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September 3, 2015

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

Re: File Code-CMS-1631-P; Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2015 NPRM; (July 15, 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) Notice of Proposed Rule Making (NPRM) on the revisions to Medicare payment policies under the Physician Payment Schedule for calendar year 2016, published in the July 15, 2015 *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)

PE RVU Methodology - Create the Indirect Cost PE RVUs

The RUC appreciates CMS continued attention to the PE RVU methodology and efforts to increase the stability of PE RVUs. We agree with CMS that although there are advantages to using the most recent year of Medicare claims data to determine specialty mix, overall it results in too much fluctuation from year to year especially for low-volume and new services. We are enthusiastic about the idea of using an average of three years of the most recent available Medicare claims data. However, for codes that are very low volume in the Medicare population, the dominant specialty(ies) should be assigned. The RUC has the expertise to assist with this work and the Agency should continue to utilize this expertise in these assignments.

Changes to Direct PE Inputs for Specific Services

PE Inputs for Digital Imaging Services

The RUC appreciates CMS' proposal to create a direct practice expense (PE) input for the picture archiving and communication system (PACS), instead of continuing to rely on the proxy input, *desktop computer*, ED021. CMS' continued solicitation of invoices in order to determine correct pricing for the new PACS input is also much appreciated. The RUC agrees that the proposed increase in price of the PACS from $2,501 for the proxy to $5,557 based on invoice information is a more accurate price. This is a positive improvement however the RUC agrees with the specialty that, the price of $5,557 only reflects the amount of the invoices provided for the "Technologists workstation" but does not capture the appropriate pricing for the "Rad (professional) Workstation." The RUC believes both the technologist and

the professional workstations are components of a PACS system and should both be considered direct expenses within the PE Methodology. The professional workstation is a direct expense for the following reasons:

- The station is used for individual studies "one at a time" in the office (non-facility) setting;
- This involves a bi-directional exchange between technologist and radiologist while the patient is still on the table and the technical component (TC) is being provided;
- For the subsequent interpretation, the professional workstation is often provided in the same office and typically provided by the same practice. Therefore, the provider providing the technical component and the interpreting physician share the same Tax Identification Number;
- Considering the professional workstation a direct expense follows the precedent established by the prior film based inputs and subsequently replaced by the digital inputs. Supply items such as alternators and film are analogous to a professional workstation and necessary for the service performed.

The CPT descriptor for code 76377 *3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation* indicates that 76377 requires "image post-processing on an independent workstation." Although the RUC included *computer workstation, 3D reconstruction CT-MR* (ED014) in its recommendation to be removed for digital imaging services, this independent workstation is separate from the PACS system. Due to the RUC recommendation, ED014 is no longer in the CMS equipment direct PE inputs list. The RUC recommends that this equipment item be restored and the appropriate clinical staff time of 38 minutes should be assigned to it. In addition the RUC recommends that 38 minutes for the PACS equipment should also be maintained as a separate direct expense as there are additional PACS related activities specific to the 3-D images after they have been created on the 3-D reconstruction computer.

Clinical Labor Tasks associated with Digital Imaging

The RUC agrees that defining standards for specific clinical labor activities has value in maintaining the relativity of direct PE inputs and to that end, CMS seeks comment regarding the appropriate standard minutes for clinical labor tasks associated with services that use digital technology. The Migration from Film to Digital Imaging Workgroup intentionally only recommended the clinical labor activities and not the number of minutes that imaging services require. Previously the RUC was not in favor of standard times for imaging clinical staff activities and the RUC recommended that the specialties should have an opportunity to determine the appropriate inputs at the individual distinct service level. The RUC did this because they determined that there was too much variability across imaging modalities to propose a standard. The clinical labor activities were subsequently integrated into "PE Worksheets" used by the RUC and CMS. This includes the five activities included in Table 5 of the NPRM, the first two of which are pre-service activities and the next three of which are post-service activities.

Although the RUC holds to its previous position that a range of times across modalities are appropriate for these clinical labor inputs, CMS has made it clear in the NPRM that they are planning to implement a standard. Even though no formal recommendations for clinical labor activities standard minutes have previously been provided, the RUC agrees that four of the five clinical labor activity minutes proposed by CMS in Table 5, are representative across imaging and could appropriately be used as standard times. However, for Technologist QC's images in PACS, checking for all images, reformats, and dose page, the RUC strongly disagrees with the number of minutes that CMS has included as typical. For this clinical

labor activity the number of minutes varies significantly for different modalities. For example, a cardiac MR with hundreds of images would require more quality control (QC) time than a single view x-ray of the chest. The RUC does not have standard times for every activity on the PE spreadsheet and maintains that even if standard times are implemented for the other digital imaging clinical labor activities, there should not be a standard for this line item. 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.

Pathology Clinical Labor Tasks

The RUC does not support the standardization of clinical labor activities across pathology services. The RUC understand CMS concern about consistencies across the codes that the specialty performs, and it may be possible to standardize across codes with the same batch sizes, however codes within a family may have different batch sizes. For instance, CMS has proposed to create a standard clinical labor time of three minutes for the task "Assist pathologist with gross specimen examination." This standard time may make sense for 88305 (Level IV - Surgical pathology, gross and microscopic examination), a two-block procedure with a previous time for that task of three minutes. However, this standard makes much less sense for a code in the same family, 88309 (Level VI - Surgical pathology, gross and microscopic examination), which is an 18-block procedure and has a RUC and CMS approved time for this task of 20 minutes. The sizes of these two procedures are incompatible with a single standard time. The RUC disagrees with the standardized clinical labor activity times as currently proposed, and urges CMS to consider pathology-specific details, such as batch size and block number, in the creation of any future standard clinical labor activity time.

Clinical Labor Task: "Complete Botox Log"

The RUC maintains that the clinical labor activity of complete Botox log is a direct resource cost for the services it was recommended for and is medically reasonable. The clinical activity was removed through PE refinement for CPT codes 64616, 64617, 64642, 64643, 64644, 64645 and 64647 for CY 2014, but was not removed for CPT codes 64612 and 64615 for CY2015. The RUC requests that the clinical labor activity be restored to all of the codes. Botox comes in 100 unit vials that are opened and used the same day. In the CMS Botox instructions, it is explicit that providers should split vials in order to reduce cost. In order for providers to do this it is critical to maintain accurate bookkeeping which is accomplished by the clinical staff in the direct PE input, *complete botox log*.

Request for Information on Nonfacility Cataract Surgery

The RUC defers to the ophthalmology specialty societies regarding whether or not it is appropriate to furnish cataract surgery in the nonfacility setting. If CMS determines that nonfacility setting direct PE inputs are needed in order to develop PE RVUs in the office, the RUC will review the specialty society recommendations for direct practice expense inputs at the January 2016 RUC meeting.

Direct PE Inputs for Functional Endoscopic Sinus Surgery Services

The RUC will request that the specialty society make a recommendation for direct practice expense inputs at the January 2016 RUC meeting.

Professional Liability Insurance (PLI) Relative Value Units

Proposed Annual Update of PLI RVUs

CMS proposes for CY 2016 to begin conducting annual PLI RVU updates to reflect changes in the mix of practitioners providing services, and to adjust PLI RVUs for risk. However, the collection of premium data will still be collected every five years. The RUC is pleased that the Agency has agreed to update the PLI RVUs annually. The RUC would still prefer for the Agency to pursue the annual collection of PLI premium data to ensure the PLI payment for every service is accurate. However, the RUC is encouraged by the Agency's actions to mitigate the distortions inherent in having staggered update schedules for physician work, practice expense and PLI.

Specialty Mix Assignment Methodology

CMS proposes to modify the specialty mix assignment methodology to use an average of the three most recent years of available data instead of a single year of data, as is the current policy. This change in policy will also be applied to low volume services, which are currently assigned the risk factor of the dominant performing specialty. The RUC agrees with the decision to include a broader range of data in the calculation of code-specific PLI RVUs. The inclusion of additional years of data is a reasonable and effective tool to alleviate year-to-year fluctuations in a code's Medicare utilization.

The RUC also agrees with the Agency's decision to maintain the code-specific overrides estimated in prior rulemaking for codes where the claims data are inconsistent with a specialty that could be reasonably expected to furnish the service. These exclusions are absolutely critical as there are numerous codes that are not performed, or rarely performed, in the Medicare population. The RUC and CMS have worked closely over many years to establish a reasonable list of crosswalks for services that are disenfranchised by the PLI update methodology. **Therefore, in an effort to be as transparent as possible, CMS still needs to publish this list of overrides each year to receive stakeholder feedback related to necessary modification to the list.**

PLI RVU Floor – Add-on Codes

CMS notes that while a 0.01 PLI RVU floor has traditionally been established for all codes, the Agency is proposing to remove this floor for add-on services. CMS notes that since add-on codes are always provided with a base procedure, which has its own PLI RVU, the 0.01 floor should not apply to these procedures. The RUC disagrees with this proposal. The incremental risk associated with performing an additional procedure is not mitigated by the risk inherent in the base procedure. Each procedure offers its own risk to the patient and should therefore be adequately accounted for when assessing the risk of the entire patient encounter. **CMS should not finalize this proposal and instead maintain a payment policy that adequately pays for the risk involved in every service performed.**

CY 2016 Identification of Potentially Misvalued Services for Review

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 1,800 services through 15 different screening criteria for further review by the RUC. 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 1,036 services, more than half of the services identified, redistributing more than $3.5 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 is appended to this letter.

Public Nomination of Potentially Misvalued Codes

Therapeutic Apheresis (CPT code 36516)

CMS notes that 11 services that have been nominated via the public as potentially misvalued. CPT code 36516 *Therapeutic apheresis; with extracorporeal selective adsorption or selective filtration and plasma reinfusion* was identified with the nominator stating that the work RVU, direct and indirect PE inputs may be incorrect. The RUC understands that the specialty societies will comment that there is no evidence that the current inputs are incorrect. **The RUC does not intend to add CPT code 36516 to the list of potentially misvalued services to review. If in the Final Rule for CY 2016, CMS continues to desire specific review of 36516, then the RUC will review at the January 2016 RUC meeting.**

Cystourethroscopy (CPT codes 52441 & 52442)

CPT codes 52441 *Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant* and 52442 *Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)* were nominated as potentially misvalued with the submitter stating that the costs of the direct practice expense inputs, including the cost of the implant, were inaccurate. The RUC understands that the comment was submitted by a manufacturer and that there may have been confusion regarding the intent of the comment. The manufacturer indicated, "Overall the process has produced an accurate list of supplies for a typical transprostatic implant procedure (TIP) and a reasonable estimate of the total cost of these supplies. We appreciate CMS's request for public comment on direct PE inputs and although we don't anticipate changes, we nominate these codes for potential misvaluation ***should*** the practice expenses change, including the cost of the implants." It appears that the commenter is only stating that if the inputs change in the future, then these services should be considered under the potentially misvalued code project. The RUC recently reviewed these services for work and direct practice expense inputs for CY 2015, and CMS accepted the RUC's recommendations. The RUC and American Urological Association believe the work and direct practice expense inputs are correct. **The RUC does not intend to review CPT codes 52441 and 52442 in the next cycle.**

Services CMS Identified as Potentially Misvalued

Electronic Analysis of Implanted Neurostimulator (CPT Codes 95970-95982)
CPT codes 95971-95973 were recently reviewed for CY 2015. Due to significant time changes in the base codes, CMS requests that the entire family should be considered as potentially misvalued and reviewed in a manner consistent with review of CPT codes 95971, 95972 and 95973. **The RUC will add CPT codes 95970 and 95974-95982 to the list of potentially misvalued services to review.**

Valuing Services That Include Moderate Sedation as an Inherent Part of Furnishing the Procedure (CPT codes 00740 and 00810)
CMS states that the anesthesia procedure codes 00740 *Anesthesia for procedure on gastrointestinal tract using an endoscope* and 00810 *Anesthesia for procedure on lower intestine using an endoscope* are used for anesthesia furnished in conjunction with lower GI procedures. In reviewing Medicare claims data, CMS noted that a separate anesthesia service is now reported more than 50 percent of the time when several types of colonoscopy procedures are reported. Given the significant change in the relative

frequency with which anesthesia codes are reported with colonoscopy services, CMS believes the relative values of the anesthesia services should be reexamined. Therefore, CMS proposed to identify CPT codes 00740 and 00810 as potentially misvalued. **The RUC will add CPT codes 00740 and 00810 to the list of potentially misvalued services to review.**

Review of High Expenditure Services across Specialties with Medicare Allowed Charges of $10,000,000 or More

The RUC reviewed the 118 services identified in Table 8 of the NPRM and requests that 21 services be removed. The RUC has reviewed nine services that CMS agreed or established new values within the last five years, since CY 2010. The RUC requests that CMS remove these services from this list as they do not fit the criteria for this list (CPT codes 51728, 51729, 51797, 76536, 78452, 92557, 92567, 93350 and 94010). Secondly, the RUC requests that CMS remove five add-on services from this list. Since 010-day and 090-day global services were excluded from the query to generate this list of high expenditure procedures, the associated add-on services should also be excluded (CPT codes 22614, 22840, 22842, 22845 and 33518). Additionally, CPT code 92002 is considered an Ophthalmological Evaluation and Management (E/M) service and should be excluded from this query along with all other E/M services. Lastly, the RUC requests that CMS remove five services that have a work RVU of 0.00 and one service that has a work RVU of 0.01. Services with no physician work have historically been excluded from any screen criteria (CPT codes 51798, 88185, 93296, 96567 and 96910). CPT code 95004 has a work RVU of 0.01 and the RUC believes it would serve little purpose to survey physician work for this code since work RVUs could not be any lower than they are currently without eliminating physician work entirely. There is clearly some physician work involved in providing this service since the physician must interpret the test and prepare a report. Therefore, the RUC requests that CPT code 95004 be removed from this list.

Also noted, are eight services that are already in the process of being reviewed and have been or will be addressed via the CPT Editorial Panel related to the CPT/RUC bundling of services efforts. The table below lists the status of the 29 aforementioned services that have been or will be addressed. **The RUC will initiate the level of interest (LOI) process to review the remaining 90 high expenditure services. However, the RUC would like to reiterate that just because a service has high costs that in itself is not an objective measure of potential misvaluation. The RUC urges CMS to use objective screens and specific indicators to identify potentially misvalued services.**

Table 8 High Expenditure Procedure Codes – RUC Requests for Removal

CPT Code	Long Descriptor	Global	Most Recent RUC Mtg	Screen	RUC Recommendation/Status
22614	Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)	ZZZ	Feb 2011	Codes Reported Together 75% or More-Part1	Remove from list because this ZZZ code is associated with a 010-day or 090-day global period service that is excluded from this query.

CPT Code	Long Descriptor	Global	Most Recent RUC Mtg	Screen	RUC Recommendation/Status
22840	Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary proced	ZZZ	Sep 2005		Remove from list because this ZZZ code is associated with a 010-day or 090-day global period service that is excluded from this query.
22842	Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure)	ZZZ	Apr 1995		Remove from list because this ZZZ code is associated with a 010-day or 090-day global period service that is excluded from this query.
22845	Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure)	ZZZ	Apr 1995		Remove from list because this ZZZ code is associated with a 010-day or 090-day global period service that is excluded from this query.
27370	Injection of contrast for knee arthrography	000	Jan 2014	High Volume Growth1 / CMS Fastest Growing / High Volume Growth2	RUC to review claims data at RAW Sept 2017. Revised at CPT.
33518	Coronary artery bypass, using venous graft(s) and arterial graft(s); 2 venous grafts (List separately in addition to code for primary procedure)	ZZZ	Aug 2005		Remove from list because this ZZZ code is associated with a 010-day or 090-day global period service that is excluded from this query.
36215	Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family	XXX	Oct 2012	Codes Reported Together 75% or More-Part1 / Harvard-Valued Annual Allowed Charges Greater than $10 million	The RUC is to review in October 2017 after more utilization data is available.

CPT Code	Long Descriptor	Global	Most Recent RUC Mtg	Screen	RUC Recommendation/Status
51728	Complex cystometrogram (ie, calibrated electronic equipment); with voiding pressure studies (ie, bladder voiding pressure), any technique	000	Apr 2009	Codes Reported Together 95% or More	This was a new bundled code for CY 2010. CMS Agreed with RUC recommendation. FR Vol. 74, No. 226, pg 61952. Remove from list as it does not fit the query criteria.
51729	Complex cystometrogram (ie, calibrated electronic equipment); with voiding pressure studies (ie, bladder voiding pressure) and urethral pressure profile studies (ie, urethral closure pressure profile), any technique	000	Apr 2009	Codes Reported Together 95% or More	This was a new bundled code for CY 2010. CMS Agreed with RUC recommendation. FR Vol. 74, No. 226, pg 61952. Remove from list as it does not fit the query criteria.
51797	Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal) (List separately in addition to code for primary procedure)	ZZZ	Feb 2008	Codes Reported Together 95% or More	This was a new bundled code for CY 2010.. RUC recommendation to maintain work RVU. Remove from list as it does not fit the query criteria.
51798	Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging	XXX	Aug 2005	N/A	Remove from screen, work RVU=0.00.
75978	Transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretation	XXX	Apr 2014	CMS-Other - Utilization over 250,000 / CMS High Expenditure Procedural Codes1 / Codes Reported Together 75% or More-Part3	Referred to CPT to bundle. CPT Code 36215 and 75978 are currently included on CMS' list of potentially misvalued services. Both of these codes will be impacted by the specialty society recently submitted angioplasty CCP. CPT Code 75978 will be bundled into the angioplasty and dialysis codes and will be deleted. The utilization for CPT Code 36215 has decreased significantly since 2013 when it was bundled into CPT codes 36222, 36223, 36225. The utilization for CPT Code 36215 will again decrease significantly when it is bundled into several of the new dialysis codes.
76536	Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation	XXX	Apr 2009	CMS Fastest Growing	CMS agreed with RUC recommendation for CY 2010. Table 5 in FR, Vol. 74, No. 226, Wednesday, November 25, 2009

CPT Code	Long Descriptor	Global	Most Recent RUC Mtg	Screen	RUC Recommendation/Status
78452	Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection	XXX	Feb 2009	Codes Reported Together 95% or More	This was a new code for CY 2010. CMS finalized a lower RVU than the RUC recommendation. FR Vol. 74, No. 226, pg 61954. Remove from list as it does not fit the query criteria.
88185	Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; each additional marker (List separately in addition to code for first marker)	ZZZ	Apr 2014	N/A	Remove from screen, work RVU=0.00.
92002	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient	XXX	Feb 2007	N/A	This is an Evaluation and Management service and should be removed from the list.
92240	Indocyanine-green angiography (includes multiframe imaging) with interpretation and report	XXX	Feb 1996	Codes Reported Together 75% or More-Part3	Referred to CPT to bundle.
92557	Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)	XXX	Apr 2009	Codes Reported Together 95% or More	This was a new bundled code for CY 2010. RUC recommendation to maintain work RVU. Remove from list as it does not fit the query criteria.
92567	Tympanometry (impedance testing)	XXX	Apr 2009	Codes Reported Together 95% or More / Low Value-High Volume	This was a new bundled code for CY 2010. RUC recommendation to maintain work RVU. Remove from list as it does not fit the query criteria.

CPT Code	Long Descriptor	Global	Most Recent RUC Mtg	Screen	RUC Recommendation/Status
93296	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system or implantable defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	XXX	Apr 2008	N/A	Remove from screen, work RVU=0.00.
93350	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation	XXX	Apr 2010	Other - Identified by RUC / Codes Reported Together 75% or More-Part1	CMS agreed with RUC recommendation for CY 2009. Table 26 in FR Vol. 73, No. 224, pg 69889
93613	Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure)	ZZZ	Oct 2013	CMS Fastest Growing / High Volume Growth2	RUC to review utilization September 2016, collect data under new bundled codes.
94010	Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation	XXX	Feb 2011	Low Value-High Volume	CMS agreed with RUC recommendation to maintain 0.17 work RVU. FR Vol. 76, No. 228, pg 73207.
95004	Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests	XXX	Feb 2007	N/A	Remove from screen, work RVU=0.01.

CPT Code	Long Descriptor	Global	Most Recent RUC Mtg	Screen	RUC Recommendation/Status
96567	Photodynamic therapy by external application of light to destroy premalignant and/or malignant lesions of the skin and adjacent mucosa (eg, lip) by activation of photosensitive drug(s), each phototherapy exposure session	XXX	Apr 2008	High Volume Growth1 / CMS Fastest Growing	Remove from screen, work RVU=0.00.
96910	Photochemotherapy; tar and ultraviolet B (Goeckerman treatment) or petrolatum and ultraviolet B	XXX	Feb 2001	N/A	Remove from screen, work RVU=0.00.
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities	XXX	Jan 2012	CMS High Expenditure Procedural Codes1	Referred to CPT.
97140	Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes	XXX	Jan 2012	CMS High Expenditure Procedural Codes1	Referred to CPT.
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes	XXX	Jan 2012	CMS High Expenditure Procedural Codes1	Referred to CPT.

