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August 30, 2018

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: **CMS-1693-P**
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: File Code CMS-1693-P; Revisions to Payment Policies under the Physician Payment Schedule and Other Revisions to Part B for CY 2019; (July 27, 2018)

Dear Administrator Verma:

The American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) Notice of *Proposed Rule* Making (*Proposed Rule*) on the revisions to Medicare payment policies under the Physician Payment Schedule for calendar year 2019, published in the July 27, 2018 *Federal Register (Vol. 83, No. 145 FR, pages 35704-36368).*

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

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

A. Standardization of Clinical Labor Tasks

B. Balloon Sinus Surgery Kit (SA106) Comment Solicitation

C. Market-Based Supply and Equipment Pricing Update

D. Breast Biopsy Software (EQ370)

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

III. Potentially Misvalued Services Under the PFS

A. RUC Progress in Identifying and Reviewing Potentially Misvalued Codes

B. Public Nominations of Potentially Misvalued Services

C. Global Surgery Data Collection

IV. Valuation of Specific Codes

A. Inappropriate Physician Time Ratio Calculations

B. RUC Survey Process, Reference Services and Crosswalks

C. Practice Expense Refinement Table

D. Proposed Valuation of Specific Codes for CY 2019

V. Evaluation & Management (E/M) Office Visits

VI. Technical Corrections for CY 2019 CMS Time File

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

A. Standardization of Clinical Labor Tasks

The RUC supports CMS' efforts to revise the direct practice expense (PE) database to provide the number of clinical labor minutes assigned for each clinical labor activity for each code. However, the RUC is concerned with the over-standardization of clinical labor activities. Each service requires different clinical labor resources and the PE Subcommittee is careful to consider situations where different types of clinical work are required. When standard times are applied to certain activities, the PE Subcommittee carefully considers the specialty societies rationales for additional time over the standard and often determines that additional time is justified. It is important to keep in mind that many of the clinical activities mean different things depending on the context of the service they are used in and creating standard times is not possible for all clinical labor activities. In implementing standard clinical labor tasks, the RUC encourages CMS to seriously consider the rationale that the specialties and the PE Subcommittee provide for time over the standards in both the PE Summary of Recommendation and at the table at the PE Subcommittee meetings. Throughout refinements to the direct PE inputs for specific codes within this *Proposed Rule*, CMS states that there are standards for clinical activities where they do not exist or misstates the standard number of minutes for clinical activities. The RUC is concerned that CMS is making assumptions about clinical activity standards and/or confusing PE Subcommittee precedent with formal standards, rather than carefully reviewing the standards/guidelines for clinical activity time laid out in the practice expense reference materials that the specialties consult in developing their PE recommendations. An example of this problem is outlined below, but there are multiple examples which are referenced in the RUC comments on proposed valuation of specific codes for CY2019 in this letter.

At the October 2015 RUC meeting the Practice Expense (PE) Subcommittee formed a Workgroup to revamp the practice expense spreadsheet. The impetus behind the Workgroup was to address variability of PE spreadsheets that results from differences in standards and conventions between specialties and from CPT code to CPT code in the description and time of clinical activities. The new PE spreadsheet includes a coding system similar to the coding system for clinical labor type, supplies, and equipment, making it possible to include the breakdown of clinical staff time in the CMS public use files which are then used in the RUC database. The updated spreadsheet was piloted for the October 2016 RUC meeting and implemented for the January 2017 RUC meeting. Prior to this update there was a unique spreadsheet already developed for imaging, and there were less formal but still consistent differences in the way that radiation oncology, pathology, and other specialties presented their direct practice expense inputs in the PE spreadsheet. In the imaging PE spreadsheet, there was a line item for "Patient clinical information and questionnaire reviewed by technologist, order from physician confirmed and exam protocoled by radiologist" that appeared in the pre-service period. During discussion, the Workgroup revised the clinical activity as indicated below in red to make it applicable to a wider variety of services:

- Patient clinical information and questionnaire reviewed ~~by technologist~~, order ~~from physician~~ confirmed and exam protocoled/prepared ~~by radiologist~~

The Workgroup determined that if the above line item is truly to protocol an exam, it would need to be moved to the service period because the clinical staff would need to be in the treatment room to perform the task. If it is reviewing information in the chart, it would remain in the pre-service period. A Workgroup member confirmed that the exam protocol would need to be in the treatment room. The Workgroup determined that this clinical labor activity should be divided into two line items, the first in the pre-service period and the second in the service period as follows:

- Pre-service period
  - Review patient clinical extant information and questionnaire
- Service period

- Confirm order, protocol exam

The standard/guidelines included in the PE spreadsheet in column C and also listed with the clinical activities in the 2nd worksheet of the PE spreadsheet workbook are as follows:

Clinical Activity Code	Clinical Activity Descriptor	Type of Activity	Standards/Guidelines
CA007	Review patient clinical extant information and questionnaire	General Activity	• Standard time for this activity is 1 minute • For use in imaging services
CA014	Confirm order, protocol exam	General Activity	• Standard time for this activity is 1 minute • For use in imaging services

In the CY 2019 *Proposed Rule,* CMS states that "3 minutes of clinical labor time traditionally assigned to the "Prepare room, equipment and supplies" (CA013) clinical labor activity were split into 2 minutes for the "Prepare room, equipment and supplies" activity and 1 minute for the "Confirm order, protocol exam" (CA014)". The standard for CA013 is 2 minutes. This standard dates back many years, well before the implementation of the new spreadsheet and clinical activity code numbers. The standard/guidelines included in the PE spreadsheet in column C and also listed with the clinical activities in the 2nd worksheet of the PE spreadsheet workbook are as follows:

Clinical Activity Code	Clinical Activity Descriptor	Type of Activity	Standards/Guidelines
CA013	Prepare room, equipment and supplies	General Activity	2 minute standard

The reason that the current direct PE inputs for the RUC reviewed codes do not have time listed for CA014 is not because the work is not performed, but because the work is listed under clinical activity, *Patient clinical information and questionnaire reviewed by technologist, order from physician confirmed and exam protocoled/prepared by radiologist,* with a standard of 2 minutes, in the old imaging PE spreadsheet. This clinical activity does not exist in the new PE spreadsheet and, as stated previously, is divided into CA007 and CA014, with a standard of 1 minute for each activity. The RUC recognizes that the refinement CMS is proposing has no effect on the total clinical labor direct costs since the total minutes remain the same. However, the refinement is inaccurate and will have long term effects on the direct practice expense inputs across the payment schedule if not corrected. **The RUC requests that CMS remove the minute of clinical staff time that was added to CA013 to maintain a standard of 2 minutes for that clinical activity and accept 1 minute of clinical staff time as originally recommended by the RUC for CA014 in order to maintain a standard of 1 minute for that clinical activity, wherever the refinement has been proposed throughout the RUC reviewed codes for CY 2019.**

B. Balloon Sinus Surgery Kit (SA106) Comment Solicitation

In the *Proposed Rule* CMS has solicited comment on the number of sinus dilation procedures that typically can be performed per balloon included in supply item SA106 *balloon sinus surgery kit*. Since

there has been considerable debate over the number of balloons needed per service, the RUC will simply reiterate past recommendations and comments on the issue, that the quantity of supply items should reflect the actual units of the item utilized in the performance of an individual procedure. The variability inherent in the underlying anatomy, particularly the frontal sinus, makes it extremely difficult to reliably assign a fixed number of sinuses that can be dilated per balloon. **The RUC urges CMS to create a separate HCPCS code for the balloon sinus surgery kit that would be billable based on the number of balloons used per patient**.

C. Market-Based Supply and Equipment Pricing Update

In the *Proposed Rule,* CMS used their authority under Section 220(a) of the Protecting Access to Medicare Act of 2014 (PAMA) to initiate a market research contract with a consulting firm, StrategyGen, to update the direct practice expense inputs for supply and equipment pricing for CY 2019. Based on the report from StrategyGen, CMS is proposing updated pricing recommendations for 2,017 supply and equipment items currently used as direct practice expense (PE) inputs. Market research resources and methodologies included field surveys, aggregate databases, vendor resources, market scans, market analysis, physician substantiation, and statistical analysis. CMS is proposing to update supply and equipment pricing over a 4-year phase-in.

StrategyGen used a number of primary and secondary market research resources and methodologies to estimate and validate current prices for medical equipment and supplies. Research sources included: Buyer Benchmark Databases, Amazon Business, Cardinal Health, Inc., GSA Schedule and GSA Advantage, Vendor Survey and Physician Panel. Ultimately StrategyGen determined the recommended price (RP) based on the researched-commercial prices, which were gathered from subscription-based benchmark databases combined with publicly available commercial pricing data. Where the research-commercial price was not available, Strategy Gen used the current CMS price. StrategyGen also provided options 1-4 as alternatives to their recommended price and CMS chose option 1, which incorporates General Services Administration (GSA) pricing.

As CMS states in the *Proposed Rule* there has not been a comprehensive review of supply and equipment prices since 2004-2005. There has, however, been repricing of equipment and supplies on an item-by-item basis that was based on invoices submitted by specialty societies as part of their practice expense recommendation to the RUC. The RUC PE Subcommittee does not evaluate pricing, rather the RUC collects the information and submits it to CMS as part of the RUC recommendation process. This process, although not comprehensive, represents collaboration between physicians and CMS. The RUC agrees with CMS that there is a need for comprehensive review of supply and equipment pricing and, in general, supports CMS' efforts to this effect. However, the RUC has concerns about the approach, data, and methodology used to develop the CMS recommended price. These concerns are the following:

1. The subscription-based benchmark databases are not publicly available and cannot be analyzed. Without access to the data used in determining the pricing update, there is no systematic way to evaluate pricing accuracy. The RUC and specialty societies are only able to analyze supplies and equipment specific to the CPT codes that their specialty performs. This will likely mean that most specialty societies will not comment on more general supplies and equipment even though these items could have a significant impact. For example, the proposed final price for supply item SG056 *gauze, sterile 4in x 4in (10 pack uou)* is $0.03, down from the current price of $0.80. This supply item appears in 767 CPT codes across a wide range of specialties. It is unlikely that any one specialty will think of this supply item as "their specialties supply" and submit invoices for CMS review. The RUC is concerned that the specialties may not fully appreciate the long-term impact of seemingly low-cost

changes in this repricing effort.

2. In the example above, supply item SG056 *gauze, sterile 4in x 4in (10 pack uou)* specifies the units in the supply description as a 10 pack; however, the recommended price is the same as supply item *gauze, sterile 4in x 4in.* Although cost is expected to decrease as larger units are purchased, we would not expect for these two items to be priced identically at $0.03, especially considering that the current price for the single item is $0.16 and the current price for the 10 pack is $0.80. This raises concerns about accuracy of units of measure throughout the recommended pricing of supplies. The RUC has also learned from a number of specialty societies that they also have concerns that the proposed prices do not reflect the proper product, quantity and/or unit of measure associated with the service.

3. When conducting their research, StrategyGen "prioritized" the equipment and supply research based on the current share of PE RVUs attributable by item provided as directed by CMS. This, by definition, creates an inherent bias. Any attempt to accurately price items in the supply and equipment list should reflect a desire to obtain accurate information that reflects prices paid by the typical non-facility provider. Using utilization data as the primary driver for identifying supply and equipment items to review suggests that there may have been specific intent to lower the cost of high utilization items, perhaps to the detriment of accuracy.

4. There are five repricing options presented to CMS by Strategy Gen in their report. There was StrategyGen's recommendation and four additional options. Rather than selecting StrategyGen's recommendation, which is what they have termed the "researched commercial price," CMS chose option 1. The RUC is concerned about the methodology option that CMS chose from the StrategyGen report. Although the RUC supports the method of using a weighted average of the market share and sample size for the top three commercial products, we agree with StrategyGen that "it is ill-advised to integrate the GSA price into the recommended CMS price". Rather than use the "recommended price (RP)" as outlined by StrategyGen in their report, CMS chose to use option 1 which integrates GSA pricing when the researched commercial price is not available. CMS outlines the methodology of option 1 in the *Proposed Rule* as the following:
    a. If the market share, as well as the sample size, for the top three commercial products were available, the weighted average price (weighted by percent market share) was the reported RP. Commercial price, as a weighted average of market share, represents a more robust estimate for each piece of equipment and a more precise reference for the RP.
    b. If StrategyGen did not have market share for commercial products, then they used a weighted average (weighted by sample size) of the commercial price and GSA price for the RP. The impact of the GSA price may be nominal in some of these cases since it is proportionate to the commercial samples sizes.
    c. Otherwise, if single price points existed from alternate supplier sites, the RP was the weighted average of the commercial price and the GSA price.
    d. Finally, if no data were available for commercial products, the GSA average price was used as the RP; and when StrategyGen could find no market research for a particular piece of equipment or supply item, the current CMS prices were used as the RP.

    Although a small number of supplies and equipment lacked market share data, and thereby only a small number of supplies and equipment factored in the GSA pricing, StrategyGen states in their report "…the GSA system by design provides the lowest available prices to government purchasers, the lack of data within the GSA system for many equipment codes also impacted the results. This lack of data may indicate that eligible physicians typically use sources other than the GSA to purchase medical equipment or it may indicate that certain types of medical equipment are not frequently purchased by government entities." The RUC agrees that the GSA is not representative of the typical

prices available to a private practice, which lacks the negotiating power of a large government entity. The RUC encourages CMS to use the researched-commercial price, when available and where the researched commercial price is not available, the current CMS price, as recommended by StrategyGen.

5. There are a several supply and equipment items that have lacked CMS pricing information for several years despite having direct PE inputs in CPT codes. This adversely affects the payment for CPT codes that utilize the items. The RUC has attempted to obtain invoices from the specialty societies to submit to CMS; however, the specialties were not able to obtain invoices for these particular items (in general obtaining paid invoices is extremely difficult for the specialty societies). StrategyGen's review of more than 1300 supply items and 750 equipment items seems exhaustive; however, the supply and equipment items that were not previously priced remain unpriced and therefore will continue to be omitted from the final payment calculation. This seems very strange as StrategyGen should have been able to obtain market-based research on these items. In an effort to more completely reflect the cost of non-facility procedures, these items should be valued and included in the PE RVU calculation.

6. The specific source of the pricing benchmark databases used by StrategyGen is not available for independent review. StratagyGen stated, "Commercial prices were gathered from subscription-based benchmark databases for medical supplies and equipment that is operated by a nonprofit organization that represents more than 5,000 members. Its members include integrated health delivery systems, hospitals, physicians and other health care professionals, as well as public and private payers, federal and state agencies, policymakers, and accrediting agencies." One such commercial subscription-based benchmark database, the ECRI Institutes' PriceGuide, obtains its data nearly entirely from hospital systems and GPOs. On their website, they boast that ECRI "offers the largest database of supply pricing in the industry, representing all U.S. hospital types and group purchasing organizations." Furthermore, ECRI's PriceGuide "database is a compilation of pricing information submitted by our member hospitals and health systems." Although this source was not cited in the *Proposed Rule*, it appears likely that this is the source of the subscription-based benchmark databases used by StrategyGen. The RUC has no reason to believe that the ECRI Institute is not an appropriate source of pricing data. However, the RUC is concerned that small physician practices are not well represented in the benchmark databases. The RUC is concerned that the proposed repricing does not reflect the typical price paid by stakeholders. **The RUC encourages CMS to consider that there are vast differences in product and equipment pricing between physician groups around the country due to significant variability with respect to geography, practice size, purchasing method, procedure volume, and bulk versus consignment purchasing arrangements.** Practitioners of procedures in a non-facility setting are a heterogeneous group that ranges from multistate corporations to sole practitioners. Any methodology that more heavily weighs larger physician groups, group purchasing organizations (GPOs), or even hospital contract pricing would result in pricing that is significantly depressed when compared to those that could be obtained by an individual practitioner. This has the potential to result in pressuring smaller practices out of business and forcing lower cost non-facility procedures into hospital outpatient or inpatient sites of service.

StrategyGen states in their report there is no statistically significant difference between the current supply and equipment pricing and the recommended CMS price; however, there are certainly specialties that will experience adverse impacts based on supplies and equipment repricing for items that are frequently used in their services. For example, the RUC has heard from the Society of Interventional Radiology (SIR) that supply item SD254, *covered stent (VIABAHN, Gore)*, which was decreased from $3,768.00 to $2,573.00 is significantly misvalued in the repricing effort. SIR reports that market prices for these items range from

the listed RP for the shortest non-heparin-coated versions to greater than $6,800 for the longer length heparin-coated stents. The more expensive heparin-coated covered stents are more typical than the shorter version both in dialysis access circuit procedures and lower extremity revascularization procedures. The previous pricing was conservative with regards to the actual price paid for devices used in practice. The proposed RP value significantly undervalues the price of this supply item and would make its appropriate usage impossible. The RUC also heard from the College of American Pathologists (CAP) that the prices for SL493 Antibody Estrogen Receptor monoclonal and SL012 antibody IgA FITC may not have been adjusted for their proper unit of measure. Although it is not the role of the RUC PE Subcommittee to make recommendations about the pricing of supplies and equipment, the RUC will support and assist adversely affected specialties in presenting invoices and comments on supply and equipment items that they have determined to be misvalued in the supplies and equipment repricing effort. The RUC strongly encourages CMS to carefully consider all pricing data including invoices and other supporting evidence that they receive from the specialty societies throughout the comment period. The RUC supports CMS direct PE pricing transition over a 4-year phase-in period as outlined in the *Proposed Rule*. The *Proposed Rule* suggests that this four-year phase-in would be used as an opportunity for specialty societies to continue to evaluate the new pricing and submit invoices and other pricing data as needed. The RUC believes this is extremely important as it is difficult for specialty societies to identify every supply and equipment item that might be inaccurately priced during the limited comment window. **The RUC wishes to confirm that CMS plans to keep comment open on supplies and equipment throughout the four-year phase-in, and we urge CMS to accept and carefully consider pricing data *throughout the four years.***

The RUC is especially concerned about repricing supply and equipment items where invoice data was submitted as part of a recent RUC recommendation. In these cases, it would be logical for CMS to rely on its own detailed individual analyses to establish the prices for supplies and equipment. For example, in the Final Rule for 2018, CMS established CPT code 95250 *Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; physician or other qualified health care professional (office) provided equipment, sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording* and a new price for SD114 *sensor, glucose monitoring (interstitial)* of $53.08, based in part on its analysis of 19 invoices for this specific item. The proposed RP for 2019 is a further reduction in this price down to $43.95. We strongly encourage CMS to override the proposed amount in favor of the current price which was developed recently using extensive invoice data. Also for 95250 in the *Final Rule* for 2018, CMS indicated that it had conducted a detailed analysis of the cost of the EQ125 *continuous glucose monitoring system*, including literature review and evaluation of vendor prices, and it established a new price of $1170.54. This price represented a cut of more than 50% from the previous allowed price and the proposed RP for 2019 is a further reduction in this price down to $835.53. **Once again, the RUC strongly encourages CMS to override the proposed amount in favor of the current price which was developed recently following a detailed analysis of this equipment item.**

CMS requested comment regarding the supply and equipment pricing for CPT codes 95165 *Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses)* and 95004 *Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests.* CPT code 95165 was recently reviewed in January 2016, yet CMS proposes to reduce supply item SH007, *antigen, multi (pollen, mite, mold, cat),* from $6.70 to $4.78 for 1 ml of antigen. SH007 is the average cost of a variety of antigens, because this code describes preparing the antigens and the typical amount to prepare is 10 doses. It is important that the RUC know which antigens were reviewed to develop the proposed price as there are many different pollen and mold antigens. The RP of $4.78 is too

low to reflect the full range of antigens and their costs. The current price of $6.70 better reflects the full range of antigen costs; however, this price may need to be updated as costs have increased dramatically just within the last year. The RUC does not think it is necessary to review the direct PE inputs for CPT code 95165 as it was recently reviewed and the RUC is confident in the supply amounts as submitted in the PE recommendation for CY 2017. **However, the RUC encourages CMS to accept invoices and other supporting materials from the interested specialty societies to revise the pricing of the antigen, supply item SH007**. CPT code 95004 was recently reviewed in October 2016. The direct practice expense costs for the code will only decrease by $0.01 from $3.03 in 2018 to $3.02 in 2019, if the repricing proposal is implemented. This seems to be without a decrease to the antigen SJ092 *allergen, diagnostic, multi (eg, pollen, mold, environmental)* as this supply item is not listed on the recommended CMS price report, nor is SJ093 *allergy single-test device* and the RUC assumes that the current CMS price remains effective as those are the prices listed in the direct PE input public use files. Despite the minor direct PE cost decreases, the non-facility PE RVU for CPT code 95004, is going from 0.13 to 0.10, and from 0.30 to 0.26 for CPT code 95165. Because these are small dollar amounts, even $0.01 and $0.26 could have an outsized impact. There are a number of factors used in the PE RVU methodology, including direct costs, as well as direct and indirect scaling adjustments, indirect costs, physician time and work RVU to name a few. In a complex formula, it is difficult to single out one primary driver of a PE RVU change. However, the dramatic change in the PE RVU for many services including 95004 and 95165 are certainly tied to the dramatic decrease in the Indirect Practice Cost Indices (IPCI). The Allergy/Immunology IPCI is 36% lower in 2019 (0.59153) as compared to 2018 (0.92911). The larger then typical fluctuation in IPCI are linked to defining Evaluation and Management (E/M) as its own specialty in the specialty level IPCIs and PE/HR, impacting the indirect PE used in the formula to determine the PE RVU. The RUC will discuss this is greater detail in the RUC's comments regarding Evaluation and Management proposals in this comment letter.

CMS also requests comment on whether the clinical labor staff cost per minute should be updated along with the supplies and equipment. The pricing for clinical labor types was based on Bureau of Labor Statistics (BLS) data**. The RUC does not object to these inputs being updated if the updated pricing continues to be based on BLS data and is open for public comment through the rulemaking process.**

D. Breast Biopsy Software (EQ370)

In the CY 2014 MPFS, CMS stated that they believe equipment item EQ370 *Breast Biopsy software* serves a clinical function similar to items already included in the equipment item EL008 *MR room* and would not create a new input. However, CAD or biopsy software is not part of any standard MRI room package available for purchase, as these are different equipment items that are sold by different vendors. The RUC understands the need to avoid duplicity in the practice expense, and if the equipment is part of the MR room we do not wish to duplicate it. However, the current description of EL008 *MR room* is "1.5T MR scanner with power injector and monitoring system" and as far as we can tell this does not include the necessary breast biopsy software. **The RUC requests that CMS clarify the equipment items that make up EL008 *MR room* so the RUC is able to verify whether or not legitimate duplication exists between the two equipment items.**

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

The RUC appreciates that CMS is proposing to add 28 codes identified as low volume services to the list of codes for expected specialty assignment. These codes are reported with the -26 modifier and were recommended by the RUC.

CMS seeks specific comment on ways to improve how specialties in the state-level raw rate filings data are crosswalked for categorization into CMS specialty codes in order to develop the specialty-level risk factors and the PLI RVUs. In a March 30, 2018 letter to CMS, the RUC clearly offers to assist CMS with the categorizations of the rate filings and applying the specialty descriptions from the rate filings to the appropriate specialty codes. The letter is attached for your reference *(attachment 01).*

In the Addendum for the CY 2019 Malpractice Risk Factors and Premium Amounts by Specialty, CMS continues to crosswalk non-MD specialties to the lowest MD risk factor specialty, Allergy Immunology. The RUC has consistently maintained that a risk factor linked to a physician specialty is too high for many of the non-physician health care professions. **The RUC again refers to the attached letter submitted by the RUC to CMS in March 2018.**

III. Potentially Misvalued Services Under the PFS

A. RUC Progress in Identifying and Reviewing Potentially Misvalued Codes

Since the inception of the Relativity Assessment Workgroup, the RUC and the CMS have identified 2,386 services through 20 different screening criteria for further review by the RUC. The RUC has recommended reductions and deletions to 1,401 services, more than half of the services identified, redistributing $5 billion. The RUC looks forward to working with CMS on a concerted effort to address potentially misvalued services. A detailed report of the RUC's progress is appended to this letter *(attachment 02).*

B. Public Nominations of Potentially Misvalued Services

CMS received two public nominations for nine codes. The first nomination included seven codes in which the nominator stated that they are overvalued and that previous RUC reviews of these services did not result in reductions in valuation that adequately reflected reductions in surveyed times. CMS staff indicated that this nomination was not received during the *Proposed Rule* comment period and therefore is not publicly available in the Federal Docket Management System. The nomination was sent directly to CMS by the February 10th deadline. **The RUC requests CMS publicly provide the source of comment and entire comment letter submitted to provide transparency and aide the RUC's discussion of these services. The RUC requests that CMS provide greater transparency and publicly provide all public nomination requests identifying potentially misvalued services.**

The Society for Cardiovascular Angiography and Interventions (SCAI) submitted the second nomination for two services, CPT code 92992 *Atrial septectomy or septostomy; transvenous method, balloon (eg, Rashkind type) (includes cardiac catheterization* and 92993 *Atrial septectomy or septostomy; blade method (Park septostomy) (includes cardiac catheterization).* These services are typically performed on children, a non-Medicare population, and are contractor-priced. The specialty society requests that these services be surveyed through the RUC process. The RUC will discuss these services at the October 2018 Relativity Assessment Workgroup meeting.

C. Global Surgery Data Collection

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) included a provision requiring CMS to implement a process to collect data on the number and level of postoperative visits and use these data to assess accuracy of global surgical package valuation. In response, CMS finalized a claims-based data collection process intended to determine the typical number of post-operative visits for certain commonly performed surgical services in the CY2017 MPFS Final Rule. Since July 1, 2017, Medicare practitioners in 9 states have been required to report on the postoperative visits they furnish during the global period of specified procedures using CPT code 99024 *Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure*. The 293 010-day or 090-day surgical global procedures included in this initiative are those that are furnished by more than 100 practitioners and either are nationally furnished more than 10,000 times annually or have more than $10 million in annual allowed charges. Medicare physicians and other health care professionals who are in practices with fewer than 10 practitioners are exempted from required reporting, but were encouraged to participate.

In the CY2019 *Proposed Rule*, CMS provided a snapshot of the data collected so far using CPT code 99024. Of practitioners that met criteria for reporting in the 9 states, only 45 percent participated by reporting CPT code 99024. Surgical oncology, hand surgery and orthopedic surgery were the highest participants at 92, 90 and 87 percent respectively. Among 010-day global services, only 4 percent had one or more matched visits reported. Among 090-day global services, 67 percent had one or more visits reported. The logistics of matching up procedures to visits proved difficult, so the Agency excluded many instances of 99024 as part of their analyses.

CMS observed "one potential explanation for these findings is that many practitioners are not consistently reporting postoperative visits using CPT code 99024." As only 45 percent of eligible physicians and other health care professionals participated and with several large specialties having participation rates of less than 5 percent, it is evident that lack of participation is not simply *one potential explanation* but the dominant factor driving this early snapshot of the dataset. These preliminary results are not yet actionable as they are incomplete and are more likely to lead one to false conclusions than to provide any illumination.

CMS inquired whether the Agency needs to do more to increase awareness or consider implementing an enforcement mechanism. The RUC agrees that more needs to be done to increase awareness for participants in these nine states. CMS should work with state medical societies and national specialty societies to further increase visibility for this new reporting program. We encourage CMS to contact eligible practices directly to remind them of their obligation. Regarding some type of enforcement mechanism, the RUC believes that it would be premature and encourages the Agency to allow sufficient time to collect a robust sample of data. When new data collection processes or other new CMS initiatives are first implemented, widespread uptake typically takes several years. For example, Transitional Care Management has seen almost 400 percent growth since it was first implemented in CY2013. CMS Quality Programs have also typically experienced similar growth trajectories. Some participants may not have been able to start participation until the beginning of CY2018, whereas others may simply not yet been aware of their obligation. The AMA encourages CMS to continue collaborating with organized medicine to increase awareness of this new initiative and to allow sufficient time as major reporting programs typically take several years to attain broad adoption.

CMS is also seeking comment on whether or not it may be reasonable to assume that many visits included in the valuation of 010-day global services are not being furnished, given this early snapshot of the global surgery data collection initiative. The RUC does not believe that this early review of the dataset can reasonably be used to forecast any trends, given the limited and likely intermittent participation as well as the current difficulty the Agency has implied in matching up procedures to CPT code 99024.

For the 114 010-day global codes included in this reporting program, 62 percent of their CY2017 Medicare utilization in the 9 states is from only two services, CPT codes 17000 and 17110. Both services are predominantly performed by a single specialty. The summary data cited in the CY2019 only drilled down to the global level instead of the individual service and therefore, would have been dominated by these two services. It would be a highly inappropriate generalization to make any assumptions about all 010-day global services for all specialties based on an early snapshot of an incomplete dataset where more than half the claims are only for two services mostly performed by a single specialty. The RUC recommends for CMS to conduct more in depth analyses of the dataset once much larger participation is achieved. Also, the Agency should explore more robust methods for linking procedures to CPT code 99024. Excluding all claims with multiple procedures and overlapping globals from your analyses creates a sample that is not representative.

To assess the extent of underreporting, CMS performed an analysis where they identified a set of "robust reporters" who appeared to be regularly reporting CPT code 99024. The criterion they used for this analysis was those physicians that performed 10 or more procedures with 090-day global periods where they could match up the procedure with 99024 without ambiguity. As CMS' "robust reporters" analysis did not also include physicians that were only reporting 010-day global period services, the analysis would not be representative for 010-day global services. For the top performing 010-day global specialty, Dermatology with 57 percent of 010-day global claims in the 9 states, only 3 percent of their total utilization for procedures included in this reporting program are for 090-day global services. Using these criteria for the analysis likely resulted in heavily skewed data. **The RUC recommends that CMS should determine a more accurate way of determining which physicians and other health care professionals are participating in the data collection initiative.**

CMS also solicited comment on whether the Agency should consider requiring the use of modifier 54 "for surgical care only" and modifier 55 for "postoperative management only," regardless of whether there is a formal transfer of care. As the use of these modifiers is already required when one provider performs only the surgery and another provider performs the postoperative care for the same global service, it is unclear what CMS is implying. If the Agency is implying that, in the atypical case where postoperative services are not needed for a global service for an individual case, then the provider would need to use the -54 modifier and their payment would be reduced, then this would be highly inappropriate. The purpose of the global period is to have payment be for the typical case. In addition, the implementation of this idea could potentially be perceived as a roundabout way of partially unbundling the surgical global which is expressly prohibited by MACRA.

CMS noted that the claims-based data collection using 99024 only captures the number of post-operative visits and not the level of those visits, which is also required by MACRA. To collect data on the level of post-operative visits for global services, CMS contracted with the RAND Corporation to conduct a survey to collect additional data on pre- and post-operative services, including the level of post-operative services. CMS noted that they anticipate launch of a survey to collect post-op visit level, time, staff and activities involved in post-op visits and non-face-to-face services. RAND had launched a pilot of the survey and got a very low response rate, causing the Agency and RAND to refocus on a small number of high-volume procedure codes. To date, CMS has only provided stakeholders and the general public with

broad, ambiguous updates on the methodology being employed for this separate data collection project. CMS and the RAND Corporation have not provided stakeholders an opportunity to provide input on the survey methodology that they intend to use. **To ensure the stakeholder community can fairly and accurately provide input on the RAND survey and to increase the likelihood of conducting a successful survey, CMS and RAND should be fully transparent about the survey methodology that they intend to employ. In addition, CMS and RAND should formally seek input from the public on the proposed survey methodology.**

IV. Valuation of Specific Codes

The RUC appreciates that CMS accepted 71% of the RUC's work relative value recommendations submitted for 2019. However, we have significant concerns regarding the recommendations rejected by CMS, particularly the methodology and rationale utilized for many codes. In preparing the RUC comments, specialties were provided with the opportunity to share additional information for CMS consideration. It is the RUC's intention that the following comments will provide enough clarity to persuade the Agency to reconsider its proposed recommendations and instead affirm the RUC's recommended values in final rulemaking.

A. Inappropriate Physician Time Ratio Calculations

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

The RUC would like to remind CMS of both the Agency's and the RUC's longstanding position that treating all components of physician time (pre-service, intra-service, post-service and post-operative visits) as having identical intensity is incorrect and inconsistently applying it to only certain services under review creates inherent payment disparities in a payment system which is based on relative valuation. In many scenarios, CMS selects an arbitrary combination of inputs to apply, including: total physician time, intra-service physician time, "CMS/Other" physician times, Harvard study physician times, existing work RVUs, RUC-recommended work RVUs, work RVUs from CMS-selected crosswalks, work RVUs from a base code, etc. This selection process has the appearance of seeking an arbitrary value from the vast array of possible mathematical transformations, rather than seeking a valid clinically relevant relationship that would preserve relativity. The RUC is increasingly concerned that CMS is eschewing the bedrock principles of valuation within the RBRVS (namely, magnitude estimation, survey data and clinical expertise) in favor of arbitrary mathematical formulas.

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

We would also like to highlight that all RUC recommendations now explicitly state when physician time has changed and address whether and to what magnitude these changes in time impact the work involved. For example, our rationales explain the original source (or lack therefore) of time data and whether the

source can be relied upon as an appropriate baseline. RUC recommendations also provide rationale justifying changes in physician work intensity, when applicable, often with supporting clinical information. CMS should carefully consider this critical information when determining proposed and final work values.

B. RUC Survey Process, Reference Services and Crosswalks

Throughout the specific code valuations for 2019 it appears there is some confusion by the Agency regarding the survey process and the difference between "reference services" and "crosswalks." CMS is incorrectly interpreting the RUC recommendations regarding these terms, as well as incorrectly using these terms in proposing work RVUs.

There are two kinds of reference services, "key reference services" and "reference services". First, when specialty societies are preparing to survey a code, they develop a reference service list (RSL). An RSL is a list of 10-20 services that are well-known and commonly provided by the specialties surveying the services. The RSL services are recently validated codes, RUC/CMS reviewed, and do not have a source of Harvard or CMS/Other, and are the same global period as the surveyed service. These services also span a broad range of work RVUs as not to compromise the objectivity of the survey results by influencing the respondents' valuation of a service. The survey respondents only see the CPT code number, code descriptor, work RVU and global period. The survey respondent does not see the physician time components of the RSL codes as they are completing the survey.

The "key reference services" indicated on the RUC summary of recommendation (SOR) document or indicated in the RUC rationale recommendation are the top two services selected by the survey respondents as most similar to the code being surveyed. The key reference services included on the SOR are not changed when the specialty societies or the RUC make any changes (work RVU, physician time, etc.) to the original specialty recommendation.

"Reference Services" are services indicated by the specialty society or the RUC as a good comparator that demonstrates relativity using magnitude estimation as requiring similar physician work, time, intensity and complexity. Please note that reference codes listed on the RUC SOR form are not codes that were selected by the RUC to support the RUC recommendation. These are codes that were included on the SOR by the specialty societies as part of their initial submission to the RUC. One type of reference service is a service from the Multi-Specialty Points of Comparison (MPC) list. The MPC list contains approximately 300 common, widely performed, broad range of CPT codes that link all specialties so that cross-specialty relativity can be established.

"Crosswalks" are services that have similar or exact-intra-service time or similar total time and require the same physician work (work RVU). When specialty societies and the RUC recommend that a surveyed code abandon the survey 25th, median or 75th work RVU data point and "crosswalk" to another CPT code, they are recommending the exact same work RVU.

CMS appeared to use the term crosswalk in numerous proposed work RVUs for codes in this *Proposed Rule*, when it appeared to mean it may have been a good reference or comparator code. CMS also incorrectly assumes that some of the reference codes indicated by the specialty societies on the SOR or in the RUC recommendations did not have exactly the same time and physician work RVU. Reference codes do not have the exact same work RVU or times, but are similar and comparable. CMS confuses this term with the "crosswalk" term defined above. RUC recommendations typically provide reference services

with higher and lower work RVUs to bracket the code in question and support relativity among services in the physician payment schedule as well as justify its placement among other services.

The RUC urges CMS to carefully re-examine the many specific code valuations in which reference services and crosswalk services were misinterpreted. We have noted these instances in the proposed Valuation of Specific Codes section below.

C. Practice Expense Refinement Table

The RUC appreciates CMS' effort to maintain appropriate relativity among PE and work components of PFS payment and in some cases we agree with the refinement of direct PE inputs listed in Table 14; however, there are many instances where the RUC disagrees with the refinements. Please see a complete list of the *CY 2019 Proposed Direct PE Refinements* with specialty society comments in the attached table *(attachment 03).*

D. Proposed Valuation of Specific Codes for CY 2019

(1) Fine Needle Aspiration (CPT codes 10021, 10X11, 10X12, 10X13, 10X14, 10X15, 10X16, 10X17, 10X18, 10X19, 76492, 77002, 77012 and 77021)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
10021	**Fine needle aspiration biopsy; without imaging guidance; first lesion**	**1.03**	**1.20**
10X11	Fine needle aspiration biopsy; without imaging guidance; each additional lesion	0.80	0.80
10X12	**Fine needle aspiration biopsy, including ultrasound guidance; first lesion**	**1.46**	**1.63**
10X13	Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion	1.00	1.00
10X14	Fine needle aspiration biopsy, including fluoroscopic guidance; first lesion	1.81	1.81
10X15	Fine needle aspiration biopsy, including fluoroscopic guidance; each additional lesion	1.18	1.18
10X16	**Fine needle aspiration biopsy, including CT guidance; first lesion**	**2.26**	**2.43**
10X17	Fine needle aspiration biopsy, including CT guidance; each additional lesion	1.65	1.65
10X18	Fine needle aspiration biopsy, including MR guidance; first lesion	C	C
10X19	Fine needle aspiration biopsy, including MR guidance; each additional lesion	C	C
76942	Ultrasonic guidance for needle placement (eg, biopsy, fine needle aspiration biopsy, injection, localization device), imaging supervision and interpretation	0.67	0.67

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
77002	Fluoroscopic guidance for needle placement (eg, biopsy, fine needle aspiration biopsy, injection, localization device)	0.54	0.54
77012	Computed tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation	1.50	1.50
77021	Magnetic resonance guidance for needle placement (eg, for biopsy, fine needle aspiration biopsy, injection, or placement of localization device) radiological supervision and interpretation	1.50	1.50

The RUC thoroughly analyzed this family of fine needle aspiration services by review of the history, survey data and magnitude estimation to other similar services. The RUC **unanimously approved** the work RVUs for all services in this family and urges CMS to accept the RUC recommended values. Details on why CMS should accept the RUC recommendations for each code in this family are outlined below.

CMS evaluated the RUC's recommendations for this code family while under the assumption that the proposal was not budget neutral. In the CY2019 *Proposed Rule*, the Agency notes that the recommended work pool is "increasing by approximately 20 percent for this family while the recommended time pool is only increasing by 2 percent." The work pool based on the RUC recommended values would actually decrease by 15 percent. Based on the CMS proposed reductions, the work pool for the family would decrease by 23 percent. In the CY2019 *Proposed Rule* addendum file "CY 2018 Analytic Crosswalk to CY 2019", CMS accepted every utilization crosswalk percentage provided by the RUC, so it is unclear how CMS came to their flawed assumption that the RUC recommendations would represent an increase in payment for this code family. Perhaps for the Agency's internal calculation, they did not account for the associated savings with bundling the image guidance codes. Below is a table which demonstrates that implementing the RUC recommended work values would result in a 15 percent decrease in the work value pool for this family of services.

CPT Source	Deleted	Source 2016 Utilization	New/ Revised Code	New/ Revised Code Utilization (reference 2016)	Percent	Source RVU	RUC Rec RVU	New/ Revised Total RVUs	Total Source RVUs	
10021		23,974	10021	21,577	0.900	1.27	1.20	25,892	27,402	
10021		23,974	10X11	2,397	0.100	1.27	0.80	1,918	3,045	
10022	D	188,006	10X12	135,364	0.720	1.27	1.63	220,644	171,913	
76942		1,199,473	10X12	135,364	0.113	0.67	0.00	0	90,694	
10022	D	188,006	10X13	15,040	0.080	1.27	1.00	15,040	19,101	
76942		1,199,473	10X13	15,040	0.013	0.67	0.00	0	10,077	
10022	D	188,006	10X14	3,384	0.018	1.27	1.81	6,125	4,298	
77002		495,234	10X14	3,384	0.007	0.54	0.00	0	1,827	
10022	D	188,006	10X15	376	0.002	1.27	1.18	444	478	
77002		495,234	10X15	376	0.001	0.54	0.00	0	203	
10022	D	188,006	10X16	30,410	0.162	1.27	2.43	73,896	38,621	
77012		204,058	10X16	30,410	0.149	1.16	0.00	0	35,276	
10022	D	188,006	10X17	3,384	0.018	1.27	1.65	5,584	4,298	
77012		204,058	10X17	3,384	0.017	1.16	0.00	0	3,926	
10022	D	188,006	10X18	43	0.000	1.27	0.00	0	55	
77021		2,164	10X18	43	0.020	1.50	0.00	0	65	
10022	D	188,006	10X19	4	0.000	1.27	0.00	0	5	
							Total RVUs	349,543	411,282	-15%

Separately, CMS articulates their expectation that the bundling of the procedure codes with the image guidance codes "… will achieve savings via elimination of duplicative assumptions of the resources involved in furnishing particular servicers." Not all bundling of services can be thought of in the same manner. There is no overlap between the current descriptions of work for the bundled codes. Furthermore, CPT code 10022 is never performed on the same patient without an image guidance code and the image guidance codes are never performed on the same patient without a corresponding procedure code. The RUC and CMS fully accounted for this when previously valuing these existing services. Any associated reduction in payment would be due to other factors, not due to the code bundling.

10021

For CPT code 10021, CMS disagrees with the RUC recommended work RVU of 1.20 and proposes a work RVU of 1.03 based on a direct crosswalk to CPT code 36440 *Push transfusion, blood, 2 years or younger* (work RVU= 1.03, intra-service time of 15 minutes, total time of 35 minutes).

Code 10021 is a revised service that has a new reporting structure. Currently, this service is reported per lesion. Once the CPT changes go into effect for CY2019, this code will be a base code with a separate add-on code of 10X11 which will have an impact on the work intensity for this code. In the rationale provided by CMS for their rejection, the Agency did not reference this coding structure change though

does reference a slight reduction in intra-service time and a larger reduction in total time and the lack of a one-to-one reduction in work RVU. When this service was last evaluated by the RUC and CMS in 1995, both the RUC and CMS evaluated physician time with much less rigor — it is typically not prudent to give times that are more than 20 years old much weight when evaluating new recommendations. In addition, the 1995 RUC recommendation was based on a crosswalk — not on the survey data — further decoupling the relationship between the 1995 physician time and work value. The RUC noted that the current times in the RUC database were from 1995 and resulted in an inappropriately low IWPUT of 0.034. Therefore, the drop in total time did not warrant a proportional change in work RVU as the previous times were not appropriate. CMS cited a drop in intra-service time from 17 minutes to 15 minutes. It would be somewhat atypical for a new survey to return an identical result to a prior survey, when the original survey results were not a multiple of 5 minutes. That is simply the nature of using median survey data as it states the individual's response at the midpoint — referencing this slight discrepancy implies that CMS does not appreciate or intentionally disregards this nuance. Using median survey data is optimal as it better filters out outlier responses, but it does not consistently result in times ending in the number 7.

The RUC recommendation was based on the 25th percentile work RVU from robust survey results and favorable comparison to MPC codes 70470 *Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections* (work RVU= 1.27) and 99283 *Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity.…* (work RVU=1.34). As the premise for rejecting the RUC's recommendation is based on an erroneous budget neutrality interpretation, **the RUC urges CMS to accept a work RVU of 1.20 for CPT code 10021.**

10X12

For CPT code 10X12, CMS disagrees with the RUC recommended work RVU of 1.63 and proposes a work RVU of 1.46 based on adding the incremental difference between the RUC recommended work RVUs for codes 10021 and 10X12 (0.43 work RVU difference) to the CMS proposed work RVU for code 10021. The RUC urges CMS to use valid methods of evaluating services instead of using an increment. The RUC recommendations were based on valid survey data, not on an incremental difference in work RVUs between codes 10021 and 10X12. The RUC used magnitude estimation valuing these services compared to the physician work, time, intensity and complexity and CMS should not pick out the increment to go forward with valuing this service. The RUC provided appropriate references services supporting a work RVU of 1.63 for CPT code 10X12.

CMS references "crosswalk codes" 99225 *Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of 3 key components*; and 99232 *Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of 3 key components*, which have different work RVUs than the CMS proposed work RVU. We would like to remind CMS that the term "crosswalk" is reserved only for services that have identical work RVUs. The RUC recommendation was based on the 25th percentile work RVU from robust survey results and favorable comparison to reference codes 93351 *Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report;…* (work RVU=1.75) and 75572 *Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3D image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed)* (work RVU= 1.75). As the premise

for rejecting the RUC's recommendation is based on an erroneous budget neutrality interpretation, **the RUC urges CMS to accept a work RVU of 1.63 for CPT code 10021.**

10X16

For CPT code 10X16, CMS disagrees with the RUC recommended work RVU of 2.43 and proposes a work RVU of 2.26 based on adding the incremental difference between the RUC recommended work RVUs for codes 10021 and 10X16 (1.23 work RVU difference) to the CMS proposed work RVU for code 10021. The RUC urges CMS to use valid methods of evaluating services instead of using an increment. The RUC recommendations were based on valid survey data, not on an incremental difference in work RVUs between 10021 and 10X16. The RUC used magnitude estimation valuing these services compared to the physician work, time, intensity and complexity and CMS should not pick out the increment to go forward with valuing this service. The RUC provided appropriate references services supported a work RVU of 2.43 for CPT code 10X16.

The Agency references "crosswalk" code 74263 *Computed tomographic (CT) colonography, screening, including image postprocessing* as support for their alternate value. CPT code 74263 is not covered by Medicare and therefore, not an ideal reference code. The RUC recommendation was based on the 25th percentile work RVU from robust survey results and favorable comparison to reference codes 99204 *Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity…* (work RVU=2.43) and 75574 *Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)* (work RVU=2.40). As the premise for rejecting the RUC's recommendation is based on an erroneous budget neutrality interpretation, **the RUC urges CMS to accept a work RVU of 2.43 for CPT code 10X16.**

Practice Expense

CMS is proposing refinements to the RUC-recommended direct PE inputs for the codes in this family. In their refinements to direct PE inputs for CPT codes 77012 and 77021, CMS is removing 1 minute from clinical activity, *Confirm order, protocol exam* (CA014) and adding 1 minute to clinical activity, *Prepare room, equipment and supplies* (CA013). CMS' reason for this refinement is inaccurate and the RUC strongly encourages CMS to reverse this proposal. The RUC requests that CMS remove the minute of clinical staff time that was added to CA013 to maintain a standard of 2 minutes for that clinical activity and accept 1 minutes of clinical staff time as originally recommended by the RUC for CA014 to maintain a standard of 1 minute for that clinical activity. Please see an explanation of this request under Standardization of Clinical Labor Tasks in the PE section of this comments letter. For CPT code 77012, the RUC disagrees with CMS applying the RS&I standard room time for angiographic rooms to CT guidance. The room time is included in CT guidance, as it is in US guidance (76942) because that is the room the procedure is performed in. **For other RUC's comments on individual refinements of direct PE inputs please see the attached refinement table.**

(3) Skin Biopsy (CPT codes 11X02, 11X03, 11X04, 11X05, 11X06, and 11X07)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
11X02	Tangential biopsy of skin, (eg, shave, scoop, saucerize, curette), single lesion	0.66	0.66
11X03	**Tangential biopsy of skin, (eg, shave, scoop, saucerize, curette), each separate/additional lesion**	**0.29**	**0.38**
11X04	Punch biopsy of skin, (including simple closure when performed), single lesion	0.83	0.83
11X05	Punch biopsy of skin, (including simple closure when performed), each separate/additional lesion	0.45	0.45
11X06	Incisional biopsy of skin (eg, wedge), (including simple closure when performed), single lesion	1.01	1.01
11X07	Incisional biopsy of skin (eg, wedge), (including simple closure when performed), each separate/additional lesion	0.54	0.54

For CPT code 11X03 *Tangential biopsy of skin, (eg, shave, scoop, saucerize, curette), each separate/additional lesion*, CMS disagrees with the RUC recommended work RVU of 0.38 and are proposing a work RVU of 0.29. CMS states that when comparing the RUC recommended work RVU of 0.38 to other add-on codes in the RUC database, CPT code 11X03 would have the second-highest work RVU for any code with 7 minutes or less of total time. CMS did not agree that the tangential biopsy service being performed should have a higher work value in comparison to other similar add-on codes.

The total number of add-on codes CMS identified with RUC total time of 7 minutes or less is 18. Only five of these services have total time of 6 or 7 minutes and the rest are lower, thus the majority of work RVUs are lower and not comparable. The services with the 6 or 7 minutes are for immunization administration, intravenous infusion and chemotherapy administration and appropriately have a lower work RVU because these are short services that do not require significant physician work. These add-on codes are not comparable because the physician work described is an additional injection or as providing "direct supervision". CPT code11X03 is actually an entirely new procedure, performed on a separate site and lesion than the base code, frequently involving an entirely different technique than the primary code. The additional procedure involves performing all the work elements of the base code from scratch, including re-positioning the patient, prepping and anesthetizing the new site, performing the biopsy, collecting specimen, achieving hemostasis, and bandaging the surgical site. Everything that is completed for the primary procedure is also completed for the add-on procedure in a different site. The RUC recommended work RVU of 0.38 for CPT code 11X03 is appropriate since this service is performed on a separate site than the base code and there is additional physician work to transition to a different site.

CMS should examine the magnitude estimation between the physician work, time and intensity, not apply time ratios to arrive at work RVUs for any service especially when examining such a small increment of time, the difference of two minutes between 11X03 and the key reference service 11732 *Avulsion of nail plate, partial or complete, simple; each additional nail plate (List separately in addition to code for primary procedure)* (work RVU = 0.38 and 8 minutes intra-service time) leads to inaccurate comparisons. The RUC notes it decreased the intra-service time for 11X03 by 1 minute, from 7 minutes to 6 minutes, to be identical to the base code 11X02.

In terms of intensity of service, the direct crosswalk to code 11732, which describes procedures with significant physician effort in removing a nail plate with its anesthesia and hemostasis challenges, is a much better comparator code to code 11X03 which involves the biopsy of a vascular tumor, typically on the face. CMS's proposed cross walk code 11201 *Removal of skin tags, multiple fibrocutaneous tags, any area; each additional 10 lesions, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 0.29) involves snipping barely vascularized skin tags in areas of little cosmetic concern.

Furthermore, the proposed work RVU of 0.29 for CPT code 11X03 is too low to maintain relativity within this family of services and causes a rank order anomaly when comparing the base code to add-on codes for the punch biopsy and incisional biopsy codes. **The RUC urges CMS accept a work RVU of 0.38 for CPT code 11X03.**

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

(4) Injection Tendon Origin-Insertion (CPT code 20551)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
20551	Injection(s); single tendon origin/insertion	0.75	0.75

The RUC appreciates that CMS is proposing the RUC-recommended work RVU of 0.75 for CPT code 20551. However, CMS is proposing refinements to the RUC-recommended direct PE inputs. CMS is proposing to remove the clinical labor time for the "Provide education/obtain consent" (CA011) and the "Review home care instructions, coordinate visits/prescriptions" (CA035) activities because CPT code 20551 is typically billed with a same day E/M service. The RUC does not agree that these clinical activities are duplicative. The home care instructions in CA035 refer directly to the tendon injection and may include discussion of care for the affected area and home restrictions (ie, activity, bathing, medications). The RUC assures CMS that it is careful to remove any duplication with E/M and encourages CMS to accept the direct PE inputs for CA011 and CA035. CMS is also proposing refinements to the equipment times for this code. **For the RUC's comments on individual refinements of direct PE inputs please see the attached refinement table.**

(6) Knee Arthrography Injection (CPT code 27X69)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
27X69	**Injection procedure for contrast knee arthrography or contrast enhanced CT/MRI knee arthrography**	**0.77**	**0.96**

The RUC thoroughly analyzed this code by review of the history, survey data and magnitude estimation to other similar services. The RUC **unanimously approved** the work RVU for this service and urges CMS to accept the RUC recommended value. Details on why CMS should accept the RUC recommendation for this code are outlined below.

For CPT code 27X69, the RUC recommended a work RVU of 0.96 based on maintaining the current work RVU of deleted code 27370 *Injection of contrast for knee arthrography* (work RVU = 0.96). CMS disagrees with the RUC recommended work RVU of 0.96 and is proposing a work RVU of 0.77 for CPT code 27X69, a calculation using reverse building block methodology. Although the description of the method in the *Proposed Rule* was somewhat ambiguous, the RUC believes CMS is using reverse building block based on the IWPUT of the deleted code applied to the survey times of the new code to get 0.60 work RVUs and then using a crosswalk to CPT code 29075 *Application, cast; elbow to finger (short arm)* (work RVU = 0.77) to get to the desired work RVU of 0.77. The RUC recommends that CMS use valid survey data and review the actual relativity for all elements (physician work, time, intensity and complexity) when developing the work RVU for services, rather than calculating increments of work value based on time and then finding a reference code with the same work RVU. Additionally, the RUC strongly disagrees with the Agency's statement that the reduced intra-service and total times in code 27X69, in comparison to deleted code 27370, should result in a lower work value for code 27X69. Deleted code 27370 was Harvard valued long ago and the Harvard method is less robust. The flawed methodology of constructing a time increment based on reverse-building block methodology to determine work value in a relative value scale is especially flawed when the time increment is based on an unknown time source.

