July 5, 2011

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Donald Berwick, MD
Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue SW
Room 314 G
Washington, DC 20201

Dear Secretary Sebelius and Administrator Dr. Berwick:

The undersigned medical societies are writing to express our concern about the Centers for Medicare and Medicaid Services' (CMS) interim values for physician work for surgical specialty medical services, as published in the final 2011 Medicare physician fee schedule. CMS rejected a larger than average number of recommendations of the American Medical Association/Specialty Society Resource Based Relative Value Scale Update Committee (RUC), for reasons which are very unclear to us. We strongly urge you to accept the values that were developed and approved by the RUC as the appropriate, final values.

The rigorous RUC evaluation process has been used to establish relative values for physician work under the Resource-Based Relative Value Scale (RBRVS) since 1992. Historically, CMS has accepted over 90% of the RUC's recommendations. In the 2011 Fee Schedule however, CMS only accepted 71% of the 291 recommendations submitted by the RUC, and only 2/3 of the 2010 five-year review recommendations were accepted in 2011. While we understand that CMS has intensified its scrutiny of the work valuations of codes, CMS' decisions must be made using a transparent consistent process, and must be based on credible data.

Yet these criteria were not met for many specialty services in the 2011 fee schedule. This includes codes that CMS identified because of a site of service change. Despite a clear consensus within medicine that hospital admission status does not impact the physician work in visits to the patient, CMS insists on devaluing procedures when the hospital designation has gone from inpatient to outpatient. All of the specialties participating in the RUC agree that if a patient stays 23 hours and the hospital designates the patient stay as "outpatient" the work of the physician visit is the same as it would have been if the patient stay was designated as "in-patient" and the physician saw the patient 24 or more hours after admission. Nevertheless, CMS has continued to hold fast to a view that defies the very concept of physician work.

Specific examples of CMS arbitrarily disregarding RUC recommendations include:

Obstetric Services

Because global obstetric care includes the 10 months of care, from the first antepartum visit through the final post-delivery office visit, the RUC used the equivalent value of each of those visits, plus the physician work during labor and during the delivery, to determine the correct values for the services reported with CPT codes 59400–59622. After the American Academy of

Family Physicians (AAFP) and the American Congress of Obstetricians and Gynecologists (ACOG) conducted the survey of practicing physicians required as part of this process, the RUC provided CMS with updated obstetric values based on meaningful current data.

CMS however, with the exception of codes 59412 and 59414, decided to multiply those values by 0.8922, reducing the value of care provided to pregnant women relative to the value of care provided to other patients by 11%. In the 2011 Final Rule, CMS asserted that there was no evidence that the work in maternity care has changed, but failed to recognize why it asked the RUC to review these codes: that the previous values weren't based on meaningful data – data which the RUC now provides. CMS originally acknowledged that there was no justification for the previous work values, and now has decided the previous values were correct, even with evidence to the contrary. CMS' 11% reduction is not based on transparent expert review of the RUC recommendations or alternative survey or data.

Pain Medicine

The codes that describe transforaminal epidural injections were recently revised by the CPT to bundle the required imaging guidance. Prior to 2011, it was proper to report both the injection procedure and the imaging – typically fluoroscopy. Codes 64479–64484 were revised to bundle the imaging and subject to the RUC survey and subsequent review.

Prior to this revision and survey, code 64483 had 1.90 work RVUs and the separately reported fluoroscopic guidance (code 77003) had .0.60 work RVUs. The RUC recommended a work RVU of 1.90 for the code, as revised, to represent the bundled service. While the relevant specialties (American Society of Anesthesiologists, North American Spine Society, International Spine Intervention Society, American Academy of Pain Medicine, American Academy of Physical Medicine and Rehabilitation, Society of International Radiology, and American Society of Neuroradiology) had concerns with the recommendation, we are most concerned with CMS's decision to assign only 1.75 work RVUs to this code for 2011. We understand that CMS believes that the service was potentially overvalued; 1.75 is however a significant undervaluation and contradicts the evidence collected by the RUC survey.