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

In response to the CY 2015 NPRM, the RUC stated its support of CMS' intention to establish a uniform approach for valuing Appendix G services for which moderate sedation is no longer inherent. The RUC also continues to agree with CMS that it is important to value moderate sedation accurately when it is furnished so that duplicative payments will not occur when anesthesia is furnished.

In response to the CMS proposal, the RUC and the CPT Editorial Panel established the Joint CPT/RUC Moderate Sedation Workgroup in 2014. For the past year, this Joint Workgroup has completed a lot of work in implementing the "blueprint" set for by CMS in the CY 2015 NPRM. The Workgroup developed a new coding structure (codes 991X1X-991X6X) to describe moderate sedation which was approved by

the CPT Editorial Panel in February 2015. Interested stakeholders, in collaboration with the Moderate Sedation Workgroup and the RUC's Research Subcommittee, have undertaken the challenging task of ensuring that the survey methodology will effectively capture the physician time and work provided by differing specialties for a wide range of patient and procedural characteristics. The collaborating specialties will present their survey data and joint recommendations to the RUC in October 2015. The RUC will submit its recommendations to CMS for consideration for the CY 2017 NPRM prior to the February 2016 deadline.

Improving the Valuation and Coding of the Global Service Package

CMS outlines the provisions of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 which prohibits the implementation of the CMS policy to transition all surgical global packages into 000-day global packages. In place of the transition, the Act requires CMS to develop a process to gather information needed to value surgical services from a representative sample of physicians, and requires that the data collection shall begin no later than January 1, 2017. The collected information must include the number and level of medical visits furnished during the global period and other items and services related to the surgery.

Data Sets and Collection Methods

CMS states they are soliciting comments regarding the kinds of auditable, objective data needed to increase the accuracy of the values for surgical services. Additionally, the Agency is seeking comment on the most efficient means of acquiring these data.

Prior to discussing potential collection methods of post-operative visit data, it is critical to put the current post-operative visits breakouts included in surgical global packages into perspective. This understanding is important because it highlights the need for CMS to take a measured approach to this issue and not implement a blanket collection policy which adds administrative burdens to Medicare payment for relatively little gain.

There are currently 4,256 CPT codes with surgical global packages in the Medicare payment schedule. Of the 473 services which have a 010-day global period, the average number of post-operative office visits included in the global package is one. Additionally, of the 3,783 services which have a 090-day global period, the average number of post-operative office and hospital visits is three. Furthermore, according to 2014 Medicare utilization, there are only 108 010-day global and 152 090-day global codes performed more than 10,000 times.

In addition, the level of post-operative E/M visits must also be considered. On average, the global surgical packages have much lower levels of office and hospital visits compared 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 44% of all separately-reported E/M visits are reported as a 99214 or 99215.

CPT Code	2014 Global Surgical E/M Utilization Percentage (All codes)	2014 Separately Reported E/M Utilization Percentage
99211	0.38%	2.42%
99212	57.08%	7.10%
99213	41.29%	45.11%
99214	1.22%	41.19%
99215	0.03%	4.19%
TOTALS	100.00%	100.00%

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	2014 Global Surgical E/M Utilization Percentage (All codes)	2014 Separately Reported E/M Utilization Percentage
99231	57.22%	11.35%
99232	29.75%	56.90%
99233	10.01%	25.59%
99291	3.02%	6.16%
TOTALS	100.00%	100.00%

The RUC takes seriously the accuracy of the currently composed surgical global packages. A comprehensive review of all services with a 99214 and/or 99215 post-operative E/M visits was just conducted to determine potential misvaluation. The Relativity Assessment Workgroup will, at the October 2015 RUC meeting, review nine of these services which were billed greater than 10,000 times in 2014.

These data, along with the RUC's past and ongoing work to identify outlier services with high post-operative E/M visits, serve to highlight the relatively low likelihood that large disparities currently exist in the surgical global period packages. However, despite these data, the RUC has undergone aggressive research to identify existing data sets and collection methods and provide this information to CMS. The RUC has discussed and previously submitted to CMS the following list of collection methods to determine the reliability of post-operative visits performed in the global period. These three methods represent reasonable opportunities for the Agency to collect post-operative visit information through existing channels.

Data collection of CPT code 99024

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 E/M service(s) was performed during a post-operative period for a reason(s) related to the original procedure. 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 (Mayo Clinic & Geisinger) 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.

At the January RUC meeting, CMS officials requested assistance from the RUC in gathering specific contact information from Medical Systems and other stakeholders that collect data on post-operative visits. In March 2015, the RUC forwarded the contact information of several large group practices to CMS officials in order to facilitate the Agency's search for a representative data set to examine. The RUC is happy to again forward this information to CMS.

Use Medicare length of stay data to assess hospital visits

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.

Identification of services CMS considers of high concern

This option would target the collection of post-operative E/M visit data to the level of services the Agency and/or other stakeholders identify as high concern. This process could also work in tandem with one of the options above to allow RUC and other stakeholder review of these critical services prior to finalizing any decisions.

CMS must consider a number of different data sources when developing the scope of their collection methodology. Furthermore, these data sources must be truly representative, including geographically diverse large and small practices. By identifying large existing data sets, the Agency has the opportunity to ensure services are accurately valued, while limiting intrusive protocols to providers.

Individual Components of the Global Surgical Package

In addition to seeking comments related to the collection of post-operative visit data, CMS also solicits comments related to the individual component services within the global packages. CMS notes that they are seeking information about whether or not post-operative visits differ from stand-alone E/M visits and what items and services are furnished related to surgery, aside from the post-operative visit.

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. Physicians are often performing care coordination and care collaboration with other providers during the post-operative period. In addition, the Medicare Claims Processing Manual (Chapter 12, Section 40.1) provides several examples of services which are currently bundled into the global surgical package:

- 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

The RUC has maintained, since CMS initially proposed to transition away from surgical global periods, 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. The RUC asks CMS to again review the attached documents, which contain the 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.

Given the robust nature of the existing practice expense data, it is counterintuitive for CMS to undergo a vast collection process for ascertaining the individual components of the surgical global package. Furthermore, there are many physician services like care coordination with other physicians which make the task of identifying each individual component within the surgical bundle a complicated process. **Therefore, CMS should forgo a formal collection process for determining the individual components of surgical services and instead focus on currently available data to ensure services are accurately valued.**

Valuation of Individual Components

CMS also solicits comments related to the valuation of the individual components, including the procedure itself and pre/post-operative care, within a surgical package. The Agency states:

The RUC maintains its adamant opposition to any systematic formula that adjusts the value of a service within a surgical global package based on any one component therein. 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. Thus, 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. The RUC then employs magnitude estimation based on survey data to assign the work RVU and reviews the data to determine the typical E/M services provided in the global period.

CMS should use existing data sets to identify services with large post-operative work that may be currently misvalued. After identifying these services, the RUC should have time to review each service to determine if they are in fact misvalued. Allowing stakeholders input into the valuation process has been the bedrock of the RBRVS since its inception. Continuing this open process, through which valuation determinations are made through RUC review and magnitude estimation, is paramount.

CY 2016 Refinement Panel Proposal

For CY 2016, CMS proposes to permanently eliminate its Refinement Panel process. CMS states their belief that since proposed work RVUs will now be published in the Proposed Rule, the Refinement Panel process will no longer be necessary. The Agency believes that the opportunity for stakeholders to provide comments on codes in both the Proposed and Final Rules "…will allow better mechanism and ample opportunity for providing any additional data for our consideration, and discussing any concerns with our interim final values, than the current refinement process." While the change to including proposed work RVUs in each year's NPRM continues to be strongly support by the RUC, we do not agree that this process change makes the Refinement Panel process obsolete. These separate processes are not mutually exclusive and could be undertaken in tandem to provide stakeholders with multiple avenues of appeal.

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 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 rely upon outside stakeholders to provide accountability through an appeals process for stakeholders who do not agree with the Agency's decisions. **The RUC recommends that CMS consider these issues and maintain an objective, transparent and consistently-applied formal appeals process that would be open to any commenting organization.**

Improving Payment Accuracy for Primary Care and Care Management Services

The CPT Editorial Panel and the RUC have defined and recommended valuation of numerous services utilized to improve care coordination and care collaboration over the past decade. We appreciate the CMS decision to recognize and pay for transitional care management (TCM) in 2013 and chronic care

management (CCM) in 2015. There are numerous other services that CMS should recognize and implement separate payment beginning January 1, 2016, including:

- Anticoagulant Management (CPT Codes 99363 and 99364)
- Education and Training for Patient Self-Management (CPT Codes 98960-98962)
- Medical Team Conference (CPT Codes 99366-99368)
- Telephone Services (CPT Codes 99441-99443 and 98966-98969)
- Analysis of Computer Transmitted Data (CPT Code 99091)
- Complex Chronic Care Management Services (CPT Codes 99487 and 99489)

The RUC recommendations for each of these services are attached for your review and consideration. The RUC confirms the comments sent to CMS initially in October 2011, for each of the above category of services. We are hopeful that CMS will now be receptive to implementing separate payment for these services. We would also urge you to consider any impact from implementation as "redistribution" from other services and toward your goal of improving payment for care coordination and care collaboration. For example, implementation of the anticoagulant management CPT codes in 2016 would lead to $230 million in physician payment for these services. The implementation should be factored into redistribution from other services and account for .25% of the 1% in redistribution mandated by Congress for 2016.

Anticoagulant Management (CPT Codes 99363 and 99364)

In 2007, the CPT Editorial Panel created the following CPT codes to describe anticoagulant management:

- 99363 *Anticoagulant management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; initial 90 days of therapy (must include a minimum of 8 INR measurements)*
- 99364 *Anticoagulant management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; each subsequent 90 days of therapy (must include a minimum of 3 INR measurements)*

CMS published relative values for these codes, based on information provided by the RUC, which would result in nominal payment ($43 per month for initial 90 days and $15 per month for subsequent 90 days of management). However, CMS has to date considered these services "bundled" into E/M and not separately paid.

Immediate implementation of CPT codes 99363 and 99364 *Anticoagulant management* would signal that CMS is serious about providing incentives for care coordination. These services are also cost effective, eliminating unnecessary face-to-face physician services which are required as a substitute to a more common sense strategy to pay for the management of these patients. As stated in our earlier recommendations (and included in the attachments):

> *In 2001, the Centers for Medicare and Medicaid Services (CMS) stated that the standard of care for anticoagulant services was suboptimal and the current payment policy requires the physician to have the beneficiary schedule an office visit to discuss prothrombin time tests results and necessary adjustments to receive separate payment. Although it is clinically optimal for a physician to discuss results with a patient and make an adjustment during a face-to-face encounter under some circumstances, physicians*

> *often engage in these activities outside of a face-to-face encounter with the patient. The CPT Editorial Panel agreed with the specialty that bundling this post service time into the payment for the visit is unfair when physicians are managing patients on long-term anticoagulants. In addition, the Panel believed that CMS policy provides inadequate avenues for physicians to be paid for managing patients on long term anticoagulant and may contribute to the problem of underutilization of anticoagulant drugs that has adverse effects on the health of patients. Failure to receive anticoagulant drugs when indicated and under-anticoagulation can increase patient risk of thrombosis and embolism, and over anticoagulation can increase patient risk of bleeding. The CPT Editorial Panel discussed the issue at its February 2006 meeting and created two new codes to allow the reporting of anticoagulant management services. To ensure appropriate utilization of these codes, the Panel added minimum International Normalized Ratio (INR) measurements, eight for the initial anticoagulant management and three for subsequent therapy, and stated that this service cannot also be reported with another Evaluation and Management (E/M) code.*

While unfortunate that CMS elected to deny separate payment of this important service in the past, there is a new opportunity to consider implementation. In their comments related to the July 19, 2011 Proposed Rule on the 2012 Medicare Physician Payment Schedule, specialty societies ranging from primary care (American College of Physicians, American Academy of Family Physicians and American Geriatrics Society) to internal medicine subspecialties (Infectious Disease Society of America) to surgery (American College of Surgeons and American Academy of Otolaryngology – Head and Neck Surgery) united in their support of separate payment for anticoagulant management.

This proposal has the support of multiple specialty societies, and has many features that are completely aligned with the stated goals of CMS as it transforms the payment system into a vehicle for quality improvement and cost savings. There is ample evidence that better anticoagulation management can reduce thromboembolic and bleeding events that are devastating to Medicare Beneficiaries and add cost to health care. These anticipated outcomes would be an easily measurable expectation of implementing the anticoagulation codes.

This proposal would identify a discrete population of patients with a chronic condition that would have historical Medicare utilization data regarding Part A, B and D services. Upon initiation of funding, this patient population would be identified and ongoing health care utilization collected for comparison to this historical baseline. Additional comparisons could be made to Medicare Beneficiaries with similar conditions, but who are either not managed with the anticoagulation codes or who are being treated with newer, more expensive direct thrombin inhibitors whose cost effectiveness and outcome measures rely on limited clinical trial evidence.

Should these codes be funded, the RUC would be eager to participate in exploring the cost and quality measurement aspects of implementation with CMS, as the results may be generalizable to other planned interventions to link payment policy to anticipated positive outcomes. This highly feasible immediate implementation would also provide real experience to practicing physicians, organized medicine, and CMS in working toward other similar bundled care coordination codes. **The RUC recommends that CMS implement separate payment for CPT codes 99363 and 99364 *Anticoagulant Management* beginning January 1, 2016.**

Education and Training for Patient Self-Management (CPT Codes 98960-98962)

In 2006, the CPT Editorial Panel implemented three codes to describe patient education and training. CMS accepted direct practice expense inputs submitted by the RUC; however, the Agency implemented the codes as bundled within E/M services. These services are clearly separate and distinct from E/M, requiring 30 minutes of education provided by non-physician clinical staff.

- 98960 *Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient*
- 98961 *2-4 patients*
- *98962 5-8 patients*

The vignette for 98960 is as follows and describes the patient that would benefit from care coordination and team based care:

> *A 60 year-old man with a symptomatic established illness or disease, e.g. diabetes or asthma, or the desire to delay disease co-morbidities, e.g. cardiovascular co-morbidities, is referred by a physician to a qualified, non-physician health care professional, e.g. RD or RN, for education/training.*

The estimated national payment for these services, based on CMS published relative values, range from $10-$28, dependent upon the number of patients in the education session. **Immediate implementation of the education and training services (CPT codes 98960-98962) is recommended to recognize the costs associated with team based service.**

Medical Team Conference (CPT Codes 99366-99368)

Another service that would be included in a medical home or global payment in the long-term, but could be implemented short-term to recognize team based care is the medical team conference (CPT Codes 99366-99368). When a physician is involved in a team conference with the patient and other health care professionals, an E/M service may be reported. However, if the patient is not present (CPT 99367), no separate reporting is allowed by Medicare. Non-physicians, such as dieticians, physical and occupational therapists, are not allowed to separately report the time that they spend in team conferences, whether the patient is present (CPT 99366) or not (CPT 99368). Similar to the education and training codes described above, these time-based team codes are important in capturing real costs to a physician's practice. **Immediate implementation of the medical team conferences (CPT codes 99366-99368) is recommended to recognize the costs associated with team based care.**

Telephone Services (CPT Codes 99441-99443 and 98966-98969)

While technical issues related to audit standards and appropriateness may have precluded CMS from considering separate payment for telephone service in the past, the CPT Editorial Panel's revisions for *CPT 2008* and the enclosed RUC's recommendations illustrate that there is a path forward to appropriately pay for these services. Documentation for these services is required and the instructions are clear:

> Telephone services are non-face-to-face evaluation and management (E/M) services provided to a patient using the telephone by a physician or other qualified health care

professional, who may report evaluation and management services. These codes are used to report episodes of care initiated by an established patient or guardian of an established patient. If the telephone service ends with a decision to see the patient within 24 hours or next available urgent visit appointment, the code is not reported; rather the encounter is considered part of the pre-service work of the subsequent E/M service, procedure, and visit. Likewise, if the telephone call refers to an E/M service performed and reported by that individual within the previous seven days (either requested or unsolicited patient follow-up) or within the postoperative period of the previously completed procedure, then the service(s) are considered part of that previous E/M service or procedure. (Do not report 99441-99443, if reporting 99441-99444 performed in the previous seven days.)

(For telephone services provided by a qualified nonphysician who may not report evaluation and management services (eg, speech-language pathologists, physical therapists, occupational therapists, social workers, dietitians), see 98966-98968)

- 99441 *Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion*
- 99442 *11-20 minutes of medical discussion*
- 99443 *21-30 minutes of medical discussion*

(Do not report 99441-99443 when using 99339-99340, 99374-99380 for the same call (s))

(Do not report 99441-99443 for anticoagulation management when reporting 99363-99364)

(Do not report 99441-99443 during the same month with 99487-99489)

(Do not report 99441-99443 when performed during the service time of codes 99495 or 99496)

Relative values are already developed and published by CMS for these services. CMS may also consider a modest roll-out of these services to beneficiary groups who may benefit the most from such care coordination. Another alternative is to cap the number of phone calls per beneficiary per month (eg, two calls per month). The concerns about misuse of phone calls should be alleviated in part by the ease of understanding by the Medicare patient of the involved service. Medicare beneficiaries will easily understand an Explanation of Benefits (EOB) statement that describes telephone calls and determine whether or not a call had been convened for the time stated clearly in the CPT short description (eg, 99441 *Phone E/M by Phys 5-10 minutes).*

The RUC recommends that CMS implement separate payment for Telephone Services (CPT Codes 99441-99443 and 98966-98969) beginning January 1, 2016.

Analysis of Computer Transmitted Data (CPT Code 99091)

In 2002, The CPT Editorial Panel created a new code 99091 *Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, requiring a minimum of 30 minutes of time* to specifically describe the review of data sent to the physician electronically from a patient and/or caregiver for their analysis and interpretation. This service may be reported only once per month and may not be reported in conjunction with an Evaluation and Management service on the same day.

The RUC's recommendation for this service was based primarily on reviewing the minimum required physician time to report this service and in comparison to existing E/M services. There are no associated direct practice expense inputs with this service. CMS accepted and published the RUC's recommendation. However, CMS assigned a status of "B (bundled)" for this code. **The RUC recommends that CMS implement separate payment for Analysis of Computer Transmitted Data (CPT Code 99091) beginning January 1, 2016.**

Complex Chronic Care Management Services (CPT Codes 99487 and 99489)

In 2013, the CPT Editorial Panel created complex chronic care management services (CPT codes 99487 and 99489) to describe significant clinical staff time (greater than 60 minutes) in performing care management services. The RUC submitted recommendations (attached) for these services and CMS had initially published relative values for these codes.

CMS indicates a new willingness to consider implementation of these codes and has requested comments for data demonstrating that this amount of care management time (ie, greater than 60 minutes) is required for some Medicare patients. In the comments to follow, we suggest that CMS hire a vendor to collect these data. However, since the codes require that a minimum of 60 minutes of clinical staff time be documented, CMS could proceed with implementation immediately. **The RUC recommends that CMS implement separate payment for Complex Chronic Care Management Services (CPT Codes 99487 and 99489) beginning January 1, 2016.**

There are a number of additional codes that address physician care planning that CMS might also consider for separate payment, including CPT codes 99339, 99340, 99358, 99359, 99374-99380. These care plan services have been available with published values since 2007.

Opportunity to Describe and Value Additional Services

The CPT Editorial Panel and RUC have restructured the former Chronic Care Coordination Workgroup (C3W) to a new Emerging CPT and RUC Issues Workgroup to develop, in part, a specific response to many of the questions that CMS outlined in this Proposed Rule. In the coming months, we understand that individual specialty societies and/or a coalition of specialties will develop CPT coding proposals to address the CMS proposal to identify add-on services to existing Evaluation and Management codes. The Workgroup has convened and had preliminary discussions regarding the potential coding and valuation opportunities. CMS has proposed to move quickly to identify such services. The current CPT time frame, as modified in response to CMS request, required all CPT 2017 proposals to be submitted in early July 2015. Therefore, new coding proposals will be considered for the CPT 2018 publication. As discussed in comments above, there are a number of existing codes that CMS could implement immediately as the services have published CPT codes and relative values. We strongly encourage CMS

to begin working with the medical community to ensure efficient implementation of any new CPT or G codes to be developed in response to the Proposed Rule.

Improved Payment for the Professional Work of Care Management Services

The current covered chronic care management service (CPT 99490) assumes 15 minutes of physician time spent over the course of one month. CMS has proposed that there may be need to describe and pay for the professional work (physician and other qualified health care professionals) that extends beyond the 15 minutes. In addition to the more extensive complex chronic care management services already described in CPT, the RUC recommends that CMS re-consider the other existing CPT codes described previously in this letter (eg, anticoagulant management, telephone calls, team conferences, etc). The RUC understands that specialty societies may propose additional codes, such as one similar to the current CPT code 90785 *Interactive complexity (List separately in addition to the code for primary procedure)*, in an attempt to better describe services that require intensive communication with the family and/or family members. Another example of a proposal may be a new CPT code to describe extensive physician work related to medication management and reconciliation.

