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August 26, 2016

The Honorable Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1654-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: File Code-CMS-1654-P; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; (July 15, 2016).

Dear Acting Administrator Slavitt:

The American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) Notice of *Proposed Rule* Making (NPRM) on the revisions to Medicare payment policies under the Physician Payment Schedule for calendar year 2017, published in the July 15, 2016 *Federal Register (Vol. 81, No. 136 FR, pages 46162-46476)*.

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

- ***A.*** *PE RVU Methodology*
- ***B.*** *Practice Expense (PE) Inputs for Digital Imaging Services*
- ***C.*** *Standardization of Clinical Labor Tasks*
- ***D.*** *Clinical Labor Tasks Associated with Digital Imaging*
- ***E.*** *Equipment Recommendations for Scope Systems and Appropriate Direct PE Inputs Involved in Procedures Involving Endoscopes*
- ***F.*** *Appropriate Direct PE Inputs in the Facility Post-Service Period When Post-Operative Visits are Excluded*
- ***G.*** *Radiation Treatment Delivery, IMRT and IGRT G Codes*

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B. *PLI RVU Variation for Low Volume Services*

IV. Phase-in of Significant RVU Reductions

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ii. Insertion of Spinal Stability Distractive Device (CPT Codes 228X1, 228X2, 228X4, 228X5)

iii. Bone Biomechanical Device Insertion - Intervertebral, Interbody (CPT Codes 22X81, 22X82, 22X83)

iv. Closed Treatment of Pelvic Ring Fracture (CPT codes 271X1 and 271X2)

v. Bunionectomy (CPT codes 28289, 282X1, 28292, 28296, 282X2, 28297, 28298, and 28299)

vi. Endotracheal Intubation (CPT Codes 31500)

vii. Flexible Laryngoscopy (CPT codes 31575, 31576, 31577, 31578, 317X1, 317X2, 317X3, and 31579)

viii. Laryngoplasty (CPT codes 31580, 31584, 31587, and 315X1-315X6)

ix. Closure of Left Atrial Appendage with Endocardial Implant (CPT code 333X3)

x. Valvuloplasty (CPT codes 334X1 and 334X2)

xi. Mechanochemical (MOCA) Vein Ablation (CPT Codes 36X41, 364X2, 36475, 36476 36478, 36479)

xii. Dialysis Circuit (CPT codes 369X1, 369X2, 369X3, 369X4, 369X5, 369X6, 369X7, 369X8, 369X9)

xiii. Esophageal Sphincter Augmentation (CPT codes 432X1 and 432X2)

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

xv. Cystourethroscopy (CPT code 52000)

xvi. Biopsy of Prostate (CPT code 55700)

xvii. Hysteroscopy (CPT codes 58555-58563)

xviii. Epidural Injections (CPT codes 623X5, 623X6, 623X7, 623X8, 623X9, 62X10, 62X11, and 62X12) *Rejected PE Only*

xix. Endoscopic Decompression of Spinal Cord Nerve (CPT Codes 630X1)

xx. Retinal Detachment Repair (CPT codes 67101 and 67105)

xxi. Fluoroscopic Guidance (CPT codes 77001, 77002, and 77003)

xxii. Radiation Treatment Devices (CPT codes 77332, 77333, and 77334)

xxiii. Special Radiation Treatment – CPT Code 77470 Rejected *PE Only*

xxiv. Flow Cytometry Interpretation (CPT codes 88184, 88185, 88187, 88188, and 88189)

xxv. Mammography - Computer Aided Detection Bundling (CPT codes 770X1, 770X2 and 770X3) *Rejected PE Only*

xxvi. Closure of Paravalvular Leak (CPT codes 935X1, 935X2, and 935X3)

xxv. Parent, Caregiver-Focused Health Risk Assessment (CPT Codes 961X0, 961X1)

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

xxvii. Prostate Biopsy, Any Method (HCPCS code G0416)

D. *Valuation of Specific Codes CY 2017 Proposed Codes That Were Also CY 2016 Proposed Codes*

i. Genitourinary Procedures (CPT codes 50606, 50705, and 50706)

ii. Immunohistochemistry (CPT Codes 88341, 88342, 88344, and 88350)

iii. Morphometric Analysis (CPT Codes 88364, 88365, 88367, 88368, 88369, and 88373)

iv. Open and Percutaneous Transluminal Angioplasty (CPT codes 372X1, 372X2, 372X3, and 372X4)

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

vi. Intracranial Endovascular Intervention (CPT codes 61645, 61650, and 61651)

VI. Valuing Services that Include Moderate Sedation

A. *Moderate Sedation Services (CPT Codes 991X1, 991X2, 991X3, 991X4, 991X5, 991X6)*

B. *Proposed Valuation of Services Where Moderate Sedation is an Inherent Part of the Procedure (CPT Appendix G Services)*

VII. Collecting Data on Resources Used in Furnishing Global Services

VIII. Practice Expense Refinement Table

IX. Improving Payment Accuracy for Primary Care and Care Management Services

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

A. PE RVU Methodology

For CY 2016, CMS finalized a policy to use the average of the three most recent years of available Medicare claims data to determine the specialty mix assigned to each code. This policy applied to the development of both the professional liability insurance (PLI) and practice expense (PE) relative value units (RVUs). Since the proposed PE RVUs include a new year of claims into the three year average for the first time, the Agency is seeking comment on the CY 2017 RVUs and whether or not the policy mitigates the need for alternative service-level overrides.

While in general the RUC is supportive of the three year average policy, we remain concerned that for low volume codes, even a multi-year average creates distortions that cause wide variability for these services. An analysis of the PE and PLI RVUs for low volume services shows fluctuations to RVUs, which should otherwise be stable, due to their rarity of Medicare claims (see section on PLI RVUs). **Given these fluctuations, the RUC recommends that CMS accept the attached list of service-level overrides to determine the specialty mix** *(see Addendum A - PLI Low Volume Overrides-Final)***. This list has input from specialty societies and has been provided to the Agency previously.** The current override list of 54 codes is clearly not adequate in easing the volatility in year-to-year RVU changes for low volume codes.

B. Practice Expense (PE) Inputs for Digital Imaging Services

The RUC appreciates CMS' acknowledgement that the professional workstation is similar in principle to the previous direct film inputs in the practice expense database and incorporated into the PE RVU of both the global and technical components for applicable codes. CMS proposes incorporating the professional PACS workstation at a price of $14,616.93 based on submitted invoices. We appreciate this step and we encourage CMS to reconsider the three items of equipment that specialties submitted invoices for that were not incorporated into the price for the professional PACS workstation. The equipment items are listed below:

- 3rd & 4th monitor (for speech recognition, etc.) - Dell Ultra HD priced at $1,715.98
- Admin Monitor (the extra working monitor) priced at $279.27
- Powerscribe Mic priced at $424.00

Although CMS did not include a rationale for excluding the above items, the RUC infers that monitors and microphones for speech recognition were assumed to be atypical. However, the RUC found that various specialties, including but not limited to Radiology, indicate that speech recognition equipment is typical for a professional PACS workstation. Family Medicine indicated that the physician typically has a dedicated computer and monitor and the monitor has greater resolution than what the physician typically uses for other purposes (e.g. electronic medical record), but they would not have the same equipment as a professional PACS workstation. Family Medicine also indicated that it is not typical for their specialty to have a separate power backup for the system or a switch, because the power backup is typically a shared generator.

The RUC appreciates CMS acceptance of the RUC recommendation to tie the equipment time of the professional PACS workstation to the physician work pre-service and intra-service time. CMS is proposing to assign equipment time equal to the intra-service work time plus half of the pre-service physician work time associated with the codes. The RUC encourages CMS to reconsider this policy and

allocate the entire pre-service physician work time associated with the codes as the RUC recommended at the January and April RUC meetings. The RUC understands that certain physician work activities in the pre-service period, such as reviewing lab studies may not directly involve the professional workstation. However, even when the physician is engaged in these parallel work activities, the professional workstation is "open" to the patient at hand and unavailable for other patients. The RUC also disagrees with the CMS proposal to use half the total time for older codes in which there is only a total time and no separation of pre-service and intra-service period times. The RUC encourages CMS to use the total time for the professional PACS Workstation rather than half as there is no accurate way to estimate the pre- and intra-service time. Also, there are a limited number of codes that this applies to and using half the total time will cause confusion about the equipment formula for the workstation in the future.

The RUC recommends that CMS amend the proposed components of the professional PACS Workstation to include the three additional items bulleted above. The RUC also recommends that the full pre-service and intra-service times be used to determine the equipment time for the professional PACS workstation. In instances where there is only total time, the RUC recommends using the total time for the professional PACS workstation equipment time as there is no more granular way to determine the time the equipment is in use.

The RUC applauds CMS for proposing to include the new professional PACS workstation for the 426 codes listed in table 4 of the *Proposed Rule*. The RUC supports CMS proposal to add the professional PACS workstation to all codes that currently use the technical PACS workstation (ED050), however the RUC disagrees 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. 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 recommends that CMS expand the proposed list of 426 codes within the 70000 series to include all add-on codes and therapeutic services. Additionally, the RUC has included a list of services outside of the 70000 series that currently include the technical PACS workstation (ED050). Specialty societies were asked to indicate services on this list that they recommend a professional PACS workstation be added to and their rationale. The RUC recommends adding the professional PACS workstation to all services where the specialties indicated "Yes" in column Q in the attached spreadsheet *(see Addendum B - Prof PACS Codes not in NPRM for Review_Spec Comment)***. The list also includes the following codes within the 70000 series that CMS asked for comment on specifically: 77002, 77003, 77011, 77071, 77073, 77077, 77080, 77081, 77085, and 77086. As indicated by the specialties the RUC recommends that all of these codes except for 77071 include a professional PACS workstation in the direct PE inputs for 2017.**

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. This is evidenced by the RUC's efforts to consolidate the number of clinical labor activities and implement a coding system for those clinical labor activities through the PE Spreadsheet Update Workgroup. 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. *Clinical Labor Tasks Associated with Digital Imaging*

Table 5: Clinical Labor Tasks Associated with Digital Imaging Technology

Clinical Labor Task	Typical Minutes
Availability of prior images confirmed	2
Patient clinical information and questionnaire reviewed by technologists, order from physician confirmed and exam protocoled by radiologist.	2
Review examination with interpreting MD	2
Exam documents scanned into PACS. Exam completed in RIS system to generate billing process and to populate images into Radiologists work queue.	1

In the CY 2016 PFS *Final Rule* with comment period, CMS finalized appropriate standard minutes associated with the four clinical labor activities listed in Table 5 above. CMS did not finalize standard minutes for the activity "Technologist QC's images in PACS, checking for all images, reformats, and dose page" based on agreement with stakeholder comments that this QC task may require a variable length of time depending on the modality and images obtained. In this proposed rule, CMS proposes:

> "…2 minutes as the standard for the simple case, 3 minutes as the standard for the intermediate case, and 4 minutes as the standard for the complex case. We are proposing the simple case of 2 minutes as the standard for the typical procedure code involving routine use of imaging. These values are based upon a review of the existing minutes assigned for this clinical labor activity; we have determined that 2 minutes is the duration for most services and a small number of codes with more complex forms of digital imaging have higher values. We are proposing to use 2 minutes for services involving routine x-rays (simple) , 3 minutes for services involving CTs and MRIs (intermediate), and 4 minutes for the most highly complex services which would exceed these more typical cases."

The RUC supports an effort to establish categories to capture general ranges of standard minutes but cautions against applying those categories to specific modalities, as this activity could vary for services even within the same modalities. For example, a complex contrast enhanced cardiac CT will require more QC time than a non-contrast CT of a different less complex body part. There are a number of criteria that can be used to judge the complexity of a case when deciding how much time is appropriate for the clinical labor activity *Technologist QCs images in PACS*. The most common and quantifiable variables to use include the number of images, phases of contrast enhancement, number and types of reconstructions created, the need to use separate post-processing software and workstation, and the training required by the technologist to perform and therefore assess the quality of the exam (e.g. additional training is needed to perform cardiac and other time/motion gated exams, as well as many MRI exams including cardiac and fetal MRI). Most of this data is not recorded in the RUC database and is clinically oriented. The RUC continues to disagree with the need for a standard time for this clinical labor activity and continues to urge CMS to consider adjudication on a code by code basis at the RUC. If CMS is determined to set standard times for *Technologist QCs images in PACS*, the RUC advocates that at a minimum greater granularity is necessary than that which CMS proposes.

Short of no standard times at all, the RUC proposes the establishment of categories as follows: simple (2 min); intermediate (3 min), complex (4 min) and highly complex (5 min).

E. *Equipment Recommendations for Scope Systems and Appropriate Direct PE Inputs Involved in Procedures Involving Endoscopes*

The RUC is interested in providing comment on the separate pricing structure that CMS has proposed for scopes, scope video systems, and scope accessories as well as the appropriate endoscopic equipment and supplies for endoscopic procedures. Because of the complexity of this issue and the need to incorporate input from all specialty societies, the RUC has determined that the best approach to this issue is to form a Workgroup of the PE Subcommittee and review both issues at once. The Chair of the Subcommittee will select the members of the Workgroup at the October RUC meeting with the goal of submitting a recommendation to CMS in time to be considered for CMS' 2018 *Proposed Rule*. Given that the RUC has not had the opportunity to evaluate the separate pricing structure for scopes proposal and provide input from all specialty societies and that CMS has acknowledged that and requested input regarding the overall concept, the RUC is confused by CMS implementation of the proposal for the flexible laryngoscopy family (CPT codes 31575, 31576, 31577, 31578, 315X1, 315X2, 315X3, 31579) and the Laryngoplasty family (CPT codes 31580, 31584, 31587, 315Y1, 315Y2, 315Y3, 315Y4, 315Y5, 315Y6). Additionally, the RUC would like to point out that for the flexible laryngoscopy codes CMS obtained quotes from a vendor in order to revalue direct PE inputs within rulemaking. If CMS is willing to rely on vendor pricing, the RUC requests that specialty societies should also be allowed to submit quotes for pricing as they are much easier to obtain than paid invoices which many practices are unable to share. CMS should also be transparent about which companies they have obtained quotes from and why they feel they are appropriate to use rather than more accurate invoices supplied by specialties via the RUC process.

The RUC urges CMS to implement the RUC recommended direct PE inputs and postpone action on the proposed changes for scopes within the flexible laryngoscopy and laryngoscopy codes pending RUC recommendations on the subject.

F. *Appropriate Direct PE Inputs in the Facility Post-Service Period When Post-Operative Visits are Excluded*

CMS identified the codes in the table below as potentially inconsistent in instances where there are direct PE inputs included in the facility postservice period even though post-operative visits are not included in a service.

21077 Impression and preparation of eye socket prosthesis
21079 Impression and custom preparation of temporary oral prosthesis
21080 Impression and custom preparation of permanent oral prosthesis
21081 Impression and custom preparation of lower jaw bone prosthesis
21082 Impression and custom preparation of prosthesis for roof of mouth enlargement
21083 Impression and custom preparation of roof of mouth prosthesis
21084 Impression and custom preparation of speech aid prosthesis
66986 Exchange of lens prosthesis

For CPT codes 21077-21084 listed in the table, the RUC reviewed these services for work in 1994 and it was discussed that there is extensive work that is performed by a lab technician and a nurse to produce and fit patients with these extremely individualized prosthetics. The RUC reviewed detailed time data collected by American Academy of Maxillofacial Prosthetics and were able to differentiate physician time from technician time. This data was not in the survey format that we currently use and post-operative visits were bundled into the total time. This is why these services are listed as CMS/Other. The practice expense time in the postservice period in the facility setting is completely distinct from the physician post-operative visits. Time must be accounted for the manufacture and fitting of the prosthetics and in 1995 when CMS accepted the RUC recommendations for these services they chose to place the time in the post service period.

28636 Insertion of hardware to foot bone dislocation with manipulation, accessed through the skin
28666 Insertion of hardware to toe joint dislocation with manipulation, accessed through the skin

For CPT codes 28636 and 28666 a cast or splint would be required as evidence by the cast related supplies. These types of services routinely place the time to remove the cast in the post-service period. This time is performed by clinical staff and is completely distinct from the physician work time.

43652 Incision of vagus nerves of stomach using an endoscope

The RUC reviewed CPT code 43652 for physician work in 1993. The code number changed in 2000 from 56323. This occurred at the same time that CMS began reviewing practice expense inputs through the Practice Expense Advisory Committee (PEAC). It appears that the hospital and office visits assigned were dropped from the database in the renumbering process. It is clear from a review of the 1997-1998 changes in work RVUs for this code (corresponding to the global change for increases in E/M services) that the visits were included in the visit data for this code. In addition, the PEAC utilized two 99213 in March 2001 and submitted the spreadsheet to CMS. The spreadsheet is provided as an attachment with this letter *(see Addendum C - CMS PE Refinements w spec comment)*.

The RUC recommends that two 99213 post-operative visits be reinstated into the CMS time file. The RUC will also correct the RUC database.

47570 Connection of gall bladder to bowel using an endoscope

The RUC reviewed CPT code 47570 for physician work in 1993. The code number changed in 2000 from 56324. This occurred at the same time that CMS started the PEAC. It appears that the hospital and office visits assigned were dropped from the database in the renumbering process. It is clear from a review of the 1997-1998 changes in work RVUs for this code (corresponding to the global change for increases in E/M services) that the visits were included in the visit data for this code. The office visits were recommended by the specialty societies, approved by the RUC and accepted by CMS as two 99212. In addition the PEAC utilized two 99212 for the facility setting in March 2001 and submitted the spreadsheet to CMS. The spreadsheet is provided as an attachment with this letter *(Addendum D - PE for Table 8 Response 00 19120-5 47562-47570)*.

The RUC recommends that two 99212 post-operative visits be reinstated into the CMS time file. The RUC will also correct the RUC database.

46900 Chemical destruction of anal growths

For code 46900, it appears that the "RUC survey data" tab does not include an office visit in error; however, the CMS time file is correct. It is clear from a review of the 1997-1998 changes in work RVUs for this code (corresponding to the global change for increases in E/M services) that one 99213 was included in the visit data for this code. The spreadsheet data for this code is provided as an attachment with this letter *(Addendum E - PE for Table 8 Response 01 46900, 45520, 46500 March_04 PEAC Revised by PEAC)*. In addition, the CMS time and visit file received from HCFA on 7/21/1997 include one 99213. In addition the PEAC utilized one 99213 in March 2004 and submitted the spreadsheet to CMS.

The RUC agrees that one 99213 post-operative visit is correct for this code. The RUC will correct the RUC database RUC survey data tab.

TABLE 8: Codes that have Direct PE Inputs in the Facility Postservice Period when Post-Operative Visits are Excluded	
CPT Code	**Long Descriptor**
21077	Impression and preparation of eye socket prosthesis
21079	Impression and custom preparation of temporary oral prosthesis
21080	Impression and custom preparation of permanent oral prosthesis
21081	Impression and custom preparation of lower jaw bone prosthesis
21082	Impression and custom preparation of prosthesis for roof of mouth enlargement
21083	Impression and custom preparation of roof of mouth prosthesis
21084	Impression and custom preparation of speech aid prosthesis
28636	Insertion of hardware to foot bone dislocation with manipulation, accessed through the skin
28666	Insertion of hardware to toe joint dislocation with manipulation, accessed through the skin
43652	Incision of vagus nerves of stomach using an endoscope
46900	Chemical destruction of anal growths
47570	Connection of gall bladder to bowel using an endoscope
66986	Exchange of lens prosthesis

G. *Radiation Treatment Delivery, IMRT and IGRT G Codes*

In the CMS *Final Rule* for 2016, CMS did not finalize its proposal to implement the new set of conventional radiation treatment delivery, IMRT or IGRT codes. CMS instead decided to retain the 2015 G-codes and values for another year. In December 2015, Congress passed and the President signed into law the Patient Access and Medicare Protection Act (PAMPA). PAMPA freezes the Treatment Delivery, IMRT and IGRT G Codes and the associated "definitions, units, and inputs for such services" for 2017 and 2018.

In the CMS *Proposed Rule* for 2017 CMS proposes a non-facility practice expense RVU for G6011 *Radiation Treatment Delivery* of 8.09, a 10 percent decrease from the current 9.03 non-facility PE RVU. The direct practice expense inputs (i.e. clinical labor, supplies, equipment) have not changed from the current inputs in the CMS direct PE inputs database. G6011 is used by various specialties (i.e. radiation oncology, hematology, medical oncology, etc.) and the RUC is seeking clarification from the CMS regarding the decrease.

II. Technical Corrections Needed

The RUC has identified several errors which are detailed below. We anticipate all the changes in this section will be implemented as technical corrections immediately in CMS files to be ready for both the CY2017 MFS Final Rule and January 1, 2017 payments.

Follow the publication of the CY2017 NPRM, the AMA notified CMS of the below errors in Addendum B:

CPT Code	Mod	Short Descriptor	Incorrect Work RVU - CY2017 NPRM Addendum B	Proposed Work RVU- CY2017 NPRM Text
66170		Glaucoma surgery	11.27	13.94
66172		Incision of eye	12.57	14.84
67107		Repair detached retina	14.06	16.00
67108		Repair detached retina	15.19	17.13
67110		Repair detached retina	8.31	10.25
78264		Gastric emptying study	0.74	0.79
78264	26	Gastric emptying study	0.74	0.79

For the above 6 physician services, CMS proposed to accept the 2016 refinement panel recommended work RVU in the text of the CY2017 NPRM. The Agency did not also update the work RVUs for these services in the Addendum B file. Also, as these errors would have impacted the formula CMS uses to derive PE RVUs, the PE RVUs should be corrected as well. The RUC expects CMS will address these errors immediately in the CMS files and appropriately update the work RVUs for these services to be ready for both the CY2017 MFS Final Rule and January 1, 2017 payments.

III. Determination of Professional Liability Insurance (PLI) RVUs

A. CY 2017 GPCI Update PLI premium data update

CMS notes that the proposed CY 2017 GPCI update collected 2014 PLI premium data for the purpose of proposing updates to the PLI GPCIs. However, CMS proposes to not use this data to update the current 2011 premium data used in the creation of the PLI RVUs since it goes against their stated policy of only updating premium data every five years for PLI RVUs. The RUC disagrees with the CMS proposal. The RUC is on record as favoring a yearly collection schedule of premium data. However, since CMS has rejected that recommendation, the most recent available PLI premium data should be used. Review of the *Draft Report on CY 2017 GPCI Update* by Acumen shows that they conducted a similarly robust collection method as the CY 2015 premium data collection for PLI RVUs. With these data readily available to the Agency, there seems to be no logistical reason not to update the PLI RVUs accordingly.

The RUC recommends CMS use the 2014 PLI premium data collected as part of the CY 2017 GPCI update in the creation of PLI RVUs for CY 2017.

