AMA
AMERICAN MEDICAL ASSOCIATION

ama-assn.org
t (312) 464-5000

August 22, 2014

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

Re: File Code-CMS-1612-P; Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2015; Proposed Rule; (July 11, 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) Notice of Proposed Rule Making (NPRM) on the revisions to Medicare payment policies under the Physician Payment Schedule for calendar year 2015, published in the July 11, 2014 *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
- Improving the Valuation and Coding of the Global Package
- Valuing Services that Include Moderate Sedation as an Inherent Part of Furnishing the Procedure
- Professional Liability Insurance (PLI) RVUs
- Valuing New, Revised and Potentially Misvalued Codes
- Chronic Care Management

Resource-Based Practice Expense Relative Value Units

Practice Expense Relative Value Methodology

In 2010, CMS completed a transition to a "bottom-up" practice expense RVU methodology. According to the CMS PE formula (Table 4, 79 NPRM 40327) 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 paying 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 Medicare 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 increased again in 2013 to 60% before dropping to less than 55% in 2014. **Although the RUC is pleased that the percentage of direct costs covered by CMS has increased to a proposed 59% for 2015, the RUC maintains that CMS should revise their method to pay the actual direct PE costs to provide a service.**

Changes to Direct PE Inputs for Specific Services

The RUC greatly appreciates CMS's review and agreement with many of our recommendations, including:

- RUC recommendation for changes to monitoring time following moderate sedation
- RUC recommendation for the addition of a stretcher to the standard moderate sedation package
- RUC recommendations regarding the migration from film to digital technology
- RUC recommendations to add supply items to the cleaning and disinfecting endoscope pack and the IV starter kit
- RUC recommendation for new standard supply package for contrast imaging
- RUC recommendation for direct PE inputs for Stereotactic Radiosurgery (SRS) services

RUC Recommendation for Migration from Film to Digital Practice Expense Inputs

The Practice Expense Subcommittee Migration from Film to Digital Imaging Workgroup completed their work and their recommendations were submitted to CMS by the RUC following the April 2013 RUC meeting. The RUC recommended that for existing codes, CMS remove 21 supply items and 9 equipment inputs from 604 imaging CPT codes and replace the film supplies and equipment with the recommended Picture Archiving and Communication System (PACS) equipment. The RUC recommended that there be no modifications to clinical labor activities for existing codes. The RUC also recommended revised clinical labor activities and times for the new codes and codes that are being reviewed by the RUC moving forward. CMS accepted the RUC recommendation to remove the identified supplies and equipment, however they removed the supplies and equipment from the CMS direct PE input database entirely, including from 50 additional codes purposefully excluded from the RUC recommendation because digital technology is not yet typical or because the code describes a service that is not imaging, but does require one piece of equipment that is used to view past imaging studies. As a proxy for the PACS equipment recommended by the RUC, CMS proposes to allocate equipment minutes for a *desktop computer*, ED021.

In addition to the RUC recommendations that CMS approved regarding the migration from film to digital, CMS also agreed with the RUC's recommendation to revise clinical labor time resulting from changes in film technology as CPT codes are reviewed and to make no modifications to clinical labor activities for existing codes. This recommendation stems from the fact that the CMS direct PE input database includes only the total pre, intra and post-service time, rather than the time for each individual task, making changes to clinical labor time extremely cumbersome. CMS has indicated that they are considering revising the direct PE input database to include task-level clinical labor time information for every code and has provided an example in the supporting data files.

The RUC appreciates CMS' proposal to revise the direct PE input database to include task-level clinical labor time information. The RUC agrees that the current system makes it difficult to implement certain RUC recommendations and to understand past RUC direct PE input recommendations and CMS refinements to those recommendations. The RUC strongly endorses greater transparency and accuracy in the practice expense process. Upon review of the example provided with the supporting data files, the RUC is concerned that when all codes with direct PE inputs are included, the file would be too large to realistically implement. In addition, this approach does not take into account the supporting materials submitted with the practice expense spreadsheets that provide rationale for clinical labor activities that have times which differ from PE standards or explain the allocation of equipment minutes. The RUC is concerned that the format would be unwieldy and unsustainable. As an alternate, more feasible approach, the RUC recommends that CMS posts all practice expense spreadsheets and supporting materials in code order on its website. The RUC reiterates that is it very much in support of transparency and accuracy. We are happy to work with CMS to develop other options to make the breakdown of clinical labor time available in the direct PE input database and devise a more manageable solution to the problem.

Inputs for Digital Mammography Services

The RUC appreciates the opportunity to review mammography CPT codes 77055 *Mammography; unilateral,* 77056 *Mammography; bilateral*, and 77057 *Screening mammography, bilateral (2-view film study of each breast)* as requested by CMS. CMS stated in the proposed rule that they "…do not believe there is a reason to continue the separate use of the CPT codes and the G-codes for mammography services since both sets of codes would have the same values when priced based upon the typical digital technology." Although the G codes were created to pay for digital mammography services the non-facility payment amounts for G0202 *Screening mammography, producing direct digital image, bilateral, all views;* G0204 *Diagnostic mammography, producing direct digital image, bilateral, all views;* and G0206 *Diagnostic mammography, producing direct digital image, unilateral, all views* were determined by Congress in section 104(d) of the Medicare, Medicaid, and State Children's Health Insurance Program SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). The RUC disagrees with CMS' assertion that the codes should have the same value when priced based on digital technology, since the practice expense RVU for the mammography codes G0202 and G0204 are based on a legislative mandate that calls for payment for digital mammography at an amount equal to 150% of the payment for an equivalent film mammogram and the practice expense payment for G0206, is $15 higher than the film mammogram. The methodology to set the rate for mammography G codes was simply based on an arbitrary percentage and not on the actual cost of the digital resources that are necessary to perform the service. CMS will crosswalk the mammography CPT codes to the G codes for 2015, temporarily shielding the codes from reduced resource costs resulting from the migration from film to digital practice expense inputs. However, once these codes are reviewed by the RUC and fully transitioned to a resource based system the RUC anticipates that the payment may be significantly reduced.

For example, this proposal would mean that mammography G code G0202 *Screening mammography, producing direct digital image, bilateral, all views* will be billed using CPT code 77057 *Screening mammography, bilateral (2-view film study of each breast)* at a crosswalked non-facility PE RVU of 3.03. This will not have an impact in 2015; however 77057 had a non-facility PE RVU of 1.56 in CY2014. The practice expense inputs that are accounted for in the PE RVU of 1.56 will be the starting point for the RUC review of 77057. In addition, many of the supplies as well as ER029 *film*

alternator (motorized film viewbox) at a purchase price of $30,900 will no longer be a direct PE inputs in the code. **The RUC does not dispute that digital technology is typical for mammography services however we would like to make it clear that moving from the non-resource based G codes to the resource based CPT codes will result in a significant reduction that will be the result from the resource costs methodology, not from any future RUC review. The CMS proposal merely postpones a reduction that will result, regardless of the pending review of the direct practice expense inputs.**

Updates to Price for Existing Direct Inputs

The RUC appreciates CMS' efforts to update the prices of PE direct inputs to reflect typical market value. The RUC continues to work with specialty societies to facilitate collection of paid invoices for CMS review. We understand that it can be difficult to determine the typical price from the invoices submitted and we will reiterate to specialties that multiple paid invoices are preferred and the invoices should represent typical pricing and that the item(s) in question should be clearly identifiable. In addition we will communicate to specialties that if they are submitting an invoice for an existing direct PE input in order to request an update the intent should be clear.

