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

August 31, 2017

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1676-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: File Code-CMS-1676-P; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; (July 21, 2017).

Dear Administrator Verma:

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 2018, published in the July 21, 2017 *Federal Register (Vol. 82, No. 139 FR, pages 33950-34203)*.

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

**I. Determination of Practice Expense Relative Value Units (PE RVUs)**

***A.*** *PE RVU Methodology - Separate Payment for High Cost Medical Supplies*

***B.*** *PE Inputs for Digital Imaging Services*

***C.*** *Standardization of Clinical Labor Tasks*

***D***. *Preservice Clinical Labor for 0-Day and 10-Day Global Services*

***E.*** *Obtain Vital Signs Clinical Labor*

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***G.*** *Updates to Prices for Existing Direct PE Inputs*

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## I. Determination of Practice Expense Relative Value Units (PE RVUs)

### *A.* *PE RVU Methodology*

*Separate Payment for High Cost Medical Supplies*

The RUC has repeatedly called on CMS to separately identify and pay for high cost disposable supplies using distinct J codes, rather than bundle into the service described by CPT so that these expenses may be monitored closely and paid appropriately. There are 33 supply items that CMS has priced in excess of $1,000 and bundled into the practice expense RVU for various CPT codes. **The RUC urges CMS to establish J codes for high cost supplies. The pricing of these supplies should be based on a transparent process, where items are annually reviewed and updated.**

### *B.* *PE Inputs for Digital Imaging Services*

The RUC applauds CMS for finalizing the proposal for 2017 to add the professional PACS workstation (ED053) to all codes that currently use the technical PACS workstation (ED050). At that time the RUC queried the specialty societies and determined that the services would not be limited to diagnostic services as there are many therapeutic services that also require a professional PACS workstation. The specialty societies indicated that there are multiple specialties, including but not limited to Radiology that would typically utilize a professional PACS workstation in the office setting. The typical offices of radiologists, spine surgeons, neurologists, sleep medicine physicians, vascular surgeons and orthopaedic surgeons have professional PACS workstations. In addition, surgical subspecialties such as breast surgeons (reported as general surgery), head and neck cancer surgeons (reported as otolaryngology), and hand surgeons (reported as orthopaedic or plastic surgeons) also have professional PACS workstations in their offices. The RUC appreciates that CMS took that information into account and added many of the therapeutic services as recommended in our comment letter on the NPRM for CY2017. The RUC continues to disagree with CMS regarding the exclusion of add-on codes from the list as the add-on codes require additional time to perform and therefore more time with the technical PACS workstation for the technician as well as additional time for the review and interpretation performed by the physician using the professional PACS workstation.

In the *Proposed Rule* CMS requested comment on the codes brought to the Agency's attention by a stakeholder, specifically CPT codes 93880, 93882, 93886, 93888, 93890, 93892, 93893, 93922, 93923, 93924, 93925, 93926, 93930, 93931, 93965, 93970, 93971, 93975, 93976, 93978, 93979, 93980, 93981, 93990, and 76706, and HCPCS code G0365.When the specialties were queried regarding the need for a professional PACS workstation for codes outside of the 70000 series for the RUC comment letter on the NPRM for CY2017, the dominant provider of Transcranial Doppler Studies (93886, 93888, 93890, 93892, and 93893) indicated that a professional PACS workstation is needed. For the Duplex Scan codes (93880, 93882, 93925, 93926, 93930, 93931, 93970, 93971, 93975, 93976, 93978, 93979, 93980, 93981, 93990) the specialty societies did not comment at that time, however they were queried for this comment letter and agree with the stakeholder that the Duplex Scan codes require a professional PACS workstation. CPT code 76706 *Ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal aortic aneurysm (AAA)* was reviewed by the PE Subcommittee in October 2015 before the advent of the professional PACS workstation, but the technical PACS workstation (ED050) is included as a direct PE input and the description of the service specifies image documentation, therefore the RUC recommends that a professional PACS workstation (ED053) be added to CPT code 76706. HCPCS code G0365 may have been mistakenly included on this

list as it already has a professional PACS workstation added for 2017 for 20 minutes of equipment time in the non-facility setting. CPT code 93965 was deleted. **The RUC recommends that the professional PACS workstation (ED053) be added as a direct PE input to CPT codes 93880, 93882, 93886, 93888, 93890, 93892, 93893, 93925, 93926, 93930, 93931, 93970, 93971, 93975, 93976, 93978, 93979, 93980, 93981, 93990, and 76706 for 2018.**

***C.*** *Standardization of Clinical Labor Tasks*

The RUC supports CMS efforts to revise the direct PE database to provide the number of clinical labor minutes assigned for each clinical labor activity for each code. However, the RUC is concerned with the over standardization of clinical labor activities. Each service requires different clinical labor resources and the PE Subcommittee is careful to consider situations where different types of clinical work are required. When standard times are applied to certain activities, the PE Subcommittee carefully considers the specialty societies rationales for additional time over the standard and often determines that additional time is justified. Although it may be possible to develop a standard set of clinical labor activities, it is important to keep in mind that many of those activities mean different things in the context of the service they are used in and creating standard times is not possible for all clinical labor activities. In implementing standard clinical labor tasks, the RUC encourages CMS to seriously consider the rationale that the specialties and the PE Subcommittee provide for time over the standards in both the PE Summary of Recommendation and at the table at the PE Subcommittee meetings.

***D***. *Preservice Clinical Labor for 0-Day and 10-Day Global Services*

As CMS has noted in the NPRM, the RUC PE Subcommittee has reviewed the preservice clinical labor times for CPT codes with 0-day and 10-day global periods and concluded that these codes are assumed to have no pre-service clinical staff time unless the specialty can provide evidence that preservice time is appropriate. For CY 2018, the Agency notes that 41 of the 53 reviewed codes with 0-day or 10-day global periods includes preservice clinical labor of some kind which suggests that it is typical for clinical staff to make preparations prior to the arrival of the patient. CMS requests comments on whether or not they should apply the "standard" of zero preservice time for all 0-day and 10-day global period codes in future rulemaking. The RUC appreciates CMS highlighting the high percent of 0 and 10-day globals that are allocated pre-service time of some kind and agrees that this is of concern. The RUC acknowledges that this also raises the question of the utility of the standard if there such a high number of exceptions. However, the RUC strongly opposes eliminating clinical staff preservice time from all 0- and 10-day global procedures in future rulemaking.

CMS states that the assumption behind the standard is that for minor procedures there is "no clinical staff time typically spent preparing for the specific procedure prior to the patient's arrival." The RUC maintains that it is accurate to assume that no clinical staff time is necessary for minor procedures; however as more procedures are able to be performed without extensive follow-up it is no longer true that all 0 and 10-day globals can be classified as minor procedures. Additionally, in the past decade several complex procedures were implemented as 0-day procedures to allow flexibility for multiple clinicians on the care team to care for a patient without being limited by a 90-day global period. The RUC continues to assume that there is no pre-service time typical for minor procedures, but has concluded that it is no longer appropriate to determine whether a procedure is minor or major based on it being a 0 or 10-day global.

For example, many endoscopic procedures performed in a facility are "major" including ureteroscopy procedures, some ENT procedures and some GI procedures. Scheduling these procedures is no different

than scheduling a 90 global procedure. For example CPT code 47562 Laparoscopy, surgical; cholecystectomy is a 90 day global, which can be done in an outpatient setting if deemed appropriate for the patient and is the same in concept as a 52353 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)* which is a 0 day global. They are both performed under anesthesia in an operating room, they are both invasive and may be performed in either an outpatient or inpatient setting.

**The RUC thanks CMS for bringing this discrepancy to light and we urge CMS not to standardize pre-service time for 000 and 010 day globals as the RUC PE Subcommittee works with the specialty societies to develop a strategy to better determine which services truly are minor and what criteria the RUC should use moving forward to determine which codes require no pre-service clinical staff time.**

***E.*** *Obtain Vital Signs Clinical Labor*

CMS notes that they have traditionally assigned a clinical labor time of 3 minutes to obtain vital signs based on the amount of time typically required to take a patient's vital signs. However, over time the Agency has noted an upward trend in the recommended time associated with this task due to the addition of obtaining the patient's weight and height. The RUC points out that although CMS may typically assign a clinical labor time of 3 minutes for obtain vital signs, the RUC PE Subcommittee's current practice expense standard for obtaining vital signs is divided into three levels of service with the following times:

- Level 0 (no vital signs taken) = 0 minutes
- Level 1 (1-3 vitals) = 3 minutes
- Level 2 (4-6 vitals) = 5 minutes

The RUC continues to believe that the above stated standard is accurate and the best way to make sure that individual codes are allocated the correct amount of time for the clinical staff work done. Even if it has become more common to collect height and weight information, there continue to be a significant amount of services that only obtain 1-3 vital signs so it is important to include this option. The RUC does not have any reason to believe that medical practice has changed and does not support standardizing this allocation of clinical staff time further. The RUC encourages CMS to regard each CPT code as separate and distinct and keep in mind that the RUC carefully scrutinizes each recommendation for typicality, particularly when the time associated with any clinical labor task is increased. We urge CMS to evaluate each CPT code independently based on what is typical for that service, rather than unilaterally increase or decrease direct PE inputs without physician input.

Additionally, the RUC's PE Subcommittee recently reviewed the vital signs standard and determined that the time categories are appropriate. At the October 2015 RUC meeting during discussion of the physical therapy evaluation services the PE Subcommittee began to question what vital signs are appropriate to justify clinical staff time. The Vital Signs Workgroup met on November 24, 2015 via conference call to discuss the applicable vital signs for use in the PE Subcommittee clinical staff time standard. The Workgroup noted that according to Medicare's Evaluation and Management Services Guide an examination needs to include measurement of any three of the following seven vital signs (may be measured and recorded by ancillary staff):

1) sitting or standing blood pressure,
2) supine blood pressure,

3) pulse rate and regularity,
4) respiration,
5) temperature,
6) height,
7) weight

Workgroup members discussed that appropriate vital signs are dependent on the specialty performing the service, for instance, head circumference is a typical vital signs for pediatrics. A Workgroup member inquired about any concerns regarding accuracy of the time standard. It was confirmed that there is no objection to the vital sign time standard.

**The RUC does not recommend that CMS finalize this proposal and encourages the Agency to consider the recommended number of vital signs obtained as appropriate to the service and specialty on a code-by-code basis.**

***F.*** *Equipment Recommendations for Scope Systems*

In the Proposed Rule for CY2017, CMS outlined a pricing structure that separated out the components for scopes, scope video systems, and scope accessories. Because of the complexity of the issues CMS raised, and the need to incorporate input from all specialty societies, the RUC submitted comments to CMS that the best approach to this issue is to form a Workgroup and review the Agency's issues. The Scope Systems and Endoscopes Workgroup was formed at the October 2016 RUC meeting and met via conference call on November 2, 2016 to discuss the CMS request for standardization within the description of scope equipment and supplies. The RUC apologizes for miscommunication about the finalization of the CMS proposed structure. The RUC believed that the structure was finalized in the CMS Final Rule for 2017. The RUC generally supports the proposed structure as outlined in the CMS *Proposed Rule* for CY 2018, however, we have concerns regarding CMS' proposal to create a single scope equipment code for each anatomical application: 1) rigid scope; 2) semi-rigid scope; 3) non-video flexible scope; 4) non-channeled flexible video scope; and 5) channeled flexible video scope. The RUC has significant concerns that, while it conceptually makes sense, to streamline these direct PE inputs for ease of review and pricing via rulemaking, this equipment is not always apples to apples across specialties who utilize it. For example, a rigid endoscope used by a gastroenterologist as compared to one used by an otolaryngologist may vary in price significantly. Given this, we urge CMS not to aggregate prices for these five types of scopes across all specialties, but rather, create packages, per specialty, for these five categories of scopes, as applicable. The RUC is supportive of the changes to the scope video system (ES031) to include the LED light rather than a separate light as well as include in the pricing the expense of miscellaneous small equipment associated with the system such as cables, microphones, foot pedals, etc. The RUC encourages CMS to continue to describe scope accessories as justified per each individual procedure. **The RUC recommends that CMS finalize their proposal with the exception of the five categories of scopes which should be reconfigured into packages per specialty.**

***G.*** *Updates to Prices for Existing Direct PE Inputs*

The RUC agrees with the CMS proposal to update the price of the thirteen supplies and one equipment item listed on Table 14: Invoices Received for Existing Direct PE Inputs. In addition, in response to the CMS' request for additional updated pricing information for other equipment items, we have provided

an attachment (see attachment 04) to this comment letter with current valid invoices for the following equipment items: EQ072, EQ084, EQ206, and EP001.

***H.*** *Supply and Equipment Items with No Price Information*

Although CMS has not specifically asked for comment on the following items, the RUC would like to bring attention to the fact that there are a number of supply and equipment items that currently do not have a price. This adversely affects the specialties when they use these items since the cost of the item is not being factored into the formula used to determine the PE RVU. CMS has stated in past rulemaking that some supplies and equipment are left without a price because they have not been supplied with valid paid invoices for the items. The RUC reminds CMS that by statute it is the obligation of the Agency to evaluate the resources that are necessary to provide medical services. The RUC also points out that on many occasions CMS independently does research on pricing and uses pricing information obtained from sources other the RUC to determine pricing information. **The RUC welcomes the opportunity to forward pricing information when received from the specialties to help facilitate this process and when that information is not provided by the specialties. CMS should use other means to ensure that all supplies and equipment have a price included in the database in order to facilitate payment for all the resources associated with a service.**

SJ082 paste, registration
SF054 wire, orthodontic
SL208 alloy framework, laboratory processing
SJ085 triad tray material
SL236 reline material, Trusoft
SJ087 wax, boxing
SJ086 wax, baseplate
SJ083 polyurethane sheets (quantity as rolls)
SL230 impression material, final
SL205 acylic, dental
SL237 silicone
SJ084 teeth set
SL228 Greenstick compound
SD279 Fibrillar, surgical
SD255 Reentry device (Frontier, Outback, Pioneer)
SD251 Sheath Shuttle (Cook)
SD285 catheter, optical endomicroscopy
SD283 needle, endoscopic ultrasound, cytology
SD257 Tunneler
SL262 Anerobic culture tube
SH098 chlorhexidine 4.0% (Hibiclens)
SD316 Catheter securement device
SL187 balance salt solution (BSS), sterile, 15cc
SL501 cytology, preservative and vial, (cytospin) 88108 - 30ml
SL263 Plastic storage container, 11oz
SK115 Reproduced patient worksheet
SC098 catheter, angiographic, Berman
SD276 Indicator powder
SK108 MCMI-III kit and manual
SB051 Disposable underwear

EQ370 Breast biopsy software
ES037 Forcepts, Landolt bipolar coagulation
ER095 transnasal esophagoscope 80K series
EQ355 optical endomicroscope processor unit system
EQ357 esophageal bougies, set, reusable
ED047 Thermal Printer
ER086 Ultrasound probe
ER088 Infrared illuminator
ED039 psychological testing equipment

The RUC would also like to correct an error in the CMS' database for direct PE inputs. SL501cytology, preservative and vial, (cytospin) 88108 - 30ml should be deleted from CMS' database as it is redundant with SL040 cytology, preservative and vial (Preserv-cyt) and the quantity of SL040 for CPT code 88108 should be 1 item. This was an error made in 2014 and in 2015 when these codes were reviewed. The RUC urges CMS to correct this error. **Please see attachments for clear paid invoices for SL040 cytology, preservative and vial (Preserv-cyt) (See attachment 04).**

## II. Determination of Professional Liability Insurance Relative Value Units (PLI RVUs)

### *A.* *Low Volume Service Codes*

The RUC applauds the CMS proposal to override claims data for low volume services with an expected specialty for both the practice expense and professional liability insurance valuation process. This proposal is consistent with a long-standing RUC recommendation to use the expected specialty for services performed less than 100 times per year. Even a few claims made in error by one physician could result in substantial year-to-year payment swings to these codes. This has been particularly problematic when the low volume services in Medicare are actually high volume codes in the Medicaid or private pay population. The RUC understands that CMS relied on the RUC's list from 2016 to initiate this proposal. We have used a specialty society review process and the RUC's Professional Liability Insurance Workgroup to update this list. Attached to this letter is an excel file that includes a few modifications to the expected specialties in the Proposed Rule list as well as additional codes that have fewer than 100 claims in the early 2016 claims data. There are 2,054 total codes included on this list (see attachment 01), and **the RUC recommends that CMS utilize this list for rate-setting for the CY 2018 Medicare Physician Payment Schedule.** We understand that the list will require maintenance on an annual basis. The RUC will review updated claims data each year to determine if any new codes fall below 100 claims and submit an expected specialty recommendation for these additional codes.

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

***B.*** *Premium Crosswalks*

CMS has again proposed to crosswalk non-MD specialties to the lowest MD risk factor specialty for which their contractor collects premium rates, Allergy Immunology. The RUC has consistently maintained that even a risk factor of 1 is too high for many of the non-MD specialties. Premium rates collected from the AMA Physician Practice Information (PPI) 2006 survey data shows that the rates are substantially lower than the proposed crosswalk premium rate of $8,201 for CY 2018 for Allergy Immunology. The RUC is concerned that non-MDs are being overcompensated by using the crosswalk to Allergy Immunology and point to the large discrepancies displayed in the PPI survey data table below. While these premium rates reflect 2006 payments and do not represent every non-physician specialty, this data still provides a practical comparison to suggest that a direct crosswalk to Allergy Immunology is unreasonable.

| Specialty Code | Specialty Name | Risk Factor | PPI 2006 PLI Premium Rate | Proposed- Risk Factors Assigned Via Crosswalk | PPI 2006 PLI Premium Rate Allergy Immunology |
|---|---|---|---|---|---|
| 64 | Audiology | 1 | $1,506 | Reclassified to Allergy Immunology | $8000 |
| 35 | Chiropractic | 1 | $4,742 | Reclassified to Allergy Immunology | $8000 |
| 68 | Clinical Psychologist | 1 | $1,466 | Reclassified to Allergy Immunology | $8000 |
| 80 | Clinical Social Worker | 1 | $1,115 | Reclassified to Allergy Immunology | $8000 |
| 67 | Occupational Therapist | 1 | $1,821 | Reclassified to Allergy Immunology | $8000 |
| 41 | Optometry | 1 | $8,109 | Reclassified to Allergy Immunology | $8000 |
| 65 | Physical Therapist | 1 | $1,821 | Reclassified to Allergy Immunology | $8000 |
| 62 | Psychologist | 1 | $1,466 | Reclassified to Allergy Immunology | $8000 |

**The RUC continues to maintain that CMS should collect premium data for the non-MD specialties and recommends that CMS use updated data from all fifty states or otherwise use the PPI data from 2006.**

CMS seeks comments as to the appropriateness of the crosswalk methodology used in developing the PLI RVUs. The RUC reviewed the proposed crosswalks in Table 6 where specialties for which there was not premium data for at least 35 states, and specialties for which there were not distinct premium data in the rate filings, were cross-walked to a similar specialty. While we question the arbitrariness of the 35 state minimum threshold, it is also difficult to understand how the contractors were unable to get sufficient data from all fifty states for common specialties like hand surgery, podiatry, etc. Though the crosswalks proposed by CMS appear to be appropriate, the RUC is seriously concerned with the data collection process and strongly believes that CMS needs to use updated premium data from all fifty states. **The RUC recommends that moving forward, rather than cross-walking, CMS acquire adequate premium data.**

The RUC also noted an anomaly in Table 8 where the proposed surgical risk factor for neurology is higher than neurosurgery and requests that CMS look into this discrepancy.

The RUC further notes that some sub-specialties may have few or no members in some states. In such cases the 35-state threshold should be decreased.

In addition to the specific concern related to cardiology, discussed below, additional specialties are concerned that they have been assigned blended specialty risk factors, rather than distinct non-surgical and surgical risk factors.

**The RUC is concerned about the proposed dramatic valuation changes that are not indicative of what is occurring in the PLI premium market. In general, the market has not reflected significant changes in the past several years. CMS should consider delaying implementation of new premium data until the Agency has the opportunity to seek additional data to avoid blending risk factors and cross-walking.**

***C.*** *Cardiology Surgical Risk Factor*

The RUC discussed Table 7 of the Proposed Rule where CMS has proposed premium calculation approaches by specialty type. Specifically, cardiology is being classified as a blend rather than split into surgical and non-surgical risk factors as it has been in the past. According to the contractor report, there was insufficient premium data to justify the split this year; 12 states compared to 41 states in the previous year. It appears that some states are now categorizing some cardiologists who perform interventional procedures as "interventional cardiologists." However, even if the two data sets for cardiology and interventional cardiology were combined, it does not reach the established CMS' threshold of 35 states to construct a unique risk factor. **The RUC recommends that cardiology continue to be split into surgical and non-surgical risk factors. We propose a crosswalk to Cardiac Surgery surgical risk factor as an interim solution for CY 2018 while expressing concern with the inadequate data collection.**

The RUC is pleased that CMS continues to classify cardiac catheterization and angioplasty, as well as the injection procedures used in conjunction with these services, as surgical procedures for the purpose of establishing PLI premium rates and risk factors. The RUC reviewed the list of invasive cardiology services that fall out of the CPT surgical range and noted CPT codes 92992 and 92993 are missing from the list of exceptions for CY 2018. Therefore, **the RUC recommends that CPT codes 92992 and 92993 be added to the CMS list of Invasive Cardiology Outside of Surgical Range.**

## III. Potentially Misvalued Services Under the PFS

### *A.* *RUC Progress in Identifying and Reviewing Potentially Misvalued Codes*

Since the inception of the Relativity Assessment Workgroup, the RUC and CMS have identified nearly 2,300 services through 17 different screening criteria for further review by the RUC. The RUC has recommended reductions and deletions to 1,325 services, more than half of the services identified, redistributing nearly $4.5 billion. The RUC looks forward to continuing its work with CMS in a concerted effort to address potentially misvalued services. *A detailed report of the RUC's progress is appended to this letter* (see attachment 02).

### *B.* *CMS Identified Potentially Misvalued Services*

CMS identified CPT codes 27279 *Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device*, 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)* as potentially misvalued based on stakeholder comments. **The RUC added these services to the potentially misvalued services list and will review if CMS finalizes these services as misvalued.**

*Dialysis Circuit (36901-36909)*
CMS indicated that they are considering alternate work valuations for CY 2018, such as the RUC recommended work RVUs from CY 2017, or other potential values based on submission of data through the public comment process to value the dialysis circuit services. The RUC disagrees with the current work RVUs for CPT codes 36901-36909 as CMS used inappropriate crosswalks to establish values. CPT codes 36901-36909 involve obtaining new access to the dialysis circuit, while the codes CMS uses as crosswalks (44388, 44403 and 44408) involve colonoscopy through an existing access (i.e. the enteric stoma). Comparing these endovascular codes involving a high flow arterialized fistula or graft to colonoscopy/ERCP is inappropriate. The typical patient for the dialysis code set is ASA 3 or 4. Chronic renal insufficiency is an inherently complex patient population. Cross-walking urgent dialysis procedures in a medically complex patient population to (typically) elective GI procedures is improper. The illness severity of the typical dialysis patient was taken into consideration and directly discussed in significant detail during the RUC review process. Given the great amount of work on behalf of the specialties and RUC, we do not agree with the inappropriate and seemingly arbitrary crosswalks recommended by CMS. This inappropriately undervalues the work related to acquiring access, which is a key component of the technical skill and judgment required of these and all similar codes requiring de novo access. Additionally, as the RUC has maintained since CMS began its propensity to use work-time ratios, the use of direct crosswalks based only on intra-service time comparison or ratios of intra-service time inappropriately discount the variation in technical skill, judgment, and risk inherent to these procedures. This argument is undermined further when the comparison codes are not similar clinically with regards to risk. The use of 43264 as a crosswalk for 36904 ignores the inherent differences in risk to the patient when working in the vascular system as opposed to the bile ducts. *The 2017 RUC recommendations are attached to this letter* (see attachment 03).

**The RUC urges CMS to finalize the 2017 RUC recommended work RVUs for the dialysis circuit services:**

- **CPT code 36901, work RVU= 3.36**
- **CPT code 36902, work RVU= 4.83**
- **CPT code 36903, work RVU= 6.39**
- **CPT code 36904, work RVU= 7.50**
- **CPT code 36905, work RVU= 9.00**
- **CPT code 36906, work RVU= 10.42**
- **CPT code 369X7, work RVU= 3.0**
- **CPT code 36908, work RVU= 4.25**
- **CPT code 36909, work RVU= 4.12**

*Emergency Department Visits (99281-99285)*
CMS stated that they have received information suggesting that the work RVUs for emergency department visits may not appropriately reflect the full resources involved in furnishing these services. If CMS decides to proceed with the review of CPT codes 99281-99385 (Emergency department visits for the evaluation and management of a patient) then the RUC will add them to the list of potentially misvalued services.

## IV. Proposed Valuation of Specific Codes

### 01. Anesthesia Services for Gastrointestinal (GI) Procedures (CPT codes 007X1, 007X2, 008X1, 008X2, and 008X3)

| CPT Code | Long Descriptor | CMS Proposed/ RUC Recommended Base Unit |
|---|---|---|
| 007X1 | Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; not otherwise specified | 5 |
| 007X2 | Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum endoscopic retrograde cholangiopancreatography (ERCP) | 6 |
| 008X1 | Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; not otherwise specified | 4 |
| 008X2 | Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy | **3*** |
| 008X3 | Anesthesia for combined upper and lower gastrointestinal endoscopic procedures, endoscope introduced both proximal to and distal to the duodenum | 5 |

**008X2 3 base units was the final RUC recommendation and CMS' alternate consideration*

In the CY 2016 PFS proposed rule, CMS discussed that in reviewing Medicare claims data, a separate anesthesia service is typically reported more than 50 percent of the time when various colonoscopy procedures are reported. CMS discussed that given the significant change in relative frequency with

which anesthesia codes are reported with colonoscopy services, they believed the relative values of the anesthesia services should be reexamined and proposed to identify CPT codes 00740 (Anesthesia upper GI visualize) and 00810 (Anesthesia low intestine scope) as potentially misvalued. For CY 2018, the CPT Editorial Panel is deleting CPT codes 00740 and 00810 and creating new codes for anesthesia services furnished in conjunction with and in support of gastrointestinal endoscopic procedures: two codes for upper GI procedures (007X1 and 007X2), two codes for lower GI procedures (008X1 and 008X2), and one code for upper and lower GI procedures (008X3).

For CY 2018, the RUC submitted an interim recommendation for 008X2 of 4 base units. The survey response rate did not meet the RUC's required minimum threshold based on the high utilization of previous code 00810, therefore 008X2 was resurveyed. The RUC reviewed the new survey data and submitted a new recommendation of 3 base units for CPT code 008X2 after the February 10, 2017 deadline for the Proposed Rule for 2018. The RUC noted that the survey respondents indicated that the intensity and complexity measures for 008X2 are identical to slightly less intense than those for the top two key reference services 00910 *Anesthesia for transurethral procedures (including urethrocystoscopy); not otherwise specified* (base unit = 3) and 00914 *Anesthesia for transurethral procedures (including urethrocystoscopy); transurethral resection of prostate* (base unit = 5), which supports the base unit recommendation. The majority of respondents chose key reference service 00910 and the RUC determined that the work for 008X2 is more closely related the top key reference service. Based on the RUC reviewer comments, screening colonoscopies that do not result in the removal of polyps are typically less intense and take less time than a therapeutic/procedural colonoscopy, therefore 3 base units is appropriate. The RUC agreed that this service should be valued lower than the anesthesia for upper GI services CPT codes 007X1, 007X2 and for diagnostic colonoscopy 008X1, thus is valued appropriately. **The RUC urges CMS to accept the final RUC recommended base unit of 3 for CPT code 008X2.**

**02. Acne Procedure (CPT code 10040)**

| CPT Code | Long Descriptor | CMS Proposed/ RUC Recommended Work RVU |
|---|---|---|
| 10040 | Acne surgery (eg, marsupialization, opening or removal of multiple milia, comedones, cysts, pustules) | 0.91 |

CMS is proposing to accept the RUC recommended work RVU for CPT code 10040. CMS has proposed to accept the RUC recommended direct practice expense inputs and times for 10040.

CMS is seeking comment on the typical number of post-operative visits for this code. There was significant discussion regarding this issue at the RUC and the RUC's written recommendations discuss this issue in detail. CMS is considering using the current number of 0.5 post-procedure office visit 99212, instead of 1 post-procedure office visit recommended by the RUC in the follow-up period.

The RUC recommends that CMS to accept the post-procedure office visit that the RUC recommended for this service. One 99212 post-operative visit is medically necessary for this procedure. The typical patient is a teenager who will often need to return due to the management of medication, including changing topical treatment and/or adjusting retinoid dosage. Patients also may have new lesions that need to be treated within the global period. The specialty society also noted that the survey respondents

indicated a 99213 office visits was typical, but the expert panel reduced the visit to a 99212 to better align with clinical appropriateness.

CMS is also considering reducing the clinical labor time for assisting the physician to perform the procedure from 10 minutes to 3 minutes. CMS' questions whether the clinical staff are present and participating in the entire procedure. The specialty society indicated that the clinical staff is present for the entire procedure assisting the physician by stabilizing the patient's head, holding pressure to bleeding areas, and passing instruments. Additionally, the clinical staff wears gloves the entire time with no opportunity for overlapping responsibilities. **The RUC recommends that CMS implement the work RVU of 0.91 for 10040, along with the direct practice expense inputs for this service recommended by the RUC.**

**03. Muscle Flaps (CPT codes 15734, 15736, 15738, 157X1, and 157X2)**

| CPT Code | Long Descriptor | CMS Proposed/ RUC Recommended Work RVU |
|---|---|---|
| 15734 | Muscle, myocutaneous, or fasciocutaneous flap; trunk | 23.00 |
| 15736 | Muscle, myocutaneous, or fasciocutaneous flap; upper extremity | 17.04 |
| 15738 | Muscle, myocutaneous, or fasciocutaneous flap; lower extremity | 19.04 |
| 157X1 | Midface flap (ie, zygomaticofacial flap) with preservation of vascular pedicle(s) | 13.50 |
| 157X2 | Muscle, myocutaneous, or fasciocutaneous flap; head and neck with named vascular pedicle (ie, buccinators, genioglossus, temporalis, masseter, sternocleidomastoid, levator scapulae) | 15.68 |

CMS is proposing the RUC recommended work RVUs for CPT codes15734, 15736, 15738, 157X1, and 157X2. CMS has proposed to accept the RUC direct practice expense inputs for 15734, 15736, 15738, and 157X2, and proposed minor adjustments to 157X1. For the RUCs comments on minor, individual refinements of direct Practice Expense (PE) inputs for 157X1, please see the attached practice expense refinement table.