CPT code 29075 *Application, cast; elbow to finger (short arm)* (work RVU = 0.77), the crosswalk used to justify CMS' proposed valuation, is not performed by the specialty society performing code 27X69, nor is it clinically similar work. An external application of a cast is not an appropriate comparison to injecting contrast into a joint. A review of RUC-reviewed codes performed by the specialty society with intra-service times between 12-17 minutes and total times between 20-35 minutes shows a work RVU range between 0.69 and 1.50. As an invasive procedure, magnitude estimation would justify its placement further away from the bottom of this range, and toward more appropriate crosswalks to justify the RUC recommended work RVU of 0.96.

The RUC strongly recommends the work RVU of 0.96 for code 27X69, which is below the survey 25th percentile but is the existing work RVU for deleted code 27370. **The RUC urges CMS to accept a work RVU of 0.96 for CPT code 27X69.**

Practice Expense

In their refinements to direct PE inputs from this service(s) CMS is removing 1 minute from clinical activity, *Confirm order, protocol exam* (CA014) and adding 1 minute to clinical activity, *Prepare room, equipment and supplies* (CA013). CMS' reason for this refinement is inaccurate and the RUC strongly encourages CMS to reverse this proposal. The RUC requests that CMS remove the minute of clinical staff time that was added to CA013 to maintain a standard of 2 minutes for that clinical activity and accept 1 minutes of clinical staff time as originally recommended by the RUC for CA014 to maintain a standard of 1 minute for that clinical activity. Please see an explanation of this request under Standardization of Clinical Labor Tasks in the PE section of this comment letter.

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

(7) Application of Long Arm Splint (CPT code 29105)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
29105	Application of long arm splint (shoulder to hand)	0.80	0.80

The RUC appreciates that CMS is proposing the RUC-recommended work RVU of 0.80 for CPT code 29105. However, CMS is proposing refinements to the RUC-recommended direct PE inputs. **For the RUC's comments on individual refinements of direct PE inputs please see the attached refinement table.**

(9) Bronchoscopy (CPT codes 31623 and 31624)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
31623	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with brushing or protected brushings	2.63	2.63
31624	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial alveolar lavage	2.63	2.63

The RUC appreciates that CMS is proposing the RUC-recommended work RVU of 2.63 for CPT codes 31623 and 31624. However, CMS is proposing refinements to the RUC-recommended direct PE inputs for clinical labor and equipment times for the codes in this family. CMS is proposing to refine the clinical labor time for the "Complete post-procedure diagnostic forms, lab and x-ray requisitions" (CA027) activity from 4 minutes to 2 minutes for both codes. CMS states that "Two minutes is the standard time, as well as the current time for this clinical labor activity, and we have no reason to believe that the time to perform this task has increased since the codes were last reviewed." We are confused by this statement

because there is no standard for CA027. The RUC encourages CMS to accept the direct PE inputs for CPT codes 31623 and 31624 as recommended by the RUC. **For the RUCs comments on individual refinements of direct PE inputs please see the attached refinement table.**

(12) Aortoventriculoplasty with Pulmonary Autograft (CPT code 335X1)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
335X1	Replacement, aortic valve; by translocation of autologous pulmonary valve and transventricular aortic annulus enlargement of the left ventricular outflow tract with valved conduit replacement of pulmonary valve (Ross-Konno procedure)	64.00	64.00

The RUC thanks CMS for accepting the RUC recommended work RVU of 64.00 for 335X1. However, CMS is proposing refinements to the RUC recommended direct PE inputs for CPT codes 335X1.

The RUC has no objections to CMS' proposal to refine the pre-service clinical labor times for the direct PE inputs for code 335X1 to match the 90-day global procedure standards and adding 15 minutes of clinical labor time to activity code CA008 "Perform regulatory mandated quality assurance activity (pre-service)." The RUC distributed the additional time in the PE recommendation per the clinical activities involved in this complex congenital cardiac procedure. These activities include the clinical labor time associated with additional coordination between multiple specialties prior to patient arrival; securing the correct homograft sizes and specialized equipment used to thaw and wash the homograft; and providing education and obtaining/witnessing consent from the family for this double cardiac valve procedure. Although the RUC does not object because the time remains in the code, we do think that the allocation amount of the pre-service activities was appropriate, whereas CA008 is not an accurate description of the additional work being done. The RUC hopes that CMS will continue to recognize the extra clinical staff time needed for cardiothoracic services and not use the allocation of time to CA008 as a way to reduce the pre-service time in future rulemaking. **For the RUC's comments on individual refinements of direct PE inputs, please see the attached practice expense refinement table.**

(13) Hemi-Aortic Arch Replacement (CPT code 33X01)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
33X01	Aortic hemiarch graft including isolation and control of the arch vessels, beveled open distal aortic anastomosis extending under one or more of the arch vessels, and total circulatory arrest or isolated cerebral perfusion	19.74	~~19.74~~ Interim Recommendation Rescinded

The RUC recommended work value included in the *Proposed Rule* is not accurate for CPT code 33X0. Following the April 2018 RUC meeting, the RUC had rescinded its previous interim recommendation. At

the April 2018 RUC meeting, the specialty societies determined that this family of services should be submitted to the CPT Editorial Panel for the following revisions: 1) To develop distinct codes for ascending aortic repair for dissection and ascending aortic repair for other ascending aortic disease such as aneurysms and congenital anomalies. The specialties expressed that there is a sufficient difference in the work associated with these procedures and now there is sufficient volume to allow for more accurate capture of the work and outcomes data for these distinct patient populations, which was not the case when the code was first developed; 2) Revise the descriptor for the transverse arch code, 33870 to further clarify the difference in work between that code and the new add-on code 33X01; 3) Revise the guidelines to provide additional instructions on the appropriate use of these codes. The specialty societies already submitted a new coding proposal for consideration at the May 2018 CPT Editorial Panel meeting for CPT 2020. **The RUC supported referral to CPT. At the April 2018 RUC meeting, the RUC rescinded the interim value recommendation to CMS for code 33X01 for CPT 2019.**

(14) Leadless Pacemaker Procedures (CPT codes 33X05, 33X06)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
33X05	**Transcatheter insertion or replacement of permanent leadless pacemaker, right ventricular, including imaging guidance (eg, fluoroscopy, venous ultrasound, ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed**	**7.80**	**8.77**
33X06	**Transcatheter removal of permanent leadless pacemaker, right ventricular**	**8.59**	**9.56**

The RUC thoroughly analyzed this family of leadless pacemaker procedures by review of the history, survey data and magnitude estimation to other similar services. The RUC **unanimously approved** the work RVUs for all services in this family and urges CMS to accept the RUC recommended values. Details on why CMS should accept the RUC recommendations for each code in this family are outlined below.

33X05

For CPT code 33X05, CMS disagrees with the RUC recommended work RVU of 8.77 and proposes a work RVU of 7.80 based on a direct crosswalk to CPT code 33207 *Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); ventricular* (work RVU= 7.80, intra-service time of 60 minutes, total time of 233.5 minutes). The Agency acknowledges that the survey code is a more intense service to perform, though asserts that the impact of the increased intensity should not have a larger impact than the impact of difference in total time between these two services. They provide no qualitative or quantitative rationale to support their assumption that the difference in time completely mitigates the difference in intensity. Patients receiving leadless pacemakers are more complex and have more comorbidities and contraindications than transvenous patients. Thresholds tend to change more than with transvenous devices and the risk of embolization is higher. Groin complications are higher than wound complications from transvenous implants. Tamponade is more commonly present, and leadless pacemaker patients are also more likely to have chronic atrial fibrillation and poor venous access; all contributing to code 33X05 being a much more intense service.

The RUC recommendation was based on the 25th percentile work RVU from robust survey results and favorable comparison to reference MPC codes 14060 *Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less* (work RVU= 9.23, intra-service time of 60 minutes, total time of 183 minutes) and 50590 *Lithotripsy, extracorporeal shock wave* (work RVU= 9.77, intra-service time of 60 minutes, total time of 207 minutes). **The RUC urges CMS to accept a work RVU of 8.77 for CPT code 33X05.**

33X06

For CPT code 33X06, CMS disagrees with the RUC recommended work RVU of 9.56 and proposes a work RVU of 8.59 based on adding the increment between RUC recommended codes 33X05 and 33X06 (0.79 RVUs) to the CMS proposed RVU for CPT code 33X05. The RUC urges CMS to use valid methods of evaluating services instead of using an increment. The RUC recommendations were based on valid survey data, not on an incremental difference in work RVUs between codes 33X05 and 33X06. The RUC used magnitude estimation valuing these services compared to the physician work, time, intensity and complexity and CMS should not pick out the increment to go forward with valuing this service. The RUC provided appropriate reference services supporting a work RVU of 9.56 for CPT code 33X06.

The RUC recommendation was based on the 25th percentile work RVU from robust survey results and favorable comparison to reference MPC codes 14060 *Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less* (work RVU= 9.23, intra-service time of 60 minutes, total time of 183 minutes) and 50590 *Lithotripsy, extracorporeal shock wave* (work RVU= 9.77, intra-service time of 60 minutes, total time of 207 minutes). **The RUC urges CMS to accept a work RVU of 9.56 for CPT code 33X06.**

(15) PICC Line Procedures (CPT codes 36X72, 36X73, 36584)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
36568	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, without imaging guidance; younger than 5 years of age	2.11	2.11
36569	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, without imaging guidance; age 5 years or older	1.90	1.90
36X72	**Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the insertion; younger than 5 years of age**	**1.82**	**2.00**

36X73	**Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the insertion; age 5 years or older**	**1.70**	**1.90**
36584	**Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the replacement**	**1.20**	**1.47**
76937	Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure)	N/A	N/A
77001	Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)	0.38	0.38

The RUC thanks CMS for proposing to retain the RUC recommended work RVU for CPT codes 36568, 36569, 76937, and 77001. However, CMS has proposed to reduce the RUC recommended work RVU from 2.00 to 1.82 for CPT code 36X72, 1.90 to 1.70 for CPT code 36X73, and 1.47 to 1.20 for CPT code 36584. The RUC thoroughly analyzed this family of codes by review of the history, survey data, and magnitude estimation to other similar services. The RUC **unanimously approved** the work RVUs for codes 36X72 and 36584 and urges CMS to accept the RUC recommended values. Details on why CMS should accept the RUC recommendations for these codes are outlined below.

36X72

For CPT code 36X72, the RUC recommended a work RVU of 2.00. CMS disagrees with the RUC recommended work RVU of 2.00 and is proposing a work RVU of 1.82 for code 36X72 based on a direct crosswalk to CPT code 50435 *Exchange nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation* (work RVU = 1.82).

The RUC disagrees with CMS that directly crosswalking code 36X72 to code 50435 is supported clinically. Although code 50435 is a recently reviewed code that includes radiological supervision and interpretation with similar intra-service and total time values, there are significant clinical differences between the two services, including differences in work intensity and patient population. Code 36X72 involves establishing new deep venous access on a pediatric patient, after other means of vascular access

without imaging guidance have failed, while ensuring maximum sterile barrier technique so as to prevent a hospital acquire infection such as CLABSI. Code 50435 involves the exchange of an existing catheter (i.e. access into end organ has already been established) in an adult who understands the procedure involved and has had previous catheter exchanges to maintain patency. In this regard, the pre-service and post-service effort is frequently more intense with code 36X72 relative to code 50435. CMS expressed concern about the possibility that the recommended work RVU of 2.00 would create a rank order anomaly with the other codes in the family. The RUC disagrees with CMS' concern that rank order within the family is not maintained. The RUC confirmed that since revised CPT code 36568 *Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, without imaging guidance; younger than 5 years of age* (recommended work RVU = 2.11 and 38 minutes intra-service time) requires more physician time to complete than code 36X72 (38 versus 22 minutes intra-service time), the recommended work RVU of 2.00 for CPT code 36X72 maintains the proper rank order within this family of services considering differences in patient population and differences in clinical intensity of work.

The CMS proposed work value was driven by their usage of an intra-service time ratio with revised CPT code 36568. The RUC strongly opposes this methodology. Please refer to our comments on "Inappropriate Physician Time Ratio Calculations" in the introduction of this section. The RUC urges CMS to use valid survey data and supportive relative reference services when valuing codes. The RUC thoroughly discussed the physician work, time, intensity and complexity required to perform code 36X72. Additionally, the RUC strongly disagrees with the Agency's statement that the reduced intra-service and total times in code 36X72 should result in a lower work value. The RUC understands that the recommended intra-service time for code 36X72 as compared to revised code 36568 is lower (22 minutes compared to 38 minutes) as well when compared to code 36569. However, the RUC strongly disagrees with CMS' premise that this simplistic comparison means work is decreasing. CPT code 36X72 and revised code 36568 are technically different procedures, involving different patient populations and different service intensity. Specifically, with respect to patient population, the patient undergoing code 36X72 no longer has superficial venous access. Code 36X72 involves establishing de novo image guided percutaneous access into a deep vein, which cannot be established based on palpation or anatomic landmarks and revised code 36568 involves access into a superficial vein that is apparent visually. With respect to technical differences between the codes, each step in the non-image guided code 36568 takes longer, though involves more periods of low intensity intra-service work. When performing code 36X72, each procedural step is being performed sequentially without the less intense intra-service work of the non-image guided code 36568. The image guided code 36X72 is significantly more intense than the non-image guided codes 36568 and 36569, despite lower intra-service times due to the skill required to establish vascular access in a deep vessel under imaging guidance and the higher risk of complications such as arterial or nerve injury.

The RUC strongly recommends the work RVU of 2.00, which is well below the survey 25th percentile. To justify the work RVU of 2.00, the RUC directly crosswalked code 36X72 to code 19283 *Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including stereotactic guidance* (work RVU = 2.00, intra-service time of 20 minutes) and noted that both services should be valued identically rather than seeking the survey 25th percentile. **The RUC urges CMS to accept a work RVU of 2.00 for CPT code 36X72.**

CMS has also proposed minor adjustments to the equipment times for this code. **For the RUC's comments on individual refinements of direct PE inputs, please see the attached practice expense refinement table.**

36X73

For CPT code 36X73, the RUC recommended a work RVU of 1.90. CMS disagrees with the RUC recommended work RVU of 1.90 and is proposing a work RVU of 1.70 for code 36X73 based on the current work RVU of 1.70 for bundled code 36569 and based on "crosswalk" code 36556 *Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older* (work RVU = 1.75, 20 minutes of pre-service time, 15 minutes intra-service time, and 5 minutes of post-service time). The RUC urges CMS to use valid survey data and supportive relative reference services when valuing codes. The RUC thoroughly discussed the physician work, time, intensity and complexity required to code 36X73. CMS should not use a code value that is no longer in existence as the service (36569) itself has been revised and is currently under review in this family. Therefore, the reference is not valid to the old work RVU. Code 36X73 involves a different patient population than code 36569. The patient population for code 36X73 does not have peripheral venous access present that can be used to obtain central venous access. Code 36X73 involves obtaining new percutaneous access in a deep vein which cannot be palpated or visually identified and therefore requires imaging to minimize risk of complications. On the other hand, code 36569 involves access into a superficial vein that is visually apparent. Considering the differences in intensity and patient population, there is no evidence for a rank order anomaly within the codes in the family. The RUC acknowledged that the recommended intra-service time for code 36X73 as compared to code 36569 is lower (15 minutes compared to 27 minutes). The RUC disagrees with CMS that time is decreasing as these are different procedures with different patient populations. Code 36X73 describes insertion of PICC lines with imaging guidance for deeper veins such as the brachial or basilic veins that one cannot see or feel, often after a non-imaging PICC failed. The RUC accurately accounted for these differences with the recommended work RVU value of 1.90. It would not be correct to imply that a decrease in time should necessarily correlate to decrease in work RVU given considerable differences in patient population and inherent differences in procedural technique, intensity, and skills required to perform the procedure as noted above.

Additionally, CMS is using the term "crosswalk" incorrectly. The RUC would like to clarify that if CMS is directly crosswalking a service to another service, the crosswalk code must have identical work RVUs as the service being valued. CMS' choice of code 36556 (work RVU= 1.75) is not a direct crosswalk if the Agency proposes to maintain the work RVU of 1.70, but rather a reference service only. Furthermore, the RUC strongly disagrees with CMS' proposal to identically value code 36X73 with reference code 36556 *Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older* (work RVU = 1.75). Code 36556 describes line placement in a larger and more central vein such as the internal jugular vein or the subclavian vein with known anatomical landmarks and a shorter distance between access and where the tip terminates centrally. Code 36X73 describes access into a smaller vein without anatomic landmarks. Although imaging is inherent to code 36X73, the catheter is longer and there is need to navigate the catheter through these peripheral and central veins for adequate placement. A chest x-ray is also necessary to confirm line placement for code 36556. Code 36X73 requires more work to position a longer catheter and this additional imaging necessary for code 36556 needs to be accounted for.

Because of the rationale described above, the RUC strongly recommends the work RVU of 1.90 for code 36X73 which is well below the survey 25th percentile. To justify the work RVU of 1.90, the RUC directly crosswalked CPT code 36X73 to code 62327 *Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)* (work RVU = 1.90, intra-service time of 15 minutes) and noted that both services should be valued identically rather than seeking the survey 25th percentile. **The RUC urges CMS to accept a work RVU of 1.90 for CPT code 36X73.**

CMS has also proposed minor adjustments to the equipment times for this code. **For the RUC's comments on individual refinements of direct PE inputs, please see the attached practice expense refinement table.**

36584

For revised CPT code 36584, the RUC recommended a work RVU of 1.47. CMS disagrees with the RUC recommended work RVU of 1.47 and is proposing a work RVU of 1.20 for code 36584 based on maintaining the current work value for this service.

The RUC urges CMS to use valid survey data and supportive relative reference services when valuing codes, instead of reducing the proposed work value by the same ratio as the reduction in the intra-service and total work time. Please refer to our comments on "Inappropriate Physician Time Ratio Calculations" in the introduction of this section. The RUC thoroughly discussed the physician work, time, intensity and complexity required to perform code 36584.

CMS indicates that a work RVU of 1.20 is supported by "directly crosswalking" code 36584 to code 40490 *Biopsy of lip* (work RVU = 1.22). CMS is using the term "crosswalk" incorrectly. The RUC would like to clarify that if CMS is directly crosswalking a service to another service, the crosswalk must have identical work RVUs as the service being valued. CMS' choice of code 40490 is not a direct crosswalk, but rather simply a reference code. The RUC recommends that CMS use valid survey data and review the actual relativity for all elements (physician work, time, intensity and complexity) when developing the work RVU for services and not foster flawed methodologies in valuing this service. Moreover, the RUC strongly disagrees with CMS' proposal to use reference code 40490 to value code 36584 because the Agency is completely dismissing the additional work that was bundled in with code 36584. CPT Code 77001 *Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)* (work RVU= 0.38) was previously reported with code 36584 about 78 percent of the time according to claims data, however, codes 36584 and 77001 have been recently bundled. CMS' proposed work RVU of 1.20 discounts the extra work being brought in. The RUC recommended work RVU takes into account these two bundled codes. The RUC acknowledged and agreed that the recommended work RVU of 1.47 involves less time but involves a significant increase in intensity, as well as gaining efficiencies rather than leaving the value as is, which would discount the additional work involved. The work RVU should not remain at the current work RVU as code 36584 is now a bundled service. The RUC strongly recommends the work RVU of 1.47 for code 36584, which is the survey 25th percentile and is strongly supported by the statements above. **The RUC urges CMS to accept a work RVU of 1.47 for CPT code 36584.**

Practice Expense

CMS has also proposed minor adjustments to the equipment times for this code. **For the RUC's comments on individual refinements of direct PE inputs, please see the attached practice expense refinement table.**

(16) Biopsy or Excision of Inguinofemoral Node(s) (CPT code 3853X)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
3853X	Biopsy or excision of lymph node(s); open, inguinofemoral node(s)	6.74	6.74

For CPT code 3853X, the RUC recommended a work RVU of 6.74 based on the RUC survey 25th percentile. CMS has agreed with the RUC-recommended work RVU of 6.74 for this code. However, CMS is concerned that code 3853X is described as having a 010-day global period. The two codes that are often reported with code 3853X are codes 56630 and 56633, which are both 090-day global codes. Additionally, code 3853X has a half-day discharge visit (99238) and two follow up visits (99213) in the global period. CMS believes this is consistent with the number of postoperative visits typically associated with 090-day global codes. CMS is proposing to assign code 3853X a 090-day global period in lieu of the 010-day global period reviewed by the RUC.

Additionally, CMS states the service described by code 3853X is often reported with codes 56630 and 56633 which are 090-day global codes. This service was previously reported with unlisted code. Code 3853X is a new service for 2019 and although there is a parenthetical that these services may be reported together if it is a radical vulvectomy, the data on which code 3853X will be reported together is currently unknown. It may be appropriate that the radical codes are 090-day global services because of their intense and radical nature, long length of stay, and post-operative care. However, the global period of CPT codes 56630 and 56633 does not directly correlate to code 3853X as having the same global period because they may be reported together.

Immediately following each CPT Editorial Panel meeting, CMS reviews all global periods for new and revised services and approves or recommends changes. In the future, the RUC requests that CMS adjust global periods at that time in the process before a service is surveyed. This service was surveyed and valued as a 010-day global period service. **The RUC urges CMS to accept CPT code 3853X as a 010-day global period.**

(19) Gastrostomy Tube Replacement (CPT codes 43X63 and 43X64)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
43X63	Replacement of gastrostomy tube, percutaneous, includes removal, when performed, without imaging or endoscopic guidance; not requiring revision of gastrostomy tract	0.75	0.75
43X64	Replacement of gastrostomy tube, percutaneous, includes removal, when performed, without imaging or endoscopic guidance; requiring revision of gastrostomy tract	1.41	1.41

The RUC appreciates that CMS is proposing the RUC-recommended work RVU of 0.75 for CPT code 43X63 and the RUC-recommended work RVU of 1.41 for CPT code 43X64. However, CMS is proposing

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

(20) Diagnostic Proctosigmoidoscopy – Rigid (CPT code 45300)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
45300	Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	0.80	0.80

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

(21) Hemorrhoid Injection (CPT code 46500)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
46500	**Injection of sclerosing solution, hemorrhoids**	**1.74**	**2.00**

For CPT code 46500, CMS disagrees with the RUC recommended work RVU of 2.00 and is proposing a work RVU of 1.74 based on a direct crosswalk to CPT code 68811 *Probing of nasolacrimal duct, with or without irrigation; requiring general anesthesia* (work RVU = 1.74 and 10 minutes intra-service time). CMS states that when CPT code 46500 was previously reviewed as described in the CY 2016 *Final Rule*, the Agency finalized a proposal to reduce the work RVU from 1.69 to 1.42, which reduced the work RVU by the same ratio as the reduction in the total work time.

CMS now agrees, in light of additional evidence provided by the new survey, that the work RVU should be increased from the current value. CMS again uses an intra-service time ratio in justifying the crosswalk and states that the 3 percent increase in surveyed work time for CPT code 46500 matches a 3 percent increase in the historic work RVU of the code from 1.69 to 1.74. The RUC continues to disagree with CMS calculating intra-service time ratios to account for changes in time. Further, CPT code 46500 possesses a negative IWPUT as the result of CMS rejecting the RUC recommendation for CY 2016 and using a flawed methodology to calculate a work RVU based on a ratio of RUC recommended total time to Harvard total time. Please refer to our comments on "Inappropriate Physician Time Ratio Calculations" in the introduction of this section.

The RUC recommended work RVU of 2.00 is based on the survey 25th percentile. CMS should use the valid survey data and not an erroneous ratio when establishing the work RVU for CPT code 46500. The RUC compared CPT code 46500 to the two key reference services CPT code 46221 *Hemorrhoidectomy, internal, by rubber band ligation(s)* (work RVU = 2.36 and 15 minutes intra-service time) and CPT code 46930 *Destruction of internal hemorrhoid(s) by thermal energy (eg, infrared coagulation, cautery,*

radiofrequency) (work RVU = 1.61, 5 minutes intra-service time and 0.047 IWPUT). The recommended work RVU of 2.00 places the value correctly between the key reference services and results in similar procedure intensity. CPT codes 46500, 46221 and 46930 are reported for similar a grade of hemorrhoids. The CMS-proposed crosswalk yields an intensity of 0.021 for code 46500, which is not well-aligned with the top two key reference services that have an intensity over 0.04.

In addition, the RUC reviewed MPC code 68810 *Probing of nasolacrimal duct, with or without irrigation;* (work RVU= 1.54 and 10 minutes intra-service time) and noted that the codes have the same intra-service time but the comparison code includes a lower level follow-up visit and therefore correctly has a lower work RVU. Specifically, CPT code 46500 follow-up office visit will include an anoscopy to determine the effectiveness of the treatment and to monitor for infection or sepsis. The anoscopy—which is not separately reportable—adds work to the visit. The proposed CMS crosswalk code 68811 includes an even lower level office visit (CPT code 99211 nurse visit) than the MPC code 68810. While CPT code 46500 and the proposed crosswalk have the same intra-service time, it should be noted that the RUC recommended a work RVU of 2.03 for CPT code 68811 when it was reviewed in January 2015. The CMS did not accept the RUC recommendation. Instead, CMS used the ratio of pre-survey and post-survey total time to further decrease the work RVU from the RUC recommendation. We note that this results in an IWPUT that is almost zero. Thus, the RUC does not support a crosswalk based on an inappropriate ratio itself. The RUC maintains that CPT code 46500 as currently valued is too low and should rise to the 25th percentile supported by the survey and supported by similar work reference codes. **The RUC urges CMS to accept a work RVU of 2.00 for CPT code 46500.**

Practice Expense

CMS is seeking more information about why the clinical labor associated with the additional staff member (CA018) was left out of previous reviews and the activities the additional staff member would be undertaking during the procedure. It is our understanding that two clinical staff are needed to assist the physician during the intra-service portion of the service: one staff person is handling suction and holding the retractor while the surgeon identifies and injects anesthetic and sclerosant into the poles of the hemorrhoids and the second staff person is handing supplies (syringes, gauze) and taking soiled supplies away. In other words, one staff person will assist with tasks such as irrigation, suction, etc. and one circulating staff person will hand syringes, sponges, etc. This is different than, for example, performing a diagnostic anoscopy. **The RUC urges CMS to accept the clinical staff time of 10 minutes assigned to each of the two clinical staff for CPT code 64500 and to retain the related supplies (SB027, SB034, SB039).**

CMS is also proposing to remove the clinical labor time for the "Review home care instructions, coordinate visits/prescriptions" (CA035) activity because CPT code 46500 is typically billed with a same day E/M service. The RUC does not agree that this clinical activity is duplicative. The home care instructions directly pertain to the procedure and would not be provided during an evaluation of the patient. The RUC is careful to remove any duplication with E/M, for example, three minutes was removed in the pre-service period for contacting the patient prior to coming to the office as this time would be included in the E/M service when performed. CMS is also proposing refinements to the equipment times for this code. **For the RUC's comments on individual refinements of direct PE inputs please see the attached refinement table.**

(23) Dilation of Urinary Tract (CPT codes 50X39, 50X40, 52334, and 74485)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
50X39	**Dilation of existing tract, percutaneous, for an endourologic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, as well as post procedure tube placement, when performed;**	**2.78**	**3.37**
50X40	**Dilation of existing tract, percutaneous, for an endourologic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, as well as post procedure tube placement, when performed; including new access into the renal collecting system**	**4.83**	**5.44**
52334	Cystourethroscopy with insertion of ureteral guide wire through kidney to establish a percutaneous nephrostomy, retrograde	3.37	3.37
74485	Dilation of ureter(s) or urethra, radiological supervision and interpretation	0.83	0.83

The RUC appreciates that CMS is proposing the RUC-recommended work RVUs of 3.37 for CPT code 52334 and 0.83 for CPT code 74485. The RUC notes that Section 220(e) of the Protecting Access to Medicare Act of 2014 (PAMA) specifies that for services that are not new and revised, if the total RVU for a service would be decrease by 20 percent or more as compared to the total RVUs for the previous year the applicable adjustments shall be phased in over a 2-year period. According to these guidelines, CPT code 52334 should be subject to phase-in for CY2019 because it will decrease more than 20 percent and is not a new or revised code. **The RUC urges CMS to add CPT code 52334 to the list of codes subject to phase-in for significant RVU reductions for CY 2019.**

Regarding CPT codes 50X39 and 50X40, we would first like to point out that the reference codes listed on the RUC summary of recommendation (SOR) form are not codes that were selected by the RUC to support the RUC recommendation. Due to this misinterpretation, CMS seems to not have reviewed the actual reference codes the RUC cited to support the RUC recommendations. The codes on the SOR were included by the specialty societies as part of their submission to the RUC. Also, for the top key reference codes, which are selected by the survey respondents, the respondents do not get to see the CMS times as they are completing the survey. The reference codes include on the SOR are not changed when the societies or the RUC make any changes (work RVU, physician time, etc.) to the original specialty recommendation. Furthermore, as the SOR has two fields for MPC comparator codes, specialties typically provide two MPC codes as part of their original submission, even if the MPC codes are not very similar to the survey code in work and time. There are approximately 280 MPC codes to reference, so the physician work and time may not be exactly the same but these MPC services serve as a cross-specialty reference.

50X39

For CPT code 50X39, CMS disagrees with the RUC recommended work RVU of 3.37 and proposes a work RVU of 2.78 based on a direct crosswalk to CPT code 31646 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with therapeutic aspiration of tracheobronchial tree, subsequent, same hospital stay* (work RVU= 2.78, intra-service time of 30 minutes, total time of 70 minutes) which was spurred by examining various "intraservice time ratios." The components of total time (pre-service time, intra-service time, post-service time, post-operative visits) consist of differing levels of physician intensity with code specific durations—and it is therefore inaccurate to apply time ratios from one code to the another, as has been done, when more than one type of physician time is involved. In addition, CPT code 31646 is a less intense service and typically involves a less complex patient than 50X39. For the procedure code that is being bundled into code 50X39 (50432), CMS rejected the RUC recommendation in CY2016 based on flawed assumptions, where the Agency inadvertently failed to consider the bundling of code 50390 *Aspiration and/or injection of renal cyst or pelvis by needle, percutaneous* into CPT code 50432 as part of their CY2016 review. The further reduction of code 50X39 based on comparisons to the already arbitrarily reduced value for code 50432 will further compound the underlying service's misevaluation. When CPT codes 50694 and 50695were last valued (two of the service CMS calculated a comparison time ratio for), CMS implemented a much lower value than the RUC recommended work RVUs, though implemented the RUC recommended time. Please refer to our comments on "Inappropriate Physician Time Ratio Calculations" in the introduction of this section.

The RUC recommendation is strongly supported by reference codes 52287 *Cystourethroscopy, with injection(s) for chemodenervation of the bladder* and 52214 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands*. CMS failed to consider these reference codes as the Agency instead mistook the codes included in the SOR as the codes that the RUC cited as support for its recommendation. **The RUC urges CMS to accept a work RVU of 3.37 for CPT code 50X39.**

50X40

For CPT code 50X40, CMS disagrees with the **unanimously approved** RUC work RVU of 5.44 and proposes a work RVU of 4.83 based on adding the increment between the RUC recommendations between codes 50X39 and 50X40 (2.07 RVUs) to the CMS proposed RVU for CPT code 50X39. CMS made a tabulation error when summing the increment to their proposed value for 50X39. Although we do not support CMS' alternate method, we would like to point out that adding the CMS proposed work RVU of 2.78 to the 2.07 increment would actually equal 4.85.

CMS also disagrees with the RUC recommended intra-service time of 60 minutes and instead proposes an intra-service time of 45 minutes. CMS did not provide any clinical rationale for why they rejected the intra-service time, instead only noting that they typically accept the survey median intra-service time. The specialties recommended, and the RUC agreed, that the survey 75th percentile intra-service time better represents the additional time needed to introduce the guidewire into the renal pelvis and/or ureter, above and beyond the work involved to perform code 50X39. Only 15 minutes of additional intra-service time is insufficient to account for the additional amount of physician work inherent to performing this service. The physician work involved with introducing a guidewire into the renal pelvis or ureter is what occurs during CPT code 50432 *Placement of nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, Imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation*, which takes a much longer time to perform than 15 minutes. The CMS time for CPT Code 50432 from CY 2016 was 48 minutes. CMS' proposal to reduce the intra-service time appears to be the principle driver for also proposing an alternate work RVU. Also, neither reference code that CMS noted as being the basis of the RUC

recommendation was included in the RUC rationale, but instead only in the SOR form submitted by the specialty.

CMS supported their valuation with a crosswalk to CPT code 36902 *Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report; with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty*. However, the RUC recommended value for 36902 in 2016 was rejected by CMS, and CMS created a lower value. For 36902 the RUC recommended 6.00 and then CMS reduced it to 4.83. So, CMS is using as a comparator a code that they changed in 2016. In addition, CMS mistook the codes included in the SOR as the codes that the RUC cited as support for its recommendation. The specialties recommended and the RUC agreed that the survey 75th percentile intra-service time better represents the additional time needed to introduce the guidewire into the renal pelvis and/or ureter, above and beyond the work involved in performing code 50X39.

For one of the procedure codes bundled into code 50X40 (50432), CMS rejected the RUC recommendation in CY2016 based on flawed assumptions, where the Agency inadvertently failed to consider the bundling of code 50390 *Aspiration and/or injection of renal cyst or pelvis by needle, percutaneous* into CPT code 50432 as part of their CY2016 review. The further reduction of code 50X39 based on comparisons to the already arbitrarily reduced value for code 50432 will further compound the underlying service's misevaluation.

The RUC recommendation was based on the 25th percentile work RVU from robust survey results and favorable comparison to reference code 52235 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; MEDIUM bladder tumor(s) (2.0 to 5.0 cm.* CMS failed to consider the reference code as the Agency instead mistook the codes included in the SOR as the codes that the RUC cited as support for its recommendation. **The RUC urges CMS to accept a work RVU of 5.44 for CPT code 50X40.**

Practice Expense

CMS is proposing refinements to the RUC-recommended direct PE inputs for the codes in this family. For CPT code 52334, the equivalent of *Confirm availability of prior images/studies* (CA006) did not exist when this service was last reviewed by the Practice Expense subcommittee in 2002. Many surgical procedures and other types of services that do not have imaging bundled involve the physician reviewing images and studies before performing the service. This review is not duplicative with image-guidance codes as it instead involves reviewing distinct previous studies. That was the intent of the Practice Expense Spreadsheet Update Workgroup when they created CA006, was for CA0006 to be used for multiple types of services instead of only imaging. **The RUC notes, midway through the discussion of CPT code 52334, CMS erroneously referenced the wrong code number ("52234") several times.** If the Agency was inadvertently reviewing the wrong code when considering the RUC's practice expense recommendations for 52334, CMS should again review this service while reviewing the historical information for the correct code. **For the RUC's other comments on individual refinements of direct PE inputs please see the attached refinement table.**

(24) Transurethral Destruction of Prostate Tissue (CPT codes 53850, 53852, and 538X3)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
53850	Transurethral destruction of prostate tissue; by microwave thermotherapy	5.42	5.42
53852	Transurethral destruction of prostate tissue; by radiofrequency thermotherapy	5.93	5.93
538X3	**Transurethral destruction of prostate tissue; by radiofrequency generated water vapor thermotherapy**	**5.70**	**5.93**

The RUC appreciates that CMS is proposing the RUC-recommended work RVUs of 5.42 for CPT code 53850 and 5.93 for CPT code 53852, as **unanimously approved** by the RUC. The RUC notes that Section 220(e) of the Protecting Access to Medicare Act of 2014 (PAMA) specifies that for services that are not new and revised, if the total RVU for a service would be decrease by 20 percent or more as compared to the total RVUs for the previous year the applicable adjustments shall be phased in over a 2-year period. According to these guidelines, both CPT codes 53850 and 53852 should be subject to phase-in for CY2019 because they will decrease more than 20 percent and are not new or revised codes. **The RUC urges CMS to add CPT codes 53850 and 53852 to the list of codes subject to phase-in for significant RVU reductions for CY 2019.**

CMS disagrees with the RUC recommended work RVU of 5.93 (25 minutes intra-service time) for CPT code 538X3 and is proposing a work RVU of 5.70 based on a crosswalk to CPT code 24071 *Excision, tumor, soft tissue of upper arm or elbow area, subcutaneous; 3 cm or greater* (work RVU = 5.70 and 45 minutes intra-service time). The RUC indicated that CPT code 538X3 is the most intense of the three CPT codes in this family, thereby justifying a work RVU identical to that of CPT code 53852 despite lower intra-service and total times. However, CMS did not agree with the RUC recommending a work RVU the same as CPT code 53852, given that the total time is 5 minutes lower and the post-service times are identical.

The CMS states "The RUC stated that 15 minutes of post service time is appropriate due to greater occurrence of post-procedure hematuria necessitating a longer monitoring time. However, the post-service monitoring time for this CPT code, 15 minutes, is identical to that for CPT code 53852." We are confused by this statement because the RUC clarified that, while CPT code 53850 has 10 minutes post-service time because a catheter is used, both CPT codes 53852 and 538X3 require 15 minutes of post-service time because there are actual punctures of the prostate and the patient must be monitored due to greater occurrence of post-procedure hematuria.

The RUC indicated that the intra-service survey time decreases as the codes progress from CPT codes 53850 to 53852 and 538X3 and the intensity of the procedures increase. The third code in the family, CPT code 538X3, is the most intense due to the use of hot water causing potential injury to adjacent anatomic structures. The RUC recommendations codify the progressive intensity in this family of codes with IWPUT of 0.041, 0.071 and 0.085, respectively. Thus, the RUC justified a work RVU identical to that of CPT code 53852 given the intensity of the service which reflects the use of a new technology. As noted, this CPT code will be reviewed again in 3 years.

CMS requested comments about the time and intensity required to furnish this new service. CPT code 538X3 is a procedure unique to urology. As with all endoscopic surgical procedures on the prostate, there is a significant risk of bleeding, urinary retention and damage to the external urinary sphincter with resultant incontinence of urine if not performed properly. CMS identifies CPT code 24071 as a more appropriate crosswalk. To perform this procedure requires basic open surgical skills with a scalpel, scissors and suture and knot tying that all surgeons are already expert at performing. It involves making a superficial skin incision in the arm and dissecting a subcutaneous tumor, typically a lipoma (a benign fatty tumor). Stress is minimal, no arteries, veins or nerves are in danger with very minimal risk for long-term or permanent disability. The skill and intensity due to the potential for bleeding and damage to the external urinary sphincter are the reasons that CPT code 538X3 should be considered a higher value than CMS is proposing and the same value as CPT code 53852.

CPT codes 53852 and 538X3 both involve somewhat similar hand held endoscopic devices and the intensity and skill required are similar. Urologists have more experience with CPT code 53852 as it has been performed for a number of years so the estimates of time may be more reliable. As 538X3 is a new code, where the clinical practitioners are still in the learning phase, and few urologists are performing it, the estimates of time may be based on limited experience. Thus, the RUC offered work RVU crosswalk values to more adequately match the survey reductions in time. For CPT code 538X3, the RUC supported a direct work RVU crosswalk to CPT code 67917 *Repair of ectropion; extensive (eg, tarsal strip operations)* (work RVU = 5.93 and 33 minutes intra-service time) and believes it is a better reflection of the work involved in furnishing CPT code 538X3 than the CMS-proposed crosswalk.

Further, CMS states that the intra-service time ratio between this new CPT code and CPT code 53852 (4.94) and the total time ratio between the two CPT codes (5.72) suggest that the RUC-recommended work RVU of 5.93 overestimates the work involved in furnishing this service. The RUC continues to disagree with CMS calculating intra-service time ratios to account for changes in time. Please refer to our comments on "Inappropriate Physician Time Ratio Calculations" in the introduction of this section. **The RUC urges CMS to accept a work RVU of 5.93 for CPT code 538X3.**

Practice Expense

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

(26) Biopsy of Uterus Lining (CPT codes 58100 and 58110)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
58100	Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)	1.21	1.21
58110	Endometrial sampling (biopsy) performed in conjunction with colposcopy (List separately in addition to code for primary procedure)	0.77	0.77

The RUC appreciates that CMS is proposing the RUC-recommended work RVU of 1.21 for CPT code 58100 and the RUC-recommended work RVU of 0.77 for CPT code 58110. However, CMS is proposing refinements to the RUC-recommended direct PE inputs for the codes in this family. CMS is proposing to remove the clinical labor time from clinical activity, *Review/read post-procedure x-ray, lab and pathology reports* (CA028) for CPT code 58100 because this code is typically billed with a same day E/M service. The RUC does not agree that this clinical activity is duplicative. CA028 is designed specifically for post-procedure activity during the *post-service of the service period* which would not overlap with activities in the E/M (Review/read X-ray, lab, pathology reports) which typically occur prior to the procedure and are listed as a pre-service clinical activity in the E/M codes.

The clinical description of the service/vignette for CPT code 58100 clearly notes that the E/M is done the day before the service and the patient is returning for the biopsy. The clinical time is mandatory because the physician has to have a chaperone at the minimum during the procedure. The pathology report results and notification occurs in the post-service of the service period as a result of the procedure and is not part of the E/M determination to perform the procedure which occurred the day prior.

The RUC assures CMS that it is careful to remove any duplication with E/M and encourages CMS to accept the direct PE inputs for CA028. CMS is also proposing refinements to the equipment times for this code. **For the RUC's comments on individual refinements of direct PE inputs please see the attached refinement table.**

(27) Injection Greater Occipital Nerve (CPT code 64405)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
64405	Injection, anesthetic agent; greater occipital nerve	0.94	0.94

The RUC appreciates that CMS is proposing the RUC-recommended work RVU of 0.94 for CPT code 64405. However, CMS is proposing refinements to the RUC-recommended direct PE inputs. **For the RUC's comments on individual refinements of direct PE inputs please see the attached refinement table.**

(28) Injection Digital Nerves (CPT Code 64455)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
64455	Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (eg, Morton's neuroma)	0.75	0.75

CMS is proposing to accept the RUC work recommendation for CPT code 64455. However, CMS is proposing refinements to the RUC recommended direct PE inputs for this code. **For the RUC's comments on individual refinements of direct PE inputs please see the attached refinement table.**

(29) Removal of Foreign Body – Eye (CPT codes 65205 and 65210)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
65205	Removal of foreign body, external eye; conjunctival superficial	0.49	0.49
65210	**Removal of foreign body, external eye; conjunctival embedded (includes concretions), subconjunctival, or scleral nonperforating**	**0.61**	**0.75**

For CPT code 65210, CMS disagrees with the RUC recommended work RVU of 0.75 and is proposing a work RVU of 0.61 based on a direct crosswalk to CPT code 92511 *Nasopharyngoscopy with endoscope* (work RVU = 0.61 and 5 minutes intra-service time). CMS uses an intra-service time ratio in justifying the crosswalk and states that the recommended intra-service time for CPT code 65210 is decreasing by 62 percent (13 to 5 minutes) and the recommended total time is decreasing by 48 percent (25 to 13 minutes); however, the RUC recommended work RVU is only decreasing by about 11 percent. The RUC continues to disagree with CMS calculating intra-service time ratios to account for changes in time. The RUC noted that CPT code 65210 had never been surveyed and was based on Harvard time which contributed to the median survey intra-service time of 5 minutes being less than half of the current value of 13 minutes. Harvard times should be not be used for any sort of time comparison, especially when the code was not originally surveyed by Harvard. The current work value of CPT code 65210 was based on flawed methodology such that the original source of time data cannot be relied upon as an appropriate baseline and makes the practice of time ratios even more egregious and ineffective. Please refer to our comments on "Inappropriate Physician Time Ratio Calculations" in the introduction of this section.

Moreover, CMS notes that the recommendation for the other code in this family, CPT code 65205, "appears to have been developed under a methodology similar to our ongoing use of time ratios as one of several methods used to evaluate work." While the RUC takes changes in work and time into account, we can assure you that time ratios were not used in arriving at the value of 0.49 for CPT code 65205. Given that the survey 25th percentile work RVU was higher than the current work RVU for the service, the RUC recommended a direct crosswalk to the second top key reference service 68200 *Subconjunctival injection* (work RVU = 0.49 and 11 minutes total time). CPT codes 65205 and 68200 both require the same total time to perform and the survey respondents indicated that the overall intensity and complexity of these services is identical. We appreciate that CMS agrees with the RUC-recommended work RVU of 0.49 for CPT code 65205 as **unanimously approved** by the RUC.

For CPT code 65210, the RUC recommended work RVU of 0.75 is based on the survey 25th percentile. The RUC agreed with the consensus of the specialty societies that the procedure has not fundamentally changed and recommended a work RVU at the 25th percentile in accordance with the recent survey. The RUC does not agree with either of the proposed CMS crosswalks because CPT code 92511 (nasopharyngoscopy) and CPT code 51700 *Bladder irrigation, simple, lavage and/or instillation* are clearly not as intense as removal of an embedded foreign body, in which an incision into ocular tissue is required. The RUC strongly recommends that CMS rely on valid survey data. The RUC **unanimously approved** the work RVUs for both CPT codes 65205 and 65210 and urges CMS to also accept the RUC recommended value for code 65210.

CMS further notes two injection codes, CPT code 20551 *Injection(s); single tendon origin/insertion* and CPT code 64455 *Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (eg, Morton's neuroma)* were reviewed at the same RUC meeting in April 2017 and have identical RUC-recommended work RVUs of 0.75. All three codes share the same intra-service time of 5 minutes while CPT code 65210 has slightly less total time of 13 minutes compared to 21 minutes for the other two services. CMS states that "Due to the fact that CPT code 65210 has a lower total time and a lower intensity than both of these injection procedures, we did not agree that CPT code 65210 should be valued at the same work RVU of 0.75." The RUC is confused by this statement because the two codes that are referenced both have IWPUT of 0.093 which is lower than the IWPUT of 0.117 for CPT code 65210. Therefore, CPT code 65210 has a lower total time and a *higher* intensity than both of these injection procedures, justifying the recommended work RVU of 0.75. Again, this is borne out by survey data compiled from clinicians familiar with the procedure. If either of the codes were key reference services, it would be reasonable to compare intensity because then it would be possible to compare the intensity measures as valued by the respondents. In addition, the RUC notes that IWPUT is best suited for 010 and 090-day services than XXX or 000-day services. **The RUC urges CMS to accept a work RVU of 0.75 for CPT code 65210.**

Practice Expense

CMS disagrees that the screening lane (EL006) equipment would typically be in use for the total work time, given that this includes the pre-service evaluation time and the immediate post-service time. CMS is soliciting comments on whether the use of the intra-service work time would be more typical than the total work time for CPT codes 65205 and 65210. We are confused by this request for comment because the screening lane (EL006) is the ophthalmic equivalent of an exam room in the non-facility setting which is obviously needed for the total time of the procedure.

For CPT code 65205, the 2 minutes of clinical staff time includes 1 minute to prepare the room, equipment and supplies and 1 minute to clean the room/equipment, in addition to the total physician work time of 11 minutes for a total of 13 minutes equipment time for the screening lane. For CPT code 65210, a total of 5 minutes of clinical staff time is necessary, 2 minutes to prepare the room, equipment and supplies and 3 minutes to clean the room/equipment, in addition to the 13 minutes of total physician work time for a total of 18 minutes equipment time for the screening lane. The RUC notes that line 107 EL006 *lane, screening (oph)* represents the total time taken by the physician to perform the service in the screening lane (which is not able to be occupied by another patient during the time of the procedure), plus the time inputs for the technician work as listed above.
The RUC would like to further clarify that the physician pre-service time (evaluation, scrub/dress/wait and positioning) is different than the PE pre-service time in that the physician is in the screening lane with the patient when performing the pre-service tasks; for these services that includes describing the planned procedure, obtaining informed consent and anesthetizing the ocular surface. These activities are all done at the patient's side in the screening lane, which cannot be used in any other manner during that time.

Post-service time is likewise performed in the screening lane as the patient hasn't been moved, and the counseling is done at the patient's side while they are in the chair. It is typical in ophthalmology to dictate the report in front of the patient prior to their leaving the chair. Any assumption that the patient and physician move out of the screening lane for pre- and/or post- service activities is incorrect.

The RUC strongly believes that the use of the total work time in addition to the clinical labor time is typical for the screening lane equipment time in CPT codes 65205 and 65210.

(30) Injection – Eye (CPT codes 67500, 67505, and 67515)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
67500	Retrobulbar injection; medication (separate procedure, does not include supply of medication)	1.18	1.18
67505	**Retrobulbar injection; alcohol**	**0.94**	**1.18**
67515	**Injection of medication or other substance into Tenon's capsule**	**0.75**	**0.84**

67505

For CPT code 67505, CMS disagrees with the RUC recommended work RVU of 1.18 and is proposing a work RVU of 0.94 based on a direct crosswalk to CPT code CPT code 31575 *Laryngoscopy, flexible; diagnostic* (work RVU = 0.69 and 5 minutes intra-service time). CMS did not agree with the recommendation to propose the same work RVU of 1.18 for both CPT codes 67500 and 67505.

CMS notes that the current work value for CPT code 67500 is higher than that of CPT code 67505. However, the survey 25th percentiles indicate that the physician work of code 67505 (work RVU =1.30) is higher than that of code 67500 (work RVU = 1.18). The reason for performing surveys is to determine current work values and times in order to adjust for changes in physician work that have occurred since the prior survey. It is inappropriate to put more weight on old data than on the most recent data.

CMS further states that this comparison of current values and times supports the view that CPT code 67500 should continue to be valued higher than CPT code 67505 due to its greater intensity. The Agency is proposing a lower work RVU for CPT code 67505 due to its lesser intensity because the procedure is performed in a blind eye. In fact, CPT code 67505 has a higher intensity than CPT code 67500, not because of potential vision loss, but because of the risk of death if the absolute alcohol is injected accidentally into the optic nerve sheath. In addition, the risk of globe perforation and resulting infection leading to a need for enucleation, which CPT code 67505 is designed to avoid, is still present.

The RUC supports the same work RVU as CPT code 67500 based on the clinical consideration of the procedure risk. The alcohol injection in CPT code 67505 is typically very painful, even after a local anesthetic injection, and carries with it the risk of death if the alcohol is injected into the optic nerve sheath. This makes CPT code 67505 a high-intensity procedure for both patient and physician. We ask that CMS carefully consider this critical clinical information when determining proposed and final work values instead of selecting a cross-walk that does not match the clinical work and intensity. We strongly advocate against using a crosswalk to code CPT code 31575 *Laryngoscopy, flexible; diagnostic* (work RVU = 0.69 and 5 minutes intra-service time), as it is inappropriate given the clinical considerations stated above.

Further, CMS states that "At the recommended identical work RVUs, CPT code 67500 has almost triple the intensity of CPT code 67505." We are confused by this statement because, as noted above, the RUC recommendation for CPT code 67505 has less total time and slightly *higher* intensity (26 minutes total time and IWPUT = 0.156) than CPT code 67500 (33 minutes total time and IWPUT = 0.125). Therefore, CPT code 67505 has a lower total time and a higher intensity than the base code, justifying the recommended work RVU of 1.18.

CMS also uses an intra-service time ratio in justifying the crosswalk to CPT code 31575 and states that the RUC-recommended total time of 26 minutes for CPT code 67505 was approximately 21 percent lower than the RUC-recommended total time for CPT code 67500 of 33 minutes, and the total time ratio between the two codes produces a suggested work RVU of 0.93, which is almost identical to the 0.94 value of the proposed crosswalk code. The RUC continues to disagree with CMS calculating intra-service time ratios to account for changes in time. Please refer to our comments on "Inappropriate Physician Time Ratio Calculations" in the introduction of this section. **The RUC urges CMS to accept a work RVU of 1.18 for CPT code 67505.**

67515

For CPT code 67515, the RUC **unanimously approved** a work RVU of 0.84. However, CMS disagrees with the RUC recommended work RVU and is proposing a work RVU of 0.75 based on a direct crosswalk to CPT code 64450 *Injection,anesthetic agent; other peripheral nerve or branch* (work RVU = 0.75 and 5 minutes intra-service time). CMS states that CPT code 64450 is a more accurate crosswalk because it has a more similar intra-service time to CPT code 67515 (3 minutes intra-service time). The RUC disagrees and believes that the intensity of an injection adjacent to the eye in which the physician is unable to see the needle tip is clearly greater than that of an injection into a peripheral nerve as in the CMS proposed crosswalk to CPT code 64450. For further support, the RUC references CPT code 64405 *Injection, anesthetic agent; greater occipital nerve* (work RVU = 0.94 and 5 minutes intra-service time) which appropriately considers potential impacts to patients' vision and reflects the skill needed to be certain that the needle is not accidentally placed into the eye and that the medication is injected into a small space between Tenon's capsule and the sclera.

CMS also uses an intra-service time ratio with the first code in the family, CPT code 67500, to justify the valuation of 0.75 for CPT code 67515. The RUC continues to disagree with CMS calculating intra-service time ratios to account for changes in time. Please refer to our comments on "Inappropriate Physician Time Ratio Calculations" in the introduction of this section. **The RUC urges CMS to accept a work RVU of 0.84 for CPT code 67515.**

Practice Expense

We appreciate that CMS is not proposing any refinements to the direct PE inputs for this code family.

