



December 29, 2015

Andy Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1631-FC
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1631-FC Medicare Program; Payment Policies Under the Medicare Physician Fee Schedule (MPFS) and Other Revisions to Part B for CY 2016 Final Rule

Dear Mr. Slavitt:

On behalf the American Association of Neurological Surgeons (AANS), the American College of Radiology (ACR), the American Society of Neuroradiology (ASNR), the Congress of Neurological Surgeons (CNS), the Society of Interventional Radiology (SIR), the Society of NeuroInterventional Surgery (SNIS), and the Society of Vascular and Interventional Neurology (SVIN), we appreciate the opportunity to comment on an important payment provision in the above referenced Centers for Medicare and Medicaid Services' (CMS) 2016 Medicare Physician Fee Schedule (MPFS) Final Rule. For the reasons described below, we disagree with the CMS proposal regarding valuation for Intracranial Endovascular Intervention procedures reported with new CPT codes 61645, 61650, and 61651 and believe they are based on fundamentally inaccurate assumptions.

Summary

Inaccuracies in CMS Interim Final RVUs for Intracranial Endovascular Intervention Codes

- CMS has stated that the services now reported with the three new CPT codes 61645, 61650, and 61651 were previously reported using CPT codes 61640-61642 (Balloon dilatation of intracranial vasospasm). This is incorrect. The codes were previously reported with CPT code 37184 (66% Inpatient Hospital), 36224 (58% Inpatient Hospital) and 36228 (84% Inpatient Hospital) according to 2014 Medicare claims data—all predominately inpatient.
- CMS has stated that CPT codes 61645, 61650, and 61651 would be performed in the outpatient setting. However, these procedures are for acute stroke patients who require constant neurologic monitoring in a dedicated stroke unit or in an intensive care unit for at least several days.
- CMS has changed the RUC recommended crosswalk for the malpractice relative values for these codes based on an incorrect assumption regarding the specialty mix most likely to

perform the procedures. These procedures will be performed primarily by neurosurgeons and the malpractice crosswalk used should reflect this fact.

- CMS has listed the global period for CPT code 61650 as ZZZ but this is incorrect and should be a zero day global period. CPT code 61650, is a base code and not an add-on service, making a ZZZ global designation incorrect.

Specific Comments

Work Relative Values

CPT code 61645

The RUC recommended a work RVU of 17.00 for CPT code 61645 (Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial), referencing CPT code 37231 (Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed) and CPT code 37182 (Insertion of transvenous intrahepatic portosystemic shunt(s) (TIPS)). CMS recommended CPT code 37231 as a direct crosswalk and established an interim final work RVU of 15.00. **This crosswalk is not accurate for many reasons, including the fact that 2014 Medicare Claims data shows it is performed about 51.02% of the time in the office setting, 27.28% of the time in the hospital outpatient setting** and only about 21.30% of the time in an inpatient setting.

In addition, CMS objected to the work time for CPT code 61645 that includes postservice work time associated with postoperative visit CPT code 99233 (level 3 subsequent hospital care, per day). CMS stated that they believed that for the typical patient, these services would be considered hospital outpatient services and that the 55 minutes of work time associated with CPT code 99233 (subsequent hospital care) should be removed and instead 30 minutes of intraservice time from CPT code 99233 should be added to the immediate postservice time of the procedure. This reduces the total work time from 266 minutes to 241 minutes and increases the immediate post service time from 53 minutes to 83 minutes.

We object to this reduction, as these codes are performed in the inpatient setting, not the outpatient setting. All of these patients require intensive neurologic and hemodynamic monitoring following the procedure to prevent and/or diagnose intracranial hemorrhage, a potentially devastating complication. Many of these procedures are also performed under general anesthesia. The intensity of the visit work is similar to an ICU visit. A request for an ICU visit was considered and the request for a 99233 visit is more than justified. CMS has allowed inpatient hospital visits with zero day global inpatient procedures in the past. Indeed, there are currently over 50 inpatient facility only 0 and ZZZ codes that have a post-op visit – reviewed and accepted by CMS, including codes passed in the last few years.

CPT code 61650

The RUC recommended a work RVU of 12.00 for CPT code 61650 (Endovascular intracranial prolonged administration of pharmacologic agent(s) other than for thrombolysis, arterial, including catheter placement, diagnostic angiography, and imaging guidance; initial vascular territory). CMS asserted that the RUC-recommended work RVU overestimates the work involved in furnishing this procedure and used a direct crosswalk from CPT code 37221 (Revascularization, endovascular, open or percutaneous,

iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed), to propose an interim final work value of 10.00 for CPT code 61650.

