AMA/Specialty RVS Update Committee
Meeting Minutes
April 27-30, 2006

I. Welcome and Call to Order

Doctor William Rich called the meeting to order on Thursday, April 27, 2006, at 1:00 pm. The following RUC Members were in attendance:

William Rich, MD (Chair)
Bibb Allen, Jr., MD
James Anthony, MD*
Dennis M. Beck, MD*
Michael D. Bishop, MD
James Blankenship, MD
Dale Blasier, MD*
Ronald Burd, MD*
Norman A. Cohen, MD
Bruce Deitchman, MD*
James Denneny, MD*
John Derr, Jr., MD
Verdi DiSesa, MD*
Thomas A. Felger, MD
Mary Foto, OTR
John O. Gage, MD
William F. Gee, MD*
Robert S. Gerstle, MD*
David F. Hitzeman, DO
Peter Hollmann, MD
Charles F. Koopmann, Jr., MD
Michael Kuettel, MD, MBA, PhD*
Gregory Kwasny, MD*
Walt Larimore, MD*
M. Douglas Leahy, MD*
Barbara Levy, MD
Brenda Lewis, DO*
J. Leonard Lichtenfeld, MD
Charles D. Mabry, MD*
Scott Manaker, MD
Charles Mick, MD
Bill Moran, Jr., MD
Bernard Pfeifer, MD
Gregory Przybylski, MD
David Regan, MD
James B. Regan, MD
Daniel Mark Siegel, MD
J. Baldwin Smith, III, MD
Peter Smith, MD
Robert J. Stomel, MD*
Susan M. Strate, MD
Trexler Topping, MD
Arthur Traugott, MD*
Richard Tuck, MD
Richard W. Whitten, MD
John A. Wilson, MD*

*Alternate

II. Chair's Report

Doctor Rich made the following announcements:

- Doctor Rich stated that financial disclosure statements must be submitted to AMA staff prior to presenting. If a form is not signed before your presentation, you will not be allowed to present.

- Doctor Rich welcomed Gregory Kwasny MD, as a new RUC member from the American Academy of Ophthalmology.

- Doctor Rich welcomed the CMS Staff attending the meeting, including:
  - Edith Hambrick, MD, CMS Medical Officer
  - Carolyn Mullen, Deputy Director of the Division of Practitioner Services
  - Ken Simon, MD, CMS Medical Officer
  - Pam West, PT, DPT, MPH

- Doctor Rich welcomed the following Medicare Payment Advisory Commission (MedPAC) staff:
  - Carol Carter, PhD

- Doctor Rich welcomed the Practice Expense Review Committee (PERC) Members attending. The members in attendance for this meeting were:
  - Bill Moran, MD (Chair)
  - James Anthony, MD
  - Katherine Bradley, PhD, RN
  - Joel Brill, MD
  - Neal Cohen, MD
  - Manuel D. Cerqueria, MD
  - Neal H. Cohen, MD
  - Thomas Felger, MD
  - Gregory Kwasny, MD
  - Peter McCreight, MD
  - Tye Ouzounian, MD
  - James Regan, MD

- Doctor Rich welcomed the following Medicare Carrier Medical Director:
  - William J. Mangold, Jr., MD

- Doctor Rich announced the members of the Facilitation Committees:

  <u>Facilitation Committee #1</u>
  James Regan, MD (Chair)
  Michael D. Bishop, MD
  James Blankenship, MD
  Ronald Burd, MD
  Norman Cohen, MD
  Mary Foto, OTR
  Charles Koopmann, MD
  Barbara Levy, MD
  Bernard Pfeifer, DC
  Susan Strate, MD
  Arthur Traugott, MD
  Richard Tuck, MD

Richard Whitten, MD

Facilitation Committee #2
Scott Manaker, MD (Chair)
Bibb Allen, MD
Katherine Bradley, PhD, RN
John O. Gage, MD
Meghan Gerety, MD
J. Leonard Lichtenfeld, MD
Larry Martinelli, MD
Daniel Mark Siegel, MD
Lloyd Smith, DPM
Trexler Topping, MD

Facilitation Committee #3
Gregory Przybylski, MD (Chair)
Sherry Barron-Seabrook, MD
Dale Blasier, MD
Joel Brill, MD
John Derr, MD
Thomas Felger, MD
Emily H. Hill, PA-C
David Hitzeman, DO
Willard Moran, MD
Charles Mick, MD
J. Baldwin Smith, MD
Peter Smith, MD
David Regan, MD

- Doctor Rich welcomed the following individuals as observers at the April 2006 meeting:
  - Michael Bigby – American Academy of Dermatology
  - Robert Blaser – Renal Physicians Association
  - Kenneth Bouchard, PhD – American Speech-Language-Hearing Association
  - Paul Christo, MD – American Academy of Pain Medicine
  - Brett Coldiron – Society of Investigative Dermatology
  - R. Duane Davis – Society of Thoracic Surgeons
  - Megan Fogelson-Dahlby – American Association of Neuromuscular Electrodiagnosticology
  - Edwardo Fraifeld – American Academy of Pain Medicine
  - Denise Garris – American College of Cardiology
  - Lawrence Green – American Academy of Dermatology
  - David Han – Society for Vascular Surgery
  - Kirk Kanter – Society of Thoracic Surgeons

- Frank Lagattuta, MD – American Academy of Physical Medicine and Rehabilitation
- Gary Leiserowitz, MD – American College of Obstetricians and Gynecologists
- John McInnis – Academy of Pharmaceutical Physician Investigators
- Joanne Miller – North American Spine Society
- Richard Molteni, MD – American Academy of Pediatrics
- Jonathan Myles, MD – College of American Pathologists
- Bernard Patashnik – Consultant
- Diane Pedulla – American Psychological Association
- Sarika Rane – The Endocrine Society
- Chad Rubin – American College of Surgeons
- Stuart Trembath, MA – American Speech-Language-Hearing Association
- James Vavricek – American Association of Neuromuscular Electrodiagnosticology
- Brian Whitman – American College of Physicians
- Kadyn Williams, AuD – American Academy of Audiology

- Doctor Rich delivered a brief personal presentation regarding pay-for-performance issues. The slide presentation is available through AMA staff.

III. Directors Report

Sherry Smith made the following announcements:

- Kathy Kuntzman, Vice President of Health Policy at the AMA has retired. Rob Otten, Director of Socioeconomic Policy Development, is serving as the Acting Vice President of Health Policy. Ms. Smith welcomed Mr. Otten to the RUC Meeting.
- David Barrett is the new Senior Policy Analyst for the Department of Physician Payment Policy and Systems. Revised copies of AMA RUC staff contact information and areas of responsibility have been included in the meeting materials.
- The next RUC meeting will be in Arlington, VA, October 5-8, 2006, at the Hilton Alexandria Mark Center. The February 2007 meeting will be held in San Diego, CA at the Omni Hotel and the April 2007 meeting will be held in Chicago, IL.
- RUC staff is beginning a complete redesign of the RBRVS web site which is planned to include a restricted access site for RUC participants with access to a library of RUC information.
- Staff is moving forward with a survey of non-Medicare use of the RBRVS. The results of the survey will be presented at the October

meeting and will be published in *Medicare RBRVS: The Physicians' Guide 2007*.

- Staff is currently planning the 2007 CPT/RBRVS Symposium. The Symposium will be reformatted this fall. The program will no longer be split between CPT and RBRVS, but rather, the presentations will be integrated. This will allow for time to discuss more issues more thoroughly.
- The AMA Board of Trustees will appoint the AMA representative to the RUC prior to the October 2006 RUC meeting. Once selected, the new representative will be announced to the RUC.
- An updated listing of all recent specialty society RUC and RUC alternate appointments and reappointments has been included in the agenda materials.
- RUC members and alternates will be asked to provide their recommended format for future meeting materials and where and in which format they prefer to receive the materials.

IV. Approval of Minutes for the February 2-5, 2006 RUC meeting:

The RUC reviewed the minutes and accepted them as presented.

V. CPT Editorial Panel Update

Doctor Peter Hollmann informed the RUC that:

- The CPT updates for calendar year 2007 have been included in the agenda materials.
- The CPT Editorial Panel is reviewing all coding modifiers and will look particularly at the codes that are -51 exempt. The Panel plans to develop standard criteria for codes that are -51 exempt.
- The CPT Editorial Panel has received a request to establish seven-day global periods for all Evaluation and Management codes. This would require all phone calls and electronic communication to be billed separately. A work group has been created to discuss this proposal.
- The CPT Editorial Panel plans to make refinements to the drug administration codes.
- The CPT Editorial Panel has established a work group to review all skin graph codes.

VI. CMS Update

- Doctor Ken Simon reported to the RUC that the Proposed Rule for the Five-Year Review will be published separately from the Proposed Rule for the Medicare Physician Payment Schedule for 2007. Both Proposed Rules are scheduled to be published in the near future.

- Doctor Simon also reported that the push for Pay-for-Performance initiatives is continuing to escalate. CMS Administrator, Doctor Scott McClellan, is considering the introduction of a proposal that will transform the Physician Voluntary Reporting Program (PVRP) that is already operating through CMS into a Pay-for-Performance plan.
- There is continued collaboration between CPT and CMS in the development of Category II CPT codes for performance measures. Doctor Simon reported that another 16 new Category II codes have been accepted by CMS.
- The CMS department on Program Integrity is preparing a document on the recently released National Correct Coding Initiative's Medically Unbelievable Edits (MUEs). CMS is responding to the comments from providers and is working with the AMA to clarify the MUEs.

VII. CMD Update

Doctor William Mangold provided the RUC with an update on the following issues:

- A new workgroup of Carrier Medical Directors has been formed to solicit recommendations from providers of misvalued codes. This listing of codes will be submitted as formal recommendations to CMS for the next Five-Year Review.
- The CMD representative to the RUC should serve as a true liaison and format for interaction between Carrier Medical Directors, the RUC and each of the specialty societies. Doctor Mangold informed the RUC that the AAO recently submitted a request to the CMDs and issues pertaining to non-payment or non-coverage of services can be brought to the CMDs via the RUC meetings.

VIII. Washington Update

Sharon McIlrath, AMA staff, updated the RUC on the impending cuts to the Medicare Physician Payment Schedule for 2007 and provided an overview of the AMA's actions to advocate for a remedy. She reported that overall, physicians can expect a cut of approximately 5% in 2007. The AMA anticipates nine consecutive years of reductions, totaling roughly 34% by 2015. In order to provide a freeze of the current conversion factor through 2015, it will cost approximately $127 billion and to adequately increase the conversion factor through 2015, as was recommended by MedPAC, it will cost $218 billion

The AMA is requesting at least one Medicare Economic Index update, plus additional payment to cover administrative costs of those who participate in voluntary reporting. The primary debate promulgated by AMA staff to Congress

is that physician payments by Medicare are the same as they were in 2001, while costs have continued to rise and will rise another 15% over 10 years.

The problem with the SGR and reductions in the conversion factor is due to the fact that there is a gap between target spending and actual spending. The SGR is cumulative and considers target rather than actual spending. The gap between the two, which is also cumulative, is now nearly $50 billion. Half of the problem is due to the fact that Congress continues to provide updates to the payment schedule without correcting the targeted spending rates.

The other half of the problem is due to accelerated utilization growth, which began in 2001. Perception on the Hill is that the problem is solely based on volume growth and that a significant part of this growth is due to inappropriate care provided.

Both CMS and MedPAC are pressing forward with recommendations for the inclusion of quality measures in the payment schedule. The Consortium is working with specialty societies to ensure that Pay-for-Performance initiatives are based on clinically appropriate measures developed by physicians. There are currently 93 measures and work is underway on multiple measures in 10 other clinical areas. It is unlikely that the earlier predicted number of 140 will be reached this year.

Although nearly all measures until now are based only on quality, both MedPAC and CMS are pursuing efficiency measures. Their aim is to compare physicians on their costs for specific types of care. Initially, the data would be shared only on a confidential basis with physicians.

Ms. McIlrath concluded by stating the AMA needs to make it clearer to Congress that unfunded pay increases will exacerbate the problem. Further, the AMA must make patients, press, and Congress more aware of what they are getting for their money. The AMA needs help on providing a fairer analysis of the volume numbers, seeking more details, data, and anecdotes from the members. Physicians have a positive story to tell and we need to widen the circle of people who are aware of just how much progress has been made.

Dr. Kurt Gillis, AMA staff economist, provided a detailed report to the RUC regarding the Sustainable Growth Rate expenditures and resultant changes to the Medicare Physician Payment Schedule for 2007. A handout was provided to the RUC with a highly detailed estimate for the 2005 SGR spending with a breakdown of spending by type of service and procedure code. Dr. Gillis reported that this analysis will provide a more accurate assessment of the actual expenditures versus the targeted expenditures making for more precise predictions on changes to the conversion factor in future years.

Dr. Gillis stated that his analysis is based on CMS utilization and spending data, of which 90% of all expenditures for fiscal year 2005 are complete and have been included.

Overall, 10% of Medicare expenditures are for prescription drugs and 7% are for clinical laboratory reimbursement. In 2005, there was 6.5% growth in SGR spending, which is down from 11% growth in 2004. This is due a number of factors. First, new enrollment rates in Medicare Part B were lower and the total Medicare Physician Payment Schedule growth was lower. Second, the Medicare Modernization Act boosted reimbursements for some geographic regions and was not budget neutral. Third, there was a drop in the price for prescription drugs, down about 20% from 2004 to 2005. Lastly, there is slow-down in utilization growth overall. The AMA analysis differs from the predictions of CMS. CMS expects 8.5% growth in SGR spending (as opposed to AMA's 6.5% prediction).

Dr. Gillis reported that his handout includes a breakdown of where the utilization growth is taking place and pointed out some significant factors. Even though spending growth may be slowing, relative to 2004, it is still growing. Specifically, there is above average growth in utilization of chemotherapy services, imaging, minor procedures, drug administration, critical care visits, emergency department visits, pacemakers, and hip replacements. There is below average growth in office visits and 2005 shows the first sign of abatement in the growth of SGR spending.

Doctor Rich and Ms. Smith commented that questions regarding the presentations by Ms. McIlrath or Dr. Gillis may be emailed to staff. Further, per Ms. McIlrath's comments, any personal or professional experience with a change in utilization contributing to additional volume should be relayed to AMA staff.

Doctor Rich thanked Ms. McIlrath and Dr. Gillis for their reports.

IX. Special Requests

<u>Removal of Pelvis Contents (Tab 4)</u>
George A. Hill, MD, American College of Obstetrics and Gynecology (ACOG)
Gary S. Leiserowitz, MD, American College of Obstetrics and Gynecology (ACOG)

The RUC reviewed code 58240 *Pelvic exenteration for gynecologic malignancy, with total abdominal hysterectomy or cervicectomy, with or without removal of tube(s), with or without removal of ovary(s), with removal of bladder and ureteral transplantations, and/or abdominoperineal resection of rectum and colon and colostomy, or any combination thereof* because of a rank-order anomaly which was created when CPT code 45126 *Pelvic exenteration for colorectal malignancy,*

with proctectomy (with or without colostomy), with removal of bladder and ureteral transplantations, and/or hysterectomy, or cervicectomy, with or without removal of tube(s), with or without removal of ovary(s), or any combination thereof (Work RVU=45.09) was revalued at the Second Five-Year Review in August 2000. The RUC rationale for code 45126 noted that code 58240 may need to be reviewed to ensure a rank order anomaly has not been created. The RUC determined that there was a rank order anomaly and therefore there was compelling evidence to review code 58240.

The RUC reviewed code 58240 and determined that although code 58240 and 45126 represent two different types of cancer, the physician work involved to perform these services is similar. The RUC recommended that the physician pre-service time and post-service time as indicated by the survey respondents be reduced to more closely reflect the reference service code 45126. The RUC recommends crosswalking the work RVU of reference code 45126 (Work RVU = 45.09) to code 58240, which is very similar to the survey 25th percentile of 49.00 work RVUs. **The RUC recommends a work RVU of 45.09 for code 58240. The RUC recommends the following physician times:**

Pre-service evaluation = 75 minutes
Pre-service positioning = 30 minutes
Pre-service scrub, dress, wait = 15 minutes
Intra-service = 420 minutes
Immediate Post-Service = 75 minutes
Hospital Visits = Three 99231, Six 99232 and Three 99233
Discharge Day Management = One 99239
Office visits = One 99212, Four 99213, and One 99214

Practice Expense
The RUC assessed and modified the facility only practice expense inputs for code 58240. The RUC modified the post-service period practice expense office visits to correctly indicate that there are four 99213 visits. **Additionally, the RUC modified the following medical supplies:**

Minimum multi-specialty visit pack = 6
Pelvic exam pack = 6
Non-sterile drape, sheet 40in X 60in = 6

Standard Backbench Procedures (Tab 5)

At its February 2004 meeting the CPT Editorial Panel created codes for organ transplantation. Initially, the codes related to backbench standard preparation were to be reimbursed through Medicare Part A, therefore the RUC did not review these codes in its process. In 2005, CMS made a decision to move these procedures reimbursement from Medicare Part A to Medicare Part B. Therefore,

these procedures are now to be reviewed through the RUC process. It is important to note that CPT Code 47145 *Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary, and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and common bile duct for implantation; with lobe split of whole liver graft into two partial liver grafts (ie, left lobe (segments II, III, and IV) and right lobe (segments I and V through VIII))* was assigned a XXX global period by CMS. In the original summary, there was a typo with the incorrect global period assigned.