In addition, given that CMS requested comment on how best to use the invoices that they receive, we also encourage CMS to explore other options to update prices for high cost disposable supplies. The RUC has repeatedly called on CMS to separately identify and pay for high cost disposable supplies using distinct J codes, rather than bundling them into the service described by CPT. Medicare payment for these few supply items should be accurate as the total impact is significant. There are approximately 28 supply items that CMS has priced in excess of $1,000, impacting 43 CPT codes, which accounts for more than 300 million dollars in direct costs. **The RUC urges CMS to consider the establishment of J codes for high cost supplies. The pricing of these supplies should be based on a transparent process, where items are annually reviewed and updated.**

Inclusion of Capnograph for Pediatric Polysomnography Services

In response to the CMS' Final Rule for CY2013, the RUC disagreed with CMS refinement of direct PE inputs for EQ348, capnography to zero equipment minutes for codes 95782 *Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist* and 95783 *Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist.* The RUC included the following supporting evidence in our comment letter:

"Capnography, also referred to as breath-by-breath CO2 or end-tidal PCO2 monitoring, is a required component of polysomnography for patients under age 6. The American Academy of Sleep Medicine (AASM) Manual for the Scoring of Sleep and Associated Events requires the use of capnography for patients under age 13 and recommends capgnography for patients ages 13-18. All 2,500 sleep centers accredited by AASM are required to comply with the AASM Scoring Manual. Capnography during pediatric polysomnography is therefore required standard practice. To confirm the prevalence of capnography in pediatric studies, the AASM conducted a member survey. An overwhelming majority (over 92%) of respondents indicated that they use capnography on patients under age 6."

The RUC greatly appreciates CMS' review of this issue and supports its proposed reversal of its prior decision.

Practice Expense Equipment Item Change and Reaffirmation of RUC Recommendations for CPT code 88375

Although it was not part of this proposed rule the RUC would like to bring to CMS' attention an error in the practice expense for CPT code 88375 *Optical endomicroscopic image(s), interpretation and report, real-time or referred, each endoscopic session*, which is typically performed by a pathologist in the facility setting while a gastroenterologist performs specific endoscopic procedures such as CPT codes 43206 and 43253.

In January 2013 the RUC reviewed the PE inputs of 88375 and discussed the ownership of the equipment and the associated clinical labor time for preparing the equipment for use, turning it off, and storing it after completion of the service. The College of American Pathologists (CAP) and PE Subcommittee agreed that the clinical labor time for those tasks should be deleted (8 minutes) as the equipment is owned and maintained by the gastroenterologist who performs the endoscopic procedures. However, the extraction of the equipment item and its minutes of use from this pathology service were inadvertently overlooked by the CAP and the Subcommittee. The recommendation, in error, was subsequently approved by the RUC and sent to CMS in May 2013.

The RUC recommends that the equipment item "Surgical Pathology Optical Image Processing and Review Station" and the 25 minutes of time assigned to it, be extracted from the RUC recommended direct PE inputs for 88375. In addition, CMS has assigned a Medicare procedure status of "I" (Not valid for Medicare purposes. Medicare uses another code for the reporting of and the payment for these services) for CY2014. CPT code 88375 was established specifically to distinguish between the work done by a physician interpreting referred images by the endoscopist and work performed directly by the endoscopist for optical endomicroscopy. The RUC disagrees that there are other codes more appropriate to report the service. The RUC requests that CMS assign a Medicare Status of A for CY2015 and immediately publish all of the relative value units for this service. A letter from the College of American Pathologists, and the practice expense spreadsheet noting the recommended equipment minutes change are attached to the RUC comment letter for your review.

Correction of Practice Expense Inpputs for CPT codes 17000, 17003, and 17004

In 2013 the RUC reviewed and recommended work and PE RVUs for the actinic keratosis destruction codes, 17000, 17003, and 17004. In our comments on the 2014 final Medicare physician fee schedule rule, we noted that the AADA and the RUC made an error in the PE inputs in recommending 3 units (grams) of LMX 4% anesthetic cream (SH092) for each additional AK destruction, CPT 17003. The correct quantity is 1 gram. We ask that CMS correct the practice expense inputs for CPT 17003 (destruction of premalignant lesions, 2-14) in the CY 2015 Medicare Physician Fee Schedule Final Rule.

Potentially Misvalued Services under the Physician Payment Schedule

RUC Progress in Identifying and Reviewing Potentially Misvalued Codes

Since the inception of the Relativity Assessment Workgroup, the RUC and the Centers for Medicare and Medicaid Services (CMS) have identified over 1,700 services through 15 different screening

criteria for further review by the RUC. Most recently, the RUC has identified 010-day and 090-day global period services which appear as outliers in regards to the number of post-operative office visits included in the global period. The RUC will review and submit recommendations for these services for the 2016 Medicare Physician Payment Schedule.

The RUC appreciates the recognition from CMS that the Committee is a vital part of the Agency's valuation process of Medicare services. The RUC has recommended reductions and deletions to 935 services, more than half of the services identified, redistributing more than $3 billion. 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 report is appended to this letter.

Potentially Misvalued Services

CMS notes three services that have been nominated via the public as potentially misvalued. CPT® codes 37250, 37251 and 41530 were identified largely due to questions regarding the direct practice expense inputs. The Relativity Assessment Workgroup intends to discuss these services at the September 2014 meeting.

CMS identified six families of services in which the interim values need further examination and/or the Agency requests specific review. The Relativity Assessment Workgroup intends to review the Epidural Injection and Fluoroscopic Guidance, Neurostimulator Implantation, Mammography, Abdominal Aortic Aneurysm Ultrasound Screening, Prostate Biopsy Codes and Obesity Behavioral Group Counseling services at the September 2014 meeting to discuss next steps.

Table 10: Proposed Potentially Misvalued Codes Identified through High Expenditure Specialty Screen Medicare Allowed Charges > $10 million

CMS identified 64 high expenditure services as potentially misvalued. The RUC notes that CPT® codes 36475, 36478, 76700, 76770, 76775 and 93978 were recently reviewed and the RUC submitted recommendations for the CPT® 2015 cycle. CPT® codes 11750, 65855, 73560, 73562 and 73564 have been identified through other screens or are part of a family of an identified service and are scheduled to be reviewed. Recommendations for these five services will be submitted for the CPT® 2016 cycle. CPT® codes 97032, 97035, 97110, 97112, 97113, 97116, 97140, 97530 and G0283 are all currently referred to the CPT® Editorial Panel as the entire Physical Medicine and Rehabilitation section is undergoing revision.

