

February 10, 2019

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted via email to Larry.Chan@cms.hhs.gov

RE: Public Nomination of CPT Codes 10021 and 10005 as Potentially Misvalued

Dear Administrator Verma:

In accordance with the procedures for public nomination of potentially misvalued CPT codes, as outlined in 76 FR 73058-9, the Endocrine Society (ES), the American Association of Clinical Endocrinologists (AACE), and the American Thyroid Association (ATA) wish to propose to CMS that CPT codes 10021 (fine needle aspiration without imaging guidance) and 10005 (fine needle aspiration with ultrasound guidance) are potentially misvalued. In particular, we believe that the recent valuation of these codes (83 FR 59517 -59521), in which the RUC recommendations for physician work were reduced significantly by CMS, resulted from a faulty process based on flawed and incorrect assumptions, one of the criteria outlined in 76 FR 73058. The basis of our nominations is outlined below.

Estimation of Changes in Total Work Pool for the FNA Code Family

One of the key CMS justifications for its decision to reduce the values for 10021 and 10005 below the RUC recommendations was the CMS estimate that the RUC recommendations would lead to an increase of 20% in the total work pool for the FNA code family. The AMA RUC staff had presented to CMS its own calculation showing that the RUC recommendations would actually lead to a 15% **decrease** in the total work pool for the FNA family. We are informed that, as a result of recent discussions between CMS staff and AMA RUC staff, the agency has now agreed that its calculation of changes in the total work pool for the FNA code family included double-counting and was in error. Consequently, this rationale for CMS action to reduce the values for 10021 and 10005 below the RUC recommendations no longer exists.

Discrepancy Between Changes in Time and Changes in Work

Another of the CMS justifications for its decision to reduce the value for some FNA codes below the RUC recommendations was the seeming disproportion between changes in time and changes in work ensuing from the RUC recommendations. For example, the RUC recommendations reduced the total time for 10021 by 32% from the previous value while reducing the work RVU by 5%.

However, there has been a significant increase in intensity of the FNA procedure between the original 1995 values and the present time which serves to explain this discrepancy. In particular, new clinical

practice guidelines have emphasized the critical role of FNA in diagnosis. Consequently, FNA is now frequently being performed on many lesions that are much smaller and/or much deeper than was the case 20 years ago. In addition, the equipment has become more complicated to use and the specimen requirements are now more stringent. These factors have greatly increased the average complexity of the FNA procedure and explain the increase in intensity as compared to 20 years ago.

Selection of Crosswalk and Comparator Codes

CMS chose to establish the value of 10021 by crosswalking to 36440 (neonatal push transfusion). CMS then established the value for 10005 by adding an increment of 0.46 to the value of 36440 in order to cover the extra work of the ultrasound guidance. Thus, the valuation of both codes is heavily dependent on the selection of 36440 as a crosswalk code. We strongly disagree with the selection of 36440 as the crosswalk code on which to base the value of 10021.

The purpose of using crosswalk and comparator codes when defining a work value for a new code is to put the new code in its proper place on the relative value scale by making reference to codes whose values already well established on the relative value scale and whose physician work is most similar to that of the new code. Thus, a good crosswalk code should meet two criteria: its work should be similar to the new code, and its relative value should be well established.

To establish similarity of physician work, the times of the new code and any potential comparators should be similar. However, when selecting from a group of potential comparators, all of whom have similar times to the new code, then it would seem that the most appropriate selection of comparators are those codes whose work is most similar in nature to that of the new code, as judged by clinicians. For 10021 and 10005, the essence of the procedure is an invasive test involving insertion of a needle into a subcutaneous lesion to obtain diagnostic information. There are several potential crosswalks for 10021 that meet the criteria of having similar time and similar procedure (insertion of a needle into a subcutaneous location to obtain diagnostic information), including 40490 (lip biopsy) and 95865 (needle EMG of the larynx). But 36440 fails this test completely: although the time is similar, it is not invasive; no diagnostic information has to be obtained; the site of service and patient population are completely different, etc. It would seem more appropriate to choose as a crosswalk for 10021 one of the other available comparators whose time is similar to 10021 and the nature of whose procedure is also similar.

CMS states that it decided not to use comparators other than 36440 because the “intensity” of these other comparators is different. Yet, how was it determined that 36440 had the proper “intensity”? It would seem logical that the intensity and complexity of a new code (e.g. IWPUT) is established by comparison with similar procedures. This reasoning is in keeping with the basic nature of a relative value scale. Conversely, it would seem backwards to identify a priori a potential comparator and then eliminate from consideration all other potential comparators whose IWPUT was different.

The “correct” IWPUT for 10021 is much more likely to be the IWPUT of comparators involving similar procedures than comparators that seem totally unrelated. For example, 43 respondents in the survey for 10021 chose 32554 (thoracentesis) as the key reference service, the service most similar to 10021. The IWPUT for 32554 is 0.054, so one would infer that the IWPUT for 10021 should be roughly similar to 0.054, since 32554 was judged by clinicians to be similar to 10021. The IWPUT for the RUC-recommended value for 10021 is 0.053, almost identical to the IWPUT for 32554, confirming that

32554 and the RUC value for 10021 are describing procedures of similar intensity and complexity. By contrast, the IWPOT for the CMS-selected crosswalk for 10021, namely 36440, is 0.039, much lower than the key reference service 32554, suggesting that 36440 is a much less complex and intense procedure than 32554, and therefore 36440 would not be an appropriate crosswalk for 10021.

Another criterion for selection of a crosswalk code is that the value for the code be robust and well established. 36440 clearly fails this test: the code is very rarely used, even by neonatologists; the number of survey respondents was quite small, the performance rate of the service by the survey respondents was very low. The value for 36440 seems far from robust, and it seems highly undesirable that this code should be used as a comparator when many other options, more well-established and more robust, are available.

In summary, we believe that the current values for 10021 and 10005 were established by CMS through inappropriate and faulty assumptions and procedures, and we request that 10021 and 10005 should be designated as potentially misvalued for purposes of further action. However, if there is a way to address the valuation of the FNA codes more expeditiously than having CPT codes 10005 and 10021 added to the misvalued code list, our societies welcome the opportunity to work with CMS to do so.

Thank you for your attention to this issue. If you require any further information, please contact Meredith Dyer at mdyer@endocrine.org or (202) 971-3636.

Sincerely,

American Association of Clinical Endocrinologists
American Thyroid Association
Endocrine Society