Establishing Separate Payment for Collaborative Care

CMS discussed four CPT codes, created in 2014, to describe interprofessional telephone/internet consultative services (CPT codes 99446-99449) in this Proposed Rule. CMS is considering separate payment for these services to "account for the resource costs of a more robust interprofessional consultation within the current structure of Physician Payment Schedule payment." CMS should work with interested parties through the CPT Editorial Panel to ensure that the CPT codes are described in a manner that would allow CMS to offer separate payment for the services. The RUC will re-review the codes, as modified, to ensure that the resource costs are appropriately described for CMS consideration.

As CMS notes in the proposed rule, the management of patients with multiple chronic conditions, a particularly complicated disease or acute condition, or common behavioral health conditions often requires extensive discussion, information-sharing and planning between the patient's primary care physician and the specialists who are managing the patient's other conditions. CMS also provides a good example of the need to recognize collaborative care as a separate service when a primary care physician and a neurologist consult with one another about a patient who has Alzheimer's disease plus other chronic diseases. CMS further notes that, in 2014, the CPT Editorial Panel created four CPT codes to describe interprofessional telephone/internet consultative services (CPT codes 99446-99449). Currently Medicare does not provide separate payment to physicians for these codes.

Lack of funding for interprofessional consultative services under the Medicare physician payment schedule makes it difficult for physicians to take the time to engage in this collaboration. In the CMS example, not only would the primary care physician and neurologist who consult with one another not be paid for the work involved in this joint treatment planning, but they would lose revenue they could have earned from face-to-face patient services. Over the last several years, the AMA has met with physicians from many different specialties about how they want to reform delivery of care for patients with particular conditions to improve quality and coordination while lowering Medicare spending. Each and every new model that specialties have proposed involves interprofessional consultative services that are not supported within the current Medicare payment system:

- Patients with ovarian and endometrial cancer could benefit from fewer repeat operations and complications of surgery as well as improved health outcomes through a team approach in which

- Gynecologic oncologists collaborate with other surgeons, medical and radiation oncologists, and other physicians and health professionals involved in the patient's care.

- Collaboration between cardiologists and primary care physicians in diagnosing and managing patients with ischemic heart disease can improve the appropriateness of diagnostic test ordering and reduce the risk of heart attacks.

- Patients with diabetes could benefit from reduced hospitalizations through collaboration between endocrinologists and primary care physicians in managing care for this chronic disease.

- Breast cancer patients could benefit from fewer repeat operations and better health outcomes through coordination and joint advance treatment planning by the breast surgeon who is removing the patient's cancer, the plastic and reconstructive surgeon, and the radiation and medical oncologists involved in the patient's care.

- Collaboration between neurologists, emergency medicine, and primary care could help prevent seizures and injuries and complications due to epilepsy, reducing the need for patients to be hospitalized.

- Nephrologists and vascular surgeons could utilize collaborative care for chronic kidney disease patients to plan ahead for vascular access using an arteriovenous fistula for hemodialysis, which would avoid the need for multiple catheters and reduce infections and other complications associated with dialysis.

- Nursing home medical directors and hospitalists could collaborate to manage exacerbations in the long-term care setting and reduce the number of patients cycling between the hospital and nursing home.

- Hospitalists could consult with a thyroid patient's endocrinologist to obtain information about the patient's medical history, prescribed medications, recent laboratory data and treatment and management options to be considered when the patient is hospitalized with chest pain.

- Primary care and specialist physicians could consult with one another to discuss treatment options in response to findings from imaging tests, such as a thyroid nodule found during a CT exam for a patient experiencing recurrent severe headaches.

As the foregoing examples illustrate, there are many opportunities to improve patient care by providing separate Medicare payment for physicians to collaborate with one another in their patients' care. These opportunities exist both for individual patients and for populations of patients, particularly when the population is defined as patients who have a particular disease or condition. CMS should make it possible for two or more physicians to collaborate in care planning for an individual patient and also for groups of patients. Using CMS' example of collaboration between primary care and neurology for patients with Alzheimer's and other chronic diseases, this collaboration could either take the form of a primary care physician discussing a particular patient

with the neurologist, or it could take the form of a discussion about a population of the primary care physician's patients who all have Alzheimer's and other conditions.

The above examples show that Medicare policy providing separate payment for interprofessional consultations should not be limited to one physician. Both physicians involved in the service should be able to bill for it. Nor should payment be limited to primary care physicians or medical specialists, as funding for these services could also have a major positive impact on surgical care.

Collaborative Care Models for Beneficiaries with Common Behavioral Health Conditions

CMS is persuaded that randomized controlled trials have provided evidence that the collaborative care models for patients with common behavioral health conditions (eg, depression and anxiety) have been successful. In this model (described at http://aims.uw.edu), the primary care office (the primary care physician and a designated care manager) collaborates with a psychiatric consultant in managing a population of patients to ensure that patient treatment is effective and to make necessary adjustments in a timely manner to reach individual patient treatment goals. Much of this collaboration is performed non face-to-face by the psychiatrist and by the primary care physician's care manager. CMS will consider new codes to describe this collaboration since current codes do not accurately represent the work entailed in this model. The RUC understands that the organizations that represent psychiatry and other mental health professionals will work with the primary care organization to develop CPT coding proposals in the near future.

CCM and TCM Services

The RUC agrees that Medicare payment for transitional care management (TCM) and chronic care management (CCM) services demonstrate a positive step in paying for non face-to-face services that improve the quality of health care provided to patients, while ultimately leading to potential overall savings to the program. CMS has asked the public to comment on potential ways to reduce the administrative burdens associated with reporting the services as well as consideration of data to demonstrate that the more resource-intensive CCM services (CPT codes 99487 and 99489) should be covered.

One potential improvement to reporting the CCM and TCM services would be to allow the physician to file the claim at the point in time that the service is rendered and the requirements to report have been completed. Some physicians are reporting difficulty with their claims processing systems in accommodating the requirement that the physician wait until the end of a 30 day period to file the claim. CMS should reconsider the claims processing requirements to alleviate administrative burden.

The new CCM code, 99490, requires at least 20 minutes of clinical staff time spent in care management activities. Physician practices are required to document this time. Accordingly, CMS should contract with a vendor to collect information on the actual time spent in these activities. These data would support that the time spent is likely bimodal and provide evidence to CMS that the more resource-intensive CCM services (CPT codes 99487 and 99489) should be payable.

Target for Relative Value Adjustments for Misvalued Services

The Protecting Access to Medicare Act of 2014 (PAMA) enacted on April 1, 2014 established an annual target for reductions in Medicare Payment Schedule expenditures resulting from adjustments to relative values of misvalued codes. Following this, the Achieving a Better Life Experience Act of 2014 (ABLE)

enacted on December 19, 2014 accelerated the application of the expenditure reduction target, setting a 1 percent target for CY 2016 and 0.5 percent for CYs 2017 and 2018.

Cumulative Savings to Date

With estimated total allowed charges of $88.4 billion for CY 2016, 1% would roughly equate to a net reduction target of $884 million. According to the regulatory impact section of the NPRM, CMS estimates a net reduction of approximately 0.25 percent of expenditures under the Medicare Payment Schedule for codes under review by CMS under the NPRM timeline. (This reduction target does not account for RUC reviewed services that were not submitted to CMS by the February 2015 deadline for inclusion in the NPRM.) After analysis of the available information published by CMS, the RUC has confirmed the Agency's published reduction target seems accurate. However, the process for determining the net reduction target remains non-transparent. The RUC's independent calculations came after several conversations with CMS staff and a comprehensive knowledge of the utilization crosswalk assumptions. Individual stakeholders without this knowledge base will be significantly burdened to conduct a reasonable analysis of the net reduction target. Therefore, CMS should establish a transparent process to ensure stakeholders can independently verify the updated net reduction calculations each year.

CMS should take several steps towards establishing a transparent calculation process. First, the Agency must publish the dollar figure estimate in each year. In this NPRM, CMS simply publishes an estimated target reduction of 0.25 percent. When estimating such large reductions, small changes, including rounding errors, can result in fluctuations in the millions of dollars. Second, CMS should publish each issue's estimated impact on the net target reduction. CMS could publish this information per CPT code, or identify each family of services and publish a combined impact. While estimating the impact of existing services is straightforward, new codes resulting from the revision of large families of services can be difficult to assess. **To ensure the stakeholder community can fairly and accurately calculate the published reduction, CMS should publish the exact target reduction number and individual service-level impacts for each year.**

Prior to commenting on the elements of the CMS proposal, it is important to recall the work the RUC has already undergone since the creation of the misvalued code project in 2006. Over 1,850 services have undergone review, redistributing more than $3.5 billion. Considering the rigor the RUC has taken to review potentially misvalued services, establishing a net target reduction of nearly $900 million this year is unreasonable. By implementing this target almost ten years into the misvalued code project, this legislation is essentially penalizing physicians for having undergone the difficult work of identifying and re-valuing potentially misvalued codes. Since the RBRVS is a fixed pool of resources, identifying additional redistribution over the $3.5 billion already achieved is overly burdensome.

Distinguishing "Misvalued Code" Adjustments from Other RVU Adjustments

CMS discusses several ways to identify a subset of the adjustments in RVUs for a year to reflect an estimated "net reduction" in expenditures. The Agency then states, "we believe that the best approach is to define the reduction in expenditures as a result of adjustments to RVUs for misvalued codes to include the estimated pool of all services with revised input values."

The RUC agrees with the CMS proposal to include all services that receive revised input values. This approach is especially appropriate given the amount of work the Practice Expense Subcommittee has done recently to update practice expense inputs, including the film-to-digital migration for imaging services and moderate sedation monitoring time.

The RUC would like to comment on one subset of services that need to also be included in the target reduction- existing codes in which large volume changes occur due to new coding structure. These volume changes could result from coding changes to large families of services and/or the deletion of obsolete codes. For example, the RUC reviewed new technology rib fracture fixation codes (21811-21813). As part of these revisions, three other rib fracture treatment codes (21800, 21805 and 21810) were identified as potentially misvalued and were deleted by the CPT Editorial Panel. Under the current proposal, codes, such as the ones described above, would not be included in the target reduction because inputs are not changing. However, the utilization for these services is changing and should be included as they are related to the activity of either the misvalued code project and/or the CPT Editorial Panel. These codes are identified by the RUC in the utilization crosswalk spreadsheet submitted with each RUC recommendation submission. **CMS should include existing codes which are either being deleted or will have utilization changes as a result of the misvalued code project and/or the CPT Editorial Panel process.**

RVU Determinations over Three Years

Additionally, CMS discusses the challenges presented by calculating an annual target when changes in values take place over three years: the original value in the first year, the interim final value in the second year, and the finalized value in the third year. The Agency proposes to exclude code-level input changes from CY 2015 interim final values from the calculation of the CY 2016 misvalued code target since the misvalued change occurred over multiple years, including years not applicable to the misvalued code target provision.

The RUC agrees with this proposal for two primary reasons. First, as the Agency notes, the year two to year three changes represent an incomplete picture of the redistributive effects from the review of misvalued services. These changes largely represent increases in value to services that, after receiving public comment, CMS had previously proposed to decrease. The vast majority of redistribution happens between year one and year two, where the RUC recommendations are initially reviewed and receive interim final values. Second, because of the nature of these changes, reductions that occurred on an interim final basis for CY 2015 were not counted towards achievement of the target. Thus, accepting changes resulting from CMS decisions to modify CY 2015 interim final recommendation would distort the overall net impact of the RUC and CMS work on the service level input changes for CY 2015.

Calculating "Net Reduction"

CMS states that the requirement to calculate net reductions implies that both decreases and increases must be considered. The Agency also notes that this is the only practical approach given that revising families of services can often lead to both increases and decreases within the same family (e.g. splitting one code into two codes, simple and complex).

When considering the net impact of service-level input changes in a given year, it is important for CMS to understand specific scenarios in which codes under review should not be included in the net reduction target calculation. Below are three examples from the CY 2016 recommendations. In general, however, these examples represent broad concepts that CMS should continue throughout each rulemaking process.

Targeted Payment Initiatives – Advance Care Planning

The RUC, specialty societies and CMS have worked extremely hard over the past few years to develop several coding solutions that recognize the important components of care management, which lead to better health outcomes for individuals and help reduce downstream costs within the healthcare system.

Services like the transitional care management (TCM) and chronic care management (CCM) services represent targeted payment initiatives that were specifically created to provide appropriate incentives to provide the best patient care possible.

Along this line, for CY 2016, CMS also accepted the RUC recommendations on advanced care planning services. Given the implicit nature of services like advanced care planning, the RUC is disappointed to learn that CMS included these services in the net reduction target for CY 2016. The advance care planning codes represent new services, which are not currently reportable. The RUC estimates roughly $4 million will be spent on these services in CY 2016. Creating a scenario in which payment for these services is immediately offset by a reduction in the conversion factor, resulting from not hitting the target, is counterintuitive to the recent work to recognize important care management services. **Therefore, CMS should instead estimate the cost of implementation of the advanced care planning services as "redistribution" from other services for CY 2016.**

Finally, CMS also proposes several additional refinements to payment for care management services that should be considered by stakeholders, including: physician work of care management services, interprofessional telephone/internet consultation services and collaborative care for behavioral health conditions. **These proposals also represent the same type of targeted initiatives that have been implemented recently and should be considered as "redistribution" from other physician services, bringing the estimation closer to the required 1%.**

New Services without Predecessor Codes

Each year, CPT codes are created for services which reflect new technology and other physician work that are not accurately reportable prior to implementation. These services are outside the scope of any payment initiatives between the RUC and CMS, as described above, and are often billed as Category III codes or unlisted codes. Examples include the transcatheter pulmonary valve implantation code 3347A, the rib fracture fixation codes (21811-21813) and the high resolution anoscopy codes (46001 and 46607). Since codes of this nature are not accurately reportable prior to the creation of new codes, their RVU inputs cannot be considered revisions. **Taking into account the lack of predecessor payment and the CMS definition that the target will only consist of services with input changes, net RVU changes that result when new families of services are created should not count towards the target calculation.**

Phased-in Refinements

CMS proposes to phase-in over two years refinements that result in a year over year reduction in total RVUs of 20 percent or more. For purposes of calculating the net reduction target, CMS uses the fully reduced total RVUs, not the first year phase-in RVUs. However, for a subgroup of services, CMS proposes to not follow this standard. During review of the radiation treatment services, the Agency proposes a change in the equipment utilization rate assumption for the linear accelerator from 50 percent to 60 percent by CY 2016 and 70 percent for CY 2017. For purposes of calculating the target reduction for CY 2016, CMS uses the 60 percent threshold for these services. The RUC does not agree with this proposal because it creates two separate rules for codes affected by phased-in RVU reductions. As stated initially, CMS must establish an open, transparent process to ensure stakeholders are fully aware of the impact the net target reduction will have on physician payment. Establishing a consistent methodology for codes with phased-in RVU reductions is a necessary component of that mission. **CMS should calculate the full impact of the change in the linear accelerator equipment utilization for radiation treatment services, and any future instances of multi-year phase-in proposals, from the year CMS initially establishes the decision.**

Valuation of Specific Codes – Methodology for Establishing the Direct PE Inputs used to develop PE RVUs

Common Refinements

In the Proposed Rule, Table 13 lists the AMA RUC's direct practice expense (PE) recommendations accepted with refinements. In the preamble text this CMS explains some of the common refinements. The following is the RUC response to some of the issues that CMS identified as common refinements.

Changes in Work Time

The RUC agrees that some PE inputs are directly affected by revisions in work time and agrees with the example of this that are given in the proposed rule, intraservice portions of the work time and the number or level of postoperative visits associated with the global periods. However in the refinements table CMS seems to include discharge day management time in this category as well. In reviewing the PE refinements the RUC found 25 CPT codes where 6 minutes of discharge management same day (0.5 x 99238) time was removed. The CMS comment is "Aligned clinical labor discharge day management time with the work time discharge day code". The RUC disagrees with CMS that in the case of discharge time the clinical staff time in the facility setting aligns with the work time discharge day code. The work discharge time reflects physician work involved in discharging from a facility setting, so if the service is typically performed in the nonfacility setting the post-service time for 99238 will not be included. The practice expense is constructed differently, because if the service is provided, even infrequently, in the facility setting or the nonfacility setting, direct PE inputs for both settings are included in the RUC recommendation. In total there are 15 codes that are 000 day globals and the RUC agrees that for 000 day global services in the facility there should not be any discharge management time allotted to the clinical staff in the office. There are 9 010 day global services where the time was removed and the RUC disagrees with removing the 6 minutes for these services. Even if it is not included as discharge management, there is clinical staff time that needs to be accounted for. The clinical staff must instruct the patient regarding home care prior to the post-operative visit and call in any prescriptions that the patient needs for their recovery period. The RUC requests that CMS include the 6 minutes as 2 phone calls, under the direct PE input in the post-service period, *conduct phone calls/call in prescriptions* for the 010 global CPT codes 11760, 12041, 12054, 20240, 30300, 40804, 42809, 68801 and 68810.

In addition, CPT code 657XG was included in this group of services refined to remove 6 minutes of clinical staff time for same day discharge management. This service is a 090 day global, but is typically performed in the office. The RUC believes that the time was removed in error. In the rare occasion that the service is performed in the facility setting 6 minutes for discharge management for the clinical staff in the office is appropriate. The RUC requests that CMS include 6 minutes under the direct PE input in the post-service portion of the service period for *discharge mgmt. same day (0.5 x 99238)* as recommended for 657XG.

Standard Tasks and Minutes for Clinical Labor Tasks

The RUC contends that CMS overstates the extent to which the "other clinical activity" category on the PE spreadsheet is used. The RUC encourages the use of existing categories, but does accept some "other clinical activity" tasks only if the specialty society can provide a reasonable rationale regarding why it is needed. For existing codes under review because of the misvalued codes initiative the PE Subcommittee would hesitate to accept clinical labor activities that do not fit into a category, unless the additions were consistent with other codes in the family, and thus maintain relativity.. That being said the examples that CMS uses are from Pathology which has very different direct practice expense inputs than other

specialties and services. This practice may be more common among Pathology services and the RUC defers to Pathology to determine if the standard PE inputs presented toward the beginning of this proposed rule are appropriate or if a revised set of standard pathology clinical labor activities and times is feasible. The RUC understands that batching plays a key role in the direct PE inputs for pathology services and it may not be possible to have standard PE inputs across pathology.

The RUC has specific sets of PE standards for 000, 010, and 090 day global codes and very few for XXX global codes. These standards apply to common activities that most services have however there are differences between specialties and family of services. The RUC does not anticipate that code specific tasks can be standardized across all PE spreadsheets. The RUC will continue to allow the direct PE input for *other clinical activity,* while also working to minimize its utilization. We agree with the criteria that CMS has outlined to evaluate tasks included under other clinical activity: fully distinct from existing clinical labor tasks; typically included for other clinically similar services; and thoroughly explained in the recommendation. We will communicate these criteria to the specialty societies as well as the PE Subcommittee.

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 13, however there are many instances where the RUC disagrees with the refinements. Please see a complete list of the *CY 2016 Proposed Codes with Direct PE Input Recommendations Accepted with Refinements* with specialty society comments in the attached table.

Invoices Received for Existing Direct PE Inputs Table

The RUC appreciates CMS' effort to continually update equipment pricing by soliciting paid invoices from stakeholders. Table 10 lists invoices received for existing direct PE inputs including for a *radiofrequency generator* (EQ214), effecting CPT codes 41530, 43228, 43229, 43270, 64633, 64634 64635 and 64636. This invoice was submitted in relation to CPT code 41530, an otolaryngology code, and is not the same radiofrequency generator used to perform the services described by CPT codes 64633, 64634, 64635 and 64636. The invoice received leads CMS to reduce the price of this input from $32,900 to $10,000, which would have a significantly negative impact on the practice expense for the services associated with this piece of equipment. The RUC requests that the equipment input represented in the invoice be assigned an equipment code separate from existing code EQ214 and that CMS maintains the current price of $32,900 for EQ214.