CPT® Code	**RUC Review Status**
11750	On Sept 2014 RUC agenda, to submit RUC recommendation for CPT 2016.
36475	RUC Recommendation Submitted for CPT® 2015.
36478	RUC Recommendation Submitted for CPT® 2015.
65855	Previously identified via 010-Day Global Post-Operative Visits and scheduled to be surveyed and reviewed at April 2015 RUC meeting. RUC recommendations to be submitted for CPT® 2016.
73560	Surveying for September 2014 with other x-ray services. RUC recommendations to be submitted for CPT® 2016.

73562	Surveying for September 2014 with other x-ray services. RUC recommendations to be submitted for CPT® 2016.
73564	Surveying for September 2014 with other x-ray services. RUC recommendations to be submitted for CPT® 2016.
76700	RUC Recommendation Submitted for CPT® 2015.
76770	RUC Recommendation Submitted for CPT® 2015.
76775	RUC Recommendation Submitted for CPT® 2015.
93978	RUC Recommendation Submitted for CPT® 2015.
97032	Referred to CPT® Editorial Panel, part of revision to entire Physical Medicine and Rehabilitation CPT® book section.
97035	Referred to CPT® Editorial Panel, part of revision to entire Physical Medicine and Rehabilitation CPT® book section.
97110	Referred to CPT® Editorial Panel, part of revision to entire Physical Medicine and Rehabilitation CPT® book section.
97112	Referred to CPT® Editorial Panel, part of revision to entire Physical Medicine and Rehabilitation CPT® book section.
97113	Referred to CPT® Editorial Panel, part of revision to entire Physical Medicine and Rehabilitation CPT® book section.
97116	Referred to CPT® Editorial Panel, part of revision to entire Physical Medicine and Rehabilitation CPT® book section.
97140	Referred to CPT® Editorial Panel, part of revision to entire Physical Medicine and Rehabilitation CPT® book section.
97530	Referred to CPT® Editorial Panel, part of revision to entire Physical Medicine and Rehabilitation CPT® book section.
G0283	Referred to CPT® Editorial Panel, part of revision to entire Physical Medicine and Rehabilitation CPT® book section.

The Relativity Assessment Workgroup intends on discussing the remaining 44 services identified at the September 2014 meeting to determine next steps.

Prostate Biopsy Codes – HCPCS Codes G0416, G0417, G0418 and G0419

In the 2014 Final Rule, CMS modified the code descriptors of G0416 through G0419 so that these codes could be used for any method of prostate needle biopsy services, rather than only for prostate saturation biopsies. However, since the implementation of these codes, CMS notes that the current coding structure may be confusing, as the number of specimens associated with prostate biopsies is relatively homogenous. Given this, CMS proposes to revise the descriptor for G0416 to define the service regardless of the number of specimens, and to delete codes G0417, G0418, and G0419. The RUC does not agree with this proposal. The most accurate coding structure to best define this service and capture accurate payment is to utilize CPT code 88305 Level IV - Surgical pathology. This CPT code was recently reviewed by the RUC and modified recommendations were implemented by CMS in the 2014 Medicare Payment Schedule Final Rule. This additional revaluation and scrutiny finalized by the agency in 2014 for surgical pathology code 88305 together with the greater granularity in payment addresses the agency's intent to establish straightforward coding and accurate payment for these services. **Therefore, the RUC requests that CMS use the well-established and RUC valued CPT code 88305 for the examination of prostate biopsy specimens.**

Improving the Valuation and Coding of the Global Service Package

CMS proposes to transition all 010-day and 090-day global codes to 000-day global codes by 2017 and 2018, respectively. As support for this proposal, CMS references challenges it has experienced in obtaining available data to verify the number, level and relative costs of post-operative visits included in global packages. CMS also expresses concern that 010-day and 090-day global packages may, in some cases, no longer accurately reflect the post-operative care provided to the typical patient.

In general, the AMA supports increasing the accuracy of physician payment and commends CMS for investigating methods to more accurately pay Medicare practitioners for the services they provide. However, the RUC is seriously concerned that the current proposal would not accurately account for physician work, practice expense and malpractice risk for services performed within the current surgical global period. We would also like to highlight several logistical hurdles and other major consequences, some of which CMS may have not yet fully taken into account. We also recommend for CMS to jointly work with the Relativity Assessment Workgroup to collect and review existing, objective data in order to validate bundled post-operative visits. Finally, given the complications that may arise from these logistical difficulties, we believe that the proposed timeline is simply unrealistic.

Post-operative physician work that is not part of separately-reported E/M codes would also need to be separately-reported

In addition to hospital visits, office visits, critical care visits and discharge day management, there are many other post-operative care services that are also bundled into the 010-day and 090-day global packages. If CMS's proposal is enacted, these other physician services would also need to have their physician work, practice expense and malpractice risk separately compensated using either new or existing CPT/HCPCS codes.

The Medicare Claims Processing Manual (Chapter 12, Section 40.1) provides several examples of services which are currently bundled into the global surgical package. If post-operative care is unbundled, examples of services that would need to be separately reported 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
- Nasogastric and rectal tubes
- Changes and removal of tracheostomy tubes

Before the finalization of any proposal, CMS should work with the RUC and the CPT Editorial Panel to ensure physicians are accurately paid for these vital, routine patient care services.

Practice Expense

As CMS pointed out in its proposal, there is a different mix of post-operative direct practice expense (PE) inputs for global period Evaluation and Management (E/M) services and separately-reported E/M services. The RUC reaffirms that these differences are warranted and strongly recommends that, if unbundling were to take place, CMS should still account for these additional direct PE inputs for the post-operative period of surgical procedures via new and/or existing CPT/HCPCS codes.

The only example that CMS provided for this issue in the proposal was to compare the clinical labor time for separately-reportable E/M codes includes a staff blend listed as "RN/LPN/MTA" (L037D) and priced at $0.37 per minute, whereas some codes with post-operative visits include the staff type "RN" (L051A) priced at a higher rate of $0.51 per minute. We would like to provide some context for this example. We conducted an analysis of the 3,329 facility-only 010-day and 090-day global codes, which took into account volume and only examined clinical labor minutes in the post-operative period. The post-operative clinical labor time for these codes was paid 61% of the time at $0.37 per minute (L037D), 36% of the time at $0.38 per minute (L038A) and only 3% of the time at $0.51 per minute (L051A). Therefore, the sole example provided by CMS is far from representative and should not be used to justify the inappropriate non-payment of thousands of direct PE supply inputs and hundreds of direct PE equipment inputs.