Esophageal and Paraesophageal Hernia Services

We also have serious concerns about CMS' decision to deviate from the AMA RUC recommendations on the esophageal and paraesophageal hernia codes. The most egregious error was CMS' assumption that the deleted and new codes in the CPT proposal were a "family" of codes. Although, the codes are "related" in terms of the patient population they are, in fact, not a family. Therefore, the uniform application of budget neutrality is incorrect.

New CPT code 43327 (old code 43324) requires separate consideration from the rest of the codes. CPT code 43324 was not directly cross-walked to all of the codes. In fact, deleted code 43324 was only cross-walked to new codes 43327 and 43328. For this reason, we disagree with CMS' application of the same work budget neutrality factor to 43327 and 43328 that was applied to the other codes.

Furthermore, the RUC reduced the specialty recommendation for 43327 from 20.00 work RVUs to 18.10 work RVUs. This was based on comparison to the key reference code 43820, the laparoscopic version of 43337. The RUC believed that total work, independent of approach (open abdominal versus laparoscopic), would be the same. This represented a significant reduction in work RVUs from the deleted code (22.99 to 18.10). Given that 43327 is directly compared to 43820, we recommend that CMS accept the RUC approved work RVU of 18.10 for 43327.

Additionally, new code 43328 is the same procedure as 43327, only via thoracotomy. However, in CMS' review of the new paraesophageal hernia repair codes, no changes were made to the work RVU differential for abdominal versus thoracic code pairs. The RUC and CMS agreed that there is a 2.5 work RVU differential between the codes with and without implantation of mesh or other prosthesis. A differential of 2.5 work RVUs was approved for 43334/43336 and 43333/43335 code pairs. In contrast, the CMS recommendation for 43327/43328 results in a differential of 6.5 work RVUs. Therefore, we recommend the same differential of 2.5 work RVUs be added to the American College of Surgeons, Society for Thoracic Surgeons, and RUC recommended work RVU (18.10) for 43327, so that the code pair 43327/43328 is comparable to 43334/43336 and 43333/43335. Thus, we recommend a work RVU of 20.60 for 43328.

The remaining codes (43332-43337) were not cross-walked from 43324. The remaining codes are only cross-walked from deleted codes 39502, 39520, 39530, 39531, and 43326, with the addition of work for implantation of mesh that was previously reported with an unlisted code or modifier 22. Following the correction of the misapplication of budget neutrality to codes 43327 and 43328, we recommend an interim technical correction of application of a work BN factor of 0.68 to the RUC recommendations for new codes 43332-43337.

Diabetic Retinopathy Screening

CMS made an arbitrary decision to choose the low survey value of 0.3 WRVU for the new CPT code 92228 Remote imaging for monitoring and management of active retinal disease (eg. diabetic retinopathy) with physician review, interpretation and report, unilateral or bilateral. The RUC recommended a value of .44. By choosing the low value, CMS is relying on an outlier value put forward by one survey respondent. The choice of the lowest survey result is statistically and methodologically flawed for numerous reasons. An extreme high or low value that isn’t replicated by other responses should never be considered representative of a true survey value. In this instance, the response of 0.3 was non-representative of any other survey participant. In fact discarding the high and low results before analysis of a survey is considered to be a statistically sound option in survey methodology. CMS is setting a dangerous precedent for its own future work by taking such action. Further, it is completely contradictory of its own decision that its refinement panels for work values will now utilize the median survey value.

The Obama Administration has long stated that in order to bring our health care costs under control we must focus on preventing the nation’s worst chronic diseases and their devastating effects. One of the most costly of these chronic diseases is the epidemic of diabetes. The incidence of diabetes is especially high for African Americans and Native Americans. For eye care, diabetes has a profound effect on vision health. Diabetic retinopathy is the most common

diabetic eye disease and a leading cause of blindness in American adults. The importance of monitoring and managing this disease is well documented and those people with proliferative retinopathy have less than a five percent chance of becoming blind within five years when they get timely and appropriate treatment. Medicare has long recognized that the standard of care for diabetics includes an annual dilated eye exam. It is also known that nearly 50 percent of Medicare beneficiaries with diabetes do not get this needed examination. For many, long distances or other socio-economic factors have made it difficult to see an ophthalmologist. In recent years, technology that allows for screening and monitoring remotely at a primary care or other facility have been developed to help overcome this gap in care.

