Summary of the Final Medicare 2013 Policy

Payment Changes for Physicians

CY 2013 Medicare Physician Fee Schedule Final Rule[1]

On November 1, 2012, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that would update payment policies and payment rates for services furnished under the Medicare Physician Fee Schedule (MPFS) on or after Jan. 1, 2013. The final rule also makes changes to several of the quality reporting initiatives that are associated with MPFS payments – the Physician Quality Reporting System (PQRS), the Electronic Prescribing (eRx) Incentive Program, and the PQRS-EHR Incentive Pilot – as well as changes to the Physician Compare tool on the Medicare.gov website. Finally, the rule includes regulations implementing the physician value-based payment modifier (Value Modifier) required by the Affordable Care Act that would affect payments to physician groups based on the quality and cost of care they furnish to beneficiaries enrolled in the traditional Medicare Fee-for-Service program.

The final rule with comment period also includes a statutorily required 26.5 percent across-the-board reduction to Medicare payment rates for more than 1 million physicians and non-physician practitioners under the Balanced Budget Act of 1997's Sustainable Growth Rate (SGR) methodology. This results in a conversion factor of $25.008. However, Congress has overridden the required reduction every year since 2003. The Administration is committed to fixing the SGR update methodology and ensuring these payment cuts do not take effect. Predictable, fiscally-responsible physician payments are essential for Medicare to sustain quality and lower health care costs over the long-term.

The final rule includes a new policy to pay a patient's physician or practitioner to coordinate the patient's care in the 30 days following a hospital or skilled nursing facility stay. Recognizing the work of community physicians and practitioners in treating a patient following discharge from a hospital or nursing facility will ensure better continuity of care for these patients and help reduce patient readmissions. The changes in care coordination payment and other changes in the rule are expected to increase payment to family practitioners by seven percent—and other primary care practitioners between three and five percent—if Congress averts the statutorily required reduction in Medicare's physician fee schedule.

CMS projects the combined impact on the specialty of Cardiology reflects a 2% decrease and interventional radiology a 3% decrease.

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Fee Schedule - Regulatory Impact Analysis

CY 2013 is the final year of the 4-year transition implementing the new PE RVUs using the Physician Practice Expense Information Survey (PPIS) data that were adopted in the CY 2010 PFS final rule with comment period. The PPIS is a multispecialty, nationally representative, PE survey of both physicians and nonphysician practitioners (NPPs) using a survey instrument and methods highly consistent with those of the SMS and the supplemental surveys used prior to CY 2010. In CY 2013, the final year of the transition, PE RVUs are calculated based on 100% of the new PE RVUs developed using the PPIS data.

For CY 2013, there are two specialties whose utilization data will be newly incorporated into rate setting. CMS will use proxy PE/HR values for these specialties by cross walking values from other specialties that furnish similar services as follows: Cardiac Electrophysiology from Cardiology; and Sports Medicine from Family Practice. These final changes are reflected in the "PE HR" file available on the CMS Website under the supporting data files for the CY 2013 PFS final rule at http://www.cms.gov/PhysicianFeeSched/.

Proposal Regarding Potentially Misvalued Services

CMS has been engaged in a vigorous effort over the past several years to identify potentially misvalued codes and when codes are found to be misvalued to revise the payment accordingly. CY 2011, CMS finalized a process for the public to recommend potentially misvalued codes to CMS. In addition to reviewing publicly nominated codes, CMS final two new categories of potentially misvalued codes for review: "Harvard-valued" CPT codes with Medicare annual allowed charges of $10 million or more; and services with stand alone practice expense procedure times.

Beginning for CY 2009, CMS and the AMA RUC have identified and reviewed a number of potentially misvalued codes on an annual basis based on various identification screens. This annual review of work and PE RVUs for potentially misvalued codes was supplemented by section 3134 of the Affordable Care Act, which requires the agency to periodically identify, review and adjust values for potentially misvalued codes with an emphasis on the following categories: (1) codes and families of codes for which there has been the fastest growth; (2) codes or families of codes that have experienced substantial changes in practice expenses; (3) codes that are recently established for new technologies or services; (4) multiple codes that are frequently billed in conjunction with furnishing a single service; (5) codes with low relative values, particularly those that are often billed multiple times for a single treatment; (6) codes which have not been subject to review since the implementation of the RBRVS (the so-called 'Harvard valued codes'); and (7) other codes determined to be appropriate by the Secretary.

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CY 2012 CMS finalized a process allowing the public to nominate codes for potential misvalue. In the 60 days following the release of the CY 2012 PFS final rule with comment period, CMS received nominations and supporting documentation for review of the codes. A total of 36 CPT codes were nominated. The majority of the nominated codes were codes for which CMS finalized RVUs in the CY 2012 PFS final rule. That is, the RVUs were interim in CY 2011 and finalized for CY 2012, or proposed in either the Fourth Five-Year Review of Work or the CY 2012 PFS proposed rule and finalized for CY 2012.

Specifically for the specialty of electrophysiology, CPT codes 33282 (Implantation of patient-activated cardiac event recorder) and 33284 (Removal of an implantable, patient-activated cardiac event recorder) were nominated for review as potentially misvalued codes. The commenter asserted that CPT codes 33282 and 33284 are misvalued in the nonfacility setting because these CPT codes currently are only priced in the facility setting even though physicians perform these services in the office setting. The commenter requested that CMS establish appropriate payment for the services when furnished in a physician office. Specifically, they requested that CMS establish nonfacility PE RVUs for these services. CMS does not consider the lack of pricing in a particular setting as an indicator of a potentially misvalued code. However, given that these services are now furnished in the nonfacility setting, CMS believes that CPT codes 33282 and 33284 should be reviewed to establish appropriate nonfacility inputs. CMS notes, as did the commenter, that the valuation of a service under the PFS in a particular setting does not address whether those services and the setting in which they are furnished are medically reasonable and necessary for a patient's medical needs and condition. CMS will review CPT codes 33282 and 33284 and request recommendations from the AMA RUC and other public commenters on the appropriate physician work RVUs (as measured by time and intensity), and facility and nonfacility direct PE inputs for these services.