B. PLI RVU Variation for Low Volume Services

Beginning in CY 2016, CMS modified the specialty mix assignment methodology to use an average of the three most recent years of available data instead of a single year of data, as was the current policy.

In addition, CMS recognized a list of 54 CPT codes that would receive specific specialty mix overrides, due to their extremely low, or non-existent, Medicare volume.

The RUC has undergone a broad analysis of PLI RVUs proposed for CY 2017 and has found a worrying level of variation across many of the nearly 2,000 codes performed less than 100 times in Medicare for 2015. The RUC has always been concerned about variation within these low volume codes, was skeptical that utilizing a 3 year average of claims data would correct this problem. It appears that for many of the services, large year-to-year variation is still occurring. These fluctuations in PLI RVUs are unfair to physicians who pay the same PLI premiums, but receive differing payment from year to year. For example, four codes are listed in the below table that should have stable PLI RVUs from 2016 to 2017. Each has only one year of Medicare volume from the past three years and have unchanged work RVUs. However, their PLI RVUs have changed dramatically.

CPT code	Descriptor	2016 & 2017 work RVU	2016 PLI RVU	2017 PLI RVU	Medicare Volume		
					2013	2014	2015
26553	Single transfer toe-hand	48.17	9.94	6.49	-	1	-
33470	Revision of pulmonary valve	21.54	5.14	2.90	1	-	-
49496	Rpr strang or incarcer ing hernia	9.42	2.30	1.02	-	4	-
63195	Incise spine & cord thoracic	21.64	9.02	2.90	-	3	-

It is important to state that CMS actions regarding PLI are translated into payment errors by Medicaid and other payers who represent the actual beneficiaries of these procedures, but who are not represented in the Medicare utilization data. As well, the providers are often highly specialized such that these procedures represent a large proportion of their practices. Thus, while the low Medicare volume of these procedures might appear to be inconsequential, persistent errors CMS valuation are resulting in major adverse impacts on the providers of these services

Given the pervasiveness of this issue, and the fact that the blended malpractice risk factor is inevitably and predictably lower than actual, the RUC maintains that for all low volume Medicare services, an override should be created to an appropriate primary specialty.

The RUC has exhaustively developed a list of such services with the appropriate assigned specialty which has been variably and inconsistently utilized, often in contradiction to stated agreement by CMS. As we've submitted in the past, attached to this letter is a list of low volume services, reviewed by specialty societies and approved by the RUC, with recommended specialty overrides *(see Addendum A - PLI Low Volume Overrides-Final)*. We strongly recommend that CMS revise the specialty specific risk factors assigned to these codes utilizing this list, and make appropriate adjustments to the specialty specific PE inputs as well.

The RUC recommends that CMS perform a thorough review of their methodology for implementing PLI RVUs, especially for low Medicare volume services. Furthermore, to reduce large variations in year-to-year PLI RVUs, CMS should accept the RUC recommended specialty overrides.

IV. Phase-in of Significant RVU Reductions

CMS proposes for all codes not new or revised to have the 19 percent reduction in total RVUs continue to be the maximum one-year reduction. The RUC agrees with this proposal. Having significant reductions to any service can be disruptive to physician practices. Easing these disruptions by setting a ceiling on the amount of reductions in any one year is a reasonable and fair approach.

The RUC recommends that CMS finalize its proposal to set a 19 percent reduction ceiling on all existing codes.

V. CY 2017 Identification and Review of Potentially Misvalued Services

A. RUC Progress in Identifying and Reviewing Potentially Misvalued Codes

Since the inception of the Relativity Assessment Workgroup, the RUC and the Centers for Medicare and Medicaid Services (CMS) have identified over 2,100 services through 16 different screening criteria for further review by the RUC. The RUC has recommended reductions and deletions to 1,206 services, more than half of the services identified, redistributing nearly $4 billion. The RUC looks forward to working with CMS on a concerted effort to address potentially misvalued services. *A detailed report of the RUC's progress is appended to this letter.*

B. CMS Identified Potentially Misvalued Services

i. 000-Day Global Services that are Typically Billed with an Evaluation and Management (E/M) Service with Modifier 25

CMS identified 83 services with a 000-day global period billed with an E/M 50 percent of the time or more, on the same day of service, same patient, by the same physician, that have not been reviewed in the last five years with Medicare utilization greater than 20,000. The RUC appreciates CMS' identification of an objective screen and reasonable query. However, based on further analysis of the codes identified, it appears only 19 services met the criteria for this screen and have not been reviewed to specifically address an E/M performed on the same date. There are 38 codes that do not meet the screen criteria; they were either reviewed in the last 5 years and/or are not typically reported with an E/M. For 26 codes, the SOR, RUC rationale or practice expense inputs submitted specifically states that an E/M is typically reported with these services and the RUC accounted for this in its valuation.

The RUC does not believe that 000-day global services already adjusted for physician time and work when an E/M is typically performed, such as identified with the osteopathic manipulation treatment (OMT) services (98925-98929), warrant further review. The RUC already accounted for the typical reporting conventions in its most recent review. The RUC does not understand why CMS is requesting another review of the OMT codes, as CMS acknowledges this issue was accounted for in the current valuation.

The RUC requests that CMS remove the 64 services identified in the table below that do not meet the screen criteria or which have already been valued as typically being reported with an E/M service. The RUC requests that CMS condense and finalize the list of services for this screen to the 19 remaining services. The RUC Relativity Assessment Workgroup will review the 19 services identified that have not been reviewed as typically being reported with an E/M service. *Please see the fully detailed table attached to this letter for additional information supporting the RUC request to remove the 64 codes identified (see Addendum F - 000 Day Reported with EM).*

Table 7: 000-Day Global Services Typically Reported with an E/M
RUC requests to remove the following:

CPT	Long Descriptor	Total with E/M	Most Recent RUC Survey	CPT Year	RUC Comment to NPRM for 2017
11000	Debridement of extensive eczematous or infected skin; up to 10% of body surface	45%	Aug95	1997	Does not meet screen criteria; not typically reported with an E/M
11100	Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion	79%	Aug05	2007	*RUC rationale stated typically reported with an E/M and the RUC accounted for this in its valuation.*
11300	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less	74%	Apr12	2013	Does not meet screen criteria; surveyed within the last 5 years and the last RUC review summary of recommendation form submitted indicated that this service is typically reported with an E/M and accounted for this in its valuation. "Several of the shave codes are performed over 50% of the time with an evaluation and management service. To be consistent, it was the judgment of the specialty societies that the entire family should be treated as if it was billed with an E&M, to maintain relativity across of the family. Thus, modifications were made to the pre-service time package extracting time to account for this type of reporting."

Table 7: 000-Day Global Services Typically Reported with an E/M
RUC requests to remove the following:

CPT	Long Descriptor	Total with E/M	Most Recent RUC Survey	CPT Year	RUC Comment to NPRM for 2017
11301	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm	73%	Apr12	2013	Does not meet screen criteria; surveyed within the last 5 years and the last RUC review summary of recommendation form submitted indicated that this service is typically reported with an E/M and accounted for this in its valuation. "Several of the shave codes are performed over 50% of the time with an evaluation and management service. To be consistent, it was the judgment of the specialty societies that the entire family should be treated as if it was billed with an E&M, to maintain relativity across of the family. Thus, modifications were made to the pre-service time package extracting time to account for this type of reporting."
11302	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 1.1 to 2.0 cm	67%	Apr12	2013	Does not meet screen criteria; surveyed within the last 5 years and the last RUC review summary of recommendation form submitted indicated that this service is typically reported with an E/M and accounted for this in its valuation. "Several of the shave codes are performed over 50% of the time with an evaluation and management service. To be consistent, it was the judgment of the specialty societies that the entire family should be treated as if it was billed with an E&M, to maintain relativity across of the family. Thus, modifications were made to the pre-service time package extracting time to account for this type of reporting."

Table 7: 000-Day Global Services Typically Reported with an E/M
RUC requests to remove the following:

CPT	Long Descriptor	Total with E/M	Most Recent RUC Survey	CPT Year	RUC Comment to NPRM for 2017
11305	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less	48%	Apr12	2013	Does not meet screen criteria; surveyed within the last 5 years and data show not typically reported with an E/M. However, last RUC review summary of recommendation form submitted indicated that this service is typically reported with an E/M and accounted for this in its valuation. "Several of the shave codes are performed over 50% of the time with an evaluation and management service. To be consistent, it was the judgment of the specialty societies that the entire family should be treated as if it was billed with an E&M, to maintain relativity across of the family. Thus, modifications were made to the pre-service time package extracting time to account for this type of reporting."
11306	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm	58%	Apr12	2013	Does not meet screen criteria; surveyed within the last 5 years and the last RUC review summary of recommendation form submitted indicated that this service is typically reported with an E/M and accounted for this in its valuation. "Several of the shave codes are performed over 50% of the time with an evaluation and management service. To be consistent, it was the judgment of the specialty societies that the entire family should be treated as if it was billed with an E&M, to maintain relativity across of the family. Thus, modifications were made to the pre-service time package extracting time to account for this type of reporting."

Table 7: 000-Day Global Services Typically Reported with an E/M
RUC requests to remove the following:

CPT	Long Descriptor	Total with E/M	Most Recent RUC Survey	CPT Year	RUC Comment to NPRM for 2017
11307	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm	57%	Apr12	2013	Does not meet screen criteria; surveyed within the last 5 years and the last RUC review summary of recommendation form submitted indicated that this service is typically reported with an E/M and accounted for this in its valuation. "Several of the shave codes are performed over 50% of the time with an evaluation and management service. To be consistent, it was the judgment of the specialty societies that the entire family should be treated as if it was billed with an E&M, to maintain relativity across of the family. Thus, modifications were made to the pre-service time package extracting time to account for this type of reporting."
11310	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less	66%	Apr12	2013	Does not meet screen criteria; surveyed within the last 5 years and the last RUC review summary of recommendation form submitted indicated that this service is typically reported with an E/M and accounted for this in its valuation. "Several of the shave codes are performed over 50% of the time with an evaluation and management service. To be consistent, it was the judgment of the specialty societies that the entire family should be treated as if it was billed with an E&M, to maintain relativity across of the family. Thus, modifications were made to the pre-service time package extracting time to account for this type of reporting."

Table 7: 000-Day Global Services Typically Reported with an E/M
RUC requests to remove the following:

CPT	Long Descriptor	Total with E/M	Most Recent RUC Survey	CPT Year	RUC Comment to NPRM for 2017
11311	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm	68%	Apr12	2013	Does not meet screen criteria; surveyed within the last 5 years and the last RUC review summary of recommendation form submitted indicated that this service is typically reported with an E/M and accounted for this in its valuation. "Several of the shave codes are performed over 50% of the time with an evaluation and management service. To be consistent, it was the judgment of the specialty societies that the entire family should be treated as if it was billed with an E&M, to maintain relativity across of the family. Thus, modifications were made to the pre-service time package extracting time to account for this type of reporting."
11312	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm	64%	Apr12	2013	Does not meet screen criteria; surveyed within the last 5 years and the last RUC review summary of recommendation form submitted indicated that this service is typically reported with an E/M and accounted for this in its valuation. "Several of the shave codes are performed over 50% of the time with an evaluation and management service. To be consistent, it was the judgment of the specialty societies that the entire family should be treated as if it was billed with an E&M, to maintain relativity across of the family. Thus, modifications were made to the pre-service time package extracting time to account for this type of reporting."
11740	Evacuation of subungual hematoma	30%			Does not meet screen criteria; not typically reported with an E/M

Table 7: 000-Day Global Services Typically Reported with an E/M
RUC requests to remove the following:

CPT	Long Descriptor	Total with E/M	Most Recent RUC Survey	CPT Year	RUC Comment to NPRM for 2017
11900	Injection, intralesional; up to and including 7 lesions	71%	Apr10	2011	*SOR stated not reported with E/M, no duplication in description of pre or post-service time.*
11901	Injection, intralesional; more than 7 lesions	58%	Apr10	2011	*SOR stated not reported with E/M, no duplication in description of pre or post-service time.*
12001	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less	82%	Apr10	2011	*SOR stated a separately identifiable E/M service may be reported if appropriate and the RUC accounted for this in its valuation.*
12002	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm	84%	Apr10	2011	*SOR stated a separately identifiable E/M service may be reported if appropriate and the RUC accounted for this in its valuation.*
12004	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 7.6 cm to 12.5 cm	84%	Apr10	2011	*SOR stated a separately identifiable E/M service may be reported if appropriate and the RUC accounted for this in its valuation.*
12011	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less	85%	Apr10	2011	*SOR stated a separately identifiable E/M service may be reported if appropriate and the RUC accounted for this in its valuation.*

Table 7: 000-Day Global Services Typically Reported with an E/M
RUC requests to remove the following:

CPT	Long Descriptor	Total with E/M	Most Recent RUC Survey	CPT Year	RUC Comment to NPRM for 2017
12013	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm	85%	Apr10	2011	*SOR stated a separately identifiable E/M service may be reported if appropriate and the RUC accounted for this in its valuation.*
17250	Chemical cauterization of granulation tissue (proud flesh, sinus or fistula)	29%	Oct10	2012	Does not meet screen criteria; not typically reported with an E/M
20550	Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")	76%	Jan16	2017	Does not meet screen criteria; surveyed within the last 5 years. Additionally, the summary of recommendation (SOR) form indicated that this service may typically be reported with an E/M and the RUC accounted for this in its valuation recommendation.
20552	Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)	75%	Jan16	2017	Does not meet screen criteria; surveyed within the last 5 years.
20553	Injection(s); single or multiple trigger point(s), 3 or more muscles	66%	Jan16	2017	Does not meet screen criteria; surveyed within the last 5 years.
20600	Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); without ultrasound guidance	72%	Oct10	2012	*SOR stated typically reported with an E/M and the RUC accounted for this in its valuation. RUC reaffirmed recommendation with other Arthrocentesis codes in January 2014.*

Table 7: 000-Day Global Services Typically Reported with an E/M
RUC requests to remove the following:

CPT	Long Descriptor	Total with E/M	Most Recent RUC Survey	CPT Year	RUC Comment to NPRM for 2017
20604	Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); with ultrasound guidance, with permanent recording and reporting	0%	Jan14	2015	Does not meet screen criteria; surveyed within the last 5 years. Additionally, the summary of recommendation (SOR) form indicated that this service may typically be reported with an E/M and the RUC accounted for this in its valuation recommendation.
20605	Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); without ultrasound guidance	74%	Oct10	2012	*SOR stated typically reported with an E/M and the RUC accounted for this in its valuation. RUC reaffirmed recommendation with other Arthrocentesis codes in January 2014.*
20606	Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); with ultrasound guidance, with permanent recording and reporting	0%	Jan14	2015	Does not meet screen criteria; surveyed within the last 5 years. Additionally, the summary of recommendation (SOR) form indicated that this service may typically be reported with an E/M and the RUC accounted for this in its valuation recommendation.
20610	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance	65%	Oct10	2012	*SOR stated typically reported with an E/M and the RUC accounted for this in its valuation. RUC reaffirmed recommendation with other Arthrocentesis codes in January 2014.*

Table 7: 000-Day Global Services Typically Reported with an E/M
RUC requests to remove the following:

CPT	Long Descriptor	Total with E/M	Most Recent RUC Survey	CPT Year	RUC Comment to NPRM for 2017
20611	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting	0%	Jan14	2015	Does not meet screen criteria; surveyed within the last 5 years. Additionally, the summary of recommendation (SOR) form indicated that this service may typically be reported with an E/M and the RUC accounted for this in its valuation recommendation.
29125	Application of short arm splint (forearm to hand); static	78%	Oct10	2012	*SOR stated typically reported with an E/M and the RUC accounted for this in its valuation. "For primary treatment - billed with separately reportable E/M service. For replacement splint within global, no E/M reported."*
29515	Application of short leg splint (calf to foot)	71%	Oct10	2012	*SOR stated typically reported with an E/M and the RUC accounted for this in its valuation. "29515 is billed with an E/M, approximately 65% of the time according to Medicare data. This makes sense as the typical patient is facility-based."*
30901	Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method	86%	Apr16	2018	Does not meet criteria; surveyed within the last 5 years. RUC submitted recommendation for CY 2018 and specifically accounted for the E/M typically performed (see rationale and SOR).
30903	Control nasal hemorrhage, anterior, complex (extensive cautery and/or packing) any method	82%	Apr16	2018	Does not meet criteria; surveyed within the last 5 years. RUC submitted recommendation for CY 2018 and specifically accounted for the E/M typically performed (see rationale and SOR).

Table 7: 000-Day Global Services Typically Reported with an E/M
RUC requests to remove the following:

CPT	Long Descriptor	Total with E/M	Most Recent RUC Survey	CPT Year	RUC Comment to NPRM for 2017
31231	Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)	84%	Jan12	2013	Does not meet screen criteria; surveyed within the last 5 years and the RUC rationale specifically states that this services is typically reported with an E/M and the RUC accounted for this in its valuation.
31238	Nasal/sinus endoscopy, surgical; with control of nasal hemorrhage	72%	Apr13	2014	*RUC rationale and SOR stated typically reported with an E/M and the RUC accounted for this in its valuation.*
31500	Intubation, endotracheal, emergency procedure	11%	Jan16	2017	Does not meet screen criteria; surveyed within the last 5 years and not typically reported with an E/M. Additionally, the summary of recommendation form indicated that this service is on the Modifier 51 exempt list as it is typically provided adjunctive to another service or procedure and the RUC accounted for this in its valuation and review of physician time.
31575	Laryngoscopy, flexible fiberoptic; diagnostic	87%	Oct15	2017	Does not meet screen criteria; surveyed within the last 5 years. Additionally, the rationale that this service may typically be reported with an E/M and the RUC accounted for this in its valuation recommendation.
31579	Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy	74%	Oct15	2017	Does not meet screen criteria; surveyed within the last 5 years. Additionally, the rationale that this service may typically be reported with an E/M and the RUC accounted for this in its valuation recommendation.

Table 7: 000-Day Global Services Typically Reported with an E/M
RUC requests to remove the following:

CPT	Long Descriptor	Total with E/M	Most Recent RUC Survey	CPT Year	RUC Comment to NPRM for 2017
31645	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with therapeutic aspiration of tracheobronchial tree, initial (eg, drainage of lung abscess)	26%			Does not meet screen criteria; not typically reported with an E/M and scheduled to be reviewed at October 2016 RUC meeting for CY 2018.
32551	Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open (separate procedure)	19%	Apr12	2013	Does not meet screen criteria; surveyed within the last 5 years and not typically reported with an E/M.
32554	Thoracentesis, needle or catheter, aspiration of the pleural space; without imaging guidance	39%	Oct12	2013	Does not meet screen criteria; not typically reported with an E/M (indicated by data and specified in SOR).
40490	Biopsy of lip	73%	Sept11	2013	Does not meet screen criteria; surveyed within the last 5 years
46600	Anoscopy; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	89%	Feb07	2008	*RUC supporting agenda materials indicated that this service is typically reported with an E/M and the RUC accounted for this in its valuation. Additionally, the practice expense inputs associated with an E/M were removed and are not currently included in 46600.*
51701	Insertion of non-indwelling bladder catheter (eg, straight catheterization for residual urine)	85%	Jan16	2017	Does not meet screen criteria; surveyed within the last 5 years and RUC rationale specifically noted "Code 51701 is typically reported with an Evaluation and Management service. The specialty society indicated and the RUC agreed that the pre-service time of 14 minutes does not overlap with an E/M service."

Table 7: 000-Day Global Services Typically Reported with an E/M
RUC requests to remove the following:

CPT	Long Descriptor	Total with E/M	Most Recent RUC Survey	CPT Year	RUC Comment to NPRM for 2017
51702	Insertion of temporary indwelling bladder catheter; simple (eg, Foley)	52%	Jan16	2017	Does not meet screen criteria, surveyed within the last 5 years
51703	Insertion of temporary indwelling bladder catheter; complicated (eg, altered anatomy, fractured catheter/balloon)	49%	Jan16	2017	Does not meet screen criteria; surveyed within the last 5 years and not typically reported with an E/M
56605	Biopsy of vulva or perineum (separate procedure); 1 lesion	53%	Aug95	1997	*Post-operative time description notes that this is typically performed with an E/M one to two weeks later for re-evaluation.*
64418	Injection, anesthetic agent; suprascapular nerve	53%	Apr16	2018	Does not meet screen criteria; surveyed within the last 5 years and RUC rationale and SOR note that this service is typically reported with an E/M and accounted for this in its valuation.
65222	Removal of foreign body, external eye; corneal, with slit lamp	67%	Sept11	2013	Does not meet screen criteria; surveyed within the last 5 years and RUC rationale specifically noted that this service is typically reported with an E/M and accounted for in its valuation.
67810	Incisional biopsy of eyelid skin including lid margin	68%	Sept11	2013	Does not meet screen criteria; surveyed within the last 5 years and RUC rationale specifically states that this service is typically reported with an E/M and accounted for in its valuation.
67820	Correction of trichiasis; epilation, by forceps only	79%	Apr16	2018	Does not meet screen criteria; surveyed within the last 5 years and summary of recommendation form (SOR) stated typically reported with an E/M and the RUC accounted for this in its valuation.

