



September 26, 2019

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: **CMS-1715-P**
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850
Submitted electronically: <http://www.regulations.gov>

Re: File Code CMS-1715-P; CY 2020 Revisions to Payment Policies under the Physician Payment Schedule and Other Changes to Part B Payment Policies; (August 14, 2019)

Dear Administrator Verma:

The Society of Interventional Radiology (SIR) is a professional medical association that represents approximately 8,800 members, including most US physicians who are practicing in the specialty of vascular and interventional radiology. The Society is dedicated to improving public health through pioneering advances in minimally-invasive, image-guided therapies. SIR appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services CY 2020 Revisions to Payment Policies under the Physician Payment Schedule and Other Changes to Part B Payment Policies.

Interventional radiology is a small specialty and cannot continue to offer safer minimally invasive treatments, shorter recovery times, and more advanced and cost-effective care to Medicare beneficiaries when repeated cuts to reimbursement are imposed by the Medicare payment system. SIR urges CMS to fully implement the AMA's RUC recommendations for the interventional radiology codes, as detailed in this letter. We recognize that if CMS fully implements the RUC recommendations, interventional radiologists will still see a substantial reduction in overall physician payments, but the reductions will be more equitable across specialties.

Public Nominations of Potentially Misvalued Services

CMS received public nominations for CPT Codes 10005 *Fine needle aspiration biopsy, including ultrasound guidance; first lesion* and 10021 *Fine needle aspiration biopsy, without imaging guidance; first lesion* as potentially misvalued services. The RUC submitted recommended values for newly revised codes 10005 and 10021 in October 2017 to CMS. CPT Codes 10021 and 10005 were reviewed using multi-specialty survey data and valued by the RUC, a process, which included discussion and consideration of intensity.

Recommendation: While SIR believes the codes should have a higher value, we support the RUC process and accept RUC recommended values. SIR strongly disagrees with CMS' proposed reduction in value for CPT Codes 10021 and 10005 as discussed in our previous comments specific to the valuation of that code family. SIR strongly urges the Agency to reinstate the RUC recommendations for CPT Codes 10005 and 10021 as part of the Final Rule for the 2020 Medicare Physician Fee Schedule.

Payment for Evaluation and Management (E/M) Services

The SIR appreciates the Agency's efforts to reduce the physician burden related to evaluation and management documentation. We also appreciate the Agency's willingness to work with the medical community through the AMA CPT/RUC process. However, the anticipated interventional radiology cuts in reimbursement to offset the evaluation and management changes in RVUs for CY2021 are devastating. Interventional Radiology physicians and practices cannot withstand such drastic cuts particularly in addition to all the other payment cuts the specialty has suffered over the past several years.

Recommendation: SIR urges the Agency to work with stakeholders to mitigate the crushing impacts on the many specialties that are carrying the weight of these changes.

(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	\$92,979	0%	0%	0%	0%
INTERVENTIONAL RADIOLOGY	\$432	-3%	-3%	0%	-6%
RADIOLOGY	\$4971	-5%	-3%	0%	-8%

Proposed Add-On Code (GPCIX)

CMS is proposing an add-on code for the evaluation and management services and although, the codes descriptor implies that all physicians may report the code, only a subset of specialties are projected to receive payment for the service in the CMS published impact tables. The application of this new add-on code is not clear.

Recommendation: SIR recommends the code be discussed through the AMA's CPT/RUC workgroup PRIOR to being implemented in the fee schedule.

Office Visits Included in Surgical Global Payment and RAND Reports

CMS is proposing not to apply the office visit increases to the visits bundled into global surgery payment. CMS cites their continued efforts with RAND to collect information on global surgery codes as the reason for not applying the updates to the global surgical visits. SIR feels strongly that

the RAND initiatives continues to have dramatic flaws in their methodology and reported findings. It is inappropriate for the Agency to abandon the bedrock of the Medicare Fee Schedule, *relativity*.

Recommendation: SIR strongly requests that CMS implement the RUC recommended values to the post-operative office visits bundled visits.

Practice Expense Direct Inputs

CMS has declined to accept the desktop computer, ED021, *computer, desktop, with monitor*, used in examination rooms as a direct medical expense, stating that they believe it is an indirect expense. Although there are instances throughout practice expense where a computer is considered an indirect practice expense, there are many that consider it a direct PE input. Equipment items should not be categorized as indirect across the board, rather their direct/indirect status should be considered based on the work that the clinical staff is performing using that piece of equipment on a code-by-code basis. For office visits, the work being performed using the computer is not administrative in nature. Rather, it is used to record, analyze and communicate to the physician about every element of data that the clinical staff collects from the individual patient for the individual service.

Recommendation: SIR request that CMS include ED021 as a direct PE expense for the evaluation and management codes when the values go into effect in CY2021.

Revised Impacts

SIR has concerns with the validity of the published impacts in Table 111.

