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September 11, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

Re: Medicare Program: Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program; Proposed Rule (CMS-1676-P)

Dear Ms. Verma:

On behalf of the more than 80,000 members of the American College of Surgeons (ACS), we appreciate the opportunity to submit comments to the proposed rule: *Medicare Program: Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program; Proposed Rule* (proposed rule) that was published in the *Federal Register* on July 21, 2017.

The ACS is a scientific and educational association of surgeons, founded in 1913, to improve the quality of care for the surgical patient by setting high standards for surgical education and practice. Our comments below are presented in the order in which they appear in the proposed rule.

## PROVISIONS OF THE PROPOSED RULE FOR PFS

### Determination of Practice Expense Relative Value Units

*PE RVU Methodology*

In the calendar year (CY) 2016 Medicare Physician Fee Schedule (PFS) final rule, the Centers for Medicare & Medicaid Services (CMS) finalized the use of

an average of the three most recent years of available Medicare claims data (instead of the most recent full year) to determine the specialty mix assigned to each code for the purpose of calculating practice expense (PE) relative value units (RVUs). CMS believed that the three-year average would mitigate the need to use the dominant or expected specialty instead of the claims data. In this proposed rule, CMS states that, after reviewing the finalized PE and malpractice expense (MP) RVUs for the CY 2017 PFS final rule, the use of the three-year average of claims data has not fully mitigated year-to-year distortions and variability for many low volume codes. CMS indicates that the use of service-level overrides for low volume services would provide greater stability in the valuation of these services. CMS therefore proposes to use the most recent year of claims data to determine which codes are low volume for the coming year and to assign the expected specialty developed by the AMA/Specialty Society RVS Update Committee (RUC) in addition to CMS' proposed expected specialty for certain low volume codes for which CMS has historically used expected specialty assignments.

**The ACS agrees with CMS' proposal to reinstate specialty overrides for low volume codes and appreciates CMS' willingness to allow the RUC to recommend the anticipated specialty for codes with Medicare utilization less than 100. With representation from all national medical specialties and subspecialties, the RUC is best positioned to perform an expedient review of a list of low volume codes.**

*Standardization of Clinical Labor Tasks*

Preservice Clinical Labor for 0-Day and 10-Day Global Services

CMS seeks comment on whether a standard preservice clinical labor time of 0 minutes should be consistently applied for 0-day and 10-day global codes. **The ACS believes that preservice clinical labor time should be addressed for each service separately.** There are numerous examples of codes that have been assigned a 0-day global status that are not minor procedures (e.g., endoscopic retrograde cholangio-pancreatography). Such codes may require clinical staff preservice time for activities similar to time allowed for major procedures. CMS' proposal to zero out all preservice time for 0-day and 10-day global codes contradicts previous statements from CMS that the Agency seeks to value codes accurately. **The ACS does not support assigning a standard preservice clinical labor time of zero minutes for all 0-day and 10-day global codes and reiterates that coding accuracy is more important than consistently applying an arbitrary preservice clinical labor time as proposed by CMS.** The RUC PE Subcommittee reviews all requests for time over zero minutes carefully to be certain that additional time is justified and

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also assures that there is relativity between similar procedures if additional time is allowed. The assignment of preservice clinical labor time should be a task reserved for the RUC.

Obtain Vital Signs Clinical Labor

CMS proposes to assign five minutes of clinical labor time for 1,034 codes that include the *obtain vital signs* task that already include at least one minute assigned to this task in the CMS work time files. CMS is also proposing to update the equipment times of these codes with this clinical labor task time accordingly.

The ACS does not agree that this proposal should move forward as described. We believe that variation in clinical labor time to obtain vital signs is justified based on code level review. Some codes have been assigned one minute to obtain a specific vital, when no other vitals are necessary (e.g., 97124 (Massage therapy)). **The proposal to immediately standardize 1,034 codes to five minutes is not relative, nor accurate. Instead, we recommend that CMS allow the RUC to continue to assign *obtain vital signs* time as codes are reviewed.** The time differences for *obtain vital signs* that CMS has identified across codes were assigned purposefully by the RUC based on a review of required time and possible overlap with other codes; these assignments should be maintained.

*Equipment Recommendations for Scope Systems*

CMS seeks comment on creating a single scope equipment code for five scope categories: (1) a rigid scope; (2) a semi-rigid scope; (3) a non-video flexible scope; (4) a non-channeled flexible video scope; and (5) a channeled flexible video scope. **The ACS does not believe that these five categories represent all scope equipment categories and recommends adding a sixth category, a multi-channeled flexible video scope. We encourage the Agency to request that the RUC review this issue and provide guidance on the correct categorization of scope equipment.**

CMS seeks comment on pricing information for each scope category. The ACS understands that CMS would like to standardize pricing for equipment items, but we believe that different scopes within a single scope equipment category will vary both in use and in pricing. For example, rigid scopes for sinoscopy, laryngoscopy, sigmoidoscopy, and anoscopy, which are used to examine different parts of the body, can vary in price by thousands of dollars. Within the flexible scope category, the price difference between scopes can be $10,000. We also believe that, based on length and numbers of ports, scopes

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differ in the amount of supplies and time necessary to properly clean and maintain the equipment. Given these differences, we believe that the direct practice expense details associated with scope equipment should not be diluted with averages determined by CMS. This could result in both incorrect payment to physicians and overcharging or undercharging patients for scopes that were not used for a service they received. **The ACS urges CMS to delay implementation of these proposed changes until CY 2019 and encourages the Agency to request that the RUC review this issue and provide guidance on the correct pricing of endoscopes.**

CMS proposes two minor changes to PE inputs related to scopes. First, CMS proposes to add an LED light source into the cost of the scope video system (ES031), which would remove the need for a separate light source. If this proposal were to be finalized, CMS would remove the equipment time for the separate light source from codes that include the scope video system. CMS also proposes to increase the price of the scope video system by $1,000 to cover the expense of miscellaneous equipment items associated with the system that fall below the threshold of $500 for individual pricing as scope accessories. CMS seeks comments on the inclusion of the LED light in the scope video system, and the appropriate pricing of the system with the inclusion of the additional equipment items. **The ACS urges CMS to delay implementation of these proposed changes until CY 2019 and to request that the RUC review this issue and provide guidance on the correct pricing of the scope video system and whether a light source should be included or priced separately. The RUC has the advantage of representing all the specialties and subspecialties that utilize this equipment and can provide a broad-based, multi-specialty recommendation for CMS to consider.**

**Determination of Malpractice Relative Value Units**

In the CY 2015 PFS final rule with comment period, CMS implemented the third review and update of malpractice (MP) RVUs. In the proposed rule for CY 2017, CMS noted that the Agency had updated MP premium data for determining updates to the Geographic Practice Cost Index (GPCI) factors. CMS solicited comment on whether the Agency should consider updating the MP RVUs for CY 2018, prior to the scheduled fourth review that must occur no later than CY 2020. **In the ACS' CY 2017 comment letter to CMS, dated September 6, 2016, we recommended that CMS follow its normal process for updating MP RVUs, which would occur in the five-year cycle for 2020.**

In this proposed rule for CY 2018, CMS indicates that the Agency believes it would be logical to align the update of MP premium data used to determine

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the MP RVUs with the update of the MP GPCIs. Further, CMS proposes to use the most recent premium data for the proposed MP RVUs for CY 2018 and to align the update of MP premium data and MP GPCIs to once every 3 years. CMS is seeking comment on these proposals and is also seeking comment on methodologies and sources that might be used to improve the next update of MP premium data. **The ACS disagrees with the Agency's proposal to update the MP RVUs for CY 2018 and urges CMS to make changes to the update methodology and data collection in a transparent fashion through notice and comment rulemaking. We have serious concerns with respect to changes to the methodology and data collection processes as discussed below.**

*Methodology for the Proposed Revision of Resource Based Malpractice RVUs*

MP RVUs are determined in four broad steps: (1) calculate a national average MP premium for each specialty, (2) normalize specialty premiums to create a specialty-specific risk factor, (3) calculate unadjusted MP RVUs for each service based on the volume of practitioners that perform a service, and (4) adjust the RVUs for budget neutrality.

Calculating a National Average MP Premium for Each Specialty

Acumen, a CMS contractor, was charged with collecting MP premium data and calculating a national average for each specialty. Per the advice of Acumen, CMS incorporated population estimates from the American Community Survey as weights for calculating specialty premiums. The American Community Survey data replaced the use of total RVUs and MP RVUs to weight specialty premiums in the CY 2015 MP RVU update.

To assess the effect of their recommended changes, Acumen examined the differences among four calculation options for comparison and validation purposes. These calculation options included:

- Option 1: Sum all county-level price adjusted premiums, weighted by share of total population
- Option 2: Sum all county-level price adjusted premiums, weighted by the share of work and PE RVUs
- Option 3: Sum all county-level price adjusted premiums, weighted by the share of total RVUs
- Option 4: Sum the ratio of each total RVU weighted specialty premium to each MP RVU-weighted MP GPCI

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Acumen determined that there were generally no substantial differences in national average premiums (shown below) when comparing each option.[1]

| Metric | Option 1 | Option 2 | Option 3 | Option 4 |
|---|---|---|---|---|
| Minimum | $2 | $122 | $122 | $98 |
| Average | $11,538 | $12,279 | $12,280 | $12,321 |
| Maximum | $81,170 | $79,919 | $79,823 | $80,793 |

Following this analysis, CMS agreed with Acumen's advice to utilize Option 1, which weights national average premiums with population estimates. **We disagree with the assumption that the differences between the calculation options were not substantial.** We believe that these data clearly show that Option 1 (population weighting) is different than Options 2-4 (RVU weighting).

We also believe that using population to weight the premium is incorrect. This method does not reflect differences in risk-of-service among different areas of the country. Risk-of-service, not population, reflects how services differ in their contributions to professional malpractice liability. For example, if a surgeon often performs a complex, difficult surgical procedure, this would have a larger impact on the physician's premium risk classification than a surgeon who more often performs elective surgery or non-procedural services. Geographic premium rate differences are based on risk and paid claims, not on how many people live in a geographic area. Therefore, we believe the premiums should be normalized using surgical and non-surgical work RVUs for each geographic area. We believe that time, intensity, and the difficulty of services are correlated with malpractice risk. Since work RVUs reflect differences in time, intensity, and difficulty among procedures, we believe that they are the best available proxy for weighting geographic differences to calculate national average premiums. **The ACS urges CMS to use work RVUs instead of population to weight geographic differences to calculate national average premiums.**

Normalizing Specialty Premiums to Create Specialty-Specific Risk Factors

Acumen solicited malpractice insurance premium data from all 50 states, the District of Columbia, and Puerto Rico for all physician and non-physician provider (NPP) specialties and for all risk classifications (surgical, non-surgical, other) available. However, the contractor noted that not all specialties had distinct premium data in the rate filings they obtained. Additionally, for

[1] Centers for Medicare and Medicaid Services. *Acumen Interim Report on the Malpractice Relative Value Units for the CY 2018 Medicare Physician Fee Schedule*. July 2017. Available at: cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/CY2018-PFS-NPRM-MP-RVU.pdf. Accessed August 25, 2017.

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some specialties, MP premiums were not available from the rate filings in any state. Therefore, for specialties for which there were not premium data for at least 35 states, and for specialties for which there were not distinct premium data in the rate filings, Acumen crosswalked the specialty to a similar specialty, either conceptually or by available premium data.

**The ACS has several concerns about the validity of the premium data used to calculate the proposed MP RVUs for CY 2018.** Most importantly, we question the reliability of the MP RVU calculation methodology, as nearly 40 percent of the specialties were crosswalked because of insufficient data. We believe it was Acumen's obligation to find sources to obtain sufficient data and we question why data from 35 states was set as a minimum. We outline our specific concerns about individual methodology issues below.

Blending All Available Premium Data

For 24 specialties, there was wide variation across the rate filings in terms of whether or not premium classes were reported and which categories were reported (e.g., surgery versus non-surgery). Because there was no clear strategy for these specialties, Acumen blended the available rate information into one general premium rate using a weighted average "blended" premium at the national level, according to the percentage of work RVUs correlated with the premium classes within each specialty. For example, the surgical premiums for a given specialty were weighted by that specialty's work RVUs for surgical services; the nonsurgical premiums were weighted by the work RVUs for non-surgical services and the unspecified premiums were weighted by all work RVUs for the specialty type to yield a single premium rate. **We do not believe that a single premium that blends whatever data are available for surgical, non-surgical and unspecified premiums accurately and fairly contributes to the final calculation of MP RVUs.** This methodology will overpay providers whose practices furnish more non-surgical services and underpay providers whose practices furnish more surgical services.