Review of Harvard-Valued Services with Medicare Allowed Charges of $10,000,000 or More

For many years, CMS has been reviewing 'Harvard-valued' CPT codes through the potentially misvalued code initiative. The RVUs for Harvard-valued CPT codes have not been reviewed since they were originally valued in the early 1990s at the beginning of the PFS. While the principles underlying the relative value scale have not changed, over time the methodologies CMS uses for valuing services on the PFS have changed, potentially disrupting the relativity between the remaining Harvard-valued codes and other codes on the PFS. At this time, nearly all CPT codes that were Harvard-valued and had Medicare utilization of over 30,000 allowed services per year have been reviewed. Moving forward, CMS proposes to review Harvard-valued services with Medicare allowed charges of $10 million or greater per year. The CPT codes meeting these criteria have relatively low Medicare utilization (as CMS has reviewed the services with utilization over 30,000), but

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account for significant Medicare spending annually and have never been reviewed. CMS recognizes that several of the CPT codes meeting these criteria have already been identified as potentially misvalued through other screens and may currently be scheduled for review for CY 2013. CMS also recognizes that other codes meeting these criteria have been referred by the AMA RUC to the CPT Editorial Panel. In these cases, CMS is not proposing re-review of these already identified services, but for the sake of completeness, includes them as a part of this category of potentially misvalued services. The following codes relate to cardiovascular and interventional radiology services:

36215** Place catheter in artery
36245** Ins cath abd/l-ext art 1st

**Referred by the AMA RUC to the CPT Editorial Panel

Multiple Procedure Payment Reduction Policy

Medicare has a longstanding policy to reduce payment for the second and subsequent surgical procedures performed on the same patient by the same physician or physician group practice on the same day, largely based on presumed efficiencies in the practice expense (PE) and pre- and post-surgical physician work. For CY 2013, CMS proposed to apply a multiple procedure payment reduction policy to the technical component of certain cardiovascular and ophthalmology diagnostic services. CMS proposed to make full payment for the highest paid cardiovascular or ophthalmology diagnostic service and reduce the technical component payment for subsequent cardiovascular or ophthalmological diagnostic services furnished by the same physician or group practice to the same patient on the same day by 25 percent. After consideration of the public comments received, CMS adopted the CY 2013 proposal to apply an MPPR to the TC of diagnostic cardiovascular and ophthalmology services, with a modification to apply a 20 percent reduction for diagnostic ophthalmology services rather than the 25 percent reduction proposed. The reduction percentage for diagnostic cardiovascular services remains at 25 percent, as proposed. CMS continues to believe that efficiencies exist in the TC of multiple diagnostic cardiovascular and ophthalmology services and will continue to monitor code combinations for possible future adjustments to the reduction percentage applied through this MPPR policy. In summary, beginning in CY 2013 adopted a MPPR that applies a 25 percent reduction to the TC of second and subsequent diagnostic cardiovascular, and a 20 percent reduction to the TC of second and subsequent diagnostic ophthalmology services, furnished by the same physician (or physicians in the same group practice) to the same beneficiary , on the same day.

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The complete list of services subject to the MPPR for the TC of diagnostic cardiovascular and ophthalmology services is shown in Addendum X of the Final Rule.

Physician Incentive Programs

The final rule makes changes to several of the incentive programs that are associated with MPFS payments – electronic health records (EHRs), and the Physician Quality Reporting System (PQRS) – as well as changes to the Physician Compare tool on the Medicare.gov web site. These changes are summarized below.

Electronic Health Records Incentive Program

The Electronic Prescribing (eRx) Incentive Program is a reporting program that uses a combination of incentive payments and downward payment adjustments to encourage electronic prescribing by EPs. The program provides incentive payments through 2013 to individual EPs and group practices that are successful e-prescribers for covered professional (MPFS) services furnished to Medicare Part B fee-for-service beneficiaries (including Railroad Retirement Board and Medicare Secondary Payer). From 2012 through 2014, the program applies a payment adjustment to those EPs who are not successful electronic prescribers. For purposes of this program, EPs are identified on claims by their individual National Provider Identifier (NPI) and Tax Identification Number (TIN).

The requirements for the 2013 eRx incentive and 2014 eRx payment adjustment were established in the CY 2012 MPFS final rule with comment period. In the CY 2013 final rule:

- CMS implements new criteria for being a successful electronic prescriber for groups of 2-24 EPs using the eRx GPRO
- CMS implements two additional significant hardship exemptions to the 2013 and 2014 payment adjustments related to participation in the EHR Incentive Program
- CMS implements an informal review process

PQRS-MEDICARE ELECTRONIC HEALTH RECORDS (EHR) INCENTIVE PILOT

EPs, eligible hospitals, and CAHs that choose to participate in the Medicare and Medicaid EHR Incentive Programs are required to electronically submit clinical quality measure (CQM) results as calculated by certified EHR technology. Under the CY 2013 MPFS final rule, CMS will continue for CY

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2013 the attestation method and the Physician Quality Reporting System-Medicare EHR Incentive Pilot for reporting CQMs that was established in the CY 2012 MPFS final rule with comment period.