(31) X-Ray Spine (CPT codes 72020, 72040, 72050, 72052, 72070, 72072, 72074, 72080, 72100, 72110, 72114, and 72120)
(32) X-Ray Sacrum (CPT codes 72200, 72202, and 72220)
(33) X-Ray Elbow-Forearm (CPT codes 73070, 73080, and 73090)
(34) X-Ray Heel (CPT code 73650)
(35) X-Ray Toe (CPT code 73660)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
72020	Radiologic examination, spine, single view, specify level	0.23	0.15
72040	Radiologic examination, spine, cervical; 2 or 3 views	0.23	0.22
72050	Radiologic examination, spine, cervical; 4 or 5 views	0.23	0.31
72052	Radiologic examination, spine, cervical; 6 or more views	0.23	0.35

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
72070	**Radiologic examination, spine; thoracic, 2 views**	**0.23**	**0.22**
72072	**Radiologic examination, spine; thoracic, 3 views**	**0.23**	**0.22**
72074	**Radiologic examination, spine; thoracic, minimum of 4 views**	**0.23**	**0.22**
72080	**Radiologic examination, spine; thoracolumbar junction, minimum of 2 views**	**0.23**	**0.22**
72100	**Radiologic examination, spine, lumbosacral; 2 or 3 views**	**0.23**	**0.22**
72110	**Radiologic examination, spine, lumbosacral; minimum of 4 views**	**0.23**	**0.31**
72114	**Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views**	**0.23**	**0.31**
72120	**Radiologic examination, spine, lumbosacral; bending views only, 2 or 3 views**	**0.23**	**0.22**
72200	**Radiologic examination, sacroiliac joints; less than 3 views**	**0.23**	**0.17**
72202	**Radiologic examination, sacroiliac joints; 3 or more views**	**0.23**	**0.18**
72220	**Radiologic examination, sacrum and coccyx, minimum of 2 views**	**0.23**	**0.17**
73070	**Radiologic examination, elbow; 2 views**	**0.23**	**0.15**
73080	**Radiologic examination, elbow; complete, minimum of 3 views**	**0.23**	**0.17**
73090	**Radiologic examination; forearm, 2 views**	**0.23**	**0.16**
73650	**Radiologic examination; calcaneus, minimum of 2 views**	**0.23**	**0.16**
73660	**Radiologic examination; toe(s), minimum of 2 views**	**0.23**	**0.13**

For the 20 CPT codes included in the X-Ray Spine, X-Ray Sacrum, X-Ray Elbow-Forearm, X-Ray Heel and X-Ray Toe code families, CMS disagrees with the RUC recommended work values listed in the table above and, instead, proposes the same work RVU of 0.23 for all 20 services based on a utilization-weighted average. This disregards the differences in the number of views, anatomical site, positioning of the patient and the amount of physician work. The Agency took issue with these services not undergoing a RUC survey and lack of new data provided.

On an February 2017 Research Subcommittee conference call, the Subcommittee reviewed the recommendation made by the specialty societies to crosswalk times and values for these identified codes to other codes performed by the specialty societies in lieu of conducting individual RUC surveys for these low work RVU and physician time services. The Research Subcommittee approved the proposed methodology, noting past precedent of the Research Subcommittee approving a similar request for X-ray codes in 2010. For CY2011, the Agency took no issue with the crosswalk methodology in lieu of survey for several X-ray codes and accepted the RUC recommended values at that time.

It would set an unacceptable precedent to set disparate X-ray services at the same work RVU of 0.23, as these services vary considerably on the number of views, anatomical site, positioning of the patient and the amount of physician work. Furthermore, it is CMS' statutory obligation to pay procedures based on the actual resource costs expended.

The Agency has made it clear that it has changed its mind on using the crosswalk methodology in lieu of survey for low work RVU services. As setting all 20 services at the same value would set an inappropriate precedent, the RUC would like to offer a potential solution for consideration. **The RUC recommends for CMS to maintain the CY2018 work RVU for all 20 services on an interim basis and will request for the specialties to survey all 20 services and review them again at the January 2019 RUC meeting (CY 2020 cycle):**

Code	Long Descriptor	Newly Proposed Interim Value for CY2019 (maintaining CY2018 Work RVUs)
72020	Radiologic examination, spine, single view, specify level	0.15
72040	Radiologic examination, spine, cervical; 2 or 3 views	0.22
72050	Radiologic examination, spine, cervical; 4 or 5 views	0.31
72052	Radiologic examination, spine, cervical; 6 or more views	0.36
72070	Radiologic examination, spine; thoracic, 2 views	0.22
72072	Radiologic examination, spine; thoracic, 3 views	0.22
72074	Radiologic examination, spine; thoracic, minimum of 4 views	0.22
72080	Radiologic examination, spine; thoracolumbar junction, minimum of 2 views	0.22
72100	Radiologic examination, spine, lumbosacral; 2 or 3 views	0.22
72110	Radiologic examination, spine, lumbosacral; minimum of 4 views	0.31
72114	Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views	0.32
72120	Radiologic examination, spine, lumbosacral; bending views only, 2 or 3 views	0.22
72200	Radiologic examination, sacroiliac joints; less than 3 views	0.17
72202	Radiologic examination, sacroiliac joints; 3 or more views	0.19
72220	Radiologic examination, sacrum and coccyx, minimum of 2 views	0.17
73070	Radiologic examination, elbow; 2 views	0.15
73080	Radiologic examination, elbow; complete, minimum of 3 views	0.17
73090	Radiologic examination; forearm, 2 views	0.16
73650	Radiologic examination; calcaneus, minimum of 2 views	0.16
73660	Radiologic examination; toe(s), minimum of 2 views	0.13

Also, the RUC used a similar cross-walking methodology for 7 other X-ray codes that were reviewed at the April 2018 meeting for CY2020, CPT codes 70210, 70220, 70250, 70260, 70360, 72170 and 72190. The RUC will also request for the specialties to survey these 8 services and review them again at the January 2019 RUC meeting (CY 2020 cycle).

Practice Expense

CMS is proposing refinements to the RUC-recommended direct PE inputs for the codes in this family. CMS separately made the observation that several X-ray codes that have a minimum number of views or describe range of views (ie *X-ray Cervical Spine 2-3 views*) select a specific number of typical views to value the clinical labor intra-service (of the service period) time which is not always the minimum of the range described. The Practice Expense Subcommittee discusses the typical patient with the presenting specialties in detail and recommended clinical labor intraservice time that matches the typical number of views necessary to examine the typical patient. CMS did not refine these times, but instead noted that they continue to be interested in data sources for intraservice clinical labor times for services where the clinical staff time is not the same as the physician time. The RUC and the Practice Expense Subcommittee would be open to reviewing and considering other data sources on clinical staff time. **For the RUC's other comments on individual refinements of direct PE inputs please see the attached refinement table.**

(36) X-Ray Esophagus (CPT codes 74210, 74220 and 74230)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
74210	Radiologic examination; pharynx and/or cervical esophagus	0.59	0.59
74220	Radiologic examination; esophagus	0.67	0.67
74230	Swallowing function, with cineradiography/videoradiography	0.53	0.53

CMS is proposing to accept the RUC work recommendations for CPT codes 74210, 744220 and 74230. However, CMS is proposing refinements to the RUC recommended direct PE inputs for the codes in this family. Codes 74210 and 74220 involve the use of barium and fluoroscopy to evaluate the pharynx and upper esophagus or the esophagus, respectively. The barium suspension quantity listed for code 74210 prior to review was only 1mL which appears to be an error mistaking number of milliliters for number of items. This is an insufficient quantity of barium for a procedure that requires viewing the patient during multiple swallows in different positions. Similarly, code 74420 did not have barium suspension listed as a supply item, which is an oversight. The RUC agreed that a typical fluoroscopic evaluation of the esophagus could be accomplished with 150mL of barium (polibar) for CPT code 74210 and 100 ml of barium (polibar) and 12 oz of high density barium for CPT Code 74220. The patient first swallows a small quantity of high density barium to outline the esophagus. Multiple subsequent swallows of normal density barium are assessed under fluoroscopy from different angles to evaluate the esophageal anatomy and mucosa, with particular attention to the gastroesophageal junction. Then the patient is placed in a prone oblique position and multiple swallows of regular barium are viewed with fluoroscopy to assess esophageal motility and the presence of reflux or a hernia. Additional swallows of barium in other positions or with additional water are performed to highlight abnormalities previously identified or as a challenge to induce reflux. **For the RUC's other comments on individual refinements of direct PE inputs please see the attached refinement table.**

(37) X-Ray Urinary Tract (CPT code 74420)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
74420	Urography, retrograde, with or without KUB	0.52	0.52

CMS is proposing to accept the RUC work recommendation for CPT code 74420. However, CMS is proposing refinements to the RUC-recommended direct PE inputs for the codes in this family. CMS is removing 1 minute from clinical activity, *Confirm order, protocol exam* (CA014). CMS' reason for this refinement is inaccurate and the RUC strongly encourages CMS to reverse this proposal. This service is distinct from the other X-ray services reviewed during this cycle and requires CA014. Please see an explanation of this request under Standardization of Clinical Labor Tasks in the PE section of this comment letter. **For the RUC's other comments on individual refinements of direct PE inputs please see the attached refinement table.**

(39) Echo Exam of Eye Thickness (CPT code 76514)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
76514	**Ophthalmic ultrasound, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness)**	**0.14**	**0.17**

For CPT code 76514, CMS disagrees with the RUC-recommended work RVU of 0.17 and is proposing a work RVU of 0.14 based on taking half of the intra-service time ratio. CMS states that the recommended intra-service time for CPT code 76514 is decreasing by 40 percent (5 to 3 minutes) and the recommended total time is decreasing by 67 percent (15 to 5 minutes); however, the RUC recommended work RVU is staying the same. In addition to the changes in time, the workflow for the procedure has changed which CMS believes should result in a reduction in the work RVU. Recognizing that the two minutes that were shifted to clinical staff time are less intense, CMS applied half of the intra-service time ratio for a reduction of 0.03 RVUs, resulting in a proposed work RVU of 0.014.
Using an approach that takes a fraction of the intra-service time ratio in lieu of strong crosswalks and input from the RUC and physicians providing these services is unfounded. Please refer to our comments on "Inappropriate Physician Time Ratio Calculations" in the introduction of this section. The RUC urges CMS to use valid survey data and supportive relative reference services when valuing services, instead of placing everything in a calculation. The RUC thoroughly discussed the physician work, time, intensity and complexity required to perform CPT code 76514. The RUC compared CPT code 76514 to top key reference service CPT code 92145 *Corneal hysteresis determination, by air impulse stimulation, unilateral or bilateral, with interpretation and report* (work RVU = 0.17 and 5 minutes intra-service time), noting that the recommended total intra-service time for CPT code 76514 is 2 minutes less but represents the same overall work. Additionally, the overall intensity/ complexity rating was identical or somewhat more relative to the key reference code. For additional support, the RUC referenced MPC codes: 71010 *Radiologic examination, chest; single view, frontal* (work RVU = 0.18), 73120 *Radiologic*

examination, hand; 2 views (work RVU = 0.16), and CPT code 73080 *Radiologic examination, elbow; complete, minimum of 3 views* (work RVU = 0.17) and noted that all three codes have an identical intra-service time of 3 minutes and total time of 5 minutes as CPT code 76514.

The RUC recommended work RVU of 0.17 for CPT code 76514 based on the survey 25th percentile. Like CMS, the RUC questioned the reductions in time reflected in the survey and that the median survey intra-service time of 3 minutes is 2 minutes less than the current value. The specialties explained the change in workflow and that smaller, portable, easier to use pachymeters are now used such that the technician typically takes the measurements that used to be taken by the physician. It should also be noted that instructions to respondents were revised between the prior survey and this survey, instructing respondents not to round time up. The decrease in intraservice time from 5 to 3 minutes could be indicative of a change in survey methodology rather than the amount of time the physician spends performing the procedure. Nevertheless, the intra-service time was reduced by 2 minutes to account for the technician performing this service. The remaining 3 minutes of intra-service time reflects the more intense cognitive work performed by the physician after the measurements are taken. Thus, the RUC agreed with the consensus of the specialty societies that the procedure has not fundamentally changed and recommended a work RVU at the 25th percentile in accordance with the recent survey. The RUC urges CMS to use the valid survey 25th percentile work RVU of 0.17 for CPT code 76514. **The RUC urges CMS to accept a work RVU of 0.17 for CPT code 76514.**

Practice Expense
We appreciate that CMS is not proposing any refinements to the direct PE inputs for this code.

(40) Ultrasound Elastography (CPT codes 767X1, 767X2, and 767X3)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
767X1	Ultrasound, elastography; parenchyma	0.59	0.59
767X2	Ultrasound, elastography; first target lesion	0.59	0.59
767X3	Ultrasound, elastography; each additional target lesion	0.50	0.50

The RUC appreciates that CMS is proposing the RUC-recommended work RVU of 0.59 for CPT codes 767X1 and 767X2 and the RUC-recommended work RVU of 0.50 for CPT code 767X3. However, CMS is proposing refinements to the RUC-recommended direct PE inputs for clinical labor and equipment times for the codes in this family. CMS is proposing to add one minute to clinical activity, *Prepare room, equipment and supplies* (CA013) and to remove 1 minute from clinical activity *Confirm order, protocol exam* (CA014) activity for CPT codes 767X1 and 767X2. CMS' reason for this refinement is inaccurate and the RUC strongly encourages CMS to reverse this proposal. The RUC requests that CMS remove the minute of clinical staff time that was added to CA013 to maintain a standard of 2 minutes for that clinical activity and accept 1 minute of clinical staff time as originally recommended by the RUC for CA014 to maintain a standard of 1 minute for that clinical activity. Please see an explanation of this request under Standardization of Clinical Labor Tasks in the Practice Expense section of this comment letter. **For the RUC's comments on individual refinements of direct PE inputs please see the attached refinement table.**

(41) Ultrasound Exam – Scrotum (CPT code 76870)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
76870	Ultrasound, scrotum and contents	0.64	0.64

CMS proposes to accept the RUC recommended work RVU of 0.64 for CPT code 76870. However, CMS is proposing refinements to direct PE inputs from this service(s) CMS is removing 1 minute from clinical activity, *Confirm order, protocol exam* (CA014) and adding 1 minute to clinical activity, *Prepare room, equipment and supplies* (CA013). CMS' reason for this refinement is inaccurate and the RUC strongly encourages CMS to reverse this proposal. The RUC requests that CMS remove the minute of clinical staff time that was added to CA013 to maintain a standard of 2 minutes for that clinical activity and accept 1 minutes of clinical staff time as originally recommended by the RUC for CA014 to maintain a standard of 1 minute for that clinical activity. Please see an explanation of this request under Standardization of Clinical Labor Tasks in the PE section of this comment letter.

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

(42) Contrast-Enhanced Ultrasound (CPT codes 76X0X and 76X1X)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
76X0X	**Ultrasound, targeted dynamic microbubble sonographic contrast characterization (non-cardiac); initial lesion**	**1.27**	**1.62**
76X1X	Ultrasound, targeted dynamic microbubble sonographic contrast characterization (non-cardiac); each additional lesion with separate injection (List separately in addition to code for primary procedure)	0.85	0.85

The RUC thanks CMS for accepting the recommended work RVU of 0.85 for CPT code 76X1X. For CPT code 76X0X *Ultrasound, targeted dynamic microbubble sonographic contrast characterization (non-cardiac); initial lesion*, CMS disagrees with the RUC recommended work RVU of 1.62 and is proposing a work RVU of 1.27, the survey 25th percentile. CMS did not agree with the RUC selected crosswalk, CPT code 73719 *Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less (List separately in addition to code for primary procedure)* (work RVU = 1.62, 20 minutes intra-service time), stating that it is among the highest potential crosswalks.

Although the RUC understands that CMS is proposing the 25th percentile, the RUC urges CMS to consider the intensity and complexity of this service, as well as the fact that it is new technology. The assumption by CMS that a code cannot be at the high end of the range of values for a given intra-service time is an example of discounting the importance of intensity in valuing physician services in favor of

considering only time. CMS cites that the RUC agreed with the survey 25th percentile for the add-on code; however, the RUC reviews the physician work, intensity and complexity for each code separately and uses its clinical expertise to determine a services' relativity among other services. Simply because the RUC agreed with one data point for one code does not mean that the same data point is appropriate for all codes in a family. The RUC **unanimously approved** a work RVU of 1.62 for CPT code 76X0X. The RUC agreed with the specialty society that the 25th percentile of 1.27 undervalues the work required to perform this service. The RUC agreed that the population receiving the service is more complex given that the codes are used for patients with lesions in solid organs who cannot have standard contrast enhanced CT or MRI studies. The specialty does not anticipate these exams to replace CT or MRI studies but rather to be used as a problem-solving tool for appropriate patients. The RUC compared 76X0X to CPT code 93306 *Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography* (work RVU = 1.50 and 20 minutes intra-service time), which only has a work RVU of 1.50 and noted that the survey code is appropriately valued higher given the hands-on work involved in assessing the flow of contrast within the lesion in real time while scanning the patient with ultrasound and coordinating multiple physiologic variables. If CMS implements the proposal at 1.27, this additional work would not be accounted for appropriately. Contrast Enhanced Ultrasound (CEUS) is a new technology that requires more technical skill and time than other established ultrasound services. Survey respondents with little experience performing the service may over or under value the time and work involved. In this case the survey respondents undervalued the service. Additionally the RUC reminds CMS that these services will be placed on the New Technology/New Services list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions. The expectation is that as the service is performed more frequently and physician experience increases, the time to perform the procedure and RVU will appropriately decrease. **The RUC urges CMS accept a work RVU of 1.62 for CPT code 76X0X.**

Practice Expense

CMS is proposing refinements to the RUC-recommended direct PE inputs for the codes in this family. In their refinements to direct PE inputs from this service(s) CMS is removing 1 minute from clinical activity, *Confirm order, protocol exam* (CA014) and adding 1 minute to clinical activity, *Prepare room, equipment and supplies* (CA013). CMS' reason for this refinement is inaccurate and the RUC strongly encourages CMS to reverse this proposal. The RUC requests that CMS remove the minute of clinical staff time that was added to CA013 to maintain a standard of 2 minutes for that clinical activity and accept 1 minutes of clinical staff time as originally recommended by the RUC for CA014 to maintain a standard of 1 minute for that clinical activity. **Please see an explanation of this request under Standardization of Clinical Labor Tasks in the Practice Expense section of this comment letter.**

Additionally, the RUC agrees that SL180, which is used to flush the intravenous lines before and after the injection of the contrast agent, can be replaced with "normal saline", however the change was not made because an appropriate replacement could not be identified. When looking at the PE refinements, the RUC observes that SL180 *phosphate buffered saline (PBS)* is removed but "normal saline" has not replaced it. The RUC agrees that the change is appropriate and urges CMS to add the correct supply item for the appropriate type of saline. **For the RUC's comments on individual refinements of direct PE inputs please see the attached refinement table.**

(43) Magnetic Resonance Elastography (CPT code 76X01)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
76X01	**Magnetic resonance (eg, vibration) elastography**	**1.10**	**1.29**

For CPT code 76X01 *Magnetic resonance (eg, vibration) elastography,* CMS disagrees with the RUC-recommended work RVU of 1.29 and is proposing a work RVU of 1.10 based on a crosswalk to CPT code 71250 *Computed tomography, thorax; without contrast material* (work RVU = 1.16). CMS states that the work involved in code 71250 and the survey code are similar. However, the RUC recommended work RVU of 1.29 is based on the survey 25th percentile. The RUC **unanimously approved** a work RVU of 1.29 for CPT code 76X01. CMS also states that "using the RUC selected two top reference CPT codes as a point of comparison, the intra-service time ratio in both instances suggests that a work RVU closer to 1.10 would be more appropriate." The RUC would like to clarify that when the RUC uses the term "crosswalk" it means that the two services have identical intra-service time and should be valued identically. By this definition CPT code 71250 is not a crosswalk, but rather what the RUC refers to as a reference code. Please refer to our comments on "RUC Survey Process, Reference Services and Crosswalks" in the introduction of this section.

Despite the stated crosswalk rationale, CMS is using the intra-service time ratios between the survey code and the two top reference services, CPT codes 74183 *Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s), followed by with contrast material(s) and further sequences* (work RVU = 2.20, 30 minutes intra-service time) and 74181 *Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s)* (work RVU = 1.46, 20 minutes intra-service time) to derive the proposed work RVU of 1.10. This is not a valid methodology in which to value services. CMS states that the RUC selected the two top reference services; however these services were selected by the survey respondents as a service that they are familiar with and are most similar to the surveyed code. Within the set of radiology codes with intra-service time of 15 minutes and total times from 20-30 minutes, there is a range of RVUs from 0.67 to 1.50. The higher end of this range are MRI codes, including 70548 *Magnetic resonance angiography, neck; with contrast material(s)* (work RVU = 1.50) and 73718 *Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s)* (work RVU = 1.35). Both of these codes have higher values than that recommended for code 76X01 at 1.29 work RVUs. To decrease code 76X01 to 1.10 based on a methodologically inappropriate time ratio creates rank order problems by valuing an intense MRI procedure less than a comparable CT procedure such as code 74160 *Computed tomography, abdomen; with contrast material(s)* (work RVU = 1.27). Rather than using time ratios, CMS should examine the magnitude estimation between the physician work, time and intensity. Please refer to our comments on "Inappropriate Physician Time Ratio Calculations" in the introduction of this section. Furthermore, this approach, when used in place of the survey 25th percentile, is antithetical to the rationale that CMS has laid out in other proposed work RVU changes in this rule. For example, for CPT code 76X0X CMS proposes a change from a RUC recommended value between the 25th percentile and median to the survey 25th percentile. It is unclear why CMS is proposing to ignore the survey data in this case. **The RUC urges CMS accept a work RVU of 1.29 for CPT code 76X01.**

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

(44) Computed Tomography (CT) Scan for Needle Biopsy (CPT code 77012)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
77012	Computed tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation	1.50	1.50

CMS proposes to accept the RUC recommended work RVU of 1.50 for CPT code 77012. However, CMS is proposing refinements to direct PE inputs from this service(s) CMS is removing 1 minute from clinical activity, *Confirm order, protocol exam* (CA014) and adding 1 minute to clinical activity, *Prepare room, equipment and supplies* (CA013). CMS' reason for this refinement is inaccurate and the RUC strongly encourages CMS to reverse this proposal. The RUC requests that CMS remove the minute of clinical staff time that was added to CA013 to maintain a standard of 2 minutes for that clinical activity and accept 1 minutes of clinical staff time as originally recommended by the RUC for CA014 to maintain a standard of 1 minute for that clinical activity. The RUC also disagrees with CMS applying the RS&I standard room time for angiographic rooms to CT guidance. The room time is included in CT guidance, as it is in US guidance (76942) because that is the room the procedure is performed in. Please see an explanation of this request under Standardization of Clinical Labor Tasks in the PE section of this comment letter.

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

(46) Breast MRI with Computer-Aided Detection (CPT codes 77X49-77X52)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
77X49	**Magnetic resonance imaging, breast, without contrast material; unilateral**	**1.15**	**1.45**
77X50	**Magnetic resonance imaging, breast, without contrast material; bilateral**	**1.30**	**1.60**
77X51	**Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD- real time lesion detection, characterization and pharmacokinetic analysis) when performed; unilateral**	**1.80**	**2.10**

77X52	**Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD- real time lesion detection, characterization and pharmacokinetic analysis) when performed; bilateral**	**2.00**	**2.30**

For the Breast MRI with Computer-Aided Detection codes (77X49- 77X52), CMS has disagreed with the RUC recommended work RVUs for all four codes. CMS is proposing to decrease the work RVU from 1.45 to 1.15 for code 77X49, 1.60 to 1.30 for code 77X50, 2.10 to 1.80 for code 77X51, and 2.30 to 2.00 for code 77X52. CMS believes that their pick of alternate work RVUs more closely aligns with the valuation of these codes than the RUC recommended. However, the RUC recommended work RVUs for codes 77X49-77X52 are all based on survey 25th percentile data. CMS should use valid survey data in establishing the work RVUs for these four codes. The RUC thoroughly analyzed this family of codes by review of the history, survey data and magnitude estimation to other similar services. The RUC **unanimously approved** the work RVUs for all four services in this family and urges CMS to accept the RUC recommended values. Details on why CMS should accept the RUC recommendations for this family of codes are outlined below.

77X49

For CPT code 77X49, the RUC recommended a work RVU of 1.45 based on the survey 25th percentile. CMS disagrees with the RUC recommended work RVU of 1.45 and is proposing a work RVU of 1.15 based on a crosswalk to CPT code 77334 *Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)* (work RVU = 1.15, 30 minutes intra-service time, and 35 minutes of total time).

CMS is proposing a work RVU of 1.15 for code 77X49 and also notes an intra-service time ratio with deleted code 77058, not code 74177 as is misstated in the *Proposed Rule*. Code 74177 is the key reference service (KRS). Moreover, the RUC thoroughly provided compelling evidence that these services involve different physician work than the old codes. CMS should not compare these new services with the old deleted services as it is incorrect. The work involved in the breast MRI code family has fundamentally changed and met the compelling evidence standard, further evidence that this time comparison is not supported. To decrease the work RVU of code 77X49 to 1.15 based on a methodologically inappropriate time ratio creates profound rank order problems by valuing this service significantly less than other comparable MRI procedures. Valuing services by using an incremental approach in lieu of valid survey data and supportive relative reference services is unjustified. The RUC strongly disagrees with CMS' statement that the reduced intra-service and total times in code 77X49 in comparison to deleted code 77058 should result in a lower work value. CMS' argument is flawed because predecessor code 77058 cannot be used as a comparison for code 77X49. They are different procedures used on different patients. Code 77058 was used to cover a varied population of patients having either a unilateral breast MRI without contrast, a unilateral breast MRI with contrast, or a unilateral breast MRI with and without contrast. This set of patients has now been broken out into two different codes (77X49 and 77X51, which bundles in CAD). Therefore, the prior time is invalid not only because the procedure it is based upon is different than the one that is currently being compared, but its values also date from the First Five-Year Review (1995). As such, it has only had a total time, with no indication of the service periods. The RUC does not consider these time comparisons directly comparable for valuing current services. As a result, these codes are not used in reference service lists or as key reference services.

CMS has proposed a work RVU of 1.15 for code 77X49 by cross-walking this service with code 77334. The comparison code (77334) chosen by CMS is also incongruous. The two codes being compared are

performed by different physicians on entirely different patient populations. Moreover, code 77334 has no pre-service time, it is a service reported with multiple other services and has a different intra-service time. Additionally, the services performed in code 77334 have varying intensity with significant low intensity time spent moving around the patient and positioned external equipment, as opposed to code 77X49, which is similar to other radiological exams with its fairly uniform high intensity work throughout the intra-service period. For these reasons, it is reasonable for these two codes to have different work values and it is apparent that code 77334 was chosen only because the work value was similar to that achieved by using a time ratio without consideration to its accuracy as a crosswalk.

The RUC strongly recommends the work RVU of 1.45 for code 77X49, which is the survey 25th percentile from robust survey results and strongly supported by favorable comparison to reference codes. **The RUC urges CMS to accept a work RVU of 1.45 for CPT code 77X49.**

77X50

For CPT code 77X50, the RUC recommended a work RVU of 1.60 based on survey 25th percentile data. CMS disagrees with the RUC recommended work RVU of 1.60 and is proposing a work RVU of 1.30 for code 77X50 based on adding the increment of the RUC recommended values for 77X49 and 77X50 to the CMS proposed value for 77X49. CMS accepts the RUC work RVU increments, yet disagrees with the RUC recommended work RVU for code 77X50. The Agency argues that it is appropriate to reduce the work RVU for the unilateral procedure based on the value proposed by the RUC, yet the Agency also believes it is appropriate to recalibrate the work RVU for code 77X50 relative to the RUC's recommended difference in work between this code and base code 77X49. This is a flawed valuation methodology and should not be applied to code 77X50 or any other code in the family. For the reasons stated in the comments provided for code 77X49, the RUC strongly disagrees with CMS' proposed value for base code 77X49. Therefore, the RUC also does not agree with the subsequently adjusted values for codes 77X50, 77X51, and 77X52 which were derived by increments from the adjusted value of base code 77X49. It is imperative that RUC survey data must be used to correctly value this code. Using an incremental approach in lieu of survey data, strong crosswalks, and input from the RUC and physicians providing these services is unjustified. CMS does not provide any supporting rationale to the proposed work RVU other than the incremental difference between codes.

The RUC strongly recommends the work RVU of 1.60 for code 77X50, which is the survey 25th percentile from robust survey results and strongly supported by favorable comparison to reference codes. **The RUC urges CMS to accept a work RVU of 1.60 for CPT code 77X50.**

77X51

For CPT code 77X51, the RUC recommended a work RVU of 2.10 based on survey 25th percentile data. CMS disagrees with the RUC recommended work RVU of 2.10 and is proposing a work RVU of 1.80 for code 77X51 based on adding the increment of the RUC recommended values for codes 77X49 and 77X51 to the CMS proposed value for 77X49. The Agency argues that it is appropriate to reduce the work RVU for this procedure based on the value proposed by the RUC, yet the Agency also believes it is appropriate to recalibrate the work RVU for code 77X51 relative to the RUC's recommended difference in work value between this code and base code 77X49. However, this is a flawed valuation methodology and should not be applied to code 77X51 or any other code in the family. For the reasons stated in the comments provided for code 77X49, the RUC strongly disagrees with CMS' proposed value for base code 77X49. Therefore, the RUC also does not agree with the subsequently adjusted values for codes 77X50, 77X51, and 77X52 which were derived by increments from the adjusted value of base code 77X49. It is imperative that RUC survey data must be used to correctly value this code. Using an incremental approach in lieu of survey data, strong crosswalks, and input from the RUC and physicians

providing these services is unjustified. CMS does not provide any supporting rationale to the proposed work RVU other than the incremental difference between codes.

The RUC strongly recommends the work RVU of 2.10 for code 77X51, which is the survey 25th percentile from robust survey results and strongly supported by favorable comparison to reference codes. **The RUC urges CMS to accept a work RVU of 2.10 for CPT code 77X51.**

77X52

For CPT code 77X52, the RUC recommended a work RVU of 2.30 based on survey 25th percentile data. CMS disagrees with the RUC recommended work RVU of 2.30 and is proposing a work RVU of 2.00 for code 77X52 based on adding the increment of the RUC recommended values for 77X49 and 77X52 to the CMS proposed value for 77X49. The Agency argues that it is appropriate to reduce the work RVU for the procedure based on the value proposed by the RUC, yet the Agency also believes it is appropriate to recalibrate the work RVU for code 77X52 relative to the RUC's recommended difference in work between this code and base code 77X49. However, this is a flawed valuation methodology and should not be applied to code 77X52 or any other code in the family. For the reasons stated in the comments provided for code 77X49, the RUC strongly disagrees with CMS' proposed value for base code 77X49. Therefore, the RUC also does not agree with the subsequently adjusted values for codes 77X50, 77X51, and 77X52 which were derived by increments from the adjusted value of base code 77X49. It is imperative that RUC survey data must be used to correctly value this code. Using an incremental approach in lieu of survey data, strong crosswalks, and input from the RUC and physicians providing these services is unjustified. CMS does not provide any supporting rationale to the proposed work RVU other than the incremental difference between codes.

The RUC strongly recommends the work RVU of 2.30 for code 77X52, which is the survey 25th percentile from robust survey results and strongly supported by favorable comparison to reference codes. **The RUC urges CMS to accept a work RVU of 2.30 for CPT code 77X52.**

Practice Expense

In the *Proposed Rule*, CMS indicated that they did not receive invoices for the five new equipment items requested for 77X51 and 77X52: CAD Server (ED057), CAD Software (ED058), CAD Software - Additional User License (ED059), Breast coil (EQ388), and CAD Workstation (CPU + Color Monitor) (ED056). If the invoices were not submitted to CMS, this may have been an oversight and they are enclosed with this letter (*attachment 04*). CAD Software (ED058) is actually synonymous with the "breast biopsy software" (EQ370), included in breast biopsy codes 19085 and 19086. In hindsight, we should have been consistent in identifying the equipment item between the breast biopsy codes and the MR breast codes. The RUC agrees with CMS's proposal to update the name for EQ370 to "Breast MRI computer aided detection and biopsy guidance software." The RUC disagrees that CMS' statement that "Prepare room, equipment and supplies" (CA013) traditionally had 3 minutes of clinical labor time is accurate. This activity has always had 2 minutes of standard time. The 1 minute for "Confirm order, protocol exam" (CA014) is a separate clinical activity. The RUC requests that CMS make corrections to the practice expense inputs where they made adjustments to the clinical labor time for "prepare room, equipment and supplies" and "confirm order, protocol exam." In their refinements to direct PE inputs from this service(s) CMS is removing 1 minute from clinical activity, *Confirm order, protocol exam* (CA014) and adding 1 minute to clinical activity, *Prepare room, equipment and supplies* (CA013). CMS' reason for this refinement is inaccurate and the RUC strongly encourages CMS to reverse this proposal. The RUC requests that CMS remove the minute of clinical staff time that was added to CA013 to maintain a standard of 2 minutes for that clinical activity and accept 1 minutes of clinical staff time as originally recommended by the RUC for CA014 to maintain a standard of 1 minute for that clinical

activity. Please see an explanation of this request under Standardization of Clinical Labor Tasks in the PE section of this comments letter. **For the RUC's comments on individual refinements of direct PE inputs, please see the attached practice expense refinement table.**

(47) Blood Smear Interpretation (CPT code 85060)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
85060	**Blood smear, peripheral, interpretation by physician with written report**	**0.36**	**0.45**

For CPT code 85060 *Blood smear, peripheral, interpretation by physician with written report,* CMS disagrees with the RUC recommended work RVU of 0.45 and is proposing a work RVU of 0.36 based on the time ratio between the current and survey intra-service time. The difference of three minutes between the current and survey intra-service time for code 85060 does not constitute a "significant decrease" as CMS states. Especially when examining such a small amount of time, a time ratio should not be used because any decrease will result in a large ratio and a corresponding but inappropriate decrease to the physician work RVU. Rather than using time ratios CMS should examine the magnitude estimation between the physician work, time and intensity. The RUC **unanimously approved** a work RVU of 0.45 for CPT code 85060. Additionally, the current time is CMS/Other, which means that the time was not based on a survey and it's unclear how the time was determined. CMS/Other time has historically been deemed invalid through the RUC process. The flawed methodology of constructing a time ratio to determine work value in a relative value scale is especially flawed when the ratio is between CMS/Other time source and survey data. Please refer to our comments on "Inappropriate Physician Time Ratio Calculations" in the introduction of this section.

CMS states that the recommended work value of 0.45 is higher than "nearly all of the other global XXX codes with similar time values." A search of the RUC database contradicts this finding showing that eleven XXX codes with 12 minutes of intra-service time have values lower than 0.45 and thirteen XXX codes with 12 minutes of intra-service time have values the same or higher than 0.45 RVUs. None of these services are pathology services and are not comparable, except for CPT code 88388 *Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); in conjunction with a touch imprint, intraoperative consultation, or frozen section, each tissue preparation (eg, a single lymph node) (List separately in addition to code for primary procedure)* (work RVU = 0.45 and 12 minutes intra-service time), which has identical work value and intra-service time and was the reference code cited in the RUC recommendation. The "crosswalk" service that CMS compared the survey code to, CPT code 95930 *Visual evoked potential (VEP) checkerboard or flash testing, central nervous system except glaucoma, with interpretation and report* (work RVU = 0.35 and 10 minutes intra-service time), is not a pathology service and describes the physician work to perform a vision test whereas code 85060 describes comparing blood samples, lab results and review of a blood smear under the microscope to determine the features of the red blood cells, white blood cells, and platelets.

The work value that the CMS proposes would create significant rank order anomalies within the array of pathology services. When a pathologist performs this service, there are a number of variables that must be considered in the evaluation of a blood smear when compared to others, including red blood cell count, size and morphology, platelet morphology and number, white blood cell morphology and the presence of white

blood cell precursors. The diagnostic considerations of an abnormal complete blood cell count ("CBC") are remarkably diverse, including a wide gamut of causes for anemias, multiple types of acute and chronic leukemias, and platelet disorders. Obviously, evaluation of all patients who have peripheral blood abnormalities must be based on multiple clinical factors, including age. To assess the significance of the peripheral smear morphologic features, correlation to the CBC results and consideration of the patient's condition as reflected in their medical record is necessary.

A comparison of codes 85060 to 95930 is difficult and inappropriate, as code 95930 has pre and post service time and 2 minutes less intra-service time, it is clearly appropriately valued less than the RUC recommended work value of 0.45 for CPT code 85060. The work value CMS proposes would present significant rank order anomalies within the array of pathology services. When a pathologist performs this service, there are a number of variables that must be considered in the evaluation of a blood smear when compared to others. These variables include, red blood cell count, size, shape and morphology, platelet morphology and number, white blood cell morphology and the presence of white blood cell precursors. The diagnostic considerations of an abnormal complete blood cell count (CBC) are remarkably diverse including a wide gamut of causes for anemias, multiple types of acute and chronic leukemias and platelet disorders. Additionally, all patients that have peripheral blood abnormalities must be considered dependent on multiple clinical factors including age. To assess the significance of the peripheral smear morphologic features, correlation to the CBC results and a careful review of the patient's medical record is necessary.

The survey results for CPT code 85060 were reviewed by an expert panel of pathologists, including many who perform the service. The expert panel agreed that the survey results, although robust, overestimated the physician work of a peripheral blood smear interpretation. The expert panel, considering the total work, time, intensity, and complexity of the patient case, agreed that the current work RVU of 0.45 is appropriate for CPT code 85060. Again, CPT code 85060 has "CMS/Other" time, which was not from any physician survey, and it has never been determined how it was derived nor what it represents. It is therefore <u>not</u> appropriate to compare the survey time to the current CMS/Other time. The RUC agreed that the median surveyed time is representative of the physician work involved in the service. The panel agreed that the survey respondents overestimated the physician work RVU (median WRVU = 0.75) and therefore they agreed the physician work RVU for 85060 should be maintained with the current value of 0.45 with the survey median time of 12 minutes.
Other services with identical physician work are code 88314 *Special stain including interpretation and report; histochemical stain on frozen tissue block (List separately in addition to code for primary procedure)* (work RVU = 0.45, 13 minutes total time) and code 93923 *Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, 3 or more levels (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental blood pressure measurements with bidirectional Doppler waveform recording and analysis, at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental volume plethysmography at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental transcutaneous oxygen tension measurements at 3 or more levels), or single level study with provocative functional maneuvers (eg, measurements with postural provocative tests, or measurements with reactive hyperemia)* (work RVU= 0.45, 16 minutes total time).

Finally, the RUC would like to clarify that when the RUC uses the term "crosswalk" it means that the two services have identical intra-service time and should be valued identically. By this definition CPT code 95930 is not a crosswalk, but rather what the RUC refers to as a reference code and the other codes that CMS cites as "crosswalks," CPT codes 99152 and 93923, are also reference codes. **Please refer to our**

comments on "RUC Survey Process, Reference Services and Crosswalks" in the introduction of this letter. The RUC urges CMS accept a work RVU of 0.45 for CPT code 85060.

(48) Bone Marrow Interpretation (CPT code 85097)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
85097	**Bone marrow, smear interpretation**	**0.94**	**1.00**

For CPT code 85097, CMS disagrees with the RUC recommended work RVU of 1.00 and is proposing a work RVU of 0.94 based on the current work value. CMS states that "…significant decreases in time should be reflected in decreases to work RVUs," however this argument is out of place in this context because the survey respondents indicate that the service requires 25 minutes to perform rather than the current time of 30 minutes, yet CMS proposes to maintain the current work value. Additionally, the current time is CMS/Other, which means that the time was not based on a survey and the code was not reviewed by the Harvard studies or through the RUC process. CMS/Other codes were gap-filled for physician work and time, most often via crosswalk to some other servie by CMS. It is actually unknown how this time was determined and what it actually represents. CMS/Other time has historically been deemed invalid. It is completely invalid to compare the old CMS/Other time to current survey data obtained from physicians who regularly perform this service. The RUC agreed with the specialty that incorrect assumptions were made in the previous valuation of this service because it was based on a crosswalk of indeterminate significance by CMS. The RUC also agreed with the specialty that it is not appropriate to compare the surveyed time to the current CMS/Other time, as CMS/Other time is of unknown significance and must therefore be considered quantitatively invalid.

The RUC agreed with the specialty that given the total work, time, intensity, and complexity of the patient case, the current work RVU of 0.94 was too low for the physician work involved. The RUC chose the crosswalk to CPT code 88121 *Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; using computer-assisted technology* (work RVU = 1.00 and 25 minutes intra-service time), specifically because it is a similar pathology code with a value between the current work value of 0.94 and the survey 25th percentile of 1.15. The RUC **unanimously approved** a work RVU of 1.00 for CPT code 85097. The "crosswalk" service that CMS compared the survey code to, CPT code 88361 *Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, per specimen, each single antibody stain procedure; using computer-assisted technology* (work RVU = 0.95 and 25 minutes intra-service time) is less intense and complex to perform. The physician work involved in code 88361 is evaluating a single antibody and determining the percentage of tumor cells that are positive for that antibody. For code 85097, the work involves evaluating all blood cell precursors for quantitative and morphologic abnormalities, as well as evaluating for metastatic tumor cells, evidence of infection (e.g.. granulomas), or evidence of lymphoid neoplasms (e.g., lymphoma, myeloma), on multiple smears. Additionally, the end result of the work of code 88361 is a numerical score. In contrast, the end result of code 85097 is often an interpretation with a clinically actionable diagnosis. This is clearly much more complex and intense than code 88361. Finally, the RUC would like to clarify that when the RUC uses the term "crosswalk," it means that the two services have identical intra-service time and should be valued identically. By this definition, CPT code 88361 is not a crosswalk but rather what the RUC refers to as a

reference code because the work value is 0.95, not 0.94 CMS is proposing. Please refer to our comments on "RUC Survey Process, Reference Services and Crosswalks" in the introduction of this section.

CMS states "We also considered a work RVU of 0.90 based on double the recommended work RVU of 0.45 for CPT code 85060 *Blood smear, peripheral, interpretation by physician with written report*. When both of these CPT codes were under review, the explanation was offered that in a peripheral blood smear, typically, the practitioner does not have the approximately 12 precursor cells to review, whereas in an aspirate from the bone marrow, the practitioner is examining all the precursor cells. Additionally, for CPT code 85097, there are more cell types to look at as well as more slides, usually four, whereas with CPT code 85060 the practitioner would typically only look at one slide. While we do not propose to value CPT code 85097 at twice the work RVU of CPT code 85060, we believe this analysis also supports maintaining the current work RVU of 0.94 as opposed to raising it to 1.00." The RUC wishes to clarify that this explanation was put forward to a RUC member whom was simply asking why this service requires twice the time of CPT code 85060 *Blood smear, peripheral, interpretation by physician with written report.* Simply doubling the RUC recommended work RVU of 0.45 for code 85060 based on the amount of time does not account for the considerably greater intensity and complexity of code 85097 over code 85060 described in the explanation above. **The RUC urges CMS to accept a work RVU of 1.00 for CPT code 85097.**

Practice Expense

For the direct PE inputs the RUC urges CMS to consider pathology clinical staff activities apart from the standard practice expense clinical activities, in fact that is the exact reason that the PE Subcommittee determined that separate and distinct pathology clinical activity codes were needed when the PE Spreadsheet Update Workgroup developed the codes for clinical activities. Although the RUC understands that the clinical activity description for PA001 *accession and enter information* and PA008 *file specimen, supplies and other materials* appear to describe data entry and filing activities, these tasks are *very* different in the pathology lab. These clinical activities are integral elements performed by health care professionals in order to analyze a specimen and are not administrative tasks that go into the indirect practice expense. The RUC assures CMS that these clinical activities are allocable to a particular patient for this service and should not be considered a form of indirect expense. **The RUC urges CMS to accept direct practice expense clinical activity inputs, PA001 and PA008, for CPT code 85097.**

(50) Electroretinography (CPT codes 92X71, 92X73, and 03X0T)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
92X71	**Electroretinography (ERG) with interpretation and report; full field (eg, ffERG, flash ERG, Ganzfeld ERG)**	**0.69**	**0.80**
92X73	**Electroretinography (ERG) with interpretation and report; multifocal (mfERG)**	**0.61**	**0.72**
03X0T	Electroretinography (ERG) with interpretation and report, pattern (PERG)	0.40	N/A

92X71

For CPT code 92X71, CMS disagrees with the RUC recommended work RVU of 0.80 and are proposing a work RVU of 0.69 based on a direct crosswalk to CPT code 88172 *Cytopathology, evaluation of fine*

needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site (work RVU = 0.69). CMS states it believes that code 88172 is a more accurate comparison code than the RUC's reference services. However, the RUC recommended work RVU of 0.80 is based on the survey 25th percentile. CMS should use the valid survey data in establishing the work RVU for CPT code 92X71. The RUC noted that the decrease in intra-service time of deleted code 92275 from when it was last surveyed in 1995 is because the physician no longer participates in the acquisition of the data or performing the test on the patient, which is the technician's work. The RUC determined that the physician work is not the same as it was with code 92275 and the recommended decrease in work RVUs appropriately addresses the decrease in physician time to perform this service.

While the time required for code 92X71 is less than the time required for code 92275, the code it replaced, the intensity and complexity of the work involved in interpreting the test has increased significantly. The newer machines are easily programmed to produce more images and numbers for interpretation (double or more) than the machines in use in 1995 when the procedure was last valued. In addition, advances in medical knowledge have identified more specific retinal dystrophy diagnoses with specific genotypes that the clinician must consider when interpreting the test and formulating advice regarding further testing, patient counseling, and genetic testing to communicate to the referring physician. While the machine may be more efficient, as CMS states, the cognitive work required by the physician interpreting the test has increased significantly. This is why the work value of the code has increased: the intensity and complexity of the work has increased significantly since 1995. This is reflected in the survey results, which showed a median work value of 1.00, almost identical to the value of the replaced ERG code, 92275, and which showed greater intensity and complexity values than either of the reference service codes. This data, derived from clinicians who perform the test, was carefully reviewed by clinicians on the RUC was supported by similar service CPT 92242 *Fluorescein angiography and indocyanine-green angiography (includes multiframe imaging) performed at the same patient encounter with interpretation and report, unilateral or bilateral* (work RVU = 0.95 and intra-service time of 20 minutes) as properly representative of the physician work required for code 92X71. **The RUC urges CMS to accept a work RVU of 0.80 for CPT code 92X71.**

92X73

For CPT code 92X73, CMS disagrees with the RUC recommended work RVU of 0.72 and are proposing a work RVU of 0.61 based on a crosswalk to CPT code 92100 *Serial tonometry (separate procedure) with multiple measurements of intraocular pressure over an extended time period with interpretation and report, same day (eg, diurnal curve or medical treatment of acute elevation of intraocular pressure)* (work RVU = 0.61 and 20 minutes intra-service time). CMS proposed to take the incremental difference of 0.08 work RVUs between codes 92X71 and 92X73 to arrive at a work RVU for code 92X73. The RUC urges CMS to use valid methods of evaluating services instead of using an increment. The RUC recommendations were based on valid survey data, not on an incremental difference in work RVUs between codes 92X71 and 92X73. The RUC used magnitude estimation to value these services comparing the physician work, time, intensity and complexity and CMS should not pick out the increment to go forward with valuing this service. The RUC recommended the survey 25th percentile work RVU of 0.72 and 1 minute pre-time, 19 minutes intra-service time and 1 minute post-service time. The RUC also accounted for efficiencies because this service is typically reported with an Evaluation and Management (E/M) service. The RUC noted that the pre and post-times were significantly reduced from the survey time to ensure there is no overlap in physician work associated with the E/M included in this service. The 2 minutes of total pre and post-time are for the physician to explain the exam and findings to the patient.

While there is no predecessor code for direct comparison, the intensity and complexity of the work involved in interpreting the test has increased significantly compared to 1995, when CPT code 92275 was

last valued. As noted in our comments on CPT code 92X71, the newer machines are easily programmed to produce more images and numbers for interpretation (double or more) than the machines in use in 1995. The clinician must consider more specific retinal dystrophy diagnoses with specific genotypes when interpreting the test and formulating advice regarding further testing, patient counseling, and genetic testing to communicate to the referring physician. The cognitive work required by the physician interpreting the test has increased significantly. This is reflected in the survey results, which showed a median work value within 0.07 work RVUs of the value of the replaced ERG code 92275. The RUC provided appropriate references services supporting a work RVU of 0.72 for CPT code 92X73. The RUC compared code 92X73 to similar service code 92235 *Fluorescein angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral* (work RVU = 0.75 and 15 minutes intra-service time) and noted that CPT code 92X73 is slightly less intense and complex to perform than code 92235, therefore is valued lower. The RUC also referenced similar service, CPT code 77333 *Treatment devices, design and construction; intermediate (multiple blocks, stents, bite blocks, special bolus)* (work RVU = 0.75 and 20 minutes total time). The RUC recommended work RVU of 0.72 maintains rank order with code 92X71 and is based on survey data derived from clinicians who perform the test after careful review by physicians on the RUC. The value accounts for both time and intensity of work.

CPT code 92X73 requires more physician work than the crosswalks CMS proposes. CPT code 88387 *Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); each tissue preparation (eg, a single lymph node)* (work RVU = 0.62) is a straightforward manual dissection that does not require interpretation of multiple images and numeric values to arrive at a diagnosis from amongst multiple possibilities. This is reflected in the survey intensity and complexity metrics being greater than or similar to the key reference codes chosen, and the fact that both key reference codes, because of the greater cognitive work required, are more intense than code 88387. Additionally, CPT code 92100 also requires less physician work. CPT code 92X73 requires interpretation of significantly more data and consideration of many more diagnostic possibilities than code 92100. Again, this is reflected in the survey intensity and complexity metrics. **The RUC urges CMS to accept a work RVU of 0.72 for CPT code 92X73.**

Practice Expense

In response to CMS' proposal that there should be no pre-service time in the facility setting, this procedure, when done in a facility, must be scheduled in the operating room, just like an appendectomy or cataract surgery. It is typically done in these settings only when unable to do so in the clinic, such as for children, the cognitively impaired, or for other medical concerns. It takes substantial amounts of time for the staff to accomplish this coordination of care for these higher-needs patients and to ensure that equipment that is not usually part of a typical operating room is made available and/or properly transported and set up for use in the operating room, including passing through equipment processing protocols. Because the procedure and equipment used is not routinely performed in the facility, this coordination of care is significantly in excess of what is typically done in commonly performed minor or major procedures.

CMS proposes to remove clinical staff time for CA009 *Greet patient, provide gowning, ensure appropriate medical records are available* and CA011 *Provide education/obtain consent* as being duplicative with the E/M visit performed on the same day. CA009 is generally removed when a service is reported with E/M however the RUC determined that additional above the E/M time was needed for these complex services. CA011 is not a clinical activity that is performed as part of an E/M service and the time should not be removed. The clinical staff work for this code is completely different than the clinical staff work that is done for an office visit. Although slightly more than 50% of these services are done on the same day as an office visit, the clinical staff time involved is completely divorced from the office visit

and the staff performing the test are different from the staff assisting in the office visit. This machine is housed in a different room, the patient needs to be transported from the ophthalmic exam lane to the ERG room and back, additional instructions are required that are never done during a typical office visit, and the nature of this test requires extra supplies and work in addition to those used for the office visit. The RUC assures CMS that the time included for CA009 and CA011 is not duplicative of the E/M visit. The RUC is careful to remove any duplication with E/M and encourages CMS to accept the direct PE inputs of 3 minutes for CA009 and 1 minute for CA011for both codes.

In the refinements to direct PE inputs from this service(s) CMS is removing 1 minute from clinical activity, *Confirm order, protocol exam* (CA014) and adding 1 minute to clinical activity, *Prepare room, equipment and supplies* (CA013). CMS' reason for this refinement is inaccurate and the RUC strongly encourages CMS to reverse this proposal. The RUC requests that CMS remove the minute of clinical staff time that was added to CA013 to maintain a standard of 2 minutes for that clinical activity and accept 1 minutes of clinical staff time as originally recommended by the RUC for CA014 to maintain a standard of 1 minute for that clinical activity. Please see an explanation of this request under Standardization of Clinical Labor Tasks in the PE section of this comment letter.

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

Regarding CMS' proposed reduction of clinical activity time for CA024 *clean room/equipment by clinical staff*, this is the time that the specialty society found when directly shadowing the process to clean the patient and the equipment. The technician needs to clean the patient's skin, rinse their eyes, and clean around the patient and escort them out. Then the equipment needs to be cleaned. The extremely expensive and delicate eye electrodes (comprised of silver or other precious metals) require a significant amount of time to remove and clean the conductive paste and Goniosol without damaging the electrodes. This needs to be performed after each procedure so that the electrodes can be re-used for the next procedure. There is a significant amount of scrubbing of the patient's skin and the electrode to remove the conductive paste. Also, because the contact lens electrode is applied directly to the conjunctiva (mucous membrane), meticulous mechanical cleaning as well as chemical cleaning of the contact lens electrode are necessary for patient protection and to prevent spread of communicable diseases. There is a strict protocol for the concentration of the cleaning solution and the time to soak. Following the soak, ultrasound sonication is performed and needs to be continuously monitored to ensure that the silver does not get damaged by the sonication process. Following the sonication, the electrodes are manually washed again, and then left to dry. These electrodes are expensive and need re-conditioning every two years at most. If over-exposed in the process of cleaning, their life diminishes due to corrosion, if under-treated, they risk the spread of communicable disease. This process requires meticulous care and a significant amount of technician time.

Regarding CMS' proposed reduction CA030 *Technologist QC's images in PACS, checking for all images, reformats, and dose page*, the RUC disagrees with the decrease. Unlike most radiology centers, the machine used for the ERG codes is not typically integrated into the clinic's electronic medical record. This requires printing all images created by the testing machine and uploading them into the EMR for subsequent review by the physician. It is not unusual for re-printing using a different scale or limits to be necessary following initial physician review, although that was not included in the recommended value because it is not typical. This recommended time is literally what the specialty societies observed directly in their time motion study of typical procedures being performed at two different institutions. It differs from a typical radiology scenario because the procedure is in fact different from a typical imaging study. The recommended time reflects accurate practice.

Regarding CMS' proposed reduction of CA031 *Review examination with interpreting MD/DO*, this input was again calculated by direct observation of typical procedures with a stopwatch. This test is performed in a different room than the office visit, and the technician needs to take time to find the ordering/interpreting physician and review the quality of the gain and results.