CMS is seeking comment on whether the RUC recommendation for 157X1 is appropriate given the significant variation in intensity among these services and also seeking comment on the effect that an alternative work RVU of 14.50 for 157X2 would have on relativity among the codes in this family. There was significant discussion regarding these issues at the RUC and the RUC's written recommendations discuss these issues in greater detail.

**157X1**

For CPT code 157X1, CMS is considering a work RVU of 12.03, cross-walking 157X1 to CPT code 36830 *Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); nonautogenous graft (eg, biological collagen, thermoplastic graft)*. The RUC strongly disagrees with the crosswalk code (36830). The RUC recommended to crosswalk 157X1 to 36832 *Revision, open, arteriovenous fistula; without thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)* (work RVU = 13.50 and 90 minutes of intra-service time) because both

require the same intra-service time and similar intensity to complete. Work values are derived from magnitude estimation on survey, and are based on both time and intensity. With matching intra-service times, a crosswalk based on total time rather than estimated work places undue and improper emphasis on time and too little emphasis on intensity/complexity, as well as the clinical attributes of the procedure. CMS has made this error in the past when attempting to determine work values based on time alone, without appropriate consideration of intensity. According to statute, CMS must consider both time and intensity.

CMS is also considering refinements to the clinical labor time for "check dressings & wound/home care instructions" for 157X1 from 10 minutes to 5 minutes and is seeking comments on the typical time input for checking dressings, and if removing and replacing dressings, typically occurs during the intra-service or post-service periods. With the advent of the updated PE spreadsheet, the time for check dressings and home care instructions has been separated into two separate clinical activities. 1 minute to check dressings and 2 minutes for wound/home care instructions. At the time of this recommendation, there was not a standard time allocated to this service to allow for variation based on the service. Also, because the clinical activities were not codified at the time of this recommendation, the specialty also included coordinate office visits/prescriptions as part of this line item; this and the complexity of the service and severity of the wound account for the 10 minutes of time. Although 10 minutes would not be typical for the majority of services, the specialties' expert panel and the PE Subcommittee agreed that this service required greater time. **The RUC urges CMS to maintain 10 minutes for this clinical activity.**

As part of the intra-service time, dressings are placed on the patient by the physician at the end of surgery. Dressing and wound checks and dressing removal and replacement are fundamentally part of post-service work for muscle flap procedures. For patients undergoing these surgical procedures, post-operative dressing changes involve more than simple suture removal. These post-operative dressing changes involve evaluation of the integrity of the pedicle's blood supply, the adequacy of the reconstructed eyelid position, and function and flap/eyelid impact on the ocular surface/blink. The typical patient for these procedures has to be counseled at each visit about eye/flap care for urgent as well as for a typical follow-up meeting with his/her physician.

CMS is also seeking comments regarding the use of a new supply "plate, surgical, mini-compression, 4 hole" (SD189) included in 157X1 and seeks comment whether the use of this supply is typical and if it should be included in the work description. Supply item, SD189 is mentioned in the direct practice expense recommendations, but the supply does not appear in the work description. CMS states "in the work description, the fixation screws are applied to the orbital rim and lateral nasal wall, not the surgical plate."

The use of SD189 is typical, it offers greater stability, less risk of infection, fewer screws, and allows surgical options with a wide area of support along the orbital rim. These advantages are important in trying to establish adequate closure to protect the eye in a difficult procedure in a patient with scarring and altered anatomy from prior surgery. The use of SD189 was discussed extensively at the PE committee and was approved by the committee and the RUC. The recommendation forms with the work descriptor do not normally list all supplies or materials used before, during, or after the surgery in great detail. Listing all supplies and materials occurs in the PE forms and considerations, and not normally included in the brief descriptions of the physician work included in the RUC summary forms.

**157X2**

CMS is seeking comment on the effect that an alternative work RVU of 14.50 would have on relativity among the codes in this family. The RUC does not agree with CMS regarding its proposal for an alternative work RVU because an alternative work RVU of 14.50 would not have appropriate relativity compared to other muscle flap services. In April 2016 the RUC reviewed code 15732 and the specialties explained that just like the three previous surveys for this procedure, the results indicate the typical patient will have inpatient status (72%) and the typical length of stay will be four days. As in the past, this conflicted with the Medicare utilization data that shows the primary place of service as outpatient hospital. Therefore, the specialties determined that the code needs to be referred to the CPT Editorial Panel to better differentiate and describe the work of large flaps performed on patients with head and neck cancer who will have inpatient status and be similar to the other procedures in this family. This is in contrast to smaller flaps that may be accomplished in an office or outpatient setting and would be best coded by the adjacent tissue transfer codes. CPT code 157X2 was redesigned in CPT to encompass those flaps requiring facility usage and likely inpatient hospitalization. To justify a work RVU of 15.68, the RUC compared the survey code to 2nd key reference and MPC code 60500 *Parathyroidectomy or exploration of parathyroid(s);* (work RVU 15.60, intra-service time 120 minutes, total time 313 minutes) and noted that both services have identical intra-service times and similar total times. The RUC agreed with the specialty that the survey code involves moderately more intense physician work. The RUC recommended a work RVU of 15.68, which is appropriate given the history.

**The RUC recommends that CMS implement the current work RVUs of 23.00 for CPT code 15734, 17.04 for CPT code 15736, 19.04 for CPT code 15738, 13.50 for CPT code 157X1, and 15.68 for CPT code 157X2, along with the direct practice expense inputs for each service as recommended by the RUC.**

**04. Application of Rigid Leg Cast (CPT code 29445)**

| CPT Code | Long Descriptor | CMS Proposed/ RUC Recommended Work RVU |
|---|---|---|
| 29445 | Application of rigid total contact leg cast | 1.78 |

CMS has proposed to retain the current work RVU of 1.78 for CPT code 29445, as recommended by the RUC, and is seeking comment on whether the initial application of a new cast would be typical for this code, as claims indicate that 3 casts are typically applied. CPT code 29445 has become the gold standard for treatment of diabetic ulcerations on the plantar aspect of the foot. Typically, these wounds take approximately one month to heal. These casts are removed and replaced every week. Thus the typical patient would have three casts applied over a three to four week period.

The RUC disagrees with the Agency's consideration of refinements to the clinical labor time for "Remove cast" from 22 minutes to 11 minutes as only taking place during the initial casting. There was significant discussion at the RUC regarding the casting and the RUC's written recommendations address the issue. "A detailed discussion was convened that CPT code 29445 is a 000-day global code for the application of a rigid leg cast. CPT guidelines and CMS policy indicate that casting and strapping procedures include removal of cast or strapping. Therefore, 22 minutes for the physician and clinical staff to remove the cast on a subsequent date is included in the post-service period of the casting code." The RUC offers the following detailed account of the 22 minutes approved for staff assistance with cast removal:

- Review charts, greet patient, provide education (3 min)
- Prepare room, equipment, supplies (3 min)
- Assist physician in performing procedure (10 min)
- Clean room/equipment by physician staff (3 min)
- Conduct phone calls/call in prescriptions/ lab slips completed, call lab (3 min)

CMS has proposed refinements to the RUC direct practice expense inputs for 29445. **For the RUCs comments on individual refinements of direct PE inputs, please see the attached practice expense refinement table.**

**The RUC recommends that CMS implement the current work RVU of 1.78 for CPT code 29445, along with the direct practice expense inputs for this service as recommended by the RUC.**

**05. Strapping Multi-Layer Compression (CPT codes 29580 and 29581)**

| CPT Code | Long Descriptor | CMS Proposed/ RUC Recommended Work RVU |
|---|---|---|
| 29580 | Strapping; Unna boot | 0.55 |
| 29581 | Application of multi-layer compression system; leg (below knee), including ankle and foot | 0.60 |

CMS has proposed to retain the current work relative values for both codes in this family as recommended by the RUC. For CY 2018, CMS is proposing the RUC-recommended work RVUs of 0.55 for CPT code 29580 and 0.60 for CPT code 29581, and is seeking comment on whether the alternative values considered would be more appropriate.

**29580**

For CPT code 29580, the RUC questions the Agency's concern "about the changes in preservice time reflected in the specialty's survey compared to the RUC-recommended work RVUs." Perhaps the Agency is referring to the difference between the surveyed pre-times and package pre-times. The surveyed pre-service time was 16 minutes. The application of pre-time packages reduced that to 7 minutes. The use of pre-time packages is a long-standing policy of the RUC. CMS typically accepts and supports this methodology.

CMS considered a crosswalk to CPT code 98925 *Osteopathic manipulative treatment (OMT); 1-2 body regions involved* which has a similar, though not identical, intra-service time and a work RVU of 0.46. The RUC, however, compared 29580 to top key reference code 29515 *Application of short leg splint (calf to foot)* (work RVU=0.73, intra-service time of 15 minutes) and second key reference code 29405 *Application of short leg cast (below knee to toes);* (work RVU=0.80, intra-service time of 15 minutes). Codes 29515 and 29405 are highly appropriate comparison codes. These services require slightly more time than 29580 for molding the cast/splint while the plaster sets and have a slightly higher intensity to account for maintaining bone alignment while applying the cast/splint. In addition, the RUC compared the surveyed code to MPC codes 46600 *Anoscopy; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)* (work RVU=0.55, intra-service time of 5 minutes) and 69210 *Removal impacted cerumen requiring instrumentation, unilateral* (work

RVU=0.61, intra-service time of 10 minutes) and determined that both reference codes have similar physician time and work and provide appropriate magnitude estimation to the recommended value.

The RUC stresses that the physician work for CPT code 29580 has not changed and the survey supports maintaining the current work RVU of 0.55. The RUC disagrees with the crosswalk to 98925 for a lower work RVU.

**29581**

For CPT code 29581, CMS considered a work RVU of 0.50 by using the RUC-recommended work RVU increment between CPT codes 29580 and 29581 (+0.05), added to the work RVU that CMS considered for CPT code 29580 (0.46), and crosswalking to CPT code 97597 *(Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; first 20 sq cm or less*). First, we would like to point out a typographical error; CMS listed the incorrect work RVU for the alternative crosswalk code, which instead has a work RVU of 0.51 (and is also the sum of 0.46 plus 0.05). The RUC determined that the current work RVU of 0.60, which is lower than the survey 25$^{th}$ percentile, appropriately accounts for the work required to perform this service. To validate a work RVU of 0.60, the RUC compared the survey code to top key reference code 29405 *Application of short leg cast (below knee to toes);* (work RVU =0.80, intra-service time of 15 minutes) and noted that the survey code has slightly lower intra-service time, and the survey respondents indicated that the survey code is identical to somewhat more intense to perform, further justifying this valuation. Further, CPT code 64566 *Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming* (work RVU=0.60, intra-service time of 10 minutes) provides an excellent comparison of work with identical work RVU, nearly identical intra-service time, and identical pre and post-service times. For these reasons, the RUC disagrees with the proposed crosswalk.

CMS has also proposed minor adjustments to the equipment time for both codes. **For the RUCs comments on individual refinements of direct PE inputs, please see the attached practice expense refinement table.**

**The RUC recommends that CMS implement the current work RVUS of 0.55 for CPT code 29580 and 0.60 for CPT code 29581, along with the direct practice expense inputs for each service as recommended by the RUC.**

**06. Resection Inferior Turbinate (CPT code 30140)**

| CPT Code | Long Descriptor | CMS Proposed/ RUC Recommended Work RVU |
|---|---|---|
| 30140 | Submucous resection inferior turbinate, partial or complete, any method | 3.00 |

In October 2015, AMA staff re-ran the Harvard valued codes with utilization over 30,000 based on 2014 Medicare claims data and this service was identified. In April 2016, the RUC recommended an interim work RVU of 3.57 for CPT code 30140. The RUC noted that because this service has a negative IWPUT and the post-operative visits were highly variable, it should be considered as a 000-day global period. The specialty society agreed with this conversion to a 000-day global as they felt it would have

more relativity across the fee schedule with the modified global, and the code was resurveyed for October 2016.

For CY 2018, the RUC recommended and CMS has proposed a work RVU of 3.00 for CPT code 30140 as a 000-day global code. Although CMS is proposing to accept the RUC's recommendation, the Agency noted that it also considered whether a work RVU of 2.68 would be warranted, which was the survey 25th percentile. CMS is seeking comment on the appropriateness of the alternative work RVU and changes in practice patterns.

CMS questioned whether a work RVU of 2.68 would better maintain relativity among similar codes and noted that codes 31240 *Nasal/sinus endoscopy, surgical; with concha bullosa resection* and 31295 *Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine fossa* have similar times yet lower work RVUs relative to 30140. Reference code 31240, which has an IWPUT of 0.783, involves a concha bullosa which is the middle turbinate with a big air pocket. However, there is little chance that the physician will over or under resect as it is very clear on what needs to be removed. Whereas, CPT code 30140 requires an incision at the anterior part of the inferior turbinate and to raise a tunnel in between the bone and the mucosa; it is difficult not to tear the mucosa and if torn leads to more bleeding and longer healing time. The physician removes the bone and the turbinate, if too little bone is removed than the procedure is not successful and the patient continues to have obstruction. If the physician removes too much bone, then the patient will have excessive loss of nasal structure and a feeling of constant nasal congestion which is irreversible. Unlike 30140, CPT code 31295 (IWPUT of 0.0772) does not include the actual removal of tissue and therefore is a less intense procedure to perform relative to 30140. The RUC agrees that these differences account for the added intensity to perform 30140 compared to these similar services.

Also, as the RUC has pointed out in several past comment letters, CMS' continued practice of referencing physician times and derived intensities created several decades ago under the Harvard study as a method to critique RUC recommendations is not appropriate. The code being Harvard valued is the reason it was identified as potentially misvalued in the first place. In addition, the intensity for the Harvard study times is lower than that of a mid-level office visit, which illustrates that the times from the Harvard study for this service were not accurate.

CMS noted that the value of the unbundled post-operative visits is not proportional to the decrease in the proposed work value. This is due to the current misvaluation of this service. The RUC's recommendation of 3.00 work RVUs puts the valuation in line with similar services and is appropriate for this relatively intense service.

The main change in practice patterns since the code was previously reviewed is the understanding of the importance of avoiding over-resection. This phenomenon was not understood well previously, and there was little concern about over-resection of the inferior turbinates. The medical community now understands that over-resection leads to something called "empty nose syndrome," a clinical syndrome which manifests as significant nasal obstruction in the absence of any obstruction on examination. The etiology is thought to be a lack of sensory feedback due to over-resection of normal structures. This accounts for the change in service since being previously reviewed.

**The RUC recommends CMS finalize the proposed work RVU of 3.00 for CPT code 30140.** For the RUCs comments on individual refinements of direct PE inputs please see the attached refinement table.

**07. Control Nasal Hemorrhage (CPT codes 30901, 30903, 30905, and 30906)**

| CPT Code | Long Descriptor | CMS Proposed/ RUC Recommended Work RVU |
|---|---|---|
| 30901 | Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method | 1.10 |
| 30903 | Control nasal hemorrhage, anterior, complex (extensive cautery and/or packing) any method | 1.54 |
| 30905 | Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; initial | 1.97 |
| 30906 | Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; subsequent | 2.45 |

In their discussion of proposed values for this family of codes, CMS notes that as part of its recommendation, the RUC informed them that the specialty societies presented evidence stating that the 1995 valuations for these services factored in excessive times, specifically to account for infection control procedures that were necessary at that time due to the prevalence of HIV/AIDS. The specialty societies also noted that increased availability and use of blood thinner medications compared to those available in 1995, has increased the difficulty and intensity of these procedures. CMS requested additional information regarding the presumption that the relative resource intensity of these services, specifically, would be affected by the commercial availability of additional blood thinner medications. CMS states that blood thinner medications were widely available before 1995 when these codes were last valued. Additionally, they asked for comment on the prevalence of HIV/AIDS and whether the work related to infection control procedures would be relative across many PFS services or specifically related to nasal hemorrhage control procedures.

There are more blood thinners available today than there were in 1995, and more patients using them as indications have changed, leading to more widespread use. Furthermore, many of the newer blood thinners are not as easily reversible as traditional blood thinners, leading to more recalcitrant bleeds, and thus making these particular services more intense. Regarding the prevalence of HIV/AIDS, this point was made by the specialty society during the review in 1995, accounting for a change in physician work. This compelling evidence argument was not accepted by the RUC to increase work RVUs, but the survey times were accepted. While infection control procedures would be relative across many PFS services, there are very few conditions and procedures that induce significant sneezing and coughing on par with epistaxis, and control thereof, leading to significant exposure risk for the practitioner.

For CY 2018, CMS is proposing the RUC-recommended work RVUs for all four CPT codes in this family.

**30901**

For CPT code 30901, CMS considered a work RVU of 1.00, the 25th percentile survey result, crosswalking to CPT code 20606 (Drain/inj joint/bursa w/us), which has similar service times. The difference in total time reflected a small decrease in preservice time, with no change in intra-service time (10 minutes).

The RUC disagrees with the alternate work RVU CMS is considering for CPT code 30901. CMS is discussing a difference of 2 minutes. The survey times actually indicated 15 minutes of total pre-service time, 5 minutes of evaluation, 5 minutes of positioning and 5 minutes of scrub/dress/wait pre-service time. The RUC reviewed the pre-service time and recommended 3 minutes for evaluation, 1 minute for positioning and 5 minutes for scrub/dress/wait. This service is typically reported with an Evaluation and Management (E/M) service, therefore the RUC reduced the evaluation time by 14 minutes from the standard package. The specialty society indicated and the RUC agreed that 3 minutes for evaluation is necessary for the physician to obtain supplies and equipment (packing material and silver nitrate for cautery) and drape and gown for the patient which is not included in the E/M. The RUC agreed that 5 minutes of scrub/dress/wait time is necessary for the physician to scrub, obtain gown, shoe covers and eye shield.

CMS is neither looking at this service relative to other services nor analyzing the pre-service physician time based on the actual care that is provided. CMS is only looking at one data point differential (a 2 minute decrease) without considering the survey data, reductions in pre-time to standards or relativity to other services in this family. **The RUC recommends CMS finalize the proposed work RVU of 1.10 for CPT code 30901.**

**30903**

CMS considered a work RVU of 1.30, the 25th percentile survey result, stating support by CPT codes 36584 and 51710 which have similar service times to the median survey results. The RUC recommended a decreased total time of 39 minutes compared to the existing total time (70 minutes), with intra-service time dropping from 30 to 15 minutes.

The RUC disagrees with the alternate work RVU CMS is considering. The RUC noted that the previous intra-service time, from when this service was last valued 22 years ago, was excessive and fully explained the increased intensity of providing this service. Many more people are now on some form of a blood thinner, given that so many are commercially available today. This makes the epistaxis more difficult to control, and the procedure more intense which provides a rationale for the increase in intensity given the reduced intra time.

In reviewing CMS' alternative RVUs and crosswalks, the alternative values' incremental increase between 30903 and 30905 does not take into account the significant difference between the etiology of the clinical situation, as well as the significantly increased work required to correct the issue. Posterior bleeding is arterial in origin, and therefore requires much more rapid attention. Also, because it is posterior, blood travels into the nasopharynx, oropharynx and larynx first, instead of out the nostrils. This leads to coughing, choking and aspiration. The procedure to stop these bleeds is also much more intense, requiring much deeper and noxious nasal packing.

For additional support the RUC referenced similar services 15271 *Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area* (work RVU = 1.50), 64447 *Injection, anesthetic agent; femoral nerve, single* (work RVU = 1.50), and 64493 *Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level* (work RVU = 1.52) all which require the same intra-service time and similar physician work to perform. **The RUC recommends CMS finalize the proposed work RVU of 1.54 for CPT code 30903.**

**30905**
CMS considered a work RVU of 1.73, using the RUC-recommended work RVU increment between CPT codes 30903 and 30905 (0.43), added to the work RVU CMS considered for CPT code 30903 (1.30), and crosswalking to CPT code 45321 (Proctosigmoidoscopy volvul), which has similar service times. The surveyed intra-service time dropped from 48 to 20 minutes.

The RUC disagrees with the alternate work RVU CMS is considering for CPT code 30905. The RUC disagrees with this methodology as the alternate work RVU considered for 30903 is incorrect. CMS is ignoring the physician work, time, and intensity required to perform this service and is breeding flawed methodology to establish work RVUs by using the current incremental difference in work. The RUC noted that the previous intra-service time was excessive and fully explained the increased intensity of providing this service. Many more people are now on some form of a blood thinner, given that so many are commercially available today. This makes the epistaxis more difficult to control, and the procedure more intense which provides a rationale for the increase in intensity given the reduced intra time.

In reviewing CMS' alternative RVUs and crosswalks, the alternative value's incremental increase between 30903 and 30905 does not take into account the significant difference between the etiology of the clinical situation, as well as the significantly increased work required to correct the issue. Posterior bleeding is arterial in origin, and therefore requires much more rapid attention. Also, because it is posterior, blood travels into the nasopharynx, oropharynx and larynx first, instead of out the nostrils. This leads to coughing, choking and aspiration. The procedure to stop these bleeds is also much more intense, requiring much deeper and noxious nasal packing. **The RUC recommends CMS finalize the proposed work RVU of 1.97 for CPT code 30905.**

**30906**
CMS considered a work RVU of 2.21, using the RUC-recommended work RVU increment between CPT codes 30905 and 30906 (0.48), added to the work RVU CMS considered for CPT code 30905 (1.73), and crosswalking to services with similar service times (CPT codes 19281 (Perq device breast 1st imag), 51727 (Cystometrogram w/up), 49185 (Sclerotx fluid collection), and 62305 (Myelography lumbar injection)). The surveyed median intra-service time dropped from 60 to 30 minutes.

The RUC disagrees with the alternate work RVU considered for 30906. Again, we strongly discourage CMS from relying on building block methodologies that while repeatable, do not properly consider anatomy, intensity, or risk involved in individual procedures. The RUC rigorously reviewed the physician work and the recommended work RVUs were based on robust survey data from providers who conduct these services on a regular basis.

The RUC noted that the previous intra-service time was excessive and fully explained the increased intensity of providing this service. Many more people are now on some form of a blood thinner, given that so many are commercially available today. This makes the epistaxis more difficult to control, and the procedure more intense which provides a rationale for the increase in intensity given the reduced intra time.

For additional support the RUC referenced similar services 12016 *Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 12.6 cm to 20.0 cm* (work RVU = 2.68 and 30 minutes intra-service time) and 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure* (work RVU = 2.78 and 30 minutes intra-service time) which require similar time and physician work to

perform. **The RUC recommends CMS finalize the proposed work RVU of 2.45 for CPT code 30906.**

**08. Nasal Sinus Endoscopy (CPT codes 31254, 31255, 31256, 31267, 31276, 31287, 31288, 31295, 31296, 31297, 31XX1, 31XX2, 31XX3, 31XX4, and 31XX5)**

| CPT Code | Long Descriptor | CMS Proposed/ RUC Recommended Work RVU |
|---|---|---|
| 31254 | Nasal/sinus endoscopy, surgical with ethmoidectomy; partial (anterior) | 4.27 |
| 31255 | Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior) | 5.75 |
| 31256 | Nasal/sinus endoscopy, surgical, with maxillary antrostomy; | 3.11 |
| 31267 | Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus | 4.68 |
| 31276 | Nasal/sinus endoscopy, surgical; with frontal sinus exploration, including removal of tissue from frontal sinus, when performed | 6.75 |
| 31287 | Nasal/sinus endoscopy, surgical, with sphenoidotomy; | 3.50 |
| 31288 | Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus | 4.10 |
| 31295 | Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or canine fossa | 2.70 |
| 31296 | Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (eg, balloon dilation) | 3.10 |
| 31297 | Nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium (eg, balloon dilation) | 2.44 |
| 31XX1 | Nasal/sinus endoscopy, surgical; with ligation of sphenopalatine artery | 8.00 |
| 31XX2 | Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including frontal sinus exploration, with removal of tissue from frontal sinus, when performed | 9.00 |
| 31XX3 | Nasal/sinus endoscopy, surgical with ethmoidectomy; otal (anterior and posterior), including sphenoidotomy | 8.00 |
| 31XX4 | Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy, with removal of tissue from the sphenoid sinus | 8.48 |
| 31XX5 | Nasal/sinus endoscopy, surgical; with dilation of frontal and sphenoid sinus ostia (eg, balloon dilation) | 4.50 |

In October 2016, the CPT Editorial Panel created five new codes (CPT codes 31XX1, 31XX2, 31XX3, 31XX4 and 31XX5) and revised CPT codes 31238, 31254, 31255, 31276, 31287, 31288, 31296, and 31297. CPT codes 31XX2 – 31XX5 are newly bundled services representing services that are frequently reported together. CPT code 31XX1 represents a new service. For CY 2018, CMS is proposing the RUC-recommended work RVUs for all 15 CPT codes in this family.

**31296**

For CPT code 31296, CMS is considering a work RVU of 2.82, supported by a crosswalk to CPT code 36901 (Intro cath dialysis circuit) with an intra-service time of 25 minutes and total time of 66 minutes, similar to the service times for CPT code 31296. CMS notes concern about the decrease in service time compared to the work RVU and seeks comment on whether or not a work RVU of 2.82 might improve relativity with other PFS services."

The RUC does not support CMS's alternate consideration of crosswalking 31296 to 36901. First, in this NPRM for 2018, CMS is still seeking input under the potentially misvalued services for the crosswalk code indicated, 36901. The RUC disagreed with the current work RVU for 36901 and reiterates in this comment letter that CMS should accept the 2017 RUC recommendations for the entire Dialysis Circuit family of services (36901-36909). Second, the RUC deliberately and carefully considered the decrease in physician time and recommended a direct crosswalk to CPT 19083 *Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance* (work RVU = 3.10 and 25 minutes intra-service time). These services require the same intra-service time of 25 minutes and similar total time 59 versus 66 minutes. The RUC noted that the decrease from the current work RVU appropriately accounts for the 5 minute decrease in intra-service work as indicated by the survey respondents. The specialty society noted that the site of service for this procedure has changed and this service is now typically performed in the office setting under topical and local anesthesia. The specialty noted and the RUC agreed that this service is more intense performed on wide awake patient without any sedation. The RUC also noted that the frontal sinus is the most complex sinus for the balloon dilation endoscopy services. Not only is it in close proximity to the orbit and skull base, the narrow opening requires meticulous tissue handling. Any inadvertent abrasions in the surrounding mucosa put the patient at significant risk for scarring of the frontal sinus outflow tract, which would require a subsequent procedure to correct. The intraoperative work is more intense and complex than 36901. The RUC recommended a decrease in the physician work relative to the decrease in physician time. CMS considering lowering the work RVU skews the relativity of this service among the services in this family and other services in the Physician Payment Schedule. **The RUC recommends CMS finalize the proposed work RVU of 3.10 for CPT code 31296.**

**31256**

For CPT code 31256, CMS considered a work RVU of 2.80, by a crosswalking it to CPT code 43231 (Esophagoscopy, flexible, transoral; with endoscopic ultrasound examination), which has 30 minutes of intra-service time and 81 minutes of total time, similar to the RUC-recommended service times. CMS is concerned about the difference in total time between CPT code 31256 and the RUC-recommended crosswalk to CPT code 43247. CPT code 43247 has 30 minutes intra-service time and 58 minutes total time), and CPT code 31256 (30 minutes intra-service time and 83 minutes total time).

The RUC does not support CMS' alternate considerations for CPT code 31256. The physician times are consistent with the alternate crosswalk, but the work RVU is 10% lower and would skew the relativity among services in this family and the rest of the Physician Payment Schedule. The RUC did not recommend or agree with current work RVU for 43231 which was arbitrarily reduced for CPT 2014. The RUC had recommended a work RVU of 3.19 for 43231 which would have placed these two services in the appropriate relativity if CMS had accepted that recommendation.

While CPT code 43231 is closer in total time to CPT code 31256 than code 43247, CPT code 43231 represents a diagnostic service. In contrast, CPT code 31256 is therapeutic in nature and as such, includes significantly more intensity and complexity than 43231. The RUC recommended a value lower

than the survey 25th percentile, recommending a direct crosswalk to CPT 43247 *Esophagogastroduodenoscopy, flexible, transoral; with removal of foreign body(s)* (work RVU = 3.11 and 30 minutes intra-service time) appropriately accounts for the work and time required to perform this service. The RUC noted that the decrease from the current work RVU appropriately accounts for the decrease in intra-service work as indicated by the survey respondents. The RUC noted that the services' intensity was probably undervalued previously based on the understanding of the complexity of this service. For additional support, the RUC referenced similar service 43214 *Esophagoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)* (work RVU = 3.40 and 30 minutes intra-service time). **The RUC recommends CMS finalize the proposed work RVU of 3.11 for CPT code 31256.**

**31254**

For CPT code 31254, CMS notes the RUC's explanation that this service is more intense than the functional endoscopic sinus surgery on the maxillary or sphenoid sinuses due to the risk of major complications such as injury to the eye muscles, bleeding into the eye or brain fluid leak and, consequently, that the RUC concluded that it should be valued higher than either CPT code 31256 or CPT code 31287. Since CPT code 31256 has the same total time (30 minutes) and intra-service time (30 minutes) as CPT code 31254, CMS considered whether the incremental difference recommended by the RUC between these two codes (work RVU of 1.16) would reflect the intensity of the service. CMS is considering an alternate work RVU of 3.97 for CPT code 31254.

The RUC disagrees with arbitrarily applying an incremental difference to consider a work RVU of 3.97 for CPT code 31254. Using an incremental approach in lieu of strong crosswalks and input from the RUC and physicians providing these services is unfounded. Furthermore, while each code represents sinus surgery, there are distinct differences in work and intensity that occur with each sinus. The RUC provided a direct crosswalk to CPT 43243 *Esophagogastroduodenoscopy, flexible, transoral; with injection sclerosis of esophageal/gastric varices* (work RVU = 4.27 and 30 minutes intra-service time) appropriately accounts for the work and time required to perform this service. The RUC noted that the decrease from the current work RVU appropriately accounts for the decrease in intra-service work as indicated by the survey respondents. The RUC pre-facilitated and fully examined the direct crosswalk and confirmed the physician time, intensity and complexity and physician work are appropriate. The RUC also provided reference to comparable service 37191 *Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed* (work RVU = 4.46 and 30 minutes intra-service time). **The RUC recommends CMS finalize the proposed work RVU of 4.27 for CPT code 31254.**

**31287**

For CPT code 31287, CMS considered a work RVU of 3.19 based on the difference between the RUC-recommended work RVU for the maxillary sinus surgery (CPT code 31256) and the sphenoid sinus surgery (CPT code 31287) added to the work RVU that we considered for the base code (CPT code 31256, a work RVU of 2.80). CMS noted that the magnitude of the decrease in service times is greater than those for the work RVU, which potentially could affect relativity among PFS services.