Another critical distinction that CMS must recognize is that E/M services performed in a surgical global period often include additional, justifiably more expensive, supplies and equipment relative to standard, separately-billed E/M services. **Listed in addenda A-B are direct PE inputs for supplies and equipment that are used when facility-only services are performed.**

Certain surgical E/M services also include additional clinical staff time relative to the clinical staff time for separately-reported E/M visits. Examples include the additional clinical labor time required to care for stomas or for the setup and cleaning of scope equipment required at a post-operative visit. The post-operative clinical staff type and time are both carefully considered by the RUC, and are directly related to the typical patient condition and type of service performed for the specific CPT code that has been valued.

Finally, CMS must also consider the effects of this proposal, not just on the direct PE but also on the indirect PE as well. Indirect practice expense payment is derived from the weighted average of the specialty mix that performs each service. Currently, the indirect PE related to the post-operative work for surgical services is correctly derived from the costs associated with the surgical specialties performing the service. Under the proposal, this identical post-operative work would be inappropriately diluted due to the broad mix of specialties that perform separately reported E/M services. The main input for indirect practice expense in the practice expense RVU formula, indirect PE percentage, is higher for many of the surgical specialties relative to the indirect PE percentage for many separately-reported hospital and office visits. For example, the indirect PE percentage for CPT code 99213 is 75% whereas the indirect PE percentage for Neurosurgery is 87%. Therefore, the unbundling of post-operative E/M visits would result in a decline in indirect practice expense payment for many specialties due to an inappropriate, artificial reduction of the indirect PE resources for post-operative services.

As the Medicare payment system is 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. It is CMS's statutory obligation to pay procedures based on the actual resource costs expended. These direct and indirect PE inputs would need to be accounted for in any unbundled reporting system.

Medicare Payment for PLI

Another consequence of this proposal that needs to be addressed would be the large redistribution of Physician Liability Insurance (PLI) payment away from the primary providers of surgical procedures and into a more diverse group of providers. The PLI RVU for each service is calculated by multiplying the work RVU by the specialty risk factor of the specialty(ies) who perform the service.

Currently the work RVUs of the proxy E/M services contained in the global period for 010- and 090-day surgical codes are part of the PLI calculation. This valuation is appropriate because the liability costs of a specific service should be derived from those of the performing specialties. However, under the CMS proposal, the liability costs associated with the post-operative work would be removed from the primary service and would be artificially diluted by the wide mix of specialties performing E/M services. For instance, the liability associated with thoracic surgeons is significant, with a surgical risk factor of 7.27. Therefore, all the work RVUs associated with the physician's work in the post-operative period are assigned to this risk factor. Under the proposal, the work RVUs associated with the post-operative work will be reduced due to the great number of provider specialties who perform E/M services, with the primary providers having significantly lower risk factors (e.g. Family Practice risk factor = 4.18 and Internal Medicine risk factor = 2.07). Therefore, the risk of more severe complications that may result during the post-operative period of complex procedures will be artificially decremented due to the transition away from 010- and 090-day global periods.

The RUC requests that if CMS were to unbundle surgical global periods, the agency should allow for a separate mechanism to account for this disparity. Without global periods, a one-size-fits-all approach to PLI will be unsustainable and result in great disparities between the actual and realized malpractice costs for many physician specialties.

Level of Office and Hospital Visits

On average, the global surgical packages have much lower levels of office and hospital visits relative to separately-reported E/M visits.

The median established office visit in a global surgical package is a 99212, whereas the median level for separately-reported visits is a 99213. Only 1% of all established patient office visits in 010-day and 090-day global surgery packages have a visit level above a 99213, whereas 43% of all separately-reported E/M visits are reported as a 99214 or 99215.

CPT Code	2013 Global Surgical E/M Utilization Percentage (All codes)	2013 Global Surgical E/M Utilization Percentage (RUC reviewed since 2004)*	2013 Separately Reported E/M Utilization Percentage
99211	0.39%	0.28%	2.84%
99212	56.83%	73.77%	7.70%
99213	41.52%	25.73%	45.70%
99214	1.23%	0.21%	39.58%
99215	0.03%	0.01%	4.19%
TOTALS	100.00%	100.00%	100.00%

**Only includes codes reviewed by the RUC from 2004-2013.*

The median hospital visit in a global surgical package is a 99231, whereas the median level for separately-reported hospital visit is a 99232. 57% of hospital visits in a global package have a hospital visit level of 99231, whereas only 12% of all separately-reported hospital visits are reported as a 99231.

CPT Code	2013 Global Surgical E/M Utilization Percentage (All codes)	2013 Global Surgical E/M Utilization Percentage (RUC reviewed since 2004)*	2013 Separately Reported E/M Utilization Percentage
99231	57.25%	38.78%	12.31%
99232	29.73%	33.26%	56.89%
99233	9.99%	20.86%	24.82%
99291	3.03%	7.10%	5.98%
TOTALS	100.00%	100.00%	100.00%

**Only includes codes reviewed by the RUC in from 2004-2013.*

Given the vast majority of 010-day and 090-day global codes have post-operative visits that are typically coded at relatively lower levels, CMS should take into account the upward shift in the level of post-operative E/M reporting that would likely occur when assessing both the viability and impact of this proposal.

Administration Burden

Another area of concern is that the separate submission, processing and payment of post-operative E/M codes and other miscellaneous post-operative services and supplies would place an additional administrative burden on Medicare providers, Medicare Administrative Contractors (MACs) and CMS. The increase in the total number of Medicare claims per year would include the 62.7 million bundled post-operative E/M services in 2013, as well as the many bundled miscellaneous post-operative services and supplies.

Furthermore, some private payors may choose to retain 010-day and 090-day surgical global packages, whereas many others would likely delay their transitions until several years after CMS made the change. Heterogeneous reporting mechanisms between payors would certainly result in additional administrative burden and confusion for all involved stakeholders, including patients.

When conducting future cost-benefit analyses, CMS should not only factor in the necessary budget neutrality implications of this proposal, but also the additional administrative burdens for all stakeholders and the additional expense for CMS to pay A/B Medicare MACs for processing the large amount of additional claims.

Impact on CMS Multiple Surgery, Bilateral Surgery, Co-Surgeons Reduction Policies

CMS payment reduction policies that impact 010-day and 090-day global procedures, including the multiple surgeries reduction, bilateral payment reduction, co-surgeons and team surgeon payment reductions and the assistant-at-surgery reduction, are largely based on and justified by the redundancy of bundled post-operative E/M visits between multiple services or when multiple surgeons are performing the same surgery.