As shown in Table 1 below, the proxy for the surgical premium for some specialties is significantly less than the 2017 rate and also significantly less than those for general practice or family practice.[2] In 2015, cardiology premium data was collected from 41 states for "major surgery". In 2017, cardiology premium data was only collected from 12 states for "major surgery". We do not believe this is due to a decrease in the number of

[2] Centers for Medicare and Medicaid Services. *CY 2018 PFS Proposed Rule Malpractice Risk Factors and Premium Amounts by Specialty*. July 2017. Available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1676-P.html

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interventional cardiologists performing surgery, but instead a difference in the data collection process and/or a change in practice from individual to group or employed, which would make it more difficult to obtain premium data. This difference is likely found in other specialties with "blended" data premium rates. **We urge CMS to ask its contractor to increase collaboration with state medical societies and specialty societies to obtain separate surgical and non-surgical premium data. We recommend that CMS use the previous premium data until more data can be obtained instead of using blended premiums for MP RVU calculations.**

**TABLE 1. CHANGES IN NORMALIZED PREMIUM RATES FOR SELECTED SPECIALTIES FROM CY 2017 TO CY 2018 (PROPOSED)**

| | | 2017 | 2018p | 2017 | 2018p |
|---|---|---|---|---|---|
| Specialty Code | Specialty Name | Non-surgical Normalized Premium Rate | Non-surgical Normalized Premium Rate | Surgical Normalized Premium Rate | Surgical Normalized Premium Rate |
| 1 | General Practice | $14,657 | $14,776<br>+1% | $33,836 | **$30,521**<br>**-10%** |
| 8 | Family Practice | $14,471 | $13,696<br>-5% | $33,676 | **$30,640**<br>**-9%** |
| 7 | Dermatology | $11,696 | $22,750<br>+95% | $37,442 | **$22,750**<br>**-39%** |
| 10 | Gastroenterology | $17,563 | $19,659<br>+12% | $32,166 | **$19,659**<br>**-39%** |
| 6 | Cardiology | $16,216 | $15,587<br>-4% | $58,634 | **$15,587**<br>**-73%** |
| 46 | Endocrinology | $14,252 | $14,386<br>+1% | $29,754 | **$14,386**<br>**-52%** |
| 39 | Nephrology | $13,787 | $12,779<br>-7% | $31,080 | **$12,779**<br>**-59%** |

Premium Rate Increases for Facility Providers

The premium rate increased by 15 percent for the seven specialty designations as shown in Table 2. [3] We believe that most of these providers have umbrella policies that cover the facility, equipment, and technical staff, but not the physicians who work at the facilities. Therefore, we question the use of these normalized premium data for physician work. We note that, for

[3] Centers for Medicare and Medicaid Services. *CY 2018 PFS Proposed Rule Malpractice Risk Factors and Premium Amounts by Specialty*. July 2017. Available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1676-P.html

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some of these specialties, state premium data were obtained, but not used. **We urge CMS to review the available premium data, however minimal, to verify that the Agency supports the normalized premium rate that was increased to correspond to the premium rate for allergy/ immunology before applying these premiums to the MP RVU calculations.**

**TABLE 2. MALPRACTICE RISK FACTORS AND PREMIUM AMOUNTS BY SPECIALTY**

| | | 2017 | 2018p | 2017 | 2018p |
|---|---|---|---|---|---|
| **Specialty Code** | **Specialty Name** | **Non-surgical Risk Factor** | **Non-surgical Risk Factor** | **Non-surgical Normalized Premium Rate** | **Non-surgical Normalized Premium Rate** |
| **45** | Mammography Screening Center | 0.87 | 1.00 | $7,306 | $8,201 |
| **47** | Independent Diagnostic Testing Facility | 0.87 | 1.00 | $7,306 | $8,201 |
| **47-TC** | IDTFs (TC only) | 0.87 | 1.00 | $7,306 | $8,201 |
| **63** | Portable X-Ray Supplier | 0.87 | 1.00 | $7,306 | $8,201 |
| **69** | Clinical Laboratory (billing independently) | 0.87 | 1.00 | $7,306 | $8,201 |
| **74** | Radiation Therapy Centers | 0.87 | 1.00 | $7,306 | $8,201 |
| **75** | Slide Preparation Facilities | 0.87 | 1.00 | $7,306 | $8,201 |

Crosswalking Non-Physician Providers to Allergy/Immunology

**We disagree that all specialties that were crosswalked to allergy/immunology are supported by data.** The AMA Physician Practice Information (PPI) Survey data used by CMS for calculating PE RVUs have shown that most of these NPP specialties have significantly lower premiums than allergy/immunology. For example, physical therapy and occupational therapy had rates that were less than 20 percent of the rate for allergy/immunology. In consideration of the fact that physical therapy and occupational therapy together account for 11 percent of all claims, we believe this unsubstantiated crosswalk may significantly impact the MP RVUs for all other specialties.[4] **We urge CMS to review the collected**

[4] Centers for Medicare and Medicaid Services. *Acumen Interim Report on the Malpractice Relative Value Units for the CY 2018 Medicare Physician Fee Schedule*. July 2017. Available at: cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/CY2018-PFS-NPRM-MP-RVU.pdf.

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**data, however minimal, for these specialties to determine if the crosswalk to allergy/immunology is supported before implementation of these crosswalks for future MP RVU calculations.**

**TABLE 3. MALPRACTICE RISK FACTORS AND PREMIUM AMOUNTS BY SPECIALTY**

| | | 2017 | 2018p | 2017 | 2018p |
|---|---|---|---|---|---|
| Specialty Code | Specialties Crosswalked to Allergy Immunology | Non-surgical Normalized Premium Rate | Non-surgical Normalized Premium Rate | Surgical Normalized Premium Rate | Surgical Normalized Premium Rate |
| 3 | Allergy Immunology | $8,398 | $8,201 | $8,398 | $8,201 |
| 12 | Osteopathic Manipulative Medicine | $8,398 | $8,201 | $8,398 | $8,201 |
| 15 | Speech Language Pathology | $8,398 | $8,201 | $8,398 | $8,201 |
| 17 | Hospice and Palliative Care | $8,398 | $8,201 | $8,398 | $8,201 |
| 35 | Chiropractic | $8,398 | $8,201 | $8,398 | $8,201 |
| 41 | Optometry | $8,398 | $8,201 | $8,398 | $8,201 |
| 62 | Psychologist | $8,398 | $8,201 | $8,398 | $8,201 |
| 64 | Audiologist | $8,398 | $8,201 | $8,398 | $8,201 |
| 65 | Physical Therapist | $8,398 | $8,201 | $8,398 | $8,201 |
| 67 | Occupational Therapist | $8,398 | $8,201 | $8,398 | $8,201 |
| 68 | Clinical Psychologist | $8,398 | $8,201 | $8,398 | $8,201 |
| 79 | Addiction Medicine | $8,398 | $8,201 | $8,398 | $8,201 |
| 80 | Licensed Clinical Social Worker | $8,398 | $8,201 | $8,398 | $8,201 |
| 97 | Physician Assistant | $8,398 | $8,201 | $8,398 | $8,201 |

Low Volume Service Codes

CMS proposes to use a list of anticipated specialties instead of the claims-based specialty mix for low volume services in order to address stakeholder concerns about the year-to-year variability in MP (and PE) RVUs for low volume services. **In prior comment letters, we urged CMS to use service-level overrides for low volume services. We thank CMS for agreeing to a process of using code level overrides.**

New or Revised Codes

CMS believes that there would no longer be a need to apply service-level MP RVU crosswalks for new or revised codes in order to assign a specialty-mix risk factor, and instead would derive the specialty mix assumption for the first

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year for a new or revised code from the specialty mix used for purposes of rate-setting. In subsequent years, when claims data are available, CMS would assign the specialty based on such data unless the service does not exceed the low volume threshold of 99 or fewer allowed services. If a service is low volume, CMS would assign ae expected specialty, establishing a new expected specialty through rulemaking as needed. **We agree with CMS' proposal and support this change to calculating MP RVUs for new or revised codes.**

**Medicare Telehealth Services**

*Elimination of the Required Use of the GT Modifier on Professional Claims*

CMS currently requires the inclusion of the telehealth GT modifier (via interactive audio and video telecommunications systems) on professional claims for telehealth services. Effective January 1, 2017, CMS also requires Place of Service (POS) code 02 Telehealth to be included on professional claims for telehealth services. In this proposed rule, CMS indicates that the use of both the GT modifier and POS code for telehealth services is redundant, and therefore proposes to eliminate the required use of the GT modifier on professional claims. **The ACS agrees that the inclusion of both the GT modifier and POS code on professional claims for telehealth services is unnecessary and supports CMS' proposal to eliminate the required use of the GT modifier.**

*Comment Solicitation on Remote Patient Monitoring*

CMS seeks comment on whether to make separate payment for Current Procedural Terminology (CPT) codes that describe remote patient monitoring. The Agency specifically seeks comments regarding separate payment for CPT codes 99090 (Analysis of clinical data stored in computers (e.g., ECGs, blood pressures, hematologic data)) and 99091 (Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time).

**The ACS does not believe that separate payment for 99090 and 99091 is warranted.** Remote patient monitoring services should obtain new, precise CPT codes as literature and new technologies appear. Codes 99090 and 99091 are generic codes that are duplicative of Category I codes that are more specific (e.g., 93297 (Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system, including analysis of 1 or more

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recorded physiologic cardiovascular data elements from all internal and external sensors, analysis, review(s) and report(s) by a physician or other qualified health care professional) or 93228 (External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional)).

**Potentially Misvalued Services under the Physician Fee Schedule**

*CY 2018 Identification and Review of Potentially Misvalued Services*

Dialysis Circuit

In the CY 2017 PFS final rule, CMS included comments regarding appropriate values for dialysis circuit codes newly created in CY 2017 (codes 36901 through 36909). CMS expressed concern that no data were included with the recommendations that would warrant increases to the work RVUs. CMS urged interested stakeholders to consider submitting robust data regarding costs for these and other services. Subsequently, stakeholders expressed concerns regarding the typical patient for these procedures as reflected in the information included in the RUC recommendations for CY 2017 and the importance of appropriate payment to ensure access to care for Medicare beneficiaries. In the CY 2018 PFS proposed rule, CMS is seeking additional comment and continuing to request robust data regarding the potentially misvalued work RVUs for codes 36901 through 36909 and is considering alternate work valuations for CY 2018, such as the RUC recommended work RVUs, or other potential values based on submission of data through the public comment process.

These new dialysis codes include invasive work to obtain new access as well as secondary access to the dialysis circuit, and are not comparable to the codes CMS used as crosswalks (44388, 44403 and 44408), which 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/endoscopic retrograde cholangiopancreatography is inappropriate. The typical patient for the dialysis code set can be classified as American Society of Anesthesiologists (ASA) Physical Status level 3 or 4. Chronic renal insufficiency is an inherently medically complex patient population, and crosswalking dialysis procedures in a complex patient population to (typically) elective gastrointestinal procedures is an improper comparison. The illness

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severity of the typical dialysis patient, which impacts physician work, was taken into consideration and discussed in significant detail during the RUC review process to assure relativity.

In addition, the use of direct crosswalks based only on intraservice time comparison or ratios of intraservice time do not appropriately account for the variation in technical skill, judgment, and risk inherent to these procedures. This argument is undermined further when the comparison codes are not clinically similar with regard to risk. The use of 43264 as a crosswalk for 36904 ignores the inherent differences in risk to the patient when working in the vascular system as opposed to the bile ducts.

We have no reason (or data) to believe that the vignettes used to survey this new family of dialysis codes were inappropriate. The survey respondents agreed that all nine vignettes were typical. **We urge CMS to accept the RUC's broad-based, multispecialty consensus recommendations for this code set as follows:**

- **CPT code 36901, work RVU= 3.36**
- **CPT code 36902, work RVU= 4.83**
- **CPT code 36903, work RVU= 6.39**
- **CPT code 36904, work RVU= 7.50**
- **CPT code 36905, work RVU= 9.00**
- **CPT code 36906, work RVU= 10.42**
- **CPT code 36907, work RVU= 3.00**
- **CPT code 36908, work RVU= 4.25**
- **CPT code 36909, work RVU= 4.12**

*Collecting Data on Resources Used in Furnishing Global Services*

Section 523 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS to use rulemaking to obtain information needed to value surgical services from a representative sample of physicians. MACRA requires that CMS begin the data collection 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, as appropriate. Beginning in 2019, the information collected, along with any other available data, must be used to improve the accuracy of the valuation of surgical services.

In the CY 2017 PFS final rule, CMS set forth a global codes data collection policy consisting of three components: (1) claims-based data reporting; (2) a survey of practitioners; and (3) data collection from accountable care

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organizations (ACOs). For claims-based reporting, CMS finalized a policy whereby practitioners who are in groups of 10 or more and who are located in any of nine designated states would be required to report CPT code 99024 for every post-operative visit that they provide related to any of the 293 10- and 90-day global codes specified by CMS. This mandatory data collection began July 1, 2017. Additionally, few details are known about the other two components, namely, the survey of practitioners and data collection from ACOs. Although MACRA allows a 5 percent withhold in payment for those practitioners who fail to report, we appreciate that CMS has not implemented this penalty.

While not addressed in the CY 2018 PFS proposed rule, we restate below some of our concerns with the claims-based data reporting implementation and questions regarding how the collected data will be used. We also request more information regarding the global codes list for 2018 in addition to information on the survey of practitioners conducted by the RAND Corporation. **We strongly urge that CMS not use data collected via the claims-based data collection methodology to revalue global codes starting in 2019.** Without sufficient time, provider education on this policy, or a detailed plan for data validation, the data collected will be inherently flawed and of low statistical quality. It is not appropriate to use these data to revalue global codes, especially if CMS assigns values to some CPT codes using a methodology that is completely independent from the RUC process.

Claims-Based Data Reporting – Current Policy Implementation Hurdles

As the claims-based data reporting is in the early stages, we have not been able to gather enough feedback from our members on their experience with reporting the 99024 code for postoperative visits. Leading up to July 1 data collection start date, the issue on which we received the most questions related to the definition of a "practice." For the purposes of postoperative data reporting, "practice" is defined not as practitioners sharing the same tax ID number (TIN) as CMS defines groups in all other cases of CMS reporting, but rather as practitioners sharing "business or financial operations, clinical facilities, records, or personnel." Practices of 10 or more practitioners are required to report the postoperative CPT code 99024 to CMS via claims.

This definition has led to confusion for our members. For example, one ACS Fellow asked if he is required to report given that he is part of a two-person neurosurgical practice, yet operates at an ambulatory surgical center (ASC) with 19 other partners from multiple specialties. The facility is used exclusively for procedures, such as no consultative services or postoperative care is provided by any of the physicians who practice there; postoperative care

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is furnished in the physicians' private offices. Surgical billing is carried out under different TINs, as the physicians who operate at the ASC are wholly independent practices with different staff and different specialties. The only connection this surgeon has with the other physicians is through the facility which bills the facility fee with a single, unique TIN. It does not appear that this surgeon should count as being part of a group practice with the other 19 physicians, but based on CMS' definition of "practice", they do in fact share a facility (albeit JUST for procedures and nothing else). We have submitted questions, starting in May 2017, to the email address (MACRA_Global_Surgery@cms.hhs.gov) provided during CMS calls on this topic and have followed up, but have still not received a response.