The RUC reviewed the letter submitted by the American Society of Transplant Surgeons (ASTS) which explains that due to large variations in their survey responses as well as problems with their reference service list, ASTS would like to recommend that these procedures be carrier priced for CPT 2007. During the CPT 2008 cycle, the ASTS plans to meet with the Research Subcommittee to address these issues and present their survey data to the full RUC at a subsequent meeting. The RUC agreed with this timeline and recommends that for CPT 2007 the standard backbench procedures be carrier priced.

X. Relative Value Recommendations for CPT 2007

Anterior Spine Anesthesia (Tab 6)
James D. Grant, MD, American Society of Anesthesiologists (ASA)
Tripti C. Kataria, MD, American Society of Anesthesiologists (ASA)
Brenda S. Lewis, DO, American Society of Anesthesiologists (ASA)

The CPT Editorial Panel met in February 2006 to discuss creating two new codes to provide specificity to anesthesia services performed via a transthoracic approach. Existing anesthesia codes that cover anesthesia for procedures on the thoracic spine had not taken into account the additional factors involved when the thoracic cavity is invaded as it is when surgical procedures are performed via an anterior/transthoracic approach. These procedures may or may not require one lung ventilation, and existing anesthesia codes that encompass one-lung ventilation are limited by descriptor to procedures involving the lungs, pleura, diaphragm and mediastinum.

New CPT codes 00625 *Anesthesia for procedures on the thoracic spine and cord; via an anterior transthoracic approach, not utilizing one lung ventilation* and 00626 *Anesthesia for procedures on the thoracic spine and cord; via an anterior transthoracic approach, utilizing one lung ventilation* were reviewed by the RUC and it was understood that these procedures were previously reported through one of the three following codes:
00620 *Anesthesia for procedures on thoracic spine and cord; not otherwise specified* (Base Units = 10.00),

00670 *Anesthesia for extensive spine and spinal cord procedures (eg, spinal instrumentation or vascular procedures*) (Base Units = 13.00),
00541 *Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); utilizing one lung ventilation* (Base Units = 15.00).

The RUC believed that anesthesia for the transthoracic spine cases are more complex than anesthesia for the thoracotomy cases that are reported with 00540 *Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); not otherwise specified* (Base Units = 12.00). Both procedures are open thoracotomy, cases but 00625 typically has more intraservice time and complexity which leads to more risks associated with intraoperative and postoperative hypoxemia and atelectasis. In addition, 00625 has increased work associated with an anesthetic technique that must be tailored and adjusted to allow for accurate neurophysiologic monitoring. While both 00540 and 00625 can have significant blood loss, 00625 typically has greater blood loss risks than 00540.

The RUC believed that the physician work of code 00625 was similar to code 00622 *Anesthesia for procedures on thoracic spine and cord; thoracolumbar sympathectomy* (Base Units = 13.00). In addition, the work of code 006216 was similar in complexity and intensity to code 00541. **The RUC recommends a relative base unit value of 13.00 for code 00625 and 15.00 for 00626.**

Skin Graft Recipient Site Preparation (Tab 7)
Keith Brandt, MD, FACS, American Society of Plastic Surgeons (ASPS)
Richard J. Kagan, MD, FACS, American Burn Association (ABA)
Charles Mabry, MD, FACS, American College of Surgeons (ACS)
Scott Oates, MD, American Society of Plastic Surgeons
Chad Rubin, MD, FACS, American College of Surgeons (ACS)

The CPT Editorial Panel deleted two codes and created four new codes to describe excision of hidradentitis suppurativa lesions that are able to be closed primarily, whether by simple, intermediate or complex closure. The existing codes do not adequately describe the physician work and technical difficulty involved in the excision of diffuse and extensive disease that precludes primary closure.

15002 Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or one percent of body area of infants and children

15004 Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet

and/or multiple digits; first 100 sq cm or one percent of body area of infants and children

The RUC reviewed the service times that the specialty society recommended for code 15002 and 15004. The RUC discussed the intra-service times associated with 15002 and determined that the intra-service time be reduced to 20 minutes as this more accurately reflects the procedure. After amending the intra-service time, the RUC reviewed the reference code 15000 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture; first 100 sq cm or one percent of body area of infants and children* (Work RVU=3.99) in comparison to the surveyed code and agreed that due to the increased total time of the surveyed code in comparison to the reference code (115 and 90 minutes, respectively), as well as the surveyed code's higher intensity/complexity measures as compared to the reference code, the median RVU of 3.99 seemed appropriate.

The RUC discussed the intra-service times associated with 15004 and determined that the intra-service time be reduced to 45 minutes as this more accurately reflects the procedure. The RUC noted that there was additional intra-service allocated to this code in comparison to 15002 because of the location of where the procedure is taking place. After amending the intra-service time, the RUC reviewed the reference code 15000 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture; first 100 sq cm or one percent of body area of infants and children* (Work RVU=3.99) in comparison to the surveyed code and agreed that due to the increased total time of the surveyed code in comparison to the reference code (150 and 90 minutes, respectively), as well as the surveyed code's higher intensity/complexity measures as compared to the reference code, the median RVU of 5.00 seemed appropriate.

However, when the RUC reviewed this procedure it had to review the recommendations of all of these codes as a group to determine if the recommendations were work neutral. The specialty society, during its consensus panel discussion to value the codes used the survey data and then had to scale it to account for work neutrality. Therefore, the specialty society established a ratio of how these procedures would be performed by analyzing their survey data. It was determined that the utilization from 15000, which the CPT editorial panel has now deleted, would be divided in a 64:36 split between 15002 and 15004, respectively. It was also determined from the survey that in terms of work there is a 1:1.25 ratio between 15002 and 15004. Therefore, to account for the work neutrality and maintain these two ratios, the specialty society decreased the work RVU recommendations from the median 3.99 RVUs to 3.65 RVUs for 15002 and from the median 5.00 to 4.58 RVUs for 15004. **The RUC agreed with the adjustment and recommends 3.65 RVUs for 15002 and 4.58 RVUs or 15004.**

15003 Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar

contracture, trunk, arms, legs; each additional 100 sq cm or each additional one percent of body area of infants and children (List separately in addition to code for primary procedure)

15005 Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; each additional 100 sq cm or each additional one percent of body area of infants and children (List separately in addition to code for primary procedure)

The RUC reviewed the service times that the specialty society recommended for code 15003 and 15005. The RUC discussed the intra-service times associated with 15003 and determined that the intra-service time be reduced to 15 minutes as this more accurately reflects the procedure. In addition, the RUC determined that the pre-service time for these codes should be zero as there is no additional pre-service work associated with this code as it is billed in addition to 15002. Furthermore, the post-service time recommended by the specialty society was reduced to 1 minute to apply additional dressing as the wound would be larger in the instances where this procedure would be used. After amending the pre-,intra- and post-service times, the RUC reviewed the reference code 15001 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture; each additional 100 sq cm or each additional one percent of body area of infants and children* (Work RVU=1.00) in comparison to the surveyed code and agreed that due to similar total service times of the surveyed code and the reference code (16 and 15 minutes, respectively), as well as the similar intensity and complexity measures, the median of 1.50 seemed appropriate.

The RUC discussed the service times associated with 15005 and determined that the intra-service time be reduced to 20 minutes as this more accurately reflects the procedure. The RUC noted that there was additional intra-service allocated to this code in comparison to 15003 because of the location of where the procedure is taking place. In addition, the RUC determined that the pre-service time for this code should be zero as there is no additional pre-service work associated with this code as it is billed in addition to 15004. Furthermore, the post-service time recommended by the specialty society was reduced to 1 minute to apply additional dressing as the wound would be larger in the instances where this procedure would be used. After amending the pre-, intra-, and post-service times, the RUC reviewed the reference code 15001 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture; each additional 100 sq cm or each additional one percent of body area of infants and children* (Work RVU=1.00) in comparison to the surveyed code and agreed that due to the increased total time of the surveyed code in comparison to the reference code (22 and 15 minutes, respectively), as well as the surveyed code's higher intensity/complexity measures as compared to the reference code, the median RVU of 3.00 seemed appropriate.

However, when the RUC reviewed this procedure it had to review the recommendations of all of these codes as a group to determine if the recommendations were work neutral. The specialty society, during its consensus panel discussion to value the codes used the survey data and then had to scale it to account for work neutrality. Therefore, the specialty society established a ratio of how these procedures would be performed by analyzing their survey data. It was determined that the utilization from 15001, which the CPT Editorial Panel has now deleted, would be divided in a 76:24 split between 15003 and 15005, respectively. It was also determined from the survey that in terms of work there is a 1:2 ratio between 15003 and 15005. Therefore, to account for the work neutrality and maintain these two ratios, the specialty society decreased the work RVU recommendations from the median 1.50 RVUs to 0.80 RVUs for 15003 and from the median 3.00 to 1.60 RVUs for 15004. **The RUC agreed with the adjustment and recommends 0.80 RVUs for 15003 and 1.60 RVUs or 15004.**

Practice Expense:
The RUC reviewed the recommendations made by the specialty society and determined that the practice expense inputs for the new codes (15002, 15003, 15004 and 15005) have been crosswalked from the deleted codes (15000 and 15001) which were approved by the RUC with one exception the addition of 10 minutes for cleaning the surgical pack which was not allocated to the deleted codes during their review. All clinical staff intra-service times will be modified to reflect the modified physician intra-service times. The practice expense inputs as modified were approved.

Axial Pattern Forehead Flap (Tab 8)
Keith Brandt, MD, FACS, American Society of Plastic Surgeons (ASPS)
Scott Oates, MD, American Society of Plastic Surgeons (ASPS)

The CPT Editorial Panel created one new code, based on the RUC's Five-Year Review recommendation, to more accurately describe axial pattern forehead flap procedures and differentiate from the original coding which described the procedure on any area. These procedures represent regional vascularized fasciocutaneous flaps for coverage of Mohs defects, coverage of small traumatic defects and reconstruction of contractures from the forehead.

The RUC reviewed the survey results from 35 plastic surgeons regarding 15731 *Forehead flap with preservation of vascular pedicle (eg axial pattern flap, paramedian forehead flap)* noting its relation to the key reference service code, 14300 *Adjacent tissue transfer or rearrangement, more than 30 sq cm, unusual or complicated, any area* (work RVU = 11.74). The RUC agreed with the specialty society that the work for 15731 is greater than 14300 due to the high level of intensity/complexity of performing this new service as compared to the reference code. The surveyed code was rated higher than the reference code in

intensity/complexity in every measurable category by survey respondents. The RUC also noted that the physician intra-service time for 15731 is greater than the reference service code (120 minutes and 102 minutes, respectively). Further, the specialty noted that the procedure is so intense due to its location and visibility. Any mistake will cause problems for the patient in two areas of their face, where the section was taken from and the area that the section was to cover. The RUC also considered the appropriateness of a 99214 office visit. It was decided that due to the variability of the section, the medical decision making involved, the potential for serious complications, and the time spent with the patient, a 99214 office visit is appropriate. Due to the high intensity/complexity of the procedure, the RUC agreed the 25th percentile work RVU of 12.95 for 15731 was appropriate. **The RUC recommends a work RVU of 12.95 for code 15731.**

Practice Expense

The standard inputs for 090 day global period were applied and 15731 was also priced in the non-facility setting. Due to the introduction of 15731, the RUC further recommended that 15732 be priced in the facility setting only. **The RUC recommends that 15732 be priced in the facility setting only.**

Panniculectomy (Tab 9)

Keith Brandt, MD, FACS, American Society of Plastic Surgeons (ASPS)
Scott Oates, MD, American Society of Plastic Surgeons (ASPS)
Charles Mabry, MD, FACS, American College of Surgeons (ACS)
Chad Rubin, MD, FACS, American College of Surgeons (ACS)

The CPT Editorial Panel created one new code and revised a second code, based on the RUC's Five-Year Review recommendations, to more accurately differentiate between abdominoplasty and panniculectomy. This coding change was necessitated by a recent change in the patient population due to the drastic rise in patients undergoing bariatric surgery and experiencing excessive weight loss. Panniculectomy involves the excision of skin and subcutaneous tissue and is commonly performed to treat recurring rashes, skin maceration, and yeast infections while abdominoplasty includes a whole host of secondary nonfunctional procedures such as transposition of the umbilicus, undermining to the costal region margin, imbrication of rectus diastasis, lateral contouring imbrications, suction assisted liposuction, and others.

Code 15830

The RUC reviewed the survey data for 15830, *Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy* in comparison to the key reference service code 19318 *Reduction mammaplasty* (work RVU = 15.60). The surveyed code very closely compares with the intensity/complexity measures for the key reference service code. However, the RUC assessed the physician time from the specialty society survey and agreed that the one 99214 office visit should be reduced to a 99213 office

visit to reflect the typical patient encounter. In addition, the RUC also agreed that the 25th percentile intra-service time (120 minutes) was more appropriate as well. With these reductions in the intra-service time and post-operative office visits, the RUC agreed the specialty's surveyed 25th percentile work RVU of 15.60 accurately reflected the service. **The RUC recommends a work RVU of 15.60 for code 15830.**

Codes 15831 and 15846

The RUC reviewed the specialty society presentation regarding 15831 *Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen (eg, abdominoplasty) (includes umbilical transposition, fascial plication and undermining)* (work RVU = 12.38) which was revised due to the creation of 15830. The procedure now accurately reflects an add-on procedure to 15830 typically for morbidly obese patients experiencing excessive weight loss, usually following bariatric surgery. However, the code could be misinterpreted and used to describe a purely cosmetic "tummy-tuck" procedure. Such a procedure should be coded by using an unlisted procedure code, 17999 *Unlisted procedure, skin, mucous membrane and subcutaneous tissue* (work RVU = 0.00). To prevent confusion and potential abuse, the RUC recommended that15831 be deleted and renumbered to 15846. Further, the RUC agreed with the presenters that assigning carrier pricing will also reduce the potential for abuse and provide adequate valuation for the service in situations where it should be covered. **The RUC recommends that this procedure now identified with CPT Code 15846 be carrier priced.**

Practice Expense

The RUC reviewed the practice expense inputs for 15830. These inputs were assessed and the RUC removed one minimum multi-specialty visit pack and reflected the changes from the change in post-service office visits. Following these amendments, the RUC agreed that the practice expense inputs met the RUC's standard of clinical labor time, supplies, and equipment.

Mohs Surgery (Tab 10)

Brett Coldiron, MD, American Academy of Dermatology (AAD)
James A. Zalla, MD, American Academy of Dermatology (AAD)
John A. Zitelli, MD, American Academy of Dermatology (AAD)
Pre-Facilitation Committee #1

The Centers for Medicare and Medicaid Services (CMS) requested in 2005 that the RUC review the work relative values for the Mohs Surgery family of CPT codes. In this Five-Year Review of the RBRVS, the committee agreed with the prior conclusions of the RUC and was unable to validate the current work relative values absent a fundamental coding change within this section of CPT. The RUC concluded that this section of CPT required review and revision of the descriptors prior to any relative value determinations. This is consistent with the RUC's

actions in February 2003, when the RUC recommended the following related to all of Mohs surgery:

The code descriptors for these services remain confusing and open to various interpretations. Although the RUC understands that many in the Mohs community and payors had historically interpreted CPT code 17310 as an add-on code to be reported for each additional specimen beyond the first five specimens, concern was expressed regarding the potential for over-utilization of this code. In addition, the workgroup noted that the nomenclature for these services is not consistent with other integumentary coding conventions in CPT, which are based on the size of the lesion and anatomical site, rather than the number of specimens. The RUC, therefore, recommends that the specialty work with the CPT Editorial Panel to re-define the Mohs Micrographic Surgery section in CPT. After this revision is complete, the RUC believes that these codes can be appropriately re-evaluated.

In February 2006, the CPT Editorial Panel did review the Mohs Surgery section and replaced it with a new section of CPT codes.

The specialty surveyed the new codes in March 2006. The RUC concluded that it could not use the survey work relative value data to determine an appropriate valuation and, therefore, a building block approach was utilized. However, the physician time from the 116 respondents was determined to be appropriate and it is recommended that this data only be slightly revised.

Building Block Assumptions

Excision Component:

The most appropriate comparison to the work related to the excision element of this service is the shaving of dermal lesion family: 11313 *Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 2.0 cm* (work RVU = 1.62; total time = 42 minutes) and *11312 Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm* (work RVU = 1.20; total time = 35 minutes).

Pathology Component:

The pathology work for each individual tissue block was determined to be generally equivalent to CPT code 88332 *Pathology consultation during surgery; each additional tissue block with frozen section(s)* (work RVU = 0.59; intra/total time = 15 minutes). However, it was acknowledged that a small additional increment above the value for 88332 is appropriate for each block as there is additional intensity related to drawing or mapping the tissue and its pieces to correspond to the surgical wound. An additional increment of 0.07 [(50% of 0.59 = 0.295, for four blocks/first stage)/4 blocks = .07 per block]. The total

pathology work related to each tissue block is 0.66. The time related to each tissue block pathology service is 15 minutes (same as 88332).

First Stage of Mohs Surgery
The first stage typically includes four tissue blocks.

The Harvard intra-service time of 50 minutes related to the excision work only and this had previously been confirmed by Hsaio. The facilitation committee recommends that 50 and 40 minutes of intra-service time for the excision work for face and trunk respectively, and 60 minutes for pathology work for both (total time = 110/100 minutes) is reasonable as the survey median for intra-service time for the first stage codes (V1/face = 120 and V3/trunk = 111) is similar. The survey pre and post time (total 28 minutes) for the first stage is appropriate.

