Submitter : **Maggie Tinsman** **Date: 08/21/2006**

Organization : **Maggie Tinsman**

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1512-PN-2134-Attach-1.DOC

2134

Maggie Tinsman
Iowa State Senator
3541 East Kimberly Road
Davenport, IA 52807
563-359-3624

Committees
Appropriations
Human Resources
Judiciary
State Government
Health and Human Services
Appropriations Subcommittee,
Co-Chair

August 21, 2006

The Honorable Mark B. McClellan, MD, PhD
Administrator
Centers of Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1512-PN
PO Box 8014
Baltimore, MD 21244-8014

Dear Dr. McClellan:

As Co-chair of Iowa's Health and Human Service Appropriations Committee, I am writing to express my concern regarding the suggested cuts to reimbursement for screening technologies. Because access to high quality health care is a critical part of Iowa's health agenda, we, in Iowa, are deeply concerned that these cuts will have dramatic and far-reaching implications for women's health.

We note that significant cuts are proposed to central DXA for osteoporosis and to Computer Aided Detection (CAD) for mammography in a proposed rule affecting the Physician Fee Schedule, published in late June (CMS-1512-PN, RIN 0938-AO12, Medicare Program; Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology). I hope that you and your colleagues will respond seriously to our concerns, described below.

Breast Cancer Screening: Because breast cancer remains the second leading cause of cancer deaths among American women, we strongly support CMS' efforts to promote breast cancer screening by spreading awareness of its benefits. Indeed, we know that newer technologies offer very important benefits for women—since these technologies assist radiologists to find more cancers, and at ever-earlier stages of disease progression.

We, therefore, are shocked that your proposed reimbursement cuts target the very technology that has proven its ability to increase early detection of breast cancer. In fact, CMS proposes to cut CAD as an adjunct to mammography by more than 50 percent over four years. This is unacceptable – and inexplicable – given that the FDA, upon approving CAD in 2000, said that the use of CAD could increase early detection of cancer by as much as 20%. The American Cancer Society agreed, and the use of CAD has grown significantly. In fact, in our community, many radiologists refuse to read a mammogram without CAD.

Osteoporosis Screening: There is no question that osteoporosis affects millions of women in this country – and our numbers will continue to increase as our population ages. Early diagnosis is essential to preventing early disability and death and women diagnosed early in disease progression now have effective treatments available that can keep them healthy for much longer. Needless to say, this saves the health care industry—and our families—substantial amounts of money each year.

Early detection is possible through screening for bone mineral density, which has been recommended in the strongest terms by the US Preventive Services Task Force and the Surgeon General. Central DXA is the only technology recognized as authoritative by standard setting organizations for the diagnosis of osteoporosis. It is also the modality of choice for three-quarters of the screening done annually for osteoporosis.

We, therefore, are distressed that CMS would propose to cut reimbursement for central DXA performed in doctors' offices by 75 percent and, in addition, to cut Vertebral Fracture Assessment (a spine imaging that detects the tiny fractures that may be early indicators of osteoporosis) by 50 percent. How will we encourage older women—including "baby boom" women and seniors – who are most at risk, to get screened without reimbursement? Indeed, CMS should be encouraging such screening in every way possible – since screening rates are dismally low – probably below 25 percent of the Medicare population, for example.

We are hard pressed to understand why CMS would propose such cuts—which certainly will discourage older women from getting screened and would, inevitably, result in even more frail elderly women, and men.

I do believe that Senator Charles Grassley has been extremely supportive of both these programs. As you know, Iowa has a very large senior population so these particular programs are essential. Further, I believe that Iowans that can afford to pay for their own screening will do that whenever possible. It is the thousands of women who are low income that will not be served. We are grateful for your efforts to promote disease prevention, and hope that you will reconsider these proposed cuts in reimbursement for central DXA and for CAD as an adjunct to mammography. Instead, please ensure that these technologies remain available to women. You will be saving women's lives.

Sincerely,

Maggie Tinsman
Iowa State Senator

cc: Senator Charles Grassley

Submitter : Mr. Terry Wicks **Date:** 08/21/2006

Organization : American Association of Nurse Anesthetists

Category : Health Care Professional or Association

Issue Areas/Comments

**Discussion of Comments-
Evaluation and Management
Services**

Discussion of Comments- Evaluation and Management Services

Comments from American Association of Nurse Anesthetists (AANA).

CMS-1512-PN-2136-Attach-1.PDF

Attachment 2136

Advancing the Art & Science of Anesthesia for 75 Years

AANA 1931-2006

August 21, 2006

Centers for Medicare & Medicaid Services
Department of Health & Human Services
Room 445-G, Hubert H. Humphrey Bldg
200 Independence Ave., SW
Washington, DC 20201

ATTN: CMS-1512-PN

Re: Comments on Medicare Program; Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology (71 Fed. Reg. 37170, June 29, 2006).

Dear Sir/Madam:

The American Association of Nurse Anesthetists (AANA) welcomes the opportunity to comment on the proposed notice for the Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology. *(71 Fed. Reg. 37170, June 29, 2006)* The AANA is submitting comments in the area of "Evaluation and Management Services." We are particularly concerned with the impact applying budget neutrality on such a large scale to pay for increased values for some evaluation and management (E/M) services will have on nurse anesthesia practice and Medicare beneficiaries' access to anesthesia services.

The AANA is the professional association for more than 36,000 Certified Registered Nurse Anesthetists (CRNAs) and student nurse anesthetists representing over 90 percent of the nurse anesthetists in the United States. CRNAs are advanced practice nurses who are directly involved in approximately 65 percent of all anesthetics given to patients each year. CRNA services include administering the anesthetic, monitoring and interpreting the patient's vital signs, and managing the patient throughout the surgery. CRNAs also

provide assessment and evaluation for acute and chronic pain management services. CRNAs provide anesthesia for a wide variety of surgical cases and are the sole anesthesia providers in almost 70 percent of rural hospitals, affording these medical facilities obstetrical, surgical, and trauma stabilization, and pain management capabilities. Nurse anesthesia predominates in Veterans Hospitals and in the U.S. Armed Forces. CRNAs work in every setting in which anesthesia is delivered including hospital surgical suites and obstetrical delivery rooms, ambulatory surgical centers (ASCs), pain management units and the offices of dentists, podiatrists, and all varieties of specialty surgeons.

EVALUATION AND MANAGEMENT SERVICES

We understand the importance of valuing healthcare services accurately. Accurate values allow providers to continue to provide Medicare beneficiaries with access to a wide-range of necessary services. For instance, we appreciate and agree with CMS' proposal to increase the value of CPT code 00797, anesthesia for obesity surgery, so that the work value more accurately reflects the work required of the anesthesia provider when he/she provides anesthesia services specifically for this procedure. We respect the need for fiscal responsibility in times of tight budget constraints and many new and growing demands on the national budget. However, the CMS' imposition of such a drastic, unprecedented and unjustified budget neutrality adjustor to pay for increasing the work value of some services over others would have exactly the opposite effect, and in reality would have wide-ranging negative impacts on patient access to healthcare services.

The proposed notice mandates a seven to eight percent cut in anesthesiology and nurse anesthetist reimbursement by 2007, and a 10 percent cut by 2010. With these cuts, Medicare payment for an average anesthesia service would lie far below its level in 1991, adjusting for inflation.[1] At no other time has there been such a drastic cut in work values. The last two CMS five-year review Part B payment formula changes in 2002, and 1997, adjusted anesthesia payment work value less than one percent each. And yet, CMS now proposes to cut anesthesia payment work values by 10 percent. While we appreciate

[1] An average anesthesia service is 12 units, times the mean Medicare anesthesia conversion factor for that year. The mean anesthesia CF in 1991 was $15.50; in 2006, $17.76; and for 2007 it would be $15.68.

CMS' proposal to increase the value of CPT code 00797, this small increase does not justify or adequately counterbalance CMS' proposed cut. Other factors, not anesthesia, are the reasons for such massive cuts. CMS' decision to increase Medicare E/M codes for only certain services by nearly 40 percent would increase Medicare Part B payment for physician services by $4 billion, thereby forcing CMS to make up for this increase by slashing services such as anesthesia by 10 percent.

In addition, CMS proposes to make these cuts without due consideration of the fact that Medicare already undervalues anesthesia services at 37 percent of market rates, while most physician services are reimbursed at about 80 percent of the market level. The 10 percent budget neutrality adjustor is not the only cut anesthesia providers would face. Piled on top of the 10 percent cut is CMS' anticipated Sustainable Growth Rate (SGR) formula-driven cut of 4.7 percent on all Part B services effective January 1, 2007. In effect, in 2007, anesthesia providers could face a whopping 14 percent cut in payment for their already undervalued services.

CMS' proposed cut would cause an unprecedented shift in payment from certain groups of providers to other providers. Such a momentous shift calls for a thorough understanding of the effects this would have on Medicare beneficiaries' access to *all* healthcare services. A comprehensive assessment of this impact on patient access remains absent from CMS' equations.

AMA-RUC Should Represent All Specialties

The American Medical Association (AMA) Specialty Society Relative Value Update Committee (RUC) is charged by CMS with representing all healthcare specialties in making recommendations to CMS on Relative Value Units (RVUs) for new and revised CPT codes. While CRNAs continue to directly provide a majority of the anesthesia services in the United States and can bill directly for 100 percent of the value of their services, CRNAs are not physicians and therefore are excluded from directly participating in AMA-RUC activities and initiatives. Changes in these codes directly impact CRNA practice and payment. Without fair representation by all specialties who

bill Part B directly, CMS' reliance on the AMA-RUC as representing the professional views and knowledge of all healthcare specialties is deeply flawed. The AMA-RUC and CMS are missing out on the long-standing knowledge and experience in anesthesia and in related healthcare services that CRNAs could bring to the AMA-RUC table. For CMS to conclude that CRNA viewpoints are fairly represented by coming under the "umbrella" of representation of the American Society of Anesthesiologists (ASA) or the American Nurses Association (ANA) is inadequate. The AMA-RUC is not representative of all specialties because it excludes providers such as CRNAs who have an equal stake in the success of the healthcare system. We therefore request that CMS encourage and persuade the AMA-RUC to provide CRNAs with an opportunity to have meaningful and direct representation on the AMA-RUC and related committees such as the Health Care Professionals Advisory Committee (HCPAC).

CMS E/M Payment Policy: Call for Recognition of All Providers

We understand that one of the primary reasons CMS is proposing to increase certain E/M codes is to reward patient management of care through one-on-one communication and "face time" between a healthcare provider and a patient. We agree that recognizing the value of "face-time" with a patient to improving healthcare outcomes is very important. Healthcare providers who are not physicians such as CRNAs spend a considerable amount of face-time with patients directly providing these necessary services and yet they commonly cannot directly bill Medicare for providing these services. Medicare payment policy should acknowledge all providers who provide these E/M services. We welcome the opportunity to work with CMS to adjust its payment policies so that they are consistent with its goal of maintaining and increasing Medicare beneficiaries' access to E/M services.

We thank you for the opportunity to comment on the proposed rule. Should you have any questions regarding these matters, please feel free to contact the AANA Senior Director of Federal Government Affairs, Frank Purcell, at 202.484.8400.

Sincerely,

Terry C. Wicks, CRNA, MHS
AANA President

cc: Jeffery M. Beutler, CRNA, MS, AANA Executive Director
Frank Purcell, AANA Senior Director of Federal Government Affairs

Submitter : **Date: 08/21/2006**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Other Issues

Other Issues

CMS-1512-PN-2144-Attach-1.DOC

Attachment
3144

RMH
Rehab Services

Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human services
Attention: CMS-1512-PN
P.O. Box 8014
Baltimore, MD 21244-8014

Subject: Medicare Program; Five-Year Review of Work Relative Value Units under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology

Dear Dr. McClellan;

I am a physical therapist with 30 years experience in patient care, most of which have been spent serving rural populations in Virginia and North Carolina. I have worked in home health, acute inpatient, nursing home and outpatient environments and wish to comment on the June 29 proposed notice relating to the above subject.

I urge you to transition the changes to the work relative value units over a four-year period in order to allow us to continue provision of needed services to patients and to ensure that severe Medicare payment cuts for physical therapists and other health care professionals do not occur in 2007.

My concerns:

- Proposed policies result in multiple cuts, which in aggregate have a very negative impact. These include a projected 4.6% cut in 2007 as a result of the SGR formula, as well as a budget neutrality adjuster proposed in the 5-year review rule.
- Because PT's cannot bill for E/M codes, they will receive no benefit from increased payment.
- These proposed cuts could seriously impact and even impede patient access to care, as well as the quality of care received.
- PT's provide intensive, hands-on treatment. Our goal is that every patient regains the highest level of functional independence possible, thus assuring downstream value to our entire health care system.

Thank you for your serious consideration of these comments.

Sincerely,

W.G. Garnett, PT, MBA
Director, Rehab Services

235 Cantrell Avenue, Harrisonburg, Virginia 22801
540-433-4100
www.rmhonline.com

RMH: We're here for you.

Submitter : Mr. Andrew Radoszewski **Date:** 08/21/2006

Organization : Langhorne Cardiology Consultants, M.D.'s, PA

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1512-PN-2146-Attach-1.DOC

2146

CardiologyConsultants,PA
CardiothoracicSurgicalAssociates of Northwest Florida
Members of the Pensacola Heart Institute

August 31, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
CMS-1512-PN
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: Proposed Notice re: Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology (June 29, 2006); Comments re: Practice Expense

Dear Dr. McClellan:

On behalf of Langhorne Cardiology Consultants, M.D.'s, PA and our 26 individual practicing cardiologists and cardiovascular surgeons, we appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Service ("CMS") regarding the June 29, 2006 Proposed Notice ("Notice") regarding Proposed Changes to the Practice Expense ("PE") Methodology and its impact on our practice. We are located in Pensacola, Florida a nd o wn two outpatient cardiovascular catheterization labs t hat together perform nearly 1800 procedures per year.

The proposed approach is biased against procedures, such as outpatient cardiovascular catheterizations, for which the Technical Component ("TC") is a significant part of the overall procedure. Catheterization procedures are being used as an example of the impact of the proposed methodology on procedures with significant TC costs because they share the same problems that we will outline below. We also believe that the same solution should be applied to all of the procedures listed below.

With regard to catheterizations, the proposed change in PE RVUs would result in a 53.1 percent reduction of payments for CPT 93510 TC. Similarly, payment for two related codes—93555 TC and 93556 TC would be reduced substantially. In fact, under the Medicare Physician Fee Schedule ("PFS"), payment for these three codes would fall from 94 percent of the proposed

2007 APC rate for these three codes to 34 percent of the APC payment amount. These codes are representative of a range of procedures performed in cardiovascular outpatient centers.

CPT Code	Description
93510 TC	Left Heart Catheterization
93555 TC	Imaging Cardiac Catheterization
93556 TC	Imaging Cardiac Catheterization
93526 TC	Rt & Lt Heart Catheters

The stated purpose of the proposed change to a bottom up micro-costing approach is laudable and consistent with the statutory requirement that the Medicare program base payment on the use of necessary resources. However, the proposed methodology and inputs to the calculation do not comport with the statutory requirement that would match resources to payments. After reviewing the proposed methodology, including the 19 step calculation, we have identified several flaws that result in the PE RVU underestimating the resources needed to provide the technical component of cardiac catheterizations. We will address our concerns with the calculation of direct costs and indirect costs separately, as set forth below.

Direct Costs

The estimate of direct costs is critical for the first step in calculating the PE RVU for each procedure code. The direct costs are based on inputs from the American Medical Association's RVS Update Committee ("RUC") and reflect the direct costs of clinical labor, medical supplies and medical equipment that are typically used to perform each procedure. The RUC-determined direct costs do not reflect estimates of additional labor, supply and equipment costs that were submitted by (The Society for Cardiovascular Angiography and Interventions ("SCAI") or an industry group). As a result, the RUC-determined cost estimate is about half of the estimate that would result if all of the data were included. The addition of these additional costs which are consistent with the RUC protocol would increase the proposed PE RVUs by 24 percent.

Even if the RUC estimates included the additional costs submitted by SCAI or an industry group, the estimate is not an accurate reflection of direct costs of the resources necessary to provide the procedure because the RUC takes a narrow view of direct costs. Specifically, the RUC includes costs only if they are relevant to 51 percent of the patients. This definition of direct costs does not count the costs of supplies and the clinical labor time that may be required for the other 49 percent of the patients that may not fit the average profile. This approach is particularly inconsistent with the realities of the clinical staff needed for a catheterization facility and does not reflect the differences in clinical practice patterns. For example, some catheterization labs may use wound closure devices that will increase supply costs while lowering clinical staff time. Other labs may not use closure devices to the same extent and may allocate more staff time to apply compression to the wound. These costs would not be counted in the RUC-determined direct cost estimate unless they apply to 51 percent of the patients.