Recommendation: CMS must consider the public comments submitted in response to the proposed rule, revisit the assumptions for the use of the add-on code, as well as the additional anticipated updates to the underlying code level data and develop a revised impact table in the CY2020 Final Rule indicating the impacts by specialty.

Quality Payment Program (QPP) and MIPS Value Pathways (MVPs)

SIR agrees with CMS that QCDR measures be integrated into MVPs along with MIPS measures, however, the Proposed Rule lacks enough detail to allow stakeholders to provide meaningful comments on how QCDR measures would be used in MVPs.

Recommendation: SIR urges CMS to publish a separate request for information (“RFI”) or notice of proposed rulemaking adequately describing the proposed integration of QCDR measures into MVPs, so that the public can provide a thoughtful response. SIR urges CMS to provide clear details on how the proposed change to allow APM Entities and MIPS eligible clinicians participating in APMs the option to report on MIPS quality measures for the MIPS Quality performance category would look like.

Beginning with the 2021 performance period, CMS is proposing to require that all QCDR measures submitted at the time of self-nomination be fully developed and tested with complete testing results at the clinician level.

Recommendation: SIR strongly opposes this potentially burdensome proposal, as it would stifle measure development and possibly lead to increases in licensing fees. Currently QCDRs typically review performance data after implementing a measure in the registry. This allows QCDRs to determine how feasible it is for providers to report the measure. This change would require QCDRs to invest significantly more resources in terms of time and money with uncertain benefits with respect to measure validity.

Ownership Rights of QCDR and MIPS Measure Developers

CMS is proposing that, as part of their QCDR measure approval process, they may consider the extent to which a QCDR measure is available to MIPS eligible clinicians reporting through QCDRs other than the owner of the QCDR measure. This would give CMS the discretion to not approve a QCDR measure if it concludes that such a measure is not available to MIPS eligible clinicians, groups and virtual groups reporting through other QCDRs. SIR strongly opposes this proposal because it undermines QCDR measure ownership and development. The ability of QCDRs to license measures and charge reasonable fees or royalties allows QCDRs to ensure the appropriate use of their measures and incentivizes organizations to invest in the development of new and improved measures. CMS has not yet published guidance on the licensing of MIPS measures from their measure owners. Out of concern that certain MIPS measure owners have been limiting or prohibiting the use of their MIPS measures, CMS is proposing to adopt removal criteria for when CMS determines the MIPS measure owner is not making the MIPS quality measure available for MIPS reporting. As with QCDR measures, SIR strongly opposes this proposal because it undermines MIPS measure ownership and development.

Recommendation: SIR urges CMS to explicitly recognize and respect the intellectual property rights of MIPS measure developers.

Comment Solicitation on Opportunities for Bundled Payments under the PFS

CMS is requesting information on opportunities to expand the concept of bundling to improve payment for services under the RBRVS. Specifically, CMS seeks to explore options for establishing MPFS payment rates or adjustments for services that are furnished together. CMS notes options could include a per-beneficiary payment for multiple services or condition-specific episodes of care. CMS specifically notes that it believes the statute, while requiring CMS to pay for physicians' services based on the relative resources involved in furnishing the service, allows considerable flexibility for developing payments under the RBRVS.

SIR is very troubled by CMS' request to further expand 'bundled payments'. The specialties have been working with the AMA CPT/RUC, through the Relativity Adjustment Workgroup (RAW) to bundle services based on established thresholds (i.e. services reported together greater than 75% of the time). SIR interprets this request as an additional way to inappropriately lower reimbursement for physician services without transparent criteria.

Recommendation: SIR urges the Agency to work with the AMA CPT/RUC if they have concerns with a set of services.

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

CMS is seeking comment on the proposed methodological improvements to the development of the professional liability insurance (PLI) premium data. For CY 2020, CMS uses a broader set of PLI filings, available online from the System for Electronic Rates & Forms Filing (SERFF) Filing Access Interface and largest market share insurers in each state, to obtain a more comprehensive data set. SIR appreciates the Agency's willingness to improve their PLI source data.

SIR has concerns with the CMS proposal. CMS proposes to combine minor surgery and major surgery premiums to create the surgery service risk group, which it claims will yield a more representative surgical risk factor.

Recommendation: SIR urges the Agency to work with the AMA to address inherent flaws in that methodology (i.e. the definition of "minor" vs. "major" surgery, variation in premium data and physician work RVU shares by service risk type). We also seek a clear and transparent description (analysis?) of CMS' imputed methodology (based on the notion of trying to represent the rate that an insurer would charge a provider in that specialty, given that the insurer does not list the specialty).