First, the RUC disagrees with arbitrarily applying an incremental difference to consider an alternate work RVU for CPT code 31287. Using an incremental approach in lieu of strong crosswalks and input from the RUC and physicians providing these services is unfounded. While each code represents sinus surgery, there are distinct differences in work and intensity that occur with each sinus. Secondly, CMS is selecting some services in this family to apply an incremental difference to lower and not to others.

This would skew the relativity of the services in this each sinus family, among the entire family of nasal-sinus endoscopies as well as other services in the Physician Payment Schedule. The RUC carefully considered appropriate crosswalks based on the decrease in intra-service time to appropriately account for any efficiency. The RUC pre-facilitated and fully examined the direct crosswalk and confirmed the physician time, intensity and complexity and physician work are appropriate. The RUC reiterates that a direct crosswalk to CPT 36473 *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated* (work RVU = 3.50 and 30 minutes intra-service time) appropriately accounts for the work and time required to perform this service. For additional support, the RUC referenced similar service 43233 *Esophagogastroduodenoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)* (work RVU = 4.07 and 30 minutes intra-service time). **The RUC recommends CMS finalize the proposed work RVU of 3.50 for CPT code 31287.**

**31255**

For CPT code 31255, CMS considered a work RVU of 5.30, based on a crosswalk to CPT codes 36475 (Endovenous rf 1st vein) and 36478 (Endovenous laser 1st vein) since both of these services have the same intra-service times, total times, and work RVUs). CMS notes that there are several CPT codes with similar total and intra-service times that have lower work RVUs than the crosswalk to CPT code 36246 (Ins cath abd/l-ext art 2nd) noted by the RUC, which has 45 minutes intra-service and 96 minutes total time, has work RVU of 5.02; CPT code 36475 (Endovenous rf 1st vein) has 94 minutes intra-service and 94 minutes total time and has work RVU of 5.30).

The RUC disagrees with the alternate consideration for CPT 31255. The RUC acknowledges that there are several CPT codes with similar total and intra-service times. The CMS alternate value does not adequately reflect the intensity and complexity required to perform CPT code 31255. CPT code 31255 requires careful dissection along the entire anterior skull base, as well as along the entire medial orbital wall. There is significant risk of injury to these areas, including cerebrospinal fluid leak and injury to ocular muscles. Furthermore, every person has a different configuration and aeration pattern of their ethmoid sinuses, making procedures very different from person to person which increases the intensity of the procedure as compared to other services. **The RUC recommends CMS finalize the proposed work RVU of 5.75 for CPT code 31255.**

**31276**

For CPT code 31276, CMS considered a work RVU of 6.30, which is similar to other functional endoscopic surgeries. CMS notes that the services reported with CPT code 31276 are the most intense and complex of the functional endoscopic surgeries due to the risks of working in the narrow confines in the frontal recess. However, CMS has concerns that a crosswalk to CPT code 52352 (Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)), and is seeking comment on whether the RUC-recommended decrease in service times is appropriate since CPT code 52352 has 20 minutes more total time than CPT code 31276.

The RUC disagrees with the alternate work RVU considered for CPT code 31276. CMS does not provide a direct crosswalk or any rationale for this work RVU, other than it is similar to other functional endoscopic surgeries. A current search of the entire Physician Payment Schedule only yields six CPT codes with a work RVU of 6.30, none of which appear to be a functional endoscopic surgery. Without exact crosswalks or references from CMS, the RUC cannot properly respond to an arbitrary number.

The RUC noted that this is the most intense and complex functional endoscopic sinus surgery. The specialty societies reiterated that this is the most difficult working with 45-70 degree endoscope working in the narrow confines up in the frontal recess. The frontal sinus is the least forgiving; if the physician inadvertently strips the mucosa or if scarring develops, the risk of failure is significant. The RUC noted that the survey top reference services were not comparable for physician work and time. The specialty society recommended and the RUC agreed that a direct crosswalk to CPT code 52352 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)* (work RVU = 6.75 and 45 minutes intra-service time) appropriately accounts for the work and time required to perform this service. The RUC noted that the decrease from the current work RVU appropriately accounts for the decrease in intra-service work as indicated by the survey respondents. The RUC pre-facilitated and fully examined the direct crosswalk and confirmed the physician time, intensity and complexity and physician work are appropriate. For additional support, the RUC referenced similar service 37192 *Repositioning of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed* (work RVU = 7.10 and 45 minutes intra-service time). **The RUC recommends CMS finalize the proposed work RVU of 6.75 for CPT code 31276.**

**31XX1**

For CPT 31XX1, CMS has concerns and is seeking comment regarding the accuracy and applicability of the surveys as the RUC indicated that the specialty society did not use the survey instrument that contains questions about the number and types of visits and that this service requires a half day discharge day management as the patients typically stay overnight to be monitored for further bleeding. CMS is seeking comment on whether inclusion of a half day discharge day visit is typical for this service. CMS is considering reducing the total time from 142 minutes to 123 minutes by removing the half day discharge.

CMS considered work RVU of 7.30 for CPT code 31XX1, supported by a direct crosswalk to CPT code 36253 (Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image post processing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral), since CPT code 36253 has a similar total time compared to our alternative total time.

The RUC disagrees with CMS's removing the half discharge day management 99238 and the physician time associated with that visit. A half day discharge day management is necessary as the patients typically stay overnight to be monitored for further bleeding and monitored due to the recent acute blood loss. The specialty society indicated that this code represents an anomaly in the family based on the fact that an overnight stay is typical following this procedure. The specialty society indicates that it would be agreeable to resurvey this code with the proper survey instrument. The RUC would review any future survey if CMS finalizes that it would prefer that this code be resurveyed. **However, for 2018, the RUC recommends CMS finalize the proposed work RVU of 8.00 for CPT code 31XX1.**

**31XX3**

For CPT code 31XX3 CMS considered a work RVU of 7.30 based on a crosswalk to CPT code 36253, which is the same as the alternate consideration for 31XX1.

The RUC disagrees with CMS' alternate work RVU considered for CPT code 31XX3. The RUC recommended crosswalk for this code is clinically appropriate and represent similar work, intensity, and complexity to the bundled procedures being valued. Additionally, the RUC recommended values for all of these codes was considerably less than the combined value of the two standalone procedures, as well as compared to the survey respondent's selected key reference service codes. The RUC recommended a direct crosswalk to CPT code 52356 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (eg, Gibbons or double-J type)* (work RVU = 8.00 and 60 minutes intra-service time). The RUC noted that this new service bundles 31255 (recommended work RVU = 5.75 and 45 minutes intra-time) and 31287 (recommended work RVU = 3.50 and 30 minutes intra-service time). The RUC notes that the recommended physician time and work RVU appropriately accounts for the efficiencies of these services being performed together. The RUC confirmed the physician time and work for 31XX3 and 31XX1 are the same and thus should be valued the same. **The RUC recommends CMS finalize the proposed work RVU of 8.00 for CPT code 31XX3.**

**31XX4**

CPT code 31XX4 is a new code representing a combination of the services previously described by CPT codes 31255 and 31288. CMS notes the changes in overall service times compared to other codes in this family and other PFS services. CMS considered a work RVU of 7.85 for CPT code 31XX4, crosswalking to CPT code 93461 (R&l hrt art/ventricle angio), which has identical intra-service times.

The RUC does not understand CMS's comment on noticing the overall service time changes compared to other codes in this family. This service is a new bundled service and the previous standalone codes were resurveyed and new recommendations are proposed. Therefore, the RUC is unclear exactly what the "changes in overall service times" is referring to as this service is new. The RUC disagrees with CMS' alternate work RVU considered because this would skew the relationship with CPT 31XX2 if changed. The RUC recommended a direct crosswalk to CPT code 43274 *Endoscopic retrograde cholangiopancreatography (ERCP); with placement of endoscopic stent into biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent* (work RVU = 8.48 and 68 minutes intra-service time). The RUC notes that the recommended physician time and work RVU appropriately accounts for the efficiencies of these services being performed together. **The RUC recommends CMS finalize the proposed work RVU of 8.48 for CPT code 31XX4.**

**31XX5**

CPT code 31XX5 represents a bundling of CPT codes 31296 and 31297. CMS has concerns about the use of CPT codes 47532 and 58558, which were used by the RUC as comparison codes, due to differences in both intra-service and total time compared to the service times for CPT code 31XX5. CMS considered a work RVU of 4.10 for CPT code 31XX5, crosswalking to CPT code 44406 (Colonoscopy w/ultrasound), which has similar service times.

The RUC disagrees with the alternate work RVU considered for CPT code 31XX5. The RUC recommended a valid survey data point, a work RVU of 4.50, which was the survey 25$^{th}$ percentile. The RUC did not recommend or agree with current work RVU for 44406, which was arbitrarily reduced for CPT 2015. The RUC had recommended a work RVU of 4.41 for CPT code 44406, which would have placed these two services in the appropriate relativity if CMS had accepted that recommendation. The RUC recommended crosswalk for this code is clinically appropriate and represent similar work, intensity, and complexity to the bundled procedures being valued. Additionally, the RUC recommended values for all of these codes was considerably less than the combined value of the two standalone

procedures, as well as compared to the survey respondent's selected key reference service codes. **The RUC recommends CMS finalize the proposed work RVU of 4.50 for CPT code 31XX5.**

**Practice Expense**

Regarding the recommended direct PE inputs, CMS expresses concern about the supply item "sinus surgery balloon (maxillary, frontal, or sphenoid) kit" (SA106). They note that in the current recommendations, half of one kit (each kit has sufficient supply for two sinuses) is included in the practice expense inputs for CPT codes 31295, 31296, and 31297, but that the new CPT code 31XX5 has one full kit, reflecting a service consisting of two sinuses, according to the RUC's explanation. The price of the full kit (two sinuses) of this disposable supply is $2599.06. CMS' analysis of 2016 Medicare claims data indicates that 48 percent of the time one of the three CPT codes (31295, 31296, and 31297) is billed, it is reported on a claim with either one or both of the other codes. Ten percent of the time one of the three CPT codes is reported, it is reported on a claim with both of the other two codes. Effectively, 10 percent of claims reporting these CPT codes are being paid for three sinuses. They seek comment on the number of units of this supply item that are used for each service.

As discussed in the PE presentation for these codes, the typical balloon procedure accesses two sinuses, so a 0.5 kit is appropriate to avoid overpayment. This equates to a half balloon per sinus, so a total of one when two sinuses are accessed. If all three codes are billed together 10% of the time, it is not typical. The RUC recommended allocating resources for the typical reporting scenario. Therefore, the RUC reiterates that half of a *kit, sinus surgery, balloon (maxillary, frontal, or sphenoid) (SA106)* is appropriate for the typical reporting of these services. As the data above indicates, it is very rare for individuals to only utilize a balloon on one sinus, but can occasionally be clinically appropriate. Given this, and the lengthy history that follows this particular PE input, **the RUC again reiterates support for CMS to develop a standalone HCPCS supply code for the balloon kit, as we feel that is the most accurate method for reimbursing providers for the exact supplies they utilize in a given procedure. Historically CMS has not been interested in pursuing a HCPCS code for this purpose, but we raise it again now as we understand that this concern persists and it appears to us, to address the potential concerns**.

Finally, CMS states that in reviewing the RUC recommendations for this family of CPT codes, they noticed in an analysis of the claims data, that the average number of HCPCS codes in this family reported together on a claim line is approximately 2.89. In addition, about 15 percent of claims have two of the newly bundled CPT codes reported together on a claim line. They express concern about the frequency with which the nasal sinus endoscopy CPT codes in this family are billed together and seek comment on whether they should consider the endobase code adjustments as a better approach to adjusting payment for these services instead of the current multiple procedure reduction.

**The RUC strongly objects to the proposal to apply an endobase code adjustment to these procedures.** In cases where multiple endoscopies are provided on the same date of service this would result in the base procedure not being reimbursed, as it would be considered "bundled" into the other endoscopic procedure done that day. Given that these are all therapeutic procedures, it would be grossly inappropriate to value the lesser valued procedure at zero simply because it is done on the same day as another endoscopic procedure. Each sinus represents very different work and risks. Simply utilizing a base code plus adjustments ignores the significant differences between these distinct anatomic sites. Further, CMS gives no indication as to why the current application of the multiple procedure reduction is not sufficient to capture any redundancies in pre and post-operative work that may apply when two therapeutic endoscopies are done on the same day.

**09. Tracheostomy (CPT codes 31600, 31601, 31603, 31605, and 31610)**

| CPT Code | Long Descriptor | CMS Proposed/ RUC Recommended Work RVU |
|---|---|---|
| 31600 | Tracheostomy, planned (separate procedure); | 5.56 |
| 31601 | Tracheostomy, planned (separate procedure); younger than 2 years | 8.00 |
| 31603 | Tracheostomy, emergency procedure; transtracheal | 6.00 |
| 31605 | Tracheostomy, emergency procedure; cricothyroid membrane | 6.45 |
| 31610 | Tracheostomy, fenestration procedure with skin flaps | 12.00 |

CPT code 31600 was identified as part of a screen of high expenditure services with Medicare allowed charges of $10 million or more that had not been recently reviewed. CPT codes 31601, 31603, 31605, and 31610 were added and reviewed as part of the code family. CMS is proposing the RUC-recommended work RVUs for all five codes in this family.

**31601**

CMS considered a work RVU of 6.50 for CPT code 31601. CMS is seeking comment on the effect that this alternative value would have on relativity compared to other PFS services, especially since the survey data does not suggest an increase in the time required to perform the procedure.

The RUC clearly explained the compelling evidence that CPT code 31601 current work value was based on flawed methodology. Therefore, CMS should not compare the current value/physician time to that of the recommend work RVU and physician time. The RUC compelling evidence specified:

> Harvard reviewed code 31601 as a 090-day global code. In that study, the intra-operative work estimates were provided by only ten general otolaryngologists and the pre-and post-operative work were computed by algorithm. The specialty societies also noted that the 1992 Medicare Physician Payment Schedule indicated a 090-day global period for 31601 with a footnote that the work RVU was "gap-filled" by CMS. In the 1993 Medicare Physician Payment Schedule, the global period was changed to 000-day and the work RVU reduced without resurvey and without any discussion in the Federal Register text. The specialty societies further noted that, during the first five-year-review in 1995, a comment was made to CMS that the intra-operative work of 31601 was undervalued and the code was surveyed. However, in 1995, the society did not have the history of the CMS global period changes and "gap fill" changes in valuation for this low volume procedure. Therefore, the RUC concluded that the patient population and procedure had not changed since the Harvard review and the Harvard work RVU was maintained. The rejected survey data were entered into the RUC database several years later and were marked "do not use to validate for physician work" because the surveyed physician time did not correspond to the Harvard work RVU that the RUC maintained.

The RUC does not support CMS' alternate consideration of 6.50 for CPT code 31601. CMS does not state any crosswalks or reference to how they arrived at this alternate work RVU. The RUC recommends that CMS rely on valid survey data and not an arbitrary number. **The RUC recommends CMS finalize the proposed work RVU of 8.00 for CPT code 31601.**

**31605**

CMS considered a work RVU of 4.77 for CPT code 31605, based on the survey 25th percentile from the combined survey total. CMS also considered an intra-service work time of 15 minutes, based on the median intra-service work time from the combined survey total for CPT code 31605. CMS is seeking comments on the methodology used to determine the RUC-recommended work RVU and intra-service work time. CMS is concerned that the number of respondents (20) is below the threshold typically required for submission of a survey, and the effect of using survey results only from physicians who had personal experience performing the procedure (20 respondents). CPT code 31605 has a lower intra-service and total time, but a higher work RVU than comparable codes under the PFS. CMS notes that the next highest 000-day global code with 20 minutes of intra-service time is CPT code 16035 (Escharotomy; initial incision) at a work RVU of 3.74. All other 000-day global codes with a work RVU of 6.45 or greater have at least 40 minutes of intra-service time. CMS is seeking comment on the effect that an alternative work RVU of 4.77 would have on the relativity of this service compared to other services in this family of codes and compared to other PFS services, taking into account that CPT code 31605 describes a difficult and dangerous life-threatening emergency procedure."

The RUC does not agree with CMS' alternate consideration of 4.77 for 31605. The RUC specifically noted that this service was originally based on flawed methodology and changed without previous notification in a Federal Register. The RUC is trying to correct flaws regarding the valuation of this service. If CMS uses the 25$^{th}$ percentile combination of survey data between those who perform this services and those who have not, this will cause a rank order anomaly within this family of services and result in a lower work RVU for this intense emergency tracheostomy compared to a planned tracheostomy, CPT code 31600, and lower than the less intense and less physician work compared to the transtracheal emergency tracheosotomy, CPT code 31603. The RUC considered the physician work, time and intensity as a whole in developing the recommended work RVU of 6.45 for this service as well as its relativity among this family of services. CMS should not consider one element, in this case physician time. Although this service has as shorter intra-service time does not solely correlate that there is less intensity or physician work required. **The RUC recommends CMS finalize the proposed work RVU of 6.45 for CPT code 31605.**

**31610**

CMS considered a work RVU of 6.50 for CPT code 31610 based on a direct crosswalk to CPT code 31601. CMS understands that the RUC considered the possibility of recommending this code be assigned a 000-day global period based on concerns about negative derived intensity. CMS shares the RUC's concerns with the current construction of CPT code 31610, particularly with the 242 minutes of work time included in the postoperative visits, which is an unusually large amount for a procedure with only 45 minutes of intra-service time. CMS did not identify any other comparable codes under the PFS with 45 minutes of intra-service time and more than 300 minutes of total time. CMS seeks comment on whether the unusual volume of physician work time included in the postoperative visits for CPT code 31610 contributed to the negative derived intensity reported by the survey data. Considering that the other codes in this family have 000-day global periods, CMS considered and are seeking comment on whether a 000-day global period should be assigned to CPT code 31610. Removal of the postoperative E/M visits from CPT code 31610 would result in an intra-service time of 45 minutes and a total time of 125 minutes, similar to CPT code 31601 with 45 minutes of intra-service time and 135 minutes of total time.

The RUC does not agree with CMS's alternate consideration of 6.50 work RVUs for CPT code 31610. There are multiple issues with that consideration.

1) The work RVU crosswalk of 6.50 to the other alternate consideration work RVU of 31601 is arbitrary as stated above. The work RVU considered for 31601 is unsubstantiated and unsupported by any crosswalks or valid survey data. CMS did not indicate how that work RVU considered was developed. Assigning an arbitrary work RVU to either 31601 or 31610 will continue a flawed methodology for the valuation of these services.
2) Simply because codes 31601 and 31610 have the same intra-service time of 45 minutes does not mean they require the same physician work or intensity to perform. CPT code 31601 is a planned tracheostomy performed on a pediatric patient, whereas 31610 is a tracheostomy with fenestration procedure with skin flaps on an adult. The differences in physician work for these services are outlined in the summary of recommendation form description of intra-service physician work.
3) The RUC did discuss the possibility of changing 31610 to a 000-day global service. However, that was when the RUC interim recommended work RVU resulted in a negative IWPUT. The specialty societies appealed the interim RUC recommendation and re-discussed/presented this issue. The specialty societies appealed the interim recommendation and change to the global period because a negative IWPUT should not be the primary criteria to change a global period. CPT code 31610 is a major surgery and is appropriately classified as a 090-day global period. Additionally, the post-operative work is stable and the level and physician work was specifically outlined in the rationale for the April 2016 meeting; and there is compelling evidence that the original valuation was flawed. The specialty societies requested that the RUC maintain the current 090-day global period and reconsider compelling evidence. The Committee noted that, while the RUC will submit the specialties' recommendations for the global period to CMS, the Agency makes the ultimate global period assignment. **The RUC indicated concern that if this service was changed to a 000-day global period that direct practice expense activities associated with the care of the tracheostomy in the post-operative care would be lost.**
4) The RUC extensively reviewed the necessity of each post-operative visits associated with this service and specified what occurred at each visit. The RUC recommended 2-99231 subsequent hospital care visits, 1-99232 subsequent hospital care visit, 1-99233 subsequent hospital care visit, 1-99238 discharge day management and 3-99213 office visits. The RUC agreed that the 99232 visit is typically the first inpatient post-operative visit and is more intense and complex than the two 99231 visits because the physician is checking for significant complications such as pneumothorax subcutaneous crepitus and subcutaneous emphysema. The 99231 visits are to evaluate the skin flaps for viability and make sure there is no infection. The 99233 service is typically 4-5 days after the procedure and is the most intense visit because it includes changing the tracheostomy, taking out sutures, removing the tracheostomy, inspecting the area and inserting a new tracheostomy into the stoma. Further, the RUC agreed that 3-99213 office visits are appropriate in order to examine the patient, inspect the larynx, remove the tracheostomy, examine stoma and skin flaps, replace the tracheostomy, cauterize any granulation tissue at the stoma, answer patient/family questions, assess for adequacy of pain control and discuss proper maintenance of the tracheostomy including stomal care.

**The RUC urges CMS to finalize the proposed work RVU of 12.00 and maintain the 090-day global period assignment for CPT code 31610.** Altering unsubstantiated work RVUs and global periods for these services will continue the flawed methodology for this family of services.

**10. Bronchial Aspiration of Tracheobronchial Tree (CPT codes 31645 and 31646)**

| CPT Code | Long Descriptor | CMS Proposed/ RUC Recommended Work RVU |
|---|---|---|
| 31645 | Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed with therapeutic aspiration of tracheobronchial tree, initial | 2.88 |
| 31646 | with therapeutic aspiration of tracheobronchial tree, subsequent, same hospital stay | 2.78 |

CMS has proposed the work RVUs of 2.88 for CPT code 31645 and 2.78 for CPT code 31646, as recommended by the RUC, and is seeking comment on whether they should finalize refined values consistent with the implementation of separately billable codes for moderate sedation.

We appreciate that CMS is proposing the RUC-recommended work RVUs for both codes in this family, and disagree with the alternative work RVUs of 2.72 for 31645 and 2.53 for 31646 which the Agency considered. The RUC thoroughly discussed issues related to moderate sedation and the RUC's written recommendations address the issue. For CPT code 31645, the RUC clarified that "with the transition to the new separately reported moderate sedation codes, this value, the survey 25$^{th}$ percentile, does not include any physician work for this separate procedure. This is reflected in the descriptions of work, which does not mention moderate sedation." Furthermore, the RUC agreed that for both codes "the pre-service evaluation time should be 10 minutes, 5 minutes less than the survey median to ensure that the work of moderate sedation, which is now reported separately, is not included." Similarly, the RUC recommendation for CPT code 31646 also states that "with the transition to the new separately reported moderate sedation codes, this value, the survey 25$^{th}$ percentile, does not include any physician work for this separate procedure. This is reflected in the descriptions of work, which does not mention moderate sedation." The RUC reiterates that moderate sedation was not inadvertently included in the development of the recommended work RVUs for these two services.

The RUC disagrees with the Agency's consideration of a crosswalk for CPT code 31646 to CPT code 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)* (work RVU = 2.53). Code 31646 includes all the work of a diagnostic procedure plus the additional work of the work of the pulmonary aspiration. Therefore, under no circumstances should code 31646 be valued the same as the base code 31622. Second, the CPT revisions to code 31646 now require that this code be performed in the inpatient hospital setting, due to the clarification of "same hospital stay" in the descriptor. This means that the typical patient will now be sicker with higher amounts of comorbidities, causing increased physician work.

CMS has proposed refinements to the RUC direct practice expense inputs for 31645. **For the RUC's comments on individual refinements of direct PE inputs, please see the attached practice expense refinement table.**

**The RUC recommends that CMS finalize the proposed work RVUs of 2.88 for CPT code 31645 and 2.78 for CPT code 31646, along with the direct practice expense inputs for each service as recommended by the RUC.**

**11. Cryoablation of Pulmonary Tumor (CPT codes 32998 and 32X99)**

| CPT Code | Long Descriptor | CMS Proposed/ RUC Recommended Work RVU |
|---|---|---|
| 32998 | Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; radiofrequency | 9.03 |
| 32X99 | Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; cryoablation | 9.03 |

For CY 2018, the CPT Editorial Panel created a new code (32X99) to report cryoablation of pulmonary tumors and revised CPT code 32998 to include imaging for ablation of tumor. The RUC recommended and CMS has proposed a work RVU of 9.03 for CPT code 32998 and a work RVU of 9.03 for CPT code 32X99. Although CMS is proposing to accept the RUC's recommendation, the Agency noted that it also considered whether a work RVU of 7.69 would be warranted for each code, which was derived via a flawed building block methodology. CMS started with the old value of CPT code 32998 of 5.68 and arbitrarily added half the value of the most common image guidance code, 77013.

CMS noted that they reviewed the Medicare claims data from 2014 and perceived that 32998 was not typical reported with a separate image guidance code. They are seeking guidance on why image guidance was bundled into these services, given their interpretation. The analysis that CMS performed appears to have accidentally excluded the 26 modifier data for the CT guidance codes. Both in CY 2014 and CY 2015, CPT code 32998 was reported with CT guidance the vast majority of the time. Furthermore, image guidance is the appropriate standard of care for cryoablation of pulmonary tumors. In order to appropriately target tumor and minimize risk, percutaneous Cryo/RFA of a lung tumor cannot be performed without imaging guidance.

*2014 Medicare Carrier 5% Standard Analytic File:*

| CPT Code 1 | Mod 1 | CPT Code 2 | Mod 2 | Percent Billed Together |
|---|---|---|---|---|
| 32998 | | 77012 | 26 | 8% |
| 32998 | | 77012 | | 4% |
| 32998 | | 77013 | 26 | 85% |
| 32998 | | 77013 | | 8% |

*2015 Medicare Carrier 5% Standard Analytic File:*

| CPT Code 1 | Mod 1 | CPT Code 2 | Mod 2 | Percent Billed Together |
|---|---|---|---|---|
| 32998 | | 77012 | 26 | 14% |
| 32998 | | 77013 | 26 | 86% |

CMS' premise for considering alternate work values for these services is mistaken. **The RUC recommends CMS finalize the proposed work RVU of 9.03 for CPT code 32998 and 9.03 for CPT code 32X99.** For the RUCs comments on individual refinements of direct PE inputs, please see the attached refinement table.

**12. Artificial Heart System Procedures (CPT codes 339X1, 339X2, and 339X3)**

| **CPT Code** | **Long Descriptor** | **CMS Proposed/ RUC Recommended Work RVU** |
|---|---|---|
| 339X1 | Implantation of a total replacement heart system (artificial heart) with recipient cardiectomy | 49.00 |
| 339X2 | Removal of a total replacement heart system (artificial heart) for heart transplantation (List separately in addition to code for primary procedure) | Contractor Priced |
| 339X3 | Removal and replacement of total replacement heart system (artificial heart) | Contractor Priced |

For CY 2018, the CPT Editorial Panel deleted Category III CPT Codes 0051T through 0053T and created CPT codes 339X1, 339X2, and 339X3 to report artificial heart system procedures. CMS is proposing the RUC-recommended work RVU of 49.00 for CPT code 339X1, and proposing to assign contractor-priced status to CPT codes 339X2 and 339X3 as recommended by the RUC. CMS considered assigning contractor-priced status for CPT code 339X1. CMS has concerns regarding the accuracy of the RUC-recommended work valuation for CPT code 339X1, due to its low utilization and the resulting difficulties in finding enough practitioners with direct experience of the procedure for the specialty societies to survey. CMS is seeking comment on the sufficiency of the survey data, especially since new technologies and those with lower utilization are typically contractor-priced.

**339X1**

For CY 2018, CMS is proposing the RUC-recommended work RVUs for CPT code 339X1. CMS is seeking comment on alternative pricing for this CPT code 339X1. CMS is not proposing any direct PE inputs, as there are no direct practice expense inputs for these facility-only services. . These three codes will be placed on the RUC's new technology list and will be re-reviewed by the RUC in 3 years.

The RUC went into great detail regarding the survey process of 339X1. The specialty societies indicated that these services are rarely performed in the US. Currently, there are 76 centers in the US certified to perform these procedures. Only those hospitals that are certified transplant centers, working on becoming a transplant center, use MCS devices, or JCAHO certified DT LVAD center are certified. Certain exceptions may apply such as some children's centers may only have had experience with the

Berlin Heart. There is currently only one total artificial heart (TAH) available in the US market. Other TAH manufactures have either gone out of business or are not currently implanting in the US. The specialty societies used a targeted list approved by the RUC Research Subcommittee from the company that included 128 individuals who are considered implanting surgeons, explanting surgeons or assistants.

The specialty societies distributed the survey to the entire sample size of physicians who perform this service and received 24 responses after multiple solicitations. CPT code 339X1 should be valued by CMS and not contractor priced because it will be at a higher frequency at 100 per year. Additionally, 18 survey respondents with a median experience of 2 cases per year were able to make reasonable intensity, work and time estimates compared to a solid reference CPT code 33983 *Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, with cardiopulmonary bypass* (work RVU = 44.54 and 345 minutes intra-service time, 560 total time). This code was the highest valued reference code available on the reference service list and the respondents for the combined and experienced groups all indicated that that code being surveyed was significantly more complex in the intensity for all measures examined compared to the key reference code 33983. The specialty societies indicated and the RUC agreed that the median physician time data of 360 minutes from the experienced respondents was more representative of the work involved in the TAH implantation. The specialty societies indicated and the RUC agreed that the respondents with no experience underestimated the work involved. The RUC also agreed that the time involved for implantation of biventricular pumps and the associated components with the replacement of total heart function with right and left sided circulation management was longer than that represented by physician time of CPT code 33983, which involves replacement of only the pump for one ventricle and the management of supplementing partial heart function.