Based on the PEAC Direct Input data from the CMS website, it appears that the RUC inputs assume the time that may be required if wound closures were used, but it fails to include a wound closure device in the supply list of direct costs.

Unless the RUC considers the actual costs of the clinical labor, supply and equipment used to perform a cardiac catheterization, the PE RVU that results at the end of the 19 step calculation will never reflect the actual resources needed to perform the procedure and will result in destabilizing practice expense payments to physicians. Therefore, CMS must evaluate the adequacy of the direct inputs and focus on developing a methodology that captures the average direct costs of performing a procedure, rather than the direct costs of performing a procedure that represents 51 percent of the patients.

A new methodology is needed based on the best data available so that the direct costs shown in the third column of the table below can be allocated in a manner similar to the allocation of indirect costs. This would result in a PE RVU that is a more accurate reflection of the direct and indirect costs for the resources that are critical to performing the procedure.

Categories of Cardiac Catheterization Direct Costs Included or Excluded From RUC–Determined Estimates

Direct Cost Category	***Included In RUC–Determined Estimate***	***Excluded From RUC–Determined Estimate***
Clinical Labor	• Direct Patient Care For Activities Defined by RUC • Allocation of Staff Defined by RUC Protocol (1:4 Ratio of RN to Patients in Recovery)	• Direct Patient Care For Activities Not Defined by RUC • Actual Staff Allocation Based on Patient Needs
Medical Supplies	• Supplies Used For More Than 51% of Patients	• Supplies Used For Less Than 51% of Patients
Medical Equipment	• Equipment Used For More Than 51% of Patients	• Equipment Used For Less Than 51% of Patients
All Direct Costs for Cardiac Catheterization	• Approximately 55% of the direct costs are included in the RUC estimate	• Approximately 45% of the direct costs are included in the RUC estimate

A complete accounting of all of the direct costs associated with performing a cardiac catheterization procedure would result in a PE RVU that is almost two times the proposed amount, and would begin to approximate the actual costs of providing the service. There are additional improvements that can be made in the manner by which the indirect costs are estimated that are outlined below.

Indirect Costs

The "bottom-up" methodology estimates indirect costs at the procedure code level using data from surveys of practice costs of various specialties. The methodology uses the ratio of direct to indirect costs at the practice level in conjunction with the direct cost estimate from the RUC to estimate the indirect costs for each procedure code. As a result, the indirect costs of cardiac catheterization procedure codes are understated because the direct costs do not reflect all of the actual costs. In addition, most of the PE RVUs reflect a weighted average of the practice costs of two specialties – Independent Diagnostic Treatment Facilities ("IDTFs"), which account for about two-thirds of the utilization estimate f or 93510 TC, and cardiology. The IDTF survey includes a wide range of facilities, but do not reflect the cost profile of cardiac catheterization facilities--that may have a cost profile similar to cardiology in terms of the higher indirect costs that are associated with performing these services.

If CMS were to base the PE RVU for cardiac catheterization on the practice costs from cardiology surveys rather than a weighted average of cardiology and IDTFs, the PE RVU would increase about 24 percent. However, the payment would still fall far below the costs associated with the resources needed to provide the service efficiently. This finding supports the conclusion that the inputs to the calculations are flawed and need to be changed to ensure that they reflect accurately both (1) the direct costs at the procedure level, and (2) the indirect costs at the practice level.

Solutions

We believe that the proposed "bottom up" methodology is flawed with respect to cardiac catheterization procedures and CMS needs to develop a new approach that identifies the actual direct costs at the procedure level. The set of costs that are considered by the RUC are incomplete and need to be expanded now that the non-physician work pool ("NPWP") has been eliminated. The RUC-determined costs need to reflect all of the costs of clinical labor, not only the labor associated with the sub-set of patient care time that is currently considered. The supply and equipment costs also need to reflect current standards of care.

The problem created under the PE-RVU methodology set out in the Notice would result in a draconian cut in reimbursement for cardiac catheterization performed in practice or IDTF locations. The magnitude of the inequitable treatment caused by the resulting cuts is immediately apparent from a comparison with the APC payment rate for similar procedures. As a result, we request that CMS freeze payment for these cardiac catheterization-related procedure codes for one year to allow time for a complete assessment of the cost profile of the services listed in the chart provided above.

We will be collaborating with our membership organization, the Cardiovascular Outpatient Center Alliance ("COCA") to develop improved estimates of direct and indirect costs that may be submitted to CMS to supplement these comments either separately or as part of our comments in our response to the Proposed Rule addressing Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2007. It is our understanding that CMS will accept additional data that helps CMS in evaluating the impact of the PE RVU methodology on our practices.

Sincerely,

Andrew Radoszewski, M.B.A., M.P.H., CMPE
Administrator

Submitter : Dr. Gary Kauffman **Date:** 08/21/2006

Organization : North Phoenix Heart Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1512-PN-2150-Attach-1.DOC

Attach
2150

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
CMS-1512-PN
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: Comments regarding Proposed Notice re: Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology (Federal Register: June 29, 2006)

August 21, 2006

Dear Dr. McClellan:

North Phoenix Heart Center appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) regarding the June 29, 2006 Proposed Notice re: Proposed Changes to the Practice Expense (PE) Methodology and the Five-Year Review of Work RVUs under the Physician Fee Schedule.

North Phoenix Heart Center represents 13of physicians and 60 employees who serve more than 10,000 patients in the greater Phoenix area. We, along with more than 220 private practices and 3,700 cardiologists as represented by the Cardiology Advocacy Alliance (CAA), are concerned that the changes currently proposed by CMS to the practice expense portion of the Relative Value Unit (RVU) system are based on incomplete data and a flawed methodology. North Phoenix Heart Center requests that CMS delay implementation of the rule for one year until (1) data are corrected to accurately reflect the direct and indirect costs of providing care, and (2) the methodology is updated to better reflect the ratio of direct to indirect costs. Our comments on the five-year review of the Work RVUs under the Physician Fee Schedule also are included below.

Comments regarding Proposed Changes to the Practice Expense Methodology

North Phoenix Heart Center wants to ensure that the revisions to the practice expense component of Medicare's RBRVS are methodologically sound and are driven by accurate, representative data on physicians' practice costs. Our physicians are particularly concerned about the methodology, data sources and assumptions used to estimate the direct and indirect practice expense costs associated with cardiovascular CPT codes, including services performed in cardiac catheterization labs.

The rule as currently proposed is biased against procedures, such as outpatient cardiovascular catheterizations, for which the Technical Component (TC) is a significant part of the overall procedure. **North Phoenix Heart Center will use catheterization procedures as an example as outlined below of the impact of the proposed methodology on all procedures with significant TC costs. We also believe that the same solution should be applied to all procedures with significant TC costs.**

With regard to catheterizations: the proposed change in PE RVUs would decrease payments for CPT 93510 TC by more than 53 percent. Payment for two related codes—93555 TC and 93556 TC - also would decrease significantly. Under the Medicare Physician Fee Schedule (PFS), payment for these three codes would fall from 94 percent of the proposed 2007 APC rate to 34 percent of the APC payment amount. These codes are representative of a range of procedures performed in cardiovascular outpatient centers.

CPT Code	Description
93510 TC	Left Heart Catheterization
93555 TC	Imaging Cardiac Catheterization
93556 TC	Imaging Cardiac Catheterization
93526 TC	Rt & Lt Heart Catheters

The stated purpose of the proposed change to a bottom-up cost approach is consistent with the statutory requirement that the Medicare program base payment on the use of necessary resources. However, the proposed methodology and inputs to the calculation do not comply with the statutory requirement to match resources to payments. After reviewing the proposed methodology, including the 19-step calculation, CAA and other organizations have identified several flaws that result in an underestimation of the resources needed to provide the technical component of cardiac catheterizations:

Direct Costs

The estimate of direct costs is critical first step in calculating the PE RVU for each procedure code. The direct costs are based on inputs from the American Medical Association's RVS Update Committee (RUC) and are to reflect the direct costs of clinical labor, medical supplies and medical equipment that are typically used to perform each procedure. However, the direct costs submitted to CMS by the RUC do not reflect estimates of additional labor, supply and equipment costs that were submitted by the Society for Cardiovascular Angiography and Interventions (SCAI). As a result, the RUC-determined cost estimate is about half of what would result if all of the data were included. Including these additional costs, consistent with the RUC protocol, would increase the proposed PE RVUs by 24 percent.

Even if the RUC estimates included the additional costs submitted by SCAI, the estimate is not an accurate reflection of direct costs of the resources necessary to provide the procedure because the RUC takes a narrow view of direct costs. Specifically, the RUC includes costs only if they are relevant to 51 percent of the patients. This definition of direct costs does not count the costs of supplies and the clinical labor time that may be required for the other 49 percent of the patients that may not fit the average profile. This approach is particularly inconsistent with the realities of the clinical staff needed for a catheterization facility and does not reflect the differences in clinical practice patterns.

For example, some catheterization labs may use wound closure devices that will increase supply costs while lowering clinical staff time. Other labs may not use closure devices to the same extent and may allocate more staff time to apply compression to the wound. These costs would not be counted in the RUC-determined direct cost estimate unless they apply to 51 percent of the patients. Based on the PEAC Direct Input data from the CMS website, it appears that the RUC inputs assume the time that may be required if wound closures were used, but it fails to include a wound closure device in the supply list of direct costs.

Unless the RUC considers the actual costs of the clinical labor, supply and equipment used to perform a cardiac catheterization, the PE RVU that results at the end of the 19-step calculation will never reflect the actual resources needed to perform the procedure and will result in destabilizing practice expense payments to physicians. Therefore, CMS must evaluate the adequacy of the direct inputs and focus on developing a methodology that captures the average direct costs of performing a procedure, rather than the direct costs of performing a procedure that represents 51 percent of the patients.

A new methodology is needed based on the best data available so that the direct costs shown in the third column of the table below can be allocated in a manner similar to the allocation of indirect costs. This would result in a PE RVU that is a more accurate reflection of the direct and indirect costs for the resources that are critical to performing the procedure.

Categories of Cardiac Catheterization Direct Costs Included or Excluded From RUC-Determined Estimates

Direct Cost Category	*Included In RUC- Determined Estimate*	*Excluded From RUC-Determined Estimate*
Clinical Labor	• Direct Patient Care For Activities Defined by RUC • Allocation of Staff Defined by RUC Protocol (1:4 Ratio of RN to Patients in Recovery)	• Direct Patient Care For Activities Not Defined by RUC • Actual Staff Allocation Based on Patient Needs
Medical Supplies	• Supplies Used For More Than 51% of Patients	• Supplies Used For Less Than 51% of Patients
Medical Equipment	• Equipment Used For More Than 51% of Patients	• Equipment Used For Less Than 51% of Patients
All Direct Costs for Cardiac Catheterization	• Approximately 55% of the direct costs are included in the RUC estimate	• Approximately 45% of the direct costs are not included in the RUC estimate

A complete accounting of all of the direct costs associated with performing a cardiac catheterization procedure would result in a PE RVU that is almost two times the proposed amount, and would begin to approximate the actual costs of providing the service. In addition, there are further improvements that can be made in the manner by which the indirect costs are estimated.

Indirect Costs

The "bottom-up" methodology estimates indirect costs at the procedure code level using data from surveys of practice costs of various specialties. The methodology uses the ratio of direct to indirect costs at the practice level in conjunction with the direct cost estimate from the RUC to estimate the indirect costs for each procedure code. As a result, the indirect costs of cardiac catheterization procedure codes are understated because the direct costs do not reflect all of the actual costs. In addition, most of the PE RVUs reflect a weighted average of the practice costs of two specialties - Independent Diagnostic Treatment Facilities (IDTFs), which account for about two-thirds of the

utilization estimate for 93510 TC, and Cardiology. The IDTF survey includes a wide range of facilities, but does not reflect the cost profile of cardiac catheterization facilities that may have a cost profile similar to Cardiology in terms of the higher indirect costs that are associated with performing these services.

If CMS were to base the PE RVU for cardiac catheterization on the practice costs from cardiology surveys rather than a weighted average of cardiology and IDTFs, the PE RVU would increase about 24 percent. However, the payment would still fall far below the costs associated with the resources needed to provide the service efficiently. This finding supports the conclusion that the inputs to the calculations are flawed and need to be changed to ensure that they reflect accurately both the direct costs at the procedure level and the indirect costs at the practice level.

Summary of North Phoenix Heart Center comments on the Proposed Rule re: Practice Expense changes

Our practice believes that the proposed "bottom up" methodology is flawed with respect to cardiac catheterization and other TC-heavy procedures, and that CMS needs to develop a new approach that identifies the actual direct costs at the procedure level. The set of costs that are considered by the RUC are incomplete and need to be expanded now that the non-physician work pool has been eliminated. The RUC-determined costs need to reflect all of the costs of clinical labor, not only the labor associated with the sub-set of patient care time that is currently considered. The supply and equipment costs also need to reflect current standards of care.

The problem created under the PE-RVU methodology set out in the Notice would result in a draconian cut in reimbursement for cardiac catheterizations. Should CMS adopt its proposed rule on practice expenses as it is currently written, the unintended consequences would be significant:

1. Insufficient reimbursement would force outpatient cath labs to close. Medicare patients would be directed back to the inpatient setting for cath services. This runs counter to CMS' long-term goal of providing care in the outpatient setting whenever clinically appropriate.
2. Hospitals are not prepared to handle a large influx of catheterization cases, and the resulting wait times may very well endanger Medicare beneficiaries who need these critical cardiac services.
3. Medicare beneficiaries' out-of-pocket costs would increase, as hospital co-pays are up to 40 percent higher than those in the outpatient setting.
4. Medicare patients also would be inconvenienced by longer drive times and increased waiting periods for test results.
5. Driving Medicare patients back into the hospital setting for imaging tests also would include increased costs to the Medicare program as a whole.
6. Physician practices are small businesses, employing hundreds of thousands of people and providing valuable services to the Medicare population. The physician sector must have stable reimbursement patterns that keep pace with the increasing cost of providing care.

The magnitude of the inequitable treatment caused by the resulting cuts is immediately apparent from a comparison with the APC payment rate for similar procedures. We are concerned that the problems with the catheterization codes as outlined above may extend to other CPT codes with significant TC costs as well, since the inadequate funding of catheterization codes illustrates that the data and formula used to calculate practice expense components is incomplete and inaccurate. As a result, **North Phoenix Heart Center requests that CMS delay implementation of the practice expense changes for one year. During this time period, CMS, RUC, SCAI, CAA and other interested parties will be able to complete a thorough assessment of the direct and indirect cost data and the methodology currently under consideration to ensure that they are accurate and complete. CAA will be collaborating with our members and other organizations to develop improved estimates of direct costs and to offer additional comments in our response to the**

Proposed Rule addressing Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2007.

Comments regarding Proposed Notice re: Five-Year Review of Work Relative Value Units under the Physician Fee Schedule

North Phoenix Heart Center understands that CMS is required by statute to offset costs in excess of $20 million that result from the Agency's mandatory five-year review of Work RVUs under the Physician Fee Schedule. Our practice believes that the $20 million offset threshold set for five-year mandatory reviews in the early 1990s should be adjusted for inflation and the rising costs of providing medical care to our nation's growing Medicare population. We and other CAA members are working with Congressional leaders to address this issue legislatively. It seems nonsensical that CMS must complete the rigorous task of realigning Work RVU weights every five years only to reduce the fee schedule as a whole to pay for the review, which was mandated to ensure that Work RVUs accurately reflect the amount of time medical professionals devote to procedures and ensure appropriate reimbursement. CAA members will see their total reimbursements slashed by up to $1.65 million in 2007 as a result of the 2006 review, depending upon the method CMS chooses to offset costs. Until such time as the arbitrary $20-million cap is changed, we acknowledge that CMS must continue its actions to offset the 2006 Work RVU review.

Sincerely,

Gary Kauffman MD FACC
Tim Beckwith
Kauffman2003@nphc.com
On behalf of North Phoenix Heart Center
9100 North 2nd Street, Suite 321, Phoenix, AZ 85250
602-861-1168

Attachment
2154

SOCIETY FOR VASCULAR SURGERY

August 21, 2006

The Honorable Mark McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS–1502-P
PO Box 8017
Baltimore, MD 21244–8017

RE: CMS-1512-PN; Medicare Program; Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology

Dear Dr. McClellan:

On behalf of the 2,300 members of the Society for Vascular Surgery (SVS), I offer the following comments on the Proposed Rule published in the *Federal Register* on June 29, 2006. We will address the work RVUs for vascular codes in the five-year review, E/M codes in the five-year review, the budget neutrality adjustment for the five-year review of work, and practice expense methodology.

