recommended work RVU understates the costs inherent in performing this service, and that the survey 25th percentile value of 0.10 is more accurate for this service. While we are proposing the RUC-recommended 0.05, we are soliciting public comment on this stakeholder-recommended potential alternative value.

We are proposing the RUC-recommended direct PE inputs for CPT code 94200 without refinement.

(63) Long-Term EEG Monitoring (CPT Codes 95X01, 95X02, 95X03, 95X04, 95X05, 95X06, 95X07, 95X08, 95X09, 95X10, 95X11, 95X12, 95X13, 95X14, 95X15, 95X16, 95X17, 95X18, 95X19, 95X20, 95X21, 95X22, and 95X23)

In January 2017, the RUC identified CPT code 95951 via the high volume growth screen, which considers if the service has total Medicare utilization of 10,000 or more and if utilization has increased by at least 100 percent from 2009 through 2014. The RUC recommended that this service be referred to the CPT Editorial Panel for needed changes, including code deletions, revision of code descriptors, and the addition of new codes to this family. In May 2018, the CPT Editorial Panel approved the revision of one code, deletion of five codes, and addition of 23 new codes for reporting long-term EEG professional and technical services.

We are proposing the RUC-recommended work RVU for six of the professional component codes in this family. We are proposing a work RVU of 3.86 for CPT code 95X18 (*Electroencephalogram, continuous recording, physician or other qualified health care professional review of recorded events, complete study; greater than 36 hours, up to 60 hours of EEG recording, without video*), a work RVU of 4.70 for CPT code 95X19 (*Electroencephalogram, continuous recording, physician or other qualified health care professional review of recorded events, complete study; greater than 36 hours, up to 60 hours of*

EEG recording, with video), a work RVU of 4.75 for CPT code 95X20 (*Electroencephalogram, continuous recording, physician or other qualified health care professional review of recorded events, complete study; greater than 60 hours, up to 84 hours of EEG recording, without video*), a work RVU of 6.00 for CPT code 95X21 (*Electroencephalogram, continuous recording, physician or other qualified health care professional review of recorded events, complete study; greater than 60 hours, up to 84 hours of EEG recording, with video*), a work RVU of 5.40 for CPT code 95X22 (*Electroencephalogram, continuous recording, physician or other qualified health care professional review of recorded events, complete study; greater than 84 hours of EEG recording, without video*) and a work RVU of 7.58 for CPT code 95X23 (*Electroencephalogram, continuous recording, physician or other qualified health care professional review of recorded events, complete study; greater than 84 hours of EEG recording, with video*).

We are also proposing the RUC-recommended work RVU of 0.00 for the 13 technical component codes in the family: CPT code 95X01 (*Electroencephalogram (EEG) continuous recording, with video when performed, set-up, patient education, and take down when performed, administered in-person by EEG technologist, minimum of 8 channels*), CPT code 95X02 (*Electroencephalogram (EEG) without video, review of data, technical description by EEG technologist, 2-12 hours; unmonitored*), CPT code 95X03 (*Electroencephalogram (EEG) without video, review of data, technical description by EEG technologist, 2-12 hours; with intermittent monitoring and maintenance*), CPT code 95X04 (*Electroencephalogram (EEG) without video, review of data, technical description by EEG technologist, 2-12 hours; with continuous, real-time monitoring and maintenance*), CPT code 95X05 (*Electroencephalogram (EEG) without video, review of data, technical description by EEG technologist, each increment*

of 12-26 hours; unmonitored), CPT code 95X06 (*Electroencephalogram (EEG) without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance*), CPT code 95X07 (*Electroencephalogram (EEG) without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; with continuous, real-time monitoring and maintenance*), CPT code 95X08 (*Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; unmonitored*), CPT code 95X09 (*Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with intermittent monitoring, and maintenance*), CPT code 95X10 (*Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with continuous, real-time monitoring and maintenance*), CPT code 95X11 (*Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; unmonitored*), CPT code 95X12 (*Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance*), and CPT code 95X13 (*Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; with continuous, real-time monitoring and maintenance*).