Establishing CY 2016 Interim Work Relative Values

For many of CMS' proposed work RVU recommendations that differed from the RUC recommendation, the Agency employed a variety of ratio formulas to derive their alternate proposed work value. These calculations often involved multiplying the work RVU by a ratio derived from the difference between the RUC recommended physician time and existing physician time. The components of total time (pre-service time, intra-service time, post-service time, post-operative visits) consist of differing levels of physician intensity with code specific durations—and it is therefore inaccurate to apply time ratios from one code to the another, as has been done, when more than one type of physician time is involved. In many scenarios, CMS selects an arbitrary combination of inputs to apply, including: total physician time, intra-service physician time, "CMS/Other" physician times, Harvard study physician times, existing work RVUs, RUC-recommended work RVUs, work RVUs from CMS-selected crosswalks, work RVUs from a base code, etc. This selection process has the appearance of seeking an arbitrary value from the vast array

of possible mathematical transformations, rather than seeking a valid clinically relevant relationship that would preserve relativity. **The RUC is increasingly concerned that CMS is eschewing the bedrock principles of valuation within the RBRVS (namely, magnitude estimation, survey data and clinical expertise) in favor of arbitrary mathematical formulas. The RUC urges CMS to continue to value services using the established methodology of magnitude estimation.**

Lower GI Endoscopy Services and Sleeve Gastrectomy (43775, 44380-46607, G0104, G0105, G0121)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy)	21.4	20.38	Disagree
44380	Ileoscopy, through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	0.97	0.90	Disagree
44381	Ileoscopy, through stoma; with transendoscopic balloon dilation	1.48	1.48	Agree
44382	Ileoscopy, through stoma; with biopsy, single or multiple	1.27	1.20	Disagree
44384	Ileoscopy, through stoma; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)	3.11	2.88	Disagree
44385	Endoscopic evaluation of small intestinal pouch (eg, Kock pouch, ileal reservoir [S or J]); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	1.30	1.23	Disagree
44386	Endoscopic evaluation of small intestinal pouch (eg, Kock pouch, ileal reservoir [S or J]); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	1.60	1.53	Disagree
44388	Colonoscopy through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	2.82	2.75	Disagree
44389	Colonoscopy through stoma; with biopsy, single or multiple	3.12	3.05	Disagree
44390	Colonoscopy through stoma; with removal of foreign body(s)	3.82	3.77	Disagree
44391	Colonoscopy through stoma; with control of bleeding, any method	4.22	4.22	Agree
44392	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	3.63	3.63	Agree

44394	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	4.13	4.13	Agree
44401	Colonoscopy through stoma; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre-and post-dilation and guide wire passage, when performed)	4.44	4.44	Agree
44402	Colonoscopy through stoma; with endoscopic stent placement (including pre- and post-dilation and guide wire passage, when performed)	4.96	4.73	Disagree
44403	Colonoscopy through stoma; with endoscopic mucosal resection	5.81	5.53	Disagree
44404	Colonoscopy through stoma; with directed submucosal injection(s), any substance	3.13	3.05	Disagree
44405	Colonoscopy through stoma; with transendoscopic balloon dilation	3.33	3.33	Agree
44406	Colonoscopy through stoma; with endoscopic ultrasound examination, limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures	4.41	4.13	Disagree
44407	Colonoscopy through stoma; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures	5.06	5.06	Agree
44408	Colonoscopy through stoma; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed	4.24	4.24	Agree
45330	Sigmoidoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	0.84	0.77	Disagree
45331	Sigmoidoscopy, flexible; with biopsy, single or multiple	1.14	1.07	Disagree
45332	Sigmoidoscopy, flexible; with removal of foreign body(s)	1.85	1.79	Disagree
45333	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	1.65	1.65	Agree
45334	Sigmoidoscopy, flexible; with control of bleeding, any method	2.10	2.10	Agree
45335	Sigmoidoscopy, flexible; with directed submucosal injection(s), any substance	1.15	1.07	Disagree

45337	Sigmoidoscopy, flexible; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed	2.20	2.20	Agree
45338	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	2.15	2.15	Agree
45340	Sigmoidoscopy, flexible; with transendoscopic balloon dilation	1.35	1.35	Agree
45341	Sigmoidoscopy, flexible; with endoscopic ultrasound examination	2.43	2.15	Disagree
45342	Sigmoidoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)	3.08	3.08	Agree
45346	Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)	2.97	2.84	Disagree
45347	Sigmoidoscopy, flexible; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)	2.98	2.75	Disagree
45349	Sigmoidoscopy, flexible; with endoscopic mucosal resection	3.83	3.55	Disagree
45350	Sigmoidoscopy, flexible; with band ligation(s) (eg, hemorrhoids)	1.78	1.78	Agree
45378	Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	3.36	3.29	Disagree
45379	Colonoscopy, flexible; with removal of foreign body(s)	4.37	4.31	Disagree
45380	Colonoscopy, flexible; with biopsy, single or multiple	3.66	3.59	Disagree
45381	Colonoscopy, flexible; with directed submucosal injection(s), any substance	3.67	3.59	Disagree
45382	Colonoscopy, flexible; with control of bleeding, any method	4.76	4.76	Agree
45384	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	4.17	4.17	Agree
45385	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	4.67	4.67	Agree
45386	Colonoscopy, flexible; with transendoscopic balloon dilation	3.87	3.87	Agree
45388	Colonoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)	4.98	4.98	Agree

45389	Colonoscopy, flexible; with endoscopic stent placement (includes pre- and post-dilation and guide wire passage, when performed)	5.50	5.27	Disagree
45390	Colonoscopy, flexible; with endoscopic mucosal resection	6.35	6.07	Disagree
45391	Colonoscopy, flexible; with endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures	4.95	4.67	Disagree
45392	Colonoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures	5.60	5.60	Agree
45393	Colonoscopy, flexible; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed	4.78	4.78	Agree
45398	Colonoscopy, flexible; with band ligation(s) (eg, hemorrhoids)	4.30	4.30	Agree
46500	Injection of sclerosing solution, hemorrhoids	1.69	1.42	Disagree
46601	Anoscopy; diagnostic, with high-resolution magnification (HRA) (eg, colposcope, operating microscope) and chemical agent enhancement, including collection of specimen(s) by brushing or washing, when performed	1.60	1.60	Agree
46607	Anoscopy; with high-resolution magnification (HRA) (eg, colposcope, operating microscope) and chemical agent enhancement, with biopsy, single or multiple	2.20	2.20	Agree
G0104	Colorectal cancer screening; flexible sigmoidoscopy	0.84	0.77	Disagree
G0105	Colorectal cancer screening; colonoscopy on individual at high risk	3.36	3.29	Disagree
G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk	3.36	3.29	Disagree

In reviewing the RUC recommendations for the lower GI endoscopy series of codes, CMS states:

> *Where we did not agree [with the RUC's recommendations], we consistently applied the incremental methodology… To calculate the base RVU for the colonoscopy subfamily, we looked at the current intraservice time for CPT code 45378 Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed, which is 30 minutes, and the current work RVU, which is 3.69. The RUC recommended an intraservice time of 25 minutes and 3.36 RVUs. We then compared that service to the*

> *base EGD CPT code 43235 Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed for which the RUC recommended a work RVU of 2.26, giving an increment between EGD and colonoscopy of 1.10 RVUs. We added that increment to our proposed work RVU for CPT 43235 of 2.19 to arrive at our proposed work RVU for the base colonoscopy CPT code 45378 of 3.29.*

Prior to responding to the specifics of the CMS proposed methodology, the RUC seeks clarification on the rationale for these changes. CMS proposed work RVU changes to 26 CPT codes recommendations submitted by the RUC. For each service, CMS provided no rationale for why these changes were made. It appears that they made the decision to selectively lower the value of specific services including, stent placement, ablation, foreign body removal and submucosal injections. However, without stating why the RUC recommended work increments for these components are inappropriate compared to work component increments in which CMS found appropriate (e.g. balloon dilation or hot biopsy), these reductions appear arbitrary and punitive. Furthermore, analysis of the CMS proposed changes show that the average reduction is less than 5 percent. Without any additional rationale, it is difficult to understand how the CMS decisions provide additional accuracy to the individual work values of these services.

To be clear, while the RUC and the involved specialty societies applied the incremental methodology to value the vast majority of both the upper and lower GI endoscopy services over several years, each recommended work value was scrutinized under the broad concept of magnitude estimation. This ensured that each recommendation was appropriate to other codes across the RBRVS. 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.

Increments between Separate Families of Services

The most troubling feature of the CMS proposal is the methodology used to establish the work RVU for the base colonoscopy code 45378 *Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed*. CMS compared the current RUC recommended work RVU for code 45378 to last year's RUC recommended work RVU for code 43235 *Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed* and determined an increment of 1.10 work RVUs between these two recommendations. Establishment of an increment in this fashion is unprecedented and inappropriate.

During the review of roughly 50 upper and lower GI endoscopy services over the period of two years, the RUC established an incremental methodology that set a specific work value increment to a specific component of physician work included in addition to the main endoscopy procedure. These increments were then carried forward, as appropriate, to each family of service within both the upper and lower GI endoscopy services. However, at no time were base procedures across families of services used to establish increments.

The RUC takes the relativity between services across families very seriously when valuing a service. However, measuring relativity differences between services with different physician work is done using magnitude estimation, not assigning an exact increment. For each separate base procedure, the RUC reviewed the survey data and similar reference services to establish an appropriate base work value for that family of services. Establishing increments for the physician work of additional work components is only beneficial when accurate base values are established. Thus, relying on exact comparisons between completely different base procedures is counterintuitive to the incremental approach, which is trying to measure the additional work which is objectively quantifiable regardless of the procedures performed in

tandem. **Given the unprecedented use of the CMS methodology, the RUC requests that CMS accept the RUC recommendations for the following services.**

Colonoscopy

As mentioned above, CMS reduced the RUC recommended work value for the base colonoscopy service 45378, by determining an increment of 1.10 between the RUC recommended work RVU for this service and the CY 2015 RUC recommended work RVU for EGD base code 43235. The Agency then added that increment to the work RVU that CMS adopted for the EGD code of 2.19 RVUs to arrive at the CY 2016 proposed work RVU for the base colonoscopy CPT code 45378 of 3.29. The RUC does not agree with this valuation and finds CMS' employment of this convoluted methodology concerning. Deriving an exact increment between the work of colonoscopy, performed in the lower GI tract, and an EGD, performed in the upper GI tract is inappropriate. CPT code 45378 is a more intense procedure than code 43235, with nearly double the intra-service time. Therefore, the incremental approach in this comparison is invalid. There is no analogous physician work between these two services that can be independently assessed incrementally and added to the base procedures. Both these services represent their respective family's base procedure.

The RUC spent a great deal of time reviewing this procedure as it represents the base value for many high volume, critically important services. After reviewing the survey data of 165 practicing gastroenterologists, general surgeons, and colon and rectal surgeons, the RUC determined that the 25th percentile work value at 3.60 was too high. Therefore, the RUC reviewed the Key Reference Service CPT code 31625 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites* (work RVU= 3.36) and noted that while the reference code has 5 additional minutes of intra-service time, 30 minutes compared to 25 minutes, 45378 is a slightly more intense procedure and should be valued identically to 31625. Therefore, the RUC recommended a direct work RVU crosswalk from 31625 for code 45378. The RUC agreed that a work RVU of 3.36 was appropriate because it represented a reasonable reduction in value commensurate with the reduction in intra-service time.

For CMS to further reduce the work RVU from 3.36, below the survey 25th percentile, is unwarranted and arbitrary. **Considering that CMS uses an unprecedented methodology, with no further justification using magnitude estimation, CMS should accept the RUC recommended work RVU of 3.36 for CPT code 45378.**

Since CMS, for the rest of the family of services, uses the incremental methodology in a sound manner, the RUC simply requests that the RUC recommendations for 45378 be accepted and the RUC recommended increments be applied to the following colonoscopy codes.

- **CPT Code 45379 – RUC Recommended work RVU of 4.37**
- **CPT Code 45380 – RUC Recommended work RVU of 3.66**
- **CPT Code 45381 – RUC Recommended work RVU of 3.67**
- **CPT Code 45389 – RUC Recommended work RVU of 5.50**
- **CPT Code 45390 – RUC Recommended work RVU of 6.35**
- **CPT Code 45391 – RUC Recommended work RVU of 4.95**

Ileoscopy

CMS reviewed the Ileoscopy base procedure CPT code 44380 *Ileoscopy, through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed* and compared it to their

recommended work RVU of 3.29 for the base colonoscopy code 45378. The Agency then calculated the incremental difference between the RUC recommended work RVU for 45378 (work RVU= 3.36) and 44380 (work RVU= 0.97). The resulting RVU difference, 2.39, was then subtracted from the CMS proposed work RVU for 45378 (3.29) for a resulting work value of 0.90 for CPT code 44380.

The RUC reiterates its insistence that determining incremental differences between base procedures across families is counterintuitive to the goal of the incremental approach. These two services have vastly different intensity and complexities (44380, IWPUT= 0.017 and 45378, IWPUT= 0.100), while the colonoscopy code has almost double the intra-service time. Given the vast differences between the two base procedures, ensuring these two services are relative using magnitude estimation is the most appropriate methodology.

The RUC reviewed the survey data from 76 gastroenterologists and gastrointestinal and endoscopic surgeons and determined that the survey's 25th percentile work RVU of 1.30 was too high. So, the RUC reviewed CPT code 91040 *Esophageal balloon distension provocation study* (work RVU= 0.97) and noted that both services have identical intra-service time of 15 minutes and similar total time, 45 minutes and 50 minutes, respectively. The RUC agreed that code 44380 should be value at 0.97 work RVUs, identical to the reference code. In addition, to ensure relativity within the endoscopic family, the RUC noted that the recommended RVU of 0.97 places diagnostic ileoscopy appropriately between diagnostic flexible sigmoidoscopy (RUC recommended work RVU= 0.84) and diagnostic esophagoscopy (RUC recommended work RVU= 1.59) in terms of comparative physician work. By eschewing magnitude estimation, the CMS proposed incremental cut is arbitrary, lacking any reasonable validity to further reducing the RUC's recommendation, which was below the current value and the survey 25th percentile. **Therefore, CMS should accept the RUC recommended work RVU of 0.97 for CPT code 44380.**

Since CMS, for the rest of the family of services, uses the incremental methodology in a sound manner, the RUC simply requests that the RUC recommendations for 44380 be accepted and the RUC recommended increments be applied to the following ileoscopy codes.

- **CPT Code 44382 – RUC Recommended work RVU of 1.27**
- **CPT Code 44384 – RUC Recommended work RVU of 3.11**

Pouchoscopy

CMS reviewed the pouchoscopy base procedure CPT code 44385 *Endoscopic evaluation of small intestinal pouch (eg, Kock pouch, ileal reservoir [S or J]); diagnostic, including collection of specimen(s) by brushing or washing, when performed* and compared it to their recommended work RVU of 3.29 for the base colonoscopy code 45378. The Agency then calculated the incremental difference between the RUC recommended work RVU for 45378 (work RVU= 3.36) and 44385 (work RVU= 1.30). The resulting RVU difference, 2.06, was then subtracted from the CMS proposed work RVU for 45378 (3.29) for a resulting work value of 1.23 for CPT code 44385.

As with the previous base codes, the pouchoscopy base service and the colonoscopy base code offer no directly comparable increment of physician work. CPT code 45378 has nearly three times the intensity and complexity of 44385 (44385, IWPUT= 0.036 and 45378, IWPUT= 0.100), with nearly double the intra-service time. Furthermore, the RUC reviewed the survey results from 63 gastroenterologists and several surgical subspecialties including: general, gastrointestinal, endoscopic and colorectal and determined that the 25th percentile work RVU of 1.30 was appropriate. This was a decrease of 28% from the current value, 1.82. The RUC noted that the recommended work RVU of 1.30 maintains the appropriate rank order between this pouchoscopy diagnostic procedure and the ileoscopy and esophagoscopy diagnostic

procedures. The RUC's original recommendation of 1.30 appropriately placed this service relative to services both within and outside the family of services. CMS provided no additional rationale for its proposed work value and provided no further justification as to why their proposed value is more appropriate than the RUC recommendation. **Therefore, CMS should accept the RUC recommended work RVU of 1.30 for CPT code 44385.**

Since CMS, for the other service in the family, uses the incremental methodology in a sound manner, the RUC simply requests that the RUC recommendations for 44385 be accepted and the RUC recommended increment be applied to the following pouchoscopy code.

- **CPT Code 44386 – RUC Recommended work RVU of 2.82**

Colonoscopy through Stoma

CMS reviewed the colonoscopy through stoma base procedure CPT code 44388 *Colonoscopy through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed* and compared it to their recommended work RVU of 3.29 to the base colonoscopy code 45378. The Agency then calculated the incremental difference between the RUC recommended work RVU for 45378 (work RVU= 3.36) and 44388 (work RVU= 2.82). The resulting RVU difference, 0.54, was then subtracted from the CMS proposed work RVU for 45378 (3.29) for a resulting work value of 2.75 for CPT code 44388.

As with the previous base codes, the colonoscopy through stoma base service and the colonoscopy base code are separate, distinct procedures and should not have values that are computed based on the difference between their individual work RVUs. The RUC reviewed the survey results of 86 gastroenterologists, general surgeons, and colon and rectal surgeons and noted that the current value of 2.82 is below the survey 25th percentile. Therefore, the RUC determined that there was no compelling evidence to increase the value and recommended the current value of 2.82. However, the RUC also made it clear that there is no evidence that the work intensity has lessened since the last valuation. No technological or patient demographic changes have occurred; thus, the current value remains valid. **Therefore, CMS should accept the RUC recommended work RVU of 1.30 for CPT code 44385.**

Since CMS, for the rest of the family of services, uses the incremental methodology in a sound manner, the RUC simply requests that the RUC recommendations for 44388 be accepted and the RUC recommended increments be applied to the following colonoscopy through stoma codes.

- **CPT Code 44388 – RUC Recommended work RVU of 2.82**
- **CPT Code 44389 – RUC Recommended work RVU of 3.12**
- **CPT Code 44390 – RUC Recommended work RVU of 3.82**
- **CPT Code 44402 – RUC Recommended work RVU of 4.96**
- **CPT Code 44403 – RUC Recommended work RVU of 5.81**
- **CPT Code 44404 – RUC Recommended work RVU of 3.13**

Sigmoidoscopy

CMS reviewed the sigmoidoscopy base procedure CPT code 45330 *Sigmoidoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed* and compared it to their recommended work RVU of 3.29 for the base colonoscopy code 45378. The Agency then calculated the incremental difference between the RUC recommended work RVU for 45378 (work RVU= 3.36) and 45330 (work RVU= 0.84). The resulting RVU difference, 2.52, was then subtracted from the CMS proposed work RVU for 45378 (3.29) for a resulting work value of 0.77 for CPT code 45330.

As with the previous base codes, the sigmoidoscopy base service and the colonoscopy base code offer no directly comparable increment of physician work. CPT code 45330 has over four times the intensity and complexity of 44385 (44385, IWPUT= 0.022 and 45378, IWPUT= 0.100), with nearly triple the intra-service time. The RUC reviewed the survey results of 103 gastroenterologists, general surgeons, and colon and rectal surgeons and noted that the survey's 25th percentile work RVU of 1.00 was too high. To value this service, the RUC reviewed CPT code 12001 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less* (work RVU= 0.84) and agreed that since both these services have identical intra-service time and similar work intensity, they should be valued identically. The RUC agreed that a work RVU of 0.84, a direct crosswalk to code 12001, appropriately valued 45330 to similar services across the RBRVS. This value represents a 13% decrease from the current value. Therefore, an additional arbitrary reduction, as CMS proposes, is simply unnecessary. **CMS should accept the RUC recommended work RVU of 0.84 for CPT code 45330.**

Since CMS, for the rest of the family of services, uses the incremental methodology in a sound manner, the RUC simply requests that the RUC recommendations for 45330 be accepted and the RUC recommended increments be applied to the following sigmoidoscopy codes.

- **CPT Code 45331 – RUC Recommended work RVU of 1.14**
- **CPT Code 45332 – RUC Recommended work RVU of 1.85**
- **CPT Code 45335 – RUC Recommended work RVU of 1.15**
- **CPT Code 45341 – RUC Recommended work RVU of 2.43**
- **CPT Code 45346 – RUC Recommended work RVU of 2.97**
- **CPT Code 45347 – RUC Recommended work RVU of 2.98**
- **CPT Code 45349 – RUC Recommended work RVU of 3.83**

Malpractice (PLI) Crosswalk

CMS notes that for five codes in the family (43775, 44407, 44408, 46601 and 46607) the Agency received PLI crosswalk codes from the RUC which were inconsistent with the CMS expected specialty mix. CMS proposes to use the specialty mix of the source code(s) in the RUC-recommended utilization crosswalk in order to calculate the malpractice risk factor for these services instead of the RUC-recommended PLI crosswalk. The RUC notes that for CPT code 43775, the original RUC recommendation was submitted in 2010. There is currently Medicare utilization for this service for 2014 and this newer data should be used to determine the PLI RVU. The RUC does not agree with this proposed decision for the four remaining services. These codes received appropriate PLI crosswalks based off the intended specialty mix. The Agency's decision to use the utilization crosswalk information to ascertain a more appropriate PLI crosswalk is irrational because the current utilization for these services is reported in either unlisted CPT codes or category III codes. If CMS were to use the current codes as PLI crosswalks, the anticipated PLI RVUs will not represent any of the risk associated with four of these procedures. Therefore, CMS should accept the following RUC recommended PLI crosswalks, as originally submitted:

- **CPT Code 44407 – PLI Crosswalk - 45382**
- **CPT Code 44408 – PLI Crosswalk - 44394**
- **CPT Code 46601 – PLI Crosswalk – 45520**
- **CPT Code 46607 – PLI Crosswalk - 45520**

Radiation Treatment and Related Image Guidance Services

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
77014	Computed tomography guidance for placement of radiation therapy fields	0.85	0.85	Agree
77402	Radiation treatment delivery, >= 1 MeV; simple	N/A (PE Only)	N/A (PE Only)	N/A
77407	Radiation treatment delivery, >= 1 MeV; intermediate	N/A (PE Only)	N/A (PE Only)	N/A
77412	Radiation treatment delivery, >= 1 MeV; complex	N/A (PE Only)	N/A (PE Only)	N/A
77385	Intensity modulated treatment radiation delivery (IMRT), includes guidance and tracking when performed, simple	N/A (PE Only)	N/A (PE Only)	N/A
77386	Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking when performed, complex	N/A (PE Only)	N/A (PE Only)	N/A
77387	Guidance for localization of target volume for delivery of treatment delivery, includes intrafraction tracking when performed	0.58	0.58	Agree

Background

At the October 2013 CPT Editorial Panel meeting, the Panel deleted 14 radiation treatment and related imaging codes and replaced them with the new code set listed in the table above. Intensity Modulated Radiation Therapy (IMRT) treatment delivery, previously reported under a single CPT code, was split into two new codes, 77385 *Intensity modulated treatment delivery, includes guidance and tracking when performed: simple* and 77386 *Intensity modulated treatment delivery, includes guidance and tracking when performed: complex*. One new code was also created to report guidance for localization for delivery of radiation therapy (IGRT), CPT code 77387 *Guidance for localization of target volume for delivery of treatment delivery, includes intrafraction tracking when performed*. The Panel also revised three codes to report radiation treatment delivery: simple, intermediate and complex. In the revised CPT code set, IGRT is now bundled into the IMRT codes.