Valuation of Specific Codes

SIR strongly disagrees with CMS failure to fully adopt the RUC recommendations regarding numerous billing codes. Specifically, with the methodologies and rationale utilized for many codes. SIR believes the Agency is applying incorrect methodologies regarding time sources. CMS/Other and Harvard codes have never been surveyed. The crosswalk or methodology used in the original valuation of such services is unknown and not resource-based, therefore it is invalid to compare the current time and work to the surveyed time and work. In addition, for many diagnostic services, only total time was captured in the Harvard study. Therefore, comparing total time to intra-service only time from the modern RUC surveyed codes is not appropriate. In addition, the use of time ratio is not a valid methodology for valuation of physician services. CMS "time/ratio methodology" does not consider intensity, which is a KEY component of evaluating services. SIR believes the Agency's inconsistent application of approved valuation methodologies is undermining the very nature of the relative value system.

Recommendation: SIR strongly disagrees with the CMS proposal and asks CMS to fully implement all RUC recommendations forwarded for CY2020. CMS to adopt ALL the RUC recommendations forwarded for CY2020. SIR requests that CMS publish annually the list of low volume services and their proposed crosswalk specialty. This will ensure the specialties the ability to comment on the proposals before they go into effect.

Bone Biopsy Trocar-Needle (CPT Codes 20220 and 20225)

In October 2017, CPT code 20225 (Biopsy, bone, trocar, or needle; deep (e.g., vertebral body, femur)) was identified as being performed by a different specialty than the one that originally surveyed this service. CPT code 20220 (Biopsy, bone, trocar, or needle; superficial (e.g., ilium, sternum, spinous process, ribs)) was added as part of the family, and both codes were surveyed and reviewed for the January 2019 RUC meeting.

CPT Code 20220

For CPT Code 20220, CMS disagrees with the RUC recommended work RVU of 1.93 and proposes a work RVU of 1.65 based on a direct work RVU crosswalk to CPT code 47000 *Biopsy of liver, needle; percutaneous* (work RVU= 1.65, intra-service time of 20 minutes, total time of 55 minutes). Contrary to the implication in the *Proposed Rule*, the multispecialty advisory committee clarified in their summary of recommendation form that a superficial bone biopsy is more intense to perform than a liver biopsy — the RUC had concurred with this assessment. The typical indication for CPT code 20220, a potentially infectious or malignant lesion, requires biopsy with an 11-gauge bone biopsy needle. Accurate placement and increased risk of adjacent structures results in a greater intensity of physician work relative to CPT code 47000 which is more typically performed as a random biopsy to evaluate for severity of liver disease.

The crosswalk or methodology used in the original valuation of this service is unknown and not resource-based, therefore it is invalid to compare the current time and work to the surveyed time and work. This code's source of time is Harvard, implying that the time was merely extrapolated and not measured directly. Referencing physician times and derived intensities created almost 30 years ago under the Harvard study as a method to critique RUC recommendations is not appropriate.

The RUC recommendation was based on the 25th percentile work RVU from robust survey results and favorable comparison to reference codes 30905 *Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; initial* (work RVU= 1.97, intra-service time of 20 minutes, total time of 44 minutes) and 45334 *Sigmoidoscopy, flexible; with control of bleeding, any method* (work RVU= 2.00, intra-service time of 20 minutes, total time of 53 minutes).

Recommendation: SIR disagrees and urges CMS to accept a work RVU of 1.93 for CPT code 20220.

CPT Code 20225

For CPT Code 20225, CMS disagrees with the RUC recommended work RVU of 3.00 and proposes a work RVU of 2.45 based on a direct work RVU crosswalk to CPT code 30906 *Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; subsequent* (work RVU= 2.45, intra-service time of 30 minutes, total time of 63 minutes). Cross walking a deep bone biopsy performed on typical patient with a destructive malignant lesion to a CPT code for controlling an established patient's nosebleed is inappropriate. The IWPUT of the CMS proposed value, 0.0591, is actually somewhat lower than the IWPUT for CMS' proposed crosswalk code. SIR strongly urges the Agency to rethink their proposal.

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. Furthermore, the existing 2019 near zero IWPUT (0.0032) indicates a severely anomalous relationship between the current work value and current physician time. Most often an IWPUT close to zero or negative indicates that the current times are greatly overstated relative to the current work RVU.

The RUC recommendation was based on the 25th percentile work RVU from robust survey results and favorable comparison to reference codes 43247 *Esophagogastroduodenoscopy, flexible,*

transoral; with removal of foreign body(s) (work RVU= 3.11, intra-service time of 30 minutes, total time of 58 minutes) and 44389 *Colonoscopy through stoma; with biopsy, single or multiple* (work RVU= 3.02, intra-service time of 30 minutes, total time of 65 minutes).

Recommendation: SIR strongly disagrees and urges CMS to accept a work RVU of 3.00 for CPT code 20225.