CPT code 339X1 is performed at reasonable volumes at regional centers even though nationally the number is low compared for example to left ventricular assist devices (LVADs). There is no additional population to survey, therefore the survey information gathered is the most reliable and valid data to date. This service should not be contractor priced and as CMS noted the RUC will review this service via the new technology/new services list of services after 3 years of utilization data are available. **The RUC recommends that CMS finalize the proposed work RVU of 49.00 for CPT code 339X1.**

**13. Endovascular Repair Procedures (CPT codes 34X01, 34X02, 34X03, 34X04, 34X05, 34X06, 34X07, 34X08, 34X09, 34X10, 34X11, 34X12, 34X13, 34812, 34X15, 34820, 34833, 34834, 34X19, and 34X20)**

| CPT Code | Long Descriptor | CMS Proposed/ RUC Recommended Work RVU |
|---|---|---|
| 34X01 | Endovascular repair of infrarenal aorta by deployment of an aorto-aortic tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the aortic bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the aortic bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer) | 23.71 |

| | | |
|---|---|---|
| 34X02 | for rupture including temporary aortic and/or iliac balloon occlusion when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption) | 36.00 |
| 34X03 | Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-uniiliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer) | 26.52 |
| 34X04 | for rupture including temporary aortic and/or iliac balloon occlusion when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption) | 45.00 |
| 34X05 | Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-biiliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer) | 29.58 |
| 34X06 | for rupture including temporary aortic and/or iliac balloon occlusion when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption) | 45.00 |
| 34X07 | Endovascular repair of iliac artery by deployment of an ilio-iliac tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally to the iliac bifurcation, and treatment zone angioplasty/stenting when performed, unilateral; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation) | 22.28 |

| | | |
|---|---|---|
| 34X08 | for rupture including temporary aortic and/or iliac balloon occlusion when performed (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation, traumatic disruption) | 36.50 |
| 34X09 | Placement of extension prosthesis(es) distal to the common iliac artery(ies) or proximal to the renal artery(ies) for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, penetrating ulcer, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting when performed, per vessel treated (List separately in addition to code for primary procedure) | 6.50 |
| 34X10 | Delayed placement of distal or proximal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, endoleak, or endograft migration, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting when performed; initial vessel treated | 15.00 |
| 34X11 | each additional vessel treated (List separately in addition to code for primary procedure) | 6.00 |
| 34X12 | Transcatheter delivery of enhanced fixation device(s) to the endograft (eg, anchor, screw, tack) and all associated radiological supervision and interpretation | 12.00 |
| 34X13 | Percutaneous access and closure of femoral artery for delivery of endograft through a large sheath (12 French or larger), including ultrasound guidance, when performed, unilateral (List separately in addition to code for primary procedure) | 2.50 |
| 34812 | Open femoral artery exposure for delivery of endovascular prosthesis by groin incision, unilateral | 4.13 |
| 34X15 | Open femoral artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by groin incision, unilateral (List separately in addition to code for primary procedure) | 5.25 |
| 34820 | Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure) | 7.00 |

| | | |
|---|---|---|
| 34833 | Open iliac artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure) | 8.16 |
| 34834 | Open brachial artery exposure for delivery of endovascular prosthesis, unilateral (List separately in addition to code for primary procedure) | 2.65 |
| 34X19 | Open axillary/subclavian artery exposure for delivery of endovascular prosthesis by infraclavicular or supraclavicular incision, unilateral (List separately in addition to code for primary procedure) | 6.00 |
| 34X20 | Open axillary/subclavian artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by infraclavicular or supraclavicular incision, unilateral (List separately in addition to code for primary procedure) | 7.19 |

In October 2015, the CPT/RUC Joint Workgroup on Codes Reported Together recommended to bundle endovascular abdominal aortic aneurysm repair (EVAR) codes with radiologic supervision and interpretation (34800, 34802, 34803, 34804, 34825, 75952 and 75953). In September 2016, the CPT Editorial Panel bundled endovascular repair of abdominal aortic aneurysm and radiologic supervision and interpretation services with the addition of 16 new codes 34X01-34X20, revision of 4 category I codes (34812, 34820, 34833 and 34834), deletion of 14 codes (34800-34806, 34825, 34826, 34900, 75952-75954, 93982, 0255T), and revision of category III code 0254T.

For CY 2018, CMS has proposed the RUC-recommended work RVU for all 20 codes in this family of services. Although CMS is proposing to accept the RUC's recommendation, the Agency noted that it also considered alternative work values for 12 of the 20 codes in this family of services and considered alternate global periods for 8 of those services.

**34X02**

For CPT code 34X02, CMS noted that they considered an alternate work RVU of 32.00 based on the survey 25th percentile, which the Agency felt was further supported by reference code 48000 *Placement of drains, peripancreatic, for acute pancreatitis;* (work RVU of 31.95, intra-service time of 120 minutes). CPT code 48000 is a very low volume service that has not been reviewed by the RUC in almost 20 years and has an anomalously low IWPUT of 0.0586 making it a poor reference point. CMS noted that their reservations with the RUC-recommended value of 36.00 work RVUs were due to the Agency's inability to "…find any 90-day global services with 120 minutes of intra-service time and approximately 677 minutes of that had a work RVU greater than 36.00." As there is only one other services which has an intra-service time of 120 minutes and a total time +/- 25 total minutes from CPT code 34X02, the provided justification by CMS is based on a flawed premise.

Justifying the rejection of a RUC-recommendation based on a flawed crosswalk and inappropriately restrictive search criteria is simply not appropriate. The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents appropriately valued the physician

work involved in performing this highly complex, emergent service at the median work RVU of 36.00. To justify a work RVU of 36.00, the RUC compared the survey code to CPT code 33390 *Valvuloplasty, aortic valve, open, with cardiopulmonary bypass; simple (ie, valvotomy, debridement, debulking, and/or simple commissural resuspension)* (work RVU of 35.00, intra-service time of 180 minutes, total time of 622 minutes) and noted that although the reference code has more intra-service time, the survey code has much more total time and involves a similar amount of physician work.

**34X04**

For CPT code 34X04, CMS noted that they considered an alternate work RVU of 40.00 based on the survey 25th percentile, which the Agency felt was further supported by reference code 33534 *Coronary artery bypass, using arterial graft(s); 2 coronary arterial grafts* (work RVU 39.88, intra-service time of 193 minutes). CMS noted that their reservations with the RUC-recommended value of 36.00 work RVUs were due to the Agency's inability to "…find any 90-day global services with 180 minutes of intraservice time and approximately 737 minutes of total time that had a work RVU greater than 45.00."

It does not appear that any of the services that meet these restrictive search criteria are emergent, so the usage of these restrictive search criteria does not make a compelling rationale for rejecting the RUC's recommendation. The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents appropriately valued the physician work involved in performing this emergent service at the median work RVU of 45.00. To justify a work RVU of 45.00, the RUC compared the survey code to CPT code 43415 *Suture of esophageal wound or injury; transthoracic or transabdominal approach* (work RVU of 44.88, intra-service time of 180 minutes, total time of 842) and noted that both services have identical intra-service time and involve a similar total amount of physician work. Although the reference code has more total time, the survey code is a much more intense procedure to perform.

**34X06**

For CPT code 34X06, CMS noted that they considered an alternate work RVU of 40.00 based on the survey 25th percentile, which the Agency felt was further supported by 34X06 having very similar intra-service and total times to CPT code 34X04. The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents appropriately valued the physician work involved in performing this service at the median work RVU of 45.00. To justify a work RVU of 45.00, the RUC compared the survey code to CPT code 43415 *Suture of esophageal wound or injury; transthoracic or transabdominal approach* (work RVU of 44.88, intra-service time of 180 minutes, total time of 842) and noted that the services have very similar intra-service times and involve a similar total amount of physician work. Although the reference code has more total time, the survey code is a much more intense procedure to perform.

**34X08**

For CPT code 34X08, CMS noted their concern with a potential rank order anomaly for the RUC's recommendation for this service of 36.05 work RVUs. CMS is considering the alternate value of 30.00 work RVUs, which was the survey 25th percentile. CMS compared the relative value between code 34X01/34X02 and 34X07/34X08, noting that the RUC's recommendation for each non-emergent/emergent pairing does not seem to have appropriate rank order. In the proposed alternative values for codes 34X02 and 34X08, CMS has only focused on physician time while disregarding the intensity of the procedure. The IWPUT for these ruptured aneurysm repair codes would be inappropriately lower than the intensity for the non-ruptured codes at the 25th percentile values. The RUC recommended work values account for the significantly increased intensity of the life and death repair of a ruptured aneurysm with the recommended values. The RUC had reviewed the survey

respondents' estimated physician work values and agreed that the respondents appropriately valued the physician work involved in performing this service at the median work RVU of 36.50. To justify a work RVU of 36.50, the RUC compared the survey code to CPT code 33390 *Valvuloplasty, aortic valve, open, with cardiopulmonary bypass; simple (ie, valvotomy, debridement, debulking, and/or simple commissural resuspension)* (work RVU of 35.00, intra-service time of 180 minutes, total time of 622 minutes) and noted that although the reference code has more intra-service time, the survey code has much more total time and involves slightly more total physician work.

With respect to the rank order of 34X02 and 34X08, the RUC recommended work value differential of 0.50 RVUs can be explained clinically. Ruptured isolated iliac aneurysms occur less frequently than ruptured aortic aneurysms and as a result often have a longer delay in diagnosis resulting in more unstable patients requiring higher intensity procedures to save their life. This clinical nuance is accurately reflected in the additional 0.50 work RVUs for 34X08 when compared to 34X02.

**34X13, 31812, 34X15, 34820, 34833, 34834, 34X19 and 34X20**

For add-on codes 34X13, 34812, 34X15, 34820, +34833, +34834, +34X19 and 34X20, CMS noted that they considered assignment of a 0-day global period, instead of the RUC-recommended add-on (ZZZ) global period and subsequently adding back the preservice and immediate post-service work time, and increasing the work RVU of each code accordingly using a building block methodology. CMS highlighted that as add-on procedures, these eight codes would not be subject to the multiple procedure payment discount. The Agency noted concern that the total payment for these services will be increasing in the aggregate based on changes in coding that alter MPPR adjustments, despite the information in the surveys that reflects a decrease in the intra-service time required to perform the procedures, and a decrease in their overall intensity as compared to the current values.

The usage of add-on codes for services that cannot be reported alone is a longstanding and fundamental aspect of CPT and the Medicare physician payment schedule. Several of these add-on codes describe new services that were not previously reportable, so it is unclear what CMS is referring to in their case. It would not be appropriate to add pre-service and post-service time via building block that would be fully duplicative with the pre and post-service time that is already part of the base codes. This family of vascular access codes was created as add-on services (ZZZ global) to prevent duplication of service time, to provide maximum flexibility in the description of the multitude of accesses for the performance of these procedures and due to there was no one access that was typical for the performance of EVAR.

Furthermore, the specialties included budget neutrality calculations with their submission to the RUC and the RUC also provided CMS with budget neutrality calculations as part of the submission of RUC recommendations. When applying all applicable payment policy rules to this family of services (surgical MPPR and bilateral reduction), implementing the RUC's recommendation for these codes would result in an overall work savings that should be redistributed back to the Medicare conversion factor. When valuing these services, the RUC valued these services as add-on codes. In addition, two of these services currently have direct practice expense inputs, 34833 and 34834. As add-on services, the RUC is no longer recommending direct practice expense inputs for any of these 8 services.

**CMS should finalize the proposed values based on the RUC recommendations.** For the RUCs comments on individual refinements of direct PE inputs, please see the attached refinement table.

**14. Selective Catheter Placement (CPT codes 36215, 36216, 36217, and 36218)**

| CPT Code | Long Descriptor | CMS Proposed/RUC Recommended Work RVU |
|---|---|---|
| 36215 | Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family | 4.17 |
| 36216 | Selective catheter placement, arterial system; initial second order thoracic or brachiocephalic branch, within a vascular family | 5.27 |
| 36217 | Selective catheter placement, arterial system; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family | 6.29 |
| 36218 | Selective catheter placement, arterial system; additional second order, third order, and beyond, thoracic or brachiocephalic branch, within a vascular family | 1.01 |

CMS has proposed the RUC recommended work RVUs for 36215, 36216, 36217, and 36218. CMS has proposed to accept the RUC direct practice expense inputs for 36218 and proposed minor adjustments to 36215, 36216, and 36217. **For the RUC's comments on minor, individual refinements of direct PE inputs for 36215, 36216, and 36217, please see the attached practice expense refinement table.**

**36217**

CMS is seeking comment on refinements to the intra-service work time for CPT code 36217 from 60 to 50 minutes. CMS has some concerns that the use of the recommended survey 75th percentile intra-service work time will not be clinically appropriate for this code and the use of this value would not "preserve the incremental, linear consistency" between the work RVU and the intra-service time within the family.

The RUC strongly supports the recommendation to use the survey 75th percentile intra-service time for 36217, which is appropriate from a clinical standpoint as the time increment between 36216 and 36217 was not long enough to account for the additional work of 36217. The RUC had significant discussions regarding the appropriate intra-service time for this procedure. The median survey intra-service time was 50 minutes. However, CPT code 36217 includes the work of both 36215 (intra time= 30 minutes) and 36216 (intra time= 45 minutes). Therefore, the median intra-service time of 50 minutes, only 5 minutes above 36216, is not clinically appropriate. The RUC recommends the 75th intra-service time of 60 minutes in order to accurately account for the physician work of placing a catheter in the third order branch. This more accurate intra-service time, preserves the incremental, linear consistency between the work RVU and intra-service time throughout the family of services. If the intra-service time for 36217 is reduced from the 75th to the 50th survey percentile (decrease of 10 minutes), this adjustment does not preserve the incremental, linear consistency between the work RVU and intra-service time within the family as suggested by CMS. Instead, it is clinically incongruous given the work and time it would take for a procedure to progress to 36217 as opposed to 36216. The RUC recognizes the appeal of having a straight linear stepwise increase, but this does not track well with the clinical work required. Therefore, the RUC strongly reiterates the recommended adjusted intra-service time for 36217 as was discussed extensively at the RUC and in the RUC recommendations for CY 2018.

**The RUC recommends that CMS implement the current work RVUs of 4.17 for CPT code 36215, 5.27 for CPT code 36216, 6.29 for CPT code 36217, and 1.01 for CPT code 36218, along with the direct practice expense inputs for each of the services as recommended by the RUC.**

**15. Treatment of Incompetent Veins (CPT codes 36470, 36471, 364X3, 364X4, 364X5, and 364X6)**

| CPT Code | Long Descriptor | CMS Proposed/ RUC Recommended Work RVU |
|---|---|---|
| 36470 | Injection of sclerosant; single incompetent vein (other than telangiectasia) | 0.75 |
| 36471 | Injection of sclerosant; multiple incompetent veins (other than telangiectasia), same leg | 1.50 |
| 364X3 | Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; first vein treated | 3.50 |
| 364X4 | Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure) | 1.75 |
| 364X5 | Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; single incompetent extremity truncal vein (eg, great saphenous vein, accessory saphenous vein) | 2.35 |
| 364X6 | Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; multiple incompetent truncal veins (eg, great saphenous vein, accessory saphenous vein), same leg | 3.00 |

In September 2016, the CPT Editorial Panel created four new codes to describe the treatment of incompetent veins, and revised existing CPT codes 36470 and 36471. These six codes were reviewed together as part of the same family of procedures. For CY 2018, CMS are proposing the RUC recommended work RVU for all six codes.

**364X3 & 364X4**

CMS considered a work RVU of 4.38 for CPT code 364X3, which would have been based on the RUC-recommended work RVU of 3.50 plus half of the RUC-recommended work RVU of CPT code 364X4. CMS also considered assigning CPT code 364X4 a status indicator of "bundled." CMS has concerns about the frequency that the current services include treatment of an initial vein (CPT code 364X3) as compared to the treatment of initial and subsequent veins (CPT codes 364X3 and 364X4 together). It may be more accurate to describe these services through the use of a single code, as in the rest of this code family, instead of a base code and add-on code pair. Under this potential scenario,

CMS looked at the RUC recommended crosswalk and noted that the add-on CPT code 364X4 was estimated to be billed 50 percent of the time together with CPT code 364X3. CMS therefore considered adding half of the RUC recommended work RVU of CPT code 364X4 (0.88) to the RUC-recommended work RVU of CPT code 364X3 (3.50), resulting in a work RVU of 4.38.

The RUC does not agree with CMS' alternate consideration to bundle 364X3 and 364X4. Historically, the RUC has bundled services that are performed together 75% or more. These codes do not meet that threshold. Separate base codes and add-on codes allow the service to be reported alone as to not account for work that is not performed and reported together with one or more add-on codes to appropriately account for the work actually being performed. The current coding structure allows the physician work and direct practice expense to be resource-based. The structure of this code pair mirrors the existing code structure for treatment of incompetent veins with radiofrequency ablation (CPT 36475, 36476), laser ablation (CPT 36477, 36478) and mechanochemical ablation (CPT 36473, 36474). The new CPT code pair represents another new technology for ablation of incompetent veins as an alternative to existing treatment options.

The estimated billing frequencies were only estimates from the existing claims of CPT code 37799 *Unlisted procedure, vascular surgery*. Since these are new codes and were only minimally reported previously with the unlisted code, it is only an estimate until actual utilization data become available. In no way were they meant to indicate that 50% of the time an additional vein would be treated at the same time as an initial vein. Additionally, the RUC reviews all work neutrality for each CPT cycle to make sure the estimates were accurate.

The RUC strongly disagrees with CMS's assertion that there is a potential for abuse with this new code set. The occurrence of treatment of an additional vein is a reflection of the disease process and not a reflection of the technology. There is no utilization data available for CPT codes 36473 and 36474. There is, however, utilization data available for CPT codes 36475, 36476, 36477 and 36478. These show that an additional vein is treated between 8-34% of the time and in decreasing frequency. The RUC has no reason to believe that the claims for 364X4 will be substantially different from 36476 or 36479 as it will be an alternative modality to treat the same disease process.

CMS provides no rationale as to why half of 364X4 would be added to the base code 364X3 if bundled. The RUC recommended value for 364X4 is already half of the base code. To further reduce the value that to one-fourth of the value of the base code does not properly value the physician work required to perform this service.

Therefore, for all the aforementioned reasons, the RUC disagrees with the alternative proposal for an RVU of 4.38 for 364X4 and a bundled status for 364X4. The RUC recommends that CMS maintain the current coding structure to value 364X3 and 364X4 correctly by ensuring that they are resource-based and not introduce a flawed methodology regarding the valuation of these services. **The RUC recommends that CMS finalize the proposed work RVU of 3.50 for CPT code 364X3 and 1.75 for 364X4.**

**Practice Expense**

CMS is proposing refinements to the RUC-recommended direct PE inputs for the codes in this family. **For the RUCs comments on individual refinements of direct PE inputs please see the attached refinement table.**

**16. Therapeutic Apheresis (CPT codes 36511, 36512, 36513, 36514, 36516 and 36522)**

| CPT Code | Long Descriptor | CMS Proposed/ RUC Recommended Work RVU |
|---|---|---|
| 36511 | Therapeutic apheresis; for white blood cells | 2.00 |
| 36512 | Therapeutic apheresis; for red blood cells | 2.00 |
| 36513 | Therapeutic apheresis; for platelets | 2.00 |
| 36514 | Therapeutic apheresis; for plasma pheresis | 1.81 |
| 36516 | Therapeutic apheresis; with extracorporeal immunoadsorption, selective adsorption or selective filtration and plasma reinfusion | 1.56 |
| 36522 | Photopheresis, extracorporeal | 1.75 |

In the Proposed Rule for 2016, CPT code 36516 was nominated for review as potentially misvalued. In September 2016, the CPT Editorial Panel deleted 36515 and revised 36516 to included immunoabsorption. CPT codes 36511-36514 and 36522 were added as part of this family of services.

For CY 2018, CMS has proposed the RUC-recommended work RVU for all 6 codes in this family of services.

Although the Agency has proposed to accept the RUC's direct practice expense recommendations without refinement, the Agency is seeking comment on the appropriate amount of clinical labor time for the clinical labor time for the "Prepare room, equipment, and supplies" activity for CPT codes 36514, 36522, and 36516. The Agency is considering whether refining the clinical labor time for this activity from 20 to 10 minutes would make more sense for codes 36514 and 36522 and from 30 to 10 minutes for code 36516. The Agency also noted that it considered refining the clinical labor time for "'Prepare and position patient/monitor patient/set up IV" for these same three services. CMS noted their concern about the lack of rationale provided for these changes and whether these changes are typical. A rationale was included with the RUC recommendation specifically for these two clinical labor input types; it appears that Agency staff inadvertently overlooked this section of the RUC recommendation. The RUC recommendation stated:

> The Subcommittee discussed the significant time needed to prepare the room, equipment, and supplies. The specialties explained that the clinical staff time hadn't been accurately accounted for when it was last reviewed in 2004. The PE Subcommittee also discussed that much of the time requested in the post-service time was duplicative of the monitoring time and removed most of that time while maintaining the specialty recommended 10 minutes for monitoring in the service period.

CMS is also seeking comment on whether these procedures are creating a new point of venous access or utilizing a previously placed access. The specialties noted that, for the typical patient for these services, previously placed venous access is utilized. While in some cases a revision to the access site

may need to be made, this is not representative of the typical patient. Frequently, apheresis services are performed on multiple days, sometimes for months at a time.

**The RUC recommends CMS finalize the proposed work RVU of 2.00 for CPT code 36511, 2.00 for CPT code 36512, 2.00 for CPT code 36513, 1.81 for CPT code 36514, 1.56 for CPT code 36516 and 1.75 for CPT code 36522. The RUC also recommends for CMS to finalize the RUC-proposed direct practice expense inputs.**

**17. Insertion of Catheter (CPT codes 36555, 36556, 36620, and 93503)**

| CPT Code | Long Descriptor | CMS Proposed/ RUC Recommended Work RVU |
|---|---|---|
| 36555 | Insertion of non-tunneled centrally inserted central venous catheter; younger than 5 years of age | 1.93 |
| 36556 | Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older | 1.75 |
| 36620 | Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous | 1.00 |
| 93503 | Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes | 2.00 |

For CY 2018, CMS is proposing the RUC-recommended work RVUs for all four codes in this family.

For the RUCs comments on individual refinements of direct PE inputs for 36555, please see the attached practice expense refinement table. The RUC disagrees with the Agency's proposal to remove the direct PE inputs related to moderate sedation from CPT code 36555 as this has already been done.

**The RUC recommends that CMS finalize the proposed work RVUS of 1.93 for CPT code 36555, 1.75 for CPT code 36556, 1.00 for CPT code 36620, and 2.00 for CPT code 93503, along with the direct practice expense inputs as recommended by the RUC.**

**18. Insertion of PICC Catheter (CPT code 36569)**

| CPT Code | Long Descriptor | CMS Proposed/ RUC Recommended Work RVU |
|---|---|---|
| 36569 | Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; age 5 years or older | 1.70 |

CMS is proposing a work RVU of 1.70 for CPT code 36569 as recommended by the RUC. CMS has proposed adjustments to the direct practice expense inputs for 36569 as they relate to duplicative equipment time and equipment because this service is typically billed together with CPT code 77001.

The RUC previously noted that CPT codes 77001 and 76937 are typically reported on the same day of service as 36569. The RUC examined the current PE inputs for these two imaging codes and assessed whether or not there was duplication in clinical staff time between the codes. From this analysis, 2

minutes from *Prepare and position patient/ monitor patient/ set up IV* and 3 minutes from *Clean room/equipment by physician staff* were removed for code 36569. **The RUC recommends that CMS accept the direct practice expense inputs as modified by the RUC.** For further comments on individual refinements of direct PE inputs for 36569, please see the attached practice expense refinement table.

**The RUC recommends CMS finalize the proposed work RVU of 1.70 for CPT code 36569, along with the direct practice expense inputs for this service as recommended by the RUC.**

**19. Bone Marrow Aspiration (CPT codes 38220, 38221, 382X3, and 2093X)**

| CPT Code | Long Descriptor | CMS Proposed/ RUC Recommended Work RVU |
|---|---|---|
| 38220 | Diagnostic bone marrow; aspiration(s) | 1.20 |
| 38221 | Diagnostic bone marrow; biopsy(ies) | 1.28 |
| 382X3 | Diagnostic bone marrow; biopsy(ies) and aspiration(s) | 1.44 |
| 2093X | Bone marrow aspiration for bone grafting, spine surgery only, through separate skin or fascial incision | 1.16 |

CMS is proposing the work RVUs as recommended by the RUC for this family of services. CMS has proposed to accept the RUC direct practice expense (PE) inputs for 2093X and proposed minor adjustments to 38220, 38221, and 382X3. For the RUC's comments on individual refinements of direct PE inputs for 38220, 38221, and 382X3, please see the attached practice expense refinement table.

**38220, 38221 and 382X3**

CMS agreed with the RUC recommendation to change the global period for CPT codes 38220, 38221, and 382X3 from XXX to 0-day global periods. CMS is also proposing to eliminate HCPC code G0364 for CY 2018, given the interest to value 382X3. The RUC agrees that the G-code should be deleted and is confident that the changes to the three codes will accurately describe the services currently reported by G0364.

**2093X**

For 2093X, CMS is considering a work RVU of 1.00 based on a direct crosswalk to CPT codes 64494 *Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level* and 64495 *Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s)*. CMS states in the *Proposed Rule* for CY 2018 that 2093X is a "global ZZZ add-on code for CPT code 38220" and that they are concerned "with maintaining relativity among PFS services, considering that an add-on code typically has significantly less intra-service time and total time compared to the base code."

CPT code 2093X is an add-on code; however, 2093X will not be reported with CPT code 38220. CPT code 2093X will be used to report bone marrow aspirations for bone grafting in spinal surgery

procedures only. The potential base codes for 2093X include the following spinal fusion codes: 22319, 22532, 22533, 22534, 22548, 22551, 22552, 22554, 22556, 22558, 22590, 22595, 22600, 22610, 22612, 22630, 22633, 22634, 22800, 22802, 22804, 22808, 22810, and 22812.

For 2093X, CMS has also considered alternative crosswalks to CPT codes 64494 (work RVU of 1.00) and 64495 (work RVU of 1.00). CPT code 2093X is more intense and complex than codes 64494 and 64495 because 2093X describes harvesting bone marrow which involves performing a corticotomy, often with a trephine, in order to gain access to and withdraw the bone marrow, comprised of both hematogenous and trabecular bone tissue. The procedure requires targeting, confirmation of position, and retrieval/ acquisition of bone marrow to mix with the allograft. With corticotomy, there is risk for complication including excessive bleeding and infection in the bone tissue. The valid survey 25$^{th}$ percentile work RVU of 1.16 appropriately accounts for the physician work required to perform this service. To justify the work RVU of 1.16, the RUC referenced CPT code 64491 *Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure)* (work RVU=1.16, intra-service time of 15 minutes, total time of 15 minutes) and noted that both services have identical intra-services times, total times and intensities, and therefore should be valued similarly. The RUC also reviewed CPT code 64636 *Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)* (work RVU=1.16, intra-service time of 15 minutes, total time of 15 minutes) and noted that both services have identical intra-service times, total times, and intensity, further supporting a work RVU of 1.16 for the survey code. **The RUC recommends CMS finalize the proposed work RVU of 1.16 for CPT code 2093X.**

Additionally, CMS is proposing to remove the breakout lines included in the practice expense spreadsheet for the "lab tech activities". CMS believes that the "breakout of activities into numerous sub-activities generally tends to inflate the total time assigned to clinical labor activities and results in values that are not consistent with the analogous times for other PFS services." At the time of review it was general practice for the specialty societies to provide as much granular detail as possible directly on the PE spreadsheet. This type of granular detail is now included on the PE Summary of Recommendation (SoR). For the RUC's comments on individual refinements of direct PE inputs for 38220, 38221, and 382X3, please see the attached practice expense refinement table. CMS has considered refining the clinical labor for "provide preservice education/obtain consent" for 38220, 38221, and 382X3 from 12 to 6 minutes. The RUC understands CMS' concerns regarding whether 12 minutes is typical for education and consent prior to these diagnostic bone marrow procedures. As a consequence of the medications given to patients prior and during the procedure, patients are impaired after the procedure. While clinicians do give patients instructions post procedure in writing, education and consent for post procedure care are given prior to the service.

**The RUC recommends that CMS implement the current work RVUs of 1.20 for CPT code 38220, 1.28 for CPT code 38221, 1.44 for CPT code 382X3, and 1.16 for CPT code 2093X, along with the direct practice expense inputs for each service as recommended by the RUC.**

**20. Esophagectomy (CPT codes 43107, 43112, 43117, 432X5, 432X6, and 432X7)**

| CPT Code | Long Descriptor | CMS Proposed/ RUC Recommended Work RVU |
|---|---|---|
| 43107 | Total or near total esophagectomy, without thoracotomy; with pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty (transhiatal) | 52.05 |
| 43112 | Total or near total esophagectomy, with thoracotomy; with pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty (ie, McKeown esophagectomy, or tri-incisional esophagectomy) | 62.00 |
| 43117 | Partial esophagectomy, distal two-thirds, with thoracotomy and separate abdominal incision, with or without proximal gastrectomy; with thoracic esophagogastrostomy, with or without pyloroplasty (Ivor Lewis) | 57.50 |
| 432X5 | Esophagectomy, total or near total, with laparoscopic mobilization of the abdominal and mediastinal esophagus and proximal gastrectomy, with laparoscopic pyloric drainage procedure if performed, with open cervical pharyngogastrostomy or esophagogastrostomy (ie, laparoscopic transhiatal esophagectomy) | 55.00 |
| 432X6 | Esophagectomy, distal two-thirds, with laparoscopic mobilization of the abdominal and lower mediastinal esophagus and proximal gastrectomy, with laparoscopic pyloric drainage procedure if performed, with separate thoracoscopic mobilization of the middle and upper mediastinal esophagus and thoracic esophagogastrostomy (ie, laparoscopic-thoracoscopic esophagectomy, Ivor Lewis esophagectomy) | 63.00 |
| 432X7 | Esophagectomy, total or near total, with thoracoscopic mobilization of the upper, middle, and lower mediastinal esophagus, with separate laparoscopic proximal gastrectomy, with laparoscopic pyloric drainage procedure if performed, with open cervical pharyngogastrostomy or esophagogastrostomy (ie, thoracoscopic, laparoscopic and cervical incision esophagectomy, McKeown esophagectomy, tri-incisional esophagectomy) | 66.42 |

CPT codes 432X5, 432X6, and 432X7 were created by the CPT Editorial Panel to report esophagectomy via laparoscopic and thoracoscopic approaches. CPT codes 43107, 43112, and 43117 were also reviewed as part of the family with the three new codes. CPT code 43112 was revised to clarify the nature of the service being performed. CMS are proposing the RUC-recommended work RVUs and work times for all six codes in the family. CMS are also proposing the RUC-recommended work times for all six codes in this family. CMS considered removing 20 minutes from the preservice evaluation work time from all six of the codes in this family. CMS have concerns as to whether this additional evaluation time should be included for surgical procedures, due to the lack of evidence indicating that it takes longer to review outside imaging and lab reports for surgical services than for non-surgical services. CMS also considered refining the pre-service positioning work time and the

immediate post-service work time for all six of the codes in this family consistent with standard pre-service and post-service work times allocated to other PFS services.