On-board Imaging

CMS proposed significant changes to the image guidance equipment for the new radiation treatment delivery and IGRT codes. The Agency stated their belief that the direct practice expense (PE) input for the linear accelerator (ER089) already included "on-board imaging" (OBI) capability and proposed to reject the RUC's Recommendation to include OBI as a separate PE line item of the new IMRT codes and for the new IGRT code 77387.

The specialty societies which presented these code families to the RUC did not submit the invoice(s) used to price ER089; the process CMS used to value ER089 was not made public. The presenting societies explained to the RUC that a linear accelerator with integrated on-board imaging capabilities costs much more than the current price for ER089 and noted their belief that ER089 only represents the expense for a

linear accelerator without OBI capabilities. Furthermore, as IGRT continued to be separately reportable from IMRT after ER089 was created in 2012, it would not have made sense for OBI capability to have been included with ER089. The RUC is very concerned that CMS may have incorrectly assumed that ER089 included integrated on-board imaging.

A linear accelerator without OBI capabilities can undergo an upgrade to give it the capability for on-board imaging. This upgrade necessitates a separate direct practice expense to install on-board imaging capability. The RUC submitted three invoices to CMS which account for this added equipment expense for making this upgrade.

The RUC urges CMS to accept its original direct practice expense recommendations for CPT codes 77385 and 77386. It is CMS's statutory obligation to pay procedures based on the actual resource costs expended. Direct practice expense inputs for on-board imaging would need to be incorporated into these new IMRT and IGRT codes for the practice expense to accurately reflect practice costs.

Image Guidance Services

The RUC appreciates CMS' acceptance of the RUC's work RVU recommendation of 0.58 RVUs for CPT code 77387 *Guidance for localization of target volume for delivery of treatment delivery, includes intrafraction tracking when performed*. Regarding CMS' request for comment on the appropriate work time for this service, the RUC reiterates its recommendation of 3 minutes of pre-service time, 10 minutes of intra-service time and 3 minutes of post-service time for CPT code 77387. The total time for the RUC recommendation is lower than the existing times for 77014 *CT guidance* and 77421 *stereoscopic x-ray guidance* and higher than the total time for 76950 ultrasound guidance; it is unclear what increase in time CMS is referencing in their comments.
Also, the RUC appreciates CMS' acceptance of the RUC's recommendation to maintain the work RVUs for CPT code 77014 *Computed tomography guidance for placement of radiation therapy fields*. As stated in the RUC's recommendation, the RUC projects for the Medicare utilization of CPT code 77014 to drop to negligible levels shortly after implementation of new CPT code 77387. The RUC will re-review CPT Code 77014 once the new radiation treatment delivery codes go into effect and two years of Medicare data are available.

Separately, CMS expressed concern for potential duplication of the linear accelerator capital costs between radiation treatment delivery codes 77402, 77407 and 77412 and image guidance code 77387. The RUC would like to clarify that its practice expense recommendations for these services are not duplicative and are consistent with all existing and new CPT introductory language. Radiation treatment delivery codes 77402, 77407 and 77412 do not have direct practice expense inputs for image guidance as the direct practice expense input for the linear accelerator ER089 is for a linear accelerator without on-board imaging capability, and no separate direct PE line item for the on-board imaging upgrade was included in the RUC recommendation for these services. Also, the radiation treatment delivery codes and the image guidance code both have the same linear accelerator input (ER089) since these recommendations are time-based. When guidance is needed with conventional radiation treatment delivery, the linear accelerator is used for a longer period of time which necessitates incorporating minutes for the linear accelerator into both the conventional radiation treatment codes and the image guidance code. **The RUC urges CMS to accept its original direct practice expense inputs for CPT codes 77402, 77407, 77412 and 77387.**

Equipment Utilization Rate for Linear Accelerators

CMS proposed a change in the equipment utilization rate assumption for the linear accelerator from 50 percent to 60 percent by CY 2016 and 70 percent for CY 2017. The RUC recommends for CMS to give consideration to the impacts of this proposal on rural practice, as utilization rates may not be as high as in urban areas. In addition, if CMS decides to finalize the proposal to change the utilization rate to 60 percent for CY 2016 and 70 percent for CY 2017, the RUC recommends that the impact of the full 70 percent utilization rate be counted in the redistribution total as required under the Medicare Access and CHIP Reauthorization Act (MACRA). Although, CMS is proposing to transition the percentage over a 2 year period, the RUC believes that the full impact of any proposal should be measured from the year CMS made the proposal.

Radiation Treatment Delivery Rank-order Anomaly

CMS included estimated CY2016 PE RVUs for the three new treatment delivery codes in Addenda B of the NPRM. The RUC is concerned about a practice expense RVU rank-order anomaly for the new family of codes for Radiation Treatment Delivery:

CPT code	Descriptor	CMS Proposed NF PE RVUS
77402	Radiation treatment delivery, >= 1 MeV; simple	3.84
77407	Radiation treatment delivery, >= 1 MeV; intermediate	6.63
77412	Radiation treatment delivery, >= 1 MeV; complex	5.89

CPT code 77412 *Radiation treatment delivery, >= 1 MeV; complex* has lower proposed PE RVUs than CPT code 77407 *Radiation treatment delivery, >= 1 MeV; intermediate* despite having more expensive direct practice expense inputs. This may be due to an anomaly in the data used to calculate indirect practice expense. The highest-volume service that was bundled into 77407 was done primarily by dermatologists. Dermatology has a higher indirect PE allocation than radiation oncology, which potentially impacted the relative indirect PE for codes 77407 and 77412. So, despite the direct cost portion of the RVU being higher for 77412 than 77407, the PE RVUs are projected to be lower. Although this is not an "error" in the data, the outcome is not logical. **The RUC recommends for CMS to work with stakeholders to estimate projected utilization data and use that in the formula to establish CY2016 NF PE RVUs for CPT codes 77402, 77407 and 77412 to correct this rank order anomaly.**

Advance Care Planning Services

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
99497	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate	1.50	Status A	Agree
99498	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)	1.40	Status A	Agree

CMS proposes to implement CPT codes 99497 and 99498 *Advance care planning* on January 1, 2016, with a Medicare Physician Payment Schedule indicator of "A" for active status. CMS proposes to adopt the RUC recommended values (work RVUs, physician time, and direct PE inputs). **The RUC agrees with the CMS proposal and urges the Agency to implement the RUC recommendations for advance care planning.**

Bone Biopsy Excisional (CPT Code 20240)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
20240	Biopsy, bone, open; superficial (eg, ilium, sternum, spinous process, ribs, trochanter of femur)	3.73	2.61	Disagree

The RUC recommends that CMS reconsider its decision to not accept the RUC recommendation for CPT code 20240 listed in the table above. The RUC requested and CMS approved a global period change for 20240 from a 010-day to a 000-day global period. Instead of accepting the RUC's recommendation, which had fully accounted for the global period change, CMS used a reverse building-block methodology to further reduce the work value by the RVUs of the previously bundled post-operative visits. Simply using a reverse building block methodology to systematically convert a 010-day global code to 000-day global code by backing out the bundled E/M services is highly inappropriate, due to the fact that magnitude estimation was used initially when establishing the work RVUs for surgical codes and since the RUC already fully accounted for the unbundling of post-operative visits during its deliberations. In addition, CMS' proposed work RVU has an inappropriately low work intensity, valuing it similar to a nursing visit (code 99211). This is a perfect illustration of the RUC's concern with CMS mathematical manipulations and its overarching approach to global code conversion, which if maintained will result in a

value that is anomalous and unable to be reconciled for relativity within the PFS. There is no rational justification for the CMS proposed value, which is at odds with all multidisciplinary input from the RUC and the specialties that perform the procedure. That input is based upon clinical understanding of the procedures as well as a full, considered and complete understanding to related codes, their values, and the source and veracity of those values and times.

The RUC emphasizes that this service met its compelling evidence criteria for being potentially misvalued. CMS' reliance on existing work RVU and time to derive a new proposed work value for this potentially misvalued service is misguided, as the service was last valued by the Harvard study over 20 years ago. The RUC agreed with the specialty society that incorrect assumptions were made in the previous valuation of the service. The current intra-service time is based on a Harvard study of 8 general surgeons, while the pre- and post-service times were derived from an algorithm. Furthermore, the Harvard survey of general surgeons no longer represents the dominant provider, which is now podiatry.

The RUC recommendation is based on pre-service time of 58 minutes, intra-service time of 30 minutes and immediate post-service time of 30 minutes. The RUC reviewed the survey respondents' 25th percentile work RVU of 3.73 accurately values the physician work of CPT code 20240. To justify a work RVU of 3.73, the RUC reviewed many 000-day reference codes which provided strong support for this service, including CPT codes 11044, 52214, 52224 and several other recently reviewed 000-day services which had identical intra-service time to the survey code. **The RUC urges CMS to accept its original recommendation of 3.73 RVUs for CPT code 20240.**

Endotracheal Ultrasound (EBUS): 31622, 3160A, 3160B, 31625, 31626, 31628 31629, 3160C, 31632, 31633

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
31622	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)	2.78	2.78	Agree
3160A	with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration(s)/biopsy(ies)), one or two mediastinal and/or hilar lymph node stations or structures	5.00	4.71	Disagree
3160B	with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration(s)/biopsy(ies), 3 or more mediastinal and/or hilar lymph node stations or structures	5.50	5.21	Disagree

3160C	with endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) for peripheral lesion(s) (List separately in addition to code for primary procedure[s])	1.70	1.40	Disagree
31625	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites	3.36	3.36	Agree
31626	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of fiducial markers, single or multiple	4.16	4.16	Agree
31628	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe	3.80	3.80	Agree
31629	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)	4.00	4.00	Agree
31632	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), each additional lobe (List separately in addition to code for primary procedure)	1.03	1.03	Agree
31633	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), each additional lobe (List separately in addition to code for primary procedure)	1.32	1.32	Agree

After reviewing these services, CMS states:

> *For CY 2016, the CPT Editorial Panel deleted one code, CPT 31620 (Ultrasound of lung airways using an endoscope), and created three new codes, CPT 3160A-3160C, to describe bronchoscopic procedures that are inherently performed with endobronchial ultrasound (EBUS). In their review of the newly revised EBUS family, the RUC recommended a change in the work RVU for CPT code 31629 from 4.09 to 4.00. The RUC also recommended maintaining the current work RVUs for CPT codes 31622, 31625, 31626, 31628, 31632 and 31633. We are proposing to use those values for CY 2016.*

> *For the newly created codes, the RUC recommended a work RVU of 5.00 for CPT code 3160A, 5.50 for CPT code 3160B and 1.70 for CPT code 3160C. We believe the recommended work RVUs for these services overstate the work involved in furnishing the procedures. In order to develop proposed work RVUs for CPT code 3160A, we compared the service described by the new code to deleted CPT codes 31620 and 31629, because this new code describes a service that combines services described by 31620 and 31629. Specifically, we took the sum of the current work RVU of CPT code 31629 (WORK RVU=4.09) and the CY 2015 work RVU of CPT code 31620 (WORK RVU=1.40) and multiplied it by the quotient of CPT code 3160A's RUC-recommended intraservice time (INTRA=60 min) and the sum of CPT codes 31620 and 31629's current and CY 2015 intraservice times (INTRA=70 min), respectively. This resulted in a work RVU of 4.71 and we are proposing that value. To value CPT code 3160B, we used the RUC recommended increment of 0.5work RVU between this service and CPT code 3160A to calculate for CPT code 3160B our proposed work RVUs of 5.21. Lastly, because the service described by new CPT code 3160C is very similar to deleted CPT code 31620, we believe a direct crosswalk of the previous values for 31620 accurately reflects the time and intensity of furnishing the service described by 3160C. Therefore, we are proposing a work RVUs of 1.40 for CPT code 3160C.*

3160A ***Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration(s)/biopsy (ies)), one or two mediastinal and/or hilar lymph node stations or structures***
The RUC disagrees with the calculations used by the Agency to arrive at work RVU for 3160A. First, CMS's calculation is based on inconsistent data. CMS uses work RVUs from deleted codes, CY 2015 work RVUs for existing codes in which different work RVUs for CY 2016 are proposed and a ratio of intra-service time from deleted and new codes without accounting for the work associated with physician pre-service and post-service time. Second CMS's calculation does not include 31633 (each additional lobe) in its base calculation. Newly described 3160A service was previous reported with 31629, 31620 and 31633 if an additional lobe was treated.

The RUC reiterates that the 2015 current coding structure for this would involve 5.49 RVUs for one lymph node station (31629 + 31620) and 6.81 for two lymph node stations (31629 + 31620 + 31633). The RUC recommendation of a work RVU of 5.00 appropriately accounted for the work required to perform this service based on survey data and magnitude estimation. **The RUC recommends that CMS use magnitude estimation and not an inconsistent calculation to arrive at an appropriate work RVU for 3160A. The RUC urges CMS to accept a work RVU of 5.00 for code 3160A.**

3160B ***Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration(s)/biopsy (ies), 3 or more mediastinal and/or hilar lymph node stations or structures***
The RUC does not agree with the aforementioned calculation CMS conducted to derive a work RVU for code 3160A, and therefore does not agree with the proposed recommendation of 5.21 work RVUs for 3160B. The RUC would like to reiterate that the 2015 coding structure for this would involve 8.13 RVUs for three lymph node stations (31629 + 31620 + 31633 + 31633). The RUC used survey data and magnitude estimation to recommend a work RVU of 5.50 for code 3160B. The RUC does not agree with CMS using a work RVU increment of 0.50 added to the calculated work RVU for 3160A, as it is no longer the appropriate magnitude estimation when the work RVU of 3160A is adjusted to an erroneous value. **The RUC recommends that CMS use magnitude estimation, instead of an incorrect calculation to arrive at an appropriate work RVU for 3160B. The RUC urges CMS to accept a work RVU of 5.50 for code 3160B.**

3160C ***Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) for peripheral lesion(s) (List separately in addition to code for primary procedure[s])***
The RUC does not agree with CMS' proposal to crosswalk 3160C to deleted code 31620 *Endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) (List separately in addition to code for primary procedure[s])* (work RVU = 1.40 and intra-service time of 40 minutes). These services do not describe the same physician work or time and their use, by definition, creates new, anomalous relativity relationships within the PFS, and are not acceptable crosswalks. Code 3160C is a distinct and separate service from both 3160A and 3160B. Code and 3160C also requires a totally different device and indication. Code 3160C relates to the original radial probe catheter based EBUS introduced via the working channel of a standard bronchoscope. It acts as an add-on to a bronchoscopic procedure. It is now more commonly used to sample peripheral lesions and associated with various forms of inspection or sampling (31622 - 31627) but may at times be used to determine depth of tumor invasion in a bronchial wall. There are some situations where the available sampling devices will not reach the lesion or simply not be used by the operator for a number of safety or other technical concerns. Code 3160C may be used with 3160A and 3160B if nodal sampling and sampling of a peripheral lesion is warranted.

Additionally, the RUC flagged 31620 as "not to use to validate physician work". When the RUC reviewed CPT code 31620, it used the 25th percentile for physician time and determined that this service should not be used when establishing the work or time for other services. **The RUC urges CMS to accept a work RVU of 1.70 for CPT code 3160C.**

Practice Expense

Immediately following the January RUC meeting, CMS published a technical correction for the 2015 Final Rule that included new equipment codes used in this family of services, making the *endoscope, ultrasound radial probe (ES045), endoscope, ultrasound probe, drive (ES015),* and *endoscope, ultrasound probe, processor and keyboard (ES016)* no longer relevant as direct PE inputs for newly created CPT codes 3160A, 3160B, 3160C. The revised spreadsheet is included as an attachment to this letter. In the Proposed Rule for CY 2016, ES045 and ES016 are included for 3160A, 3160B and 3160C, but these equipment inputs are not a RUC recommendation for this service. ES015 is in 3160C but is not a RUC recommendation for this service. Other discrepancies for these services are listed below and the RUC requests that CMS review the attached revised spreadsheet and make the necessary corrections:

- CPT 3160C is not listed at all in the CMS direct PE inputs clinical labor time file.
- CPT 31629 line 30 and 31 for assist physician in performing procedure and assist physician moderate sedation in CMS clinical labor time file is 30 minutes, however the RUC recommended 35 minutes which is consistent with the physician work recommendations. Subsequently for CPT 31629 as the 30 minutes is incorrect all of the equipment is off by the five minutes therefore all the equipment times should go up by 5 minutes, excluding the stretcher, which should remain 89 minutes as that equipment is not needed during the procedure. In addition the calculation of supply item *gas, oxygen (SD084)* would also be affected by the assist physician time and should be 105 liters, rather than 90 liters as currently indicated in the supply direct PE input CMS file.

Laparoscopic Lymphadenectomy (CPT codes 38570, 38571 and 38572)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
38570	Laparoscopy, surgical; with retroperitoneal lymph node sampling (biopsy), single or multiple	9.34	8.49	Disagree
38571	Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy	12.00	12.00	Agree
38572	Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy and peri-aortic lymph node sampling (biopsy), single or multiple	15.60	15.60	Agree

The RUC recommends for CMS to reconsider its decision to not accept the RUC recommendation for CPT code 38570 listed in the table above. CMS stated that they did not agree with the RUC recommendation to maintain the current work RVU since the intra-service and total times were reduced relative to the existing times. However, it does not appear that CMS considered that this service was last reviewed in 1993, when the RBRVS was in its infancy and fewer standards were in place.

The erroneous calculation that CMS employed to derive their proposed work value of 8.49, which involved simply multiplying the RUC recommended work RVU by the ratio between RUC recommended total time and existing total time (8.49 RVUs= 9.34 RVUs X (220 minutes /242 minutes)), is methodologically flawed for several reasons. First, the calculation assumes that the existing time, last determined in 1993, is correct. In addition, physician intensity does not necessarily remain constant for a service over a period of many years. Finally, different components of total time (pre-service time, intra-service time, post-service time, post-operative visits) consist of differing levels of physician intensity. Using the change in total time as the sole rationale for not accepting the RUC recommendation is unprecedented and misguided.