We disagree with the RUC-recommended work RVU of 2.00 for CPT code 95X14 (*Electroencephalogram, continuous recording, physician or other qualified health care professional review of recorded events, 2-12 hours of EEG recording; without video*) and we are proposing a work RVU of 1.85 based on a crosswalk to CPT code 93314 (*Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); image acquisition, interpretation and report only*). CPT code 93314 is a recently-reviewed code

with 2 additional minutes of intraservice time and 4 additional minutes of total time as compared to CPT code 95X14. When considering the work RVU for CPT code 95X14, we looked to the second reference code chosen by the survey participants, CPT code 95957 (*Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis)*). This code has 2 additional minutes of intraservice time and 9 additional minutes of total time as compared to CPT code 95X14, yet has a work RVU of 1.98, lower than the recommended work RVU of 2.00. These time values suggested that CPT code 95X14 would be more accurately valued at a work RVU slightly below the 1.98 of CPT code 95957. We also looked at the intraservice time ratio between CPT code 95X14 and some of its predecessor codes. The intraservice time ratio with CPT code 95953 (*Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG, electroencephalographic (EEG) recording and interpretation, each 24 hours, unattended*) suggests a similar potential work RVU of 1.91 (28 minutes divided by 45 minutes times a work RVU of 3.08). Based on this information, we are proposing a work RVU of 1.85 for CPT code 95X14 based on the aforementioned crosswalk to CPT code 93314.

We disagree with the RUC-recommended work RVU of 2.50 for CPT code 95X15 (*Electroencephalogram, continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and report, 2-12 hours of EEG recording; with video (VEEG)*) and we are proposing a work RVU of 2.35. Although we disagree with the RUC-recommended work RVU, we concur that the relative difference in work between CPT codes 95X14 and 95X15 is equivalent to the recommended interval of 0.50 RVUs. Therefore, we are proposing a work RVU of 2.35 for CPT code 95X15, based on the recommended interval of 0.50 additional RVUs above our proposed work RVU of 1.85 for CPT code 95X14. We are supporting this work RVU with a reference to

CPT code 99310 (*Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of the 3 key components*), which shares the same intraservice time of 35 minutes and the identical work RVU of 2.35. CPT code 99310 is a lower intensity procedure but has increased total work time as compared to CPT code 95X15.

We disagree with the RUC-recommended work RVU of 3.00 for CPT code 95X16 (*Electroencephalogram, continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and report after each 24-hour period; without video*) and we are proposing a work RVU of 2.60 based on a crosswalk to CPT code 99219 (*Initial observation care, per day, for the evaluation and management of a patient, which requires 3 key components*). CPT code 99219 shares the same intraservice time of 40 minutes and has a slightly higher total time as compared to CPT code 95X16. We also note that the observation care described by CPT code 99219 shares some clinical similarities to the long term EEG monitoring described by CPT code 95X16, although we note as always that the nature of the PFS relative value system is such that all services are appropriately subject to comparisons to one another, and that codes do not need to share the same site of service, patient population, or utilization level to serve as an appropriate crosswalk.

In addition, we believe that the proposed crosswalk to CPT code 99219 at a work RVU of 2.60 more accurately captures the intensity of CPT code 95X16. At the recommended work RVU of 3.00, the intensity of CPT code 95X16 is anomalously high in comparison to the rest of the family, higher than any of the other professional component codes. We have no reason to believe that the 24-hour EEG monitoring done without video as described in CPT code 95X16 would be notably more intense than the other codes in the same family. Furthermore, the

recommendations for this code family specifically state that the codes that describe video EEG monitoring are more intense than the codes that describe non-video EEG monitoring. However, at the recommended work RVU for CPT code 95X16, this non-video form of EEG monitoring had the highest intensity in the family. At our proposed work RVU of 2.60, the intensity of CPT code 95X16 is no longer anomalously high in comparison to the rest of the family, and also remains lower than the intensity of the 24 hour EEG monitoring with video procedure described by CPT code 95X17.

