July 25, 2011

Donald M. Berwick, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1582-PN
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD  21244-1850

Submitted Electronically: http://www.regulations.gov

Re:  Medicare Program; Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule; Proposed Rule; CMS-1582-PN

Dear Dr. Berwick:

The American Society of Plastic Surgeons (ASPS) appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid Services (CMS) proposed rule for “Medicare Program; Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule” that was published in the Federal Register on June 6, 2011. ASPS is the largest association of plastic surgeons in the world, representing more than 7,000 members and 94 percent of all American Board of Plastic Surgery board-certified plastic surgeons in the United States. Plastic surgeons provide highly skilled surgical services that improve both the functional capacity and quality of life of patients. These services include the treatment of congenital deformities, burn injuries, traumatic injuries, and cancer. ASPS promotes the highest quality patient care, professional, and ethical standards and supports education, research, and public service activities of plastic surgeons.

ASPS will comment on specific codes of concern to plastic surgeons in detail, and we offer the following general comments on the analytical approach CMS officers describe in the proposed rule regarding the Fourth Five-Year Review of physician work. We do not agree with CMS that “the values of the codes that fall into the 23 hour stay category, that is, services that typically have lengthy hospital outpatient recovery periods, should not reflect work that is typically associated with an inpatient service.” As we have stated before, we believe that whether the patient is in observation status or admitted to the hospital, the work provided by the physician is the same. Our stance is strongly supported by the RUC. Medicine’s disagreement with CMS over this principle continues to cause undue angst over the valuation of procedures, and we believe that the values of many services are being inappropriately decreased as a result. This problem is severely affecting one plastic surgery code, CPT 15732, that is discussed in detail below. It also affects many other surgical codes for which we understand the RUC and other medical specialties will be submitting comments, and we support their arguments in favor of
using an equivalent payment methodology for services that are typically provided to patients in the hospital whether they be admitted or in observation.

Rejection of RUC Recommendations for CPT 12045, 12046, 12047, 12055, 12056, 12057

For the Fourth Five-Year Review of physician work RVUs, ASPS participated with the American Academy of Emergency Medicine, the American Academy of Dermatology, and the American College of Surgeons in a review and RUC surveys of the 1204X and 1205X families of intermediate wound repair codes. CMS identified codes 12042 and 12051 (as well as 12031 and 12032) as potentially misvalued through the “Harvard-Valued-Utilization Over 30,000” screen. ASPS and the other surveying specialties agreed to add the remaining codes in this family of services (as well as the 1203X family) for the review.

In the proposed rule, CMS disagreed with the RUC-recommended work RVUs for CPT 12045, 12046, 12047, 12055, 12056, and 12057. CMS proposes to reduce the work RVUs to the survey 25th percentile as “consistent with the relativity adjustments recommended by the AMA RUC” for the other codes in the family. **This decision is flawed and perpetuates one of the problems ASPS and the other specialties identified regarding the original valuation of these services. Namely, these codes should not be treated exactly the same, because some codes are typically provided in the office while others are typically provided in the facility.** We presented compelling evidence that was accepted by the RUC that CMS refinement of the Harvard data in 1992 underestimated work by refining all 19 codes in this family to include no hospital work and only one office visit even though the original Harvard estimates indicated some of the codes would be facility-based and include more office time. Many of the codes affected did not have pre/post estimates and were mis-predicted. Based on our 2010 RUC surveys, CPT 12045, 12046, 12047, 12055, 12056, and 12057 are typically facility-based procedures. Our specialty consensus panel and the RUC agreed these codes deserved higher RVUs represented by the survey median values not the 25th percentile values that were recommended for the office-based codes.