The RUC recommendation for code 38570 was based on the following physician time: pre-service time of 53 minutes, intra-service time of 60 minutes and immediate post-service time of 30 minutes, as well as a full discharge day (99238) and two post-operative visits (99212 and 99213). To support its recommendation of 9.34 work RVUs, the RUC compared the surveyed code to CPT code 31239 *Nasal/sinus endoscopy, surgical; with dacryocystorhinostomy* (work RVU= 9.04, intra-service time of 60 minutes, total time of 168 minutes) and noted that with identical intra-service time and higher total time, the current work value of 9.34 is an appropriate value relative to the comparator code. To further justify a work RVU of 9.34 for 38570, the RUC reviewed MPC code 50590 *Lithotripsy, extracorporeal shock wave* (work RVU= 9.77, intra-service time of 60 minutes, total time of 207 minutes) and noted that both services have identical intra-service time, whereas the survey code has slightly more total time, which confirms that maintaining the current value for 38570 would be appropriate. **The RUC urges CMS to accept its original recommendation of 9.34 RVUs for CPT code 38570.**

Mediastinoscopy with Biopsy (CPT Codes 3940A and 3940B)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
3940A	Mediastinoscopy; includes biopsy(ies) of mediastinal mass (eg, lymphoma), when performed	5.44	5.44	Agree
3940B	with lymph node biopsy(ies) (eg, lung cancer staging)	7.50	7.25	Disagree

CMS reviewed these codes and states:

> *The RUC identified CPT code 39400 (Mediastinoscopy, including biopsy(ies) when performed) as a potentially misvalued code due to an unusually high preservice time and Medicare utilization over 10,000. In reviewing the code's history, it became apparent that the code has been used to report two distinct procedural variations although the code was valued using a vignette for only one of them. As a result, CPT code 39400 is being deleted and replaced with CPT codes 3940A and 3940B to describe each of the two mediastinoscopy procedures.*
>
> *We are proposing to accept the RUC-recommended work RVU of 5.44 for code 3940A. We agree with the RUC that the crosswalk from CPT code 52235 (Cystourethroscopy, with fulguration) appropriately estimates the overall work for CPT code 3940A. For CPT code 3940B, we disagree with the RUC recommended work RVU of 7.50. We believe that the work value for CPT code 3940A establishes an accurate baseline for this family of codes, so we are scaling the work RVU of CPT code 3940B in accordance with the change in the intraservice times between CPT codes 3940A and 3940B. Applying this ratio in the intraservice time to the work value of CPT code 3940A yields a total work RVU of 7.25 for CPT code 3940B. We also note that the RUC recommendation for CPT code 3940A represents a decrease in value by 0.64 work RVUs, which is roughly proportionate to the reduction from a full hospital discharge visit (99238) to a half discharge visit assumed to be typical in the post-operative period. The RUC recommendation for CPT code 3940B had the same reduction in the post-operative work without a corresponding decrease in its recommended work RVU. In order to reflect the reduction in post-operative work and to maintain relativity between the two codes in the family, we are proposing 7.25 as the work RVU for CPT code 3940B.*

3940B *Mediastinoscopy; with lymph node biopsy(ies) (eg, lung cancer staging)*
The RUC disagrees with the methodology the Agency used to arrive at a work RVU for 3940B. CMS' calculation uses the ratio of intra-service time difference between 3940B and 3940A (15 minutes) to the total time of 3940A (15/45), to calculate an increment of 1.81 RVW. This is then added to the accepted value of 3940A (5.44) to result in the proposed 7.25 RVW for 3940B. This employment of the relationship of intraservice time between codes to adjust total RVW that includes other time and work inputs has no basis in fact, logic, clinical review or comparator relationships with established codes.

The RUC recommended value is based upon magnitude estimation of a robust physician survey, utilizing the 25th percentile RVW of 7.5. This, with appropriate additional crosswalks comparisons and rationale as presented and considered by the RUC, is a recommendation that is almost universally accepted by CMS and constitutes a bedrock example of RUC methodology "getting it right."

As CMS appears to be fixated on the value of the 15 minute of additional intraservice time for 3940B, and compelled to employ this in conjunction with its accepted value of 3940A, we call CMS's attention to the additional rationale considered by the RUC that directly addresses this "increment."

From the Summary of Recommendations for 3940B:

> The recommended value is supported in relation to 3940X1 [3940A] by reference to CPT code 32674 Thoracoscopy, surgical; with mediastinal and regional lymphadenectomy (List separately in addition to code for primary procedure). This is a ZZZ code valued by the RUC in 2011 with RVW 4.12 for 30 minutes of intraservice work. This work is almost identical to the [additional] work of 3940X2 [3940B], requiring endoscopic operation to a similar extent and on the same target lymph nodes in the same anatomic location. If anything, 3940X2 is more difficult due to the more limited endoscopic exposure compared to the wide visualization afforded by the lung collapse and open pleural space created for thoracoscopy. If one then considers [the initial] 3940X2 (45 minutes of intraservice time) to be similar to 3940X1 (45 minutes of intraservice time) plus 15 minutes of 32674 level physician work, the following building block RVW results:

CPT Code	CPT Descriptor	Intraservice Time	IWPUT	RVW
3940A	Mediastinoscopy; includes biopsy(ies) of mediastinal / mass (eg, lymphoma), when performed	45	0.071	5.44
32674	Thoracoscopy, surgical; with mediastinal and regional lymphadenectomy ZZZ	30	0.137	4.12
1/2 32674		15	0.137	2.06
3940A + 1/2 32674		60	0.088	7.50
3940X2	Mediastinoscopy; with lymph node biopsy(ies) (eg, lung cancer staging)	60	0.088	7.50

The result precisely supports the RUC recommended value of 7.50 RVW, utilizing an **intraservice time only** ZZZ value that serves as a compelling direct crosswalk to a virtually identical service valued by the RUC and CMS. The fact that the resulting RVW is exactly the same as the 25th percentile magnitude estimation, while relying upon an appropriately calculated increment, is not simply an elegant coincidence but rather a validation of the accuracy of the RUC process.

We also call upon CMS to review the content of the SOR and RUC recommendation which it will find to be responsive to any additional concerns. The RUC does not agree with the erroneous calculation CMS proposed to arrive at a value for code 3940B. **The RUC recommends that CMS use survey data and magnitude estimation when proposing a work RVU for 3940B. The RUC urges CMS to accept the work RVU of 7.50 for code 3940B.**

Hemorrhoid Injections

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
46500	Injection of sclerosing solution, hemorrhoids	1.69	1.42	Disagree

The RUC recommends for CMS to reconsider its decision to not accept the RUC recommendation for CPT code 46500 listed in the table above. CMS stated that they did not agree with the RUC recommendation to maintain the current work RVU since the intra-service and total times were reduced relative to the existing times. However, it does not appear that the Agency considered that this service was last reviewed by the Harvard Study during the infancy of the RBRVS.

CMS derived their alternate proposed work value by simply multiplying the current work RVU by the ratio of RUC proposed total time to the existing total time. This methodology did not account for differences in pre-service or post-service time. Furthermore, different components of total time (pre-service time, intra-service time, post-service time, post-operative visits) consist of differing levels of physician intensity. CMS' calculations do not appear to be based on any clinical information or any measure of physician intensity. In several other sections of the proposed rule, proposed work RVUs were derived based on intra-service time ratios or other miscellaneous methodologies.

CMS' reliance on existing work RVU and time to derive a new proposed work value for this potentially misvalued service is misguided, as the service was last valued by the Harvard study over 20 years ago. The current intra-service time is based on a Harvard study of a few general surgeons, while the pre- and post-service times were derived from an algorithm.

Furthermore, it is unclear whether the Harvard estimated intra-service time included time for applying and waiting for effect of anesthesia since, at the time, there were no definitions for intra-service work other than "skin-to-skin", whereas for the new RUC recommendation that work is categorized as during the pre-service period. The current work RVU and physician work times resulted in an IWPUT of 0.0194 and that the RUC recommended work RVU with changes to time and visits resulted in a lower IWPUT of 0.018. The CMS proposed work RVU of 1.42 is not valid as it dismisses the evidence and discussion presented to the RUC and results in a negative IWPUT of -0.009. **The RUC urges CMS to review the RUC submission and maintain the current value for 46500 at 1.69 work RVUs.**

Liver Allotransplantation (CPT code 47135)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
47135	Liver allotransplantation; orthotopic, partial or whole, from cadaver or living donor, any age	91.78	90.00	Disagree

The RUC recommends that CMS reconsider its decision to not accept the RUC recommendation for CPT code 47135 listed in the table above. Revising the work RVU for 47135 to 1.9 percent below the RUC's recommendation is arbitrary and punitive. **The RUC continues to believe that its original reference code is the most appropriate comparator for this service and urges CMS to use survey data and magnitude estimation and to accept the RUC's original recommendation of 91.78 RVUs for CPT code 47135.**

Genitourinary Catheter Procedures (CPT Codes 5039A, 5039B, 5039C, 5039D, 5039M, 5039E, 5069G, 5069H, 5069I)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
5039A	Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (eg, ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; new access	3.15	3.15	Agree
5039B	existing access (Do not report 5039X1, 5039X2 in conjunction with 5039X3, 5039X4, 5039X5, 5039X13, 506XX6, 50684, 5069X7, 5069X8, 5069X9, 507XX11, 507XX12, 74425)	1.42	1.10	Disagree
5039C	Placement of nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (Do not report 5039X3 in conjunction with 50395, 5039X1, 5039X2, 5039X4, 5069X8, 5069X9, 507XX11, 507XX12, 74425)	4.70	4.25	Disagree

5039D	Placement of nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; new access (Do not report 5039X4 in conjunction with 50395, 5039X1, 5039X2, 5039X3, 5069X7, 5069X8, 5069X9, 507XX11, 507XX12, 74425) (For nephroureteral catheter removal and replacement, use 50387)	5.75	5.35	Disagree
5039M	Convert nephrostomy catheter to nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; via pre-existing nephrostomy tract (Do not report 5039X5 in conjunction with 5039X1, 5039X2, 5069X7, 74425)	4.20	4.00	Disagree
5039E	Remove and replace nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (Do not report 5039X5 in conjunction with 5039X1, 5039X2, 5039X13, 5069X7, 507XX11, 507XX12, 74425 for the same renal collecting system and/or associated ureter) (For removal of nephrostomy catheter requiring fluoroscopic guidance, use 50389)	2.00	1.80	Disagree
5069G	Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; via a pre-existing nephrostomy tract	4.60	4.21	Disagree
5069H	new access, without separate nephrostomy catheter	6.00	5.50	Disagree

5069I	new access, with separate nephrostomy catheter (Do not report 5069X7, 5069X8, 5069X9 in conjunction with 5039X1, 5039X2, 5039X3, 5039X4, 5039X13, 5039X5, 50684, 74425 for the same collecting system and/or associated ureter[3])	7.55	7.05	Disagree

The 2016 NPRM states that for CY 2016, the CPT Editorial Panel is deleting six codes (50392, 50393, 50394, 50398, 74475, and 74480) that were commonly reported together, and is creating 12 new codes both to describe these genitourinary catheter procedures more accurately and to bundle inherent imaging services. Three of these codes (506XF, 507XK, and 507XL) were referred back to CPT to be resurveyed as add-on codes. The other nine codes were reviewed at the January 2015 RUC meeting and assigned recommended work RVUs and direct PE inputs.

The RUC appreciates CMS' careful review of the RUC recommendations for this new family of genitourinary catheter procedures codes. However, we have significant concern with the CMS methodology used to create these proposed work values. CMS assumes that each code within a family has an identical work intensity measure and that the selected time based comparator codes also have identical intensity. The currently accepted methodology used to value services not only recognizes time as a factor but also recognizes intensity. Ignoring this significant work differentiator is inappropriate.

CMS is proposing to use the RUC recommended work RVU of 3.15 for CPT code 5039A. We appreciate CMS' acceptance of the compelling evidence arguments for this family of codes. We agree that 3.15 work RVUs, an increase over the existing procedure coding convention (work RVU = 2.32) is appropriate. CMS goes on to say that they believe the value is appropriate and that the code should be used as a basis for establishing relativity with the rest of the family. The RUC agrees that this new family of genitourinary codes should maintain relativity within the family.

The RUC's concern with the proposed rule, however, is that CMS' alternative recommendations for the balance of this family are based on flawed methodology. We believe CMS utilized circular arguments to develop proposed work RVUs. First, they used an incremental work methodology to propose a value. Then they ignored all intensity, similar patient population and risk profile considerations. Then they pointed to the current coding convention as a validation that their proposed value is more appropriate (again ignoring intensity considerations and compelling evidence arguments) and then argued that the RUC recommendations must be wrong without providing a supporting rationale. The RUC is very disappointed with CMS' methodology to establish alternative work RVUs for this genitourinary code family.

CMS disagreed with the RUC recommended work RVU of 1.42 for CPT code 5039B and proposed an alternative work RVU of 1.10. They cite the survey minimum statistic of 1.10 as well as an alternative crosswalk to CPT code 49460 (Mechanical removal of obstructive material from gastrostomy) as their justification for a revised value of 1.10. The RUC disagrees with the CMS proposed value and reminds the Agency that compelling evidence arguments were met for this entire family. After a robust discussion, the RUC chose to crosswalk this code with clinically similar injection and genitourinary codes. CMS selected a crosswalk to a genitourinary code without any clinical similarity to the reference code. The CMS chosen crosswalk code does not have the same infectious considerations (bacteremia) or the magnitude of diagnostic considerations as code 5039B or the similar RUC crosswalks. CMS disagreed with the RUC recommended work RVU of 4.70 for CPT code 5039C and proposed an alternative work

RVU of 4.25. CMS cited the current coding convention as a basis for rejection of the RUC recommendations. CMS then used an incremental work methodology and an alternative crosswalk to CPT code 31660 (Bronchoscopy, rigid or flexible, including fluoroscopic guidance) to justify rejection of the RUC recommendations. The RUC disagrees with the CMS proposed value. The RUC also notes that CMS used a different convention than the specialty societies did in their submission. CMS used three codes as their bases with respective work values of 3.37 (CPT code 50392), 0.54 (CPT code 74475), and 0.36 (CPT code 74425); together these sum to 4.27 work RVUs. However, they did not include CPT Code 50390, which is typical and was also included with the specialty societies' submission. In the typical case, a needle is inserted into the collecting system and contrast material is injected. A second needle is then inserted into the collecting system in the optimal location for nephrostomy tube placement. As such, the previous coding of this procedure should equal 5.25 RVUs. Again, the RUC recommendations were thoughtfully crosswalked to clinically similar catheter drainage codes. CMS' recommendations were based on reference to inaccurate coding conventions and clinically dissimilar crosswalks. CMS selected codes consist of vastly different physician work, patient population and potential complications compared to code 5039C and the RUC chosen crosswalks.

CMS disagreed with the RUC recommended work RVU of 5.75 for CPT Code 5039D and proposed an alternative work RVU of 5.30. CMS used the value of 5039C as one of their arguments for rejecting the RUC recommended value as well as selecting a different cross reference code, 57155 (Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy). While the RUC appreciates that CMS maintained the 1.05 work RVU differential with 5039C, we disagree with the CMS proposed value because, we believe, CMS has a fundamental misunderstanding of the typical 5039C procedure as described above. Again, the RUC recommendations were thoughtfully crosswalked to clinically similar genitourinary codes. The CMS recommendation does not use the appropriate base work RVU in the coding conventions and uses clinically dissimilar crosswalks to justify its choice. CMS chosen comparator codes consist of vastly different physician work, patient population and potential complications compared to code 5039D and the RUC chosen crosswalks.

CMS disagreed with the RUC recommended work RVU of 4.20 for CPT Code 5039M and proposed an alternative work RVU of 4.00. CMS used an incremental work methodology and an alternative crosswalk to the comparator CPT code 31634 (Bronchoscopy, rigid or flexible, with balloon occlusion). The RUC disagrees with the CMS proposed value and its methodology. The RUC recommendations were thoughtfully crosswalked to clinically similar catheter drainage codes and an interventional bronchoscopy code. CMS provided no clinically similar crosswalk. The crosswalk CMS provided describes dissimilar work, patient population, and potential complications compared to code 5039M and the RUC chosen crosswalks.

CMS disagreed with the RUC recommended work RVU of 2.00 for CPT code 5039E and proposed an alternative work RVU of 1.82. CMS again used an incremental work methodology as well as alternative crosswalk CPT code 64416 (Injection, anesthetic agent; brachial plexus) and CPT code 36569 (Insertion of peripherally inserted central venous catheter). The RUC disagrees with the CMS proposed value. The RUC recommendations were thoughtfully crosswalked to a clinically similar catheter exchange code. An additional crosswalk was made to a separate but similar solid-organ (liver) code. The CMS provided crosswalk describes dissimilar work, patient population and potential complications compared to code 5039E and the RUC chosen crosswalks.

The remaining three codes all utilize ureteral stents and form their own subfamily within the larger family of genitourinary catheter procedures. CMS rejected the RUC recommended work RVU of 4.60 for CPT code **5069G** and proposed an alternative work RVU of 4.21. CMS cited the survey 25th percentile as their basis for rejecting the RUC recommendation as well as an alternative crosswalk to CPT code 31648

(Bronchoscopy, rigid or flexible, with removal of bronchial valve). The RUC does not agree with the CMS recommendations. The placement of a ureteral stent requires more work than placement of a nephroureteral catheter and the 0.21 RVU differential proposed is insufficient to reflect the additional work difficulty of placing a ureteral stent verses a nephroureteral stent. Again, the RUC recommendations were thoughtfully crosswalked to clinically similar genitourinary and catheter exchange codes. The CMS crosswalk is significantly different from the reference code and the RUC chosen crosswalks with respect to patient populations, potential infectious complications or solid organ/collecting system trauma.

CMS disagreed with the RUC recommended value of 6.00 for CPT code 5069H and proposed an alternative work RVU of 5.50. CMS again used an incremental work methodology and an alternative crosswalk to CPT Code 50382 (Removal and replacement of internally dwelling ureteral stent). The RUC disagrees with CMS' proposed work RVU recommendation for 5069H. The RUC recommendation was based on thoughtful crosswalk to similar genitourinary codes with similar patient populations and risk profiles. The reference code and RUC crosswalks describe treatment of a ureteral stricture. CMS' crosswalk is similar in patient population, however, the placement of a ureteral sent (reference code and RUC crosswalk) is more difficult and higher risk compared with ureteral stent removal.

Finally, CMS rejected the RUC recommended value of 7.55 for CPT code 5069I and proposed a work RVU of 7.05. Again, CMS used an incremental work methodology and an alternative crosswalk to CPT code 36481 (Percutaneous portal vein catheterization by any method). While the RUC appreciates maintaining the RUC recommended differential to account for the use of a nephrostomy tube, we do not support the proposed work RVU for 5069I. The RUC reference code is both a diagnostic and interventional code with larger bore access into the kidney compared to smaller size hepatic access for diagnostic evaluation in the CMS crosswalk.

For the reasons stated above, the RUC strongly recommends that CMS implement the original RUC recommended work RVUs for this new family of genitourinary catheter procedures.

Moderate Sedation

For the practice expense component of these services under the clinical labor inputs, CMS proposed to remove the *RN/LPN/MTA (L037D)* (intra-service time for assisting physician in performing procedure) for CPT codes 5039B and 5039E. This amounts to 15 minutes removed for CPT code 5039B and 20 minutes removed for CPT code 5039E. CMS stated rationale is that since moderate sedation is not inherent in these procedures, they do not believe that this clinical labor task would typically be completed in the course of this procedure.
The RUC strongly disagrees with CMS' proposal to eliminate the *RN/LPN/MTA* blend for assisting the physician during procedures 5039B and 5039E. CMS indicated its rationale was based on the fact that these procedures do not include inherent moderate sedation. If moderate sedation were inherent to these procedures, an RN would be utilized, not a blend. However, these procedures do require patient monitoring (HR, blood pressure, 02 sat, pain control, medication administration, etc) for stability during the procedure, which the attending physician cannot simultaneously perform. A blend *RN/LPN/MTA* is most appropriate for these procedures.

During the post-service portion of the clinical labor service period, CMS proposed to change the labor type for the *patient monitoring following service/check tubes, monitors, drains (not related to moderate sedation)* input. There are 45 minutes of clinical labor time assigned under this category to CPT codes 5039A, 5039C, 5039D, 5039M, 5069G, 5069H, and 5069I. Although they agree that the 45 minutes are appropriate for these procedures as part of moderate sedation, they are changing the clinical labor type

from the recommended *RN (L051A)* to *RN/LPN/MTA (L037D)* to reflect the staff that will typically be doing the monitoring for these procedures.

The RUC strongly disagrees with CMS' proposal to substitute an RN with a nurse blend for post-procedure monitoring tasks. The RUC recommended 15 minutes of RN time for one hour of monitoring following moderate sedation and 15 minutes of RN time per hour for post-procedure monitoring (unrelated to moderate sedation). Although the post procedure monitoring time standard uses a blend for the monitoring unrelated to moderate sedation, the RUC allows for specialties to use an RN with justification. **In reviewing these services the RUC determined that this new family of genitourinary procedures needs an RN assigned to the patients for all of the post procedure monitoring.**

Nephrouretreral Catheter

CMS seeks clarification regarding the use of the nephroureteral catheter for CPT code 5039D. A nephroureteral catheter is a required element in 5039D and 5039M to complete the procedure. This was reflected in the PE spreadsheet as well as the submitted invoice. Within the description of work, the sentence "An 8 Fr nephroureteral stent is inserted with the distal pigtail in the bladder and the proximal pigtail in the renal pelvis." accurately describes the use of a nephroureteral catheter. In the context of genitourinary and biliary procedures, the historic term "stent" has been used interchangeably with catheter, however since the introduction of endovascular stents, the use of the term "stent" in this context is falling out of favor due to the potential confusion with balloon-expandable or self-expanding endoluminal devices now known as stents. **The RUC requests that CMS add the nephroureteral catheter SD306 as a supply item for CPT code 5039D and leave it in 5039M.**

Angiography Room

The RUC recommended the inclusion of *room, angiography (EL011)* for this new family of genitourinary codes. CMS does not agree with the RUC that an angiography room would be used in the typical case for these procedures. The agency is proposing to replace equipment item *room, angiography (EL011)* with equipment item *room, radiographic-fluoroscopic (EL014)* for the same number of minutes.

