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AMERICAN MEDICAL ASSOCIATION

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December 17, 2015

The Honorable Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1631-FC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: File Code-CMS-1631-FC; Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2016 Final Rule; (November 16, 2015).

Dear Acting Administrator Slavitt:

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 2016, published in the November 16, 2015 *Federal Register (Vol. 80, No. 220 FR, pages 70886-71386, November 16, 2015).*

The Final Rule includes a number of policy and technical modifications within the Resource-Based Relative Value Scale (RBRVS). This letter includes RUC recommendations and comments regarding the following:

I. RUC Work Value Recommendations Not Addressed in Final Rule
- **A.** Pre-time Analysis

II. Technical Corrections Needed
- **A.** Global Period Errors
- **B.** Echo Guidance for Ova Aspiration (CPT Code 76948)
- **C.** Errors on Phase In
- **D.** Technical Corrections to Direct PE Inputs

III. Establishing 2016 Interim Final Work Relative Values
- **A.** CMS' Inappropriate Physician Time Ratio Calculation

B. Repair Flexor Tendon (CPT Codes 26356, 26357, and 26358)

C. Esophagogastric Fundoplasty Trans-Oral Approach (CPT Code 43210)

D. Percutaneous Biliary Procedures (CPT Codes 47531, 47532, 47533, 47534, 47535, 47536, 47537, 47538, 47539, 47540, 47541, 47542, 47543, and 47544)

E. Percutaneous Image Guided Sclerotherapy (CPT Code 49185)

F. Genitourinary Catheter Procedures (CPT Codes 50606, 50705, and 50706)

G. Laparoscopic Radical Prostatectomy (CPT Code 55866)

H. Intracranial Endovascular Intervention (CPT Codes 61645, 61650 and 61651)

I. Paravertebral Block Injection (CPT Codes 64461, 64462 and 64463)

J. Ocular Reconstruction Transplant (CPT Code 65780)

K. Trabeculoplasty by Laser Surgery (CPT code 65855)

L. Glaucoma Surgery (CPT Codes 66170 and 66172)

M. Retinal Detachment Repair (CPT Codes 67107, 67108, 67110, and 67113)

N. Fetal MRI (CPT Codes 74712 and 74713)

O. Interstitial Radiation Source Codes (CPT Codes 77778 and 77790)

P. Colon Transit Imaging (CPT Codes 78264, 78265, and 78266)

Q. Reflectance Confocal Microscopy (CPT Codes 96931-96936)

IV. CY 2016 Identification and Review of Potentially Misvalued Services

V. Resource-Based Practice Expense (PE) Relative Value Units (RVUs)
- **A.** Practice Expense Inputs for Digital Imaging Services
- **B.** Clinical Labor Tasks associated with Digital Imaging
- **C.** Pathology Clinical Labor Tasks
- **D.** Methodology for Establishing the Direct PE Inputs Used to Develop PE RVUs
  - **1.** New Supply and Equipment Items
  - **2.** Refinement Table

I. RUC Work Value Recommendations Not Addressed in Final Rule

The RUC noticed that the Pre-Time Analysis recommendations submitted in October 2014 were never addressed. In light of this omission, we have reiterated the recommendation below and attached the associated action plans (*see 00 Addendum - Pre-Time Analysis Action Plans*). The RUC requests that the Agency conduct a full review as soon as possible.

A. Pre-Time Analysis

The RUC continues efforts in identifying and providing recommendations for potentially misvalued services. In January 2014, the RUC identified codes reviewed prior to April 2008 (prior to the creation of pre-time packages) with pre-time greater than *pre-time package 4 Facility - Difficult Patient/Difficult Procedure* (63 minutes), the longest standardized package, for services with 2012 Medicare Utilization over 10,000.

The Relativity Assessment Workgroup noted that all services were valued by magnitude estimation; therefore the readjustments in pre-service time category did not alter the work RVU. Additionally, crosswalks for each service were presented validating the pre-time adjustment recommended. The Workgroup determined that this screen was useful, however the screen did not reveal any large outliers and therefore the utilization threshold does not need to be lowered to identify more services.

In September 2014, the RUC reviewed action plans submitted by the specialty societies and recommended the specific adjustments below. The submitted action plans and pre-time recommendations were also included in the submission attachments and the physician time file sent on October 6, 2014.

CMS did not address these recommendations in Rulemaking for 2015 or 2016. The RUC requests that the Agency consider the pre-time recommendations below in the notice for proposed rulemaking for 2017.

CPT Code	Recommendation	Eval	Positioning	SDW	Total
15002	Maintain work RVU and adjust the times from pre-time package 4 to be consistent with pre-time packages for this family of services.	40	15	15	70
15004	Maintain work RVU and adjust the times from pre-time package 4 to be consistent with pre-time packages for this family of services.	40	15	15	70
15100	Maintain work RVU and adjust the times from pre-time package 4 to be consistent with pre-time packages for this family of services.	40	10	10	60
15240	Maintain work RVU and adjust the times from pre-time package 4 to be consistent with pre-time packages for this family of services.	40	3	10	53
20680	Maintain work RVU and adjust the times from pre-time package 3 to be consistent with pre-time packages for this family of services.	33	15	15	63
22612	Maintain work RVU and adjust the times from pre-time package 4 to be consistent with pre-time packages for this family of services.	40	18	15	73
23412	Maintain work RVU and adjust the times from pre-time package 4 to be consistent with pre-time packages for this family of services.	40	15	15	70
25609 25606 25607 25608	Maintain work RVU and adjust the times from pre-time package 3. Change the pre-time for codes 25606, 25607 and 25608.	33	10	15	58
27134	Maintain work RVU and adjust the times from pre-time package 4 to be consistent with pre-time packages for this family of services.	40	15	20	75
27814	Maintain work RVU and adjust the times from pre-time package 3 to be consistent with pre-time packages for this family of services.	33	10	15	58
29827	Maintain work RVU and adjust the times from pre-time package 3 to be consistent with pre-time packages for this family of services.	33	15	15	63

47562	Maintain work RVU and adjust the times from pre-time package 3 to be consistent with pre-time packages for this family of services.	33	10	15	58
63030	Maintain work RVU and adjust the times from pre-time package 4 to be consistent with pre-time packages for this family of services.	40	18	17	75
63042	Maintain work RVU and adjust the times from pre-time package 4 to be consistent with pre-time packages for this family of services.	40	18	20	78
93641	Maintain work RVU and adjust the times from pre-time package 2B.	33	1	5	39

II. Technical Corrections Needed

The RUC has identified several errors which are detailed below. We anticipate all the changes in this section will be implemented as technical corrections immediately in CMS files to be ready for January 1, 2016 payments.