**Preoperative evaluation time**
The RUC recommended the additional 20 minutes of pre-service evaluation time for the services in this family as outlined in the summary of recommendation form. During the presentation to the RUC and CMS representatives at the RUC meeting, the specialty societies indicated that the preoperative evaluation time for these six esophagectomy codes was atypical. Patients have undergone chemoradiation therapy and imaging and labs are extensive, showing the progression of the lesions from discovery, through non-surgical treatment, to lesion size and anatomy prior to surgery. These data come from many sources and different specialties, each providing their own unique service (eg, radiation oncology, radiology, gastroenterology, primary care). All of these data are not typical for most surgical procedures. In comparison, when more work is performed for non-surgical services such as E/M services, a higher level of E/M code is reported (ie, reflective of more counselling and coordination of care). In addition to reviewing extensive and atypical imaging and labs, the evaluation component of preoperative time also includes time to coordinate planning the multi-incisional approach with the assistant surgeon, anesthesia providers who lines will cross the operative anatomy, and scrub nurses who will assist. The intraoperative time for these infrequently performed procedures ranges from five to seven (or more) hours. Preoperative team planning is important and not typical for a majority of surgical procedures. The additional time recommended by the RUC is consistent with other major procedures requiring multiple surgeons. The RUC acknowledges that a majority of procedures are well represented by the standard 40 minutes for preoperative evaluation. However, in some instances, such as emergent procedures, the time for preoperative evaluation will be less, and in some instances where multiple surgeons are involved and extensive data and preoperative planning is included, the time for preoperative evaluation will be greater. The RUC also notes that these procedures involve two surgeons who will both be involved in the evaluation of the patient and patient data and involved in the planning, but the requested 60 minutes is only 1.5 times the standard 40 minutes for procedures that typically include only one surgeon. **The RUC recommends CMS finalize the proposed preoperative evaluation time of 60 minutes for the atypical work required on the day before and the day of the operation for CPT codes 43107, 43112, 43117, 432X5, 432X6 and 432X7.**

**Preoperative positioning time**
CMS considered refining the preservice positioning time for all six of the codes in this family to be consistent with standard preservice times allocated to other PFS services. The standard "base" preoperative time for positioning is three minutes. This represents positioning the patient supine with no additional positioning work. The typical positioning for patients undergoing these procedures includes additional work to account for padding the patient for a five to seven hour operation that includes securing the patient to a table that will adjust (eg, reverse Trendelenburg, roll, etc.) during the operation. This work also includes additional positioning, re-positioning, and re-padding for neck, chest, and abdominal incisions and accommodation of double lumen endotracheal tube, and lines near the operative field. **The RUC recommends CMS finalize the proposed preoperative positioning time of 20 minutes for 43107 and 432X5 and for 30 minutes for CPT codes 43112, 43117, 432X6, and 432X7.**

**Immediate postoperative time**
CMS also considered refining the immediate postoperative time for all six of the codes in this family to be consistent with standard postoperative times allocated to other PFS services. The additional time recommended by the RUC accounts for multiple site dressings; reversing excessive padding prior to transfer off table; extensive post-operative notes from a five to seven hour procedure; extensive post-

operative orders for multiple drains, tubes and other devices; and review of postoperative labs and films before transferring the patient to the ICU.

Additionally, for the open codes, the patient's anesthesia level is reduced after the fascia is closed and while the skin is closed and dressings applied. However, for the scope codes, anesthesia needs to be maintained at full level until the last laparoscope/thoracoscope is pulled, intraperitoneal gas is allowed to escape and the skin is closed. This results in a longer time to monitor the patient prior to extubation and moving the patient to recovery. The RUC recommended additional 15 minutes for this additional work time is justified.

All of the work described above and at the RUC meeting is in addition to the typical work for more straightforward operations where a standard postoperative time would apply. **The RUC recommends CMS finalized the proposed immediate postoperative time of 45 minutes for CPT codes 43107, 43112, 43117 and for 60 minutes for CPT codes 432X5, 432X6, 432X7.**

**432X5, 432X6 & 432X7**

CMS expressed concern about the presence of two separate surveys conducted for the three new codes. CMS notes that CPT codes 432X5, 432X6, and 432X7 were surveyed initially in January 2016, and then were surveyed again in October 2016 together with CPT codes 43107, 43112, and 43117 due to concerns about the description of the typical patient in the original vignette and a change in the codes on the reference service list (RSL). CMS noted that CPT codes 432X5 and 432X6 had the same median intra-service time on both surveys, while CPT code 432X7 had a median intra-service time that was an hour longer on its second survey (420 minutes) as compared to its first survey (360 minutes). CMS also observed that the total survey time for CPT code 432X5 decreased from 1,058 minutes in the first survey to 972 minutes in the second survey, while the median work RVU increased from 50.00 to 65.00. The Agency expressed concern with how the survey median intra-service time could increase so significantly from the first survey to the second survey for CPT code 432X7, or how the surveyed times for CPT code 432X5 could be decreasing while the work RVU was simultaneously increasing by 15.00 work RVUs.

Based on CMS' observation, the Agency hypothesized that the accompanying RSL is the main difference between the two surveys; the codes on the initial RSL had a median work RVU of 44.18, while the codes on the second RSL had a median work RVU of 59.64. This increase of 15.00 work RVUs between the two RSLs that accompanied the surveys appear to account for the increase in the work RVUs for the three new codes. CMS are concerned that the second survey may have overestimated the work required to perform these procedures, as the 25th percentile work RVU of the second survey is higher than the median work RVU of the initial survey for all three codes, despite no change in the median intra-service work time for CPT codes 432X5 and 432X6.

CMS considered a work RVU of 50.00 for CPT code 432X5, a work RVU of 60.00 for CPT code 432X6, and a work RVU of 61.00 for CPT code 432X7, by using the survey median work RVU from the first survey for the three new codes.

The RUC does not agree with CMS' alternate values considered for 432X5, 432X6 and 432X7. The specialty societies and the RUC carefully examined the issue with the two surveys for these services. The specialty societies tried to avoid surveying these services with an incorrect vignette. However, through CPT and the timeline of surveying, these services were first surveyed with the vignette describing the typical patient as not including neoadjuvant chemotherapy and radiation therapy prior to surgery. The initial survey respondents indicated that the vignette did not describe the typical patient.

Therefore, it is understandable that the initial survey work RVUs would be lower and the survey respondents had to base their recommended work RVU for the service described in the vignette provided. **The first survey was flawed and the data points should not be used for valuation of these services.** Secondly, the RUC re-examined the reference service list to ensure appropriate relative services were included. The median of each of the RSLs were different because the low and high reference codes were removed and more middle point reference codes were added. The range of services based on work RVUs was narrowed and provided the survey respondents with 15 reference services for comparison on relativity. CMS should not use data points from the flawed survey and should instead use the survey 25th percentile work RVUs from the second valid survey. **The RUC recommends that CMS finalize the proposed work RVU of 55.00 for CPT code 432X5, 63.00 for CPT code 432X6 and 66.42 for CPT code 432X7.**

**43107 and 43117**

For CPT codes 43107 and 43117, CMS considered employing the intra-service time ratio between the laparoscopic version of the procedure represented by the new code and the open version of the same procedure represented by the existing code. CMS considered a work RVU of 45.00 for CPT code 43107 based on the intra-service time ratio with CPT code 432X5 and a work RVU of 55.00 for CPT code 43117 based on the intra-service time ratio with CPT code 432X6. CPT code 43107 has 270 minutes of intra-service time as compared with 300 minutes of intra-service time for CPT code 432X5, which produces a ratio of 0.90, and when multiplied by a work RVU of 50.00 (CPT code 432X5), results in the proposed work RVU of 45.00. CMS considered using the same methodology for CPT codes 43117 and 432X6.

The RUC disagrees with CMS alternate work RVU consideration of 45.00 for CPT code 43107 and 55.00 for CPT code 43117. The RUC has iterated and CMS has previously agreed that the usage of time ratios to reduce work RVUs is typically not appropriate. Additionally, the alternate value considered for 43107 would cause a rank order anomaly with 43121 *Partial esophagectomy, distal two-thirds, with thoracotomy only, with or without proximal gastrectomy, with thoracic esophagogastrostomy, with or without pyloroplasty* (work RVU= 51.43). CPT code 43121 is a partial esophagectomy and also requires less physician time to perform.

**CMS Intra-service Time Ratio**

When discussing the Agency's methodology for proposing work values, CMS acknowledges that physician work intensity per minute is typically not linear and also that making reductions in RVUs in strict proportion to changes in time is inappropriate. For the past several comment periods, the RUC has laid out a compelling case justifying this position — we greatly appreciate CMS agreeing with the RUC's assertion that the usage of time ratios to reduce work RVUs is typically not appropriate, as often a change in physician time coincides with a change in the physician work intensity per minute.

The RUC would like to remind CMS of both the Agency's and the RUC's longstanding position that treating all components of physician time (pre-service, intra-service, post-service and post-operative visits) as having identical intensity is incorrect and inconsistently applying it to only certain services under review creates inherent payment disparities in a payment system which is based on relative valuation. When physician times are updated in the Medicare payment schedule, the ratio of intra-service time to total time, the number and level of bundled post-operative visits, the length of pre-service and length of immediate post-service time may all potentially change for the same service. These changing components of physician time result the physician work intensity per minute often changing when physician time also changes. The RUC recommends for CMS to always account for these nuanced variables.

We would also like to highlight that all RUC recommendations now explicitly state when physician time has changed and address whether and to what magnitude these changes in time impact the work involved. For example, our rationales explain the original source (or lack therefore) of time data and whether the source can be relied upon as an appropriate baseline. RUC recommendations also provide rationale justifying changes in physician work intensity, when applicable, often with supporting clinical information. CMS should carefully consider this critical information when determining proposed and final work values.

**The RUC requests that CMS not use a ratio of intra-service methodology solely to reduce the work RVU of services. The RUC recommends that CMS finalize the proposed work RVUs of 52.05 for CPT code 43107 and 57.50 for CPT code 43117.**

**43112**

CMS considered a work RVU of 58.94 for CPT code 43112 based on a direct crosswalk to CPT code 46744 (Repair of cloacal anomaly by anorectovaginoplasty and urethroplasty, sacroperineal approach). CMS note that the intra-service time ratio when applied to CPT codes 43112 and 432X7, the paired McKeown esophagectomy procedures, would have produced a potential work RVU of 52.29, creating a rank order anomaly within the family by establishing a higher work RVU for CPT code 43117 than CPT code 43112, and are concerned with whether this is an appropriate valuation for the code.

The RUC does not agree with CMS' alternate work RVU of 58.94 considered for CPT code 43112. CMS should use the valid survey data obtained instead of applying a crosswalk for the sole purpose of lowering the work RVU of this service. **The RUC recommends that CMS finalize the proposed work RVU of 62.00 for CPT code 43211.**

**Practice Expense**

CMS proposed the RUC-recommended direct PE inputs for all six codes in the family without refinement. CMS considered changing the preservice clinical labor type for all six codes from an RN (L051) to an RN/LPN/MTA blend (L037D). CMS has concerns about whether the use of RN clinical labor would be typical for filling out referral forms or for scheduling space and equipment in the facility.

The typical providers for these services are cardiothoracic surgeons. It is typical for cardiothoracic surgeons to employ PAs and NPs as their clinical staff due to their complex patient population. Since CMS does not recognize PAs and NPs as clinical staff for practice expense and cardiothoracic surgeons typically employ PAs and NPs, it was established many years ago that the clinical staff type of RN would be typical for cardiothoracic surgeons. The majority of the cardiothoracic surgery procedures have an RN staff type, including the existing codes 43107, 43112 and 43117, it would create rank order anomalies in practice expense and would not be representative of the level of employee employed by cardiothoracic surgeons to assign a clinical blend for these services. The RUC recommended RN clinical labor type is justified and consistent with the majority of cardiothoracic surgical procedures in the PFS. **The RUC recommends that CMS finalize the proposed RN (LO51) clinical staff for the direct practice inputs associated with these services.**

**21. Transurethral Electrosurgical Resection of Prostate (CPT code 52601)**

| CPT Code | Long Descriptor | CMS Proposed/ RUC Recommended Work RVU |
|---|---|---|
| 52601 | Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included) | 13.16 |

CPT code 52601 appeared on a screen of potentially misvalued codes which indicated that it was performed less than 50 percent of the time in the inpatient setting, yet included inpatient hospital E/M services within the global period. For CY 2018, CMS is proposing the RUC-recommended work RVU of 13.16 for CPT code 52601 and proposing to use the RUC-recommended direct PE inputs without refinements.

CMS considered a work RVU of 12.29 for CPT code 52601 based on a direct crosswalk to CPT code 58541 (Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less), which is one of the reference codes. CPT code 58541 may potentially be a more accurate crosswalk for CPT code 52601 than the RUC-recommended direct crosswalk to CPT code 29828 (Arthroscopy, shoulder, surgical; biceps tenodesis). Although all three of these codes share the same intra-service time of 75 minutes, CPT code 58541 is a closer match in terms of the total time at only 10 minutes difference. CPT code 58541 also shares the same postoperative office visits as CPT code 52601, a pair of CPT code 99213 office visits, while CPT code 29828 also contains two CPT code 99212 office visits that are not present in the reviewed code.

For CPT code 52601, CMS is concerned as to how the RUC-recommended derived intensity of the procedure could be increasing by 30 percent over the current derived intensity, while at the same time the typical site of service is changing from inpatient to outpatient status. In other words, if it is now typical for CPT code 52601 to be performed on an outpatient basis, then CMS would generally expect the intensity of the procedure to be decreasing, not increasing. CMS considered a work RVU of 12.29 for CPT code 52601 based on a direct crosswalk to CPT code 58541, and seeks comment on whether this alternative value might better reflect relativity.

The RUC disagrees with the assertion that the intensity of a procedure decreases with transition from inpatient to outpatient. Intensity measures include many factors including physical effort, psychological stress and risk of adverse outcome. All three of these factors might increase in the outpatient setting, with fewer ancillary resources and reduced support services. Therefore, it would not be appropriate to assume that the outpatient transition results in increased intensity either. Thus, the RUC recommends that work and work intensity measures be determined by survey and expert review, not by generalizations that may be convenient but have no basis in fact.

The RUC does not agree with the alternate crosswalk considered for CPT code 52601 to 58541 *Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less;* (work RVU = 12.29). The alternate crosswalk provided with a similar work value may equilibrate numbers but it does not recognize the differences in procedures and unique aspects of that work. Every patient treated with CPT code 52601 involves the management of a catheter in the immediate post-operative period because of bleeding and blood clots, which still occur in spite of advancements in technology. Every patient has a

bladder irrigation system attached to the catheter in the immediate post-operative period, and this catheter must be managed. Catheter management is not present in the CMS recommended crosswalk code 58541 code suggested. In addition, the intensity required for CPT 52601 is greater than CPT code 58541 and the total time for 52601 is marginally higher by 10 minutes (236 vs 226). **The RUC recommends that CMS finalize the proposed work RVU of 13.16 for CPT code 52601.**

**22. Peri-Prostatic Implantation of Biodegradable Material (CPT code 55X87)**

| CPT Code | Long Descriptor | CMS Proposed/ RUC Recommended Work RVU |
|---|---|---|
| 55X87 | Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed | 3.03 |

In October 2016, the CPT Editorial Panel deleted CPT Category III code 0438T and created CPT code 55X87, to report transperineal placement of biodegradable material. For CY 2018, CMS has proposed a work RVU of 3.03 for CPT code 55X87, as recommended by the RUC.

CMS noted the decrease in pre-service time compared to the current time and is seeking comment on whether its alternative value of 2.68 should be considered given the changes in time reflected in the survey data. The RUC questions the Agency's position that there is a decrease in pre-service time (30 minutes) compared to the current pre-service time. The current code is a Category III code (0438T), which has not been surveyed. There are no current physician time inputs for this service. Perhaps the Agency is referring to the difference between the surveyed pre-times and package pre-times. The surveyed pre-time was 55 minutes. The application of pre-time packages reduced that to 25 minutes total pre-service time. The use of pre-time packages is a long-standing policy of the RUC. CMS also typically accepts and supports this methodology.

The RUC disagrees with CMS calculating intra-service time ratios to account for changes in time. The RUC confirmed that the time and description of intra-service work are correct in that, after the ultrasound probe is placed and anesthesia is conducted, hydrodissection is the initial step in the procedure. Once the hydrodissection is completed, the syringe is removed but the needle is intact; at that time, the biodegradable material is prepped. It is never prepped prior to the procedure but is done after the hydrodissection which is why it is included in the intra-service time of 30 minutes.

When discussing the Agency's methodology for proposing work values, CMS acknowledges that physician work intensity per minute is typically not linear and also that making reductions in RVUs in strict proportion to changes in time is inappropriate. For the past several comment periods, the RUC has laid out a compelling case justifying this position — we greatly appreciate CMS agreeing with the RUC's assertion that the usage of time ratios to reduce work RVUs is typically not appropriate, as often a change in physician time coincides with a change in the physician work intensity per minute.

The RUC would like to remind CMS of both the Agency's and the RUC's longstanding position that treating all components of physician time (pre-service, intra-service, post-service and post-operative visits) as having identical intensity is incorrect and inconsistently applying it to only certain services under review creates inherent payment disparities in a payment system which is based on relative valuation. When physician times are updated in the Medicare payment schedule, the ratio of intra-

service time to total time, the number and level of bundled post-operative visits, the length of pre-service and length of immediate post-service time may all potentially change for the same service. These changing components of physician time result the physician work intensity per minute often changing when physician time also changes. The RUC recommends for CMS to always account for these nuanced variables.

We would also like to highlight that all RUC recommendations now explicitly state when physician time has changed and address whether and to what magnitude these changes in time impact the work involved. For example, our rationales explain the original source (or lack therefore) of time data and whether the source can be relied upon as an appropriate baseline. RUC recommendations also provide rationale justifying changes in physician work intensity, when applicable, often with supporting clinical information. CMS should carefully consider this critical information when determining proposed and final work values.

Finally, the RUC-recommended work RVU appropriately ranks this procedure within the urology and radiation oncology families as well as within the Physician Payment Schedule.

**Practice Expense**

CMS is seeking public comments related to whether equipment item EQ250 (portable ultrasound) includes probes. The RUC confirms that EQ250 ultrasound unit, portable does not include an intracavitary probe, the probe necessary to perform this procedure. **The RUC recommends that both the portable unit and the intracavitary probe should be recognized as direct practice expense inputs for this procedure.**

CMS also commented on pricing information regarding two new supply items: "endocavity balloon" and "biodegradeable material kit – periprostatic". The RUC agrees that the new supply item "endocavity balloon" has a unit price of $39.90, as correctly indicated on the PE spreadsheet. CMS has proposed refinements to the RUC direct practice expense inputs for 55X87. **For the RUCs comments on individual refinements of direct PE inputs, please see the attached practice expense refinement table.**

**The RUC requests that CMS not rely on a ratio of intra-service methodology solely to reduce the work RVU of services. The RUC recommends that CMS finalize the proposed work RVU of 3.03 for CPT code 55X87, along with the direct practice expense inputs for this service as recommended by the RUC.**

**23. Colporrhaphy with Cystourethroscopy (CPT codes 57240, 57250, 57260 and 57265)**

| CPT Code | Long Descriptor | CMS Proposed/ RUC Recommended Work RVU |
|---|---|---|
| 57240 | Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele, including cystourethroscopy, when performed | 10.08 |
| 57250 | Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy | 10.08 |
| 57260 | Combined anteroposterior colporrhaphy, including cystourethroscopy, when performed; | 13.25 |

| | | |
|---|---|---|
| 57265 | Combined anteroposterior colporrhaphy, including cystourethroscopy, when performed; with enterocele repair | 15.00 |

In October 2015, CPT code 57240 was identified by analysis of the Medicare data from 2011- 2013 that indicated that services reported with CPT code 57240 were performed less than 50 percent of the time in the inpatient setting, yet include inpatient hospital E/M services within the global period. The RUC referred this family to the CPT Editorial Panel for revision. In September 2016, the CPT Editorial Panel revised 57240, 57260 and 57265 to preclude separate reporting of follow up cystourethroscopy after colporrhaphy (CPT code 52000). For CY 2018, CMS is proposing the RUC-recommended work RVUs for all four services in this family.

**57240**

CMS noted that there were changes in service times reflected in the specialty surveys compared to the RUC-recommended work RVUs for CPT code 57240. Specifically, CMS notes that the RUC recommended a 48 minute decrease in total time, compared to the specialty survey total time of 259 minutes. The difference in total time reflected a decrease in preservice time (29 minutes) and inpatient visits (0.5 visits = 19 minutes). CMS considered a work RVU of 9.77 for CPT code 57240, crosswalking to CPT code 50590 (Lithotripsy, extracorporeal shock wave), which has similar service times. CMS are seeking comment on whether CPT code 57250 would be a relevant comparator for CPT code 57240, based on the described elements of each service and existing or surveyed service times, compared to CPT code 57240.

The RUC disagrees with the alternate work RVU of 9.77 considered for CPT code 57240. The RUC already considered the decrease in pre-service and post-operative visits and recommended a decrease in work RVUs from the current. Additionally, codes 57240 and 57250 require the exact same physician work and post-operative visits and should be valued the same. The alternate value considered creates a rank order anomaly in this family of services. The use of CPT Codes 50590 as a crosswalk ignores the inherent differences in risk to the patients when working in the vesico-vaginal space and the high rectovaginal space. Colporrhaphies are performed in very close proximity to highly variable anatomic structures affecting lower extremity nerve and vascular supply and have a high potential for viscus injury of bowel and bladder as dissection techniques for these procedures are now in much closer proximation to the viscus.

The RUC recommendation of 33 minutes of pre-service evaluation time, 8 minutes of pre-service positioning, 15 minutes of pre-service scrub/dress/wait, intra-service time of 60 minutes, immediate post-time of 30 minutes, a half-day discharge (99238) and 2 99213 post-op office visits was based on 115 RUC surveys. To find an appropriate work RVU crosswalk for CPT code 57240, the RUC compared the surveyed code to MPC code 53850 *Transurethral destruction of prostate tissue; by microwave thermotherapy* (work RVU of 10.08, intra-service time of 60 minutes and total time of 204) and noted that both services involve a similar amount of physician work and have identical intra-service time and similar total time. Therefore, the RUC recommended a direct RVU crosswalk from code 53850 to 57240, with a work RVU of 10.08, well below the 25$^{th}$ percentile. The RUC noted that, with this change, the code would have an IWPUT of 0.096, appropriate relative to the top and second key reference codes. To further support the value, the RUC also noted the proposed value compared favorably to CPT code 19301 *Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);* (work RVU of 10.13, intra-service time of 60 minutes, total time of 216 minutes).

The CMS comparison to CPT Code 50590 *Lithotripsy, extracorporeal shock wave* (work RVU = 9.77) is not appropriate. CPT Code 50590 requires no tissue dissection or development of anatomic spaces. The physician is utilizing fluoroscopy to position the patient for correct location of a shock wave administration. The intensity of work is not similar. There is no opportunity for sudden vascular injury with resultant catastrophic blood loss or nerve injury resulting in pelvic or lower extremity dysfunction. Using CPT Code 57250 as a comparator excludes the additional work of the cystoscopy and possible need for reconstruction if injury of ureter or bladder mucosa is present. **The RUC recommends that CMS finalize the proposed work RVU of 10.08 for CPT code 57240.**

**57265**

CMS considered a work RVU of 11.47 for CPT code 57265, crosswalking to CPT code 47563 *Laparoscopy, surgical; cholecystectomy with cholangiography* with similar service times. CMS seeks comment on how an alternative work RVU of 11.47 for CPT code 57265 would affect relativity among PFS services, and on whether CPT code 57260 is a relevant comparator for CPT code 57265, considering differences in the described procedures and service times.

The RUC does not agree with the alternate work RVU of 11.47 for CPT code 57265. This causes a rank order anomaly with the parent code 57260 which includes the same physician work less the work associated with enterocele repair. The RUC does not understand why 57265 would be valued less than 57260 as 57265 requires more physician work and 30 more minutes of intra-service time. The use of CPT code 47563 as a crosswalk ignores the inherent differences in risk to the patients when working in the vesico-vaginal space and the high rectovaginal space. Colporrhaphies are performed in very close proximity to highly variable anatomic structures affecting lower extremity nerve and vascular supply and have a high potential for viscus injury of bowel and bladder as dissection techniques for these procedures are now in much closer proximation to the viscus.

The RUC recommendation of 33 minutes of pre-service evaluation time, 8 minutes of pre-service positioning, 15 minutes of pre-service scrub/dress/wait, intra-service time of 120 minutes, immediate post-time of 30 minutes, a half-day discharge (99238) and 2 99213 post-op office visits was based on 114 RUC surveys. The RUC reviewed the survey 25$^{th}$ percentile work RVU of 15.00 and agreed that the survey respondents correctly valued the physician work involved in performing this service. To justify a work RVU of 15.00, the RUC compared the survey code to CPT code 58544 *Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)* (work RVU of 15.60, intra-service time of 120 minutes and total time of 271 minutes) and noted that both services have identical intra-service and total times and are both typically performed in the outpatient setting. To further support a work RVU of 15.00, the RUC compared the survey code to top key reference code 58572 *Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g;* (work RVU 17.71, intra-service time of 120 minutes and total time of 271 minutes) and noted that both services have identical time components and identical post-op visit components. Both services are typically performed in the hospital outpatient setting, and while the reference code involves somewhat more intense intra-service work, with a value of 17.71 it further supports a value of 15.00 for the survey code. The RUC confirmed that the specialty's original recommendation of 15.00 is appropriate relative to the recommended values for the other codes in the family.

The CMS comparison to CPT Code 47563 *Laparoscopy, surgical; cholecystectomy with cholangiography* is not appropriate. CPT Code 47563 is a laparoscopic procedure that allows for total visualization of the operative field and dissection of a very small area near the cystic artery and common duct. This procedure certainly has risks involved however, the magnitude and quantity of severity is not similar. CPT code 57265 typically requires 10 to 12 cm of anterior compartment

dissection and 10-12 cm of posterior compartment dissection with deep nerve and vascular components that are identified by palpation instead of visualization in an anatomic region where variability of normal anatomy is common. This increases the possibility of viscus perforation during CPT code 57265 procedure, especially when working in prior surgical sites, which is common in this procedure. Additionally, the functionality of the vagina for intimacy weighs heavily on the surgeon during the reconstruction phase of this procedure and that component is not a part of CPT Code 47563. Using CPT code 57260 as a comparator for CPT code 57265 excludes the higher cephalad dissection and correction of the intraperitoneal hernia that resulted in the defect. The intensity of work is magnified by the depth of the operative field and the impingement of small bowel into the operative field. Visualization is limited and this is technically the most difficult portion of the procedure.

The RUC urges CMS to use valid survey data and maintain relativity among this family of services. **The RUC recommends that CMS finalized the proposed work RVU of 15.00 for CPT code 57265.**

**24. Nerve Repair with Nerve Allograft (CPT codes 64910, 64911, 64X91 and 64X92)**

| CPT Code | Long Descriptor | CMS Proposed/ RUC Recommended Work RVU |
|---|---|---|
| 64910 | Nerve repair; with synthetic conduit or vein allograft (eg, nerve tube), each nerve | 10.52 |
| 64911 | Nerve repair; with autogenous vein graft (includes harvest of vein graft), each nerve | 14.00 |
| 64X91 | Nerve repair; with nerve allograft, each nerve, first strand (cable) | 12.00 |
| 64X92 | Nerve repair; with nerve allograft, each additional strand (List separately in addition to code for primary procedure) | 3.00 |

For CY 2018, the CPT Editorial Panel created two new Category I codes to report the repair of a nerve using a nerve allograft. Codes 64910 and 64911 were added as family codes for review.

CMS has proposed the RUC recommended work RVUs for this family of services. Although CMS is proposing to accept the RUC's recommendation, the Agency noted that it also considered alternative work values for the four codes.

**64910**

For CPT code 64910, CMS notes a decrease in preservice time (7 minutes) and considered a work value crosswalk of 10.15 from CPT code 15120 based on both services having similar times. The decrease of 7 minutes is not in the preservice time, but in the total time (from 264 minutes to 257 minutes. This represents a 2.6% decrease in total time. The RUC and the specialty recommended a decrease in work RVUs from 11.39 to 10.52 (survey 25$^{th}$ percentile) which represents a decrease of 7.6%. In addition, as 64910 includes 3 99213 post-operative visits and 1 99212 post-operative visit, whereas CMS's crosswalk code 15120 only has 2 99213 post-operative visits and 1 99212 visit, the average intensity of the post-operative services is higher for the survey code.

Even though RUC recommendation of 10.52 is higher relative to the reference code, its IWPUT is lower than that of the reference code (0.066 vs. 0.068). Therefore, the RUC's recommendation is in line

with the intensity of reference code 15120. The RUC compared the survey code to top key reference code 64831 *Suture of digital nerve, hand or foot; 1 nerve* (work RVU of 9.16, intra-service time of 60 minutes, total time of 237 minutes) and noted that the survey code includes more intra-service and total time. Both services have a near identical IWPUT which is consistent since both services involve a similar intensity of physician work. Furthermore, all of the survey respondents that selected 64831 as their key reference service indicated that the survey code is either more intense or identical in intensity relative to the reference code.

**64911**

For CPT Code 64911, CMS considered a work value crosswalk of 13.50 from CPT code 31591, also based on similar times. **First off, the work RVU of the cited crosswalk code is actually 13.56.** Second, we note that there was only a decrease of 2 minutes total for 64911 from the previous review and recommendation that CMS accepted. In addition, CMS did not accept the RUC recommendation for 31591, which was 15.60, and instead finalized a value which did not appropriately account for the bundling of the diagnostic exam. To justify a work RVU of 14.00, the RUC had compared the survey code to MPC code 52649 *Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)* (work RVU of 14.56, intra-service time of 120 minutes, total time of 279 minutes) and noted that although the reference code has more intra-service time, the survey code includes more total time. To further support a work RVU of 14.00, the RUC had also compared the survey code to CPT code 58543 *Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g;* (work RVU of 14.39, intra-service time of 110 minutes, total time of 261 minutes) and noted that both services have identical intra-service time whereas the survey code includes more total time.

