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September 13, 2019

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

Submitted electronically via [www.regulations.gov](http://www.regulations.gov)

**Subject: CMS-1715-P Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule (PFS) and Other Revisions to Part B for CY 2020; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program**

Dear Administrator Verma:

On behalf of the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS), representing more than 4,000 neurosurgeons in the United States, we appreciate the opportunity to comment on the payment provisions of the above-referenced notice of proposed rulemaking.

## **EXECUTIVE SUMMARY**

### ***Evaluation and Management Office/Outpatient Visit Valuation and Global Surgical Codes***

- The AANS and the CNS strongly object to the failure of CMS to incorporate proposed increases in the evaluation and management (E/M) office visit codes in the 10- and 90-day global surgical services. We urge you to review the letter from AANS, the CNS and more than 50 other specialty societies representing the supermajority of physicians in the house of medicine asking the agency to reconsider this decision and to adjust the global codes to reflect the AMA/Specialty Society Relative Value Scale (RVS) Update Committee (RUC)-recommended increases in office visit work.
- The AANS and the CNS note that CMS has disregarded the original intent of the agency and the CPT/RUC Workgroup on E/M Coding proposals, which was to reduce administrative and documentation burden for physicians. The CPT/RUC Workgroup specifically stated that its intention was to maintain relativity and not to redistribute payment between specialties. CMS' failure to increase the global surgical payments to account for the E/M office/outpatient visits ignores this intent, destroys the relativity of the entire physician fee schedule and pays physicians of different specialties different amounts for the same work. The AANS and the CNS urge CMS to increase the global surgical services to reflect increases in E/M office/outpatient visit codes. This will more fairly reduce the redistribution in payment.

### ***RAND Reports on Global Surgical Services***

- CMS has proposed ignoring the RUC-approved E/M work increases in the 10- and 90-day global services because of ongoing “consideration” of data about number and level of post-operative visits for global codes. CMS references reports prepared by RAND responding to the Medicare Access and CHIP Reauthorization Act’s (MACRA) mandate that CMS collect these data, and RAND has generated three reports. The AANS and the CNS strongly object to this rationale, and we concur with the RUC that the three RAND reports generated faulty data that led to erroneous conclusions, and we urge CMS to consider ceasing any further review. The agency has fulfilled the MACRA requirement to gather data, and the process has revealed many flaws in the RAND data acquisition and interpretation. Using these data and interpretations as an excuse for failing to incorporate the changed E/M office visit work into global service valuation further subverts the RUC process that has served CMS well for 27 years, and is a clear break with earlier standard practice for changes in E/M code valuation.
- In RAND report one, *Claims-Based Reporting of Post-Operative Visits for Procedures with 10- or 90-Day Global Periods*, the results demonstrate the flawed methodology for assessing post-operative visits provided in the global period. The response rate from providers was extremely limited, and RAND rightly points to the difficulties encountered matching specific procedures to specific reporting of CPT code 99024. In addition, data was only gathered from Medicare practitioners in nine states and may not be generalizable across the nation. In spite of these methodological flaws, these data then informed the subsequent studies, which compounded the errors (especially in the third report). The AANS and the CNS recommend that CMS not implement any changes in the global surgical services based on the RAND sample of physicians reporting CPT code 99024 and abandon any further data collection.
- In RAND report two, *Survey-Based Reporting of Post-Operative Visits for Select Procedures with 10- or 90-Day Global Periods*, RAND concluded that the physician time of post-op visits was shorter than anticipated. However, RAND incorrectly accounted for staff time and physician extender time in the calculations. In fact, the physician times reported in the survey conducted by RAND are indistinguishable from the time for the E/M codes incorporated in 10- and 90-day global codes, which are predominately CPT Codes 99212 and 99213. In the new code descriptors recently approved by CPT and valued by RUC, a physician reports the work of 99212 if 10 minutes is spent with the patient on the day of the encounter. The AANS and the CNS believe that the new E/M office visit framework will address RAND’s observation that the time of post-operative visits was shorter than anticipated, and the RAND survey report is not useful due to methodologic problems and low response rate.
- In RAND report three, *Using Claims-Based-Estimates of Post-Operative Visits to Revalue Procedures with 10- and 90-Day Global Periods*, the AANS and the CNS strongly oppose the use of reverse building block methodology to fabricate new, spurious values for procedures while eliminating the global period aspect of these codes. The RUC has consistently opposed using the flawed reverse building block methodology for determining work values. More importantly, the claims-based estimates of post-operative visits do not bear any resemblance to clinical practice, fail the sniff test of validity and highlight the fact that these data have no utility for deriving new values for the global codes.

### ***Proposed Add-on Code GPC1X***

The AANS and the CNS oppose the implementation of add-on code GPC1X. The rationale proposed is unclear, the work associated with the code is not well defined, and the estimated negative impact on specialists that do not report the code is excessive. CMS estimates that more than \$1.5 billion would be redistributed between specialties if the code is adopted.