Physician Quality Reporting System

The Physician Quality Reporting System (PQRS) is a pay-for-reporting program that uses a combination of incentive payments and downward payment adjustments to promote reporting of quality information by eligible professionals (EPs). The program provides an incentive payment to EPs and group practices who satisfactorily report data on quality measures for covered professional services furnished to Medicare Part B fee-for-service beneficiaries during the applicable reporting period. Beginning in 2015, a payment adjustment applies to EPs who do not satisfactorily report data on quality measures for covered professional services. For purposes of this program, EPs are identified on claims by their individual National Provider Identifier (NPI) and Tax Identification Number (TIN).

In the CY 2013 MPFS final rule, CMS finalizes the following updates to the PQRS related to the 2013 and 2014 PQRS incentives and the 2015 and 2016 PQRS payment adjustments:

Summary of Final PQRS Measures: Over CYs 2013 and 2014, CMS includes a total of 264 individual measures that EPs can choose from, including regulations to align the PQRS measures that would be available for EHR-based reporting with the measures available for reporting under the EHR Incentive Program. In addition, CMS includes 26 measures groups for reporting. With respect to final measures for reporting via the Group Practice Reporting Option (GPRO) web-interface, CMS aligns these measures with the measures required under the Medicare Shared Savings Program.

Reporting PQRS Measures as Individual EPs:

Reporting PQRS Measures for the 2013 and 2014 PQRS Incentive: CMS implements criteria similar to the criteria for satisfactory reporting for the 2012 incentive. Notable final changes include:

- Criteria for reporting using the EHR-based reporting mechanism that would align with the reporting criteria for meeting the clinical quality measure (CQM) component of meaningful use for the Medicare EHR Incentive Program.

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- For the 12-month 2013 and/or 2014 incentive reporting period, decreasing the minimum threshold of patients on which EPs are required to report using measures groups via registry from 30 to 20.

Reporting PQRS Measures for the 2015 and 2016 PQRS Payment Adjustments:

- For the applicable payment adjustment reporting period, implement the following criteria for satisfactory reporting for the 2015 and/or 2016 payment adjustments: Report 1 PQRS measure or measures group.
- Implement option to elect using the final administrative claims-based reporting option for final set of administrative claims-based measures.

Reporting PQRS Measures as a Group Practice under the Group Practice Reporting Option (GPRO):

Definition: CMS is expanding the definition of group practice to include groups of 2-24 EPs,

Reporting PQRS Measures for the 2013 and 2014 PQRS Incentives:

- CMS is expanding the use of the claims, registry, and EHR-based reporting mechanisms to groups of 2-99 EPs, in addition to groups of 25 or more EPs.
- CMS will use an assignment methodology similar to the one used under the Medicare Shared Savings Program for groups that report using the GPRO web-interface.

Reporting PQRS Measures for the 2015 and 2016 PQRS Payment Adjustments:

- CMS is allowing group practices to elect using the final administrative claims-based reporting option.

Medicare Shared Savings Program:

- CMS is finalizing the satisfactory reporting criteria for the Physician Quality Reporting System payment adjustment that would apply to EPs within group practices in accountable care organizations (ACOs) under the Medicare Shared Savings Program.

PHYSICIAN COMPARE WEBSITE

Section 10331 of Affordable Care Act requires CMS to implement a plan for making information on physician performance publicly available no later than Jan. 1, 2013. This provision supports CMS's overarching goals of providing consumers with quality of care information to make informed decisions about their health care, while encouraging clinicians to improve the quality of the care

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they provide to their patients. In the 2012 MPFS final rule, CMS finalized a plan to report performance rates for group practices participating in the 2012 Physician Quality Reporting System GPRO on the Physician Compare website.

The CY 2013 final rule outlines the next phase of the plan to publicly report physician performance information on Physician Compare. In this next phase, CMS will post performance rates on the quality measures submitted by group practices participating in the Physician Quality Reporting System GPRO and ACOs participating under the Medicare Shared Savings Program, respectively, where technically feasible, starting with measures submitted in 2013. CMS will post patient experience survey data - such as the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) - for group practices participating in the PQRS GPRO and ACOs participating in the Medicare Shared Savings Program, starting with survey data for 2013.

Value-Based Payment Modifier and The Physician Feedback Program

Background: Section 1848(p) of the Act, as established by section 3007 of the Affordable Care Act, requires the Secretary of Health and Human Services ("Secretary") to establish a Value Modifier that provides for differential payment to a physician or group of physicians under the MPFS based upon the quality of care furnished to Medicare beneficiaries compared to the cost of that care during a performance period. Further, the statute requires the Secretary to begin applying the Value Modifier on Jan. 1, 2015, with respect to items and services furnished by specific physicians and groups of physicians (as determined by the Secretary of the Department of Health and Human Services) and to apply it to all physicians and groups of physicians beginning not later than Jan. 1, 2017. The statute also requires that the Value Modifier be implemented in a budget neutral manner meaning that upward payment adjustments for high performance will balance the downward payment adjustments applied for poor performance.

IMPLEMENTING THE VALUE MODIFIER

In developing its proposals for the Value Modifier, CMS has focused on providing physicians choices as to how their quality of care will be measured and how their payments will be adjusted. Physician groups can avoid all negative adjustments simply by participating in the PQRS. Physicians seeking to be paid according to their measured cost and quality may elect to do so for 2015. CMS' proposals are also designed to align with other CMS quality initiatives to reduce the burden of submitting information, and promote shared physician accountability for beneficiaries.

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Performance Period

CMS previously established CY 2013 as the performance period for the determination of the Value Modifier to be applied in CY 2015 and will use CY 2014 as the performance period for the Value Modifier to be applied in CY 2016. CMS will apply the Value Modifier at the Tax Identification Number (TIN) level to items and services paid under the MPFS to physicians under that TIN. This means that if a physician moves from one group to another between the performance period (2013) and the payment adjustment period (2015), the physician's payment will be adjusted based on the Value Modifier earned by the TIN where the physician is practicing in 2015.