CMS also questioned the new code structure for 64X91 and 64X92 and noted that they considered bundled status for 64X92 and incorporating the relative resources in furnishing the add-on code into the base code, 64X91. CPT code 64X92 is an add-on code for the additional work related to insertion of an additional nerve allograft for the same nerve. This separate, additional work is not typically performed with the base code and therefore would not be appropriate to bundle into the work of the base code. It is atypical for CMS to question the coding structure of newly proposed services via rulemaking. In the future, we request for CMS to voice concerns regarding coding structure as part of the Agency's participation in the CPT Editorial Panel review process. In addition, bundling the service as CMS suggests would also place a financial burden on the patients who do not require multiple strands because they would be charged 120% of what they should be charged.

**The RUC recommends CMS finalize the proposed work RVU of 10.52 for CPT code 64910, 14.00 for CPT code 64911, 12.00 for CPT code 64X91 and 3.00 for CPT code 64X92.** For the RUCs comments on individual refinements of direct PE inputs please see the attached refinement table.

**25. CT Soft Tissue Neck (CPT codes 70490, 70491, and 70492)**

| CPT Code | Long Descriptor | CMS Proposed/ RUC Recommended Work RVU |
|---|---|---|
| 70490 | Computed tomography, soft tissue neck; without contrast material | 1.28 |
| 70491 | with contrast material(s) | 1.38 |
| 70492 | without contrast material followed by contrast material(s) and further sections | 1.62 |

CMS has proposed to retain the current work relative values, as recommended by the RUC, for CPT codes 70490 and 70491 and has proposed to accept the RUC recommendation for CPT code 70492.

**70490**

For CPT code 70490, CMS considered alternative work RVU of 1.07, based on a crosswalk to CPT code 72125, and is seeking comment on how the relativity among other CT services would be affected by applying the alternative work RVUs. The RUC disagrees with the alternate work RVUs and supports maintaining the current work RVU of 1.28 for 70490, which was supported by the specialty survey and fell below the 25th percentile. While CPT code 70490 and the proposed crosswalk have the same intra-service time, the clinical work is different, due to the patient population and intensity of the services provided. CPT code 72125 is a CT of the cervical spine, which excludes many of the soft tissue structures in the neck to concentrate on the osseous structures in the cervical spine, usually in the setting of trauma. CPT code 70490 is a CT covering both the soft tissues in the neck and the cervical spine, which is more often performed in patients with malignancy or infection involving the complicated soft tissue planes in the neck that may also involve the spine. These differences in patient population and the anatomy included in the exam justify the higher work value for 70490 compared to 72125. The RUC compared 70490 to CPT code 70470 *Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections* (work RVU = 1.27, intra-service time of 15 minutes) and noted that both services have similar physician work and identical intra-service times and should be valued similarly.

The RUC confirmed that the relativity for these three CT of the neck codes and across the larger family of CT codes is appropriate. Therefore, the RUC also disagrees with the methodology proposed to use an incremental difference between the suggested crosswalk and target code as CMS considered for 70490 to similarly decrease the values of contrast enhanced codes, 70491 and 70492. There is not a standardized difference in work between the without and with contrast codes because each exam is different depending upon the modality, clinical circumstance, typical patient, and body part being examined. The value of the RBRVS is its ability to capture these intensity differences and appropriately account for them in each clinical context.

**The RUC recommends that CMS implement the current work RVU of 1.28 for CPT code 70490 and 1.38 for CPT code 70491 and finalize the proposed work RVU of 1.62 for CPT code 70492, along with the direct practice expense inputs for each service as recommended by the RUC.**

**26. Magnetic Resonance Angiography (MRA) Head (CPT codes 70544, 70545, and 70546)**

| CPT Code | Long Descriptor | CMS Proposed/ RUC Recommended Work RVU |
|---|---|---|
| 70544 | Magnetic resonance angiography, head; without contrast material(s) | 1.20 |
| 70545 | Magnetic resonance angiography, head; with contrast material(s) | 1.50 |
| 70546 | Magnetic resonance angiography, head; without contrast material(s), followed by contrast material(s) and further sequences | 1.80 |

The RUC recommended and CMS is proposing a work RVU of 1.20 for CPT code 70544, 1.50 for CPT code 70545 and 1.80 for CPT code 70546.

CMS is seeking comment on the appropriate amount of clinical labor time for "acquiring images," noting that the RUC recommendation has a higher amount of time for the non-contrast code relative to the contrast code. The Agency is considering an alternative amount of time of 20 minutes. The longer clinical labor time for the non-contrast MRA of the head and neck is accurate because of the unique physics properties related to an MR Angiogram as opposed to the typical MRI. Without the administration of intravenous contrast, the acquisition of images takes a longer time in order to visualize the blood vessels, because the signal received from the vessels, is low compared to the adjacent soft tissues/structures. Once intravenous contrast is given, the scan time decreases because the contrast highlights the vessels. Less time is required to acquire the images compared to the without contrast images because the signal from these vessels is much stronger than the adjacent soft tissues/structures. In addition, MRA with contrast images a "blood pool of contrast" as opposed to enhancement of soft tissues or masses in an MRI with contrast. Blood pool imaging can be acquired quicker than the typical MRI evaluating for enhancement.

**The RUC recommends CMS finalize the proposed work RVU of 1.20 for CPT code 70544, 1.50 for CPT code 70545 and 1.80 for CPT code 70546.** For the RUCs additional comments on individual refinements of direct PE inputs please see the attached refinement table.

**27. Magnetic Resonance Angiography (MRA) Neck (CPT codes 70547, 70548, and 70549)**

| CPT Code | Long Descriptor | CMS Proposed/ RUC Recommended Work RVU |
|---|---|---|
| 70547 | Magnetic resonance angiography, neck; without contrast material(s) | 1.20 |
| 70548 | Magnetic resonance angiography, neck; with contrast material(s) | 1.50 |

| | | |
|---|---|---|
| 70549 | Magnetic resonance angiography, neck; without contrast material(s), followed by contrast material(s) and further sequences | 1.80 |

The RUC recommended and CMS has proposed work RVUs of 1.20 for CPT code 70547, 1.50 for CPT code 70548 and 1.80 for CPT code 70549.

CMS is seeking comment on the appropriate amount of clinical labor time for "acquiring images," noting that the RUC recommendation has a higher amount of time for the non-contrast code relative to the contrast code. The Agency is considering an alternative amount of time of 20 minutes. The longer clinical labor time for the non-contrast MRA of the head and neck is accurate because of the unique physics properties related to an MR Angiogram as opposed to the typical MRI. Without the administration of intravenous contrast, the acquisition of images takes a longer time in order to visualize the blood vessels, because the signal received from the vessels, is low compared to the adjacent soft tissues/structures. Once intravenous contrast is given, the scan time decreases because the contrast highlights the vessels. Less time is required to acquire the images compared to the without contrast images because the signal from these vessels is much stronger than the adjacent soft tissues/structures. In addition, MRA with contrast images a "blood pool of contrast" as opposed to enhancement of soft tissues or masses in an MRI with contrast. Blood pool imaging can be acquired quicker than the typical MRI evaluating for enhancement.

**The RUC recommends CMS finalize the proposed work RVU of 1.20 for CPT code 70547, 1.50 for CPT code 70548 and 1.80 for CPT code 70549.** For the RUCs additional comments on individual refinements of direct PE inputs please see the attached refinement table.

**28. CT Chest (CPT Codes 71250, 71260, and 71270)**

| CPT Code | Long Descriptor | CMS Proposed/ RUC Recommended Work RVU |
|---|---|---|
| 71250 | Computed tomography, thorax; without contrast material | 1.16 |
| 71260 | Computed tomography, thorax; with contrast material(s) | 1.24 |
| 71270 | Computed tomography, thorax; without contrast material, followed by contrast material(s) and further sections | 1.38 |

The RUC recommended and CMS has proposed work RVUs of 1.16 for CPT code 71250, 1.24 for CPT code 71260 and 1.38 for CPT code 71270. Although CMS is proposing to accept the RUC's recommendation, the Agency noted that it also considered alternative work values for the 3 codes.

**72150, 72160 and 72170**

For CPT code 71250, CMS noted that they considered maintaining the current work RVU of 1.02. The Agency noted they were "concerned with the lack of evidence that the physician time or intensity of furnishing this service has changed since it was last valued."

It is accurate that the physician time and intensity of the underlying service has not change since it was last valued, and that is why the RUC is affirming its previous recommendation from 2009 of 1.16 work RVUs, which is supported by the new survey data. When this service was last valued, CMS employed a highly inappropriate method for deriving the work RVU by assigning a work RVU of 1.02 based on the single lowest response to the survey. The society noted that a flawed methodology was used in the previous valuation for this service instead of accepting the RUC recommended value of 1.16, CMS assigned a work RVU of 1.02 based on the single lowest response to the survey. Using a work RVU based on the survey minimum RVU is statistically invalid and highly inappropriate. Furthermore, using this arbitrary methodology as a building block to derive alternate values for 72160 and 72170 is also highly inappropriate.

The RUC recommendations are appropriately relative to other CT services which involve a similar amount of physician time. The RUC compared 72150 to MPC code 70470 *Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections* (work RVU= 1.27, intra-service time of 15 minutes, total time of 25 minutes) and noted that both services have identical intra-service and total times, whereas the survey is somewhat less intense. The RUC also compared 72150 to CPT code 78071 *Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT)* (work RVU= 1.20, intra-service time of 15 minutes, total time of 25 minutes) and noted that both services have identical intra-service and total times and involve similar amounts of physician work. The RUC compared 72160 to MPC code 73721 *Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material* (work RVU= 1.35, intra-service time of 20 minutes, total time of 30 minutes) and noted that both services have identical intra-service and total times and involve similar physician work. The RUC compared 72170 to MPC code 73721 *Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material* (work RVU= 1.35, intra-service time of 20 minutes, total time of 30 minutes) and noted that both services have identical intra-service and total times and while the survey code involves somewhat more physician work.

**The RUC recommends CMS finalize the proposed work RVU of 1.16 for CPT code 71250, 1.24 for CPT code 71260 and 1.38 for CPT code 71270.** For the RUCs comments on individual refinements of direct PE inputs please see the attached refinement table.

**29. MRI of Abdomen and Pelvis (CPT codes 72195, 72196, 72197, 74181, 74182, and 74183)**

| CPT Code | Long Descriptor | CMS Proposed/ RUC Recommended Work RVU |
|---|---|---|
| 72195 | Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s) | 1.46 |
| 72196 | Magnetic resonance (eg, proton) imaging, pelvis; with contrast material(s) | 1.73 |

| | | |
|---|---|---|
| 72197 | Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s), followed by contrast material(s) and further sequences | 2.20 |
| 74181 | Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s) | 1.46 |
| 74182 | Magnetic resonance (eg, proton) imaging, abdomen; with contrast material(s) | 1.73 |
| 74183 | Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s), followed by with contrast material(s) and further sequences | 2.20 |

CPT codes 74182 and 72196 were identified as part of the screen of high expenditure services across specialties with Medicare allowed charges of $10 million or more. CPT codes 74181, 74183, 72195, and 72197 were also reviewed as part of this code family. CMS is proposing all the work RVUs as recommended by the RUC for this family of services.

CMS is seeking comment on the appropriate amount of clinical labor time for "acquiring images". The Agency is considering an alternative amount of time of 30 minutes for CPT codes 74181 and 74182.The Agency also noted that the RUC-proposed times originated from a specialty consensus panel over 15 years ago. CMS noted their concern was based in part on the times being based on expert panel consensus rather than survey data. As almost all clinical labor time inputs in the physician fee schedule are based on expert panel, the isolated expression of this concern solely for this one family of services seems inconsistent with the Agency's review of other services in current and past rulemaking. The RUC affirms that these direct practice expense inputs are accurate and are based on standards that have been in place for several years.

**The RUC recommends CMS finalize the proposed work RVU of 1.46 for CPT code 72195, 1.73 for CPT code 72196, 2.20 for CPT code 72197, 1.46 for CPT code 74181, 1.73 for CPT code 74182 and 2.20 for CPT code 74183. For the RUCs additional comments on individual refinements of direct PE inputs please see the attached refinement table.**

**30. MRI Lower Extremity (CPT codes 73718, 73719, and 73720)**

| CPT Code | Long Descriptor | CMS Proposed/ RUC Recommended Work RVU |
|---|---|---|
| 73718 | Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s) | 1.35 |
| 73719 | Magnetic resonance (eg, proton) imaging, lower extremity other than joint; with contrast material(s) | 1.62 |
| 73720 | Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s), followed by contrast material(s) and further sequences | 2.15 |

CPT codes 73718 and 73720 were identified as part of the screen of high expenditure services, and CPT code 73719 was included for review as part of the code family. The RUC recommended and CMS has proposed work RVUs of 1.35 for CPT code 73718, 1.62 for CPT code 73719 and 2.15 for CPT code 73720. **The RUC recommends CMS finalize the proposed work RVU of 1.35 for CPT code 73718,**

**1.62 for CPT code 73719 and 2.15 for CPT code 73720. For the RUCs comments on individual refinements of direct PE inputs please see the attached refinement table.**

**31. Abdominal X-ray (CPT codes 74022, 740X1, 740X2, and 740X3)**

| CPT Code | Long Descriptor | CMS Proposed/ RUC Recommended Work RVU |
|---|---|---|
| 74022 | Radiologic examination, abdomen; complete acute abdomen series, including supine, erect, and/or decubitus views, single view chest | 0.32 |
| 740X1 | Radiologic examination, abdomen; 1 view | 0.18 |
| 740X2 | Radiologic examination, abdomen; 2 views | 0.23 |
| 740X3 | Radiologic examination, abdomen; 3 or more views | 0.27 |

In the Final Rule for CY2016, CMS re-ran the screen for high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. CPT codes 74000 *Radiologic examination, abdomen; single anteroposterior view* and 74022 *Radiologic examination, abdomen; complete acute abdomen series, including supine, erect, and/or decubitus views, single view chest* were identified via this screen. The specialty elected to submit the entire family of abdominal X-ray codes to the CPT Editorial Panel to modernize the reporting of these services. The CPT Editorial panel deleted three of the four existing codes in the abdominal X-ray family and created three new codes for reporting abdominal X-ray.

The RUC recommended and CMS has proposed work RVUs of 0.32 for CPT code 74022, 0.18 for CPT code 740X1, 0.23 for CPT code 740X2 and 0.27 for CPT code 740X3. CMS noted that, as part of the RUC's recommendations, the RUC's utilization crosswalk suggests that 25 percent of services currently reported with CPT code 74010 will be reported with CPT code 740X2 and 75 percent will be reported with CPT code 740X3; and 75 percent of services currently reported with CPT code 74020 will be reported with CPT code 740X2 and 25 percent will be reported with CPT code 740X3.

These utilization assumptions are accurate and were based on recommendation from the specialty's expert panel. As the previous code structure was not based on the number of views, it is not possible to determine via Medicare claims data what proportion of each deleted code's volume should be allocated to 740X2 and 740X3. In addition, irrespective of whether the RUC's recommended utilization crosswalk or CMS' alternate utilization crosswalk assumptions are used, the RUC's recommended work RVUs would result in an overall work savings that should be redistributed back to the Medicare conversion factor. Since the RUC started providing CMS with utilization crosswalk recommendations, the Agency has worked directly with AMA staff to answer any outstanding questions CMS officials had with respect to the utilization crosswalk recommendations well before the NPRM is drafted and it is unprecedented for CMS to include these questions within the rulemaking process.

In the NPRM, CMS stated that "…for purposes of calculating the proposed RVUs, we used an even distribution of services previously reported as CPT codes 74010 and 74020." It is unclear what CMS is referring to here, as in the previous paragraph CMS noted that they are proposing to accept the RUC's recommendation and there is no mention in the text of any alternate RVUs that were considered. Furthermore, CMS is required by statute to determine the work component by the resources in provider time and intensity required to perform the service. A service's potential future Medicare utilization should never be used to determine the work RVU of that service.

**The RUC recommends CMS finalize the proposed work RVU of 0.32 for CPT code 74022, 0.18 for CPT code 740X1, 0.23 for CPT code 740X2 and 0.27 for CPT code 740X3.** For the RUCs comments on individual refinements of direct PE inputs please see the attached refinement table.

**32. Angiography of Extremities (CPT codes 75710 and 75716)**

| CPT Code | Long Descriptor | CMS Proposed/ RUC Recommended Work RVU |
|---|---|---|
| 75710 | Angiography, extremity, unilateral, radiological supervision and interpretation | 1.75 |
| 75716 | Angiography, extremity, bilateral, radiological supervision and interpretation | 1.97 |

The RUC recommended and CMS has proposed work RVUs of 1.75 for CPT code 75710 and 1.97 for CPT code 75716. **The RUC recommends CMS finalize the proposed work RVU of 1.75 for CPT code 75710 and 1.97 for CPT code 75716. For the RUCs comments on individual refinements of direct PE inputs please see the attached refinement table.**

**33. Ophthalmic Biometry (CPT codes 76516, 76519, and 92136)**

| CPT Code | Long Descriptor | CMS Proposed/ RUC Recommended Work RVU |
|---|---|---|
| 76516 | Ophthalmic biometry by ultrasound echography, A-scan | 0.40 |
| 76519 | Ophthalmic biometry by ultrasound echography, A-scan; with intraocular lens power calculation | 0.54 |
| 92136 | Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation | 0.54 |

CMS is proposing the RUC recommended work RVUs for CPT codes 76516, 76519, and 92136. CMS is seeking comment on whether their alternative values of 0.44 for CPT codes 76519 and 92136 would improve relativity. There was significant discussion regarding this issue at the RUC and the RUC's written recommendations discuss this issue in greater detail.

**76519 and 92136**

For both 76519 and 92136, CMS states that the RUC recommended adding an additional 8 minutes of immediate post-service time for dictating the report, review and sign the report, communicating the results to the patient, discussing lens implant options, and entering an order for the lens implant. CMS is considering time and work values that would not include the additional 8 minutes of immediate post-service time in both of these codes noting its concern that the additional time may not reflect the typical case for these two procedures. It is unclear where CMS is determining the extra 8 minutes of immediate post-service time in both codes as each of these services currently have 5 minutes of post-service time. The RUC recommended 2 minutes of post-service time for CPT code 76516, so perhaps that is the differential that the Agency is implicitly referencing. The RUC based their recommendation on the median survey time and a thorough review of the clinical attributes of performing this service. The RUC-recommended post-service time is appropriate due to the need for the provider to discuss the multiple lens options and refractive outcomes with the patient. Many of these options were not available when the code was last surveyed. The RUC recommends for CMS to finalized physician times as proposed by the RUC.

CMS Total Time Ratio

When discussing the Agency's methodology for proposing work values, CMS acknowledges that physician work intensity per minute is typically not linear and also that making reductions in RVUs in strict proportion to changes in time is inappropriate. For the past several comment periods, the RUC has laid out a compelling case justifying this position — we greatly appreciate CMS agreeing with the RUC's assertion that the usage of time ratios to reduce work RVUs is typically not appropriate, as often a change in physician time coincides with a change in the physician work intensity per minute.

The RUC would like to remind CMS of both the Agency's and the RUC's longstanding position that treating all components of physician time (pre-service, intra-service, post-service and post-operative visits) as having identical intensity is incorrect and inconsistently applying it to only certain services under review creates inherent payment disparities in a payment system which is based on relative valuation. When physician times are updated in the Medicare payment schedule, the ratio of intra-service time to total time, the number and level of bundled post-operative visits, the length of pre-service and length of immediate post-service time may all potentially change for the same service. These changing components of physician time result in the physician work intensity per minute often changing when physician time also changes. The RUC recommends for CMS to always account for these nuanced variables.

We would also like to highlight that all RUC recommendations now explicitly state when physician time has changed and address whether and to what magnitude these changes in time impact the work involved. For example, our rationales explain the original source (or lack therefore) of time data and whether the source can be relied upon as an appropriate baseline. RUC recommendations also provide rationale justifying changes in physician work intensity, when applicable, often with supporting clinical information. CMS should carefully consider this critical information when determining proposed and final work values.

**The RUC requests that CMS not use a ratio of change in total time solely to reduce the work RVU of services. The RUC recommends that CMS finalize the proposed work RVUs of 0.40 for CPT code 76516, 0.54 for CPT code 76519, and 0.54 for CPT code 92136.**

**34. Ultrasound of Extremity (CPT codes 76881 and 76882)**

| CPT Code | Long Descriptor | CMS Proposed/ RUC Recommended Work RVU |
|---|---|---|
| 76881 | Ultrasound, ~~extremity, nonvascular,~~ complete joint (ie, joint space and peri-articular soft tissue structures) real-time with image documentation~~; complete~~ | 0.63 |
| 76882 | Ultrasound, limited, ~~anatomic specific~~ joint or other nonvascular extremity structure(s) (eg, joint space, peri-articular tendon[s], muscle[s], nerve[s], other soft tissue structure[s], or soft tissue mass[es]), real-time with image documentation | 0.49 |

CMS has proposed to retain the current work relative values, as recommended by the RUC, for CPT codes 76881 and 76882. CMS has proposed to accept the RUC direct practice expense (PE) inputs for 76881 and proposed minor adjustments to CPT code76881. For the RUC's comments on minor, individual refinements of direct PE inputs for CPT code 76881 please see the attached PE refinement table.

CMS is seeking comment on the use of portable ultrasound equipment versus an ultrasound room for these two codes. There was significant discussion regarding this issue at the RUC and the RUC's written recommendations discuss this issue in detail. The anatomic specific code (76882) describes a service most commonly performed by radiologists. We note that 56% of the claims are submitted by radiologists. The CMS statement that "the dominant specialty for both of these services is podiatry" is incorrect. As a reminder, for services that are split by professional and technical components, it is necessary to review both the global claims data and the 26 modifier claims data in aggregate to determine the dominant specialty. Radiologists would typically use an ultrasound room, and therefore, the ultrasound room should be allocated to 76882. Podiatry typically performs the complete ultrasound study (76881) and typically utilizes a portable ultrasound room. We agree with CMS that these changes should be implemented immediately for 2018.

The RUC was concerned that the definition of "complete" and "limited" was not clear in CPT and accordingly, recommended that following guidelines be added to CPT to clarify the intended reporting of each code. Additionally, changes were made to the descriptors, as noted above. CPT will implement the following changes for CPT 2018:

*Code 76881 represents a complete evaluation of a specific joint in an extremity. Code 76881 requires ultrasound examination of all of the following joint elements: joint space (eg, effusion), peri-articular soft-tissue structures that surround the joint (ie, muscles, tendons, other soft tissue structures), and any identifiable abnormality. In some circumstances, additional evaluations such as dynamic imaging or stress maneuvers may be performed as part of the complete evaluation. Code 76881 also requires permanently recorded images and a written report containing a description of each of the required elements or reason that an element(s) could not be visualized (eg, absent secondary to surgery or trauma).*◄

*When fewer than all of the required elements for a "complete" exam (76881) are performed, report the "limited" code (76882).*◄

*Code 76882 represents a limited evaluation of a joint or an evaluation of a structure(s) in an extremity other than a joint (eg, soft-tissue mass, fluid collection, or nerve[s]). Limited evaluation of a joint includes assessment of a specific anatomic structure(s) (eg, joint space only [effusion] or tendon, muscle, and/or other soft tissue structure[s] that surround the joint) that does not assess all of the required elements included in 76881. Code 76882 also requires permanently recorded images and a written report containing a description of each of the elements evaluated.*◄

**The RUC recommends that CMS implement the current work RVUs of 0.63 for CPT code 76881 and 0.49 for CPT code 76882, along with the direct practice expense inputs for each service as recommended by the RUC.**

**35. Radiation Therapy Planning (CPT codes 77261, 77262, and 77263)**

| CPT Code | Long Descriptor | CMS Proposed/ RUC Recommended Work RVU |
|---|---|---|
| 77261 | Therapeutic radiology treatment planning; simple | 1.30 |
| 77262 | Therapeutic radiology treatment planning; intermediate | 2.00 |
| 77263 | Therapeutic radiology treatment planning; complex | 3.14 |

CMS is proposing the RUC recommended work RVUs for CPT codes 77261, 77262, and 77263. However, CMS is seeking comment on alternative values given the RUC-recommended work RVUs and decreases in service times.

**77263**

The RUC disagrees with CMS's alternate consideration of a work RVU of 2.60 for CPT code 77263. The RUC does not understand CMS' comment regarding the decreases in service time for 77263 as previously the total time which was all designated in the intra-service component with 75 minutes and the recommended total time is now 82 minutes (7 minutes pre-time, 60 minutes intra-service time and 15 minutes immediate post-service time). The overall total time has increased and the RUC recommended maintaining the current work RVU of 3.14 for CPT code 77263. The decrease CMS is considering is unwarranted because total time did not decrease. Even if CMS were to crosswalk, a crosswalk to 96111 *Developmental testing, includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments) with interpretation and report* (work RVU = 2.60 and total time of 95 minutes) is inappropriate. CPT code 77263 is more intense and complex than 96111. CPT code 96111 does not include treatment planning, and therefore is an inappropriate crosswalk to use for the radiation therapy treatment planning codes. Additionally, the use of direct crosswalks based only on time comparison or ratios of time inappropriately discount the variation in technical skill, judgment, and risk inherent to procedures. It is also critical to acknowledge that CMS' proposed crosswalk (96111) is billed with an Evaluation and Management (E/M) code more than fifty percent of the time (54%):

| CPT Code 1 | Mod 1 | CPT Code 2 | Mod 2 | Percent Billed Together |
|---|---|---|---|---|
| 96111 | | 99203 | | 2% |
| 96111 | | 99205 | | 2% |
| 96111 | | 99212 | | 2% |
| 96111 | | 99213 | | 6% |
| 96111 | | 99214 | | 30% |
| 96111 | | 99215 | | 12% |

When CPT code 77263 was previously surveyed during the third 5-year review in 2005, total time was only surveyed, not pre, intra, and post-service times, making CMS' alternative valuation that only takes into account the intra-service time to the surveyed time inapplicable and incorrect. **The RUC recommends that CMS finalize the proposed work RVU of 3.14 for CPT code 77263.**

**77261 and 77262**

For CPT codes 77261 and 77262, CMS is considering applying the ratio of the crosswalk work RVU of CPT code 96111to the RUC-recommended work RVU of CPT code 77263 (2.60/3.14 = 0.83), to the RUC-recommended work RVU for CPT code 77261 (0.83 × 1.30 = 1.08), and CPT code 77262 (0.83 × 2.0= 1.66), which would have results in work RVUs of 1.08 for CPT code 77261and 1.66 for CPT code 77262.

For the aforementioned reasons in the discussion of CPT code 77263, the alternate considered value for 77263 is inappropriate since the total time did not decrease. Further offering alternate work RVUs for 77261 and 77262 institutes a flawed methodology for these services. The RUC utilized valid surveys and recommended the survey 25$^{th}$ percentile work RVUs for these services. Additionally, the RUC noted that these two services were CMS/Other valued codes. These services were originally assigned a work value and times by CMS over 20 years ago using some unknown methodology, making it inappropriate to compare changes in total time. The existing times were assigned using a flawed methodology. The RUC noted that only existing total time was assigned, making it not possible to compare changes in intra-service time. Accounting for appropriate time allocation, the intensity has not meaningfully changed.

CMS Intra-service Time Ratio

When discussing the Agency's methodology for proposing work values, CMS acknowledges that physician work intensity per minute is typically not linear and also that making reductions in RVUs in strict proportion to changes in time is inappropriate. For the past several comment periods, the RUC has laid out a compelling case justifying this position — we greatly appreciate CMS agreeing with the RUC's assertion that the usage of time ratios to reduce work RVUs is typically not appropriate, as often a change in physician time coincides with a change in the physician work intensity per minute.

The RUC would like to remind CMS of both the Agency's and the RUC's longstanding position that treating all components of physician time (pre-service, intra-service, post-service and post-operative visits) as having identical intensity is incorrect and inconsistently applying it to only certain services under review creates inherent payment disparities in a payment system which is based on relative valuation. When physician times are updated in the Medicare payment schedule, the ratio of intra-service time to total time, the number and level of bundled post-operative visits, the length of pre-

service and length of immediate post-service time may all potentially change for the same service. These changing components of physician time result the physician work intensity per minute often changing when physician time also changes. The RUC recommends for CMS to always account for these nuanced variables.

We would also like to highlight that all RUC recommendations now explicitly state when physician time has changed and address whether and to what magnitude these changes in time impact the work involved. For example, our rationales explain the original source (or lack therefore) of time data and whether the source can be relied upon as an appropriate baseline. RUC recommendations also provide rationale justifying changes in physician work intensity, when applicable, often with supporting clinical information. CMS should carefully consider this critical information when determining proposed and final work values.

**The RUC requests that CMS not use a ratio of intra-service methodology solely to reduce the work RVU of services. The RUC recommends that CMS finalize the proposed work RVUs of 1.30 for CPT code 77261, 2.00 for CPT code 77262, and 3.14 for CPT code 77263.**

**36. Pathology Consultation during Surgery (CPT codes 88333 and 88334)**

| CPT Code | Long Descriptor | CMS Proposed/ RUC Recommended Work RVU |
|---|---|---|
| 88333 | Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), initial site | 1.20 |
| 88334 | Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site (List separately in addition to code for primary procedure) | 0.73 |

CMS has proposed to retain the current work relative values for both codes in this family as recommended by the RUC (work RVU of 1.20 for CPT code 88333 and work RVU of 0.73 for CPT code 88334). CMS has proposed adjustments to the clinical labor for CPT code 88333. For the RUC's comments on individual refinements of direct PE inputs, please see the attached practice expense refinement table.

CMS is seeking comments on the equipment time assigned to the "grossing station w-heavy duty disposal" (EP015) and clarification on how it is derived. It is our understanding that the time assigned to EP015 grossing station w-heavy duty disposal is derived from a combination of the total clinical labor time for the service and the physician time of reviewing the patient case at the same grossing station. The current time of 10 minutes represents a reduction from 25 minutes for code 88333 and 20 minutes for code 88334 from the direct inputs in 2014.

