five-year review in 2020 before addressing these concerns.

Thank you for your careful consideration of the RUC's comments on the proposals for the 2015 Medicare Physician Payment Schedule. We look forward to continued opportunities to offer recommendations to improve the RBRVS.

Sincerely,



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