2007 may be the year when vascular surgeons are forced to reduce access to Medicare beneficiaries. Our specialty is currently facing an intolerable 11% Medicare reimbursement reduction based on CMS projections. This massive pay-cut represents the combination of -5% due to the SGR impact on the Conversion Factor, -5% due to the impact of the Deficit Reduction on Noninvasive vascular laboratory studies, and -1% related to changes in work RVUs and Practice Expense. Although we are deeply committed to caring for our nation's seniors, this combination of negative impacts may simply make it impossible to carry on an open practice.

The SVS comments will follow in this order:

1. Five-Year Review of Work for vascular surgery codes
2. Five-Year Review of Work for E/M codes
3. Practice Expense
4. Preliminary Comments on Deficit Reduction Act

1. Five-Year Review of Work for Vascular Surgery Codes

SVS submitted a total of 21 physician work recommendations that the society and its members believe to be substantially undervalued. Of these, SVS is pleased that CMS accepted recommendations for 14 procedures (CPT 27880, 28805, 34001, 34201, 34471, 35216, 35506, 35508, 35515, 35516, 35606, 35616, 60600, and 60605). Unfortunately, the seven procedures regarding which CMS rejected SVS and/or RUC recommendations represent a group of our most complex and labor-intensive open vascular surgery operations. SVS is extremely concerned that CMS, in their enthusiasm to reject NSQIP information, failed to consider a large body of high quality data submitted in support of work RVUs for these services. Our society will present this detailed information herein, supplemented by additional supportive data.

The Agency rejected SVS recommendations for seven CPT codes that represent the core of sophisticated vascular surgery, benchmark open aortic aneurysm repairs and lower extremity bypass grafts. These codes are 33877, 35081, 35102, 35556, 35566, 35583, and 35585. The operations are performed to prevent death from aneurysm rupture and to prevent leg amputation from ischemic gangrene. The CMS proposed values for these codes create rank order anomalies of physician work, both within the family of vascular codes and when considered in light of other specialties

General Comments on CMS Review of Vascular Surgery Codes

In the NPRM discussion of the vascular surgery codes, CMS states "For these services, the RUC used NSQIP time data to increase the work values above the survey median, and even for above several codes the 75th percentile. For the reasons discussed above, we reject such a use of the NSQIP data at this time. Therefore, we are proposing to use the survey median work RVUs for these CPT codes". The facts demonstrate that in several instances, use of NSQIP data for vascular codes decreased, rather than increased, work RVU recommendations, intra-service time, and hospital length of stay.

Here are several important points regarding NSQIP data for vascular surgery codes:

- NSQIP time was available for only 10 of the 21 vascular surgery procedures we submitted, including the 7 in question here. When available, SVS used NSQIP because we felt accuracy was a goal in the 5-year review. NSQIP intra-service times were higher than survey time for 6 codes, equal to survey time for 1 code, and LESS THAN survey time for 3 codes. We used the data in all instances.
- SVS used NSQIP intra-service time even when NSQIP served to reduce the recommendation compared to RUC survey.
    - CPT 33877: Intra-service time from the RUC survey was 360 minutes. Intra-service time from NSQIP was 323 minutes. Intra-service time from the STS database was 326 minutes. SVS recommended 324 minutes intra-service, midway between the two databases. CMS rejected the SVS/RUC-recommended work RVU for this service, with the only stated objection being that we used NSQIP data. SVS would be pleased to increase the intra-service

time back to the survey value of 360 minutes if that helps achieve an appropriate work RVU for this service.

- SVS used NSQIP hospital length of stay even when it served to reduce the LOS recommendation:
  - CPT 33877: RUC Survey Length of Stay was 12 days, while NSQIP LOS was 10 days. SVS recommended a 10-day LOS for this procedure, thinking that accuracy was a goal of the five-year review exercise. CMS rejected the SVS/RUC-recommended work RVU for this service really only stated explanation that we used NSQIP data. SVS would be pleased to increase the hospital length of stay to 12 days if that helps achieve an appropriate work RVU for this service.

- CMS did not object to NSQIP data when it served to reduce the recommended work RVU:
  - CPT 27880: RUC Survey intra-time was 90 minutes, but NSQIP intra-time was 80 minutes. SVS recommended an intra-time of 80 minutes, and we reduced the work RVU recommendation to ~ 25th percentile based on the lower NSQIP intra-time. CMS did not reject this recommendation even though we used NSQIP data.

In summary, the use of NSQIP data comprised only one portion of the total rationale provided by SVS to make work RVU recommendations. It is important to note that SVS recommended work RVUs less then median survey when that was appropriate based on all available data including NSQIP. Likewise, we recommended work RVUs greater than median survey when the values were substantiated by a large body of hard data. It should be noted that the RUC rarely makes recommendations above median survey. That happened in only a few situations during the entire five-year review. The RUC is extremely conservative in this regard. We believe CMS should reconsider the overwhelming evidence that we presented to the RUC regarding these seven benchmark procedures.

CPT Code 33877 Open repair of thoracoabdominal aortic aneurysm

This service was submitted to the five-year review because 1) it was undervalued originally during the Harvard studies, and 2) it has never been evaluated by the RUC. The procedure is one of the most complex and greatest magnitude surgical operations performed on humans, and the RUC recognized that when it accepted the SVS recommendation for 64.04 work RVUs. This is nearly a six hour operation performed on patients who typically have coincident coronary artery disease and COPD. A very large incision opens both the thorax and abdomen. In most cases, the diaphragm is transected to allow continuous access to the aorta across the two body cavities. Patients are extremely ill postoperatively. Even in the hands of world experts, this procedure carries a substantial perioperative mortality and morbidity. Nevertheless, if left untreated, the natural history of large thoracoabdominal

aortic aneurysm is one of rupture and death. For most patients, surgery is the most successful option. This operation sets of benchmark for complexity and intensity.

CPT Code 33877 Open Thoracoabdominal Aneurysm Repair

SVS Recommended work RVU: 64.04
RUC Recommended work RVU: 64.04
CMS Proposed work RVU: 53.00

Building Block Components of 33877 using RUC approved time & visits:

CPT Code: [redacted]		RVW:	64.04
SVS/RUC REC w RUC TIMES	RUC Time	RUC Std.	RVW
Pre-service:	Time	Intensity	time x intensit
Pre-service eval & positioning	95	0.0224	2.13
Pre-service scrub, dress, wait	15	0.0081	0.12
Pre-service total			**2.25**
Post-service:	Time	Intensity	time x intensit
Immediate post	60	0.0224	1.34
Subsequent visits:	Visit n	E/M RVW	(=n x RVW)
ICU 99291	3	4.00	12.00
ICU 99292		2.00	0.00
NICU 99296		16.00	0.00
NICU 99297		8.00	0.00
99233	3	1.51	4.53
99232	2	1.06	2.12
99231	1	0.64	0.64
Discharge 99238	0	1.28	0.00
Discharge 99239	1	1.75	1.75
99215		1.73	0.00
99214	1	1.08	1.08
99213	2	0.65	1.30
99212	0	0.43	0.00
99211		0.17	0.00
Post-service total			**24.76**
	Time	IWPUT	INTRA-RVW
Intra-service:	324	0.114	37.03
Total Time	1014		

Comparison of 33877 with other Vascular Codes by IWPUT Analysis

Intra-service work per unit time has become an accepted analytic tool to help determine appropriate work relative values. Research articles have been published regarding IWPUT in peer-reviewed journals. CMS used IWPUT during the current five-year review as it determined work RVU recommendations for CPT codes 95872 (NPRM page 104) as well as many of the cardiothoracic surgery codes (NPRM page 142). The IWPUT analysis provided by SVS under "Additional Rationale" of the RUC summary recommendation constituted one reason the RUC recommended a value above median survey.

From 2000 to 2006 the RUC reviewed 16 new or revised vascular surgery codes that relate to elective aneurysm repairs of the aorta or peripheral arteries, or other aortic surgery. The IWPUTs for these codes are displayed here and represent a tight range from 0.082 to 0.109. Generally speaking, procedures of lesser intensity and complexity fall in the lower end of this range, while procedures of higher intensity and complexity are in the upper end. The IWPUTs presented here are calculated using actual 2006 MFS work RVUs. "5Yr" means an established code that was brought forth with compelling evidence arguments for review in the 5-year review process. "New" means a new CPT code introduced in the stated year, typically evaluated by the RUC in the preceding calendar year.

IWPUT Intensity Measure for Aneurysm Repairs Aortic Surgery, 2000-2006

Code	Short Descriptor	Year Implemented	IWPUT
CMS would put 33877 thoracoabd aneurysm here			**0.080**
35141	Repair femoral aneurysm	2002 5Yr	0.082
34900	Endovasc rep iliac aneurysm	2003 new	0.088
35646	Aorto-bifemoral bypass synth	2002 new	0.093
35151	Rep popliteal aneurysm	2002 5 Yr	0.094
33881	Endovasc rep thoracic aorta	2006 new	0.095
35011	Rep axillary/brach aneurysm	2002 5 Yr	0.099
35131	Rep Iliac aneurysm	2002 5 Yr	0.101
34802	Endo rep abd AAA 2-piece	2001 new	0.101
34805	Endo rep Abd AAA aorto-uni	2001 new	0.101
35647	Aorto-fem bypass synth	2002 new	0.102
35045	Rep radial/ulnar aneurysm	2002 5 Yr	0.102
34803	Endo rep abd AAA 3-piece	2005 new	0.104
35121	Rep mesenteric aneurysm	2002 5 Yr	0.105
33880	Endovasc rep thoracic	2006 new	0.105
35111	Rep splenic aneurysm	2002 5 Yr	0.109
34800	Endovasc rep abd AAA	2001 new	0.109
SVS data appropriately places 33877 here			**0.114**

The proposed CMS work RVU of 53.00 for 33877 would result in an IWPUT of 0.080, setting a new low benchmark of intensity for this family. This would represent a flagrant rank order anomaly with respect to all aneurysm repairs approved by CMS over the past 7 years. 33877 deserves the highest IWPUT within this family, not the lowest.

SVS also considered whether an IWPUT of 0.114 for thoracoabdominal aortic aneurysm repair is excessive compared to other RUC-evaluated and CMS approved services. Our response is that 0.114 is fully appropriate in comparison to highly complex procedures in other specialty areas. While 0.114 lies appropriately at the top of the aneurysm range, it is important to note that 62 RUC-valued and CMS approved services have IWPUTs >0.114. Here are some examples. None of these services were considered during the current five-year review, so the specialty society and CMS must consider them appropriate:

IWPUT Intensity Measure for Complex RUC & CMS-Approved Procedures

CPT Code	Short Descriptor	IWPUT
93581	Transcatheter closure of VSD	0.124
67218	Treatment of retinal lesion	0.128
53620	Dilate urethral stricture	0.128
45160	Excision of rectal tumor	0.130
62161	Dissect brain with scope	0.130
66982	Cataract surgery, complex	0.130
16035	Incision of burn scab	0.131
45170	Excison of rectal tumor	0.132
65855	Laser surgery of eye	0.133
93580	Transcatheter closure of ASD	0.133
47130	Partial removal of liver	0.134
52647	Laser surgery of prostate	0.134
33681	Repair heart septum defect	0.137

In summary, the SVS and RUC-recommended work RVU of 64.04, represents a fully appropriate value based on IWPUT intensity analysis of vascular and non-vascular procedures.

Additional Observations on 33877 Intra-service Time

It is important to note that the intra-service time of 33877 submitted to the RUC and CMS was NOT 360 minutes determined by 39 RUC survey respondents, but rather a lower value, 324 minutes, based on 156 data-points from NSQIP and 108 data-points from the STS database. If the RUC survey is to be considered the gold-standard, this service really deserves another 36 minutes of high intensity intra-service time and associated RVUs. If CMS denies the accuracy of NSQIP, perhaps the intra-service time of this procedure should be increased to the RUC survey value of 360 minutes, and the work RVU should be adjusted upward accordingly. SVS does not necessarily advocate this approach because we feel the time data are accurate. Nevertheless, if CMS rejects the NSQIP data, we should consider using 360 minutes for intra-time and appropriately adjust the work RVU.

Additional Observations on 33877 Length of Stay

The 39 RUC survey respondents noted a median hospital length of stay of 12 days. The NSQIP hospital length of stay is 10 days. SVS recommended, and the RUC accepted, a 10-day length of stay. If CMS rejects the NSQIP data, perhaps the hospital length of stay for this service should be increased to 12 days and the work RVU adjusted upward accordingly. SVS does not necessarily advocate this approach because we feel the LOS is accurate at 10 days. Nevertheless, we would consider this in order to achieve an accurate work RVU.

Comparison of 33877 with Complex Intra-abdominal General Surgery Service 47130

Forty-one percent of the 39 RUC survey respondents chose the key reference service CPT 47130, "Hepatectomy, resection of liver; total right lobectomy". 47130 is an MPC "A List" service, so it is a solid reference. SVS believes 47130 is appropriately valued, and 47130 was not part of the current five-year review. The 2005 and 2006 work RVW for 47130 is 53.27. Hepatic resection is an intra-abdominal operation that sometimes requires extension of the incision into the chest. Thoracoabdominal aortic aneurysm repair is an operation performed on the largest artery in the body, and it usually requires both intra-abdominal and intra-thoracic incisions. Survey respondents identified the intensity and complexity of 33877 to be greater than that of reference service 47130. The major difference is intra-service time, where 33877 has 84 minutes more skin-to-skin time than the reference service (324 vs. 240). Both services have a 10-day hospital LOS and three office visits. 33877 entails one more ICU visit and one more 99233 than 47130. Thus, assuming the value of this MPC "A" reference service is correct at 53.27, the value for 33877 must be substanially higher to reflect 84-minutes of extremely high-intensity additional intra-service time. Using 47130 to calculate an RVU for 33877, start with 53.27, then add 84 min x 0.114 (IWPUT for 33877, =9.58) and add the 5.26 RVU post-work difference = 68.11. This comparison with a general surgery service fully justifies a work RVU of 64.04 for 33877.

Comparison of 33877 thoracoabdominal aneurysm with MPC Reference 61700 Intracranial Aneurysm

CPT 61700 is "Surgery of simple intracranial aneurysm, intracranial approach; carotid circulation". 61700 is an "A" reference service on the RUC MPC list, meaning it is felt to be a stable and well-analyzed service. 61700 has a 90-day global and a 2005 and 2006 RVW of 50.44. This code served as one of our "Additional Rationale" comparison services on the RUC Summary of Recommendations. 61700 has an intra-service time of 270 minutes, 54 minutes less than the service under evaluation, 33877 (324 min). 61700 has an 11-day stay compared to 10-days for 33877, but 33877 patients are substantially more ill and require significantly more intense in-hospital care. Office visit pattern for the two procedures is similar. Thus, 33877 has a much longer intra-service time and a markedly more intense hospital stay. This comparison with an MPC "A" service convinces us that the work of 33877 is substantially more than that of 61700. Adjusting for intra-service time adds 6.16 RVUs to the value of 61700. Adjusting for the post-service work adds 8.82 RVUs to the value of 61700 (2x99291 + 2x99233 – 5x99231). Thus, basing a value of 33877 on the MPC code 61700 results in a value of 50.44+6.16+8.82=65.42.