In addition, the laboratory technician prepares the room and grossing station, including filtering and replenishing or replacing supplies needed for the services. These supplies include slides, labels, forceps, blades, colored stains, and any other necessary items. **The RUC recommends maintaining the current equipment time of 10 minutes assigned to the grossing station for both CPT codes 88333 and 88334.**

Additionally, the RUC recommended that CPT code 88334 should have a ZZZ global period rather than a XXX global period because it is an add-on code and does not include any pre-service or post-service time. CPT code 88334 is an add-on code for the additional physician work related to the second needle core only. The physician work related to the first needle core would be reported separately with the primary code 88333. In Addendum B, the global period remains XXX for code 88334. **The RUC reiterates its request that CMS assign a ZZZ global period to CPT code 88334.**

**The RUC recommends that CMS implement the current work RVUS of 1.20 for CPT code 88333 and 0.73 for CPT code 88334 along with the direct practice expense inputs for each service as recommended by the RUC. The RUC also requests that CMS assign a ZZZ global period to CPT code 88334.**

**37. Morphometric Tumor Immunohistochemistry (CPT codes 88360 and 88361)**

| CPT Code | Long Descriptor | CMS Proposed/ RUC Recommended Work RVU |
|---|---|---|
| 88360 | Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, per specimen, each single antibody stain procedure; manual | 0.85 |
| 88361 | Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, per specimen, each single antibody stain procedure; using computer-assisted technology | 0.95 |

For CY 2018, the RUC recommended and CMS has proposed a work RVU of 0.85 for CPT code 88360 and a work RVU of 0.95 for CPT code 88361. CMS is proposing the RUC-recommended work RVUs for both codes in this family, and is seeking comment on additional pricing information for the EP001 DNA image analyzer equipment as well as the appropriate equipment time typically required for use in CPT code 88361. These codes reflect how breast cancers are measured for Estrogen receptor-progesterone receptor-Her2 status. ER and PR stain one part of the cancer cell and use one counting algorithm while Her2 stains another part of the cancer cell and uses another algorithm. Accurate measurement affects therapeutic approach and was one of the first steps in personalized medicine. 88360 refers to the manual counting while 88361 uses a computer assisted digital image analyzer.

CMS is considering reducing the equipment time for the DNA image analyzer for CPT code 88361 from 30 to 5 minutes based on equipment literature that specifies the machine can run 50 slides per hour. The literature does provide throughput information for 20x and 40x (50 slides/hr. @ 20x and 20 slides/hr. @ 40x), however, this is just the initial step in the analytical process, that of obtaining an image of the tissue stained for the appropriate antigen. It is the additional steps of analysis that resulted in the RUC recommending 30 minutes. Prior to the photography step, the slides are labeled and loaded into the imaging instrument. The additional steps for 88361 of 30 minutes that is typical for these services include the histotechnologist performing instrument calibration and instrument quality control during start up and shutdown of the imaging instrument. The technologist must also transfer, or access, the photographed digital image into the quantitative cellular imaging system (which is a separate function from line 14 of the RUC recommendation spreadsheet "Verify order and accession immunohistochemical stain order in laboratory information system"). The histotechnologist then uses

the instrument to gate, or circle, the areas of cancer cells to be analyzed (and exclude the non-cancer areas) in the image and then the run is initiated. In many cases, the technician will take the recut slide back to the original pathologist and ask for the tumor to be identified on the slide. In addition, after the machine counts the stained cells and measures their intensity of staining, the histotechnologist needs to review the machine's work for accuracy, unload it, and meticulously clean it.

All of this time adds up to at least 30 minutes where the DNA image analyzer (EP001) cannot be used for any other purpose or patient case. This does not translate into a reduction of 25 minutes in equipment time. **The RUC continues to maintain and recommend that 30 minutes of equipment time is appropriate for the DNA image analyzer (EP001).**

The CMS is proposing to refine the equipment time for the "Benchmark ULTRA auto slide prep & EBar Label system" (EP112) from 18 minutes to 16 minutes for both CPT codes 88360 and 88361. Within CMS' 2016 Final PFS Ruling, page 70982, equipment items EP112 and EP113 EBar II Barcode Slide Label System were reclassified as a single item, which will use equipment code EP112 with the equipment minutes remaining unchanged. Because of this ruling the equipment minutes of both items should have been added together for all codes within CMS' database with EP112 and EP113. These CPT codes include 88342, 88341, 88344, 88360, and 88361.

The RUC recommendations for April 2014 and April 2016 reflect both equipment items. These recommendations were reviewed by the RUC and accepted by CMS.

**The RUC recommends the following additions in equipment time by CPT code:**

| CPT Code | EP112 Minutes | EP113 Minutes | Total time reclassified as EP112 |
|---|---|---|---|
| **88341** | 15 | 1 | **16** |
| **88342** | 15 | 3 | **18** |
| **88344** | 30 | 3 | **33** |
| **88360** | 15 | 3 | **18** |
| **88361** | 15 | 3 | **18** |

The RUC urges the CMS to correct the addition error made when equipment items EP112 and EP113 were combined by adding back lost minutes from EP113. The total times for EP112 for 88342, 88341, 88344, 88360, and 88361 is shown above. In addition, the RUC recommends the description of EP112 be renamed in CMS' database to "Benchmark ULTRA auto slide prep & EBar Label system".

**For the RUCs comments on individual refinements of direct PE inputs, please see the attached practice expense refinement table. Please see attachments for clear paid invoices for the EP001 DNA image analyzer equipment and its component parts.** (See attachment 04).

**The RUC recommends CMS finalize the proposed work RVU of 0.85 for CPT code 88360 and 0.95 for CPT code 88361 along with the direct practice expense inputs for each service as recommended by the RUC.**

**38. Cardiac Electrophysiology Device Monitoring Services (CPT codes 93279, 93281, 93282, 93283, 93284, 93285, 93286, 93287, 93288, 93289, 93290, 93291, 93292, 93293, 93294, 93295, 93296, 93297, 93298, and 93299)**

| CPT Code | Long Descriptor | CMS Proposed/ RUC Recommended Work RVU |
|---|---|---|
| 93279 | Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; single lead pacemaker system | 0.65 |
| 93280 | Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; dual lead pacemaker system | 0.77 |
| 93281 | Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; multiple lead pacemaker system | 0.85 |
| 93282 | Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; single lead transvenous implantable defibrillator system | 0.85 |
| 93283 | Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; dual lead transvenous implantable defibrillator system | 1.15 |
| 93284 | Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; multiple lead transvenous implantable defibrillator system | 1.25 |
| 93285 | Programming device evaluation (in person) with iterativeadjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; implantable loop recorder system | 0.52 |
| 93286 | Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review and report by a physician or other qualified health care professional; single, dual, or multiple lead pacemaker system | 0.30 |

| | | |
|---|---|---|
| 93287 | Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review and report by a physician or other qualified health care professional; single, dual, or multiple lead implantable defibrillator system | 0.45 |
| 93288 | Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead pacemaker system | 0.43 |
| 93289 | Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead transvenous implantable defibrillator system, including analysis of heart rhythm derived data elements | 0.75 |
| 93290 | Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; implantable cardiovascular monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors | 0.43 |
| 93291 | Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; implantable loop recorder system, including heart rhythm derived data analysis | 0.37 |
| 93292 | Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; wearable defibrillator system | 0.43 |
| 93293 | Transtelephonic rhythm strip pacemaker evaluation(s) single, dual, or multiple lead pacemaker system, includes recording with and without magnet application with analysis, review and report(s) by a physician or other qualified health care professional, up to 90 days | 0.31 |
| 93294 | Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional | 0.60 |
| 93295 | Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead implantable defibrillator system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional | 0.74 |
| 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 | PE Only |

| | | |
|---|---|---|
| 93297 | Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors, analysis, review(s) and report(s) by a physician or other qualified health care professional | 0.52 |
| 93298 | Interrogation device evaluation(s), (remote) up to 30 days; implantable loop recorder system, including analysis of recorded heart rhythm data, analysis, review(s) and report(s) by a physician or other qualified health care professional | 0.52 |
| 93299 | Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system or implantable loop recorder system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results | PE Only |

As part of the CY 2016 PFS final rule (80 FR 70914), several services in this family (reported with CPT codes 93288, 93293, 93294, 93295, and 93296) were identified as potentially misvalued through the high expenditure by specialty screen. Seven of the 21 services in this family involve remote monitoring of cardiovascular devices, and two of these services (reported with CPT codes 93296 and 93299) are valued for practice expense only. For CY 2018, CMS are proposing the RUC-recommended work RVUs for the 19 CPT codes in this family.

**93283**

CMS considered a work RVU of 0.91 (25th percentile survey result) and seeks comment on whether this alternative work RVU for this service would better maintain relativity between single and dual lead pacemaker systems and cardioverter defibrillator services.

The RUC does not agree with CMS' alternate consideration for physician work. A robust survey was conducted and there is no evidence that the current value of 1.15 should be lowered. The physician work slightly increased by 2 minutes of pre-service time base on the survey respondents. There has been no change in the physician work or intra-service time to warrant a decrease. The comparison between pacemakers and cardioverter defibrillators is not 1:1 or 1:2, but in general, cardioverter defibrillator services warrant more work due to hardware, software, and complexity considerations. Decreasing this service will disrupt the relativity among these services and is unwarranted. **The RUC recommends that CMS finalize the proposed work RVU of 1.15 for CPT code 93283.**

**93282**

CMS considered reducing the work RVU for CPT code 93282 by 0.11 work RVUs and seek comments on whether this alternative value would better reflect relativity between the single and dual lead systems that exist within pacemaker services and within cardioverter defibrillator services.

The RUC does not agree with CMS' alternate consideration for physician work. A robust survey was conducted that confirmed the current relativity between the pacemaker and cardioverter defibrillator services are appropriate. The alternate consideration of reducing this service by 0.11 is arbitrary and does not account for the physician work, time and intensity, but is a random number chosen with the sole purpose to lower the work RVU. No crosswalk or survey link was offered, so it not clear how this value was identified as a potential alternative. It is also not clear whether this would be in addition to the alternative for 93283 or in lieu of that change. Assuming the former, this would create an increment of 0.15 between the two cardioverter defibrillator services. The recommended increment of 0.30 better represents the increased work of programming a dual-lead cardioverter defibrillator. Additionally, by

lowering the single-lead cardioverter defibrillator code, CMS is creating other relativity problems by making 93282 close in value to 93279. Survey respondents clearly indicated 93282 is more work than both 93279 and 93280. The current value and survey 25th percentile confirm a work RVU of 0.85 is correct. **The RUC recommends that CMS finalize the proposed work RVU of 0.85 for CPT code 93282.**

**93289**

CMS also noted that there is a difference of 0.10 work RVUs between the RUC-recommended values for CPT codes 93289 and 93282. Therefore, CMS considered a proportionate reduction for CPT code 93289 to a work RVU of 0.69.

The RUC does not agree with CMS' alternate consideration for physician work. A robust survey was conducted and the RUC significantly reduced the work RVU to the survey 25th percentile based on the reduction in time. The RUC also supported this recommendation with other services in Physician Payment Schedule such as, MPC code 76817 *Ultrasound, pregnant uterus, real time with image documentation, transvaginal* (work RVU = 0.75 and 10 minutes intra-service time) which appropriately requires the same physician work. CMS' alternate consideration of reducing this service by 0.10 work RVUs is arbitrary and does not account for the physician work, time and intensity, but is a random number chosen with the sole purpose to lower the work RVU. **The RUC recommends that CMS finalize the proposed work RVU of 0.75 for CPT code 93289.**

**Remote Monitoring Codes**

As noted in this section of the proposed rule, several of the CPT codes (93292, 93294, 93295, 93297, and 93298) reviewed by the RUC in January 2017 involve remote monitoring services for cardiac devices. CMS agrees with the RUC that these services are difficult to value considering that the monitoring duration (number of days between 30 and 90) and the average number of transmissions vary. CMS also notes that these codes were surveyed twice, and in both cases the intra-service and total times were considered by the specialty societies to be inconsistent with existing times. The RUC explained that they extrapolated total and intra-service time data for these codes and warned against making comparisons. Without additional information about the methods and sources used for extrapolation, however, CMS have no basis for assuming the imputed values are of higher quality and/or accuracy than those from the survey. CMS does not agree that survey results should not be used as a point of comparison in the context of other factors, particularly when they are used to support other considerations. CMS is proposing the RUC recommended work RVUs for each of these codes.

The RUC did not indicate that CMS should not use the survey results as a point of comparison. The RUC specified that the **current** intra-service times for these services were not survey times but were extrapolated from other codes in the family and should not be used to compare the time required to perform these services. Comparing the incorrect **existing** times demonstrate an artificial decrease in time to the recent actual survey times. Also, for some of the codes the 2008 survey times were incorrectly entered in the RUC database and thus should not be compared. The information on the previous extrapolated values is indicated below as well as historically noted in the RUC database.

**93293**

The RUC recommended a work RVU of 0.31 for CPT code 93293, which is 0.01 work RVUs lower than the existing work RVU for this code. CMS has concerns that the amount of the reduction in the work RVU recommended by the RUC may not be consistent with the decrease in total time of 7 minutes. CMS considered an alternative crosswalk for CPT code 93293 (Pm phone r-strip device eval) (5 minutes intra-service time and 13 minutes total time) to CPT code 94726 (Pulm funct tst

plethysmograp), which has 5 minutes intra-service time and 15 minutes total time and a work RVU of 0.26.

The RUC does not agree with CMS' alternate consideration of 0.26 for CPT code 93293. In 2008, the RUC noted it derived at a work RVU by taking the frequency of reporting this service multiplied by the work RVU for 93010 (1.9 x 0.17 = 0.32 work RVUs). The RUC determined that the physician time required to perform this service is the survey physician time multiplied by the frequency of reporting this service (5/10/5 x 1.9 = 9.5 minutes pre-, 19 minutes intra-, and 7.5 minutes post-service time). The RUC also noted in its recommendation and in the RUC database that physician times for codes 93286, 93287, 93293, 93294, 93295, 93297 and 93298 should not be used for comparison as these times were calculated from crosswalks and are not specialty society survey data.

Therefore, CMS's current consideration is comparing the difference of 7 minutes of total time from the current survey to the previous calculated physician time are inapplicable. The RUC recommends that CMS use the current valid survey 25$^{th}$ percentile work RVU of 0.31 and physician times. The RUC also provided multiple comparisons as indicated by the physicians who perform this service and other similar services such as the second top key reference service 93018 *Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; interpretation and report only* (work RVU = 0.30 and 5 minutes intra-service time) which requires similar intensity and complexity, physician time and work to perform. Also, MPC codes 72114 *Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views* (work RVU = 0.32 and 5 minutes intra-service time) and 92081*Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)* (work RVU = 0.30 and 7 minutes intra-service time), which provide a good comparison relative to services in the Medicare physician payment schedule. **The RUC recommends that CMS finalize the proposed work RVU of 0.31 for CPT code 93293.**

**93294**

For CPT code 93294, CMS considered a work RVU of 0.55, crosswalking from CPT code 76706 (Us abdl aorta screen aaa), and CMS seeks comment on whether it would better align with the RUC recommended service times. CMS is concerned that a work RVU of 0.60 may not account for the difference between existing service times and the RUC-recommended service times. Similarly, the RUC recommended a work RVU for CPT code 93294 of 0.60, which is 0.05 work RVUs less than the existing work RVU. The total time for furnishing services reported with CPT code 93294 decreased by 10 minutes, however, and CMS believes this reduction in time may not be appropriately reflected by a decrease of 0.05 work RVUs. Compared to services with similar total and intra-service times, CMS identified CPT code 76706 (Us abdl aorta screen aaa) as potentially a more appropriate crosswalk. CPT code 76706 has identical intra-service and total service times as CPT code 93294, with a work RVU of 0.55. CMS seeks comments on whether our alternative value would better reflect the time and intensity involved in furnishing this service.

The RUC does not agree with CMS' alternate consideration of 0.55 work RVUs for CPT code 93294. In 2008, the RUC noted that it derived at a work RVU by taking the frequency of reporting this service multiplied by the work RVU for 93288 (1.5 x 0.43 RVU = 0.65 work RVUs). The RUC determined that the physician time required to perform this service was also 1.5 multiplied by the service times for 93288 (1.5 x 5/10/5 = 7.5 minutes pre-, 15 minutes intra-, and 7.5 minutes post-service time). The RUC also noted in its recommendation and in the RUC database that physician times for codes 93286, 93287,

93293, 93294, 93295, 93297 and 93298 should not be used for comparison as these times were calculated from crosswalks and are not specialty society survey data.

Therefore, CMS's current consideration is comparing the difference of 10 minutes of total time from the current survey to the previous calculated physician time are inapplicable. The RUC recommends that CMS use the current valid survey 25th percentile work RVU of 0.60 and physician times. The RUC also provided multiple comparisons as indicated by the physicians who perform this service such as MPC codes 76815 *Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), 1 or more fetuses* (work RVU = 0.65 and 5.5 minutes intra-service time) and 69210 *Removal impacted cerumen requiring instrumentation, unilateral* (work RVU = 0.61 and10 minutes intra-service time), which provide a good comparison relative to services in the Medicare physician payment schedule. **The RUC recommends that CMS finalize the proposed work RVU of 0.60 for CPT code 93294.**

**93295**

For CPT code 93295, CMS considered a work RVU of 0.69, crosswalking to CPT code 76586, which has identical intra-service and total times compared to CPT code 93295. CMS considered using a work RVU of 0.69 to maintain the differential between CPT code 93295 and the work RVU CMS considered for the previous code in this family (a work RVU of 0.11 for CPT code 93295). CMS are concerned about the decrease in service time compared to the work RVU. CMS notes that the existing intra-service time is 22.5 minutes, compared to the RUC-recommended intra-service time of 10 minutes. CMS seeks comments on whether our alternative value would better reflect the time and intensity involved in furnishing this service.

The RUC does not agree with CMS' alternate consideration of 0.69 work RVUs for CPT code 93295. In 2008, the RUC noted that it derived at a work RVU by taking the frequency of reporting this service multiplied by the work RVU for 93289 (1.5 x 0.92 RVU = 1.38 work RVUs). The RUC determined that the physician time required to perform this service was also 1.5 multiplied by the service times for 93289, 1.5 x 5/15/5 = 7.5 minutes pre-, 22.5 minutes intra-, and 7.5 minutes post-service time). Additionally, the April 2008 survey times are incorrect in the RUC database. The April 2008 survey times were 5 minutes pre/15 minutes intra/5 minutes immediate post-service time and the 25th percentile work RVU of 0.78. The RUC confirmed that the previous times and work RVU calculations could not be used as comparison as they reflect an artificial decrease in physician time. The RUC noted in its recommendation and in the RUC database that physician times for codes 93286, 93287, 93293, 93294, 93295, 93297 and 93298 should not be used for comparison as these times were calculated from crosswalks and are not specialty society survey data.

In 2017, the RUC determined that the current survey 25th percentile work RVU of 0.69 and median work RVU of 0.95 did not appropriately account for the work required to perform this service. The RUC recommends a direct crosswalk to CPT code 76770 *Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; complete* (work RVU = 0.74 and 10 minutes intra-service time). This is a significant reduction to the current work RVU of 1.29. Any further reduction is inappropriate relative to the other services in this family. **The RUC recommends CMS finalize the proposed work RVU of 0.74 for CPT code 93295.**

**93297 & 93298**

For CPT code 93298, the RUC recommended a work RVU of 0.52, which is unchanged from the current work RVU for this code. CMS are concerned about that recommendation given the reduction in both intra-service and total time for this service. The intra-service time decreased from 24 to 7 minutes,

while total time decreased from 44 to 17 minutes. CMS acknowledges that the current times for this CPT code and others in this family are extrapolations. However, without additional information about the extrapolation of data from survey results, CMS questions whether the survey results should be excluded from consideration altogether.

CMS considered a work RVU of 0.37 for CPT code 93297, crosswalking to CPT code 96446 (Chemotx admn prtl cavity). CMS also considered a work RVU of 0.37 for CPT code 93298 based on a crosswalk to CPT code 96446, since the RUC indicated that the work RVUs for CPT codes 93297 and 93298 should be the same. CMS is seeking comment on our proposed valuation and whether our alternative valuation would be more appropriate for this code.

The RUC does not agree with alternate work RVU of 0.37 considered for CPT codes 93297 and 93298. In 2008, The RUC reviewed code 93297 and 93298, determined that the average number of transmissions per patient per 30 days is two. The RUC determined that other than the physician work associated with transmissions, the physician work for 93297 is parallel to 93290 (recommended work RVU = 0.43). The RUC discussed taking the frequency of reporting this service and multiplying it by the work RVU for 93290 (2 x 0.43 RVU = 0.86 work RVUs) to develop a work RVU for 93297 and 93298. The RUC determined that the physician time required to perform these services was the service times for 93290 multiplied by 2 ( 2 x 5/12/8 = 10 minutes pre-, 24 minutes intra-, and 16 minutes post-service time). Additionally the April 2008 survey times are incorrect in the RUC database. The April 2008 survey times for 93297 were 5 minutes pre/12 minutes intra/8 minutes immediate post-service time and for 93298 were 5 minutes pre/10 minutes intra/5 minutes immediate post-service time. The RUC confirmed that the previous times and work RVU calculations could not be used as comparison as they reflect an artificial decrease in physician time.

In 2017, the RUC compared the surveyed code to the top key reference code 93224 *External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation by a physician or other qualified health care professional* (work RVU = 0.52 and 15 minutes intra-service time) and agreed with the survey respondents that the surveyed code is more intense and complex to perform and requires less physician time. For additional support the RUC referenced similar MPC codes 76536 *Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation* (work RVU = 0.56 and 10 minutes intra-service time) and 76857 *Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles)* (work RVU = 0.50 and 7 minutes intra-service time), which provide a good comparison relative to services in the Medicare physician payment schedule. For additional support the RUC reference 92136 *Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation* (work RVU = 0.54 and 5 minutes intra-service time). **The RUC recommends CMS finalize the proposed work RVU of 0.52 for CPT codes 93297 and 93298.**

**The RUC recommends that CMS finalize all the proposed work RVUs for this family of services.**

**Practice Expense**

CMS is proposing refinements to the RUC-recommended direct PE inputs for some of the codes in this family. **For the RUCs comments on individual refinements of direct PE inputs please see the attached refinement table.**

**39. Transthoracic Echocardiography (TTE) (CPT codes 93306, 93307, and 93308)**

| CPT Code | Long Descriptor | CMS Proposed/ RUC Recommended Work RVU |
|---|---|---|
| 93306 | Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography | 1.50 |
| 93307 | Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography | 0.92 |
| 93308 | Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study | 0.53 |

In the CY 2016 PFS final rule with comment period (80 FR 70914), CMS identified CPT code 93306 through the high expenditures screen. Subsequently, the RUC reviewed CPT codes 93307 and 93308, in addition to CPT code 93306 as part of this family of codes that describe transthoracic echocardiograms. For CY 2018, CMS is proposing the RUC-recommended work RVUs for these three services.

**93306**

CMS considered maintaining the CY 2017 work RVU of 1.30. The surveyed total time for this code dropped slightly due to changes in the immediate post-service time. The median preservice and intra-service time remained unchanged.

The RUC does not agree with the alternate work RVU of 1.30 considered for CPT code 93306. The specialty societies provided robust information and the RUC agreed that the intensity for this service has increased in the last 10 years because the physician reviews more images in the same amount of time and performs additional testing such as diastolic function and spectral tracking. Part of the standard of care now includes the physician calculation of left ventricular ejection fraction in many patient populations. This is all incremental physician work that is not an automated function. The RUC agreed that there may be minor efficiencies in time for this service; however the intensity in work has been compounded by the increase in technology and the number of images to review, additional testing and calculations that the physician is now conducting.

The survey data and similar services in the Physician Payment Schedule support the survey 25$^{th}$ percentile work RVU of 1.50 for CPT code 93306. The RUC compared 93306 to top key reference service 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* (work RVU = 1.62 and 20 minutes intra-service time). The survey respondents indicated that 93306 is somewhat more intense/complex than 78452, however the intra-service times are identical (20 minutes). The specialty societies indicated that the higher intensity and complexity measures, likely reflect the more diverse disease processes to consider when the physician is reviewing the images. CPT code 93306 provides a non-invasive comprehensive assessment of cardiac structure and function which includes measurements performed in the course of the examination, 2-

dimensional and/or M-Mode numerical data for transthoracic echocardiograms, and Doppler/color flow data. Whereas, CPT code 78452 assesses heart conditions including myocardial wall motion abnormalities with myocardial perfusion at stress and rest. The total time differences between codes 78452 and 93306 were solely based on the shorter pre- and post-service time periods, which are balanced by the difference in work RVUs.

For additional support, the RUC referenced MPC code 74176 *Computed tomography, abdomen and pelvis; without contrast material* (work RVU = 1.74 and 22 minutes intra-service) and similar service72146 *Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material* (work RVU = 1.48 and 20 minutes intra-service time). **The RUC recommends that CMS finalize the proposed work RVU of 1.50 for CPT code 93306.**

**93307**

CMS considered a work RVU of 0.80, crosswalking to services with similar service times (CPT codes 93880 (Extracranial bilat study), 93925 (Lower extremity study), 93939, 93976 (Vascular study), and 93978 (Vascular study)). The surveyed total time dropped 3 minutes (from the intra-service time) compared to the existing service times for this code.

The RUC does not agree with alternate work RVU of 0.80 considered for CPT code 93307. The RUC noted that CPT code 93307 was last RUC reviewed in 2007; since that time there have been technological and clinical advances which allow for efficient review of additional images. The Intersocietal Accreditation Commission (IAC) standards last updated in 2015 require eleven separate imaging windows, with approximately 4-5 views per window (even without color Doppler or pulse Doppler). Quantitative evaluation of cardiac structures, such a left atrial volume, is now the expected standard. While digital technology has afforded some improvement in intra service time, the physician no longer must passively wait as videotape advances, the volume and complexity of information to evaluate in the study has increased. The RUC agreed that this appropriately explains the increased intensity that results from maintaining the work RVU while slightly reducing the intra-service time.

The survey data and similar services in the Physician Payment Schedule support the current value of 0.92 for CPT code 93307. The RUC referenced MPC codes 76805 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; single or first gestation* (work RVU = 0.99 and 15 minutes intra-service time) and 95819 *Electroencephalogram (EEG); including recording awake and asleep* (work RVU = 1.08 and 15 minutes intra-service time). **The RUC recommends that CMS finalize the proposed work RVU of 0.92 for CPT code 93307.**

**93308**

CMS considered a work RVU of 0.43, crosswalking to CPT code 93292 (Wcd device interrogate) based on similar service times. The surveyed total time dropped by 5 minutes (from the intra-service time) compared to the existing service times for this code.

The RUC does not agree with alternate work RVU of 0.43 considered for CPT code 93308. The RUC noted that CPT code 93308 was last RUC reviewed in 2011. This limited study is a problem-specific study, such a follow up for left ventricular ejection fraction in a patient undergoing chemotherapy. Once again, the array of tools now applied in this "limited" setting has advanced considerably since the last valuation. Use of contrast detailed analysis of regional ventricular function and quantitative assessment of ejection fraction are now routinely applied in "limited" echo studies, in stark contrast to the clinical standard at the time of the prior valuation. Additionally, while digital technology has afforded some

improvement in intra service time, the volume and complexity of information the physician must evaluate for the study has increased. The RUC agreed that this appropriately explains the increased intensity that results from maintaining the work RVU while slightly reducing the intra-service time.

Similar services in the Physician Payment Schedule support the current value of 0.53 for CPT code 93307. For additional support, the RUC referenced similar codes 78014 *Thyroid imaging (including vascular flow, when performed); with single or multiple uptake(s) quantitative measurement(s) (including stimulation, suppression, or discharge, when performed)* (work RVU = 0.50 and 10 minutes intra-service time), 93882 *Duplex scan of extracranial arteries; unilateral or limited study* (work RVU = 0.50 and 10 minutes intra-service time) and 93979 *Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; unilateral or limited study* (work RVU = 0.50 and 10 minutes intra-service time). **The RUC recommends CMS finalize the proposed work RVU of 0.53 for CPT code 93308.**

**40. Stress Transthoracic Echocardiography (TTE) Complete (CPT codes 93350 and 93351)**

| CPT Code | Long Descriptor | CMS Proposed/ RUC Recommended Work RVU |
|---|---|---|
| 93350 | Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; | 1.46 |
| 93351 | Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with supervision by a physician or other qualified health care professional | 1.75 |

CPT code 93351 was identified as potentially misvalued and the RUC reviewed CPT code 93350 as part of the same code family. For CY 2018, CMS is proposing the RUC-recommended work RVUs for these services. **The RUC agrees and recommends that CMS finalize the proposed work RVU of 1.46 for 93350 and 1.75 for 93351.**

CMS is proposing refinements to the RUC-recommended direct PE inputs for CPT codes 93350 and 93351. **For the RUCs comments on individual refinements of direct PE inputs please see the attached refinement table.**

**41. Peripheral Artery Disease (PAD) Rehabilitation (CPT code 93668)**

| CPT Code | Long Descriptor | CMS Proposed/ RUC Recommended Work RVU |
|---|---|---|
| 93668 | Peripheral arterial disease (PAD) rehabilitation, per session | 0.00 (PE Only) |

A new national coverage determination (NCD) established Medicare coverage of supervised exercise therapy (SET) for the treatment of beneficiaries with peripheral artery disease with intermittent claudication. CMS indicates that existing code 93668, currently assigned PROCSTAT N (non-covered service by Medicare), for SET will be payable by the end of CY 2017, retroactive to the NCD effective date. For CY 2018, CMS proposes the most recent RUC-recommended work and direct PE inputs. The RUC supports that approach for CY2018. Since the RUC has not reviewed CPT code 93668 since 2001, CMS is seeking comments on the direct PE inputs assigned to the code. The RUC will add CPT code 93668 for review of direct practice expense inputs at the January 2018 RUC meeting.

CMS also seeks input on coding structure and valuation going forward. The RUC intends to work with the appropriate specialty societies through the CPT Editorial Panel and RUC processes to evaluate coding structure and valuation assumptions. That forthcoming effort may or may not entail creation of new codes or coding instruction by the CPT Editorial Panel. The current CPT coding instructions correctly prescribe that "the development of new arrhythmias, symptoms that might suggest angina or the continued inability of the patient to progress to an adequate level of exercise may require review and examination of the patient by a physician…These services would be separately reported with an appropriate level E/M service code…" Such work would not overlap with the patient's SET.