Vertebral Augmentation

A multispecialty group responded to the CMS request to review vertebral augmentation codes (vertebroplasty and kyphoplasty), CPT codes 22520 through 22525, identified because CMS claimed there had been a change in the site of service since the codes were last valued. Specifically, for vertebroplasty and kyphoplasty, CMS lowered the value for three of the six codes presented, because they claimed the codes were last valued as in-patient procedures. However, the RUC reviewed the issue and concluded that the evidence is clear that the RUC did value these codes knowing that they were typically outpatient procedures. Nevertheless, CMS insisted on reducing the value for these codes, creating a rank order anomaly between CPT code 22523 Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); thoracic and while accepting the value for thoracic and Percutaneous vertebroplasty, 1 vertebral body, unilateral or bilateral injection; thoracic. These are similar procedures but CMS has chosen to devalue the former to 8.62 work RVUs, while maintaining the latter at a more appropriate 9.22 work RVUs.

Spinal Neurostimulator

In addition, CPT Code 63655 *Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural* was identified by CMS due to a site of service change. The code was identified as undervalued by neurosurgery, orthopaedics, anesthesia, and pain medicine during the 2005 Five Year Review but withdrawn due to low survey response. CMS flagged for a site of service review in 2008. Compelling evidence that the code was undervalued was rejected but the specialty societies made a strong case in April 2009 that the code was certainly not overvalued at its current value. The RUC confirmed this view at the September/October 2010 Five Year Review Meeting. However, CMS insisted on removing further value, because of a change in site of service. This code is a prime example of the inaccuracy of the CMS logic. There is no evidence that the work of this procedure, which include a full laminectomy, had changed since April 2009.

Fracture Care

We also recommend reinstating the RUC recommendation values for CPT codes 25600 and 25605. In the case of 25600, CMS removed the value of some pre-service evaluation time and immediate post-service time on the logic that 25600 is commonly billed with an Evaluation and

Management visit code on the same day as the original service. The presenting societies accounted for the overlap in E/M work by reducing the pre-service time already and the RUC specifically acknowledged this reduction in time. In addition, there is zero reason to assume that because an E/M was performed on the same day that some immediate post-service work would also be overlapping. The immediate post-service time for the procedure accounts for post-operative monitoring of the patient not pre-operative evaluation and management. We recommend maintaining the RUC's recommended value of 2.78 for CPT code 25600. CMS likewise adjusted the work RVU for CPT code 25605 which was the survey 25th percentile recommended work RVU and also compared to other similar procedure codes. CMS stated the low survey value of 6.00 is more appropriate, however we do not believe the survey low value should be used for valuation purposes; instead we recommend CMS affirm the RUC recommended value for 25605 of 6.50.

Urologic Services

The American Urological Association pointed out in their comments to the Physician Fee Schedule Final Rule that CPT code 52332 Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type) was incorrectly given a work RVU of 1.47, which according to CMS was the 25th percentile from the RUC survey data. After pointing out the incorrect value of 1.47, CMS revised the work RVU to 2.60 in their January 2011 Correction Notice. There was no rationale to validate why CMS selected the work RVU of 2.60 instead of retaining the current value of 2.83 as determined by the RUC and supported by the American Urological Association, which is well below the 25th percentile determined by the RUC urology survey respondents of 3.20 RVU. CMS without justification or explanation chose the "low value" of 2.60. The AUA strongly urges CMS to revisit the work value of 52332 and reinstate the 2010 work value of 2.83.

We strongly urge you to use the values that were developed and approved by the RUC for the 2011 fee schedule to more accurately reflect the work associated with the above discussed services, and reject CMS' interim values. Thank you for your consideration on this important matter. Please contact Lucia DiVenere, Senior Director, Government Affairs, ACOG at ldivenere@acog.org with any questions or concerns.

Sincerely,

American Academy of Ophthalmology

American Academy of Orthopaedic Surgeons

American Association of Neurological Surgeons

American College of Osteopathic Surgeons

American College of Surgeons

American Congress of Obstetricians and Gynecologists

American Osteopathic Academy of Orthopedics

American Society of Anesthesiologists

American Society of Plastic Surgeons

American Urological Association

Congress of Neurological Surgeons