### ***Determination of Malpractice (MP) RVUs***

- The AANS and the CNS urge CMS to review thoroughly our comments and those of the RUC regarding professional liability insurance (PLI) issues, particularly regarding the glaring erroneous assumption in the methodological refinements for MP RVUs for neurosurgery.
- The AANS and the CNS are pleased that CMS has improved the crosswalk for five non-physician provider groups but note that there continue to be 11 non-physician provider specialties for whom the crosswalk significantly exceeds the actual premium costs. CMS continues to crosswalk many non-physician specialties to the lowest physician risk factor specialty, allergy immunology. As the percentage of non-physician providers billing Medicare for services increases, this distortion becomes increasingly problematic.
- The AANS and the CNS have significant concerns regarding the change in the MP Surgery Service Risk Group and the definition of major vs. minor surgery and the resulting obvious errors for neurosurgery.
- The AANS and the CNS strongly object to the imputation of neurosurgery PLI premiums from neurology that results in glaring inaccuracies for our specialty.
- We commend the agency for accepting the RUC specialty designation “overrides” for very low volume services to prevent significant variation in year-to-year MP RVUs. We note that there were errors in this process in CY 2019, and CMS — at the urging of organized neurosurgery, the RUC and other stakeholders — published a correction. For CY 2020, we urge CMS to adopt the RUC-provided list of 112 low volume services with their expected specialties.

### ***Practice Expense (PE) Issues***

- The AANS and the CNS agree with the CMS proposed refinement to increase direct PE inputs for CPT code 22310 *Closed treatment of vertebral body fracture(s), without manipulation, requiring and including casting or bracing*.
- The AANS and the CNS disagree with the refinement for direct PE inputs for 11 of the 16 *Somatic Nerve Injection* codes for which CMS reduced the clinical labor time for patient education from 3 to 2 minutes and support the RUC comments on this issue.

### ***CMS Valuation of Specific Codes***

- The AANS and the CNS oppose the CMS plan to reduce the RUC-passed values for CPT code 22310 *Closed Treatment Vertebral Fracture*.
- The AANS and the CNS oppose the CMS plan to reduce the values for CPT codes 62270, 622X0, 62272 and 622X1 *Lumbar Puncture*.
- The AANS and the CNS suggest that CMS wait until CPT code 27279 *Arthrodesis Sacroiliac Joint* is next captured by a RUC screen to consider changing the value.

## **DETAILED COMMENTS**

### **Evaluation and Management Office/Outpatient Visit Valuation and Global Surgical Codes**

In the CY 2019 Medicare PFS proposed rule, CMS proposed revisions to the E/M documentation guidelines intended to reduce the administrative burden on physicians. In response, the CPT Editorial Panel and the RUC formed a workgroup to change the existing coding and documentation requirements for office E/M with the stated purpose of simplifying the work of the provider and improving the health of

patients. The new proposed codes focused on medical decision making and reduced the emphasis on history and physical exam documentation. The CPT/RUC E/M Workgroup leadership made clear that the code change proposal was to change documentation requirements. **It was explicitly stated that the purpose was *not* to redistribute payments between specialties.**

The code change proposal was approved at the February 2019 meeting of the CPT Editorial Panel and brought before the RUC at the April 2019 meeting. All specialties represented at the RUC were involved in surveying these codes for values, with strong survey response rates. In spite of methodological concerns and heterogeneity in responses, the presenting societies (a subset of the surveyed societies, focused predominantly on pediatrics, primary care and geriatric specialties) proposed significant increases in work RVUs for these codes. The AANS and the CNS joined several specialty societies in expressing concern about these changes in values, as they would significantly redistribute work value among specialties based on the utilization of the new E/M codes (something specifically disavowed by the CPT/RUC E/M Workgroup). Once values were assigned to the E/M codes, to maintain relativity in the fee schedule, **the RUC overwhelmingly voted (27-1) to apply the new E/M visit values to the global codes to maintain relativity in the fee schedule.**

### ***Global Surgical Codes***

The AANS and the CNS strongly object to the failure of CMS to incorporate the adjusted values for the revised office/outpatient E/M codes into the global surgical codes. By setting aside the explicit recommendations from the RUC, and failing to incorporate the recommended work and time values for the revised office visit E/M codes for CY 2021 into adjustments to the 10- and 90-day global codes, CMS improperly proposes to implement these new E/M values in an arbitrary fashion that specifically undervalues the work of providers performing 10- and 90-day global procedures. **If CMS adopts the RUC approved office/outpatient E/M code values, the agency must also apply these updated values to the global codes.** Doing otherwise will:

- **Disrupt resource-based relativity in the fee schedule.** When the Resource-Based Relative Value Scale (RBRVS) was first implemented, global periods were developed for surgical procedures. Global periods include E/M post-operative visits, so the procedure values are resource-based and relative to non-procedural parts of the PFS. Applying the RUC-recommended E/M values to stand-alone E/M codes, but not to the E/M work included in the global surgical package, would disrupt the relativity between procedural and non-procedural codes that forms the bedrock of RBRVS, which has been refined by CMS and the RUC over the past 27 years.

Since the inception of the fee schedule, E/M codes have been revalued four times:

- In 1993, through refinement after implementation of extensive E/M coding changes;
- In 1997, after the first five-year review;
- In 2007, after the third five-year review; and
- In 2011, after CMS eliminated consult codes and moved work RVUs into the office visit codes.

Each time, when payments for new and established office visits were changed, CMS incorporated these changes into the post-operative visits within the global period. CMS has provided an unsatisfactory rationale for failing to incorporate the proposed E/M code increases in the CY 2020 Medicare PFS, and in the absence of a compelling rationale, CMS should maintain precedent and preserve relativity across the PFS.