Practice Expense

CMS is proposing refinements to the RUC recommended direct PE inputs for the codes in this family. The RUC agreed and acknowledged that SF055 bone biopsy device is necessary to perform this procedure and the omission of this supply item when this service was last reviewed in 2004 was an oversight. In most cases, deep bone biopsies are performed percutaneously using a bone biopsy drill device that allows for access to sclerotic bony lesions (e.g. prostate or breast metastasis) in a manner that a bone biopsy needle (Jamshidi) cannot. SF055 bone biopsy device is typically used to perform this service in the non-facility setting. The RUC urges CMS to include supply item, SF055 as a direct practice expense input as recommended.

Intravascular Ultrasound (CPT Codes 37252 and 37253)

In CY 2014, the CPT Editorial Panel deleted CPT codes 37250 ((Ultrasound evaluation of blood vessel during diagnosis or treatment) and 37251 (Ultrasound evaluation of blood vessel during diagnosis or treatment) and created new bundled codes 37252 (Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; initial noncoronary vessel) and 37253 (Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel) to describe intravascular ultrasound (IVUS).

CPT codes 37252 and 37253 were identified via the Work Neutrality screen for CPT 2016 codes. Any code family that has an increase in work RVUs over 10% of what was estimated is reviewed by the RUC to determine what is occurring to impact claims. Intravascular ultrasound, CPT codes 37252 and 37253 were reviewed at the January 2015 RUC meeting and assumed to be a savings. However, the codes had a 44% increase in work RVUs over the old codes from 2015 to 2016 and the utilization was double from that of the coding structure, not considering the radiological activities. Therefore, the RUC recommended to resurvey these services.

CMS disagreed with the RUC recommendation to maintain the current work RVU of 1.80 for CPT code 37252, which was also the survey 25th percentile. CMS is proposing a work RVU of 1.55 based on a crosswalk to CPT code 19084 *Biopsy, breast, with placement of breast localization device(s) (e.g., clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)* (work RVU = 1.55 and 20 minutes intra-service time and 25 minutes of total time). In reviewing CPT code 37252, CMS notes, that in CY 2015 the specialty society stated that bundling this service would achieve savings. However, since 2015 observed utilization for CPT code 37252 has greatly exceeded proposed estimates, thus CMS is proposing to restore work neutrality to the intravascular ultrasound code family to achieve the initial estimated savings.

The RUC noted that while there was a reduction in work RVUs with the original bundling in 2014, there was an overall increase in utilization offsetting the projected work savings. The increase in utilization came from the concurrent CMS decision to price these services in the non-facility setting and to expand coverage to venous disease. The RUC agreed that the site of service changes (migrating into the office setting) for these services and change in patient population (venous disease) constitute compelling evidence to allow for the observed growth. The RUC noted that these services are performed approximately 35,000 in the Medicare 2017 estimated utilization data. Likewise, the *Physician and Other Supplier Data for CY 2016* indicates that 11% of the utilization for CPT code 37252 are performed by 10 individual providers and 18% of the utilization of CPT code 37253 are performed by 10 individual providers. The claims for these services in the office appear to be highly concentrated in relatively few offices. Due these reasons, the RUC determined there is compelling evidence explaining the growth of these services. The specialty presented new survey data that support the current valuation of these services.

The RUC notes that increased utilization of 37252 and 37253 may be for a host of reasons, some of which include increased complexity of interventions being performed in the arterial, venous, and aortic spaces. As noted, a large proportion of the use is by a few physicians and by reducing the RVUs, many physicians, and more importantly patients, may be affected. An attempt to enforce neutrality may result in harm to a large group of patients while a small group of physicians are at fault and should be addressed at a local level. The specialties pointed out during the RUC presentation that if the Agency has concerns about possible overutilization or outlier users for CPT codes 37252 and 37253, they should use the Recovery Audit Contractor (RAC) process to review claims.

CPT Code 37252

SIR does not believe that CPT code 37252 requires the same physician work as CPT code 19084. The intra-service time of 20 minutes for CPT code 37252 is very different from that of 19084. IVUS assists in medical decision making during the intervention and by many operators is used for problem solving and assessment of adequacy of the intervention, which could result in further intervention. This inherently is more complex than the 20-minute intra-service time of CPT code 19084 where a breast lesion biopsy and clip placement is performed using imaging guidance. The intra-service time for 19084 is a similar process in every patient and is binary, whereby the lesion is biopsied or not. The findings of IVUS, however, can help determine what is the best course of treatment for the patient.

The RUC recommended work RVU of 1.80 for CPT code 37252 is supported by the survey key reference service chosen by physicians who perform this service, CPT code 92978 *Endoluminal imaging of coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel (List separately in addition to code for primary procedure)* (work RVU = 1.80 and intra-service time of 25 minutes).

Recommendation: SIR strongly disagrees and urges CMS to accept a work RVU of 1.80 for CPT code 37252.

37253

For CPT code 37253, CMS disagreed with the RUC recommendation to maintain the work RVU of 1.44, which was also the survey 25th percentile. However, CMS notes the relative difference in work between CPT codes 37252 and 37253 is an interval of 0.36 RVUs. CMS is proposing a work RVU of 1.19 for CPT code 37253, based on the recommended interval of 0.36 fewer RVUs than the proposed work RVU of 1.55 for CPT code 37252.