The first stage includes debulking and is also more intense overall than the subsequent stages. Therefore, the facilitation committee recommends that two increments of 11313 (work RVU = 1.62) are appropriate for the excision work. This corresponds to the total time for the for two, 11313 of 84 minutes and the total excision time for Mohs 78 minutes (50 intra + 28 pre/post).

Subsequent Stages
Each subsequent stage typically includes three tissue blocks.

The pathology time is 45 minutes (3 x 15 minutes). The excision intra-service time is 20 minutes face and 15 minutes for trunk. An additional increment of 8 minutes of positioning time is appropriate for this ZZZ service as the patient must re-enter the room and be re-draped, etc.

Relativity between anatomical sites
The facilitation committee reviewed the relativity between the following two code families 11601 – 11606 *Excision, malignant lesion including margins, trunk, arms, or legs* and 11641 – 11646 *Excision, malignant lesion including margins, face, ears, eyelids, nose, lips* to approximate the relativity differences in the work related to the excision for the face vs. trunk: Excision related to the face is approximately 20% greater work than excision related to the trunk, etc.

Computation/Recommendations
Mohs, First Stage:

Excision:	11313 (work RVU = 1.62) x 2 (debulking and excision) =	3.24
Pathology	[88332 (0.59) + (0.07) = 0.66] x 4 blocks	2.64
Total Work related to first stage		5.88

Note: Original Harvard valuation for 17304 was 5.84.

17311 (V1) *First stage, face, etc.* [(3.24 x 110% = 3.56) + 2.64] **6.20**
Time: pre= 20; intra = 110 (50 excision+60 path); post = 8

17313 (V3) *First stage, trunk, etc.* [(3.24 x 90% = 2.92) + 2.64] **5.56**
Time: pre= 20; intra = 100 (40 excision+60 path); post = 8

Mohs, Each Subsequent Stage:

Excision	11312 (work RVU = 1.20)	1.20
Pathology	[88332 (0.59) + 0.07) = 0.66] x 3 blocks	1.98
Total Work related to subsequent stage		3.18

17312 (V2) Subsequent *stage, face, etc.* [(1.20 x 110% = 1.32) + 1.98] **3.30**
Time: pre= 8; intra = 65 (20 excision+45 path)

17314 (V4) *Subsequent stage, trunk, etc.* [(1.20 x 90% = 1.08) + 1.98] **3.06**
Time: pre= 8; intra = 60 (15 excision+45 path)

Mohs, Each Additional Block
CPT code 17315 (V5) incorporates additional work related to an excision and pathology services. The RUC agreed that the majority of this service relates to the pathology service and should be valued in comparison to 88332 (0.58), with the 50% intensity adjustment (0.58 x 1.5 = .087). **The RUC recommendation of 0.87 and the survey intra-service time of 30 minutes is appropriate.**

IWPUT Review

CPT Code	Excision IWPUT	Pathology IWPUT	Total IWPUT
17311 (V1)	0.060	0.044	0.050
17312 (V2)	0.057	0.044	0.050
17313 (V3)	0.060	0.044	0.050
17314 (V4)	0.060	0.044	0.050
17315 (V5)	0.014	0.044	0.029

Reference Services
These services are unique and it is difficult to find appropriate reference services. However, the facilitation committee did search the database in its review of the first stage of Mohs, search for 000 day global codes, with at least 60 minutes of intra-service time. This search resulted in the following services:

Reference services related to generic first stage Mohs (5.88 estimated value):

15776 *Punch graft for hair transplant* (work RVU = 5.53, intra-time = 90 minutes)
31561 *Laryngoscopy* (work RVU = 5.99, intra-time = 90 minutes)
32602 *Thoracoscopy, diagnostic* (work RVU = 5.95; intra-time =75 minutes)

Practice Expense
The RUC agreed that the revised practice expense inputs, as provided by the specialty, and reviewed by the PERC, are appropriate. The clinical staff time related to assisting the physician with the excision service will computed at 2/3 of the physician time for this element.

PLI Crosswalk
The PLI relative values for the new codes should be crosswalked to the existing codes. (ie, 17311 and 17313 – crosswalk to 17304; 17312 and 17314 – crosswalk to 17305; and 17315 – crosswalk to 17310.

Fibroadenoma Cryoablation (Tab 11)
Charles Mabry, MD, FACS, American College of Surgeons (ACS)
Eric Whittacre, MD, FACS, American College of Surgeons (ACS)

The CPT Editorial Panel changed the status of the current code descriptor for cryosurgical ablation of fibroadenoma from a Category III emerging technology code to a Category I CPT code due to an increase in utilization and additional peer-reviewed literature that provides long-term follow-up data since the Category III code was originally created.

Code 19105
The RUC reviewed the survey data for 19105 *Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma* in comparison to the key reference service code, 19103 *Biopsy of breast; percutaneous, needle core, using imaging guidance* (work RVU = 3.69). The presenters explained that the new procedure was similar in intensity to the reference service; however, the surveyed code indicated slightly more pre-service and intra-service time (45 minutes pre-service and 45 minutes intra-service as compared to 20 minutes pre-service and 30 minutes intra-service, respectively). Due to the similar intensity/complexity measures and comparable service times, the RUC agreed the work RVUs were directly comparable to the key reference service, 19103, and agreed that a work RVU recommendation of 3.69 was appropriate for code 19105. **The RUC recommends a work RVU of 3.69 for code 19105.**

New Technology/Services
Because the code represents a newer technology used for an innovative technique and because the code was last converted from a Category III CPT code, the RUC agreed that it should be placed on the new technology list for potential changes in its valuation. **The RUC recommends that code 19105 be added to the list of new technology codes.**

Practice Expense
The RUC reviewed the practice expense inputs for 19105. These inputs were assessed and the RUC made several revisions. Following these amendments, the

RUC agreed that the practice expense inputs met PEAC accepted standards of clinical labor time, supplies, and equipment.

Breast Reconstruction (Tab 12)
Keith Brandt, MD, FACS, American Society of Plastic Surgeons (ASPS)
Scott Oates, MD, American Society of Plastic Surgeons (ASPS)
Charles Mabry, MD, FACS, American College of Surgeons (ACS)
Eric Whittacre, MD, FACS, American College of Surgeons (ACS)

The CPT Editorial Panel revised one code, 19361 *Breast reconstruction with latissimus dorsi flap; without prosthetic implant* at the request of the RUC after analysis during the Five-Year Review to more accurately describe two separate and distinct procedures previously included within a single code. The revised coding allows for more appropriate reporting and valuation for breast reconstruction surgery with and without insertion of a prosthesis.

Code 19361
The RUC reviewed the survey data for 19361 *Breast reconstruction with latissimus dorsi flap; without prosthetic implant* from 45 general and plastic surgeons. The RUC reviewed the code in relation to the reference service code 19367 *Breast reconstruction with transverse rectus abdonomis myocutaneous flap (TRAM), single pedicle, including closure of donor site* (work RVU = 25.69). While the specialty survey results indicated the physician pre-service, intra-service, and post-service time differed between the two codes (pre-service = 70 minutes, intra-service = 240 minutes, and post-service = 30 minutes for 19361 as compared to pre-service = 60 minutes, intra-service = 300 minutes, and post-service = 0 minutes for 19367) the measures of intensity/complexity are nearly identical. The RUC disagreed with the specialty representatives regarding the number of office follow-up visits for the procedure. The RUC agreed that a single 99214 office visit in addition to three 99213 and two 99212 visits, accounting for six total post-service visits, was not appropriate as the key reference service code provides only five visits. As such, the RUC removed the 99214 office visit and reduced one 99213 visit to a 99212 visit. Due to this reduction in post-operative visits, the RUC removed 1.50 work RVUs, the associated work, from the survey median 23.50 for a resultant value of 22.00 work RVUs or the 25th percentile of the survey results.

In addition, the original code was brought before the RUC for the Five-Year Review and was referred to CPT for revision. The society was asked to provide compelling evidence for why this code should not be restricted by budget neutrality. The RUC agreed with the presenters that the original code was never valued by the RUC or valued using the Harvard data; and the code (prior to revision) included two distinct services that could not feasibly be valued together. As currently valued, the code presents a rank order anomaly within the breast reconstruction code family. Taking this information into consideration, the RUC

agreed that this procedure should not be restricted by work neutrality and agreed a work relative value of 22.00 is appropriate for 19361 considering the physician time and intensity/complexity. **The RUC recommends a work RVU of 22.00 for code 19361.**

Practice Expense
This service is performed in the facility setting only. The specialty society's practice expense inputs for the facility setting were modified to reflect the amended post-operative visits. These direct practice expense inputs are consistent with the 090 day standards approved by the PERC and the RUC.

Percutaneous Intradiscal Annuloplasty (Tab 13)
Brenda Lewis, DO, American Society of Anesthesiologists (ASA)
Eddy Fraifield, MD, American Academy of Pain Medicine (AAPM)
Robert Barr, MD, American Society of Neuroradiology (ASNR)
David Kloth, MD, American Society of Interventional Pain Physicians (ASIPP)
Francis Lagattuta, MD, American Academy of Physical Medicine and Rehabilitation (AAPMR)
Facilitation Committee #2

The CPT Editorial Panel created two new codes to replace two tracking codes 0062T and 0063T report percutaneous intradiscal annulopasty to treat patients with chronic low back pain.

22526
The RUC reviewed the physician service surveyed times that the specialty society presented for code 22526 *Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level.* The RUC agreed that the pre-service, intra-service and immediate post-service time as modified and presented by the specialty society were appropriate. The RUC then reviewed the post-service and reduced the 99238 to a half day since this service is typically provided in the outpatient hospital setting. Additionally, the RUC agreed that one 99212 visit was more appropriate than a 99213 visit.

The RUC reviewed the physician work and agreed that the specialty societies' survey 25th percentile work RVU of 6.05 more appropriately reflected the physician work provided for this service due to slightly higher technical skill/physical effort involved compared to reference service code 22521 *Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; lumbar* (Work RVU=8.3, global period=010-days). **The RUC recommends the specialty's survey 25th percentile work RVU of 6.05 for code 22526. The RUC recommends the following physician time for 22526:**

Pre-service evaluation = 30 minutes
Pre-service positioning = 15 minutes
Pre-service scrub, dress, wait = 15 minutes
Intra-service = 45 minutes
Immediate Post-Service = 15 minutes
Discharge Day Mgmt = ½ 99238
Office visit = One 99212

22527
The RUC reviewed the physician service surveyed times that the specialty society presented for add-on code 22527 *Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; one or more additional levels*. The RUC agreed that the intra-service time of 45 minutes from the specialty societies survey for 22527 was appropriate and noted that pre and post-service time was not appropriate for the typical patient encounter. The RUC and the specialty society agreed that there was no pre and post- service physician time, however, the RUC reviewed the physician work involved for this service and agreed that the physician work for 22527 is 50% of the physician work of the base code 22526. **The RUC recommends a work RVU of 3.03 for code 22527, and an intra-service time of 45 mintues with no pre-service or post-service time.**

The RUC identified that codes 22526 and 22527 are performed bilaterally approximately 25% of the time, however most of the bilateral instances would be performed in the facility.

Practice Expense
The RUC assessed and modified the practice expense inputs for codes 22526 and 22527.

New Technology/Services
The RUC identified this code as utilizing new technology. **The RUC recommends that these codes are put on the new technology/services list and return to the RUC for re-review once this technology has become more widespread.**

Excision of Tendon (Tab 14)
Daniel J. Nagle, MD, FACS, American Society for Surgery of the Hand (ASSH)
Dale Blaiser, MD, FACS, American Association of Orthopaedic Surgeons (AAOS)

The CPT Editorial Panel created new code 25109 *Excision of tendon, forearm and/or wrist, flexor or extensor, each* and editorially revised two existing codes 26170 *Excision of tendon, palm, flexor or extensor, single, each* (Work RVU=4.76)

and 26180 *Excision of tendon, finger, flexor or extensor, each tendon* (Work RVU=5.17) to provide a method for coding the excision of either an extensor or flexor tendon in the forearm or wrist. Currently, there are only codes to report in the hands and fingers but not the wrist or forearm.

The RUC reviewed the specialty society's survey results for code 25109 and agreed that the physician technical skill, physical effort and intensity and complexity involved was similar to reference code 25295 *Tenolysis, flexor or extensor tendon, forearm and/or wrist, single, each tendon* (Work RVU=6.54). The specialty society believed that the survey pre-service evaluation time and pre-service scrub, dress, wait time from their survey was inappropriate in comparison to the reference service code 25295 and recommended a reduction from the survey results for pre-service time. The RUC agreed that the adjustments in physician time and the physician work involved were appropriate in comparison to the reference service code 25295. **The RUC recommends the survey median work RVU of 6.25 for code 25109.**

The RUC recommends the following physician time:
Pre-service evaluation = 25 minutes
Pre-service positioning = 10 minutes
Pre-service scrub, dress, wait = 15 minutes
Intra-service = 40 minutes
Immediate Post-Service = 20 minutes
Discharge Day Mgmt = ½ 99238
Office visits = One 99212 and Two 99213

Practice Expense
The RUC assessed and modified the practice expense inputs to reflect three minimum multi-specialty visit packs rather than four packs.

Percutaneous RF Pulmonary Tumor Ablation (Tab 15)
Geraldine McGinty, MD, American College of Radiology (ACR)
Jonathan Berlin, MD, American College of Radiology (ACR)
Robert L. Vogelzang, MD, Society of Interventional Radiology (SIR)
Facilitation Committee #3

In February 2006, the CPT Editorial Panel created one new code and edited three to provide clarity to the expansion of tumor eradication services by radio frequency ablation to a new anatomic site and tumor type that was not described in existing CPT codes. Percutaneous Radio Frequency Tumor Ablation is a treatment option for a subset of patients with metastases to the lung and patients with primary pulmonary malignances who may be poor candidates for resection. In addition, this new service is used to reduce pulmonary tumors with the expectation of enhanced effectiveness of adjunctive chemotherapy and/or radiation therapy.

The specialty provided an overview of the type of service provided by the physician, as well as the intensity and complexity for code 32998 *Ablation therapy for reduction or eradication of one or more pulmonary tumor(s) including pleur or chest wall when involved by tumor extension, percutaneous, radiofrequency, unilateral*. The RUC compared the intensity of 32998 to code 50592 *Ablation, one or more renal tumor(s), percutaneous, unilateral, radiofrequency* (010 Global, Work RVU = 6.75, intra-service time of 60 minutes) and agreed that the intra-service work per unit of time of this new code was less than this reference code of 0.089. The RUC then agreed that the code's intensity was higher than to code 31288 *Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus* (000 Global, Work RVU = 4.57, intra-service work time of 60 minutes) and with an additional 15 minutes of pre-service work time.

The RUC believed the IWPUT was approximately 0.07 with this comparison of work and with the IWPUT comparisons of traditional ablation codes (e.g. codes 47382 *Ablation, one or more liver tumor(s), percutaneous, radiofrequency* (010 global, Work RVU = 15.17, intra time of 180 minutes). The committee used a building block method with an IWPUT of 0.70 as shown below:

ACTIVITY	32998 TIME	IWPUT	> intensity*	Recommended RVUs
pre service eval/positioning time	30	0.0224		0.67
pre scrub time	15	0.0081		0.08
Intra time	60	0.075	0.702	4.21
immediate post time	30	0.0224		0.67
TOTAL RVU				**5.68**

The RUC recommends a relative work value of 5.68 for code 32998.

Practice Expense for 32998.
The practice expense inputs were reviewed and refined extensively at the PERC and at the RUC.

Initial Epicardial Electrode Insertion (Tab 16)
Kirk Kanter, MD, Society of Thoracic Surgeons (STS)
Facilitation Committee #2

The CPT Editorial Panel created two new codes to accurately reflect the variation in approach and physician involvement for pacemaker insertions specifically, the new biventricular pacemaker technology and the ability to place the leads through various approaches such as thoracotomy, thoracoscopy, subxiphoid and median sternotomy.

33202 Insertion of epicardial electrode(s); open incision (eg, thoracotomy, median sternotomy, subxiphoid approach)

The RUC reviewed the physician service times that the specialty society recommended for code 33202. The RUC discovered that these times were the pre- and post service times used for the cardiothoracic procedures from the Five Year Review (60 minutes evaluation time, 15 minutes positioning time, 20 minutes scrub, dress and wait time and 40 minutes immediate post time). The RUC agreed that this crosswalk of times was inappropriate and recommended that the pre- and post-service times be changed to the median surveyed times (55 minutes evaluation time, 15 minutes positioning time, 15 minutes scrub, dress and wait time and 30 minutes immediate post time). In addition, the specialty recommended that the 99214 office visit be changed to a 99213 office visit as this was more typical of the service provided. After amending the pre- and post-service times and post-operative visits, the RUC reviewed the reference code 33140 *Transmyocardial laser revascularization, by thoracotomy; (separate procedure)* (Work RVU = 19.97) in comparison to the surveyed code and agreed that due to less intra-service time and post-service time of the surveyed code in comparison to the reference code (65/30 minutes and 120/45 minutes, respectively), as well as the surveyed code's lower intensity/complexity measures as compared to the reference code, the survey 25th percentile RVU of 13.23 seemed appropriate. However, to account for the reduction in pre- and post-service times, the RUC recommended that the associated work with this reduction in time be removed from the 25th percentile RVU.

25th percentile RVU		13.23
Pre-Service Time Reductions	5 minutes evaluation time	(0.11)
	5 minutes scrub, dress & wait time	(0.04)
	10 minutes immediate post	(0.22)
	Reduction from a 99214 to a 99213 office visit	(0.43)
RUC's recommended work RVU for 33202		12.43

Therefore, the RUC recommends a work RVU of 12.43 for code 33202.