Regarding CMS' question regarding equipment item EQ391 *Contact lens electrode for mfERG and ffERG* being listed twice for CPT code 92X71 and only once for CPT code 92X73, this was not an error but was intentional and reflects typical practice. As is described in detail in each of the PE SORs, the ffERG test (92X71) is performed with two contact lenses in place (one in each eye at the same time) in a simultaneous testing fashion. The mfERG test (92X73) is typically performed sequentially one eye at a time, re-using the same contact lens for each eye. This discrepancy is primarily due to the dark and light-adaptation needs for the ffERG, which if done sequentially would double the amount of clinical time. Also, the visual stimuli for the mfERG test require excellent fixation to accurately map the macular response such that monocular testing provides more accuracy. Sequential testing re-using the same contact lens is typical for mfERG (92X73).

(51) Cardiac Output Measurement (CPT codes 93561 and 93562)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
93561	**Indicator dilution studies such as dye or thermodilution, including arterial and/or venous catheterization; with cardiac output measurement**	**0.60**	**0.95**
93562	**Indicator dilution studies such as dye or thermodilution, including arterial and/or venous catheterization; subsequent measurement of cardiac output**	**0.48**	**0.77**

CMS needs to value these services on current valid data and not value these services on old assumptions of physician work and time that were manipulated and have changed. The previous data utilized has zero validity and is incorrect. There are three intertwined flawed assumptions that CMS is considering when proposing values for CPT codes 93561 and 93562, which if finalized will lead to continued mis-valuation of these services.

1. CMS compares the survey data to Harvard data. The current time data is from the Harvard studies, has zero validity and should not be used to compare to current valid survey data. Additionally, there has been a change in patient population since the Harvard studies. These codes were reportable with general cardiac catheterization codes that did not discriminate between non-congenital (typically performed in adults) and congenital (typically pediatric) patient populations. Congenital cardiac catheterization codes were added to CPT in 1998. Therefore, codes 93561 and 93562 were valued based on a non-congenital, adult patient population. Today, CPT codes 93561 and 93562 are only reportable in addition to the congenital cardiac catheter patient population, which are typically pediatric patients. Thus, further justifying that comparing the Harvard time to the current survey time is inaccurate.

2. CMS compares the recommended physician work RVUs to old RVUs, dismissing the history of why the work RVUs were lowered in 2017. CMS states that they are aware that these codes were

previously included in the Appendix G list of codes for which moderate sedation was inherent. Removal of the physician work value for moderate sedation from these adjunct procedures has compounded the negative IWPUT. CPT code 93561 previously had a value of 0.50, which was reduced to 0.25 and CPT code 93562 previously had a value of 0.16, which was reduced to 0.01 because CMS did not create a negative work RVU when it removed 0.25 for moderate sedation. The negative IWPUT confirms that this previous methodology in which the current work RVU was derived from is flawed. However, CMS still is comparing the increase in work RVUs to the existing flawed work RVUs. CMS continues this flawed circular argument to compare decreasing flawed physician times to flawed work RVUs. CMS should not compare the old work RVUs to any new surveyed work RVUS or physician time which has been manipulated and has changed.

3. CMS uses an intra-service time ratio. This inaccurately treats all components of the physician time as having identical intensity and is incorrect. CMS should carefully consider the clinical information justifying the changes in physician work intensity provided by the RUC. Please refer to our comments on "Inappropriate Physician Time Ratio Calculations" in the introduction of this section, for the full rationale on the inaccuracies of using an intra-service time ratio.

93561

For CPT code 93561, CMS disagrees with the RUC recommended work RVU of 0.95 and are proposing a work RVU of 0.60 based on a crosswalk to CPT code 77003 *Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid)* (work RVU = 0.60). Although CPT code 77003 has the same intra-service time as CPT code 93561, it is not a good crosswalk. CPT code 93561 requires more physician work than code 77003. CPT code 77003 is merely the imaging guidance code for needle placement for the epidural injection. Placing a catheter in the heart and lungs of a child is not merely an imaging procedure. A more appropriate injection procedure comparison would be the actual epidural injection procedure code, 62320 *Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance* (work RVU = 1.80), which also has an intra-service time of 15 minutes.

A better comparison is to the top key reference service 93567 *Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for supravalvular aortography (List separately in addition to code for primary procedure)* (work RVU = 0.97 and 15 minutes intra-service), noting that these services require the same physician time and nearly the same physician work. CPT code 93567 is an add-on code that involves placing a catheter into the patient's heart/vessels and is an injection procedure. Although the interpretation of the thermodilution data is a bit more cumbersome than an angiographic interpretation, this would fall under post-procedure, therefore the difference is inconsequential. **The RUC urges CMS to accept a work RVU of 0.95 for CPT code 93561.**

93562

For CPT code 93562, CMS disagrees with the RUC recommended work RVU of 0.77 and are proposing a work RVU of 0.48 based on the intra-service time ratio with CPT code 93561. The survey process values a service compared to other similar services. Using an incremental approach in lieu of strong crosswalks and input from the RUC and physicians providing these services is unfounded. CMS does not provide any rationale to the proposed work RVU other than the incremental difference. The RUC **unanimously approved** the survey 25th percentile work RVU of 0.77 for CPT code 93562 and urges CMS to use valid survey data and supportive relative reference services when valuing services, instead of placing everything in a calculation. The RUC thoroughly discussed the physician work, time, intensity and complexity required to perform code 93562. The RUC compared CPT code 93562 to top key reference

service 93567 *Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for supravalvular aortography (List separately in addition to code for primary procedure)* (work RVU = 0.97 and 15 minutes intra-service), noting that CPT code 93562 requires slightly less physician time and physician work. For additional support the RUC referenced MPC codes 51797 *Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal) (List separately in addition to code for primary procedure)* (work RVU = 0.80 and 15 minutes intra-service time) and 15003 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children (List separately in addition to code for primary procedure)* (work RVU = 0.80 and 15 minutes intra-service time). **The RUC urges CMS to accept a work RVU of 0.77 for CPT code 93562.**

(52) Coronary Flow Reserve (CPT code 93571)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
93571	**Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; initial vessel**	**1.38**	**1.50**
93572	Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; each additional vessel (List separately in addition to code for primary procedure)	1.00	1.00

The RUC thanks CMS for proposing to retain the RUC recommended work RVU of 1.00 for CPT code 93572. However, CMS has proposed to reduce the RUC recommended work RVU from 1.50 to 1.38 for CPT code 93571, an already reduction from the current work value and survey 25th percentile of 1.80.

93571

For CPT code 93571, the RUC recommended a work RVU of 1.50. The RUC strongly recommends a direct crosswalk to CPT code 15136 *Dermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)* (work RVU= 1.50 and intra-service time of 15 minutes). The RUC noted that both services have identical intra-service times and require the same amount of physician work. The RUC also noted the lack of ZZZ global period codes with similar work RVUs and intra-service times as code 93571, and agreed that a crosswalk to code 15136 is very appropriate. CMS disagrees with the RUC recommended work RVU of 1.50 and is proposing a work RVU of 1.38 for code 93571 based on a direct crosswalk to CPT code 61517 *Implantation of brain intracavitary chemotherapy agent (List separately in addition to code for primary procedure)* (work RVU = 1.38 and 15 minutes intra-service time). CMS is proposing a decrease in work RVU for code 93571 because the Agency reduced the work value by the same ratio as the reduction in the total work time. Please refer to our comments on "Inappropriate Physician Time Ratio Calculations" in the introduction of this letter.

CMS is proposing a work RVU of 1.38 for CPT code 93571 using a reverse building block calculation. This flawed methodology ignores the fact that low-intensity time for setup accounts for the total time reduction, making a work RVU reduction proportionate to the time reduction too large. Were CMS to apply the established intensity of 0.0224 for "scrub, dress, and wait" time to the five-minute reduction based on the current work RVU of 1.80, the value would be 1.69. This comparison further justifies a recommended work RVU of 1.50 for code 93571 based on crosswalking this service to a code with identical time. CMS indicates that a work RVU of 1.38 is supported by crosswalking code 93571 to code 61517 *Implantation of brain intracavitary chemotherapy agent (List separately in addition to code for primary procedure)* (work RVU = 1.38 and 15 minutes intra-service time). Despite the reduction in time from 20 minutes to 15 minutes, surveys supported maintenance of the current work RVU of 1.80 for code 93571. The work to perform the measurement of code 93571 has not changed. Rather, the equipment to perform this service and the staff workflow that occurs to perform the measurement once the decision has been made to measure flow reserve has been streamlined. This is a reduction in low intensity waiting time, not the time to actually introduce the catheter wire into the vessels and perform the measurement. The RUC determined that the time reduction still warranted a work RVU reduction from the current work RVU and strongly recommended a crosswalk to code 15136 (work RVU = 1.50). Additionally, the RUC strongly disagrees with the Agency's statement that the reduced intra-service and total times in code 93571 should result in a lower work value than the RUC's recommendation. Also, CMS' recommended crosswalk code 61517 is an old code last reviewed in April 2002 with a utilization of less than 100 claims, which does not make this service a strong crosswalk to value code 93571.

The RUC strongly recommends the work RVU of 1.50 which is below the current work value and also below the survey 25th percentile for code 93571. The RUC's recommendation for this code will still result in an overall work savings that should be redistributed back to the Medicare conversion factor. The RUC agreed that for code 93571, the work RVU should be directly crosswalked to code 15136, noting specifically that the crosswalk code involves an identical amount of both intra-service and total time as well as a similar amount of physician work, undoubtedly supporting a work RVU of 1.50 for code 93571. **The RUC urges CMS to accept a work RVU of 1.50 for CPT code 93571.**

(54) Home Sleep Apnea Testing (CPT codes 95800, 95801, and 95806)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
95800	**Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (eg, by airflow or peripheral arterial tone), and sleep time**	**0.85**	**1.00**
95801	**Sleep study, unattended, simultaneous recording; minimum of heart rate, oxygen saturation, and / respiratory analysis (eg, by airflow or peripheral arterial tone)**	**0.85**	**1.00**
95806	**Sleep study, unattended, simultaneous recording of, heart rate, oxygen saturation, respiratory airflow, and respiratory effort (eg, thoracoabdominal movement)**	**0.93**	**1.08**

The RUC thoroughly analyzed this family of home sleep apnea testing codes by review of the history, survey data and magnitude estimation to other similar services. The RUC **unanimously approved** the

work RVUs for all services in this family and urges CMS to accept the RUC recommended values. Details on why CMS should accept the RUC recommendations for each code in this family are outlined below.

95800 & 95801

For CPT codes 95800 and 95801, the RUC recommended a work RVU of 1.00 based on the survey 25th percentile values. CMS disagrees with the recommended values and are proposing a work RVU of 0.85 based on a pair of crosswalk codes: CPT code 93281 *Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; multiple lead pacemaker system* (work RVU = 0.85) and CPT code 93260 *Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; implantable subcutaneous lead defibrillator system* (work RVU = 0.85). Both of these codes have a work RVU of 0.85 and the same intra-service time of 15 minutes. It is unclear why CMS chose these two codes which are not at all similar to the home sleep apnea test codes and are cardiovascular implantable recording device codes, not diagnostic studies. CPT codes 95800, 95801, and 95806 are all sleep apnea diagnostic service codes which include recording, interpretation, and reports of these sleep studies

CMS notes the decreases of 5 minutes intra-service time for CPT code 95800 and therefore are proposing a decrease in work RVU because the RUC recommended decrease was not a large enough percentage based on the decrease in time. Please refer to our comments on "Inappropriate Physician Time Ratio Calculations" in the introduction of this section, for the full rationale on the inaccuracies of using an intra-service time ratio.

The RUC specifically stated that these services were new the last time it was surveyed and is currently being re-reviewed via identification of the new technology/new services list. The specialty societies indicated that the existing times are likely an overestimate due to the lack of experience providing these then new services in April 2010. Physicians are now more familiar with home sleep apnea testing and the new survey times are more reflective of this family of services.

The RUC urges CMS to use the valid survey 25th percentile work RVUs of 1.00 for CPT codes 95800 and 95801. The RUC again references similar service 95907 *Nerve conduction studies; 1-2 studies* (work RVU = 1.00 and 15 minutes intra-service time), which requires the same physician work and time to perform, further supporting the RUC recommended work RVU. **The RUC urges CMS to accept a work RVU of 1.00 for CPT codes 95800 and 95801.**

95806

For CPT code 95806, the RUC recommended a work RVU of 1.08 based on a crosswalk to CPT code 95819 *Electroencephalogram (EEG); including recording awake and asleep* (work RVU = 1.08). CMS disagrees with the RUC recommended work RVU of 1.08 but agrees that the relative difference in work between CPT codes 95800 and 95801 and CPT code 95806 is equivalent to the recommended interval of 0.08 RVUs and proposes a work RVU of 0.93 for CPT code 95806. CMS did not provide any crosswalk services to support their recommendation.

The survey process values a service compared to other similar services. Using an incremental approach in lieu of strong crosswalks and input from the RUC and physicians providing these services is unfounded. CMS does not provide any rationale to the proposed work RVU other than the incremental difference.

The RUC urges CMS to use supportive relative reference services when valuing services, instead a mere calculation that does not consider the physician work beyond an incremental number.

The RUC also noted that the two previous work RVU recommendations for this service were not accepted by CMS and subsequently decreased; however, the survey times were accepted. Thus, an incorrect correlation is suggested when comparing physician work RVU and times between the 2010 survey data to the current survey data and recommended work RVU. **The RUC urges CMS to accept a work RVU of 1.08 for CPT code 95806.**

(55) Neurostimulator Services (CPT codes 95970, 95X83, 95X84, 95X85, and 95X86)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
95970	**Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group(s), interleaving, amplitude, pulse width, frequency (Hz), on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve neurostimulator pulse generator/transmitter, without programming**	**0.35**	**0.45**
95X83	**Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group(s), interleaving, amplitude, pulse width, frequency (Hz), on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple cranial nerve neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional**	**0.73**	**0.95**
95X84	**95X84 Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group(s), interleaving, amplitude, pulse width, frequency (Hz), on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with complex cranial nerve neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional**	**0.97**	**1.19**

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
95X85	**Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group(s), interleaving, amplitude, pulse width, frequency (Hz), on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator /transmitter programming, first 15 minutes face-to-face time with physician or other qualified health care professional**	**0.91**	**1.25**
95X86	**Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group(s), interleaving, amplitude, pulse width, frequency (Hz), on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/transmitter programming, each additional 15 minutes face-to-face time with physician or other qualified health care professional**	**0.80**	**1.00**

The RUC thoroughly analyzed this family of neurostimulator services by review of the history, survey data and magnitude estimation to other similar services. The RUC **unanimously approved** the work RVUs for all services in this family and urges CMS to accept the RUC recommended values. Details on why CMS should accept the RUC recommendations for each code in this family are outlined below.

95970

For CPT code 95970, the RUC recommended a work RVU of 0.45 and 3 minutes pre-service, 7 minutes intra-service and 5 minutes post-service time. CMS disagrees with the RUC's recommendation because they do not believe that maintaining the work RVU, given a decrease of four minutes in total time, is appropriate. CMS is comparing accurate survey time to Harvard time, which holds zero validity for comparison. Additionally, the survey pre-service time was reduced, which accounts for this service being reported with an Evaluation and Management (E/M) service. The previous Harvard time most likely did not take this into account. The RUC urges CMS to use accurate survey data for physician time and not to adjust the work RVU based on instituting inaccurate comparisons.

The RUC compared code 95970 to the top key reference service 62368 *Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming* (work RVU = 0.67 and 27 minutes total time). CMS notes that the reference CPT codes chosen by the survey respondents have much higher intra-service and total times than CPT code 95970, and also have higher work RVUs, making them poor comparisons. The survey respondents chose these reference services as a comparison,

not recommending direct crosswalks. The respondents and the RUC agreed that CPT code 95970 requires less physician time and work and thus valued it lower than the reference codes. To clarify, the survey respondents choose a *similar* service from a list of 10-20 services and not all are going to match up with the exact same time. Additionally, the survey respondents do not see the physician times for any of the services in the reference list. Additionally, the respondents then indicate the time, work, intensity and complexity differences and relativity between these services. The RUC examines the services based on clinical relativity of all measures compared to other services. CMS should not review one element, physician intra-service time, and compare to invalid data or disregard the relativity between reference services.

CMS recommends that code 95970 be directly crosswalked to CPT code 95930 *Visual evoked potential (VEP) checkerboard or flash testing, central nervous system except glaucoma, with interpretation and report* (work RVU = 0.35, 10 minutes intra-service time and 14 minutes total time). CPT code 95930 is when the physician reviews and interprets ophthalmological results of brain electrical activity measurements. CPT code 95970 requires more physician work and is more intense because the physician is performing the electronic analysis of the implanted neurostimulator pulse generator/transmitter (eg, contact group(s), interleaving, amplitude, pulse width, frequency (Hz), on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) and documenting the diagnostic analysis, including the battery state, current program settings, and impedances of electrodes, as well as any event logs from the programming equipment and patient device interrogation. **The RUC urge CMS to accept a work RVU of 0.45 for CPT code 95970.**

95X83

For CPT code 95X83, the RUC recommended a work RVU of 0.95 and 3 minutes pre-service, 11 minutes intra-service and 10 minutes post-service time. CMS noted that this new code does not exactly replace the deleted CPT code 95974 *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, with or without nerve interface testing, first hour* (work RVU = 3.00 and 30 minutes pre-time, 60 minutes intra-service time and 20 minutes post-service time). The description of the work involved in furnishing CPT code 95X83 differs from that of the deleted CPT code in a few important ways, notably that the time parameter has been removed so that the CPT code no longer describes the first hour of programming. In addition, the new CPT code refers to simple rather than complex programming. Yet, CMS is still comparing the physician work and time of these two services. The physician work and times should be different and CMS should not compare these two vastly different services.

CMS states that the top key reference service 95816 *Electroencephalogram (EEG); including recording awake and drowsy* (work RVU = 1.08, 15 minutes intra-service time and 26 minutes total time) is not an appropriate crosswalk. Again, the survey respondents are not recommending code 95X83 be crosswalked to code 95816, but notes that CPT code 95816 was chosen to assess the relativity and to establish a work RVU and physician time recommendation. Clearly, services performed by the same physician, intra-service time differences of 4 minutes, total time differences of 2 minutes, overall intensity and complexity measures indicated as 60 percent identical and 40 percent somewhat more for the key reference code, all support the RUC recommended work RVU of 0.95 and physician time relative to another similar service.

CMS recommends code 95X83 be crosswalked to CPT code 76641 *Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete* (work RVU = 0.73 and 12

minutes of intra-service time and 22 minutes of total time). The RUC disagrees with crosswalking to another service of a different specialty when a valid survey was conducted and accurate same specialty reference services were provided. CPT code 76641 is not a good crosswalk because although the physician time may be similar, CPT code 95X83 requires more physician work to interact with the patient and make programming adjustments to multiple parameters which result in real time changes in patient behavior; including but not limited to speech, breathing patterns, heartrate, and seizure activity. Side effects and risks of parameter adjustments are significant, and considerations must be weighed carefully, including identifying the correct parameter to manipulate. The identification of and adjustment of the correct parameter(s) requires considerable decision-making effort and concern for patient safety. **The RUC urges CMS to accept a work RVU of 0.95 for CPT code 95X83.**

95X84

CMS states that the RUC compared CPT code 95X84 with deleted CPT code 95975 *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial nerve neurostimulator pulse generator / transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour* (work RVU = 1.70, ZZZ global period and 30 minutes total time). The RUC recommendation ***did not*** compare code 95X84 to deleted code 95975. The RUC recommended the survey 25th percentile work RVU of 1.19. The specialty societies reduced the pre-service time, which accounts for this service being reported with an E/M service. The RUC recommended 3 minutes pre-service, 17 minutes intra-service and 10 minutes post-service time. The specialty societies indicated and the RUC agreed that the 10 minutes required for the post-time include reviewing all the parameters, documenting final program measurements and any other relevant clinical information obtained during the programming session, reducing side effects and making treatment adjustments. The physician will also address patient and family questions about planned therapy and re-educate the patient and family on the use of the patient device. The RUC confirmed that the physician times appropriately mirror other similar services.

The RUC noted that the top two key reference services were disparate compared to this service. Therefore, as a better reference, the RUC compared code 95X84 to MPC codes 99308 *Subsequent nursing facility care, per day, for the evaluation and management of a patient* (work RVU = 1.16, 15 minutes of intra-service time and 31 minutes total time) and 12013 *Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm* (work RVU = 1.22, 15 minutes of intra-service time and 27 minutes total time), which support the recommended work RVU as the survey code involves somewhat more intra-service and total time and a comparable amount of physician work. For additional support, the RUC referenced codes 93975 *Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study* (work RVU = 1.16, 20 minutes of intra-service time and 30 minutes total time) and 67810 *Incisional biopsy of eyelid skin including lid margin* (work RVU = 1.18, 13 minutes of intra-service time and 27 minutes total time). Thus, the survey 25th percentile work RVU appropriately places CPT code 95X84 relative to the top key reference service and other similar services.

CMS is proposing to use a reverse building block in developing the work RVU for code 95X84. The RUC has long stated that codes that are not developed using building block should not be manipulated with a reverse building block methodology. CMS is proposing a work RVU of 0.97 for CPT code 95X84 without the use of survey data or a direct crosswalk to another similar code. CMS is taking the difference in work RVUs from the RUC recommended values of 0.24. This inaccurately treats all components of the physician time as having identical intensity and is incorrect. The RUC strongly discourages as use of valuing a service by increment. The RUC recommends that CMS use valid survey data to develop work

RVUs and not foster a flawed methodology in valuing this family of services. **The RUC recommends a work RVU of 1.19 for CPT code 95X84.**

95X85

For CPT code 95X85, CMS states that the RUC's recommendation of 1.25 work RVUs is based on codes 12013 *Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm* (work RVU = 1.22, intra-service time of 15 minutes and 27 minutes total time) and 70470 *Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections* (work RVU = 1.27, 15 minutes of intra-service time and 25 minutes total time). The RUC actually based its recommendation on the survey 25th percentile work RVU of 1.25. Then to support the valid survey data the RUC referenced similar services from the Multi-Specialty Points of Comparison (MPC) list. The RUC recommended 3 minutes pre-service, 15 minutes intra-service and 10 minutes post-service time for CPT code 95X85, which tight in relativity for physician work and time to CPT codes 12013 and 70470.

CMS is comparing CPT code 95X85 which describes the first 15 minutes to the deleted CPT code 95978 which described the first hour. There is a coding nuance here — CPT code 95978 could still be reported for the first hour as long as it was over 31 minutes. Therefore, comparing the old coding structure to the new coding structure is not straightforward based on comparing the time in the descriptor and actual time to what will be reported now. The RUC examined this family of services and the RUC recommended values are work neutral, even when assuming code 95X85 may be reported once and code 95X86 reported multiple times.

CMS examines the use of a reverse building block in developing the work RVU for code 95X85. The RUC has long stated that codes that are not developed using building block should not be manipulated with a reverse building block methodology. CMS is proposing a work RVU of 0.91 for CPT code 95X85 by directly crosswalking CPT Code 95X85 to CPT code 93886 *Transcranial Doppler study of the intracranial arteries; complete study* (work RVU = 0.91, intra-service time of 17 minutes, and total time of 27 minutes). Although, CPT code 95X85 requires similar physician time as code 93886, code 95X85 is more intense and complex and requires more physician work because it entails programming adjustments to multiple parameters which result in real time patient behavior. This includes monitoring for changes in the patient's speech, mobility, strength, voice, and ADLs, (as they can be assessed on an immediate basis). Side effects and risks of parameter adjustments are significant, and considerations must be weighed carefully to consider the benefits of clinical improvement with minimal negative side effects. The service includes observations based on adjustment made, a review of the results and further adjustments as needed. **The RUC urges CMS to accept a work RVU of 1.25 for CPT 95X85.**

95X86

For CPT code 95X86, CMS states that the RUC's recommendation of 1.00 work RVUs is based on is based on the key reference service CPT code 64645 *Chemodenervation of one extremity; each additional extremity, 5 or more muscles (List separately in addition to code for primary procedure)* (work RVU = 1.39 and 15 minutes of intra-service time). The RUC actually based its recommendation on the survey 25th percentile work RVU of 1.00. To support the valid survey data, the RUC indicated that the survey respondents chose code 64645 as the key reference service for comparison for what they thought was the most similar services. The RUC noted that the survey respondents indicated the surveyed code is more intense and complex to perform but CPT code 64645 requires more technical skill. Therefore, CPT code 64645 appropriately requires slightly more work than code 95X86.

The RUC does not understand why CMS is not relying on survey data and is portraying the RUC's comparison to key reference services and MPC codes as a direct crosswalk, instead of examining as support in establishing the appropriate relativity of services.

CMS is proposing a work RVU of 0.80 for CPT code 95X86, which is a random calculation using building block methodology and the incremental difference between codes 95X85 and 95X86, followed by CMS choosing an RVU in between these calculations of 0.75 and 0.82. CMS then indicates that a work RVU of 0.80 is supported by crosswalking code 95X86 to code 51797 *Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal)* (work RVU = 0.80 and 15 minutes intra-service/total time). The RUC recommends that CMS use valid survey data and review the actual relativity for all elements (physician work, time, intensity and complexity) when developing the work RVU for services and not place everything in a box by calculating increments and then pick a code to mirror the calculation. The RUC strongly discourages as use of valuing a service by increment. The RUC recommends that CMS use valid survey data to develop work RVUs and not foster a flawed methodology in valuing this family of services. Additionally, CPT code 51797 is not a good crosswalk for CPT code 95X86. CPT code 95X86 require more physician work to perform programming adjustments to multiple parameters which result in real time patient behavior. This includes monitoring for changes in the patient's speech, mobility, strength, voice, and ADLs, (as they can be assessed on an immediate basis). Side effects and risks of parameter adjustments are significant, and considerations must be weighed carefully to consider the benefits of clinical improvement with minimal negative side effects. The service includes observations based on adjustment made, a review of the results and further adjustments as needed. **The RUC urges CMS to accept a work RVU of 1.00 for CPT code 95X86.**

(56) Psychological and Neuropsychological Testing (CPT Codes 96105, 96110, 96116, 96125, 96127, 963X0, 963X1, 963X2, 963X3, 963X4, 963X5, 963X6, 963X7, 963X8, 963X9, 96X10, 96X11, 96X12)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
96X11	Psychological or neuropsychological test administration using single instrument, with interpretation and report by physician or other qualified health care professional and interactive feedback to the patient, family member(s), or caregivers(s), when performed	0.51	Rescinded Recommendation Referred to CPT for revision

CMS states they are proposing the RUC recommended work RVU of 0.51 for CPT code 96X11. However, the in the February 5, 2018, RUC submission to CMS, the RUC rescinded its interim recommendation from October 2017. **CPT code 96X11 is deleted and will not be a CPT code for CPT 2019. The RUC recommends that CMS delete this service and work RVU recommendation for the 2019 Physician Payment Schedule.**

Practice Expense

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

(57) Electrocorticography (CPT code 96X00)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
96X00	**Electrocorticogram from an implanted brain neurostimulator pulse generator/transmitter, including recording, with interpretation and report, up to 30 days**	**1.98**	**2.30**

CMS disagrees with the RUC-recommended work RVU of 2.30 for CPT code 96X00 and are proposing a work RVU of 1.98 based on a direct crosswalk to the top reference, CPT code 95957 *Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis* (work RVU = 1.98). CMS states that they agree with the survey respondents that this is a correct valuation for code 96X00. However, the survey respondents chose code 95957 as a reference service, not as a direct crosswalk. The survey respondents pick from a list of 10-20 services to use as a comparison and then recommend a work RVU based on the intensity, complexity and physician time required to perform the surveyed code. The median survey work RVU was actually 2.97, much higher than the key reference service. The respondents specifically indicated that CPT code 96X00 is more intense and complex than CPT code 95957 on all measures (mental effort/judgment, technical still/physical effort and psychological stress), which justifies the higher work value. Therefore, CMS crosswalking the work RVU to the key reference service and suggesting that it represents the work value that the survey respondents indicated is completely false. **Please refer to our comments on "RUC Survey Process, Reference Services and Crosswalks" in the introduction of this letter. The RUC urges CMS to accept the valid surveyed 25th percentile work RVU of 2.30 for CPT code 96X00.**

Practice Expense

For the direct PE inputs the specialty society did not submit any direct PE inputs. The RUC and CMS took this to mean that it is a facility only code as is generally the case when there are no PE inputs. This was a misunderstanding on the RUC's part and we apologize to both CMS and the specialty society for the error. 96X00 can be performed in both the non-facility and the facility setting and the non-facility is actually the typical setting for this service. This is a unique service in that there is no equipment expense because the manufacturer provides the equipment free of charge to the physician, the service is provided by a physician without a nurse or technician and there are no supplies associated with the service. However, there is indirect practice expense associated with providing the service in the non-facility. The PE RVU in the facility setting reflects the indirect expense associated with this service and is proposed to be 0.87. The PE RVU should be 0.87 in the non-facility as well. **The RUC urges CMS to correct this inadvertent error and value the service for practice expense in the facility and non-facility setting by implementing a non-facility PE RVU of 0.87 for CPT code 96X00.**

(58) Chronic Care Remote Physiologic Monitoring (CPT Codes 990X0, 990X1 and 994X9)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
990X0	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment	PE Only	PE Only
990X1	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days	PE Only	PE Only
994X9	Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month	0.61	0.61

CMS is proposing to accept the RUC work recommendations for this family of services.

Practice Expense

For the direct PE inputs, CMS is proposing to remove the "monthly cellular and licensing service fee'' supply from CPT code 990X1. CMS states that they do not believe that these licensing fees would be allocated to the use of an individual patient for an individual service, and instead believe they can be better understood as forms of indirect costs similar to office rent or administrative expenses. Therefore, CMS is proposing to remove this supply input as a form of indirect PE.

The RUC disagrees with CMS's proposal that the monthly cellular and licensing service fee is an indirect cost. The RUC had extensive discussion about the indirect and direct supply items for this family and removed some items such as shipping costs and a device reprocessing fee, however the RUC determined that the monthly cellular and licensing service fee was a direct practice expense inputs as it is allocable to the patient for this service. The RUC clarifies that the fee is not a license for the entire practice; rather it is an individually allocable fee for the period that the patients is monitored. The physician would not incur such fees if the patient did have the wireless monitor. The remote monitor wireless fee is not an overhead fee that the physician maintains, but is a fee incurred per patient with each remote wireless monitor. **The RUC urges CMS to allocate the "monthly cellular and licensing service fee" as a direct medical supply input for CPT code 990X1.**

(59) Interprofessional Internet Consultation (CPT codes 994X6, 994X0, 99446, 99447, 99448, and 99449)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
994X0	Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or qualified health care professional, 30 minutes	0.50	0.50
994X6	**Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 or more minutes of medical consultative time**	**0.50**	**0.70**
99446	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified healthcare professional; 5-10 minutes of medical consultative discussion and review	0.35	0.35
99447	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified healthcare professional; 11- 20 minutes of medical consultative discussion and review	0.70	0.70
99448	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified healthcare professional; 21- 30 minutes of medical consultative discussion and review	1.05	1.05
99449	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified healthcare professional; 31 minutes or more of medical consultative discussion and review	1.40	1.40

994X6

The RUC recommended work RVUs are 0.50 for CPT code 994X0 and 0.70 for CPT code 994X6. Since the CPT code for the treating/requesting physician or qualified healthcare professional and the CPT code for the consultative physician have similar intra-service times, CMS believes that these CPT codes should have equal values for work. Therefore, CMS is proposing a work RVU of 0.50 for both CPT codes 994X0 and 994X6.

CPT codes 994X6 and 994X0 should not be valued the same. While CPT codes 994X0 and 994X6 may share a similar intra-service time, the work is inherently different. The treating/requesting physician knows the patient and has determined the information and advice he/she seeks from the specialist. Therefore, the intra-service time is the actual time of call or internet communication. In contrast, the consulting physician is learning of the patient for the first time and must integrate patient history and other factors communicated by the treating/requesting physician, consider all the diagnostic possibilities, and recommend a management plan or a series of diagnostic tests in reaching a diagnosis. Components of consulting physician work that merit the higher valuation for code 994X6 as recommended by the RUC include:

- Code 994X6 requires greater physician effort and judgment than code 994X0: Physician effort and judgment necessary with respect to the amount of clinical data that needs to be considered by the consulting physician, the fund of knowledge required, the range of possible decisions, the number of factors considered in deciding, and the degree of complexity of the interaction of these factors.
- Code 994X6 requires greater technical skill than code 994X0: Technical skill required with respect to knowledge, training and actual experience necessary to perform the consulting service.
- Code 994X6 involves more psychological stress than code 994X0: Psychological stress represents the weight of responsibility incurred when the outcome is heavily dependent upon skill and judgment and when a potentially adverse outcome has serious consequences faced by the consulting physician.
- The consulting physician (994X6) is rendering recommendations -- whereas the treating/requesting physician (994X0) is consolidating information into a focused patient story for the consultant to review. The consulting physician assumes more risk because he/she is the clinician making a recommendation.
- Similarly, there is more medical judgement required by code 994X6. The work of the consulting physician in code 994X6 mirrors the work of the existing ITC codes, which describe only the work of the consultant (minus the phone call).
- The patient is typically new to the consultant, whereas the patient has likely already established a relationship (had at least one visit) with the treating/requesting physician before the consult is requested.

Furthermore, the RUC concluded that code 994X6 is equivalent in intensity to code 99447, which requires 11-20 minutes of medical consultative discussion, as well as both a written and verbal report. When the RUC valued code 99447 in October 2012, it used code 99442 *Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion* (work RVU = 0.50) as its key reference service, concluding that code 99447 is a more intense procedure due to the fact that the patient is typically unknown to the consulting physician, making the service provided in a complex/urgent situation and the medical decision-making required more intense than code 99442. These same concepts apply to code 994X6.

As with code 994X0, the RUC recommendation for CPT code 994X6 is based on robust survey results and diligent consideration of relative values of similar services. The RUC **unanimously approved** a work RVU of 0.70 for CPT code 994X6. CMS' proposal devalues the consultant's more intense work and creates a rank order anomaly within the code family. **Therefore, the RUC urges CMS to accept a work RVU of 0.70 for CPT code 994X6.**

(60) Chronic Care Management Services (CPT code 994X7)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
994X7	**Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored**	**1.22**	**1.45**

For CPT code 994X7, the RUC recommended a work RVU of 1.45 for 30 minutes of physician time. CMS believes this work RVU overvalues the resource costs associated with the physician performing the same care coordination activities that are performed by clinical staff in the service described by CPT code 99490 *Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored* (work RVU = 0.61 and 15 minutes intra-service/total time). Additionally, CMS stated that this valuation of the work is higher than that of CPT code 99487 *Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, establishment or substantial revision of a comprehensive care plan, moderate or high complexity medical decision making; 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month* (work RVU = 1.00 and 26 minutes intra-service/total time), which includes 60 minutes of clinical staff time, creating a rank order anomaly within the family of codes if CMS were to accept the RUC recommended value. CPT code 99490 has a work RVU of 0.61 for 15 minutes of physician time. Therefore, as CPT code 994X7 describes 30 minutes of physician time, CMS is proposing a work RVU of 1.22, which is double the work RVU of CPT code 99490.

The RUC indicated that code 994X7 is different than existing chronic care management services codes 99490 (work RVU = 0.61) and 99487 (work RVU = 1.00), which are performed by clinical staff under the supervision of a physician. The patient acuity criteria for all these services are the same but the physician work is different and more intense for code 994X7. CPT code 994X7 cannot be reported with codes 99490 or 99487 and must capture all the work for the month. CMS is making a flawed assumption in proposing to value the work the same as CPT code 994X7, which is twice the value of code 99490 based on the fact the physician time of code 994X7 is twice that of code 99490. Specifically, CMS assumes the intensity of a physician personally performing CCM is equal to the intensity of a physician supervising the performance of CCM by clinical staff.

When a physician personally performs CCM activities for a patient, he or she does so because the patient and the patient's condition(s) requires a level of knowledge and skill that only the physician can provide. Mental effort and judgment and technical skill are all elements of intensity. The value recommended by the RUC recognizes that when a physician's mental effort and judgment and technical skill are personally brought to bear on behalf of a patient, the intensity of the service is greater than when the physician is simply supervising the efforts of the clinical staff.

There is precedence elsewhere in the Medicare Physician Payment Schedule for attributing greater intensity to a service when done personally by a physician rather than clinical staff. For example, code 96101 describes *Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report*. It has an intra-service work per unit of time (IWPUT) of 0.0284. In comparison, code 96102 describes P*sychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI and WAIS), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face* and has an IWPUT of 0.0214. CMS has attributed a greater intensity (as reflected in the IWPUT) to code 96101, the psychological testing personally administered by the physician or psychologist, than it has to the same testing administered by a technician. The same principle applies in valuing code 994X7 relative to code 99490.

Far from avoiding a rank order anomaly among the CCM codes, CMS's proposed value of 1.22 for code 994X7 would create a rank order anomaly among other E/M codes personally provided by physicians. As noted in the RUC recommendations to CMS, a level 4 established patient office visit 99214 has 25 minutes intra-service time and work RVU of 1.50, which compares very favorably to the 1.45 work RVUs for 30 minutes of physician time recommended for code 994X7. The proposed value of 1.22 work RVUs would undervalue the 30 minutes of physician work compared to other E/M codes with 30 minutes of total physician time, including CPT codes 99381 *Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/ anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age younger than 1 year)* (work RVU = 1.50) and 99392 *Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; early childhood (age 1 through 4 years)* (work RUV = 1.50). **The RUC urges CMS to use the robust survey 25th percentile work RVU of 1.45.**

(62) External Counterpulsation (HCPCS code G0166)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
G0166	External counterpulsation, per treatment session	0.00	0.00

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

(63) Wound Closure by Adhesive (HCPCS code G0168)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
G0168	**Wound closure utilizing tissue adhesive(s) only**	**0.31**	**0.45**

For HCPCS code G0168, the RUC recommended a work RVU of 0.45 based on maintaining the current work RVU. CMS disagrees with the recommended value and are proposing a work RVU of 0.31 for HCPCS code G0168 based on a direct crosswalk to CPT code 93293 *Transtelephonic rhythm strip pacemaker evaluation(s) single, dual, or multiple lead pacemaker system, includes recording with and without magnet application with analysis, review and report(s) by a physician or other qualified health care professional, up to 90 days* (work RVU = 0.31, 5 minutes intra-service time and 13 minutes total time). CMS is proposing a decrease in work RVUS for code G0168 because the current CMS/Other source intra time is 2 minutes pre-time, 10 minutes intra-service time and 4 minutes post-service time and the RUC recommended survey time is 5 minutes evaluation time, 1 minute positioning time, 5 minutes intra-service time and 3 minutes immediate post-service time, which is a difference of 2 minutes total. CMS should not compare the valid survey time to the initial CMS/Other time because the initial CMS/Other source data is flawed and maintains zero validity for comparison. The initial CMS/Other time does not capture accurate physician time or direct practice expense inputs from the current dominant specialties performing this service. In 2000, CMS cross-walked code G0168 to code 99212 *Office or other outpatient visit for the evaluation and management of an established patient* for physician work and time, therefore surveyed time was never obtained from physicians who perform this service and should not be used as a comparison.

Code G0168 should not be cross-walked to code 93293, as this is an evaluation of pacemaker strips over a 90 day period. The skill of closing a facial laceration on the face, typically near the eye, using a surgical tissue adhesive for code G0168 is more intense and complex to perform than code 93293 thus should be valued higher. A better reference service is MPC code 51702 *Insertion of temporary indwelling bladder catheter; simple (eg, Foley)* (work RVU = 0.50 and 5 minutes intra-service time). The RUC urges CMS not to compare this surveyed code to flawed times established by a proxy. **The RUC requests that CMS finalize a work RVU of 0.45 for code G0168.**

(64) Removal of Impacted Cerumen (HCPCS Code G0268)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
G0268	Removal of impacted cerumen (one or both ears) by physician on same date of service as audiologic function testing	0.61	0.61

CMS is accepting the RUC recommended work RVU of 0.61 for G0268. However, CMS is proposing refinements to the RUC-recommended direct PE inputs for code G0268 *Removal of impacted cerumen (one or both ears) by physician on same date of service as audiologic function testing*. **For the RUC's comments on individual refinements of direct PE inputs please see the attached refinement table.**

V. Evaluation & Management (E/M) Office Visits

CMS has proposed a bold strategy to reduce the administrative burden in documenting and auditing Evaluation and Management (E/M) services. The Agency felt compelled to address coding and payment of physician office visits at the same time as proposing welcomed burden relief. Unfortunately, the proposed implementation of the E/M coding and payment changes is not workable. CMS will receive comments from the AMA, national and state medical specialty societies, and other health care professional organizations. We urge CMS to seriously consider these comments and postpone any E/M payment and coding changes for 2019. We understand that organizations will call on CMS to implement certain elements of their burden reduction plan immediately, and we support those efforts. The RUC will limit our comments to those that pertain to the serious implications to relativity and the RBRVS that result from this proposal.

The E/M payment collapse led to a series of "corrections" that appeared to have snowballed as impact analysis and policymaking was underway. When CMS opted to eliminate differentiated payment for levels of E/M office visits, primary care physicians and specialists who report higher level E/M visits were negatively impacted, while specialties who report lower level E/M visits were positively impacted. CMS desired a proposal that was budget neutral, so a series of add-on codes and payment policies were proposed. These proposals are not resource-based and often not well articulated in the *Proposed Rule*. For example, the add-on payment for primary care services is clearly not resource-based, relying on a partial crosswalk to another code that is unrelated and not comparable. The add-on code for a specific list of specialties (or specialty services) is arbitrary and is also not resource-based. There may be merit in rewarding complexity or currently undescribed resource costs in additional CPT codes (eg, a new shorter prolonged services code), however, we urge CMS to work through the current processes to ensure such services are adequately described and valued.

Additional efforts to incorporate the CMS proposal into the current constraints of budget neutrality, and a complex practice expense methodology, have led to an unacceptable payment proposal. The multiple procedure payment reduction (MPPR) and the unintended outcome within the rate setting process via the indirect practice cost indices (IPCIs) lead to significant redistribution. The RUC discusses these two issues below

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A. Multiple Procedure Payment Reduction

Intertwined with the proposed E/M payment collapse and new add-on payments, is a faulty and redundant multiple procedure payment reduction (MPPR) proposal. Based on information contained in the *Proposed Rule*, information appended to payment files on the CMS website, and statements made by CMS staff, we understand that the 10 office visit CPT codes (99201-99215) and the two proposed podiatry codes (GPD0X and GPD1X) will be added to the 2019 list of codes with a surgical multiple procedure payment indicator of "2." When two codes on this list are performed on the same date of service, by the same physician or other health care professional, the payment for the code with the lowest total RVU would be reduced by 50%. There are more than 5,000 codes on this list, so the application of this policy will be broad. In fact, our analysis indicates that this policy alone accounts for $850 million in redistribution. For most code pairs, the office visit payment will be reduced by 50%. There are fewer than 200 procedures or services that are valued lower than office visits on this list and in those cases, the procedure payment will be reduced by 50%. **The MPPR proposal is flawed as it represents duplication of payment reduction that has already been made to the same-day procedures. The RUC urges CMS to not move forward with its implementation.**

The RUC, national medical specialty societies, and other health care professionals have worked diligently to ensure that there are no duplicate resource costs imbedded in procedure codes typically performed with E/M services. The RUC's Relativity Assessment Workgroup has conducted screening and reviewed all procedures where same-day E/M services are typically reported to ensure that the duplicate work has been accounted for. AMA staff provides ongoing data analyses to specialties and the RUC in the development and review of both work RVUs and direct practice expense costs in preparation for RUC review. These analyses include information regarding the performance of E/M on the same date of each procedure code. At every point in the review process, we ensure that the work and direct costs assigned to the procedure are over-and-above the resources included in E/M services (*see attachment 05 for examples)*. When CMS determines that a duplicate cost has not been addressed, the Agency removes that cost from the procedure codes in rulemaking. On page 35744 of this *Proposed Rule*, CMS confirms this process and history.

> *"…in cases where we believed that the RUC has not adequately accounted for the overlapping activities in the recommended work RVU and/or times, we adjusted the work RVU and/or times to account for the overlap. The work RVU for a service is the product of the time involved in furnishing the service multiplied by the intensity of the work. Pre-service evaluation time and Post-service time both have a long-established intensity of work per unit of time (IWPUT) of 0.0224, which means that 1 minute of preservice evaluation or post-service time equates to 0.0224 of a work RVU. Therefore, in many cases when we removed 2 minutes of preservice time and 2 minutes of post-service time from a procedure to account for the overlap with the same day E/M service, we also removed a work RVU of 0.09 (4 minutes × 0.0224 IWPUT) if we did not believe the overlap in time had already been accounted for in the work RVU. The RUC has recognized this valuation policy and, in many cases, now addresses the overlap in time and work when a service is typically furnished on the same day as an E/M service."*

The RUC and the RUC's Practice Expense Subcommittee specifically remove any overlap in direct practice costs. For example, the RUC removes any overlap in clinical labor time for the following clinical activities: greet patient, provide gowning, ensure appropriate medical records are available; obtain vital signs; prepare room, equipment and supplies; prepare and position patient; and clean room/equipment by clinical staff which would otherwise total to 15 minutes per the RUC's standard rules.

The proposed MPPR policy on page 35840-35841 of this *Proposed Rule* completely ignores specific CMS proposals and adjustments that are discussed in pages that precede the E/M proposal. The following are examples of reductions to individual procedure codes in this *Proposed Rule* to ensure no overlap with E/M services performed on the same date of service:

> *<u>Page 35715-35718 – Multi-Specialty Visit Supply Packs (165 codes)</u>*
> *"The RUC alerted us that there are 165 CPT codes billed with an office E/M code more than 50 percent of the time in the non-facility setting that have more minimum multi-specialty visit supply packs (SA048) than post-operative visits included in the code's global period. This indicates that either the inclusion of office E/M services was not accounted for in the code's global period when these codes were initially reviewed by the PE Subcommittee, or that the PE Subcommittee initially approved a minimum multi-specialty visit supply pack for these codes without considering the resulting overlap of supplies between SA048 and the E/M supply pack (SA047). The RUC regarded these overlapping supply packs as a duplication, due to the fact that the quantity of the SA048*

supply exceeded the number of postoperative visits, and requested that CMS remove the appropriate number of supply item SA048 from 165 codes. After reviewing the quantity of the SA048 supply pack included for the codes in question, we are proposing to refine the quantity of minimum multi-specialty visit packs as displayed in Table 6."

Page 35748 - Skin Biopsy (CPT codes 11X02, 11X03, 11X04, 11X05, 11X06, and 11X07)
"For the direct PE inputs, we are proposing to remove the 2 minutes of clinical labor time for the "Review home care instructions, coordinate visits/prescriptions" (CA035) activity for CPT codes 11X02, 11X04, and 11X06. These codes are typically billed with a same day E/M service, and we believe that it would be duplicative to assign clinical labor time for reviewing home care instructions given that this task would typically be done during the same day E/M service."

Page 35749 - Injection Tendon Origin-Insertion (CPT code 20551)
"For the direct PE inputs, we are proposing to remove the clinical labor time for the "Provide education/obtain consent" (CA011) and the "Review home care instructions, coordinate visits/prescriptions" (CA035) activities for CPT code 20551. This code is typically billed with a same day E/M service, and we believe that it would be duplicative to assign clinical labor time for obtaining consent or reviewing home care instructions given that these tasks would typically be done during the same day E/M service."

Page 35750 - Strapping Lower Extremity (CPT codes 29540 and 29550)
"We are also proposing to remove the 2 minutes of clinical labor time for the "Review home care instructions, coordinate visits/ prescriptions" (CA035) activity for both codes. CPT codes 29540 and 29550 are both typically billed with a same day E/M service, and we believe that it would be duplicative to assign clinical labor time for reviewing home care instructions given that this task would typically be done during the same day E/M service."

Page 35754 - Hemorrhoid Injection (CPT code 46500)
"We are proposing to remove the clinical labor time for the "Review home care instructions, coordinate visits/prescriptions" (CA035) activity. CPT code 46500 is typically billed with a same day E/M service, and we believe that it would be duplicative to assign clinical labor time for reviewing home care instructions given that this task would typically be done during the same day E/M service."

Page 35756 - Biopsy of Uterus Lining (CPT codes 58100 and 58110)
"For the direct PE inputs, we are proposing to remove the clinical labor time for the "Review/read post-procedure x-ray, lab and pathology reports" (CA028) activity for CPT code 58100. This code is typically billed with a same day E/M service, and we believe that it would be duplicative to assign clinical labor time for reviewing reports given that this task would typically be done during the same day E/M service."

Page 35765 - Electroretinography (CPT codes 92X71, 92X73, and 03X0T)
"We are proposing to remove the clinical labor time for the "Greet patient, provide gowning, ensure appropriate medical records are available" (CA009) and the "Provide education/obtain consent" (CA011) activities for CPT codes 92X71 and 92X73. Both of these CPT codes will typically be reported with a same day E/M service, and we believe

that these clinical labor tasks will be carried out during the E/M service. We believe that their inclusion in CPT codes 92X71 and 92X73 would be duplicative."

The RUC urges CMS to abandon the proposed MPPR policy to reduce payment when procedures are performed on the same date as a separately identifiable E/M service. The RUC will continue to work with CMS to ensure that all services reflect the resource costs required to provide the service.

B. Indirect Practice Costs Indices (IPCIs)

The formula to compute Medicare Physician Payment is based on the resource costs of physician work, practice expense and professional liability insurance. The practice expense component is subdivided into practice overhead costs that are directly related to performing the physician service (eg clinical staff salaries/benefits, medical supplies and medical equipment) and those practice overhead costs that are indirectly related (eg, rent, administrative staff salaries/benefits, utilities, etc.).

Practice expense accounts for nearly 45 percent of Medicare Allowed Charges. The portion of practice expense that is indirect is typically 65 to 85 percent for a large majority of services and is approximately 30 percent of the entire Medicare Physician Payment Schedule (nearly $30 billion in Medicare Allowed Charges). A not widely known but significant component of the formula to determine indirect practice expense payment is the Indirect Practice Cost Indices (or IPCIs). The purpose of the IPCIs is to adjust the practice expense payment for each service to account for variation in indirect practice costs by volume-weighted specialty. A percentage reduction in the service-level IPCI for a CPT code would result in the same percentage reduction in the indirect practice expense component of Medicare payment, all else held equal (ie a -25% reduction in service-level IPCI would result in a -25% reduction in indirect practice expense payment). The other main year-over-year changes to the formula for indirect practice expense for CY2019 are a reduction of 2 percent for the practice expense budget neutrality multiplier and an increase of 3 percent for a separate multiplier intended to hold overall indirect practice expense constant year-to-year — these other changes largely offset each other overall.

The CMS proposal to collapse payment for office visits included creating a new IPCI solely for office visits, overriding the current methodology for these services by treating Office E/M as a separate Medicare Designated Specialty. This change would also result in the exclusion of the indirect practice costs for office visits when deriving every other specialty IPCI. The proposed policy change would result in a large shift in the specialty-level IPCIs for CY2019 for several specialties and large swings in payment for many services predominantly performed by those specialties. The following Medicare designated specialties have at least a +/-10 percent change in their specialty-level IPCIs:

Medicare Designated Specialty	**Percent Change in Specialty IPCI**
66 - Rheumatology	-39%
03 - Allergy/immunology	-36%
90 - Medical oncology	-27%
76 - Peripheral vascular disease	-23%
C0 - Sleep Medicine	-21%

Medicare Designated Specialty	Percent Change in Specialty IPCI
83 - Hematology/oncology	-20%
19 - Oral surgery (dentists only)	-19%
09 - Interventional Pain Management	-17%
04 - Otolaryngology	-15%
72 - Pain management	-15%
07 - Dermatology	-12%
34 - Urology	-10%
77 - Vascular surgery	-10%
08 - Family practice	10%
71 - Registered Dietician/Nutrition Professional	11%
11 - Internal medicine	13%
26 - Psychiatry	17%
79 - Addiction medicine	24%

There are 1,100 CPT codes that are proposed to experience a non-facility practice expense payment reduction, which cannot be explained by any other factor other than the change in their service level IPCI predominantly due to the E/M payment collapse. The 1,100 codes, which collectively account for $10 billion in Medicare allowed charges, meet the following criteria:

- No change in work RVU
- Little change or an increase in direct practice costs
- Not reviewed by CMS and the RUC for CY2019
- Not subject to the CY2018 phase-in policy required by PAMA
- Are in existence for both CY2018 and CY2019

We estimate that the change in the specialty-level IPCI will result in a redistribution of almost $1 billion between Medicare specialties based on an analysis which involved determining the percentage change in the volume-weighted service level IPCIs and multiplying that by an estimate of the indirect practice expense allowed charges for each service. Of the Medicare specialties with at least $1 million in allowed charges for office visits and $10 million in indirect allowed charges for other services, we project that those specialties would experience the following impacts (*Note, as CMS does not disclose service level IPCIs or several other nuances of the practice expense formula to the public, these impacts are based on approximations of the year-to-year change in service level IPCIs and CY2019 indirect practice expense RVUs)*:

- Twenty-one different specialties would face at least a 5 percent reduction in their indirect practice expense allowed charges (excluding office visits), whereas only two specialties would see an increase of at least 5 percent.

- Thirteen specialties would experience at least a $20 million reduction in Medicare allowed charges due to service level IPCI changes, whereas only two specialties would experience an increase of at least $20 million.
- Three specialties would face a reduction of at least $50 million in their indirect practice expense allowed charges for all services excluding office visits (Dermatology, Ophthalmology and Otolaryngology), whereas only one would experience an increase of at least $50 million (Internal Medicine).
- Allergy and Immunology, Hematology/Oncology, Medical Oncology, Rheumatology, Pain Management and Pathology are examples of other Medicare specialties that would experience large reductions in their total allowed charges.
- For 17 specialties, the IPCI methodology policy change would have a larger impact on their total allowed charges than the net effect of the E/M payment collapse and the E/M MPPR policies.