The multiple surgery payment reduction policy pays for multiple surgeries performed by a single physician or same group practice on the same patient at the same operative session or on the same day at 100% of the fee schedule amount for the highest valued procedure, 50% for the second highest valued procedure, 25% for the third through fifth highest valued procedures and "by report" for six or more procedures. The vast majority of efficiency between surgeries is due to the overlap of bundled E/M services between multiple surgeries. Continuing to apply the same reduction percentage to current codes after they were converted to 000-day global codes would be onerous and greatly reduce the payment for second and subsequent surgical services. This same issue would apply to all other payment reductions that currently impact 010-day and 090-day global procedures, including but not limited to: bilateral surgery reductions, co-surgeon and team surgeon reductions and assistant-at-surgery reductions. **If the proposal is enacted, all CMS payment reduction policies that impact 010-day and 090-day global codes would need to be analyzed in detail and the reduction percentages would need to be lowered by a substantial amount.**

Current RUC Review of 010-day and 090-day Global Period Services

The RUC is currently engaged in reviewing 010-day and 090-day global period services though two different screens identified by the Relativity Assessment Workgroup. In January 2014, the RUC separately reviewed all 010-day and 090-day global codes to search for potentially misvalued code. When screening codes with higher than 1,000 Medicare utilization, the Relativity Assessment Workgroup identified 19 010-day services with more than 1.5 office visits and ten 090-day services with more than six office visits. The RUC expanded the services identified in the 090-day global screen to 18 to also incorporate codes from the same code families.

The RUC submitted recommendations for two 010-day services for the 2015 Medicare Physician Payment Schedule and reaffirmed the post-operative visits for five others. The RUC also submitted recommendations for one 090-day service for the 2015 Medicare Physician Payment Schedule, reaffirmed the post-operative visits for one other and referred two more to CPT® for deletion. The RUC will submit recommendations to CMS for the remaining 12 010-day and 14 090-day global services for the 2016 Medicare Physician Payment Schedule.

Data Collection and Post-operative Period Validation

The RUC agrees with CMS that collecting data on post-operative visits furnished by the practitioner reporting current 010-day and 090-day global codes is paramount. Therefore, the RUC strongly recommends that CMS collect and examine existing post-operative visit data in order to validate current surgical bundles and to facilitate informed decision-making on how to proceed with current and future proposals.

One potential method for data capture would be to collect and examine large group practice data for CPT code 99024 *Post-operative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a post-operative period for a reason(s) related to the original procedure* on all post-operative follow-up visits. This service is currently status "B" (bundled) in Medicare physician payment schedule and is therefore not paid.

The RUC has identified several large hospital-based physician group practices that internally use CPT code 99024 to report each bundled post-operative visit, and therefore data is already being captured for many Medicare providers. Separately, the RUC also understands that CMS may have denied-claims data available for CPT code 99024 via the Medicare claims processing system. We recommend that CMS work with the RUC to explore the availability, usefulness and appropriateness of these group practice data and the CMS denied-claims dataset in validating the number of post-operative visits. The RUC and CMS should work in concert to gather existing, objective data in order to validate the actual number of post-operative visits for 010-day and 090-day procedures.

Finally, it is currently possible for CMS to review Medicare Part A claims data to determine the length of stay of surgical services performed in the hospital facility setting. Matching the average length of stay with the post-operative visits in the physician time file would give CMS and other stakeholders the opportunity to identify anomalies within the data set that could be reviewed further.

The Relativity Assessment Workgroup, working with CMS, could review the post-operative visit and length of stay data for outliers. This approach is advantageous for two reasons. First and foremost, it would not completely undo the hard work done since the inception of the RBRVS to properly value surgical services in a bundled global period. It maintains the current global period structure and does not cause the myriad unintended consequences of dissolving the current bundled system. Second, it provides objective data, across a large sample to determine if a service is currently valued with anomalous visit data. This allows for only the targeted review of services with anomalous data, not a blanket review of all services, with varying degrees of Medicare volume and physician work.

Gathering objective data on the number of post-operative visits and the length of stay would give the RUC and CMS useful mechanisms to better determine appropriate levels of post-operative visits. Using these data would allow the RUC and CMS to accurately and efficiently prioritize and identify anomalies that most impact the Medicare Physician payment schedule.

Proposed timeline unachievable without inappropriate shortcuts

The proposed timeline to transition codes from 010-day and 090-day global periods to 000-day global periods is not achievable unless several inappropriate shortcuts are taken. Any systemic transition of values would be seriously flawed and would result in payment that would no longer be resource-based or appropriately relative. There is no solution to systematically, accurately and efficiently, transition codes from 010-day and 090-day global periods to 000-day global periods.

Since its inception, the RUC has worked under the prevailing assumption that magnitude estimation is the standard for valuation of all physician services, including those with global surgical packages. Consequently, the work values associated with E/M services in a code's global period are not necessarily added to the physician work value to determine the final work RVU. These services are proxies representing a physician's typical case. Therefore, even if accurate claims data were available for post-operative E/M visits, simply using a reverse building block methodology to systematically convert all 010-day and 090-day global codes to 000-day global codes by backing out the bundled E/M services would be highly inappropriate. **To preserve appropriate relativity, these codes would need to be transitioned to a 000-day global period on a code-by-code basis, taking into consideration all the issues discussed above regarding practice expense and liability insurance.**

In a separate section of the Proposed Rule, CMS emphasizes that the RUC recommendations are an essential element that it considers when valuing a code. We thank CMS for this accolade and would implore it to allow sufficient time for the RUC review process if unbundling were to take place. If the proposal is finalized without modification in the CY 2015 Final Rule, the RUC would only have four meetings prior to implementation of the CY 2017 proposed conversion of the 473 010-day global surgical codes and only three meetings after that for the CY 2018 proposed conversion of 3,773 090-day global surgical codes. It would be virtually impossible to review that many codes over that short of time frame.

If CMS does in fact decide to proceed with implementing some version of this proposal, the RUC highly recommends 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 decide and vet the accurate resource costs for over 4,200 codes.

Scope of the Proposal

We would like to clarify that there are over 4,200 services on the Medicare Physician Payment Schedule with a 010-day or 090-day global period, not 3,000 as the Proposed Rule had incorrectly stated. Therefore, the scope of this proposal is actually larger than it appears in the NPRM. However, even given this expanded scope, only 268 of these services, or 6%, were performed more than 10,000 times accordingly to 2013 Medicare claims data. We would also like to point out that only 9% of all 010-day global codes have more than one post-operative office visit and 85% of all established patient office visits in 010-day surgical packages are a relatively low level office visit, 99212. In addition, only 4% of all 090-day global codes have more than 5 post-operative office visit and 98% of all established patient office visits in 090-day surgical packages are a 99213 or lower. Therefore, the proposal would likely take both substantially more effort to implement and have a smaller impact relative to what the authors of the proposal may have originally envisioned.

Adverse Impact on Patient Access and Compliance Issues

The RUC has serious apprehension concerning the impact the current proposal would have on patient compliance and access to care. Unbundling post-operative E/M services would result in patients having to pay co-payments separately for each visit, instead of upfront as a single bundled payment. Medicare beneficiaries are often on a tight fixed income, where an additional co-pay per visit would

incentivize many patients to consider not showing up for follow-up visits in order to save money. By spreading these payments out, the physician's ability to properly manage their patients' status would be seriously mitigated due to the potential for the patient not to return for post-operative services.