Table 7: 000-Day Global Services Typically Reported with an E/M
RUC requests to remove the following:

CPT	Long Descriptor	Total with E/M	Most Recent RUC Survey	CPT Year	RUC Comment to NPRM for 2017
68200	Subconjunctival injection	57%	Sept11	2013	Does not meet screen criteria; surveyed within the last 5 years and RUC rationale specifically states that this service is typically reported with an E/M and accounted for in its valuation.
69100	Biopsy external ear	82%	Apr09	2010	*SOR stated typically reported with an E/M and the RUC accounted for this in its valuation.*
69200	Removal foreign body from external auditory canal; without general anesthesia	82%	Sept11	2013	Does not meet screen criteria; surveyed within the last 5 years
69210	Removal impacted cerumen requiring instrumentation, unilateral	72%	Jan13	2014	Does not meet screen criteria; surveyed within the last 5 years and SOR specifically stated that this service is typically reported with an E/M and the RUC accounted for in its valuation.
69220	Debridement, mastoidectomy cavity, simple (eg, routine cleaning)	67%	Oct10	2012	*RUC rationale stated typically reported with an E/M and the RUC accounted for this in its valuation.*
92511	Nasopharyngoscopy with endoscope (separate procedure)	88%	Oct10	2012	*RUC rationale stated typically reported with an E/M and the RUC accounted for this in its valuation.*

Table 7: 000-Day Global Services Typically Reported with an E/M
RUC requests to remove the following:

CPT	Long Descriptor	Total with E/M	Most Recent RUC Survey	CPT Year	RUC Comment to NPRM for 2017
92941	Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel	5%	Jan12	2013	Does not meet screen criteria; surveyed within the last 5 years and not typically reported with an E/M. Even previously reported deleted code 92980 was not typically reported with an E/M.
92950	Cardiopulmonary resuscitation (eg, in cardiac arrest)	32%	Oct10	2012	Does not meet screen criteria; data show not typically reported with an E/M. However, last RUC review summary of recommendation form submitted indicated that this service is typically reported with an E/M and accounted for this in its valuation.
98925	Osteopathic manipulative treatment (OMT); 1-2 body regions involved	79%	Feb11	2012	*RUC rationale stated typically reported with an E/M and the RUC accounted for this in its valuation.*
98926	Osteopathic manipulative treatment (OMT); 3-4 body regions involved	78%	Feb11	2012	*RUC rationale stated typically reported with an E/M and the RUC accounted for this in its valuation.*
98927	Osteopathic manipulative treatment (OMT); 5-6 body regions involved	84%	Feb11	2012	*RUC rationale stated typically reported with an E/M and the RUC accounted for this in its valuation.*
98928	Osteopathic manipulative treatment (OMT); 7-8 body regions involved	90%	Feb11	2012	*RUC rationale stated typically reported with an E/M and the RUC accounted for this in its valuation.*

Table 7: 000-Day Global Services Typically Reported with an E/M *RUC requests to remove the following:*					
CPT	**Long Descriptor**	**Total with E/M**	**Most Recent RUC Survey**	**CPT Year**	**RUC Comment to NPRM for 2017**
98929	Osteopathic manipulative treatment (OMT); 9-10 body regions involved	91%	Feb11	2012	*RUC rationale stated typically reported with an E/M and the RUC accounted for this in its valuation.*

ii. End-Stage Renal Disease Home Dialysis Services (CPT Codes 90963-90970)

CMS identified home ESRD codes 90963 – 90970 as potentially misvalued based on the volume of claims submitted for these services relative to those submitted for monthly facility ESRD services. CMS requests examination of Medicare policies for monthly ESRD payments and to revise them if necessary to ensure that these policies are consistent with the goal of encouraging the use of home dialysis among patients for whom it is appropriate.

The RUC does not offer any comment on the policy or other rationale that impacts utilization of ESRD home dialysis services. However, if CMS finalizes this proposal the RUC will examine the valuation of these services, as well as the other ESRD codes in the family.

iii. Equipment Recommendations for Scope Systems and Appropriate Direct PE Inputs Involved in Procedures Involving Endoscopes

CMS notes that during their routine review of services, there are unexplained inconsistencies involving the use of scopes and their associated video systems. To maintain consistency, CMS proposes a structure that separates the scope and the associated video system as distinct equipment items for each code. The scope video system is defined as including: (1) a monitor; (2) a processor; (3) a form of digital capture; (4) a cart; and (5) a printer.

While the RUC is not immediately opposed to the CMS proposal to separate the scopes from the scope video systems, significant concerns arise over the new pricing of the individual items defined within the video system. CMS has garnered quotes from an unknown vendor, which significantly reduce the cost of the video system (ES031). Given the large payment disparities between the current equipment and what is being proposed, as well as the comprehensive restructuring of these important equipment items, the Practice Expense Subcommittee will create a workgroup to analyze and provide input on the CMS proposal. This is essential so that all stakeholder specialty societies have a chance to weigh in on these important changes. The Chair of the Subcommittee will select the members of the Workgroup at the October 2016 RUC meeting with the goal of submitting a recommendation to CMS in time to be considered for CMS' 2018 *Proposed Rule*.

iv. Insertion and Removal of Drug Delivery Implants (CPT Codes 11981-11983)

CMS identified codes 11981, 11982 and 11983as potentially misvalued since stakeholders have suggested that current coding describes insertion and removal of drug delivery implants as too broad and new coding is needed to account for specific additional resource costs associated with particular treatment. The RUC understands that a coding change proposal has been submitted to revise these services.

The RUC will review and provide recommendations for CPT codes 11981-11983 for CY 2018.

v. Improving Payment Accuracy for Preventive Services: Diabetes Self-Management Training (DSMT)

CMS identified codes G0108 and G0109 as potentially misvalued and are requesting information regarding the resources required to provide these services as well as the time and intensity of the services provided.

The RUC already identified these services via the CMS/Other Source codes with utilization over 100,000 screen and will provide recommendations for these services.

vi. Therapy Codes

CMS indicated that since 2010, in addition to the codes for evaluative services, CMS has periodically added codes that represent therapy services to the list of potentially misvalued codes. CMS identified a list of 10 therapy codes based on the statutory category "codes that account for the majority of spending under the physician fee schedule," as specified in section 1848(c)(2)(K)(ii)(VII) of the Act. CMS indicated that they understand that the therapy specialty organizations have pursued the development of coding changes through the CPT process for these modality and procedures services. However, the Agency is seeking information now regarding the appropriate valuation for existing codes 97032, 97035, 97110, 97112, 97113, 97116, 97104, 97530, 97535 and G0283.

The RUC clearly understands CMS' request for recommendations on the work, time and direct practice expense inputs for these current existing services.

The RUC/HCPAC intends on providing recommendations for the therapy services identified and their related families for CY 2018.

vii. Electromyography Studies (CPT codes 51784 and 51785)

CMS identified CPT code 51784 as potentially misvalued through the High Expenditure Procedures screen. CMS reviewed the RUC recommendation for 51784 and accepted the work RVU. However, CMS indicated that 51784 should have a XXX global period instead of a 000-day global period. Additionally, 51785 should be reviewed as part of this family with an XXX global period as well. **The RUC will add codes 51784 and 51785 to the next level of interest (LOI) if this proposal is finalized. The RUC requests that CMS indicate any global period changes and requests for codes as part of the family when CMS initially nominates a code or reviews the RUC LOI prior to distribution.**

C. *CY 2017 Proposed Codes*

Prior to discussing the RUC's concerns with the CMS proposed decisions on codes under review for CY 2017, we reiterate the long-standing position of the AMA and medical specialties that all adjustments to work relative values should be solely based on the resources involved in performing each procedure or service. All adjustments to work RVUs should either be work neutral to the family or result in budget neutral adjustment to the conversion factor. Broadly redistributing work RVUs would distort the relative value system and create unintended consequence (i.e. misaligning physician productivity measurement systems and adding complexity to the ongoing valuation process).

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.

CMS is seeking comment on "…whether, within the statutory confines, there are alternative suggestions as to how changes in time should be accounted for when it is evident that the survey data and/or the RUC recommendation regarding the overall work RVU does not reflect significant changes in the resource costs of time for codes describing PFS services." The Agency is also "…seeking comment on potential alternatives, including the application of the reverse building block methodology, to making the adjustments that would recognize overall estimates of work in the context of changes in the resource of time for particular services."

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 (*see Addendum G - Changing Physician Time Components Example*). 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 does not agree with any suggested methodology to use a "reverse building block methodology" to systematically reduce a work RVUs for services. The RUC strongly believes that reverse building block methodology, or any other purely formulaic approach, should never be used as

the primary methodology to value services. It is highly inappropriate, due to the fact that magnitude estimation was used to establish work RVUs for services in the RBRVS.

i. Bone Biopsy Excisional (CPT Code 20245)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
20245	Biopsy, bone, open; deep (eg, humerus, ischium, femur)	6.50	6.00	Disagree

Summary of CMS Actions:

- CMS believes the recommendations for 20245 overestimates the overall work involved in performing this procedure.

- CMS proposed a crosswalk to CPT code 19298 *Placement of radiotherapy afterloading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, includes imaging guidance* with a work RVU of 6.00, pre-service time of 60 minutes, intra-service time of 60 minutes, immediate post-service time of 30 minutes for a total of 169 minutes and an IWPUT of 0.0593.

- The RUC appreciates CMS accepting the recommended Practice Expense direct inputs and global change for this code.

RUC Comments:

- The RUC disagrees with the proposed crosswalk from CMS as it underestimates the total time by 10 minutes, as well as the work of CPT code 20245.

- The RUC compared CPT code 20245 to the second key reference code 20902 *Bone graft, any donor area; major or large* (work RVU= 4.58, intra time= 45 minutes) and noted that since code 20245 has 15 additional minutes of intra-service time, the recommended value apporpriately places the code higher than this reference code and maintains a similar intra-operative intensity. The RUC also reviewed 19 codes with a 000-day global period and 60 minutes of intra-time that were reviewed by the RUC and finalized by CMS between 2011 and 2015 and noted that a work RVU of 6.50 approximately fit in the middle of these services.

- Two additional reference codes that closely bracketed the recommended value are: 36247 *Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family* (work RVU= 6.29, intra time= 60 minutes) and 43262 *Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy* (work RVU= 6.60, intra time= 60 minutes).

- As noted in the RUC recommendations, the current time was based on a survey of 35 indivdiuals over 15 years ago. Due to the previous flawed survey, the resulting IWPUT was almost zero. Given these discrepenacies, the surveyed time of 60 minutes better reflects an appopriate level of intensity and complexity (IWPUT= 0.071) for this service relative to other 000-day global procedures.

  The RUC recommends CMS accept a work RVU of 6.50 for CPT code 20245.

ii. Insertion of Spinal Stability Distractive Device (CPT Codes 228X1, 228X2, 228X4, 228X5)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
228X1	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level	15.00	13.50	Disagree
228X2	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level (List separately in addition to code for primary procedure)	4.00	4.00	Agree
228X4	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level	7.39	7.03	Disagree
228X5	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure)	2.34	2.34	Agree

Summary of CMS Actions:

- CMS believes the recommendations for 228X1 and 228X4 overestimate the overall work involved in performing these procedures.
  - For 228X1, the Agency proposed a direct work RVU crosswalk to CPT code 36832 *Revision, open, arteriovenous fistula; without thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)* (work RVU= 13.50), citing a similarity in total time, work intensity, number of visits between both codes.
  - For 228X4, CMS proposed a direct work RVU crosswalk to CPT code 29881 *Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any*

meniscal shaving) including debridement/ shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed (work RVU= 7.03), stating their observation that both services have similar intensity, total time and clinical attributes.

- The RUC appreciates that CMS accepted the RUC's physician work recommendations for codes 228X2 and 228X5. The RUC also appreciates that CMS accepted the RUC's direct practice expense and physician time recommendations for the entire family of services.

RUC Comments:

- For 228X1, the RUC recommended a direct work RVU crosswalk to CPT code 29915 *Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion)*. CPT code 29915 has identical intra-service time, very similar total time (270 vs 271 minutes), very similar intensity (IWPUT of 0.1083 vs. 0.1065) and a similar amount of time for post-op visits (97 vs. 88 minutes). The RUC's crosswalk code is either an as good or better match than the CMS crosswalk under virtually every point of comparison. CMS did not indicate why CPT code 29915 is not an appropriate crosswalk.

- For 228X4, the RUC recommended a direct work RVU crosswalk to CPT code 29880 *Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed* . CMS simply just picked a different crosswalk code that is in the same code family as the RUC crosswalk. The RUC's crosswalk is closer to the survey code in both intra-service time and physician intensity. Other than those differences, all other time components of 29880 and 29881 are identical. As both proposed crosswalk codes are in the same code family, their clinical comparison to the survey code is indistinguishable. The RUC's crosswalk code is either identical or a better match than the CMS crosswalk under *every* point of comparison.

- CMS' proposed work RVU recommendation is only 4.8% less than the RUC's recommendation and relies on a weaker crosswalk. Rejecting the RUC's proposed recommendation in this case is completely unreasonable and absent a rationale consistent with the precepts of valuation that form the foundation of fair relative valuation.

  The RUC urges CMS to accept a work RVU of 15.00 for CPT code 228X1 and a work RVU of 7.39 for 228X4. The RUC also requests Refinement Panel consideration for these services.

iii. Biomechanical Device Insertion - Intervertebral, Interbody (CPT Codes 22X81, 22X82, 22X83)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
22X81	Insertion of interbody biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges) when performed to intervertebral disc space in conjunction with interbody arthrodesis, each interspace (List separately in addition to code for primary procedure)	4.88	4.25	Disagree
22X82	Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges) when performed to vertebral corpectomy(ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect	5.50	5.50	Agree
22X83	Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh, methylmethacrylate) to intervertebral disc space or vertebral body defect without interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)	6.00	5.50	Disagree

Summary of CMS Actions:

- CMS believes the recommendations for 22X81 and 22X83 overestimate the overall work involved in performing these procedures.
    - For 22X81, the Agency proposed a direct work RVU crosswalk to CPT code 37237 *Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; each additional artery (List separately in addition to code for primary procedure)* (work RVU= 4.25), citing a similarity in time and intensity.
    - CMS explained that they compared 22X83 to 22X82 and that they believed that the two procedures "…contain many clinical similarities and do not have a quantifiable

difference in overall intensity." Therefore, CMS proposed a direct crosswalk the value of 22X83 to 228X2, which is 5.50 RVUs.

- The RUC appreciates that CMS accepted the RUC's physician work recommendations for 22X82. The RUC also appreciates that CMS accepted the RUC's direct practice expense and physician time recommendations for the entire family of services.

RUC Comments:

- For 22X81, the RUC recommended a direct work RVU crosswalk to CPT code 57267 *Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach (List separately in addition to code for primary procedure)* (work RVU = 4.88). CPT code 57267 has an identical amount of intra-service and total physician time relative to the survey code, whereas CMS' chosen crosswalk has physician times which are not identical. Following extensive deliberation, the RUC agreed that the survey code and 57267 involve an identical amount of physician work. The RUC's crosswalk code is either an as good or better match than the CMS crosswalk under virtually every point of comparison. CMS did not indicate why CPT code 57267 is not an appropriate crosswalk.

- For 22X83, this service involves more physician time and intensity relative to 22X82 for the following reasons. Proposing to value both procedures demonstrates a misunderstanding of the work being performed. The specialty provided additional information to help the Agency better understand the differences between the two services:

    - When trauma, tumor, or infection destroys a vertebral segment, this segment must be reconstructed and durable bony fusion (arthrodesis) achieved from the segment above to the segment below the reconstructed segment. The work of 22X82 describes reconstruction of a vertebral body with a biomechanical spacer, to achieve an arthrodesis that will stabilize the unstable spinal segment and ultimate achieve bony healing and permanent durable spine stability with little risk to subsequent shifts in the construct. Immediate short-term stability is provided by the hardware, but it may weaken or fail over time; arthrodesis achieves the goal of one bone fusing to another through the 22X82 device and provides the long-term stability.

    - The work described by 22X83 is for placement of a biomechanical device with no intention of eventual bony arthrodesis. When tumor or infection causes neural compression, and the underlying pathology or its treatment creates spinal instability, the structural defect must be corrected but bony fusion may not be possible or expected. In this setting, the biomechanical device must be fashioned and placed to provide durable spinal stability without the added security of arthrodesis. The additional precision required for creating a stand-alone construct that will be stable over time results in a quantifiable difference in the overall intensity of the work, even though there are similarities in the code descriptors and the description of work. This is why the RUC recommends a higher work RVU for 22X83 relative to 22X82.

- By way of example, 22X83 would be used in the circumstance where a patient with a thoracic metastatic lesion causing spinal cord compression undergoes a decompression. The patient will need immediate postoperative radiation, and arthrodesis is therefore exceedingly unlikely. In this case, the surgeon completes a transpedicular decompression and then reconstructs the anterior column with either the Steinman pin and methyl methacrylate or other biomechanical spacer. The increased intensity of work in that circumstance warrants a higher valuation.

The RUC urges CMS to accept a work RVU of 4.88 for CPT code 22X81 and a work RVU of 6.00 for 22X83. The RUC also requests Refinement Panel consideration for these services.

iv. Closed Treatment of Pelvic Ring Fracture (CPT codes 271X1 and 271X2)

CPT Code	CPT Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
271X1	Closed treatment of posterior pelvic ring fracture(s), dislocation(s), diastasis or subluxation of the ilium, sacroiliac joint, and/or sacrum, with or without anterior pelvic ring fracture(s) and/or dislocation(s) of the pubic symphysis and/or superior/inferior rami, unilateral or bilateral; without manipulation	5.50	1.53	Disagree
271X2	Closed treatment of posterior pelvic ring fracture(s), dislocation(s), diastasis or subluxation of the ilium, sacroiliac joint, and/or sacrum, with or without anterior pelvic ring fracture(s) and/or dislocation(s) of the pubic symphysis and/or superior/inferior rami, unilateral or bilateral; with manipulation, requiring more than local anesthesia (ie, general anesthesia, moderate sedation, spinal/epidural)	9.00	4.75	Disagree

Summary of CMS Actions:

- CMS is proposing to change the global period for these codes from 090 day globals to 000 day globals and then crosswalk 271X1 to CPT code 65800 *Paracentesis of anterior chamber of eye (separate procedure); with removal of aqueous* (work RVU = 1.53) and crosswalk 271X2 to 93452 *Left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed* (work RVU = 4.75).

RUC Comments:

- In the *Final Rule* for CY 2014, CMS proposed CPT codes 21800, 22305 and 27193 for review to consider the appropriateness of having a 90-day global surgical package for a

procedure that is performed in settings other than the inpatient setting 33 percent of the time. CMS believed that it is unlikely that it is appropriate for a procedure performed outside of the inpatient hospital setting at this frequency to have such a long global period. Codes 27193 and family code 27194 were referred to CPT and in October 2015, the CPT Editorial Panel deleted codes 27193 and 27194 and created two new codes 271X1 and 271X2 to differentiate higher energy fractures and isolated lower energy fractures. In addition, a parenthetical was added to direct physicians to use E/M coding for the closed treatment of isolated lower energy fractures of the anterior pelvic ring (typically low energy falls from standing in the elderly) to distinguish these injuries from the higher energy and more unstable posterior pelvic ring injuries that may also include the anterior elements of the pelvic ring simultaneously. The inherently stable anterior only fracture should not require close monitoring, manipulation, or treatment and therefore can be reported with an E/M service when diagnosed. These coding changes were made to address the issue of site of service because a patient with a high energy impact injury would not present to an office setting and would/should not be treated in an office setting.

- In the *Proposed Rule* for CY 2017, CMS ignores these coding solutions and is proposing a different reason for their intention to change these services from a 090 day global to a 000 day global stating that "We are proposing to change the global period for these services from 90 days to 0 days because these codes typically represent emergent procedures with which injuries beyond pelvic ring fractures are likely to occur; we believe it is typical that multiple practitioners would be involved in providing post-operative care and it is likely that a practitioner furnishing a different procedure is more likely to be providing the primary post-operative care."

- CMS states that "if other practitioners are typically furnishing care in the post-surgery period, we believe that the six post service visits included in CPT code 271X1, and the seven included in 271X2, would likely not occur. Even if CMS makes the argument that the surgeon does not perform the primary post-operative care, the proposal ignores that 3 of the 6 post service visits for 271X1 and 4 of the 7 post service visits for 271X2 are in the hospital and would likely be performed by the surgeon.

The RUC urges CMS to accept the RUC recommended work RVUs of 5.50 and 9.00 for CPT codes 271X1 and 271X2, respectively.

v. Bunionectomy (CPT codes 28289, 282X1, 28292, 28296, 282X2, 28297, 28298, and 28299)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
28289	Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; without implant	6.90	6.90	Agree

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
282X1	Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; with implant	8.01	7.81	Disagree
28292	Correction, hallux valgus (bunionectomy), with sesamoidectomy-, when performed; with resection of proximal phalanx base, when performed, any method	7.44	7.44	Agree
28296	Correction, hallux valgus (bunionectomy), with sesamoidectomy-, when performed; with distal metatarsal osteotomy, any method	8.25	8.25	Agree
282X2	Correction, hallux valgus (bunionectomy), with sesamoidectomy-, when performed; with proximal metatarsal osteotomy, any method	8.57	8.25	Disagree
28297	Correction, hallux valgus (bunionectomy), with sesamoidectomy-, when performed; with first metatarsal and medial cuneiform joint arthrodesis, any method	9.29	9.29	Agree
28298	Correction, hallux valgus (bunionectomy), with sesamoidectomy-, when performed; with proximal phalanx osteotomy, any method	7.75	7.75	Agree
28299	Correction, hallux valgus (bunionectomy), with sesamoidectomy-, when performed; with double osteotomy, any method	9.29	9.29	Agree

Summary of CMS Actions:

- CMS believes the recommendation for 282X1 overestimates the overall work involved in performing this procedure given the decrease in intra-service time, total time, and postoperative visits when compared to deleted predecessor CPT code 28293 *Correction, hallux valgus (bunion), with or without sesamoidectomy; resection of joint with implant* (work RVU = 11.48).

- Due to similarity in intra-service and total times, CMS believes a direct crosswalk of the work RVUs for CPT code 65780 *Ocular surface reconstruction; amniotic membrane transplantation, multiple layers* (work RVU = 7.81), to CPT code 282X1 more accurately reflects the time and intensity of furnishing the service.

- CMS indicated they believe the recommendation for 282X2 overestimates the work involved in performing this procedure given the similarity in the intensity of the services

and identical intra-service and total times as CPT code 28296. Therefore, are proposing a direct RVU crosswalk from CPT code 28296 to CPT code 282X2, a work RVU of 8.25 for CPT code 282X2.

RUC Comments:

- The valuation for deleted code 28293 is noted by the RUC not to use for validation of physician work. The previous time was based off of Harvard time and when reviewed in 1995 the RUC maintained the physician work and Harvard time because there was no compelling evidence to revise at that time.

- CPT code 28293 had 30 minutes more intra-service time and a higher work RVU of 11.48 compared to the recommended work RVU of 8.01 for 282X1. The RUC appropriately accounted for the differences in the physician work, time, intensity and the actual new service as described in CPT code 282X1.

- The RUC disagrees with CMS crosswalking 282X1 to CPT code 65780. The RUC compared the family and relative ranking, code 282X1 is more complex and intense than 28298. The relative difference in work and complexity/intensity was reviewed and correctly ranked by the survey respondents. The RUC appropriately valued 282X1 based on the survey the 25th percentile work RVU of 8.01.

- The RUC specifically indicated that 282X2 is more intense than 28296.

    - CPT code 28296 is a metatarsal neck osteotomy and is already exposed at that level and has been operated on.

    - However, CPT code 282X2 requires separate areas of dissection and is more complex than 28296 where the osteotomy and soft tissue procedure are performed at the same anatomic location. This nuance in complexity is the rationale for separate codes and is similar to the rationale for separate cervical versus lumbar spine codes or artery versus vein codes for vascular work. In each of these instances, although the operative time may be the same, the complexity of the procedure is greater for one area versus the other and this is reflected in a difference in work RVUs.