Final Election on How the Value Modifier is Calculated for 2015

In this first phase of implementation, CMS is finalizing that groups of physicians with 25 or more eligible professionals would be included in the Value Modifier framework. These groups, however, would have options, depending upon whether they satisfactorily report under the PQRS, regarding how their Value Modifier would be calculated for CY 2015 payment.

Proposals for Measuring Quality of Care and Cost in the Value Modifier

The law requires CMS to measure quality of care furnished as compared to cost using composites of appropriate quality and cost measures. In the MPFS final rule for CY 2012, CMS adopted both a total per capita cost measure for all beneficiaries, as well as four total per capita cost measures for beneficiaries with certain chronic conditions (chronic obstructive pulmonary disease, heart failure, coronary artery disease, and diabetes) to be used under the Value Modifier.

To obtain the quality data, CMS is finalizing that groups of physicians with 25 or more eligible professionals satisfactorily submit data using one of the final PQRS quality reporting mechanisms for groups of physicians: (1) a common set of quality measures based on clinical data and that focus on preventive care and care for prevalent and costly chronic conditions in the Medicare population; (2) quality measures of their own selection that they report through claims, registries, or EHRs, or (3) a common set of quality measures that focus on preventive care and care for chronic conditions that CMS would calculate from administrative claims data that require no action for the physician group beyond notifying CMS that the group elects this option.

Additionally, CMS is finalizing to assess each such group of physicians with 25 or more eligible professionals on quality measures relating to reducing potentially preventable hospital admissions

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for specific chronic and acute conditions, reducing hospital readmission rates, and increasing the frequency of hospital post-discharge visits.

Value Modifier Payment Adjustments

To balance the goals of beginning the implementation of the Value Modifier in a way that is consistent with the legislative requirements and to give CMS and the physician community experience in its operation, CMS will separate groups of physicians into two categories. The first category will include those groups of physicians that have met the criteria for satisfactory reporting for an incentive under the options available to groups of physicians under the PQRS Group Practice Reporting Option. In addition, this category includes groups that elect the new PQRS administrative claims-based reporting option. CMS will set the Value Modifier at 0.0 percent for these groups of physicians, meaning that the Value Modifier would not affect their payments under the MPFS, unless such groups of physicians elect the further evaluation of quality and cost of care described below.

CMS will provide groups of physicians that are satisfactory PQRS reporters with the choice of having their value-based payment modifier calculated using a quality tiering approach. Choosing this option would allow these groups of physicians to earn an upward payment adjustment for high performance (high-quality tier and low-cost tier), and be at risk for a downward payment adjustment for poor performance (low-quality tier and high-cost tier). In 2013, CMS will provide Physician Feedback reports to groups of physicians with 25 or more eligible professionals that preview their Value Modifier (based on 2012 data), prior to the deadline for electing the quality-tiering approach.

The second final category would include those groups of physicians with 25 or more eligible professionals that have not met the PQRS satisfactory reporting criteria identified above, including those groups that do not submit any data on quality measures. Because CMS would not have quality measure performance rates on which to assess the quality of care furnished by these groups of physicians, CMS will set their Value Modifier at -1.0 percent. This downward payment adjustment for the 2015 Value Modifier would be in addition to the -1.5 percent payment adjustment that is required under the PQRS for failing to meet the satisfactory reporting criteria. Groups of physicians with 25 or more eligible professionals that fail to meet the PQRS satisfactory reporting criteria would, therefore, be subject to downward adjustments during 2015 of 1.5 percent (for not being a satisfactory reporter under the PQRS) and 1.0 percent (for the Value Modifier).

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Physician Feedback Reports

Since 2010, CMS has provided confidential Physician Feedback reports to certain physicians and groups of physicians. The reports quantify and compare the quality of care furnished and costs among physicians and physician group practices, relative to the performance of their peers. Starting in 2013, CMS anticipates using these reports to inform groups of physicians about their Value Modifier score.

In September, 2011, CMS provided Physician Feedback reports (also known as "Quality and Resource Use Reports") to the 35 large medical group practices (each with 200 or more physicians) that participated in the Physician Quality Reporting System Group Practice Reporting Option in 2010. In March 2012, CMS disseminated feedback reports to 23,730 individual Medicare fee-for-service physicians in Iowa, Kansas, Missouri, and Nebraska. The individual physician reports, in summary, showed that approximately 20 percent of beneficiaries received care from multiple physicians without a single physician directing their overall care, based on proportion of visits or costs. These beneficiaries were also the highest risk and highest cost populations. CMS believes the policies for the Value Modifier encourage high quality and less fragmented care for these beneficiaries.

CMS intends to include episode-based cost measures for several conditions in the Physician Feedback reports. CMS is studying how "episode groupers" that would connect all claims for a beneficiary during a certain timeframe may be used in the reports and will seek input from stakeholders on the development and use of episode groupers before phasing these measures into the Value Modifier.

New 2013 CPT Codes

New Bundled Codes for Upper Extremity Angiography with Catheter Placement
These codes have been replaced by 8 combination codes 36211-36228 which include the work of accessing the vessel, placement of catheter(s), contrast injection, fluoroscopy, radiological supervision and interpretation, and closure of the arteriotomy by pressure or application of an arterial closure device. Codes 33222-33228 are unilateral codes therefore when performed bilaterally a -50 modifier would be applied. Code 33221 is described as unilateral or bilateral so a 50 modifier would not be appropriate.

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There is a parenthetical note that has been added to 37215-37216 CAS codes which reads "Do not report 36222-36224 for treated carotid artery" Therefore the same guidelines as in the past apply that diagnostic angiography performed on same side as carotid stent is not separately billable.