33203 Insertion of epicardial electrode(s); endoscopic approach (eg. thoracoscopy, pericardioscopy)

The RUC reviewed the physician service times that the specialty society recommended for code 33203. The RUC discovered that these times were the pre- and post service times used for the cardiothoracic procedures from the Five Year Review (60 minutes evaluation time, 15 minutes positioning time, 20 minutes scrub, dress and wait time and 40 minutes immediate post time). The RUC agreed that this crosswalk of times was inappropriate and recommended that the pre- and post-service times be changed to the median surveyed times (55 minutes evaluation time, 15 minutes positioning time, 15 minutes scrub, dress and

wait time and 30 minutes immediate post time). In addition, the specialty recommended that the 99214 office visit be changed to a 99213 office visit as this was more typical of the service provided. After amending the pre- and post-service times and post-operative visits, the RUC reviewed the reference code 32662 *Thoracoscopy, surgical; with excision of mediastinal cyst, tumor, or mass* (Work RVU = 16.42) in comparison to the surveyed code and agreed that due to less intra-service time and post-service time of the surveyed code in comparison to the reference code (90/40 minutes and 180/150 minutes, respectively), the survey 25th percentile RVU of 14.00 seemed appropriate. However, to account for the reduction in pre- and post-service times, the RUC recommended that the associated work with this reduction in time be removed from the 25th percentile RVU.

25th percentile RVU		14.00
Pre-Service Time Reductions	5 minutes evaluation time	(0.11)
	5 minutes scrub, dress & wait time	(0.04)
	10 minutes immediate post	(0.22)
	Reduction from a 99214 to a 99213 office visit	(0.43)
RUC's recommended work RVU for 33202		13.20

Therefore, the RUC recommends a work RVU of 13.20 for code 33203.

The RUC addressed the budget neutrality issue surrounding these new codes. The specialty society informed the RUC that the utilization for 33202 and 33203 is estimated to be 3400 and 600, respectively. With that in mind the RUC calculated the following budget neutrality analysis:

Deleted Code 33245 Total RVUs	21,620
Deleted Code 33246 Total RVUs	11,579
Deleted Code 33200 Total RVUs	15,388
Deleted Code 33201 Total RVUs	2,408
Deleted Total Existing RVUs	50,935 RVUs

	RUC's Recommended Work RVUs	Specialty Society's Estimated Frequency	Potential New RVUs
33202	12.43	3,400	42,262
333203	13.20	600	7,920
Potential Total New RVUs			50,182

Because the deleted total existing RVUs is comparable to the potential total new RVUs, the RUC's recommendation is budget neutral.

Practice Expense
The RUC recommends the specialty society's recommended inputs for these procedures as they are standard 090 Day Global inputs with the deletion of the post-op incision care pack (suture & staple) for the 33203 as it is performed endoscopically.

Atrial Tissue Ablation and Reconstruction (Tab 17)

Verdi DiSesa, MD, Society of Thoracic Surgeons (STS)
Facilitation Committee #1

The CPT Editorial Panel created five new codes to accurately describe the new technology and new surgical techniques that can be used to treat atrial fibrillation.

The RUC reviewed the concern that 33254, 33255 and 33256 when billed with other median sternotomy or cardiopulmonary bypass procedures would have duplicative pre- and post-service activities and thereby physician times. Therefore, the RUC recommends that the CPT Editorial Panel incorporates in the introductory language for this section of codes that if 33254, 33255 and 33256 are performed with one or more other median sternotomy or cardiopulmonary bypass procedures, then an unlisted code should be billed. The following work recommendations are based on this recommendation to the CPT Editorial Panel.

33254 Operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure)
The RUC reviewed specialty society surveyed physician times recommended for code 33254. The RUC discussed the post-operative visits associated with this code and determined that the 99291 critical care visit should be replaced with the 99233 hospital visit as this was more typical of the service provided. After amending the post-operative visits, the RUC reviewed the reference code 33300 Repair of cardiac wound; without bypass (Work RVU=17.89) in comparison to the surveyed code and agreed that due to the increased pre-service and intra-service time of the surveyed code in comparison to the reference code (95/120 minutes and 60/118 minutes, respectively), as well as the surveyed code's higher intensity/complexity measures as compared to the reference code, the median RVU of 25.00 seemed appropriate. However, to account for the change in post-operative visits, the RUC recommended that the associated work with this change be removed from the median RVU.

Median RVU		25.00
Post-Operative Visit Change	Reduction from a 99291 to a 99233 visit	(2.48)
RUC's recommended work RVU for 33254		22.52 (IWPUT=0.113)

Therefore, the RUC recommends a work RVU of 22.52 for code 33254.

33255 Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); without cardiopulmonary bypass

The RUC reviewed the specialty society surveyed physician times recommended for code 33255. The RUC discussed the post-operative visits associated with this code and determined that the 99291 critical care visit should be replaced with the 99233 hospital visit as this was more typical of the service provided. After amending the post-operative visits, the RUC reviewed the reference code 33140 *Transmyocardial laser revascularization, by thoracotomy*; (Work RVU=19.97) in comparison to the surveyed code and agreed that due to the increased pre-service and intra-service time of the surveyed code in comparison to the reference code (95/180 minutes and 30/120 minutes, respectively), as well as the surveyed code's higher intensity/complexity measures as compared to the reference code, the median RVU of 30.00 seemed appropriate. However, to account for the change in post-operative visits, the RUC recommended that the associated work with this change be removed from the median RVU.

Median RVU		30.00
Post-Operative Visit Change	Reduction from a 99291 to a 99233 visit	(2.48)
RUC's recommended work RVU for 33254		27.52 (IWPUT=0.097)

Therefore, the RUC recommends a work RVU of 27.52 for code 33255.

33256 Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); with cardiopulmonary bypass

The RUC reviewed the service times that the specialty society recommended for code 33256. The RUC agreed that for this procedure the 99291 critical care visit should be retained as it is a cardio-pulmonary bypass code and all other cardio-pulmonary bypass codes in the RUC database have critical care associated with them. The RUC reviewed the reference code 33430 *Replacement, mitral valve, with cardiopulmonary bypass*; (Work RVU=33.45) in comparison to the surveyed code and noted the increased total service time of the surveyed code in comparison to the reference code (604 minutes and 571 minutes, respectively), as well as the surveyed code's higher intensity/complexity measures as compared to the reference code. In addition, the RUC reviewed the surveyed code to another reference code 34830 *Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; tube prosthesis* (Work RVU=32.54) and agreed that due to the similar total service times (604 and 611, respectively) and similar intensity and complexity between the two procedures, this reference code was more appropriate than the key reference code selected by the survey respondents. Therefore, the RUC agreed that the appropriate value for this procedure should be directly crosswalked from 34830. **The RUC recommends a work RVU of 32.54 for code 33256.**

33265 Endoscopy, surgical; operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure), without cardiopulmonary bypass
The RUC reviewed the specialty society surveyed physician times recommended for code 33265. The RUC discussed the post-operative visits associated with this code and determined that the 99291 critical care visit should be replaced with the 99233 hospital visit as this was more typical of the service provided. After amending the post-operative visits, the RUC reviewed the reference code 32663 *Thoracoscopy, surgical; with lobectomy, total or segmental* (Work RVU=18.44) in comparison to the surveyed code and agreed that although the total service time of the surveyed code was lower in comparison to the reference code (472 minutes and 614 minutes, respectively), the surveyed code had much higher intensity/complexity measures as compared to the reference code, and therefore agreed that the median RVU of 25.00 seemed appropriate. However, to account for the change in post-operative visits, the RUC's recommended that the associated work with this change be removed from the median RVU.

Median RVU		25.00
Post-Operative Visit Change	Reduction from a 99291 to a 99233 visit	(2.48)
RUC's recommended work RVU for 33254		22.52 (IWPUT=0.090)

Therefore, the RUC recommends a work RVU of 22.52 for code 33265.

33266 Endoscopy, surgical; operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure), without cardiopulmonary bypass
The RUC reviewed the specialty society surveyed physician times recommended for code 33266. The RUC discussed the post-operative visits associated with this code and determined that the 99291 critical care visit should be replaced with the 99233 hospital visit as this was more typical of the service provided. After amending the post-operative visits, the RUC reviewed the reference code 33426 *Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring* (Work RVU=32.95) in comparison to the surveyed code and agreed that although the total service time of the surveyed code was lower in comparison to the reference code (552 minutes and 571 minutes, respectively), the surveyed code had much higher intensity/complexity measures as compared to the reference code, and therefore agreed that the median RVU of 34.00 seemed appropriate. However, to account for the change in post-operative visits, the RUC's recommended that the associated work with this change be removed from the median RVU.

Median RVU		34.00
Post-Operative Visit Change	Reduction from a 99291 to a 99233 visit	(2.48)
RUC's recommended work RVU for 33254		31.52 (IWPUT=0.108)

Therefore, the RUC recommends a work RVU of 31.52 for code 33266.

Practice Expense:
The RUC recommends the standard 090 Day Global direct practice expense inputs with the clinical staff of RN.

New Technology/Services
The RUC identified these codes as utilizing new technology. **The RUC recommends that these codes are put on the new technology/services list and return to the RUC for re-review once this technology has become more widespread.**

Multiple Ventricular Septal Defect Corrections (Tab 18)
Kirk Kanter, MD, Society of Thoracic Surgeons (STS)
Facilitation Committee #2

The CPT Editorial Panel created three new codes to report the treatment of multiple ventricular septal defects which occur in roughly 5% of children with ventricular septal defect.

33675 Closure of multiple ventricular septal defects;
The RUC reviewed the physician surveyed times that the specialty society recommended for code 33675. The RUC discovered that these times were the pre-service times used for the cardiothoracic procedures from the Five Year Review (60 minutes evaluation time, 15 minutes positioning time and 20 minutes scrub, dress and wait time). The RUC agreed that this crosswalk of times was inappropriate and recommended that the pre- and post-service times be changed to the median surveyed times (70 minutes evaluation time, 15 minutes positioning time and 15 minutes scrub, dress and wait time). After amending the pre- times, the RUC reviewed the reference code 33681 *Closure of ventricular septal defect, with or without patch* (Work RVU = 30.56) in comparison to the surveyed code and agreed that because the total times associated with the surveyed code were higher than the reference code (594 minutes and 497 minutes respectively) and the intensity and complexity measures for the surveyed code were substantially greater than the reference code. Therefore, the RUC agreed that the survey median of 34.00 RVUs was appropriate. To further support the median value, the RUC attempted to use a building block methodology by utilizing time and intensity components of the existing code 33681 *Closure of single ventricular septal defect, with or without patch;* (RVU=30.56) and applying this to this new code. The resultant RVU of this process exceeded the survey median further supporting the RUC's recommendation. **The RUC recommends the survey median of 34.00 work RVUs for 33675.**

33676 Closure of multiple ventricular septal defects; with pulmonary valvotomy or infundibular resection (acyanotic)
The RUC reviewed the physician surveyed times that the specialty society recommended for code 33676. The RUC discovered that these times were the pre-

service times used for the cardiothoracic procedures from the Five Year Review (60 minutes evaluation time, 15 minutes positioning time and 20 minutes scrub, dress and wait time). The RUC agreed that this crosswalk of times was inappropriate and recommended that the pre- and post-service times be changed to the median surveyed times (70 minutes evaluation time, 15 minutes positioning time and 15 minutes scrub, dress and wait time). After amending the pre- times, the RUC reviewed the reference code 33694 *Complete repair tetralogy of Fallot without pulmonary atresia; with transannular patch* (Work RVU = 33.95) in comparison to the surveyed code and agreed that although the total times associated with the surveyed code were lower than the reference code (624 minutes and 704 minutes respectively), the intensity and complexity measures for the surveyed code were substantially greater than the reference code. Therefore the RUC agreed that the survey median of 35.00 RVUs was appropriate. To further support the median value, the RUC attempted to use a building block methodology by utilizing time and intensity components of the existing code 33684 *Closure of ventricular septal defect, with or without patch; with pulmonary valvotomy or infundibular resection (acyanotic)* (RVU=29.61) and applied this to this new code. The resultant RVU of this process exceeded the survey median further supporting the RUC's recommendation. **The RUC recommends the survey median of 35.00 work RVUs for 33676.**

33677 Closure of multiple ventricular septal defects; with removal of pulmonary artery band, with or without gusset

The RUC reviewed the physician surveyed times that the specialty society recommended for code 33677. The RUC discovered that these times were the pre-service times used for the cardiothoracic procedures from the Five Year Review (60 minutes evaluation time, 15 minutes positioning time and 20 minutes scrub, dress and wait time). The RUC agreed that this crosswalk of times was inappropriate and recommended that the pre- and post-service times be changed to the median surveyed times (70 minutes evaluation time, 15 minutes positioning time and 15 minutes scrub, dress and wait time). After amending the pre- times, the RUC reviewed the reference code 33694 *Complete repair tetralogy of Fallot without pulmonary atresia; with transannular patch* (Work RVU = 33.95) in comparison to the surveyed code and agreed that although the total times associated with the surveyed code were lower than the reference code (654 minutes and 704 minutes respectively), the intensity and complexity measures for the surveyed code were substantially greater than the reference code. Therefore the RUC agreed that the survey median of 36.50 RVUs was appropriate. To further support the median value, the RUC attempted to use a building block methodology by utilizing time and intensity components of the existing code 33688 *Closure of ventricular septal defect, with or without patch; with removal of pulmonary artery band, with or without gusset* (RVU=30.57) and applied this to this new code. The resultant RVU of this process exceeded the survey median further supporting the RUC's recommendation. **The RUC recommends the survey median of 36.50 work RVUs for 33677.**

The RUC addressed the work neutrality issue surrounding these new and revised codes. The specialty society informed the RUC that the utilization for 33681, 33684, 33688, 33675, 33676 and 33677 is estimated to be 1924, 285, 285, 76, 15 and 15, respectively. The utilization for these codes was derived from the STS database as this is the most accurate source of information for these codes as the patient population is children. With that in mind the RUC calculated the following work neutrality analysis:

	Existing Work RVUs	Frequency	Existing RVUs
33681	30.56	2000	61,120
33684	29.61	300	8,883
33688	30.5	300	9,170
Total Existing RVUs			79,173

	RUC's Recommended Work RVUs	Specialty Society's Estimated Frequency	Potential New RVUs
33681	30.56	1924	58,797
33684	29.61	285	8,439
33688	30.50	285	8,693
33675	34.00	76	2,584
33676	35.00	15	525
33677	36.50	15	548
Potential Total New RVUs			79,586

Because the deleted total existing RVUs is comparable to the potential total new RVUs, the RUC's recommendation is work neutral.

Practice Expense

The RUC recommends the standard 090 day global direct practice expense inputs with the clinical staff of RN.

Venous Anomalies (Tab 19)

Kirk Kanter, MD, Society of Thoracic Surgeons (STS)

The CPT Editorial Panel created one new code for the repair of sinus venosus atrial septal defect, usually associated with partial anomalous venous return or drainage. However, isolated partial anomalous pulmonary venosus return can occur as an isolated defect without an associated atrial septal defect. The CPT Editorial Panel created a second new code for this related service, to repair isolated pulmonary vein stenosis, which previously had an almost universally fatal outcome. As such, there was no coding to accurately describe the services. The changes resulted in the deletion of two codes and renumbering of four subsequent codes.

Code 33724

The RUC reviewed the survey results for 33724 *Repair of isolated partial anomalous pulmonary venous return* from the specialty society especially in comparison to the key reference service code 33645 *Direct or patch closure, sinus venosus, with or without anomalous pulmonary venous drainage* (work RVU = 24.78). The RUC noted that the total physician time of the surveyed code is slightly higher than the reference code, 183 minutes and 164 minutes respectively. In addition, the RUC agreed that 33724 requires more mental effort and judgment as well as greater technical skill and physical effort accounting for the survey respondents reporting higher work intensity and complexity for the pre-service, intra-service, and post-service periods. However, the RUC agreed the surveys response rate was low and the specialty society's recommended survey median may not accurately reflect the service. In comparison to the reference code, the RUC concurred that the 25th percentile survey work RVU of 26.13 is the most accurate relative value. **The RUC recommends a work RVU of 26.13 for code 33724.**

Code 33726

The RUC reviewed the survey results and presentation for 33726 *Repair of pulmonary venous stenosis* provided by the specialty society and observed that the key reference service code considered, 33730 *Complete repair of anomalous venous return (supracardiac, intracardiac, or infracardiac types)* (work RVUs = 34.20) had lower intra-service time (225 minutes) in comparison to the surveyed code (240 minutes). Additionally, in comparing the two codes, the RUC noted that the intensity/complexity measures for the surveyed code were significantly higher than the reference service code in almost every category within the mental effort and judgment, technical skill/physical effort, and psychological stress components. Therefore, the RUC agreed with the specialty society's recommendation of 35.50 work RVUs, the survey median data for code 33726. **The RUC recommends a work RVU of 35.50 for code 33726.**

Practice Expense

This service is performed in the facility setting only. The specialty society's practice expense inputs for the facility setting were accepted, including a clinical staff type of RN. These practice expense inputs are consistent with other cardiothoracic surgery procedures approved by the PEAC and the RUC in the past.