We disagree with the RUC-recommended work RVU of 3.86 for CPT code 95X17 (*Electroencephalogram, continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and report after each 24-hour period; with video (VEEG)*) and we are proposing a work RVU of 3.50 based on the survey 25th percentile value. The RUC-recommended work RVU of 3.86 was based on a crosswalk to CPT code 99223 (*Initial hospital care, per day, for the evaluation and management of a patient, which requires 3 key components*), a code that shares the same intraservice time of 55 minutes but has 15 additional minutes of total time as compared to CPT code 95X17, at 90 minutes as compared to 75 minutes. We disagree with the use of this crosswalk, as the 15 minutes of additional total time in CPT code 99223 result in a higher work valuation that overstates the work RVU of CPT code 95X17. These 15 additional minutes of preservice and postservice work time in the recommended crosswalk code have a calculated work RVU of 0.34 under the building block methodology; subtracting out this work RVU of 0.34 from the crosswalk code's work RVU of 3.86 results in an estimated work RVU of 3.52, which is nearly identical to the survey 25th percentile work RVU of 3.50. Similarly, if we were to calculate a

total time ratio between CPT code 95X17 and the recommended crosswalk code 99223, it would produce a noticeably lower work RVU of 3.22 (75 minutes divided by 90 minutes times a work RVU of 3.86). Based on this rationale, we do not believe that it would serve the interests of relativity to propose a work RVU of 3.86 based on the recommended crosswalk.

Instead, we are proposing a work RVU of 3.50 for CPT code 95X17 based on the survey 25th percentile value. We note that among the predecessor codes for this family, CPT code 95956 (*Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, electroencephalographic (EEG) recording and interpretation, each 24 hours, attended by a technologist or nurse*) has a higher intraservice time of 60 minutes and a higher total time of 105 minutes at a work RVU of 3.61. This prior valuation of CPT code 95956 does not support the RUC-recommended work RVU of 3.86 for CPT code 95X17, but does support the proposed work RVU of 3.50 at the slightly lower newly surveyed work times. We also note that at the recommended work RVU of 3.86, the intensity of CPT code 95X17 was anomalously high in comparison to the rest of the family, the second-highest intensity as compared to the other professional component codes. We have no reason to believe that the 24 hour EEG monitoring done with video as described in CPT code 95X17 would be notably more intense than the other codes in the same family. At our proposed work RVU of 3.50, the intensity of CPT code 95X17 is no longer anomalously high in comparison to the rest of the family, while still remaining slightly higher than the intensity of the 24 hour EEG monitoring performed without video procedure described by CPT code 95X16.

For the direct PE inputs, we are proposing to make a series of refinements to the clinical labor times of CPT code 95X01. Many of the clinical labor times for this CPT code were derived using a survey process and were recommended to CMS at the survey median values.

This was in contrast to the typical process for recommended direct PE inputs, where the inputs are usually based on either standard times or carried over from reference codes. We believe that when surveys are used to recommended direct PE inputs, we must apply a similar process of scrutiny to that used in assessing the work RVUs that are recommended based on a survey methodology. We have long expressed our concerns over the validity of the survey results used to produce work RVU recommendations, such as in the CY 2011 PFS final rule (75 FR 73328), and we have noted that over the past decade the AMA RUC has increasingly chosen to recommend the survey 25th percentile work RVU over the survey median value, potentially responding to the same concerns that we have identified.

As a result, we believe that when assessing the survey of direct PE inputs used to produce many of the recommendations for CPT code 95X01, it would be more accurate to propose the survey 25th percentile direct PE inputs as opposed to the recommended survey median direct PE inputs. Therefore, we are proposing to refine the clinical labor time for the "Provide education/obtain consent" (CA011) activity from 13 minutes to 7 minutes and to refine the clinical labor time for the "Review home care instructions, coordinate visits/prescriptions" (CA035) activity from 10 minutes to 7 minutes. In both of these cases, the recommended clinical labor times based on the survey median values are more than double the standard time for these activities. Although we agree that additional clinical labor time would be required to carry out these activities for CPT code 95X01, we do not believe that the survey median times would be typical. We are proposing the survey 25th percentile times of 7 minutes for each activity as we believe that this time would be more typical for obtaining consent and reviewing home care instructions.

We are also proposing to refine the clinical labor time for the "Complete pre-procedure phone calls and prescription" (CA005) activity from 10 minutes to 3 minutes for CPT code 95X01. This is another situation where we are proposing the survey 25th percentile clinical labor time of 3 minutes instead of the survey median clinical labor time of 10 minutes. However, we also note that many of the tasks that fell under the CA005 activity code as described in the PE recommendations appear to constitute forms of indirect PE, such as collecting supplies for setup and loading equipment and supplies into vehicles. Collecting supplies and loading equipment are administrative tasks that are not individually allocable to a particular patient for a particular service, and therefore, constitute indirect PE under our methodology. Due to the fact that many of the tasks described under the CA005 activity code are forms of indirect PE, we believe that the RUC-recommended survey median clinical labor time of 10 minutes overstates the amount of direct clinical labor taking place. We believe that it is more accurate to propose the survey 25th percentile clinical labor time of 3 minutes for this activity code to reflect the non-administrative tasks performed by the clinical staff.