Most private insurers would follow CMS's lead in unbundle global periods. Some of these private payors do not charge co-payment for surgery, though do charge them for separately-reported office visits. Patients covered by certain private payors would have to pay more out of pocket, adversely impacting them financially. This proposal has the potential to disproportionally impact chronically ill and low-income patients who will have the highest amount of return visits and therefore the most co-pays.

Global Service Package Conclusion

Thanks in large part to the shift from a five-year review for potentially misvalued codes to an annual rolling review by CMS and the Relativity Assessment Workgroup, the RUC is confident that the vast majority of 010-day and 090-day global period services include few post-operative visit outliers. Therefore, eliminating the surgical global period is an inefficient, broad policy which is unlikely to accomplish the agency's limited, focused concerns. The RUC, along with the partnership of CMS, have worked at a grueling pace over the last several years to ensure that the vast majority of services are accurately valued based on their typical resource costs. **Given the unintended consequences and logistical challenges of the CMS proposal highlighted above, the RUC has severe reservations that the perceived benefits outweigh the time, expense and risk necessary to properly implement this proposal. Further, CMS and the Relativity Assessment Workgroup should jointly gather and examine existing data to validate post-operative visits and work jointly to identify anomalies.**

Valuing Services that Include Moderate Sedation as an Inherent Part of Furnishing the Procedure

In the Proposed Rule, CMS is proposing changes to add separate codes for moderate sedation and then review of the codes currently listed in Appendix G of the CPT® book. Currently, CMS assumes that "to the extent moderate sedation is typically furnished as part of the diagnostic or therapeutic service, the inclusion of moderate sedation in the valuation of the procedure is appropriate." However, CMS notes that practice patterns for endoscopic procedures are changing, and anesthesia is increasingly being separately reported for these services. Additionally, CMS reports that their data clearly indicate that moderate sedation is no longer typical for all of the procedures listed in Appendix G. Therefore, CMS will no longer assume that moderate sedation is inherent in these codes.

The RUC supports the intention of CMS to establish a uniform approach for valuing Appendix G services for which moderate sedation is no longer inherent. The RUC also agrees that it is important to value moderate sedation accurately when it is furnished so that duplicate payments will not occur when anesthesia is furnished. In anticipation of developing a more consistent approach to valuation of these services, the RUC in conjunction with the CPT Editorial Panel established the Joint CPT/RUC Moderate Sedation Workgroup. This Workgroup has already started work on this issue and will now focus on the "blueprint" set forth by CMS in the NPRM. The Workgroup will develop separate codes to describe moderate sedation which the CPT Editorial Panel. Finally, the RUC appreciates the fact that CMS will not change existing policies associated with valuing moderate sedation as inherent in the procedures listed in Appendix G until they have an opportunity to consider overall valuation of these codes.

Professional Liability Insurance Relative Value Units

As part of this NPRM, CMS has again proposed improvements under its statutory obligations for the Five-Year Review of the Professional Liability Insurance RVUs. While the RUC is pleased with several of the proposals the agency introduces this review cycle, we remain concerned over a few proposals which have maintained the current, flawed status quo.

Annual Review of PLI RVUs

Over the past several years, CMS has made concerted efforts to ensure services are accurately paid on the Medicare RBRVS. Removing the five-year review of potentially misvalued services has streamlined the review process and provided stakeholders an opportunity to provide comment to CMS, in a timely fashion, on services that may be misvalued. In addition, practice expense inputs are updated frequently, with direct PE inputs updated within the RUC recommendations for specific services, and indirect inputs updated each year based on shifting PE percentages for each physician specialty. Given that CMS has modernized their process for updating these two components to reflect the most accurate information available, it seems logical that the third component of physician payment, PLI, should also be updated in a yearly fashion. Instituting a yearly collection of 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. This would also allow CMS to rescale the PLI RVUs each year, like practice expense, to further increase the accuracy of any redistribution to the conversion factor. Second, it would provide additional transparency for stakeholder comments. Under the current five-year review process, stakeholders only have one opportunity every five years to identify potential problems and/or improvements to a service's PLI RVU. If problems are not addressed in the Final Rule, then they must wait five years. An annual review would eliminate this problem and allow PLI RVUs to be treated identically to physician work and PE RVUs. **The RUC recommends that CMS implement an annual collection and review of PLI premium data.**

Dominant Specialty for Low Volume Codes

The RUC is again pleased that CMS is proposing to use the risk factor of the dominant performing specialty for each procedure which is performed less than 100 times based on 2013 Medicare claims data. The RUC agrees that the current methodology works for most codes, since using a weighted average of the specialty mix for such low volume services would often inappropriately lower the risk factor due to a few instances per year reported by a non-dominant specialty. While this approach works in most cases, the RUC remains concerned about this method since it does not adequately cover the PLI premium costs for a subset of low volume services. 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 notes that while these services are low volume, it is important that within an RBRVS construct, services should reasonably reflect the typical costs associated with performing them. Furthermore, it is a well-known fact that many third-party payors use the Medicare Physician Payment Schedule as the basis for their own payment schedules. Therefore, many of these low volume Medicare services realize undue year-to-year volatility in payment due to inconsistent reporting on Medicare claims.

To illustrate the RUC's concern, below is an example of the impact of having an inappropriate dominant specialty listed:

	Specialty in Medicare Utilization	Work	PE	PLI
61575	Neurosurgery	36.56	22.55	14.74
61576	Otolaryngology	55.31	35.54	7.64

In this case, the RUC has previously recommended that CPT code 61576 should have the PLI risk factor of neurosurgery rather than otolaryngology. The comparison to a similar code in the same family, 61575, with less work RVUs, is stark.

The RUC is also concerned specifically about existing codes with no Medicare volume reported for any given year. According to the contractor report, CPT codes lacking utilization received a crosswalk created by CMS that assigns the same risk factor to codes with a similar specialty mix. In contrast, when a service is existing it receives the average risk factor for all physician specialties. The crosswalks are clear when related to new CPT codes reviewed by the RUC, as the RUC provides, and CMS uses, specified crosswalks for each code which are reviewed to ensure the providing specialties are analogous. However, it is inappropriate for a service to have fluctuating PLI risk factors simply due to whether or not it is reported in Medicare claims data for a given year. According to 2013 Medicare claims data, there are 120 codes which have inaccurate PLI risk and premium data due to the effects of applying the average risk factor for all physician specialties.