A. Global Period Errors

Following the publication of the 2016 MFS Final Rule, the AMA notified CMS of the below global period discrepancies:

CPT	Mod	Status	Short Descriptor	Global from CMS - Addendum B	Global on RUC Recommendation
20240		A	Bone biopsy excisional	010	000
43210		A	Egd esophagogastrc fndoplsty	YYY	000
61650		A	Evasc prlng admn rx agnt 1st	ZZZ	000
67227		A	Dstrj extensive retinopathy	090	010
67228		A	Treatment x10sv retinopathy	090	010
73060	TC	A	X-ray exam of humerus	000	XXX
73060	26	A	X-ray exam of humerus	000	XXX
73560	26	A	X-ray exam of knee 1 or 2	000	XXX

RUC Comments:

- The AMA believes these discrepancies to be typos for the following reasons:
    - CMS officials explicitly approved the global period changes for CPT codes 20240, 67227 and 67228 in a communication to the AMA on February 24, 2015.
    - For CPT codes 73060 and 73560, Addendum B lists two separate global periods for these codes depending on the modifier.
    - For CPT code 61650, this service is a base code and not an add-on service, making a ZZZ global incorrect.
    - For CPT code 43210, the RUC recommended and CMS implemented valuation for this service and the Medicare status is active. It would not make sense for the global period to be determined by the carrier (YYY).
- **The RUC believes all of these changes would be technical corrections. We look forward to these issues being corrected immediately in the CMS files and the correct global periods being ready for January 1, 2016 payments.**

B. Echo Guidance for Ova Aspiration (CPT Code 76948)

In the RUC comment letter on the NPRM for CY 2016, the RUC noted a typo for CPT code 76948 *Ultrasonic guidance for aspiration of ova, imaging supervision and interpretation* that was not addressed in the Final Rule for 2016.

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
76948	Ultrasonic guidance for aspiration of ova, imaging supervision and interpretation	0.85	0.56	Disagree

Summary of CMS Actions:

- In the CY 2014 PFS Final Rule, CMS requested additional information to assist them in the valuation of ultrasound guidance codes. They nominated a series of codes as potentially misvalued, which included CPT Code 76948. CPT code 76948 was surveyed by the specialty societies and the RUC issued a recommendation for CY 2016.
- CMS proposed to crosswalk CPT Code 76948 to the work RVU of CPT Code 76945. In the RUC comment letter in response to the Proposed Rule, the RUC indicated that **CPT Code 76945 currently has a work RVU of 0.67, not 0.56 as indicated.**

- CMS finalized the crosswalk of 76948 to 76945 – but still needs to correct the work RVU as it should be 0.67. Additionally, the Final Rule Addendum B has a work RVU of 0.38 for CPT code 76948.

RUC Comments:

- Immediately following the publication of the 2016 MFS Final Rule, the AMA requested a technical correction for CPT Code 76948 (November 3, 2015).

- The RUC fully discussed the comparison of 76948 to key reference services 76945 *Ultrasonic guidance for chorionic villus sampling, imaging supervision and interpretation* (work RVU = 0.67) and 76942 *Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation* (work RVU = 0.67) and noted both reference codes require less physician work. CPT code 76948 requires multiple follicle punctures whereas 76945 and 76942 require one single needle placement.

- **The RUC urges CMS to accept the RUC survey 25th percentile work RVU of 0.85 for CPT code 76948.**

- **The RUC expects that CMS will address the typo in the crosswalk RVU listed for 76945 immediately as a technical correction. We look forward to this issue being corrected immediately in the CMS files and the correct value being ready for January 1, 2016 payments.**

C. Errors on Phase In

- Following the publication of the 2016 MFS Final Rule, the AMA notified CMS of the below errors on phase in:

    - In the same family of retina codes, CPT codes 67108 and 67113 were not included, as others in the family were, in phase in. Thus, the percent change is higher in error.

CPT Code	Short Descriptor	2015 Total FAC RVUs	2016 Total FAC RVUs	FAC Pct Change
67108	Repair detached retina	45.39	30.83	-32%
67113	Repair retinal detach cplx	49.34	38.09	-23%

- **The RUC expects CMS will address these errors immediately in the CMS files and appropriately include CPT codes 67108 and 67113 in phase in to be ready for January 1, 2016 payments.**

D. Technical Corrections to Direct PE Inputs

- Please also find a list of potential technical corrections to direct PE inputs that the RUC has identified in the CMS CY 2016 direct PE input database (*see 01 Addendum – Tech Corrections to CY2016 PE Database*).

III. Establishing 2016 Interim Final Work Relative Values

The RUC appreciates that CMS accepted 76% of the RUC's work relative value recommendations submitted for 2016. However, we have significant concerns regarding the recommendations rejected by CMS, particularly the methodology and rationale utilized for many codes. In preparing the RUC comments, specialties were provided with the opportunity to share additional information for CMS consideration. It is the RUC's 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.

A. CMS' Inappropriate Physician Time Ratio Calculations

Prior to reviewing each individual recommendation in which CMS has disagreed with the RUC recommendation, the RUC would like to outline its concerns over the Agency's growing use of time ratios to determine derived physician work values.

Summary of CMS Actions:

- CMS has, for many codes, opted for an inappropriate ratio calculation to determine the work values for services which have RUC recommended physician time less than the current time.

- CMS employs these ratios seemingly arbitrarily through an inconsistent set of base assumptions, for instance below is a brief review of some of the permutations of the ratio covering the CPT 2016 codes under review:

    - Ratio of total time difference to current work RVU (65780, Final Rule).

    - Ratio of intra-service time difference to current work RVU (65855, 66170, 66172, 67107, Final Rule).

    - Ratio of the sum of intra-service time differences for a bundled code to the sum of the current work RVUs (31652, NPRM).

    - Ratio of the total time difference to RUC recommended work RVU (38570, NPRM).

    - Ratio of the total time difference, in which current total time is Harvard-based (46500, NPRM).

RUC Comments:

- CMS cannot take one modified element and apply an overall ratio reduction based on changes to that single data component; this renders the value no longer resource-based.

- The Agency's inconsistent use of the time ratio methodology has rendered it ineffective for valuation purposes. By choosing the starting base work value and/or physician time at random, CMS is essentially reverse engineering the work value it wants under the guise of a standard algorithm.