**Given the level of confusion that CMS' definition of "practice" has created, in addition to the lack of response to our emailed questions, we believe that CMS has severely undermined the integrity of the data that it intends to collect and should issue an immediate withdrawal of the requirement.** MACRA does require CMS to collect data on the number and level of postoperative visits, but CMS is not mandated to collect these data via claims. CMS has the ability to use a different method to fulfill the MACRA requirement. In the event that CMS continues to require reporting of 99024 in the specified scenarios, **we strongly urge the Agency to revise the definition of a "practice" to conform to the definition of a group as practitioners sharing a TIN, which is used in other cases of CMS reporting.** This definition is a bright-line rule, is more familiar and intuitive to practitioners, and avoids surgeons having to calculate "practice" under one methodology for this Medicare requirement and "group" using completely different definitions for other Medicare programs.

In early 2017, CMS posted the list of 293 10- and 90-day global codes to be reported starting July 1, 2017, based on the articulated frequency criteria. However, CMS made no attempt to discuss or update the list of codes in this proposed rule for 2018 to ensure that the list of codes continues to meet CMS' finalized criteria. We are now uncertain as to whether these are the same codes that practitioners should use for reporting in 2018. Again, we believe that these discrepancies have severely undermined the integrity of the data being collected. However, if CMS continues to require the reporting of 99024 in certain scenarios, **we ask that CMS clarify whether practitioners should use the 2017 list of high volume/high value 10- and 90-day global codes or whether CMS plans to release a new list for 2018 reporting.**

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Claims-Based Data Reporting – Analysis and Use of Collected Data

We reiterate several logistical and policy questions on how CMS will analyze and use the data that are collected via the claims-based process. Specifically:

- How will CMS keep the appropriate 99024 code attached to the index procedure? This is especially important in cases where multiple CPT codes from the list of 293 codes are reported within the same global period.
- What process has CMS developed for providers to confirm that all 99024 codes they submitted have been captured?
- How will CMS confirm that data have been reported accurately?
- How will CMS handle the data from practitioners who do not consistently report 99024? Despite best efforts at education, some practitioners will not reliably report 99024 as required, most often because EMR systems between facilities and offices are not compatible. How will CMS take this into consideration?
- How will CMS handle procedures that are submitted with modifiers? There are a number of modifiers that are appended to surgery claims that impact the provision of postoperative care, which could significantly impact data collection.

With these questions unanswered, we do not believe it is appropriate for CMS to use data collected via the claims-based process to revalue codes in 2019. In addition, it is inappropriate to assign values to some CPT codes using a methodology that is completely independent from the magnitude estimation process used by Harvard and the RUC. **The RUC recommends work values for CPT codes based on their relativity to other CPT codes and not based on a sum of component services (e.g., the building block methodology), so attempting to assign values outside of this relative value scale for some, but not all, CPT codes would be improper and methodologically unsound.** This process disproportionately impacts some specialties, both in terms of administrative data collection burden and how the data will be used.

RAND Survey

We also have very little information regarding the survey of practitioners (the second component of global codes data collection). The CY 2017 PFS final rule stated that the survey will be in the field by mid-2017, yet we have no information about the survey to begin educating our members on what to expect. In addition, it is critical that clinical experts from the specialties who will be surveyed have the opportunity to review and provide feedback on the survey design, methodology, content, and data analyses. At this point, our

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understanding is that just one member from a selection of specialties will be interviewed and only those without payment expertise have been considered. We have many questions and concerns regarding the survey development and **we urge CMS not to move forward with this practitioner survey until it has been thoroughly vetted and the specialties to be surveyed have had an opportunity to review it and provide feedback**.

**Proposed Valuation of Specific Codes**

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

- **Code 15734:** We appreciate that CMS proposes accepting the RUC-recommended work RVU for 15734 that reflects the increased change in both intra-service time and postoperative work.

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

- **Code 29580:** CMS proposes to accept the RUC's broad-based, multispecialty consensus work RVU of 0.55 for 29580 (Strapping; Unna boot). However, CMS is concerned that the RUC recommended a slight decrease (9 minutes) in preservice time for CPT code 29580, with the intraservice and immediate postservice times remaining unchanged.

  The survey preservice times for code 29580 were reduced to the standard times for pre-time package 5 with one minute subtracted because local anesthesia is not used. Code 29580 is not typically reported with an evaluation and management (E/M) service, however, the preservice time includes significant patient evaluation as presented in the preservice work description: *Review chart with general medical and surgical history update, including current medications and allergies. Perform evaluation of neurological and vascular status of lower extremity, along with a dermatologic and musculoskeletal examination of the foot, ankle, and lower leg. Examine and measure the size and depth of the ulcer. Conduct proper patient screening to exclude those with deep infection, excessive edema, or excessively fragile skin. Communicate with the patient and/or family to explain the procedure, including a discussion of possible risks and complications. Verify all required instruments and supplies are available. Perform time out.*

  In contrast, the CMS comparator code 98925 (Osteopathic manipulative treatment (OMT); 1-2 body regions involved) is typically reported with an E/M service. This was taken into account by the specialty, the RUC,

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and CMS when the time in pre-time package 5 was reduced and maintaining the current work RVU was finalized for 98925. Therefore, we do not agree that 98925 is a good comparator code.

In the summary of recommendation form for 29580, we cited two multispecialty point of comparison (MPC) codes to use for relative comparison: 46600 (Anoscopy; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)) [work RVU=0.55, total time = 22 min] and 69210 (Removal impacted cerumen requiring instrumentation, unilateral) [work RVU=0.61, total time = 17 min].

We also offer additional high volume and well understood codes with similar intra-time and intensity as support: 69100 (Biopsy external ear) [work RVU=0.81, intra-time = 12 min], 64566 (Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming) [work RVU=0.60, intra-time = 10 min], and 11721 (Debridement of nail(s) by any method(s); 6 or more) [work RVU=0.54, intra-time = 10 min].

**The CMS alternative value is not appropriate. The RUC recommended work RVU of 0.55 for 29580 is the correct relative value.**

- **Code 29581:** CMS proposes to accept the RUC's broad-based, multispecialty consensus work RVU of 0.60 for 29581 (Application of multi-layer compression system; leg (below knee), including ankle and foot). However, CMS considers an alternative value for 29581 based on the RUC recommended work RVU increment between 29580 and 29581. While we agree that the work RVU increment is appropriate, as stated above, the RUC recommended work RVU of 0.55 for 29580 is more than justified. Therefore, the RUC recommended value of 0.60 for 29581 is also justified.

  We do not agree that 97597 is an appropriate crosswalk for 29581. The work RVU for code 97597 was derived by a work neutrality calculation when codes 11040 and 11041 were deleted. The survey median work RVU of 0.80 and 25th percentile work RVU of 0.70 were not considered valid for 97597 because compelling evidence was not presented and work neutrality needed to be maintained.

  In the summary of recommendation form for 29581, we cited two MPC codes to use for relative comparison: 46600 (Anoscopy; diagnostic,

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including collection of specimen(s) by brushing or washing, when performed (separate procedure)) [work RVU=0.55, total time = 22 min] and 69210 (Removal impacted cerumen requiring instrumentation, unilateral) [work RVU=0.61, total time = 17 min].

We also offer additional high volume and well understood codes with similar intra-time and intensity as support: 69100 (Biopsy external ear) [work RVU=0.81, intra-time = 12 min], 12011 (Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less) [work RVU=1.07, intra-time = 12 min], and 11901 (Injection, intralesional; more than 7 lesions) [work RVU=0.80, intra-time = 13 min].

**The CMS alternative value is not appropriate. The RUC recommended work RVU of 0.60 for 29581 is the correct relative value.**

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

- **Code 31601:** CMS proposes to accept the RUC's broad-based multispecialty consensus work RVU of 8.00 for 31601 (Tracheostomy, planned (separate procedure); younger than 2 years). CMS requests comment on the effect of an alternative work RVU of 6.50, but CMS does not provide a rationale for this alternative value.

  We do not believe the alternative work RVU of 6.50 for 31601 would be appropriate relative to other PFS services that represent high intensity and complex work. This alternative value would also result in an intraoperative work intensity that is less than code 31600 (Tracheostomy, planned (separate procedure)). The intraoperative work for 31601 (infant) is more intense/complex than 31600 (adult) and more intense/complex than both key reference codes 43274 (ERCP through a natural orifice) and 43210 (Transoral EGD treatment for GERD) as presented and discussed at the RUC meeting.

  Performing a tracheostomy carries the risk of serious complications including bleeding, damage to the trachea, subcutaneous emphysema, pneumothorax, and hematoma, any of which can compromise continued breathing and survival. In addition, performing a tracheostomy in pediatric patients has added difficulty because a child's neck is anatomically different from an adult's neck in the following ways: the dome of the pleura extends into the neck and is thus vulnerable to injury; the trachea is pliable and can be difficult to

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palpate; the neck is short, and there is significantly less working space; and the cricoid can be injured if it is not correctly identified.

The intraoperative work for code 31601 is intense and complex and carries the risk of serious complications that could compromise a patient's survival. Code 31601, which is a major procedure, is not easily compared with other 000 global codes, many of which are performed as outpatient and/or office procedures for ambulatory patients. As support of our recommendation, we provided a list of codes on the summary of recommendation form that CMS received. These codes have been recently reviewed by the RUC and approved by CMS and have intraoperative intensities comparable to the intensity for 31601 with a work RVU of 8.00.

**We believe the discussion at the RUC about the inherent intense nature of 31601 and appropriate relativity to other similarly intense procedures supports the RUC recommended work RVU of 8.00.**

- **Code 31605:** CMS proposes to accept the RUC's broad-based, multispecialty consensus work RVU of 6.45 for 31605 (Tracheostomy, emergency procedure; transtracheal). However CMS requests comment on an alternative work RVU of 4.77 based on the RUC survey 25th percentile for all survey responses. CMS also considers an alternative intraoperative time of 15 minutes based on all the survey responses. During the RUC meeting, the specialties presented a compelling rationale that the recommendation for this low volume procedure should be based on survey responses from physicians who have performed the procedure. The data clearly showed that those physicians with experience indicated a higher intraoperative time and a higher work value for this life or death procedure. We argued that physicians who have not performed the procedure could not objectively judge the intensity and complexity of the work. Practicing on a mannequin in medical school or as a resident will not impart the extreme intensity/complexity of the procedure. All RUC members, representing all medical disciplines, agreed that this procedure is most similar in intensity to 31500 (emergency intubation). The alternative work RVU and time that CMS suggests would result in an intensity for 31605 that is one-half the intensity of 31500 and is similar to a cataract procedure (e.g., 66984). We believe that no physician in America would equate the intraoperative work intensity of 31605 to code 66984.

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CMS also expressed concern about the number of responses (20) that were used to formulate the recommendation. We acknowledge that the RUC has requirements for survey response rates based on code utilization, however, the RUC also allows less than the standard for rarely performed services with appropriate justification.

**We believe the unanimous agreement at the RUC about the inherent intense nature of 31605 and agreement that 31605 is best compared to 31500 (and not to other 0-day global codes) supports the RUC recommended work RVU of 6.45.**

- **Code 31610:** CMS proposes to accept the RUC's broad-based, multispecialty consensus work RVU of 12.00 for code 31610 (Tracheostomy, fenestration procedure with skin flaps). However, CMS considered an alternative work RVU of 6.50 based on a direct crosswalk to code 31601 (Incision of windpipe) and likely a change in global period to 0-day because code 31610 is a 90-day global procedure.

  We acknowledge that the RUC initially was concerned because the survey work RVU estimation did not fully capture all the necessary postoperative work. CMS expresses concern that they could not identify codes with 45 minutes of intraoperative time and 242 minutes of postoperative work.

  We agree that, for most 90-day global codes, there is a relationship between intraoperative time and postoperative work. However, codes in the PFS are not standardized such that only codes with large intraoperative time will also have a large number of minutes for postoperative work directly related to the operation or vice versa. For example, code 66170 (Glaucoma surgery) has 45 minutes of intra-time and almost 200 minutes of postoperative E/M work.

  The RUC initially considered the possibility of recommending that this code be assigned a 0-day global period based on concerns about a negative derived intensity. We argued, and the RUC agreed, that a negative intraoperative work value is not related to the global period for this code, but instead to the fact that there are no good references for the survey respondents to correctly capture the value of the postoperative work in their total work estimation. The RUC also agreed that maintaining a 90-day global period appropriately bundled the necessary related postoperative work and was more similar to the

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direction that CMS is taking to move toward bundled payments for typical work.

In addition, there are many reimbursement concerns that CMS has not resolved related to unbundling global procedures. We are primarily concerned that unbundling could lead to more postoperative services reported because the typical patient is straightforward and all other patients will be complex. We are also concerned about the lack of accurate reimbursement for practice expense and malpractice expense for the surgeons who perform the postoperative work because E/M codes do not reflect the necessary supplies, equipment and staff time for the work involved.

**Code 31610 is not a bimodal procedure (e.g., performed equally in a facility and an office) and instead is a very good example of a bundled episode of care. We believe the RUC's recommendation to maintain a 90-day global period and the RUC recommended work RVU of 12.00 correctly reflects the bundled work related to a planned permanent tracheostomy with flaps.**

*Endovascular Repair Of Abdominal Aorta and/or Iliac Arteries (EVAR) Procedures (CPT codes 34X01, 34X02, 34X03, 34X04, 34X05, 34X06, 34X07,34X08, 34X09, 34X10, 34X11, 34X12, 34X13, 34812, 34X15, 34820, 34833, 34834, 34X19, and 34X20)*

Codes 34X01-34X08

Prior to the EVAR coding changes, endovascular aneurysm repairs performed for rupture and in elective circumstances were reported with the same code; however, the original codes were developed exclusively for elective repair. In 2000, it was not technically feasible to repair a ruptured aortic aneurysm using endovascular techniques. Over time, physicians developed the appropriate skill such that endovascular repair of a ruptured aortic aneurysm is now possible.