Codes 36221-36226 are base codes to report the cath placement and angiography performed. These codes are based on progressive hierarchies with more intensive services inclusive of less intensive services. Only one code in range of 36222-36224 may be reported for ipsilateral carotid territory. And only one code in range of 36225-36226 may be reported for each ipsilateral vertebral territory. There are 2 add-on codes which represent additional diagnostic imaging of branches in external carotid 36227 and internal or vertebral 36228.

CPT codes 36221 through 32668 were identified as potentially misvalued through the Codes Reported Together 75 percent or More screen. For CY 2012, the AMA RUC requested that the CPT Editorial Panel create eight new codes to bundle selective catheter placement with radiological supervision and interpretation, including angiography.

<u>CPT code 36221(Non-selective catheter placement, thoracic aorta, with angiography of the extracranial carotid, vertebral, and/or intracranial vessels, unilateral or bilateral, and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed)</u> After clinical review CMS assigned a work RVU of 4.17 to appropriately capture the work of the service, with refinement of 30 minutes to the post-service time. The AMA RUC reviewed the survey results, and after a comparison to similar CPT codes, recommended a value of 4.51 work RVUs and a post-service time of 40 minutes. The AMA RUC used a direct crosswalk to the two component codes being bundled, CPT code 32600 (Introduction of catheter, aorta) (work RVU = 3.02) and CPT code 75650 (Angiography, cerviocerebral, catheter, including vessel origin, radiological supervision and interpretation) (work RVU=1.49) and the recommended value of 4.51 is the sum of the RVUs for these component codes. CMS disagreed with the AMA RUC noting that it believes that that there are efficiencies gained when services are bundled. CMS believes crosswalking to the work RVU of CPT code 32550 (Insertion of indwelling tunneled pleural catheter with cuff), which has a work RVU of 4.17, appropriately accounts for the physician time and intensity with CPT code 36221. Additionally, CMS believes that the survey post-service time of 30 minutes more accurately accounts for the time involved in furnishing this service than the AMA RUC recommended post-service time of 40 minutes. Therefore, CMS assigned a work RVU of 4.17 with refinement to time for CPT code 36221 on an interim final basis for CY 2013.

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CPT code 36222 ((Non-selective catheter placement, thoracic aorta, with angiography of the extracranial carotid, vertebral, and/or intracranial vessels, unilateral or bilateral, and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed)
After clinical review CMS believes the survey 25th percentile work RVU of 5.53 appropriately captures the work of this service, particularly the efficiencies when two services are bundled together. The AMA RUC recommended the survey median work RVU of 6.00. Like CPT code 36221, CMS believes the survey post-service time of 30 minutes is more appropriate than the AMA RUC-recommended post-service time of 40 minutes. CMS assigned a work RVU of 5.53 with refinement to time for CPT code 36222 as interim final for CY 2013.

CPT code 36223(Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed)
CMS believes a work RVU value of 6.00, the survey 25th percentile value, appropriately captures the work of the service, particularly efficiencies when two services are bundled together. The AMA RUC reviewed the survey results, and after a comparison to similar CPT codes, recommended a work RVU of 6.50. Like many of the other CPT codes in this family, CMS believes the survey post-service time of 30 minutes is more appropriate than the AMA RUC-recommended time of 40 minutes. CMS assigned a work RVU of 6.00 with refinement to time for CPT code 36223 as interim final for CY 2013.

CPT code 36224(Selective catheter placement, internal carotid artery, unilateral, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed)
CMS believes a work RVU of 6.50, the survey 25th percentile value, appropriately captures the work of the service, particularly efficiencies when two services are bundled together. CMS believes 30 minutes of post-service times more appropriately accounts for the work of this service. The AMA RUC reviewed the survey results, and after a comparison to similar CPT codes, recommended a value of 7.55 and a post-service time of 40 minutes for CPT code 36224. Accordingly, CMS assigned a work RVU of 6.50 with refinement to time for CPT code 36224 as interim final for CY 2013.

CPT code 36225 (Selective catheter placement, subclavian or innominate artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed)

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CMS believes that this code should be valued the same as the CPT code 36223, to which CMS assigns a work RVU of 6.00. Comparable to CPT code 36223, CMS believes 30 minutes of post-service times more appropriately accounts for the work of this service. The AMA RUC reviewed the survey results and recommended the survey median work RVU of 6.50 and a post-service time of 40 minutes for CPT code 36225. CMS assigned a work RVU of 6.00 with refinement to time for CPT code 36225 as interim final for CY 2013.

CPT code 36226 (Selective catheter placement, vertebral artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed)

CMS believes that this CPT code should be valued the same as CPT code 36224, which has a work RVU as 6.50. Comparable to CPT code 36224, CMS believes 30 minutes of post-service times more appropriately accounts for the work of this service. The AMA RUC reviewed the survey results, and after a comparison to similar CPT codes, recommended a value of 7.55 and a post-service time of 40 minutes for CPT code 36226. CMS assigned a work RVU of 6.50 with refinement to time for CPT code 36226 as interim final for CY 2013.

CPT code 36227 (Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (list separately in addition to code for primary procedure)

CMS determined that there are efficiencies gained when services are bundled, and identified a work RVU of 2.09 for this service. This work RVU reflects the application of a very conservative estimate of 10 percent for the work efficiencies that CMS would expect to occur when multiple component codes are bundled together to the sum of the work RVUs for the component codes. The AMA RUC reviewed the survey results, and after a comparison to similar CPT codes, recommended a value of 2.32 for CPT code 36227. The AMA RUC used a direct crosswalk to the two component codes being bundled, CPT code 36218 (Selective catheter placement, arterial system; additional second order, third order, and beyond, thoracic or brachiocephalic branch, within a vascular family (list in addition to code for initial second or third order vessel as appropriate) (work RVU= 1.01) and CPT code 75660 (Angiography, external carotid, unilateral, selective, radiological supervision and interpretation) (work RVU = 1.31). CMS assigned a work RVU of 2.09 as the interim final value of CPT code 36227 for CY 2013.