- **Create specialty differentials.** Per the Medicare statute, CMS is prohibited from paying physicians differently for the same work, and the “Secretary may not vary the...number of relative value units for a physicians’ service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician.” Failing to adjust the global codes will invariably pay some

physicians less for providing the same E/M services, in violation of the law. As discussed below, the AANS and the CNS strongly dispute the suggestion from the RAND reports that care provided by surgeons in the global period is different, and cognitively less difficult, than that provided by cognitive specialists. RAND states, “For example, a practitioner may only need to examine the wound site when addressing a potential post-operative infection.” To suggest that surgeons merely assess surgical wounds and are not engaging in a holistic view of their surgical patients with coordination of care in a multi-disciplinary fashion is not only insulting, it is refuted by Medicare data showing that transitional care management codes (CPT 99495 & 99496) were only billed approximately 1.2 million times in 2018. Most of these instances related to non-procedure-related hospitalizations, which further supports the fact that surgeons are providing the primary care of their patients during the global period.

- **Violate section 523(a) of MACRA.** CMS points to the ongoing global code data collection effort as a reason for not applying the RUC-recommended changes to office visit E/M codes to global codes. In addition, the agency states that it is required to update global code values based on objective data on all of the resources used to furnish the services included in the global package. These arguments conflate two separate issues. The issue that CMS raises regarding MACRA legislation is not related to maintaining relativity across the fee schedule based on current data in the CMS work/time file. In fact, section 523(a) specifically authorizes CMS to make adjustments to surgical services, notwithstanding the mandate concomitantly to undertake the MACRA-mandated global code data collection project.
- **Ignore recommendations endorsed by nearly all medical specialties.** As mentioned above, the RUC, which represents the entire medical profession, voted overwhelmingly (27-1) to recommend that the full increase of work and physician time for office visits be incorporated into the global periods for all 10- and 90-day CPT codes. The RUC also recommends that the practice expense inputs should be modified for the office visits within the global periods.

### ***RAND Reports on Global Surgical Codes***

As part of MACRA, Congress mandated that CMS collect data on the number and level of post-operative visits for global surgical services provided to Medicare beneficiaries. The law stipulated for CMS to use these and other available data, as appropriate, to improve the valuation of global surgical services. The AANS and the CNS have long believed that the MACRA requirement was inadvisable and unnecessary, as CMS already has in place a process for reviewing and adjusting the value of surgical services with input from the RUC. CMS has collected data, and we believe that the agency’s data collection project has met the requirements of the statute, and the agency should abandon any intention of eliminating the global surgical periods. CMS expresses in the proposed rule its interest in increasing bundled payments under the Medicare PFS. If this is the goal of the agency, it is counter-intuitive to attempt to deconstruct bundled payment for surgical procedures. These bundled procedures include all pre-operative work in the 24 hours before surgery, the surgery itself, and then post-operative work on the date of the surgery and in the 10 or 90 days following. These services include not only direct face-to-face interactions with the patient and family, but also care management services.

We have reviewed the three RAND reports, and they only serve to reinforce our position that the MACRA requirement to review global surgical services was a waste of time and resources. We support the RUC comments regarding the flaws in the three RAND reports. To the extent there may be specific outlier global surgical procedures that have not recently been reviewed by the RUC, CMS can follow well-established precedent by identifying those codes as potentially misvalued and allow the RUC to conduct a thorough review without a sweeping, useless and burdensome disruption to surgeons and their patients. Otherwise, no further action on this project is warranted. Below are some additional comments on each of the RAND Reports.

- **RAND Report 1, Claims-Based Reporting of Post-Operative Visits for Procedures with 10- or 90-Day Global Periods.** Since July 1, 2017, Medicare practitioners in nine 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 299 10-day or 90-day global surgical 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.

The AANS and the CNS agree with the RUC that this dataset cannot reasonably be used to forecast any overall trends, given the limited and likely intermittent participation of eligible physicians as well as the current difficulty the agency and RAND researchers have implied in matching up procedures to CPT code 99024. Only 46 percent of practitioners that were expected to participate submitted tracking code 99024 through June 2018. Fifty-four percent of physicians eligible for this data collection project were either not aware of the requirement to participate or were unable to participate for another reason. Also, only 17 percent of eligible physicians were classified as “robust reporters,” indicating that a majority of those that did participate did so intermittently or did not begin until partway through the reporting period. If most of the eligible providers did not participate for a CPT code, which was the case for many codes, the median count of post-op visits would be zero irrespective of what study participants reported, and the mean number of visits would be greatly understated.

Furthermore, the dataset that includes only practices with 10 or more practitioners is potentially not representative as most physicians are in practices that have fewer than 10 providers. The AMA 2018 Physician Practice Benchmark Survey indicated that 54 percent of physicians are in practices with fewer than 10 physicians. Also, for surgical specialties, 64 percent of physicians are in practices with fewer than 10 physicians. We are especially concerned about this issue with practicing neurosurgeons, who often practice in groups smaller than 10.