Thromboendarterectomy (Tab 20)
Gary Seabrook, MD, Society for Vascular Surgery (SVS)
Bob Zwolak, MD, PhD, Society for Vascular Surgery (SVS)
Facilitation Committee 1

These changes in CPT coding were at the original request of the RUC during its Five Year Review Process. During the Five Year Review, the RUC agreed with the specialty society that code 35381 *Thromboendarterectomy, with or without patch graft; femoral and/or popliteal, and/or tibioperoneal* (Work RVU = 15.79) cannot undergo the RUC evaluation process before having its descriptor revised to reflect a single operation rather than multiple or the code needs to be deleted. Therefore CPT Editorial Panel editorially revised one code, created five new codes and deleted one code to add some clarity, specificity and granularity to the thromboendartectomy procedures.

35302 Thromboendarterectomy, including patch graft if performed; superficial femoral artery
The RUC reviewed the specialty surveyed physician service time recommended for code 35302. The RUC discussed the pre-service times and post-operative visits associated with this code and determined that specialty society recommended pre-service times (50 minutes evaluation time, 15 minutes positioning time, 20 minutes scrub, dress and wait time) should be reduced and recommended that the pre-service times be changed to more accurately reflect the service (40 minutes evaluation time, 15 minutes positioning time, 20 minutes scrub, dress and wait time). In addition, the specialty recommended that a 99213 office visit be changed to a 99212 office visit as this was more typical of the service provided. After amending the pre-service times and post-operative visits, the RUC reviewed the reference code 35141 *Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, common femoral artery (profunda femoris, superficial* (Work RVU=19.97) in comparison to the surveyed code and agreed that due to slightly more total service time of the surveyed code in comparison to the reference code (419 minutes and 412 minutes, respectively), as well as the surveyed code's significantly higher intensity/complexity measures as compared to the reference code, the survey median RVU of 20.75 seemed appropriate. However, to account for the reduction change in post-operative visits, the RUC recommended that the associated work with this change be removed from the median RVU.

Median RVU		20.75
	Reduction from a 99213 to a 99212 office visit	(0.22)
RUC's recommended work RVU for 35302		20.53

Therefore, the RUC recommends a work RVU of 20.53 for code 35302.

35303 Thromboendarterectomy, including patch graft if performed; popliteal artery
The RUC reviewed the specialty surveyed physician service time recommended for code 35303. The RUC discussed the pre-service times and post-operative visits associated with this code and determined that specialty society recommended pre-service times (50 minutes evaluation time, 15 minutes positioning time, 20 minutes scrub, dress and wait time) should be reduced and recommended that the pre-service times be changed to more accurately reflect the service (40 minutes evaluation time, 15 minutes positioning time, 20 minutes scrub, dress and wait time). In addition, the specialty recommended that a 99213 office visit be changed to a 99212 office visit as this was more typical of the service provided. After amending the pre-service times and post-operative visits, the RUC reviewed the reference code 35151 *Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, popliteal artery* (Work RVU=22.61) in comparison to the surveyed code and agreed that although the total service time of the surveyed code is lower than total service time of the reference code (419 minutes and 456 minutes, respectively), the surveyed code's significantly higher intensity/complexity measures as compared to the reference code, the survey median RVU of 23.00 seemed appropriate. However, to account for the reduction change in post-operative visits, the RUC recommended that the associated work with this change be removed from the median RVU.

Median RVU		23.00
	Reduction from a 99213 to a 99212 office visit	(0.22)
RUC's recommended work RVU for 35303		22.78

Therefore, the RUC recommends a work RVU of 22.78 for code 35303.

35304 Thromboendarterectomy, including patch graft if performed; tibioperoneal trunk artery
The RUC reviewed the specialty surveyed physician service time recommended for code 35304. The RUC discussed the pre-service times and post-operative visits associated with this code and determined that specialty society recommended pre-service times (50 minutes evaluation time, 15 minutes positioning time, 20 minutes scrub, dress and wait time) should be reduced and recommended that the pre-service times be changed to more accurately reflect the service (40 minutes evaluation time, 15 minutes positioning time, 20 minutes scrub, dress and wait time). In addition, the specialty recommended that a 99213 office visit be changed to a 99212 office visit as this was more typical of the service provided. After amending the pre-service times and post-operative visits, the RUC reviewed the reference code 35151 *Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, popliteal artery* (Work RVU=22.61) in comparison to the surveyed code and agreed that although the total service time of the surveyed code is slightly lower than total service time of the

reference code (449 minutes and 456 minutes, respectively), the surveyed code's significantly higher intensity/complexity measures as compared to the reference code, the survey median RVU of 24.00 seemed appropriate. However, to account for the reduction change in post-operative visits, the RUC recommended that the associated work with this change be removed from the median RVU.

Median RVU		24.00
	Reduction from a 99213 to a 99212 office visit	(0.22)
RUC's recommended work RVU for 35304		23.78

Therefore, the RUC recommends a work RVU of 23.78 for code 35304.

35305 Thromboendarterectomy, including patch graft if performed; tibial artery
The RUC reviewed the specialty surveyed physician service time recommended for code 35305. The RUC discussed the pre-service times and post-operative visits associated with this code and determined that specialty society recommended pre-service times (50 minutes evaluation time, 15 minutes positioning time, 20 minutes scrub, dress and wait time) should be reduced and recommended that the pre-service times be changed to more accurately reflect the service (40 minutes evaluation time, 15 minutes positioning time, 20 minutes scrub, dress and wait time). In addition, the specialty recommended that a 99213 office visit be changed to a 99212 office visit as this was more typical of the service provided. After amending the pre-service times and post-operative visits, the RUC reviewed the reference code 35151 *Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, popliteal artery* (Work RVU=22.61) in comparison to the surveyed code and agreed that although the total service time of the surveyed code is slightly lower than total service time of the reference code (429 minutes and 456 minutes, respectively), the surveyed code's significantly higher intensity/complexity measures as compared to the reference code, the survey median RVU of 23.00 seemed appropriate. However, to account for the reduction change in post-operative visits, the RUC recommended that the associated work with this change be removed from the median RVU.

Median RVU	23.00
Reduction from a 99213 to a 99212 office visit	(0.22)
RUC's recommended work RVU for 35305	22.78

Therefore, the RUC recommends a work RVU of 22.78 for code 35305.

35306 Thromboendarterectomy, including patch graft if performed; each additional tibial or peroneal artery
The RUC reviewed the service times that the specialty society recommended for code 35306. The RUC discussed the intra-service time associated with this code and agreed it was appropriate. The RUC then compared the surveyed code to the

reference code 35500 *Harvest of upper extremity vein, one segment, for lower extremity or coronary artery bypass procedure* (Work RVU=6.44) and agreed that because the intra-service time of the surveyed code is higher than intra-service time of the reference code (90 minutes and 60 minutes, respectively), and the surveyed code's significantly higher intensity/complexity measures as compared to the reference code, the survey median RVU of 9.25 seemed appropriate. **Therefore, the RUC recommends a work RVU of 9.25 RVUs for code 35306.**

Practice Expense
The RUC recommends the specialty society's recommended inputs for these procedures as they are standard facility only 090 day global inputs.

Carotid Bypass (Tab 21)
Gary Seabrook, MD, Society for Vascular Surgery (SVS)
Bob Zwolak, MD, PhD, Society for Vascular Surgery (SVS)
Facilitation Committee 1

These changes in CPT coding were at the original request of the RUC during its Five Year Review Process. During the Five Year Review, the RUC agreed with the specialty society that code 35501 *Bypass graft, with vein; common carotid-ipsilateral internal carotid* and 35509 *Bypass graft, with vein; carotid-contralateral carotid* cannot undergo the RUC evaluation process before having its descriptor revised to reflect a single operation rather than multiple or the code needs to be deleted. Therefore, the CPT Editorial Panel revised two existing codes to add some clarity to the existing carotid bypass procedures as the current descriptors are ambiguous and do not specify the inflow artery and the target outflow artery like every other bypass graft operation.

35501 Bypass graft, with vein; common carotid-ipsilateral internal carotid
The RUC reviewed the specialty surveyed physician service time recommended for code 35501. The RUC discussed the pre-service times with this code and determined that specialty society recommended pre-service times (60 minutes evaluation time, 15 minutes positioning time, 20 minutes scrub, dress and wait time) should be reduced and recommended that the pre-service times be changed to more accurately reflect the service (40 minutes evaluation time, 15 minutes positioning time, 20 minutes scrub, dress and wait time. In addition, the RUC recommended replacing the 99291 crtical care visit with a 99233 hospital visit as this was agreed to be more reflective of the procedure being performed as this procedure does not require the immediate presence of a physician in the post-operative period to manage the patient at the critical care level. After amending the pre-service times and post-operative visits, the RUC reviewed the reference code 35510 *Bypass graft, with vein; carotid-brachial* (Work RVU=22.97) in comparison to the surveyed code and agreed that due to more total service time of the surveyed code in comparison to the reference code (477 minutes and 431 minutes, respectively), as well as the surveyed code's significantly higher

intensity/complexity measures as compared to the reference code, the survey median RVU of 28.00 seemed appropriate. **The RUC recommends 28.00 RVUs for 35501.**

35509 Bypass graft, with vein; carotid-contralateral carotid
The RUC reviewed the specialty surveyed physician service time recommended for code 35509. The RUC discussed the pre-service times with this code and determined that specialty society recommended pre-service times (60 minutes evaluation time, 15 minutes positioning time, 20 minutes scrub, dress and wait time) should be reduced and recommended that the pre-service times be changed to more accurately reflect the service (40 minutes evaluation time, 15 minutes positioning time, 20 minutes scrub, dress and wait time. In addition, the RUC recommended replacing the 99291 crtical care visit with a 99233 hospital visit as this was agreed to be more reflective of the procedure being performed as this procedure does not require the immediate presence of a physician in the post-operative period to manage the patient at the critical care level. After amending the pre-service times and post-operative visits, the RUC reviewed the reference code 35510 *Bypass graft, with vein; carotid-brachial* (Work RVU=22.97) in comparison to the surveyed code and agreed that due to more total service time of the surveyed code in comparison to the reference code (467 minutes and 431 minutes, respectively), as well as the surveyed code's significantly higher intensity/complexity measures as compared to the reference code, the survey median RVU of 27.00 seemed appropriate. **The RUC recommends 27.00 RVUs for 35501**

Practice Expense
The RUC recommends the specialty society's recommended inputs for these procedures as they are standard facility only 090 day Global inputs.

Aortobifemoral-Aortofemoral Bypass (Tab 22)
Gary Seabrook, MD, Society for Vascular Surgery (SVS)
Bob Zwolak, MD, PhD, Society for Vascular Surgery (SVS)
Facilitation Committee 1

These changes in CPT coding were at the original request of the RUC during its Five Year Review Process. During the Five Year Review, the RUC agreed with the specialty society that code 35546 *Bypass graft, with vein; aortofemoral or bifemoral* (Work RVU= 25.50) cannot undergo the RUC evaluation process before having its descriptor revised to reflect a single operation rather than multiple or the code needs to be deleted. Therefore, CPT Editorial Panel created two new codes to differentiate between an aortofemoral bypass procedure and an aortobifemoral bypass procedure as these are two distinct and well established services.

35539 Bypass graft, with vein; aortofemoral

The RUC reviewed the specialty surveyed physician service time recommended for code 35539. The RUC discussed the pre-service times and post-operative visits with this code and determined that specialty society recommended pre-service times (75 minutes evaluation time, 20 minutes positioning time, 20 minutes scrub, dress and wait time) should be reduced and recommended that the pre-service times be changed to more accurately reflect the service (60 minutes evaluation time, 20 minutes positioning time, 20 minutes scrub, dress and wait time). In addition, the RUC recommended that the 99239 discharge day management visit be changed to a 99328 visit and the 99214 office visit be removed. In addition, the RUC agreed that the 99291 critical care visit associated with this procedure was warranted for the typical patient described. After amending the pre-service times and post-operative visits, the RUC reviewed the reference code 35531 *Bypass graft, with vein; aortoceliac or aortomesenteric* (Work RVU=36.15) in comparison to the surveyed code and noted that there was more total service time of the surveyed code in comparison to the reference code (770 minutes and 681 minutes, respectively), as well as the surveyed code's significantly higher intensity/complexity measures as compared to the reference code. The RUC then reviewed the specialty society's recommendation of the 75th percentile 44.50 RVUs and agreed that this value was inappropriate. The RUC, using a building block approach, computed the following calculation:

Work RVUs for 35531 (Reference Code)	36.15
60 Minutes of Intra-Service Time and the IWPUT of 33531 (0.087)	5.22
Addition of a 99231	0.64
Resultant RVU	42.01

Further support for the building block approach is that with the exclusion of 5 Year Review codes from the reference service list may have created the problems with accurate magnitude estimation of these fairly highly valued services. The reference service chosen was, according to the presenters, the highest valued service on the list. Consequently, the complexity of the aortobifemoral/aortofemoral cases exceeded that of the reference service. **The RUC recommends 42.01 RVUs for 35539**

35540 Bypass graft with vein; aortobifemoral

The RUC reviewed the service times that the specialty society recommended for code 35540, a low utilization procedure. The RUC discussed the pre-service times and post-operative visits with this code and determined that specialty society recommended pre-service times (75 minutes evaluation time, 20 minutes positioning time, 20 minutes scrub, dress and wait time) should be reduced and recommended that the pre-service times be changed to more accurately reflect the service (60 minutes evaluation time, 20 minutes positioning time, 20 minutes scrub, dress and wait time). In addition, the RUC recommended that the 99239 discharge day management visit be changed to a 99328 visit; the 99214 office visit be removed and a 99231 and 99232 hospital visit be removed. In addition, the RUC

agreed that the 99291 critical care visit associated with this procedure was warranted for the typical patient described. After amending the pre-service times and post-operative visits, the RUC reviewed the reference code 35531 *Bypass graft, with vein; aortoceliac or aortomesenteric* (Work RVU=36.15) in comparison to the surveyed code and noted that there was more total service time of the surveyed code in comparison to the reference code (830 minutes and 681 minutes, respectively), as well as the surveyed code's significantly higher intensity/complexity measures as compared to the reference code. The RUC then reviewed the specialty society's recommendation of the 75th percentile 48.00 RVUs and agreed that this value was inappropriate. The RUC, using a building block approach, computed the following calculation:

Proposed Work RVUs for 35539 (Reference Code)	42.01
60 Minutes of Intra-Service Time and the IWPUT of 33531 (0.087)	5.22
Resultant RVU	47.23

Further support for the building block approach is that with the exclusion of 5 Year Review codes from the reference service list may have created the problems with accurate magnitude estimation of these fairly highly valued services. The reference service chosen was, according to the presenters, the highest valued service on the list. Consequently, the complexity of the aortobifemoral/aortofemoral cases exceeded that of the reference service. **The RUC recommends 47.23 RVUs for 35540.**

Practice Expense

The RUC recommends the specialty society's recommended inputs for these procedures as they are facility only standard 090 day global inputs with the associated modifications as described above.

Aortobiliac-Aortoiliac Bypass (Tab 23)
Gary Seabrook, MD, Society for Vascular Surgery (SVS)
Bob Zwolak, MD, PhD, Society for Vascular Surgery (SVS)
Facilitation Committee 1

These changes in CPT coding were at the original request of the RUC during its Five Year Review Process. During the Five Year Review, the RUC agreed with the specialty society that code 35541 *Bypass graft, with vein; aortoiliac or bi-iliac* (Work RVU=25.76) and 35641 *Bypass graft, with other than vein; aortoiliac or bi-iliac* (Work RVU=24.53) cannot undergo the RUC evaluation process before having its descriptor revised to reflect a single operation rather than multiple or these codes need to be deleted. Therefore, the CPT Editorial Panel created four new codes to distinguish between the aortobiliac and aortoiliac bypass procedures as these are two separate and distinct procedures.