The RUC urges CMS to accept the RUC recommended work RVU of 8.01 for CPT code 282X1 and a work RVU of 8.57 for CPT code 282X2. The RUC also requests Refinement Panel consideration for these services.

vi. Endotracheal Intubation (CPT Codes 31500)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
31500	Intubation, endotracheal, emergency procedure	3.00	2.66	Disagree

Summary of CMS Actions:

- CMS believes the recommendation for 31500 overestimates the overall work involved in performing these procedures. The Agency proposed a direct work RVU crosswalk to CPT code 65855 *Trabeculoplasty by laser surgery* (work RVU= 2.66), noting their observation of a similar intensity and proposed physician time (though these observations are both incorrect).

- The RUC appreciates that CMS accepted the RUC's direct practice expense and physician time recommendations for this service.

RUC Comments:

- CMS' proposed crosswalk code 65855 is not an appropriate comparator to 31500, as these services have widely different physician times (61 minutes vs 32 minutes of total time), different global periods (010-day vs. 000-day), they have differing patient populations and 31500 is a much more intense physician service relative to 65855. CMS' proposed crosswalk is not emergent, being performed 68 percent of the time in the office setting according to 2015 Medicare claims data, while 31500 is performed in the emergency department 46 percent of the time and in the inpatient hospital setting 53 percent of the time.

- Given the unique, emergent nature of 31500, there are few direct work RVU and physician time-based comparisons within the RBRVS. This service is one of the most immediate, intense services physicians can perform. The survey median intra-service time is 10 minutes, representing a doubling of the current time.

  The RUC urges CMS to accept the work RVU of 3.00 for CPT code 31500. The RUC also requests Refinement Panel consideration for this service.

vii. Flexible Laryngoscopy (CPT codes 31575, 31576, 31577, 31578, 317X1, 317X2, 317X3, and 31579)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
31575	Laryngoscopy, flexible fiberoptic; diagnostic	1.00	0.94	Disagree
31576	Laryngoscopy, flexible fiberoptic; with biopsy	1.95	1.89	Disagree
31577	Laryngoscopy, flexible fiberoptic; with removal of foreign body	2.25	2.19	Disagree
31578	Laryngoscopy, flexible fiberoptic; with removal of lesion	2.49	2.43	Disagree

317X1	Laryngoscopy, flexible; with ablation or destruction of lesion(s) with laser, unilateral	3.07	3.01	Disagree
317X2	Laryngoscopy, flexible; with therapeutic injection(s) (eg, chemodenervation agent or corticosteroid, injected percutaneous, ransoral, or via endoscope channel), unilateral	2.49	2.43	Disagree
317X3	Laryngoscopy, flexible; with injection(s) for augmentation (eg, percutaneous, transoral), unilateral	2.49	2.43	Disagree
31579	Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy	1.94	1.88	Disagree

Summary of CMS Actions:

- For the base CPT code 31575 *Laryngoscopy, flexible fiberoptic; diagnostic*, CMS notes a decrease in total time from 28 to 24 minutes and applies a time/work ratio to arrive at a work RVU of 0.94. The Agency then directly crosswalks the value to CPT code 64405 *Injection, anesthetic agent; greater occipital nerve* (work RVU= 0.94).

- CMS then applies the same increments from the RUC recommendations between all the services, with a 0.06 reduction to all codes.

Practice Expense:

- CMS proposes large changes to the direct practice expense inputs for scope equipment. Specifically, CMS is proposing to separate the scopes used in these procedures from scope video systems.

- In addition, CMS updated the pricing for equipment code ES031 *video system, endoscopy (processor, digital capture)* with their own vendor, negating the competing invoices submitted by the specialty society.

RUC Comments:

- The RUC does not agree with the reduction in work RVU for code 31575. The use of a work/time ratio is inconsistent with the standard RUC methodology of magnitude estimation. When the Agency uses a ratio to "back out" work RVUs, there is an assumption that if time changes, work must change in tandem. When work RVUs are reduced via mathematical formulas, it can arbitrarily manipulate intensities without giving credence to robust survey data from experts who perform the service. The RUC urges **CMS to accept the RUC recommendation of a work RVU of 1.00 for CPT code 31575.**

- For CMS to reduce the work RVU of the base code and then apply the same reduction across the board to the other family codes represents a misunderstanding of the valuation methodology taken by the RUC. While it's true that there is incremental work within this family, the RUC did not use a pure incremental approach to value these services. Unlike the previously valued lower endoscopy codes, these codes do not have widely agreed upon increments that were used to across the family. Therefore, the RUC reviewed each code individually, assessing the survey data to ascertain specific values for each code. It is unfair for the Agency to use a separate methodology to value the entire family. Each service should be valued as an individual service AND within the family to ensure relativity is maintained.

- The RUC urges **CMS to accept the RUC recommended work RVUs for the following services:**

    - **CPT code 31576, work RVU= 1.95**
    - **CPT code 31577, work RVU= 2.25**
    - **CPT code 31578, work RVU= 2.49**
    - **CPT code 317X1, work RVU= 3.07**
    - **CPT code 317X2, work RVU= 2.49**
    - **CPT code 317X3, work RVU= 2.49**
    - **CPT code 31579, work RVU= 1.94**

  The RUC also requests Refinement Panel consideration for these services.

  Practice Expense:

  - While the RUC isn't opposed to the CMS proposal to separate the scopes from the scope video systems, it's objectionable that the Agency backtracked on their initial decision to bundle them. The specialty society involved in these recommendations spent a great deal of time crafting the proposed packages and to obtain recent, paid invoices. The RUC is concerned that CMS neglected to implement this comprehensive work.

  - The RUC strongly disagrees with CMS's proposal to reduce the value of the current PE input ES031 video system, endoscopy by half given that the specialty submitted PE input data total $ 49,400 in contrast to the proposed price for CY 2017 of $15,045.00. CMS should, at a minimum, consider the single item prices contained in the invoices submitted following the January 2016 RUC meeting for the standard endoscope equipment. Finally, if CMS is willing to rely on quotes obtained by the Agency directly to revalue direct PE inputs within rulemaking, specialty societies should also be allowed to submit quotes for pricing as they are much easier to obtain than paid invoices which many centers are unable to share. CMS should also be transparent about which companies they've obtained quotes from and why they feel they are appropriate to use rather than paid invoices supplied by specialties via the RUC process.

viii. Laryngoplasty (CPT codes 31580, 31584, 31587, and 315X1-315X6)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
31584	Laryngoplasty; with open reduction of fracture	20.00	17.58	Disagree
315X5	Laryngoplasty, medialization; unilateral	15.60	13.56	Disagree

Summary of CMS Actions:

- The RUC appreciated CMS acceptance of the RUC recommended work RVUs for 31580, 31587, 315X1-X4, and 315X6.

- CMS recommended a decreased work RVU of 17.58 for CPT code 31584 and a decreased work RVU of 13.56 for CPT code 315X5.

RUC Comments:

- When evaluating CPT code 31584, the RUC compared the survey code to several reference codes, including: 35301 *Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision* (work RVU= 21.16, intra time= 120 minutes) and 24160 *Removal of prosthesis, includes debridement and synovectomy when performed; humeral and ulnar components* (work RVU= 18.63, intra time= 120 minutes). Additionally, it is important to note that this code now represents the procedure plus the trach which combined would be over 27 RVUs if the codes were added together using the building block approach. The RUC approved value of 20.00 RVUs adequately takes into consideration the efficiencies of bundling these procedures together and is lower than the existing value for 31584 on its own. Reducing down to the 25th percentile severely underestimates the work that is required to perform this complicated airway procedure.

- For CPT code 315X5, the RUC directly crosswalked to code 58544. To justify a work RVU of 15.60, the RUC reviewed MPC codes 60500 P*arathyroidectomy or exploration of hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)* (work RVU= 17.31, intra time= 120 minutes) and agreed that both these reference codes provide appropriate magnitude estimation to justify the recommended work value of 15.60. Additionally, it is important to note that this code now represents the procedure plus the diagnostic exam (31575) which combined would be over 16 RVUs if the codes were added together using the building block approach. The RUC approved value of 15.60 RVUs adequately takes into consideration the efficiencies of bundling these procedures together. Reducing down to the 25th percentile severely underestimates the work that is required to perform this complicated airway procedure.

The RUC urges CMS to accept the RUC recommendations of a work RVU of 15.60 for CPT code 315X5 and 20.00 for CPT code 31584. The RUC also requests Refinement Panel consideration for these services.

ix. Closure of Left Atrial Appendage with Endocardial Implant (CPT code 333X3)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
333X3	Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, when performed, and radiological supervision and interpretation	14.00	13.00	Disagree

Summary of CMS Actions:

- CMS recommended a decreased work RVU of 13.00 for CPT code 333X3 to reflect the minimum survey responses instead of the work RVU of 14.00 recommended.

- The RUC appreciated CMS accepting the physician time and direct practice expense inputs for CPT code 333X3.

RUC Comments:

- CMS incorrectly indicates that the RUC's 14.00 RVU recommendation is the survey 25th-percentile value. In fact, the survey 25th-percentile value is 19.88 work RVUs.

- CMS also indicates that it considered 333X3 in comparison to "key reference codes discussed in the RUC recommendations with higher intraservice and total service times" as part of its rationale to reduce the work RVU. The RUC recommendations submitted to CMS referenced codes 93583 (*Percutaneous transcatheter septal reduction therapy (e.g., alcohol septal ablation) including temporary pacemaker insertion when performed*) and 37244 (*Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation*). Those services have times of 90 minutes intraservice, 188 minutes total time and 90 minutes intraservice, 176 minutes total time, respectively. The service time recommendations that CMS proposes to adopt from the RUC are 90 minutes intraservice, 183 minutes total time, squarely between 93583 and 37244. 93583 and 37244 both have work RVUs of 14.00.

- The identical intraservice times and similar total service times, as well as the clinical similarity of two services that both involve catheter-based, cardiovascular therapies, support the RUC's crosswalk recommendation of 14.00 work RVUs. It is unclear to what

services CMS compared 333X3, but it appears it was not the same as CPT codes 93583 or 37244 cited by the RUC recommendations.

- The RUC is alarmed by the opaque decision-making process CMS sometimes uses when it sets work values that differ from the multispecialty, expert RUC process. The CMS proposal inaccurately summarized the RUC survey results, inaccurately characterized the RUC recommendation, and determined that in the Agency's "clinical judgment" a lower value is more accurate. This perfunctory treatment suggests that CMS did not understand the information it was given. Further, it is difficult to understand what clinical judgment the Agency can have about the work required to perform a breakthrough, transcatheter therapy provided at dozens of sites by a few hundred physicians since it was approved by the FDA in March 2015.

- The RUC also recognizes this is a new technology and it will be re-reviewed by the RUC in three years to ensure correct valuation.

  The RUC urges CMS to explain its thought process for this decision making and to accept the RUC recommended work RVU of 14.00 for CPT code 333X3.

x. Valvuloplasty (CPT codes 334X1 and 334X2)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
334X2	Valvuloplasty, aortic valve, open, with cardiopulmonary bypass; complex (eg, leaflet extension, leaflet resection, leaflet reconstruction or annuloplasty)	44.00	41.50	Disagree

Summary of CMS Actions:

- CMS compares CPT code 334X2 to the currently billed code CPT code 33400 *Valvuloplasty, aortic valve; open, with cardiopulmonary bypass* (work RVU= 41.50) and noted similar intra-service time and decreased total time. CMS proposes a work RVU of 41.50 for code 334X2, noting the typical service and work RVU should remain consistent.

RUC Comments:

- CMS has again completely discounted any discussion of intensity changes since code 33400 was last valued in 2005. The RUC specifically noted while the total survey time for this procedure goes down slightly, from 742 minutes to 676 minutes, the previous valuation had slightly varied post-operative visits. Aortic valve repairs are predominately performed in the congenital cardiac patient population. However, complex aortic valve repairs that are now being performed in increasing numbers of adult cardiac patients in whom aortic valve replacement was previously the norm. Although the dominate population will still be congenital cardiac patients, the complex valvuloplasty procedures introduces a broader mix of patients that can have aortic valve repair procedures. The

decreased length of stay and shift in the postoperative pattern reflects the shift in the patient population that can now be treated with complex valve repair procedures. However the change in total time does not diminish the change that has occurred in the complexity and intensity of the procedure.

- Also, the complex procedure, when it was last surveyed over 10 years ago, is not comparable to the procedure today. Even though it is estimated that 70% of the services will be reported by the new code 334X2 and only 30% will be reported with code 334X1, this is due to the shift in services, changes in technology, advances in knowledge of the function and treatment of the aortic valves and, finally, should not be considered as related to the existing code 33400. When taking into a comprehensive view the valuation for this procedure (time and intensity), it is inappropriate to have the more complex code 334X2 valued identically to the deleted code 33400.

CMS should accept the RUC recommendation of 44.00 work RVUs for CPT code 334X2. The RUC also requests Refinement Panel consideration for these services.

xi. Mechanochemical (MOCA) Vein Ablation (CPT Codes 36X41, 364X2, 36475, 36476, 36478, 36479)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
36X41	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated	3.50	3.50	Agree
364X2	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	2.25	1.75	Disagree
36475	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated	5.30	5.30	Agree
36476	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	2.65	2.65	Agree
36478	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated	5.30	5.30	Agree

36479	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	2.65	2.65	Agree

Summary of CMS Actions:

- CMS believes the recommendation for 364X2 overestimates the overall work involved in performing this procedure. The Agency proposed a work RVU of 1.75, half the RUC proposed work RVU for 364X1, noting a similar multiple for the median survey data for these two services.

RUC Comments:

- CMS attempted to support their proposed work valuation by stating the "… value is supported by the ratio between work and time in the key reference service, CPT code 36476 *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; second and subsequent veins treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)*." The ratio between CMS' proposed physician time and physician work for the survey code is 0.058, whereas that same ratio for the key reference code is 0.0883, or 53 percent higher. CMS' rationale for their proposed value is based on a fundamental error; the divergent ratios between these two services do not even warrant comparison.

  The RUC urges CMS to accept the work RVU of 2.25 for CPT code 364X2. The RUC also requests Refinement Panel consideration for CPT code 364X2.

xii. Dialysis Circuit (CPT codes 369X1, 369X2, 369X3, 369X4, 369X5, 369X6, 369X7, 369X8, 369X9)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
369X1	Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiologic supervision and interpretation and image documentation and report;	3.36	2.82	Disagree

369X2	Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiologic supervision and interpretation and image documentation and report; with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	4.83	4.24	Disagree
369X3	Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiologic supervision and interpretation and image documentation and report; with transcatheter placement of intravascular stent(s) peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis segment	6.39	5.85	Disagree
369X4	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s)	7.50	6.73	Disagree

369X5	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	9.00	8.46	Disagree
369X6	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of an intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation to perform the stenting and all angioplasty within the peripheral dialysis circuit	10.42	9.88	Disagree
369X7	Transluminal balloon angioplasty, central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the angioplasty (List separately in addition to code for primary procedure)	3.00	2.48	Disagree

369X8	Transcatheter placement of an intravascular stent(s), central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the stenting, and all angioplasty in the central dialysis segment (List separately in addition to code for primary procedure)	4.25	3.73	Disagree
369X9	Dialysis circuit permanent vascular embolization or occlusion (including main circuit or any accessory veins), endovascular, including all imaging and radiological supervision and interpretation necessary to complete the intervention (List separately in addition to code for primary procedure)	4.12	3.48	Disagree

Summary of CMS Actions:

- CMS rejected the RUC recommendations for the nine new dialysis circuit CPT codes. CMS uses several different methodologies for deriving new values for these codes. For five codes (369X1, 369X2, 369X4, 369X8 and 369X9), CMS uses a different direct work value crosswalk from the RUC. For the remaining four codes (369X3, 369X5, 369X6 and 369X7) the Agency uses either a work-time ratio or incremental approach.

RUC Comments:

- For CPT codes 369X1-X3, CMS uses inappropriate crosswalks. These new codes 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. Crosswalking urgent dialysis procedures in a medically complex patient population to (typically) elective GI procedures is an improper comparison. The illness severity of the typical dialysis patient was taken into context 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 intraservice time comparison or ratios of

intraservice 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 369X4 ignores the inherent differences in risk to the patient when working in the vascular system as opposed to the bile ducts.

Given this evidence, CMS should accept the following RUC recommendations, as originally submitted:

- **CPT code 369X1, work RVU= 3.36**
- **CPT code 369X2, work RVU= 4.83**
- **CPT code 369X3, work RVU= 6.39**
- **CPT code 369X4, work RVU= 7.50**
- **CPT code 369X5, work RVU= 9.00**
- **CPT code 369X6, work RVU= 10.42**
- **CPT code 369X7, work RVU= 3.00**
- **CPT code 369X8, work RVU= 4.25**
- **CPT code 369X9, work RVU= 4.12**

The RUC also requests Refinement Panel consideration for these services.

Practice Expense:

- CMS proposes to remove the "kit, for percutaneous thrombolytic device (Trerotola)" supply (SA015) from CPT codes 369X4, 369X5, and 369X6 because the Agency believes the "catheter, thrombectomy-Fogarty" (SD032) provide essentially the same supply.

    - These two supplies should remain for these codes. These devices are both used during the thrombectomy procedures for different portions of the procedure. The standard techniques involve the use of a thrombectomy device such as the Trerotola device to macerate and obliterate the thrombus within the fistula/graft. Once this is completed, the arterial plug which forms at the arterial anastomosis must be pulled from the arterial anastomosis into the access. This requires the use of the Fogarty thrombectomy catheter. These two devices are complimentary but not redundant. **The RUC recommends that the listed devices "catheter, thrombectomy-Fogarty" (SD032) and "kit, for percutaneous thrombolytic device (Trerotola)" supply (SA015) both remain in the supply list for the CPT codes 369X4, 369X5, and 369X6.**

- CMS also proposes to refine the quantity of the "Hemostatic patch" (SG095) from 2 to 1 for CPT codes 369X4, 369X5, and 369X6.

    - CPT codes 369X4, 369X5, and 369X6 refer to the percutaneous thrombectomy procedures. These procedures require two different access sites within the dialysis circuit, which require hemostasis at the completion of the procedure. **The RUC recommends that the quantity of the "Hemostatic patch" (SG095) remain at 2 for CPT codes 369X4, 369X5, and 369X6.**

- CMS proposes to remove the recommended supply item "covered stent (VIABAHN, Gore)" (SD254) and replace it with the "stent, vascular, deployment system, Cordis SMART" (SA103) for CPT codes 369X3 and 369X6.

    - Covered stents are the only stent devices that are FDA approved and supported by evidence from randomized controlled trials for use in dialysis access procedures. They are typically used in recurrent or elastic stenosis in dialysis access and have become the standard of care for these interventions. They are also used to repair venous rupture caused by balloon angioplasty. This is the reason that a covered stent is included in 369x3 and 369x6. Bare metal stents are still used in central venous angioplasty because of concern that covered stents will occlude the internal jugular vein. That is the reason that the Cordis bare metal stent is included in 369x8. **The RUC recommends CMS keep SD254 in the supplies for codes 369X3 and 369X6.**

- CMS is soliciting comments regarding whether the Betadine solution has been replaced by a Chloraprep solution in the typical case for these procedures. CMS is also soliciting comments regarding whether the "ChloraPrep applicator (26 ml)" detailed on the submitted invoices is the same supply as the SH098 "chlorhexidine 4.0% (Hibiclens)" applicator currently in the direct PE database.

    - The RUC notes that in typical cases, Chloraprep solution has replaced Betadine solution when performing sterile preparation of the dialysis access circuit for the procedure. This is most accurately represent by the "ChloraPrep applicator (26 ml)" as was submitted by invoice. Hibiclens as listed, SH098 "chlorhexidine 4.0% (Hibiclens)", is a detergent sterilization material more often used for pre-cleaning an area prior to sterile preparation using either Betadine or Chloraprep. This is not typically used for sterile preparation prior to endovascular procedures.

- Finally, CMS also solicits comments about the use of guidewires for these procedures. They are requesting feedback about which guidewires would be typically used for these procedures, and which guidewires are no longer clinically necessary.

    - The dialysis access procedures (CPT codes 369X1-369X9) supply list include three guidewires for the procedures, a hydrophilic wire (SD089), for steering and navigating vessels, a "working wire", (SD172), which is used for initial access and delivering the vascular sheath into the vessel, and finally an Amplatz guidewire (SD252), which is more sturdy for delivering devices for interventions such as angioplasty and stenting. These three wires are the minimum required for these interventions and frequently additional wires are needed in more complicated cases or in cases in which more than one access must be used. The guidewires submitted are the bare minimum needed for the typical case by the specialty societies.

xiii. Esophageal Sphincter Augmentation (CPT codes 432X1 and 432X2)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
432X1	Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie, magnetic band), including cruroplasty when performed	10.13	9.03	Disagree
432X2	Removal of esophageal sphincter augmentation device	10.47	9.37	Disagree

Summary of CMS Actions:

- For CPT code 432X1, the RUC recommended a work RVU of 10.13.
- CMS compared 432X1 code to CPT code 43180 *Esophagoscopy, rigid, transoral with diverticulectomy of hypopharynx or cervical esophagus (eg, Zenker's diverticulum*), *with cricopharyngeal myotomy, includes use of telescope or operating microscope and repair, when performed* (work RVU = 9.03) which has identical intra-service time and similar total time.
- CMS believes the overall intensity of 432X1 and 43180 is similar, therefore, are proposing a direct crosswalk to 43180.
- For CPT code 432X2, the RUC recommended a work RVU of 10.47.
- CMS used the increment between the RUC-recommended work RVU for 432X2 and CPT code 432X1 (0.34 RVUs) to develop the proposed work RVU of 9.37 for CPT code 432X2.

RUC Comments:

- The crosswalk that CMS proposes, CPT code 43180 has 10 minutes less immediate post-service time and one less 99213 post-operative visit.
- The RUC recommended that CPT code 432X1 be crosswalked to CPT code 19301 *Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy* (work RVU = 10.13) as both require the same intra-service time and almost identical total time. Additionally, both services require similar work intensity to perform and are both outpatient procedures.
- For additional support, the RUC referenced neighboring CPT codes 45171 *Excision of rectal tumor, transanal approach; not including muscularis propria (ie, partial thickness)* (work RVU = 8.13 and 45 minutes) and 36821 *Arteriovenous anastomosis, open; direct, any site (eg, Cimino type) (separate procedure)* (work RVU = 11.90 and 75 minutes intra-service time).

The RUC urges CMS to accept the direct crosswalk to CPT code 19301 *Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy* **(work RVU = 10.13) for CPT code 432X1. The RUC also requests Refinement Panel consideration for this service.**

- The RUC recommended a direct crosswalk to CPT code 47562 *Laparoscopy, surgical; cholecystectomy* (work RVU = 10.47 and 80 minutes intra-service time). The RUC noted that although 47562 requires more intra-service time than the aggregate survey median time for 432X2, the median intra-service time may be understated because of the number of people without experience. The RUC noted that the total time for these services is nearly identical and both require similar work and intensity.