The proposed recommendation is not valid because it is only a calculation and not based on survey data nor directly cross walked to any service. SIR strongly discourages the use of valuing the increment. 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.

CMS should rely on valid survey data and relative services in the Physician Payment Schedule such as CPT code 92978 *Endoluminal imaging of coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel (List separately in addition to code for primary procedure)* (work RVU = 1.80 and intra-service time of 25 minutes) and 92979 *Endoluminal imaging of coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; each additional vessel (List separately in addition to code for primary procedure)* (work RVU = 1.44 and 25 minutes intra-service time). The RUC noted that the intensity and complexity to perform these services are similar warranting a similar work RVU.

Recommendation: SIR strongly disagrees and urges CMS to accept a work RVU of 1.44 for CPT code 37253.

Abdominal Aortography (CPT Codes 75625 and 75630)

In October 2017, the RAW requested that AMA staff compile a list of CMS/Other codes with Medicare utilization of 30,000 or more. In January 2018, the RUC recommended to survey these services for the October 2018 RUC meeting. Subsequently, the specialty society surveyed these codes.

CPT Code 75625

CMS disagrees with the RUC recommended work RVU of 1.75 and is proposing a work RVU of 1.44 for code 75625 based on an analysis to the top key reference service (KRS) 75710 *Angiography, extremity, unilateral, radiological supervision and interpretation* (work RVU = 1.75, 40 minutes intra-service time). CMS is proposing a work RVU reduction of 1.44 for CPT code 75625 based on an intra-service time and total-service time ratio with KRS code 75710. The Agency compares the intra-service time ratio between the survey time of 30 minutes and the KRS time of 40 minutes and found a ratio of 25 percent, or a work RVU of 1.31. Additionally, the Agency compares the total-service time ratio between the survey time of 60 minutes and the KRS time of 70 minutes and found a ratio

of 14 percent, or a work RVU of 1.51. CMS believes an accurate value for CPT code 75625 would lie between the range of 1.31 and 1.51 RVUs. This is an invalid methodology to identify an RVU range.

In addition, the Agency chooses code 38222 *Diagnostic bone marrow; biopsy(ies) and aspiration(s)* (work RVU = 1.44, 30 minutes intra-service time) as a crosswalk to support a proposed work RVU of 1.44 that fits within their range. This is a poor code to use as a crosswalk because 1) it is performed by physicians from a different specialty, 2) it does not involve imaging and exposure to radiation, 3) it does not require intra-arterial access or monitoring of hemodynamic parameters, 4) it does not involve injection of intra-arterial iodinated contrast, and 5) it is a much lower risk procedure. The choice of code 38222 for a crosswalk is inappropriate because there is no clinical coherence between both codes. One is a vascular interpretive procedure while the other is a sampling procedure.

Recommendation: SIR urges CMS to use valid survey data and review the actual relativity for all elements (physician work, time, intensity and complexity) when developing work values for services and not foster flawed methodologies and solely focus on time. SIR urges CMS to consider the clinical output of 54 physicians who perform this service and the RUC's collective review of the relativity of this service. SIR requests CMS to accept a work RVU of 1.75 for CPT code 75625.

Lumbar Puncture (CPT Codes 62270, 622X0, 62272, and 622X1)

In October 2017, these lumbar puncture services were identified as being performed by a different specialty than the specialty that originally surveyed this service. In January 2018, the RUC recommended that these services be referred to CPT to bundle image guidance. At the September 2018 CPT Editorial Panel meeting, the Panel created two new codes to bundle diagnostic and therapeutic lumbar puncture with fluoroscopic or CT image guidance and revised the existing diagnostic and therapeutic lumbar puncture codes so they would only be reported without fluoroscopic or CT guidance.

For the lumbar puncture codes (62270, 622X0, 62272, 622X1), CMS has disagreed with the RUC recommended work RVUs for all four codes. CMS proposes that their alternate work RVUs more closely align with the valuation of these codes than the RUC recommended. However, three of the four RUC recommended work RVUs for the lumbar puncture codes are based on survey data. SIR urges the Agency to implement the RUC recommendations for this family of lumbar puncture services.