In general, the elective endovascular repairs (34X01, 34X03, 34X05, 34X07) represent approximately 85 percent of reported services, while the repair of ruptured aneurysms (34X02, 34X04, 34X06, 34X08) represent approximately 15 percent of total reported services. For the much more common elective repairs, the RUC recommended work RVUs are significantly lower than the current value of the component services that were bundled. For the less common ruptured aneurysm repairs, the RUC recommended work RVUs are higher than the existing value of the component services that were bundled;

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however, the combined result is a net reduction in work RVUs despite the fact that the additional work associated with ruptured aortic and iliac aneurysms was never considered when this family of endovascular repairs was created.

- **34X01:** CMS proposes to accept the RUC's broad-based, multispecialty consensus work RVU of 23.71 for CPT code 34X01.

  This new code bundles preservice endograft planning, bilateral non-selective catheterization, endograft deployment, all angioplasty and/or stenting and all proximal and/or distal extensions from the level of the renal arteries down to the level of the aortic bifurcation, and all radiologic supervision and interpretation (S&I). **We appreciate that CMS recognizes that a work RVU of 23.71 is the correct relative value for 34X01 within this family of EVAR codes and relative to other codes in the PFS.**

- **34X02:** CMS proposes to accept the RUC's broad-based, multispecialty consensus work RVU of 36.00 for CPT code 34X02. However, CMS requests comment on an alternative work RVU of 32.00 based on the survey 25th percentile and relative to CPT code 48000 (Placement of drains, peripancreatic, for acute pancreatitis), which has the same intraservice time of 120 minutes and a work RVU of 31.95. CMS indicates that they were unable to find any 90-day global services with 120 minutes of intraservice time and approximately 677 minutes of total time that had a work RVU greater than 36.00.

  Code 48000 is not a valid comparator code for several reasons. First, the code did not undergo a full RUC survey. Second, the code has an extremely low utilization. Third, a mini-survey was conducted that resulted in a specialty work RVU recommendation of 39.49; however, the RUC determined not to accept the mini-survey results and instead applied a work RVU percentage adjustment based on a full survey of code 48005, which was deleted in 2007.

  A ruptured aortic aneurysm is a catastrophic event with a high perioperative mortality rate despite best possible care. Without rapid treatment, death is certain. These patients present in varying degrees of hemorrhagic shock and are typically plagued by multisystem organ failure postoperatively. Despite advances in detection and treatment of aneurysmal disease, the rupture rate has remained relatively constant over the past two decades at roughly 15 percent of the total number of patients who present for abdominal aortic and iliac aneurysm repair.

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Code 34X02 offers a less invasive approach for treatment, but remains an extremely intense service in an attempt to save the life of an actively dying patient. Code 34X02 captures significantly different work compared to an elective aneurysm repair and includes the additional work of temporary balloon aortic occlusion as needed for hemodynamic instability as well as the significantly different, longer and more complex postoperative care.

We acknowledge that identifying comparator codes may be difficult if the focus is only on the survey code intraoperative and total time. Procedures that have high intensity and/or procedures with low intraoperative time, but high pre- and postoperative work, are difficult to compare using these parameters. In this instance, it is more logical to consider intraoperative intensity to find comparator codes as support that the recommended work RVU is correct.

The table below was presented to the RUC to demonstrate that the median work RVU of 36.00, which results in an intraoperative work intensity of 0.1369, is relative to other highly intense services. This type of analysis allows for comparison of intraoperative work relativity across codes that have variable pre- and postoperative work. **We believe the discussion at the RUC about the inherent intense nature of 34X02 and appropriate relativity to other similarly intense procedures supports the RUC recommended work RVU of 36.00.**

| CPT | Descriptor | IWPUT | RVW | INTRA | Total Time |
|---|---|---|---|---|---|
| 22864 | Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical | 0.1335 | 29.40 | 150 | 457 |
| 47130 | Hepatectomy, resection of liver; total right lobectomy | 0.1338 | 57.19 | 240 | 870 |
| 22861 | Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical | 0.1345 | 33.36 | 180 | 477 |
| 33681 | Closure of single ventricular septal defect, with or without patch | 0.1369 | 32.34 | 150 | 507 |

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| CPT | Descriptor | IWPUT | RVW | INTRA | Total Time |
|---|---|---|---|---|---|
| *34X02* | *Endovascular repair of infrarenal aorta by deployment of an aorto-aortic tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the aortic bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the aortic bifurcation; for rupture, including temporary aortic and/or iliac balloon occlusion when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)* | *0.1369* | *36.00* | *120* | *677* |
| 61798 | Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 complex cranial lesion | 0.1372 | 19.85 | 120 | 225 |
| 22856 | Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); single interspace, cervical | 0.1386 | 24.05 | 120 | 367 |
| 22551 | Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2 | 0.1403 | 25.00 | 120 | 395 |
| 43313 | Esophagoplasty for congenital defect (plastic repair or reconstruction), thoracic approach; without repair of congenital tracheoesophageal fistula | 0.1741 | 48.45 | 178 | 713 |
| 45126 | Pelvic exenteration for colorectal malignancy, with proctectomy (with or without colostomy), with removal of bladder and ureteral transplantations, and/or hysterectomy, or cervicectomy, with or without removal of tube(s), with or without removal of ovary(s), or any combination thereof | 0.1983 | 49.10 | 120 | 755 |

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- **34X03:** CMS proposes to accept the RUC's broad-based, multispecialty consensus work RVU of 26.52 for CPT code 34X03.

  This new code bundles preservice endograft planning, bilateral non-selective catheterization, endograft deployment, all angioplasty and/or stenting and all proximal and/or distal extensions from the level of the renal arteries down to the level of the aortic bifurcation, and all radiologic S&I. **We appreciate that CMS recognizes that a work RVU of 26.52 is the correct relative value for 34X03 within this family of EVAR codes and relative to other codes in the MPFS.**

- **34X04.** CMS proposes to accept the RUC's broad-based, multispecialty consensus work RVU of 45.00 for CPT code 34X04. However, CMS requests comment on an alternative work RVU of 40.00 based on the survey 25th percentile and relative to code 33534 (Coronary artery bypass, using arterial graft(s); 2 coronary arterial grafts), which has a work RVU of 39.88. The Agency notes that code 33534 has 193 minutes of intraservice time, but a lower total time of 717 minutes. CMS indicates they were unable to find any 90-day global services with 180 minutes of intraservice time and approximately 737 minutes of total time that had a work RVU greater than 45.00.

  Code 33534 is not a valid comparator code for several reasons. First, the value for code 33534 is not based on a RUC survey using magnitude estimation, but rather a calculation using a building block methodology based on the Society of Thoracic Surgeons' Adult Cardiac Surgery Database using the mean intraoperative time and mean length of stay. In addition, the intensity used for calculation was surveyed separately and the pre- and postoperative time and visits were developed by an expert panel. More importantly, the typical patient undergoing a two graft coronary artery bypass graft (CABG) is not typically an urgent or emergent procedure, but rather a scheduled procedure. In comparison, a ruptured aortic aneurysm is a catastrophic event with a high perioperative mortality rate despite best possible care. Without rapid treatment, death is certain. These patients present in varying degrees of hemorrhagic shock and are typically plagued by multisystem organ failure post-operatively. Despite advances in detection and treatment of aneurysmal disease, the rupture rate has remained relatively constant over the past two decades at roughly 15 percent of the total number of patients who present for abdominal aortic and iliac aneurysm repair.

  Code 34X04 offers a less invasive approach for treatment, but remains an extremely intense service in an attempt to save the life of an actively

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dying patient. Code 34X04 captures significantly different work compared to an elective aneurysm repair and includes the additional work of temporary balloon aortic occlusion as needed for hemodynamic instability as well as the significantly different, longer and more complex postoperative care.

We acknowledge that identifying comparator codes may be difficult if the focus is only on the survey code intraoperative and total time. Procedures which have high intensity and/or procedures with low intraoperative time, but high pre- and postoperative work are difficult to compare using these parameters. In this instance, it is more logical to consider intraoperative intensity to find comparator codes as support that the recommended work RVU is correct.

The table below was presented to the RUC to demonstrate that the median work RVU of 45.00 results in an intraoperative work intensity of 0.1413, which is relative to other highly intense services. This type of analysis allows for comparison of intraoperative work relativity across codes that have variable pre- and postoperative work. **We believe the discussion at the RUC about the inherent intense nature of 34X04 and appropriate relativity to other similarly intense procedures supports the RUC recommended work RVU of 45.00.**

| CPT | Descriptor | IWPUT | RVW | INTRA | Total Time |
|---|---|---|---|---|---|
| 47130 | Hepatectomy, resection of liver; total right lobectomy | 0.1338 | 57.19 | 240 | 870 |
| 22861 | Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical | 0.1345 | 33.36 | 180 | 477 |
| 33681 | Closure of single ventricular septal defect, with or without patch; | 0.1369 | 32.34 | 150 | 507 |
| 61798 | Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 complex cranial lesion | 0.1372 | 19.85 | 120 | 225 |
| 22856 | Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); single interspace, cervical | 0.1386 | 24.05 | 120 | 367 |

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| CPT | Descriptor | IWPUT | RVW | INTRA | Total Time |
|---|---|---|---|---|---|
| 22551 | Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2 | 0.1403 | 25.00 | 120 | 395 |
| *34X04* | *Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-uniiliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for rupture, including temporary aortic and/or iliac balloon occlusion when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)* | *0.1413* | *45.00* | *180* | *737* |
| 43313 | Esophagoplasty for congenital defect (plastic repair or reconstruction), thoracic approach; without repair of congenital tracheoesophageal fistula | 0.1741 | 48.45 | 178 | 713 |
| 45126 | Pelvic exenteration for colorectal malignancy, with proctectomy (with or without colostomy), with removal of bladder and ureteral transplantations, and/or hysterectomy, or cervicectomy, with or without removal of tube(s), with or without removal of ovary(s), or any combination thereof | 0.1983 | 49.10 | 120 | 755 |

- **34X05**: CMS proposes to accept the RUC's broad-based, multispecialty consensus work RVU of 29.58 for CPT code 34X05.

  This new code bundles preservice endograft planning, bilateral non-selective catheterization, endograft deployment, all angioplasty and/or stenting and all proximal and/or distal extensions from the level of the renal arteries down to the level of the aortic bifurcation, and all radiologic S&I. **We appreciate that CMS recognizes that a work RVU of 29.58 is the correct relative**

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**value for 34X05 within this family of EVAR codes and relative to other codes in the MPFS.**

- **34X06**: CMS proposes to accept the RUC's broad-based, multispecialty consensus work RVU of 45.00 for CPT code 34X06. However, CMS requests comment on an alternative work RVU of 40.00 based on the survey 25th percentile and a comparison to CPT code 34X04, with 2 fewer minutes of intraservice time and total time. CMS also indicates they believe the survey respondents thought that these two codes had a comparable amount of work, as the survey 25th percentile work RVU was 40.00 for both codes.

  We do not disagree that survey respondents indicated that 34X06 and 34X04 represent comparable work; however, the correct statistical measure of comparability is the survey median, not the 25th percentile. All of the discussion above for 34X04 also applies to 34X06. Code 33534 is not a valid comparator code for several reasons, including the different valuation methodology and different typical patient. A ruptured aortic aneurysm is a catastrophic event with patients who present in varying degrees of hemorrhagic shock and are typically plagued by multisystem organ failure postoperatively.

  Code 34X06 offers a less invasive approach for treatment, but remains an extremely intense service in an attempt to save the life of an actively dying patient. Code 34X06 captures significantly different work compared to an elective aneurysm repair and includes the additional work of temporary balloon aortic occlusion as needed for hemodynamic instability as well as the significantly different, longer and more complex postoperative care.

  We acknowledge that identifying comparator codes may be difficult if the focus is only on the survey code intraoperative and total time. Procedures which have high intensity and/or procedures with low intraoperative time but high pre- and postoperative work are difficult to compare using these parameters. In this instance, it is more logical to consider intraoperative intensity to find comparator codes as support that the recommended work RVU is correct.

  The table below was presented to the RUC to demonstrate that the median work RVU of 45.00 results in an intraoperative work intensity of 0.1429 that is relative to other highly intense services. This type of analysis allows for comparison of intraoperative work relativity across codes that have variable pre- and postoperative work. **We believe the discussion at the RUC about the inherent intense nature of 34X06 and appropriate relativity to other**

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**similarly intense procedures supports the RUC recommended work RVU of 45.00.**

| CPT | Descriptor | IWPUT | RVW | INTRA | Total Time |
|---|---|---|---|---|---|
| 47130 | Hepatectomy, resection of liver; total right lobectomy | 0.1338 | 57.19 | 240 | 870 |
| 22861 | Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical | 0.1345 | 33.36 | 180 | 477 |
| 33681 | Closure of single ventricular septal defect, with or without patch; | 0.1369 | 32.34 | 150 | 507 |
| 61798 | Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 complex cranial lesion | 0.1372 | 19.85 | 120 | 225 |
| 22856 | Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); single interspace, cervical | 0.1386 | 24.05 | 120 | 367 |
| 22551 | Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2 | 0.1403 | 25.00 | 120 | 395 |
| *34X06* | *Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-biiliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for rupture including temporary aortic and/or iliac balloon occlusion when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)* | *0.1429* | *45.00* | *178* | *735* |

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| CPT | Descriptor | IWPUT | RVW | INTRA | Total Time |
|---|---|---|---|---|---|
| 43313 | Esophagoplasty for congenital defect (plastic repair or reconstruction), thoracic approach; without repair of congenital tracheoesophageal fistula | 0.1741 | 48.45 | 178 | 713 |
| 45126 | Pelvic exenteration for colorectal malignancy, with proctectomy (with or without colostomy), with removal of bladder and ureteral transplantations, and/or hysterectomy, or cervicectomy, with or without removal of tube(s), with or without removal of ovary(s), or any combination thereof | 0.1983 | 49.10 | 120 | 755 |

- **34X07:** CMS proposes to accept the RUC's broad-based, multispecialty consensus work RVU of 22.28 for CPT code 34X07.