This large redistribution in Medicare payment would occur even though there was little or no change in the underlying resource costs involved in performing most services. For example, chemotherapy services, which have a slight increase in proposed direct practice costs for CY2019 due to an unrelated CMS proposal to reprice Medicare supplies and equipment, would still experience a total Medicare payment cut of over 10 percent (ie, CPT codes 96401, 96409, 96411, 96413, 96415, 96416, 96417, 96422, 96423 and 96425, which accounted for almost $400 million in total Medicare allowed charges for 2017, are each individually proposed to decrease in total Medicare payment of at least 10 percent). Chemotherapy services were also not subject to the phase-in and were not recently reviewed for CY2019.

CPT Code	2019 Description	% Change Work RVU	% Change Non-Facility PE RVU	% Change PLI RVU	% Change NF Total RVU	% Change NF Direct PE
96401	Chemo anti-neopl sq/im	0%	-12%	-20%	-11%	+2%
96409	Chemo iv push sngl drug	0%	-12%	-29%	-11%	+1%
96411	Chemo iv push addl drug	0%	-11%	0%	-10%	+2%
96413	Chemo iv infusion 1 hr	0%	-12%	-13%	-11%	+1%
96415	Chemo iv infusion addl hr	0%	-13%	0%	-10%	0%
96416	Chemo prolong infuse w/pump	0%	-12%	-13%	-11%	+1%
96417	Chemo iv infus each addl seq	0%	-11%	-25%	-10%	+2%

96422	Chemo ia infusion up to 1 hr	0%	-17%	8%	-16%	+1%
96423	Chemo ia infuse each addl hr	0%	-16%	-33%	-15%	+1%
96425	Chemotherapy infusion method	0%	-16%	-7%	-15%	+1%

The CY2019 Proposed Rule did not disclose the impact of the E/M payment collapse on indirect practice expense for other services. CMS' impact analyses in the Proposed Rule also do not appear to account for these large changes. Therefore, most stakeholders are not even aware of the impact of the IPCI policy change and have not been provided with an opportunity to comment. In the past, changes in specialty-level IPCI year-to-year have had relatively minimal impact on Medicare payment. It is unclear whether CMS even accounted for the specialty level-IPCI change when designing their E/M payment collapse and multiple procedure reduction proposal. Also, given this additional impact on the indirect practice expense for all services, it is unclear whether the proposed E/M payment collapse and E/M MPPR are budget neutral. **The RUC concludes that the development of an E/M IPCI distorts the relativity of the RBRVS and should not be implemented.**

C. Proposed Podiatry Evaluation and Management Services

Podiatry has played an important part in the CPT and RUC Processes for more than two decades. Since the inception of the RBRVS, podiatrists have been paid based on the resource-costs required to perform the office visits services (99201-99215). CMS proposes to implement two new codes for 2019 and direct podiatrists to report these codes, rather than the CPT office visits.

GPD0X *Podiatry services, medical examination and evaluation with initiation of diagnostic and treatment program, new patient*

GDP1X *Podiatry services, medical examination and evaluation with initiation of diagnostic and treatment program, established patient*

CMS' proposals would effectively serve to provide differential payment for the same E/M services, based on specialty, singling out podiatry for reduced payment. The Social Security Act Section 1848(c)(6) expressly prohibits differential valuation (and thereby payment) of services paid under the Medicare Physician Payment Schedule based on specialty. CMS does not provide any rationale for why the E/M required for patients seeking care from podiatrists is distinct from that provided to patients seeking medical care from other physicians. **Therefore, we urge CMS to not finalize its proposal to provide differential payment to podiatrists by requiring them to utilize separate E/M codes.**

The CPT Editorial Panel and the RUC created a workgroup, the CPT/RUC Workgroup on E/M, (*see attachment 06*) to develop a coding proposal to simplify the documentation burden related to the provision of E/M office visits. The Workgroup believes that modifications to the office visit relative values must be resource-based. The RUC supports these efforts and urges CMS to actively participate with the Workgroup. Any major changes to physician payment must be considered carefully and with the input of the physician community.

VI. Technical Corrections for CY 2019 CMS Time File

The RUC reviewed the CY 2019 *Proposed Rule* Physician time file and discovered an issue with 13 codes which have incorrect times. **The RUC recommends for these services to be corrected in the CY 2019 CMS Time file for the CY 2019 Final Rule. The correct inputs for these 13 services and justifications for each correction are available under attachment *07 Technical Correction - Corrected Physician Times for CY2019 CMS Time File*.**

Thank you for your careful consideration of the RUC's comments on the CMS *Proposed Rule* on the revisions to Medicare payment policies under the Physician Payment Schedule for calendar year 2019, published in the July 27, 2018 *Federal Register (Vol. 83, No. 145 FR, pages 35704-36368)*. Please do not hesitate to contact the RUC with questions about our recommendations and comments. We appreciate the continued opportunities to offer recommendations to improve the RBRVS.

Sincerely,

Peter K. Smith, MD

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

AMA
AMERICAN MEDICAL ASSOCIATION

March 30, 2018

Ryan Howe, Director
Division of Practitioner Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Mr. Howe:

In the CY 2018 Final rule for the Medicare physician payment schedule (CMS–1676–F), the Centers for Medicare and Medicaid Services (CMS) indicated that the agency would not finalize its proposal to use the most recent data for the CY 2018 professional liability insurance relative value units (PLI RVUs). Significant comments had been submitted surrounding the accuracy of the premium data collection. The American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC) welcomes the opportunity to work together to make the PLI RVUs as accurate as possible for all specialties and other health care professionals and offers input below on three key areas: non-physician health care professional premium rates, premium data collection, and crosswalk assistance.

Non-Physician Health Care Professional Premium Rates
While CMS continues to crosswalk non-physician health care professionals to the lowest physician specialty risk factor for which its contractor collects premium rates (Allergy Immunology), the RUC has consistently maintained that a risk factor linked to a physician specialty is too high for many of the non-physician health care professions. The RUC has repeatedly called for improvements in data collection efforts such that updated premium data is obtained for the non-physician health care professions from all fifty states. In a meeting with CMS, Acumen, and the RUC in January 2018, representatives from Acumen noted that adequate premium data was obtained for some non-physician health care professionals (eg, CRNAs and nurse-midwives) but could not explain why insufficient data was collected for most other non-physician professions. AMA staff referenced an insurance carrier, Health Providers Service Organization (HPSO) www.hpso.com, as a source of potential information for collection of premium data for most non-physician health care professions.

A simple collection of current premium rate quotes from HPSO demonstrates that the rates are substantially lower for certain non-physician health care professionals than the proposed crosswalk premium rate of $8,398 for CY 2018 for Allergy Immunology. The liability premiums are not at all comparable, and the RUC is concerned that non-physician health care professionals are being overcompensated by using the crosswalk to Allergy Immunology. Note the large discrepancies displayed in the data table below. While these premium rates reflect an estimate from one source for one state and do not represent every non-physician health care profession, this data still provides a pointed comparison to suggest that a direct crosswalk to Allergy Immunology is unreasonable and excessive.

Non-Physician Health Care Professional Annual PLI Premium Amounts

Specialty Code	Specialty Name	Crosswalked to Specialty	CY 2018 Natl. Average PLI Premium (Allergy)	HPSO 2018 Estimate PLI Premium (Illinois)
15	Speech Language Pathologist	Allergy/ Immunology	$8,398	**$151**
62 / 68	Psychologist	Allergy/ Immunology	$8,398	**$1006**
64	Audiologist	Allergy/ Immunology	$8,398	**$151**
65	Physical Therapist	Allergy/ Immunology	$8,398	**$496**
67	Occupational Therapist	Allergy/ Immunology	$8,398	**$235**
71	Registered Dietitian/Nutrition Professional	Allergy/ Immunology	$8,398	**$278**
80	Licensed Clinical Social Worker	Allergy/ Immunology	$8,398	**$320**

Data obtained from http://www.hpso.com for self-employed; full-time; $1,000,000 / $3,000,000 policy.

In September 2005, the RUC submitted a comment letter to CMS on the Notice of Proposed Rule Making (NPRM) for the 2006 Physician Payment Schedule, published in the August 8, 2005 *Federal Register* (Attachment 1). The letter recommended that the risk factor be set to 1.00 for eight non-physician health care professions rather than to the higher "all physicians" category (3.04), "as conventional wisdom suggests that their PLI premium data is not greater than $6,152 per year." This comment letter is attached along with two letters from the RUC Health Care Professionals Advisory Committee (HCPAC) from 2005-06 which gathered premium data for eight non-physician health care professions and presented a far more accurate estimation of the premium data than the $6,152 figure utilized by CMS at that time (Attachments 2 & 3).

Over a decade later, the issue with non-physician health care professional premiums is even more pronounced. The premium rate for the lowest physician specialty risk factor has risen to $8,398 and the contractors are unable to consistently obtain premium data from all states for all non- physician health care professionals. In response to our inquiry (Attachment 4), HCPAC staff from the National Association of Social Workers stated:

> "Thank you for the opportunity to make comments on the PLI Premium Amount for Clinical Social Workers. I consulted with NASW Assurance Services which is the insurance component of NASW that sells liability insurance to NASW members and other social workers in 50 states and three United States territories.
>
> The pricing model for the table on the far right (2018 HPSO Estimate PLI Premium) is based on rates offered by HPSO at $320, who has the highest priced *occurrence policy* for social workers in the industry.
>
> A fair price for the same coverage outside of HPSO is offered by two other PLI Occurrence product competitors to the HPSO policy with a comparable product, but differing lower annual pricing, $280 for one carrier and $205 for another carrier.
>
> Many social work professionals choose the *optional PLI claims made contract* where the industry pricing for this product starts around $60 for a full time social work professional, peaking over $200 after 6 years, with the ultimate responsibility to buy a tail at the end. The claims made pricing differs by single digits among the carriers that offer this product.
>
> In the category from your excel document, "CY 2018 Natl. Average PLI Premium (Allergy)", this price would not be accurate for a social worker professional liability policy annual expectation nor a corporate/legal entity account unless it is very large. Most clinical social workers in an independent private practice setting are in a small solo or group practice.
>
> Therefore NASW recommends a lower PLI Premium based on the information above."

Clearly, the CMS assumption of $8,398 per year overestimates the actual PLI premium data. The seven non-physician health care professions listed above receive $129 million for PLI-specific Medicare payment (Attachment 5). The RUC recommends that CMS collect actual premium data for non-physician health care professionals. In the meantime, consideration should be given to establishing a cap on the PLI RVUs for non-physician health care professionals that we would recommend at 0.01 RVU per service. The attached list reflects all impacted services (Attachment 6).

Premium Data Collection
The RUC comment letter from 2005 also commented on the PLI relative value methodology:

> "The RUC continues to remain concerned regarding the sources of data utilized for PLI premiums. Representatives from our PLI Workgroup have discussed this issue with CMS staff on behalf of the RUC. We understand that CMS staff will review the potential use of other data sources, such as the Physicians Insurers Association of America (PIAA), in determining how best to collect PLI premium data in the future. We look forward to our work with you to improve this data collection effort."

The RUC comment letter on the NPRM for the 2018 Physician Payment Schedule, published in the July 21, 2017 *Federal Register*, reiterated the same concerns about premium data collection as reflected in a comment letter from over twelve years ago. The RUC remains concerned by the difficulty encountered by the contractors in obtaining sufficient data from all fifty states for all specialties, especially common specialties like hand surgery, interventional cardiology, etc.

The RUC appreciates that in the CY 2018 Final rule for the Medicare physician payment schedule (CMS–1676–F), CMS did not finalize its proposal to use the most recent data for the PLI RVUs and sought comment on "methodologies and sources that we might use to improve the next update of MP premium data." Below is a list of alternative data collection points that could be utilized in addition to the current sources (National Association of Insurance Commissioners (NAIC) SERFF Access Interface and state departments of insurance):

- Physicians Insurers Association of America (PIAA) - the insurance industry trade association that represents a full range of entities doing business in the medical professional liability arena
- Large national PLI brokers (for example, Gallagher, Marsh) - contact large PLI carriers to obtain data on premiums for physicians they insure
- Large health care systems (for example, Kaiser) - work with large medical groups/systems whose physicians do not pay individual premiums, but where the costs of malpractice insurance for different specialties within their group/system are known
- Individual physicians - obtain data on malpractice premiums directly from physicians and other providers by survey.
- Medical Group Management Association (MGMA)
- CMS Survey of specialty societies, physicians, and allied health professionals

There are likely other alternative data sources that CMS could use in addition to those listed above. The RUC again conveys its concern with the data collection process and strongly believes that CMS should be able to obtain premium information for all Medicare physician specialties and other health care professionals and facility providers, in all states.

Crosswalk Assistance
In its recent comment letter on the NPRM for the 2018 Physician Payment Schedule, the RUC recommended that moving forward, rather than cross-walking to a similar specialty, CMS acquire adequate premium data. The crosswalk methodology used by CMS in developing the PLI RVUs for specialties for which there was not premium data for at least 35 states, and specialties for which there were not distinct premium data in the rate filings, is concerning. The letter states that,

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

In the subsequent meeting with CMS, Acumen, and the RUC in January 2018, CMS and Acumen representatives explained that in the CY 2018 proposed rule, the reason that certain specialties, like Cardiology, did not have sufficient data to compute separate surgical and non-surgical risk factors was directly due to how the raw rate filings were categorized, rather than to data availability itself. CMS and Acumen acknowledged that there are many rate filings that do not necessarily map cleanly to one single specialty. They presented an alternative option to count select raw rate filings toward the risk factor calculations for multiple related specialties in cases where several specialties are applicable. The RUC agrees that it would make sense to consider including a single rate filing in the risk factor calculations for multiple specialties and offers its assistance with the categorization process. The RUC could assist CMS in applying the specialty descriptions from the rate filings to the appropriate specialty codes. To avoid

future inappropriate crosswalks, like what occurred with Cardiology and Interventional Radiology, the RUC could translate the data to the appropriate specialties and assist CMS with the categorizations of the rate filings.

CMS recognizes that "differences regarding variances in the descriptions on the raw rate filings as well as how these raw data were categorized to conform with the CMS specialties" need to be resolved. The RUC is willing and available to help reconcile the coding changes and categorizations in the raw rate filings in order to avoid data fluctuations. Further, the RUC would readily assist CMS with appropriate crosswalks or in any other way that would be useful to the Agency.

Thank you for your consideration of the RUC's comments on the PLI RVU data collection methodology. Please do not hesitate to contact the RUC with any questions. We appreciate the continued opportunity to offer recommendations to improve the RBRVS.

Sincerely,

Peter K. Smith, MD

Attachments

cc: RUC Participants
Edith Hambrick, MD
Geri Mondowney
Karen Nakano, MD
Marge Watchorn
Patrick Sartini

American Medical Association
Physicians dedicated to the health of America

September 28, 2005

Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-P, P.O. Box 8017
Baltimore, Maryland 21244-8017

Dear Doctor McClellan:

The American Medical Association/Specialty Society RVS Update Committee (RUC) appreciates the opportunity to comment on the Notice of Proposed Rule for the 2006 Physician Payment Schedule, published in the August 8, 2005 *Federal Register*.

Practice Expense Relative Values

The Centers for Medicare and Medicaid Services (CMS) has proposed to use the direct practice expense data generated by the RUC and its Practice Expense Advisory Committee (PEAC) to determine direct practice expenses at the CPT code level. CMS has stated that they believe this change in methodology will lead toward the following goals:

- To ensure that the PE payments reflect, to the greatest extent possible, the actual relative resources required for each of the services on the physician payment schedule. This could only be accomplished by using the best available data to calculate the PE relative values.

- To develop a payment system for PE that is understandable and at least somewhat intuitive, so that specialties could generally predict the impact of changes in the PE data.

- To stabilize the PE payments so that there are not large fluctuations in the payment for given procedures from year-to-year.

The RUC completely agrees with these goals. Although we do not believe that each of these goals have been completely met, we look forward to our work with you to meet each of these objectives.

The PEAC completed its review of the direct practice expense data (clinical staff, medical supplies, and medical equipment) for existing codes in March 2004. The RUC, PEAC, and specialty societies have contributed significant resources over the past five years to ensure that the direct practice expense data are fair and relative across all CPT codes. The RUC also congratulates CMS for the sincere and extraordinary effort of your staff in reviewing this data and implementing it in a timely fashion each year. We are proud of this effort and its end result and strongly encourage the continued utilization of this data.

The review of direct practice expense data, however, must continue. The RUC will continue its process of reviewing practice expense data for new and revised codes on an annual basis. In addition, the RUC will be exploring how to best address ongoing practice expense refinement needs, such as new technology that moves into the physician office, at our February 2006 meeting.

In addition, the RUC requests that CMS consider a different approach for payment of high-priced disposable medical supplies, such as the creation of J codes for the separate reporting of such items. The RUC is concerned that under the current payment methodology, these supplies are priced at one point and time and then hidden within the overall physician payment for this service, without further review. Disposable supplies that reflect new technology may reflect pricing changes within the first six months to one year after a wider release into the market. The RUC strongly encourages CMS to review and re-price medical supplies, priced at or above $200, on an annual basis. We understand that currently there are only 40 such supply items priced above $200.

Finally, the RUC requests that any savings from any new policies related to imaging multiple procedure reductions to be applied within the practice expense relative values, rather than to all relative values. The RUC has consistently commented that the physician work relative values should remain stable and again request that CMS not apply budget neutrality adjustments to this portion of the RBRVS.

Payment for Splint and Cast Supplies

Since 2000, CMS has excluded cast and splint supplies from the practice expense database for the Current Procedural Terminology (CPT) codes for fracture management and cast/strapping application procedures, since these supplies could otherwise be separately billed using Healthcare Common Procedure Coding System (HCPCS) codes Q4001 through Q4051. CMS now proposes to eliminate the separate HCPCS codes for these casting supplies and to again include these supplies in the practice expense database. By bundling the cost of the cast and splint supplies into the practice expense component of the applicable procedure codes under the fee schedule, physicians will no longer need to bill Q-codes in addition to the procedure codes to be paid for these

materials. This change would affect the practice expense RVUs for the following CPT codes: 23500 through 23680, 24500 through 24685, 25500 through 25695, 26600 through 26785, 27500 through 27566, 27750 through 27848, 28400 through 28675, and 29000 through 29750.

We appreciate that this proposal makes coding and billing for fracture management and casting/strapping easier by reducing the number of codes that physicians must submit in such situations. We also appreciate that CMS has invited the relevant medical specialties to review direct practice expense inputs for the codes in question and provide CMS with feedback regarding the appropriateness of the type and amount of casting and splinting supplies and about the amount of casting supplies needed for the 10-day and 90-day global procedures. We are interested in reviewing this data, so the resulting inputs enjoy the same level of scrutiny and cross-specialty refinement that all of the other direct practice expense inputs have.

Implanted Neuraxial Pump and Stimulator Programmer

CMS has proposed eliminating the direct practice expense inputs for the cost of purchasing the programming devices for implanted neuraxial drug infusion pumps and dorsal column stimulators, based on the Medtronics Corporation's contention that these programmers are provided free of charge to physicians. Several organizations representing pain medicine physicians, including ASA, AAPM and ASIPP, performed an e-mail based survey of practicing pain physicians to determine the validity of the Medtronics claim. Of the over 70 responses received thus far, 60% of physicians report paying for the programmers and only 40% reported receiving a programmer without charge.

Given that the majority of the survey responses received indicate that the physicians do pay for these programming units, the RUC believes that Medtronics claim has questionable validity, payment for these programmers is typical and recommends that the previously RUC approved direct inputs for the programmers be maintained for codes 62367, 62368 and 95970-79. In addition, the RUC recognizes that a number of manufacturers, in addition to Medtronics, also produce pumps and stimulators and is concerned that CMS would base this proposed change solely on the recommendation from a single manufacturer.

Professional Liability Insurance Relative Values

The RUC sent the attached letters to CMS on March 4, 2005 and May 26, 2005 regarding our recommendations on improvements to the methodology to calculate Professional Liability Insurance (PLI) relative value. We appreciate the CMS response to each of these recommendations in the NPRM. Our comments will focus on your proposals and

we offer several suggestions for modification to the PLI relative value methodology for consideration in your Final Rule on the 2006 Medicare Physician Payment Schedule.

Five Percent Specialty Threshold

The RUC has consistently argued that the dominant specialty should be utilized to determine which risk factor to apply to a CPT code. CMS has determined that the dominant approach will not be utilized, but has offered to review other solutions to remove anomalous data from the utilization. In May, the RUC recommended that CMS remove specialties from the methodology if the specialties represent less than a 5% threshold of the utilization. CMS has proposed utilizing this approach, however, the agency has removed the Evaluation and Management (E/M) codes from this threshold approach. The RUC recommends that the 5% threshold approach be applied in determining PLI relative values for all services, including E/M.

Specialty Crosswalk Issues

In March, the RUC recommended that the following professions risk factor be set to 1.00 as conventional wisdom suggests that their PLI premium data is not greater than $6,152 per year:

Clinical Psychologist	Optician
Licensed Clinical Social Worker	Optometry
Occupational Therapist	Chiropractic
Psychologist	Physical Therapist

CMS has agreed with the RUC's recommendation and proposes to set the 2006 PLI risk factor to 1.00 for each of the above professions. Each of these professions are represented on the RUC's Health Care Professional Advisory Committee (HCPAC). The HCPAC agreed that these professions should review the current available data on their PLI premium data and report back to the HCPAC at their September 29 meeting. Each of these professions has responded with estimated premium data. For all but optometry, the organization has verified that the annual PLI premium is less than $6,152 per year. Optometry does not provide any data, but requests that CMS assume that the PLI premium is the same as ophthalmology.

The American Physical Therapy Association (APTA) suggests that CMS should utilize PLI premium amount of $1,500 to compute the risk factor for physical therapy in 2006. The HCPAC will review all of these submissions on September 29 and will forward that information to CMS immediately after the meeting. The RUC recommends that you consider this information in establishing risk factors for all specialties in 2006 and beyond.

CMS has announced that it agrees the RUC that the following groups should be treated as the other 34 Medicare specialties that were excluded from the analysis of determining PLI relative values: certified clinical nurse specialist; clinical laboratory; multi-specialty clinic or group practice; nurse practitioner; physician assistant; and physiologist laboratory (independent). We agree with CMS determination to establish PLI relative values based upon the mix of specialties exclusive of these professions and specialties. The RUC recommended that certified registered nurse anesthetists (CRNA) be cross-walked to Anesthesiology (currently 2.84), rather than to the "all physicians" category (currently 3.04). CMS has rejected this recommendation. We do not understand this determination and common sense indicates that the PLI premiums for CRNAs are not higher than anesthesiologists. We request that CMS reconsider this decision.

The RUC also recommended the following crosswalks be considered:

- Gynecologist/oncologist (currently 5.63) should be crosswalked to surgical oncology (currently 6.13 – based on a crosswalk to general surgery).

- Colorectal surgery (currently 4.08) should be crosswalked to general surgery (currently 6.13).

- Hand surgery (currently 4.71) be crosswalked to orthopaedic surgery (without spine) (currently 8.06).

CMS rejected the new crosswalk for gynecology oncology and colorectal surgery and did not mention hand surgery in the NPRM. We request that CMS reconsider this action and adopt the RUC recommendations in the Final Rule.

Cardiac Catheterization and Angioplasty Exception

The RUC fully supports the CMS proposal to correct an ACC clerical error, which resulted in the omission of several cardiac catheterization and angioplasty codes from an exception list, where the risk factor should be "surgical" versus "non-surgical" procedures. The RUC supports adding the following codes to the existing exception list: 92975; 92980-92998; and 93618 – 93641.

Dominant Specialty for Low Volume Codes

After an exhaustive review of 1,844 codes with utilization less than 100 Medicare claims per year, the RUC forwarded a suggested dominant specialty for each of these low volume codes to CMS and suggested the use of this list as a substitution for claims data. CMS has indicated that in most cases, the dominant specialty suggested by the RUC is reflected as the specialty with the highest utilization in the most recent dataset. This may

be true, as these errors in claims will impact low volume codes differently each year. Our point is that CMS should not rely on claims data to determine the appropriate PLI specialty risk factor for these very low volume codes, but instead use the list as developed by the RUC.

The selection of the appropriate specialty may have a significant effect, particularly for those specialties with high PLI premiums. The following is an example of this impact:

	Specialty in Medicare Utilization	Work	PE	PLI
61705	Neurosurgery	36.15	19.25	8.76
61708	Diagnostic Radiology	35.25	15.15	2.49

In this case, staff predicted that neurosurgery should be the specialty for this entire family of services 61705, 61708, and 61710. The only way to safeguard these low volume services from this type of error caused by claims data is to assign the specialty for these codes and avoid any year-to-year fluctuations.

We submit the attached list of recommended specialties for low volume codes again and urge its use for establishing PLI relative values for 2006.

PLI Premium Data Collection

The RUC continues to remain concerned regarding the sources of data utilized for PLI premiums. Representatives from our PLI Workgroup have discussed this issue with CMS staff on behalf of the RUC. We understand that CMS staff will review the potential use of other data sources, such as the Physicians Insurers Association of America (PIAA), in determining how best to collect PLI premium data in the future. We look forward to our work with you to improve this data collection effort.

Publishing Relative Value Units (RVUs) for Non-covered Services

The American Academy of Pediatrics has noted that CMS has not yet published relative values for two CPT codes 99173 *Screening test of visual acuity, quantitative, bilateral)* and 92551 *Screening test, pure tone, air only.* The RUC submitted direct practice expense inputs for both of these services. CPT code 99173 was reviewed in May 1999 and CPT code 92551 was reviewed in February 2005. We reaffirm our previously stated position that CMS has a responsibility to publish relative values for all services, regardless of your coverage policies. We urge you to publish practice expense relative values for these services in the *Final Rule.*

The RUC appreciates the opportunity to offer these comments to CMS. We look forward to our continued relationship to further improve the RBRVS.

Sincerely,

William L. Rich, III, MD, FACS

cc: RUC participants
Glenn M. Hackbarth, Chairman of MedPAC

Attachment

February 27, 2006

Terry Kay
Centers for Medicare and Medicaid Services
7500 Security Blvd, C4-01-15
Baltimore, MD 21244

Dear Mr. Kay,

In the 2004 November 15 *Final Rule*, CMS indicated that the agency was interested in RUC input on the appropriateness of the PLI crosswalk assumptions. The risk factors are currently set at the all physician risk factor for the professions indicated below. The RUC requested the PLI risk factor be set to 1.00 ($6,100) for the following eight health professionals and that CMS investigate other data as $6,100 most likely over estimates the PLI premium for these professions. The RUC also invited these professions to present evidence that their annual PLI premiums are greater than $6,100. These professions include:

- Clinical Psychologist
- Licensed Clinical Social Worker
- Occupational Therapist
- Psychologist
- Optician
- Optometry
- Chiropractic
- Physical Therapist

The HCPAC professions made their best effort to gather information on the collection of PLI premium data and submitted it to the HCPAC at the September 29, 2005, meeting. The professions indicated above, except opticians/optometry, submitted PLI premium data to the HCPAC. Subsequently, the HCPAC submitted this data to CMS in a letter dated October 6, 2005. However, the letter did not include data from opticians/optometry.

At the February 2, 2006, HCPAC meeting, the American Optometric Association (AOA) had PLI premium data available and submitted it the HCPAC. The HCPAC believes that the yearly average PLI premium data per profession indicated in the following table is now complete, accurate and should be utilized in determining the risk factors for use in the PLI methodology. The CMS assumption of $6,100 per year overestimates the actual PLI premium data and results in an underestimation of the PLI risk factors for physician specialties.

Specialty Society	Average Yearly Premium	Yearly Premium Range
American Chiropractic Association	$1,870 (in 2005)	Up to $4,000 - $6,000 (New York averages $4,000 and Florida $6,000)
American Occupational Therapy Association		$250 - $1,000 (in 2004/2005)
American Psychological Association	$1,500	
American Physical Therapy Association	$1,100 (2005) $1,500 (projected for 2006)	
American Speech-Language-Hearing Association	$700 (Typical private practice with hearing aid dispensing capabilities)	$62 (Individual) $167 (Group)
National Association of Social Workers	$500	
American Optometric Association		$500 to $2,000
American Dietetic Association		$118-$144 (hospital facility) $900 (small practice)

Following the February 2, 2006, HCPAC meeting, the American Optometric Association informed AMA staff that they were recently informed that PLI premiums for optometrists are to increase ranging from $511.00 to $4,800.00. The HCPAC reviewed and approved the initial premium range of $500.00 to $2,000.00 submitted by AOA. However, enclosed are both letters submitted from AOA.

Enclosed are the letters each specialty submitted to the RUC HCPAC.

Sincerely,

Richard W. Whitten, MD, FACP
HCPAC Chair

Mary Foto, OTR
HCPAC Co-Chair

cc: Carolyn Mullen
Rick Ensor
Stephanie Monroe
HCPAC Participants

American Optometric Association
1505 Prince Street • Alexandria, VA 22314 • (703) 739-9200
FAX: (703) 739-9497

January 31, 2006

Richard W. Whitten, MD, Chair
Health Care Professionals Advisory Committee
American Medical Association
515 N. State Street
Chicago, IL 60610

Dear Doctor Whitten:

In late 2004, the RUC PLI workgroup recommended changes in the professional liability insurance (PLI) risk factor for eight specialties including optometry to 1.0 based on conventional wisdom that actual premiums for these specialties were less than the $6,200 represented by the 1.0 risk factor. In the 2005 PFS optometry was assigned a PLI risk factor of 2.35 (cross walked to the non-surgical risk factor for ophthalmology) as recommended in the August 2004 Bearing Point report. The workgroup requested the affected specialties provide premium data to refute the requested change.

The American Optometric Association opposed the proposed change in the PLI risk factor for optometry based on "conventional wisdom" and has attempted to obtain valid representative data of PL insurance premiums for optometry. We have contacted several different insurance carriers who provide PL for optometrists and have either had no response or they have declined to provide premium data.

Informal information obtained from a variety of providers regarding premium data for optometry reflects a wide variety of practice patterns, different demographics and the non-uniform scope of practice for optometry across the country. We have concluded it is not possible for AOA to accurately determine a precise estimate of premium data for optometry. Nonetheless, we can provide the following information based on our informal survey of providers. Most optometrists have professional liability premiums ranging from $500.00 to $2,000.00 per year. We realize that some practitioners have premiums lower than this and that some have premiums in excess of this estimate.

The AOA would appreciate the opportunity to submit additional evidence supporting a different range of professional liability premiums if future data supports this. Therefore, we would ask the RUC to ask CMS to refine its PLI risk factor for optometry should that happen. Thank you.

Sincerely,

Christopher J. Quinn, OD
Member, RUC/HCPAC

American Optometric Association
1505 Prince Street, Alexandria, VA 22314•(703) 739-9200
FAX: (703) 739-9497

February 8, 2006

Richard W. Whitten, MD, Chair
Health Care Professionals Advisory Committee
American Medical Association
515 N. State Street
Chicago, IL 60610

Dear Doctor Whitten:

In late 2004, the RUC PLI workgroup recommended changes in the professional liability insurance (PLI) risk factor for eight specialties including optometry to 1.0 based on conventional wisdom that actual premiums for these specialties were less than the $6,200 represented by the 1.0 risk factor. In the 2005 PFS optometry was assigned a PLI risk factor of 2.35 (cross walked to the non-surgical risk factor for ophthalmology) as recommended in the August 2004 Bearing Point report. The workgroup requested the affected specialties provide premium data to refute the requested change.

The American Optometric Association opposed the proposed change in the PLI risk factor for optometry based on "conventional wisdom" and has attempted to obtain valid representative data of PL insurance premiums for optometry. We have contacted several different insurance carriers who provide PL for optometrists and have either had no response or they have declined to provide premium data.

Informal information obtained from a variety of providers regarding premium data for optometry reflects a wide variety of practice patterns, different demographics and the non-uniform scope of practice for optometry across the country. We have concluded it is not possible for AOA to accurately determine a precise estimate of premium data for optometry. Nonetheless, we can provide the following information based on our informal survey of providers. Most optometrists have professional liability premiums ranging from $511.00 to $4,800.00 per year. We realize that some practitioners have premiums lower than this and that some have premiums in excess of this estimate.

The AOA would appreciate the opportunity to submit additional evidence supporting a different range of professional liability premiums if future data supports this. Therefore, we would ask the RUC to ask CMS to refine its PLI risk factor for optometry should that happen. Thank you.

Sincerely,

Christopher J. Quinn, OD
Member, RUC/HCPAC

American Chiropractic Association

DEDICATED TO IMPROVING THE HEALTH AND WELLNESS OF AMERICA, NATURALLY.

September 1, 2005

Sherry Smith
American Medical Association
RBRVS Update Committee
515 North State Street
Chicago, IL 60610

Dear Sherry,

This letter is in response to the RUC HCPAC request for data relative to Professional Liability premium levels paid by the chiropractic profession. To this end we contacted the National Chiropractic Mutual Insurance Corporation (NCMIC) for some insight into current premium levels. We believe this particular company has the largest number of insureds in the country.

According to Mr. Rod E. Warren, chief operating officer of NCMIC, in 2005 the average doctor of chiropractic will pay approximately $1870.00 in annual premiums (an arithmetic mean). A number of factors go into this premium average, including discounts for new practitioners, claims made step factors and limits selected. Per Mr. Warren, it is important to note that the range of premium rates is skewed and broad with a significant number of insureds paying much higher premiums, typically in the $4,000-6,000 range. For example Florida chiropractors pay an average of $6,000, while those in New York pay an average of $4,000. As these numbers demonstrate, the average we cited is accurate but not necessarily a good representation of the actual premium paid by many chiropractors.

The American Chiropractic Association along with NCMIC feels that our profession is practicing sound patient care, excellent interpersonal skills and solid risk management practices thus decreasing lawsuits and lowering the cost of professional liability insurance premiums.

Should you need further information, please feel free to contact me personally.

Sincerely,

Anthony W. Hamm, D.C.

Anthony W. Hamm, DC
American Chiropractic Association

AOTA® The American Occupational Therapy Association, Inc.

Via Facsimile

August 31, 2005

Susan Dombrowski
American Medical Association
Relative Value Update Committee
515 N. State Street
Chicago, IL 6061

Dear Susan,

The American Occupational Therapy Association (AOTA) requested professional liability insurance (PLI) information from members and also attempted to obtain data from some of the insurance carriers. The information received varied widely. Certainly, we can definitely state that the amount is considerably less than the $6,100 floor.

Self-employed occupational therapists provided premium information that ranged from about $250 to $1,000 in 2004/2005. Therapists report increases of 50% to 200% over the past 3 years. There also seems to be a differential related to geographic location.

I'm sorry that we were unable to obtain more definitive data, but found that insurers are very reluctant to provide current numbers, and PLI rates appear to be moving targets. Please let me know if you would like us to pursue further.

Sincerely,

Judy Thomas
Senior Policy Manager

APTA
American Physical Therapy Association

1111 North Fairfax Street
Alexandria, VA 22314-1488
703.684.2782
703.684.7343 fax
www.apta.org

August 24, 2005

Sherry Smith
American Medical Association
Relative Value Update Committee
515 North State Street
Chicago, IL 60610

Dear Sherry,

In response to the charge of the HCPAC to seek data regarding the professional liability insurance paid by physical therapists, we have checked with those insurers who cover such risks. They have indicated that they are not willing to publicly release their costs/prices.

To obtain at least a view of the professional liability costs that are borne by physical therapists, we made contact with several therapists and discussed the rates that they are paying. There was an interesting variation, seeming to be centered on when they had received their most recent annual billing. Increases of 50% in a given year were not uncommon. It would appear that annual rates for typical physical therapist practices are approximately $1,100 per therapist per year (in a $1 million/ $3 million, no claims made history) for renewals currently being received.

To further verify this value, we spoke with numerous therapists at our recent Annual Conference in Boston. For those who have not received their annual premium for 2005, the numbers were significantly lower; however, one therapist shared that her practice had, over the last three years, increased from less than $500 per therapist in 2003, to $750 in 2004 and to over $1,100 in 2005 (again, in a $1-3 million, no claims made environment).

While this information may be considered anecdotal, I am not sure, given the rate of increase, that precision is possible - whatever is calculated in one month will be out of date three months later. However, I do believe that the figure of $1,100 per therapist for 2005 is far more accurate than the current figure of $6,100 that is being used.

I would further suggest, given the rate of increase of the last several years, that an appropriate amount for 2006 is going to be in the neighborhood of $1,500 per therapist, and would request that this figure be considered for calculations for the 2006 professional liability component.

Sincerely,

James J. Nugent
American Physical Therapy Association

From: "Coleman, Mirean" <MColeman@naswdc.org>
To: "Susan Dombrowski" <Susan_Dombrowski@ama-assn.org>
Date: 03/22/05 11:30:57 AM
Subject: RE: PLI for Clinical Social Workers

Hi Susan:

The average annual premium is approximately $500.00.

Mirean Coleman, MSW, LICSW, CT
Senior Policy Associate
National Association of Social Workers
202-336-8265

-----Original Message-----
From: Susan Dombrowski [mailto:Susan_Dombrowski@ama-assn.org]
Sent: Tuesday, March 22, 2005 12:15 PM
To: Coleman, Mirean
Subject: Re: PLI for Clinical Social Workers

Hi Mirean,

Does NASW have an average national amount for what the annual premium is for clinical social workers?

Sincerely,

Susan Dombrowski
Physician Payment Policy and Systems
American Medical Association
515 N. State Street
Chicago, Illinois 60610
Susan.Dombrowski@ama-assn.org
312.464.4308
312.464.5849 Fax

>>> "Coleman, Mirean" <MColeman@naswdc.org> 03/22/05 9:43:41 AM >>>

Good Morning Susan:

Clinical social workers have an annual premium that is far below $6,100. Therefore, our risk factor should remain at 1. Please let me know if you have any questions about this or require additional information. Thanks!

Mirean Coleman, MSW, LICSW, CT
Senior Policy Associate
National Association of Social Workers
202-336-8265

From: "Moore, Kimberley" <kmoore@apa.org>
To: <Susan_Dombrowski@ama-assn.org>
Date: 08/31/05 11:53:59 AM
Subject: Liability Rates for psychologists

Hi Susan,

I checked with our liability insurance company on the average cost of premiums for psychologists. It is approximately $1,500.

Also, Medicare listed "clinical psychologists" and "psychologists." Those are delineations that Medicare makes. The liability premium data is the same for either classification.

Kimberley Moore
Federal Regulatory Affairs Officer
Govt. Relations Dept.
American Psychological Association
750 First St. NE
Washington, DC 20002
202.336.5889 ph.
KMoore@apa.org

UNIVERSITY OF Miami
SCHOOL OF MEDICINE

September 1, 2005

Susan Dombrowski
American Medical Association
Relative Value Update Committee
515 North State Street
Chicago, IL 60610

Dear Susan:

We were able to examine PLI premium data from a primary carrier of liability coverage for audiologists and speech-language pathologists to obtain an estimate of our PLI expenses for you. Our expenses in this area are much lower than many professional disciplines primarily because we, both audiology and speech-language pathology, are rarely sued for malpractice. That situation is changing somewhat with our professions moving from strictly the clinical setting into the operating room setting for neurophysiological intraoperative monitoring of patients undergoing neurosurgical procedures. However, our rates are still very modest with an individual premium costing $62.00 for $1,000,000/$3,000,000 coverage. The owner of a group practice pays $167.00 for personal coverage with $2,000,000/$5,000,000 limits. However, the group practice owner commonly must also provide coverage for each professional employee and each facility that requires by contract listing the facility as an additional insured. If hearing aids are dispensed, an additional premium is required. As a result, a typical private practice with a principle owner, four professional staff, contracts with two outside facilities and hearing aid dispensing capabilities would pay a premium of approximately $700.00 per year in PLI expenses.

Sincerely,

Robert Fifer PhD

Robert C. Fifer, Ph.D.
HCPAC Representative
American Speech-Language-Hearing Association

Mailman Center for Child Development D-820
Department of Pediatrics
Division of Audiology
Tel: (305) 243-5937
Division of Speech-Language Pathology
Tel: (305) 243-6204
1601 N. W. 12th Avenue
Miami, Florida 33136
Fax: (305) 243- 6921

American Dietetic Association
Your link to nutrition and health.[sm]

120 South Riverside Plaza, Suite 2000
Chicago, IL 60606-6995
800/877-1600
www.eatright.org

Policy Initiatives and Advocacy
1120 Connecticut Avenue, Suite 480
Washington, DC 20036-3989
202/775-8277 FAX 202/775-8284

September 26, 2005

Susan Dombrowski
American Medical Association
Relative Value Update Committee
515 N. State Street
Chicago, IL 60610

Dear Susan:

The American Dietetic Association requested professional liability insurance (PLI) information from some of our members and also reviewed rates from two of the main vendors that offers liability insurance to registered dietitians. Of the data we received, we noticed considerable variability in the rates depending on the size of the RD practice, the employment setting and the amount of coverage selected. The yearly premium range for an individual RD, who obtains additional liability coverage over and above the coverage available at the hospital facility where the RD is employed for greater than 20 hours per week, is approximately $144-$118. Whereas an RD who is self-employed and owns a small practice with 2 RD FTEs may have a premium of approximately $900 or more.

Similar to other non-physician practitioners, ADA believes CMS should set the risk factor to 1.00 for RDs who provide medical nutrition therapy services.

Sincerely,
Jane White, PhD, RD, FADA
American Dietetic Association HCPAC RUC representative

Cc: Pam Michael, ADA Nutrition Services Coverage Team

October 6, 2005

Stephen M. Phillips
Director, Division of Practitioner Services
Center for Medicare Management
C4-03-06
7500 Security Blvd.
Baltimore, MD 21244

Dear Mr. Phillips:

In the 2004 November 15 *Final Rule*, CMS indicated that the agency was interested in RUC input on the appropriateness of the PLI crosswalk assumptions. The risk factors are currently set at the all physician risk factor for the professions indicated below. The RUC requested the PLI risk factor be set to 1.00 ($6,100) for the following eight health professionals and that CMS investigate other data as $6,100 most likely over estimates the PLI premium for these professions. The RUC also invited these professions to present evidence that their annual PLI premiums are greater than $6,100. These professions include:

- Clinical Psychologist
- Licensed Clinical Social Worker
- Occupational Therapist
- Psychologist
- Optician
- Optometry
- Chiropractic
- Physical Therapist

The HCPAC professions made their best effort to gather information on the collection of PLI premium data and submitted it to the HCPAC at the September 29, 2005 meeting. The professions indicated above (except opticians/optometry,) submitted PLI premium data to the HCPAC. The HCPAC believes that the yearly average PLI premium data per profession indicated in the following table is accurate and should be utilized in determining the risk factors for use in the PLI methodology. The CMS assumption of $6,100 per year overestimates the actual PLI premium data and results in an underestimation of the PLI risk factors for physician specialties.

Specialty Society	Average Yearly Premium	Yearly Premium Range
American Chiropractic Association	$1,870 (in 2005)	Typical range is $4,000 - $6,000 (New York averages $4,000 and Florida $6,000)
American Dietetic Association		$118-$144 (hospital facility) $900 (small practice)
American Occupational Therapy Association		$250 - $1,000 (in 2004/2005)
American Psychological Association	$1,500	
American Physical Therapy Association	$1,100 (2005) $1,500 (projected for 2006)	
American Speech-Language-Hearing Association	$700 (Typical private practice with hearing aid dispensing capabilities)	$62 (Individual) $167 (Group)
National Association of Social Workers	$500	
American Optometric Association	AOA does not have current premium PLI data. AOA does not agree with CMS' crosswalk to the non-surgical risk factor of 1.00.	

Enclosed are the letters each specialty submitted to the RUC HCPAC.

Sincerely,

Richard W. Whitten, MD, FACP
HCPAC Chair

Mary Foto, OTR
HCPAC Co-Chair

From: Coleman, Mirean [mailto:MColeman.nasw@socialworkers.org]
Sent: Thursday, March 08, 2018 12:44 PM
To: Rebecca Gierhahn
Subject: RE: NPP Annual PLI Premium Amounts
Importance: High

Hi Rebecca:

Thank you for the opportunity to make comments on the PLI Premium Amount for Clinical Social Workers. I consulted with NASW Assurance Services which is the insurance component of NASW that sells liability insurance to NASW members and other social workers in 50 states and five United States territories.

The pricing model for the table on the far right (2018 HPSO Estimate PLI Premium) is based on rates offered by HPSO at $320, who has the highest priced **occurrence policy** for social workers in the industry.

A fair price for the same coverage outside of HPSO is offered by two other PLI Occurrence product competitors to the HPSO policy with a comparable product, but differing lower annual pricing, $280.00 for one carrier and $205 for another carrier.

Many social work professionals choose the **optional PLI claims made contract** where the industry pricing for this product starts around $60 for a full time social work professional, peaking over $200 after 6 years, with the ultimate responsibility to buy a tail at the end. The claims made pricing differs by single digits among the carriers that offer this product.

In the category from your excel document, “CY 2018 Natl. Average PLI Premium (Allergy)”, this price would not be accurate for a social worker professional liability policy annual expectation nor a corporate/legal entity account unless it is very large. Most clinical social workers in an independent private practice setting are in a small solo or group practice.

Therefore NASW recommends a lower PLI Premium based on the information above.

If you have additional questions, please do not hesitate to let me know.

Thanks!

From: Rebecca Gierhahn
Sent: Monday, March 05, 2018 4:22 PM
To: mcoleman@naswdc.org
Cc: Sherry Smith; Samantha Ashley
Subject: NPP Annual PLI Premium Amounts

Good Afternoon,

The attached table contains PLI premium data information for your specialty. Please respond as to whether the premium amount is reasonable?

If not, please provide the correct amount and/or other data sources by Wed. March 7th .

Thank you,
Rebecca

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Medicare Spending on PLI Premiums - Non-Physician Health Care Professionals

Specialty Code	Specialty Description	PLI-Specific Medicare Payment
15	SPEECH LANGUAGE PATHOLOGIST	$ 860,691
62	CLINICAL PSYCHOLOGIST (IND.)	$ 430,291
64	AUDIOLOGIST (IND.)	$ 1,757,255
65	PHYSICAL THERAPIST (IND.)	$ 75,523,342
67	OCCUPATIONAL THERAPIST	$ 5,338,851
68	CLINICAL PSYCHOLOGIST	$ 22,711,010
71	REGISTERED DIETITIAN/NUTRITION PROFESSIONAL	$ 485,829
80	LICENSED CLINICAL SOCIAL WORKER	$ 21,959,141
	Subtotal	$ 129,066,410
	All Specialties - Excluding Anesthesia Codes	$ 4,009,049,544
	Selected Specialties as a Percentage of Total	3.2%

Sources: 1. CY 2017 estimated Medicare Physician Fee Schedule utilization

Attachment 6

Codes Predominately Performed by Non-Physician Health Care Professionals

CPT Code	Short Descriptor	Current PLI RVU	Propose PLI RVU
29200	STRAPPING OF CHEST	0.02	0.01
29240	STRAPPING OF SHOULDER	0.02	0.01
29520	STRAPPING OF HIP	0.02	0.01
29530	STRAPPING OF KNEE	0.02	0.01
64550	APPLY NEUROSTIMULATOR	0.01	0.01
90785	PSYTX COMPLEX INTERACTIVE	0.01	0.01
90791	PSYCH DIAGNOSTIC EVALUATION	0.11	0.01
90832	PSYTX W PT 30 MINUTES	0.05	0.01
90834	PSYTX W PT 45 MINUTES	0.07	0.01
90837	PSYTX W PT 60 MINUTES	0.11	0.01
90839	PSYTX CRISIS INITIAL 60 MIN	0.11	0.01
90840	PSYTX CRISIS EA ADDL 30 MIN	0.05	0.01
90845	PSYCHOANALYSIS	0.08	0.01
90846	FAMILY PSYTX W/O PT 50 MIN	0.09	0.01
90847	FAMILY PSYTX W/PT 50 MIN	0.09	0.01
90849	MULTIPLE FAMILY GROUP PSYTX	0.03	0.01
90853	GROUP PSYCHOTHERAPY	0.02	0.01
90880	HYPNOTHERAPY	0.08	0.01
90901	BIOFEEDBACK TRAIN ANY METH	0.02	0.01
92507	SPEECH/HEARING THERAPY	0.05	0.01
92508	SPEECH/HEARING THERAPY	0.01	0.01
92521	EVALUATION OF SPEECH FLUENC	0.08	0.01
92522	EVALUATE SPEECH PRODUCTION	0.07	0.01
92523	SPEECH SOUND LANG COMPREHEN	0.12	0.01
92524	BEHAVRAL QUALIT ANALYS VOIC	0.07	0.01
92526	ORAL FUNCTION THERAPY	0.05	0.01
92538	CALORIC VSTBLR TEST W/REC	0.02	0.01
92545	OSCILLATING TRACKING TEST	0.02	0.01
92550	TYMPANOMETRY & REFLEX THRES	0.02	0.01
92553	AUDIOMETRY AIR & BONE	0.01	0.01
92555	SPEECH THRESHOLD AUDIOMETRY	0.01	0.01
92556	SPEECH AUDIOMETRY COMPLETE	0.01	0.01
92557	COMPREHENSIVE HEARING TEST	0.03	0.01

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Codes Predominately Performed by Non-Physician Health Care Professionals

CPT Code	Short Descriptor	Current PLI RVU	Propose PLI RVU
92562	LOUDNESS BALANCE TEST	0.01	0.01
92563	TONE DECAY HEARING TEST	0.01	0.01
92567	TYMPANOMETRY	0.01	0.01
92570	ACOUSTIC IMMITANCE TESTING	0.03	0.01
92571	FILTERED SPEECH HEARING TES	0.01	0.01
92575	SENSORINEURAL ACUITY TEST	0.02	0.01
92576	SYNTHETIC SENTENCE TEST	0.01	0.01
92579	VISUAL AUDIOMETRY (VRA)	0.03	0.01
92582	CONDITIONING PLAY AUDIOMETR	0.02	0.01
92583	SELECT PICTURE AUDIOMETRY	0.01	0.01
92584	ELECTROCOCHLEOGRAPHY	0.02	0.01
92586	AUDITOR EVOKE POTENT LIMIT	0.02	0.01
92588	EVOKED AUDITORY TST COMPLET	0.03	0.01
92596	EAR PROTECTOR EVALUATION	0.02	0.01
92597	ORAL SPEECH DEVICE EVAL	0.07	0.01
92602	REPROGRAM COCHLEAR IMPLT 7/	0.08	0.01
92603	COCHLEAR IMPLT F/UP EXAM 7/	0.09	0.01
92604	REPROGRAM COCHLEAR IMPLT 7/	0.05	0.01
92607	EX FOR SPEECH DEVICE RX 1HR	0.08	0.01
92608	EX FOR SPEECH DEVICE RX ADD	0.03	0.01
92609	USE OF SPEECH DEVICE SERVIC	0.05	0.01
92610	EVALUATE SWALLOWING FUNCTIO	0.06	0.01
92620	AUDITORY FUNCTION 60 MIN	0.06	0.01
92621	AUDITORY FUNCTION + 15 MIN	0.01	0.01
92625	TINNITUS ASSESSMENT	0.05	0.01
92626	EVAL AUD REHAB STATUS	0.05	0.01
92627	EVAL AUD STATUS REHAB ADD-O	0.01	0.01
92640	AUD BRAINSTEM IMPLT PROGRAM	0.07	0.01
95833	BODY MUSCLE TESTING MANUAL	0.02	0.01
95851	RANGE OF MOTION MEASUREMENT	0.01	0.01
95852	RANGE OF MOTION MEASUREMENT	0.01	0.01
95992	CANALITH REPOSITIONING PROC	0.04	0.01
96101	PSYCHO TESTING BY PSYCH/PHY	0.07	0.01

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Codes Predominately Performed by Non-Physician Health Care Professionals

CPT Code	Short Descriptor	Current PLI RVU	Propose PLI RVU
96105	ASSESSMENT OF APHASIA	0.07	0.01
96116	NEUROBEHAVIORAL STATUS EXAM	0.09	0.01
96118	NEUROPSYCH TST BY PSYCH/PHY	0.07	0.01
96119	NEUROPSYCH TESTING BY TEC	0.02	0.01
96125	COGNITIVE TEST BY HC PRO	0.07	0.01
96150	ASSESS HLTH/BEHAVE INIT	0.02	0.01
96151	ASSESS HLTH/BEHAVE SUBSEQ	0.02	0.01
96152	INTERVENE HLTH/BEHAVE INDIV	0.02	0.01
96153	INTERVENE HLTH/BEHAVE GROUP	0.01	0.01
96154	INTERV HLTH/BEHAV FAM W/PT	0.02	0.01
97012	MECHANICAL TRACTION THERAPY	0.01	0.01
97016	VASOPNEUMATIC DEVICE THERAP	0.01	0.01
97018	PARAFFIN BATH THERAPY	0.01	0.01
97022	WHIRLPOOL THERAPY	0.01	0.01
97024	DIATHERMY EG MICROWAVE	0.01	0.01
97026	INFRARED THERAPY	0.01	0.01
97028	ULTRAVIOLET THERAPY	0.01	0.01
97032	ELECTRICAL STIMULATION	0.01	0.01
97033	ELECTRIC CURRENT THERAPY	0.01	0.01
97034	CONTRAST BATH THERAPY	0.01	0.01
97035	ULTRASOUND THERAPY	0.01	0.01
97036	HYDROTHERAPY	0.01	0.01
97110	THERAPEUTIC EXERCISES	0.02	0.01
97112	NEUROMUSCULAR REEDUCATION	0.02	0.01
97113	AQUATIC THERAPY/EXERCISES	0.01	0.01
97116	GAIT TRAINING THERAPY	0.01	0.01
97124	MASSAGE THERAPY	0.01	0.01
97140	MANUAL THERAPY 1/> REGIONS	0.01	0.01
97150	GROUP THERAPEUTIC PROCEDURE	0.01	0.01
97161	PT EVAL LOW COMPLEX 20 MIN	0.10	0.01
97162	PT EVAL MOD COMPLEX 30 MIN	0.10	0.01
97163	PT EVAL HIGH COMPLEX 45 MIN	0.10	0.01
97164	PT RE-EVAL EST PLAN CARE	0.07	0.01

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Codes Predominately Performed by Non-Physician Health Care Professionals

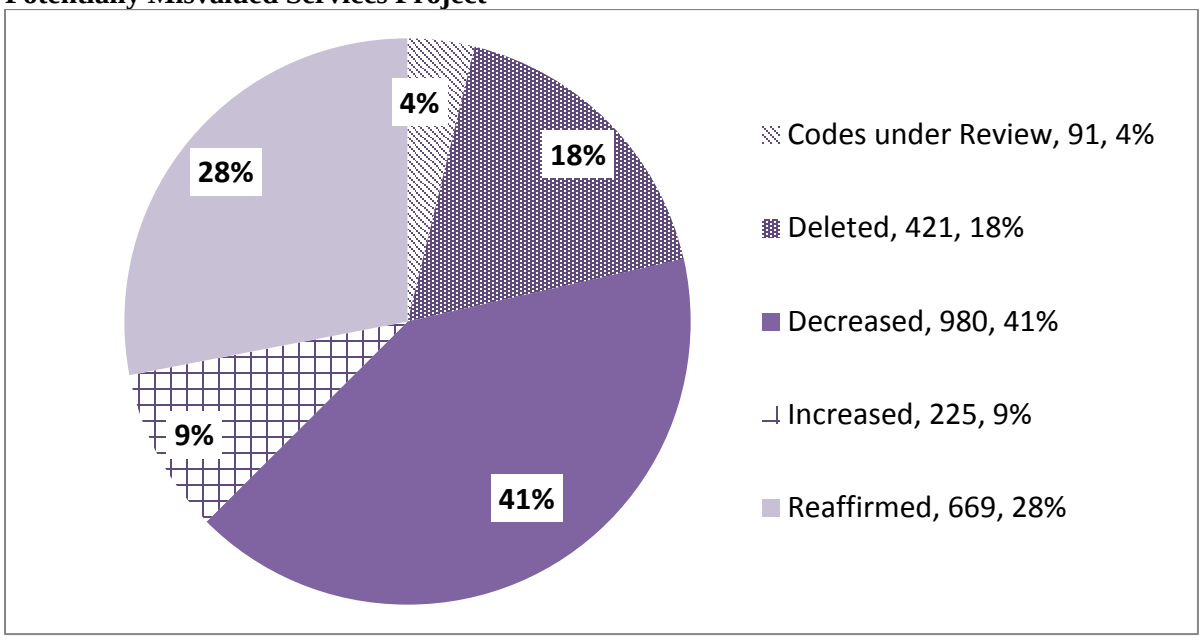
CPT Code	Short Descriptor	Current PLI RVU	Propose PLI RVU
97165	OT EVAL LOW COMPLEX 30 MIN	0.10	0.01
97166	OT EVAL MOD COMPLEX 45 MIN	0.10	0.01
97167	OT EVAL HIGH COMPLEX 60 MIN	0.10	0.01
97168	OT RE-EVAL EST PLAN CARE	0.06	0.01
97530	THERAPEUTIC ACTIVITIES	0.01	0.01
97532	COGNITIVE SKILLS DEVELOPMEN	0.01	0.01
97533	SENSORY INTEGRATION	0.01	0.01
97535	SELF CARE MNGMENT TRAINING	0.02	0.01
97537	COMMUNITY/WORK REINTEGRATIO	0.02	0.01
97542	WHEELCHAIR MNGMENT TRAINING	0.02	0.01
97750	PHYSICAL PERFORMANCE TEST	0.02	0.01
97755	ASSISTIVE TECHNOLOGY ASSESS	0.02	0.01
97760	ORTHOTIC MGMT AND TRAINING	0.02	0.01
97761	PROSTHETIC TRAINING	0.02	0.01
97762	C/O FOR ORTHOTIC/PROSTH USE	0.01	0.01
97802	MEDICAL NUTRITION INDIV IN	0.02	0.01
97803	MED NUTRITION INDIV SUBSEQ	0.02	0.01
97804	MEDICAL NUTRITION GROUP	0.01	0.01
G0109	Diab manage trn ind/group	0.01	0.01
G0270	Mnt subs tx for change dx	0.02	0.01
G0271	Group mnt 2 or more 30 mins	0.01	0.01
G0281	Elec stim unattend for pres	0.01	0.01
G0283	Elec stim other than wound	0.01	0.01

The RUC Relativity Assessment Workgroup Progress Report

In 2006, the AMA/Specialty Society RVS Update Committee (RUC) established the Five-Year Identification Workgroup (now referred to as the Relativity Assessment Workgroup) to identify potentially misvalued services using objective mechanisms for reevaluation prior to the next Five-Year Review. Since the inception of the Relativity Assessment Workgroup, the Workgroup and the Centers for Medicare and Medicaid Services (CMS) have identified 2,386 services through 20 different screening criteria for further review by the RUC. Additionally, the RUC charged the Workgroup with maintaining the "new technology" list of services that will be re-reviewed by the RUC as reporting and cost data become available.