Compared to CPT 61700 simple incracranial aneurysm repair, 33877 is appropriately valued at 64.04:

SVS/RUC Recommendation		RVW:	64.04
with RUC times & visits	RUC Time	RUC Std.	RVW
Pre-service:	Time	Intensity	(=time x intensity)
Pre-service eval & positioning	95	0.0224	2.13
Pre-service scrub, dress, wait	15	0.0081	0.12
Pre-service total			**2.25**
Post-service:	Time	Intensity	(=time x intensity)
Immediate post	60	0.0224	1.34
Subsequent visits:	Visit n	E/M RVW	(=n x RVW)
ICU 99291	3	4.00	12.00
ICU 99292		2.00	0.00
NICU 99296		16.00	0.00
NICU 99297		8.00	0.00
99233	3	1.51	4.53
99232	2	1.06	2.12
99231	1	0.64	0.64
Discharge 99238	0	1.28	0.00
Discharge 99239	1	1.75	1.75
99215		1.73	0.00
99214	1	1.08	1.08
99213	2	0.65	1.30
99212	0	0.43	0.00
99211		0.17	0.00
Post-service total			**24.76**
	Time	IWPUT	INTRA-RVW
Intra-service:	324	0.114	37.03
Total Time:	1014		

2006 rvu. MPC A		RVW	50.44
Note: Considered in 2007 5-year	Svy Data	RUC Std.	RVW
Pre-service:	Time	Intensity	(=time x intensity)
Pre-service eval & positioning	100	0.0224	2.24
Pre-service scrub, dress, wait	20	0.0081	0.16
Pre-service total			**2.40**
Post-service:	Time	Intensity	(=time x intensity)
Immediate post	45	0.0224	1.01
Subsequent visits:	Visit n	E/M RVW	(=n x RVW)
ICU 99291	1	4.00	4.00
ICU 99292		2.00	0.00
NICU 99296		16.00	0.00
NICU 99297		8.00	0.00
99233	1	1.51	1.51
99232	2	1.06	2.12
99231	6	0.64	3.84
Discharge 99238	1	1.28	1.28
Discharge 99239		1.75	0.00
99215		1.73	0.00
99214	0	1.08	0.00
99213	4	0.65	2.60
99212	0	0.43	0.00
99211		0.17	0.00
Post-service total			**16.36**
	Time	IWPUT	INTRA-RVW
Intra-service:	270	0.117	31.68
Total time:	841		

As it turns out, CPT 61700 is an even more interesting example because it was also considered in the current five-year review for work. The intra-service time for 61700 was reduced from 270 minutes to 240 minutes. Interestingly, the hospital length of stay for 61700 has apparently gone up from 11 days to 13 days. Patients undergoing surgery for simple intracranial aneurysm do not require critical care. The post-discharge office visit pattern for these two services is identical. SVS agrees that the new RUC/CMS recommendation of 46.01 work RVUs for 61700 is correct. One can build a work RVU for 33877 from that of 61700 by adjusting the intra-service work and the postservice work. Interest service work adjustment is 84 minutes multiplied by an IWPUT of 0.114. This equals 9.58 RVUs. Post work adjustment is 7.78 RVUs based on RUC approved visit pattern. If the work value for 61700 is correct, the work value for 33877 should be 46.01 + 9.58 + 7.78 = 63.37.

In conclusion, whether one uses the 2006 work RVU for 61700, or the newly proposed by CMS 2007 work RVU, a value of approximately 64.00 RVUs is appropriate for thoracoabdominal aortic aneurysm repair.

Using the CMS-proposed work RVU for 61700 simple intracranial aneurysm repair, 33877 thoracoabdominal aneurysm repair remains appropriately valued at 64.04:

SVS/RUC Recommendation	[redacted]	RVW:	64.04
with RUC times & visits	RUC Time	RUC Std.	RVW
Pre-service:	Time	Intensity	(=time x intensity)
Pre-service eval & positioning	95	0.0224	2.13
Pre-service scrub, dress, wait	15	0.0081	0.12
Pre-service total			**2.25**
Post-service:	Time	Intensity	(=time x intensity)
Immediate post	60	0.0224	1.34
Subsequent visits:	Visit n	E/M RVW	(=n x RVW)
ICU 99291	3	4.00	12.00
ICU 99292		2.00	0.00
NICU 99296		16.00	0.00
NICU 99297		8.00	0.00
99233	3	1.51	4.53
99232	2	1.06	2.12
99231	1	0.64	0.64
Discharge 99238	0	1.28	0.00
Discharge 99239	1	1.75	1.75
99215		1.73	0.00
99214	1	1.08	1.08
99213	2	0.65	1.30
99212	0	0.43	0.00
99211		0.17	0.00
Post-service total			**24.76**
	Time	IWPUT	INTRA-RVW
Intra-service:	324	0.114	37.03
Total Time:	1014		

New CMS 2007 RVU	[redacted]	RVW	46.01
	Svy Data	RUC Std.	RVW
Pre-service:	Time	Intensity	(=time x intensity)
Pre-service eval & positioning	90	0.0224	2.02
Pre-service scrub, dress, wait	15	0.0081	0.12
Pre-service total			**2.14**
Post-service:	Time	Intensity	(=time x intensity)
Immediate post	40	0.0224	0.90
Subsequent visits:	Visit n	E/M RVW	(=n x RVW)
ICU 99291	0	4.00	0.00
ICU 99292		2.00	0.00
NICU 99296		16.00	0.00
NICU 99297		8.00	0.00
99233	4	1.51	6.04
99232	3	1.06	3.18
99231	5	0.64	3.20
Discharge 99238	1	1.28	1.28
Discharge 99239		1.75	0.00
99215		1.73	0.00
99214	1	1.08	1.08
99213	2	0.65	1.30
99212	0	0.43	0.00
99211		0.17	0.00
Post-service total			**16.98**
	Time	IWPUT	INTRA-RVW
Intra-service:	240	0.112	26.90
Total time:	854		

Comparison of 33877 thoracoabdominal aneurysm repair with CMS 2007 proposed RVU for intracranial aneurysm repair CPT 61698

CMS has proposed a work RVU of 64.03 for CPT 61698 brain aneurysm repair, complex, and after thorough scrutiny, SVS agrees with the proposed value. The work RVU is essentially identical to the 64.04 recommended by SVS and the RUC for 33877. Both are highly complex services. Brain surgery requires quiet precision in the OR, while thoracoabdominal aortic aneurysm repair requires huge capability to deal with bleeding vessels, a large surgical field, and rapid hemodynamic alterations. Postoperatively the brain surgery patients are much less ill than the thoracoabdominal aneurysm patient; they have essentially a single system disorder.

Pre-op times are nearly identical 100+15 for 61698, 95+15 for 33877. Intra-service time is 36 minutes less for 33877 if we use NSQIP time (identical if we use survey time). Nevertheless, assuming NSQIP time of 324 minutes, 33877 is 36 minutes less x 0.114 = 4.1 RVUs less. Hospital LOS is 10 days for 33877 (12 if CMS prefers survey data), while LOS for 61698 is longer (16 days total) but less intense. Thus, if CPT 61698 is appropriately valued at the CMS-recommended 64.03, then the RVU for 33877 can be built as 64.03 minus 4.1 RVUs for intra-work, plus 4.38 for post-work = 64.40.

Step-by-step comparison of intracranial aneurysm repair 61698 with thoracoabdominal aneurysm repair 33877 justifies the SVS recommendation of 64.04 for 33877

CPT Code: [redacted]		RVW:	64.04
SVS/RUC REC w RUC TIMES	RUC Time	RUC Std.	RVW
Pre-service:	Time	Intensity	(=time x Intensity)
Pre-service eval & positioning	95	0.0224	2.13
Pre-service scrub, dress, wait	15	0.0081	0.12
Pre-service total			**2.25**
Post-service:	Time	Intensity	(=time x intensity)
Immediate post	60	0.0224	1.34
Subsequent visits:	Visit n	E/M RVW	(=n x RVW)
ICU 99291	3	4.00	12.00
ICU 99292		2.00	0.00
NICU 99296		16.00	0.00
NICU 99297		8.00	0.00
99233	3	1.51	4.53
99232	2	1.06	2.12
99231	1	0.64	0.64
Discharge 99238	0	1.28	0.00
Discharge 99239	1	1.75	1.75
99215		1.73	0.00
99214	1	1.08	1.08
99213	2	0.65	1.30
99212	0	0.43	0.00
99211		0.17	0.00
Post-service total			**24.76**
	Time	IWPUT	INTRA-RVW
Intra-service:	324	0.114	37.03
Total Time	1014		

61698 CMS PROPOSED for 2007	[redacted] Svy Data	RVW RUC Std.	64.03 RVW
Pre-service:	Time	Intensity	(=time x intensity)
Pre-service eval & positioning	100	0.0224	2.24
Pre-service scrub, dress, wait	15	0.0081	0.12
Pre-service total			**2.36**
Post-service:	Time	Intensity	(=time x intensity)
Immediate post	50	0.0224	1.12
Subsequent visits:	Visit n	E/M RVW	(=n x RVW)
ICU 99291	0	4.00	0.00
ICU 99292		2.00	0.00
NICU 99296		16.00	0.00
NICU 99297		8.00	0.00
99233	4	1.51	6.04
99232	6	1.06	6.36
99231	5	0.64	3.20
Discharge 99238	1	1.28	1.28
Discharge 99239		1.75	0.00
99215		1.73	0.00
99214	1	1.08	1.08
99213	2	0.65	1.30
99212	0	0.43	0.00
99211		0.17	0.00
Post-service total			**20.38**
	Time	IWPUT	INTRA-RVW
Intra-service:	360	0.115	41.29
Total time:	1084		

Why is survey respondents median value for 33877 less than 64.04? As noted above the RUC is very stingy when it comes to recommending work RVUs above median survey, yet they did so for this complex thoracoabdominal aneurysm repair. In this case, there were no reference services on our list that approximated the total work involved in 33877. When we tallied the time and visit pattern supplied by survey respondents it was clear that they were unable to integrate the individual components into an appropriate work value. At

median survey, the service simply does not add up. Median survey is the wrong value for this complex service, and the RUC agreed.

In conclusion, SVS requests that CMS reconsider its proposal for 33877 because the work RVU of 53.00 is unfair based on multiple objective analyses and comparisons with the work within vascular surgery and in other surgical specialties. A work RVU of 53.00 will cause a major rank order anomaly. The appropriate work RVU is 64.04.

CPT 35102 Open Repair of abdominal aortic aneurysm requiring bifurcated graft

CPT 35102 is open repair of an infrarenal abdominal aortic aneurysm using a bifurcated graft. This service was submitted to the five-year review because the work has changed. Endovascular aortic aneurysm repair is performed in patients with 15 mm or longer normal segments of aorta below the renal artery origins plus non-calcified, minimally angulated infrarenal necks. This leaves aneurysms with short, angulated and calcified infrarenal necks for open aneurysm repair. All of these factors increase the intensity and complexity of this service. The net result is that this service is more complex and time consuming than it was five years ago.

Source	Work RVU	IWPUT (using RUC time/visit)
SVS Recommendation:	39.80	0.096
RUC Recommendation:	36.28	0.083
CMS Proposal:	34.00	0.074

Service Components and IWPUT for 35102, SVS recommendation vs. CMS proposal. The CMS proposal results in an inappropriately low IWPUT intensity.

SVS Rec RVU	[redacted]	RVW:	39.80
with RUC time & Visits	RUC time	RUC Std.	RVW
Pre-service:	**Time**	**Intensity**	**(=time x intensity)**
Pre-service eval & positioning	75	0.0224	1.68
Pre-service scrub, dress, wait	15	0.0081	0.12
Pre-service total			**1.80**
Post-service:	**Time**	**Intensity**	**(=time x intensity)**
Immediate post	30	0.0224	0.67
Subsequent visits:	**Visit n**	**E/M RVW**	**(=n x RVW)**
ICU 99291	1	4.00	4.00
ICU 99292		2.00	0.00
NICU 99296		16.00	0.00
NICU 99297		8.00	0.00
99233	0	1.51	0.00
99232	3	1.06	3.18
99231	2	0.64	1.28
Discharge 99238	1	1.28	1.28
Discharge 99239	0	1.75	0.00
99215		1.73	0.00
99214	1	1.08	1.08
99213	1	0.65	0.65
99212	1	0.43	0.43
99211		0.17	0.00
Post-service total			**12.57**
	Time	**IWPUT**	**INTRA-RVW**
Intra-service:	265	**0.096**	25.43
Total Time:	688		

CMS Rec RVU	[redacted]	RVW:	34.00
with RUC time & visits	RUC Time	RUC Std.	RVW
Pre-service:	**Time**	**Intensity**	**(=time x intensity)**
Pre-service eval & positi	75	0.0224	1.68
Pre-service scrub, dress,	15	0.0081	0.12
Pre-service total			**1.80**
Post-service:	**Time**	**Intensity**	**(=time x intensity)**
Immediate post	30	0.0224	0.67
Subsequent visits:	**Visit n**	**E/M RVW**	**(=n x RVW)**
ICU 99291	1	4.00	4.00
ICU 99292		2.00	0.00
NICU 99296		16.00	0.00
NICU 99297		8.00	0.00
99233	0	1.51	0.00
99232	3	1.06	3.18
99231	2	0.64	1.28
Discharge 99238	1	1.28	1.28
Discharge 99239	0	1.75	0.00
99215		1.73	0.00
99214	1	1.08	1.08
99213	1	0.65	0.65
99212	1	0.43	0.43
99211		0.17	0.00
Post-service total			**12.57**
	Time	**IWPUT**	**INTRA-RVW**
Intra-service:	265	**0.074**	19.63
Total Time:	688		

SVS recommended an RVW of 39.80, which resulted in an appropriate IWPUT of 0.096 even after applying the RUC's reductions in pre-service time. An IWPUT of 0.096 places 35102 at the mid-point of the established IWPUT range for aneurysms and aortic surgery (see table below). Anything less would create a rank order anomaly. The RUC recommendation of 36.28 would result in an inappropriately low IWPUT of 0.083 at the bottom of the established IWPUT range for aneurysm repairs and aortic surgery. The CMS recommendation of 34.00 RVUs would establish a totally inappropriate new low IWPUT benchmark for open aneurysm services at 0.074. As noted above, the following IWPUTs

have been established by the RUC and CMS for aneurysm repairs and aortic surgery over the past 6 years:

RUC/CMS IWPUT Intensity Measure for Aneurysm Repairs and Aortic Surgery

Code	Short Descriptor	Year Implemented	IWPUT
**CMS places 35102 Aortic Aneurysm Repair here			**0.074**
35141	Repair femoral aneurysm	2002 5Yr	0.082
34900	Endovasc rep iliac aneurysm	2003 new	0.088
35646	Aorto-bifemoral bypass synth	2002 new	0.093
35151	Rep popliteal aneurysm	2002 5 Yr	0.094
33881	Endovasc rep thoracic aorta	2006 new	0.095
**SVS would put 35102 Aortic Aneurysm Repair here			**0.096**
35011	Rep axillary/brach aneurysm	2002 5 Yr	0.099
35131	Rep Iliac aneurysm	2002 5 Yr	0.101
34802	Endo rep abd AAA 2-piece	2001 new	0.101
34805	Endo rep Abd AAA aorto-uni	2001 new	0.101
35647	Aorto-fem bypass synth	2002 new	0.102
35045	Rep radial/ulnar aneurysm	2002 5 Yr	0.102
34803	Endo rep abd AAA 3-piece	2005 new	0.104
35121	Rep mesenteric aneurysm	2002 5 Yr	0.105
33880	Endovasc rep thoracic	2006 new	0.105
35111	Rep splenic aneurysm	2002 5 Yr	0.109
34800	Endovasc rep abd AAA	2001 new	0.109

Open aortic aneurysm repair is a complex operation with an established 30-day mortality of 4-6% in the best surgical hands. An IWPUT of 0.074 (using the CMS proposed RVW of 34.00) fails to approximate the true intensity and complexity of this service. This analysis indicates that the service will be undervalued by the CMS proposal.

Comparison of 35102 to Other Vascular Surgery Services, MPC "A" List 35631

CPT 35631 is "Bypass graft, with other than vein; aortoceliac, aortomesenteric, aortorenal". It serves as a RUC MPC "A" list standard service. 35631 is a 90-day global intra-abdominal operation that was analyzed by the RUC during the 2nd five-year review. 35631 has an RVW of 33.95. Pre-service time of 35631 (110 minutes) is very slightly more than 35102, which has 90 RUC-approved pre-service minutes (reduced from survey time). This accounts for only a 0.2 rvu difference. Intra-service work for 35102 at the SVS recommended RVW of 39.40 is 265 min x 0.096 = 25.43 rvus. Intra-service work for 35631 is 225 min x 0.102 = 23.00 rvus. Thus, 35102 has 2.43 rvus more intra-service than 35631. Post-service work is greater for 35102 (12.57 rvus) compared to 35631 (8.77 rvus) because the patients are generally older and sicker.

Based on this analysis, 35102 should be 0.2 rvus less than 35631 for pre-service work, 2.43 rvus more for intra-service work and 3.80 rvus more for post-service work. 35631 has a work RVU of 33.95. If appropriately valued in comparison to 35631, 35102 should have a work RVU of 33.95 - 0.2 +2.43 + 3.80 = 39.98. Thus, based on this comparison with an MPC "A" list vascular service, the SVS recommended work RVU of 39.80 is totally appropriate.

Comparison of aortic aneurysm repair CPT 35102 to simple intracranial aneurysm repair CPT 61702

CPT 61702 is "Surgery of simple intracranial aneurysm, intracranial approach; vertebrobasilar circulation." 61702 was granted 25 minutes more pre-service time than 35102 by the RUC. CPT 61702 has 280 minutes of intra-service time compared to 265 for CPT 35102. CPT 61702 has a longer length of stay, but the cerebral aneurysm patient is less ill (typical patient has single-system disease without overt hemodynamic instability) than the one recovering from open abdominal aneurysm repair. The typical 61702 patient does not require critical care service. The two procedures have an identical office visit pattern. Overall, 61702 has 20.83 post-service RVUs compared to 12.57 for 35102, a difference of 8.26.