Currently this service does not include physician work, only practice expense inputs. CMS requests comment on the current practice expense inputs for use in CY 2018. Finally, while a typical, individual session of SET does not currently include physician work, SET programs do require the overall medical direction of a physician. This will be considered in the discussion of this service at the RUC. A coding solution may be the result of these efforts. **The RUC recommends use of the current PE inputs for CY 2018 and will review and provide recommendations for the practice expense for CY 2019.**

**42. Pulmonary Diagnostic Tests (CPT codes 94621, 946X2, and 946X3)**

| CPT Code | Long Descriptor | CMS Proposed/ RUC Recommended Work RVU |
|---|---|---|
| 94621 | Cardiopulmonary exercise testing, including measurements of minute ventilation, CO2 production, O2 uptake, and electrocardiographic recordings | 1.42 |
| 946X2 | Exercise test for bronchospasm, including pre- and post-spirometry and pulse oximetry | 0.70 |
| 946X3 | Pulmonary stress testing (eg, 6-minute walk test), including measurement of heart rate, oximetry, and oxygen titration, when performed | 0.48 |

CMS is proposing the RUC recommended work RVUs for CPT codes 94621, 946X2, and 946X3. **For the RUC's comments on individual refinements of direct PE inputs for CPT codes 94621, 946X2, and 946X3, please see the attached PE refinement table.** CMS is seeking additional comment on whether their alternative clinical labor times would better reflect the work and times for these services. There was significant discussion regarding this issue at the RUC and the RUC's written recommendations discuss this issue in greater detail. The RUC would like to point out that the clinical activity time changes for CPT codes 94621 and 946X2 below are not listed in the CMS refinement table.

**94621**

CMS is seeking comment on refining the clinical labor time for the "pre exercise ECG, VC, Min Vent. Calculation" activity from 27 to 15 minutes for 94621, and CMS believes that each of these components would not take longer than 5 minutes for this clinical labor activity. CMS is considering proposing this value of 15 minutes based on assigning 5 minutes apiece for the ECG, the maximum voluntary ventilation (MVV), and the spirometry.

The RUC strongly disagrees with CMS on refining the clinical labor time as CMS has made some incorrect assumptions, specifically; that performing an ECG is for a standard ECG that takes 5 minutes. The RUC agrees with CMS that a standard ECG takes five minutes. However, for 94621, in the context of a CPET, the tech has to do a regular ECG with limb leads, then transfer the leads to the patient's torso and do the modified ECG which is then used for comparing tracings during the test. In effect, two ECGs are being performed and the tech has to make sure the torso leads are firmly attached so as not to become dislodged during vigorous exercise. This is different from performing a standard ECG with disposable electrodes and this portion would, at minimum, take 10 minutes for the ECG. For the pre-exercise spirometry, the RUC would agree that 5 minutes is reasonable. The FVC maneuver has to be repeated three times and then one or two MVV maneuvers of 12- 15 seconds are performed. Physicians use the highest of either the FEV1 x 35 or MVV to estimate the patients expected level of ventilation during the CPET. Therefore, the RUC-recommended value of 27 minutes is reasonable and necessary for these activities.

CMS is also considering refining the clinical labor time for the "clinical staff performs procedure" activity from 14 to 12 minutes for 94621 due to insufficient justification to increase the time by 2 additional minutes. The RUC strongly encourages CMS to keep 14 minutes of clinical labor time for this activity because 12 minutes to perform this procedure is not reasonable. Typically, sites perform 2-5 of resting gas collection, followed by a protocol designed to reach the patients max VO2 in 10 minutes. Symptomatic patients often go less than 10 minutes, but other patients exceed the expected maximum. There is typically a crucial 2-5 minute cool down period since HR recovery is recorded and deleterious BP and ECG changes often occur post-exercise. Therefore, the RUC recommendation of 14 minutes of clinical labor time for this activity should not be adjusted or reduced by 2 minutes.

**946X2**

CMS is considering refining the clinical labor time for the "clinical staff performs procedure" activity from 55 to 35 minutes for 946X2. CMS argues that the RUC-recommended materials for the PE inputs for this clinical labor task consists of performing 5 spirometries at 9 minutes each, plus 10 minutes of exercise time for 946X2. CMS is considering adjusting the spirometries to 5 minutes each, which would ultimately reduce this activity from 55 to 35 minutes.

For 946X2, pre-test spirometry typically takes 5 minutes. However, for 946X2, sites typically use either a 12-lead or 3-lead ECG to monitor HR. The specialty societies recommend using a HR of 85-

95% of predicted max for 6-8 minutes as an adequate stimulus to elicit exercise-induced bronchospasm. Therefore, the patient is hooked to an ECG as noted above. Spirometry (2-3 FVC maneuvers) is repeated at 5, 10, 15, 20, and 30 minutes, unless they have a decrease in their FEV1 of 10-15%. Sites that perform these studies typically use the EIB protocol with exhaled gas analysis, just as it is done for a full CPET. This allows physicians to monitor ventilation as well as HR during the test to make sure an adequate level of ventilation is achieved to elicit EIB. If patients do exhibit EIB, they typically then get a SABA, wait 10 minutes, and repeat spirometry to document a return to within 10% of baseline. This procedure, from start to finish, suggests that CMS' refinement from 55 to 35 minutes is not adequate for this activity, and the RUC-recommended time of 55 minutes for this activity should be accepted.

**The RUC recommends that CMS implement the current work RVUs of 1.42 for CPT code 94621, 0.70 for CPT code 946X2, and 0.48 for CPT code 946X3, along with the direct practice expense inputs for each service as recommended by the RUC.**

**43. Percutaneous Allergy Skin Tests (CPT code 95004)**

| CPT Code | Long Descriptor | CMS Proposed/ RUC Recommended Work RVU |
|---|---|---|
| 95004 | Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests | 0.01 |

CMS proposes refinements to the RUC recommendations for direct practice expense inputs.
**For the RUCs comments on individual refinements of direct PE inputs please see the attached refinement table.**

**44. Continuous Glucose Monitoring (CPT codes 95250 and 95251)**

| CPT Code | Long Descriptor | CMS Proposed/ RUC Recommended Work RVU |
|---|---|---|
| 95250 | Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; physician (office) provided equipment, sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording | 0.00 (PE Only) |
| 95251 | Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report | 0.70 |
| 9525X | Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; patient-provided equipment, sensor placement, hook-up, calibration of monitor, patient training and printout of recording | 0.00 (PE Only) |

In October 2016, the RUC established recommendations for the physician work and direct practice expense inputs for CPT codes 95250 and 95251; these codes are included in the 2018 NPRM.

The RUC recommendations from October 2016 for 95250 and 95251 were affirmed without change at the RUC meeting in April 2017. At this meeting, the RUC also established recommendations for the direct PE inputs for a newly approved PE-only code in this same code family, 9525X. The PE recommendations were derived by removing some of the direct PE inputs from 95250 without adding any inputs.

The CPT Editorial Panel has indicated that the new PE-only code 9525X, as well as codes 95250 and 95251 (with editorial revisions), will appear in the 2018 CPT coding manual. **Therefore, we request that, as an exception to policy, CPT code 9525X, as well as CPT codes 95250 and 95251, be considered and included in the 2018 Final Rule**. *The RUC recommendation for these services is included as an attachment to this letter* (see attachment 05).

We recognize that this request for inclusion of 9525X in the 2018 Final Rule represents an exception to policy since 9525X was not submitted to CMS in time for inclusion in the 2018 NPRM. However, we would point out that 9525X includes no physician work to be subject to public comment. In addition, the practice expense recommendations for 9525X were derived directly from 95250 by removal of some clinical staff time, supplies, and equipment, without any additions, and 95250 is included in the 2018 NPRM for public comment.

The RUC appreciates that CMS proposes the RUC recommended work RVU of 0.70 for CPT code 95251.

CMS states that they are concerned about the 2 minutes of physician pre-service time included in 95251 because this activity may be performed by clinical staff rather than by the physician and because this activity may be duplicative of activities included in the E/M service typically billed on the same day as 95251. The RUC took into account the work of the E/M and adjusted the values to remove duplicate activities. The pre-service evaluation time was reduced from a survey time of 6 minutes to 2 minutes and the immediate post-service time was reduced from a survey time of 10 minutes to 3 minutes. The RUC discussed and agreed that there is distinct work in the pre-service period separate from the E/M service and that obtaining the CGM report is not part of the E/M service.

The E/M services that could be reported with CPT code 95251 include various amounts of clinical staff time ranging from 0 to 4 minutes allocated for the clinical staff to "review/read x-ray, lab, pathology reports". These are different reports and not related to the CGM reports. Furthermore, the work of 95251 is completed well prior to the arrival of the patient and the beginning of the same-day E/M service. 52% of the time the E/M visit would occur on the same day as 95251, but after the work of 95251 is complete. The RUC has concluded that the retrieval of the CGM data and patient diary prior to interpretation of the CGM data is not included in the pre-service direct PE inputs for the E/M service, but is part of the physician pre-service time of the preceding 95251 service. **The RUC recommends that CMS finalize the proposed work RVU of 0.70 for CPT code 95251 with inclusion of 2 minutes of physician pre-service time.**

**45. Parent, Caregiver-Focused Health Risk Assessment (CPT codes 96160 and 96161)**

| CPT Code | Long Descriptor | CMS Proposed/ RUC Recommended Work RVU |
|---|---|---|
| 96160 | Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument | 0.00 (PE Only) |
| 96161 | Administration of caregiver-focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument | 0.00 (PE Only) |

**The RUC appreciates CMS review of these services and we agree with the refinement to aggregate the four distinct clinical activities into one direct PE input.**

**46. Chemotherapy Administration (CPT codes 96401, 96402, 96409, and 96411)**

| CPT Code | Long Descriptor | CMS Proposed/ RUC Recommended Work RVU |
|---|---|---|
| 96401 | Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic | 0.21 |
| 96402 | Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic | 0.19 |
| 96409 | Chemotherapy administration; intravenous, push technique, single or initial substance/drug | 0.24 |
| 96411 | Chemotherapy administration; intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure) | 0.20 |

For CY 2018, CMS are proposing the RUC-recommended work RVUs for this family of services. **The RUC agrees and recommends that CMS finalize the proposed work RVU of 0.21 for CPT code 96401, 0.19 for CPT code 96402, 0.24 for CPT code 96409 and 0.20 for CPT code 96411.**

For CPT code 96402, CMS are proposing the RUC-recommended equipment times with refinements for the biohazard hood (EP016) and exam table (EF023) from 31 minutes to 34 minutes to reflect the service period time associated with this code. CMS are proposing the RUC-recommended direct PE inputs for CPT codes 96401, 96409, and 96411 without refinements. **The RUC agrees with refinement to the biohazard hood (EP016) and exam table (EF023) from 31 minutes to 34 minutes to reflect the service period time associated with CPT code 96402, and will add this issue to the attached refinement table.**

**47. Photochemotherapy (CPT code 96910)**

| CPT Code | Long Descriptor | CMS Proposed/ RUC Recommended Work RVU |
|---|---|---|
| 96910 | Photochemotherapy; tar and ultraviolet B (Goeckerman treatment) or petrolatum and ultraviolet B | 0.00 (PE Only) |

The RUC appreciated that CMS is proposing the RUC recommended clinical activity times for the following direct PE inputs:

- 15 minutes for the *Prepare and position patient/monitor patient/set up IV*
- 16 minutes for the *Monitor patient during procedure*
- 15 minutes for the *Clean room/equipment by physician staff*

The RUC acknowledges the Agency's concern and consideration of maintaining the current time; however we do not agree that maintaining the current values would improve relativity. All 15 minutes are necessary for *Prepare and position patient/monitor patient/set up IV* because there is distinct work to prepare the patient for the procedure before the patient enters the whole body UV machine. This work occurs in the pre-service portion of the service period. During the 15 minutes, the nurse applies topical tar product and occlusive dressings (ie impermeable sauna suit, non-latex impermeable gloves and saran wrap) are applied over the tar. The tar product is allowed to penetrate for 4 hours and the patient has to be monitored once every half hour and helped to bathroom. After incubation, the tar is removed. UV protective topicals are applied to areas that the physician doesn't want exposed to UV. The patient also needs to be monitored for the duration of the treatment while they are in the in ultraviolet treatment unit. This takes place during the intra-service portion of the service period described as clinical activity *Monitor patient during procedure*. The nurse positions the patient in the whole body UV machine and then starts the exposure. After first exposure, the nurse moves the patient to the hand/foot UV machine, positions the patient properly and activates the second UV exposure. The narrow band ultraviolet treatment unit is loud and hot and the patient is naked and has petroleum/tar fumes generated from their body. The patient has no way to communicate with staff in a closed room and no way to stop treatment if they have a problem. The patient has to be closely monitored for the entire 16 minutes as the patient is often disoriented and may put themselves at risk by taking off the googles, touching the UV bulbs or sitting when they should not do so. The clinical activity, *Clean room/equipment by physician staff*, is allocated 15 minutes of clinical staff time because the room cleaning needed for this procedure is more than the standard room cleaning. The room has to be cleaned multiple times due to the tar, which has carcinogenic properties, for illuminating the patient for photochemotherapy. The room needs to be cleaned after the application of tar and then another cleaning is required after removing the tar. Lastly, the room is also cleaned a final time after the treatment is done. It takes a long time to clean the room with large equipment, which requires cleaning scale off of the bulbs and the ultraviolet treatment unit. **CMS should finalize the proposed direct practice expense inputs based on the RUC recommendation.**

**48. Photodynamic Therapy (CPT codes 96567, 96X73, and 96X74)**

| CPT Code | Long Descriptor | CMS Proposed/RUC Recommended Work RVU |
|---|---|---|
| 96567 | Photodynamic therapy by external application of light to destroy premalignant ~~and/or malignant~~ lesions of the skin and adjacent mucosa with application and ~~(eg, lip) by~~ illumination/activation of photosensitive drug(s), per day ~~each phototherapy exposure session~~ | 0.00 (PE Only) |
| 96X73 | Photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitizing drug(s), per day | 0.48 |
| 96X74 | Debridement of premalignant hyperkeratotic lesion(s) (ie, targeted curettage, abrasion) followed with photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitizing drug(s), per day | 1.01 |

CMS is proposing the RUC recommended work RVUs for CPT codes 96X73 and 96X74. CMS has proposed practice expense adjustments to 96X73 and 96X74. For the RUCs comments on minor, individual refinements of direct practice expense (PE) inputs for both codes, please see the attached PE refinement table.

CMS is specifically seeking comment on direct PE inputs with refinements due to inconsistencies between the stated description of clinical activities and the submitted spreadsheets. There was significant discussion regarding PE input issues at the RUC and the RUC's written recommendations discuss these issues in greater detail.

CMS has proposed to add 10 minutes of assist physician clinical staff time to 96X73 and 16 minutes to 96X74, which is equivalent to the physician intra-service times for these services. For both codes, CMS has proposed a decrease "from 35 minutes to 17 minutes for clinical activity in the post-service time, consistent with the description of clinical work in the summary of recommendations, which states that the patient receives activation of the affected area with the BLU-U Photodynamic Therapy Illuminator for approximately 17 minutes." **The RUC would like to point out that neither of these clinical activity time changes are listed in the CMS refinement table.** The RUC believes the post-service time reduction is inappropriate, considering the time staff has to prepare the room for the patient to incubate in a dark room for the period of time determined by a physician, as well as monitor the patient at irregular intervals during incubation. Staff reviews the treatment requirements and adheres to any reactions or complaints regarding the photosensitizing agent. In addition, staff monitors the following: pre-illumination topical skin scrub for removal of topical products; patient positioning for illumination and proper monochromatic eye protection application; patient receiving irradiation of the affected area with the BLU-U Photodynamic Therapy Illuminator for approximately 17 minutes; patient observation and continuous monitoring to provide intervention to any adverse reaction; application of interventions for discomfort and monitor treatment breaks; once illumination is complete, the application of photo-protective topical product, and application of dressing, when appropriate; instruction of patient

regarding post-procedure skin care, continued duration of photosensitivity, functional risks, and potential complications; communication with patient and family on post-procedural care and ensuring understanding of prescriptions; and schedule follow up. The RUC also highly recommends for CMS to maintain the equipment time for the power table because the patient has to stay on the table during the illumination period and the room isn't available for other patients' use.

For supply item LMX 4 percent cream (SH092), CMS has found an alternative vendor for significantly less than the existing $1.60 per gram. Based on CMS' research of vendors, the Agency is proposing to set the price of supply item SH092 to $0.78 per gram. The RUC is concerned with the price reduction of the LMX 4% cream. There may be online suppliers that promise to sell LMX 4% cream at a cheaper price; however, many physicians purchase drugs from reputable medical suppliers in order to insure the safety of their patients.

The RUC forwarded an invoice for a new supply item along with their recommendations and priced safety goggles at $6.00, requesting three goggles each for 96X73 and 96X74. CMS does not distinguish the requested new goggles from the existing UV-blocking goggles and considers this invoice to be an "additional price point for SJ027 rather than an entirely new item. CMS has proposed a price of $4.10 for supply item SJ027 (the average of the two prices for this supply item ($2.30 + $6.00)/2=$4.10))." The RUC disagrees with CMS on this issue. The safety goggles utilized in PDT are different than the UV-blocking googles that are listed in the supply list provided by CMS. The PDT goggles cover a different and necessary range of the electromagnetic spectrum that the ultraviolet goggles do not cover, and therefore should be priced at $6.00 per goggle.

**The RUC recommends that CMS implement the recommended work RVUs of 0.48 for CPT code 96X73 and 1.01 for CPT code 96X74, along with the direct practice expense inputs for each service as recommended by the RUC.**

**49. For RUC HCPAC comments on Physical Medicine and Rehabilitation (PM&R) (CPT codes 97012, 97016, 97018, 97022, 97032, 97033, 97034, 97035, 97110, 97112, 97113, 97116, 97140, 97530, 97533, 97535, 97537, 97542, and HCPCS code G0283), please see 2018 Proposed Rule RUC HCPAC Comment Letter**

**50. For RUC HCPAC comments on Management and/or Training: Orthotics and Prosthetics (CPT codes 97760, 97761, and 977X1), please see 2018 Proposed Rule RUC HCPAC Comment Letter**

**51. For RUC HCPAC comments on Cognitive Function Intervention (CPT code 97X11), please see 2018 Proposed Rule RUC HCPAC Comment Letter**

**52. INR Monitoring (CPT codes 993X1 and 993X2)**

| CPT Code | Long Descriptor | CMS Proposed/ RUC Recommended Work RVU |
|---|---|---|
| 993X1 | Patient/caregiver training for initiation of home INR monitoring under the direction of a physician or other qualified health care professional, including face-to-face, use and care of the INR monitor, obtaining blood sample, instructions for reporting home INR test results, and documentation of patient's/caregiver's ability to perform testing and report results | 0.00<br><br>(PE Only) |
| 993X2 | Anticoagulant management for a patient taking warfarin, must include review and interpretation of a new home, office, or lab International Normalized Ratio (INR) test result, patient instructions, dosage adjustment (as needed), and-scheduling of additional test(s) when performed | 0.18 |

In October 2015, AMA staff assembled a list of all services with total Medicare utilization of 10,000 or more that have increased by at least 100% from 2008 through 2013 and these services were identified. In January 2016, the RAW recommended to survey G0250 along with G0248 and G0249 for April 2016. In April 2016, the specialty society indicated that they intend to develop Category I codes to describe home INR monitoring services for the September 2016 CPT meeting with review at the January 2017 RUC meeting. The RUC recommended that codes G0248, G0249 and G0250 be referred to CPT to create Category I codes to describe these services. In September 2016, the CPT Editorial Panel deleted code 99363 and 99364 and created two new codes to replace G0248 and G0250.

The RUC recommended and CMS has proposed work RVUs of 0.00 for CPT code 993X1 and 0.18 for CPT code 993X2. In the RUC's original recommendation to CMS, the RUC recommended that G-codes G0248, G0249 and G0250 to be deleted. However, CMS has noted they do not intend to delete these G codes since they are "…used to report related services under a national coverage determination." **As the CPT Editorial Panel did not create a new code to replace HCPCS supply code G0249, the RUC withdraws its recommendation to delete that service.** The RUC reiterates its recommendation for CMS to delete codes G0248 and G0250, as these the work these services describe is fully replaced by new CPT codes 993X1 and 993X2, respectively. These G-codes were created to allow billing consistent with the national coverage determination (NCD), though the NCD does not name those codes or that they have to be described in that exact fashion. The G codes were written to bundle together the interpretation of 4 home tests, though that is not a specific requirement of the NCD. The new CPT codes were instead devised so that any interpretation of an INR could be billed per interpretation, regardless of the site the test was performed.

CMS' decision to both cover the new CPT codes and proposal to not delete the G-codes would cause confusion since G0248 and G0250, describe the same services as 993X1 and 993X2. If CMS does decide to keep G0248 and G0250, the Agency would need to issues guidance pertaining to what scenarios it would be appropriate to use the G-codes for going forward.

**The RUC recommends CMS finalize the proposed work RVU of 0.00 for CPT code 993X1 and 0.18 for CPT code 993X2, as well as to finalize the deletion of codes G0248 and G0250.** For the RUCs comments on individual refinements of direct PE inputs please see the attached refinement table.

**53. Psychiatric Collaborative Care Management Services (CPT codes 994X1, 994X2, 994X3, and 99XX5)**

| CPT Code | Long Descriptor | CMS Proposed/ RUC Recommended work RVU |
|---|---|---|
| 994X1 | Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional | 1.70 |
| 994X2 | Subsequent psychiatric collaborative care management**,** first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional | 1.53 |
| 994X3 | Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional (List separately in addition to code for primary procedure) | 0.82 |
| 99XX5 | Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month | 0.61 |

In the CY 2017 PFS final rule (81 FR 80230), CMS established separate payment for three services (HCPCS codes G0502, G0503, and G0504) under the psychiatric collaborative care model that paralleled CPT codes that were being created to report these services as well as a G-code for general behavioral health integration (BHI) services (HCPCS code G0507).

For CY 2018, the CPT Editorial Panel is creating CPT codes 994X1, 994X2, 994X3, and 99XX5 to describe these services. CMS are proposing the RUC-recommended work RVUs for each of these services, which are identical to the current values for HCPCS codes G0502, G0503, G0504, and G0507. CMS are proposing the RUC-recommended PE inputs, with one refinement. The RUC recommended values included clinical labor inputs in the facility setting, but CMS is not proposing to include these minutes in developing the facility PE RVUs. **For the RUCs comments on individual refinements of direct PE inputs please see the attached refinement table.**

## V. Technical Corrections for CY 2018 CMS Time File

The RUC reviewed the CY2018 NPRM Physician time file and discovered an issue with 108 codes which have incorrect immediate post-service times and total times. In the CY2014 *Final Rule,* CMS had stated that they would fix the issue, though due to the immediate post-service time for these codes never being corrected, this issue was never fully resolved.

In the 2013 *Proposed Rule*, CMS requested comments on methods of obtaining accurate and current data on Evaluation and Management services furnished as part of the global surgical package. CMS mentioned several examples of codes within the same family that had widely disparate levels of E/M visits listed in the physician time file. In the RUC's comment letter at the time, the RUC explained that in 2007 a data error occurred that inappropriately altered the post-operative hospital E/M visit information for over 100 codes. The RUC submitted the correct information to the Agency. CMS states in the CY2013 Final Rule that, "we are reviewing this file, and if appropriate, we intend to propose modifications to the physician time file in the CY 2014 PFS proposed rule."

For CY 2014 *Final Rule* CMS stated: "After extensive review, we believe that the data were deleted from the time file due to an inadvertent error as noted by the AMA RUC. To correct this inadvertent error, in the CY2014 *Proposed Rule*, we proposed to replace the missing post-operative hospital E/M visit information and time for the 117 codes that were identified by the AMA RUC and displayed in Table 14. Thus, we believe this correction will populate the physician time file with data that, absent the inadvertent error, would have been present in the time file."

For the CY2014 *Final Rule* time file, CMS did implement the correct number and level of post-operative visits and correct total times, though inadvertently kept erroneously inflated immediate post-service times for these codes. For CY2015 to present, this erroneous immediate post-service time was added back into the total time, resulting in the total times being again incorrect for these 100+ services.

As several of these codes have since been re-reviewed by the RUC and CMS, there are 108 codes that still have this issue. The correct times for these remaining 108 services are included (see attachment 06) to assist CMS in implementing this technical correction. An excerpt from the CY2014 final rule is also appended (see attachment 07) where the Agency stated that they would correct the erroneous times for these services.

**For the Agency's reference, we also provide a chronology of the issue for an example codes below**:

**33503** ***Repair of anomalous coronary artery from pulmonary artery origin; by graft, without cardiopulmonary bypass*****:**

**Correct times for Code 33503 from 2017 RUC Database:**

| CPT Code | Median Intra Service Time | Immediate Post Service Time | Total Time |
|---|---|---|---|
| 33503 | 240 | 45 | 838 |

**CY2013 CMS Final Rule Time File:**

| CPT Code | Median Intra Service Time | Immediate Post Service Time | Total Time |
|---|---|---|---|
| 33503 | 240 | 420 | 890 |

**CY2014 CMS Final Rule Time File:**

| CPT Code | Median Intra Service Time | Immediate Post Service Time | Total Time |
|---|---|---|---|
| 33503 | 240 | 420 | 838 |

**CMS Time file from CY2015 to present:**

| CPT Code | Median Intra Service Time | Immediate Post Service Time | Total Time |
|---|---|---|---|
| 33503 | 240 | 420 | 1213 |

*Other services identified for correction in the CMS Time file codes identified:*

| CPT Code | CY2018 CMS Time File Total Time | 2017 RUC Database Total Time | Difference in Total Time |
|---|---|---|---|
| 28122 | 249 | 230 | 19 |
| 46900 | 40 | 63 | -23 |
| 47562 | 228 | 251 | -23 |
| 76948 | 25 | 31 | -6 |
| 77767 | 22 | 32 | -10 |
| 93668 | 35 | 0 | 35 |
| 96904 | 80 | 0 | 80 |

For CPT code 28122 *Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); tarsal or metatarsal bone, except talus or calcaneus*, in the CY2012 Final Rule, CMS noted that the Agency was finalizing 0.5 99238 discharge visits. The CY2018 CMS Time File incorrectly still lists this service as having 1 99238 visit.

For CPT code 46900 *Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical*, the CY2018 CMS Time File is inadvertently omitting one 99213 post-operative visit for this 010-day global service. When this service was last reviewed by the Practice Expense Advisory Committee (PEAC) in March 2004, the PEAC recommended and CMS

agreed with 36 minutes of RN/LPN/MTA post-service period time, which corresponds with one 99213 office visit bundled into the 010-day global period. Therefore, the CY2018 direct PE inputs and the physician time file for this service do not match. In addition, the RUC first five year review recommendation submitted to CMS stated: "There is also a follow-up appointment within the 10-day global period to evaluate the anoderm and repeat the anoscopy."

For CPT code 47562 *Laparoscopy, surgical; cholecystectomy*, the CY2013 final rule only mentions refining pre-service time and does not reference not accepting RUC recommended post-op visits. The CMS time file should have 2 99213 post-operative visits, instead of one.

For CPT code 76948 *Ultrasonic guidance for aspiration of ova, imaging supervision and interpretation*, the CY2014 Final Rule said no refinement to RUC times for the interim final valuation of this service. For the CY2015 Final Rule, the text discussed removing pre-, post-times for a different service in this family of codes 76945, though it appears that this was inadvertently applied to both 76948 and 76945 in CMS time file.

For CPT code 77767 *Remote afterloading high dose rate radionuclide skin surface brachytherapy, includes basic dosimetry, when performed; lesion diameter up to 2.0 cm or 1 channel*, the CY2016 NPRM time file included the RUC recommended pre-, intra- and post-times though incorrect summed the total time (listed as CPT dummy code number 7778A). This error appears to have carried forward. Furthermore, there is no mention of time refinement in text for CY2016 final rule.

For CPT codes 93668 *Peripheral arterial disease (PAD) rehabilitation, per session* and 96904 *Whole body integumentary photography, for monitoring of high risk patients with dysplastic nevus syndrome or a history of dysplastic nevi, or patients with a personal or familial history of melanoma*, the RUC had recommended and CMS had agreed that these services do not include physician work. However, the CY2018 CMS Time file erroneously lists physician time for these services.

**The RUC Recommends for these services to be corrected in the CY2018 CMS Time file for the CY2018 Final Rule. The correct inputs for these 115 services are available under attachment 06.**

## VI. Publication of RUC Recommendations for Non-Covered/Bundled Medicare Services in the Medicare Physician Payment Schedule Proposed Rule for CY 2018

The RUC requests that CMS publish the values for non-covered/bundled Medicare services in which the RUC has made a recommendation. The American Medical Association (AMA) reviewed the need for CMS to publish the RVUs for non-covered and bundled Medicare services at the 2017 AMA House of Delegates Annual Meeting and determined that it is important for the Agency to publish relative values for all services, including non-covered and bundled services. There is a long-standing precedent established by the preventive medicine services codes (99381-99397) and other codes, which are Medicare status indicator "N," yet have had RUC recommended values published on the Medicare Physician Payment Schedule Appendix B since their inception.

We have identified 27 services reviewed by the RUC in which CMS has determined a Medicare status of "Bundled", "Not valid for Medicare purposes", "Non-covered" or "Contractor Priced" but did not publish the RUC recommended value.

It is imperative that the Agency publish the work, practice expense and professional liability insurance relative values for these 27 services (see attachment 08) in the Medicare Physician Payment Schedule

because the resource-based relative value scale (RBRVS) is used by Medicaid and many private payors. CMS established this precedent and the RUC requests that CMS continue to follow it. Physicians have reported problems seeking payment for these services by other payors because CMS simply has not published RVUs for these services.

## VII. Practice Expense 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 11, however there are many instances where the RUC disagrees with the refinements. Please see a complete list of the *CY 2018 Proposed Codes with Direct PE Input Recommendations Accepted with Refinement* with specialty society comments in the attached table (see attachment 09).

Thank you for your careful consideration of the RUC's comments on the CMS NPRM on the revisions to Medicare payment policies under the Physician Payment Schedule for calendar year 2018, published in the July 21, 2017 *Federal Register (Vol. 82, No. 139 FR, pages 33950-34203)*. Please do not hesitate to contact the RUC with questions about our recommendations and comments. We appreciate the continued opportunities to offer recommendations to improve the RBRVS.

Sincerely,

Peter K. Smith, MD

cc: RUC Participants
Edith Hambrick, MD
Ryan Howe
Karen Nakano, MD
Marge Watchorn
Michael Soracoe