- For additional support of a 10.47 work RVU for 432X2, the RUC referenced MPC codes 50590 *Lithotripsy, extracorporeal shock wave* (work RVU = 9.77 and 60 minutes) and 57288 *Sling operation for stress incontinence (eg, fascia or synthetic)* (work RVU = 12.13 and 60 minutes intra-service time).

The RUC urges CMS to accept the direct crosswalk to CPT code 47562 *Laparoscopy, surgical; cholecystectomy* **(work RVU = 10.47) for CPT code 432X2. The RUC also requests Refinement Panel consideration for this service.**

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

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
47541	Placement of access through the biliary tree and into small bowel to assist with an endoscopic biliary procedure (eg, rendezvous procedure), percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation, new access	7.00	5.63	Disagree

Summary of CMS Actions:

- CMS accepted the revised recommendations sent by the RUC after review in the October 2015 meeting for all but one code. The initial recommendations were made in April 2015, but were deemed interim. For CPT code 47541, CMS notes that the survey times were identical as conducted for the April and October 2015 RUC meetings, yet the RUC recommendation increased from a work RVU of 5.61 in April to a work RVU of 7.00 in October. Therefore, the Agency crosswalked code 47541 to the work value of code 47533, work RVU= 5.63.

RUC Comments:

- The RUC disagrees with the CMS decision for CPT code 47541. Although the time is similar for codes 47541 and 47533, the patient for code 47541 is more complex with post-surgical anatomy and atypical problem (a post-surgical stricture of a biliary-enteric anastomosis). Therefore, the direct crosswalk creates a sharp rank order anomaly within the family. The RUC and the specialty societies spent considerable amounts of time, over two meetings, ensuring that the magnitude estimation within this family was appropriate. By drastically cutting the work value of 47541, CMS has created anomalous relationships between these services. **The RUC recommends that CMS accept the RUC recommendation of 7.00 work RVUs for CPT code 47541. The RUC also requests Refinement Panel consideration for these services.**

xv. Cystourethroscopy (CPT code 52000)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
52000	Cystourethroscopy (separate procedure)	1.75	1.53	Disagree

Summary of CMS Actions:

- CMS noted that the RUC recommended work RVUs of 1.75 for CPT code 52000 is larger than the work RVUs for all 000-day global codes with 10 minutes of intra-service time and CMS does not believe that the overall intensity of this service is greater than all of the other codes.

- CMS believes the overall work for 52000 compares favorably to CPT code 58100 *Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure* (work RVU = 1.53) and has identical intra-service time and similar total time.

- Therefore, CMS' is proposing a direct crosswalk to CPT code 58100 and a work RVU of 1.53 for CPT code 52000.

RUC Comments:

- The RUC urges CMS to accept the valid survey of 162 physicians 25th percentile work RVU of 1.75.

- The RUC recommendation was bracketed by the two key reference services and is relative to the physician work, time and intensity and complexity measures.

    - The top key reference service was 52005 *Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;* (work RVU = 2.37 and 30 minutes intra-service time) and the RUC noted that the physician time, work and intensity and

complexity required to perform 52005 is much greater, thus the recommended RVU is appropriate.

- The RUC compared the surveyed code to the second key reference service 57420 *Colposcopy of the entire vagina, with cervix if present;* (work RVU = 1.60 and 19 minutes intra-service time) and noted the physician time is slightly higher, but the survey respondents indicated that CPT code 52000 is slightly more intense and complex to perform for all measures (mental effort, technical skill and psychological stress) and thus is appropriately valued slightly higher than 57420.

The RUC urges CMS to accept the work RVU of 1.75 for CPT code 52000. The RUC also requests Refinement Panel consideration for this service.

xvi. Biopsy of Prostate (CPT code 55700)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
55700	Biopsy, prostate; needle or punch, single or multiple, any approach	2.50	2.06	Disagree

Summary of CMS Actions:

- The RUC reviewed this code for physician work and practice expense and recommended a work RVU of 2.50 based on the 25th percentile of the survey.
- CMS believes the RUC recommended work RVU overestimates the work involved in furnishing 55700 given the reduction in total service time; specifically, the reduction in pre-service and post-service times.
- CMS noted that that the RUC recommendation also appears overvalued when compared to similar 000-day global services with 15 minutes of intra-service time and comparable total times. CMS is proposing to crosswalk the work RVUs for this code from CPT code 69801 *Labyrinthotomy, with perfusion of vestibuloactive drug(s), transcanal*, noting similar levels of intensity, similar total times, and identical intra-service times.
- Therefore, CMS is proposing a work RVU of 2.06 for CPT code 55700.

RUC Comments:

- The RUC compared 55700 to other 000-day global services with 15 minutes of intra-service time and determined that the intensity required for 55700 (0.1416 IWPUT) was appropriate relative to the physician work required.

- The RUC compared the surveyed code to similar services 93503 *Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes* (work RVU = 2.91, intra-service time of 15 minutes and 0.1659 IWPUT) and 36556 *Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older* (work RVU = 2.50, intra-service time of 15 minutes and 0.1192 IWPUT) and the RUC determined that these services required the same intra-service time, comparable physician work and intensity.

  The RUC urges CMS to accept the work RVU of 2.50 for CPT code 55700. The RUC also requests Refinement Panel consideration for this service. Additionally, the RUC continues to urge specialty societies to submit invoices for new equipment.

xvii. Hysteroscopy (CPT codes 58555-58563)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
58555	Hysteroscopy, diagnostic (separate procedure)	3.07	2.65	Disagree
58558	Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C	4.37	4.17	Disagree
58559	Hysteroscopy, surgical; with lysis of intrauterine adhesions (any method)	5.54	5.20	Disagree
58560	Hysteroscopy, surgical; with division or resection of intrauterine septum (any method)	6.15	5.75	Disagree
58561	Hysteroscopy, surgical; with removal of leiomyomata	7.00	6.60	Disagree
58562	Hysteroscopy, surgical; with removal of impacted foreign body	4.17	4.00	Disagree
58563	Hysteroscopy, surgical; with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation)	4.62	4.47	Disagree

Summary of CMS Actions:

- For each of the seven codes in the hysteroscopy family, CMS chose a different direct crosswalk to a value lower than the RUC recommendations.
  - CPT code 58555- CMS crosswalk to CPT codes 43191 *Esophagoscopy, rigid, transoral* and 31295 *Nasal/sinus endoscopy, surgical*

- CPT code 58558- CMS crosswalk to CPT code 36221 *Non-selective catheter placement, thoracic aorta, with angiography of the extracranial carotid, vertebral, and/or intracranial vessels, unilateral or bilateral, and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed*

- CPT code 58559- CMS crosswalk to CPT code 52315 *Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); complicated*

- CPT code 58560- CMS crosswalk to CPT code 52351 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic*

- CPT code 58561- CMS crosswalk to CPT code 35475 *Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel*

- CPT code 58562- CMS crosswalk to CPT code 15277 *Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm*

- CPT code 58563- CMS crosswalk to CPT code 33962 *Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician*

RUC Comments:

- For each code, CMS simply lists a crosswalk code and states that this new, lower value, more accurately reflects the resources involved in furnishing the services. CMS does not indicate that they seriously reviewed the robust survey data that the RUC submitted or considered any discussions the RUC had regarding the differing intensities amongst the family. This is shown in that CMS proposes a 20.4% reduction in value, with an overall 20% reduction in time from the surveys for the family. It appears that CMS used a time to work ratio to value these services.

- For example, for CPT code 58555, this service requires a forced dilation of a natural orifice, very small in size and can be difficult to identify especially in a post-menopausal patient or a patient with prior cervical surgery. The CMS crosswalk codes are for a natural orifice that might not require any dilation or only a10% dilation. The orifice is consistently the same with little variation among patients.

- For CMS's other crosswalk codes (36221, 35475, 15277 and 33962), these are all not natural orifice procedures. They are catheter procedures and cutaneous procedures, so they are not as invasive to the body as the hysteroscopy procedures.

The RUC urges CMS to accept the RUC recommendations as originally submitted:

- **CPT code 58555, work RVU= 3.07**
- **CPT code 58558, work RVU= 4.37**

- **CPT code 58559, work RVU= 5.54**
- **CPT code 58560, work RVU= 6.15**
- **CPT code 58561, work RVU= 7.00**
- **CPT code 58562, work RVU= 4.17**
- **CPT code 58563, work RVU= 4.62**

xviii. Epidural Injections (CPT codes 623X5, 623X6, 623X7, 623X8, 623X9, 62X10, 62X11, and 62X12) *Rejected PE Only*

Summary of CMS Actions:

- CMS proposes to accept the RUC-recommended work RVU for all eight of the codes in this family.

- CMS proposes to remove the 10-12ml syringes (SC051) and the RK epidural needle (SC038) from all eight of the codes in this family, stating that they are duplicative of the epidural tray (SA064).

RUC Comments:

- The RUC appreciates that CMS is proposing to accept the RUC recommended work RVUs for all eight of the codes in this family.
- The RUC disagrees that the 10-12ml syringes (SC051) and the RK epidural needle (SC038) are duplicative of the epidural tray (SA064). Although there are three syringes listed in the epidural tray, none of the syringes in the tray are the 10-12ml syringe. One 10-12ml syringe is needed for codes without imaging guidance and two 10-12ml syringes are needed for codes with imaging guidance. In addition, none of the needles currently listed in the epidural tray (SA064) are an epidural needle. The RUC and the specialties agree that the RK needle may not be necessary; however there is no question that an epidural needle is needed to perform the services.
- Everything in the epidural tray (SA064) is used in these services and in addition the 10-12ml syringes (SC051) and an epidural needle is needed. As such, there is no reason to replace the epidural tray with the individual components.
- The RUC will work with the specialty societies that perform this service to provide CMS with paid invoices to update the current typical commercial contents and pricing of the epidural tray (SA064).

The RUC recommends that CMS accept the RUC recommendation for the 10-12ml syringes (SC051) for all eight of the codes in this family. Additionally, the RUC recommends that CMS maintain the epidural tray as an input for these codes rather then divide it into individual supply components and add an epidural needle to the epidural tray (SA064).

xix. Endoscopic Decompression of Spinal Cord Nerve (CPT Codes 630X1)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
630X1	Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar	10.47	9.09	Disagree

Summary of CMS Actions:

- CMS believes the recommendation for 630X1 overestimates the overall work involved in performing these procedures. The Agency proposed a direct work RVU crosswalk to CPT code 49507 *Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated* (work RVU= 9.09), noting their observation that both services have similar intensity and identical intraservice physician time.

- The RUC appreciates that CMS accepted the RUC's direct practice expense and physician time recommendations for this service.

RUC Comments:

- The RUC recommended a direct work RVU crosswalk to MPC code 47562 *Laparoscopy, surgical; cholecystectomy* (work RVU=10.47). CPT codes 630X1 and 47562 have similar physician time, however the RUC agreed the intensity of 630X1 was greater, offsetting the 10 minute difference in intra-service time between the two codes. The difference in intensity between these procedures is based upon 630X1 involving decompression around neural elements and the spinal cord, where opportunity for complications and for loss of function is high. The IWPUT of the RUC recommended value is 0.085, a comparable valuation when compared with other spinal decompression procedures. The RUC determined that these two codes were appropriate comparators.

  The RUC urges CMS to accept the work RVU of 10.47 for CPT code 630X1. The RUC also requests Refinement Panel consideration for these services.

xx. Retinal Detachment Repair (CPT codes 67101 and 67105)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
67105	Repair of retinal detachment, 1 or more sessions; photocoagulation, including drainage of subretinal fluid, when performed	3.84	3.39	Disagree

Summary of CMS Actions:

- CMS noted that historically CPT code 67105 has been valued lower than code 67101. Given this historical precedence, CMS calculated the ratio between the Harvard valued work RVUs for the two procedures and applied the resulting quotient to the RUC recommended value for 67101.

RUC Comments:

- These two CPT codes are currently Harvard valued and thus haven't had their work valued in nearly 30 years. During the Harvard studies, CPT code 67101 was valued higher due to greater total time. However, now photocoagulation is reported at vastly higher levels than the cryotherapy procedure, as it is considered to be a more effective treatment. Given the changing nature of the service since the last valuation decades ago, the RUC agreed that the intensity of code 67105 is now greater.

  CMS should accept the original RUC recommendation of 3.84 work RVUs for CPT code 67105.

xxi. Fluoroscopic Guidance (CPT codes 77001, 77002, and 77003)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
77001	Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)	0.38	0.38	Agree
77002	Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)	0.54	0.38	Disagree
77003	Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid) (List separately in addition to code for primary procedure)	0.60	0.38	Disagree

Summary of CMS Actions:

- For CPT code 77001, CMS is proposing the RUC recommended work RVU of 0.38.
- CMS indicated that they believe that the RUC recommended work RVUs for CPT codes 77002 and 77003 do not appear to account for the significant decrease in total times for these codes relative to the current total times.
- CMS believes that these three codes describe remarkably similar services and have identical intra-service and total times.
- Based on the identical times and notable similarity for all three of these codes, CMS is proposing a work RVU of 0.38 for all three codes.

RUC Comments:

- The RUC noted that the only reason there was a recommended decrease in time for the pre-service and post-service was because CMS changed the global period from an XXX service to a ZZZ add-on service.
- The RUC clearly stated that it discussed the same physician time for all three services and agreed with the specialty societies that the physician work, intensity and complexity of 77001, the central venous catheter code, is less compared to 77002 and, likewise, the physician work, intensity and complexity for 77002 is less than that required to perform 77003.
- The intensity regarding guidance relates to the nature of the base code with which these services were reported. The intensity and complexity increases as the physician moves through the body where there are additional anatomy considerations, superficial and deep structures to consider with 77002 and then additional neuro and spinal structures to consider when performing 77003.

  The RUC urges CMS to acknowledge the different intensity and physician work required for these three services. The RUC urges CMS to accept a work RVU of 0.54 for CPT code 77002 and 0.60 for 77003. The RUC also requests Refinement Panel consideration for these services.

xxii. Radiation Treatment Devices (CPT codes 77332, 77333, and 77334)

CPT Code	CPT Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
77332	Treatment devices, design and construction; simple (simple block, simple bolus)	0.54	0.45	Disagree

77333	Treatment devices, design and construction; intermediate (multiple blocks, stents, bite blocks, special bolus)	0.84	0.75	Disagree
77334	Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)	1.24	1.15	Disagree

Summary of CMS Actions:

- CMS disagreed with the RUC's recommendation to maintain the work values below the survey 25th percentile for CPT code 77332, 77333 and 77334. CMS recommended a crosswalk to CPT code 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* (work RVU = 0.45). Starting with 0.45 for 77332, CMS proposes to maintain the same increment recommended by the RUC proposing a decreased work value of 0.75 for 77333 and 1.15 for 77334.

RUC Comments:

- In the *Proposed Rule* for 2016, CMS justified the decrease in work value for 77332 by arguing that maintaining the work value does not reflect the decrease in total time from 28 minutes to 18 minutes, however in decreasing the work value, CMS ignores that it is not appropriate to compare the surveyed time to the current CMS/Other source time, which represents time, not derived from a survey, but assigned by CMS over 20 years ago.

- It is unclear if crosswalk code 93287 is being compared to the current physician work time of 77332 or the survey time that the RUC recommendation was based on. In either case the statement that crosswalk code 93287 has "…identical intraservice time, similar total time, and similar level of intensity" is false. If the comparison is based on the current physician work time, there is no separate intra-service time available for the current value of CPT code 77332 because its source time is CMS/Other and the only information we have is the total time of 28 minutes. Furthermore the intensity cannot be calculated without the intra-service time being separated out. If the comparison is based on the RUC recommendation, the intraservice time is 15 minutes, not identical to CPT code 93287 intraservice time of 13.5 minutes, the total time is 18 minutes, not similar to CPT code 93287 total time of 26 minutes and the intensity is 0.032, not similar to CPT code 93287 intensity of 0.0126.

- Crosswalk code 93287 is not a radiation treatment services and should not be used to determine the value of 77332.

- CPT codes 77333 and 77334 are valued by CMS incrementally based on the base code 77332 for a simple procedure. The RUC does not disagree with this approach as it is the same approach used by the RUC, but the RUC does disagree with the anchor value for 77332 and as a result the decreased work values for 77333 and 77334.

- CMS' states in the *Proposed Rule* that a 34 percent reduction in total time is not reflected in the recommended RVUs, thus CMS believes that the recommended RVUs overstate the work involved. That is a **misleading** statement and argument. The RUC survey times and the existing times are (1) almost identical for 77334, (2) identical for 77333 and (3) greater than for 77334.

CPT Code	RUC survey total time	Existing time
77332	25 minutes (5, 15, 5)	28 minutes
77333	33 minutes (8, 20, 5)	33 minutes
77334	45 minutes (10, 30, 5)	35 minutes

- These treatment device codes are XXX global periods and do not have standard pre or post service packages. These standard pre and post services packages did not exist at the time that this service was valued and therefore the convention of eliminating pre-service time and applying minimal post-service time to services that with XXX global periods was not applied at that time.

- The recommended/existing values along with the refined/surveyed RUC times yield reasonable and appropriate intensities for these services.

CPT Code	wRVU	IWPUT	Total Time	Pre	Intra	Post
77332	0.54	0.032	18	-	15	3
99212	0.48	0.034	16	2	10	4
77333	0.84	0.036	25	-	20	5
77334	1.24	0.038	35	-	30	5
77470	2.09	0.040	55	-	50	5
77300	0.62	0.041	15	-	15	-
77295	4.29	0.042	112	7	90	15
77301	7.99	0.050	195	30	130	35
99213	0.97	0.053	23	3	15	5

- After CMS found a crosswalk to lower the value for 77332, they then systematically reduced the intermediate and complex codes. There is no data to support these arbitrary reductions. If you look at CPT Code 77334 the surveyed time is greater, the RUC recommended time is identical – yet CMS is reducing the RVUs because they reduced 77332.

  The RUC urges CMS to accept the RUC recommended work RVUs of 0.54, 0.84 and 1.24 for CPT codes 77332, 77333 and 77334 respectively.

xxiii. Special Radiation Treatment – CPT Code 77470 *Rejected PE Only*

Summary of CMS Actions:

- CMS is approving the RUC recommended work RVU value of 2.03. However, CMS expressed concern that the description of the service and the vignette used for the RUC recommendation describes different and unrelated treatments being performed by the physician and clinical staff for a typical patient. According to CMS, this represents a discrepancy between the work RVUs and the PE RVUs. CMS is seeking feedback on whether the issue can be addressed through the establishment of two G-Codes, one, which describes the physician work portion of the service and one which describes the PE portion.

RUC Comments:

- For clarification, the Medicare data shows ICD9 code 162 *MALIGNANT NEO TRACHEA/BRONCHUS/LUNG* to be the typical patient. The vignette used on the RUC physician work survey was {a 68-year-old male with stage IIIA non- small cell lung cancer will be treated with chemo/radiotherapy preoperatively}. The description of physician work describes the work done for a typical 77470 patient.

- The RUC recommended description of clinical labor for practice expense is for a lung special procedure. The clinical description of labor submitted and presented describes what the radiation therapist typically performs in a lung case that requires a special procedure service.

- The issue may be that some of the description uses the term "treatment device". Although that term also appears in CPT codes (77332-77334), those codes describe the design and construction of treatment devices. It is important to note that the treatment device codes were surveyed and presented at the same meeting. The work is not the same.

- The RUC does not agree with CMS' proposal to create two new G-Codes, one to describe the physician work portion of the service and one to describe the PE portion. The CPT descriptor is accurate and represents the typical patient in the Medicare database and what was surveyed and presented on both the work and PE side.

- The direct practice expense inputs include clinical labor and no supplies or equipment. When the code is used for another diagnosis the resources would be the same and do not pose any issues.

- If CMS is suggested that there be multiple CPT codes for every possible diagnosis for the use of this code, the RUC does not support that approach nor is it the appropriate use of CPT coding.

  The RUC urges CMS to finalize the practice expense RUC recommendation for CPT code 77470.

xxiv. Flow Cytometry Interpretation (CPT codes 88184, 88185, 88187, 88188, and 88189)

CPT Code	CPT Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
88188	Flow cytometry, interpretation; 9 to 15 markers	1.40	1.20	Disagree

Summary of CMS Actions:

- CMS disagreed with the survey 25th percentile work RVU of 1.40 for CPT code 88188 and recommended a crosswalk to CPT code 88120 *Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; manual* (work RVU = 1.20).

- CMS disagreed with some of the direct PE inputs for CPT codes 88184 and 88185. They have suggested a CPT coding change to consolidate the base code and the add-on code into one code to describe the technical component of flow cytometry. Absent a coding change they have proposed a number of refinements to the direct PE inputs.

RUC Comments:

- CMS proposes a cross-walked value of 1.20 for CPT code 88188 rather than the RUC recommended value of 1.40. The RUC disagrees with the cross-walked value for several reasons. First, the CMS states that the value was arrived at "by noticing that there were no comparable codes with no global period in the RUC database with intra-service time and total time of 30 minutes that had a work RVU higher than 1.20." This statement is not supported as there are at least 10 such codes, valued over 1.20 RVUs in the 2016 RUC database (1 XXX and 9 ZZZ global codes, ZZZ codes that are add-on codes to XXX codes). These 10 codes range in work value from 1.38 to 2.40 RVUs, with a median of 1.67.

- The RUC disagrees with CMS that there is a "current maximum value" for pathology services. CMS does not take into account that the RUC survey collects information from respondents about time, intensity and relative value. If the survey respondents select a relative value unit that is greater than other codes with the same intra-service time, it indicates that the work intensity is significantly greater than other services with the same intra-service time. CMS ignores that survey respondents rated CPT code 88188 as having higher intensity/complexity measures than key reference service 88307 *Level V - Surgical pathology, gross and microscopic examination…*(work RVU = 1.59, intra-service time of 47 minutes).

- CMS should realize that the establishment of physician work value that is greater than any other within its global concept and physician time is not unprecedented. New and revised medical services and procedures are constantly being developed and refined. The

establishments of new physician work values reflect the resources utilized to provide them. The RUC disagrees with the logic that led to the CMS proposed cross-walk of CPT code 88188 to CPT code 88120 because the step by step physician work efforts are very different, as are their intensities and complexities.