The RUC disagrees with CMS' proposal to assign this new genitourinary family of procedures to a fluoroscopy room instead of an angiographic room. If a physician were to attempt these genitourinary procedures on an radiography/fluoroscopy (R/F) table it would result in unacceptable radiation doses to the physicians, their staff and their patients, which would be contrary to *as low as (is) reasonably achievable* (ALARA) principles. Additionally it would be near impossible to perform a sterile genitourinary procedure on an R/F table.
CMS stated in its rationale that it believes the angiographic room assignment is improper due to their belief that because there are more vascular procedure codes associated with an angiographic room PE expense, the angiography room is therefore not an appropriate PE line item in non-vascular interventions. The number of existing procedure codes is an invalid measure of the utilization of a given imaging room. In this argument, the greater number of existing CPT codes simply denotes a more granular description of procedural work and bears no relationship to procedural volume. The specialty societies noted and the RUC agrees that non-vascular interventional procedures typically are performed in these angiographic rooms and together they comprise more than 50 percent of room utilization of a typical "angiographic" room. Finally, it is also important to note that a standard fluoroscopic/radiographic device is incapable of 3-axis rotational imaging required to perform these services.

The typical equipment utilized for these new genitourinary procedures are the items included in CMS' angiographic room. We have reviewed all the items currently included in *EL011*:

- *100 KW at 100 kV (DIN6822) generator*
- *C-arm single plane system, ceiling mounted, integrated multispace*
- *T motorized rotation, multiple operating modes*
- *real-time digital imaging*
- *40 cm image intensifier at 40/28/20/14cm*
- *30 x 38 image intensifier dynamic flat panel detector*
- *floor-mounted patient table with floating tabletop designed for angiographic exams and interventions (with peistepping for image intensifiers 13in+)*
- *18 in TFT monitor*
- *network interface (DICOM)*
- *Careposition: radiation free positionong of collimators*
- *Carewatch: acquisition and monitoring of configurable dose area product*
- *Carefilter: Cu-prefiltration*
- *DICOM HIS / RIS*
- *Control room interface*
- *Injector, Provis*
- *Shields, lower body and mavig*
- *Leonardo software*
- *Fujitsu-Siemens high performance computers*
- *Color monitors*
- *Singo modules for dynamic replay and full format images*
- *Prepared for internal networking and Siemens remote servicing, both hardware and software*

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 genitourinary procedures.

For the reasons stated above, the RUC strongly urges CMS to reverse this proposed refinement and assign EL011 to these new genitourinary catheter procedures.

Penile Trauma Repair (CPT Codes 5443A and 5443B)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
5443A	Repair of traumatic corporeal tear(s) (For repair of urethra, see 53410, 53415)	11.5	11.5	Agree
5443B	Replantation, penis, complete amputation including urethral repair (To report replantation of incomplete penile amputation, see 5443X1 for repair of corporeal tear(s), and 53410, 53415 for repair of urethra)	24.5	22.1	Disagree

The RUC recommends for CMS to reconsider its decision to not accept the RUC recommendation for CPT code 5443B listed in the table above. We would like to remind CMS that the Agency and the RUC regularly accept the median survey work RVU for one service and the 25th percentile work RVU for another when both are in the same code family, particularly when the services diverge largely in the amount of time and type of work. The RUC disagrees with the alleged inconsistency as being used as a

rationale to not accept our recommendation for 5443B. Furthermore, reducing the intensity of intraservice work below that of the RUC recommendation for 5443B (IWPUT of 0.071) is inappropriate for such an intense, complex and emergent service.

The RUC recommendation for 5443B was based on the following physician time: pre-service time of 58 minutes, intra-service time of 180 minutes and immediate post-service time of 28 minutes. The RUC also reviewed the post-operative visits and agreed that the following number of post-operative visits was necessary due to the extremely high level of complexity of the patient who is typically schizophrenic and the time intensive nature of the continuous follow-up care: two 99232 and one 99233 hospital visits, one full-day 99238 discharge management code and four 99213 office visits.

To justify a work RVU of 24.50, the RUC compared the surveyed code to the key reference service 53448 *Removal and replacement of inflatable urethral/bladder neck sphincter including pump, reservoir, and cuff through an infected field at the same operative session including irrigation and debridement of infected tissue* (work RVU= 23.44) and agreed that since 5443B has slightly more intra-service time compared to the reference code, 180 minutes and 170 minutes, respectively, the median value of 24.50 accurately values the surveyed code higher. In addition, the RUC reviewed 23473 *Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component* (work RVU= 25.00) and noted that both services have identical intra-service time, 180 minutes, and should be valued similarly. **The RUC urges CMS to accept its original recommendation of 24.50 RVUs for CPT code 5443B.**

Clinical Labor Pre-service Time for Penile Trauma Repair

The RUC is also seeking comment regarding 60 minutes of pre-service time in the facility setting for this emergency 090-day global service, noting that clinical staff in the office may not have the opportunity to perform the same pre-service activities in cases of emergency. At the January 2015 RUC meeting, during discussion of the direct practice expense inputs for penile trauma repair services (5443A and 5443B), the PE Subcommittee considered reducing the pre-service time from 60 minutes to 15 minutes based on a direct crosswalk to CPT code 44950 *Appendectomy*. The PE Subcommittee noted that CPT code 44960 *Appendectomy; for ruptured appendix with abscess or generalized peritonitis* also has 15 minutes of pre-service time. The Subcommittee discussed that there was some precedent for reducing the amount of pre-service time from the 60 minutes that is standard for most 90 day global services for emergency surgery, however the Subcommittee and the RUC have previously accepted varying time elements for emergent procedures. At the April 2015 RUC meeting, the PE Subcommittee formed a Workgroup to look at the issue and the Workgroup agrees with the PE Subcommittee and CMS that it is appropriate to reevaluate the time and determine if a new standard is warranted.

In order to determine the emergent procedures, the Emergent Procedures Workgroup used the following 2013 Medicare 5% Standard Analytic Files: *Carrier 5% file (professional claims);Outpatient hospital 5% file; Inpatient hospital 5% file.* The Workgroup's analysis is based on the 2015 Medicare physician fee schedule and shows the 000, 010 or 090-day global period services paired together with same beneficiary/same date emergency services based on Medicare billed together data. The emergency services included are: ER visits (CPT 99281-99285), critical care visits in ER (CPT 99291-99292) with place of service of "emergency room", emergency ambulance services (HCPCS A0427, A0429-A0431, A0433-A0434), outpatient ER services (revenue center codes 0450-0459, 0981) and inpatient admission services (with type of admission = "emergency", "urgent", or "trauma center"). There are 45 090 -day global services that were identified in the data as being emergent procedures greater than 50% of the time. Currently, the specialty societies are providing feedback about these services. **The PE Subcommittee will review the work of the Emergent Procedures Workgroup at the October 2015 RUC meeting.**

Intrastromal Corneal Ring Implantation (CPT Code 657XG)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
657XG	Implantation of intrastromal corneal ring segments	5.93	5.39	Disagree

The RUC recommends that CMS reconsider its decision to not accept the RUC recommendation for CPT code 657XG listed in the table above. Instead of accepting the RUC recommendation, CMS derived their proposed work value by simply multiplying the current work RVU for a reference code (67917) by the ratio of intraservice time between the RUC recommendation and the reference code. This methodology did not account for differences in pre-service or post-service time. Furthermore, different components of total time (pre-service time, intra-service time, post-service time, post-operative visits) consist of differing levels of physician intensity. CMS' calculations do not appear to be based on any clinical information or any measure of physician intensity. In several other sections of the proposed rule, proposed work RVUs were derived based on total time ratios or other miscellaneous methodologies.

CMS stated that they were unable to find a single service that have a comparable intraservice and total time that had a higher work RVU. We discovered seven CPT codes with an active Medicare payment status that have 30 minutes or less of intra-service time, 134 minutes or less of total time and a higher work RVU in 2015: CPT codes 33768, 57672, 59830, 66770, 67145, 67210 and 67220. As CMS' rationale was partially based on incomplete information, the RUC strongly recommends that CMS reevaluate their decision. **The RUC urges CMS to accept its original recommendations of 5.93 RVUs for CPT code 657XG.**

Dilation and Probing of Lacrimal and Nasolacrimal Duct (CPT Codes 66801, 68810, 68811, 68815 and 68816)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
68801	Dilation of lacrimal punctum, with or without irrigation	1.00	0.82	Disagree
68810	Probing of nasolacrimal duct, with or without irrigation;	1.54	1.54	Agree
68811	Probing of nasolacrimal duct, with or without irrigation; requiring general anesthesia	2.03	1.74	Disagree
68815	Probing of nasolacrimal duct, with or without irrigation; with insertion of tube or stent	3.00	2.70	Disagree
68816	Probing of nasolacrimal duct, with or without irrigation; with transluminal balloon catheter dilation	2.35	2.10	Disagree

The RUC recommends that CMS reconsider its decision to not accept the RUC recommendation for CPT codes 68801, 68811, 68815 and 68816 listed in the table above. CMS stated that they did not accept the RUC recommendation due to the removal of a 99211 post-operative visit without a corresponding

removal of work RVUs. CMS' usage of a reverse building block methodology to systematically reduce a work RVU for this service is highly inappropriate, due to the fact that magnitude estimation was used to establish the work RVUs for this and most other surgical codes. In addition, since the current work value has a negative IWPUT (-0.026), using the removal of a post-operative visit as the basis for CMS' argument is unsupported by quantitative analysis. CMS' proposed work value of 0.82 RVUs would have an inappropriate, IWPUT of 0.02.

CMS did not provide an explicit rationale for why they did not agree with the RUC recommendation for CPT codes 68811, 68815 and 68816. Instead, CMS simply stated their belief that the RUC recommendations do not best reflect the work for these services. CMS employed an erroneous calculation to derive their alternate proposed work value, which involved multiplying the current work RVU by the ratio between RUC recommended total time and existing total time. These calculations inappropriately rely on the assumption that none of the existing times were potentially misvalued and incorrectly assume that the process to derive physician time has always been as robust as in the present. Furthermore, different components of total time (pre-service time, intra-service time, post-service time, post-operative visits) consist of differing levels of physician intensity, which CMS calculation ignores. Finally, the existing IWPUT for each of these three surgical services is below 0.03, which calls into question the accuracy of the existing physician time and its usage in deriving a new work RVU.

The RUC urges CMS to accept its original recommendations of 1.00 RVUs for CPT code 68801, 2.03 RVUs for CPT code 68811, 2.30 RVUs for CPT code 68815 and 2.35 RVUs for CPT code 68816.

Spinal Instability (CPT code 7208A, 7208B, 7208C, and 7208D)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
7208A	Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg, scoliosis evaluation); one view	0.3	0.26	Disagree
7208B	2 or 3 views	0.35	0.31	Disagree
7208C	4 or 5 views	0.39	0.35	Disagree
7208D	minimum of 6 views	0.45	0.41	Disagree

The RUC recommends for CMS to reconsider its decision to not accept the RUC recommendation for CPT codes 7208A, 7208B, 7208C and 7208D listed in the table above.

CMS used deleted code 72069 *Radiologic examination, spine, thoracolumbar, standing (scoliosis)*, which was last reviewed by the RUC and CMS in 1995, as the basis for deriving their proposed work RVUs for these 4 new CPT codes. 72069 will be deleted for CY 2016 as it has no practical use in modern imaging in spinal instability. Part of the reason for the code deletion stems from a change in the patient population and technology for treating spinal instability as stated during the original RUC presentation by the involved specialty societies. Additionally, CMS deems 72069 to be the closest code correlate to 7208A, however, the RUC would like to remind CMS that 7208A includes skull, cervical spine and pelvis "if performed", making the deleted code a poor crosswalk. The "if performed" code descriptor language was stated to be typical by the multispecialty expert panel, hence 7208A is by definition more work than

72069. Also, the deleted code is used for scoliosis, but not necessarily other spinal instability determinations which are inherent to the newly created codes. For example, 7208A may be used to assess coronal imbalance and all of the codes in this new family may be used for complex post-operative evaluation and pre-operative planning.

The current time source for 72069 is "CMS/Other", meaning the methodology used to determine the physician time is not a valid source as it was simply assigned by CMS in the early 1990s using an unknown methodology. Furthermore, only total time is provided for "CMS/Other" codes. The breakdown of existing pre-service, intra-service and post-service time and intensity is not available. The RUC strongly recommends for CMS to avoid using existing times and RVUs from "CMS/Other" codes as the basis for any future valuation decisions. The Relativity Assessment Workgroup has employed many misvalued code screens based on whether a service is "CMS/Other" and CMS has concurred that this represented valid criteria for discovering potentially misvalued services.

The RUC urges CMS to accept its original recommendations of 0.30 RVUs for CPT code 7208A, 0.35 RVUs for CPT code 7208B, 0.39 RVUs for CPT code 7208C and 0.45 RVUs for CPT code 7208D.

Echo guidance for ova aspiration (CPT code 76948)

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

The RUC is disappointed that CMS did not accept the RUC recommendation for CPT code 76948.

CMS reviewed the RUC recommendation and states:

> *In the CY 2014 PFS final rule with comment period, we requested additional information to assist us in the valuation of ultrasound guidance codes. We nominated these codes as potentially misvalued based on the extent to which standalone ultrasound guidance codes were billed separately from services where ultrasound guidance was an integral part of the procedure.*
>
> *CPT code 76948 was among the codes considered potentially misvalued. CPT code 76948 was surveyed by the specialty societies and the RUC issued a recommendation for CY 2016. We have concerns about valuation this code, considering that it is a guidance code used only for a single procedure: 58970 (aspiration of ova), and we believe that these two codes are almost always billed concurrently. We believe codes 76948 and 58970 should be bundled to accurately reflect how the service is furnished.*
>
> *We are proposing to use work times based on refinements of the RUC-recommended values by removing the 3 minutes of pre and post service time since these times are reflected in the 58970 procedure code. We are proposing work and time values for 76948 based on a crosswalk from 76945 (Ultrasonic guidance for chorionic villus sampling, imaging supervision and interpretation) which has a physician work time of 30 minutes*

and an RVU of 0.56. Therefore we are proposing to maintain 25 minutes of intraservice time for 76948 and proposing a work RVU of 0.56.

76948 ***Ultrasonic guidance for aspiration of ova, imaging supervision and interpretation***
The RUC does not understand CMS' belief that 76948 and 58970 are almost always reported together. Based on the 2014e Medicare utilization data CPT code 76948 was performed 10 times and CPT code 58970 was performed 9 times. Therefore, no reported together data is available. It may be intuitive that these services are typically performed together in the private payer arena. However, we do not have access to those data. The RUC does not understand why CMS would request further action for such a low volume service. The RUC continues to identify and bundle services that are performed together 75 percent of the time or more.

Due to the lack of evidence that CPT codes 76948 and 58970 are typically reported together, the RUC disagrees with the removal of the 3 minutes of pre-service and 3 minutes of post-service time. There is separate and distinct physician work in both the pre- and post-service periods, not related to the base procedure. The physician must review the patients' clinical history, prior imaging studies, as well as review and sign the final report. These tasks are related specifically to the imaging portion of the procedures. **Therefore, the RUC requests that 3 minutes of pre-service and 3 minutes of post-service time are necessary and should remain**.

CMS proposed to crosswalk 76948 to the work RVU of 76945 which currently has a work RVU of 0.67, not 0.56 as indicated. The RUC fully discussed the comparison of 76948 to key reference service 76945 *Ultrasonic guidance for chorionic villus sampling, imaging supervision and interpretation* (work RVU = 0.67) and 76942 *Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation* (work RVU = 0.67) and noted both 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 pre- and post-service time and the RUC survey 25th percentile work RVU of 0.85 for CPT code 76948.**

<u>Immunohistochemistry (CPT codes 88341, 88342, and 88344)</u>

CMS states that after replacing the RUC recommended supply item "UltraView Universal DAB Detection Kit" (SL488) with "Universal Detection Kit" (SA117) in the interim final PE inputs for CY 2015, the Agency is now going to accept the RUC recommended supply item, SL488, for CPT codes 88341, 88342, and 88344, as well as the RUC-recommended equipment time for "microscope, compound" for CY 2016. The RUC appreciates the Agency re-examining the direct practice expense inputs and applying the RUC recommended *ultraview universal DAB detection kit (SL488)* for immunohistochemistry CPT codes 88341, 88342 and 88344.

Addendum B Error
The RUC would like to note that CPT codes 88341, which the RUC reviewed the physician work for CY 2015, was not discussed in the text of this NPRM for CY 2016; however a new work RVU is indicated in Addendum B for this service. **The RUC requests that CMS review CPT code 88341 to determine whether the current work RVUs listed in addendum B are correct.** CPT code 88341 (2015 RUC recommendation = 0.65, 2015 work RVU = 0.42, NPRM 2016 Addendum B work RVU = 0.53)

Immunofluorescent Studies (CPT Codes 88346 and 8835X)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
88346	Immunofluorescencet study, each per specimen; initial single antibody stain procedure; direct method	0.74	0.56	Disagree
8835X	each additional single antibody stain procedure (List separately in addition to code for primary procedure)	0.70	0.53	Disagree

CMS reviewed the RUC recommendations for these codes and states:

> *For CY 2016, the CPT Editorial Panel deleted one code, CPT 88347 (Antibody evaluation), created a new add-on service, CPT 8835X, and revised CPT code 88346 to describe immunofluorescent studies. The RUC recommended a work RVU of 0.74 for CPT code 88346 and 0.70 for CPT code 8835X. While we are accepting the RUC recommendation for CPT code 88346, we do not believe the recommendation for CPT code 8835X best reflects the work involved in the procedure due to our concerns with the relationship between the RUC recommended intraservice times for the base code and the newly created add-on code. We examined intraservice time relationships between other base codes and add-on codes and found that two codes in the Intravascular ultrasound family, CPT 37250 (Ultrasound evaluation of blood vessel during diagnosis or treatment) and 37251(Ultrasound evaluation of blood vessel during diagnosis or treatment), share a similar base code/add-on code intraservice time relationship, and are also diagnostic in nature, as are CPT codes 88346 and 8835X. Due to these similarities, we believe it is appropriate to apply the relationship, which is a 24 percent difference, between CPT codes 37250 and 37251 in calculating work RVUs for CPT codes 88346 and 8835X. Multiplying the RVU of CPT code 88346, 0.74, by 24 percent, and then subtracted the product from 0.74 results in a work RVU of 0.56 for CPT code 8835X. Therefore, for CY 2016, we are proposing a work RVU of 0.74 for CPT code 88346 and 0.56 for CPT code 8835X.*

8835X *Immunofluorescence- per specimen; each additional single antibody stain procedure (List separately in addition to code for primary procedure)*

The RUC disagrees with the methodology CMS used to arrive at the work RVU for 8835X. First, CMS is comparing an incremental difference between two intravascular ultrasound services, 37250 and 37251, that will be deleted for CY 2016. In this NPRM, CMS proposes to accept the recommendations for newly bundled intravascular ultrasound with radiological supervision and interpretation services. The RUC does not agree that CMS should use an incremental difference of either the deleted or the newly bundled intravascular ultrasound codes. Those services involve initial and additional vessels, whereas CPT codes 88346 and 8835X involve the work related to initial and additional single antibody stain procedures. There is no correlation for these services; they were not on the reference service list for respondents to compare nor were they discussed in any way as a comparison of work. The intravascular ultrasound

services, descriptions of work, physician time and work RVUs will all change for CY 2016 and should not be used to arrive at a work RVU for any services.

Secondly, the RUC disagrees with the "ratio calculation" that CMS continues to propose throughout this Rule. CMS' calculation to apply a ratio from unrelated services that have different physician time, intensity, complexity and work is flawed and not an appropriate alternate method of valuation that the RUC utilizes. Also, this type of calculation does not account for the physician work associated with pre- and post-service time. The RUC is not suggesting CMS use an intra-service work per unit of time (IWPUT) calculation, but does not agree with the erroneous calculation proposed.