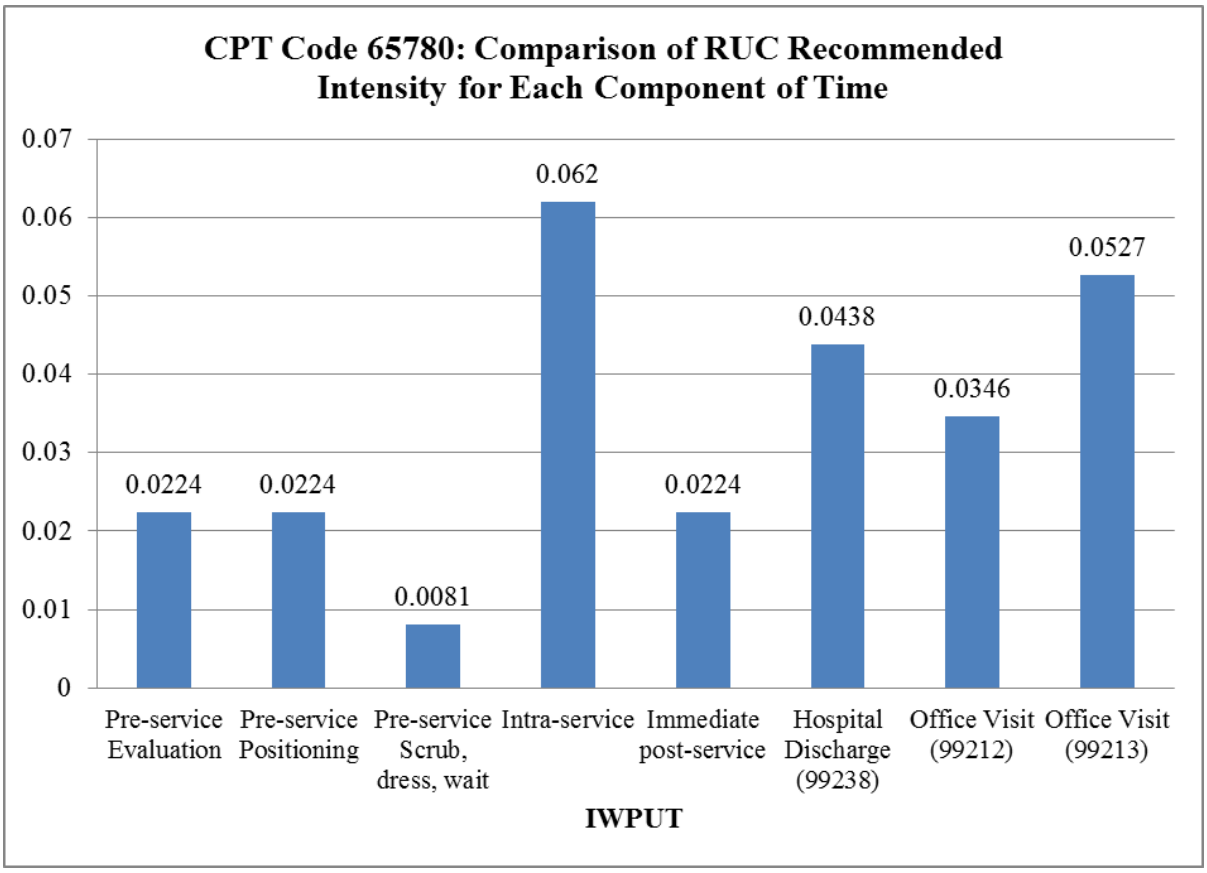
- This rough calculation distills the valuation of this service into a basic formula with the only variable being either the new total physician time or the new intra-service physician time. These methodologies are based on the incorrect assumption that the per minute physician work intensity established is permanent regardless of when the service was last valued.

- Treating all components of physician time (pre-service, intra-service, post-service and post-operative visits) as having identical intensity is incorrect and inconsistently applying it to only certain services under review creates inherent payment disparities in a payment system which is based on relative valuation. Furthermore, when physician times are updated in the Medicare payment schedule, the ratio of intra-service time to total time, the number and level of bundled post-operative visits, the length of pre-service and length of immediate post-service time may all potentially change for the same service *(see 02 Addendum - Ocular Reconstruction Transplant)*. These changing components of physician time make CMS' simplistic formulas have widely variable and inaccurate outputs.

- This valuation methodology also appears to be in opposition to statute Sec. 1848. [42 U.S.C. 1395w–4] (a) (i), which states: The Secretary shall determine a number of work relative value units for the service based on the relative resources incorporating physician time and intensity required in furnishing the service.

    - As an example, in the 2016 NPRM, CMS noted that for CPT code 39402, the Agency scaled the work in accordance with the change in the intraservice times between CPT codes 39401 and 39402. CMS goes on to explain that the work RVU for CPT code 39402 was higher than would be expected based on the difference in time between these two procedures, even considering the more difficult clinical nature of CPT code 39402. Thus, CMS acknowledges the increased intensity of the additional time present in 39402 compared to 39401, but calculates the value based on time only, ignoring the intensity difference.

- Included below is a graph to provide an additional example *(Ocular Reconstruction Transplant, CPT Code 65780*) of why the time ratios referenced by CMS are inappropriate. As graphically displayed, the different components of a physician service have vastly different intensities of physician work and thus comparing only on time is flawed.



- **The RUC urges CMS to correct these inappropriate ratio calculations to accurately reflect relative resources incorporating physician time and intensity required in furnishing services.**

B. Repair Flexor Tendon (CPT Codes 26356, 26357, and 26358)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed Interim RVU	CMS Work RVU Decision
26356	Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (e.g., no man's land); primary, without free graft, each tendon	10.03	9.56	Disagree
26357	secondary, without free graft, each tendon	11.50	10.53	Disagree
26358	secondary, with free graft (includes obtaining graft), each tendon	13.10	12.13	Disagree

Summary of CMS Actions:

- For each of the three CPT codes in the repair of flexor tendon family (26356, 26357 26358) and CMS disagreed with the RUC recommendation citing an anomalous relationship between the drop in intra-service time and the median work RVUs.

    - CMS crosswalked 26356 to 25607 *Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation.*

    - CMS crosswalked 26357 to 27654 *Repair, secondary, Achilles tendon, with or without graft*.

    - For CPT code 26358, CMS maintained the RUC recommended incremental increase 1.60 work RVUs for "with graft" (i.e., 26358-26357).

RUC Comments:

- The RUC again disagrees with the CMS decision to disregard all clinical and compelling evidence presented at the RUC meeting and instead apply an an arbitrary reduction based on a perceived imbalance in the change in time from current to the survey compared to the change in work RVUs. Below are specific concerns for the family of services:

    - CMS completely fails to even acknowledge the flaws in the current physician time for CPT code 26356. The RUC specifically addressed the drop in physician work noting that there is an anomalous relationship between the current work RVU and the imputed time components in the RUC database. Also, in 1995, fabrication of a splint was included in the intra-service work. In the current survey instrument, however, a splint is considered a dressing and is included in the post-service work. This difference would reasonably explain the 30 minute difference in survey time.

    - To value CPT code 26357, CMS used the crosswalk code 27654 *Repair, secondary, Achilles tendon, with or without graft*, which has less total time and results in an inappropriately lower intensity for 26357 compared to 26356. In contrast, the RUC recommended the survey median value which is supported by the top key reference code 23410 *Repair of rotator cuff; acute* (work RVU= 11.39) and seven additional reference codes with similar intra-service time and work RVUs.