The AANS and the CNS strongly disagree with the RAND conclusion that only 39 percent of 90-day global visits and 4 percent of 10-day global visits were performed. There are many flaws in the computation to arrive at these figures. First, 54 percent of physicians in the nine states who were eligible to participate did not do so. RAND inappropriately assumes that each of these physicians did not provide any office visits in any surgery’s global period. RAND also did not make any distinction between post-operative visits performed in the hospital setting versus those in office. For many neurosurgeons, whose patients can spend several days in the hospital, this is problematic. For physicians who use a separate electronic health record system in the office than the hospital where they perform surgery, there may be challenges in capturing and submitting claims for post-operative in-hospital visits. RAND also acknowledged the difficulty in matching 99024 visits to their associated procedures. The researchers chose to limit the potential confounder of multiple procedures performed during the same global period by focusing their analysis on so-called “clean” procedures — that is, procedures with no overlap with any other procedures during the ensuring global period. This, however, led to a significant reduction of available so-called “clean” procedures, which represented only about 60 percent of the available 90-day global procedures. However, for procedures in the category of “Nervous System: Spine and Spinal Cord,” this represented less than 40 percent of the available procedures. The information gathered cannot be extrapolated to all 10- and 90-day surgical global services, and **the AANS and the CNS recommend that CMS not implement any changes in the global surgical services based on the RAND sample of physicians reporting CPT code 99024 and abandon further data collection altogether.**

- **RAND Report 2: Survey-Based Reporting of Post-Operative Visits for Select Procedures with 10- or 90-Day Global Periods.** To comply with MACRA’s requirement for CMS to collect data on the

level of post-operative visits for global services, CMS contracted with RAND to conduct a survey to collect additional data on post-operative services, including the level of post-operative services. RAND launched a pilot of the survey in the fall of 2017 with a sample size of 557 practitioners and received only a single complete response. Following this setback, CMS and RAND decided to greatly narrow the scope of their survey initiative to only three high-volume services: cataract surgery (only CPT code 66984), hip arthroplasty (only CPT code 27130) and complex wound repair (CPT codes 13100, 13101, 13120, 13121, 13131, 13132, 13151, and 13152).

Beyond the obvious limitations of the survey instrument examining less than one thousand physicians who perform three procedures, RAND's main conclusion in the second report is flawed. They assert that the average visits were somewhat shorter than anticipated for cataract surgery (16.4 minutes vs. 19.4 minutes) and hip arthroplasty (22.9 minutes vs. 29.6 minutes) and longer for complex wound repair (21.8 minutes vs 16 minutes). However, RAND misinterpreted the findings of their survey data as they compared only the survey physician time "on the day of the visit" to the CMS physician time file, where the pre-service and post-service time of E/M services are not specific to the date of the encounter. The researchers also inappropriately excluded nurse practitioner (NP) and physician assistant (PA) time from their visit time comparison analysis. Additionally, in 2019, time is not the only factor relevant in selecting a code level.

RAND categorized NP/PA survey data as "staff time" and incorrectly observed that "...such staff time would be considered as part of PE in the RUC process and not contribute to the physician time component nor to the level of the visit." While this is the case for work performed by clinical staff, this is never the case for qualified health care professionals who can separately report Medicare services. The researchers did not account for Medicare rules on "incident to" and split/shared E/M services. When an NP or PA assists with an office visit, both the work of the physician and the work of the NP/PA is used to select the level of the visit if the requirements for "incident to" are met and the patient is an established patient.

Most importantly, the new E/M office visit framework allows for a physician to report a 99212 if 10 minutes is spent on the date of the encounter. Most surgical post-operative office visits are attributed as 99212 in the global surgical period in determining physician work, physician time and practice expense. The RAND survey instrument had significant methodological flaws, but the new coding structure developed by the RUC renders this RAND report moot.

- **Rand Report 3: Using Claims-Based Estimates of Post-Operative Visits to Revalue Procedures with 10- and 90-Day Global Periods.** This third study used the reverse building block methodology to estimate the change in Medicare payment based on RAND's summary data from the first study. The analysis included in this study is extremely flawed and disingenuous, as the researchers completely disregarded the "robust reporters" concept highlighted in the first study and made no attempt to filter out the 54 percent of eligible providers that did not participate in the data collection initiative. When 54 percent of eligible providers were assumed never to perform post-operative visits simply because they were not aware or were unable to participate in the data collection project, the median number of visits for many surgical global codes would be zero irrespective of what participating physicians reported. Also, as no specialty achieved a 100 percent participation rate, all codes included in the study would have been undercounted in the study to some extent.

For neurosurgery, specifically, the numbers extrapolated by RAND based on their claims data bear no resemblance to actual clinical practice. For example, two of the 15 neurosurgical codes captured by the RAND analysis, CPT codes 61312 and 61510, represent craniotomy codes, one for the evacuation of a hemorrhage and the other for the resection of intracranial tumor. Both of the patient populations represented by these procedures are medically complex and typically are seen multiple times — both in the hospital (often in intensive care unit setting) as well as in the clinic in the global period. However, according to the RAND analysis, the most common (mode) number of post-

operative visits for these two procedures was zero, meaning that RAND concluded that neurosurgeons **never** see patients who have undergone these procedures in the post-operative period. Obviously, this is grossly inaccurate and highlights the lack of utility in the RAND data. It is not reasonable to draw any conclusions from this flawed data or to make any significant changes in the payment of the global codes based on these findings.

The AANS and the CNS concur with the AMA and RUC, which object to the “reverse building block methodology” to systematically reduce work RVUs for services. We contend that the reverse building block methodology, or any other purely formulaic approach, should never be used as the primary methodology to value services. It is inappropriate as magnitude estimation has been used to establish work RVUs for services since the publication of the first Medicare physician payment schedule in 1992. This methodology, for example, ignores the care coordination work that is performed during the global surgical period, as evidenced by the flawed analysis in the RAND survey of hip arthroplasty.