- The specialty originally recommended work values had almost identical increments between the three services (0.60 between 88187 and 88188, and 0.63 between 88188 and 88189); however the median survey results indicated a much greater physician work increment between 88188 and 88189. The final RUC recommendations were based off of the physician expertise of the RUC process whereas the work increments between 88187 and 88188 became more pronounced (0.74) than the difference between 88188 and 88189 (0.30). The 25th percentile work RVUs also reflected a more pronounced work increment between 88187 and 88188 (0.40) in relation to the work increment between 88188 and 88189 (0.30). It is apparent that RUC agreed with this relationship and agreed with the cross-walk of CPT code 88346 to code 88187. In addition, if the median survey increment between 88187 and 88188 (0.60) was added to the final value of 88187 the work RVU would be 1.34. However, the 25th percentile survey results and the RUC's opinion that there should be a more pronounced increment of work between 88187 and 88188 than for 88188 and 88189 presents validation of the RUC recommended work value of 1.40 for CPT code 88188.

- The RUC reviewed the physician work of the flow cytometry services and they recognized that over the last decade, flow cytometric analyses have changed through new technological advances that have led to an increased interpretative sophistication. It is now typical for the physician to analyze substantially more data than in the past. With the advent of 5, 6, 8, and 10 color flow cytometry the intensity and complexity of these services has significantly increased. This increased intensity and complexity is reflected in the RUC recommendation for this service, based on new physician work associated with technological changes, time, and intensity. The RUC recommended work RVU for 88188 is based on survey results from 82 practicing pathologists from a random survey. The RUC recognized the difference in physician time from the initial work survey performed 12 years ago and understood that technological advances had reduced the physician time and work for these services. The RUC agreed with the specialty's survey effort, comparisons of the key reference services and the recommendation of the 25th percentile survey results which reflected a 17% decrease in the physician work value from its current value.

- The RUC will address the individual refinements proposed for CPT codes 88184 and 88185 in the response to the PE refinements listed in Table 25.

The RUC urges CMS to accept the survey 25th percentile work RVU of 1.40 for CPT code 88188. The RUC also requests Refinement Panel consideration for these services.

xxv. Mammography - Computer Aided Detection Bundling (CPT codes 770X1, 770X2 and 770X3) *Rejected PE Only*

Summary of CMS Actions:

- CMS has proposed to accept the RUC-recommended work RVUs, but to crosswalk the PE RVUs for the technical component of the current corresponding G-codes and seek further pricing information for the recommended equipment items.

RUC Comments:

- The RUC appreciates that CMS will accept the RUC recommended work RVUs for 2017. The RUC understands the concern about a drastic reduction in the Medicare payment for mammography services if the transition to the RUC recommended PE inputs moves forward, however since these services were based on legislative statute and implemented a fixed PE RVU rather than using PE RVUs developed under the standard PE methodology, any switch to direct practice expense inputs will result in a cut to the PE RVU whether it be implemented now or in the future.

- The RUC does not agree with CMS assertion that the RUC recommendations need to be reconsidered and that additional comment is needed. It is true that only one medical specialty society has provided CMS with a set of single invoices to price the equipment used in furnishing these services, but the specialty that provided the invoices is the specialty that performs these service and is most qualified and able to provide the correct invoices. Additional invoices will likely not be possible nor are they likely to have a significant impact on the pricing of the equipment.

- Additionally, in the CMS direct PE inputs files it appears that the inputs are what the RUC recommended so the RUC is unclear on whether or not CMS will or will not be implementing the RUC PE recommendation.

- The RUC has the following specific comments on the direct PE inputs listed in the CMS database:

    - The clinical activity "Technologist QC's images in PACS, checking for all images, reformats, and dose page" has been refined from 4 minutes to 3 minutes based on a CMS proposed "standard." Mammography is among the more complex examinations for QC. The QC activities associated with Mammography with CAD are defined by MQSA requiring additional time to ensure these standards are met and that the acquisition is sufficient to evaluate for subtle masses, densities and micro-calcifications. It is also critical that the entire breast tissue is included including the axillary region and breast tail.

    - The PACS Mammography Workstation – the RUC approved the inclusion of physician work post-service time in the calculation of PACS Mammography Workstation for diagnostic mammography since the physician typically reviews the images with the patient following the procedure. However, CMS currently proposes to only use the physician work intra time and half of the physician work pre time. The RUC recommends that CMS accept the RUC recommendation to use the entire physician work pre, intra and post work times. In the pre-time, the physician is engaged on the workstation reviewing prior examinations and guiding the technologist on the proper diagnostic images to obtain based on the screening study when warranted.

- In lieu of the digital mammography room, CMS is instead proposing to implement several individual components. However, CMS excluded several items that are listed/recommended in Table 17 of the *Proposed Rule*. The RUC recommends that CMS include the entire digital mammography room as summarized in Table 17 of the *Proposed Rule* and for which invoices have been provided.

xxvi. Closure of Paravalvular Leak (CPT codes 935X1, 935X2, and 935X3)

CPT Code	CPT Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
935X1	Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve	21.70	18.23	Disagree
935X2	Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve	17.97	14.50	Disagree
935X3	Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve each additional occlusion device (List separately in addition to code for primary service)	8.00	6.81	Disagree

Summary of CMS Actions:

- For CPT code 935X2, CMS disagreed with the RUC's recommended crosswalk to CPT code 93580 *Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant* (work RVU= 17.97), stating that "a direct crosswalk to CPT code 37227 accurately reflects the time and intensity described in CPT code 935X2 since CPT code 37227 also describes a transcatheter procedure with similar service times.

- For CPT code 935X1 CMS applied the RUC identified work RVU of 3.73 for a transseptal puncture, to the work value applied to 935X2 and derived a proposed work RVU of 18.23.

- For CPT code 935X3, CMS disagreed with the survey 25th percentile work RVU of 8.00 and instead proposed a crosswalk to CPT code 35572 *Harvest of femoropopliteal vein, 1 segment, for vascular reconstruction procedure (eg, aortic, vena caval, coronary, peripheral artery) (List separately in addition to code for primary procedure),* with a work RVU of 6.81.

RUC Comments:

- The RUC recommended that CPT code 935X2 be crosswalked to CPT code 93580 *Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant.*

    - These codes have nearly identical service times and are both percutaneous transcatheter procedures to treat structural heart disease. Despite CMS indication otherwise, the RUC recommended crosswalk code 93580 is a much better crosswalk by every measure. CMS proposed that CPT code 935X2 be crosswalked to CPT code 37227 *Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed*. These two codes also have similar service times and are both percutaneous. However, CMS's proposal fails to correctly recognize the higher intensity of 935X2 in relationship to 37227. CPT code 935X2 is a service that treats a structural defect inside the heart, not an obstructed artery in the leg. The clinical similarities and higher intensity of transcatheter structural heart therapies matter. The RUC opposes CMS' assertion that a cardiovascular intervention performed in an immobile leg is comparable in intensity and patient risk to an intervention performed in a beating, moving heart. Further speaking to the difference in intensity and risk, Lower Extremity Revascularization (LER) procedures (such as that represented by 37227) are safely performed in the non-hospital, non-facility, office setting. More than half of the procedures reported using code 37227 are performed in the office setting. Whereas, Structural Heart Disease procedures, such as PVL cannot be performed in the office setting. Due to the intensity and risks associated with these procedures, they must be performed in a facility setting and most typically are performed in special hybrid suites, in collaboration with imaging (e.g. TEE) and cardiac anesthesia expertise, needed to accommodate the special imaging needs above and beyond traditional angiography. The RUC disagrees with this proposal that incorrectly links a percutaneous transcatheter structural heart therapy to a lower extremity revascularization therapy that is less intense and recommends CMS adopt the RUC recommendations for these services.

    - Structural heart disease procedures are more intense than cardiovascular LER procedures. Unlike LER procedures, which are most commonly performed under moderate sedation, structural heart disease procedures, like PVL, are most typically performed under general anesthesia, involving greater intensity and supporting the need for greater coordination amongst the Heart Care Team (interventional cardiologist, cardiac anesthesiologist, imaging specialist, heart failure specialist). Frequently, the approach to paramitral defects includes a complex antegrade transseptal procedural expertise. In addition to the unique cardiac anesthesia needs and coordination, structural heart disease procedures also have unique imaging needs as compared to LER, requiring intraoperative transesophageal echocardiography (TEE) or real-time 3-dimensional TEE guidance be provided, in addition to standard angiography techniques, with TEE being performed by yet another physician member of the Heart Care Team, leading to even more coordination amongst providers with greater intensity and patient risk. Some procedures (e.g. for paramitral defects) require collaboration of a cardiothoracic

surgeon, with alternative approaches including retrograde transaortic cannulation or transapical access and retrograde cannulation.

- The below table demonstrates the anomaly CMS would create were it to value temporally and clinically similar services in a fashion that ignores the higher intensity of percutaneous transcatheter structural heart therapies.

CPT Code	Short Descriptor	Work RVU	Intraservice Time	Total Time	IWPUT
93580	Transcatheter closure of atrial septal defect	17.97	120	210	0.1329
935X2	Transcatheter closure of aortic paravalvular leak	-	120	208	-
37227	Femoral, popliteal stent and atherectomy	14.50	125	203	0.1026

- CMS claims that 37227 more accurately reflect the time, however 93580 has identical intraservice time and 37227 does not. In addition, 37227 is less complex to perform then both the new code 935X2 and the RUC proposed crosswalk 93580.

- The RUC noted the additional work associated with CPT code 935X1 compared to CPT code 935X2 was due to the addition of a transseptal puncture to access the mitral valve. The RUC identified a work RVU of 3.73 for a transseptal puncture from add-on code 93462 *Left heart catheterization by transseptal puncture through intact septum or by transapical puncture*. The RUC recommended that 3.73 RVUs be added to the RUC recommended RVU of 17.97 for 935X2. This produces a work RVU of 21.70 for 935X2. CMS proposes to add the work RVU of 3.73 to its proposed reduced value of 14.50 for 935X2. This produces a work RVU of 18.23 for 935X2. Although the RUC supports CMS's decision to apply 3.73 to the base code work value of 935X2, we reiterate that the work RVU for 935X2 should be the higher 17.97 value and the resulting work RVU for 935X1 should be 21.70.

- The final code in this family is an add-on for placement of additional prostheses. It can be used for either the mitral or aortic valve services. The RUC recommended the survey 25th-percentile work RVU of 8.00 for code 935X3 *Percutaneous transcatheter closure of paravalvular leak; each additional occlusion device (list separately in addition to code for primary service* with the survey median intraservice time of 60 minutes. To support this recommendation, the RUC compared 935X3 to code 33884 *Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); each additional proximal extension (List separately in addition to code for primary procedure).* This service has an identical 60 minutes intraservice time. It also has several clinical similarities to 935X3—it is an endovascular repair and involves placement of prosthesis. CMS proposes a lower work RVU of 6.81 for 9358X3, crosswalked from a

different 60-minute add-on code, 35572 *Harvest of femoropopliteal vein, 1 segment, for vascular reconstruction procedure (eg, aortic, vena caval, coronary, peripheral artery) (List separately in addition to code for primary procedure).* This comparison is just clearly inappropriate and does not recognize the intensity and skill level needed to place a PVL device in a moving, beating heart, frequently in the setting of heart failure. This service is only similar to 935X3 in that it is cardiovascular in nature. Surgical harvest of a lower extremity vein is not clinically similar to the transcatheter percutaneous structural heart therapies already discussed. 9358X3 is an additional unit of 9358X1 or 9358X2 and should have a similar, higher intensity—as shown in the below table—that aligns with the RUC recommendations for 9358X1 and 9358X2.

CPT Code	Short Descriptor	Work RVU	Intraservice Time	Total Time	IWPUT
33884	Placement of endovascular prosthesis extension, additional extension	8.20	60	60	0.1367
935X3	Transcatheter closure of paravalvular leak, additional prosthesis	-	60	60	-
35572	Femoropopliteal vein segment harvest	6.81	60	60	0.1135

- CMS should not discount the survey respondents' selection of 8.00 as the 25th percentile by choosing to crosswalk to a lower value without providing clinical evidence to support that the survey respondents overvalued the service.

The RUC urges CMS to accept the RUC recommended work RVUs of 21.70, 17.97 and 8.00 for CPT codes 935X1, 935X2 and 935X3 respectively.

xxvii. Parent, Caregiver-Focused Health Risk Assessment (CPT Codes 961X0, 961X1)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
961X0	Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument	0.00	0.00	Agree
961X1	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	Inactive	Disagree

Summary of CMS Actions:

- For CPT Code 961X1, CMS proposed a Medicare status indicator of 'I' (invalid for Medicare purposes), stating its belief that the 'typical patient is not a Medicare beneficiary' as the reason behind its actions. Furthermore, the Agency did not propose any direct practice expense inputs for 961X1.
- The RUC appreciates that CMS accepted the RUC's direct practice expense recommendations for 961X0.

RUC Comments:

- For 961X1, the RUC-presenting specialty has clarified that there are patient populations that would receive this service who are potentially eligible for Medicare coverage. These would include geriatric patients who are cared for by another adult, who may themselves have significant physical or mental health difficulties. The same may be true for non-elderly adults whose physical or cognitive status renders them incapable of independent living and dependent on another adult caregiver. Some examples might be intellectually disabled adults, seriously disabled military veterans and adults with significant musculoskeletal or central nervous system impairments. **We recommend for CMS to reconsider the Medicare payment status for 961X1.**

- Even when the Agency proposes to not cover a service for Medicare Beneficiaries, it is critical for CMS to value all services that would likely be covered by other government programs and private payors. Given that CMS is the agency responsible for administration of several key federal health care programs – including Medicaid – CMS' failure to value code 961X1 in the proposed rule is unacceptable. **The RUC recommendation for 961X1 has been appended to this letter** *(See Addendum H & I - Parent, Caregiver-focused Health Risk Assessment)***. We urge CMS to value this this service, irrespective of whether the code is assigned Medicare active status, as Medicaid and many other payors rely on Medicare valuation to determine their respective payment rates.**

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

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
96931	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition and interpretation and report, first lesion	0.80	0.75	Disagree
96932	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition only, first lesion	PE Only	PE Only	Agree
96933	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; interpretation and report, first lesion	0.80	0.75	Disagree

96934	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition and interpretation and report, each additional lesion (List separately in addition to primary procedure)	0.76	0.71	Disagree
96935	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition only, each additional lesion (List separately in addition to primary procedure)	0.00 (PE Only)	0.00 (PE Only)	Agree
96936	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; interpretation and report only, each additional lesion (List separately in addition to primary procedure)	0.76	0.71	Disagree

Summary of CMS Actions:

- CMS believes the recommendation for 96931, 96933, 96934 and 96936 overestimate the overall work involved in performing these services. The Agency proposed a direct work RVU crosswalk to CPT code 88305 *Level IV - Surgical pathology, gross and microscopic examination…* (work RVU= 0.75), citing general similarities between the services and identical intra-service times. The Agency also proposed to remove 3 minutes of pre-service time from these two services, explaining that the reference code they selected does not have pre-service time. For add-on codes 96934 and 96936, CMS is maintaining the 0.05 increment from the RUC recommendations and proposing a value of 0.71 after applying that increment to their proposed RVUs for the base codes.

RUC Comments:

- The RUC strongly disagrees with pre-service time being removed from a survey code simply due to a key reference code not also having pre-service time. 96931 and 96933 are distinct procedures from 88305; CMS proposal to remove 3 minutes of pre-time from the base RCM codes is grounded on faulty logic. The RUC agreed with the specialty that 3 minutes of pre-service time is necessary for the physician to review clinical history and referral information. With the 3 minutes of pre-service time, the RUC recommendation for the RCM base codes is appropriately in line with top key reference code 88305.

- CMS should use the valid RUC survey data for these services.

  The RUC urges CMS to accept the survey 25th percentile work RVU of 0.80 for CPT codes 96931 and 96933 and the 25th percentile work RVU of 0.76 (from 96936) for both 96934 and 96936. The RUC also requests Refinement Panel consideration for these services.

xxix. Prostate Biopsy, Any Method (HCPCS code G0416)

CPT Code	CPT Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
G0416	Surgical pathology, gross and microscopic examinations, for prostate needle biopsy, any method	4.00	3.60	Disagree

Summary of CMS Actions:

- CMS disagreed with the RUC's recommended crosswalk to CPT code 38240 *Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor* (work RVU= 4.00). CMS then used the intraservice time ratio between CPT code G0416 and CPT code 88305 to arrive at a work RVU of 3.60.

RUC Comments:

- The RUC does not agree with the CMS formulaic approach of multiplying time by intensity to arrive at a value for this code.

- The RUC valued HCPCS code G0416 through agreement of the presented cross-walk methodology and solid compelling evidence. The RUC would also like to reiterate the compelling evidence presented by the specialties and that the work of G0416 may involve the examination of 30-60+ specimens. The RUC urges the Agency to discard its time ratio methodology to value the physician work and adopt the proven RUC's methodologies of physician surveys, expert panel opinions, cross-walks, and magnitude estimation.

- The RUC agrees that CPT code 88305 accurately and specifically addresses the full work of the evaluation of a single prostate biopsy specimen. However, the RUC argues that the relationship was anomalous because CPT code 88305 has a work RVU of 0.75 and only evaluates a single specimen. CMS had stated they believe the typical number of specimens evaluated for prostate biopsies was between 10 and 12, and a specialty society statistical review of Medicare's 2013 5% sample also found that 12 specimens were typical. Therefore, the typical G0416 would be valued at 9.00 work RVUs (0.75 x 12) if the number of specimens were used rather than the time ratio. Using CMS time ratio approach would mean that only 4.8 specimens could be evaluated using G0416 at the proposed work value of 3.60. This approach goes against CMS own assertion that the typical number of specimens evaluated for prostate biopsies is between 10 and 12. In fact, the RUC agreed with compelling evidence presented by the specialties that the work of G0416 may involve the examination of 20-60 or even more specimens.

The RUC urges CMS to accept the RUC recommended work RVUs of 4.00 for CPT code G0416. The RUC also requests Refinement Panel consideration for these services.

D. *Valuation of Specific Codes CY 2017 Proposed Codes That Were Also CY 2016 Proposed Codes*

i. Genitourinary Procedures (CPT codes 50606, 50705, and 50706)

- The RUC appreciates that CMS proposes to finalize the RUC recommended physician work values for CPT codes 50606, 50705 and 50706; however the RUC strongly opposes the proposed action of CMS regarding the direct PE inputs for these CPT codes. At the January 2015 RUC meeting, the PE Subcommittee had a robust discussion about use of the angiography room for these services. At that time the specialty advisors reviewed the equipment list in detail and verified that the angiography room, and not a subset of mobile equipment, is needed for these services. In the *Final Rule* for 2016 CMS replaced the recommended equipment item "room, angiography" (EL011) with equipment item "room, radiographic-fluoroscopic" (EL014) for all three codes. In response to the *Final Rule*, the RUC and Interventional Radiology argued that the substitution of the fluoroscopic room for the angiography room was clinically unjustified and made the case that the angiography room was needed for these procedures to carry out 3-axis rotational imaging (so as to avoid rolling the patient), ensure sterility, and avoid unacceptable radiation exposure to physicians, their staff, and their patients. CMS stated that they agree that it is important to provide equipment that is medically reasonable and necessary. Their concern with the use of the angiography room for these codes is that they do not believe all of the equipment would be typically necessary to furnish the procedure. Although the RUC understands CMS reservation about including the angiography room when not every item in the room is utilized, the RUC contends that it is misguided to unbundle the components of the Angiography Room when one equipment item within the room is not utilized. There are numerous cases where a specialty uses an equipment room despite the fact that they do not utilize every item in that room because in practice the rooms are configured for the most typical type of procedure that is performed within the room and it would not be efficient or realistic to remove items from a room when a less typical service is needed. Further, it was CMS that originally requested that the RUC establish equipment rooms in the early 2000s.

- CMS is proposing to remove the angiography room from these three procedures and add in its place the component equipment that make up the room. Because CMS currently lacks pricing information for these components they are proposing to include each of these components in the direct PE input database at a price of $0.00 and are soliciting invoices from the public for their costs so that we may be able to price these items for use in developing final PE RVUs for CY 2017. There are a number of reasons that the RUC deems this to be a completely inappropriate as well as extremely punitive proposal:

    - As CMS is aware, it is difficult for specialty societies to obtain paid invoices and this proposal only allows a few weeks for the impacted specialty to obtain the invoices. This is not feasible for the specialty nor is it fair to request one specialty to take responsibility for pricing the angiography room which will ultimately impact a number of different specialty societies

- CMS is statutorily obligated to develop payment for the practice expense of CPT codes based on the resource costs of those codes. Clearly the resource costs of the individual components of the angiography room are not $0.00 and if CMS were to implement this proposal they would be shirking their obligation. Furthermore the practice of assigning $0.00 to supplies and equipment more broadly due to lack of accurate pricing information has become the policy of CMS over recent rulemaking periods. Although the RUC has not commented on the new policy to date, the RUC has noticed this trend and feels very strongly that this is not an appropriate response to CMS' frustration with a lack of accurate pricing information provided by the specialty societies.

- This is a very harsh and punitive proposal for Interventional Radiology specifically. The Angiography Room that the physician uses for these services is valued over 1.3 million dollars. CMS has recognized that it is only one item from the room that is not utilized, yet they have proposed to price all the 21 components in the room at $0.00 for these three codes. It is unacceptable for CMS to penalize the specialty out of frustration with a lack of accurate pricing information.

- **The RUC strongly urges CMS to reverse this inappropriate and punitive proposal**. Short of a total reversal as an alternative to $0.00 for all the component equipment items in the Angiography Room, we recommend that CMS back out the price of the Provis Injector from the total price of the Angiography Room and develop a modified Angiography Room equipment code that would be applied in place of the Angiography Room (EL011) direct PE input for CPT codes 50606, 50705, and 50706. As the RUC has clarified in the past, we simply facilitate specialty society's submission of paid invoices to CMS and do not make recommendations about equipment and supply item pricing.

- The RUC will encourage the impacted specialty to submit an invoice for the Provis Injector.

- In response to CMS viewpoint that this issue illustrates a potentially broad problem with their use of equipment rooms in the direct PE input database. Again we reiterate that CMS requested the development of these rooms as distinct direct PE inputs many years ago. This request was made in an attempt to provide greater standardization to the PE process. It was determined that it is common for physician practices to have rooms outfitted with all of the equipment items listed as included in the equipment room. At that time it was determined that it is appropriate to pay for the entire room, since the equipment in the room would not be removed if a few of the items of equipment are not used for the service being performed. The reasoning behind this is that because of the configuration of the rooms the equipment is not available for use for other patients. The RUC does not see the equipment rooms as a major problem and prefers the standardization of the bundling of equipment into equipment rooms where appropriate. **The RUC strongly urges CMS to maintain the equipment rooms as they currently exist as these rooms are based on current physician nonfacility practice**.