    - Finally, the RUC agrees with the Agency's assertion that 1.60 work RVUs is an appropriate work value increment between 26357 and 26358. However, this increment should be applied to the RUC recommended base RVU of 11.50 for 26357.

- **The RUC urges CMS to accept the RUC recommendations work RVUs of 10.03 for 26356, 11.50 for CPT code 26357 and 13.10 for CPT code 26358.**

C. Esophagogastric Fundoplasty Trans-Oral Approach (CPT Code 43210)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed Interim RVU	CMS Work RVU Decision
43210	Esophagogastroduodenoscopy, flexible, transoral; with esophagogastric fundoplasty, partial or complete, includes duodenoscopy when performed	9.00	7.75	Disagree

Summary of CMS Actions:

- CMS disagreed with the RUC recommended median survey work RVU of 9.00, noting that they were unable to identify other CPT codes with identical intra-service time and a work RVU of 9.00 or above. Furthermore, the Agency stated that there were no other approved Esophagogastroduodenoscopy (EGD) codes that were valued as high as 9.00 work RVUs.

RUC Comments:

- The RUC disagrees with the CMS decision for the following reasons:
    - While it is true that no other EGD procedures are valued as high as 9.00, it is also true that only one EGD procedure, 43240, has greater intra-service time. Therefore, it is reasonable that 43210, with greater total time than any procedure in the recently reviewed EGD family should be valued the highest. Furthermore, there are numerous other recently valued endoscopic retrograde cholangiopancreatography (ERCP) endoscopy services which compare favorably to the RUC recommended values.
    - The RUC recommendation compares extremely well with the Key Reference Service 43276 *ERCP; with removal and exchange of stent(s), biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent exchanged* (work RVU= 8.94, intra= 60 minutes). These services have identical intra-service time and intensity and should be valued nearly identically.
    - **Given that the RUC recommendation for CPT code 43210 has several comparators within the lower GI endoscopy family as well as strong survey data, with key reference services that are nearly identical in physician work, CMS should accept the RUC recommended work RVU of 9.00. The RUC also requests Refinement Panel consideration for this service.**

D. Percutaneous Biliary Procedures (CPT Codes 47531, 47532, 47533, 47534, 47535, 47536, 47537, 47538, 47539, 47540, 47541, 47542, 47543, and 47544)

Summary of CMS Actions:

- CMS reviewed the RUC submitted interim recommendations for the percutaneous biliary procedures from the April 2015 RUC meeting and rejected four of the interim RUC recommendations (47540, 47542, 47543 and 47544) and accepted the interim recommendations for the rest of the family.

RUC Comments:

- The RUC notes that CMS rejected the interim RUC recommendations for four codes. However, the RUC submitted revised recommendations for the entire family to CMS following the October 2015 RUC meeting.
    - While we understand that CMS did not have a large amount of time to review these recommendations prior to finalizing the Final Rule, the RUC requests that CMS consider the updated recommendations from the October 2015 submission in the 2017 MPFS and not finalize these outdated interim final recommendations. This is critical because the RUC and specialty societies agreed that the initial survey data from the April 2015 RUC meeting for this family of services was problematic. These services were resurveyed for the October 2015 RUC meeting. Leaving in physician time and work values for services that are known to be flawed is not appropriate, especially in a payment system that is based on relativity.
    - **Therefore, CMS should review the 2015 RUC recommendations for these percutaneous biliary procedures for the 2017 NPRM.** The full recommendations are attached to this comment letter (*see 03 Addendum - Percutaneous Biliary Procedures Bundling*).

E. Percutaneous Image Guided Sclerotherapy (CPT Code 49185)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed Interim RVU	CMS Work RVU Decision
49185	Sclerotherapy of a fluid collection (e.g., lymphocele, cyst, or seroma), percutaneous, including contrast injection(s), sclerosant injection(s), diagnostic study, imaging guidance (e.g., ultrasound, fluoroscopy) and radiological supervision and interpretation when performed	2.78	2.35	Disagree

Summary of CMS Actions:

- CMS did not agree with the RUC recommended direct crosswalk for CPT code 49185. Instead the Agency chose CPT code 62305 *Myelography via lumbar injection, including radiological supervision and interpretation; 2 or more regions (e.g., lumbar/thoracic, cervical/thoracic, lumbar/cervical, lumbar/thoracic/cervical).*

- CMS cites that this procedure is more similar in its complexity to the surveyed code.

RUC Comments:

- The RUC does not agree with the Agency's assertion that 62305 is a better crosswalk than the RUC recommended crosswalk to 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed*. CPT code 31622 was used as the crosswalk for three reasons:

    - The clinical nature of 31622 is analogous to the surveyed code because both are diagnostic studies with imaging included

    - Both services involve performing an analogous procedure (e.g. cell washing compared with sclerosant injection)

    - Both procedures involve the injection procedure repeated at least three separate times

- In contrast, the CMS crosswalk code, 62305, is inappropriate for the following reasons:

    - 62305 involves only a needle, whereas 49185 involves a needle plus placement of a wire, fascial dilator and a catheter

    - 62305 involves a single injection of solution (contrast) whereas 49185 involves the injection of contrast PLUS multiple injections of sclerosant, requiring a greater amount of physician work

    - 62305 is purely a diagnostic procedure, whereas 49185 is both diagnostic and therapeutic, involving greater work, mental effort, technical skill and stress.

- **Given these arguments, CMS should accept the RUC recommended work RVU of 2.78 for CPT code 49185. The RUC also requests Refinement Panel consideration for this service.**

F. Genitourinary Catheter Procedures (CPT Codes 50606, 50705, and 50706)

Summary of CMS Actions:

- The RUC recommended the inclusion of *room, angiography,* (EL011) for this family of Genitourinary Catheter Procedures (GU) codes. CMS states that:

- Since the predecessor procedure codes generally did not include an angiography room and we do not have a reason to believe that the procedure would have shifted to an angiography room in the course of this coding change, we do not believe that the use of an angiography room would be typical for these procedures.

RUC Comments:

- The RUC is not sure what codes CMS is referring to as the predecessor procedure codes in the excerpt above. If CMS is referring to the previously reported codes, than all three CPT code were previously reported using 53899 *Unlisted procedure, urinary system.* This unlisted procedure does not have any PE inputs. The reference code provided is 50387 *Removal and replacement of externally accessible transnephric ureteral stent (e.g., external/internal stent) requiring fluoroscopic guidance, including radiological supervision and interpretation* which includes a *room, angiography,* (EL011) and other codes that are being bundled together to create these new GU codes do include a *room, angiography,* (EL011) as well.

- The RUC disagrees with CMS' refinement to assign this new GU family of procedures to a radiographic-fluoroscopic (R/F) room instead of an angiography room.

