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Society of Interventional Radiology
The vision to heal

2017 Final MFS
Summary of Key IR Items

SIR

On Wednesday, November 2, 2016, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that updates payment policies and payment rates for services furnished under the Medicare Physician Fee Schedule (PFS) on or after January 1, 2017.

The final rule can be found at the Federal Register website here: https://www.federalregister.gov/public-inspection.

The Rule is scheduled to be published in the Federal Register on 11/15/2016.

TABLE 52: CY 2017 PFS Estimated Impact on Total Allowed Charges by Specialty*

(A)	(B)	(C)	(D)	(E)	(F)
Specialty	**Allowed Charges (mil)**	**Impact of Work RVU Changes**	**Impact of PE RVU Changes**	**Impact of MP RVU Changes**	**Combined Impact****
Total	**$89,866**	0%	0%	0%	0%
INTERVENTIONAL RADIOLOGY	$317	-1%	0%	0%	-1%
RADIOLOGY	$4,683	0%	0%	0%	-1%

Collecting Data on Resources Used in Furnishing Global Services
Section 523 of the Medicare Access and CHIP Reauthorization Act of 2015 requires CMS to gather data on visits in the post-surgical period that could be used to accurately value these surgical services. In this year's final rule, CMS finalizes a data collection strategy that significantly reduces the burden on practitioners compared to the proposed rule by:

- Requiring reporting of post-operative visits only for high-volume/high-cost procedures;

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- Using existing CPT code 99024 instead of the proposed G-codes;
- Requiring reporting only from a sample of practitioners consisting of those in larger practices (10 or more practitioners) in specified states; and
- Allowing all others to report voluntarily.

CMS is hopeful that use of the existing CPT code for reporting these services will be significantly less burdensome than the proposal to require time-based reporting using the G-codes.

In addition, while practitioners are encouraged to begin reporting post-operative visits for procedures furnished on or after January 1, 2017, the requirement to report will be effective for services related to global procedures furnished on or after July 1, 2017. To the extent that these data result in proposals to revalue any global packages, that revaluation will be done through notice and comment rulemaking at a future time.

Zero-day Global Services that are Typically Billed with an Evaluation and Management (E/M) Service with

CMS is prioritizing 19 services for review as potentially misvalued and intends to investigate this policy concern in future rulemaking. CMS has noted that several high volume procedure codes currently valued with routine visits as part of the global package are typically reported with a modifier that allows separate payment for visits, even though the modifier should only be used for reporting services beyond those usually provided. Therefore, CMS believes the services may be misvalued.

Valuation of Services Where Moderate Sedation is an Inherent Part of the Procedure and Valuation of Moderate Sedation Services (CPT codes 99151, 99152, 99153, 99155, 99156, and 99157; and HCPCS code G0500)

CMS is finalizing work RVUs for the moderate sedation codes as follows:

- **Work RVU of 0.50 for CPT code 99151;**
- **Work RVU of 0.25 for CPT code 99152;**
- **Work RVU of 1.90 for CPT code 99155;**
- **Work RVU of 1.65 for CPT code 99156; and**
- **Work RVU of 1.25 for CPT code 99157.**

CMS proposed to accept the RUC recommended work RVUs for four of the new moderate sedation CPT Codes (99151, 99152, 99155, and 99157). For CPT code 99156, CMS proposed a work RVU of 1.65 to maintain the 0.25 increment relative to CPT code 991X3 (a RUC-recommended work RVU of 1.90) and maintain relativity among the CPT codes in this family. CMS is proposing to use the RUC-recommended direct PE inputs for all six codes.

Backing out Moderate Sedation

To account for the separate billing of moderate sedation services, CMS is proposed to maintain current values for the procedure codes less the work RVUs associated with the

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most frequently reported corresponding moderate sedation code so that practitioners furnishing the moderate sedation services previously considered to be inherent in the procedure will have no change in overall work RVUs.

For all non-GI endoscopy procedure Appendix G procedures that currently include moderate sedation as an inherent part of the procedure, CMS proposed to remove 0.25 work RVUs from the current values. Table 22 lists the existing work RVUs for each applicable service and our proposed refined work RVU using the proposed revaluation methodology.

GI Endoscopy Procedures

CMS proposed a new endoscopy-specific moderate sedation code to reflect the differences gastroenterology and other specialties. CMS proposed a work value of 0.10 for the new GI moderate sedation code. They proposed to remove 0.10 from the GI Endoscopy Appendix G procedures.