New Bundled Codes for Coronary Interventions

2012 coronary interventional codes 92980-92996 have been deleted. A total of 6 codes deleted.

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Code 92973 for thrombectomy has been revised to include "mechanical" in the descriptor to distinguish mechanical thrombectomy from non-mechanical aspiration thrombectomy. Non-mechanical aspiration thrombectomy is included in new PCI codes and not separately billable.

The 8 deleted codes have been replaced by 13 new codes. The code structure has changed significantly. The new code language bundles into the base code the lower level intervention. So there are codes for angioplasty alone, atherectomy including angioplasty, stent including angioplasty, and stent including atherectomy and angioplasty.

In the current (CY 2012) coding structure, CPT code 92980 describes the placement of a coronary stent in a single vessel, and add-on CPT code 92981 describes placement of a stent in each additional vessel. As currently described, a single vessel includes one artery and all its branches. Under this coding convention, if a physician placed a stent in one artery and one branch to that artery, the physician would bill only CPT code 92980. If that physician placed a stent in one artery and one branch of that artery, then went on to place a stent in a second artery and one branch of that artery, the physician would bill CPT code 92980 along with add-on CPT code 92981. The CY 2013 coding structure creates more codes and more granular coding. For CY 2013, the placement of a stent in an artery is billed using a base code, and the placement of a stent in a branch of that artery is billed using an add-on code. Stenting each new artery is billed using a new base code and stenting each branch is billed using an add-on to that base code. If a physician placed a stent in one artery and one branch of that artery, and then went on to place a stent in a second artery and one branch of that second artery, the physician would bill two base code/add-on pairs.

The CPT Panel made similar changes to the current codes for angioplasty and atherectomy and added new codes for atherectomy with stenting, any revascularization of a coronary artery bypass graft, and any revascularization procedure through a chronic total occlusion of any coronary artery or graft. The CPT Panel created a separate base code for each procedure for each new artery and an add-on code for each branch within that artery. Finally, the CPT Panel created a new code for any revascularization procedure for an acute coronary artery occlusion during an acute myocardial infarction. This final code does not have an add-on code. CMS believes that this revised coding structure represents a CPT trend toward identifying greater granularity in codes describing the most intense and difficult work. Bundling is one method for structuring payment that can improve payment accuracy and efficiency. CMS believes that unbundling the placement of branch-level stents in a fee-for-service system may encourage increased placement of stents. To eliminate that incentive, on an interim final basis for CY 2013, CMS is rebundling the work associated with the placement of a stent in an arterial branch into the base code for the placement of a stent in an artery.

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Specifically, CMS is bundling as follows:

- CPT code 92921 (Percutaneous transluminal coronary angioplasty; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)) into CPT code 92920 (Percutaneous transluminal coronary angioplasty; single major coronary artery or branch);
- CPT code 92925 (Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)) into CPT code 92924 (Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; single major coronary artery or branch);
- CPT code 92929 (Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)) into CPT code 92928 (Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch);
- CPT code 92934 (Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)) into CPT code 92933 (Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch);
- CPT code 92938 (Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; each additional branch subtended by the bypass graft (list separately in addition to code for primary procedure)) into CPT code 92937 (Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel); and
- CPT code 92944 (Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; each additional coronary artery, coronary artery branch, or bypass graft (list separately in addition to code for primary procedure)) into CPT code 92943 (Percutaneous transluminal

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revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; single vessel).

To bundle the work of each new add-on code into its respective base code, CMS used the AMA RUC-recommended utilization crosswalk to determine what percentage of the base code utilization would be billed with the add-on code, and added that percentage of the add-on code AMA RUC-recommended work RVU to the base code AMA RUC-recommended work RVU. For example, the AMA RUC estimated that CPT code 92920 would have 26,848 Medicare allowed services in CY 2013, and that corresponding add-on CPT code 92921 would have 7,368 Medicare allowed services in CY 2013. Therefore, the AMA RUC estimates that CPT code 92920 will be billed without add-on CPT code 92921 for 73 percent of the Medicare allowed services, and that CPT code 92920 will be billed with add-on CPT code 92921 for 27 percent of the allowed services (7,368/26,848). To account for the additional work involved in 27 percent of the allowed services, CMS added a work RVU of 1.10 (27.44 percent of a work RVU of 4.00 for CPT code 92921) to the work RVU of 9.00 for CPT code 92920, to get to a work RVU of 10.10 for the combined service. CMS followed this methodology to establish the combined work RVUs for all the new base code/add-on code pairs. Based this methodology, CMS assigned the following interim final work RVUs for CY 2013: a work RVU of 10.10 to CPT code 92920; a work RVU of 11.99 to CPT code 92924; a work RVU of 11.21 to CPT code 92928; a work RVU of 12.54 to CPT code 92933; a work RVU of 11.20 to CPT code 92937; and a work RVU of 12.56 to CPT code 92943.

On an interim final basis for CY 2013, add-on CPT codes 92921, 92925, 92929, 92934, 92938, and 92944 will have a PFS procedure status indicator of B (Bundled code. Payments for covered services are always bundled into payment for other services, which are not specified. If RVUs are shown, they are not used for Medicare payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are bundled) and will not be separately payable.

CMS did not use this methodology directly to establish a work RVU for CPT code 92941 (Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel), which does not have a specific corresponding add-on code. After reviewing this service alongside the other services in this family, like the AMA RUC, CMS believes CPT code 92941 should have the same work RVU as CPT code 92943 to preserve the appropriate rank order of the services in this family. CMS is assigning a work RVU of 12.56 to CPT code 92943. Therefore, on an interim final basis for CY 2013 CMS is assigning

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a work RVU of 12.56 to CPT code 92941, with the AMA RUC-recommended intra-service time of 70 minutes.