CPT Code 62270

For CPT code 62270, CMS disagrees with the RUC recommended work RVU of 1.44 and proposes a work RVU of 1.22 based on a direct work RVU crosswalk to CPT code 40490 *Biopsy of lip* (work RVU = 1.22, intra-service time of 15 minutes, total time of 34 minutes). This crosswalk is inappropriate and was chosen based only on a time comparison without consideration to the intensity of the work. CPT code 40490 is performed over 95% of the time in a physician office as an elective procedure while code 62270 is performed on seriously ill patients in the emergency room or inpatient hospital setting 70% of the time and only 5% of the time in a physician office. The patient populations are vastly different reflecting the increased intensity in the lumbar puncture procedure. The patient population is now much broader, representing the continuum of patients from newborns to elderly

adults. As such, the indications for code 62270 are extensive as well. The procedure is employed in the evaluation of multiple chief complaints, including but not limited to, headache, altered mental status, and fever of unknown origin - with timely, emergent diagnosis required for such concerning pathology as CNS infection and subarachnoid hemorrhage. Emergency medicine represents a unique practice setting, which often includes altered or combative patients, patients on anticoagulation or with other hematologic derangements, as well as the potential for interruptions or other patients to require emergent attention. While providing care to patients receiving a lumbar puncture, it is very likely that the emergency physician is taking care of a dozen other patients of variable acuity, but often including the acutely ill or injured.

Clinically, the two procedures are in no way similar. CPT code 40490 is a superficial biopsy of a visible lesion whereas code 62270 requires the physician to guide a needle from the skin, through the soft tissues, between the posterior elements of the lumbar spine, and into the thecal sac within the spinal canal in a patient that is presenting with neurologic symptoms necessitating an emergent procedure. Complications of code 62270 include epidural hematoma, seizure, direct impingement of the neural elements and periprocedural changes in the CSF dynamics leading to potential irreversible neurologic compromise and brain herniation. In comparison to a lip biopsy, there is the real risk of irreversible central and peripheral nervous system damage with the spinal needle. There also exists the inherently imperfect pain control/local anesthesia leading, on average, to a moving target and making the procedure more difficult and intense. The work of code 62270 may be performed in a similar time as code 40490 but it is a more intense process, which was discussed in detail at the RUC.

CMS has proposed a work RVU reduction of 1.22 for CPT code 62270 by justifying that the intra-service and total time has decreased and so should the work value for this service. The specialties strongly disagree with the Agency's statement that the lower intra-service time in CPT code 62270 should result in a lower work value. The RUC agreed that although the current times of CPT code 62270 have changed, the overall intensity and complexity has increased due to expected change in dominant specialty to emergency medicine. The RUC also agreed that the recommended work RVU of 1.44 for CPT code 62270 maintains relativity within the lumbar puncture family.

The RUC recommendation was based well below the 25th percentile work RVU from robust survey results and favorable comparison to the direct work RVU crosswalk and MPC code 12004 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 7.6 cm to 12.5 cm* (work RVU = 1.44, intra-service time of 17 minutes, and total time of 29 minutes). The survey results demonstrate that the work RVU for code 62270 was undervalued at the current work value of 1.37. SIR urges CMS to accept a work RVU of 1.44 for CPT code 62270.

CPT Code 622X0

For CPT code 622X0, CMS disagrees with the RUC recommended work RVU of 1.95 and proposes a work RVU of 1.73 based on the relative difference in work RVUs between CPT codes 62270 and 622X0. CMS has proposed that their recommended work RVU of 1.73 for CPT code 622X0 is equivalent to the RUC recommended interval of 0.51 additional RVUs above CMS' proposed work RVU of 1.22 for CPT code 62270. The RUC agrees that this methodology in valuing services is flawed.

CMS accepts the RUC work RVU increment between these codes, yet they disagree with the RUC recommended work RVU for code 622X0. The Agency argues that it is appropriate to reduce the work RVU for code 62270 based on the value proposed by the RUC, yet the Agency also agrees that it is appropriate to recalibrate the work RVU for code 622X0 relative to the RUC's recommended difference in work between this code and code 62270. This is a flawed valuation methodology and should not be applied to code 622X0 or any other code in the family. Therefore, the specialties do not agree with the adjusted values for codes 622X0, 62272, and 622X1, which are derived by increments.

The RUC recommendation was based on the 25th percentile work RVU from robust survey results and favorable comparison to reference codes 64483 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level* (work RVU = 1.90, intra-service time of 15 minutes, and total time of 49 minutes) and 49084 *Peritoneal lavage, including imaging guidance, when performed* (work RVU = 2.00, intra-service time of 20 minutes, and total time of 58 minutes).

Recommendation: SIR urges CMS to accept a work RVU of 1.95 for CPT code 622X0.

CPT Code 62272

For CPT code 62272, CMS disagrees with the RUC recommended work RVU of 1.80 and proposes a work RVU of 1.58 based on the increment difference in work RVUs between codes 62270 and 62272, (not codes 62270 and 622X0 as it is incorrectly published in the *Proposed Rule*).

CMS has proposed that their recommended work RVU of 1.58 for CPT code 62272 is equivalent to the RUC recommended interval of 0.36 additional RVUs above CMS' proposed work RVU of 1.22 for CPT code 62270. The RUC agrees that this methodology in valuing services is flawed. CMS accepts the RUC work RVU increment between these codes, yet they disagree with the RUC recommended work RVU for code 62272. The Agency argues that it is appropriate to reduce the work RVU for code 62270 based on the value proposed by the RUC, yet the Agency also agrees that it is appropriate to recalibrate the work RVU for code 62272 relative to the RUC's recommended difference in work between this code and code 62270. This is a flawed valuation methodology and should not be applied to code 62272 or any other code in the family. It is important to note this code's source of time is Harvard, implying that the time was merely extrapolated and not measured directly.