Implementation of the methodology outlined in this RAND report would result in unreasonable reductions in total Medicare payment for many surgical specialties, putting at risk access to care for Medicare beneficiaries (e.g., payment reductions of 18.4% for cardiac surgery, 18.1% for surgical oncology, and 13.5% for neurosurgery). If CMS moves forward with the RAND recommendations, we anticipate dire unintended consequences for access to care for Medicare beneficiaries as some practitioners in these specialties may be forced to abandon Medicare altogether.

In summary, the results from the RAND studies should not be used to justify distorting the relativity of office visits within the RBRVS. Again, we point out the RUC voted 27-1 for CMS to apply the RUC office visit recommendations to both the stand-alone E/M office visit codes and the E/M office visit component of the codes with global periods. **We urge CMS to finalize a policy that adopts this recommendation for 2021. Furthermore, we believe the agency has fulfilled its requirement to collect data on global surgery services and should, therefore, drop further efforts to systematically eliminate the global periods.**

### ***Proposed Add-on Code GPC1X***

**The AANS and the CNS support the RUC recommendation urging CMS not to implement the add-on Medicare-care specific code GPC1X** for visits that serve as a focal point for all medical or for ongoing care related to a patient’s single, serious or complex chronic condition. CMS estimates that more than \$1.5 billion would be redistributed between specialties if this code were implemented in addition to the CPT/RUC recommended E/M office/outpatient visit increases. Table 118 illustrates significantly larger negative impacts for some specialties, including neurosurgery, if this code is adopted. We believe that the proposed code is too vague and more analysis is needed to understand whether there are some situations for which the CPT/RUC recommended increases in value do not account for the physician work in a few rare outlier cases.

### **Determination of Malpractice (MP) RVUs**

We have reviewed the *CY 2020 Medicare PFS Proposed Update to the GPCIs and PLI RVUs Interim Report* prepared under a new contract with Actuarial Research Corporation and the RUC comments on the report. In the CY 2018 Medicare PFS final rule (CMS–1676–F), CMS agreed with the AANS and the CNS, the RUC and other stakeholders and did not finalize its proposal to use the most recent data for the CY 2018 professional liability insurance relative value units (PLI RVUs) due to concerns about inaccuracies in the premium data provided by the previous contractor. While we appreciate the agency’s efforts to improve the data collection and methodology surrounding the PLI RVUs described in the *Interim Report*, **we have significant concerns about the noticeably incorrect data provided for neurosurgery. We request that CMS correct these errors, so the CY 2020 Medicare PFS final rule**



**MP RVUs more accurately reflect neurosurgical malpractice premium rates.** Below are specific comments regarding our concerns.

### ***Non-Physician Health Care Professional Premium Rates***

The AANS and the CNS are pleased that CMS has improved the crosswalk for five non-physician provider groups but note that there continue to be 11 non-physician provider specialties for whom the crosswalk significantly exceeds the actual premium costs. CMS continues to crosswalk many non-physician specialties to the lowest MD risk factor specialty, allergy immunology. As the percentage of non-physician providers billing Medicare for services increases, this distortion becomes increasingly problematic. The RUC has provided CMS with information from an insurance carrier, Health Providers Service Organization (HPSO), as a source of potential 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 \$8,896 for CY 2020 for allergy/immunology. While the HPSO premium rates reflect a limited number of states and specialties, the data does emphasize the fact that a direct crosswalk to allergy/immunology is unreasonable and excessive — in some cases by 80 percent or more.

A reasonable option may be to map these non-physician health care professionals to another non-physician profession, optometry, with an annual premium rate of \$1,539. Another option may be to assign codes performed predominantly by the above seven healthcare professions a 0.00 PLI as their premiums are so inconsequential that even a 0.01 PLI overcompensate them for their minimal PLI premiums. Ultimately, **CMS should collect actual premium data for all non-physician health care professionals. Until this is accomplished, however, the agency should map the eight Medicare specialty designations for non-physician health care professions to optometry for which valid premium data was collected for CY 2020 supporting a risk factor of 0.17 and annual premium rate of \$1,539.**

### ***Surgery Service Risk Group – Minor vs. Major Surgery***

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. In the previous PLI RVU update, only premiums for major surgery were used in developing the surgical risk factor. CMS considers surgical services with physician work values greater than 5.00 as “major surgeries” for this analysis. The agency recognizes that the inclusion of premiums for “minor surgery” policies as well as “major surgery” policies from insurers that charge different premiums based on a physician’s case-mix has resulted in national premiums and risk factors which are lower for surgical specialties. The RUC PLI Workgroup has identified three methodological flaws in implementing this new policy:

- 1) The definition of “minor” vs. “major” surgery is arbitrary and has led to undervaluation of certain specialties and codes;
- 2) Certain specialties and services are unfairly penalized as premium rates vary significantly within the specialty; and
- 3) The physician work RVU shares by service risk type appear to be in error and need further explanation and review.