The RUC, along with several specialty societies, requested that CMS use the same RUC-approved two-tier methodology for removing work RVUs associated with the work of moderate sedation from Appendix G services based on whether the code was assigned to one of two preservice time packages used by the RUC in developing recommendations. Using the same two-tier methodology, the RUC suggested removal of 0.10 work RVUs for some GI services and 0.19 work RVUs from other GI services, depending on the RUC's assignment of pre-service time.

SIR advocated for a two-tiered reduction, but we knew it would probably not be accepted as CMS made it clear they wanted this to be a budget neutral exercise. CMS believed that there should be a direct relationship, for each code, between the work RVUs attributable to moderate sedation, regardless of whether it is automatically included in payment for a given procedure (at current) or separately reported (as proposed).

CMS went forward with their proposal (with slight modifications). Table 26 lists the CY 2016 work RVUs for each applicable service and our proposed and final CY 2017 refined work RVUs.

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

CMS is finalizing their proposed work RVUs for the Percutaneous Biliary Procedures family of codes, with the one change to a work RVU of 6.75 for CPT code 47541. CMS is finalizing our proposed direct PE inputs without refinement.

47541

CMS is finalizing a work RVU of 6.75 for CPT code 47541, which is the RUC-recommended work RVU of 7.00 after removing 0.25 RVUs to account for the fact that moderate sedation will now be billed separately for this service. SIR disagreed with the

proposed work RVU of 5.45 for CPT code 47541 stating that although CPT codes 47541 and 47533 share similar time values, the patient population for CPT code 47541 is more complex with post-surgical anatomy and atypical problems. Therefore, the commenters stated that the direct crosswalk creates a sharp rank order anomaly within the family, and requested that CMS adopt the RUC-recommended work RVU. CMS agreed with the commenters that the proposed work RVU for CPT code 47541 has the potential to create an anomalous relationship between the services in this family of codes.

Dowd Catheter
CMS continues to believe that the Dowd ureteral balloon catheter, which is specifically designed for catheter and image guidance procedures, would be more typical than the use of a PTA balloon catheter.

Although they referred to our comments in the Final Rule language regarding the current use of balloon catheters (i.e. Bard catheters and Cook Medical catheters are frequently too small to treat some of the wide variety of pathologies that occur in the biliary tree) they criticized us for not indicating what size balloon catheter would be typically used for these particular procedures in the Percutaneous Biliary Procedures, or provide a specific rationale for why the catheter CMS proposed (the Dowd ureteral balloon catheter) would not be appropriate for these procedures. CMS noted again that they are required to assess resources based on the typical case, and the commenters did not provide data to indicate that the proposed Dowd catheter would be inadequate in the typical case for these procedures in question, only that it may be insufficient for certain pathologies in the biliary tree.

Percutaneous Image Guided Sclerotherapy (CPT code 49185)

Work RVU
CMS is finalizing a work RVU of 2.35 for CPT code 49185. CMS disagreed with SIR comments that the RUC's recommended crosswalk from CPT code 31622 has analogous clinical activities compared to CMS' proposed crosswalk from CPT code 62305. CMS continued to argue that their crosswalk code refers to a procedure with injection, drainage, and aspiration, which has more clinical similarity to CPT code 49185 than the RUC's recommended crosswalk from 31622, which is used to report a broncoscopy procedure.

Volume of Solution
CMS inadvertently included the RUC-recommended quantity of 300 mL for the sclerosing solution (supply item SH062) in developing the proposed rates for this code. For CY 2017, they are finalizing the RUC-recommended direct PE inputs, including 300 mL of sclerosing solution. They requested stakeholder feedback regarding the appropriate PE inputs for this procedure for consideration for CY 2018, including volume and pricing of the sclerosing agent.

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

Angiography Room

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While CMS continues to seek invoices for more detailed pricing information, they are restoring the angiography room (EL011) equipment to these three codes, with an equipment time of 47 minutes for CPT code 50606, 62 minutes for CPT code 50705, and 62 minutes for CPT code 50706, in each case consistent with the equipment time in CY 2016.

CMS went on to say that they have longstanding issues with the equipment rooms as they are currently constituted, due to their belief that all of the components of the room may not typically be used in performing the procedure in question. They believe that these three codes do not make use of all of the components of the angiography room, and they believe that this code family serves as a clear example of the problems in relativity associated with the use of "rooms" as equipment items for a limited set of services under the PFS.

CMS intends to continue to consider the use of equipment "rooms" more broadly for future rulemaking.

