

August 13, 2014

Marilyn B. Tavenner
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

Re: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015 – Proposal to Modify the Process for Establishing Values for New, Revised and Potentially Misvalued Codes.

Dear Administrator Tavenner:

The undersigned organizations write to express our support for additional transparency and comment opportunity in the valuation of physician and other healthcare professional services. We offer an alternative to the proposal outlined in the Proposed Rule for the 2015 Medicare Physician Payment Schedule, published in the July 11, 2014 *Federal Register*.

Initiation Year

In an effort to respond promptly to the call for greater transparency in the valuation process, the Centers for Medicare and Medicaid Services (CMS) proposes to shift the consideration of all new, revised and potentially misvalued services to the Proposed Rule (rather than an Interim Final Rule) for implementation in the 2016 Medicare Physician Payment Schedule. Unfortunately, the 2016 implementation date is premature, as it would have a serious impact on the development of new technology and new code bundles which is already underway for the Current Procedural Terminology (CPT®) 2016 code set. The cycle for the CPT 2016 code set began with code change applications for the May 2014 CPT Editorial Panel Meeting submitted by February 14, 2014 and will conclude on February 7, 2015. We believe that it would be highly inappropriate for CMS to implement this proposal in the November 1, 2014 Final Rule because the CPT Editorial process for the 2016 cycle will already be nearly complete by that date and requiring publication in a proposed rule next summer will delay their implementation in Medicare by another year. Those that have solicited new and/or revised CPT codes deserve timely consideration of their applications. They also deserve fair notice of the implementation date. If CMS were to announce a 2017 implementation date on November 1, 2014, it would provide appropriate notification to those submitting code change applications by the first CPT 2017 deadline of February 13, 2015. **We strongly urge CMS to begin implementing the new timeline and procedures for the CPT 2017 cycle and the 2017 Medicare Physician Payment Schedule.**

CPT/RUC Timeline

The CPT Editorial Panel and the AMA/Specialty Society RVS Update Committee (RUC) each meet three times per year. Historically, the May CPT/October RUC meetings have been the first meetings of each coding cycle, followed by the October CPT/January RUC meetings, and finally the February CPT/April RUC meetings. Following the last set of meetings, CPT is finalized as a code set for the next calendar year and the RUC submits recommendations to CMS for consideration and implementation. The RUC submits all recommendations no later than May 31 each year for consideration for the next payment schedule. As stated earlier, a CPT code originates with a code change application and the first applications of each cycle are due in February, followed by application deadlines in July and November. The current time required to generate a code/relative value ranges from 14 to 22 months from the time of application.

In order to accommodate the publication of proposed valuation of new, revised and potentially misvalued services, CMS proposes to require that all RUC recommendations be submitted by January 15 of each year. For 2016, this would mean that the May 2014 CPT/September RUC meeting would be the only opportunity for the medical community to offer description and recommended valuation of new technology and code bundles, since the RUC will not have the opportunity to consider codes from the October CPT Editorial Panel meeting until January 29, 2015.

In addition, this proposal would extend the time required to generate a code/relative value to 22 to 30 months for each subsequent *CPT* code set cycle at a time when CMS, the CPT Editorial Panel and the RUC are being asked to reduce the amount of time needed to accommodate changes.

The AMA offered the attached detailed and reasonable proposal to expedite the review processes for new, revised and potentially misvalued services. This proposal would retain the current meeting infrastructure for both CPT and the RUC, while shifting the workflow to accommodate the review of commonly performed services to the May CPT/October RUC and October CPT/January RUC meetings. Under this proposal, the February CPT meeting would predominantly address editorial changes, clinical lab payment schedule services, and new technology services, with expected low volume. The April RUC meeting would replace the formerly lighter September RUC meeting agenda and would be utilized to review the low volume new technology services and discuss methodological and process issues. We believe that CMS should be able to publish consideration of the low volume new technology codes in the Final Rule as interim values, as these changes would have minimal impact on the other services on the Medicare Physician Payment Schedule. The AMA proposes to submit RUC recommendations to CMS within one month of each meeting (each November and February for new, revised and potentially misvalued; and each May for low volume new technology). **We strongly urge CMS adopt the AMA proposal for modifications in CPT/RUC workflow to accommodate publication in the Proposed Rule, while ensuring that new technology may be described and valued in an efficient and timely manner.**

If CMS adopts the AMA proposal, this will eliminate the need for CMS to create G codes which essentially duplicate the CPT codes. We believe that the G code proposal is entirely unworkable and should not be considered in finalizing the new process. The creation and adoption of temporary G

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codes would unnecessarily add to the administrative burden of physicians, non-physician practitioners, and providers who would be tasked with having to learn and implement new codes to be replaced within a relatively short period. When this applies to large families of codes, the burden is even greater, as is the risk for coding errors. Moreover, this threatens to create a situation of parallel but distinct coding between Medicare and private payers, as private payers are likely to implement new CPT codes as soon as they are published.