We are also proposing to refine the quantity of the non-sterile gloves (SB022) supply from 3 to 2 for CPT code 95X01. We note that the current reference code, CPT code 95953, uses 2 of these pairs of gloves and the survey also stated that 2 pairs of gloves were typical for the procedure. Although the recommended materials state that a pair of gloves is needed to set up the equipment, to take down the equipment, and a third is required for electrode changes, we do not agree that the use of a third pair of gloves would be typical given their usage in the reference code and in the responses from the survey.

We note that we are not proposing to refine many of the other clinical labor times for CPT code 95X01, which remain at the survey median clinical labor times. Due to the nature of

the continuous recording EEG service taking place, we agree that the survey median clinical labor times of 12 minutes for the "Prepare room, equipment and supplies" (CA013) activity, 45 minutes for the "Prepare, set-up and start IV, initial positioning and monitoring of patient" (CA016) activity, and 22 minutes for the "Clean room/equipment by clinical staff" (CA024) activity would be typical for this procedure. We reiterate that we assess the direct PE inputs for each procedure individually based on our methodology of what would be reasonable and medically necessary for the typical patient.

For CPT codes 95X02-95X13, we are proposing to refine the clinical labor time for the "Coordinate post-procedure services" (CA038) activity from either 11 minutes to 5 minutes or from 22 minutes to 10 minutes as appropriate for the CPT code in question. The recommended materials for these procedures state that the tasks taking place constitute "Merge EEG and Video files (partially automated program), confirm transfer of data, delete from laptop/computer if necessary". We believe that many of the tasks detailed here are administrative in nature, consisting of forms of data entry, and therefore, would be considered types of indirect PE. We note that when CPT code 95812 (Electroencephalogram (EEG) extended monitoring; 41-60 minutes) was recently reviewed for CY 2017, we finalized the recommended clinical labor time of 2 minutes for "Transfer data to reading station & archive data", a task which we believe to be highly similar. Due to the longer duration of the procedures in CPT codes 95X02-95X13, we are proposing clinical labor times of 5 minutes and 10 minutes for the CA038 activity for these CPT codes. We are also refining the equipment time for the Technologist PACS workstation (ED050) to match the clinical labor time proposed for the CA038 activity.

For the four continuous monitoring procedures, CPT codes 95X04, 95X07, 95X10, and 95X13, we are proposing to refine the equipment time for the ambulatory EEG review station

(EQ016) equipment. The recommended equipment time for the ambulatory EEG review station was equal to four times the "Perform procedure/service" (CA021) clinical labor time plus a small amount of extra prep time. We do not agree that it would be typical to assign this much equipment time, as it is our understanding that one ambulatory EEG review station can be hooked up to as many as four monitors at a time for continuous monitoring. Therefore, we do not believe that each monitor would require its own review station, and that the equipment time should not be equal to four times the clinical labor of the "Perform procedure/service" (CA021) activity. As a result, we are proposing to refine the ambulatory EEG review station equipment time from 510 minutes to 150 minutes for CPT code 95X04, from 1480 minutes to 400 minutes for CPT code 95X07, from 514 minutes to 154 minutes for CPT code 95X10, and from 1495 minutes to 415 minutes for CPT code 95X13.

For the 10 professional component procedures, CPT codes 95X14-95X23, we are again proposing to refine the equipment time for the ambulatory EEG review station (EQ016) equipment. We believe that the use of the ambulatory EEG review station is analogous in these procedures to the use of the professional PACS workstation (ED053) in other procedures, and we are proposing to refine the equipment times for these 10 procedures to match our standard equipment time formula for the professional PACS workstation. Therefore, we are proposing an equipment time for the ambulatory EEG review station equal to half the preservice work time (rounded up) plus the intraservice work time for CPT codes 95X14 through 95X23. We believe that this equipment time is more accurate than the recommended equipment time, which was equal to the total work time of the procedures, as the work descriptors for CPT codes 95X14-95X23 make no mention of the ambulatory EEG review station in the postservice work period.