In our presentation to the RUC, CPT 12045, 12046, 12047, 12055, 12056, and 12057 were each compared to key reference services. **The CMS proposed values for these codes ignore these relationships and create rank order anomolies.** For instance, CPT 12055 (Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 12.6 cm to 20.0 cm), which is clearly a facility-based code (80% facility in 2009 Medicare claims) was compared to key reference code 11626 (Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm) that was reviewed by the RUC in August 2005. Our survey showed 39 minutes higher total physician time (10 minutes higher intra-service time) and comparable intensity and complexity for CPT 12055 versus 11626. The 2011 work RVU for CPT 11626 is 4.61, and CMS proposes 4.50 for CPT 12055, creating a clear rank order anomaly. Similar rank order problems are created for the other wound repair codes. **For these reasons, we respectfully request that CMS reconsider its decision and accept the RUC-recommended work RVUs for CPT 12045 (3.9); 12046 (4.60); 12047 (5.5); 12055 (4.65); 12056 (5.50); and 12057 (6.28).**

Changes to Physician Time for Intermediate Wound Repair Codes

We are disappointed that CMS proposes to change the recommended pre-and post-service times for CPT 12046 and 12047 indicating that these services are “typically performed on the same day as an E/M visit. We believe some of the activities conducted during the pre- and post-service
times of the procedure code and the E/M visit overlap, and, therefore should not be counted twice in developing the procedure’s work value.” ASPS is confused by this assessment by CMS, because the 2009 Medicare same day billing data provided by the Agency for the October 2010 RUC meeting did not indicate these services were performed on the same day as an E/M service. Nevertheless, the RUC’S valuation of these codes already includes a significant reduction to the pre-service time (six minutes) as requested by the specialties on the RUC summary of recommendation form “to account for H&P already performed.” Further reduction of the pre-service and same day post-service time is redundant and unnecessary, and ASPS recommends the RUC-recommended times for CPT 12046 (13 minutes each for pre-service and same day post-service time) and CPT 12047 (13 minutes for pre-service and 15 minutes for same day post-service time).

We are also extremely concerned that CMS proposes to decrease the recommended intra-service time for CPT 12055, 12056, and 12057. CMS provides no explanation for this arbitrary decrease other than to offer that they find the altered times “to be more appropriate than the AMA RUC-recommended intra-service time[s].” This is hardly an acceptable rationale from an Agency with responsibility for a relative value system with a 20 year history of relying on the expertise of the RUC as a basis for a majority of its valuation decisions. For these codes, the RUC agreed with the specialties that the recommended times for these extremely low volume procedures should be based on the times offered by the surveyees with the most experience in performing these large size wound repairs. ASPS requests that CMS accept the RUC-recommended intra-service time of 70 minutes for CPT 12055; 85 minutes for CPT 12056; and 100 minutes for CPT 12057.

Altered Physician Time for Complex Wound Repair Codes 13100 and 13101

CMS requested review of CPT 13101 (Repair, complex, trunk; 2.6 cm to 7.5 cm) through the “Harvard-Valued-Utilization Over 30,000” screen. ASPS collaborated with the American Academy of Dermatology and the American College of Surgeons to survey this code along with CPT 13100, because it is closely related to CPT 13101. In the proposed rule, we are pleased that CMS agrees to accept the RUC-recommended RVUs for both codes. However, without explanation, CMS proposes to retain the Harvard time data for these codes instead of using the new survey times. CMS also states that the work values will remain interim until the RUC reviews the entire family of complex repair codes, two of which (CPT 13131 and 13152) are scheduled for discussion at the September 2011 RUC meeting and another of which (CPT 13121) was reviewed at the August 2005 RUC meeting. Given that CMS has accepted the RUC-recommended RVUs for 13100 and 13101, ASPS recommends that CMS also incorporate the new RUC times for these codes into the RUC time database. It is illogical to use the Harvard times. Additionally, ASPS requests that CMS finalize these values for the 2012 Medicare physician fee schedule instead of making them interim. The eventual review of other codes in the complex repair family should not affect the RUC’S decision on these codes.