  This new code bundles preservice endograft planning, bilateral non-selective catheterization, endograft deployment, all angioplasty and/or stenting and all proximal and/or distal extensions from the level of the renal arteries down to the level of the aortic bifurcation, and all radiologic S&I. **We appreciate that CMS recognizes that a work RVU of 22.28 is the correct relative value for 34X07 within this family of EVAR codes and relative to other codes in the MPFS.**

- **34X08:** CMS proposes to accept the RUC's broad-based, multispecialty consensus work RVU of 36.50 for CPT code 34X08. However, CMS requests comment on an alternative work RVU of 30.00 based on the survey 25th percentile. The Agency notes that code 34X08 has identical intraservice and total times compared to code 34X02, but that the RUC recommended work RVU of 36.50 for code 34X08 is higher than the RUC recommended work RVU of 36.00 for code 34X02, which is the inverse of the relationship between codes 34X07 and 34X01, as they describe the same procedures in a non-emergent state when a rupture does not take place. CMS seeks comment on whether the RUC recommended work RVUs would create a rank order anomaly within the family by reversing the relationship between these paired codes and whether an increment of approximately 1.50 to 2.00 RVUs between the two code pairs is more appropriate.

  We believe the work RVU for code 34X02 should be greater than the RUC recommended value of 36.00. Of the four codes that CMS

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compares, code 34X02 will have the lowest utilization; the survey median experience for 34X02 was zero. We presented separate summary data for surgeons with and without experience that showed a significantly higher median work RVU from the surgeons with experience. The RUC was not inclined to use the data from a subset of 19 survey responses for this rarely performed service, and instead determined to recommend the survey median from all survey respondents. The "weak link" in this set of two code pairs is not code 34X08, but instead code 34X02 because of performance rate. There is no rationale to suggest that the 25th percentile is a better measure of work for both codes simply because it ranks appropriately, as the 75th percentile also accomplishes that goal. It is first important to look at the median work RVU for each code in comparison to similarly intense services, which is why the median for both codes is more appropriate.

Similar to the discussion above for 34X02, code 48000 is not a valid comparator code. A ruptured aortic aneurysm is a catastrophic event with a high mortality rate despite best possible care. Without rapid treatment, death is certain. These patients present in varying degrees of hemorrhagic shock and are typically plagued by multisystem organ failure postoperatively. Despite advances in detection and treatment of aneurysmal disease, the rupture rate has remained relatively constant over the past two decades at roughly 15 percent of the total number of patients who present for abdominal aortic and iliac aneurysm repair. Code 34X08 offers a less invasive approach for treatment, but remains an extremely intense service in an attempt to save the life of an actively dying patient. Code 34X08 captures significantly different work compared to an elective aneurysm repair and includes the additional work of temporary balloon aortic occlusion as needed for hemodynamic instability as well as the significantly different, longer and more complex postoperative care.

We acknowledge that identifying comparator codes may be difficult if the focus is only on the survey code intraoperative and total time. Procedures that have high intensity and/or procedures with low intraoperative time but high pre- and postoperative work are difficult to compare using these parameters. In this instance, it is more logical to consider intraoperative intensity to find comparator codes as support that the recommended work RVU is correct.

The table below was presented to the RUC to demonstrate that the median work RVU of 36.50 results in an intraoperative work intensity of 0.1411 that is relative to other highly intense services. This type of analysis

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allows for comparison of intraoperative work relativity across codes that have variable pre- and postoperative work. **We believe the discussion at the RUC about the inherent intense nature of 34X08 and appropriate relativity to other similarly intense procedures supports the RUC recommended work RVU of 36.50.**

| CPT | Descriptor | IWPUT | RVW | INTRA | Total Time |
|---|---|---|---|---|---|
| 22864 | Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical | 0.1335 | 29.40 | 150 | 457 |
| 47130 | Hepatectomy, resection of liver; total right lobectomy | 0.1338 | 57.19 | 240 | 870 |
| 22861 | Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical | 0.1345 | 33.36 | 180 | 477 |
| 33681 | Closure of single ventricular septal defect, with or without patch; | 0.1369 | 32.34 | 150 | 507 |
| 61798 | Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 complex cranial lesion | 0.1372 | 19.85 | 120 | 225 |
| 22856 | Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); single interspace, cervical | 0.1386 | 24.05 | 120 | 367 |
| 22551 | Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2 | 0.1403 | 25.00 | 120 | 395 |

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| CPT | Descriptor | IWPUT | RVW | INTRA | Total Time |
|---|---|---|---|---|---|
| *34X08* | *Endovascular repair of iliac artery by deployment of an ilio-iliac tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally to the iliac bifurcation, and treatment zone angioplasty/stenting when performed, unilateral; for rupture including temporary aortic and/or iliac balloon occlusion when performed (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation, traumatic disruption)* | *0.1411* | *36.50* | *120* | *677* |
| 43313 | Esophagoplasty for congenital defect (plastic repair or reconstruction), thoracic approach; without repair of congenital tracheoesophageal fistula | 0.1741 | 48.45 | 178 | 713 |
| 45126 | Pelvic exenteration for colorectal malignancy, with proctectomy (with or without colostomy), with removal of bladder and ureteral transplantations, and/or hysterectomy, or cervicectomy, with or without removal of tube(s), with or without removal of ovary(s), or any combination thereof | 0.1983 | 49.10 | 120 | 755 |

- **Codes +34X09, 34X10, +34X11, 34X12:** CMS proposes to accept the RUC's broad-based, multispecialty consensus work RVU of 6.50 for code +34X09, 15.00 for code 34X10, 6.00 for code +34X11, and 12.00 for code 34X12. **We appreciate that CMS acknowledges that the RUC recommended values for these four codes are correct within this family of EVAR codes and relative to other codes in the PFS.**

<u>Global Period for Codes +34X13, +34812, +34X15, +34820, +34833, +34834, +34X19, +34X20.</u>

CMS requests comment on assignment of a 0-day global period for these eight codes, instead of the RUC-recommended add-on (ZZZ) global period.

The global period assignment as add-on codes was not a RUC recommendation. The CPT proposal submitted in February 2016 proposed these eight codes as

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add-ons because they never would be performed independent of another procedure. The subsequent review and revisions by the CPT Editorial Panel, which includes CMS and other third party payer representatives, never questioned the proposed add-on code assignment. In addition, **add-on code assignment was confirmed as appropriate by CMS in October 2016, prior to the societies conducting a RUC survey.**

CMS notes that as add-on procedures, these eight codes would not be subject to the multiple procedure payment discount and is concerned that the total payment for these services will increase in the aggregate based on changes in coding that alter multiple procedure payment reduction adjustments, despite the information in the surveys that reflects a decrease in the intraservice time required to perform the procedures and a decrease in their overall intensity as compared to the current values.

The RUC considered changes in time and intraoperative intensity when determining an appropriate work RVU for each add-on code. The RUC also considered that all eight codes will be reported during repair of ruptured aneurysms, which increases the intensity of the add-on code work. When codes +34812, +34820, +34833, and +34834 were reviewed in 2000, these types of repairs for challenging patients were not technically possible yet. **Therefore, we believe that the new and revised codes represent more intensive work than originally considered in 2000 and that the slight increase in intraoperative intensity, which is consistent with the primary procedures, is appropriate.**

CMS also considers adding back the preservice and immediate postservice work time and increasing the work RVU of each code accordingly using a building block methodology.

Four of these codes were revised and four of these codes are new. The RUC recommended work RVUs for all eight codes are based on a magnitude estimation survey for add-on codes. It would be inappropriate to change the global period assignment for these codes and use a building block methodology to calculate a work RVU. **We reiterate that these procedures are never performed alone and that the only correct global assignment is ZZZ.**

<u>Valuation of Codes +34X13, +34812, +34X15, +34820, +34833, +34834, +34X19, +34X20</u>

- **Code +34X13**: CMS proposes to accept the RUC's broad-based, multispecialty consensus work RVU of 2.50 for CPT code +34X13. However, CMS requests comment on a change in global period from ZZZ to 000 and a work RVU of 3.95 based on the RUC recommended work

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RVU of 2.50 plus an additional 1.45 work RVU. This additional work results from the addition of 38 total minutes of preservice work time and 30 minutes of postservice work time based on a crosswalk to CPT code 37224 (Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty), as valued by using the building block methodology.

Code +34X13 will never be performed as a stand-alone service and therefore the correct global period for this code is ZZZ. The preoperative planning, evaluation, positioning, and work related to setting up a patient for a procedure performed under general anesthesia is inherent to the primary procedure that will be performed. Similarly, the immediate postoperative work is also inherent to the primary procedure. In addition, the pre- and post-service work assigned to 37224 does not carry the intensity of the work related to exposure and closure for EVAR. Code 37224 is typically performed as an outpatient procedure and is also approved for office-based reporting. In contrast, all EVAR patients are inpatient. **The correct global period for +34X13 is ZZZ and the correct relative work RVU is 2.50.**

- **Code +34812**: CMS proposes to accept the RUC's broad-based, multispecialty consensus work RVU of 4.13 for CPT code +34812. However, CMS requests comment on a change in global period from ZZZ to 000 and a work RVU of 6.48 based on maintaining the current 75 minutes of preservice work time and the current 30 minutes of postservice work time, with a total work RVU of 2.35 added to the RUC-recommended work RVU of 4.13.

  Code +34812 will never be performed as a stand-alone service and therefore the correct global period for this code is ZZZ. The preoperative planning, evaluation, positioning, and work related to setting up a patient for a procedure performed under general anesthesia is inherent to the primary procedure that will be performed. Similarly, the immediate postoperative work is also inherent to the primary procedure. The RUC recommended work RVU for +34812 is based on a magnitude estimation survey as an add-on code. It would be inappropriate to change the global period assignment and use a building block methodology to calculate a work RVU. **The correct global period for +34812 is ZZZ and the correct relative work RVU is 4.13.**

- **Code +34X15**: CMS proposes to accept the RUC's broad-based, multispecialty consensus work RVU of 5.25 for CPT code +34X15. However, CMS requests comment on a change in global period from ZZZ to 000 and a work RVU of 7.53 with the addition of 75 minutes of

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preservice work time and 27 minutes of postservice work time to match CPT code 34833.

Code +34X15 will never be performed as a stand-alone service and therefore the correct global period for this code is ZZZ. The preoperative planning, evaluation, positioning, and work related to setting up a patient for a procedure performed under general anesthesia is inherent to the primary procedure that will be performed. Similarly, the immediate postoperative work is also inherent to the primary procedure. The RUC recommended work RVU for +34X15 is based on a magnitude estimation survey as an add-on code. It would be inappropriate to change the global period assignment and use a building block methodology to calculate a work RVU. **The correct global period for +34X15 is ZZZ and the correct relative work RVU is 5.25.**

- **Code +34820**: CMS proposes to accept the RUC's broad-based, multispecialty consensus work RVU of 7.00 for CPT code +34820. However, CMS requests comment on a change in global period from ZZZ to 000 and a work RVU of 9.46 based on maintaining the current 80 minutes of preservice work time and the current 30 minutes of postservice work time.

  Code +34820 will never be performed as a stand-alone service and therefore the correct global period for this code is ZZZ. The pre-operative planning, evaluation, positioning, and work related to setting up a patient for a procedure performed under general anesthesia is inherent to the primary procedure that will be performed. Similarly, the immediate postoperative work is also inherent to the primary procedure. The RUC recommended work RVU for +34820 is based on a magnitude estimation survey as an add-on code. It would be inappropriate to change the global period assignment and use a building block methodology to calculate a work RVU. **The correct global period for +34820 is ZZZ and the correct relative work RVU is 7.00.**

- **Code +34833**: CMS proposes to accept the RUC's broad-based, multispecialty consensus work RVU of 8.16 for CPT code +34833. However, CMS requests comment on a change in global period from ZZZ to 000 and a work RVU of 10.44 based on maintaining the current 75 minutes of preservice work time and the current 27 minutes of postservice work time.

  Code +34833 will never be performed as a stand-alone service and therefore the correct global period for this code is ZZZ. The pre-operative planning,

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evaluation, positioning, and work related to setting up a patient for a procedure performed under general anesthesia is inherent to the primary procedure that will be performed. Similarly, the immediate postoperative work is also inherent to the primary procedure. The RUC recommended work RVU for +34833 is based on a magnitude estimation survey as an add-on code. It would be inappropriate to change the global period assignment and use a building block methodology to calculate a work RVU. **The correct global period for +34833 is ZZZ and the correct relative work RVU is 8.16.**

- **Code +34834**: CMS proposes to accept the RUC's broad-based, multispecialty consensus work RVU of 2.65 for CPT code +34834. However, CMS requests comment on a change in global period from ZZZ to 000 and a work RVU of 5.00 based on maintaining the current 70 minutes of preservice work time and the current 35 minutes of postservice work time.

  Code +34834 will never be performed as a stand-alone service and therefore the correct global period for this code is ZZZ. The pre-operative planning, evaluation, positioning, and work related to setting up a patient for a procedure performed under general anesthesia is inherent to the primary procedure that will be performed. Similarly, the immediate postoperative work is also inherent to the primary procedure. The RUC recommended work RVU for +34834 is based on a magnitude estimation survey as an add-on code. It would be inappropriate to change the global period assignment and use a building block methodology to calculate a work RVU. **The correct global period for +34834 is ZZZ and the correct relative work RVU is 2.65.**

- **Code +34X19**: CMS proposes to accept the RUC's broad-based, multispecialty consensus work RVU of 6.00 for CPT code +34X19. However, CMS requests comment on a change in global period from ZZZ to 000 and a work RVU of 8.35 with the addition of 70 minutes of preservice work time and 35 minutes of postservice work time to match CPT code 34834.

  Code +34X19 will never be performed as a stand-alone service and therefore the correct global period for this code is ZZZ. The pre-operative planning, evaluation, positioning, and work related to setting up a patient for a procedure performed under general anesthesia is inherent to the primary procedure that will be performed. Similarly, the immediate postoperative work is also inherent to the primary procedure. The RUC recommended work RVU for +34X19 is based on a magnitude estimation survey as an add-

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on code. It would be inappropriate to change the global period assignment and use a building block methodology to calculate a work RVU. **The correct global period for +34X19 is ZZZ and the correct relative work RVU is 6.00.**

- **Code +34X20**: CMS proposes to accept the RUC's broad-based, multispecialty consensus work RVU of 7.19 for CPT code +34X20. However, CMS requests comment on a change in global period from ZZZ to 000 and a work RVU of 9.47 for CPT code 34X20 with the addition of 75 minutes of preservice work time and 27 minutes of postservice work time to match CPT code 34833.