Refinement Process/Appeals Process

CMS proposes to eliminate the Refinement Panel process currently utilized by the Agency to consider comments on interim relative values. For nearly two decades, the CMS Refinement Panel Process was considered by stakeholders to be an appeals process. The Refinement Panel was organized and composed by CMS and consisted of members from the primary care organizations, contractor medical directors, a specialty related to the commenter and the commenting specialty. For many years, CMS deferred to the vote conducted by the Refinement Panel in finalizing values. Most often, the Refinement Panel would support the original RUC recommendations. CMS states that the Refinement Panel was not convened for the former Five-Year Review processes, as this process always involved proposed rulemaking. However, this is not accurate. CMS even convened multi-day face-to-face Refinement Panel meetings during the first two Five-Year Review processes.

Most recently, CMS modified the process to only consider codes for which new clinical information was provided in the comment letter. CMS also began to independently review each of the Refinement Panel decisions in determining which values to actually finalize. In many cases, the Refinement Panel supported the original RUC recommendation and the commenter's request, yet CMS chose instead to implement their original proposed value. The complete elimination of the Refinement Panel indicates that CMS will no longer seek the independent advice of contractor medical officers and practicing physicians and will solely rely on Agency staff to determine if the comment is persuasive in modifying a proposed value. The lack of any perceived organized appeal process will likely lead to a fragmented lobbying effort, rather than an objective review process. Those organizations with limited resources are disadvantaged in comparison to those vendors or organizations that will spend significant resources to overturn a CMS proposed value. **We recommend that CMS consider these issues and create a fair, objective, and consistently applied appeals process that would be open to any commenting organization.**

We appreciate this opportunity to comment and offer a reasonable transition to a process to allow greater transparency, while ensuring minimal disruption in the description and valuation of new technology. If you have any questions about this proposal, please contact Sherry Smith at the American Medical Association at sherry.smith@ama-assn.org.

Sincerely,

American Medical Association
American Academy of Allergy, Asthma and Immunology
Academy of Nutrition and Dietetics

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American Academy of Audiology
American Academy of Child and Adolescent Psychiatry
American Academy of Dermatology Association
American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Family Physicians
American Academy of Neurology
American Academy of Pediatrics
American Academy of Ophthalmology
American Academy of Otolaryngology- Head and Neck Surgery
American Academy of Physical Medicine and Rehabilitation
American Academy of Physician Assistants
American Academy of Sleep Medicine
American Association of Clinical Endocrinologists
American Association of Neurological Surgeons
American Association of Neuromuscular and Electrodiagnostic Medicine
American Association of Oral and Maxillofacial Surgeons
American Chiropractic Association
American College of Allergy, Asthma and Immunology
American College of Cardiology
American College of Emergency Physicians
American College of Medical Genetics and Genomics
American College of Phlebology
American College of Physicians
American College of Radiology
American College of Rheumatology
American College of Surgeons
American Congress of Obstetricians and Gynecologists
American Geriatrics Society
American Nurses Association
American Occupational Therapy Association
American Osteopathic Association
American Pediatric Surgical Association
American Physical Therapy Association
American Podiatric Medical Association
American Psychiatric Association
American Psychological Association
American Society for Blood and Marrow Transplantation
American Society for Surgery of the Hand
American Society of Anesthesiologists
American Society of Breast Surgeons
American Society of Cataract and Refractive Surgery
American Society of Clinical Oncology
American Society of Clinical Pathology

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American Society of Colon and Rectal Surgeons
American Society of General Surgeons
American Society of Hematology
American Society of Interventional Pain Physicians
American Society of Neuroradiology
American Society of Nuclear Cardiology
American Society of Plastic Surgeons
American Speech-Language-Hearing Association
American Thoracic Society
American Urological Association
Association of American Medical Colleges
College of American Pathologists
Congress of Neurological Surgeons
Endocrine Society
Heart Rhythm Society
Joint Council of Allergy Asthma and Immunology
Medical Group Management Association
National Association of Social Workers
North American Spine Society
Renal Physicians Association
Society for Cardiovascular Angiography and Intervention
Society for Vascular Surgery
Society of Interventional Radiologists
Society of Nuclear Medicine and Molecular Imaging
Society of Thoracic Surgeons

Attachments