To provide Medicare with reliable data on how physician work has changed over time, the RUC, with more than 300 experts in medicine and research, are examining over 2,300 potentially misvalued services accounting for $45 billion in Medicare spending. The update committee has recommended reductions and deletions to 1,401 services, redistributing $5 billion. Here are the outcomes for the committee's review of 2,386 codes:

Potentially Misvalued Services Project



Source: American Medical Association

New Technology

As the RUC identifies new technology services that should be re-reviewed, a list of these services is maintained and forwarded to CMS. Currently, codes are identified as new technology based on recommendations from the appropriate specialty society and consensus among RUC members at the time of the RUC review for these services. RUC members consider several factors to evaluate potential new technology services, including: recent FDA-approval, newness or novelty of the service, use of an existing service in a new or novel way, and migration of the service from a Category III to Category I CPT® code. The Relativity Assessment Workgroup maintains and develops all standards and procedures associated with the list, which currently contains 571 services. In September 2010, the re-review cycle began and since then the RUC has recommended 41 services to be re-examined. The remaining services

are rarely performed (i.e., less than 500 times per year in the Medicare population) and will not be further examined. The Workgroup will continue to review the remaining 180 services every October after three years of Medicare claims data is available for each service.

Methodology Improvements
The RUC implemented process improvements to methodology following its October 2013 meeting. The process improvements are designed to strengthen the RUC's primary mission of providing the final RVS update recommendations to the Centers for Medicare and Medicaid Services.

In the area of methodology, the RUC is continuously improving its processes to ensure that it is best utilizing reliable, extant data. At its most recent meeting, the RUC increased the minimum number of respondents required for each survey of commonly performed codes:

- For services performed 1 million or more times per year in the Medicare population, at least 75 physicians must complete the survey.
- For services performed from 100,000 to 999,999 times annually, at least 50 physicians will be required.

Further strengthening its methodology, the RUC also announced that specialty societies will move to a centralized online survey process, which will be coordinated by the AMA and will utilize external expertise to ensure survey and reporting improvements.

Site of Service Anomalies
The Workgroup initiated its effort by reviewing services with anomalous sites of service when compared to Medicare utilization data. Specifically, these services are performed less than 50% of the time in the inpatient setting, yet include inpatient hospital Evaluation and Management services within their global period.

The RUC identified 194 services through the site of service anomaly screen. The RUC required the specialties to resurvey 129 services to capture the appropriate physician work involved. These services were reviewed by the RUC between April 2008 and February 2011. CMS implemented 124 of these recommendations in the 2009, 2010 and 2011 Medicare Physician Payment Schedules. The RUC submitted another five recommendations as well as re-reviewed and submitted 44 recommendations to previously reviewed site of service identified codes to CMS for the 2012 Medicare Physician Payment Schedule.

Of the remaining 65 services that were not re-surveyed, the RUC modified the discharge day management for 46 services, maintained three codes and removed two codes from the screen as the typical patient was not a Medicare beneficiary and would be an inpatient. The CPT® Editorial Panel deleted 14 codes. The RUC completed review of services under this initial screen.

During this review, the RUC uncovered several services that are reported in the outpatient setting, yet, according to several expert panels and survey data from physicians who perform the procedure, the service, typically requires a hospital stay of greater than 23 hours. The RUC maintains that physician work that is typically performed, such as visits on the date of service and discharge work the following day, should be included within the overall valuation. Subsequent observation day visits and discharge day management service are appropriate proxies for this work.

The RUC will reassess the data each year going forward to determine if any new site of service anomalies arise. In 2015, the RUC identified three services in which the Medicare data from 2011-2013 indicated it was performed less than 50% of the time in the inpatient setting, yet included inpatient hospital Evaluation and Management services within the global period. These services were referred to CPT and recommendations were submitted to CMS for the 2018 Medicare Physician Payment Schedule.

In 2016, the RUC identified one site of service anomaly CPT code and submitted the recommendation to CMS for the 2019 Medicare Physician Payment Schedule. In 2017, the RUC identified one site of service anomaly CPT code and has referred this code to the CPT Editorial Panel for revision.

High Volume Growth

The Workgroup assembled a list of all services with a total Medicare utilization of 1,000 or more that have increased by at least 100% from 2004 through 2006. The query initially resulted in the identification of 81 services, but was expanded by 16 services to include the family of services, totaling 97 services. Specialty societies submitted comments to the Workgroup in April 2008 to provide rationales for the growth in reporting. Following this review, the RUC required the specialties to survey 35 services to capture the appropriate work effort and/or direct practice expense inputs. These services were reviewed by the RUC between February 2009 and April 2010.

The RUC recommended removing 15 services from the screen as the volume growth did not impact the resources required to provide these services. The CPT® Editorial Panel deleted 34 codes. The RUC submitted 44 recommendations to CMS for services for the 2012-2017 Medicare Physician Payment Schedules. In September 2011, the RUC began review of services after two years of utilization data were collected. The RUC will continue to review the remaining four services after additional utilization data is available.

In April 2013, the RUC assembled a list of all services with a total Medicare utilization of 10,000 or more that have increased by at least 100% from 2006 through 2011. The query resulted in the identification of 40 services and expanded to 62 services to include the appropriate family of services. The RUC recommended removing three services from the screen as the volume growth did not impact the resources required to provide these services. The RUC recommended review of two services after an additional two years of utilization data is collected. The CPT® Editorial Panel deleted ten codes and the RUC submitted recommendations for 47 services for the 2015-2019 Medicare Physician Payment Schedule.

In October 2015, the RUC ran this screen again for services based on Medicare utilization of 10,000 or more that have increased by at least 100% from 2008 through 2013. The query resulted in the identification of 19 services and expanded to 30 services to include the appropriate family of services. The RUC recommended removing one service from the screen as the volume growth did not impact the resources required to provide these services. The RUC will review eight services after an additional two years of utilization data is collected. The CPT Editorial Panel deleted eight codes and the RUC submitted recommendations for 13 services for the 2017-2019 Medicare Physician Payment Schedules.

In October 2016, the RUC ran this screen again and the query resulted in the identification of 12 services, which was expanded to 14 services. The RUC recommended removing three services from the screen as the volume growth did not impact the resources required to provide these services. The CPT Editorial Panel deleted one service. The RUC submitted recommendations for 9 services for the 2019 Medicare Physician Payment Schedule. The RUC will review two services after additional utilization data is available and provide recommendations for the remaining 2 services for the 2020 Medicare Physician Payment Schedule.

CMS Fastest Growing
In 2008, CMS developed the Fastest Growing Screen to identify all services with growth of at least 10% per year over the course of three years from 2005-2007. Through this screen, CMS identified 114 fastest growing services and the RUC added 69 services to include the family of services, totaling 183. The RUC required the specialties to survey 72 services to capture the appropriate work effort and/or direct practice expense inputs. These services were reviewed by the RUC from February 2008 through April 2010 and submitted to CMS for the Medicare Physician Payment Schedule.

The RUC recommended removing 27 services from the screen as the volume growth did not impact the resources required to provide the service. The CPT® Editorial Panel deleted 43codes. The RUC submitted 41 recommendations to CMS for the 2012-2019 Medicare Physician Payment Schedules. The RUC completed review of services under this screen.

High IWPUT
The Workgroup assembled a list of all services with a total Medicare utilization of 1,000 or more that have an intra-service work per unit of time (IWPUT) calculation greater than 0.14, indicating an outlier intensity. The query resulted in identification of 32 services. Specialty societies submitted comments to the Workgroup in April 2008 for these services. As a result of this screen, the RUC has reviewed and submitted recommendations to CMS for 28 codes, removing four services from the screen as the IWPUT was considered appropriate. The RUC completed review of services under this screen.

Services Surveyed by One Specialty – Now Performed by a Different Specialty
In October 2009, services that were originally surveyed by one specialty, but now performed predominantly by other specialties were identified and reviewed. The RUC identified 21 services by this screen, adding 19 services to address various families of codes. The majority of these services required clarification within CPT®. The CPT® Editorial Panel deleted 18 codes. The RUC submitted 22 recommendations for physician work and practice expense to CMS for the 2011-2014 Medicare Physician Payment Schedules. The RUC completed review of services under this screen.

In April 2013, the RUC queried the top two dominant specialties performing services based on Medicare utilization more than 1,000 and compared it to who originally surveyed the service. Two services were identified and the RUC recommended that one be removed from the screen since the specialty societies currently performing this service indicated that the service is appropriate and recommended that the other code be referred to CPT® to be revised. The RUC completed review of services under this screen.

Harvard Valued
Utilization over 1 Million
CMS requested that the RUC pay specific attention to Harvard valued codes that have a high utilization. The RUC identified nine Harvard valued services with high utilization (performed over 1 million times per year). The RUC also incorporated an additional 12 Harvard valued codes within the initial family of services identified. The CPT® Editorial Panel deleted one code. The RUC submitted 20 relative value work recommendations to CMS for the 2011 and 2012 Medicare Physician Payment Schedules. The RUC completed review of services under this screen.

Utilization over 100,000
The RUC continued to review Harvard valued codes with significant utilization. The Relativity Assessment Workgroup expanded the review of Harvard codes to those with utilization over 100,000 which totaled 38 services. The RUC expanded this screen by 101 codes to include the family of services, totaling 139 services. The CPT® Editorial Panel deleted 27 codes. The RUC submitted 112 recommendations to CMS for the 2011-2014 Medicare Physician Payment Schedules. The RUC completed review of services under this screen.

Utilization over 30,000
In April 2011, the RUC continued to identify Harvard valued codes with utilization over 30,000, based on 2009 Medicare claims data. The RUC determined that the specialty societies should survey the remaining 36 Harvard codes with utilization over 30,000 for September 2011. The RUC expanded the screen to include the family of services, totaling 65 services. The CPT® Editorial Panel deleted 12 codes. The RUC submitted recommendations for 53 services for the 2013-2014 Medicare Physician Payment Schedules. The RUC completed review of services under this screen.

Medicare Allowed Charges >$10 million
In June 2012, CMS identified 16 services that were Harvard valued with annual allowed charges (2011 data) > $10 million. The RUC expanded this screen to 33 services to include the proper family of services. The RUC removed two services from review as the allowed charges are approximately $1 million and did not meet the screen criteria. The CPT® Editorial Panel deleted one service. The RUC submitted recommendations for 30 services for the 2013-2017 Medicare Physician Payment Schedules. The RUC completed review of services under this screen.

CMS/Other
Utilization over 500,000
In April 2011, the RUC identified 410 codes with a source of "CMS/Other." CMS/Other codes are services which were not reviewed by the Harvard studies or the RUC and were either gap filled, most often via crosswalk by CMS or were part of a radiology fee schedule. "CMS/Other" source codes would not have been flagged in the Harvard only screens, therefore the RUC recommended that a list of all CMS/Other codes be developed and reviewed. The RUC established the threshold for CMS/Other source codes with Medicare utilization of 500,000 or more, which resulted in 19 codes. The RUC expanded this screen to 21 services to include the proper family of services. The CPT® Editorial Panel deleted three services. The RUC submitted recommendations for 16 services for the 2013-2015 Medicare Physician Payment Schedules. The RUC removed one service from the screen and will review one service for the 2020 Medicare Physician Payment Schedule.

Utilization over 250,000
In April 2013, the RUC lowered the threshold to the CMS/Other source codes with Medicare utilization of 250,000 or more, which resulted in 26 services and was expanded to 52 services to include the family of services. The CPT Editorial Panel deleted 11 codes identified under this screen. The RUC removed nine services and submitted 32 recommendations to CMS for the 2015-2019 Medicare Physician Payment Schedules. The RUC completed review of services under this screen.

Utilization over 100,000
In October 2016, the RUC lowered the threshold to the CMS/Other source codes with Medicare utilization of 100,000 or more, which resulted in 27 services and was expanded to 41 services to include the family of services. The RUC referred two codes to CPT for deletion and submitted recommendations for 39 services for the 2019 Medicare Physician Payment Schedule. The RUC completed review of services under this screen.

Utilization over 30,000
In October 2017, the RUC lowered the threshold to the CMS/Other source codes with Medicare utilization of 30,000 or more, which resulted in 34 services and was expanded to 55 services to include the family of services. The RUC referred 16 services to the CPT Editorial Panel for revision. The RUC submitted recommendations for 32 services for the 2019-2020 Medicare Physician Payment Schedules and will review the remaining services in the 2020 cycle.

Bundled CPT® Services

Reported 95% or More Together

The Relativity Assessment Workgroup solicited data from CMS regarding services inherently performed by the same physician on the same date of service (95% of the time) in an attempt to identify pairings of services that should be bundled together. The CPT® Editorial Panel deleted 31 individual component codes and replaced them with 53 new codes that describe bundles of services. The RUC then surveyed and reviewed work and practice costs associated with these services to account for any efficiencies achieved through the bundling. The RUC completed review of all services under this screen.

Reported 75% or More Together

In February 2010, the Workgroup continued review of services provided on the same day by the same provider, this time lowering the threshold to 75% or more together. The Relativity Assessment Workgroup again analyzed the Medicare claims data and found 151 code pairs which met the threshold. The Workgroup then collected these code pairs into similar "groups" to ensure that the entire family of services would be coordinated under one code bundling proposal. The grouping effort resulted in 20 code groups, totaling 80 codes, and were sent to specialty societies to solicit action plans for consideration at the April 2010 RUC meeting. Resulting from the Relativity Assessment Workgroup review, 81 additional codes were added for review as part of the family of services to ensure duplication of work and practice expense was mitigated throughout the entire set of services. Of the 161 total codes under review, the CPT® Editorial Panel deleted 35 individual component codes and replaced the component coding with 126 new and/or revised codes that described the bundles of services. The RUC will review two services after additional utilization data is available.

In August 2011, the Joint CPT®/RUC Workgroup on Codes Reported Together Frequently reconvened to perform its third cycle of analysis of code pairs reported together with 75% or greater frequency. The Workgroup reviewed 30 code pair groups and recommended code bundling for 64 individual codes. In October 2012, the CPT® Editorial Panel started the review of code bundling solutions. Of the 167 total codes under review, the CPT® Editorial Panel deleted 52 services. The RUC has submitted 113 code recommendations for the 2014-2019 Medicare Physician Payment Schedules and will review two services after additional utilization data is available.

In January and April 2015, the Joint CPT/RUC Workgroup on Codes Reported Together Frequently reconvened to perform its fourth cycle analysis of code pairs reported together with 75% or greater frequency. The Workgroup reviewed 8 code pair groups and recommended code bundling for 18 individual codes. In October 2015, the CPT Editorial Panel started review of the code bundling solutions. Of the 75 total codes under review, the CPT Editorial Panel deleted 26 services. The RUC submitted 47 code recommendations for the 2017-2019 Medicare Physician Payment Schedules and will review the two services after additional utilization data is available.

In October 2017 the Relativity Assessment Workgroup performed the fifth cycle analysis of code pairs reported together with 75% or greater frequency. Only groups that totaled allowed charges of $5 million or more were included. As with previous iterations, any code pairs in which one of the codes was either below 1,000 in Medicare claims data and/or contained at least one ZZZ global service were removed. Based on these criteria four groups or 8 codes were identified. The Relativity Assessment Workgroup determined two groups totaling four codes require code bundling solutions. The RUC referred four codes to CPT for code bundling solutions. The RUC submitted 2 code recommendations for the 2019 Medicare Physician Payment Schedule and will review the remaining codes for the 2020 Medicare Physician Payment Schedule.

Low Value/Billed in Multiple Units
CMS has requested that services with low work RVUs that are commonly billed with multiple units in a single encounter be reviewed. CMS identified services that are reported in multiples of five or more per day, with work RVUs of less than or equal to 0.50 RVUs.

In October 2010, the Workgroup reviewed 12 CMS identified services and determined that six of the codes were improperly identified as the services were either not reported in multiple units or were reported in a few units and that was considered in the original valuation. The RUC submitted recommendations for the remaining six services for the 2012 Medicare Physician Payment Schedule. The RUC completed review of services under this screen.

Low Value/High Volume Codes
CMS has requested that services with low work RVUs and high utilization be reviewed. CMS has requested that the RUC review 24 services that have low work RVUs (less than or equal to 0.25) and high utilization. The RUC questioned the criteria CMS used to identify these services as it appeared some codes were missing from the screen criteria indicated. The RUC identified codes with a work RVU ranging from 0.01 - 0.50 and Medicare utilization greater than one million. In February 2011, the RUC reviewed the codes identified by this criteria and added 5 codes, totaling 29. The RUC submitted 24 recommendations to CMS for the 2012 Medicare Physician Payment Schedule and five recommendations to CMS for the 2013 Medicare Physician Payment Schedule. The RUC completed review of services under this screen.

Multi-Specialty Points of Comparison List
CMS requested that services on the Multi-Specialty Points of Comparison (MPC) list should be reviewed. CMS prioritized the review of the MPC list to 33 codes, ranking the codes by allowed service units and charges based on CY 2009 claims data as well as those services reviewed by the RUC more than six years ago. The RUC expanded the list to 182 services to include additional codes as part of a family (over 100 of these codes are part of the review of GI endoscopy codes). The CPT® Editorial Panel deleted 25 codes. The RUC submitted recommendations for 157 codes for the 2012-2015 Medicare Physician Payment Schedules. The RUC completed review of services under this screen.

CMS High Expenditure Procedural Codes
In the Proposed Rule for 2012, CMS requested that the RUC review a list of 70 high Medicare Physician Payment Schedule expenditure procedural codes representing services furnished by an array of specialties. CMS selected these codes since they have not been reviewed for at least 6 years, and in many cases the last review occurred more than 10 years ago.

The RUC reviewed the 70 services identified and expanded the list to 145 services to include additional codes as part of the family. The CPT® Editorial Panel deleted 20 codes. The RUC submitted 125 recommendations to CMS for the 2013-2019 Medicare Physician Payment Schedules. The RUC completed review of services under the first iteration of this screen.

In the Final Rule for 2016, CMS requested that the RUC review a list of 103 high Medicare Physician Payment Schedule high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010.

The RUC expanded the list of services to 238 services to include additional codes as part of the family. The CPT Editorial Panel deleted 29 codes. The RUC submitted 207 recommendations to CMS for the 2017-2019 Medicare Physician Payment Schedules and will review the remaining two services after additional utilization data is available.

Services with Stand-Alone PE Procedure Time

In June 2012, CMS proposed adjustments to services with stand-alone procedure time assumptions used in developing non-facility PE RVUs. These assumptions are not based on physician time assumptions. CMS prioritized CPT® codes that have annual Medicare allowed charges of $100,000 or more, include direct equipment inputs that amount to $100 or more, and have PE procedure times greater than five minutes for review. The RUC reviewed 27 services identified through this screen and expanded to 29 services to include additional codes as part of the family. The CPT® Editorial Panel deleted 11 codes. The RUC submitted 18 recommendations for the 2014-2015 Medicare Physician Payment Schedules. The RUC completed review of services under this screen.

Pre-Time Analysis

In January 2014, the RUC reviewed codes that were RUC reviewed prior to April 2008, with pre-time greater than pre-time package 4 *Facility - Difficult Patient/Difficult Procedure* (63 minutes) for services with 2012 Medicare Utilization over 10,000. The screen identified 19 services with more pre-service time than the longest standardized pre-service package and was expanded to 24 to include additional codes as part of the family. The RUC reviewed these services and referred three services to the CPT® Editorial Panel for revision. The CPT Editorial Panel deleted one service and will review three services for CPT 2018. The RUC reviewed 18 services and noted that they were all originally valued by magnitude estimation and therefore readjustments in pre-service time categories did not alter the work values. Additionally, crosswalk references for each service were presented validating the pre-time adjustments. The RUC noted that this screen was useful, however did not reveal any large outliers and therefore the utilization threshold does not need to be lowered to identify more services. The RUC submitted 20 recommendations for the 2016 Medicare Physician Payment Schedule. The RUC completed review of services under this screen.

Post-Operative Visits

010-Day Global Codes

In January 2014, the RUC reviewed all 477, 010-day global codes to determine any outliers. Many 010-day global period services only include one post-operative office visit. The Relativity Assessment Workgroup pared down the list to 19 services with >1.5 office visits and 2012 Medicare utilization > 1,000. The RUC reviewed the 19 services, which was expanded to 21 services for additional codes in the family of services, identified via this screen. The RUC referred two codes to the CPT Editorial Panel for revision. The RUC submitted recommendations for 21 services for the 2015-2017 Medicare Physician Payment Schedule. The RUC has completed review of the services under this screen.

090-Day Global Codes

In January 2014, the RUC reviewed all 3,788, 090-day global codes to determine any outliers. Based on 2012 Medicare utilization data, 10 services were identified, that were reported at least 1,000 times per year and included more than six office visits. The RUC expanded the services identified in this screen to 38 to include additional codes as part of the family. The CPT® Editorial Panel deleted 8 services. The RUC submitted recommendations for 30 services for the 2015-2017 Medicare Physician Payment Schedule. The RUC has completed review of the services under this screen.

High Level E/M in Global Period
In October 2015, the RUC reviewed all services with Medicare utilization greater than 10,000 that have a level 4 (99214) or level 5 (99215) office visit included in the global period. There were no codes with volume greater than 10,000 that had a level 5 office visits included. Seven services were identified that have a level 4 office visit included. The RUC expanded the list of services to 11 services to include additional codes as part of the family. The RUC confirmed that the level 4 post-operative visits were appropriate and well-defined for four services. The CPT Editorial Panel deleted one code. The RUC submitted recommendations for 10 services for the 2017-2018 Medicare Physician Payment Schedules. The RUC noted that this screen will be complete after these services are reviewed because the RUC has more rigorously questioned level 4 office visits in the global period in recent years and will continue this process going forward. The RUC has completed review of the services under this screen.

000-Day Global Services Reported with an E/M with Modifier 25
In the NPRM for 2017 CMS identified 83 services with a 000-day global period billed with an E/M 50 percent of the time or more, on the same day of service, same patient, by the same physician, that have not been reviewed in the last five years with Medicare utilization greater than 20,000.

The RUC commented that it appreciated CMS' identification of an objective screen and reasonable query. However, based on further analysis of the codes identified, it appears only 19 services met the criteria for this screen and have not been reviewed to specifically address an E/M performed on the same date. There were 38 codes that did not meet the screen criteria; they were either reviewed in the last 5 years and/or are not typically reported with an E/M. For 26 codes, the summary of recommendation (SOR), RUC rationale or practice expense inputs submitted specifically states that an E/M is typically reported with these services and the RUC accounted for this in its valuation.

The RUC requested that CMS remove 64 services that did not meet the screen criteria or which have already been valued as typically being reported with an E/M service. The RUC requested that CMS condense and finalize the list of services for this screen to the 19 remaining services.

In the Final Rule for 2017, CMS did finalize the list of 000-day global services reported with an E/M to the 19 services that truly met the criteria. The RUC recommended that two additional codes be removed from this screen as the specialty societies discovered that in fact an E/M as typical was considered in the survey process. Additional codes were added as part of the family of codes identified, totaling 22. The CPT Editorial Panel deleted one code and the RUC submitted 21 recommendations for the 2019 Medicare Physician Payment Schedule. The RUC has completed review of the services under this screen.

Negative IWPUT
In October 2017, the RUC identified 22 services with a negative IWPUT and Medicare utilization over 10,000 for all services or over 1,000 for Harvard valued and CMS/Other source codes. The RUC expanded the services identified in this screen to 31 services to include additional codes as part of the family. The RUC referred seven codes to the CPT Editorial Panel for revision. The CPT Editorial Panel deleted one service. The RUC submitted 23 recommendations for the 2019-2020 Medicare Physician Payment Schedules.

Contractor Priced with High Volume
In April 2018, the RUC identified five contractor-priced Category I CPT codes that have 2017 estimated Medicare utilization over 10,000. The RUC will review action plans for the October 2018 meeting with specialty societies indicating whether these services should be reviewed for physician work/practice expense.

CPT Modifier -51 Exempt List
In April 2018, the RUC identified seven services on the CPT Modifier -51 *Multiple Procedures* exempt list with 2017 estimated Medicare utilization over 10,000. The RUC examined the data provided on the percentage reported alone, physician pre and intra time and determined that this is an appropriate screen. The RUC will review action plans for the October 2018 RAW meeting with specialty societies indicating whether these services should remain on the CPT Modifier -51 exempt list.

Public Comment Requests
In 2011, CMS announced that due to the ongoing identification of potentially misvalued services by CMS and the RUC, the Agency will no longer conduct a separate Five-Year Review. CMS will now call for public comments on an annual basis as part of the comment process on the Final Rule each year.

Final Rule for 2013
In the Final Rule for the 2013 Medicare Physician Payment Schedule, the public and CMS identified 35 potentially misvalued services, which was expanded to 39 services to include the entire code family. The RUC reviewed these services and recommended that eight services be removed from review as two G-codes lacked specialty society interest and six services are not potentially misvalued since there is no reliable way to determine an incremental difference from open thoracotomy to thorascopic procedures. The CPT Editorial Panel deleted two services. The RUC submitted recommendations for 29 services for the 2014-2019 Medicare Physician Payment Schedules. The RUC has completed review of the services under this screen.

Final Rule for 2014
CMS did not receive any publicly nominated potentially misvalued codes for inclusion in the Proposed Rule for 2014. To broaden participation in the process of identifying potentially misvalued codes, CMS sought the input of Medicare contractor medical directors (CMDs). The CMDs have identified over a dozen services which CMS is proposing as potentially misvalued. The RUC reviewed these services and appropriate families, totaling 90 services. The CPT® Editorial Panel deleted 11 services. The RUC submitted recommendations to CMS for 79 services for the 2015-2018 Medicare Physician Payment Schedules. The RUC has completed review of the services under this screen.

Final Rule for 2015
In the Final Rule for 2015 the public and CMS nominated 26 services as potentially misvalued, which the RUC expanded to 53 services to include additional codes as part of this family. The CPT Editorial Panel deleted 16 services. The RUC submitted 37 recommendations for the 2016-2019 Medicare Physician Payment Schedules. The RUC has completed review of the services under this screen.

Final Rule for 2016
In the Final Rule for 2016 the public and CMS nominated 25 services as potentially misvalued, which the RUC expanded to 53 services to include an additional code as part of the family. The CPT Editorial Panel deleted eight services. The RUC submitted 45 recommendations for the 2017-2019 Medicare Physician Payment Schedules. The RUC has completed review of the services under this screen.

Final Rule for 2017
In the Final Rule for 2017 there were no public nominations for services in which the RUC was not already addressing.

Final Rule for 2018
In the Final Rule for 2018 the public and CMS nominated six services as potentially misvalued, which the RUC expanded to nine services. The RUC submitted nine recommendations for the 2019-2020 Medicare Physician Payment Schedules. The RUC has completed review of the services under this screen.

Other Issues
In addition to the above screening criteria, the Relativity Assessment Workgroup performed an exhaustive search of the RUC database for services indicated by the RUC to be re-reviewed at a later date. Three codes were found that had not yet been re-reviewed. The RUC recommended a work RVU decrease for two codes and to maintain the work RVU for another code.

CMS also identified 72 services that required further practice expense review. The RUC submitted practice expense recommendations on 67 services and the CPT® Editorial Panel deleted 5 services. The RUC also reviewed special requests for 19 audiology and speech-language pathology services. The RUC submitted recommendations for 10 services for the 2010 Medicare Physician Payment Schedule and the remaining nine services for the 2011 Medicare Physician Payment Schedule.

CMS Requests and RUC Relativity Assessment Workgroup Code Status

Total Number of Codes Identified*	**2,386**
Codes Completed	**2,295**
Work and PE Maintained	669
Work Increased	225
Work Decreased	818
Direct Practice Expense Revised (beyond work changes)	162
Deleted from CPT®	421
Codes Under Review	**91**
Referred to CPT® Editorial Panel	44
RUC to Review for *CPT 2020*	12
RUC to review future review after additional data obtained	36

**The total number of codes identified will not equal the number of codes from each screen as some codes have been identified in more than one screen.*

The RUC's efforts for 2009-2017 have resulted in $5 billion for redistribution within the Medicare Physician Payment Schedule.

TABLE 14: CY 2019 Proposed Direct PE Refinements

HCPCS code	Specialty Society Surveyed	HCPCS code description	Input Code	Input code description	Nonfacility (NF) / Facility (F)	Labor activity (where applicable)	RUC recommendation or current value (min or qty)	CMS refinement (min or qty)	Comment	Direct costs change (in dollars)	Specialty Agree/ Disagree	(If Disagree) Specialty Comment
10021	ACR, SIR	Fna bx w/o img gdn 1st les	EF015	mayo stand	NF		29	26	E1: Refined equipment time to conform to established policies for non-highly technical equipment	0.00	AAOHNS - Agree ACR - Agree SIR - Agree	
10021	ACR, SIR	Fna bx w/o img gdn 1st les	EF023	table, exam	NF		29	26	E1: Refined equipment time to conform to established policies for non-highly technical equipment	-0.01	AAOHNS - Agree ACR - Agree SIR - Agree	
10X12	ACR, SIR	Fna bx w/us gdn 1st les	EF015	mayo stand	NF		37	35	E1: Refined equipment time to conform to established policies for non-highly technical equipment	0.00	ACR - Agree SIR - Agree	
10X12	ACR, SIR	Fna bx w/us gdn 1st les	EF023	table, exam	NF		37	35	E1: Refined equipment time to conform to established policies for non-highly technical equipment	-0.01	ACR - Agree SIR - Agree	
10X12	ACR, SIR	Fna bx w/us gdn 1st les	EQ250	ultrasound unit, portable	NF		37	35	E1: Refined equipment time to conform to established policies for non-highly technical equipment	-0.26	ACR - Agree SIR - Agree	
10X14	ACR, SIR	Fna bx w/fluor gdn 1st les	ED050	Technologist PACS workstation	NF		49	47	E1: Refined equipment time to conform to established policies for non-highly technical equipment	-0.04	ACR - Agree SIR - Agree	
10X14	ACR, SIR	Fna bx w/fluor gdn 1st les	EF015	mayo stand	NF		44	42	E1: Refined equipment time to conform to established policies for non-highly technical equipment	0.00	ACR - Agree SIR - Agree	
10X14	ACR, SIR	Fna bx w/fluor gdn 1st les	EL014	room, radiographic-fluoroscopic	NF		44	34	E2: Refined equipment time to conform to established policies for highly technical equipment	-16.87	ACR - Agree SIR - Agree	
10X16	ACR, SIR	Fna bx w/ct gdn 1st les	EF015	mayo stand	NF		52	50	E1: Refined equipment time to conform to established policies for non-highly technical equipment	0.00	ACR - Agree SIR - Agree	
11755	APMA	Biopsy nail unit	EF015	mayo stand	NF		29	25	E1: Refined equipment time to conform to established policies for non-highly technical equipment	0.00	APMA - Disagree	APMA - CMS does not indicate what service period time was removed from the calculation. This makes it difficult to determine if this is accurate or not. Since CMS is at every meeting and corrects times at the time, we do not know what further corrections were made. We request more information about this change.
11755	APMA	Biopsy nail unit	EF031	table, power	NF		29	25	E1: Refined equipment time to conform to established policies for non-highly technical equipment	-0.06	APMA - Disagree	APMA - CMS does not indicate what service period time was removed from the calculation. This makes it difficult to determine if this is accurate or not. Since CMS is at every meeting and corrects times at the time, we do not know what further corrections were made. We request more information about this change.
11755	APMA	Biopsy nail unit	EQ137	instrument pack, basic ($500-$1499)	NF		39	31	E5: Refined equipment time to conform to established policies for surgical instrument packs	-0.02	APMA - Disagree	APMA - CMS does not indicate what service period time was removed from the calculation. This makes it difficult to determine if this is accurate or not. Since CMS is at every meeting and corrects times at the time, we do not know what further corrections were made. We request more information about this change.
11755	APMA	Biopsy nail unit	EQ168	light, exam	NF		29	25	E1: Refined equipment time to conform to established policies for non-highly technical equipment	-0.02	APMA - Disagree	APMA - CMS does not indicate what service period time was removed from the calculation. This makes it difficult to determine if this is accurate or not. Since CMS is at every meeting and corrects times at the time, we do not know what further corrections were made. We request more information about this change.
11X02	AAD	Tangntl bx skin single les	EF015	mayo stand	NF		13	11	E1: Refined equipment time to conform to established policies for non-highly technical equipment	0.00	AAD - Agree	
11X02	AAD	Tangntl bx skin single les	EF031	table, power	NF		13	11	E1: Refined equipment time to conform to established policies for non-highly technical equipment	-0.03	AAD - Agree	
11X02	AAD	Tangntl bx skin single les	EQ168	light, exam	NF		13	11	E1: Refined equipment time to conform to established policies for non-highly technical equipment	-0.01	AAD - Agree	
11X02	AAD	Tangntl bx skin single les	L037D	RN/LPN/MTA	NF	Review home care instructions, coordinate visits/prescriptions	2	0	G8: Input removed; code is typically billed with an E/M or other evaluation service	-0.74	AAD - Disagree	AAD - Home care instructions furnished in a EM visit do not typically include wound care instructions. This instruction is above and beyond instuctions proved during an EM visit in which no procedure is performed
11X02	AAD	Tangntl bx skin single les	SB027	gown, staff, impervious	NF		2	1	S1: Duplicative; supply is included in SA043	-1.19	AAD - Disagree	AAD - SA043 is an instrument cleaning pack that contains items, including personal protective equipment, that is used in the dirty instrument room as part of the intrument cleaning and sterilization process. This item included in SA043 can not be used during a patient procedure as the instrument cleaning occurs after the procedure has been completed. The personal protective equipment used during the patient procedure is considered contaminated after the procedrue is concluded and that personal protective equipment must be removed and disposed of prior to leaving the procedrue room. It is unacceptabele to walk throuhg the office wearing soiled personal protective equipment.

HCPCS code	Specialty Society Surveyed	HCPCS code description	Input Code	Input code description	Nonfacility (NF) / Facility (F)	Labor activity (where applicable)	RUC recommendation or current value (min or qty)	CMS refinement (min or qty)	Comment	Direct costs change (in dollars)	Specialty Agree/ Disagree	(If Disagree) Specialty Comment
11X02	AAD	Tangntl bx skin single les	SB034	mask, surgical, with face shield	NF		2	1	S1: Duplicative; supply is included in SA043	-1.22	AAD - Disagree	AAD - SA043 is an instrument cleaning pack that contains items, including personal protective equipment, that is used in the dirty instrument room as part of the intrument cleaning and sterilization process. This item included in SA043 can not be used during a patient procedure as the instrument cleaning occurs after the procedure has been completed. The personal protective equipment used during the patient procedure is considered contaminated after the procedrue is concluded and that personal protective equipment must be removed and disposed of prior to leaving the procedrue room. It is unacceptabele to walk throuhg the office wearing soiled personal protective equipment.
11X03	AAD	Tangntl bx skin ea sep/addl	SB011	drape, sterile, fenestrated 16in x 29in	NF		1	0	S9: Add-on code. Additional supplies not typical; see preamble text	-0.58	AAD - Disagree	AAD - This is a new body site and new procedure. The prior biopsy site must be broken down, patient repositioned and the new area prepped. Draping the new body site with a new sterile disposible drape is clinically indicated and would be typically done. It is not clinically approriate to take a drape used on one body site and then reposition it to a new body site for a new porocedure.
11X03	AAD	Tangntl bx skin ea sep/addl	SB024	gloves, sterile	NF		2	0	S9: Add-on code. Additional supplies not typical; see preamble text	-1.72	AAD - Disagree	AAD - This is a new body site and new procedure. The prior biopsy site must be broken down, patient repositioned and the new area prepped. Changing to new sterile gloves is clinically indicated and would be typically done.
11X03	AAD	Tangntl bx skin ea sep/addl	SC080	needle, OSHA compliant (SafetyGlide)	NF		1	0	S9: Add-on code. Additional supplies not typical; see preamble text	-0.54	AAD - Disagree	AAD - This is not an add on code in the sense of simply a larger or more intense version of the primary code. This code represents a compleltey new body site and compleetely new skin lesion. After the first skin lesion in the primary code is numbed, the needle is sheathed to prevent staff injury prior to disposal in the sharps disposal container. The needle can not be un-sheathed and then reused at a speparte body site. Additionally, this would proceed a cross contamination risk. A new syringle a needle is needed for the addiotanl skin lesions.
11X03	AAD	Tangntl bx skin ea sep/addl	SF047	scalpel, safety, surgical, with blade (#10-20)	NF		1	0	S9: Add-on code. Additional supplies not typical; see preamble text	-2.85	AAD - Disagree	AAD- This is not an add on code in the sense of simply a larger or more intense version of the primary code. This code represents a completely new body site and completely new skin lesion. After the first skin lesion in the primary code is biopsied, the scalpel blade is sheathed to prevent staff injury prior to disposal in the sharps disposal container. The blade can not be un-sheathed and then reused at a separate body site. Additionally, reuse would produce a cross contamination risk. A new safety scalpel is needed for the additional skin lesions.
11X03	AAD	Tangntl bx skin ea sep/addl	SG033	dressing, 12-7mm (Gelfoam)	NF		1	0	S9: Add-on code. Additional supplies not typical; see preamble text	-9.88	AAD - Disagree	AAD - This procedure is a second biopsy of a completely different body location. The dressing from the first procedrue would not be retained and then used on the second procedure. The first procedure is completed in its entirety prior to performing the second procedure. Retaining dressing materials and using them for a separate and distinct procedure would introduce a contamination risk.
11X03	AAD	Tangntl bx skin ea sep/addl	SG035	dressing, 3in x 4in (Telfa, Release)	NF		1	0	S9: Add-on code. Additional supplies not typical; see preamble text	-0.12	AAD - Disagree	AAD - This procedure is a second biopsy of a completely different body location. The dressing from the first procedrue would not be retained and then used on the second procedure. The first procedure is completed in its entirety prior to performing the second procedure. Retaining dressing materials and using them for a separate and distinct procedure would introduce a contamination risk.
11X03	AAD	Tangntl bx skin ea sep/addl	SG056	gauze, sterile 4in x 4in (10 pack uou)	NF		1	0	S9: Add-on code. Additional supplies not typical; see preamble text	-0.61	AAD - Disagree	AAD - This procedure is a second biopsy of a completely different body location. The gauze from the first procedrue would not be retained and then used on the second procedure. The first procedure is completed in its entirety prior to performing the second procedure. Retaining gauze and using them for a separate and distinct procedure would introduce a contamination risk.
11X03	AAD	Tangntl bx skin ea sep/addl	SG079	tape, surgical paper 1in (Micropore)	NF		6	0	S9: Add-on code. Additional supplies not typical; see preamble text	-0.02	AAD - Disagree	AAD - The second biopsy is of a completely new lesion. The quantities of this supply in the base code are sufficient for one lesion, not more than one lesion. Simply put two lesions require more materail than one lesion.
11X03	AAD	Tangntl bx skin ea sep/addl	SJ081	swab, patient prep, 1.5 ml (chloraprep)	NF		1	0	S9: Add-on code. Additional supplies not typical; see preamble text	-1.05	AAD - Disagree	AAD - Prep swabs are single use and designed for a single skin site. The process of skin pre starts with the center of the lesion and moves outward in concentric circles to avoid bringing pathogens back into the field. The prep sponge can not be reused on a separete area of skin as it will contaminate that area by tranporting pathogens form the last concentric circle of the prior area. Moreover, they only contanin 1.5 ml of prep material, an amount insufficient to prep more that one area.
11X04	AAD	Punch bx skin single lesion	EF015	mayo stand	NF		19	17	E1: Refined equipment time to conform to established policies for non-highly technical equipment	0.00	AAD - Disagree	AAD - 2 minutes removed is not appropriate as detailed in explanation above. Equipment time needs to match staff time
11X04	AAD	Punch bx skin single lesion	EF031	table, power	NF		19	17	E1: Refined equipment time to conform to established policies for non-highly technical equipment	-0.03	AAD - Disagree	AAD - 2 minutes removed is not appropriate as detailed in explanation above. Equipment time needs to match staff time
11X04	AAD	Punch bx skin single lesion	EQ114	electrosurgical generator, up to 120 watts	NF		19	17	E1: Refined equipment time to conform to established policies for non-highly technical equipment	-0.02	AAD - Disagree	AAD - 2 minutes removed is not appropriate as detailed in explanation above. Equipment time needs to match staff time
11X04	AAD	Punch bx skin single lesion	EQ168	light, exam	NF		19	17	E1: Refined equipment time to conform to established policies for non-highly technical equipment	-0.01	AAD - Disagree	AAD - 2 minutes removed is not appropriate as detailed in explanation above. Equipment time needs to match staff time

HCPCS code	Specialty Society Surveyed	HCPCS code description	Input Code	Input code description	Nonfacility (NF) / Facility (F)	Labor activity (where applicable)	RUC recommendation or current value (min or qty)	CMS refinement (min or qty)	Comment	Direct costs change (in dollars)	Specialty Agree/ Disagree	(If Disagree) Specialty Comment
11X04	AAD	Punch bx skin single lesion	EQ351	Smoke Evacuator(tubing, covering, etc.) with stand	NF		19	17	E1: Refined equipment time to conform to established policies for non-highly technical equipment	-0.01	AAD - Disagree	AAD - 2 minutes removed is not appropriate as detailed in explanation above. Equipment time needs to match staff time
11X04	AAD	Punch bx skin single lesion	L037D	RN/LPN/MTA	NF	Review home care instructions, coordinate visits/prescriptions	2	0	G8: Input removed; code is typically billed with an E/M or other evaluation service	-0.74	AAD - Disagree	AAD - Home care instructions furnished in a EM visit do not typically include wound care instructions. This instruction is above and beyond instuctions proved during an EM visit in which no procedure is performed
11X04	AAD	Punch bx skin single lesion	SB027	gown, staff, impervious	NF		2	1	S1: Duplicative; supply is included in SA043	-1.19	AAD - Disagree	AAD - SA043 is an instrument cleaning pack that contains items, including personal protective equipment, that is used in the dirty instrument room as part of the intrument cleaning and sterilization process. This item included in SA043 can not be used during a patient procedure as the instrument cleaning occurs after the procedure has been completed. The personal protective equipment used during the patient procedure is considered contaminated after the procedrue is concluded and that personal protective equipment must be removed and disposed of prior to leaving the procedrue room. It is unacceptabele to walk throuhg the office wearing soiled personal protective equipment.
11X04	AAD	Punch bx skin single lesion	SB034	mask, surgical, with face shield	NF		2	1	S1: Duplicative; supply is included in SA043	-1.22	AAD - Disagree	AAD - SA043 is an instrument cleaning pack that contains items, including personal protective equipment, that is used in the dirty instrument room as part of the intrument cleaning and sterilization process. This item included in SA043 can not be used during a patient procedure as the instrument cleaning occurs after the procedure has been completed. The personal protective equipment used during the patient procedure is considered contaminated after the procedrue is concluded and that personal protective equipment must be removed and disposed of prior to leaving the procedrue room. It is unacceptabele to walk throuhg the office wearing soiled personal protective equipment.
11X05	AAD	Punch bx skin ea sep/addl	SB011	drape, sterile, fenestrated 16in x 29in	NF		1	0	S9: Add-on code. Additional supplies not typical; see preamble text	-0.58	AAD - Disagree	AAD - This is a new body site and new procedure. The prior biopsy site must be broken down, patient repositioned and the new area prepped. Draping the new body site with a new sterile disposible drape is clinically indicated and would be typically done. It is not clinically approriate to take a drape used on one body site and then reposition it to a new body site for a new porocedure.
11X05	AAD	Punch bx skin ea sep/addl	SB024	gloves, sterile	NF		2	0	S9: Add-on code. Additional supplies not typical; see preamble text	-1.72	AAD - Disagree	AAD - This is a new body site and new procedure. The prior biopsy site must be broken down, patient repositioned and the new area prepped. Changing to new sterile gloves is clinically indicated and would be typically done.
11X05	AAD	Punch bx skin ea sep/addl	SC080	needle, OSHA compliant (SafetyGlide)	NF		1	0	S9: Add-on code. Additional supplies not typical; see preamble text	-0.54	AAD - Disagree	AAD - This is not an add on code in the sense of simply a larger or more intense version of the primary code. This code represents a completely new body site and completely new skin lesion. After the first skin lesion in the primary code is numbed, the needle is sheathed to prevent staff injury prior to disposal in the sharps disposal container. The needle can not be un-sheathed and then reused at a separate body site. Additionally, this would proceed a cross contamination risk. A new syringe a needle is needed for the additional skin lesions.
11X05	AAD	Punch bx skin ea sep/addl	SF036	suture, nylon, 3-0 to 6-0, c	NF		1	0	S9: Add-on code. Additional supplies not typical; see preamble text	-2.60	AAD - Disagree	AAD - This procedure is a second biopsy of a completely different body location. The suture from the first procedrue would not be retained and then used on the second procedure. The first procedure is completed in its entirety prior to perfomring the second procedure. Reusing suture materail would introduce an infection risk.
11X05	AAD	Punch bx skin ea sep/addl	SF040	suture, vicryl, 3-0 to 6-0, p, ps	NF		1	0	S9: Add-on code. Additional supplies not typical; see preamble text	-6.97	AAD - Disagree	AAD - This procedure is a second biopsy of a completely different body location. The suture from the first procedrue would not be retained and then used on the second procedure. The first procedure is completed in its entirety prior to perfomring the second procedure. Reusing suture materail would introduce an infection risk.
11X05	AAD	Punch bx skin ea sep/addl	SG035	dressing, 3in x 4in (Telfa, Release)	NF		1	0	S9: Add-on code. Additional supplies not typical; see preamble text	-0.12	AAD - Disagree	AAD - This procedure is a second biopsy of a completely different body location. The dressing from the first procedrue would not be retained and then used on the second procedure. The first procedure is completed in its entirety prior to performing the second procedure. Retaining dressing materials and using them for a separate and distinct procedure would introduce a contamination risk.
11X05	AAD	Punch bx skin ea sep/addl	SG056	gauze, sterile 4in x 4in (10 pack uou)	NF		1	0	S9: Add-on code. Additional supplies not typical; see preamble text	-0.61	AAD - Disagree	AAD - This procedure is a second biopsy of a completely different body location. The gauze from the first procedrue would not be retained and then used on the second procedure. The first procedure is completed in its entirety prior to performing the second procedure. Retaining gauze and using them for a separate and distinct procedure would introduce a contamination risk.
11X05	AAD	Punch bx skin ea sep/addl	SG079	tape, surgical paper 1in (Micropore)	NF		6	0	S9: Add-on code. Additional supplies not typical; see preamble text	-0.02	AAD - Disagree	AAD - The second biopsy is of a completely new lesion. The quantities of this supply in the base code are sufficient for one lesion, not more than one lesion. Simply put two lesions require more materail than one lesion.