Dialysis Circuit (CPT codes 36901, 36902, 36903, 36904, 36905, 36906, 36907, 36908, 36909)

Physician Work
CMS is finalizing the work RVUs for the Dialysis Circuit codes as proposed. They continue to believe that the crosswalks for this family of codes are appropriate choices, since they share highly similar intensity and time values with the reviewed codes. They also continue to believe their valuation for the Dialysis Circuit codes accurately captures the reduction in physician work caused by the efficiencies gained in both time and intensity through the bundling together of frequently reported services. They do not agree at this time that the Dialysis Circuit family of codes has a uniquely different patient population that justifies an increase in valuation over other comparable codes on the PFS.

They are seeking information on how to reconcile situations where they have multiple sets of recommendations from the RUC and from other PFS stakeholders, both for this specific case and for the situation more broadly, given the need to maintain relativity among PFS services.

Practice Expense
CMS is also finalizing the proposed direct PE inputs, with the refinements detailed below:

Trerotola Kit

CMS is modifying their proposal. They believe that its inclusion in these three procedures is appropriate. According to the device literature, the kit contains a rotor for macerating the clot, a catheter for removing the clot, and a sheath for introducing the device. They will therefore restore the SA015 supply to CPT codes 36904, 36905, and 36906. However, they are removing the Fogarty catheter (SD032) and 1 of the 2 vascular sheaths (SD136), as these are contained within the kit. The literature for the percutaneous

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thrombolytic device kit clearly stipulates that there is no need for additional catheters to remove the clot, which makes the Fogarty catheter a duplicative supply, which can be removed.

VIABAHN Covered Stent

CMS is modifying their proposal. CMS is restoring the covered stent (VIABAHN, Gore) (SD254) to CPT codes 36903 and 36906 as originally recommended. Because they are including the SD254 covered stent, they are not adding the stent, vascular, deployment system, Cordis SMART (SA103) supply to these procedures.

Hemostatic Patch

CMS is modifying their proposal. CMS is finalizing inclusion of the second Hemostatic patch (SG095) to CPT codes 36904, 36905, and 36906, as recommended by the RUC.

ChloraPrep
CMS is modifying their proposal. CMS agreed with the recommended supply substitution, and they are therefore removing 60 ml of the Betadine solution (SJ041) and replacing it with two units of the swab, patient prep, 3.0 ml (Chloraprep) supply (SJ088) for CPT codes 36901-36906. They will add the Chloraprep applicator (26 ml) supply to the direct PE input database at a price of $8.48 based on an average of the three submitted invoices; it is not currently assigned to any codes. They also agree that it is a distinct supply from the "chlorhexidine 4.0% (Hibiclens)" (SH098) supply already located in the direct PE database.

Guidewires

CMS is modifying their proposal. They will use the RUC-recommended quantities for these supplies and are not finalizing any changes.

Open and Percutaneous Transluminal Angioplasty (CPT codes 37246, 37247, 37248, and 37249)

Physician Work
CMS is finalizing the proposed work RVUs for the four codes in the family.

Practice Expense
CMS is finalizing the proposed direct PE inputs, with the refinement to the sterile femoral drape detailed below. CMS is finalizing inclusion of the sterile femoral drape supply (SB009) to CPT codes 37246 and 37248. They will therefore not be adding the fenestrated drape supply (SB011) to these procedures

Intracranial Endovascular Intervention (CPT codes 61645, 61650, and 61651)
CMS is finalizing a work RVU of 15.00 for CPT code 61645, a work RVU of 10.00 for

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CPT code 61650, and a work RVU of 4.25 for CPT code 61651.

Mechanochemical Vein Ablation (MOCA) (CPT codes 36473 and 36474)

Work RVUs
CMS is finalizing a work RVU of 3.50 for CPT code 36473 and a work RVU of 1.75 for CPT code 36474.

Practice Expense

US Room

CMS is not modifying their proposal. They will include a portable ultrasound and not an US room.

ClariVein Kit

CMS is finalizing their proposed direct PE inputs for the ClariVein kits for CPT codes 36473 and 36474 without modification. They welcome additional feedback from stakeholders regarding the product data and costs for the ClariVein catheters and ClariVein kits for consideration in future rulemaking.

Fluoroscopic Guidance (CPT codes 77001, 77002, and 77003)
CMS is finalizing the RUC-recommended work RVUs for all three codes in the family, which is an increase from the proposed work RVU of 0.38 to a work RVU 0.54 for CPT code 77002 and to 0.60 for CPT code 77003. They are finalizing the proposed work RVU of 0.38 for CPT code 77001 without change.

Abdominal Aortic Ultrasound Screening (CPT code 76706)
CMS is finalizing the RUC-recommended work and PE inputs, as proposed. They stated that while the specialty mix of the practitioners furnishing services can be helpful in identifying typical PE inputs, they seek definitive information regarding the most appropriate PE inputs for this code.