To stem this volatility and provide PLI RVUs that more accurately reflect the actual premiums paid and inherent risks involved in low volume services, the RUC reached out to specialty societies and obtained recommendations for a list of 1,912 codes where volume is less than 100 claims per year. Of these 1,911 codes, 514 codes include an inappropriate dominant specialty in terms of PLI or had no utilization listed in 2013 Medicare claims data. The RUC recommends an alternative specialty for these codes. This list is attached to these comments. **The RUC implores CMS to reconsider the attached list of appropriate PLI crosswalks for use in the PLI risk factor calculations for these low volume services. In addition, the RUC requests that CMS publish the list of specialty crosswalk for all codes with no Medicare utilization, not just new codes.**

Non-MD Risk Factor/Premium Crosswalk

CMS has again chosen to crosswalk the PLI premiums of non-MD specialties to the lowest MD risk factor- Allergy Immunology (risk factor = 1, non-surgical premium rate = $8,198). Per the *Draft Report on the CY 2015 Updated of the PLI RVUs for Medicare Payment*, the RUC certainly appreciates the difficulty the CMS contractor had in obtaining comprehensive, accurate premium data across the large majority of states. In these circumstances, for similar physician specialties, it is reasonable to assume that crosswalking a more robust premium rate data set to a less robust set is appropriate. However, crosswalking non-MD specialties to even the lowest MD specialty in many cases severely overstates the PLI premiums and risks associated with these non-physician services.

The RUC has reviewed data on non-physician specialties that fall under the Health Care Professionals Advisory Committee (HCPAC) and has previously submitted these premium rates to CMS. These data were collected through the AMA Physician Practice Information (PPI) survey process. While

these premium rates reflect 2006 payments and do not represent every non-physician specialty, these data still provide a reasonable comparison to suggest that a direct crosswalk to Allergy Immunology, with a rate of $8,198, is simply unrealistic.

Specialty Code	Specialty Name	Risk Factor	Non-surgical Normalized Premium Rate	PPI 2006 PLI Premium Rate	Proposed- Risk Factors Assigned Via Crosswalk:
64	Audiology	1	$8,198	$1,506	Reclassified to Allergy Immunology
35	Chiropractic	1	$8,198	$4,742	Reclassified to Allergy Immunology
68	Clinical Psychologist	1	$8,198	$1,466	Reclassified to Allergy Immunology
80	Clinical Social Worker	1	$8,198	$1,115	Reclassified to Allergy Immunology
67	Occupational Therapist	1	$8,198	$1,821	Reclassified to Allergy Immunology
41	Optometry	1	$8,198	$8,109	Reclassified to Allergy Immunology
65	Physical Therapist	1	$8,198	$1,821	Reclassified to Allergy Immunology
62	Psychologist	1	$8,198	$1,466	Reclassified to Allergy Immunology

The RUC also strongly opposes this crosswalk methodology because the use of Allergy Immunology as the comparator is simply illogical. This specialty was not chosen due to its close association with PLI premium costs to non-physician services, but instead because it represents the lowest premium rates for a specialty in which adequate data, as defined by the contractor, was collected. **The RUC requests that CMS use the PPI survey data provided above and/or use some other measure of central tendency within the existing collected premium data to determine accurate PLI premium rates for non-physician specialties.**

Proposed Crosswalks

For the CY 2015 PLI update, CMS has chosen to crosswalk the Gynecological/Oncology specialty to Obstetrics Gynecology. Over the past several updates, the RUC has consistently recommended, and CMS has agreed, that Gynecological/Oncology should be directly crosswalked to General Surgery. If the CMS proposal were to remain, the resulting PLI risk factor would see a large decrease from the current (5.91 currently to 3.80). The RUC maintains that the PLI risk for procedures provided under

gynecological/oncology is more akin to general surgery procedures rather than non-surgical OBGYN procedures. **The RUC recommends that CMS again crosswalk Gynecological/Oncology to General Surgery.**

In addition, the RUC is pleased with the CMS decision to partially blend the surgical risk factors for Neurology and Neurosurgery. We agree that it would not be appropriate to simply crosswalk Neurosurgery directly to Neurology due to the incompatibility of the two specialties' rate filing premium data. Therefore, the blended approach, as proposed by CMS, offers the most reasonable approach to adequately account for the PLI premiums and risk associated with surgical services performed by these two specialties.

Cardiac Catheterization and Angioplasty Exception

The RUC is again pleased that CMS proposes to classify cardiac catheterization and angioplasty services as surgical procedures for the purpose of establishing PLI premium rates and risk factors. The RUC also agrees with the CMS decision to include the injection procedures used in conjunction with these services. The AMA discussed the appropriateness of the codes on the exclusion list with relevant stakeholders, and concurred with the other stakeholders that there are several additional codes in the family that have PLI premiums and risks that should instead be classified as surgical rather than non-surgical services.

CPT Code	Long Descriptor
92961	Cardioversion, elective, electrical conversion of arrhythmia; internal (separate procedure)
92986	Percutaneous balloon valvuloplasty; aortic valve
92987	Percutaneous balloon valvuloplasty; mitral valve
92990	Percutaneous balloon valvuloplasty; pulmonary valve
92992	Atrial septectomy or septostomy; transvenous method, balloon (eg, Rashkind type) (includes cardiac catheterization)
92993	Atrial septectomy or septostomy; blade method (Park septostomy) (includes cardiac catheterization)
92997	Percutaneous transluminal pulmonary artery balloon angioplasty; single vessel
92998	Percutaneous transluminal pulmonary artery balloon angioplasty; each additional vessel (List separately in addition to code for primary procedure)

The RUC recommends that CMS consider adding the above list of services to the list of invasive cardiology procedures classified in the "Surgery" risk factor category.

<u>Valuing, New, Revised, and Potentially Misvalued Services</u>

Initiation Year

In an effort to respond promptly to the call for greater transparency in the valuation process, the Centers for Medicare and Medicaid Services (CMS) proposes to shift the consideration of all new, revised and potentially misvalued services to the Proposed Rule (rather than an Interim Final Rule) for implementation in the 2016 Medicare Physician Payment Schedule. Unfortunately, the 2016

implementation date is premature, as it would have a serious impact on the development of new technology and new code bundles which is already underway for the Current Procedural Terminology (*CPT®) 2016 code set*. The cycle for the *CPT 2016* code set began with code change applications for the May 2014 CPT Editorial Panel Meeting submitted by February 14, 2014 and will conclude on February 7, 2015. We believe that it would be highly inappropriate for CMS to implement this proposal in the November 1, 2014 Final Rule because the CPT Editorial process for the 2016 cycle will already be nearly complete by that date and requiring publication in a proposed rule next summer will delay their implementation in Medicare by another year. Those that have solicited new and/or revised CPT codes deserve timely consideration of their applications. They also deserve fair notice of the implementation date. If CMS were to announce a 2017 implementation date on November 1, 2014, it would provide appropriate notification to those submitting code change applications by the first *CPT 2017* deadline of February 13, 2015. **We strongly urge CMS to begin implementing the new timeline and procedures for the CPT 2017 cycle and the 2017 Medicare Physician Payment Schedule.**

CPT/RUC Timeline

The CPT Editorial Panel and the RUC each meet three times per year. Historically, the May CPT/October RUC meetings have been the first meetings of each coding cycle, followed by the October CPT/January RUC meetings, and finally the February CPT/April RUC meetings. Following the last set of meetings, CPT is finalized as a code set for the next calendar year and the RUC submits recommendations to CMS for consideration and implementation. The RUC submits all recommendations no later than May 31 each year for consideration for the next payment schedule. As stated earlier, a CPT code originates with a code change application and the first applications of each cycle are due in February, followed by application deadlines in July and November. The current time required to generate a code/relative value ranges from 14 to 22 months from the time of application.