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11X05	AAD	Punch bx skin ea sep/addl	SJ081	swab, patient prep, 1.5 ml (chloraprep)	NF		1	0	S9: Add-on code. Additional supplies not typical; see preamble text	-1.05	AAD - Disagree	AAD - Prep swabs are single use and designed for a single skin site. The process of skin pre starts with the center of the lesion and moves outward in concentric circles to avoid bringing pathogens back into the field. The prep sponge can not be reused on a separete area of skin as it will contaminate that area by tranporting pathogens form the last concentric circle of the prior area. Moreover, they only contanin 1.5 ml of prep material, an amount insufficient to prep more that one area.
11X06	AAD	Incal bx skn single les	EF015	mayo stand	NF		33	31	E1: Refined equipment time to conform to established policies for non-highly technical equipment	0.00	AAD - Disagree	AAD - 2 minutes removed is not appropriate as detailed in explanation above. Equipment time needs to match staff time
11X06	AAD	Incal bx skn single les	EF031	table, power	NF		33	31	E1: Refined equipment time to conform to established policies for non-highly technical equipment	-0.03	AAD - Disagree	AAD - 2 minutes removed is not appropriate as detailed in explanation above. Equipment time needs to match staff time
11X06	AAD	Incal bx skn single les	EQ114	electrosurgical generator, up to 120 watts	NF		33	31	E1: Refined equipment time to conform to established policies for non-highly technical equipment	-0.02	AAD - Disagree	AAD - 2 minutes removed is not appropriate as detailed in explanation above. Equipment time needs to match staff time
11X06	AAD	Incal bx skn single les	EQ168	light, exam	NF		33	31	E1: Refined equipment time to conform to established policies for non-highly technical equipment	-0.01	AAD - Disagree	AAD - 2 minutes removed is not appropriate as detailed in explanation above. Equipment time needs to match staff time
11X06	AAD	Incal bx skn single les	EQ351	Smoke Evacuator(tubing, covering, etc.) with stand	NF		33	31	E1: Refined equipment time to conform to established policies for non-highly technical equipment	-0.01	AAD - Disagree	AAD - 2 minutes removed is not appropriate as detailed in explanation above. Equipment time needs to match staff time
11X06	AAD	Incal bx skn single les	L037D	RN/LPN/MTA	NF	Review home care instructions, coordinate visits/prescriptions	2	0	G8: Input removed; code is typically billed with an E/M or other evaluation service	-0.74	AAD - Disagree	AAD - Home care instructions furnished in a EM visit do not typically include wound care instructions. This instruction is above and beyond instuctions proved during an EM visit in which no procedure is performed
11X06	AAD	Incal bx skn single les	SB027	gown, staff, impervious	NF		2	1	S1: Duplicative; supply is included in SA043	-1.19	AAD - Disagree	AAD - SA043 is an instrument cleaning pack that contains items, including personal protective equipment, that is used in the dirty instrument room as part of the intrument cleaning and sterilization process. This item included in SA043 can not be used during a patient procedure as the instrument cleaning occurs after the procedure has been completed. The personal protective equipment used during the patient procedure is considered contaminated after the procedrue is concluded and that personal protective equipment must be removed and disposed of prior to leaving the procedrue room. It is unacceptabele to walk throuhg the office wearing soiled personal protective equipment.
11X06	AAD	Incal bx skn single les	SB034	mask, surgical, with face shield	NF		2	1	S1: Duplicative; supply is included in SA043	-1.22	AAD - Disagree	AAD - SA043 is an instrument cleaning pack that contains items, including personal protective equipment, that is used in the dirty instrument room as part of the intrument cleaning and sterilization process. This item included in SA043 can not be used during a patient procedure as the instrument cleaning occurs after the procedure has been completed. The personal protective equipment used during the patient procedure is considered contaminated after the procedrue is concluded and that personal protective equipment must be removed and disposed of prior to leaving the procedrue room. It is unacceptabele to walk throuhg the office wearing soiled personal protective equipment.
11X07	AAD	Incal bx skn ea sep/addl	SB011	drape, sterile, fenestrated 16in x 29in	NF		1	0	S9: Add-on code. Additional supplies not typical; see preamble text	-0.58	AAD - Disagree	AAD - This is a new body site and new procedure. The prior biopsy site must be broken down, patient repositioned and the new area prepped. Draping the new body site with a new sterile disposible drape is clinically indicated and would be typically done. It is not clinically approriate to take a drape used on one body site and then reposition it to a new body site for a new porocedure.
11X07	AAD	Incal bx skn ea sep/addl	SB024	gloves, sterile	NF		2	0	S9: Add-on code. Additional supplies not typical; see preamble text	-1.72	AAD - Disagree	AAD - This is a new body site and new procedure. The prior biopsy site must be broken down, patient repositioned and the new area prepped. Changing to new sterile gloves is clinically indicated and would be typically done.
11X07	AAD	Incal bx skn ea sep/addl	SC080	needle, OSHA compliant (SafetyGlide)	NF		2	0	S9: Add-on code. Additional supplies not typical; see preamble text	-1.07	AAD - Disagree	AAD - This is not an add on code in the sense of simply a larger or more intense version of the primary code. This code represents a compleltey new body site and compleetely new skin lesion. After the first skin lesion in the primary code is numbed, the needle is sheathed to prevent staff injury prior to disposal in the sharps disposal container. The needle can not be un-sheathed and then reused at a speparte body site. Additionally, this would proceed a cross contamination risk. A new syringle a needle is needed for the addiotanl skin lesions.
11X07	AAD	Incal bx skn ea sep/addl	SF036	suture, nylon, 3-0 to 6-0, c	NF		1	0	S9: Add-on code. Additional supplies not typical; see preamble text	-2.60	AAD - Disagree	AAD - This procedure is a second biopsy of a completely different body location. The suture from the first procedrue would not be retained and then used on the second procedure. The first procedure is completed in its entirety prior to perfomring the second procedure. Reusing suture materail would introduce an infection risk.
11X07	AAD	Incal bx skn ea sep/addl	SF040	suture, vicryl, 3-0 to 6-0, p, ps	NF		1	0	S9: Add-on code. Additional supplies not typical; see preamble text	-6.97	AAD - Disagree	AAD - This procedure is a second biopsy of a completely different body location. The suture from the first procedrue would not be retained and then used on the second procedure. The first procedure is completed in its entirety prior to perfomring the second procedure. Reusing suture materail would introduce an infection risk.

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11X07	AAD	Incal bx skn ea sep/addl	SF047	scalpel, safety, surgical, with blade (#10-20)	NF		1	0	S9: Add-on code. Additional supplies not typical; see preamble text	-2.85	AAD - Disagree	AAD - This is not an add on code in the sense of simply a larger or more intense version of the primary code. This code represents a completely new body site and completely new skin lesion. After the first skin lesion in the primary code is biopsied, the scalpel blade is sheathed to prevent staff injury prior to disposal in the sharps disposal container. The blade can not be un-sheathed and then reused at a separate body site. Additionally, reuse would produce a cross contamination risk. A new safety scalpel is needed for the additional skin lesions.
11X07	AAD	Incal bx skn ea sep/addl	SG035	dressing, 3in x 4in (Telfa, Release)	NF		1	0	S9: Add-on code. Additional supplies not typical; see preamble text	-0.12	AAD - Disagree	AAD - This procedure is a second biopsy of a completely different body location. The dressing from the first procedrue would not be retained and then used on the second procedure. The first procedure is completed in its entirety prior to performing the second procedure. Retaining dressing materials and using them for a separate and distinct procedure would introduce a contamination risk.
11X07	AAD	Incal bx skn ea sep/addl	SG056	gauze, sterile 4in x 4in (10 pack uou)	NF		1	0	S9: Add-on code. Additional supplies not typical; see preamble text	-0.61	AAD - Disagree	AAD - This procedure is a second biopsy of a completely different body location. The gauze from the first procedrue would not be retained and then used on the second procedure. The first procedure is completed in its entirety prior to performing the second procedure. Retaining gauze and using them for a separate and distinct procedure would introduce a contamination risk.
11X07	AAD	Incal bx skn ea sep/addl	SG079	tape, surgical paper 1in (Micropore)	NF		12	0	S9: Add-on code. Additional supplies not typical; see preamble text	-0.05	AAD - Disagree	AAD - The second biopsy is of a completely new lesion. The quantities of this supply in the base code are sufficient for one lesion, not more than one lesion. Simply put two lesions require more materail than one lesion.
11X07	AAD	Incal bx skn ea sep/addl	SJ081	swab, patient prep, 1.5 ml (chloraprep)	NF		1	0	S9: Add-on code. Additional supplies not typical; see preamble text	-1.05	AAD - Disagree	AAD - Prep swabs are single use and designed for a single skin site. The process of skin pre starts with the center of the lesion and moves outward in concentric circles to avoid bringing pathogens back into the field. The prep sponge can not be reused on a separete area of skin as it will contaminate that area by tranporting pathogens form the last concentric circle of the prior area. Moreover, they only contanin 1.5 ml of prep material, an amount insufficient to prep more that one area.
20551	AAPM&R, APMA, ASSH, AAOS, ACR (rheumatology), AOFAS	Inj tendon origin/insertion	EF023	table, exam	NF		19	14	E1: Refined equipment time to conform to established policies for non-highly technical equipment	-0.02	AAOS - Disagree AAPMR - Agree ASSH - Disagree	AAOS - See comment for proposed clinical activity reductions ASSH - Time is subtracted based on erroneous deletion of two activities.
20551	AAPM&R, APMA, ASSH, AAOS, ACR (rheumatology), AOFAS	Inj tendon origin/insertion	L037D	RN/LPN/MTA	NF	Review home care instructions, coordinate visits/prescriptions	2	0	G8: Input removed; code is typically billed with an E/M or other evaluation service	-0.74	AAOS - Disagree AAPMR - Disagree ASSH - Disagree	AAOS - Review home care instructions for this procedure is not included in an EM service. This injection is more involved / invasive than a vaccination (90470, 90471) which was allowed 3 minutes for home care instructions and recording vaccine information in the medical record (exp, lot) AAPMR - In its deliberations, the RUC PE Subcommittee reviewed duplication of work resulting from this service being billed with an E/M more than 50% of the time. The societies recommended, and the RUC agreed, that two minutes are necessary for this service to review home care instructions for the safety of the patient. ASSH - This activity is not a duplication of what would be included in an E/M visit. This is separate and distinct work related to the procedure.
20551	AAPM&R, APMA, ASSH, AAOS, ACR (rheumatology), AOFAS	Inj tendon origin/insertion	L037D	RN/LPN/MTA	NF	Provide education/obtain consent	3	0	G8: Input removed; code is typically billed with an E/M or other evaluation service	-1.11	AAOS - Disagree AAPMR - Disagree ASSH - Disagree	AAOS - Education and consent for this procedure is not included in an EM service. This injection is more involved / invasive than a vaccination (90470, 90471) which was allowed 3 minutes for "F/u on physician's discussion w/patient/parent & obtain actual consent AAPMR - In its deliberations, the RUC PE Subcommittee reviewed duplication of work resulting from this service being billed with an E/M more than 50% of the time. The societies recommended, and the RUC agreed, that additional minutes beyond those in an E/M service are required to reinforce the physician's description of the procedure and answer any questions. Additionally, consent must be specifically reviewed, confirmed and documented. ASSH - This activity is not a duplication of what would be included in an E/M visit. This is separate and distinct work related to the procedure.
27X69	ACR	Njx cntrst kne arthg/ct/mri	EL014	room, radiographic-fluoroscopic	NF		22	23	E15: Refined equipment time to conform to changes in clinical labor time	1.69	ACR - Disagree	ACR - Formula is correct but row 72 should be 2 mins, not 3 mins.
27X69	ACR	Njx cntrst kne arthg/ct/mri	L041B	Radiologic Technologist	NF	Scan exam documents into PACS. Complete exam in RIS system to populate images into work queue.	1	0	G1: See preamble text	-0.41	ACR - Agree	
27X69	ACR	Njx cntrst kne arthg/ct/mri	L041B	Radiologic Technologist	NF	Confirm order, protocol exam	1	0	G1: See preamble text	-0.41	ACR - Agree	
27X69	ACR	Njx cntrst kne arthg/ct/mri	L041B	Radiologic Technologist	NF	Prepare room, equipment and supplies	2	3	L1: Refined time to standard for this clinical labor task	0.41	ACR - Disagree	ACR - The standard is 2 mins for this clinical labor task.
29105	ASSH, AAOS, ACEP	Apply long arm splint	EF031	table, power	NF		51	49	E1: Refined equipment time to conform to established policies for non-highly technical equipment	-0.03	AAOS - Disagree ASSH - Disagree	AAOS - CMS does not indicate what service period time was removed from the calculation. This makes it difficult to determine if this is accurate or not. Since CMS is at every meeting and corrects times at the time, we do not know what further corrections were made. We request more information about this change. ASSH - We do not know what time element was removed. Specific clinical activity line item should be noted so that we can make an informed comment.

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29105	ASSH, AAOS, ACEP	Apply long arm splint	EQ080	cast cart	NF		51	49	E1: Refined equipment time to conform to established policies for non-highly technical equipment	-0.02	AAOS - Disagree ASSH - Disagree	AAOS - CMS does not indicate what service period time was removed from the calculation. This makes it difficult to determine if this is accurate or not. Since CMS is at every meeting and corrects times at the time, we do not know what further corrections were made. We request more information about this change. ASSH - We do not know what time element was removed. Specific clinical activity line item should be noted so that we can make an informed comment.
29105	ASSH, AAOS, ACEP	Apply long arm splint	EQ081	cast cutter	NF		51	49	E1: Refined equipment time to conform to established policies for non-highly technical equipment	-0.01	AAOS - Disagree ASSH - Disagree	AAOS - CMS does not indicate what service period time was removed from the calculation. This makes it difficult to determine if this is accurate or not. Since CMS is at every meeting and corrects times at the time, we do not know what further corrections were made. We request more information about this change. ASSH - We do not know what time element was removed. Specific clinical activity line item should be noted so that we can make an informed comment.
29105	ASSH, AAOS, ACEP	Apply long arm splint	EQ082	cast vacuum	NF		51	49	E1: Refined equipment time to conform to established policies for non-highly technical equipment	-0.01	AAOS - Disagree ASSH - Disagree	AAOS - CMS does not indicate what service period time was removed from the calculation. This makes it difficult to determine if this is accurate or not. Since CMS is at every meeting and corrects times at the time, we do not know what further corrections were made. We request more information about this change. ASSH - We do not know what time element was removed. Specific clinical activity line item should be noted so that we can make an informed comment.
29540	APMA	Strapping of ankle and/or ft	EF031	table, power	NF		20	17	E1: Refined equipment time to conform to established policies for non-highly technical equipment	-0.05	APMA - Disagree	APMA - CMS does not indicate what service period time was removed from the calculation. This makes it difficult to determine if this is accurate or not. Since CMS is at every meeting and corrects times at the time, we do not know what further corrections were made. We request more information about this change.
29540	APMA	Strapping of ankle and/or ft	EQ168	light, exam	NF		20	17	E1: Refined equipment time to conform to established policies for non-highly technical equipment	-0.01	APMA - Disagree	APMA - CMS does not indicate what service period time was removed from the calculation. This makes it difficult to determine if this is accurate or not. Since CMS is at every meeting and corrects times at the time, we do not know what further corrections were made. We request more information about this change.
29540	APMA	Strapping of ankle and/or ft	L037D	RN/LPN/MTA	NF	Review home care instructions, coordinate visits/prescriptions	2	0	G8: Input removed; code is typically billed with an E/M or other evaluation service	-0.74	APMA - Disagree	APMA - These home care instructions are SPECIFIC to the strappings themselves. This would not be any duplicative work that would already be part of the evaluation service. This would be instructions regarding how to care for the strappings, bathing, ambulation, how to remove the strapping if/when needed, etc.
29540	APMA	Strapping of ankle and/or ft	L037D	RN/LPN/MTA	NF	Provide education/obtain consent	3	2	L1: Refined time to standard for this clinical labor task	-0.37	APMA - Disagree	APMA - There is no set standard for this activity and 3 minutes is neded for the clinical staff to perform this clinical activity.
29550	APMA	Strapping of toes	EF031	table, power	NF		16	13	E1: Refined equipment time to conform to established policies for non-highly technical equipment	-0.05	APMA - Disagree	APMA - CMS does not indicate what service period time was removed from the calculation. This makes it difficult to determine if this is accurate or not. Since CMS is at every meeting and corrects times at the time, we do not know what further corrections were made. We request more information about this change.
29550	APMA	Strapping of toes	EQ168	light, exam	NF		16	13	E1: Refined equipment time to conform to established policies for non-highly technical equipment	-0.01	APMA - Disagree	APMA - CMS does not indicate what service period time was removed from the calculation. This makes it difficult to determine if this is accurate or not. Since CMS is at every meeting and corrects times at the time, we do not know what further corrections were made. We request more information about this change.
29550	APMA	Strapping of toes	L037D	RN/LPN/MTA	NF	Review home care instructions, coordinate visits/prescriptions	2	0	G8: Input removed; code is typically billed with an E/M or other evaluation service	-0.74	APMA - Disagree	APMA - These home care instructions are SPECIFIC to the strappings themselves. This would not be any duplicative work that would already be part of the evaluation service. This would be instructions regarding how to care for the strappings, bathing, ambulation, how to remove the strapping if/when needed, etc.
29550	APMA	Strapping of toes	L037D	RN/LPN/MTA	NF	Provide education/obtain consent	3	2	L1: Refined time to standard for this clinical labor task	-0.37	APMA - Disagree	APMA - CMS does not indicate what service period time was removed from the calculation. This makes it difficult to determine if this is accurate or not. Since CMS is at every meeting and corrects times at the time, we do not know what further corrections were made. We request more information about this change.
31623	ATS, CHEST	Dx bronchoscope/brush	EF031	table, power	NF		44	51	E1: Refined equipment time to conform to established policies for non-highly technical equipment	0.11	ATS/CHEST - Agree	
31623	ATS, CHEST	Dx bronchoscope/brush	EQ004	CO2 respiratory profile monitor	NF		34	51	E1: Refined equipment time to conform to established policies for non-highly technical equipment	0.39	ATS/CHEST - Agree	
31623	ATS, CHEST	Dx bronchoscope/brush	EQ235	suction machine (Gomco)	NF		34	51	E1: Refined equipment time to conform to established policies for non-highly technical equipment	0.03	ATS/CHEST - Agree	
31623	ATS, CHEST	Dx bronchoscope/brush	ES017	fiberscope, flexible, bronchoscopy	NF		74	69	E4: Refined equipment time to conform to established policies for scopes	-0.43	ATS/CHEST - Agree	
31623	ATS, CHEST	Dx bronchoscope/brush	ES031	scope video system (monitor, processor, digital capture, cart, printer, LED light)	NF		44	42	E19: Refined equipment time to conform to established policies for scope accessories	-0.28	ATS/CHEST - Agree	

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31623	ATS, CHEST	Dx bronchoscope/brush	L047C	RN/Respiratory Therapist	NF	Complete post-procedure diagnostic forms, lab and x-ray requisitions	4	2	L1: Refined time to standard for this clinical labor task	-0.94	ATS/CHEST - Disagree	ATS/CHEST - For Bronchoscopy we are collecting specimens and those specimens need to be verified and labeled and checked. Plus filling out the paperwork.
31624	ATS, CHEST	Dx bronchoscope/lavage	EF031	table, power	NF		44	51	E1: Refined equipment time to conform to established policies for non-highly technical equipment	0.11	ATS/CHEST - Agree	
31624	ATS, CHEST	Dx bronchoscope/lavage	EQ004	CO2 respiratory profile monitor	NF		34	51	E1: Refined equipment time to conform to established policies for non-highly technical equipment	0.39	ATS/CHEST - Agree	
31624	ATS, CHEST	Dx bronchoscope/lavage	EQ235	suction machine (Gomco)	NF		34	51	E1: Refined equipment time to conform to established policies for non-highly technical equipment	0.03	ATS/CHEST - Agree	
31624	ATS, CHEST	Dx bronchoscope/lavage	ES017	fiberscope, flexible, bronchoscopy	NF		74	69	E4: Refined equipment time to conform to established policies for scopes	-0.43	ATS/CHEST - Agree	
31624	ATS, CHEST	Dx bronchoscope/lavage	ES031	scope video system (monitor, processor, digital capture, cart, printer, LED light)	NF		44	42	E19: Refined equipment time to conform to established policies for scope accessories	-0.28	ATS/CHEST - Agree	
31624	ATS, CHEST	Dx bronchoscope/lavage	L047C	RN/Respiratory Therapist	NF	Complete post-procedure diagnostic forms, lab and x-ray requisitions	4	2	L1: Refined time to standard for this clinical labor task	-0.94	ATS/CHEST - Disagree	ATS/CHEST - For Bronchoscopy we are collecting specimens and those specimens need to be verified and labeled and checked. Plus filling out the paperwork.
335X1	AATS, STS	Rplcmt a-valve tlcj autol pv	L051A	RN	F	Provide pre-service education/obtain consent	26	20	L1: Refined time to standard for this clinical labor task	-3.06	STS - Agree	
335X1	AATS, STS	Rplcmt a-valve tlcj autol pv	L051A	RN	F	Perform regulatory mandated quality assurance activity (pre-service)	0	15	G1: See preamble text	7.65	STS - Agree	
335X1	AATS, STS	Rplcmt a-valve tlcj autol pv	L051A	RN	F	Coordinate pre-surgery services (including test results)	25	20	L1: Refined time to standard for this clinical labor task	-2.55	STS - Agree	
335X1	AATS, STS	Rplcmt a-valve tlcj autol pv	L051A	RN	F	Schedule space and equipment in facility	12	8	L1: Refined time to standard for this clinical labor task	-2.04	STS - Agree	
36X72	AAP, ACR, SVS, SIR	Insj picc rs&i <5 yr	ED050	Technologist PACS workstation	NF		54	52	E15: Refined equipment time to conform to changes in clinical labor time	-0.04	ACR - Disagree SIR - Disagree	ACR - Formula is correct, but we disagree with the refinement to row 104. SIR - Disagree with the change in the clinical labor time for positioning. This included positioning the patient as well as two imaging modalities.
36X72	AAP, ACR, SVS, SIR	Insj picc rs&i <5 yr	EL014	room, radiographic-fluoroscopic	NF		33	31	E15: Refined equipment time to conform to changes in clinical labor time	-3.37	ACR - Disagree SIR - Disagree	ACR - Formula is correct, but we disagree with the refinement to row 104. SIR - Disagree with the change in the clinical labor time for positioning. This included positioning the patient as well as two imaging modalities.
36X72	AAP, ACR, SVS, SIR	Insj picc rs&i <5 yr	EQ250	ultrasound unit, portable	NF		49	47	E15: Refined equipment time to conform to changes in clinical labor time	-0.26	ACR - Disagree SIR - Disagree	ACR - Formula is correct, but we disagree with the refinement to row 104. SIR - Disagree with the change in the clinical labor time for positioning. This included positioning the patient as well as two imaging modalities.
36X72	AAP, ACR, SVS, SIR	Insj picc rs&i <5 yr	L041B	Radiologic Technologist	NF	Prepare, set-up and start IV, initial positioning and monitoring of patient	4	2	L3: Refined clinical labor time to conform with identical labor activity in other codes in the family	-0.82	ACR - Disagree SIR - Disagree	ACR - Additional time required to position imaging equipment in a young patient SIR - Disagree with the change in the clinical labor time for positioning. This included positioning the patient as well as two imaging modalities.
36X73	AAP, ACR, SVS, SIR	Insj picc rs&i 5 yr+	ED050	Technologist PACS workstation	NF		49	47	E15: Refined equipment time to conform to changes in clinical labor time	-0.04	ACR - Disagree SIR - Disagree	ACR - We disagree with the refinement to row 108. SIR - Disagree with the change in the clinical labor time for positioning. This included positioning the patient as well as two imaging modalities.
36X73	AAP, ACR, SVS, SIR	Insj picc rs&i 5 yr+	EL014	room, radiographic-fluoroscopic	NF		26	24	E15: Refined equipment time to conform to changes in clinical labor time	-3.37	ACR - Disagree SIR - Disagree	ACR - We disagree with the refinement to row 108. SIR - Disagree with the change in the clinical labor time for positioning. This included positioning the patient as well as two imaging modalities.
36X73	AAP, ACR, SVS, SIR	Insj picc rs&i 5 yr+	EQ250	ultrasound unit, portable	NF		44	42	E15: Refined equipment time to conform to changes in clinical labor time	-0.26	ACR - Disagree SIR - Disagree	ACR - We disagree with the refinement to row 108. SIR - Disagree with the change in the clinical labor time for positioning. This included positioning the patient as well as two imaging modalities.
36X73	AAP, ACR, SVS, SIR	Insj picc rs&i 5 yr+	L041B	Radiologic Technologist	NF	Prepare, set-up and start IV, initial positioning and monitoring of patient	4	2	L3: Refined clinical labor time to conform with identical labor activity in other codes in the family	-0.82	ACR - Disagree SIR - Disagree	ACR - Additional time required to position imaging equipment. SIR - Disagree with the change in the clinical labor time for positioning. This included positioning the patient as well as two imaging modalities.
38792		Ra tracer id of sentinl node	ED020	computer workstation, nuclear pharmacy management (hardware and software)	NF		18	19	E15: Refined equipment time to conform to changes in clinical labor time	0.05	ATS/CHEST - Agree	
38792		Ra tracer id of sentinl node	ER026	dose calibration source vial set (Cs137, Co57, and Ba137)	NF		18	19	E15: Refined equipment time to conform to changes in clinical labor time	0.00	ATS/CHEST - Agree	
38792		Ra tracer id of sentinl node	ER027	dose calibrator (Atomlab)	NF		18	19	E15: Refined equipment time to conform to changes in clinical labor time	0.03	ATS/CHEST - Agree	
38792		Ra tracer id of sentinl node	ER033	gamma counter, automatic	NF		18	19	E15: Refined equipment time to conform to changes in clinical labor time	0.07	ATS/CHEST - Agree	
38792		Ra tracer id of sentinl node	ER053	radiation L-block tabletop shield	NF		18	19	E15: Refined equipment time to conform to changes in clinical labor time	0.00	ATS/CHEST - Agree	
38792		Ra tracer id of sentinl node	ER054	radiation survey meter	NF		18	19	E15: Refined equipment time to conform to changes in clinical labor time	0.00	ATS/CHEST - Agree	
38792		Ra tracer id of sentinl node	ER058	safe, storage, lead-lined	NF		18	19	E15: Refined equipment time to conform to changes in clinical labor time	0.01	ATS/CHEST - Agree	
38792		Ra tracer id of sentinl node	L049A	Nuclear Medicine Technologist	NF	Confirm order, protocol exam	1	0	G1: See preamble text	-0.62	ATS/CHEST - Agree	

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38792		Ra tracer id of sentinl node	L049A	Nuclear Medicine Technologist	NF	Prepare room, equipment and supplies	2	3	L1: Refined time to standard for this clinical labor task	0.62	ATS/CHEST - Agree	
43X63	ACEP, ACG, ACS, AGA, APSA, ASGE, SAGES	Rplc gtube no revj trc	EF023	table, exam	NF		22	23	E1: Refined equipment time to conform to established policies for non-highly technical equipment	0.00	AGA - Agree	
43X64	ACEP, ACG, ACS, AGA, APSA, ASGE, SAGES	Rplc gtube revj gstrst trc	EF014	light, surgical	NF		34	35	E1: Refined equipment time to conform to established policies for non-highly technical equipment	0.01	Agree	
43X64	ACEP, ACG, ACS, AGA, APSA, ASGE, SAGES	Rplc gtube revj gstrst trc	EF015	mayo stand	NF		34	35	E1: Refined equipment time to conform to established policies for non-highly technical equipment	0.00	Agree	
43X64	ACEP, ACG, ACS, AGA, APSA, ASGE, SAGES	Rplc gtube revj gstrst trc	EF031	table, power	NF		34	35	E1: Refined equipment time to conform to established policies for non-highly technical equipment	0.02	Agree	
45300	ASCRS, ACS, SAGES	Proctosigmoidoscopy dx	EF031	table, power	NF		30	28	E1: Refined equipment time to conform to established policies for non-highly technical equipment	-0.03	ASCRS - Disagree	ASCRS - We do not know what time element was removed. Specific clinical activity line item should be noted so that we can make an informed comment.
45300	ASCRS, ACS, SAGES	Proctosigmoidoscopy dx	EQ235	suction machine (Gomco)	NF		30	28	E1: Refined equipment time to conform to established policies for non-highly technical equipment	0.00	ASCRS - Disagree	ASCRS - We do not know what time element was removed. Specific clinical activity line item should be noted so that we can make an informed comment.
45300	ASCRS, ACS, SAGES	Proctosigmoidoscopy dx	ES003	cart, endoscopy imaging equipment	NF		30	28	E1: Refined equipment time to conform to established policies for non-highly technical equipment	-0.02	ASCRS - Disagree	ASCRS - We do not know what time element was removed. Specific clinical activity line item should be noted so that we can make an informed comment.
45300	ASCRS, ACS, SAGES	Proctosigmoidoscopy dx	ES012	endoscope, rigid, sigmoidoscopy	NF		40	34	E4: Refined equipment time to conform to established policies for scopes	-0.03	ASCRS - Disagree	ASCRS - We do not know what time element was removed. Specific clinical activity line item should be noted so that we can make an informed comment.
46500	ASCRS, ACS	Injection into hemorrhoid(s)	ES002	anoscope with light source	NF		75	72	E4: Refined equipment time to conform to established policies for scopes	-0.09	ASCRS - Disagree	ASCRS - We do not know what time element was removed. Specific clinical activity line item should be noted so that we can make an informed comment.
46500	ASCRS, ACS	Injection into hemorrhoid(s)	L037D	RN/LPN/MTA	NF	Assist physician or other qualified healthcare professional---directly related to physician work time (100% of physician intra-service time)	10	0	G1: See preamble text	-3.70	ASCRS - Disagree	ASCRS - Two staff are needed - one is handling suction and holding the retractor (takes two hands) while the surgeon identifies and injects the hemorrhoids - the other staff is handing supplies (syringes, gauze) and taking soiled supplies away.
46500	ASCRS, ACS	Injection into hemorrhoid(s)	L037D	RN/LPN/MTA	NF	Review home care instructions, coordinate visits/prescriptions	2	0	G8: Input removed; code is typically billed with an E/M or other evaluation service	-0.74	ASCRS - Disagree	ASCRS - This activity is not a duplication of what would be included in an E/M visit. This is separate and distinct work related to the procedure.
46500	ASCRS, ACS	Injection into hemorrhoid(s)	SB027	gown, staff, impervious	NF		3	2	S6: Refined supply quantity to what is typical for the procedure	-1.19	ASCRS - Disagree	ASCRS - Two staff are needed - one is handling suction and holding the retractor (takes two hands) while the surgeon identifies and injects the hemorrhoids - the other staff is handing supplies (syringes, gauze) and taking soiled supplies away.
46500	ASCRS, ACS	Injection into hemorrhoid(s)	SB034	mask, surgical, with face shield	NF		3	2	S6: Refined supply quantity to what is typical for the procedure	-1.22	ASCRS - Disagree	ASCRS - Two staff are needed - one is handling suction and holding the retractor (takes two hands) while the surgeon identifies and injects the hemorrhoids - the other staff is handing supplies (syringes, gauze) and taking soiled supplies away.
46500	ASCRS, ACS	Injection into hemorrhoid(s)	SB039	shoe covers, surgical	NF		3	2	S6: Refined supply quantity to what is typical for the procedure	-0.28	ASCRS - Disagree	ASCRS - Two staff are needed - one is handling suction and holding the retractor (takes two hands) while the surgeon identifies and injects the hemorrhoids - the other staff is handing supplies (syringes, gauze) and taking soiled supplies away.
52334	AUA	Create passage to kidney	L041B	Radiologic Technologist	F	Confirm availability of prior images/studies	2	0	G1: See preamble text	-0.82	AUA - Agree	
58100	ACOG	Biopsy of uterus lining	EF031	table, power	NF		26	22	E1: Refined equipment time to conform to established policies for non-highly technical equipment	-0.06	ACOG - Agree	
58100	ACOG	Biopsy of uterus lining	EQ168	light, exam	NF		26	22	E1: Refined equipment time to conform to established policies for non-highly technical equipment	-0.02	ACOG - Agree	
58100	ACOG	Biopsy of uterus lining	L037D	RN/LPN/MTA	NF	Review/read post-procedure x-ray, lab and pathology reports	2	0	G8: Input removed; code is typically billed with an E/M or other evaluation service	-0.74	ACOG - Disagree	ACOG - The clinical description of the service/vignette for CPT code 58100 clearly notes that the E/M is done the day before the service and the patient is returning for the biopsy. The clinical time is mandatory because the physician has to have a chaperone at the minimum during the procedure. The pathology report results and notification occurs in the post-service of the service period as a result of the procedure and is not part of the E/M determination to perform the procedure which occurred the day prior.
64405	AAN, AAPM, AAPM&R, ASA	N block inj occipital	EF023	table, exam	NF		18	16	E1: Refined equipment time to conform to established policies for non-highly technical equipment	-0.01	AAPMR - Agree	
64455	AAN, AAPM, AAPM&R, ASA	N block inj plantar digit	EF023	table, exam	NF		19	17	E1: Refined equipment time to conform to established policies for non-highly technical equipment	-0.01	AAPMR - Agree	
72020	AAOS, ACR, ASNR	X-ray exam of spine 1 view	EL012	room, basic radiology	NF		10	8	E2: Refined equipment time to conform to established policies for highly technical equipment	-1.19	ASNR - Agree	
72040	AAOS, ACR, ASNR	X-ray exam neck spine 2-3 vw	EL012	room, basic radiology	NF		18	16	E2: Refined equipment time to conform to established policies for highly technical equipment	-1.19	ASNR - Agree	
72050	AAOS, ACR, ASNR	X-ray exam neck spine 4/5vws	EL012	room, basic radiology	NF		24	22	E2: Refined equipment time to conform to established policies for highly technical equipment	-1.19	ASNR - Agree	
72052	AAOS, ACR, ASNR	X-ray exam neck spine 6/>vws	EL012	room, basic radiology	NF		30	28	E2: Refined equipment time to conform to established policies for highly technical equipment	-1.19	ASNR - Agree	
72070	AAOS, ACR, ASNR	X-ray exam thorac spine 2vws	EL012	room, basic radiology	NF		15	13	E2: Refined equipment time to conform to established policies for highly technical equipment	-1.19	ASNR - Agree	

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72072	AAOS, ACR, ASNR	X-ray exam thorac spine 3vws	EL012	room, basic radiology	NF		18	16	E2: Refined equipment time to conform to established policies for highly technical equipment	-1.19	ASNR - Agree	
72074	AAOS, ACR, ASNR	X-ray exam thorac spine4/>vw	EL012	room, basic radiology	NF		21	19	E2: Refined equipment time to conform to established policies for highly technical equipment	-1.19	ASNR - Agree	
72080	AAOS, ACR, ASNR	X-ray exam thoracolmb 2/> vw	EL012	room, basic radiology	NF		15	13	E2: Refined equipment time to conform to established policies for highly technical equipment	-1.19	ASNR - Agree	
72100	AAOS, ACR, ASNR	X-ray exam l-s spine 2/3 vws	EL012	room, basic radiology	NF		18	16	E2: Refined equipment time to conform to established policies for highly technical equipment	-1.19	ASNR - Agree	
72110	AAOS, ACR, ASNR	X-ray exam l-2 spine 4/>vws	EL012	room, basic radiology	NF		24	22	E2: Refined equipment time to conform to established policies for highly technical equipment	-1.19	ASNR - Agree	
72114	AAOS, ACR, ASNR	X-ray exam l-s spine bending	EL012	room, basic radiology	NF		30	28	E2: Refined equipment time to conform to established policies for highly technical equipment	-1.19	ASNR - Agree	
72120	AAOS, ACR, ASNR	X-ray bend only l-s spine	EL012	room, basic radiology	NF		20	18	E2: Refined equipment time to conform to established policies for highly technical equipment	-1.19	ASNR - Agree	
72120	AAOS, ACR, ASNR	X-ray bend only l-s spine	SB026	gown, patient	NF		0	1	S5: Refined supply quantity to conform with other codes in the family	1.28	ASNR - Agree	
72200	AAOS, ACR	X-ray exam si joints	EL012	room, basic radiology	NF		15	13	E2: Refined equipment time to conform to established policies for highly technical equipment	-1.19	AAOS - Disagree ACR - Agree	AAOS - CMS does not indicate what service period time was removed from the calculation. This makes it difficult to determine if this is accurate or not. Since CMS is at every meeting and corrects times at the time, we do not know what further corrections were made. We request more information about this change.
72202	AAOS, ACR	X-ray exam si joints 3/> vws	EL012	room, basic radiology	NF		18	16	E2: Refined equipment time to conform to established policies for highly technical equipment	-1.19	AAOS - Disagree ACR - Agree	AAOS - CMS does not indicate what service period time was removed from the calculation. This makes it difficult to determine if this is accurate or not. Since CMS is at every meeting and corrects times at the time, we do not know what further corrections were made. We request more information about this change.
72220	AAOS, ACR	X-ray exam sacrum tailbone	EL012	room, basic radiology	NF		15	13	E2: Refined equipment time to conform to established policies for highly technical equipment	-1.19	AAOS - Disagree ACR - Agree	AAOS - CMS does not indicate what service period time was removed from the calculation. This makes it difficult to determine if this is accurate or not. Since CMS is at every meeting and corrects times at the time, we do not know what further corrections were made. We request more information about this change.
73070	AAOS, ACR, ASSH	X-ray exam of elbow	EL012	room, basic radiology	NF		13	11	E2: Refined equipment time to conform to established policies for highly technical equipment	-1.19	AAOS - Disagree ACR - Agree	AAOS - CMS does not indicate what service period time was removed from the calculation. This makes it difficult to determine if this is accurate or not. Since CMS is at every meeting and corrects times at the time, we do not know what further corrections were made. We request more information about this change.
73080	AAOS, ACR, ASSH	X-ray exam of elbow	EL012	room, basic radiology	NF		15	13	E2: Refined equipment time to conform to established policies for highly technical equipment	-1.19	AAOS - Disagree ACR - Agree	AAOS - CMS does not indicate what service period time was removed from the calculation. This makes it difficult to determine if this is accurate or not. Since CMS is at every meeting and corrects times at the time, we do not know what further corrections were made. We request more information about this change.
73090	AAOS, ACR, ASSH	X-ray exam of forearm	EL012	room, basic radiology	NF		13	11	E2: Refined equipment time to conform to established policies for highly technical equipment	-1.19	AAOS - Disagree ACR - Agree	AAOS - CMS does not indicate what service period time was removed from the calculation. This makes it difficult to determine if this is accurate or not. Since CMS is at every meeting and corrects times at the time, we do not know what further corrections were made. We request more information about this change.
73650	AAOS, ACR, APMA, AOFAS	X-ray exam of heel	EL012	room, basic radiology	NF		13	11	E2: Refined equipment time to conform to established policies for highly technical equipment	-1.19	AAOS - Disagree ACR - Agree	AAOS - CMS does not indicate what service period time was removed from the calculation. This makes it difficult to determine if this is accurate or not. Since CMS is at every meeting and corrects times at the time, we do not know what further corrections were made. We request more information about this change.
73660	AAOS, ACR, APMA, AOFAS	X-ray exam of toe(s)	EL012	room, basic radiology	NF		15	13	E2: Refined equipment time to conform to established policies for highly technical equipment	-1.19	AAOS - Disagree ACR - Agree	AAOS - CMS does not indicate what service period time was removed from the calculation. This makes it difficult to determine if this is accurate or not. Since CMS is at every meeting and corrects times at the time, we do not know what further corrections were made. We request more information about this change.
73660	AAOS, ACR, APMA, AOFAS	X-ray exam of toe(s)	SB026	gown, patient	NF		0	1	S5: Refined supply quantity to conform with other codes in the family	1.28	AAOS - Disagree ACR - Agree	AAOS - The specialties and the RUC PE Subcommittee agreed that the typical patient for this service would not require a patient gown. This is different than other codes in the family where the patient may need to be rotated lateral and prone for different views.
74210	ACR	Contrst x-ray exam of throat	EL014	room, radiographic-fluoroscopic	NF		22	20	E2: Refined equipment time to conform to established policies for highly technical equipment	-3.37	ACR - Agree	
74220	ACR	Contrast x-ray esophagus	EL014	room, radiographic-fluoroscopic	NF		22	20	E2: Refined equipment time to conform to established policies for highly technical equipment	-3.37	ACR - Agree	
74230	ACR	Cine/vid x-ray throat/esoph	EF008	chair with headrest, exam, reclining	NF		28	26	E1: Refined equipment time to conform to established policies for non-highly technical equipment	-0.02	ACR - Agree	

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74230	ACR	Cine/vid x-ray throat/esoph	EL014	room, radiographic-fluoroscopic	NF		28	26	E2: Refined equipment time to conform to established policies for highly technical equipment	-3.37	ACR - Agree	
74420	ACR, AUA	Contrst x-ray urinary tract	ED050	Technologist PACS workstation	NF		39	38	E15: Refined equipment time to conform to changes in clinical labor time	-0.02	ACR - Agree	
74420	ACR, AUA	Contrst x-ray urinary tract	ED053	Professional PACS Workstation	NF		20	18	E18: Refined equipment time to conform to established policies for PACS Workstations	-0.12	ACR - Agree	
74420	ACR, AUA	Contrst x-ray urinary tract	EL012	room, basic radiology	NF		35	33	E2: Refined equipment time to conform to established policies for highly technical equipment	-1.19	ACR - Agree	
74420	ACR, AUA	Contrst x-ray urinary tract	L041B	Radiologic Technologist	NF	Confirm order, protocol exam	1	0	G1: See preamble text	-0.41	ACR - Agree	
76000	ACR, APMA	Fluoroscopy <1 hr phys/qhp	ER031	fluoroscopic system, mobile C-Arm	NF		19	17	E2: Refined equipment time to conform to established policies for highly technical equipment	-0.51	ACR - Agree	
767X1	ACR	Use parenchyma	ED060	sheer wave elastography software	NF		28	29	E15: Refined equipment time to conform to changes in clinical labor time	0.04	ACR - Disagree	ACR - Formula is correct but row 172 should be 2 mins, not 3 mins.
767X1	ACR	Use parenchyma	EL015	room, ultrasound, general	NF		28	29	E15: Refined equipment time to conform to changes in clinical labor time	1.17	ACR - Disagree	ACR - Formula is correct but row 172 should be 2 mins, not 3 mins.
767X1	ACR	Use parenchyma	L050B	Diagnostic Medical Sonographer	NF	Confirm order, protocol exam	1	0	G1: See preamble text	-0.50	ACR - Agree	
767X1	ACR	Use parenchyma	L050B	Diagnostic Medical Sonographer	NF	Prepare room, equipment and supplies	2	3	L1: Refined time to standard for this clinical labor task	0.50	ACR - Disagree	ACR - The standard is 2 mins for this clinical labor task.
767X2	ACR	Use 1st target lesion	ED060	sheer wave elastography software	NF		23	24	E15: Refined equipment time to conform to changes in clinical labor time	0.04	ACR - Disagree	ACR - Formula is correct but row 176 should be 2 mins, not 3 mins.
767X2	ACR	Use 1st target lesion	EL015	room, ultrasound, general	NF		23	24	E15: Refined equipment time to conform to changes in clinical labor time	1.17	ACR - Disagree	ACR - Formula is correct but row 176 should be 2 mins, not 3 mins.
767X2	ACR	Use 1st target lesion	L050B	Diagnostic Medical Sonographer	NF	Confirm order, protocol exam	1	0	G1: See preamble text	-0.50	ACR - Agree	
767X2	ACR	Use 1st target lesion	L050B	Diagnostic Medical Sonographer	NF	Prepare room, equipment and supplies	2	3	L1: Refined time to standard for this clinical labor task	0.50	ACR - Disagree	ACR- The standard is 2 mins for this clinical labor task.
76870	ACR, AUA	Us exam scrotum	ED050	Technologist PACS workstation	NF		39	36	E18: Refined equipment time to conform to established policies for PACS Workstations	-0.07	ACR - Agree	
76870	ACR, AUA	Us exam scrotum	EL015	room, ultrasound, general	NF		29	28	E2: Refined equipment time to conform to established policies for highly technical equipment	-1.17	ACR - Disagree	ACR - Formula is correct but row 179 should be 2 mins, not 3 mins.
76870	ACR, AUA	Us exam scrotum	L051B	RN/Diagnostic Medical Sonographer	NF	Prepare room, equipment and supplies	2	3	L1: Refined time to standard for this clinical labor task	0.51	ACR - Disagree	ACR - The standard is 2 mins for this clinical labor task.
76870	ACR, AUA	Us exam scrotum	L051B	RN/Diagnostic Medical Sonographer	NF	Confirm order, protocol exam	1	0	G1: See preamble text	-0.51	ACR - Agree	
76X01	ACR	Mr elastography	ED050	Technologist PACS workstation	NF		52	50	E15: Refined equipment time to conform to changes in clinical labor time	-0.04	ACR - Agree	
76X01	ACR	Mr elastography	EL008	room, MR	NF		38	36	E15: Refined equipment time to conform to changes in clinical labor time	-6.71	ACR - Agree	
76X01	ACR	Mr elastography	EL050	MR Elastography Package	NF		38	36	E15: Refined equipment time to conform to changes in clinical labor time	-0.84	ACR - Agree	
76X01	ACR	Mr elastography	L047A	MRI Technologist	NF	Prepare, set-up and start IV, initial positioning and monitoring of patient	4	3	L1: Refined time to standard for this clinical labor task	-0.47	ACR - Agree	
76X01	ACR	Mr elastography	L047A	MRI Technologist	NF	Prepare room, equipment and supplies	6	5	L1: Refined time to standard for this clinical labor task	-0.47	ACR - Agree	
76X0X	ACR	Us trgt dyn mbubb 1st les	EL015	room, ultrasound, general	NF		37	38	E15: Refined equipment time to conform to changes in clinical labor time	1.17	ACR - Disagree	ACR - Formula is correct but row 188 should be 2 mins, not 3 mins.
76X0X	ACR	Us trgt dyn mbubb 1st les	ER108	Ultrasound Contrast Imaging Package	NF		37	38	E15: Refined equipment time to conform to changes in clinical labor time	0.02	ACR - Disagree	ACR - Formula is correct but row 188 should be 2 mins, not 3 mins.
76X0X	ACR	Us trgt dyn mbubb 1st les	L050B	Diagnostic Medical Sonographer	NF	Prepare room, equipment and supplies	2	3	L1: Refined time to standard for this clinical labor task	0.50	ACR - Disagree	ACR - Thes standard is 2 mins for this clinical labor task.
76X0X	ACR	Us trgt dyn mbubb 1st les	L050B	Diagnostic Medical Sonographer	NF	Confirm order, protocol exam	1	0	G1: See preamble text	-0.50	ACR - Disagree	ACR - This time is necessary for this exam as opposed to some other US studies because of the requirements for Contrast Enhanced Ultrasound. Extra time is spent by staff to confirm with the ordering physician/office what lesion to target and ensure supplies are availalbe to perform the exam.
76X0X	ACR	Us trgt dyn mbubb 1st les	SL180	phosphate buffered saline (PBS)	NF		50	0	G1: See preamble text	-1.07	ACR - Agree	
76X1X	ACR	Us trgt dyn mbubb ea addl	SL180	phosphate buffered saline (PBS)	NF		50	0	G1: See preamble text	-1.07	ACR - Agree	
77012	ACR, SIR	Ct scan for needle biopsy	ED050	Technologist PACS workstation	NF		32	33	E18: Refined equipment time to conform to established policies for PACS Workstations	0.02	ACR - Disagree SIR - Agree	ACR - Formula is correct but row 195 should be 2 mins, not 3 mins.
77012	ACR, SIR	Ct scan for needle biopsy	EL007	room, CT	NF		28	9	G1: See preamble text	-95.06	ACR - Disagree SIR - Agree	ACR - We disagree with CMS applying the RS&I standard room time for angiographic rooms to CT guidance.
77012	ACR, SIR	Ct scan for needle biopsy	L041B	Radiologic Technologist	NF	Confirm order, protocol exam	1	0	G1: See preamble text	-0.41	ACR - Disagree SIR - Agree	ACR - This is time specifically spent protocolling the CT guidance portion of a procedure, e.g. deciding based on prior imaging how the patient should be positioned on the table, what scanner settings to use, and if the CT gantry needs to be adjusted/tilted for the procedure, and at what angle. This time is specific to the use of CT guidance and belongs in this CPT code.
77012	ACR, SIR	Ct scan for needle biopsy	L041B	Radiologic Technologist	NF	Prepare room, equipment and supplies	2	3	L1: Refined time to standard for this clinical labor task	0.41	ACR - Disagree SIR - Agree	ACR - The standard is 2 mins for this clinical labor task.
77021	ACR, SIR	Mri guidance ndl plmt rs&i	ED050	Technologist PACS workstation	NF		62	65	E18: Refined equipment time to conform to established policies for PACS Workstations	0.07	ACR - Agree SIR - Agree	

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77021	ACR, SIR	Mri guidance ndl plmt rs&i	L047A	MRI Technologist	NF	Prepare room, equipment and supplies	2	3	L1: Refined time to standard for this clinical labor task	0.47	ACR - Disagree SIR - Agree	ACR - The standard is 2 mins for this clinical labor task.
77021	ACR, SIR	Mri guidance ndl plmt rs&i	L047A	MRI Technologist	NF	Confirm order, protocol exam	1	0	G1: See preamble text	-0.47	ACR - Agree SIR - Agree	
77X49	ACR	Mri breast c- unilateral	ED050	Technologist PACS workstation	NF		55	51	E15: Refined equipment time to conform to changes in clinical labor time	-0.09	ACR - Agree	
77X49	ACR	Mri breast c- unilateral	EL008	room, MR	NF		43	36	E2: Refined equipment time to conform to established policies for highly technical equipment	-23.48	ACR - Agree	
77X49	ACR	Mri breast c- unilateral	EQ388	Breast coil	NF		43	36	E2: Refined equipment time to conform to established policies for highly technical equipment	-0.23	ACR - Agree	
77X49	ACR	Mri breast c- unilateral	L047A	MRI Technologist	NF	Prepare, set-up and start IV, initial positioning and monitoring of patient	7	3	G1: See preamble text	-1.88	ACR - Agree	
77X50	ACR	Mri breast c- bilateral	ED050	Technologist PACS workstation	NF		55	51	E15: Refined equipment time to conform to changes in clinical labor time	-0.09	ACR - Agree	
77X50	ACR	Mri breast c- bilateral	EL008	room, MR	NF		43	36	E2: Refined equipment time to conform to established policies for highly technical equipment	-23.48	ACR - Agree	
77X50	ACR	Mri breast c- bilateral	EQ388	Breast coil	NF		43	36	E2: Refined equipment time to conform to established policies for highly technical equipment	-0.23	ACR - Agree	
77X50	ACR	Mri breast c- bilateral	L047A	MRI Technologist	NF	Prepare, set-up and start IV, initial positioning and monitoring of patient	7	3	G1: See preamble text	-1.88	ACR - Agree	
77X51	ACR	Mri breast c-+ w/cad uni	ED050	Technologist PACS workstation	NF		79	75	E15: Refined equipment time to conform to changes in clinical labor time	-0.09	ACR - Agree	
77X51	ACR	Mri breast c-+ w/cad uni	ED056	CAD Workstation (CPU + Color Monitor)	NF		79	75	E15: Refined equipment time to conform to changes in clinical labor time	-0.24	ACR - Agree	
77X51	ACR	Mri breast c-+ w/cad uni	ED058	CAD Software	NF		79	75	E15: Refined equipment time to conform to changes in clinical labor time	-0.27	ACR - Agree	
77X51	ACR	Mri breast c-+ w/cad uni	EL008	room, MR	NF		62	55	E2: Refined equipment time to conform to established policies for highly technical equipment	-23.48	ACR - Agree	
77X51	ACR	Mri breast c-+ w/cad uni	EQ388	Breast coil	NF		62	55	E2: Refined equipment time to conform to established policies for highly technical equipment	-0.23	ACR - Agree	
77X51	ACR	Mri breast c-+ w/cad uni	L047A	MRI Technologist	NF	Prepare, set-up and start IV, initial positioning and monitoring of patient	9	5	G1: See preamble text	-1.88	ACR - Agree	
77X52	ACR	Mri breast c-+ w/cad bi	ED050	Technologist PACS workstation	NF		79	75	E15: Refined equipment time to conform to changes in clinical labor time	-0.09	ACR - Agree	
77X52	ACR	Mri breast c-+ w/cad bi	ED056	CAD Workstation (CPU + Color Monitor)	NF		79	75	E15: Refined equipment time to conform to changes in clinical labor time	-0.24	ACR - Agree	
77X52	ACR	Mri breast c-+ w/cad bi	ED058	CAD Software	NF		79	75	E15: Refined equipment time to conform to changes in clinical labor time	-0.27	ACR - Agree	
77X52	ACR	Mri breast c-+ w/cad bi	EL008	room, MR	NF		62	55	E2: Refined equipment time to conform to established policies for highly technical equipment	-23.48	ACR - Agree	
77X52	ACR	Mri breast c-+ w/cad bi	EQ388	Breast coil	NF		62	55	E2: Refined equipment time to conform to established policies for highly technical equipment	-0.23	ACR - Agree	
77X52	ACR	Mri breast c-+ w/cad bi	L047A	MRI Technologist	NF	Prepare, set-up and start IV, initial positioning and monitoring of patient	9	5	G1: See preamble text	-1.88	ACR - Agree	
85097	CAP	Bone marrow interpretation	L030A	Lab Tech/MTA	NF	Accession and enter information	4	0	G6: Indirect Practice Expense input and/or not individually allocable to a particular patient for a particular service	-1.20	CAP - Disagree	CAP - RUC urges CMS to consider pathology clinical staff activities apart from the standard practice expense clinical activities, in fact that is the exact reason that the PE Subcommittee determined that separate and distinct clinical activities codes were needed when the PE Spreadsheet Update Workgroup developed the codes for clinical activities. Although the RUC understands that the clinical activity description for PA001 accession and enter information and PA008 file specimen, supplies and other materials may sound like data entry and filing, it is very different in the pathology laboratory. These tasks are not routine or trivial. It is crucial for the performance of these tasks, by highly trained clinical staff, be executed accurately according to rigid patient laboratory protocols, standards, and legal processes associated with specimen/patient care. These clinical activities are integral elements performed by health care professionals in order to analyze a specimen and are not administrative tasks applicable to the indirect practice expense. The RUC assures CMS that these clinical activities are allocable to a particular patient for this service and should not be considered a form of indirect expense.