- Furthermore these rooms are currently priced in total; obtaining invoices for all the components of every equipment room is not feasible. Additionally it has been the RUC's experience that the pricing of medical equipment very rarely decreases when updated paid invoices are obtained.

ii. Immunohistochemistry (CPT Codes 88341, 88342, 88344, and 88350)

- For CY 2017, CMS is proposing physician work values of 0.56 for 88341 and 0.59 for 88350; however they still do not reflect the appropriate work involved compared to the base codes 88342 and 88346. These values represent an increase to the current CY 2016 physician values. Although the RUC appreciates these increases that come closer to the RUC recommended values, they still do not represent the proper work RVU for the work involved and present a rank order anomaly with respect to other services.

- The CMS proposes these values in relation to their corresponding base codes in a similar manner to two add-on intravascular ultrasound evaluation services, 37252 and 37253. These two intravascular procedures are absolutely not comparable medical services to CPT codes 88342 and 88341 as well as CPT codes 88346 and 88350. The physician work of 88342, 88341, 88346, and 88350 involves the pathologists' verification of staining, examination of controls and of the presence and patterns of specimen specific staining and providing an interpretation the staining patterns and intensities to determine its histologic, cellular, significance and location. The pathologist then composes and dictates a report. This work is quite different than what is required for intravascular ultrasound add-on procedures.

- In some medical procedures and services there may be efficiencies present through the lack of specific pre, intra, or post service physician work or intensities and complexities between base and add-on services, this is not the case for 88342, 88341, 88346, and 88350. Each pathology service is unique and distinct from all other medical services within and outside the scope and specialty of pathology. Each pathology service has individual intensities and complexities that terminally compromise any attempt at rational comparSpecifically, for additional immunohistochemistry services represented by add-on CPT codes 88341 and 88350, each antibody is evaluated separately on different slides. Each antibody has a specific staining pattern for true positivity as opposed to non-specific staining and the pattern of cytoplasmic, versus nuclear, and heterogeneous versus homogenous staining must be individually evaluated for each stain. Each antibody provides specific additional information for the pathologist to interpret in order to arrive at a diagnosis for the specimen. Therefore, each additional service is separate and distinct.

- The RUC's approach of evaluating the actual work associated with each unique base and each unique add-on service is far more accurate, rational, and responsive to the specific circumstances than holding codes equal to a fixed discount from the base code. Applying ratio comparisons and fixed discounts to arrive at a work relative value will continue to create inter-specialty rank order anomalies of physician work RVUs. **The RUC urges the Agency to accept the RUC recommended work values for 88342 and 88350 of 0.65 and 0.70 respectfully. The RUC also requests Refinement Panel consideration for these services.**

Practice Expense:

- CMS states a stakeholder suggested "that an error was made in the implementation of direct PE inputs for code 88341 and several other related codes." The "stakeholder stated that when CMS reclassified equipment code EP112 (Benchmark ULTRA automated slide

preparation system) and EP113 (EBar II Barcode Slide Label System) into a single equipment item, with a price of $150,000 using equipment code EP112, the equipment minutes assigned to the E-Bar II Barcode Slide Label System should have been added into the new EP112 equipment time. The stakeholder requested that these minutes should be added into the EP112 equipment time; for example, 1 additional minute should be added to CPT code 88341 for a total of 16 minutes."

- CMS seeks comment from the RUC as to "whether it would be appropriate to add the former EP113 minutes to EP112." The commenter's suggestion is accurate and consistent with the RUC's most recent recommendations provided to the Agency. The RUC agrees with the stakeholder and requests finalization of the equipment minutes of EP113 being combined and added into the new EP112 equipment time for CPT codes 88341, 88342, 88344, 88360, and 88361. T**he RUC urges the Agency to correct the current CY 2016 PE RVUs and PE input data files to reflect this edit to the equipment PE files in CMS' next quarterly update, and reflected in the PE RVUs and CMS' direct PE inputs equipment data file for CY 2017 for CPT codes 88341, 88342, 88344, 88360, and 88361.**

iii. Morphometric Analysis (CPT Codes 88364, 88365, 88367, 88368, 88369, and 88373)

- For CY 2017, CMS is proposing a physician work value of 0.70 for 88364 and 88369. These values represent an increase to the current CY 2016 physician values. Although the RUC appreciates these increases that come closer to the RUC recommended values, they still do not represent the proper work RVU for the work involved and present a rank order anomaly amongst other services. These work RVUs represent 20% discounts from their base code work RVUs of 0.88 for 88365 and 88368. Again, as mentioned above concerning immunohistochemistry and immunofluorescence studies, CMS's theoretical comparison of these codes to 37252 and 37253 as discussed above, are absolutely not comparable medical services to CPT codes 88364 and 88369. Again, there should be no comparison of intravascular ultrasound services to morphometric analysis, immunohistochemistry, immunofluorescence, or any other pathology service.

- Although in some medical procedures and services there may be efficiencies present through the lack of specific pre, intra, or post service physician work or intensities and complexities between base and add-on services, this is not the case for 88364 and 88369. Each pathology service has individual intensities and complexities that preclude any rational comparison of the physician work of intravascular ultrasound services with pathology services.

- No pathology add-on service can be presumed to have a discount in physician work from the base service. For add-on codes 88364 and 88369, the pathologist is looking at a unique and distinct second probe with an entirely different signal than that of its base code physician service. In the case of ISH add-on services, there is no corresponding interpretive diagnosis previously established when pathologists begin work on the additional single probe stain procedure. When the RUC reviewed these codes it was determined that the base codes and the add-on codes require the same identical time and intensities as their add-on codes; in other words, designation of the second and subsequent services as add-ons represents a coding convention, and does not represent an underlying difference in the characteristics of the initial (base) and subsequent services. **The RUC urges the Agency to**

accept the RUC recommendations for CPT codes 88364 and 88369 with physician work values of 0.88. The RUC also requests Refinement Panel consideration for these services.

- For CY 2017, CMS is proposing a physician work value of 0.58 for CPT code 88373. This work RVU represents a 20% discount from its base code work RVU of 0.88 for 88367. For pathology services, it is irrational to assume that all pathology add-on services require the same reduction in resources relative to the corresponding initial service. It is clear that when pathologists perform in situ hybridization add-on services there is no corresponding interpretive diagnosis previously established when their work begins on the additional single probe stain procedure.

- For pathology services, it is irrational to assume that second and subsequent services designated by convention as "add-on" services require a reduction in resources relative to the corresponding initial (by convention, "base") service. It is clear that when pathologists perform in situ hybridization add-on services there is no corresponding interpretive diagnosis previously established when their work begins on additional single probe stain procedures.

- The RUC, during its review, firmly agreed that "using computer-assisted technology," as included in the descriptor, does not replace physician work. Computer-assisted technology refers to the computer selecting the images for the pathologist to review. The computer does not establish the distinction between cancer and non-cancer cells. Specifically, the RUC reviewed the survey results for CPT code 88373 and determined that a work RVU of 0.86, the same as the recommended work RVU for CPT code 88367, appropriately accounts for the work required to perform this service. The RUC compared 88373 to 88369 and noted that CPT code 88369 is manual and requires slightly more physician work and time because the physician is scanning the slide on the fluoroscopic microscope to find the cells of interest that will be counted. In code 88373, the images that the physician evaluates are selected by the computer. CPT code 88373 still requires the physician to analyze and make decisions. **The RUC urges that CMS adopt the RUC recommended work RVU of 0.86 for CPT code 88373**. **The RUC also requests Refinement Panel consideration for these services.**

iv. Open and Percutaneous Transluminal Angioplasty (CPT codes 372X1, 372X2, 372X3, and 372X4)

- CMS proposes to remove the "drape, sterile, femoral" supply (SB009) and replace it with a "drape, sterile, fenestrated 16in x 29in" supply (SB011) for CPT codes 372X1 and 372X3. CMS notes that since the old codes, 35471 and 35476, both used SB011, there is no rationale for the switch.

  The use of supply item "drape, sterile, femoral" supply (SB009) is most typical for the new CPT codes 372X1 and 372X3. Due to bundling, there has been a change in the nature of the procedure mix that will be billed with these new services. The vast majority of these procedures will be performed from a femoral or jugular approach and will utilize a standard femoral drape. The fenestrated drape provides a limited sterile field, which does not allow room for sterile manipulation of wires and catheters as they extend away from the entry into the vascular system. With the creation of the new dialysis access circuit CPT code

family, the use of extremity access and fenestrated drapes would become much less typical for the new angioplasty code set represented by CPT cods 372X1 and 372X3. **Therefore CMS should accept the RUC recommended PE inputs and retain the supply SB009.**

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

- In the CY2016 *Final Rule*, CMS questioned the difference between the physician times from the raw survey data relative to the RUC recommended physician times, noting that the times were reduced whereas the median work RVU from the survey was recommended. Therefore, CMS proposed a work RVU of 8.00 which was the survey 25th percentile. In the CY2017 NPRM, CMS proposes to finalize the work RVU for CPT code 77778 at 8.00.

- CMS also is seeking general comment on whether the Agency should use time values based on pre-service packages if the recommended work value is based on time values that are significantly different than those from the package.

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

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

    - RUC recommendations are based on magnitude estimation and detailed review of the clinical work involved in performing a service. In this instance, the RUC determined that the survey respondents accurately estimated the work RVU based on magnitude estimation while overestimating the relatively low intensity pre-service time involved in performing this service. The Specialty had also clarified to the RUC that there is physician work associated with ordering the isotope that is being bundled in to 77778.

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

The RUC recommends for CMS to reconsider its decision to not accept the RUC recommendation for CPT code 77778 and to accept work RVUs of 8.78.

vi. Intracranial Endovascular Intervention (CPT codes 61645, 61650, and 61651)

- In April of 2015, the RUC recommended values for 61645, 61650 and 61651 of 17.00, 12.00 and 5.50 respectively. CMS proposed values for CY 2016 of 15.00, 10.00 and 4.25 respectively with the rationale that these procedures would be performed in the outpatient setting. As a result CMS recommended CPT 37231 as a direct crosswalk for 61645, 37221 as the crosswalk for 61650 and 37223 resulting in the CY 2016 values. Medicare 2014 data demonstrated that 37231, was performed in the inpatient setting only 21.3% of the time. CPT codes 37221 and 37223 are performed in the outpatient setting 53.23% and 50% and in the office setting 12.81% and 11% of the time respectively. Additionally, based on the erroneous rationale that 61645, 61650 and 61651 are performed in the outpatient setting, CMS removed the 55 minutes associated with CPT code 99233 (level 3 subsequent hospital care, per day). The 30 minutes of intra-service time associated with 99233 was added to the immediate post service time. Although the post service time was now increased from 53 minutes to 83 minutes, this artificially and inappropriately reduced the total work time from 266 minutes to 241 minutes.

- CPT code 61645 is always performed as a highly time sensitive emergent procedure for acute stroke patients with large vessel occlusions and will never be performed in the outpatient setting. CPT codes 61650 and 61651are typically performed in the setting of subarachnoid hemorrhage and cerebral vasospasm in patients with impending strokes that are in an intensive care unit. The survey results noted that these procedures were 100% performed in the inpatient setting. A multi-specialty letter from AANS, CNS, ASNR, ACR, SIR, SVIN and SNIS outlining this erroneous rationale and requesting refinement. The RUC realizing these patients are treated in the inpatient setting noted that these codes are facility-only codes and therefore made no direct practice input recommendations.

- A Refinement Conference call with CMS with conducted with the AANS, CNS, SIR, ACR, SVS and ACC on March 2, 2016 outlining the erroneous rationale, however CMS maintained the interim CY2016 values for CY 2017.

- The RUC notes that evaluating the actual physician work performed in the inpatient setting is much more accurate than the applying a crosswalk to a CPT code that is performed predominantly in the outpatient setting. **The RUC urges the CMS to accept the RUC recommended work values for 61645, 61650 and 61651 of 17.00, 12.00 and 5.50 respectively.**

VI. Valuing Services that Include Moderate Sedation

A. *Moderate Sedation Services (CPT Codes 991X1, 991X2, 991X3, 991X4, 991X5, 991X6)*

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision

991X1	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intra-service time, patient younger than 5 years of age	0.50	0.50	Agree
991X2	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intra-service time, patient age 5 years or older	0.25	0.25	Agree
991X3	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intra-service time, patient younger than 5 years of age	1.90	1.90	Agree
991X4	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intra-service time, patient age 5 years or older	1.84	1.65	Disagree
991X5	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes of intra-service time (List separately in addition to code for primary service)	PE Only	PE Only	Agree
991X6	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; each additional 15 minutes intra-service time (List separately in addition to code for primary service)	1.25	1.25	Agree

Summary of CMS Actions:

- The RUC appreciates that CMS accepted the RUC's physician work recommendations for codes 991X1, 991X2, 991X3, 991X5 and 991X6. The Agency also accepted the RUC's practice expense recommendations for all 6 services in the family.

- For 991X4, CMS arrived at their proposed value by subtracting the same increment of codes 991X1 and 991X2 (0.25 difference) to the value of 991X3 (1.90), to a derived work RVU of 1.65.

RUC Comments:

- There are some differences between when sedation is performed by the same physician and when it is performed by a separate physician. When the same physician is also performing the underlying procedure, some of the moderate sedation work can involve supervision; when a separate physician is performing moderate sedation, they are typically doing this without support staff.

- CPT code 991X4 is taking the place of deleted CPT code 99149 Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician or other qualified health care professional other than the health care professional performing the diagnostic or therapeutic service that the sedation supports; age 5 years or older, first 30 minutes intra-service time. According to 2015 Medicare Claims data, 99149 was performed in the emergency department setting 58 percent of the time, indicating that the typical patient is either acutely ill or injured. Furthermore, following a detailed review, the RUC concurred with the Specialties that when moderate sedation is performed by a separate physician (991X3-X4, 991X6), the typical case is emergent. Sedation of the acutely ill or injured patient, which is typically performed with a separate physician for the procedure, entails a different set of risks and level of work intensity then the scheduled patient undergoing a diagnostic procedure. Therefore, it is inappropriate to apply the work RVU increment of 991X1 and 991X2 to the relative valuation between 991X3 and 991X4, as these two sets of services represent very different patient populations.

- CMS should use the valid RUC survey data for 991X4.

  The RUC urges CMS to accept the survey 25th percentile work RVU of 1.84 for CPT code 991X4.

B. *Proposed Valuation of Services Where Moderate Sedation is an Inherent Part of the Procedure (CPT Appendix G Services)*

The RUC is disappointed that CMS did not accept the RUC's physician work RVU recommendations for unbundling moderate sedation from the over 400 services in CPT appendix G. The RUC appreciates that the Agency did choose to accept the RUC's other moderate sedation recommendations, including: the RUC's direct practice expense recommendations, the unbundling of moderate sedation physician time, moderate sedation physician work or time which overlaps with the skin-to-skin time of the underlying procedure should remain and that ZZZ codes should maintain their current physician work or time. We

would like to remind CMS that the RUC physician work recommendations are budget neutral and also are consistent with how these services were originally valued.

Background

CMS and the RUC originally bundled moderate sedation services into over 400 000-day, 010-day, 090-day and XXX global codes, which are listed in Appendix G of the CPT book. Physician time for administration of moderate sedation was bundled into Appendix G services by CMS and the RUC based on assigned RUC pre-service time package 1B (5 minutes of Moderate Sedation time) or pre-service time package 2B (10 minutes of Moderate Sedation time).

In the 2015 *Proposed Rule*, CMS noted its belief that practice patterns for endoscopic procedures appeared to be changing, with anesthesia increasingly being separately reported with these procedures. As many endoscopic procedures have moderate sedation bundled into the procedure, the Agency expressed concern that the resource costs associated with sedation were no longer incurred by the practitioner reporting the Appendix G procedure. The Agency again expressed these concerns in the CY 2016 *Proposed Rule*.

In response to both of these solicitations, the CPT Editorial Panel created a new code set for separately reporting moderate sedation services. Also, as part of this new coding structure to report moderate sedation services, the Appendix G section of the CPT code set will be deleted for CY2017 and the physician work and direct practice expense inputs for moderate sedation will be unbundled from all applicable services. In preparation for unbundling of moderate sedation from Appendix G, at the April 2015 RUC meeting, the RUC reviewed and approved pre-service time package proxies of either 1B Straightforward Patient/Straightforward Procedure or 2B Difficult Patient/Straightforward Procedure for all applicable codes in Appendix G that did not already have an assigned pre-time package.

At the October 2015 RUC meeting, the RUC reviewed and approved a methodology for unbundling budget neutral work RVUs from all relevant services in Appendix G as recommended by the Joint CPT/RUC Moderate Sedation Workgroup. The budget neutral outputs from this methodology were for 0.09 work RVUs for all Appendix G services with assigned pre-time package 1B and 0.18 work RVUs for all Appendix G services with assigned pre-time package 2B. The RUC also provided recommendations for unbundling physician time and all associated direct practice expense inputs.

CMS Proposed Unbundling of Moderate Sedation Physician Work

CMS proposes to unbundle moderate sedation services from all Appendix G procedures by reducing the work RVU of each 000-day, 010-day, 090-day and XXX-global procedure by the full work RVU associated with the most frequently reported moderate sedation code. CMS is also separately proposing to create a new moderate sedation only for endoscopic procedures (GMMM1). For services that would be billed with GMMM1, the proposed work RVU to remove would be 0.10. For all other Appendix G services, the Agency is proposing to unbundle the full value of 991X2 which is 0.25.

While the RUC fully agrees with the Agency's stated position "…that the RVUs assigned under the PFS should reflect the overall resource costs of PFS services", we would like to point out that CMS' unbundling proposal does not comply with this stated maxim. As administration of moderate sedation time was added to the pre-service evaluation portion of the underlying procedure (valued at 0.0224 work RVUs per minute), a derived work RVU of 0.11 RVUs for pre-time package 1B and a derived work RVU of 0.22 RVUs for pre-time package 2B can be assumed. The RUC and CMS determined the

full work RVU for the Appendix G codes using these assumptions. Unbundling the same 0.10 work RVUs for endoscopic services and 0.25 work RVUS for all other services ignores how much time or value was actually bundled originally for moderate sedation. The Agency's proposal to remove the same work RVU while removing differing times will distort the relativity of these services. Whereas, the RUC's unbundling recommendations are budget neutral and are also consistent with how these services were valued.

RUC Recommendations for Unbundling Moderate Sedation from Appendix G

With CMS proposing to value Appendix G services based on whether the CPT code describes an endoscopic procedure, the RUC has updated its analysis to account for the proposed creation of the endoscopic-specific G code and to provide the Agency with updated utilization projections for impacted moderate sedation CPT code 991X2. Employing the same RUC-approved unbundling methodology, the RUC has somewhat modified recommendations for Appendix G services which would not be reported using proposed code GMMM1.

The RUC-approved unbundling methodology involves removing a two-tier budget neutral work RVU from Appendix G codes based on whether the code was assigned RUC pre-service time package 1B (5 minutes of Moderate Sedation time) or pre-service time package 2B (10 minutes of Moderate Sedation time). For services that do not have RUC-assigned pre-time packages, the methodology continues to use the placeholder pre-time packages assigned by the top performing specialties and approved by the RUC at the April 2015 RUC meeting. The budget neutral outputs of the algorithm for all codes which will not use endoscopic-specific code GMMM1 are based on the RUC recommended and CMS proposed work RVU of 0.25 for code 991X2.

As part of the underlying analysis for this methodology, the aggregate projected Medicare Utilization for 991X2 was estimated based on the Medicare utilization for existing CPT code *99144 Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician or other qualified health care professional; age 5 years or older, first 30 minutes intra-service time*, as well as the Medicare utilization and the estimated same-day moderate sedation billed together percentage for each stand-along category I code in Appendix G. The total projected utilization for 991X2, if CMS' proposal to create GMMM1 is finalized, is 4,343,643 Medicare claims. The updated analysis *(see Addendum J - RUC-Approved Methodology for Unbundling Moderate Sedation Work RVUs from Appendix G - updated to reflect GMMM1 proposal)* also determined the proportion of these Moderate sedation services that would be performed with codes in Appendix G by pre-time package, as well as the proportion of moderate sedation services performed with underlying procedures outside of Appendix G.

Based on its approved methodology for unbundling moderate sedation, the RUC recommends removing the following budget-neutral work RVUs from all services with the XXX, 000-day, 010-day and 090-day global periods in Appendix G which would be billed with 991X2:

- **0.10 work RVUs from all Appendix G codes with assigned pre-time package of 1B**
- **0.19 from all Appendix G codes with assigned pre-time package 2B.**

The RUC continues to recommends no work RVU change for any service with the ZZZ global period, which is also CMS current proposal.

C. Collecting Data on Resources Used in Furnishing Global Services

The RUC is disappointed with the proposed CMS policy to collect data on the post-operative visits and resources used in furnishing surgical global services. While the RUC stands in agreement with the Agency that physician services valued in the RBRVS should be accurate and relative, the proposed plan goes beyond the scope of the legislative mandate to collect data in the surgical global. Furthermore, the complexity of the plan, as proposed, will create undue burden on physicians, with little if any benefit to actual payment accuracy. In fact, as described, the results of the proposed data collection exercise are likely to dramatically reduce the accuracy of physician payment, introduce major aberrations in the RBRVS derived Physician Fee Schedule and be associated with major unintended consequences to Medicare beneficiaries and selected subsets of physicians.

Background

In the 2015 *Final Rul*e, CMS finalized a plan to transition all 010-day and 090-day global codes to 000-day global codes. As support for its plan, CMS referenced challenges it has experienced in obtaining available data to verify the number, level and relative costs of post-operative visits included in global packages. CMS also expressed concern that 010-day and 090-day global packages may, in some cases, no longer accurately reflect the post-operative care provided to the typical patient. However, Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, prohibiting the implementation of the above stated CMS policy. In place of the transition, the Act requires CMS to develop a process to gather information needed to value surgical services from a representative sample of physicians, and requires that the data collection shall begin no later than January 1, 2017. The collected information must include the number and level of medical visits furnished during the global period and other items and services related to the surgery.

CMS Data Collection Proposal

CMS proposes a "three-pronged approach to collect timely and accurate data on the frequency of, and inputs involved in furnishing, global services including the procedure and the pre-operative visits, post-operative visits, and other services for which payment is included in the global surgical payment."

1. Comprehensive claims-based reporting about the number and level of pre- and postoperative visits furnished for 010- and 090-day global services.
2. A survey of a representative sample of practitioners about the activities involved in and the resources used in providing a number of pre- and post-operative visits during a specified, recent period of time, such as two weeks.
3. A more in-depth study, including direct observation of the pre- and post-operative care delivered in a small number of sites, including some ACOs.

Creation of G-codes

The primary way in which CMS proposes to collect the pre- and post-operative visits included in the global surgical bundle is the mandatory reporting of newly created HCPCS level II G codes from all physicians reporting procedural services in Medicare. The RUC has numerous concerns regarding this expansive collection of data.