Lastly, the RUC would like to reiterate that the specialty noted and the RUC agreed that 8835X is very similar to 88346. CPT code 88346 is slightly longer as the physician must review the Hematoxylin and Eosin stained (H&E) slide to determine where and what to look for on the immunofluorescent slide. In the typical case one base code and three add-on codes would be reported. The pathologist would never be reviewing multiple cases simultaneously. The RUC agreed with the survey respondents that 23 minutes of intra-service time is appropriately relative to other similar services. The RUC noted that 8835X requires only 1 minute less to perform than base code 88346 and the survey respondents have placed these services in the proper rank order. The physician work difference between base code 88346 and 8835X is minute as is the case with other pathology base and add-on services. The RUC's approach of evaluating the actual physician work associated with each unique base and add-on service is far more accurate, rational and responsive to the specific circumstances than holding codes equal to a fixed reduction from a base code. **The RUC recommends that CMS use survey data and magnitude estimation when proposing a work RVU for 8835X. The RUC urges CMS to accept the survey 25th percentile work RVU of 0.70 for code 8835X.**

Morphometric Analysis (CPT codes 88364, 88365, 88366, 88367, 88373, 88374, 88377, 88368, and 88369)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
88367	Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), using computer-assisted technology, per specimen; initial single probe stain procedure	0.86	0.73	Disagree
88368	Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), manual, per specimen; initial single probe stain procedure	0.88	0.88	Agree

NPRM for CY 2016 states:

> *CPT codes 88367 and 88368 were reviewed and valued in the CY 2015 PFS final rule with comment period (79 FR 67668 through 67669). Since then, the RUC has re-reviewed these services for CY 2016 due to the specialty society's initially low survey response rate. In our review of these codes, we noticed that the latest RUC recommendation is identical to the RUC recommendation provided for CY 2015 rulemaking. As a result, we do not believe there is any reason to modify our CY 2015 work RVUs or work time for these procedures. Therefore, we are proposing to retain the CY 2015 work RVUs and work time for CPT codes 88367 and 88368 for CY 2016.*

In establishing interim final direct PE inputs for CY 2015 for CPT codes 88364, 88365, 88366, 88367, 88373, 88374, 88377, 88368, and 88369, we refined the RUC-recommended direct PE inputs as follows. We refined the units of several supply items, including "ethanol, 100%" (SL189), "ethanol, 70%" (SL190), "ethanol, 85%" (SL191), "ethanol, 95%" (SL248), "kit, FISH paraffin pretreatment" (SL195), "kit, HER-2/neu DNA Probe" (SL196), positive and negative control slides (SL112, SL118, SL119, SL184, SL185, SL508, SL509, SL510, SL511), "(EBER) DNA Probe Cocktail" (SL497),"Kappa probe cocktails" (SL498) and "Lambda probe cocktails" (SL499), to maintain consistency within the codes in the family, and adjusted the quantities included in these codes to align with the code descriptors and better reflect the typical resources used in furnishing these services. We also adjusted the equipment time for equipment items "water bath, FISH procedures (lab)" (EP054), "chamber, Hybridization" (EP045), "microscope, compound" (EP024), "instrument, microdissection (Veritas)" (EP087), and "ThermoBrite" (EP088), to reflect the typical time the equipment is used, among other common refinements.

We re-examined these codes when valuing the immunofluorescence family of codes for CY 2016, and reviewed information received from commenters that described the typical batch size for each of these services, thereby explaining the apparent inconsistencies and discrepancies in the quantity of units among the codes in the family. We are proposing to include the RUC recommended quantities for each of these supply items for the CPT codes 88364, 88365, 88366, 88367, 88373, 88374, 88377, 88368, and 88369 for CY 2016. With regard to the equipment items, we received information explaining that the recommended equipment times already accounted for the typical batch size, and thus, the recommended times were already reflective of the typical case. Therefore, we are proposing to adjust the equipment time for equipment items EP054, EP045, and EP087 to align with the RUC-recommended times. We also received comments explaining the need for equipment item EP088. Based on that information, we are proposing to include this equipment item consistent with the RUC recommendations for CPT code 88366.

We note that the information we received regarding the typical batch size was critical in determining the appropriate direct PE inputs for these pathology services. We also note that we usually do not have information regarding the typical batch size or block size when we are reviewing the direct PE inputs for pathology services. The supply quantity and equipment minutes are often a direct function of the number of tests processed at once. Given the importance of the typical number of tests being processed by a laboratory in determining the direct PE inputs, which often include expensive supplies, we are very concerned that the direct PE inputs included in many pathology services may not reflect the typical resource costs involved in furnishing the typical service.

In particular, we note that since laboratories of various sizes furnish pathology tests and that, depending on the test, a large laboratory may be at least as likely to have furnished a test to a Medicare beneficiary compared to a small laboratory, we believe that an equipment item included in a recommendation that is commercially available to a small laboratory may not be the same equipment item that is used in the typical case. If the majority of services billed under the PFS for a particular CPT code are furnished by laboratories that run many of these tests each day, then assumptions informed by commercially available products may significantly underestimate the typical number of tests processed together, and thus the assumptions underlying current valuations for per-

test cost of supplies and equipment may be much higher than the typical resources used in furnishing the service. We invite stakeholders to provide us with information about the equipment and supply inputs used in the typical case for particular pathology services.

88367 ***Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), using computer-assisted technology, per specimen; initial single probe stain procedure***
In this proposed ruling, CMS has maintained its interim work value for CPT code 88367. The Agency had noted that CPT code 88367 is the computer-assisted version of morphometric analysis, analogous to 88368 which is the manual version. CMS accepted the RUC recommended work RVU of 0.88 for 88368 but the Agency did not believe that the RUC recommended work RVU of 0.86 adequately reflected 25 minutes of intra-service time compared to 30 minutes for CPT code 88368. CMS used a ratio of intra-service time to discount the work RVU of 88367 by 15 percent, resulting in a value of 0.73. The RUC disagrees with the manipulation of work RVUs based on an erroneous calculation, rather than the rigorous RUC review process of valuation using survey data and magnitude estimation.

When reviewed, the RUC concluded that a work RVU of 0.86 appropriately accounts for the work required to perform this service and compared this code together with its code family including CPT code 88368 for relativity. In addition, it was noted that the same number of cells are evaluated by the pathologist when rendering a diagnosis for CPT code 88367 as in CPT code 88368. Specifically, the RUC compared 88367 to 88368 and noted that CPT code 88368 is manual and requires slightly more physician work and time because the physician is moving between the images from the fluorescent microscope to find the cells of interest that will be counted. In code 88367, the images that the physician evaluates are selected by the computer. CPT code 88367 still requires the physician to independently view, analyze and make decisions as each separate image, and a ratio is calculated for each service. **The RUC recommends that CMS use survey data and magnitude estimation when proposing a work RVU for 88367. The RUC urges CMS to accept the work RVU of 0.86 for CPT code 88367.**

Practice Expense
The RUC appreciates the CMS re-examination of the RUC's direct practice expense inputs for CPT codes 88364, 88365, 88366, 88367, 88373, 88374, 88377, 88368, and 88369. The proposed changes in the supplies and equipment appropriately account for typical supplies and equipment utilized to provide these services.

The RUC would like to also remind the CMS of our CY 2015 final rule comments to the agency regarding CMS supply SL196, kit, HER-2/neu DNA Probe for CPT codes 88374 and 88377:

- 88374 Quantity of SL196: With a batch size of 5 using the computer-assisted technology CPT code: 5 patient specimen slides plus one positive control slide and one negative control slide equals 7 slides. One kit assay (SL196) is needed for each slide. Therefore the total number of kit assays equals 5 patient kit assays plus 1 positive control kit assay plus 1 negative control kit assay = 7 kit assays. Dividing the 7 kit assays divided by 5 patients (which apportions the positive and negative control kit assays among the 5 patients) = 1.40 kit assays per patient
- 88377 Quantity of SL196: With a batch size of 2 using the CPT code without computer assisted technology: 2 patient specimen slides plus one positive control slide plus one negative control slide equals 4 slides. One kit assay(SL196) is needed for each slide. Therefore the total number of kit assays equals 2 patient kit assays plus 1 positive control kit assay plus 1 negative control kit assay = 4 kit assays. Dividing the 4 kit assays divided

by 2 patients (which apportions the positive and negative control kit assays among the 2 patients) = 2.00 kit assays per patient

In addition, in CMS direct PE database the unit of measure is listed as 'kit', however on the RUC's submitted spreadsheet the unit of measure listed is 'kit assay". We recommend the unit of measure name "kit" be changed to "kit assay" as it then would correctly correlated with the cost shown in the database.

Addendum B Error
The RUC would like to note that CPT codes 88364 and 88369, which the RUC reviewed the physician work for CY 2015, were not discussed in the text of this NPRM for CY 2016; however a new work RVU is indicated in Addendum B for these services. **The RUC requests that CMS review CPT codes 88364 and 88369 to determine whether the current work RVUs listed in addendum B are correct.** CPT code 88364 (2015 RUC recommendation = 0.88, 2015 work RVU = 0.53, NPRM CY 2016 Addendum B work RVU = 0.67) and 88369 (2015 RUC rec = 0.88, 2015 work RVU = 0.53, NPRM CY 2016 Addendum B work RVU = 0.67).

Vestibular Caloric Irrigation (CPT Codes 9254A and 9254B)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
9254A	Caloric vestibular test with recording, bilateral; bithermal (ie, one warm and one cool irrigation in each ear for a total of four irrigations) (For three irrigations, use modifier 52) (For monothermal caloric vestibular testing, use 9254X2) (Do not report 9254X1 in conjunction with 92270, 9254X2)	0.80	0.60	Disagree
9254B	monothermal (ie, one irrigation in each ear for a total of two irrigations) (For one irrigation, use modifier 52) (For bilateral, bithermal caloric vestibular testing, use 9254X1) (Do not report 9254X2 in conjunction with 92270, 9254X1)	0.55	0.30	Disagree

As detailed in the proposed rule for CY 2016, the CPT Editorial Panel deleted CPT code 92543 *Assessment and recording of balance system during the irrigation of both ears* and created two new CPT codes, 9254A and 9254B, to report caloric vestibular testing for bithermal and monothermal testing procedures, respectively.

CMS did not accept the RUC recommended values for CPT codes 9254A and 9245B, as listed in the table above, opting instead to reduce those values and assign work RVUs of 0.60 and 0.30 respectively. CMS assigned the work RVU for code 9254A based on a direct crosswalk to CPT code 97606 *Negative*

pressure wound therapy, surface greater than 50 square centimeters, per session (work RVU = 0.60). To value CPT code 9254B, CMS simply divided the proposed work RVU for 9254A in half (0.30). CMS did not provide any specific rationale for rejecting the RUC recommended values other than simply stating their belief that "the recommendations for these services overstate the work involved in performing these procedures."

It is unclear how directly crosswalking CPT code 97606 to 9254A provides a more appropriate work RVU than a work RVU obtained through the RUC survey process which entailed extensive preparation and produced a robust survey. There are inherent flaws in selecting CPT code 97606 as a direct crosswalk for 9245A. As noted, this CPT code does not accurately capture the work and intensity of the service, and is not reflective of the work RVU supported by the survey data. Further we find the direct crosswalk problematic, as CPT code 97606 was last valued in 2003, more than 12 years ago. The survey for this code only yielded 16 respondents, far below the standard set by the RUC and CMS. We find this comparison incongruous, as CPT code 97606 is a low volume code (12,000) compared with the data for CPT code 92543 with much higher utilization (400,000/4= 100,000). We have provided a list of MPC codes (Table 1) and other reference codes (Table 2) that better support the work, time, and intensity of this service. **The RUC recommends that CMS use survey data and magnitude estimation when proposing a work RVU for 9254A. The RUC urges CMS to accept the work RVU of 0.80 for CPT code 9254A.**

Additionally, as reflected in the specialty surveys and as discussed extensively during the RUC meeting, the work RVU for 9254B is not accurately characterized as being half of 9245A. We recognize that the code descriptor for this procedure describes the service as having two irrigations as opposed to the four described in 9245A, yet the indication for performing 9245B occurs when a patient is unable to tolerate the more typical four irrigation test (9254A). The comorbidities of the typical patient make them more difficult to evaluate, thus increasing the intensity and complexity of the service. We have provided a list of MPC codes (Table 3) and other reference codes (Table 4) that support the RUC recommended work RVU for CPT code 9254B. **The RUC urges CMS to accept the work RVU of 0.55 for 9245B which again was based on the survey's 25th percentile work value.**

Instrument-Based Ocular Screening (CPT Codes 99174 and 9917X)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
99174	Instrument-based ocular screening (eg, photoscreening, automated refraction), bilateral; with remote analysis and report (Do not report 99174 in conjunction with 92002-92014, 99172, 99173, 99176X)	0.00	N	N/A
9917X	with on-site analysis (Do not report 99176X in conjunction with 92002-92014, 99172, 99173, 99174)	0.00	N	N/A

The RUC is disappointed that CMS did not accept the RUC recommendation for CPT code 99174 and 9917X, and instead assigned a status indicator of "N" for non-covered.

The RUC reiterates comments that it has made in previous letters that since CMS covers services provided by Medicaid, it is imperative that the Agency publish the RUC recommended values for codes 99174 and 9917X on the Medicare Physician Payment Schedule. In fact, the RUC commented separately to the Agency on this issue in February 2015 (see attached letter). There is a long-standing precedent established by the preventive medicine services codes (99381-99397) and other codes, which are status indicator "N," yet have had their RUC recommended values published on the Medicare Physician Payment Schedule since their inception. CMS established this precedent and should continue to follow it with code 99174, 9917X, and other codes as outlined in our attached February 2015 letter. This would allow CMS to publish the RUC-recommended values on the Medicare Physician Payment Schedule while maintaining the Medicare payment policy that may not cover certain services.

Direct PE Input-Only Recommendations

The RUC appreciates that CMS has decided to use the practice expense recommendations for these services. We understand CMS' concerns about implementing these PE inputs without the corresponding work being reviewed. We analyzed the 58 services that the RUC submitted PE recommendations for and determined that one or more of the following is true of many of the codes: frequency less than 10,000; reviewed for work within the last five years; included in the list of proposed potentially misvalued codes identified through high expenditure by specialty screen that CMS included in the proposed rule for 2016. If you apply these criteria only 6 codes remain. The codes are 10021, 30903, 88333, 88334, 95812 and 95813. **The RUC will request that the specialties that perform these services submit recommendations for the January 2016 RUC meeting.**

Repair of Nail Bed (CPT Code 11760)

The RUC agrees that the 22 minutes of clinical labor time represents 67 percent of the physicians' intra-service time of 33 minutes. The RUC agrees that it is appropriate to include the full 33 minutes of intraservice time in the equipment time calculation.

Cytopathology Fluids, Washings or Brushings (CPT Codes 88104, 88106, 88108)

The RUC supports CMS' proposal to update the Millipore filter supply (SL502) to crosswalk the price of the Millipore filter to the cytology specimen filter (Transcyst) supply (SL041).

Cytopathology Smears, Screening and Interpretation (CPT Codes 88160, 88161, 88162)

The RUC disagrees that there is a lack of clarity and possibility for confusion with cytopathology smears, screening and interpretation for CPT codes 88160, 88161, and 88162. Code 88160 is typically a nipple discharge smear, but other specimens include scrapings or smears from lesions in which the material is placed directly on the slide by the clinician and submitted to the laboratory as a "slide". The discharge or material is placed directly on the slide by a clinician and/or patient thus the slide is not prepared in the laboratory. The slide is received in the laboratory typically as a spray-fixed and air-dried slide that has not been stained. The slide is then stained in the laboratory with the appropriate stain per fixation prior to review and interpretation. In contrast, code 88161 is typically material from sputum, scrapings or discharge that is submitted in a container or on a broom, swab, or other collection device and is then submitted to the laboratory. That laboratory must first put the patient material on the slide - i.e. prepare the slide. The slide is then stained in the laboratory with the appropriate stain per fixation prior to review and interpretation. Both codes include staining, review and interpretation in the laboratory. CPT code

88161 includes the additional step of smearing the material on the slide. The RUC disagrees that there is any provider confusion concerning these codes. In addition, these services are specialized, low volume, and have been thoroughly reviewed and vetted through the RUC process for their direct practice expense inputs at the April 2014 and April 2015 RUC meetings. At both meetings the inputs were approved with minor edits. **There has been little change in physician work since the creation of the codes. Therefore, the RUC does not agree that these services are potentially misvalued. The RUC asks CMS to remove 88160, 88161, and 88162 from any further review.**

Further, the RUC disagrees with CMS' proposal to "remove the clinical labor minutes recommended for 'Stain air dried slides with modified Wright stain' for CPT code 88160 since staining slides would not a typical clinical labor task if there is no slide preparation taking place". For CPT code 88160, the slide is received in the laboratory typically as spray-fixed and air-dried slides that have not been stained. The slide is then stained in the laboratory with the appropriate stain per fixation prior to review and interpretation. For CPT code 88161 the laboratory must put the patient material on the slide - i.e. prepare the slide. The slide is then stained in the laboratory with the appropriate stain per fixation prior to review and interpretation. Both codes include staining, review and interpretation in the laboratory. This is the protocol for these services and the agency should account for this clinical labor time within its practice expense methodology according to the RUC's recommended clinical labor time of 5 minutes (CMS staff type L035 Lab Tech/Histotechnologist).

CMS requests additional information regarding the use of the desktop computer with monitor (ED021) for CPT code 88182. Service 88182 *Flow cytometry, cell cycle or DNA analysis*, is performed using ploidy analysis, by comparing the tumor curve to normal cells. These analyses are performed using a dedicated desktop computer with a monitor. The desktop computer with monitor is located in the same room and is dedicated to the patient each the time it is being used.

Flow Cytometry, Cytoplasmic Cell Surface (CPT Code 88184, 88185)

CMS requests additional information regarding the use of the desktop computer with monitor (ED021) for CPT codes 88184 and 88185. Services 88184 *Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; first marker* and 88185 *Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; each additional marker (List separately in addition to code for first marker)* are performed using ploidy analysis, by comparing the tumor curve to normal cells. These analyses are performed using a dedicated desktop computer with a monitor. The desktop computer with monitor is located in the same room and is dedicated to the patient each the time it is being used.

Nerve Teasing Preparations (CPT Code 88362)

The RUC disagrees with the agency's proposed refinement of CPT code 88362 clinical labor time for "Assist pathologist with gross specimen examination including the following: Selection of fresh unfixed tissue sample; selection of tissue for formulant fixation for paraffin blocking and epon blocking. Reserve some specimen for additional analysis'' from 10 minutes to 5 minutes. The pathologist must work together with clinical labor staff during the gross specimen work and examination as it is critical to the preparation of these minuscule highly fragile specimens. This clinical labor task cannot be performed in 5 minutes and 10 minutes of time for this clinical task is an understatement for many specimens as explained at the April 2014 RUC meeting.

Additionally, the RUC disagrees with the proposed refinement of CPT code 88362, clinical labor time for "Consult with pathologist regarding representation needed, block selection and appropriate technique" from 7 to 0 minutes. The clinical staff task is specific to the detailed clinical work performed to provide

the services of 88362. Clinical labor staff must collaborate with the pathologist in the pre-service time period concerning the proper representation, block selection, and techniques required for nerve teasing. The unique technical protocols required for nerve teasing pathology services requires the clinical labor staff to have complete understanding of what is necessary for each individual specimen case. 7 minutes for this task is typical for these services. This clinical labor task cannot be skipped as it is an integral component of the specimen preparation.

These pathology services are highly specialized and detailed, requiring extensive interaction and collaboration between clinical labor staff and the pathologist. Nerve teasing pathology services are very low volume, highly detailed, time intensive and complex services. In addition, the direct practice expense inputs for many pathology services are adjusted for batch sizes to reflect efficiencies gained. Nerve teasing pathology services are not and cannot be batched as they are very complex, very low volume unusual studies requiring special handling, preparation, and storage.

Nasopharyngoscopy with Endoscope (CPT Code 92511)

The RUC agrees that the endosheath (SD070) is not typically used for CPT code 92511 and were inadvertently included from past direct practice expense inputs for the service. After removing the endosheath we believe it is appropriate to retain all the clinical labor and equipment time assigned to cleaning the scope. In addition, in order to clean the equipment and to be consistent with other codes in the family, the following supply items need to be added to the code. The RUC approved practice expense did not include the following supply items because the endosheath was retained. These supplies are standard across ENT codes where scopes are utilized.

The inputs that would need to be added to allow for actual cleaning of the scope are:

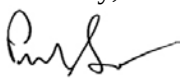
cleaning brush, endoscope	SM010	2	item
enzymatic detergent	SM015	4	oz
Glutaraldehyde 3.4% (cidex, Maxicide, Wavicide)	SM018	4	oz
glutaraldehyde test strips (Cidex, metrex)	SM019	1	item

Needle Electromyography (CPT Codes 95863, 95864, 95869, 95870)

The RUC recommendations for CPT codes 95863, 95864, 95869, 95870 do not include the supply item SA014, *kit, electrode, iontophoresis*. The only code recommendation submitted at the same time that requires supply code SA014 is CPT code 95923 *Testing of autonomic nervous system function; sudomotor, including 1 or more of the following: quantitative sudomotor axon reflex test (QSART), silastic sweat imprint, thermoregulatory sweat test, and changes in sympathetic skin potential.* The RUC has inferred that CMS meant to reference CPT code 95923, rather than CPT Codes 95863, 95864, 95869, 95870 as stated in this section because in the CMS CY 2016 direct PE input database the quantity for SA014 listed for 95923 is 3 rather than the 4 recommended by the RUC. Although the 95923 code descriptor only lists the various tests that can be conducted, the RUC confirmed that 4 electrodes or 4 of supply item SA014 is typical for this service. Several experts in the field of autonomic testing have confirmed that when providing this service they always, without exception, do at least 4 sites of iontophoresis—forearm, proximal leg, distal leg, and foot. The RUC maintains that 4 units of supply code SA014 is the appropriate quantity for CPT code 95923 and is correct in the PE spreadsheet as submitted to CMS. We have included that spreadsheet again as an attachment to this letter.

Thank you for your careful consideration of the RUC's comments on the proposals for the 2016 Medicare Physician Payment Schedule. We look forward to continued opportunities to offer recommendations to improve the RBRVS.

Sincerely,



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