New Bundled Codes for EP Study and Transcatheter Ablation

CPT codes 93651 and 93652 were identified as potentially misvalued through the Codes Reported Together 75 percent or More screen. The CPT Editorial Panel deleted CPT codes 93651 and 93652, and replaced them with new CPT codes 93653 through 93657 for CY 2013.

CMS reviewed new CPT codes

- 93653 (Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording, his recording with intracardiac catheter ablation of arrhythmogenic focus; with treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry),
- 93654 (Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording, his recording with intracardiac catheter ablation of arrhythmogenic focus; with treatment of ventricular tachycardia or focus of ventricular ectopy including intracardiac electrophysiologic 3d mapping, when performed, and left ventricular pacing and recording, when performed), and
- 93656 (Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with atrial recording and pacing, when possible, right ventricular pacing and recording, his bundle recording with intracardiac catheter ablation of arrhythmogenic focus, with treatment of atrial fibrillation by ablation by pulmonary vein isolation).

CMS believes that the survey 25th percentile work RVUs of 15.00 for CPT code 93653, 20.00 for CPT code 93654, and 20.02 for CPT code 93656 accurately account for the work involved in furnishing these services. The AMA RUC recommended these values as well, with 180 minutes of intra-service time for CPT code 93653, and 240 minutes of intra-service time for CPT codes 93654 and 93656. CMS agreed with these values. Accordingly, CMS is assigning a work RVU of 15.00 for CPT code 93653, a work RVU of 20.00 for 93654, and a work RVU of 20.02 for CPT code 93656, with no refinements to the AMA RUC-recommended time, on an interim final basis for CY 2013.

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After reviewing CPT codes

- 93655 (Intracardiac catheter ablation of a discrete mechanism of arrhythmia which is distinct from the primary ablated mechanism, including repeat diagnostic maneuvers, to treat a spontaneous or induced arrhythmia (list separately in addition to code for primary procedure)) and
- 93657 (Additional linear or focal intracardiac catheter ablation of the left or right atrium for treatment of atrial fibrillation remaining after completion of pulmonary vein isolation (list separately in addition to code for primary procedure)),

CMS believes these CPT codes have a very similar level of intensity as their related base codes: CPT codes 93653, 93654, and 93656. CPT codes 93653, 93654, and 93656 are all valued at 5.00 RVUs per 1 hour of intraservice time. CMS believes this is the appropriate increment for CPT codes 93655 and 93657 as well, which include 90 minutes of intra-service time. Therefore, CMS believes that a work RVU of 7.50 accurately accounts for the work of these services and reflects the appropriate relativity within this family of CPT codes. The AMA RUC recommended a work RVU of 9.00 for CPT code 93655 and a work RVU of 10.00 for CPT code 93657. CMS is assigning a work RVU of 7.50 to CPT codes 93655 and 93657 with no refinements to the AMA RUC-recommended time, on an interim final basis for CY 2013.

New Codes for Transcatheter Aortic Valve Replacement (TAVR)

The 4 Cat III codes (0256T through 0259T) were deleted. 9 new (33361 through 33369) Cat I codes were created based on approach and whether cardiopulmonary bypass support was used. Approach codes are defined as percutaneous femoral, open – femoral, axillary, iliac or transaortic. These new Cat I codes include the work, when performed of percutaneous access, placing the access sheath, balloon aortic valvuloplasty, advancing the valve delivery system into position, repositioning the valve as needed, deploying the valve, temporary pacemaker insertion for rapid pacing and closure of arteriotomy when performed.

There are three add-on codes that when performed in conjunction with base codes may be reported 33367 percutaneous peripheral bypass, 33368 open peripheral bypass, 33369 central bypass.

Like their predecessor Category III codes (0256T through 0259T), the new Category I CPT codes 33361 through 33365 require the work of an interventional cardiologist and cardiothoracic surgeon to jointly participate in the intra-operative technical aspects of TAVR as co-surgeons. Claims processing instructions for the CED (CR 7897 transmittal 2552) require each physician to bill with modifier-62 indicating that co-surgery payment applies. Medicare pays each co-surgeon 62.5 percent of the fee

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schedule amount. The three add-on cardiopulmonary bypass support services (CPT codes 33367 through 33369) are only reported by the cardiothoracic surgeon; therefore the AMA RUC-recommended work RVUs for those services reflect only the work of one physician. The AMA RUC-recommended work RVUs for each of the co-surgery CPT codes (33361 through 33365) reflect the combined work of both physicians, irrespective of the cosurgery payment policy. CMS debated whether it was appropriate to continue the co-surgery payment policy at 62.5 percent of the physician fee schedule amount for each physician for these codes if the work value reflected 100 percent of the work for two physicians. Ultimately, CMS decided to set work RVU values to reflect the total physician work of the procedures, and to continue to follow the co-surgery payment policy allowing the services to be billed by two physicians, in part because co-surgery is a requirement under Medicare policy for these services. CMS is not sure this is the appropriate long-term payment policy. CMS intends to reassess payment for this family of codes when it reviews national coverage for TAVR. For the time package, the AMA RUC accounted for the time each physician separately spends obtaining consent and reviewing the procedure with the patient. CMS is concerned that time for each physician to obtain consent and review the procedure with the patient is inconsistent with a framework for valuing the service as a single service.

After clinical review of CPT code 33361 (Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach), CMS believes that the specialty society survey 25th percentile work RVU of 25.13 appropriately captures the total work of the service. The AMA RUC recommended the survey median work RVU of 29.50. Regarding physician time, for CPT 33361, as well as CPT codes 33362 through 33364, CMS believes 45 minutes of pre-service evaluation time, which is the survey median time, is more consistent with the work of this service than the AMA RUC-recommended pre-service evaluation time of 50 minutes. Accordingly, CMS is assigning a work RVU of 25.13 to CPT code 33361, with a refinement of 45 minutes of pre-service evaluation time, on an interim basis for CY 2013.