CMS proposes a new series of eight G codes which are intended to collect the pre- and post-operative activities based on place of service, complexity of patient and the completion time (by 10 minutes).

Inpatient	GXXX1	Inpatient visit, typical, per 10 minutes, included in surgical package
	GXXX2	Inpatient visit, complex, per 10 minutes, included in surgical package
	GXXX3	Inpatient visit, critical illness, per 10 minutes, included in surgical package
Office or Other Outpatient	GXXX4	Office or other outpatient visit, clinical staff, per 10 minutes, included in surgical package
	GXXX5	Office or other outpatient visit, typical, per 10 minutes, included in surgical package
	GXXX6	Office or other outpatient visit, complex, per 10 minutes, included in surgical package
Via Phone or Internet	GXXX7	Patient interactions via electronic means by physician/NPP, per 10 minutes, included in surgical package
	GXXX8	Patient interactions via electronic means by clinical staff, per 10 minutes, included in surgical package

Prior to directly addressing the CMS proposal, it is important to note the current landscape of surgical global services. There are currently 4,239 CPT codes with surgical global packages in the Medicare payment schedule. According to 2015 Medicare utilization, there are only 110 010-day global and 149 090-day global codes performed more than 10,000 times. To ensure maximum success, significant data collection should be limited to a subset of these high volume services.

In addition to many of the surgical services being low volume, the level of post-operative Evaluation and Management (E/M) visits considered bundled into the global package varies widely from separately reported E/M visits. The median established office visit in a global surgical package is a 99212, whereas the median level for separately-reported visits is a 99213. Only 1% of all established patient office visits in 010-day and 090-day global surgery packages have a visit level above a 99213, whereas nearly 47% of all separately-reported E/M visits are reported as a 99214 or 99215.

CPT Code	**2015 Global Surgical E/M Utilization Percentage (All codes)**	**2015 Separately Reported E/M Utilization Percentage**
99211	0.30%	2.16%
99212	57.93%	6.54%
99213	40.67%	44.37%
99214	1.07%	42.73%

99215	0.03%	4.20%
TOTALS	100.00%	100.00%

The median hospital visit in a global surgical package is a 99231, whereas the median level for separately-reported hospital visit is a 99232. 57% of hospital visits in a global package have a hospital visit level of 99231, whereas only 11% of all separately-reported hospital visits are reported as a 99231.

CPT Code	2015 Global Surgical E/M Utilization Percentage (All codes)	2015 Separately Reported E/M Utilization Percentage
99231	56.46%	10.56%
99232	30.48%	57.31%
99233	10.02%	25.91%
99291	3.04%	6.22%
TOTALS	100.00%	100.00%

It is not necessary to distinguish the level of service in a claims collection process, as there is no identified problem to solve regarding the level of E/M bundled into the surgical global period.

It is with this understanding of the current landscape of surgical global services, that the RUC expresses alarm that CMS would propose such a burdensome data collection process. The Agency states that they are proposing this set of codes because the current E/M codes are, in their opinion, inadequately designed to capture the full scope of post-operative care and that using such codes might create confusion. The RUC disagrees and it is more likely that the redefinition of E/M services performed in the post-operative period will create more confusion, as physicians must learn the reporting requirements for these new codes within 8 weeks before they will be required on all claims, January 1, 2017. The complexity involved in redefining E/M services performed in the post-operative period, with insufficient time for education, is an unnecessary burden for physicians.

In addition, it is not feasible to also require the collection of time per patient, at the minute level, for every task that a physician and their clinical staff perform throughout the day. By establishing that these codes be billed in 10 minute increments, physicians will be burdened to both learn the reporting requirements of these new codes, while monitoring their time in 10 minute increments. To put this in perspective, the RUC reviewed specialty data on hours worked per week from the large, multi-specialty Physician Practice Information (PPI) survey conducted in 2008. Below are four of the top specialties who perform commonly billed, high cost surgical services.

Specialty	Average Hours in OR *(per week)*	Average Patient Care Hours *(per week)*	Percent NOT in OR *(per week)*
Orthopedic Surgery	17.1	59.3	71%
General Surgery	20.5	66.3	69%
Vascular Surgery	23.8	68.0	65%
Neurosurgery	21.2	63.7	67%

With these data, it's clear to see the large, negative impact this proposal will have on physician practices. More than 65 percent of the surgeon's day will be spent outside the operating room and in time with their surgical patients and/or families. CMS is asking physicians and/or their staff to catalogue every minute of this time. This will require, if not the hiring of additional staff, at the very least significant reallocation of staff time to help the physician collect this detail time accounting. Asking physicians and/or their staff to use a stop watch, conducting time motion studies for all their non-operating room patient care activities is an incredible burden.

The RUC conducted an analysis of the baseline number of claims this proposal would create. Estimating the number of codes that would need to be billed in 10 minute increments related to the pre- and post-operative work in the current surgical globals is more than 234 million. In addition, a rough estimate of the clinical staff time that would be billed is more than 217 million codes. This proposal will mandate the reporting of at least 451 million new codes. If each claim allows up to 6 codes to be entered, that is over 75 million new claims that will need to process. Previous analysis of Medicare contractors and the non-profit CAQH suggests the cost of processing a straightforward claim between $1.36 and $1.50. Therefore, the cost of processing the additional claims alone will amount to over $100 million. This does not account for the additional staff needed to redesign IT infrastructure and assist the physician in time motion accounting.

The RUC is also aware that other stakeholders have conducted independent analyses, at the institution level, of the potential number of additional codes that will need to be billed based off the Agency's proposal. We encourage CMS to review all these analyses, to understand a fuller picture of the impact of these codes on billing systems.

Finally, perhaps the greatest weakness of these G-codes is the inability to actually match them with the E/M services assumed to be bundled into the current surgical global package. It is unclear how the Agency intends to take the raw data collected by these G-codes and translate them to the existing E/M services. For example, as defined, the proposed G-codes compress the currently available 4 levels of inpatient evaluation and management into only 3 levels. By redefining the parameters of these post-operative visits, CMS has created a scenario which leaves the actual task of ensuring surgical services are accurately valued extremely difficult and nontransparent.

Representative Sample

CMS proposes that any practitioner who furnishes a procedure that is a 010 or 090-day global report the pre- and post-operative services furnished on a claim using the newly created G-codes. CMS proposes this option, citing numerous concerns including: the inability to collect a sufficient volume of data, lack of knowledge regarding factors that drive variation in pre and post-operative care and how to identify a representative sample.

The RUC not only disagrees with this data collection approach, but finds it counter to the legislative mandate to use a representative sample. The Agency believes the legislative language implicitly provides latitude to collect data from a "broad set of physicians," not just a representative sample. However, regardless of how the Agency defines their collection technique, the definition of a sample is a subset of an entire population. Therefore, under no circumstances can the CMS proposal to require the entire physician population to report these data properly align with Congress's stated intent that a representative sample must be used.

Furthermore, even if a mandated reporting mechanism was within the scope of the law, it would still be ill-advised. Requiring every practitioner to report these codes will be in many ways less representative than a targeted sample. Considering the limited time for education, only large, technologically rich practices will have the ability to properly report these services. This will leave many, smaller and/or rural practices without the proper education and robust billing systems in place to adequately, if at all, report these G-codes. Smaller, rural practices have smaller patient populations, which can often be older and sicker than the typical patient seen in a large practice. By creating a complex system that favors one type of practice, the collected data is more likely to be biased rather than representative.

Summary of Concerns

The complexity and burdensome nature of the Agency's proposal is in contrast to both the understanding of relativity within the global bundle and to the scope of the legislative mandate, as laid out in MACRA. There is no meaningful way to counterbalance the numerous ways in which these codes will be underreported. Thus, intentionally or not, this proposal is designed to under report visits done in the surgical global period. In addition, regardless of the errors incurred (e.g. misunderstanding of coding concept, inability to properly account for every minute and/or miscommunication between staff and physicians) the proposal as designed is a massive and capricious intrusion on the time and resources of the nation's professional health care workforce.

The RUC urges CMS to closely review the below recommendations, which are designed to aggressively collect post-operative visit data, enhance physician participation and ensure accurate reporting.

RUC Recommendations

First and foremost, the RUC recommends that the best way to validate the visit data included in the surgical global valuation is through a significant survey, as recommended in the Agency's second pronged approach, rather than via claims data. The legislation in MACRA is clear that a claims-based approach is not mandatory. If however, CMS decides to proceed with a claims-based approach, the RUC offers the following recommendations, as a reasonable solution to this complex issue.

The following recommendations offer both simplicity and transparency. They are simplistic in that they collect data in a manner that is within the scope of the legislative mandate and use CPT coding that is recognizable to a sizeable portion of the physician community. This creates the least burdensome process possible. In addition, they are transparent because the data collected can be easily transmuted to the current surgical global bundles. These recommendations will ensure reasonable expectations from both the collection process and any resulting valuation process CMS chooses to undertake following this data collection.

Creation of a representative sample

Prior to discussing the RUC's specific recommendations for the collection of post-operative visit data, the creation of a representative sample, with a defined set of CPT codes for review, is necessary. As 2015 Medicare data shows, there are only 110 010-day global and 149 090-day global codes performed more than 10,000 times. The collection process should not include all services, as many surgical globals are low volume and would be difficult to find a meaningful sample. The RUC reviewed publically available 2014 Medicare data and identified a set of criteria which focuses the collection process on a

wide range of relatively high volume surgical services which are commonly performed by physicians across the U.S. The criteria are as follows:

- Medicare volume of at least 10,000
- And/or $10 million in allowed charges
- At least 100 separate physicians performed the procedure

(Note: The three criteria above were applied to 2014 Medicare claims data for this analysis, as it is the most recent pubic *Medicare Provider Utilization and Payment Data* available)

These criteria identified 235 CPT codes primarily performed by 20 surgical specialties. To ensure this list is representative, the RUC confirmed that the post-operative breakout of this sample matches total pool of surgical global services.

- 97% of office/outpatient visits are either a 99212 or 99213
- 82% of hospital visits are either a 99231 or 99232

These 235 services represent 73 percent of all Medicare allowed charges for 010-day and 090-day services and 71 percent of all visits incorporated into surgical global periods. This list of codes should be the universe of codes **from which to select a targeted sample of both CPT codes and physicians**, as it provides a suitable representation of all 010-day and 090-day codes. In considering the sample collection, CMS should ensure that no single specialty is unduly burdened. This list is attached to these comments *(see Addendum K - Surgical Global Codes w 100 or grt phy)*.

In addition to defining the set pool of services available for the data collection, a representative sample must be created to stay within the legislative mandate. CMS's concerns over having inadequate information to identify a targeted sample are overstated. Once a sample of high volume codes is identified, CMS has more than enough claims data to identify specific physicians and/ or practices that perform these services. Also included in the attachment of 235 codes is the list of top performing specialties. Using geographical data on performing physicians, CMS should identify a representative sample including medium and small practices, not just large hospital-based practices that often represent modified practice patterns than the majority of the practicing physicians in suburban and rural areas.

Designing the data collection process in this manner, will not only satisfy the requirements of the law, but will actually ease the CMS concern regarding difficulties in communicating to participating physicians. CMS notes that it will be challenging to notify the participants given the limited time between the publication of the 2017 *Final Rule* and the beginning of the reporting period, January 1, 2017. However, notifying a small targeted sample is a much smaller task than notifying the entire population of participating Medicare practitioners. Furthermore, this targeted approach will encourage open dialogue between the participating practices and CMS, ensuring the data collected are reliable.

In a CMS Town Hall meeting regarding this proposal, a concern was indicated that when two surgical global services are reported on the same day, it would be extremely difficult to parse out the post-operative visits for each respective code. First, a review of the 2014 Medicare 5% sample file shows that only 18% of the time two surgical global codes are performed on the same date of service, by the same physician. Second, this concern would apply to any proposal that uses large scale claims reporting. The use of the Agency's G-codes would not alleviate this relatively small subset of instances. These appear to be relatively rare instances and should not deter CMS from implementing these recommendations. We note that CMS may likely have to eliminate these data from analyses as it will be

difficult to attribute a particular visit to a surgery done concurrent with another surgery. We assume that CMS would review the claims from codes reported alone, reflecting 82% of all claims for 010 and 090 day services.

The RUC recommends CMS select a representative sample from surgical services using the following criteria:

- **Medicare volume of at least 10,000**
- **And/Or $10 million in allowed charges**
- **At least 100 separate physicians perform the procedure**

The RUC recommends that CMS limit its data collection to services within this set of 235 codes. Recall that the recent RUC data is based on responses form 76 physicians, on average. It would make little sense to collect data on CPT codes via the claims process for service performed by fewer than 100 physicians in the U.S.

In addition, CMS should select a representative sample of physicians, based off the pool of services defined above. The sample should include medium and small practices, not just large hospital-based practices that often represent modified practice patterns than practicing physicians in suburban and rural areas.

Collection of data via CPT code 99024

The RUC supports the use of CPT code 99024 *Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure* to identify the number of post-operative visits associated with a surgical procedure. This service is currently status "B" (bundled) in Medicare physician payment schedule and is therefore not paid.

The RUC understands that CPT code 99024 is currently captured by EPIC and other EHR systems, as confirmed by several large hospital-based physician group practices. For example, Mayo Clinic & Geisinger use the code internally to report each bundled post-operative visit, and therefore data is already being captured by many Medicare providers. Separately, the RUC also understands that CMS may have denied-claims data available for CPT code 99024 via the Medicare claims processing system.

In response to the CMS call for comments on the feasibility of reporting CPT code 99024 in 10 minute increments, the RUC does not think it is appropriate to delineate incremental time from post-operative visits. As with the G-codes, the cost of requiring physicians to conduct time motion studies during their post-operative patient encounters far outweighs the perceived benefits. CPT code 99024 should simply be used to collect the post-operative visits and a separate process used to track the level of visits. Only existing E/M codes should be used in a claims based approach to fairly address the level of services.

The RUC recommends the use of CPT code 99024 *Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure* once per visit to identify the number of post-operative visits associated with a surgical procedure.

While available data suggests that there is relatively little to gain from collecting the level of post-operative visits performed in conjunction with surgical procedures, the RUC agrees that CMS has a mandate to collect this information. However, we disagree that a new system of coding needs to be established solely to track post-operative visits. CMS should instead collect the level of visit data as part of its broad survey of practitioners that the Agency describes in the NPRM. From the list of procedures that meet the criteria of services in the previous recommendation, CMS should have physicians indicate their typical level of E/M visits throughout the post-operative period. Additionally, the RUC has discussed the usefulness of a separate, secure portal created specifically to collect post-operative visit data. CMS could create a separate reporting pathway that would be separate from the survey process, and allow the data to be easily integrated among multiple reporting sites.

These processes are advantageous for two reasons: (1) it allows CMS to focus limited resources on high volume services, while also giving the Agency valuable data on the reliability of surgical package valuation and (2) it limits the administrative burden on physicians, which also increases the likelihood of compliance by busy practicing physicians.

The RUC recommends CMS collect the level of visits for specifically identified, high volume, broadly performed surgical procedures by a process separate from claims reporting. The RUC has detailed several avenues that the Agency could use to conduct this collection process, including: using the proposed survey of practitioners and/or the creation of a secure portal.

Summary of RUC Recommendations: *CMS, in many respects, have been given a large amount of latitude by Congress to conduct a data collection methodology to better understand the work being done in the surgical global package. However, the RUC is disappointed that repeatedly CMS proposes extremely burdensome initiatives to ameliorate a perceived problem that is not yet supported by data. The Agency should start with a collection process that is limited in scope and utilizes a representative sample to better understand the necessary post-op visits, and other elements furnished in the surgical global. Importantly, while the legislation mandates the collection process begin on January 1, 2017, it does not specify the extent of the data to be collected. Therefore, using the RUC recommendations listed above will allow an equitable data collection process to begin, while leaving open the possibility of further modifications once ideas about the nature of the surgical global period are informed by empirical data.*

D. 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 25, however there are many instances where the RUC disagrees with the refinements. Please see a complete list of the *CY 2017 Proposed Codes with Direct PE Input Recommendations Accepted with Refinement* with specialty society comments in the attached table *(see Addendum C - CMS PE Refinements w spec comment)*.

E. Improving Payment Accuracy for Primary Care and Care Management Services

The RUC commends CMS on its investments in care management as a valuable approach to utilize primary care collaboration with specialists as a way to reduce spending and improve patient care. The RUC appreciates CMS supporting collaborative care codes and acknowledging the work of the Emerging CPT & RUC Issues Workgroup. We greatly appreciate and support the CMS proposals to improve payment accuracy for primary care and care management services.

Psychiatric Care Collaboration

The RUC appreciates CMS guidance in CY 2016 rulemaking to describe an evidence based approach to caring for patients with behavioral health conditions called the Psychiatric Collaborative Care Model (CoCM). The RUC commends CMS for accepting the code set and descriptors as recommended by the CPT Editorial Panel for this code set.

The RUC supports the initiation of separate payment for services furnished using this code set as G codes in CY 2017 to start January 1, 2017. The RUC appreciates CMS intent to support temporary codes GPPP1, GPPP2, and GPPP3 for one year while recommendations for valuation in CY 2018 are worked on further by the RUC. The RUC looks forward to providing and appreciate CMS considering the RUC recommendations for valuation of the work RVU and direct practice expense inputs following the January 2017 RUC meeting.

The RUC also appreciates CMS acknowledgement of the need for this model while also supporting resource costs associated with furnishing behavioral health care management services to Medicare beneficiaries under related but different models of care. The RUC supports the creation of an additional code, GPPPX, to be supported while more information is collected on how other behavioral health care models are being used and implemented. Further clarification is needed as it is not clear from the proposed rule precisely which services, practitioners, patients, and circumstances would qualify for the billing of the GPPPX code.

We agree there should be an initial visit with the beneficiary before the behavioral health integration (BHI) codes (GPPP1, GPPP2, GPPP3 and GPPPX) can be billed. We also support allowing the same types of services to serve as the initiating visit for CCM services and the BHI codes. Likewise, beneficiary consent should be consistent for all the BHI codes. We support CMS' proposal to adopt a general consent standard for the BHI codes. Prior to initiating these services, the primary care physician or QHP would be required to obtain and document that the beneficiary has consented to consultation with relevant specialists, which would include conferring with a psychiatric consultant, and was informed of the beneficiary cost-sharing (deductibles and coinsurance).

Cognitive Impairment

In February 2016, the CPT Editorial Panel added a new code to describe an evidenced based cognitive service. This was one of several in response to a CMS request to capture cognitive service codes not currently described by Evaluation and Management (E/M) services. This service is provided when a comprehensive evaluation of a new or existing patient exhibiting signs of cognitive impairment is required to establish a diagnosis etiology and severity for the condition. The service includes a thorough evaluation of medical and psychosocial factors potentially contributing to increased morbidity. Typically, these patients are referred by a primary caregiver. There are ten required elements for the service, and all ten must be performed in order for the code to be reported. This service includes two distinct activities, assessment of the patient and establishment of care plan that is shared with the patient and caregiver, along with education. It is important that all elements are performed to be able to report this code. Other face-to-face E/M codes cannot be reported on the same date as this service to prevent any overlap with E/M codes.

The RUC appreciates CMS proposing a G-code that would provide separate payment to a physician for assessing and creating a care plan for beneficiaries with cognitive impairment. The CPT code will be

available for this service in 2018. The RUC reiterates its recommendations for the Cognitive Impairment Code to be valued with a work RVU of 3.44 and the direct practice expense inputs as provided. **The RUC recommendations are attached** *(see Addendum L & M - Cognitive Impairment Assessment and Care Plan Services)* **and we urge your adoption of this valuation.**

CPT Code	CPT Descriptor	Global Period	Work RVU Rec
99XX3	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: • Cognition-focused evaluation including a pertinent history and examination • Medical decision making of moderate or high complexity • Functional assessment (eg, Basic and Instrumental Activities of Daily Living), including decision-making capacity • Use of standardized instruments for staging of dementia (eg, Functional Assessment Staging Test [FAST], Clinical Dementia Rating [CDR]) • Medication reconciliation and review for high-risk medications • Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s) • Evaluation of safety (eg, home), including motor vehicle operation • Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks • Development, updating or revision, or review of an Advance Care Plan • Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (eg, rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support (Do not report 99XX3 in conjunction with E/M services [99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337,	XXX	3.44

	99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99366, 99367, 99368, 99487, 99489, 99490, 99495, 99496, 99497, 99498]; psychiatric diagnostic procedures [90785, 90791, 90792]; psychological testing [96103]; neuropsychological testing [96120]; brief emotional/behavioral assessment [96127]; medication therapy management services [99605, 99606, 99607])		

Chronic Care Management

The RUC supported the decision to recognize and pay for Chronic Care Management (CCM) since 2015 with the implementation of code 99490 *Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month,*

The RUC applauds CMS for proposing to begin implementation of additional CCM codes, as designed, valued, and advocated by the CPT and RUC for several years. On January 1, 2017, CMS will implement the CPT codes and RUC recommendations for existing CPT codes:

- 99487 *Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, establishment or substantial revision of a comprehensive care plan, moderate or high complexity medical decision making; 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month*

- 99489 *each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure).*

We appreciate CMS support of CPT provisions regarding appropriate reporting of these codes and continued resolve to ease the administrative burden to ensure that physician may appropriately report the services.

We understand that CMS' proposes to add a G-code, GPPP7 *Comprehensive assessment of and care planning by the physician or other qualified health care professional for patients requiring chronic care management services, including assessment during the provision of a face-to-face service (billed separately from monthly care management services) (Add-on code, list separately in addition to primary service)*, to improve payment for visits that may qualify as initiating visits for CCM services. We urge the Agency to work with the CPT Editorial Panel to transition the code to a CPT code.

Non Face-to-Face Prolonged Services

The RUC appreciates the CMS proposal to establish separate payment for non-face-to-face prolonged E/M service codes instead of the current bundled status. This is a critical proposal to ensure that many of the collaborative code sets can be implemented for quality patient care. We support CMS in their statement that revision of the current bundled status will help improve accuracy for cognitive service care. We greatly appreciate the CMS acceptance of the RUC-recommended values, including CPT code

99354 *Prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (List separately in addition to code for office or other outpatient Evaluation and Management or psychotherapy service)* to increase the current work RVU to 2.33, and adopting the following RUC-recommended work RVUs:

- Work RVU of 2.10 for CPT code 99358, *Prolonged evaluation and management service before and/or after direct patient care; first hour*

- Work RVU of 1.00 for CPT code 99359, *Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (List separately in addition to code for prolonged service)*

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 2017, published in the July 15, 2016 *Federal Register (Vol. 81, No. 136 FR, pages 46162-46476, July 15, 2016)*. 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
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