  Code +34X20 will never be performed as a stand-alone service and therefore the correct global period for this code is ZZZ. The pre-operative planning, evaluation, positioning, and work related to setting up a patient for a procedure performed under general anesthesia is inherent to the primary procedure that will be performed. Similarly, the immediate postoperative work is also inherent to the primary procedure. The RUC recommended work RVU for +34X20 is based on a magnitude estimation survey as an add-on code. It would be inappropriate to change the global period assignment and use a building block methodology to calculate a work RVU. **The correct global period for +34X20 is ZZZ and the correct relative work RVU is 7.19.**

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

- **Codes 36470, 36471, 364X5, 364X6**: CMS proposes to accept the RUC's broad-based, multispecialty consensus work RVU for these four codes. **We agree that the RUC recommendations are the appropriate relative values for these codes.**

- **Codes 364X3 and 364X4**: CMS proposes to accept the RUC's broad-based, multispecialty consensus work RVU of 3.50 for code 364X3 and 0.88 for code 364X4. However, the Agency considered a work RVU of 4.38 for code 364X3 based on the RUC recommended work RVU of 3.50 plus half of the RUC recommended work RVU of code 364X4. The Agency further considers assigning code 364X4 a status indicator of "bundled." CMS has concerns about the frequency that the current services include treatment of an initial vein (code 364X3) as compared to the treatment of initial and subsequent veins (codes 364X3 and 364X4 together). CMS believes it may be more accurate to describe these services through the use of a single code, as in the rest of this code family, instead

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

CPT coding should define distinct physician work for appropriate reimbursement (both physician work and practice expense) and for data collection relative to outcome and risk. Bundling the add-on service as CMS suggests would undermine the premise of coding and relative reimbursement. Bundling the service would also place a financial burden on the patients who do not require treatment of multiple veins, as they would be paying 150 percent of what they should be paying. In addition, we do not understand the Agency's statement "It may be more accurate to describe these services through the use of a single code, as in the rest of this code family, instead of a base code and add-on code pair." The structure of this code pair mirrors the existing code structure for ablation treatment of incompetent veins with radiofrequency (36475, 36476), laser (36477, 36478) and mechanochemical (36473, 36474). The new CPT code pair represents another new technology for ablation of incompetent veins as an alternative to existing treatment options.

**The RUC recommended work RVU of 3.50 for code 364X3 and 0.88 for code 364X4 represent the correct relative values for these codes.**

- **Code 36473**: We would also like to request a review of the bilateral surgery indicator for code 36473. The indicator for this code is "0" as shown below, but we believe that the correct indicator is "1." Similar to the other vein ablation treatment codes listed below, code 36473 can be performed on one or both legs. We appreciate this opportunity to bring this to CMS' attention and hope this can be corrected.

| HCPCS | Short Descriptor | Bilateral Surgery |
|---|---|---|
| 36470 | Injection therapy of vein | 1 |
| 36471 | Injection therapy of veins | 1 |
| 36473 | Endovenous mchnchem 1st vein | 0 |
| 36475 | Endovenous rf 1st vein | 1 |
| 36478 | Endovenous laser 1st vein | 1 |

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

- **Preoperative evaluation time**: CMS has expressed concerns as to whether additional evaluation time should be added to the standard

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package times for 90-day global surgical procedures for these six codes due to the lack of evidence indicating that it takes longer to review outside imaging and lab reports for surgical services than for non-surgical services. During a presentation to the RUC and CMS representatives at the RUC meeting, specialty societies indicated that the preoperative evaluation time for these six esophagectomy codes was atypical. Patients have undergone chemoradiation therapy and imaging and labs are extensive, showing the progression of the lesions from discovery, through non-surgical treatment, to lesion size and anatomy prior to surgery. These data come from many sources and different specialties, each providing their own unique service (e.g., radiation oncology, radiology, gastroenterology, primary care). All of these data are not typical for most surgical procedures. When compared with work for non-surgical services, if more work is performed for non-surgical services such as E/M services, a higher level of E/M code is reported.

In addition to reviewing extensive and atypical imaging and labs, the evaluation component of preoperative time also includes time to coordinate planning the multi-incisional approach with the assistant surgeon, anesthesia providers whose lines will cross the operative anatomy, and scrub nurses who will assist. The intraoperative time for these infrequently performed procedures ranges from five to seven (or more) hours. Preoperative team planning prior to the operation, which is part of the evaluation time component, is not typical for a majority of surgical procedures. The additional preoperative evaluation time recommended by the RUC is consistent with other major procedures requiring coordination of multiple physicians and other qualified health care providers.

We acknowledge that a majority of procedures are well represented by the standard 40 minutes for preoperative evaluation. However, in some instances, such as emergent procedures, the time for preoperative evaluation will be less, and in some instances where multiple surgeons are involved and extensive data and preoperative planning is included, the time for preoperative evaluation will be greater.

**The RUC recommended preoperative evaluation time of 60 minutes is more than justified for the atypical work required on the day before and the day of the operation for 43107, 43112, 43117, 432X5, 432X6, 432X7.**

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- **Preoperative positioning time:** CMS considers refining the preservice positioning time for all six esophagectomy codes to be consistent with standard preservice times allocated to other PFS services. The standard "base" preoperative time for positioning is three minutes, which represents positioning the patient supine with no additional positioning work. As indicated during a presentation to the RUC and CMS representatives at the RUC meeting, the typical positioning for patients undergoing these procedures includes additional work to account for padding the patient for a five to seven hour operation, which includes securing the patient to a table that will adjust (e.g., reverse Trendelenburg, roll, etc.) during the operation. This work also includes additional positioning, re-positioning, and re-padding for separate neck, chest, and abdominal incisions, and accommodation of a double lumen endotracheal tube and lines near the operative field. The times that the RUC approved are conservative for the time necessary to accomplish this work. **The RUC recommended preoperative positioning time of 20 minutes for 43107 and 432X5 and for 30 minutes for 43112, 43117, 432X6, and 432X7 is more than justified for the atypical work required.**

- **Immediate postoperative time:** CMS considers refining the immediate postoperative time for all six of the codes in this family to be consistent with standard postoperative times allocated to other PFS services. The additional time recommended by the RUC accounts for multiple site dressings, reversing excessive padding prior to transfer off table, extensive postoperative notes from a five to seven hour procedure, extensive postoperative orders for multiple drains, tubes and other devices, and ordering and reviewing postoperative labs and films before transferring the patient to the ICU. This extensive work is not typical for a majority of 90-day global procedures.

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

  All of the work described above and at the RUC meeting is in addition to the typical work for more straightforward operations where a

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standard postoperative time would apply. **The RUC recommended immediate postoperative time of 45 minutes for 43107, 43112, 43117, and for 60 minutes for 432X5, 432X6, 432X7 prior to discharge to the ICU is more than justified for the atypical work required for these patients.**

- **Reference service list:** CMS has expressed concerns about the results of two separate surveys that were conducted which produced differences in work RVUs. CMS indicates that the results varied based on the reference service lists (RSL) that were used for the surveys. CMS further believes that the values in the first survey are more accurate.

  At the RUC meeting and at a subsequent meeting with CMS, the specialty societies presented a series of facts about an invalid survey in 2000 that resulted in flawed values for 43107, 43112, and 43117. We also presented a rationale for conducting a second survey that not only correctly described the typical patient for each code, but also added these codes (43107, 43112, 43117) to the survey instead of using these codes as RSL codes for the survey of the new codes. This resulted in the need to create a revised RSL because codes 43107, 43112, and 43117 were removed. CMS expresses concern that the codes on the initial RSL had a median work RVU of 44.18, while the codes on the second RSL had a median work RVU of 59.64. While we do not disagree with CMS' observation, the codes on the second RSL represent a better continuum of work RVUs without large gaps between values. For example, in the first RSL, there was a large gap between 51.43 and 67.07. The second RSL added two codes between 51.43 and 67.07. This change alone would affect a calculated median. Also, given that these operations will have intra-times between five to seven hours, it was not appropriate to include codes for procedures that require one-third of that time for comparison. Survey respondents and the RUC cannot easily compare the relative work for such disparate procedures. **We believe the RSL used to survey all six codes, which removed codes from both the low end and the high end of the work RVU range and added codes to decrease large gaps across the range, provided a more relative list of references for the survey respondents.** We also disagree with CMS that the results of the first survey for codes 432X5, 432X6, and 432X7 are more accurate than the second survey. Not only did we receive more responses from the second survey, but the respondents were more experienced. This would indicate that the second survey was more robust and valid.

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We disagree with CMS's calculation of work RVUs for 43107, 43112, and 43117 using the intraoperative ratio of time with the new codes 432X5, 432X6, and 432X7. Physician work includes more than intraoperative time and reflects complexity and intensity and variability in preoperative and postoperative time and visits. Valuing a family of low volume "all inclusive" codes such as these is difficult as there is variability in the patient population, requiring variability in the surgical approach and work and time. The alternative values that CMS considers would create rank order anomalies, not only with other esophagectomy codes, but with other codes that have high intraoperative time and extensive preoperative and postoperative work.

We believe the RUC recommended work RVUs and time and visits are appropriate as shown in the table below that was previously submitted to CMS. **This table of codes with high intraoperative intensity clearly shows that the RUC recommendations are aligned correctly and are appropriately bracketed by the key reference codes and many other high work codes.**

| CPT | Long Descriptor | RVW | IWPUT | minutes | | | | ICU EM | INPT EM | OV EM |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Total | PRE | INTRA | POST | | | |
| **33468** | Tricuspid valve repositioning and plication for Ebstein anomaly | **45.13** | 0.095 | **806** | 63 | **240** | 60 | 2 | 6 | 1 |
| **33410** | Replacement, aortic valve, with cardiopulmonary bypass; with stentless tissue valve | **46.41** | 0.113 | **800** | 95 | **229** | 40 | 1 | 7 | 2 |
| **33516** | Coronary artery bypass, vein only; 6 or more coronary venous grafts | **49.76** | 0.105 | **883** | 95 | **264** | 40 | 1 | 8 | 2 |
| **61700** | Surgery of simple intracranial aneurysm, intracranial approach; carotid circulation | **50.62** | 0.112 | **949** | 105 | **240** | 40 | 0 | 13 | 3 |
| **33875** | Descending thoracic aorta graft, with or without bypass | **50.72** | 0.083 | **993** | 100 | **240** | 60 | 3 | 7 | 2 |

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|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Total | PRE | INTRA | POST | | | |
| **33430** | Replacement, mitral valve, with cardiopulmonary bypass | **50.93** | 0.105 | **913** | 95 | **232** | 40 | 2 | 7 | 3 |
| **KEY REF 43121** | Partial esophagectomy, distal two-thirds, with thoracotomy only, with or without proximal gastrectomy, with thoracic esophagogastrostomy, with or without pyloroplasty | **51.43** | 0.106 | **962** | 95 | **240** | 40 | 1 | 9 | 4 |
| **43107** | **TRANSHIATAL - OPEN** | **52.05** | **0.091** | **977** | 95 | **270** | **45** | 2 | 8 | 4 |
| **47765** | Anastomosis, of intrahepatic ducts and gastrointestinal tract | **52.19** | 0.105 | **882** | 75 | **290** | 53 | 1 | 9 | 3 |
| **33406** | Replacement, aortic valve, with cardiopulmonary bypass; with allograft valve (freehand) | **52.68** | 0.114 | **853** | 95 | **282** | 40 | 1 | 7 | 2 |
| **48153** | Pancreatectomy, proximal subtotal with near-total duodenectomy, choledochoenterostomy and duodenojejunostomy (pylorus-sparing, Whipple-type procedure); with pancreatojejunostomy | **52.79** | 0.073 | **1,078** | 90 | **315** | 45 | 2 | 11 | 4 |
| **47125** | Hepatectomy, resection of liver; total left lobectomy | **53.04** | 0.124 | **855** | 75 | **225** | 45 | 2 | 8 | 3 |

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|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Total | PRE | INTRA | POST | | | |
| **61526** | Craniectomy, bone flap craniotomy, transtemporal (mastoid) for excision of cerebellopontine angle tumor; | **54.08** | 0.112 | **789** | 120 | **360** | 45 | 0 | 7 | 3 |
| **61692** | Surgery of intracranial arteriovenous malformation; dural, complex | **54.59** | 0.109 | **896** | 115 | **340** | 68 | 0 | 9 | 2 |
| **432X5** | **TRANSHIATAL - Laparoscopic** | **55.00** | **0.106** | **957** | 100 | **300** | **60** | 1 | 8 | 4 |
| **47785** | Anastomosis, Roux-en-Y, of intrahepatic biliary ducts and gastrointestinal tract | **56.19** | 0.097 | **939** | 75 | **360** | 40 | 1 | 9 | 3 |
| **32442** | Removal of lung, pneumonectomy; with resection of segment of trachea followed by broncho-tracheal anastomosis (sleeve pneumonectomy) | **56.47** | 0.111 | **1,035** | 95 | **286** | 60 | 0 | 12 | 2 |
| **33545** | Repair of postinfarction ventricular septal defect, with or without myocardial resection | **57.06** | 0.121 | **939** | 95 | **236** | 40 | 3 | 7 | 2 |
| **33463** | Valvuloplasty, tricuspid valve; without ring insertion | **57.08** | 0.100 | **1,127** | 95 | **231** | 40 | 2 | 13 | 2 |
| **61520** | Craniectomy for excision of brain tumor, infratentorial or posterior fossa; cerebellopontine angle tumor | **57.09** | 0.117 | **815** | 120 | **360** | 45 | 0 | 8 | 4 |