Devaluation of CPT 15732

ASPS is gravely concerned that CMS disagreed with the RUC recommendation of 19.83 work RVUs for CPT 15732 (Muscle, myocutaneous, or fasciocutaneous flap; head and neck (eg, temporalis, masseter muscle, sternocleidomastoid, levator scapulae)) and instead proposes 16.38 RVUs, resulting in a 17.4% decrease in value. CMS officials continue to question the inpatient time assigned to this procedure and make several troubling statements in the NPRM about the
methodology used to arrive at their proposed work RVU of 16.38. For instance, CMS states, “we have no reason to believe that miscoding is the main reason that outpatient settings are the dominant place of service for this code in historical PFS claims data. Therefore, in accordance with the policy discussed in section II.A. of this proposed notice, we removed the inpatient hospital visits, reduced the discharge day management service to one half, and adjusted times.” CMS makes this claim despite the fact that the RUC has repeatedly argued that many procedures which show up in Medicare claims as “outpatient procedures” often involve patient stays in the hospital that can last two or more nights. In addition, ASPS has conducted two recent RUC surveys for this code at the request of CMS (in years 2010 and 2005) that clearly demonstrate the typical patient receiving this service when the code is appropriately billed is inpatient.

For the Fourth Five-Year Review of physician work, the ASPS and the American Academy of Otolaryngology – Head and Neck Surgery (AAO-HNS) conducted a RUC survey of 150 plastic surgeons and otolaryngologists in July 2010. These specialties represent 62% of 2009 Medicare claims for CPT 15732. Ophthalmology, which represents 31% of 2009 Medicare claims for this procedure, chose not to participate in the survey.

Of 36 survey respondents, 78% said the following survey vignette described their typical patient:

A 35 year-old male undergoes reconstruction of a large mid cheek defect resulting from a separately reported resection of a dermatofibrosarcoma protuberans. A pedicled temporalis muscle flap is tunneled into position to reconstruct the defect.

As stated in our recommendations to the RUC, 94% of our survey respondents indicated the above procedure is typically performed in the hospital. Of these respondents, 79% indicated the patient is admitted and only 15% indicated an overnight stay (less than 24 hours). The plastic surgery and otolaryngology consensus panel reviewing the survey data agreed that a majority of patients requiring this procedure would be admitted and seen on the night of surgery to check for correctable causes of impairment to flap viability including hematoma and edema in tunnel causing venous congestion. The patient will also be evaluated for pain control and ability to eat/drink. The patient will be seen the next day to re-evaluate for the same concerns. Depending on site of flap, significant facial edema can impact on inability to eat/drink and can prolong admission as can problems with pain control or impairment of visual field.

Another troubling comment from CMS officials in the NPRM is that while they acknowledge that “the survey data indicated that a majority of patients have an overnight stay,” they go on to state, “We note that it is unclear whether [survey] respondents were offered the option to state that the typical patient is in the hospital more than 24 hours, but not admitted as a hospital inpatient.” ASPS and AAO-HNS used the official survey instrument approved by the RUC for the 2010 five-year review process. CMS medical officers attend all RUC meetings and have an ongoing opportunity to review and recommend revisions to the survey. It is our understanding that the RUC Research Subcommittee is willing to consider recommendations at any time. The RUC survey process entails significant effort and expense on behalf of the specialties, and it is extremely disheartening to have the survey results ignored. If CMS is unhappy with the RUC survey instrument, these concerns should be raised in front of the RUC members, so that the limited resources of the AMA and medical specialties are not wasted. Nevertheless, in this case, we do not feel that additional survey questions are needed to address site of service issues, nor would they have made a difference in the result of our survey. We believe that the surveyees accurately responded to the very straightforward questions asked and provided the information that their typical 15732 patient would be in the hospital for more than 24 hours. As such, we believe the surgeon deserves to be compensated for his time and expertise, and it is
absolutely inappropriate for CMS to remove the postoperative inpatient physician time and corresponding work values from CPT 15732.

Justification for CPT 15732 Work RVU Recommendation

ASPS supports the RUC recommendation of 19.83 work RVUs and the RUC time data for CPT code 15732. We strongly oppose the reverse building block methodology and arbitrary removal of survey-supported physician time from this or any other code. The value of 19.83 represents the survey median, which is slightly lower than the current value of 19.90 for code 15732. It is also comparable to the key reference service, CPT 15734 (Muscle, myocutaneous, or fasciocutaneous flap; trunk), which has 29 minutes higher total time, but has less intensity of intra-service work. Head and neck muscle flaps present a higher potential for significant complications and liability due to functional issues (vision, breathing, speaking, eating) and cosmetic outcome. Similarly, the office visits are more intense due to higher patient expectations pertaining to scar management and aesthetic concerns. Overall, achieving good outcomes is more dependent on surgeon skill compared to 15734 (work RVU=19.86).