SVS agrees that the CMS proposal of 54.28 work RVUs for 61702. An appropriate work RVU for 35102 may then be constructed from 61702 by subtracting 0.56 RVUs for pre-service, 5.66 RVUs for intra-service and 8.26 RVUs for post-service work from 54.28, with the resultant RVU of 39.80 for 35102. The building blocks of these two services are listed here, assuming 35102 is valued at the SVS recommended 39.80.

Since 61702 simple intracranial aneurysm repair is correctly valued at 54.28, 35102 abdominal aortic aneurysm should be valued at 39.80:

SVS Rec RVU	[redacted]	RVW:	39.80
with RUC time & Visits	RUC time	RUC Std.	RVW
Pre-service:	Time	Intensity	(=time x intensity)
Pre-service eval & positioning	75	0.0224	1.68
Pre-service scrub, dress, wait	15	0.0081	0.12
Pre-service total			**1.80**
Post-service:	Time	Intensity	(=time x intensity)
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVW	(=n x RVW)
ICU 99291	1	4.00	4.00
ICU 99292		2.00	0.00
NICU 99296		16.00	0.00
NICU 99297		8.00	0.00
99233	0	1.51	0.00
99232	3	1.06	3.18
99231	2	0.64	1.28
Discharge 99238	1	1.28	1.28
Discharge 99239	0	1.75	0.00
99215		1.73	0.00
99214	1	1.08	1.08
99213	1	0.65	0.65
99212	1	0.43	0.43
99211		0.17	0.00
Post-service total			**12.57**
	Time	IWPUT	INTRA-RVW
Intra-service:	265	0.096	25.43
Total Time:	688		

CMS Rec RVU	[redacted]	RVW:	54.28
with RUC time & Visits	Svy Data	RUC Std.	RVW
Pre-service:	Time	Intensity	(=time x intensity)
Pre-service eval & positi	100	0.0224	2.24
Pre-service scrub, dress,	15	0.0081	0.12
Pre-service total			**2.36**
Post-service:	Time	Intensity	(=time x intensity)
Immediate post	50	0.0224	1.12
Subsequent visits:	Visit n	E/M RVW	(=n x RVW)
ICU 99291	0	4.00	0.00
ICU 99292		2.00	0.00
NICU 99296		16.00	0.00
NICU 99297		8.00	0.00
99233	5	1.51	7.55
99232	5	1.06	5.30
99231	5	0.64	3.20
Discharge 99238	1	1.28	1.28
Discharge 99239		1.75	0.00
99215		1.73	0.00
99214	1	1.08	1.08
99213	2	0.65	1.30
99212	0	0.43	0.00
99211		0.17	0.00
Post-service total			**20.83**
	Time	IWPUT	INTRA-RVW
Intra-service:	280	0.111	31.09
Total Time:	1015		

Hospital Visits for 35102 Should be Reconsidered

SVS believes that CMS and the RUC failed to take into account the fact that our expert consensus panel voluntarily reduced the hospital visit levels from the raw survey data to provide what we felt was a balanced package to justify the recommended work value. An important part of the RUC process involves consensus panel expert evaluation of the survey

data. Unfortunately, in the rush of work considerations during the five-year review process, we believe this was overlooked by the RUC and its workgroup for code 35102. SVS minimized the hospital visit pattern because we believed the packaged service deserved a work RVU of 39.20, and with only one critical care visit all the components fit together very well, resulting in an appropriate IWPUT. In fact, 65% of survey respondents included two or more 99291 critical care visits, some recommending as many as five. With the severe reductions from the SVS RVU recommendation, we suggest the visit pattern should be reconsidered. SVS would be happy to review the raw data with CMS. The typical 35102 patient has a multitude of comorbidities and hemodynamic instability that require multiple critical care services following a 4.5-hour operation that includes cross-clamping the aorta.

The non-critical care visit pattern in the survey data was a mix between 99233s and 99232s, accounting, in general, for a total of three visits between the two codes. The SVS Expert Panel considered these data and decided to downshift all the 99233s to 99232s, thereby resulting in three 99232s for the typical patient. Finally, we agreed with the remainder of the stay consistent with the typical survey pattern of two 99231s and one 99238 discharge day. SVS believes the RUC and CMS failed to consider these reductions as they rejected the SVS recommendation and reduced the RVU to unreasonable levels. Although we believe a work RVU of 39.80 is fully justified at the current visit level, the raw data should be revisited if CMS is willing.

CPT 35081 Open Repair of abdominal aortic aneurysm requiring tube graft

CPT 35081 is open repair of an infrarenal abdominal aortic aneurysm using a cylindrical "tube" graft. This service was submitted to the five-year review because the work has changed. Endovascular aortic aneurysm repair is performed in patients with 15 mm or longer normal segments of aorta below the renal artery origins plus non-calcified, minimally angulated infrarenal necks. This leaves aneurysms with short, angulated and calcified infrarenal necks for open aneurysm repair. All of these factors increase the intensity and complexity of this service. The net result is that this service is more complex and time consuming than it was five years ago.

According to the NPRM, CMS rejected the SVS and RUC recommendations because they relied upon NSQIP data. The fact is that NSQIP and SVS Survey hospital length of stay were identical at 7 days. In addition, NSQIP and SVS Survey data for intra-service time varied by only three minutes. Early on during workgroup negotiations, SVS relinquished those 3 minutes of intra-service time such that NSQIP data plays no part in our recommendation for this service.

SVS believes that if CMS rejected our recommendation based on the Agency's criticism of NSQIP data, this code was wrongfully adjudicated. We believe CMS failed to consider the extensive "Additional Rationale" submitted by SVS to support a work relative value of 34.55 RVUs for this service.

SVS recommended 34.55 RVUs for this open AAA repair based on a building block analysis of a high complexity, long duration surgery followed by a typically slow recovery in the typical patient with multiple medical comorbidities (210 skin-to-skin minutes, 633 total minutes). Our recommended RVU lies between the median and 75th percentile of the survey values. SVS believes the survey respondents undervalued the total service based on our Expert panel's analysis of the pre-, intra-, and post-service work. Virtually all respondents included critical care visits, but they failed to consider the relative value of the critical care. At the CMS proposed RVU, the IWPUT for this aortic reconstruction is only 0.079, a value inconsistent with aortic reconstruction. At the SVS recommended value of 34.55, IWPUT is 0.096, fully consistent with arterial surgery. Based on IWPUT analysis, the CMS-proposed RVU of 31.00 is too low for open aortic aneurysm construction 35081.

Source	Work RVU	IWPUT (using RUC time/visit)
SVS Recommended:	34.55	0.096
CMS Proposed:	31.00	0.079

35081 Time, Visit & IWPUT Intensity for SVS Recommended vs. CMS Proposed RVUs. The CMS Proposal results in an inappropriately low IWPUT intensity:

SVS 5Yr REC		RVW	34.55
with RUC time & visits	Svy Data	RUC Std.	RVW
Pre-service:	**Time**	**Intensity**	**(=time x intensity)**
Pre-service eval & positioning	75	0.0224	1.68
Pre-service scrub, dress, wait	15	0.0081	0.12
Pre-service total			**1.80**
Post-service:	**Time**	**Intensity**	**(=time x intensity)**
Immediate post	30	0.0224	0.67
Subsequent visits:	**Visit n**	**E/M RVW**	**(=n x RVW)**
ICU 99291	1	4.00	4.00
ICU 99292		2.00	0.00
NICU 99296		16.00	0.00
NICU 99297		8.00	0.00
99233	0	1.51	0.00
99232	3	1.06	3.18
99231	2	0.64	1.28
Discharge 99238	1	1.28	1.28
Discharge 99239	0	1.75	0.00
99215		1.73	0.00
99214	1	1.08	1.08
99213	1	0.65	0.65
99212	1	0.43	0.43
99211		0.17	0.00
Post-service total			**12.57**
	Time	**IWPUT**	**INTRA-RVW**
Intra-service:	210	0.096	20.18
Total Time:	633		

CMS Proposed			31.00
w RUC time & visits	Svy Data	RUC Std.	RVW
Pre-service:	**Time**	**Intensity**	**(=time x intensity)**
Pre-service eval & positi	75	0.0224	1.68
Pre-service scrub, dress,	15	0.0081	0.12
Pre-service total			**1.80**
Post-service:	**Time**	**Intensity**	**(=time x intensity)**
Immediate post	30	0.0224	0.67
Subsequent visits:	**Visit n**	**E/M RVW**	**(=n x RVW)**
ICU 99291	1	4.00	4.00
ICU 99292		2.00	0.00
NICU 99296		16.00	0.00
NICU 99297		8.00	0.00
99233	0	1.51	0.00
99232	3	1.06	3.18
99231	2	0.64	1.28
Discharge 99238	1	1.28	1.28
Discharge 99239	0	1.75	0.00
99215		1.73	0.00
99214	1	1.08	1.08
99213	1	0.65	0.65
99212	1	0.43	0.43
99211		0.17	0.00
Post-service total			**12.57**
	Time	**IWPUT**	**INTRA-RVW**
Intra-service:	210	0.079	16.63
Total Time:	633		

Comparison to Other Vascular Surgery Aneurysm Repairs and Aortic Surgery

SVS recommended a work RVU of 34.55, a value which results in an IWPUT of 0.096, directly in the middle of the established range for these services. The CMS proposal of only 31.00 RVUs, results in an IWPUT of 0.079, below the lowest value of the established range of intensities for aneurysm repairs and other aortic surgery. Note that the other IWPUT values in this table are calculated from RUC-recommended and CMS-approved aneurysm repairs and aortic surgery.

RUC/CMS-Approved IWPUT Intensity for Aneurysm Repairs and Aortic Surgery Indicates that CMS proposed work RVU is too low based on intensity comparison:

Code	Short Descriptor	Year Implemented	IWPUT
****CMS would put 35081 Aortic aneurysm Repair here**			**0.079**
35141	Repair femoral aneurysm	2002 5Yr	0.082
34900	Endovasc rep iliac aneurysm	2003 new	0.088
35646	Aorto-bifemoral bypass synth	2002 new	0.093
35151	Rep popliteal aneurysm	2002 5 Yr	0.094
33881	Endovasc rep thoracic aorta	2006 new	0.095
****SVS would put 35081 Aortic aneurysm Repair here**			**0.096**
35011	Rep axillary/brach aneurysm	2002 5 Yr	0.099
35131	Rep Iliac aneurysm	2002 5 Yr	0.101
34802	Endo rep abd AAA 2-piece	2001 new	0.101
34805	Endo rep Abd AAA aorto-uni	2001 new	0.101

35647	Aorto-fem bypass synth	2002 new	0.102
35045	Rep radial/ulnar aneurysm	2002 5 Yr	0.102
34803	Endo rep abd AAA 3-piece	2005 new	0.104
35121	Rep mesenteric aneurysm	2002 5 Yr	0.105
33880	Endovasc rep thoracic	2006 new	0.105
35111	Rep splenic aneurysm	2002 5 Yr	0.109
34800	Endovasc rep abd AAA	2001 new	0.109

Hospital Visits for 35081 Should be Reconsidered

SVS believes that CMS and the RUC failed to take into account the fact that our expert consensus panel voluntarily reduced the hospital visit levels from the raw survey data to provide what we felt was a balanced package to justify the recommended work value. An important part of the RUC process involves consensus panel expert evaluation of the survey data. Unfortunately, in the rush of work considerations during the five-year review process, we believe this was overlooked by the RUC and its workgroup for code 35081. SVS minimized the hospital visit pattern because we believed the packaged service deserved a work RVU of 34.55, and with only one critical care visit all the components fit together very well, resulting in an appropriate IWPUT. In reality, 62% of survey respondents included two or more 99291 critical care visits, some recommending as many as five. With the severe reductions imposed by CMS compared to the SVS RVU recommendation, we suggest the visit pattern should be reconsidered. SVS would be happy to review the raw data with CMS. The typical 35081 patient has a multitude of comorbidities and hemodynamic instability that require critical care following open aneurysm repair.

The non-critical care visit pattern in the survey data was a mix between 99233s and 99232s, accounting, in general, for a total of three visits between the two codes. The SVS Expert Panel considered these data and decided to downshift all the 99233s to 99232s, thereby resulting in three 99232s for the typical patient. Finally, we agreed with the remainder of the stay consistent with the typical survey pattern of 99231s and one 99238 discharge day. SVS believes the RUC and CMS failed to consider these reductions as they rejected the SVS recommendation and reduced the RVU to unreasonable levels. Although we believe a work RVU of 34.55 is fully justified at the current visit level, the raw data could be revisited if CMS is willing.

In summary, for 35081, SVS has provided an intensity analysis, comparison with other vascular surgery procedures, comparison with aneurysm repairs in the neurosurgical realm, and a review of our treatment of hospital visits. We believe all of this information points to our originally recommended work RVU of 34.55 as the most accurate relative value.

CPT 35556 Bypass with vein, femoral-popliteal

35556 lower extremity bypass graft is performed to prevent leg amputation due to ischemic gangrene and non-healing ischemic foot ulcers. SVS believes that this operation, in addition to three others in the same family (35566, 35583, 35585) number among the most undervalued services in the Medicare physicians fee schedule. These operations require many hours of complex surgery, and the patients are extremely ill postoperatively. The individuals who require this type of operation are elderly and almost always have coincident atherosclerotic disorders such as coronary artery disease and cerebrovascular disease. Most of these patients has smoked thousands of packs of cigarettes and have advanced COPD.

These bypass grafts were undervalued by survey respondents because they underestimated the total package of work including skin-to-skin time and the magnitude of post-operative work. This is borne out by NSQIP and building block analysis. As noted above, we believe NSQIP data provides accuracy superior to that of survey respondents. There were 1500 CPT 35556 operations recorded in the NSQIP database. The survey respondents underestimated the actual intra-service time by 41 minutes.

SVS recommended 31.58 RVUs, a value that results in IWPUT of 0.090, consistent with major arterial surgery and many other arterial bypass grafts. The RUC reduced the recommended RVW to 27.25, a value that provides an IWPUT of only 0.073, inconsistent with major arterial reconstructions. CMS reduced the value further to 25.00, a value that results in an IWPUT of only 0.064, totally inconsistent with any major arterial reconstructions. In fact, with the newly proposed CMS E&M RVUs, this complex arterial reconstruction will be valued for intensity less than a low level ED visit (99282, IWPUT 0.070). SVS believes its originally recommended value of 31.58 is the most accurate work relative value. **SVS vs. CMS Recommendations for 35556:**

SVS Rec RVU	35556	RVW:	31.58
w RUC time & visits	RUC Data	RUC Std.	RVW
Pre-service:	Time	Intensity	(=time x intensity)
Pre-service eval & positio	55	0.0224	1.23
Pre-service scrub, dress,	15	0.0081	0.12
Pre-service total			1.35
Post-service:	Time	Intensity	(=time x intensity)
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVW	(=n x RVW)
ICU 99291	0	4.00	0.00
ICU 99292		2.00	0.00
NICU 99296		16.00	0.00
NICU 99297		8.00	0.00
99233	1	1.51	1.51
99232	1	1.06	1.06
99231	2	0.64	1.28
Discharge 99238	1	1.28	1.28
Discharge 99239	0	1.75	0.00
99215		1.73	0.00
99214	0	1.08	0.00
99213	2	0.65	1.30
99212	1	0.43	0.43
99211		0.17	0.00
Post-service total			7.53
	Time	IWPUT	INTRA-RVW
Intra-service:	251	0.090	22.69
Total time:	557		

CMS Rec RVU	35556	RVW:	25.00
w RUC time & visits	RUC Data	RUC Std.	RVW
Pre-service:	Time	Intensity	=time x intensity
Pre-service eval & positi	55	0.0224	1.23
Pre-service scrub, dress,	15	0.0081	0.12
Pre-service total			1.35
Post-service:	Time	Intensity	=time x intensity
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVW	(=n x RVW)
ICU 99291	0	4.00	0.00
ICU 99292		2.00	0.00
NICU 99296		16.00	0.00
NICU 99297		8.00	0.00
99233	1	1.51	1.51
99232	1	1.06	1.06
99231	2	0.64	1.28
Discharge 99238	1	1.28	1.28
Discharge 99239	0	1.75	0.00
99215		1.73	0.00
99214	0	1.08	0.00
99213	2	0.65	1.30
99212	1	0.43	0.43
99211		0.17	0.00
Post-service total			7.53
	Time	IWPUT	INTRA-RVW
Intra-service:	251	0.064	16.11
Total time:	557		

Thirty-two bypass grafts have undergone RUC evaluation over the past seven years. The IWPUT ranges from 0.065 for relatively straightforward bypass grafts involving medium-sized arteries to values of 0.120 for more complex procedures performed in body areas difficult to reach. This chart demonstrates the inappropriateness of the CMS recommendation for CPT 35556. The SVS recommendation of 31.58 places the intensity of this code where it appropriately belongs in the middle of the range.