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|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Total | PRE | INTRA | POST | | | |
| **47130** | Hepatectomy, resection of liver; total right lobectomy | **57.19** | 0.134 | **870** | 75 | **240** | 45 | 2 | 8 | 3 |
| **43117** | **IVOR LEWIS - OPEN** | **57.50** | **0.088** | **1,067** | 105 | **330** | **45** | 2 | 9 | 4 |
| **33863** | Ascending aorta graft, with cardiopulmonary bypass, with aortic root replacement using valved conduit and coronary reconstruction (eg, Bentall) | **58.79** | 0.121 | **905** | 95 | **287** | 40 | 2 | 7 | 1 |
| **33412** | Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure) | **59.00** | 0.122 | **866** | 63 | **300** | 60 | 2 | 6 | 1 |
| **47140** | Donor hepatectomy (including cold preservation), from living donor; left lateral segment only (segments II and III) | **59.40** | 0.101 | **1,073** | 120 | **355** | 60 | 0 | 11 | 4 |
| **33860** | Ascending aorta graft, with cardiopulmonary bypass, includes valve suspension, when performed | **59.46** | 0.114 | **931** | 80 | **305** | 40 | 2 | 7 | 2 |
| **47122** | Hepatectomy, resection of liver; trisegmentectomy | **59.48** | 0.100 | **1,000** | 75 | **300** | 45 | 3 | 8 | 3 |
| **32851** | Lung transplant, single; without cardiopulmonary bypass | **59.64** | 0.095 | **1,165** | 140 | **240** | 90 | 4 | 8 | 2 |

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|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Total | PRE | INTRA | POST | | | |
| **33413** | Replacement, aortic valve; by translocation of autologous pulmonary valve with allograft replacement of pulmonary valve (Ross procedure) | **59.87** | 0.122 | **898** | 95 | **297** | 40 | 2 | 6 | 2 |
| **61702** | Surgery of simple intracranial aneurysm, intracranial approach; vertebrobasilar circulation | **60.04** | 0.111 | **1,144** | 115 | **280** | 50 | 0 | 16 | 3 |
| **33864** | Ascending aorta graft, with cardiopulmonary bypass with valve suspension, with coronary reconstruction and valve-sparing aortic root remodeling (eg, David Procedure, Yacoub Procedure) | **60.08** | 0.130 | **853** | 120 | **300** | 60 | 2 | 5 | 1 |
| **43112** | **MCKEOWN - OPEN** | **62.00** | **0.093** | **1,097** | 105 | **360** | **45** | 2 | 9 | 4 |
| **33411** | Replacement, aortic valve; with aortic annulus enlargement, noncoronary sinus | **62.07** | 0.114 | **1,059** | 95 | **283** | 40 | 2 | 10 | 2 |
| **432X6** | **IVOR LEWIS Laparoscopic, Thoracoscopic** | **63.00** | **0.097** | **1,097** | 110 | **360** | **60** | 2 | 8 | 4 |
| **61697** | Surgery of complex intracranial aneurysm, intracranial approach; carotid circulation | **63.40** | 0.111 | **1,194** | 105 | **300** | 50 | 0 | 17 | 3 |

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|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Total | PRE | INTRA | POST | | | |
| **61682** | Surgery of intracranial arteriovenous malformation; supratentorial, complex | **63.41** | 0.116 | **874** | 120 | **420** | 50 | 0 | 10 | 2 |
| **32445** | Removal of lung, pneumonectomy; extrapleural | **63.84** | 0.105 | **1,182** | 95 | **310** | 40 | 1 | 12 | 4 |
| **33622** | Reconstruction of complex cardiac anomaly (eg, single ventricle or hypoplastic left heart) with palliation of single ventricle with aortic outflow obstruction and aortic arch hypoplasia, creation of cavopulmonary anastomosis, and removal of right and left | **64.00** | 0.123 | **986** | 63 | **300** | 60 | 2 | 12 | 1 |
| **33783** | Aortic root translocation with ventricular septal defect and pulmonary stenosis repair (ie, Nikaidoh procedure); with reimplantation of 1 or both coronary ostia | **65.08** | 0.119 | **926** | 63 | **360** | 60 | 2 | 6 | 1 |
| **432X7** | **MCKEOWN Thoracoscopic, Laparoscopic, Open cervical incision** | **66.42** | **0.091** | **1,157** | 110 | **420** | **60** | 2 | 8 | 4 |

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|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Total | PRE | INTRA | POST | | | |
| **KEY REF 43118** | Partial esophagectomy, distal two-thirds, with thoracotomy and separate abdominal incision, with or without proximal gastrectomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es) | **67.07** | 0.111 | **1,184** | 95 | **327** | 40 | 1 | 12 | 4 |
| **61686** | Surgery of intracranial arteriovenous malformation; infratentorial, complex | **67.50** | 0.110 | **1,019** | 135 | **420** | 55 | 1 | 9 | 3 |
| **33877** | Repair of thoracoabdominal aortic aneurysm with graft, with or without cardiopulmonary bypass | **69.03** | 0.114 | **1,110** | 110 | **324** | 60 | 3 | 7 | 3 |
| **KEY REF 43124** | Total or partial esophagectomy, without reconstruction (any approach), with cervical esophagostomy | **69.09** | 0.097 | **1,398** | 95 | **243** | 40 | 3 | 15 | 5 |
| **61698** | Surgery of complex intracranial aneurysm, intracranial approach; vertebrobasilar circulation | **69.63** | 0.115 | **1,209** | 115 | **360** | 50 | 0 | 16 | 3 |

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| CPT | Long Descriptor | RVW | IWPUT | minutes | | | | ICU EM | INPT EM | OV EM |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Total | PRE | INTRA | POST | | | |
| **47141** | Donor hepatectomy (including cold preservation), from living donor; total left lobectomy (segments II, III and IV) | **71.50** | 0.117 | **1,101** | 135 | **420** | 60 | 0 | 10 | 5 |
| **33305** | Repair of cardiac wound; with cardiopulmonary bypass | **76.93** | 0.100 | **1,251** | 37 | **296** | 40 | 8 | 8 | 1 |
| **33916** | Pulmonary endarterectomy, with or without embolectomy, with cardiopulmonary bypass | **78.00** | 0.112 | **1,259** | 63 | **360** | 60 | 4 | 11 | 2 |
| **47142** | Donor hepatectomy (including cold preservation), from living donor; total right lobectomy (segments V, VI, VII and VIII) | **79.44** | 0.115 | **1,221** | 135 | **480** | 60 | 0 | 12 | 5 |
| **Other REF 43113** | Total or near total esophagectomy, with thoracotomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es) | **80.06** | 0.111 | **1,358** | 95 | **391** | 40 | 2 | 13 | 4 |

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| CPT | Long Descriptor | RVW | IWPUT | minutes | | | | ICU EM | INPT EM | OV EM |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Total | PRE | INTRA | POST | | | |
| **Other REF 43108** | Total or near total esophagectomy, without thoracotomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation and anastomosis(es) | **82.87** | 0.110 | **1,358** | 95 | **461** | 40 | 1 | 13 | 4 |
| **Other REF 43123** | Partial esophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es) | **83.12** | 0.109 | **1,419** | 95 | **442** | 40 | 1 | 15 | 4 |
| **32853** | Lung transplant, double (bilateral sequential or en bloc); without cardiopulmonary bypass | **84.48** | 0.113 | **1,440** | 130 | **375** | 90 | 4 | 11 | 2 |
| **33945** | Heart transplant, with or without recipient cardiectomy | **89.50** | 0.117 | **1,716** | 272 | **325** | 85 | 4 | 13 | 6 |
| **32854** | Lung transplant, double (bilateral sequential or en bloc); with cardiopulmonary bypass | **90.00** | 0.108 | **1,600** | 130 | **400** | 90 | 4 | 14 | 2 |

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**Evaluation & Management Guidelines and Care Management Services**

CMS seeks comment on specific changes to reform the E/M documentation guidelines, reduce associated burden, and better align E/M coding and documentation with the current practice of medicine. CMS specifically seeks comment on whether it would be appropriate to remove its documentation requirements for the history and physical (H&P) exam for all E/M visits at all levels. CMS also contemplates eventually allowing medical decision-making and/or time to serve as the key determinant of E/M visit level. CMS recognizes that an increase in the utilization of Electronic Health Records (EHRs) may have changed the character of extended patient histories since the guidelines were established and acknowledges that reduced clinical burden and meaningful documentation for patient care will require both updated E/M guidelines and changes in technology, clinical documentation practices, and workflow.

We agree that the E/M documentation guidelines should be modified. It is important for clinicians to document their work, but the current system requires unnecessary documentation, sometimes obscuring relevant and necessary information for patient care. **We do not support removing the documentation requirements for the H&P exam for all E/M visits at all levels at this time.** Instead, we recommend that CMS engage in a process to examine ways to streamline the H&P exam documentation requirements. In addition, **we strongly oppose the use of time as the key determinant of E/M visit level.** Using time alone is not appropriate because levels of medical decision-making can be different for different clinicians (for example, a physical therapist compared to a vascular surgeon). Therefore, although time is relevant and important to the assessment, medical decision-making is the most essential. **Therefore, CMS should explore the role of medical complexity, risk of medical decision-making, and other factors that incorporate aspects of the patient's overall state of health into a new weighting of the E/M documentation requirements.** We urge CMS to convene a group of physicians, including surgeon representatives, to revise E/M documentation guidelines for physicians to modernize these guidelines, as well as to make them more EHR-compatible. CMS should require a complete review and modernization of E/M guidelines in order to reduce burden, remove redundancies, and align use with EHRs. Such new guidelines should promote efficiency in medical records, help streamline patient care workflow, and support interoperability.

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Use of EHRs has complicated E/M code selection and amplified flaws in the current E/M guidelines due to the ease of entering new data elements and bringing forward old, potentially outdated and erroneous narrative into current records. The E/M documentation guidelines were developed in 1995 when medical records were on paper. Back then, these guidelines allowed CMS to create accountability to describe the level of E/M codes selected for the services billed. In a digital EHR era, the documentation recommended in the guidelines is easily proliferated, creating voluminous medical records. The medical record has become a hindrance to care and communication among providers. **Standards for certified EHR technology (CEHRT) should reflect all the necessary elements of the revised documentation guidelines for each patient to each provider for every visit without the need to cut, copy, or paste data into the record.** It is also critical that information can eventually be entered into data fields that can be transferred and that data are able to be added in a machine readable form. The E/M medical record note for a given visit should not need to reiterate information that is already available in the EHR for the primary purpose of meeting the requirements of the documentation guidelines. CMS should work with the Office of the National Coordinator for Health IT (ONC) to facilitate this process.

CMS also notes that the Agency has received feedback that the E/M code set itself is outdated and needs to be revised and that some stakeholders recommend an extensive research effort to revise and revalue E/M services, especially work inputs. If CMS moves forward, the Agency should engage the appropriate stakeholders and provide enough time and opportunity for input. CMS should proceed in a thoughtful manner and carefully weigh different approaches to accurately redefining the E/M codes. We recommend that CMS first examine the minimum documentation required to audit the reporting of E/M codes and use that determination as a basis for revising the E/M code set, if needed.

**Appropriate Use Criteria for Advanced Diagnostic Imaging Services**

Section 218(b) of the Protecting Access to Medicare Act (PAMA) amended Title XVIII, directing CMS to establish a program to promote the use of appropriate use criteria (AUC) for advanced diagnostic imaging services. There are four major components of the AUC program, each with its own implementation date: (1) establishment of AUC by November 15, 2015; (2) clinical decision support mechanisms (CDSMs) for consultation with AUC by April 1, 2016; (3) AUC consultation by ordering professionals and reporting on AUC consultation by furnishing professionals by January 1, 2017; and (4) annual identification of outlier ordering professionals for services furnished after January 1, 2017.

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Given numerous delays in implementation, CMS did not require ordering professionals to consult AUC using CDSMs or furnishing professionals to report information on consultation by the January 1, 2017 date. CMS is now proposing to require such consultation and reporting using a series of Healthcare Common Procedure Coding System (HCPCS) codes and modifiers starting January 1, 2019, although CMS proposes to make the first year an educational and operations testing period rather than further delay the start of the program. Under this testing period, CMS would continue to pay claims whether or not they correctly include information on AUC consultations. However, CMS does not specify that reporting is truly voluntary. Instead, CMS proposes to offer a voluntary reporting period ahead of 2019, which is anticipated to begin July 2018. Additionally, CMS solicits comment on whether the program should be delayed beyond the proposed start date of January 2019 and/or whether the testing period should be longer than a year.

ACS continues to have concerns about physicians' ability to meet CMS' AUC consultation and reporting requirements. CMS only released the list of qualified CDSMs with this year's proposed rule, and CMS did not identify specific HCPCS codes and modifiers that would be required for reporting if its policies are finalized. If CMS finalizes its proposals, physicians will have little over a year to understand the impact of final policies, assess available CDSMs with final policies in mind, select the CDSM most appropriate for their services and practice, integrate the CDSMs into their practices – including with their EHRs and billing systems (assuming HCPCS codes and modifiers are finalized at the same time) – and train clinicians on their use. At the same time, physicians will be juggling new reporting requirements for the Merit-based Incentive Payment System (MIPS), which will compete with the AUC requirements with respect to physicians' time, resources, and attention.

Given the substantial burden that we anticipate the AUC requirements will impose on clinicians, we believe it is important that they have the opportunity to implement its requirements in a thoughtful and deliberate manner that would allow for interoperability, with the CDSM integrated seamlessly into practices' health IT. Practices should also have the opportunity to develop solutions for data exchange between the ordering and furnishing physicians in order to leverage health IT to reduce burden. To accommodate all of the above, we believe it will be important for CMS to allow for gradual implementation of the AUC requirements, and as such, **we urge CMS to finalize 2019 as a truly voluntary year, similar to the proposed voluntary reporting starting mid-2018, rather than considering 2019 a "test period". Under such a policy, CMS would pay claims for advanced diagnostic imaging services whether or not the required information about the AUC consultation is included in**

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**the claim. In addition, it is critical for CMS to test that submitted claims with the AUC information are correctly processed before the program is implemented.**

As CMS moves toward full accountability under the AUC program, we also recommend that CMS carefully consider the extent to which the Agency could align goals and requirements of this program with MIPS, in order to minimize burden and limit duplication of effort.