The RUC recommendation was based on the 25th percentile work RVU from robust survey results and favorable comparison to reference codes 64490 *Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level* (work RVU = 1.82, intra-service time of 15 minutes, and total time of 42 minutes) and 62323 *Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (i.e., fluoroscopy or CT)* (work RVU = 1.80, intra-service time of 15 minutes, and total time of 45 minutes). SIR urges CMS to accept a work RVU of 1.80 for CPT code 62272.

CPT Code 622X1

For CPT code 622X1, CMS disagrees with the RUC recommended work RVU of 2.25 and proposes a work RVU of 2.03 based on the increment difference in work RVUs between codes 62270 and 622X1. CMS has proposed that their recommended work RVU of 2.03 for CPT code 622X1 is equivalent to the RUC recommended interval of 0.81 additional RVUs above CMS' proposed work RVU of 1.22 for CPT code 62270.

The RUC recommendation was based on the median work RVU from robust survey results and favorable comparison to reference codes 32555 *Thoracentesis, needle or catheter, aspiration of the pleural space; with imaging guidance* (work RVU = 2.27, intra-service time of 20 minutes, and total time of 57 minutes) and 43216 *Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps* (work RVU = 2.30, intra-service time of 22 minutes, and total time of 55 minutes).

Recommendation: SIR urges CMS to accept a work RVU of 2.25 for CPT code 622X1.

Pericardiocentesis and Pericardial Drainage (CPT Code 3X000, 3X001, 3X002, and 3X003)

CPT code 33015 (Tube pericardiostomy) was identified as potentially misvalued on a Relativity Assessment Workgroup (RAW) screen of codes with a negative IWPUT and Medicare utilization over 10,000 for all services or over 1,000 for Harvard valued and CMS or other source codes. In September 2018, the CPT Editorial Panel deleted four existing codes and created four new codes to describe pericardiocentesis drainage procedures to differentiate by age and to include imaging guidance.

For CPT 2020, the CPT Editorial Panel replaced four codes with four new codes to describe pericardiocentesis drainage procedures to differentiate by age and to include imaging guidance. CPT Code 33015, which was originally identified by the RUC's Relativity Assessment Workgroup for review due to its negative IWPUT.

CPT code 33010 *Pericardiocentesis; initial* is being deleted and will be reported using bundled code 3X000 which also newly bundles image guidance. CPT code 33015 is being replaced with bundled codes 3X001-3X003, which also newly include imaging guidance.

At the January 2019 RUC meeting, the RUC reviewed compelling evidence arguments that the current pericardiocentesis and pericardial drainage codes are misvalued. Code 33015 currently has a very general code descriptor, was valued under the Harvard study and has a negative IWPUT. Since code 33010 and 33015 were last valued, there has been a change in the patient population; patients who receive these services have become more complex, acutely ill, and heterogeneous. These used to typically be patients who had chronic effusions during renal failure and dialysis. Today this is a heterogenous population, including malignancies, infections, iatrogenic effusions with tamponade, and other complications of implanted therapeutic devices like pacemakers and ICDs. The RUC agreed that these services are likely misvalued based on several compelling evidence criteria: incorrect assumptions in prior valuation, rank order anomaly and a change in patient population.

CMS' rationale for proposing an alternate value for these services is like their inaccurate comparison in prior rulemaking stating that Cardiopulmonary Resuscitation (CPR) was less intense than Critical Care. This anomalous relationship was finalized despite numerous comments from stakeholders. CMS' proposed values for the pericardiocentesis family are based, in large part, on the Agency's similar assertion that these procedures are less intense than many procedures with similar surveyed times. However, these procedures have a higher intensity than the services CMS cited in their rationale. Pericardiocentesis and pericardial drainage procedures are performed largely for the life-threatening condition of cardiac compression by fluid or blood (cardiac tamponade). Further, with the burgeoning development and application of many transcatheter intracardiac procedures such as Afib ablation, AICD insertion and transcatheter valve replacements these procedures are emergencies related to cardiac injury. As to the procedures themselves, they include the hazard of iatrogenic cardiac injury or failure to resolve the tamponade either of which can lead to death within seconds or minutes.

CPT Code 3X003

For CPT Code 3X003, CMS disagrees with the RUC recommended work RVU of 5.00 and proposes a work RVU of 4.29 based on the survey 25th percentile value. CMS' proposed value for 3X003 would create a rank order anomaly with 3X000. Although both procedures have distinct attributes, they both involve an identical amount of physician work.