CMS/RUC IWPUTs for Vascular Surgery Bypass Codes 2000-2006

35556	**CMS Rec inappropriately places code here**	**0.064**
35558	BPG w vein femoral-femoral	0.065
35533	BPG w vein axillary-bi-femoral	0.075
35656	BPG w other than vein fem-pop	0.075
35565	BPG w vein ilio-femoral	0.076
35522	BPG w vein axillary-brachial	0.077
35521	BPG w vein axillary-femoral	0.079
35665	BPG w other than vein iliofem	0.080
35563	BPG w vein ilio-iliac	0.081
35571	BPG w vein popliteal-tibial	0.083
35510	BPG w vein carotid-brachial	0.084
35671	BPG w other than vein pop-tib	0.084
35663	BPG w other than vein ilioiliac	0.084
35587	BPG w vein insitu pop-tib	0.085
35512	BPG w vein subclavian-brachial	0.085
35666	BPG w other than vein fem-tib	0.086
35661	BPG w other than vein fem-fem	0.086
35531	BPG w vein aorto-mesenteric	0.086
35654	BPG w other than vein ax-bifem	0.089
35556	**SVS Rec Appropriately Places Code here**	**0.090**
35518	BPG w vein axillary-axillary	0.091
35646	BPG w other than vein aortobifem	0.092
35525	BPG w vein brachial-brachial	0.093
35636	BPG w other than vein splenorenal	0.094
35511	BPG w vein subclavian-subclavian	0.096
35526	BPG w vein aorto-subclavian	0.098
35621	BPG w other than vein ax-fem	0.100
35647	BPG w other than vein aortofem	0.101
35631	BPG w other than vein aorto-mes	0.101
35626	BPG w other than vein aorto-sub	0.104
35560	BPG w vein aorto-renal	0.107
35650	BPG w other than vein ax-ax	0.107
35536	BPG w vien splenorenal	0.120
35623	BPG w other than vein ax-pop	0.120

Comparison of 35556 with CMS-chosen Benchmark Vascular Bypass CPT 35671

In the proposed rule, CMS chose CPT code 35671 as a reference service when discussing orthopedic surgery code CPT 27447 (page 71). We therefore assume that CMS believes 35671 to be a solid benchmark in the relative value scale. The following data exist for 35671, which is "Bypass graft, with other than vein; popliteal-tibial or-peroneal artery".

35671 CMS REF Code	**35671**	**RVW:**	**19.30**
2nd 5-Yeaf Rev	**Svy Data**	**RUC Std.**	**RVW**
Pre-service:	**Time**	**Intensity**	**(=time x intensity)**
Pre-service eval & positioning	55	0.0224	1.23
Pre-service scrub, dress, wait	15	0.0081	0.12
Pre-service total			**1.35**
Post-service:	**Time**	**Intensity**	**(=time x intensity)**
Immediate post	30	0.0224	0.67
Subsequent visits:	**Visit n**	**E/M RVW**	**(=n x RVW)**
ICU 99291	0	4.00	0.00
ICU 99292		2.00	0.00
NICU 99296		16.00	0.00
NICU 99297		8.00	0.00
99233	0	1.51	0.00
99232	2	1.06	2.12
99231	1	0.64	0.64
Discharge 99238	1	1.28	1.28
Discharge 99239	0	1.75	0.00
99215		1.73	0.00
99214	0	1.08	0.00
99213	2	0.65	1.30
99212	1	0.43	0.43
99211		0.17	0.00
Post-service total			**6.44**
	Time	**IWPUT**	**INTRA-RVW**
Intra-service:	135	**0.085**	11.50
Total Time:	411		

SVS would be pleased to build a work RVU for 35556 based on this benchmark service chosen by CMS for comparison use in the NPRM. 35556 has 251 minutes of intra-service time compared to 135 minutes for 35671. Even using an IWPUT of 0.085 (for 35671), this represents an additional 9.86 RVUs. The two services have equal pre-service time and pre-service work. The post-service work for 35556 is 7.53 RVUs compared to 6.44 RVUs for 35671. Therefore, a work RVU for 35556 may be calculated as 19.30 plus 9.86 plus 1.09 equals 30.25.

If one were to acknowledge that working with vein conduit (as in 35556) is more complex than working with synthetic conduit (as in 35671) then the IWPUT of 0.090 (for 35556) should be employed. The calculated work RVU would then be 31.51, essentially equivalent to the SVS recommended value of 31.58.

Comparison of 35556 to General Surgery procedure 44150

CMS will be creating a major rank order anomaly if it values 35556 at only 25.00, while appropriately assigning CPT 44150 (partial removal of colon) a work RVU of 27.50. 44150 is a 180 minute skin-to-skin operation performed in patients who typically have moderate comorbidities. CPT 35556 is a 251 minute operation performed in patients who typically have advanced cardiovascular comorbidities. SVS believes 44150 will be accurately valued at 27.50, and the society strongly recommends reconsideration of a more accurate work RVU for the much longer and equally complex 35556 operation at 31.58 RVUs.

If CMS values 44150 at 27.50, it is unreasonable to propose only 25.00 RVUs for 35556. 35556 has 70 more minutes of complex skin-to-skin time:

2007 CMS Proposed RVU	44150	RVW:	27.50
Colectomy/ileostomy	Svy Data	RUC Std.	RVW
Pre-service:	Time	Intensity	(=time x intensity)
Pre-service eval & positionin	45	0.0224	1.01
Pre-service scrub, dress, wai	15	0.0081	0.12
Pre-service total			1.13
Post-service:	Time	Intensity	(=time x intensity)
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVW	(=n x RVW)
ICU 99291	0	4.00	0.00
ICU 99292		2.00	0.00
NICU 99296		16.00	0.00
NICU 99297		8.00	0.00
99233	1	1.51	1.51
99232	3	1.06	3.18
99231	3	0.64	1.92
Discharge 99238	1	1.28	1.28
Discharge 99239		1.75	0.00
99215		1.73	0.00
99214	1	1.08	1.08
99213	1	0.65	0.65
99212	2	0.43	0.86
99211		0.17	0.00
Post-service total			11.15
	Time	IWPUT	INTRA-RVW
Intra-service:	180	0.085	15.22
	585		

2007 CMS Proposed RVU	35556	RVW:	25.00
w RUC time & visits	RUC Data	RUC Std.	RVW
Pre-service:	Time	Intensity	(=time x intensity)
Pre-service eval & positioning	55	0.0224	1.23
Pre-service scrub, dress, wait	15	0.0081	0.12
Pre-service total			1.35
Post-service:	Time	Intensity	(=time x intensity)
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVW	(=n x RVW)
ICU 99291	0	4.00	0.00
ICU 99292		2.00	0.00
NICU 99296		16.00	0.00
NICU 99297		8.00	0.00
99233	1	1.51	1.51
99232	1	1.06	1.06
99231	2	0.64	1.28
Discharge 99238	1	1.28	1.28
Discharge 99239	0	1.75	0.00
99215		1.73	0.00
99214	0	1.08	0.00
99213	2	0.65	1.30
99212	1	0.43	0.43
99211		0.17	0.00
Post-service total			7.53
	Time	IWPUT	INTRA-RVW
Intra-service:	251	0.064	16.11
Total time:	557		

Hospital Visits for 35556 Should be Reconsidered

SVS believes that CMS and the RUC failed to take into account the fact that our expert consensus panel voluntarily reduced the hospital visit levels from the raw survey data to provide what we felt was a balanced package to justify the recommended work value. An important part of the RUC process involves consensus panel expert evaluation of the survey data. Unfortunately, in the rush of work considerations during the five-year review process, we believe this was overlooked by the RUC and its workgroup for code 35556. SVS minimized the hospital visit pattern because we believed the packaged service deserved a work RVU of 31.58, and the components fit together very well without critical care, resulting in an appropriate IWPUT. In reality, 59% of survey respondents included one or two 99291 critical care visits, and we downshifted those to one 99233. With the severe r eductions imposed by CMS compared to the SVS RVU recommendation, we suggest the visit pattern should be reconsidered. SVS would be happy to review the raw data with CMS. The typical

35556 patient has a multitude of comorbidities and hemodynamic instability that require critical care following open aneurysm repair. SVS believes the RUC and CMS failed to consider these reductions as they rejected the SVS recommendation and reduced the RVU to unreasonable levels. Although we believe a work RVU of 31.58 is fully justified at the current visit level, the raw data should be revisited if CMS is willing.

In conclusion for 35556, SVS has provided IWPUT data, comparison with a CMS benchmark vascular bypass operation, a comparison with a CMS endorsed general surgery operation, and a critical review of the hospital visit pattern, all of which justify the SVS-recommended value of 31.58 RVUs. We request that CMS give appropriate consideration to this information.

CPT 35566 Bypass Graft with vein, Femoral-tibial

This lower extremity bypass is performed to prevent leg amputation due to ischemic gangrene and non-healing foot ulcers. SVS believes that this bypass in addition to three others in the same family (35556, 35583, 35585) number among the most undervalued services in the Medicare physicians fee schedule. The frequency of this operation has dropped substantially over the past 10 years. The NSQIP data proves that survey respondents underestimated the intra-service time, in this case by 36 minutes. There were almost 1400 of these operations recorded in the NSQIP database. The intra-time must be more accurate than estimates by ~40 surgeons.

SVS Recommendation vs. CMS Proposed RVU for 35566 Fem-Tib Bypass with vein. The CMS proposal would set a new lowest level for bypass surgery intensity.

SVS Rec RVU	35566		39.20
RUC-approved time & visi	Svy Data	RUC Std.	RVW
Pre-service:	**Time**	**Intensity**	**(=time x intensity)**
Pre-service eval & positio	55	0.0224	1.23
Pre-service scrub, dress,	15	0.0081	0.12
Pre-service total			**1.35**
Post-service:	**Time**	**Intensity**	**(=time x intensity)**
Immediate post	30	0.0224	0.67
Subsequent visits:	**Visit n**	**E/M RVW**	**(=n x RVW)**
ICU 99291	0	4.00	0.00
ICU 99292		2.00	0.00
NICU 99296		16.00	0.00
NICU 99297		8.00	0.00
99233	1	1.51	1.51
99232	2	1.06	2.12
99231	3	0.64	1.92
Discharge 99238	0	1.28	0.00
Discharge 99239	1	1.75	1.75
99215		1.73	0.00
99214	0	1.08	0.00
99213	2	0.65	1.30
99212	1	0.43	0.43
99211		0.17	0.00
Post-service total			**9.70**
	Time	**IWPUT**	**INTRA-RVW**
Intra-service:	306	**0.092**	28.14
Total Time:	670		

CMS Rec RVU	35566		30.00
RUC-approved time & visits	Svy Data	RUC Std.	RVW
Pre-service:	**Time**	**Intensity**	**=time x intensity**
Pre-service eval & positionir	55	0.0224	1.23
Pre-service scrub, dress, wa	15	0.0081	0.12
Pre-service total			**1.35**
Post-service:	**Time**	**Intensity**	**=time x intensity**
Immediate post	30	0.0224	0.67
Subsequent visits:	**Visit n**	**E/M RVW**	**(=n x RVW)**
ICU 99291	0	4.00	0.00
ICU 99292		2.00	0.00
NICU 99296		16.00	0.00
NICU 99297		8.00	0.00
99233	1	1.51	1.51
99232	2	1.06	2.12
99231	3	0.64	1.92
Discharge 99238	0	1.28	0.00
Discharge 99239	1	1.75	1.75
99215		1.73	0.00
99214	0	1.08	0.00
99213	2	0.65	1.30
99212	1	0.43	0.43
99211		0.17	0.00
Post-service total			**9.70**
	Time	**IWPUT**	**INTRA-RVW**
Intra-service:	306	**0.062**	18.94
Total Time:	670		

At the SVS recommended RVW of 39.20, the IWPUT of this service is appropriate for major vascular arterial reconstruction to the tibial arteries at 0.092. CMS reduced the recommended value to 30.00, resulting in an IWPUT of only 0.062. At 0.062, this complex service will now have intensity less than the lowest level inpatient consult in the proposed new system (99251, IWPUT 0.078).

On the following page, SVS presents 32 arterial bypass grafts that have undergone RUC evaluation over the past seven years. The IWPUT ranges from 0.065 for relatively straightforward bypass grafts involving medium-sized arteries to values of 0.120 for more complex procedures performed in body areas that are difficult to reach. This chart demonstrates the inappropriateness of the CMS recommendation for CPT 35566. The SVS

recommendation of 39.20 RVUs places the intensity of this code appropriately in the middle of the range.

CMS/RUC Approved IWPUTs for Vascular Surgery Bypass Codes 2000-2006

CPT Code	Short Descriptor	IWPUT
35566	**CMS Rec inappropriately places code here**	**0.062**
35558	BPG w vein femoral-femoral	0.065
35533	BPG w vein axillary-bi-femoral	0.075
35656	BPG w other than vein fem-pop	0.075
35565	BPG w vein ilio-femoral	0.076
35522	BPG w vein axillary-brachial	0.077
35521	BPG w vein axillary-femoral	0.079
35665	BPG w other than vein iliofem	0.080
35563	BPG w vein ilio-iliac	0.081
35571	BPG w vein popliteal-tibial	0.083
35510	BPG w vein carotid-brachial	0.084
35671	BPG w other than vein pop-tib	0.084
35663	BPG w other than vein ilioiliac	0.084
35587	BPG w vein insitu pop-tib	0.085
35512	BPG w vein subclavian-brachial	0.085
35666	BPG w other than vein fem-tib	0.086
35661	BPG w other than vein fem-fem	0.086
35531	BPG w vein aorto-mesenteric	0.086
35654	BPG w other than vein ax-bifem	0.089
35518	BPG w vein axillary-axillary	0.091
35566	**SVS Rec Appropriately places code here**	**0.092**
35646	BPG w other than vein aortobifem	0.092
35525	BPG w vein brachial-brachial	0.093
35636	BPG w other than vein splenorenal	0.094
35511	BPG w vein subclavian-subclavian	0.096
35526	BPG w vein aorto-subclavian	0.098
35621	BPG w other than vein ax-fem	0.100
35647	BPG w other than vein aortofem	0.101
35631	BPG w other than vein aorto-mes	0.101
35626	BPG w other than vein aorto-sub	0.104
35560	BPG w vein aorto-renal	0.107
35650	BPG w other than vein ax-ax	0.107
35536	BPG w vien splenorenal	0.120
35623	BPG w other than vein ax-pop	0.120

Comparison of 35566 with CMS-chosen Benchmark Vascular Bypass CPT 35671

In the proposed rule, CMS chose CPT code 35671 as a reference service when discussing orthopedic surgery code CPT 27447 (page 71). We therefore assume that CMS believes 35671 to be a solid benchmark in the relative value scale. The following data exist for 35671, which is "Bypass graft, with other than vein; popliteal-tibial or-peroneal artery".

35671 CMS REF Code	**35671**	**RVW:**	**19.30**
2nd 5-Yeaf Rev	**Svy Data**	**RUC Std.**	**RVW**
Pre-service:	**Time**	**Intensity**	**(=time x intensity)**
Pre-service eval & positioning	55	0.0224	1.23
Pre-service scrub, dress, wait	15	0.0081	0.12
Pre-service total			**1.35**
Post-service:	**Time**	**Intensity**	**(=time x intensity)**
Immediate post	30	0.0224	0.67
Subsequent visits:	**Visit n**	**E/M RVW**	**(=n x RVW)**
ICU 99291	0	4.00	0.00
ICU 99292		2.00	0.00
NICU 99296		16.00	0.00
NICU 99297		8.00	0.00
99233	0	1.51	0.00
99232	2	1.06	2.12
99231	1	0.64	0.64
Discharge 99238	1	1.28	1.28
Discharge 99239	0	1.75	0.00
99215		1.73	0.00
99214	0	1.08	0.00
99213	2	0.65	1.30
99212	1	0.43	0.43
99211		0.17	0.00
Post-service total			**6.44**
	Time	**IWPUT**	**INTRA-RVW**
Intra-service:	135	**0.085**	11.50
Total Time:	411		

SVS would be pleased to build a work RVU for 35566 based on this benchmark service chosen by CMS for comparison use in the NPRM. 35566 has 306 minutes of intra-service time compared to 135 minutes for 35671. At the IWPUT for 35671 of 0.085, this represents an additional 14.54 RVUs. The two services have equal pre-service time and pre-service work. The post-service work for 35566 is 9.70 RVUs compared to 6.44 RVUs for 35671. Therefore, a work RVU for 35566 may be calculated as 19.30 plus 14.54 plus 3.26 equals 37.10.

If one were to take into account that working with vein conduit (as in 35566) is more complex than working with synthetic conduit (as in 35671), the IWPUT of 35566 should be used in this calculation (0.092). The resultant RVW would be 39.24, essentially identical to the original SVS recommended value of 39.20.