**Physician Quality Reporting System (PQRS) Criteria for Satisfactory Reporting for Individual EPs and Group Practices for the 2018 PQRS Payment Adjustment**

The CY 2016 PFS final rule finalized the policy that individual eligible providers (EPs) and group practices who did not satisfactorily meet the Physician Quality Reporting System (PQRS) reporting requirements for 2016 would be subject to a downward payment adjustment of 2 percent, which would impact their 2018 payment. For most providers, the requirements to meet the CY 2016 policies included: report at least 9 measures, covering at least 3 of the National Quality Strategy (NQS) domains, and report each measure for at least 50 percent of the EP's applicable Medicare Part B FFS patients, and at least one measure must be a cross-cutting measure. For providers who chose the Qualified Clinical Data Registry (QCDR) requirement, they were also required to report at least 2 outcome measures or 1 outcome measure and 1 high priority measure if 2 outcome measures did not apply for at least 50 percent of all applicable patients. High priority measures include resource use, patient experience of care, efficiency/appropriate use, or patient safety measures.

CMS explains that since the 2016 performance year, the Agency has heard from stakeholders that many providers have had difficulty meeting the 2016 requirements and will therefore face penalties in 2018. Stakeholders also requested that these requirements align with MIPS, which currently requires reporting on 6 measures (compared to 9) for 50 percent of all patients (claims reporting requires 50 percent of Medicare Part B FFS patients), including 1 outcome measure. [5] Stakeholders requested that the 2016 performance year requirement be lowered to 6 measures with no domain requirement for the 2018 payment adjustment.

In response to stakeholders, CMS proposes a number of reduced reporting requirements to avoid the 2018 PQRS downward payment adjustment. CMS

[5] For more information please visit https://qpp.cms.gov/.

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explains that while the Agency understands that the data submission period for CY 2016 has ended and all data has been submitted, it is revisiting its policy so that a provider's payment adjustment for 2018 will be determined using criteria that are "simpler, more understandable, and more consistent with the beginning of MIPS." CMS also explains that this proposal will result in fewer individual providers being subject to the 2018 payment adjustment, yet will require no additional burden on providers because these data have already been submitted.

Specifically, CMS proposes to reduce the CY 2016 program requirements to report at least 6 measures for at least 50 percent of the providers' Medicare Part B FFS patients for which the measure applies with no NQS domain or cross-cutting measure requirement. For individual providers, this would apply to the following reporting mechanisms: claims; qualified registry (except for measures groups); QCDR; and direct EHR product and EHR data submissions vendor product. Individual providers and groups reporting via claims or qualified registry would not have to report on a cross-cutting measure and groups who reported via QCDR would not have to report an outcome or high priority measure. If less than 6 measures apply, each measure that is applicable would have to been reported, and those providers would be subject to the measure application validity (MAV) process. Additionally, group practices would not be required to administer the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. CMS did not propose any changes for the PQRS measures groups criteria, and no changes are proposed for the Web Interface criteria.

**ACS greatly appreciates CMS' responsiveness to the concerns expressed by stakeholders.** ACS has consistently expressed similar concerns regarding the reporting burden the PQRS program has placed on surgeons and their staff, as well as the complexity and associated burden with implementing the Quality Payment Program (QPP). We especially appreciate CMS' acknowledgement of these issues and proposal for the reduction in the number of providers who will be impacted by a downward adjustment at a time when they are investing in changing their health care delivery systems' business operations for successful QPP participation. We also agree that aligning the PQRS program with the MIPS program will help reduce confusion during the transition to the QPP. We have also heard that many stakeholder groups voiced support for the 2016 PQRS performance year to more closely align with the 2017 QPP Pick Your Pace transition year where providers have the option to report a minimal amount of data to avoid a negative payment adjustment. CMS may also want to consider this option.

There is one provision in the proposed rule for which we seek clarity: how will CMS determine which 6 measures (out of the 9) to use in order to assess a

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given provider or group for the purposes of translating performance under PQRS to payment adjustments under the Value Modifier (VM)? Will CMS choose the 6 top performing measures? **We encourage CMS to assess providers based on the top performing measures, which would also align with the current MIPS policy where providers can report more than the required 6 measures, and CMS will determine their MIPS Quality performance score based on the top performing 6 measures.** On behalf of our members, we want to emphasize the importance of better engaging providers rather than punishing them by further penalizing them during this transition. Again, we greatly appreciate CMS' response to stakeholders at large and support the PQRS proposals.

*Physician Compare Downloadable Database – Addition of Value Modifier (VM) Data*

In the CY 2016 PFS final rule, CMS finalized that the Agency would publicly post data for the 2018 VM based on 2016 data in the Physician Compare downloadable file in late 2017. The final rule specified that CMS would report the following three sets of data:

- The 2018 VM quality tiers for cost and quality, based on the 2016 data, noting if the provider or group is high, low, or average on cost and quality per the VM.
- A notation of the payment adjustment received based on the cost and quality tiers –upward, downward, or neutral – for each provider or group.
- An indication if the EP or group was eligible to but did not report quality measures to CMS for CY 2016 under PQRS.

Given the above changes to the PQRS requirements for CY 2016, and the VM proposed changes discussed in the section below, CMS proposes to also change their finalized Physician Compare policy and not post these data. CMS explains that they believe posting these data could be confusing for the public given the fact that: (1) VM data would only be available for posting on the Physician Compare downloadable database for only one year, and (2) that the VM data may not reflect an EP or group's actual performance or payment adjustment given they could have chosen to report fewer measures.

The ACS recognizes the importance of making meaningful, objective and scientifically valid information on the quality of surgical care publicly available. It is vital, however, when presenting information to the public, that the information accurately represents the quality of care provided and is not confusing to patients when making important decisions about their care.

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**Therefore, we support these proposed changes. ACS agrees with CMS that, based on the changes to the PQRS and the VM programs (also discussed below), posting this information on Physician Compare could lead to confusion for both the public and for providers.** ACS greatly appreciates CMS' efforts to reduce burden on providers during CY 2018 as well as efforts to reduce provider and public confusion.

**Clinical Quality Measurement for Eligible Professionals Participating in the EHR Incentive Program for 2016**

CMS proposes to align reporting criteria under the EHR Incentive Program with proposed changes for the PQRS. Specifically, CMS proposes to change the reporting criteria from 9 clinical quality measures (CQMs) covering at least 3 NQS domains to 6 CQMs with no domain requirement for eligible professionals and groups who, in 2016, chose to electronically report CQMs through the PQRS Portal for purposes of the Medicare EHR Incentive Program. EPs or groups who satisfy the proposed reporting criteria may qualify for the 2016 incentive and may avoid the downward payment adjustment in 2017 and/or 2018, depending on the EP or group's applicable EHR reporting period for the payment adjustment year.

**ACS supports this change, which would provide some relief from negative payment adjustments under the program and enable clinicians and groups to focus their time and resources on reporting requirements under MIPS.**

**Value-Based Payment Modifier and Physician Feedback Program**

Following the same reasoning discussed in the PQRS, EHR Incentive Program, and Physician Compare sections of this proposed rule, CMS proposes policies to the VM which would better align VM policies with the MIPS program in order to promote a smoother transition and reduce complexity. As stated in MACRA, the VM shall not be applied to payments for items and services furnished on or after January 1, 2019. Under the MACRA statute, the VM has been replaced by the Quality and Cost performance categories in MIPS. To promote alignment in the transition from the VM to the MIPS program, CMS proposes the following modifications to the VM program:

- Quality-tiering for groups and solo practitioners in Category 1: Groups and solo practitioners who are in Category 1 for the VM in the 2016 performance year are those who meet the criteria to avoid the 2018 PQRS payment adjustment as individual practitioners, as a group practice, or groups with at least 50 percent of EPs who meet the criteria as individuals. CMS proposes to hold all groups and solo practitioners

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in Category 1 harmless from downward adjustments under the quality-tiering methodology in the CY 2018 payment adjustment period. CMS proposes this policy recognizing that some clinicians may have reported differently under PQRS if the modified reporting criteria proposed in this rule had been established prior to the reporting period. For example, it is possible that clinicians may have selected fewer or different PQRS measures to report or may have chosen to report through a different PQRS reporting mechanism, which could have resulted in a higher quality composite score under the VM.

- Reduce the automatic downward adjustment for groups and solo practitioners in Category 2: CMS defines Category 2 as those who do not meet the criteria to avoid the 2018 PQRS payment adjustment as individual solo practitioners, as a group practice, or groups with at least 50 percent of EPs who meet the criteria as individuals. CMS proposes to reduce the automatic downward adjustment for groups and solo practitioners in Category 2 to -2.0 percent for groups with 10 or more EPs and at least one physician, and -1.0 percent for groups with between 2 to 9 EPs, physician solo practitioners, and for groups and solo practitioners that consist only of non-physician EPs. Under the existing VM and PQRS policy, the total combined maximum downward adjustment for the 2018 performance year based on CY 2016 performance is 6.0 percent (-2.0 percent for PQRS and -4.0 percent for the VM), while the maximum downward adjustment under MIPS in 2019 is -4.0 percent. CMS believes this proposed reduction in payment adjustments will result in a smoother transition to the payment adjustments under MIPS.
- Reduce the Maximum Upward Adjustment: CMS explains that, in order to account for the proposed reduction in downward adjustments under this budget neutral program, to provide a smoother transition to the MIPS, and to align incentives across all groups and solo practitioners, the Agency proposes to *reduce* the maximum upward adjustment under the quality-tiering methodology from four times an adjustment factor (+4.0x) to two times an adjustment factor (+2.0x) for groups with 10 or more EPs. This (+2.0x) is the same maximum upward adjustment under the quality-tiering methodology that CMS finalized and will maintain for groups with between 2 to 9 EPs, physician solo practitioners, and for groups and solo practitioners that consist only of non-physician EPs. Under this proposal, the amount available for upward adjustments for high performers in larger groups would decrease.

Similar to our comments to the PQRS program, ACS greatly appreciates CMS listening to feedback from the physician stakeholder community, which has

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expressed great concern for the financial impact of these policies on providers during a time when they are simultaneously having to understand the new QPP requirement and change their delivery systems to account for these new policies. **We believe reducing penalties on providers and groups in 2018 will help providers during this transition and therefore we support all policies as proposed.** Because this is a budget neutral program, we understand that in order to reduce penalties to certain groups and providers, other groups (in this case, groups of 10+ EPs) will not receive as high upward adjustments for providing high value care (low cost/high quality, low cost/average quality, or average cost/high quality) under these new proposals as they would under the CY 2016 finalized proposals. We also understand that, under these proposals, CMS will provide the same upward adjustments to solo practitioners and small groups of providers with 2-9 EPs. We would like to highlight that financial rewards are only one way to acknowledge high performers, and we encourage CMS to identify other ways to recognize these top performers such as acknowledgement of their exceptional performance on the Physician Compare website.

As discussed at length in our recent comments on the CY 2018 QPP proposed rule, we also continue to have concerns regarding the reliability and validity of the measures for both the current MIPS program and the legacy PQRS/VM programs. We believe the current CMS approach to measurement science is inadequate for accurately assessing providers and that solutions are needed that provide consistent, reliable data, including: standardized data definitions; standardized risk adjustment/data analytics; consistency of data ascertainment methods; and common normalization methods. Therefore, we generally support policies that reduce reductions to payments based on the previous PQRS measures and the current MIPS measures until there are advances in measurement science across these programs.

**MACRA Patient Relationship Categories and Codes**

To facilitate the attribution of patients and episodes to one or more clinicians, MACRA requires the development of patient relationship categories and codes that define and distinguish the relationship and responsibility of a physician or applicable practitioner with a patient at the time of furnishing an item or service. MACRA also requires that claims submitted for items and services furnished by a physician or applicable practitioner on or after January 1, 2018, shall include applicable codes established for care episode groups, patient condition groups, and patient relationship categories, as deemed appropriate by the Secretary. CMS solicited feedback on a draft list of codes in both April and December 2016 and posted an operational list of codes in May 2017. In this proposed rule, CMS proposes the Level II HCPCS modifiers shown in

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Table 26 of the rule (below) as the patient relationship codes, and that reporting of these codes would be voluntary, at least initially, starting on January 1, 2018.

**TABLE 26: PROPOSED PATIENT RELATIONSHIP HCPCS MODIFIERS AND CATEGORIES**

| Number | Proposed HCPCS Modifier | Patient Relationship Categories |
|---|---|---|
| 1x | X1 | Continuous/broad services |
| 2x | X2 | Continuous/focused services |
| 3x | X3 | Episodic/broad services |
| 4x | X4 | Episodic/focused services |
| 5x | X5 | Only as ordered by another clinician |

**We oppose implementation of this policy in 2018, even at a voluntary level, due to all the critical details that have yet to be explained and worked out.** In our previous letters on the draft patient relationship codes, we generally supported the patient relationship category definitions but found it difficult to provide cogent feedback on the use of the categories in the abstract. For example, it is unclear what episodes/claims they will be used for, what level of accountability will be tied to each category, or how the categories will affect other aspects of the QPP. In addition, we questioned what effect there would be on the assignment if a physician's relationship with the patient changes over time, how the categories apply to team-based care and cross coverage where multiple physicians are in charge of a patient at different points in time, and who would arbitrate the self-assignment to ensure that the codes are being used correctly across clinicians. Given these open questions about the use of the patient relationship categories and codes, we oppose the use of these codes starting in 2018.

The ACS appreciates the opportunity to comment on this proposed rule and looks forward to continuing dialogue with CMS on these important issues. If you have any questions about our comments, please contact Vinita Ollapally, Regulatory Affairs Manager in the ACS Division of Advocacy and Health Policy, at vollapally@facs.org or at (202) 672-1510.

Sincerely,

David B. Hoyt

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