  - It is important to note that an R/F device is incapable of 3-axis rotational imaging. An R/F room (fixed imaging plane) is not conducive to performance of these procedures because it cannot image the target surgical field in multiple obliquities except by moving the patient (rolling from side to side). However, rolling the patient is impractical and dangerous while the patient is sedated.

  - Just as importantly, while performing these procedures, the patient must not physically move to avoid physical injury from the needles and other tools used during the procedure.

  - Sterility is also a major concern in an R/F room where the fixed imaging chain is not amenable to standard surgical sterile preparation. Additionally, an R/F room would create unacceptable radiation exposure to the physicians, their staff, and their patients, which would be contrary to ALARA principles of minimized patient radiation dose.

- The typical imaging equipment utilized for this family of GU procedures are the items included in CMS' angiographic room. The only piece of equipment listed in the angiography room that is not typically utilized for these procedures is the *Injector*, *Provis*. All of the other items are used for these GU procedures.

- **The RUC urges CMS to include *room, angiography,* (EL011) for this family of Genitourinary Catheter Procedures (GU) codes. The RUC also requests Refinement Panel consideration for this service.**

G. Laparoscopic Radical Prostatectomy (CPT Code 55866)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
55866	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed	26.80	21.36	Disagree

Summary of CMS Actions:

- CMS disagreed with the survey 25th percentile work RVU of 26.80 for CPT code 55866 and recommended a crosswalk to the key reference service 55840 *Prostatectomy, retropubic radical, with or without nerve sparing* (work RVU = 21.36).

RUC Comments:

- In the Final Rule for 2014, CMS noted that the majority of commenters indicated that it was appropriate that the work RVUs be higher for CPT code 55866 than for CPT code 55845 *Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes* (work RVU = 25.18). The CMS interim-final work RVU for 2016 is much lower than 25.18 and may cause a rank order anomaly.
    - Crosswalk code 55840 is not a laparoscopic procedure and includes nerve sparing when performed and does not include robotic assistance, therefore should not be valued exactly the same as 55866.
    - CPT Code 55866 requires more skill and competency even though it requires similar time as 55840. The intensity scoring by the survey respondents determined that the 55866 was more complex than the 55840. The respondents chose code 55840 as the key reference service because this was the closest procedure to "removing a prostate", however the physician work of the two procedures is totally different. The RUC instructions advise respondents to choose the code that is closest in work to the surveyed code and then determine the work RVU based on the key reference code. There was no laparoscopic/robotic code on the reference list so by default the survey respondents chose 55840 because the outcome was the same.
    - CMS should not discount the survey intensity and complexity comparison gauged by the respondents by choosing to crosswalk to a lower value without providing clinical evidence to support that the physician work is exactly the same.

- The RUC provided five additional reference codes to support the survey recommended value. 50543 *Laparoscopy, surgical; partial nephrectomy* (work RVU = 27.41 and 240 minutes intra-service time), 23473 *Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component* (work RVU = 25.00), 32670 *Thoracoscopy, surgical; with removal of two lobes (bilobectomy)* (work RVU = 28.52) and 43281 *Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh* (work RVU = 26.60).

- **The RUC urges CMS to accept the survey 25th percentile work RVU of 26.80 for CPT code 55866. The RUC also requests Refinement Panel consideration for this service.**

H. Intracranial Endovascular Intervention (CPT Codes 61645, 61650 and 61651)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
61645	Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic angiography, fluoroscopic guidance, catheter placement, and intraprocedural pharmacological thrombolytic injection(s)	17.00	15.00	Disagree
61650	Endovascular intracranial prolonged administration of pharmacologic agent(s) other than for thrombolysis, arterial, including catheter placement, diagnostic angiography, and imaging guidance; initial vascular territory	12.00	10.00	Disagree
61651	Endovascular intracranial prolonged administration of pharmacologic agent(s) other than for thrombolysis, arterial, including catheter placement, diagnostic angiography, and imaging guidance; each additional vascular territory (List separately in addition to the primary code)	5.50	4.25	Disagree

Summary of CMS Actions:

- CMS refined the physician times for certain codes based on the Agency's policy related to 23-hr outpatient surgical codes with post-operative visits (first implemented for CY 2011). For codes the Agency classified as 23-hour stay outpatient services, they removed a subsequent hospital visit and instead added the hospital visit's intra-service time to the immediate post-service time of the procedure. The Agency applied these physician time refinements to codes 61645 and 61650.

- CMS states that it believes that CPT codes 61645, 61650 and 61651 would be considered outpatient hospital services and therefore refined the work time for 61645 and 61650 and value for all three codes.

RUC Comments:

- CMS's assumption is flawed as CPT codes 61645, 61650 and 61651 were previously reported with inpatient services 37184 (66% Inpatient Hospital), 36224 (58% Inpatient Hospital) and 36228 (84% Inpatient Hospital), all based on 2014 Medicare claims data, as indicated in the summary of recommendation forms previously submitted.

    - The new intracranial endovascular intervention codes (61645, 61650 and 61651) are typically performed on acute stroke patients and **are performed in the inpatient hospital**. Therefore, the Agency's 23-hour outpatient policy was inappropriately applied to these services and the physician times for 61645 and 61650 were inappropriately revised. Additionally, 100% of the RUC survey respondents indicated that this service is performed in an inpatient setting.

    - The codes CMS used as crosswalks are inappropriate because they are outpatient codes. If fact, CPT Code 37231, which CMS used to lower the value of 61645, is predominately an office code (52%).

    - The RUC practice expense recommendation further confirms "CPT codes 61645-61651 are facility-only codes therefore the RUC does not have any direct practice input recommendations".

- Due to CMS' flawed assumption regarding the site of service, the reduction in physician time and work associated with the 99233 is inappropriate. This underestimates the time and intensity of the follow up visit which requires the physician to assess the patient's neurologic condition and review interval chart notes, record patient progress, write orders for imaging and labs, answer family questions, and discuss ongoing care with the ICU/stroke unit team.

- CMS should use the data surveyed by over 50 physicians and supported by the extensive review of the RUC. **The RUC urges CMS to accept the survey 25th percentile work RVUs of 17.00 for 61645, 12.00 for 61650 and 5.50 for 61651.**

PLI Crosswalks

Summary of CMS Actions:

- CMS refined the RUC-recommended malpractice crosswalks for this family of codes to align with the specialty mix that furnish the services in this family.

- CMS established the following interim final malpractice crosswalks in place of the RUC-recommended malpractice crosswalks: CPT code 37218 to CPT code 61645; and CPT code 37202 to CPT codes 61650 and 61651.