35537 Bypass graft with vein; aortoiliac

The RUC reviewed the specialty physician surveyed times that the specialty society recommended for code 35537. The RUC discussed the pre-service times and post-operative visits with this code and determined that specialty society recommended pre-service times (75 minutes evaluation time, 18 minutes positioning time, 20 minutes scrub, dress and wait time) should be reduced and recommended that the pre-service times be changed to more accurately reflect the service (50 minutes evaluation time, 15 minutes positioning time, 20 minutes scrub, dress and wait time). In addition, the RUC recommended that the 99214 office visit be changed to a 99213 office visit. Furthermore, the RUC agreed that the 99291 critical care visit associated with this procedure was warranted for the typical patient described. After amending the pre-service times and post-operative visits, the RUC reviewed the reference code 35531 *Bypass graft, with vein; aortoceliac or aortomesenteric* (Work RVU=36.15) in comparison to the surveyed code and noted that there was more total service time of the surveyed code in comparison to the reference code (734 minutes and 681 minutes, respectively), as well as the surveyed code's significantly higher intensity/complexity measures as compared to the reference code. The RUC then reviewed the specialty society's recommendation of the 75th percentile 44.50 RVUs and agreed that this value was inappropriate. The RUC, using a building block approach, computed the following calculation:

Work RVUs for 35531 (Reference Code)	36.15
48 Minutes of Intra-Service Time and the IWPUT of 33531 (0.087)	4.18
Reduction from a 99214 to a 99213 Office Visit	(0.43)
Resultant RVU	39.90

Further support for the building block approach is that with the exclusion of 5 Year Review codes from the reference service list may have created the problems with accurate magnitude estimation of these fairly highly valued services. The reference service chosen was, according to the presenters, the highest valued service on the list. Consequently, the complexity of the aorto-iliac cases exceeded that of the reference service. **Therefore, the RUC recommends 39.90 RVUs for 35537**

35538 Bypass graft with vein; aortobiiliac

The RUC reviewed the specialty physician surveyed times that the specialty society recommended for code 35538. The RUC discussed the pre-service times and post-operative visits with this code and determined that specialty society recommended pre-service times (75 minutes evaluation time, 18 minutes positioning time, 20 minutes scrub, dress and wait time) should be reduced and recommended that the pre-service times be changed to more accurately reflect the service (50 minutes evaluation time, 15 minutes positioning time, 20 minutes scrub, dress and wait time). In addition, the RUC agreed that the 99291 critical care visit associated with this procedure was warranted for the typical patient described. After amending the pre-service times, the RUC reviewed the reference code 35531 *Bypass graft, with vein; aortoceliac or aortomesenteric* (Work RVU=36.15) in comparison to the surveyed code and noted that there was more total service time of the surveyed

code in comparison to the reference code (847 minutes and 681 minutes, respectively), however the surveyed code's intensity/complexity measures were significantly lower as compared to the reference code. The RUC then attempted to derive the work RVU for this procedure by utilizing the building block approach, computed the following calculation:

Proposed Work RVUs for 35537 (Reference Code)	42.01
72 Minutes of Intra-Service Time and the IWPUT of 33531 (0.087)	6.26
Additional 99214 Office Visit	1.08
Resultant RVU	49.35

However, the RUC agreed this value overstated the amount of work associated with this procedure and would create rank order anomalies. Therefore, the RUC supports the 75th percentile survey RVU of 44.63 due to the aforementioned comparison with the reference code. Further support for the building block approach is that with the exclusion of 5 Year Review codes from the reference service list may have created the problems with accurate magnitude estimation of these fairly highly valued services. The reference service chosen was, according to the presenters, the highest valued service on the list. Consequently, the complexity of the aorto-biiliac cases exceeded that of the reference service. **The RUC recommends 44.63 RVUs for 35538.**

35637 Bypass graft, with other than vein; aortoiliac

The RUC reviewed the specialty physician surveyed times that the specialty society recommended for code 35637. The RUC discussed the service time associated with this code. The RUC discussed the pre-service times associated with this code and determined that specialty society recommended pre-service times (65 minutes evaluation time, 15 minutes positioning time, 20 minutes scrub, dress and wait time) should be reduced and recommended that the pre-service times be changed to more accurately reflect the service (40 minutes evaluation time, 15 minutes positioning time, 20 minutes scrub, dress and wait time). In addition, the RUC agreed that the 99291 critical care visit associated with this procedure was warranted for the typical patient described. The RUC then compared the surveyed code to the reference code 35646 *Bypass graft with other than vein, aortobifemoral* (Work RVU=30.95) and agreed that because the total service time of the surveyed code is similar to the total service time of the reference code (614 minutes and 602 minutes, respectively), and the surveyed code and the reference code had similar intensity/complexity measures, the surveyed median RVU of 30.95 seemed appropriate. **Therefore, the RUC recommends a work RVU of 30.95 RVUs for code 35637.**

35638 Bypass graft, with other than vein; aortobiliac

The RUC reviewed the service times that the specialty society recommended for code 35638. The RUC discussed the times associated with this code. The RUC discussed the pre-service times associated with this code and determined that specialty society recommended pre-service times (65 minutes evaluation time, 15

minutes positioning time, 20 minutes scrub, dress and wait time) should be reduced and recommended that the pre-service times be changed to more accurately reflect the service (40 minutes evaluation time, 15 minutes positioning time, 20 minutes scrub, dress and wait time). In addition, the RUC agreed that the 99291 critical care visit associated with this procedure was warranted for the typical patient described. The RUC then compared the surveyed code to the reference code 35646 *Bypass graft with other than vein, aortobifemoral* (Work RVU=30.95) and agreed that because the intra-service time of the surveyed code is higher than intra-service time of the reference code (240 minutes and 210 minutes, respectively), and the surveyed code's significantly higher intensity/complexity measures as compared to the reference code, the survey median RVU of 31.50 seemed appropriate. **Therefore, the RUC recommends a work RVU of 31.50 RVUs for code 35638.**

Practice Expense
The RUC recommends the specialty society's recommended inputs for these facility only procedures as they are standard 090 Day Global inputs.

Carotid Bypass Graft (Tab 24)
Gary Seabrook, MD, Society for Vascular Surgery (SVS)
Bob Zwolak, MD, PhD, Society for Vascular Surgery (SVS)
Facilitation Committee 1

These changes in CPT coding were at the original request of the RUC during its Five Year Review Process. During the Five Year Review, the RUC agreed with the specialty society that code 35601 cannot undergo the RUC evaluation process before having its descriptor revised to reflect a single operation rather than multiple or the code needs to be deleted. Therefore, the CPT Editorial Panel revised an existing code to add clarity to the current descriptor of 35601 as the current descriptor is ambiguous and unlike any other bypass graft operation, it does not specify the inflow artery and the target outflow artery.

35601 Bypass graft with other than vein; common carotid-ipsilateral internal carotid
The RUC reviewed the service times that the specialty society recommended for code 35601. The RUC discussed the pre-service times with this code and determined that specialty society recommended pre-service times (60 minutes evaluation time, 15 minutes positioning time, 20 minutes scrub, dress and wait time) should be reduced and recommended that the pre-service times be changed to more accurately reflect the service (40 minutes evaluation time, 15 minutes positioning time, 20 minutes scrub, dress and wait time). In addition, the RUC recommended replacing the 99291 critical care visit with a 99233 hospital visit as this was agreed to be more reflective of the procedure being performed as this procedure does not require the immediate presence of a physician in the post-operative period to manage the patient at the critical care level. After amending the pre-service times and post-operative visits, the RUC reviewed the reference code

35510 *Bypass graft, with vein; carotid-brachial* (Work RVU=22.97) in comparison to the surveyed code and agreed that due to more total service time of the surveyed code in comparison to the reference code (457 minutes and 431 minutes, respectively), as well as the surveyed code's significantly higher intensity/complexity measures as compared to the reference code, the survey median RVU of 26.00 was appropriate. **The RUC recommends 26.00 RVUs for 35601**

Practice Expense
The RUC recommends the specialty society's recommended inputs for this procedure as it is standard 090 Day Global inputs.

Femoral Anastomosis Revision (Tab 25)
Gary Seabrook, MD, Society for Vascular Surgery (SVS)
Bob Zwolak, MD, PhD, Society for Vascular Surgery (SVS)

The CPT Editorial Panel created two new codes to report the prophylactic treatment of a severe anastomotic stenosis through open surgical revision with a nonautogenous or autogenous patch graft which will eliminate the stenotic region.

35883 Revision, femoral anastomosis of synthetic arterial bypass graft in groin, open; with nonautogenous patch graft (eg Dacron, ePTFE, bovine pericardium)
The RUC reviewed the specialty physician surveyed times that the specialty society recommended for code 35883. The RUC discussed all of the service times associated with this code and agreedthey was appropriate. The RUC then compared the surveyed code to the reference code 35141 *Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, common femoral artery (profunda femoris, superficial femoral*) (Work RVU=19.97) and agreed that because the intra-service time of the surveyed code is higher than intra-service time of the reference code (170 minutes and 150 minutes, respectively), and the surveyed code's significantly higher intensity/complexity measures as compared to the reference code due to the risks of injuries to the synthetic graft limb, all of the femoral bifurcation arteries and the external iliac artery that typically lies directly posterior to the aortic graft limb, that the survey median RVU of 22.00 was appropriate. **Therefore, the RUC recommends a work RVU of 22.00 RVUs for code 35883.**

35884 Revision, femoral anastomosis of synthetic arterial bypass graft in groin, open; with autogenous vein patch graft
The RUC reviewed the specialty physician surveyed times that the specialty society recommended for code 35884. The RUC discussed all of the service times associated with this code and agreedthey was appropriate. The RUC then compared the surveyed code to the reference code 35141 *Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with*

or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, common femoral artery (profunda femoris, superficial femoral) (Work RVU=19.97) and agreed that because the intra-service time of the surveyed code is higher than intra-service time of the reference code (190 minutes and 150 minutes, respectively), and the surveyed code's significantly higher intensity/complexity measures as compared to the reference code due to the risks of injuries to the synthetic graft limb, all of the femoral bifurcation arteries and the external iliac artery that typically lies directly posterior to the aortic graft limb, that the survey median RVU of 23.50 was appropriate. **Therefore, the RUC recommends a work RVU of 23.50 RVUs for code 35884.**

Practice Expense
The RUC recommends the specialty society's recommended inputs for these facility only procedures as they are standard 090 Day Global inputs.

Gastric Antrum Neurostimulation (Tab 26)
Joel V. Brill, MD, American Gastroenterological Association (AGA)
Pre-Facilitation Committee #1

A treatment for patients with gastroparesis has been developed that involves electrical stimulation of the stomach. Diabetic, idiopathic or post-surgical gastroparesis with drug refractory nausea and vomiting can be treated with implanted electrical stimulation of the stomach.. Existing codes for neurostimulators do not reflect the unique features of the gastric stimulation procedure. Therefore in November 2005 the CPT Editorial Panel created four new codes (43647, 43648, 43881, and 43882), and editorially revised two existing codes (64590 and 64595) and revising three existing codes (95970, 95972 and 95973) to reflect these new technological procedures.

43647, 43648, 43881, and 43882

The RUC reviewed the specialty society recommendations for new codes: 43647 *Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum,* 43648 *Laparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum,* 43881 *Implantation or replacement of gastric neurostimulator electrodes, antrum, openm,* 43882 *Revision or removal of gastric neurostimulator electrodes, antrum, open*. The specialty society recommended codes 43647, 43648, 43881, and 43882 be carrier priced because of the great difficulty involved in surveying these rarely performed codes as these procedures are performed 500 times nationally in a one-year period. **The RUC agreed and recommends codes 43647, 43648, 43881, and 43882 be carrier priced.**

95970, 95972, and 95973
The specialty society believed and recommended that there be no change in the physician work for these existing codes, however the RUC disagreed. The RUC believed that the gastric stimulator programming was not equivalent to the spinal

cord or peripheral programming. The RUC informed CPT that this change in the descriptor was a change in physician work and that this gastric procedure should not be included in 95970, 95972 and 95973. **Therefore the RUC recommends that the CPT Editorial Panel rescind their revisions to code 95970, 95972 and 95973 and direct coding for gastric stimulator interrogation, (re)programing to the unlisted code 95999 *Unlisted neurological or neuromuscular diagnostic procedure.***

Note: CPT has incorporated this revision into CPT 2007

New Technology/Services:
Because 43647, 43648, 43881, and 43882 represents a newer technology, the RUC agreed that it should be placed on the new technology list for potential changes in its valuation. **The RUC recommends that codes 43647, 43648, 43881, and 43882 be added to the list of new technology codes.**

Laparoscopic Permanent Intraperitoneal Catheter Insertion (Tab 27)
Charles Mabry, MD, FACS, American College of Surgeons (ACS)
John Crabtree, MD, FACS, American Society of General Surgeons (ASGS)
Chad Rubin, MD, FACS, American College of Surgeons (ACS)
Facilitation Committee #3

The CPT Editorial Panel met in February 2006 and created five new CPT codes to accurately describe new procedures that primarily are designed to treat chronic renal failure and involve in insertion, revision, or placement of an intraperitoneal cannula or catheter. Existing codes did not allow for an accurate description of the services being provided.

49324 Laparoscopy, surgical; with insertion of intraperitoneal cannula or catheter, permanent
The RUC reviewed the specialty survey of 29 general surgeons for 49324 and determined that the pre-service physician time was overstated. The RUC believed that 20 minutes of pre-service evaluation time was more appropriate rather than the 40 minutes indicated by the survey. All other survey times were maintained resulting in 40 minutes of pre-service, 60 minutes of intra-service and 20 minutes of post-service time. A half day discharge day (99238) and one office visit (99213) were maintained.

After reviewing these physician times and the work associated with reference code 38570 *Laparoscopy, surgical; with retroperitoneal lymph node sampling (biopsy), single or multiple* (Work RVU=9.24), the RUC believed that due to less pre-service time, intra-service time and post-service time of the surveyed, the survey 25th percentile RVU of 6.00 most accurately reflected the physician work provided. **The RUC recommends a relative work value of 6.00 for code 49324.**

49325 Laparoscopy, surgical; with revision of previously placed intraperitoneal cannula or catheter, with removal of intraluminal obstructive material if performed

The RUC reviewed the specialty survey results for 49325 and determined that the pre-service physician time was overstated. The RUC believed that 20 minutes of pre-service evaluation time was an appropriate than the 40 minutes indicated by the survey.. All other survey times were maintained resulting in 40 minutes of pre-service, 60 minutes of intra-service and 20 minutes of post-service time. A half day discharge day (99238) and one office visit (99213) were maintained.

After reviewing these times and the reference code 49422 *Removal of permanent intraperitoneal cannula or catheter* (Work RVU=6.24), it was determined by the RUC that due to comparable pre-service times, intra-service times and post-service times of the surveyed code, the survey 25th percentile RVU of 6.50 most accurately reflected the physician work provided. This value maintains the rank order between 49325 and 49324. **The RUC recommends a relative work RVU of 6.50 for code 49325.**

49326 Laparoscopy, surgical; with omentopexy (omental tacking procedure)

The RUC reviewed the specialty survey results for 49326 and determined that that the survey median time of 45 minutes was appropriate as compared to the reference 44213 *Laparoscopy, surgical, mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy (List separately in addition to primary procedure*) (Work RVU=3.50).

Furthermore, it was determined by the RUC that due to the fact that the surveyed code and the reference code have the same intra-service time, 45 minutes, as well as similar intensity/complexity measures between the surveyed and reference code, the survey median RVU of 3.50 most accurately reflected the physician work provided. **The RUC recommends a relative work RVU of 3.50 for code 49326.**

49435 Insertion of subcutaneous extension to intraperitoneal cannula or catheter with remote chest exit site

The RUC reviewed specialty survey results for 49435 and determined that that the survey median time of 30 minutes was appropriate as compared to the reference 44139 *Mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy (List separately in addition to primary procedure)* (Work RVU=2.23).

Furthermore, it was determined by the RUC that due to the fact that the surveyed code and the reference code have the same intra-service time, 30 minute as well as similar intensity/complexity measures between the surveyed and reference code, the survey median RVU of 2.25 most accurately reflected the physician work provided. **The RUC recommends a relative work RVU of 2.25 for code 49435.**

49436 Delayed creation of exit site from embedded subcutaneous segment of intraperitoneal cannula or catheter

The RUC reviewed the surveyed physician service times and post-service visits recommended by the specialty society and felt that they were appropriate in comparison to the reference code 36589 *Removal of tunneled central venous catheter, without subcutaneous port or pump* (Work RVU=2.27). However, the RUC felt that the median survey value associated with the surveyed code, 3.00 RVUs, overstated the work associated with this code. The RUC believed that the surveyed code and the reference code shared the same intra-service intensity of work. Therefore, the RUC recommended applying the IWPUT of 36589 (0.052), the reference code, to the surveyed code, as shown below.

	Intensities	Times	Work RVU
Pre-Service Evaluation	0.0224	15	0.336
Pre-Service Positioning	0.0224	5	0.112
Pre-Service Scrub, Dress & Wait	0.0081	10	0.081
Intra-Service	0.052	15	0.78
Immediate Post	0.0224	13	0.291
99238	1.28	0.5 visit	0.64
99212	0.43	1.0 visit	0.43
		Total RVU	**2.67**

This calculation results in work RVU of 2.67. The increased time elements of the surveyed code as compared to the reference code (total time = 91 minutes and 78 minutes, respectively) and the single 99212 post-op visit compared to the 99211 in 49436 justify the increment over the reference code 36589. **The RUC recommends a relative work RVU of 2.67 for code 49436. The RUC also recommends that the global period assigned to this code be changed from a 090-day to a 010-day, which is demonstrated in the recommended post-operative visits.**

Practice Expense

The RUC discussed the specialty society's recommended practice expense inputs and determined that the 010-day standard clinical labor times (30 minutes) should be applied to the facility setting for 49324 and 49325. In addition, the RUC agreed that the supplies and equipment associated with these two codes were appropriate. There were no practice expense inputs recommended for 49326 and 49435, as they are add on codes performed in the facility setting only. In addition the RUC agreed that the supplies and equipment associated with code 49436 were appropriate. **The RUC recommends the practice expense inputs as recommended for 49324, 49325 and 49436 as amended.**

If CMS decides to change the global period for 49436 from a 090-day to a 010-day the clinical labor times associated with this code would need to be 18 minutes in the non-facility/30 minutes in facility, rather than the 90 day standard of 35 minutes in the non-facility setting and 60 minutes in the facility.

Uterine Fibroid Embolization (Tab 28)
Geraldine McGinty, MD, American College of Radiology (ACR)
Jonathan Berlin, MD, American College of Radiology (ACR)
Robert L. Vogelzang, MD, Society of Interventional Radiology (SIR)
Facilitation Committee #3

The CPT Editorial Panel created a new CPT code to provide more specificity to the procedures related to uterine fibroid embolization (UFE). The intent of the Panel was to create a new embolotherapy code that describes UFE separately and distinctly, since it is believed to have reached the point in clinical practice where it is performed with a relatively uniform technique and needed to be specified.

The specialty provided a detailed description of service, and the intensity and complexity to the RUC for code 37210 *Uterine Fibroid Embolization (UFE, embolization of the uterine arteries to treat uterine fibroids, leiomyomata), percutaneous approach inclusive of vascular access, vessel selection, embolization, and all radiological supervision and interpretation and intraprocedural roadmapping and imaging guidance necessary to complete the procedure.* The RUC had trouble accepting the survey data for this code, especially the intra-service physician time, the RUC believed a more appropriate intra-service time would be closer to the 25th percentile time of 90 minutes. However, the RUC expresses concern that the 90 minutes of intra-service work remains inconsistent with time mentioned within recent literature.