The deleted code 33015 (which is being bundled into 3X003) was last evaluated by the RUC and CMS in 1995. The extremely negative IWPUT (-0.1484) indicates an anomalous relationship between the current work value and current physician time. A negative IWPUT indicates that ratio of current total times to the current work RVU is inaccurately high and therefore these values should not be referenced when reviewing a potentially mis-valued service.

The RUC recommendation was based on the 25th percentile work RVU from robust survey results and favorable comparison to reference codes 45385 *Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique* (work RVU= 4.57, intra-service time of 30 minutes, total time of 68 minutes) and code 31276 *Nasal/sinus endoscopy, surgical, with frontal sinus exploration, including removal of tissue from frontal sinus, when performed* (work RVU= 6.75, intra-service time of 45 minutes, total time of 98 minutes) which appropriately bracket the RUC recommendation.

Recommendation: SIR urges CMS to accept a work RVU of 5.00 for CPT code 3X003.

Urography (CPT Code 74425)

The physician time and work described by CPT code 74425 (Urography, antegrade (pyelostogram, nephrostogram, loopogram), radiological supervision and interpretation) was combined with services describing genitourinary catheter procedures in CY 2016, resulting in CPT codes 50431 (Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (e.g., ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; existing access) and 50432 (Placement of nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (e.g., ultrasound and/or fluoroscopy) and all associated radiological supervision

and interpretation). CPT code 74425 was not deleted at the time, but the RUC agreed with the specialty societies that 2 years of Medicare claims data should be available for analysis before the code was resurveyed for valuation to allow for any changes in the characteristics and process involved in furnishing the service separately from the genitourinary catheter procedures. The specialty society surveyed CPT code 74425 and reviewed the results with the RUC in October 2018.

The results of the specialty society surveys indicated a large increase in the amount of time required to furnish the service and, correspondingly, to the work RVU. The total time for CPT code 74425 based on the survey results was 34 minutes, an increase of 25 minutes over the current total time of 9 minutes. In reviewing the survey results, the RUC revised the total time for this CPT code to 24 minutes, with a recommended work RVU of 0.51. The reason for the large increase in time according to the RUC, is a change in the typical patient profile in which the typical patient is one with an ileal conduit through which nephrostomy tubes have been placed for post-operative obstruction. Based on the described change in patient population and increased time required to furnish the service, CMS is proposing the RUC-recommended work RVU of 0.51 for CPT code 74425. SIR appreciates CMS' proposal to accept the RUC recommendations for this service.

Angiography (CPT Codes 75726 and 75774)

CMS is proposing the RUC-recommend work RVU for both codes in this family. They are proposing a work RVU of 2.05 for CPT code 75726 (Angiography, visceral, selective or supraseductive (with or without flush aortogram), radiological supervision and interpretation), a work RVU of 1.01 for CPT code 75774 (Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (List separately in addition to code for primary procedure)). CMS is proposing the RUC-recommended direct PE inputs for all codes in the family. SIR appreciates CMS' proposal to accept the RUC recommendations for these services.

Stab Phlebectomy of Varicose Veins (CPT Codes 37765 and 37766)

These services were identified in February 2008 via the High-Volume Growth screen, for services with a total Medicare utilization of 1,000 or more that have increased by at least 100 percent from 2004 through 2006. The RUC subsequently recommended monitoring and reviewing changes in utilization over multiple years. In October 2017, the RUC recommended that this service be surveyed for April 2018. The specialties surveyed requested a change in global period from 090 to 010. As such, the RUC survey was conducted with a 010-day global period and subsequently the CMS proposed recommendations are in Addendum B as 010-day global services. CMS is proposing the RUC-recommended work RVUs of 4.80 for CPT code 37765 (Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab incisions) and 6.00 for CPT code 37766 (Stab phlebectomy of varicose veins, 1 extremity; more than 20 incisions). SIR appreciates CMS' proposal to accept the RUC recommendations for these services.

Market-Based Supply and Equipment Pricing Update

In CY2019 CMS proposed to update pricing for over 2,000 supply and equipment items currently used as direct practice expense (PE) inputs based on their contract with StrategyGen. CMS proposed to update supply and equipment pricing over a 4-year phase-in. In the *Proposed Rule* for CY 2020 CMS received invoice submissions for approximately 30 supply and equipment codes from stakeholders as part of the second year of the market-based supply and equipment pricing update.

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CMS is proposing to update the prices of 36 supply and equipment items as listed in Table 9 of the *Proposed Rule* for CY 2020. SIR appreciates CMS' willingness to review updated pricing throughout this 4-year phase in.

SIR appreciates the opportunity to provide feedback on the proposed rule. If additional information is required, please contact Sue Sedory, SIR Executive Director at ssedory@sirweb.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Laura Findeiss". The signature is written in a cursive, flowing style.

Laura Findeiss, MD, FSIR
President

cc: Sue Sedory, Executive Director