RUC Comments:

- **The CMS recommended malpractice crosswalks do not represent the specialty mix that will perform these services.**
    - The specialty mix for new services 61645, 61650 and 61651 will be approximately 75% neurosurgery and 25% diagnostic radiology. The RUC recommended PLI crosswalk for all three services was 61791 (80% neurosurgery and 18% diagnostic radiology), which is in line with the specialty mix for the three new services.
    - CMS's recommended malpractice crosswalk of 37218 for 61645 is not appropriate because 37218 was new for 2015 and the specialty mix is not yet known, but was predicted to be 25% diagnostic radiology, 20 % neurosurgery and 20% vascular surgery. This specialty mix is not comparable to who will be performing 61645.
    - CMS's recommended malpractice crosswalk of 37202 for 61650 and 61651 is not appropriate because the specialty mix is 34% cardiology, 21% vascular surgery and 12% general surgery. Neurosurgery will be the dominant specialty performing 61650 and 61651 and only perform about 5% of the CMS recommended crosswalk 37202.
- **The RUC urges CMS to accept the malpractice crosswalk of 61791 for codes 61645, 61650 and 61651 which accounts for the appropriate specialty mix. The RUC also requests Refinement Panel consideration for this service.**

I. Paravertebral Block Injection (CPT Codes 64461, 64462 and 64463)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
64461	Paravertebral block (PVB) (paraspinous block), thoracic; single injection site (includes imaging guidance, when performed)	1.75	1.75	Agree
64462	Paravertebral block (PVB) (paraspinous block), thoracic; second and any additional injection site(s), (includes imaging guidance, when performed)	1.10	1.10	Agree
64463	Paravertebral block (PVB) (paraspinous block), thoracic; continuous infusion by catheter (includes imaging guidance, when performed)	1.90	1.81	Disagree

Summary of CMS Actions:

- CMS' interim final crosswalk for CPT 64463 is flawed as CPT code 64463 includes imaging guidance when performed and those referenced continuous injection of anesthetic agent codes (64416, 64446 and 64449) do not account for this.

RUC Comments:

- A physician work RVU of 0.09 more for 64443 appropriately reflects the physician work and intensity associated with the paravertebral block and possible imaging guidance.
    - The RUC argues that 64443 is more comparable to the key reference service 64483 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level* (work RVU = 1.90), which requires the same physician work and time to perform.
- CMS should use the valid survey data and supported by the extensive review of the RUC. **The RUC urges CMS to accept the survey 25th percentile work RVU of 1.90 for CPT code 64463. The RUC also requests Refinement Panel consideration for this service.**
- Additionally, there is a **typo** in the Federal Register/Vol. 80, No. 220/ page 71055. "We believe a direct crosswalk from three other injection codes which all have a work RVU of 1.81 (CPT codes ~~64461~~ 64416, 64446, and 64449) more accurately reflects the work involved in furnishing this service." **The numbers were transposed and should be 64416 not 64461.**

J. Ocular Reconstruction Transplant (CPT Code 65780)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
65780	Ocular surface reconstruction; amniotic membrane transplantation, multiple layers	8.80	8.00	Disagree

Summary of CMS Actions:

- CMS derived the interim-final work RVU for CPT code 65780 by simply multiplying the current work RVU by the ratio between the RUC recommended total time and the existing total time from 2003 (8.00 RVUs= 10.73 RVUs X (230 minutes /316 minutes).

RUC Comments:

- The Agency's rough calculation distills the valuation of this service into a basic formula with the only variable being the new total physician time. This methodology is based on the incorrect assumption that the per minute physician work intensity established is permanent regardless of when the service was last valued (2003 in this case).

    - The RUC would like to reiterate that different components of a physician service have vastly different intensities of physician work. The RUC recommended IWPUT for the intra-service time component of this service is 0.062, whereas other components of the physician time have established IWPUTs that are up to 7.5 times lower, as displayed in the above graph (*see Section III, A. CMS' Inappropriate Ratio Calculatio*n) in this letter.

    - The proportion of the physician time components with an IWPUT of greater than 0.05 increased from 19% of the current physician time to 42% of the new physician time. In addition, the proportion of physician time components with an intensity of 0.0224 or lower went from 75% of the current physician time to 50% of the new physician time. A full breakdown of the change in physician time is provided in the included charts *(see 02 Addendum - Ocular Reconstruction Transplant).*

- With a higher proportion of physician time shifting to the more intense skin-to-skin time and a higher office visit level (99212 to 99213), using a total time ratio to reduce the work RVU is inappropriate.

- Treating all components of physician time (pre-service, intra-service, post-service and post-operative visits) as having identical intensity is incorrect and inconsistently applying it to only certain services under review creates inherent payment disparities in a payment system which is based on relative valuation.

- **The RUC recommends for CMS to reconsider its decision to not accept the RUC recommendation for CPT code 65780 listed in the table above. The RUC also requests Refinement Panel consideration for this service.**

K. Trabeculoplasty by Laser Surgery (CPT code 65855)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
65855	Trabeculoplasty by laser surgery	3.00	2.66	Disagree

Summary of CMS Actions:

- CMS selected ratio calculation discounts the relative resources incorporating physician time and intensity required in furnishing the service.

RUC Comments:

- CMS cannot take one element that changed and apply an overall ratio reduction based on changes to intra-service time; this renders the value no longer resource-based.

- The RUC recommendation already accounted for the reduction in physician intra-service time and post-operative visit.

- CMS' recommended work RVU lacks relativity to other similar services.

- **The RUC urges CMS to accept the survey 25th percentile work RVU of 3.00 for 65855**, which correlates accurately to the key reference service 66761, with the same work RVU, intra-service time (10 minutes) and similar total time (66 minutes for 66761 and 61 minutes for 65855). **The RUC also requests Refinement Panel consideration for this service.**

L. Glaucoma Surgery (CPT Codes 66170 and 66172)

CPT Code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
66170	Fistulization of sclera for glaucoma; trabeculectomy ab externo in absence of previous surgery	13.94	11.27	Disagree
66172	Fistulization of sclera for glaucoma; trabeculectomy ab externo with scarring from previous ocular surgery or trauma (includes injection of antifibrotic agents)	14.81	12.57	Disagree

Summary of CMS Actions:

- CMS selected ratio calculation discounts the relative resources incorporating physician time and intensity required in furnishing the service.

RUC Comments:

- CMS cannot take one element that changed and apply an overall ration reduction based on changes to intra-service time; this renders the value no longer resource-based.

- CMS' recommended work RVU lacks relativity to other similar services. The two services referenced (44900 and 59100) are not comparable to 66170 and 66172. The referenced services do not require the same intensity and complexity and only account for half of the post-operative services required with 66170 and 66172 to avoid permanent vision loss for the patient.

- CMS referenced codes 44900 and 59100 are not services identified by the RUC on the Multi-Specialty Points of Comparison List.

- The RUC provided five reference codes for both 66170 and 66172, including MPC codes, to support the survey 25th percentile results. Codes 66180 (work RVU = 15.00), 66183 (work RVU = 13.20), 53445 (work RVU = 13.00), 52649 (work RVU = 14.560 and 52601 (work RVU = 15.26).