The code, was compared to code 61923 *Endovascular temporary balloon arterial occlusion, head or neck (extracranial/intracranial) including selective catheterization of vessel to be occluded, positioning and inflation of occlusion balloon, concomitant neurological monitoring, and radiologic supervision and interpretation of all angiography required for balloon occlusion and to exclude vascular injury post occlusion* (000 global, Work RVU = 9.95), however the RUC believed the true value should be lower. The RUC could not support a value equivalent to 9.95 at this time and recommends a value slightly lower, at 9.00, until the specialty surveys again for the next meeting.

The RUC recommends that code 37210 have a interim value of 9.00 RVUs and ask the specialty society to resurvey and present this code again at the October 2006 RUC meeting. In addition, moderate sedation is inherent within this procedure and this code should be added to the moderate sedation list.

Practice Expense
The practice expense inputs were amended to reflect the change in intra-service work time and corrections from the PERC.

Circumcision (Tab 29)
Steven Krug, MD, American Urological Association (AUA)
Thomas Cooper, MD, American Academy of Pediatrics (AAP)
Terry Mills, MD, American Academy of Family Physicians (AAFP)
Pre-Facilitation Committee #2

The pediatric community identified circumcision as a family of services to be reviewed during the Five-Year Review of the RBRVS. When the RUC reviewed the pediatric comments in August 2005, it was suggested that the CPT Editorial Panel first review this family of services to determine if services are described as currently performed. The CPT Editorial Panel determined that circumcision, using clamp or other device, should not be distinguished by age of patient. CPT codes 54150 and 54152 were, therefore, combined into a single code 54150 *Circumcision, using clamp or other device, with regional dorsal penile or ring block.* Editorial revisions were adopted for 54160 and 54161 to define newborn as 28 days of age or less.

Surveys were completed by pediatrics, family medicine, urology, and obstetrics/gynecology. The surveys indicated that the typical time was as follows: pre-evaluation = 15 minutes; positioning = 5; scrub/dress/wait = 5; intra = 15; and immediate post = 5. This time and the survey median are comparable to the time and current work relative value of 54100 *Biopsy of penis (separate procedure)* (work RVU = 1.90, pre-time = 31; intra-time = 19; post = 14). The RUC agreed that 54150 is appropriately valued in comparison to 54100.

The RUC recommends a work relative value of 1.90 for CPT code 54150.

Practice Expense Direct Inputs
The RUC reviewed the direct practice expense inputs and agreed that inputs should be recognized in both the non-facility and facility settings. The non-facility inputs were revised to account for the change in assist physician time to 2/3 of the physician time during the intra-service period. In addition, the supplies were revised. The facility practice expense inputs were revised to only include a three minute phone call.

Laparoscopic Radical Hysterectomy (Tab 30)
George A. Hill, MD, American College of Obstetrics and Gynecology (ACOG)
Gary S. Leiserowitz, MD, American College of Obstetrics and Gynecology (ACOG)

The CPT Editorial Panel created new code 58548 *Laparoscopy surgical, with radical hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with removal of tube(s) and ovary(s), if performed* to report total laparoscopic radical hysterectomy. Advances in laparoscopic techniques and instrumentation have lead to minimally invasive approaches to procedures that previously required laparotomy for completion.

The RUC reviewed the physician time involved for this service and the specialty society indicated that the pre-service time stated by the survey respondents seemed inappropriate, but the immediate post service time was low in comparison to reference service code 58210 *Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s)* (Work RVU=28.81, pre-service = 75 minutes, immediate post-service = 45 minutes). The RUC and specialty society agreed that the typical patient service would require less pre-service time and more post-service time. The RUC recommends the following physician times:

Pre-service evaluation = 60 minutes
Pre-service positioning = 10 minutes
Pre-service scrub, dress, wait = 5 minutes
Intra-service = 240 minutes
Immediate Post-Service = 45 minutes
Other Hospital Visits = Two 99231 and One 99232
Discharge Day Mgmt = One 99238
Office visit = Two 99213 and One 99214

The RUC then reviewed the physician work involved in this service and determined that the mental effort and judgment, technical skill and physical effort, and intensity and complexity were slightly more intense for code 58548 than the reference service code 58210 *Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s)* (Work RVU=28.81, global 090-day). The intra-service intensity and complexity of 58548 is greater than that of 58210, due to the difficulty of working in two dimensions during an extended laparoscopic procedure. The difference in total time between 58548 and 58210 is the length of a hospital stay and the level of the hospital visits. **The RUC recommends the specialty's survey 25th percentile work RVU of 30.00 for code 58548.**

Practice Expense
The RUC assessed the practice expense inputs and accepted the facility only standard 090-day practice expense inputs for 58548.

Tumor Debulking (Tab 31)
George A. Hill, MD, American College of Obstetrics and Gynecology (ACOG)
Gary S. Leiserowitz, MD, American College of Obstetrics and Gynecology (ACOG)

The CPT Editorial Panel created two new codes and revised three codes to report resection and debulking of specific recurrent malignancies. The existing codes used to report these services, 49200 and 49201, are codes that describe a wide group of unrelated procedures. Additionally, there is a "gap" in the family of excision of ovarian malignancy codes to describe these procedures when the primary organs (i.e., uterus, tubes, and ovaries) have already been resected. Additionally, these codes were all previously reported with code 49201 *Excision or destruction, open, intra-abdominal or retroperitoneal tumors or cysts or endometriomas; extensive* (Work RVU=14.82) and are not work neutral. Code 49201 was not indicated on the level of interest form for specialties in order for specialty societies to conduct a survey and provide comments. **The RUC acted to review code 49201 at the October 2006 RUC meeting after other specialties have an opportunity to review it. The RUC requests that CMS defer budget neutrality issues until the RUC reviews this issue in October 2006.**

58957 Resection (tumor debulking) of recurrent ovarian, tubal, primary peritoneal, uterine malignancy (intra-abdominal, retroperitoneal tumors), with omentectomy, if performed;
The RUC reviewed 58957 and adjusted the hospital visits to match that of the parent code/reference service code 58953 *Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking;* (Work RVU=31.95). The RUC reviewed the work RVU recommended by the specialty society which was compiled using a building block approach to recommend a work RVU of 24.53 for 58957. A building block approach was used because the specialty society believed that the survey respondents had overestimated the physician work involved because they may have included a total abdominal hysterectomy 58150 *Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);* as part of this procedure (Work RVU = 15.22, Intra-Service RVU=7.42). The building block methodology incorporated taking the parent code 58953 minus the intra-service RVU from 58150 (Intra-Service RVU=7.42), (31.95-7.42=24.53). The RUC also used additional references such as 50236 *Nephrectomy with total ureterectomy and bladder cuff; through separate incision* (Work RVU=24.82) and 22808 *Arthrodesis, anterior, for spinal deformity, with or without cast; 2 to 3*

vertebral segments (Work RVU=26.23) to support the recommended work RVU of 24.53 for 58957. **The RUC recommends a work RVU of 24.53 for 58957.**

58958 Resection (tumor debulking) of recurrent ovarian, tubal, primary peritoneal, uterine malignancy (intra-abdominal, retroperitoneal tumors), with omentectomy, if performed; with pelvic lymphadenectomy and limited para-aortic lymphadenectomy

The RUC reviewed 58958 and adjusted the hospital visits to match that of the parent code 58954 *Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking; with pelvic lymphadenectomy and limited para-aortic lymphadenectomy* (Work RVU=34.95). The RUC reviewed the work RVU presented by the specialty society in which, the specialty society used a building block approach to recommend a work RVU of 27.53 for 58958. The building block methodology incorporated taking the parent code 58954 minus the intra-service RVU from 58150 *Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);* (Work RVU = 15.22, Intra-Service RVU=7.42) (34.95-7.42=27.53). The RUC also used additional references such as 43124 *Total or partial esophagectomy, without reconstruction (any approach), with cervical esophagostomy* (Work RVU=27.28) to support the recommended work RUV of 27.53 for 58958. **The RUC recommends a work RVU of 27.53 for 58958. The RUC recommends the modified physician times below to more closely reflect the times of the reference service codes for 58957 and 58958.**

	Code 58957	**Code 58958**
Pre-service evaluation	65 minutes	65 minutes
Pre-service positioning	10 minutes	10 minutes
Pre-service scrub, dress, wait	15 minutes	15 minutes
Intra-service	180 minutes	210 minutes
Immediate Post-Service	45 minutes	45 minures
Other Hospital Visits 99231	2	2
99232	2	2
99233	1	1
Discharge Day Mgmt 99238	1	1
Office Visits 99212	1	1
99213	1	1
99214	1	1

Practice Expense

The RUC reviewed the practice expense inputs and recommend the facility only standard 090-day practice expense inputs for 58957 and 58958.

Nerve Repair Grafting (Tab A)
Keith Brandt, MD, FACS, American Society of Plastic Surgeons
Scott Oates, MD, American Society of Plastic Surgeons
Daniel Nagle, MD, FACS, American Society for Surgery of the Hand (ASSH)
Dale Blaiser, MD, FACS, American Association of Orthopaedic Surgeons (AAOS)

The CPT Editorial Panel created two new codes, 64910 *Nerve repair; with synthetic conduit or vein allograft (eg, nerve tube), each nerve* and 64911 *Nerve repair; with synthetic conduit or vein allograft (eg, nerve tube), each nerve with autogenous vein graft (includes harvest of vein graft), each nerve* to report the repair of new injuries that result in a loss of nerve tissue and repair of a nerve gap using either a synthetic conduit/vein allograft or autogenous vein graft.

The RUC reviewed 64910 and agreed that the pre-service physician times indicated in the specialty society survey were slightly high in comparison to the reference service code 64835 *Suture of one nerve, hand or foot; median motor thenar* (Work RVU=10.92, pre-service time total = 54 minutes). The RUC recommended reducing the pre-service evaluation time to 25 minutes and the pre-service positioning time to 10 minutes and the pre-service scrub dress and wait time remains the same as the survey respondents indicated at 15 minutes, for a total pre-service time of 50 minutes for 64910 to more appropriately reflect the physician time involved to perform this service. Additionally, the RUC agreed that the 99214 visit should be modified to a 99213 visit to more appropriately reflect the evaluation and management of care being provided to the patient. Therefore, 64910 will have a half day discharge day management (99238), one 99212 visit and three 99213 office visits. The RUC agreed that the physician work involved was similar to the reference code 64835. By using magnitude estimation, the total physician work for 64910 at the 25th percentile and reference code 64835 is the same. **Therefore, the RUC recommends the specialty's survey 25th percentile work RVU of 10.92 for code 64910.**

The RUC reviewed 64911 and identified that the total physician work for 64911 includes the work of 64910 plus the harvesting of the vein graft. Although the difference in the intra-service time between 64910 and 64911 is 30 minutes, the RUC agreed that the intensity is not as high as the intensity for 35500 *Harvest of upper extremity vein, one segment, for lower extremity or coronary artery bypass procedure (List separately in addition to code for primary procedure)* (Work RVU=6.44, Intra-service time = 60 minutes). The recommended difference between 64910 and 64911 is 2.46 RVUs (13.38-10.92=2.46), which the RUC agreed was appropriate to represent the harvesting of vein graft as an increment, be added to 64910 equaling the specialty society's 25th percentile survey results. **The RUC recommends the specialty's survey 25th percentile work RVU of 13.38 for code 64911.**

Additionally, the RUC recommends reducing the pre-service evaluation time to 25 minutes and the pre-service positioning time to 10 minutes and the pre-service scrub dress and wait time remains the same as the survey respondents indicated at 15 minutes, for a total pre-service time of 50 minutes for 64911 to reflect the same time as indicated in 64910. The RUC believed that the 99214 visit should be modified to a 99213 visit to more appropriately reflect the evaluation and management of care being provided to the patient. Therefore, 64910 will be modified to have a half day discharge day management (99238), one 99212 visit and three 99213 office visits.

Practice Expense
The RUC assessed the facility only practice expense inputs for 64910 and 64911 and accepted them as standard 090-day practice expense inputs.

Stereotactic Body Radiation Therapy (Tab B)
Najeeb Mohiden, MD, American Society for Therapeutic Radiation Oncology (ASTRO)
David Beyer, MD, American Society for Therapeutic Radiation Oncology (ASTRO)
John Kresl, MD, PhD, American Society for Therapeutic Radiation Oncology (ASTRO)
Brian Kavanagh, MD, MPH, American Society for Therapeutic Radiation Oncology (ASTRO)

The CPT Editorial Panel created two new codes, 77373 *Stereotactic body radiation therapy, treatment delivery, per fraction to one or more lesions, including image guidance, entire course not to exceed 5 fractions* and 77435 *Stereotactic body radiation therapy, treatment management, per treatment course, to one or more lesions, including image guidance, entire course not to exceed 5 fractions* to report treatment of localized tumors or lesions anywhere in the body using minimally-invasive stereotactic body radiation therapy (SBRT) techniques with the use of rigid immobilization and image guidance throughout the treatment.

77373
The RUC reviewed 77373, which has practice expense inputs only for clinical labor time of the SBRT treatment delivery. The RUC assessed and modified the practice expense inputs

77435
The RUC reviewed 77435 based on the vignette that the typical patient receives three fractions of SBRT. The RUC determined that 77435 will have minimal pre-service and immediate post-service time associated with this service. The RUC compared 77435 to reference service code 77432 *Stereotactic radiation treatment management of cerebral lesion(s) (complete course of treatment consisting of one*

session) (Work RVU=7.92) which is for one session of SBRT management. The RUC agreed that the the mental effort and judgment, technical skill/physical effort and psychological stress were higher for 77435 than the reference code 77432. The RUC carefully examined the intra-service time and determined that 230 minutes of intra-service time (approximately 75 minutes per fraction, based on the typical three fractions performed) was appropriate. **The RUC recommends pre-service evaluation time of 20 minutes, intra-service time of 230 minutes and immediate post-service time as 20 minutes for 77435.**

The RUC examined the survey median RVU of 13.00 and agreed that it appropriately reflected the physician work involved to perform this procedure. By having higher pre-service, intra-service, and immediate post-service times compared to the reference code 77432, these increases bring the work RVU to approximately 13.00. **The RUC recommends the median survey work RVU of 13.00 for code 77435.**

Practice Expense
The RUC assessed the approved the practice expense inputs for 77435.

New Technology
The RUC identified codes 77373 and 77435 as utilizing new technology. **The RUC recommends that these codes are put on the new technology/services list and return to the RUC for re-review once this technology has become more widespread.**

Urinary Bladder Residual Study (Tab C)
Gary Dillehay, MD, Society of Nuclear Medicine (SNM)
Geraldine McGinty, MD, American College of Radiology (ACR)
Jonathan Berlin, MD, American College of Radiology (ACR)

The CPT Editorial Panel revised code 78730 *Urinary bladder residual study* to report it as an add-on code to another procedure. Code 78730 is a nuclear medicine imaging and quantification procedure and is not used as a stand alone study, it is used in conjunction with assessment of ureteral reflux, CPT code 78740 *Ureteral reflux study (radiopharmaceutical voiding cystogram)* (Work RVU=0.57).

The RUC reviewed the vignette for 78730 and determined that the vignette used in the survey was not the final vignette approved by the CPT Editorial Panel. Therefore, the survey respondents based their responses on the typical service for 78730 as including the performance of a nuclear medicine ureteral reflux study. The RUC did not use the survey in the valuation of this service. The correct vignette is as follows:

A 2 year-old girl with a history of urinary tract infection and documented vesicoureteral reflux is referred for nuclear ureteral reflux study (separately reported). Determination of residual bladder volume was also requested and is then performed.

After extensive review, the RUC determined that the physician work intensity/complexity and physician times for code 78730 were similar to the reference service code 78000 *Thyroid uptake; single determination* (Work RVU=0.19, Intra-service time =14 minutes). The RUC reduced the pre-service and immediate-post service times to zero for code 78730 to reflect the fact that this is now an add-on code and the physician work is included in the base code 78740. The RUC agreed with the specialty society to reduce survey intra-service time from ten to five minutes. **The RUC recommends a work RVU of 0.15 and an intra-service time of 5 minutes for code 78730.**

Practice Expense
The RUC assessed and modified the practice expense inputs for code 78730 and its companion code, 78740 *Ureteral reflux study (radiopharmaceutical voiding cystogram)* (Work RVU=0.57), to reflect the typical patient encounter.

Esophageal Capsule Endoscopy (Tab D)
Klaus Mergener, MD, PhD, American Society for Gastrointestinal Endoscopy (ASGE)
Joel V. Brill, MD, American Gastroenterological Association (AGA)

The CPT Editorial Panel created a new code to provide additional clarity to the procedures involving gastrointestinal tract imaging.
Existing code 91110 *Gastrointestinal tract imaging, intraluminal (e.g. capsule endoscopy), esophagus through ileum, with physician interpretation and report)* (Work RVU = 3.64) involves more physician work than the new code which involves imaging only through the esophagus, and a new CPT code was needed to capture the lower level of physician work. For this new code a new capsule device is used that images the esophagus at a rate of 14 images per second whereas the capsule swallowed for code 91110 takes images of the esophagus, stomach and small intestine.