Comparison of 35566 to CMS proposal for General Surgery service 44151

CMS will be creating a major rank order anomaly if it values 35566 at only 30.00, while at the same time appropriately assigning CPT 44151 removal of colon an RVW of 32.00. 44151 is a 240 minute skin-to-skin operation performed in patients with moderate cardiovascular comorbidities. CPT 35566 is a 306 minute operation performed in patients who typically have advanced cardiovascular comorbidities. Total time for 44151 is 683 minutes, while total time for 35566 is 670 minutes. However, the biggest difference in these two services is the extra 66 minutes of complex intra-service time in 35566. CMS cannot fairly value 35566 at 30 RVUs, while at the same time valuing 44151 at 32.00 RVUs. SVS strongly recommends reconsideration of the more accurate value that the society recommended at 39.20 RVUs.

If 44151 is valued at 32.00, 35566 must fairly be valued substantially > 30.00:

2007 CMS Proposed RVU	44151	RVW:	32.00
Colectomy/ileostomy	Svy Data	RUC Std.	RVW
Pre-service:	Time	Intensity	(=time x intensity)
Pre-service eval & positionin	45	0.0224	1.01
Pre-service scrub, dress, wai	15	0.0081	0.12
Pre-service total			**1.13**
Post-service:	Time	Intensity	(=time x intensity)
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVW	(=n x RVW)
ICU 99291	0	4.00	0.00
ICU 99292		2.00	0.00
NICU 99296		16.00	0.00
NICU 99297		8.00	0.00
99233	1	1.51	1.51
99232	3	1.06	3.18
99231	5	0.64	3.20
Discharge 99238	1	1.28	1.28
Discharge 99239		1.75	0.00
99215		1.73	0.00
99214	1	1.08	1.08
99213	1	0.65	0.65
99212	2	0.43	0.86
99211		0.17	0.00
Post-service total			**12.43**
	Time	IWPUT	INTRA-RVW
Intra-service:	240	0.077	18.44
Total Time:	683		

CMS Rec RVU	35566		30.00
RUC-approved time & visits	Svy Data	RUC Std.	RVW
Pre-service:	Time	Intensity	(=time x intensity)
Pre-service eval & positioning	55	0.0224	1.23
Pre-service scrub, dress, wait	15	0.0081	0.12
Pre-service total			**1.35**
Post-service:	Time	Intensity	(=time x intensity)
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVW	(=n x RVW)
ICU 99291	0	4.00	0.00
ICU 99292		2.00	0.00
NICU 99296		16.00	0.00
NICU 99297		8.00	0.00
99233	1	1.51	1.51
99232	2	1.06	2.12
99231	3	0.64	1.92
Discharge 99238	0	1.28	0.00
Discharge 99239	1	1.75	1.75
99215		1.73	0.00
99214	0	1.08	0.00
99213	2	0.65	1.30
99212	1	0.43	0.43
99211		0.17	0.00
Post-service total			**9.70**
	Time	IWPUT	INTRA-RVW
Intra-service:	306	0.062	18.94
Total Time:	670		

Hospital Visits for 35556 Should be Reconsidered

SVS believes that CMS and the RUC failed to take into account the fact that our expert consensus panel voluntarily reduced the hospital visit levels from the raw survey data to provide what we felt was a balanced package to justify the recommended work value. An important part of the RUC process involves consensus panel expert evaluation of the survey data. Unfortunately, in the rush of work considerations during the five-year review process, we believe this was overlooked by the RUC and its workgroup for code 35566. SVS minimized the hospital visit pattern because we believed the packaged service deserved a work RVU of 39.20, and the components fit together very well without critical care, resulting in an appropriate IWPUT. In reality, 64% of survey respondents included one or two 99291

critical care visits, and we downshifted those to one 99233. With the severe r eductions imposed by CMS compared to the SVS RVU recommendation, we suggest the visit pattern should be reconsidered. SVS would be happy to review the raw data with CMS. The typical 35566 patient has a multitude of c omorbidities and hemodynamic instability that require critical care following open aneurysm repair. SVS believes the RUC and CMS failed to consider these reductions as they rejected the SVS recommendation and reduced the RVU to unreasonable levels. Although we believe a work RVU of 39.20 is fully justified at the current visit level, the raw visit data should be revisited if CMS is willing.

In conclusion for CPT 35566, SVS has provided IWPUT data, comparison with a CMS benchmark bypass operation, a comparison with a CMS endorsed general surgery evaluation, and a critical review of the hospital visit pattern, all of which justify the SVS-recommended value of 39.20 RVUs. We request that CMS give appropriate consideration to this information.

CPT 35583 Bypass graft with vein in-situ, femoral-popliteal:

This lower extremity bypass is performed to prevent leg amputation due to ischemic gangrene and non-healing foot ulcers. SVS believes that this bypass, in addition to three others in the same family (35556, 35566, 35585) number among the most undervalued services in the Medicare physicians fee schedule. The frequency of this operation is dwindling based on numbers in the RUC database over the past 10 years. These bypass grafts were undervalued by survey respondents based on comparisons with other complex surgical services and by IWPUT analysis. The NSQIP data proves that survey respondents underestimated the intra-service time, in this case by 13 minutes (253 minutes based on 256 accurately recorded skin-to-skin times).

SVS recommended 32.26 RVUs, generating an IWPUT of 0.092, fully consistent with many other complex major arterial bypass grafts. CMS reduced the recommended RVW to 26.00, a value that provides an IWPUT of only 0.068, inconsistent with major arterial reconstructions. SVS believes its original value of 32.26 is the most accurate relative value.

SVS Recommendation and CMS Proposed RVU for CPT 35583

SVS Rec RVU	35583		32.26
with RUC time & visits	RUC Data	RUC Std.	RVW
Pre-service:	Time	Intensity	(=time x intensity)
Pre-service eval & positioning	55	0.0224	1.23
Pre-service scrub, dress, wait	15	0.0081	0.12
Pre-service total			**1.35**
Post-service:	Time	Intensity	(=time x intensity)
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVW	(=n x RVW)
ICU 99291	0	4.00	0.00
ICU 99292		2.00	0.00
NICU 99296		16.00	0.00
NICU 99297		8.00	0.00
99233	1	1.51	1.51
99232	1	1.06	1.06
99231	2	0.64	1.28
Discharge 99238	1	1.28	1.28
Discharge 99239	0	1.75	0.00
99215		1.73	0.00
99214	0	1.08	0.00
99213	2	0.65	1.30
99212	1	0.43	0.43
99211		0.17	0.00
Post-service total			**7.53**
	Time	IWPUT	INTRA-RVW
Intra-service:	253	0.092	23.37
Total Time:	559		

CMS Rec RVU	35583		26.00
with RUC time & visits	RUC Data	RUC Std.	RVW
Pre-service:	Time	Intensity	(=time x intensity)
Pre-service eval & positioning	55	0.0224	1.23
Pre-service scrub, dress, wait	15	0.0081	0.12
Pre-service total			**1.35**
Post-service:	Time	Intensity	(=time x intensity)
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVW	(=n x RVW)
ICU 99291	0	4.00	0.00
ICU 99292		2.00	0.00
NICU 99296		16.00	0.00
NICU 99297		8.00	0.00
99233	1	1.51	1.51
99232	1	1.06	1.06
99231	2	0.64	1.28
Discharge 99238	1	1.28	1.28
Discharge 99239	0	1.75	0.00
99215		1.73	0.00
99214	0	1.08	0.00
99213	2	0.65	1.30
99212	1	0.43	0.43
99211		0.17	0.00
Post-service total			**7.53**
	Time	IWPUT	INTRA-RVW
Intra-service:	253	0.068	17.11
Total Time:	559		

On the following page, SVS presents 32 arterial bypass grafts that have undergone RUC evaluation over the past seven years. The IWPUT ranges from 0.064 for relatively straightforward bypass grafts involving medium-sized arteries to values of 0.120 for more complex procedures performed in body areas that are difficult to reach. This chart demonstrates the inappropriateness of the CMS recommendation for CPT 35583. The SVS recommendation of 32.26 RVUs places the intensity of this code appropriately in the middle of the range.

CMS/RUC IWPUTs for Vascular Surgery Bypass Codes 2000-2006

CPT Code	Short Descriptor	IWPUT	
35558	BPG w vein femoral-femoral	0.065	
35583	**CMS Rec inappropriately places code here**	**0.068**	⇦
35533	BPG w vein axillary-bi-femoral	0.075	
35656	BPG w other than vein fem-pop	0.075	
35565	BPG w vein ilio-femoral	0.076	
35522	BPG w vein axillary-brachial	0.077	
35521	BPG w vein axillary-femoral	0.079	
35665	BPG w other than vein iliofem	0.080	
35563	BPG w vein ilio-iliac	0.081	
35571	BPG w vein popliteal-tibial	0.083	
35510	BPG w vein carotid-brachial	0.084	
35671	BPG w other than vein pop-tib	0.084	
35663	BPG w other than vein ilioiliac	0.084	
35587	BPG w vein insitu pop-tib	0.085	
35512	BPG w vein subclavian-brachial	0.085	
35666	BPG w other than vein fem-tib	0.086	
35661	BPG w other than vein fem-fem	0.086	
35531	BPG w vein aorto-mesenteric	0.086	
35654	BPG w other than vein ax-bifem	0.089	
35518	BPG w vein axillary-axillary	0.091	
35583	**SVS Rec Appropriately places code here**	**0.092**	⇦
35646	BPG w other than vein aortobifem	0.092	
35525	BPG w vein brachial-brachial	0.093	
35636	BPG w other than vein splenorenal	0.094	
35511	BPG w vein subclavian-subclavian	0.096	
35526	BPG w vein aorto-subclavian	0.098	
35621	BPG w other than vein ax-fem	0.100	
35647	BPG w other than vein aortofem	0.101	
35631	BPG w other than vein aorto-mes	0.101	
35626	BPG w other than vein aorto-sub	0.104	
35560	BPG w vein aorto-renal	0.107	
35650	BPG w other than vein ax-ax	0.107	
35536	BPG w vien splenorenal	0.120	
35623	BPG w other than vein ax-pop	0.120	

Comparison of 35583 with CMS-chosen Benchmark Vascular Bypass CPT 35671

In the proposed rule, CMS chose CPT code 35671 as a reference service when discussing orthopedic surgery code CPT 27447 (page 71). We therefore assume that CMS believes 35671 to be a solid benchmark in the relative value scale. The following data exist for 35671, which is "Bypass graft, with other than vein; popliteal-tibial or-peroneal artery".

35671 CMS REF Code	**35671**	**RVW:**	**19.30**
2nd 5-Yeaf Rev	**Svy Data**	**RUC Std.**	**RVW**
Pre-service:	**Time**	**Intensity**	**(=time x intensity)**
Pre-service eval & positioning	55	0.0224	1.23
Pre-service scrub, dress, wait	15	0.0081	0.12
Pre-service total			**1.35**
Post-service:	**Time**	**Intensity**	**(=time x intensity)**
Immediate post	30	0.0224	0.67
Subsequent visits:	**Visit n**	**E/M RVW**	**(=n x RVW)**
ICU 99291	0	4.00	0.00
ICU 99292		2.00	0.00
NICU 99296		16.00	0.00
NICU 99297		8.00	0.00
99233	0	1.51	0.00
99232	2	1.06	2.12
99231	1	0.64	0.64
Discharge 99238	1	1.28	1.28
Discharge 99239	0	1.75	0.00
99215		1.73	0.00
99214	0	1.08	0.00
99213	2	0.65	1.30
99212	1	0.43	0.43
99211		0.17	0.00
Post-service total			**6.44**
	Time	**IWPUT**	**INTRA-RVW**
Intra-service:	135	**0.085**	11.50
Total Time:	411		

SVS would be pleased to build a work RVU for 35583 based on this benchmark service chosen by CMS for comparison use in the NPRM. 35583 has 253 minutes of intra-service time compared to 135 minutes for 35671. At the IWPUT of 0.085, this represents an additional 10.03 RVUs. The two services have equal pre-service time and pre-service work. The post-service work for 35583 is 7.53 RVUs compared to 6.44 RVUs for 35671. Therefore, a work RVU for 35583 may be calculated as 19.30 plus 10.03 plus 1.09 equals 30.42.

If one were to take into account that working with vein conduit (as in 35583) is more complex than working with synthetic conduit (as in 35671), and IWPUT of 0.092 (that of 35583) should be used. This action places the calculated value at 31.89, very close to the SVS recommended value of 32.26.

Comparison of 35583 to General Surgery procedure 44150

CMS will be creating a major rank order anomaly if it values 35583 at only 26.00, while at the same time appropriately assigning CPT 44150 partial removal of colon an RVW of 27.50. We believe 44150 will be appropriately valued at 27.50. 44150 is a 180 minute skin-to-skin operation performed in patients with moderate cardiovascular comorbidities. CPT 35583 is a 253 minute operation performed in patients who typically have advanced cardiovascular comorbidities. SVS believes 44150 is accurately valued at 27.50, and the society strongly recommends reconsideration of a more accurate value for the much longer and equally complex 35583 operation at 32.26 RVUs.

If CMS proposes 27.50 for 44150, it is unreasonable to propose only 26.00 RVUs for 35583, since 35583 has 73 more minutes of high-intensity skin-to-skin time:

2007 CMS Proposed RVU	44150	RVW:	27.50
Colectomy/ileostomy	Svy Data	RUC Std.	RVW
Pre-service:	Time	Intensity	(=time x intensity)
Pre-service eval & positioning	45	0.0224	1.01
Pre-service scrub, dress, wait	15	0.0081	0.12
Pre-service total			1.13
Post-service:	Time	Intensity	(=time x intensity)
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVW	(=n x RVW)
ICU 99291	0	4.00	0.00
ICU 99292		2.00	0.00
NICU 99296		16.00	0.00
NICU 99297		8.00	0.00
99233	1	1.51	1.51
99232	3	1.06	3.18
99231	3	0.64	1.92
Discharge 99238	1	1.28	1.28
Discharge 99239		1.75	0.00
99215		1.73	0.00
99214	1	1.08	1.08
99213	1	0.65	0.65
99212	2	0.43	0.86
99211		0.17	0.00
Post-service total			11.15
	Time	IWPUT	INTRA-RVW
Intra-service:	180	0.085	15.22
	585		

CMS Rec RVU	35583		26.00
with RUC time & visits	RUC Data	RUC Std.	RVW
Pre-service:	Time	Intensity	(=time x intensity)
Pre-service eval & positio	55	0.0224	1.23
Pre-service scrub, dress,	15	0.0081	0.12
Pre-service total			1.35
Post-service:	Time	Intensity	(=time x intensity)
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVW	(=n x RVW)
ICU 99291	0	4.00	0.00
ICU 99292		2.00	0.00
NICU 99296		16.00	0.00
NICU 99297		8.00	0.00
99233	1	1.51	1.51
99232	1	1.06	1.06
99231	2	0.64	1.28
Discharge 99238	1	1.28	1.28
Discharge 99239	0	1.75	0.00
99215		1.73	0.00
99214	0	1.08	0.00
99213	2	0.65	1.30
99212	1	0.43	0.43
99211		0.17	0.00
Post-service total			7.53
	Time	IWPUT	INTRA-RVW
Intra-service:	253	0.068	17.11
Total Time:	559		

Hospital Visits for 35583 Should be Reconsidered

SVS believes that CMS and the RUC failed to take into account the fact that our expert consensus panel voluntarily reduced the hospital visit levels from the raw survey data to provide what we felt was a balanced package to justify the recommended work value. An important part of the RUC process involves consensus panel expert evaluation of the survey data. Unfortunately, in the rush of work considerations during the five-year review process, we believe this was overlooked by the RUC and its workgroup for code 35583. SVS minimized the hospital visit pattern because we believed the packaged service deserved a work RVU of 32.26, and the components fit together very well without critical care, resulting in an appropriate IWPUT. In reality, well over 50% of survey respondents included one or two 99291 critical care visits, and we downshifted those to one 99233. With the severe reductions imposed by CMS compared to the SVS RVU recommendation, we suggest the

visit pattern should be reconsidered. SVS would be happy to review the raw data with CMS. The typical 35583 patient has a multitude of comorbidities and hemodynamic instability that require critical care following open aneurysm repair. SVS believes the RUC and CMS failed to consider these reductions as they rejected the SVS recommendation and reduced the RVU to unreasonable levels. Although we believe a work RVU of 32.26 is fully justified at the current visit level, the raw data should be revisited if CMS is willing.

In conclusion for 35583, SVS has provided IWPUT data, comparison with a CMS benchmark bypass operation, a comparison with a CMS endorsed general surgery evaluation, and a critical review of the hospital visit pattern, all of which justify the SVS-recommended value of 32.26 RVUs. We request that CMS give appropriate consideration to this information.