- CMS should use the data surveyed by 74-88 physicians and supported by the extensive review of the RUC. **The RUC urges CMS to accept the survey 25th percentile work RVU of 13.94 for 66170 and 14.81 for 66172**. **The RUC also requests Refinement Panel consideration for this service.**

M. Retinal Detachment Repair (CPT Codes 67107, 67108, 67110, and 67113)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
67107	Repair of retinal detachment; scleral buckling (such as lamellar scleral dissection, imbrication or encircling procedure), including, when performed, implant, including, when performed, cryotherapy, photocoagulation, and drainage of subretinal fluid	16.00	14.06	Disagree
67108	Repair of retinal detachment; with vitrectomy, any method, including, when performed, air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique	17.13	15.19	Disagree
67110	Repair of retinal detachment; by injection of air or other gas (e.g., pneumatic retinopexy)	10.25	8.31	Disagree
67113	Repair of complex retinal detachment (e.g., proliferative vitreoretinopathy, stage C-1 or greater, diabetic traction retinal detachment, retinopathy of prematurity, retinal tear of greater than 90 degrees), with vitrectomy and membrane peeling, including, when performed, air, gas, or silicone oil tamponade, cryotherapy, endolaser photocoagulation, drainage of subretinal fluid, scleral buckling, and/or removal of lens	19.00	19.00	Agree

Summary of CMS Actions:

- *67107:* Multiplying the current work RVU by the ratio between the RUC recommended intra-service time and the existing intra-service time (14.06 RVUs= 16.71 RVUs X (90 minutes /107 minutes).

- *67108:* Adding the 1.13 RVU increment, between the RUC recommendations for 67108 and 67107, to the CMS derived work RVU for 67107, resulting in a new RVU of 15.09.

- *67110:* Subtracting the 5.75 RVU increment, between CPT code 67107 and 67110, from the CMS derived work RVU for 67107, resulting in a new RVU of 8.31.

RUC Comments:

- CMS' reliance on existing time to derive new proposed work values for these potentially misvalued service is misguided, as the existing physician times were last determined by the Harvard study over 20 years ago. These reductions appear arbitrary and punitive. By accepting some increments and rejecting others, CMS has not only established inconsistencies within the family of codes, but potentially opened up anomalies across a wide range of services.

- In addition, the new IWPUT values for these three services are inappropriately low with the most egregious being 0.064 for CPT code 67110, putting the physician work intensity of that service in the same range as mid-level office visits. Furthermore, if the RVUs for the CMS-accepted post-operative visits were backed out of the interim-final work RVU for 67110, that would only leave 2.49 RVUs for the 58 minutes of very intense surgical work.

- **The RUC recommends for CMS to reconsider its decision and accept the RUC recommendation for CPT code 67107, 67108 and 67110 listed in the table above.**

- The RUC does not agree with CMS using work RVU increments added to or subtracted from the calculated work RVU for 67107, as it is no longer the appropriate magnitude estimation when the work RVU of 67107 is adjusted to an inappropriate value.

- **The RUC recommends that CMS use magnitude estimation, instead of inappropriate calculations to arrive at work RVUs for CPT codes 67107, 67108 and 67110. The RUC urges CMS to accept work RVUs of 16.00 for code 67107, 17.13 for 67108 and 10.25 for CPT code 67110. The RUC also requests Refinement Panel consideration for this service.**

N. Fetal MRI (CPT Codes 74712 and 74713)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
74712	Magnetic resonance (e.g., proton) imaging, fetal, including placental and maternal pelvic imaging when performed; single or first gestation	3.00	3.00	Agree
74713	Magnetic resonance (e.g., proton) imaging, fetal, including placental and maternal pelvic imaging when performed; each additional gestation (List separately in addition to code for primary procedure)	1.85	1.78	Disagree

Summary of CMS Actions:

- CMS rejected the RUC's recommendation for the median work RVU and instead proposed the 25th percentile work RVU for 74713. The Agency stated their belief that "the ratio of work to time for these codes" should be similar to these services.

RUC Comments:

- By changing its evaluation process to focusing primarily on the relationship between work and total time for certain services, the Agency has overlooked important clinical information, as is the case for this code family.
    - The typical patient for this service is a woman pregnant with monochorionic diamniotic twins, as 93% of the RUC survey respondents agreed.
    - When comparing CPT codes 74712 and 74713, the intensity of an additional fetus would be greater as twin gestations have a higher incidence of congenital anomalies and propensity for ischemic brain injury, especially in the presence of twin-to-twin transfusion.
    - Twin gestations are more difficult to image, given increased motion artifact of two fetuses versus one.
- **The RUC urges CMS to accept work RVUs of 1.85 for code 74713. The RUC also requests Refinement Panel consideration for this service.**

O. Interstitial Radiation Source Codes (CPT Codes 77778 and 77790)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
77778	Interstitial radiation source application, complex, includes supervision, handling, loading of radiation source, when performed	8.78	8.00	Disagree
77790	Supervision, handling, loading of radiation source	0.00	0.00	Agree

Summary of CMS Actions:

- CMS questioned the difference between the physician times from the raw survey data relative to the RUC recommended physician times, noting that the times were reduced whereas the median work RVU from the survey was recommended. Therefore, CMS proposed a work RVU of 8.00 which was the survey 25th percentile.

RUC Comments:

- The RUC and CMS have used standardized pre-service time packages for several years now. Virtually all 000-day, 010-day and 090-day services have a difference between the raw survey pre-service time and the standardized pre-service time package; identifying this for an individual service while at the same time accepting it for the vast majority of other services over the past several years is inconsistent with the vast majority CMS decisions in current and past rulemaking.

    - The work for 77790 was unbundled from CPT code 77778. The reduction in work RVUs from 11.32 to 8.78 already fully accounts for this unbundling.

    - RUC recommendations are based on magnitude estimation and detailed review of the clinical work involved in performing a service. In this instance, the RUC determined that the survey respondents accurately estimated the work RVU based on magnitude estimation while overestimating the relatively low intensity pre-service time involved in performing this service.

    - The RUC compared the survey code to the second key reference service 41019 *Placement of needles, catheters, or other device(s) into the head and/or neck region (percutaneous, transoral, or transnasal) for subsequent interstitial radioelement application* (work RVU of 8.84, intra-service time of 90 minutes) and noted that both services have identical intra-service time and post-service time and should be valued similarly. To further justify a work RVU of 8.78 for the survey code, the RUC reviewed CPT code 52355 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with resection of ureteral or renal pelvic tumor* (work RVU of 9.00, intra-service time of 90 minutes) and noted that both services have identical intra-service time and similar intensities and therefore should be valued similarly.