The RUC agreed that the two services have analogous physician work and should be valued similarly, and the CMS recommendation of 16.38 RVW for 15732 creates a significant anomaly within this family of procedures. CPT 15732 and 15734 should be valued almost identically. The RUC also compared CPT code 15732 to the MPC code 15738 Muscle, myocutaneous, or fasciocutaneous flap; lower extremity (work RVU= 19.04 and intra time= 150 minutes). The RUC agreed that these services have very similar physician work and CPT 15732 should be valued higher than 15738 due to greater intensity and more total time, 507 minutes compared to 460 minutes. Both CPT 15734 and 15738 are listed on the RUC’s Multi-Specialty Points of Comparison (MPC) list, which further exacerbates the problem of creating an anomaly within this family.

Miscoding

Another important issue relevant to CPT 15732 that was raised by ASPS and AAO-HNS at the October 2010 Five-Year Review RUC meeting was substantial concern that CPT 15732 is being miscoded in the outpatient setting. CPT 15732 was also brought forward in the 2005 five-year review by CMS. As stated in the RUC database, following an ASPS survey and discussion at the RUC at that time, “it became apparent that this CPT code describes two disparate procedures, allowing both superficial repairs and repair of more serious cancer defects to be reported with 15732. These patient populations require different work, one group of patients are typically provided the service in the inpatient setting and the other group are treated in the outpatient setting. Plastic surgery will coordinate with otolaryngology and ophthalmology to develop a coding proposal to specifically identify these different services in new CPT codes. The RUC referred this code to the CPT Editorial Panel.” For CPT 2007, ASPS worked with the CPT Panel to create a new, primarily outpatient forehead flap code, CPT 15731 (Forehead flap with preservation of vascular pedicle) which has a work RVU of 14.38. Claims for the code by plastic surgeons and otolaryngologists are increasing with time as our educational efforts continue.

We believe further education on proper use of code 15732 is needed and intend to continue working with our ophthalmology and otolaryngology colleagues on this issue. That said, it is challenging enough for ASPS to educate plastic surgeons on ethical and accurate coding, and the organization does take this role very seriously. However, any expectation by CMS that plastic surgeons should “police” the coding practices of other medical specialties is completely unrealistic. For instance, we have only been able to obtain very limited information about the types of flaps being performed by
ophthalmologists that are billed with CPT 15732. A review of literature revealed an orbicularis oculi myocutaneous flap and other random flaps around the eyelid that we consider to be adjacent tissue transfers. These procedures do not involve a vascular pedicle and would be more accurately billed with the 14XXX CPT code series. At the October 2010 RUC meeting, ophthalmologists were encouraged to examine their reporting of this procedure, to consider creating a new CPT code, and/or to lead the education efforts related to 15732. ASPS does not have any authority to enforce that recommendation, yet it is our plastic surgeon members who will suffer an inappropriate payment cut for this procedure if the problem is left unaddressed. Any assistance that CMS could offer in this regard is welcome. At a minimum, it would be useful if the Agency could share more detailed claims information for the code. However, **while this effort is ongoing, we again believe it is inappropriate for CMS to devalue CPT 15732.**

We understand that refinement panels will be convened in late August to consider comments received on the proposed payment changes for 2012 including issues related to the Fourth Five-Year Review. ASPS requests that the refinement panels thoughtfully consider all of the recommendations requested above. We are more than willing to provide plastic surgeon representation for the refinement panels and look forward to receiving further information about this process.

We greatly appreciate your consideration of these comments. As always, we will continue to carefully monitor future correspondence on these and other relevant health care issues.

Sincerely,

Scott D. Oates, MD  
Chair, Coding and Payment Policy Committee

CC: Robert X. Murphy, Jr., MD, Board Vice President, Health Policy and Advocacy  
Martha S. Matthews, MD, RUC Advisor  
Melissa A. Crosby, MD, Alternate RUC Advisor