CPT 35585 Bypass graft with vein in-situ, femoral-tibial or peroneal:

This lower extremity bypass is also performed to prevent leg amputation due to ischemic gangrene and non-healing foot ulcers. SVS believes that this bypass in addition to three others in the same family (35556, 35566, 35583) are among the most undervalued services in the Medicare physicians fee schedule. The frequency of this operation has fallen substantially over the past 10 years. These bypass grafts were undervalued by survey respondents based on IWPUT intensity analysis and on comparison to other complex surgical services. The NSQIP data proves that survey respondents underestimated the intra-service time, in this case by a full 35 minutes. There were 430 of these operations recorded in the NSQIP database, and the intra-time must be more accurate than estimates of ~40 surgeons.

The RUC and CMS failed to recognize the time and intensity involved in this procedure. The IWPUT of 0.093 justifies the SVS recommended RVW of 39.42. An IWPUT of 0.093 is consistent with many other existing arterial bypass grafts. With the CMS recommendation of only 30.00 RVUs, the IWPUT falls to 0.069, a level inconsistent with major arterial surgery.

SVS Recommendation vs. CMS Proposed RVU for CPT 35585. SVS recommendation results in appropriate IWPUT intensity measure:

SVS Rec RVU	35585		39.42
with RUC time & visits	RUC data	RUC Std.	RVW
Pre-service:	Time	Intensity	(=time x intensity)
Pre-service eval & positioning	55	0.0224	1.23
Pre-service scrub, dress, wait	15	0.0081	0.12
Pre-service total			1.35
Post-service:	Time	Intensity	(=time x intensity)
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVW	(=n x RVW)
ICU 99291	0	4.00	0.00
ICU 99292		2.00	0.00
NICU 99296		16.00	0.00
NICU 99297		8.00	0.00
99233	1	1.51	1.51
99232	2	1.06	2.12
99231	3	0.64	1.92
Discharge 99238	0	1.28	0.00
Discharge 99239	1	1.75	1.75
99215		1.73	0.00
99214	0	1.08	0.00
99213	2	0.65	1.30
99212	1	0.43	0.43
99211		0.17	0.00
Post-service total			9.70
	Time	IWPUT	INTRA-RVW
Intra-service:	305	**0.093**	28.36
Total Time:	669		

CMS Proposed RVU	35585		32.00
with RUC time & visits	RUC data	RUC Std.	RVW
Pre-service:	Time	Intensity	(=time x intensity)
Pre-service eval & positioning	55	0.0224	1.23
Pre-service scrub, dress, wait	15	0.0081	0.12
Pre-service total			1.35
Post-service:	Time	Intensity	(=time x intensity)
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVW	(=n x RVW)
ICU 99291	0	4.00	0.00
ICU 99292		2.00	0.00
NICU 99296		16.00	0.00
NICU 99297		8.00	0.00
99233	1	1.51	1.51
99232	2	1.06	2.12
99231	3	0.64	1.92
Discharge 99238	0	1.28	0.00
Discharge 99239	1	1.75	1.75
99215		1.73	0.00
99214	0	1.08	0.00
99213	2	0.65	1.30
99212	1	0.43	0.43
99211		0.17	0.00
Post-service total			9.70
	Time	IWPUT	INTRA-RVW
Intra-service:	305	**0.069**	20.94
Total Time:	669		

On the following page, SVS presents 32 arterial bypass grafts that have undergone RUC evaluation over the past seven years. The IWPUT ranges from 0.064 for relatively straightforward bypass grafts involving medium-sized arteries to values of 0.120 for more complex procedures performed in body areas that are difficult to reach. This chart demonstrates the inappropriateness of the CMS recommendation for CPT 35585. The SVS

recommendation of 39.42 RVUs places the intensity of this code appropriately in the middle of the range.

CMS/RUC IWPUTs for Vascular Surgery Bypass Codes 2000-2006

CPT Code	Short Descriptor	IWPUT
35558	BPG w vein femoral-femoral	0.065
35585	**CMS Rec inappropriately places code here**	**0.069**
35533	BPG w vein axillary-bi-femoral	0.075
35656	BPG w other than vein fem-pop	0.075
35565	BPG w vein ilio-femoral	0.076
35522	BPG w vein axillary-brachial	0.077
35521	BPG w vein axillary-femoral	0.079
35665	BPG w other than vein iliofem	0.080
35563	BPG w vein ilio-iliac	0.081
35571	BPG w vein popliteal-tibial	0.083
35510	BPG w vein carotid-brachial	0.084
35671	BPG w other than vein pop-tib	0.084
35663	BPG w other than vein ilioiliac	0.084
35587	BPG w vein insitu pop-tib	0.085
35512	BPG w vein subclavian-brachial	0.085
35666	BPG w other than vein fem-tib	0.086
35661	BPG w other than vein fem-fem	0.086
35531	BPG w vein aorto-mesenteric	0.086
35654	BPG w other than vein ax-bifem	0.089
35518	BPG w vein axillary-axillary	0.091
35646	BPG w other than vein aortobifem	0.092
35585	**SVS Rec Appropriately places code here**	**0.093**
35525	BPG w vein brachial-brachial	0.093
35636	BPG w other than vein splenorenal	0.094
35511	BPG w vein subclavian-subclavian	0.096
35526	BPG w vein aorto-subclavian	0.098
35621	BPG w other than vein ax-fem	0.100
35647	BPG w other than vein aortofem	0.101
35631	BPG w other than vein aorto-mes	0.101
35626	BPG w other than vein aorto-sub	0.104
35560	BPG w vein aorto-renal	0.107
35650	BPG w other than vein ax-ax	0.107
35536	BPG w vien splenorenal	0.120
35623	BPG w other than vein ax-pop	0.120

Comparison of 35585 with CMS-chosen Benchmark Vascular Bypass CPT 35671

In the proposed rule, CMS chose CPT code 35671 as a reference service when discussing orthopedic surgery code CPT 27447 (page 71). We therefore assume that CMS believes 35671 to be a solid benchmark in the relative value scale. The following data exist for 35671, which is "Bypass graft, with other than vein; popliteal-tibial or-peroneal artery".

35671 CMS REF Code	**35671**	**RVW:**	**19.30**
2nd 5-Yeaf Rev	**Svy Data**	**RUC Std.**	**RVW**
Pre-service:	**Time**	**Intensity**	**(=time x intensity)**
Pre-service eval & positioning	55	0.0224	1.23
Pre-service scrub, dress, wait	15	0.0081	0.12
Pre-service total			**1.35**
Post-service:	**Time**	**Intensity**	**(=time x intensity)**
Immediate post	30	0.0224	0.67
Subsequent visits:	**Visit n**	**E/M RVW**	**(=n x RVW)**
ICU 99291	0	4.00	0.00
ICU 99292		2.00	0.00
NICU 99296		16.00	0.00
NICU 99297		8.00	0.00
99233	0	1.51	0.00
99232	2	1.06	2.12
99231	1	0.64	0.64
Discharge 99238	1	1.28	1.28
Discharge 99239	0	1.75	0.00
99215		1.73	0.00
99214	0	1.08	0.00
99213	2	0.65	1.30
99212	1	0.43	0.43
99211		0.17	0.00
Post-service total			**6.44**
	Time	**IWPUT**	**INTRA-RVW**
Intra-service:	135	**0.085**	11.50
Total Time:	411		

SVS would be pleased to build a work RVU for 35585 based on this benchmark service chosen by CMS for comparison use in the NPRM. 35585 has 305 minutes of intra-service time compared to 135 minutes for 35671. At the IWPUT of 0.085, this represents an additional 14.45 RVUs. The two services have equal pre-service time and pre-service work. The post-service work for 35585 is 9.70 RVUs compared to 6.44 RVUs for 35671. Therefore, a work RVU for 35585 may be calculated as 19.30 plus 14.45 plus 3.26 equals 36.99.

If one were to take into account that working with vein conduit (as in 35585) is more complex than working with synthetic conduit (as in 35671) then the IWPUT for 35585 (0.093) should be employed. This calculation results in a value of 39.43, essentially equal to the original SVS recommended value of 39.42.

Comparison of 35585 to CMS proposal for General Surgery service 44151

CMS will be creating a major rank order anomaly if it values 35585 at only 30.00, while at the same time appropriately assigning CPT 44151 removal of colon an RVW of 32.00. 44151 is a 240 minute skin-to-skin operation performed in patients with moderate cardiovascular comorbidities. CPT 35585 is a 305 minute operation performed in patients who typically have advanced cardiovascular comorbidities. Total time for 44151 is 683 minutes, while total time for 35585 is 669 minutes. However, the biggest difference in these two services is the extra 65 minutes of complex intra-service time in 35585. CMS cannot fairly value 35585 at 30 RVUs, while at the same time valuing 44151 at 32.00 RVUs. SVS strongly recommends reconsideration of the more accurate value that the society recommended at 39.42 RVUs.

Hospital Visits for 35585 Should be Reconsidered

SVS believes that CMS and the RUC failed to take into account the fact that our expert consensus panel voluntarily reduced the hospital visit levels from the raw survey data to provide what we felt was a balanced package to justify the recommended work value. An important part of the RUC process involves consensus panel expert evaluation of the survey data. Unfortunately, in the rush of work considerations during the five-year review process, we believe this was overlooked by the RUC and its workgroup for code 35585. SVS minimized the hospital visit pattern because we believed the packaged service deserved a work RVU of 39.42, and the components fit together very well without critical care, resulting in an appropriate IWPUT. In reality, >60% of survey respondents included one or two 99291 critical care visits, and we downshifted those to one 99233. With the severe r eductions imposed by CMS compared to the SVS RVU recommendation, we suggest the visit pattern should be reconsidered. SVS would be happy to review the raw data with CMS. The typical 35585 patient has a multitude of c omorbidities and hemodynamic instability that require critical care following open aneurysm repair. SVS believes the RUC and CMS failed to consider these reductions as they rejected the SVS recommendation and reduced the RVU to unreasonable levels. Although we believe a work RVU of 39.42 is fully justified at the current visit level, the raw data should be revisited if CMS is willing.

In conclusion for CPT 35585, SVS has provided IWPUT data, comparison with a CMS benchmark bypass operation, a comparison with a CMS endorsed general surgery evaluation, and a critical review of the hospital visit pattern, all of which justify the SVS-recommended value of 39.42 RVUs. We request that CMS give appropriate consideration to this information.

2. Five-Year Review of Work for Evaluation and Management (E/M) Codes

Despite the fact that vascular surgeons commonly provide a broad spectrum of E/M codes, SVS has great concerns regarding the dramatic increases that have been proposed across the entire E/M spectrum. We do not believe that compelling evidence was presented to increase the work RVU of 99213 by more than 37 percent. The E/M codes, especially 99213 have been the bedrock of the relative value scale. Now, that bedrock will turn into quicksand. The entire relative value scale will be set adrift. We urge CMS to reconsider this gigantic increase in E/M work RVUs.

In its proposed rule, CMS expressed concern regarding specialties returning at each 5-year review to gain more RVUs, yet there appears to be no hesitation to pile on major E/M upgrades despite the fact that in the first five-year review, 35 E/M codes, including 99213, were increased by upwards of 16 percent.

In addition, SVS believes that physicians have already been compensated for the increased work of providing E/M services by billing more and higher level office visits. For example, since 1994, despite an increased number of total beneficiaries, the number of 99212 office visits has decreased from 31,656,490 to 26,354,871. At the same time, the number of 99213 office visits has increased from 83,527,221 to 112,649,520 and the number of 99214 office visits has increased from 30,561,026 to 55,837,512. These changes have cost the Medicare program more than $3.28 billion. In total, there was an 85 percent increase in allowed charges for 99213 alone between 1997 and 2004. In 2003, E/M services accounted for more than 30 percent of the growth in Medicare physician spending. With the new work RVUs, SVS is concerned that spending for E/M will spiral upwards uncontrollably as we see the multiplicative effect of more visits per beneficiary multiplied by higher billing levels per visit multiplied by substantially greater work RVUs at each level.

CMS praised the RUC for coming to agreement on its recommendations for the E/M codes, yet as a bystander, SVS watched as RUC negotiations lost all semblance of logic. RUC-surveys completed by vascular surgeons were never allowed to be entered for consideration.

SVS supports the RUC recommendation and CMS' proposal to apply the increased E/M work RVUs to E/M services included in the 10- and 90-day global period codes. These E/M services are the same as those that are performed distinctly and they have been recognized as such by both the RUC and CMS. However, it appears that CMS may have inadvertently applied a discounted or different work RVU to the 10 and 90 day global codes. The RUC recommended applying the full work RVU of the E/M codes to global procedures and because CMS did not disagree in its discussion of this issue, we urge CMS to correct this is math oversight in the final rule.

3. Practice Expense Methodology

In 1999, SVS was pleased to see passage of Section 212 of the BBRA, which allowed specialties to submit supplemental practice expense data. Indeed, our society undertook a supplemental survey in 2001, and we realized a modest increase in PE/Hr. Unfortunately, recent practice expense supplemental surveys have resulted in astronomical increases in PE/hr rates. SVS finds it difficult to believe that PE/hr rates in excess of $200 could be possible. On the other hand, if these differences between original SMS data and current expenses are real, incorporation of newly submitted supplemental data severely disadvantages the majority of specialty societies that are still functioning on the aging SMS or older supplemental survey values. SVS strongly encourages CMS to support the new all-specialty PE survey process that is being initiated by the AMA, with two caveats. First, we believe all specialties must participate in this survey, including those whose fantastically high PE/hr supplemental survey rates are being considered now by CMS. Second, this system must include some form of reality check. We worry that without a hard reality check, this new practice expense survey will be subject to wildly inflated data reminiscent of the 1998 CPEP debacle.

4. Preliminary Comments on the Deficit Reduction Act

Vascular surgeons provide accurate noninvasive vascular diagnostic studies for their patients in-office. Since noninvasive vascular studies are very operator dependent, about the only people we trust to perform these exams are individuals working directly at our sides and under our direction. Recent literature has shown that noninvasive vascular lab data derived from laboratories that are not accredited, and from technologists who are not credentialed, are filled with errors. In some publications, the accuracy of noninvasive lab studies from non-accredited labs was no better than 50%, essentially a coin-toss.

For many practitioners, the DRA will reduce payment for office-based vascular lab studies to levels less than the cost to provide the services. Office-based vascular labs will close, and vascular surgeons will be forced to consider sending their patients to hospital-based facilities, many of them non-accredited, staffed by technologists who are not credentialed. The unintended consequence of this will become readily apparent. Rather than send patients to unaccredited facilities, vascular providers will order vastly more expensive CT and MR studies will be ordered instead of much less expensive noninvasive ultrasound tests. Thus, the cost of providing care to our vascular patients will increase as a result of DRA, not decrease.

SVS urges CMS to remove noninvasive vascular lab studies from the list of services captured by the DRA, based on the fact that many of these tests include no imaging, while for the others, imaging is a minor component. SVS will be providing objective data to CMS regarding the impact of DRA on office-based vascular labs within the next month.

Yours truly,

K. Craig Kent, M.D.

President
Society for Vascular Surgery

Robert M. Zwolak, M.D.
Chair, Health Policy Committee
Society for Vascular Surgery

Submitter : **Ms. Priscilla Hartung** **Date: 08/21/2006**

Organization : **Private Practice**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

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Please direct your questions or comments to 1 800 743-3951.

Submitter : **Date: 08/21/2006**

Organization : **American College of Obstetricians and Gynecologist**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

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Please direct your questions or comments to 1 800 743-3951.

Submitter : Mr. Thomas Mintun, LCSW, CSW-G **Date:** 08/21/2006

Organization : Mr. Thomas Mintun, LCSW, CSW-G

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1512-PN-2162-Attach-1.DOC

2162

Davis Mintun
Professional Services Inc.

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Dept of Health and Human Services
Attention: CMS-1512-PN
PO Box 8014
Baltimore MD 21244-8014

To Whom It May Concern:

As a Social Worker provider of Part B Medicare, I am opposed to the 14% cut of reimbursement as a Medicare provider. I have an office practice and many of the Medicare recipients are of low income and are dependent on the service. This cut will make it difficult to serve Medicare patients and there will be fewer options to receive needed outpatient counseling services if Social Workers cannot provide outpatient counseling services.

- I recommend that CMS not reduce work values for clinical social workers on Jan. 1, 2007.
- I request CMS withdraw the proposed increase in evaluation and management codes until they have the funds to increase reimbursement for all Medicare providers
- I request CMS not to approve the proposed "bottom up "formula to calculate practice expense. Do not select a formula that penalizes clinical social workers who have a very cost effective practice and little expenses.

Sincerely,

Thomas Garth Mintun, LCSW, CSW-G, ACSW