- **The RUC recommends for CMS to reconsider its decision to not accept the RUC recommendation for CPT code 77778 and to accept work RVUs of 8.78. The RUC also requests Refinement Panel consideration for this service.**

P. Colon Transit Imaging (CPT Codes 78264, 78265, and 78266)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
78264	Gastric emptying imaging study (e.g., solid, liquid, or both);	0.80	0.74	Disagree
78265	Gastric emptying imaging study (e.g., solid, liquid, or both); with small bowel transit, up to 24 hours	0.98	0.98	Agree
78266	Gastric emptying imaging study (e.g., solid, liquid, or both); with small bowel and colon transit, multiple days	1.08	1.08	Agree

Summary of CMS Actions:

- CMS mistakenly observed that "CPT code 78264 has a higher recommended work RVU and a shorter intraservice time relative to the other codes in the family." CMS also highlighted the reduction in intra-service time from 12 minutes to 10 minutes.

- CMS proposed a work RVU of 0.74 by directly crosswalking to CPT code 78226 (Hepatobiliary system imaging, including gallbladder when present), noting that both codes have intraservice time of 10 minutes and their belief that both services have similar intensity.

RUC Comments:

- CMS' rationale is primarily based on the incorrect observation that "CPT code 78264 has a higher recommended work RVU and a shorter intraservice time relative to the other codes in the family." The RUC recommended work RVUs for these services were 0.80 for 78264, 0.98 for 78265 and 1.08 for 78266.

- When working with estimates of time, a change in the median intra-service time of only 2 minutes should not be used as the remaining sole rationale for rejecting a RUC recommendation.

- **The RUC urges CMS to accept the RUC recommendation for CPT code 78264 and urges CMS to accept work RVUs of 0.80. The RUC also requests Refinement Panel consideration for this service.**

Q. Reflectance Confocal Microscopy (CPT Codes 96931-96936)

Summary of CMS Actions:

- In the CY 2016 Final Rule, CMS proposed for reflectance confocal microscopy codes 96931-96936 to be carrier priced for CY 2016 as the Agency did not yet have the opportunity to review the RUC recommendations submitted for this new family of services in October 2015.

RUC Comments:

- The RUC resubmitted the recommendation attached to this comment letter (*see 04 Addendum – Reflectance Confocal Microscopy*). The RUC would appreciate the Agency's consideration as soon as possible

IV. CY 2016 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 1,900 codes and resulted in nearly $4 billion in redistribution within the Medicare Physician Payment Schedule. A report of the RUC's progress in this project is attached to this letter (*see 05 Addendum - Progress of Relativity Assessment Workgroup November 2015*).

- In the Final Rule, CMS revised the list of codes identified as potentially misvalued in a proposed rulemaking "High Expenditure" screen based on comments received. The RUC is prepared to start reviewing these services at the January 2016 RUC meeting.

- The RUC will also review other potentially misvalued services in which CMS is seeking public comment.

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

A. Practice Expense Inputs for Digital Imaging Services

- The RUC agrees with CMS' decision to update the price for the PACS workstation to $5,557 from the current price of $2,501 since the latter price was based on the proxy item and the former based on submitted invoices.

- We appreciate that CMS acknowledges that the professional workstations for interpretation of digital images are similar in principle to some of the previous direct film inputs incorporated into the global and technical components of the codes, and that it may be appropriate to include these costs as direct inputs for the associated CPT codes.

- The RUC defers to the radiology specialties to determine the services that require this equipment.

B. Clinical Labor Tasks associated with Digital Imaging

- The RUC appreciates that CMS accepted our recommendation to maintain line item, *Technologist QC's images in PACS, checking for all images, reformats, and dose page*, as a nonstandard clinical staff activity.

- CMS has requested comment on establishing several different standard times for this clinical labor task for a low/medium/high quantity of images to be reviewed, in future rulemaking. Although, The RUC agrees that defining standards for specific clinical labor activities has value in maintaining the relativity of direct PE inputs, we maintain that for *Technologist QC's images in PACS, checking for all images, reformats, and dose page,* the number of minutes varies significantly for different modalities and the time is not simple based on the quantity of images to be reviewed.

- If there were a standard, the appropriate time would need to be defined for each modality, recognizing that even within the same modality, QC times could vary based on the complexity of the examination. This would be confusing and add unnecessary complexity.

- **The RUC recommends that this line item remain nonstandard and that the specialty continues to have the opportunity to use their clinical judgment and expertise to make a recommendation of the appropriate number of minutes.**

C. Pathology Clinical Labor Tasks

- The RUC appreciates CMS' acknowledgment that batch size and number of blocks play an important role in the labor time of clinical staff. We support submission of detailed information regarding batch size and number of blocks as part of the RUC's PE submission for Pathology services.

- The RUC will work with the Pathology specialties to be able to include that information moving forward. As stated in our comments in response to the proposed rule, the RUC does not support the standardization of clinical labor activities across all pathology services, as each pathology service encompasses distinct and unique clinical labor tasks. We recognize that it may be possible to establish some clinical labor standards for pathology services on a "per block" or "per batch size" basis, however we defer comment on how best to do this to the Pathology specialties.

- The RUC understands CMS' concern about consistencies across the codes that the specialty performs.

- The RUC agrees that some of the clinical labor times that CMS has standardized may be appropriate for some pathology services; however the RUC maintains that it is not appropriate to standardize all clinical labor activities across Pathology and **urges CMS to limit standardization to the PE direct inputs listed in this final rule.**

D. Methodology for Establishing the Direct PE Inputs Used to Develop PE RVUs

1. New Supply and Equipment Items

- The RUC appreciates CMS' acceptance of the recommendation to create a new equipment code, *radiofrequency generator (Gyrus ENT G3 workstation)* (EQ374), for the radiofrequency generator used in otolaryngology CPT codes 41530, 43228, 43229, and 43270 and maintenance of the current pricing for *radiofrequency generator (NEURO)* (EQ214) impacting CPT codes 64633, 64634, 64635, and 64636.

2. Refinement Table

- 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 16, however there are many instances where the RUC disagrees with the refinements. Please see a complete list of the *CY 2016 Interim Final Codes with Direct PE Input Recommendations Accepted With Refinements* with specialty society comments in the attached table (*see 06 Addendum - CY2016 - CMS FR PE Refinements w-spec comment*).

Thank you for your careful consideration of the RUC's comments on the CMS Final Rule on the revisions to Medicare payment policies under the Physician Payment Schedule for calendar year 2016, published in the November 16, 2015 *Federal Register (Vol. 80, No. 220 FR, pages 70886-71386, November 16, 2015)*. Please do not hesitate to contact the RUC with questions about our recommendations and comments. We appreciate the continued opportunities to offer recommendations to improve the RBRVS.

Sincerely,

Peter K. Smith, MD

cc: RUC Participants
Edith Hambrick, MD
Ryan Howe
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