CPT code 37221 is an inappropriate crosswalk, as it is typically reported for outpatient procedures. Medicare Claims data shows that about 53.23% of 37221 claims are for outpatient procedures and about 12.81% are in the office setting. For CY 2016, CMS established interim final work time by removing the 55 minutes total time associated with CPT code 99233 (subsequent hospital care) as recommended by the RUC and instead allocating the intraservice time of 30 minutes to the immediate postservice time of the procedure. This reduces the total time from 231 minutes to 206 minutes and the immediate post service time from 45 to 75 minutes. This is not appropriate because the procedure is **not an outpatient procedure**. The typical patient and most frequent use will certainly be in the setting of cerebral vasospasm following subarachnoid hemorrhage from a ruptured intracranial aneurysm. The minimum length of hospital stay for these patients is two weeks. Patients with vasospasm severe enough to require this procedure would all be monitored in an ICU setting. This procedure would typically be performed at the peak of the cerebral vasospasm from post bleed day 5-10 in order to prevent impending stroke and neurologic deficits.

CPT Code 61651

The RUC recommended a work RVU of 5.50 for CPT code 61651 (Endovascular intracranial prolonged administration of pharmacologic agent(s) other than for thrombolysis, arterial, including catheter placement, diagnostic angiography, and imaging guidance; each additional vascular territory (List separately in addition to the primary code)). CMS used a direct crosswalk from CPT code 37223 (Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)), to establish an interim final work RVU of 4.25 for CPT code 61651. **Again, this crosswalk is inappropriate for many reasons, including the fact that 37223 is typically performed in outpatient and sometimes in the office setting** and does not include post-operative inpatient work for stroke patients who are very often in the ICU following surgery. Specifically, CPT code 37223 is reported 50% of the time as an outpatient procedure and about 11% of the time in the physician office.

Malpractice Valuation

CMS refined the RUC-recommended malpractice crosswalks for this family of codes to align with the specialty mix expected to furnish the services. However, the CMS assumptions regarding specialty mix are wrong. Specifically, CMS established the following interim final malpractice crosswalks in place of the RUC-recommended malpractice crosswalks: CPT code 37218 to CPT code 61645; and CPT code 37202 to CPT codes 61650 and 61651. However these do not represent the specialty mix that will perform these services. We expect the specialty mix for new services 61645, 61650 and 61651 will be approximately 75% neurosurgery and 25% diagnostic radiology. The RUC recommended a malpractice crosswalk for all three services of CPT code 61791 (80% neurosurgery and 18% diagnostic radiology), which is in line with the specialty mix for the three new services. CMS's recommended malpractice crosswalk of 37218 for 61645 is not appropriate because 37218 was new for 2015 and the specialty mix is not yet known, but was predicted to be 25% diagnostic radiology, 20% neurosurgery and 20% vascular surgery. This specialty mix is not comparable to the specialty mix expected to perform CPT code 61645. In addition, CMS's recommended malpractice crosswalk of CPT code 37202 for 61650 and 61651 is not appropriate because the specialty mix for CPT code 37202 is 34% cardiology, 21% vascular surgery and 12% general surgery. Neurosurgery will be the dominant specialty performing

61650 and 61651. However, they only perform about 5% of the CMS recommended crosswalk CPT code 37202. We urge CMS to accept the RUC-recommended malpractice crosswalk of 61791 for codes 61645, 61650 and 61651 which accounts for the appropriate specialty mix.

Practice Expense

With respect to the practice expense relative value units, the surveying specialties and the RUC only included inputs for the hospital inpatient setting. This is correct and in keeping with the fact that the procedures are virtually always performed in the hospital for acute stroke patients.

Request for Refinement

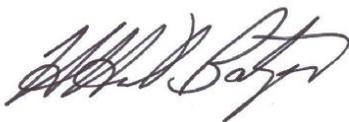
Our societies believe that CMS has enough information to correct the work and malpractice values for CPT codes 61645, 61650, and 61651. In addition, CMS must correct the global period for 61650. The latter change is certainly a technical correction. We understand there are other items identified by the RUC as technical corrections. Should CMS issues a technical correction notice, we would like to see CMS make the correction to the work and malpractice relative value units for all three codes at that time, as well as changing the global period for CPT code 61650. The inaccurate assumption that these codes would be typically performed in the outpatient setting has caused CMS to inappropriately lower the values and we would like to see the agency correct this error. However, we formally ask that these codes be sent to a refinement panel to review both the work and malpractice relative values, should the agency not take action on its own to restore the RUC recommended values.

CONCLUSION

Our societies appreciate the opportunity to comment on this important payment provision in the 2016 Medicare Physician Fee Schedule Final Rule. As always, we recognize the hard work and expertise of the many individuals involved in Medicare policy. We believe the case for restoring the RUC recommended work and malpractice values for CPT codes 61645, 61650, and 61651 is clear and look forward to working with the agency to accurately value these services.

If you have any questions or need additional information, please contact us.

Sincerely,



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Russell R. Lonser, MD, President
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