Policymakers have attempted to define “minor” and “major” surgery for years without success. CMS has selected an arbitrary definition, assigning any CPT code in the 10000-69999 section of CPT with a work RVU below 5.00 to minor surgery. While this may appear to be a reasonable approach, a more nuanced approach is necessary, as there will be exceptions. For example, there are 157 “add-on” codes with ZZZ global periods and work RVUs lower than 5.00 that clearly are a component of major surgery. **We urge CMS to change the assignment of the 157 ZZZ codes provided by the RUC to major surgery.**

As the specialty with the highest PLI premiums, neurosurgery is subject to the largest adverse impact of this flawed “major-minor surgery” methodology. The proposed national PLI premiums and professional liability risk factors by CMS specialty and service risk group (*Interim Report Table 7.C*) demonstrate a 17 percent reduction in the national premium for neurosurgery from \$103,010 to \$85,412, which translates to a reduction in the risk factor from current 12.26 to 9.60 for CY 2020. Such a drop in neurosurgery PLI premiums is not credible. Despite the recent stability in the property and casualty marketplace, malpractice premiums for neurosurgeons remain in the six figure range. *TABLE 110: CY 2020 PFS Estimated Impact on Total Allowed Charges by Specialty* in the Proposed Rule indicates a 1% reduction to neurosurgery allowed charges and a 1% increase in interventional pain medicine. This, along with dramatic decreases in neurosurgery PLI RVUs for major surgery and increases in PLI RVUs for minor surgery interventional pain procedures, illustrates the unfair impact of the application of the minor vs. major surgery premium distinction. If CMS plans to retain this methodology, separate risk factors must be developed that are then applied to codes to correspond to those physicians who are performing the procedures. A neurosurgeon removing a brain lesion, who has PLI premiums in excess of \$100,000, should not be penalized because peers in the same specialty have lower premiums reflecting their performance of mostly minor surgery/procedures, such as spine injections.

We would like to draw special attention to Table 8.B *Volume-weighted distribution of 2019 Physician Work RVUs by Service Risk Type by CMS Specialty*, which clearly contains errors for neurosurgery and other specialties. The table indicates that both neurology’s and neurosurgery’s share of total “work RVUs–no surgery” is 70 percent. **This figure is inaccurate for both neurosurgery and neurology.** Neurosurgery’s share of surgery RVUs (codes in 10000-69999 range) is 80 percent, leaving 20 percent as the correct share of total “work RVUs–no surgery.” Neurology’s share of total “work RVUs-no surgery” is 95 percent. Moreover, the numbers shown on line 13-neurology and 14-neurosurgery of table B across all columns are exactly the same, indicating a likely “copy and paste” error. **Neurosurgery agrees with the RUC recommendation that CMS either abandon the distinction of minor vs. major surgery in premium data collection or create different risk factors for these surgical specialties and apply to codes in the same manner as the current application of surgery vs. non-surgery premium data.**

### ***Imputation Methodology***

CMS has made improvements in obtaining premium data for more specialties, reducing the need for crosswalking. However, the data set is not complete, and an “imputation methodology” has been derived to estimate an amount for annual premiums for these specialties. As the RUC has pointed out in its comment letter, the CMS process for imputing the missing data contains numerous inaccuracies for neurosurgery and other specialties. Of the 23 CMS specialties that are subject to total imputation, sixteen are mapped to allergy/immunology. We join the RUC in urging CMS to collect premium data for these specialties and, in the meantime, to work with the RUC to better identify appropriate crosswalks. For example, the contractor has mapped the specialty of sleep medicine to general practice when neurology would be more appropriate clinically and in terms of MP risk. Also, **Table 8.C.1 includes manifestly flawed mappings, showing neurosurgery PLI premiums imputed from neurology. Clearly, this is incorrect and, again, we ask that this be rectified.**

### ***Expected Specialty Overrides for Low Volume Services***

The AANS and the CNS appreciate CMS’ agreement to use a list of expected specialties instead of the claims-based specialty mix for low volume services (fewer than 100 allowed services in the Medicare claims data), which also includes no volume services, and apply these overrides for both the PE and PLI valuation process. The expected specialty list is available for comment as part of the supporting documentation to the Proposed Rule: *Anticipated Specialty Assignment for Low Volume Services*. CMS indicates that the list has been updated to include a column specifying whether a service is identified as

a low volume service for CY 2020, indicating if the service-level override is being applied for CY 2020. However, we note that this additional column did not appear in the downloadable version.

In January 2019, the AANS, the CNS and the RUC notified CMS that some of the PLI RVUs were not based on the overrides for low volume services in the CY 2019 Medicare PFS Final Rule and, thus, needed correction. Of these, 15 were neurosurgery services that experienced 2.00 PLI RVU or greater reductions. While CMS did correct and increase the PLI values for most of the low volume services, for a small number of procedures, including neurosurgery CPT codes 61607, 61526, 62121, 63303, 63050 and 64792, CMS claimed that the services did not meet the definition of low volume to receive the expected specialty override — that is, codes that have fewer than 100 allowed services in the non-modified three-year average of Medicare claims data considered to be low volume. Furthermore, the utilization in the RUC database is not the same as the full claims data that CMS uses for rate setting. The RUC database utilizations come from the *CMS Physician/Supplier Procedure Summary* file, and frequencies are adjusted for certain codes based on the CPT modifiers that were appended to the code such that certain services are not over- or under-weighted. Changes are made for several other modifiers as well (bilateral modifier 50, post-op only modifier 55 and anesthesia modifiers QK, QX and QY) and the data is trimmed to remove extreme outliers. CMS, however, does not discount the utilization when determining what constitutes a low volume service and instead uses the non-modified three-year service count for this criterion. We agree with the RUC comment that this may lead to double-counting and overestimating utilization. For these reasons, **we ask CMS to ensure that the list of expected specialties is correctly and consistently applied for the low volume service-level overrides each year and we urge CMS to work with the RUC to identify the appropriate specialty assignment for these codes.**