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85097	CAP	Bone marrow interpretation	L030A	Lab Tech/MTA	NF	File specimen, supplies, and other materials	1	0	G6: Indirect Practice Expense input and/or not individually allocable to a particular patient for a particular service	-0.30	CAP - Disagree	CAP - RUC urges CMS to consider pathology clinical staff activities apart from the standard practice expense clinical activities, in fact that is the exact reason that the PE Subcommittee determined that separate and distinct clinical activities codes were needed when the PE Spreadsheet Update Workgroup developed the codes for clinical activities. Although the RUC understands that the clinical activity description for PA001 accession and enter information and PA008 file specimen, supplies and other materials may sound like data entry and filing, it is very different in the pathology laboratory. These tasks are not routine or trivial. It is crucial for the performance of these tasks, by highly trained clinical staff, be executed accurately according to rigid patient laboratory protocols, standards, and legal processes associated with specimen/patient care. These clinical activities are integral elements performed by health care professionals in order to analyze a specimen and are not administrative tasks applicable to the indirect practice expense. The RUC assures CMS that these clinical activities are allocable to a particular patient for this service and should not be considered a form of indirect expense.
92X71	AOA, AAO	Full field erg w/i&r	EQ390	mfERG and ffERG electrodiagnostic unit	NF		74	71	E15: Refined equipment time to conform to changes in clinical labor time	-0.94	AAO - Disagree	AAO - See attached comments. Original clinical labor inputs should not change, leaving this calculation unchanged also. Highly technical equipment formula should be used.
92X71	AOA, AAO	Full field erg w/i&r	EQ391	Contact lens electrode for mfERG and ffERG	NF		79	71	E15: Refined equipment time to conform to changes in clinical labor time	-0.04	AAO - Disagree	AAO - See attached comments. Two contact lens electrodes are required. Original clinical labor inputs should not change, leaving this calculation unchanged also. Standard equipment formula should be used. As is described in detail in the PE SOR, the ffERG test (92X71) is performed with two contact lenses in place (one in each eye at the same time) in a simultaneous testing fashion. Two contact lens electrodes are required during the entirety of this service. This discrepancy from the other code is primarily due to the dark and light-adaptation needs for the ffERG, which if done sequentially would *double* the amount of clinical time.
92X71	AOA, AAO	Full field erg w/i&r	EQ391	Contact lens electrode for mfERG and ffERG	NF		79	71	E15: Refined equipment time to conform to changes in clinical labor time	-0.04	AAO - Disagree	AAO - See attached comments. Two contact lens electrodes are required. Original clinical labor inputs should not change, leaving this calculation unchanged also. Standard equipment formula should be used. As is described in detail in the PE SOR, the ffERG test (92X71) is performed with two contact lenses in place (one in each eye at the same time) in a simultaneous testing fashion. Two contact lens electrodes are required during the entirety of this service. This discrepancy from the other code is primarily due to the dark and light-adaptation needs for the ffERG, which if done sequentially would *double* the amount of clinical time.
92X71	AOA, AAO	Full field erg w/i&r	L038A	COMT/COT/RN/CST	NF	Confirm order, protocol exam	1	0	G1: See preamble text	-0.38	AAO - Disagree	AAO - See attached comments. This work is done by a different technician in a different room typically in a busy clinical setting. Different settings and protocols are used for different pathology, and it is typical to take time to confirm the order and the specific testing protocol for the service. This work separate from that being done during the office visit. This time was obtained by direct observation during time motion studies done personally by the society's expert panel.
92X71	AOA, AAO	Full field erg w/i&r	L038A	COMT/COT/RN/CST	NF	Review examination with interpreting MD/DO	5	2	L1: Refined time to standard for this clinical labor task	-1.14	AAO - Disagree	AAO - See attached comments. This input was calculated by direct observation of typical procedures with a stopwatch. This test is performed in a different room than the office visit, and the technician needs to take time to locate the ordering/interpreting physician and review the quality of the gain and results. This takes time to review in order to decide whether or not the test needs to be repeated with adjustments.
92X71	AOA, AAO	Full field erg w/i&r	L038A	COMT/COT/RN/CST	NF	Clean room/equipment by clinical staff	12	8	G1: See preamble text	-1.52	AAO - Disagree	AAO - See attached comments. This time input was found during direct time motion study, and it reflects typical practice. The technician scrubs and cleans the patient's skin, rinses their eyes, and cleans around the patient, then escorts them out to the exam lane. Then the equipment is cleaned. Conductive paste and Goniosol are carefully removed without damaging the silver electrodes. Meticulous mechanical and chemical cleaning of the contact lens electrodes is mandatory for patient protection and to prevent spread of communicable diseases. Lenses then undergo a soak, then ultrasound sonication which needs to be continuously monitored to ensure that the silver does not get damaged. Electrodes are manually washed again, and then left to dry. If over-treated, the electrodes corrode, if under-treated, they risk the spread of communicable disease. This process requires meticulous care and a significant amount of technician time. Arbitrary underestimations of this work are unfounded and inaccurate.
92X71	AOA, AAO	Full field erg w/i&r	L038A	COMT/COT/RN/CST	NF	Provide education/obtain consent	1	0	G8: Input removed; code is typically billed with an E/M or other evaluation service	-0.38	AAO - Disagree	AAO - See attached comments. The patient is in a separate room from the E&M doing something totally foreign to a normal medical exam – having contact lenses with wires attached placed in the eyes and being told to hold still and keep the eye fixated for an unnatural amount of time. This simply takes time to explain the instructions to a patient, in excess of a typical E&M code, and one minute is in reality a short amount of time to do this. This clinical task is not duplicative with an E/M, as it represents totally different actions by a different technician in a different room.

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92X71	AOA, AAO	Full field erg w/i&r	L038A	COMT/COT/RN/CST	NF	Prepare room, equipment and supplies	2	3	L1: Refined time to standard for this clinical labor task	0.38	AAO - Disagree	AAO - See attached comments. This is a separate room, with different equipment, and a different technician than the office visit. This time was derived from direct observation during time motion studies. This work is unrelated to the work typically done during the office visit.
92X71	AOA, AAO	Full field erg w/i&r	L038A	COMT/COT/RN/CST	NF	Greet patient, provide gowning, ensure appropriate medical records are available	3	0	G8: Input removed; code is typically billed with an E/M or other evaluation service	-1.14	AAO - Disagree	AAO - See attached comments. This patient is meeting a new technician, and going to a new room. The ERG technician is unfamiliar with the patient, and needs to confirm appropriate medical records are available. These clinical tasks are not duplicative with an E/M, as they represent separate actions by a different technician in a different room.
92X71	AOA, AAO	Full field erg w/i&r	L038A	COMT/COT/RN/CST	F	Complete pre-service diagnostic and referral forms	3	0	G4: This input is not applicable in the facility setting	-1.14	AAO - Disagree	AAO - See attached comments. This service, when done in a facility, is typically done for children, cognitively impaired or otherwise medically challenging adults, who are unable to sit still for the extended testing with electrodes inserted onto their eyes. It takes substantial amounts of staff work to coordinate care between the outpatient ophthalmology office and the inpatient facility. Equipment is that is not typical for an operating room needs to be transported and set up for use in the OR. Coordination is required for pre- and post-procedure care with the patient's guardians and/or long-term care facility. Given the nature of the patients being tested in the facility, and the inherent complexities of the testing, this coordination of care is in excess of what is typically done for common minor or major procedures.
92X71	AOA, AAO	Full field erg w/i&r	L038A	COMT/COT/RN/CST	F	Complete pre-procedure phone calls and prescription	1	0	G4: This input is not applicable in the facility setting	-0.38	AAO - Disagree	AAO - See attached comments. This service, when done in a facility, is typically done for children, cognitively impaired or otherwise medically challenging adults, who are unable to sit still for the extended testing with electrodes inserted onto their eyes. It takes substantial amounts of staff work to coordinate care between the outpatient ophthalmology office and the inpatient facility. Equipment is that is not typical for an operating room needs to be transported and set up for use in the OR. Coordination is required for pre- and post-procedure care with the patient's guardians and/or long-term care facility. Given the nature of the patients being tested in the facility, and the inherent complexities of the testing, this coordination of care is in excess of what is typically done for common minor or major procedures.
92X71	AOA, AAO	Full field erg w/i&r	L038A	COMT/COT/RN/CST	F	Schedule space and equipment in facility	3	0	G4: This input is not applicable in the facility setting	-1.14	AAO - Disagree	AAO - See attached comments. This service, when done in a facility, is typically done for children, cognitively impaired or otherwise medically challenging adults, who are unable to sit still for the extended testing with electrodes inserted onto their eyes. It takes substantial amounts of staff work to coordinate care between the outpatient ophthalmology office and the inpatient facility. Equipment is that is not typical for an operating room needs to be transported and set up for use in the OR. Coordination is required for pre- and post-procedure care with the patient's guardians and/or long-term care facility. Given the nature of the patients being tested in the facility, and the inherent complexities of the testing, this coordination of care is in excess of what is typically done for common minor or major procedures.
92X71	AOA, AAO	Full field erg w/i&r	L038A	COMT/COT/RN/CST	F	Coordinate pre-surgery services (including test results)	3	0	G4: This input is not applicable in the facility setting	-1.14	AAO - Disagree	AAO - See attached comments. This service, when done in a facility, is typically done for children, cognitively impaired or otherwise medically challenging adults, who are unable to sit still for the extended testing with electrodes inserted onto their eyes. It takes substantial amounts of staff work to coordinate care between the outpatient ophthalmology office and the inpatient facility. Equipment is that is not typical for an operating room needs to be transported and set up for use in the OR. Coordination is required for pre- and post-procedure care with the patient's guardians and/or long-term care facility. Given the nature of the patients being tested in the facility, and the inherent complexities of the testing, this coordination of care is in excess of what is typically done for common minor or major procedures.
92X71	AOA, AAO	Full field erg w/i&r	L038A	COMT/COT/RN/CST	NF	Technologist QC's images in PACS, checking for all images, reformats, and dose page	10	3	L1: Refined time to standard for this clinical labor task	-2.66	AAO - Disagree	AAO - See attached comments. Unlike most radiology centers, the machine used for the ERG codes is not typically integrated into the clinic's electronic medical record. This requires printing all images created by the testing machine and uploading them into the EMR for subsequent review by the physician. This recommended time is precisely what the specialty societies observed directly in their time motion study of typical procedures being performed at two different high volume referral center institutions. It differs from a typical radiology scenario because the procedure and equipment are in fact different from a typical imaging study. The RUC recommended time reflects accurate practice.
92X73	AOA, AAO	Multifocal erg w/i&r	EQ390	mfERG and ffERG electrodiagnostic unit	NF		50	47	E15: Refined equipment time to conform to changes in clinical labor time	-0.94	AAO - Disagree	AAO - See attached comments. Highly technical equipment formula should be used. Original clinical labor inputs should not change, leaving this calculation unchanged also.

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92X73	AOA, AAO	Multifocal erg w/i&r	EQ391	Contact lens electrode for mfERG and ffERG	NF		55	47	E15: Refined equipment time to conform to changes in clinical labor time	-0.04	AAO - Disagree	AAO - See attached comments. One contact lens electrode is required for this service (92X73). Original clinical labor inputs should not change, leaving this calculation unchanged also. Standard equipment formula should be used. The mfERG test (92X73) requires exceptional fixation to accurately map the full response from each of the many measured macular locations, and this requires sequential testing, reusing one contact in one eye at a time for accuracy. Sequential testing re-using the same single contact lens is typical for mfERG (92X73).
92X73	AOA, AAO	Multifocal erg w/i&r	L038A	COMT/COT/RN/CST	NF	Greet patient, provide gowning, ensure appropriate medical records are available	3	0	G8: Input removed; code is typically billed with an E/M or other evaluation service	-1.14	AAO - Disagree	AAO - See attached comments. This patient is meeting a new technician, and going to a new room. The ERG technician is unfamiliar with the patient, and needs to confirm appropriate medical records are available. These clinical tasks are not duplicative with an E/M, as they represent separate actions by a different technician in a different room.
92X73	AOA, AAO	Multifocal erg w/i&r	L038A	COMT/COT/RN/CST	NF	Technologist QC's images in PACS, checking for all images, reformats, and dose page	10	3	L1: Refined time to standard for this clinical labor task	-2.66	AAO - Disagree	AAO - See attached comments. Unlike most radiology centers, the machine used for the ERG codes is not typically integrated into the clinic's electronic medical record. This requires printing all images created by the testing machine and uploading them into the EMR for subsequent review by the physician. This recommended time is precisely what the specialty societies observed directly in their time motion study of typical procedures being performed at two different high volume referral center institutions. It differs from a typical radiology scenario because the procedure and equipment are in fact different from a typical imaging study. The RUC recommended time reflects accurate practice.
92X73	AOA, AAO	Multifocal erg w/i&r	L038A	COMT/COT/RN/CST	NF	Clean room/equipment by clinical staff	12	8	G1: See preamble text	-1.52	AAO - Disagree	AAO - See attached comments. This time input was found during direct time motion study, and it reflects typical practice. The technician scrubs and cleans the patient's skin, rinses their eyes, and cleans around the patient, then escorts them out to the exam lane. Then the equipment is cleaned. Conductive paste and Goniosol are carefully removed without damaging the silver electrodes. Meticulous mechanical and chemical cleaning of the contact lens electrodes is mandatory for patient protection and to prevent spread of communicable diseases. Lenses then undergo a soak, then ultrasound sonication which needs to be continuously monitored to ensure that the silver does not get damaged. Electrodes are manually washed again, and then left to dry. If over-treated, the electrodes corrode, if under-treated, they risk the spread of communicable disease. This process requires meticulous care and a significant amount of technician time. Arbitrary underestimations of this work are unfounded and inaccurate.
92X73	AOA, AAO	Multifocal erg w/i&r	L038A	COMT/COT/RN/CST	NF	Confirm order, protocol exam	1	0	G1: See preamble text	-0.38	AAO - Disagree	AAO - See attached comments. This work is done by a different technician in a different room typically in a busy clinical setting. Different settings and protocols are used for different pathology, and it is typical to take time to confirm the order and the specific testing protocol for the service. This work separate from that being done during the office visit. This time was obtained by direct observation during time motion studies done personally by the society's expert panel.
92X73	AOA, AAO	Multifocal erg w/i&r	L038A	COMT/COT/RN/CST	NF	Provide education/obtain consent	1	0	G8: Input removed; code is typically billed with an E/M or other evaluation service	-0.38	AAO - Disagree	AAO - See attached comments. The patient is in a separate room from the E&M doing something totally foreign to a normal medical exam – having contact lenses with wires attached placed in the eyes and being told to hold still and keep the eye fixated for an unnatural amount of time. This simply takes time to explain the instructions to a patient, in excess of a typical E&M code, and one minute is in reality a short amount of time to do this. This clinical task is not duplicative with an E/M, as it represents totally different actions by a different technician in a different room.
92X73	AOA, AAO	Multifocal erg w/i&r	L038A	COMT/COT/RN/CST	NF	Review examination with interpreting MD/DO	5	2	L1: Refined time to standard for this clinical labor task	-1.14	AAO - Disagree	AAO - See attached comments. This input was calculated by direct observation of typical procedures with a stopwatch. This test is performed in a different room than the office visit, and the technician needs to take time to locate the ordering/interpreting physician and review the quality of the gain and results. This takes time to review in order to decide whether or not the test needs to be repeated with adjustments.
92X73	AOA, AAO	Multifocal erg w/i&r	L038A	COMT/COT/RN/CST	F	Complete pre-service diagnostic and referral forms	3	0	G4: This input is not applicable in the facility setting	-1.14	AAO - Disagree	AAO - See attached comments. This service, when done in a facility, is typically done for children, cognitively impaired or otherwise medically challenging adults, who are unable to sit still for the extended testing with electrodes inserted onto their eyes. It takes substantial amounts of staff work to coordinate care between the outpatient ophthalmology office and the inpatient facility. Equipment is that is not typical for an operating room needs to be transported and set up for use in the OR. Coordination is required for pre- and post-procedure care with the patient's guardians and/or long-term care facility. Given the nature of the patients being tested in the facility, and the inherent complexities of the testing, this coordination of care is in excess of what is typically done for common minor or major procedures.

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92X73	AOA, AAO	Multifocal erg w/i&r	L038A	COMT/COT/RN/CST	F	Coordinate pre-surgery services (including test results)	3	0	G4: This input is not applicable in the facility setting	-1.14	AAO - Disagree	AAO - See attached comments. This service, when done in a facility, is typically done for children, cognitively impaired or otherwise medically challenging adults, who are unable to sit still for the extended testing with electrodes inserted onto their eyes. It takes substantial amounts of staff work to coordinate care between the outpatient ophthalmology office and the inpatient facility. Equipment is that is not typical for an operating room needs to be transported and set up for use in the OR. Coordination is required for pre- and post-procedure care with the patient's guardians and/or long-term care facility. Given the nature of the patients being tested in the facility, and the inherent complexities of the testing, this coordination of care is in excess of what is typically done for common minor or major procedures.
92X73	AOA, AAO	Multifocal erg w/i&r	L038A	COMT/COT/RN/CST	F	Schedule space and equipment in facility	3	0	G4: This input is not applicable in the facility setting	-1.14	AAO - Disagree	AAO - See attached comments. This service, when done in a facility, is typically done for children, cognitively impaired or otherwise medically challenging adults, who are unable to sit still for the extended testing with electrodes inserted onto their eyes. It takes substantial amounts of staff work to coordinate care between the outpatient ophthalmology office and the inpatient facility. Equipment is that is not typical for an operating room needs to be transported and set up for use in the OR. Coordination is required for pre- and post-procedure care with the patient's guardians and/or long-term care facility. Given the nature of the patients being tested in the facility, and the inherent complexities of the testing, this coordination of care is in excess of what is typically done for common minor or major procedures.
92X73	AOA, AAO	Multifocal erg w/i&r	L038A	COMT/COT/RN/CST	F	Complete pre-procedure phone calls and prescription	1	0	G4: This input is not applicable in the facility setting	-0.38	AAO - Disagree	AAO - See attached comments. This service, when done in a facility, is typically done for children, cognitively impaired or otherwise medically challenging adults, who are unable to sit still for the extended testing with electrodes inserted onto their eyes. It takes substantial amounts of staff work to coordinate care between the outpatient ophthalmology office and the inpatient facility. Equipment is that is not typical for an operating room needs to be transported and set up for use in the OR. Coordination is required for pre- and post-procedure care with the patient's guardians and/or long-term care facility. Given the nature of the patients being tested in the facility, and the inherent complexities of the testing, this coordination of care is in excess of what is typically done for common minor or major procedures.
92X73	AOA, AAO	Multifocal erg w/i&r	L038A	COMT/COT/RN/CST	NF	Prepare room, equipment and supplies	2	3	L1: Refined time to standard for this clinical labor task	0.38	AAO - Disagree	AAO - See attached comments. This is a separate room, with different equipment, and a different technician than the office visit. This time was derived from direct observation during time motion studies. This work is unrelated to the work typically done during the office visit.
963X5	AAN, APA	Nrpsyc tst eval phys/qhp 1st	SK130	WAIS-IV Record Form	NF		0	1	S6: Refined supply quantity to what is typical for the procedure	5.25	APA - Agree	
963X5	AAN, APA	Nrpsyc tst eval phys/qhp 1st	SK131	WAIS-IV Response Booklet #1	NF		0	1	S6: Refined supply quantity to what is typical for the procedure	3.30	APA - Agree	
963X5	AAN, APA	Nrpsyc tst eval phys/qhp 1st	SK132	WMS-IV Response Booklet #2	NF		0	1	S6: Refined supply quantity to what is typical for the procedure	2.00	APA - Agree	
963X6	APA, AAP, ASHA, AAN	Nrpsyc tst eval phys/qhp ea	SK130	WAIS-IV Record Form	NF		0	1	S6: Refined supply quantity to what is typical for the procedure	5.25	AAN - Agree APA - Agree	
963X6	APA, AAP, ASHA, AAN	Nrpsyc tst eval phys/qhp ea	SK131	WAIS-IV Response Booklet #1	NF		0	1	S6: Refined supply quantity to what is typical for the procedure	3.30	AAN - Agree APA - Agree	
963X6	APA, AAP, ASHA, AAN	Nrpsyc tst eval phys/qhp ea	SK132	WMS-IV Response Booklet #2	NF		0	1	S6: Refined supply quantity to what is typical for the procedure	2.00	AAN - Agree APA - Agree	
963X7	APA, AAP, ASHA, AAN	Psycl/nrpsyc tst phy/qhp 1st	SK130	WAIS-IV Record Form	NF		0.165	1	S6: Refined supply quantity to what is typical for the procedure	4.38	APA - Agree	
963X7	APA, AAP, ASHA, AAN	Psycl/nrpsyc tst phy/qhp 1st	SK131	WAIS-IV Response Booklet #1	NF		0.165	1	S6: Refined supply quantity to what is typical for the procedure	2.76	APA - Agree	
963X7	APA, AAP, ASHA, AAN	Psycl/nrpsyc tst phy/qhp 1st	SK132	WMS-IV Response Booklet #2	NF		0.165	1	S6: Refined supply quantity to what is typical for the procedure	1.67	APA - Agree	
963X8	APA, AAP, ASHA, AAN	Psycl/nrpsyc tst phy/qhp ea	SK130	WAIS-IV Record Form	NF		0.165	1	S6: Refined supply quantity to what is typical for the procedure	4.38	APA - Agree	
963X8	APA, AAP, ASHA, AAN	Psycl/nrpsyc tst phy/qhp ea	SK131	WAIS-IV Response Booklet #1	NF		0.165	1	S6: Refined supply quantity to what is typical for the procedure	2.76	APA - Agree	
963X8	APA, AAP, ASHA, AAN	Psycl/nrpsyc tst phy/qhp ea	SK132	WMS-IV Response Booklet #2	NF		0.165	1	S6: Refined supply quantity to what is typical for the procedure	1.67	APA - Agree	
963X9	APA, AAP, ASHA, AAN	Psycl/nrpsyc tech 1st	SK130	WAIS-IV Record Form	NF		0.165	1	S6: Refined supply quantity to what is typical for the procedure	4.38	APA - Agree	
963X9	APA, AAP, ASHA, AAN	Psycl/nrpsyc tech 1st	SK131	WAIS-IV Response Booklet #1	NF		0.165	1	S6: Refined supply quantity to what is typical for the procedure	2.76	APA - Agree	
963X9	APA, AAP, ASHA, AAN	Psycl/nrpsyc tech 1st	SK132	WMS-IV Response Booklet #2	NF		0.165	1	S6: Refined supply quantity to what is typical for the procedure	1.67	APA - Agree	
96X10	APA, AAP, ASHA, AAN	Psycl/nrpsyc tst tech ea	SK130	WAIS-IV Record Form	NF		0.165	1	S6: Refined supply quantity to what is typical for the procedure	4.38	APA - Agree	
96X10	APA, AAP, ASHA, AAN	Psycl/nrpsyc tst tech ea	SK131	WAIS-IV Response Booklet #1	NF		0.165	1	S6: Refined supply quantity to what is typical for the procedure	2.76	APA - Agree	
96X10	APA, AAP, ASHA, AAN	Psycl/nrpsyc tst tech ea	SK132	WMS-IV Response Booklet #2	NF		0.165	1	S6: Refined supply quantity to what is typical for the procedure	1.67	APA - Agree	

HCPCS code	Specialty Society Surveyed	HCPCS code description	Input Code	Input code description	Nonfacility (NF) / Facility (F)	Labor activity (where applicable)	RUC recommendation or current value (min or qty)	CMS refinement (min or qty)	Comment	Direct costs change (in dollars)	Specialty Agree/ Disagree	(If Disagree) Specialty Comment
96X12	APA, AAP, ASHA, AAN	Psycl/nrpsyc tst auto result	ED055	CANTAB Mobile (per single automated assessment)	NF		10	0	G1: See preamble text	-0.11	APA - Disagree	APA – During our presentation to the PE subcommittee, of APA recommended CANTAB Mobile (per single automated assessment) as a new supply item; however, the PE Subcommittee determined that since it is a software license it would be more appropriately classified as equipment. Additionally, the amount of time required for the patient to complete the test is not directly related to clinical activity time. Subsequent to the PE subcommittee's approval of our revised recommendations, APA also provided AMA staff with paid invoices for two (2) additional software license-based automated instruments typically used when furnishing 96X12. CNS Vital Signs Neurocognitive Test, a locally installed software application, allows for computer-based administration of a 30-minute neurocognitive test with automated result. The cost is $350.00 per 10 tests administered, or $35.00 per test administered. The second instrument, Cognistat Neurobehavioral Assessment System, is a computer-based online test license that takes the patient an average 20 minutes to complete (15-20 minutes for cognitively intact individuals and 20-30 minutes for those who are cognitively impaired) and produces an automatic result. It costs $425.00 per 25 tests administered, or $17.00 per test. For consideration, APA is providing the paid invoices for these two (2) additional tests once again.
990X1	ACC	Rem mntr physiol param dev		Monthly cellular and licensing service fee	NF		1	0	G6: Indirect Practice Expense input and/or not individually allocable to a particular patient for a particular service	-69.00	ACC - Disagree	ACC - The ACC disagrees with this conclusion and urges CMS to reconsider this input removal. As indicated on the invoices submitted, individual line items are dedicated to these components on a per-device, per-user basis. It is difficult to understand how such costs should be considered indirect when they are directly attributable to a patient's monthly monitoring. If the monitoring does not occur, the cost is not incurred.
99202		Office/outpatient visit new	EF023	table, exam	NF		39	51.44	G1: See preamble text	0.06		
99202		Office/outpatient visit new	EQ189	otoscope-ophthalmoscope (wall unit)	NF		39	51.44	G1: See preamble text	0.02		
99202		Office/outpatient visit new	L037D	RN/LPN/MTA	NF	Service total costs	39	55.31	G1: See preamble text	6.03		
99203		Office/outpatient visit new	EF023	table, exam	NF		51	51.44	G1: See preamble text	0.00		
99203		Office/outpatient visit new	EQ189	otoscope-ophthalmoscope (wall unit)	NF		51	51.44	G1: See preamble text	0.00		
99203		Office/outpatient visit new	L037D	RN/LPN/MTA	NF	Service total costs	51	55.31	G1: See preamble text	1.59		
99204		Office/outpatient visit new	EF023	table, exam	NF		51	51.44	G1: See preamble text	0.00		
99204		Office/outpatient visit new	EQ189	otoscope-ophthalmoscope (wall unit)	NF		51	51.44	G1: See preamble text	0.00		
99204		Office/outpatient visit new	L037D	RN/LPN/MTA	NF	Service total costs	51	51.44	G1: See preamble text	0.16		
99204		Office/outpatient visit new	L037D	RN/LPN/MTA	NF	Preservice total costs	3	1.05	G1: See preamble text	-0.72		
99204		Office/outpatient visit new	L037D	RN/LPN/MTA	NF	Post service total costs	8	2.81	G1: See preamble text	-1.92		
99205		Office/outpatient visit new	EF023	table, exam	NF		71	51.44	G1: See preamble text	-0.10		
99205		Office/outpatient visit new	EQ189	otoscope-ophthalmoscope (wall unit)	NF		71	51.44	G1: See preamble text	-0.04		
99205		Office/outpatient visit new	L037D	RN/LPN/MTA	NF	Service total costs	71	55.31	G1: See preamble text	-5.81		
99212		Office/outpatient visit est	EF023	table, exam	NF		28	39.54	G1: See preamble text	0.06		
99212		Office/outpatient visit est	EQ189	otoscope-ophthalmoscope (wall unit)	NF		28	39.54	G1: See preamble text	0.02		
99212		Office/outpatient visit est	L037D	RN/LPN/MTA	NF	Service total costs	28	43.95	G1: See preamble text	5.90		
99213		Office/outpatient visit est	EF023	table, exam	NF		36	39.54	G1: See preamble text	0.02		
99213		Office/outpatient visit est	EQ189	otoscope-ophthalmoscope (wall unit)	NF		36	39.54	G1: See preamble text	0.01		
99213		Office/outpatient visit est	L037D	RN/LPN/MTA	NF	Service total costs	36	43.95	G1: See preamble text	2.94		
99214		Office/outpatient visit est	EF023	table, exam	NF		44	39.54	G1: See preamble text	-0.02		
99214		Office/outpatient visit est	EQ189	otoscope-ophthalmoscope (wall unit)	NF		44	39.54	G1: See preamble text	-0.01		
99214		Office/outpatient visit est	L037D	RN/LPN/MTA	NF	Service total costs	44	39.54	G1: See preamble text	-1.65		
99214		Office/outpatient visit est	L037D	RN/LPN/MTA	NF	Preservice total costs	3	1.47	G1: See preamble text	-0.57		
99214		Office/outpatient visit est	L037D	RN/LPN/MTA	NF	Post service total costs	6	2.94	G1: See preamble text	-1.13		
99215		Office/outpatient visit est	EF023	table, exam	NF		51	39.54	G1: See preamble text	-0.06		
99215		Office/outpatient visit est	EQ189	otoscope-ophthalmoscope (wall unit)	NF		51	39.54	G1: See preamble text	-0.02		
99215		Office/outpatient visit est	L037D	RN/LPN/MTA	NF	Service total costs	51	39.54	G1: See preamble text	-4.24		
99215		Office/outpatient visit est	L037D	RN/LPN/MTA	NF	Preservice total costs	4	1.47	G1: See preamble text	-0.94		
99215		Office/outpatient visit est	L037D	RN/LPN/MTA	NF	Post service total costs	8	2.94	G1: See preamble text	-1.87		
G0108	AND	Diab manage trn per indiv	ED021	computer, desktop, w-monitor	NF		0	10	G1: See preamble text	0.09	AND-Agree	
G0108	AND	Diab manage trn per indiv	EF009	chair, medical recliner	NF		0	15	G1: See preamble text	0.05	AND-Agree	
G0108	AND	Diab manage trn per indiv	EF016	scale, high capacity (800 lb)	NF		0	1	G1: See preamble text	0.00	AND-Agree	
G0108	AND	Diab manage trn per indiv	EF025	table, for seated OT therapy	NF		0	15	G1: See preamble text	0.27	AND-Agree	
G0108	AND	Diab manage trn per indiv	EQ073	body analysis machine, bioimpedence	NF		0	2.5	G1: See preamble text	0.02	AND-Agree	
G0108	AND	Diab manage trn per indiv	EQ123	food models	NF		0	10	G1: See preamble text	0.03	AND-Agree	
G0108	AND	Diab manage trn per indiv	EQ187	nutrition therapy software (Nutritionist Pro)	NF		0	10	G1: See preamble text	0.02	AND-Agree	
G0108	AND	Diab manage trn per indiv	L051A	RN	NF	Obtain vital signs	0	2	G1: See preamble text	1.02	AND-Agree	
G0108	AND	Diab manage trn per indiv	SB022	gloves, non-sterile	NF		1	0	G1: See preamble text	-0.14	AND-Agree	
G0108	AND	Diab manage trn per indiv	SK043	label for files-folders	NF		0	0.5	G1: See preamble text	0.04	AND-Agree	
G0108	AND	Diab manage trn per indiv	SK057	paper, laser printing (each sheet)	NF		2	4	G1: See preamble text	0.02	AND-Agree	
G0108	AND	Diab manage trn per indiv	SK062	patient education booklet	NF		0	0.5	G1: See preamble text	0.93	AND-Agree	
G0108	AND	Diab manage trn per indiv	SM022	sanitizing cloth-wipe (surface, instruments, equipment)	NF		1	0	G1: See preamble text	-0.05	AND-Agree	
G0109	AND	Diab manage trn ind/group	ED021	computer, desktop, w-monitor	NF		0	3	G1: See preamble text	0.03	AND-Agree	
G0109	AND	Diab manage trn ind/group	ED038	notebook (Dell Latitute D600)	NF		30	0	G1: See preamble text	-0.26	AND-Agree	
G0109	AND	Diab manage trn ind/group	EF016	scale, high capacity (800 lb)	NF		0	1	G1: See preamble text	0.00	AND-Agree	
G0109	AND	Diab manage trn ind/group	EF025	table, for seated OT therapy	NF		0	10	G1: See preamble text	0.18	AND-Agree	
G0109	AND	Diab manage trn ind/group	EF043	Set of 8 chairs	NF		30	0	G1: See preamble text	-0.31	AND-Agree	
G0109	AND	Diab manage trn ind/group	EQ123	food models	NF		0	1	G1: See preamble text	0.00	AND-Agree	
G0109	AND	Diab manage trn ind/group	EQ187	nutrition therapy software (Nutritionist Pro)	NF		0	1	G1: See preamble text	0.00	AND-Agree	
G0109	AND	Diab manage trn ind/group	EQ282	PC projector	NF		30	0	G1: See preamble text	-0.32	AND-Agree	
G0109	AND	Diab manage trn ind/group	EQ305	Diabetes education data tracking software	NF		2	4	G1: See preamble text	0.00	AND-Agree	
G0109	AND	Diab manage trn ind/group	SK043	label for files-folders	NF		0	0.25	G1: See preamble text	0.02	AND-Agree	
G0109	AND	Diab manage trn ind/group	SK062	patient education booklet	NF		0	0.1	G1: See preamble text	0.19	AND-Agree	

HCPCS code	Specialty Society Surveyed	HCPCS code description	Input Code	Input code description	Nonfacility (NF) / Facility (F)	Labor activity (where applicable)	RUC recommendation or current value (min or qty)	CMS refinement (min or qty)	Comment	Direct costs change (in dollars)	Specialty Agree/ Disagree	(If Disagree) Specialty Comment
G0168	ACEP, AAFP	Wound closure by adhesive	EF023	table, exam	NF		10	9	E1: Refined equipment time to conform to established policies for non-highly technical equipment	0.00	AAFP - Agree	
G0268	AAOHNS	Removal of impacted wax md	L037D	RN/LPN/MTA	NF	Clean surgical instrument package	3	0	G1: See preamble text	-1.11	AAOHNS - Agree	

Invoices for MR Breast

Invoice #	Item	Quantity	List Price	Paid	Purpose
1	DCAD 3X RKMNT Server	1	$ 24,000.00	$ 19,200.00	Server in data center used for interpretation.
	DYNACAD 3.1 Breast Server Software	1	$ 65,500.00	$ 52,725.00	CAD software for evaluation.
2	DYNACAD 3.1 Additional Client	1	$ 14,000.00	$ 10,191.00	The software typically comes with two user licenses. Most practices typically have 3 licenses. We are requesting an additional license.
3	Sent SMS Espree 1.5T Breast Coil	1	$ 128,000.00	$ 83,200.00	This is a 16 channel, high resolution breast coil that is attached to the MRI table. A dedicated breast coil is required for breast MRI and is used for both diagnostic breast MRI (without contrast and without and with contrast) and for MRI guided breast biopsies.
4	PC Tower	1	$ 1,531.52	$ 1,531.52	This is a CPU used to display the data that comes from the CAD server and software. This is separate from the PACS, though some post processed data from the images is transmitted to the PACS for long term storage for display, correlation with images from other modalities (for example, mammography and breast ultrasound) and for future comparison.
5	3 MP Color Monitor	1	$ 10,500.00	$ 10,500.00	The CAD images require a color monitor to display initial contrast uptake and washout characteristics of lesions.

[redacted]

Issue date		Page
06/09/2014		1 / 3

Due date	Order date	Order number
07/09/2014	02/14/2014	

Payment terms:
Net 30 Days

Ship to:

INVOICE

Contact Person:

Sold to:

Invoice to:

Customer Number:

Remit To Address:

EFT Information:

Shipping Terms: [redacted]

Packages(marks-quantity-kind-number)	Dimensions(cm)	Gross (Kg)

Item	Article - / type number / description	Quantity	Unit	Unit Amt (USD)	Total amount (USD)
0010	989603208751 DCAD 3X RKMNT SRVR Hdw noDsply	1.000	PCE	24,000.00	24,000.00
	Special Discount			20.000- %	4,800.00-
	Net Value w/out Exp Ship Chg				19,200.00
	Commodity code : [redacted]				
0020	989603208911 DYNACAD 3.1 BREAST SERVER SOFTWARE	1.000	PCE	65,500.00	65,500.00
	Special Discount			12,775.00-	12,775.00-
	Net Value w/out Exp Ship Chg				52,725.00
	Commodity code : [redacted]				

Total Gross Value 89,500.00

Please pay on this invoice. No Statement will be issued

[redacted]

Issue date		Page
06/09/2014		2 / 3

Due Date	Order Date	Order nmber
07/09/2014	02/14/2014	

Purchase Order Number:

Payment terms:
Net 30 Days

INVOICE

Packages(marks-quantity-kind-number)	Dimensions(cm)	Gross (Kg)

Item	Article - / type number / description	Quantity	Unit	Unit price	Total amount (USD)

Discount Amount	17,575.00-
Total	71,925.00

Please pay on this invoice. No Statement will be issued

[redacted]

Issue date		Page
06/09/2014		3 / 3

Due Date	Order Date	
07/09/2014	02/14/2014	

Purchase Order Number:

Payment terms:
Net 30 Days

INVOICE

Packages(marks-quantity-kind-number)	Dimensions(cm)	Gross (Kg)

Item	Article - / type number / description	Quantity	Unit	Unit price	Total amount (USD)

SELLER REPRESENTS THAT THESE GOODS WERE PRODUCED IN COMPLIANCE WITH ALL APPLICABLE REQUIREMENTS OF SECTION 6,7 AND 12 OF THE FAIR LABOR STANDARDS ACT, AS AMENDED HEREIN REGULATIONS AND ORDERS OF THE UNITED STATES DEPARTMENT OF LABOR ISSUED UNDER SECTION 14 THEREOF.

The following clause only refers to US-origin products as indicated in this document: These commodities, technology or software were exported from the United States for ultimate destination United States in accordance with the Export Administration Regulations. Diversion contrary to U.S. law is prohibited.

Health Care Providers are reminded that if the purchase of goods or services includes a discount, such as a price reduction or a loan of goods at reduced cost, they must fully and accurately report such discount on cost reports or other applicable claims for payment submitted under any Federal Health Care Program, including but not limited to Medicare and Medicaid as required by Federal law (see 42 USA 1320a - 7(b)(3) and 42 CFR 1001.92(h)).

[redacted]

Issue date		Page
06/04/2014		1 / 3

Due date	Order date	Order number
07/04/2014	03/07/2014	

Payment terms:
Net 30 Days

Ship to:

INVOICE

Contact Person:

Sold to:

Invoice to:

Customer Number:

Remit To Address:

EFT Information:

Federal EIN:

Shipping Terms: [redacted]

Packages(marks-quantity-kind-number)	Dimensions(cm)	Gross (Kg)

Item	Article - / type number / description	Quantity	Unit	Unit Amt (USD)	Total amount (USD)
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Special Discount			[redacted]	[redacted]
	Net Value w/out Exp Ship Chg				[redacted]
	Commodity code : [redacted]				
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Agreement Discount			[redacted]	[redacted]
	Special Discount			[redacted]	[redacted]
	Net Value w/out Exp Ship Chg				[redacted]
	Commodity code : [redacted]				
0030	989603208971 DYNACAD 3.1 ADDITIONAL CLIENT SW UPGD	1.000	PCE	14,000.00	14,000.00

Please pay on this invoice. No Statement will be issued

Invivo™

Issue date		Page
06/04/2014		2 / 3

Due Date	Order Date	Order nmber
07/04/2014	03/07/2014	

Purchase Order Number:

Payment terms:
Net 30 Days

INVOICE

Packages(marks-quantity-kind-number)	Dimensions(cm)	Gross (Kg)

Item	Article - / type number / description	Quantity	Unit	Unit price	Total amount (USD)
	Special Discount			3,809.00-	3,809.00-
	Net Value w/out Exp Ship Chg				10,191.00
	Commodity code : [redacted]				
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Special Discount			[redacted]	[redacted]
	Net Value w/out Exp Ship Chg				[redacted]
	Commodity code : [redacted]				

Total Gross Value	[redacted]
Discount Amount	[redacted]
Total	[redacted]

Please pay on this invoice. No Statement will be issued

[redacted]

Issue date		Page
06/04/2014		3 / 3

Due Date	Order Date	
07/04/2014	03/07/2014	

Purchase Order Number:

Payment terms:
Net 30 Days

INVOICE

Packages(marks-quantity-kind-number)	Dimensions(cm)	Gross (Kg)

Item	Article - / type number / description	Quantity	Unit	Unit price	Total amount (USD)

SELLER REPRESENTS THAT THESE GOODS WERE PRODUCED IN COMPLIANCE WITH ALL APPLICABLE REQUIREMENTS OF SECTION 6,7 AND 12 OF THE FAIR LABOR STANDARDS ACT, AS AMENDED HEREIN REGULATIONS AND ORDERS OF THE UNITED STATES DEPARTMENT OF LABOR ISSUED UNDER SECTION 14 THEREOF.

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[redacted]

Issue date		Page
06/17/2016		1 / 2

Due date	Order date	Order number
07/17/2016	04/22/2016	

Payment terms:
Net 30 Days

Ship to:

INVOICE

Contact Person:

Sold to:

Invoice to:

Customer Number:

Remit To Address:

EFT Information:

Shipping Terms: [redacted]

Packages(marks-quantity-kind-number)	Dimensions(cm)	Gross (Kg)

Item	Article - / type number / description	Quantity	Unit	Unit Amt (USD)	Total amount (USD)
0010	989603213252 Sent SMS Espree 1.5T 16ch Breast Co	1.000	PCE	128,000.00	128,000.00
	Special Discount			35.000- %	44,800.00-
	Net Value w/out Exp Ship Chg				83,200.00

Commodity code : [redacted]

Total Gross Value	128,000.00
Discount Amount	44,800.00-
Total	83,200.00

Please pay on this invoice. No Statement will be issued

[redacted]

Issue date		Page
06/17/2016		2 / 2

Due Date	Order Date	
07/17/2016	04/22/2016	

Purchase Order Number:

Payment terms:
Net 30 Days

INVOICE

Packages(marks-quantity-kind-number)	Dimensions(cm)	Gross (Kg)

Item	Article - / type number / description	Quantity	Unit	Unit price	Total amount (USD)

SELLER REPRESENTS THAT THESE GOODS WERE PRODUCED IN COMPLIANCE WITH ALL APPLICABLE REQUIREMENTS OF SECTION 6,7 AND 12 OF THE FAIR LABOR STANDARDS ACT, AS AMENDED HEREIN REGULATIONS AND ORDERS OF THE UNITED STATES DEPARTMENT OF LABOR ISSUED UNDER SECTION 14 THEREOF.

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This is your INVOICE

[redacted]

Customer Number: [redacted]
Purchase Order:
Order Number:
Order Date:

05 01 O 01 01 N

Invoice Number: [redacted]
Invoice Date:
Payment Terms:
Due Date:
Shipped Via:
Waybill Number:

SOLD TO:

[redacted]

SHIP TO:

[redacted]

PLEASE REVIEW IMPORTANT TERMS & CONDITIONS ON THE REVERSE SIDE OF THIS INVOICE

Order	Shipped	Item Number	Description	Unit	Unit Price	Amount
1	1	224-8671	Dell Precision T3500,CMT,Stand ard Power Supply,C2	EA	1,531.52	1,531.52
1	1	317-4243	Quad Core Intel Xeon W3530 2.8 0GHz,8M L3,4.8GT/s,Dell Precis ion T3500	EA	-	-
1	1	317-0120	6GB, DDR3 ECC SDRAM Memory 1333MHz, 3X2GB Dell Precision T3500	EA	-	-
1	1	330-3203	Dell, USB, Quiet KYBD, No Hot Keys, PWS, Black	EA	-	-
1	1	320-3316	Monitor Option-None	EA	-	-
1	1	320-1843	1GB nVIDIA Quadro 2000,Dual Mo nitor,2DP and 1DVI,Dell Precis ion	EA	-	-
1	1	341-8998	320GB SATA 3.0Gb/s with NCQ and 16MB DataBurst Cache, Dell Precision T3500	EA	-	-
1	1	341-8562	C1 All SATA Hard Drives,Non-RA ID for 1or 2 Hard Drive, Dell Precision T3500	EA	-	-
1	1	341-5255	No Floppy Drive, Dell Precision	EA	-	-
1	1	421-1485	Windows 7 Professional, Media, 64-bit, Fixed Precision, Engl ish	EA	-	-
1	1	330-6228	Windows 7 Label, Optiplex, Fix ed Precision, Vostro Desktop	EA	-	-
1	1	330-9458	Dell MS111 USB Optical Mouse,O ptiPlex and Fixed Precision	EA	-	-
1	1	311-7463	Mini-Tower Chassis Configuration, Dell Precision T1500 and T3500	EA	-	-
1	1	313-7457	16X DVD+/-RW Data Only Dell Precision TX500	EA	-	-
1	1	421-4371	Cyberlink Power DVD 9.5,Media, Dell OptiPlex, Latitude and P recision Workstation	EA	-	-
1	1	421-4540	Roxio Creator Starter,Media, D ell OptiPlex, Latitude and Pre cision Workstation	EA	-	-
1	1	313-2663	No Speaker option	EA	-	-
1	1	330-3156	Documentation,English,Dell Precision	EA	-	-
1	1	330-3157	Power Cord,125V,2M,C13,Dell Precision	EA	-	-

IF BALANCE DUE IS NOT PAID WITHIN TIME PERIOD NOTED ON INVOICE YOU MAY BE SUBJE CT TO A LATE PENALTY CHARGE AS ALLOWED UNDER THE TERMS OF SALE. CALIFORNIA SHIP MENTS: STATE ENVIRONMENTAL FEE UP TO $25 PER ITEM WILL BE ADDED TO INVOICES FO [redacted]. YOUR CONTRACTS HAVE BEEN ASSIGNED TO THIS ENTITY.

Ship. &/or Handling	$
Subtotal	$ [redacted]
Taxable: $ [redacted]	Tax: $ [redacted]
ENVIRO FEE	$ 0.00
Invoice Total	$ [redacted]

[redacted]

DETACH AT PERF AND RETURN WITH PAYMENT

MAKE CHECK PAYABLE/REMIT TO:

[redacted]

Invoice Number: [redacted]
Customer Name:
Customer Number:
Purchase Order
Order Number:

Ship. &/or Handling	$ [redacted]
Subtotal	$ [redacted]
Taxable: $ [redacted]	Tax: $ [redacted]
ENVIRO FEE	$ 0.00
Invoice Total	$ [redacted]
	$
	$
	$
Balance Due	$ [redacted]
Amt. Enclosed	$

[redacted]

[redacted]

(Rev 11/10)

[redacted]

[redacted]

Invoice

Date	Invoice #
[redacted]	[redacted]

Bill To	Ship To
[redacted]	[redacted]

P.O. Number	Terms	Ship	Via	F.O.B.
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Qty.	Item Code	Description	Price Each	S/N	Amount
1	DBICX30LED-DS-W5D	3MP COLOR DUAL-HEAD LED SYSTEM WITH GRAPHICS CONTROLLER: (2) 21.3" 3MP Color LED Monitor (1) 1GB PCI-e Graphics Card	10,500.00	[redacted]	10,500.00
1	X-CAL Client	Client Calibration Software - remote install	0.00		0.00
		Hand Delivered [redacted]			
		5-year warranty on monitors, 3-year warranty on card			
	[redacted]	[redacted]			

Thank you for your business.

Sales Tax (7.5%)	[redacted]
Total	[redacted]
Balance Due (USD)	[redacted]

***TERMS** Accounts not paid within 30 days of the date of the invoice will be considered delinquent. All amounts due on delinquent accounts will be charged interest on the account balance at the rate of 24% per annum, which is 2% per month. If the account becomes delinquent and is referred to an attorney for the purpose of initiating litigation or to enforce collection on the account, applicant agrees to pay all costs of collection, including r[redacted] consents to venue in any court of competent jurisdiction located in the State of Colorado.*

[redacted]

RUC Recommendations Exclude Overlap with Same Day E/M

- RUC recommendations do not include any duplicative physician work or practice expense for procedures typically billed with an E/M visit on the same day; CMS recognized this on page 57 of the CY2018 MPFS Final Rule, noting that the RUC "…addresses the overlap in time and work when a service is typically furnished on the same day as an E/M service."
- The RUC physician work survey instructs respondents to exclude work from "distinct evaluation and management services provided in addition to the procedure (reported with modifier -25)." The RUC survey includes an equivalent exclusionary statement for modifier -57.
- The RUC removes any overlap in clinical labor time for the following clinical activities: greet patient, provide gowning, ensure appropriate medical records are available; obtain vital signs; prepare room, equipment and supplies for a typical office visit; clean room by clinical staff which would otherwise total to 15 minutes per the RUC's standard rules.
- Practice Expense supplies & equipment for office visits represent only approximately $3.00 in direct practice expense cost.

CPT Code	CPT Code Short Descriptor	Percent Billed with E/M in Non-Facility (Medicare)	Pre- and Immediate Post-Time (minutes)	Pre-service work	Post-service work	2018 Practice Expense Supplies and Equipment Costs	2018 Clinical Staff Costs
11300	*SHAVE SKIN LESION 0.5 CM/<*	77.2%	Pre-pos: 1 Pre-s/d/w: 5 Imm Post: 5	• Lesion is Measured and Documented • Positioning Patient • Scrub/dress/wait • Provide local anesthetic	• Ointment and dressing • Wound care Instruction • Dictate report and communicate with referring physician.	$36.00	$8.88
17000	*DESTRUCT PREMALG LESION*	81.9%	Pre-eval: 1 Pre-pos: 1 Imm Post: 2	• Lesion is Measured and Documented • Positioning Patient	• Ointment and dressing • Wound care instruction • Dictate report and communicate with referring physician.	$6.51	$14.43
20550	*INJ TENDON SHEATH/ LIGAMENT*	79.3%	Pre-eval: 5 Pre-pos: 1 Pre-s/d/w: 5 Imm Post: 5	• Review prior imaging • Explain procedure and answer any questions • Positioning Patient • Scrub/dress/wait • Provide local anesthetic	• Cleanse area and apply bandage. • Wound care Instruction • Dictate report and communicate with referring physician.	$2.81	$6.29
31575	*DIAGNOSTIC LARYNGOSCOPY*	90.8%	Pre-eval: 8 Pre-pos: 1 Pre-s/d/w: 5 Imm Post: 5	• Explain procedure • Positioning Patient • Scrub/dress • Provide local anesthetic	• Findings are discussed and treatment options are reviewed and implemented. • Dictate report and communicate with referring physician.	$28.21	$18.87
69210	*REMOVE IMPACTED EAR WAX UNI*	73.8%	Pre-eval: 3 Pre-pos: 2 Imm Post: 2	• Explain procedure and answer any questions • Positioning Patient	• Counsel patient regarding future cerumen management • Provide necessary medication • Dictate report and communicate with referring physician.	$3.40	$8.51

CPT Editorial Panel and AMA/Specialty Society RVS Update Committee
Workgroup on Evaluation and Management (E/M)

Name	CPT/RUC	Specialty	Other
Peter Hollmann, MD Co-Chair	RUC, AMA Alternate Representative CPT Editorial Panel, Former Chair	Geriatric Medicine	AMA HoD
Barbara Levy, MD Co-Chair	CPT Editorial Panel Member RUC, Former Chair	Obstetrics & Gynecology	AMA HoD
Margie Andreae, MD	RUC Member	Pediatrics	
Linda Barney, MD	CPT Editorial Panel	General Surgery	
Patrick Cafferty, PA-C	CPT Editorial Panel Member (Former) Health Care Professionals Advisory Committee (HCPAC)	Physician Assistant	
Scott Collins, MD	RUC Member	Dermatology	
David Ellington, MD	CPT Editorial Panel Member (Former) Chair of Previous CPT E/M Workgroup	Family Medicine	AMA HoD
Chris Jagmin, MD	CPT Editorial Panel Member Medical Director, Aetna	Family Medicine	
Douglas Leahy, MD	RUC Member	Internal Medicine	
Scott Manaker, MD	RUC Member Chair, PE Subcommittee	Pulmonary Medicine	
Robert Piana, MD	CPT Editorial Panel Member	Cardiology	
Robert Zwolak, MD	RUC Member (Former & Present Alternate)	Vascular Surgery	

CPT Code	Pre-Service Eval Time	Pre-Service Scrub-Dress-Wait	Pre-Service Positioning Time	Intra-Service Time	Immediate Post Service Time	99204	99211	99212	99213	99214	99215	99231	99232	99233	99238	99239	99291	99292	Total Time	RUC Time Source	Most Recent RUC Review	Rationale
15220	27	15	15	90	27			4.5							0.5				265	Harvard		Our records show CMS missing 15 min of positioning time from Harvard study
22558	80			180	25				4			2			1		1		525	RUC	1995-04	CMS file accidentally also double counting post-op visit time in immediate post-op time field
43760																			N/A			Code is being deleted for CY2019
61645	40	15	3	100	53									1					266	RUC	2015-04	CMS incorrectly applied 23 hour stay rule for code even though RUC recommended typically inpatient; now that there is available data, can see that is 98% inpatient with recent data
61650	33	5	3	90	45									1					231	RUC	2015-04	CMS incorrectly applied 23 hour stay rule for code even though RUC recommended typically inpatient; now that there is available data, can see that it is 86% inpatient with recent data
91200	3			10	5														18	RUC	2015-04	RUC recommended 5 min of post-time, not 3 min; Table 15 from CY2016 Final Rule says no time refinement
93281	7			15	10														32	RUC	2016-10	CMS has wrong intra time, though table 12 from CY2018 Final rule says no time refinement
93284	9			18	10														37	RUC	2016-10	CMS has wrong intra time, though table 12 from CY2018 Final rule says no time refinement
93286	5			10	7														22	RUC	2016-10	CMS has wrong intra time, though table 12 from CY2018 Final rule says no time refinement
97166	10			45	15														70	RUC	HCPAC	HCPAC recommended 15 min of post-time, not 10 minutes; Table 27 from CY2017 Final Rule says no time refinement
33X01																			N/A			RUC recommendation was rescinded
96X11																			N/A			Code is not being created for CY2019
G0281	1			11	1														13	CMS/Other		Our records show CMS/Other intra-service time for this code was 11 minutes; not 7 minutes