After clinical review of CPT code 33362 (Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open femoral artery approach), CMS believes that the specialty society survey 25th percentile work RVU of 27.52 appropriately captures the total work of the service. The AMA RUC recommended the survey median work RVU of 32.00. Like CPT code 33361, CMS also believes 45 minutes of pre-service evaluation time is more appropriate for this service than the AMA RUC-recommended preservice evaluation time of 50 minutes. Accordingly, CMS is assigning a work RVU of 27.52 to CPT code 33362, with a refinement to 45 minutes of pre-service evaluation time, on an interim basis for CY 2013.

After clinical review of CPT code 33363 (Transcatheter aortic valve replacement (TAVR/TAVI)

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with prosthetic valve; open axillary artery approach), CMS believes that the specialty society survey 25th percentile work RVU of 28.50 appropriately captures the total work of the service. The AMA RUC reviewed the survey results and recommended the survey median work RVU of 33.00. Like CPT codes 33361 and 33362, CMS also believes 45 minutes of pre-service evaluation time is more appropriate for this service than the AMA RUC-recommended time of 50 minutes. Accordingly, CMS is assigning a work RVU of 28.50 to CPT code 33363, with a refinement to 45 minutes of pre-service evaluation time, on an interim basis for CY 2013.

After clinical review of CPT code 33364 (Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open iliac artery approach), CMS believes that the specialty society survey 25th percentile work RVU of 30.00 more appropriately captures the total work of the service. The AMA RUC reviewed the survey results and recommended the survey median work RVU of 34.87. Like CPT codes 33361 through 33363, CMS also believes 45 minutes of pre-service evaluation time is more appropriate for this service than the AMA RUC-recommended time of 50 minutes. Accordingly, CMS is assigning a work RVU of 30.00 to CPT code 33364, with a refinement to 45 minutes of pre-service evaluation time, on an interim basis for CY 2013.

After clinical review of CPT code 33365 (Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach (eg, median sternotomy, mediastinotomy), CMS believes a work RVU of 33.12 accurately reflects the work associated with this service. The AMA RUC reviewed the survey results and recommended the survey median work RVU of 37.50. After clinical review, CMS determined that the work associated with this service is very similar to reference CPT code 33410 (Replacement, aortic valve, with cardiopulmonary bypass; with stentless tissue valve) (work RVU = 46.41), which has a 90-day global period that includes inpatient hospital and office visits. Because CPT code 33365 has a 0- day global period that does not include post-operative visits, CMS calculated the value of the preoperative and post-operative visits in the global period of CPT code 33410, which totaled 13.29 work RVUs, and subtracted that from the total work RVU of 46.41 for CPT code 33410 to determine the appropriate work RVU for CPT code 33365. With regard to time, CMS decided to maintain the 50 minutes of pre-service evaluation time because it believes that the procedure described by CPT code 33365 involves more pre-service evaluation time since it is performed by surgically opening the chest via median sternotomy. Accordingly, CMS is assigning a work RVU of 33.12 for CPT code 33365 on an interim basis for CY 2013.

CPT codes 33405, 33430, and 33533 were identified as potentially misvalued through the High Expenditure Procedure Code screen. When reviewing these services, the specialty society utilized data from the Society of Thoracic Surgeons (STS) National Adult Cardiac Database in developing

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recommended times and RVUs for CPT codes 33405 (Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve), 33430 (Replacement, mitral valve, with cardiopulmonary bypass), and 33533 (Coronary artery bypass, using arterial graft(s); single arterial graft), and did not conduct a survey of physician work and time. After reviewing the mean procedure times for these services in the STS database alongside other information relating to the value of these services, the specialty society and AMA RUC concluded that CPT codes 33405 and 33430 are valued appropriately and that the current work RVUs of 41.32 for CPT code 33405, and 50.93 for CPT code 33430 should be maintained. After reviewing the mean procedure time for CPT code 33533 in the STS database alongside other information relating to the value of the service, the specialty society and AMA RUC concluded that the work associated with CPT code 33553 had increased since this service was last reviewed. The AMA RUC recommended a work RVU of 34.98 for CPT code 33533, which is a direct crosswalk to CPT code 33510 (Coronary artery bypass, vein only; single coronary venous graft).

CMS believes the STS database, which captures outcome data in addition to time and visit data, is a useful resource in the valuation of PFS services. However, the AMA RUC recommendations on these services show only the STS database mean time for CPT codes 33405, 33430, and 33533. CMS is interested in seeing the distribution of times, including the 25th percentile, median, and 75th percentile values (which are the data points reported on the specialty society surveys), in addition to any other information STS believes would be relevant to the valuation of the services, such as case-mix, or time data for similar services. The STS database is a robust source of information and CMS believes it would be helpful to review additional data points for these three services beyond the mean time provided by the AMA RUC. In order to complete our clinical review of these services, CMS would like to see the distribution of procedure times for CPT codes 33405, 33430, and 33533. CMS is also interested in more information on the methodology used to develop the recommended work RVUs based on the time data, and, using that methodology, the different RVUs that correspond to the 25th percentile, median, and 75th percentile time data.

For CY 2013 CMS is maintaining the current work RVUs for these services on an interim basis. CMS will consider additional time and other data submitted in response to comments on this final rule with comment period in the CY 2014 PFS final rule with comment period. Specifically, CMS is maintaining a work RVU of 41.32 for CPT code 33405; a work RVU of 50.93 for CPT code 33430; and a work RVU of 33.75 for CPT code 33533.

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