### **Practice Expense (PE) RVUs**

#### ***PE for Clinical Labor Tasks***

Regarding the CMS review of PE for clinical labor tasks, we continue to agree with the RUC and other stakeholders that CMS seems to often arbitrarily strip out time for clinical labor for tasks such as educating patients. **We urge the agency to consider the RUC comments on this issue.** The day before each full RUC meeting, the PE Subcommittee spends hours reviewing each PE input for all codes to be reviewed by the full RUC at the meeting. CMS staff attends the meeting at which specialties are thoroughly and thoughtfully questioned about the rationale for each minute of clinical staff time recommended. While we do agree with the CMS proposal to increase the direct PE for clinical labor for CPT Code 22310 *Closed treatment of vertebral body fracture(s), without manipulation, requiring and including casting or bracing*, we contend that CMS continues confuse issues of standards and RUC-developed minutes for clinical labor tasks. For example, for eleven of the sixteen *Somatic Nerve Injection* code family CMS reduced the clinical labor time for patient education from three minutes to two minutes without appropriate rationale.

### **Valuation of Specific Codes**

#### ***CPT Code 22310 Closed Treatment of Vertebral Fracture***

The AANS and the CNS oppose the CMS plan to reduce the RUC-passed values for CPT code 22310 *Closed Treatment of Vertebral Fracture*. The RUC identified CPT code 22310 through the negative “Intraservice Work per Unit of Time” (IWPUT) and Medicare utilization over 10,000 for all services or over 1,000 for Harvard valued and CMS/Other source codes. 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.

For CPT code 22310, CMS does not agree with the RUC recommended work RVU of 3.75 based on a crosswalk to CPT code 67914 *Repair of ectropion; suture* (work RVU = 3.75, 20 minutes intra-service time). CMS disagrees with the RUC's recommendation because they do not believe the reduction in work RVUs from the current value of 3.89, given a decrease of 33 minutes in intra-service time and 105 minutes in total time, is appropriate. CMS is comparing accurate survey time to Harvard time, which is not valid for comparison. **The AANS and the CNS urge CMS to use accurate survey data for physician time and not to adjust the work RVU based on instituting inaccurate comparisons.** Further, CMS states that the agency understands that "...the RUC considers the Harvard study time values for this service to be invalid time estimations..." However, CMS fails to acknowledge that the Harvard work value was much higher based on the Harvard study physician work times than the current work value of the service. In the CY 1992 Medicare PFS proposed rule, the work RVU for CPT code 22310, based on the Harvard study, was 6.31. In the CY 1992 Medicare PFS final rule, the work RVU was reduced to 1.95. In 1997, hospital and office visits were assigned by algorithm for practice expense purposes. The entire valuation history of this code is fraught with incorrect estimates of time and the current work RVU of 3.89 is irrelevant to the Harvard study. CMS continues to look at the survey intra-service and total time as a reduction from "current" rather than evaluate the RUC survey as independent data.

The RUC compared CPT code 22310 to CPT code 21073 *Manipulation of temporomandibular joint(s) (TMJ), therapeutic, requiring an anesthesia service (i.e., general or monitored anesthesia care* (work RVU = 3.45 and 20 minutes intra-service time), the same code that CMS is proposing as a direct crosswalk. Although CPT code 21073 is a helpful comparison the RUC compared it to the survey code as a lower bracket relative to the RUCs recommended work RVU of 3.75. The RUC recommended crosswalk code, CPT code 67914 *Repair of ectropion; suture* (work RVU = 3.75, 20 minutes intra-service time), which, like the CMS crosswalk code, has identical intra-service time and similar total time, is a more appropriate crosswalk. The IWP/UT is appropriately aligned with the survey second key reference service, CPT code 27267 *Closed treatment of femoral fracture, proximal end, head; without manipulation*, which is also a closed treatment service. **We urge CMS to consider that 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. **The AANS and the CNS urge CMS to accept a work RVU of 3.75 for CPT code 22310.**

### **CPT codes 62270, 622X0, 62272 and 622X1 Lumbar Puncture**

For the lumbar puncture codes (62270, 622X0, 62272, 622X1), CMS has disagreed with the RUC recommended work RVUs for all four codes. CMS has proposed to decrease the work RVU from 1.44 to 1.22 for code 62270, 1.95 to 1.73 for code 622X0, 1.80 to 1.58 for CPT code 62272, and 2.25 to 2.03 for CPT code 622X1. CMS proposes that their alternate work RVUs more closely align with the valuation of these codes than the RUC recommended. However, the RUC recommended work RVUs for the lumbar puncture codes are based on survey data. CMS should use valid survey data in establishing the work RVUs for all four codes. The RUC thoroughly analyzed this family of codes by review of history, survey data and magnitude estimation to other similar services. Further rationale explaining our support for the RUC recommendations for these four codes is outlined below.