In order to accommodate the publication of proposed valuation of new, revised and potentially misvalued services, CMS proposes to require that all RUC recommendations be submitted by January 15 of each year. For 2016, this would mean that the May 2014 CPT/September RUC meeting would be the only opportunity for the medical community to offer description and recommended valuation of new technology and code bundles, since the RUC will not have the opportunity to consider codes from the October CPT Editorial Panel meeting until January 29, 2015.

In addition, this proposal would extend the time required to generate a code/relative value to 22 to 30 months for each subsequent *CPT* code set cycle at a time when CMS, the CPT Editorial Panel and the RUC are being asked to reduce the amount of time needed to accommodate changes.

The AMA offered the attached detailed and reasonable proposal to expedite the review processes for new, revised and potentially misvalued services. This proposal would retain the current meeting infrastructure for both CPT and the RUC, while shifting the workflow to accommodate the review of commonly performed services to the May CPT/October RUC and October CPT/January RUC meetings. Under this proposal, the February CPT meeting would predominantly address editorial changes, clinical lab payment schedule services, and new technology services, with expected low volume. The April RUC meeting would replace the formerly lighter September RUC meeting agenda and would be utilized to review the low volume new technology services and discuss methodological and process issues. We believe that CMS should be able to publish consideration of the low volume

new technology codes in the Final Rule as interim values, as these changes would have minimal impact on the other services on the Medicare Physician Payment Schedule. The AMA proposes to submit RUC recommendations to CMS within one month of each meeting (each November and February for new, revised and potentially misvalued; and each May for low volume new technology). **We strongly urge CMS adopt the AMA proposal for modifications in CPT/RUC workflow to accommodate publication in the Proposed Rule, while ensuring that new technology may be described and valued in an efficient and timely manner.**

If CMS adopts the AMA proposal, this will eliminate the need for CMS to create G codes which essentially duplicate the CPT codes. We believe that the G code proposal is entirely unworkable and should not be considered in finalizing the new process. The creation and adoption of temporary G codes would unnecessarily add to the administrative burden of physicians, non-physician practitioners, and providers who would be tasked with having to learn and implement new codes to be replaced within a relatively short period. When this applies to large families of codes, the burden is even greater, as is the risk for coding errors. Moreover, this threatens to create a situation of parallel but distinct coding between Medicare and private payers, as private payers are likely to implement new CPT codes as soon as they are published.

Refinement Process/Appeals Process

CMS proposes to eliminate the Refinement Panel process currently utilized by the Agency to consider comments on interim relative values. For nearly two decades, the CMS Refinement Panel Process was considered by stakeholders to be an appeals process. The Refinement Panel was organized and composed by CMS and consisted of members from the primary care organizations, contractor medical directors, a specialty related to the commenter and the commenting specialty. For many years, CMS deferred to the vote conducted by the Refinement Panel in finalizing values. Most often, the Refinement Panel would support the original RUC recommendations. CMS states that the Refinement Panel was not convened for the former Five-Year Review processes, as this process always involved proposed rulemaking. However, this is not accurate. CMS even convened multi-day face-to-face Refinement Panel meetings during the first two Five-Year Review processes.

Most recently, CMS modified the process to only consider codes for which new clinical information was provided in the comment letter. CMS also began to independently review each of the Refinement Panel decisions in determining which values to actually finalize. In many cases, the Refinement Panel supported the original RUC recommendation and the commenter's request, yet CMS chose instead to implement their original proposed value. The complete elimination of the Refinement Panel indicates that CMS will no longer seek the independent advice of contractor medical officers and practicing physicians and will solely rely on Agency staff to determine if the comment is persuasive in modifying a proposed value. The lack of any perceived organized appeal process will likely lead to a fragmented lobbying effort, rather than an objective review process. Those organizations with limited resources are disadvantaged in comparison to those vendors or organizations that will spend significant resources to overturn a CMS proposed value. **The RUC recommends that CMS consider these issues and create a fair, objective, and consistently applied appeals process that would be open to any commenting organization.**

Chronic Care Management

The RUC supports payment for chronic care management (CCM) services and has worked with the CPT Editorial Panel and the CPT/RUC Complex Chronic Care Workgroup (C3W) to describe and estimate resource costs associated with these important non face-to-face services. The C3W has advocated for separate payment for other non face-to-face services that are critical components of care management, including team conferences, patient education, telephone calls and anticoagulant management. In 2013, CMS implemented payment for transitional care management services (TCM) based on the work of CPT and the RUC. In 2015, CMS will begin payment for CCM services for 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. We appreciate the CMS decision to pay for TCM and CCM services and urge CMS to continue consideration of payment for other non face-to-face services.

In the Proposed Rule, CMS discusses nomenclature for a G code originally proposed in July 2013. **The CPT Editorial Panel has created a new code 99490X for 2015 intended to address the CMS proposal and we urge that CMS use this new CPT code, rather than the G code.** The CPT code does describe the service "per calendar month," rather than the G code description of "per 30 days." The calendar month verbiage will be easier to implement and we urge CMS to recognize this improvement in their recognition of the new CPT code 99490X.

The RUC reviewed survey data from 338 respondents in April and these data were presented to CMS in late May. The RUC recommendation of 1.00 is based on a median physician time of 30 minutes (25^{th} percentile was 20 minutes). We understand that CMS may not have yet had the opportunity to consider the RUC recommendations as the Proposed Rule was drafted prior to the submission of the RUC recommendations. CMS should now consider these survey data and the RUC recommendations to finalize physician work for 2015. Additionally, the RUC recommended that typically 60 minutes of an RN time would be expended each month for these complex patients. CMS proposed 20 minutes of clinical labor time. We urge you to adopt the RUC clinical staff recommendations. The RUC recommendations for CPT 99490X is attached for your consideration. **In addition to implementing the RUC recommendations for 99490X, CMS should also continue to publish, and ideally pay and recognize, the RUC recommended relative values and direct practice expenses for CPT codes 99487 and 99489.**

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,

Barbara S. Levy, MD

cc: RUC Participants, Jessica Bruton, Kathy Bryant, Edith Hambrick, MD, Ryan Howe, Steve Phurrough, MD