- **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 percent of the time in a physician office as an elective procedure while 62270 is performed on seriously ill patients in the emergency room or inpatient hospital setting 70 percent of the time and only 5 percent of the time in a physician office. The patient populations are vastly different reflecting the increased intensity in the lumbar puncture

procedure. Clinically, the two procedures are not similar at all. CPT code 40490 is a superficial biopsy of a visible lesion whereas CPT 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 CPT code 62270 include epidural hematoma leading to 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 CPT code 62270 may be performed in a similar time as CPT 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 RUC strongly disagrees 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 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 25<sup>th</sup> percentile work RVU from robust survey results and favorable comparison to the direct work RVU crosswalk and Multispecialty Points of Comparison (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 AANS and CNS urge CMS to accept the RUC-passed work RVU of 1.44 for CPT code 62270.**

- **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 disagrees with the RUC recommended work RVU for CPT code 622X0. The agency argues that it is appropriate to reduce the work RVU for CPT code 62270 based on the value proposed by the RUC, yet CMS also agrees that it is appropriate to recalibrate the work RVU for CPT code 622X0 relative to the RUC's recommended difference in work between this code and CPT code 62270. This is a flawed valuation methodology and should not be applied to CPT code 622X0 or any other code in the family. Therefore, we do not agree with the adjusted values for codes 622X0, 62272 and 622X1, which are derived by increments. It is imperative that RUC survey data be used correctly to value this code and the family. 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 their proposed work RVU other than the incremental difference between codes.

The RUC recommendation was based on the 25<sup>th</sup> percentile work RVU from robust survey results and favorable comparison to reference CPT 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). **The AANS and the CNS urge CMS to accept a work RVU of 1.95 for CPT code 622X0.**

- **62272.** 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. 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 CPT codes 62270 and 62272, not CPT codes 62270 and 622X0 as it is misstated in the Proposed Rule.

CMS has proposed that its 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 the agency disagrees with the RUC recommended work RVU for CPT code 62272. CMS argues that it is appropriate to reduce the work RVU for CPT 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 CPT code 62272 relative to the RUC's recommended difference in work between this code and CPT code 62270. This is a flawed valuation methodology and should not be applied to CPT code 62272 or any other code in the family. Therefore, the RUC does not agree with the adjusted values for CPT codes 622X0, 62272 and 622X1, which are derived by increments. It is imperative that RUC survey data be used correctly to value this code and the family. Using an incremental approach instead of survey data, strong crosswalks and input from the RUC and physicians providing these services is unjustified. CMS does not provide any supporting rationale for its proposed work RVU other than the incremental difference between codes.

The RUC recommendation was based on the 25<sup>th</sup> percentile work RVU from robust survey results and favorable comparison to reference CPT 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). **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. The AANS and the CNS urge CMS to accept a work RVU of 1.80 for CPT code 62272.**

- **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 CPT 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. 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 CPT code 622X1. The agency argues that it is appropriate to reduce the work RVU for CPT code 62270 based on the value proposed by the RUC, CMS also agrees that it is appropriate to recalibrate the work RVU for CPT code 622X1 relative to the RUC's recommended difference in work between this code and CPT code 62270. This is a flawed valuation methodology and should not be applied to CPT code 622X1 or any other code in the family. Therefore, the RUC does not agree with the adjusted values for CPT codes 622X0, 62272 and 622X1, which are derived by increments. It is imperative that RUC survey data must be used to correctly value this code and the family. 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 their proposed work RVU other than the incremental difference between codes.

The RUC recommendation was based on the median work RVU from robust survey results and favorable comparison to reference CPT 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). **The AANS and the CNS urge CMS to accept a work RVU of 2.25 for CPT code 622X1.**

### ***CPT Code 27279 Arthrodesis Sacroiliac Joint***

The AANS and the CNS agree with the RUC that the recommendation by an unnamed requestor to crosswalk CPT code 27279 to CPT code 27280, the open arthrodesis sacroiliac joint code at a value of 20 work RVUs, is not appropriate. However, we would like to point out that neurosurgery participated with other specialties in the presentation of CPT Code 27279 at the RUC and had recommended a higher value than the current 9.03 work RVU but, as the RUC points out in their comments, compelling evidence to raise the value was not accepted. We would note that CPT code 27280 has been captured by a RUC Relativity Assessment Workgroup (RAW) screen. As part of this process, neurosurgery has recommended that data for CPT code 27280 be reviewed in two years and that CPT code 27279 be included in that analysis. This will allow a plan for addressing the value of CPT code 27279 in two years.

### **CONCLUSION**

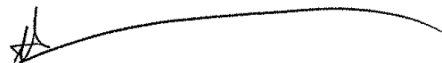
The AANS and the CNS appreciate the opportunity to provide feedback on these specific payment provisions in the CY 2020 Medicare PFS proposed rule. We are particularly concerned about the failure of the agency to incorporate proposed increases in E/M office visit work into the 10- and 90-day global surgical services for the many reasons we've noted above, and CMS must make these adjustments in the final rule. Additionally, we look forward to corrections of the errors and flawed methodology used to value MP RVUs for neurosurgery.

Thank you for giving careful consideration to our comments. If you have any questions or need additional information, please feel free to contact us. We are eager to work with the agency to provide the best care possible for our patients and we appreciate the expertise, hard work and dedication of CMS leaders and staff.

Sincerely,



Christopher I. Shaffrey, President  
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Ganesh Rao, MD, President  
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