The RUC reviewed the specialty society survey results for code 91111 *Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), esophagus with physician interpretation and report* and agreed with the specialty that the median physician work RVU of 2.85 from the survey was too high and that the work was more closely aligned with the survey's low value of 1.00. The RUC also believed that the physician time from the survey was also too high (pre-evaluation = 20, intra-service = 20, and immediate post = 15). The RUC reviewed the work of 92615 *Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing by cine or video recording; physician interpretation and report only* (Work RVU = 0.63)

and understood that there was more work in code 91111. The RUC and the specialty agreed that the physician time from the survey was overstated and the pre-service evaluation time was typically 5 minutes instead of 15 minutes, the intra-service time was 15 minutes instead of 20 minutes, and the post service time was 15 minutes as indicated from the survey. **The RUC recommends pre-service time of 5 minutes, intra-service of 15 minutes, and 15 minutes immediate post service time, and a relative work value of 1.00 for code 91111.**

Practice Expense

The PERC and the RUC reviewed the practice expense inputs of code 91111 and agreed to lower the clinical labor time by a total of 6 minutes from the specialty's initial recommendation to reflect the typical patient service.

Surfactant Administration (Tab E)

Steve Krug, MD, FAAP, American Academy of Pediatrics (AAP)
Rich Molteni, MD, FAAP, American Academy of Pediatrics (AAP)
Facilitation Committee #3

The CPT Editorial Panel acknowledged that surfactant administration, available over the last 10 years, should be separately reported when the physician is not reporting Critical Care Services (99289 – 99296) on the same date. CPT code 94610 *Intrapulmonary surfactant administration by a physician through endotracheal tube* was created to describe this service. It was noted that this service may be reported most often with 99440 *Newborn resuscitation: provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output* (work RVU = 2.93).

The RUC reviewed the survey data from pediatrics and determined that the respondents overstated the physician work necessary to perform this service. The RUC understands that this service will always be reported in addition to an Evaluation and Management (E/M) service performed on the same date, most typical 99440. Therefore, all pre and post physician time/work will be performed as part of the E/M service. The surfactant administration is valued as a code that will be -51 modifier exempt and CPT will add this code to the Modifier -51 exempt appendix.

After reviewing the survey results, the RUC agreed that the service most typically requires 20 minutes of intra-service time. As this service is most typically an add-on and continuation of 99440, the RUC valued the work at the same intensity (IWPUT = 0.058) as 99440. The computed work relative value of 1.16 is comparable to the following codes:

1. 64627 *Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, each additional level (List separately in addition to*

code for primary procedure) (ZZZ Global, Work RVU = 1.16, 30 minutes intra-service time)

2. 13102 *Repair, complex, trunk; each additional 5 cm or less (List separately in addition to code for primary procedure)* (ZZZ Global, Work RVU = 1.24, 25 minutes intra-service time)
3. 64472 *Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; cervical or thoracic, each additional level (List separately in addition to code for primary procedure)* (ZZZ Global, Work RVU = 1.29, 15 minutes intra-service time)
4. 64484 *Injection, anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, each additional level (List separately in addition to code for primary procedure)* (ZZZ Global, Work RVU = 1.33, 20 minutes intra-service time)

The RUC recommends a work relative value of 1.16 for CPT code 94610.

Practice Expense
This service is always performed in a facility on an emergent basis and, therefore, there are no direct practice expense inputs related to this service.

Ventilator Management (Tab F)
Edward Diamond, MD, American College of Chest Physicians (ACCP) and American Thoracic Society (ATS)
Jim Grant, MD, American Society of Anesthesiologists (ASA)
Pre-Facilitation Committee #3

The Centers for Medicare and Medicaid Services (CMS) requested that the RUC review CPT code 94657 *Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathings; subsequent* days (work RVU = 0.83) in the Five-Year Review of the RBRVS. The specialty society surveyed this service in 2005 and recommended an increase to the RUC. It was noted that an increase in 94657 would create a rank order anomaly with 94656 *Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathings; subsequent days* (work RVU = 1.22) and the specialty society also recommended an increase for 94656. The RUC reviewed these recommendations in September 2005 and concluded that the CPT Editorial Panel should first review this family of services to differentiate between those patients who received ventilation management services on an acute versus a long-term basis. CPT codes 94656 and 94657 have been replaced with four new codes to differentiate between ventilation management in the acute care setting (initial and subsequent) and long-term care setting (nursing facility and home).

The specialties (pulmonary medicine, critical care, and anesthesiology) surveyed the new code family. The specialties indicated that the survey respondents over-

stated the work for performing these services and recommended alternative work relative value recommendations. The RUC reviewed the specialty society recommendations and agreed with their rationale for each, as follows:

94002 Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day

The RUC agreed that the survey respondents had overstated the physician work for this service (survey median = 2.45). The specialties recommended, and the RUC agreed, that the previous work relativity for 94656/94657 should be applied to new codes 94002/94003. Utilizing the survey data from July 2005 for 94003, the specialty and RUC agreed to a computed value of 1.99 for 94002.. The survey time of pre = 15; intra = 30; and post = 15 is appropriate. This service is similar in work to CPT code 99233 *Subsequent hospital care* (work RVU recommendation = 2.00, time: pre = 10; intra = 30 post = 15).

The RUC recommends a work relative value of 1.99 for CPT code 94002.

94003 Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, subsequent day

The RUC reviewed the survey data collected in July 2005 for the Five-Year Review and March 2006 for the new codes. In both surveys, the respondents indicated consistent physician time of pre-time = 10 minutes; intra-time = 20 minutes; and post-time = 10 minutes. The RUC agreed that this time was reflective of the typical time for this service. The RUC agreed that the survey median (1.37) from the initial survey conducted in 2005 was more appropriate than the current survey median (1.50). This service is similar in work to CPT code 99232 *Subsequent hospital care* (work RVU recommendation = 1.39, time: pre = 10; intra = 20; post = 10).

The RUC recommends a work relative value of 1.37 for CPT code 94003.

94004 Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; nursing facility, per day

The specialty society recommended the 25th percentile for the work relative value of 1.00 and physician time of pre = 10; intra = 15; and post = 10. The RUC agreed that this was reasonable in comparison to 99308 *Subsequent nursing facility care, per day* (work RVU = 1.00, time: pre = 5 ; intra = 15; post = 10).

The RUC recommends a work relative value of 1.00 for CPT code 94004.

940055 Home ventilator management care plan oversight of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living) requiring review of status, review of laboratories and other studies and revision of orders and respiratory care plan (as appropriate), within a calendar month, 30 minutes or more

The specialty indicated that this service was most similar in work to CPT code 99375 *Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility)* (work RVU = 1.73; pre = 10; intra = 32; post = 15). The specialty survey data indicated typical time for 94005 of pre = 15; intra = 25; and post = 15. However, it should be noted that the CPT code requires an intra-service time of at least 30 minutes. The RUC recommended time, for this service, therefore, is pre = 10; intra = 30; and post = 15). Although the total time for these two care plan oversight services is the same, the RUC concluded that the total work of managing the ventilator is less work than managing the overall care of the patient, reported by the primary care doctor at the same time that code 9460X5 would be reported by the pediatric pulmonologist. The 25% of the survey median is 1.50.

The RUC recommends a work relative value of 1.50 for CPT code 94005.

Practice Expense

CPT codes 94002, 94003, and 94004 are all codes that may also be reported if performed in the hospital inpatient/observation or nursing facility and, therefore, there are no practice expense inputs for these services. CPT code 94005 is reported for home ventilator management of a patient in the home, domiciliary or rest home. The RUC recognized that 36 minutes of clinical staff time would be typical within one calendar month. This reflects six, three minute phone calls with the patient's home and six, three minute phone calls with other health care professionals, for a total of 36 minutes.

Home Apnea Monitoring (Tab G)

Steve Krug, MD, FAAP, American Academy of Pediatrics (AAP)
Rich Molteni, MD, FAAP, American Academy of Pediatrics (AAP)

The CPT Editorial Panel created a new family of codes to describe home apnea monitoring and the evaluation and interpretation of long term airway and cardiac data in infants. The RUC discussed this family of codes and there was significant confusion regarding the interaction between the physician involvement in home apnea monitoring and that of the home health agency. The RUC requested that CMS and CPT provide additional clarification prior to a RUC review of these services.

Allergy Test Interpretation (Tab H)
Donald W. Aaronson, MD, MPH, Joint Council of Allergy, Asthma, and Immunology (JCAAI)

95004, 95024, 95027
The specialty society initially came to the RUC 2005 Five Year Review in order to present physician work values for these Allergy codes. At the meeting the specialty presented each code with physician work representing staff supervision and the interpretation of the tests results. The codes are typically billed with an E/M service which according to CPT the "actual performance and/or interpretation of diagnostic tests/studies ordered during a patient encounter are not included in the level of E/M services." The RUC could not value the codes based upon the CPT descriptor and the survey results, and referred the specialty to CPT Editorial Panel for clarification and possible revision of the codes to include physician work. In February 2006, the CPT Editorial Panel made modifications to these allergy testing codes in order to include the test interpretation and report provided by a physician.

Prior to the April 2006 RUC meeting, the specialty society met with AMA staff and asked for advice on how to proceed on valuing the codes based upon the specialty's 2005 Five Year Review survey results. AMA staff and the specialty agreed that a new survey should be conducted using the new CPT descriptors. The specialty then withdrew their initial recommendations for the April 2006 RUC meeting and suggested a deferral of full RUC consideration for the codes until the October 2006 meeting, and the continued assignment of zero work values. Therefore, RUC made a recommendation to the CPT Editorial Panel to postpone their revision of these codes until CPT 2008 pending acquisition of survey data by the society or submission of an alternate request for a single allergy test interpretation and report code.

Physician Anticoagulant Management Services (Tab I)
Doug Leahy, MD, American College of Physicians (ACP)
James J. Anthony, MD, American Academy of Neurology (AAN)
Pre-Facilitation Committee #3

In 2001, the Centers for Medicare and Medicaid Services (CMS) stated that the standard of care for anticoagulant services was suboptimal and the current payment policy requires the physician to have the beneficiary make an office visit to discuss prothrombin time tests results and necessary adjustments to receive separate payment. Although it is clinically optimal for a physician to discuss results with a patient and make an adjustment during a face-to-face encounter under some circumstances, physicians often engage in these activities outside of a face-to-face encounter with the patient. The CPT Editorial Panel agreed with the specialty that bundling this post service time into the payment for the visit is unfair when physicians are managing patients on long-term anticoagulants. In addition, the Panel believed that CMS policy provides inadequate avenues for

physicians to be paid for managing patients on long term anticoagulant may contribute to the problem of underutilization of anticoagulant drugs that has adverse effects on the health of patients. Failure to receive anticoagulant drugs when indicated can increase patient risk of thrombosis and embolism, and under or over anticoagulation can increase patient risk of bleeding. The CPT Editorial Panel discussed the issue at its February 2006 meeting and created two new codes to allow the reporting of anticoagulant management services. To ensure appropriate utilization of these codes, the Panel added minimum International Normalized Ratio (INR) measurements, eight for the initial anticoagulant management and three for subsequent therapy, and stated that this service cannot also be reported with another Evaluation and Management (E/M) code.

99605

The RUC reviewed the specialty society's survey results for new CPT code 99605 *Anticoagulant management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; initial 90 days of therapy (must include a minimum of 8 INR measurements.* The RUC agreed that INR testing is typically performed 10 times over the initial 90 days of therapy to appropriate control anticoagulation. The typical code that is currently billed for this service is a 99211 *Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services* (Work RVU = 0.17). The current RVU total for ten E/M codes is similar (10 x 0.17 = 1.70) to the specialty survey median and recommended value (1.65) for the new code 99605. The RUC and the specialty agreed that the physician work and time of new code 99605 was similar to the work of ten 99211 E/M services. The RUC and specialty also agreed that the intra-service physician time would typically total 50 minutes rather than what the surveyed median time of 100 minutes.

The RUC recommends a relative work value of 1.65 for code 99605 with an intra-service and total time of 50 minutes.

99606

The RUC reviewed the survey data for CPT code 99606 *Anticoagulant management for a patient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; each subsequent 90 days of therapy (must include a minimum of three INR measurements).* The RUC agreed that the typical code that is currently billed for this services is a 99211 *Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services* (Work RVU = 0.17). The RUC agreed that there are typically four INR measurements in each subsequent 90 days of therapy. The

current RVU total for four 99211 services is similar (4 x 0.17 = 0.68) to the specialty survey median value (0.63) for the new code 99606. The RUC and the specialty agreed that the physician work and time of new code 99606 was similar to the work of four 99211 E/M services. The RUC and specialty also agreed that the intra-service physician time would typically total 20 minutes rather than the surveyed median time of 40 minutes.

The RUC recommends a relative work value of 0.63 for code 99606 with an intra-service and total time of 20 minutes.

Practice Expense
The RUC reviewed the direct practice expense inputs for these codes and recommended a total of 90 minutes of clinical labor time for 99605 and 24 minutes for 99606, for phone calls and assisting the physician with patient information and chart review.

New Technology/Services
The RUC identified codes 99605 and 99606 as new services to be reviewed again under the RUC's new technology process. **The RUC recommends that these codes are put on the new technology/services list and return to the RUC for re-review considering its utilization patterns once this service has become more widespread.**

XI. Practice Expense Review Committee Report (Tab J)

The following issues concerning existing codes were addressed by the PERC and from CMS's November 2006 final rule for 2006:

1) 91010, 91034, 91037, and 91038
2) 58555, 58558, 58562, and 59812 Site of Service Change
3) 598120 Addition of Equipment and Supplies
4) 52648 and 51715 Site of Service Recommendations, Cystourethroscopy add-ins, and additional disposable supply for 52332
5) 96101-3 and 96118-96120 Licensing Fees Request
6) Eye Codes – Wrong Eye Visit Package code
7) Other 090 day Global Issues
8) Anesthesia Pre-Service Time Issue

New and Revised PE Input Recommendations
The PERC reviewed all the direct practice expense inputs for the new and revised codes brought forward for RUC review at this meeting**. The RUC approved the PERC report and it is attached to these minutes.**

XII RUC HCPAC Review Board (Tab K)

Mary Foto, OTR briefed the RUC on the HCPAC meeting. Ms. Foto informed the RUC that the HCPAC recommends practice expense inputs for code 926XX *Diagnostic analysis with programming of auditory brainstem implant, per hour*. **The HCPAC reviewed and modified the practice expense inputs so that the clinical labor time equals 60 minutes. The HCPAC modified medical supplies by adding toupee tape and a disposable razor. Additionally, a cochlear implant programming system was added to the equipment expenses.**

Ms. Foto briefed the RUC that when codes 96103 *Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI), administered by a computer, with qualified health care professional interpretation and report* (Work RVU=0.51) and 96120 *Neuropsychological testing (eg, Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report* (Work RVU=0.51) were valued by the HCPAC in April 2005, the American Psychological Association (APA) overlooked that a licensing fee should be added to the medical supply direct inputs. **The HCPAC recommended that the licensing fee ($26.83) be added to the direct practice expense inputs for codes 96103 and 96120.**

The HCPAC also discussed the non-physician work pool and practice expense methodologies and work proxies. The HCPAC agrees with the American Dietetic Association (ADA) and American Speech-Language-Hearing Association (ASHA) that the assignment of professional work values for their services is equitable and consistent with the approaches taken with other similar non-physician professional services including physical therapy, occupational therapy and psychological testing services.

In July 2000 the HCPAC submitted work recommendations for the ADA's medical nutrition therapy (MNT) codes (97802-97804). However, work values were not implemented by CMS for the MNT codes. The HCPAC recognizes dieticians, SLPs and audiologists perform professional clinical services that stand alone. Additionally, that the knowledge, skills and judgments that must be made by dieticians, SLPs and audiologists are from a clinical process viewpoint the same as those of physical therapists, occupational therapists and psychologists. **The HCPAC wrote a letter to CMS dated May 16, 2006, recommending that CMS designate work RVUs for the MNT codes and recommending work values be developed and implemented for speech language pathologists and audiologists.**

Ms. Foto also informed the RUC that the HCPAC identified that the Pre-Time Workgroup is currently discussing the standardization of physician pre-service time. The HCPAC acknowledged that there may be unique activities that may impact pre-service work provided by non-physician practitioners. The HCPAC

confirmed that they contributed to the Pre-Time Workgroup's request of identifying such activities.

Lastly, Ms. Foto announced that this meeting ends Doctor Whitten's term as the HCPAC Chair. On behalf of the HCPAC Ms. Foto thanked Doctor Whitten for his years of service and significant contributions he has provided to the HCPAC.

The HCPAC report was filed and is attached to these minutes.

XIII. Practice Expense Subcommittee (Tab L)

Doctor Trexler Topping briefed the RUC on issues discussed at the PE Subcommittee. The following issues were discussed:

Update on Multi-Specialty Practice Expense Survey
AMA staff updated the RUC on the status of the multi-specialty survey. During the week of May 8-14th AMA staff is scheduled to meet with CMS to discuss a potential survey. The previous SMS survey data was performed over multiple years, however there is a current need for a large sample size of data in the first year and therefore will lead to a higher cost initially. AMA staff has already received a financial commitment from one specialty and will send out a letter requesting each specialty's contribution in this survey effort.

In addition, AMA staff has received funds from management for design and pre-testing in 2006. AMA staff foresees that the survey would be fielded for at least 9 months starting in the second quarter of 2007 and continuing through the year. The data would be compiled in the first quarter of 2008 and submitted to CMS in the spring of 2008 for implementation for the 2009 fee schedule. The RUC members reviewed the importance of the immediate data collection need, and made the following recommendation:

The RUC reiterates the importance of a new multi-specialty practice expense data collection process and requests that it be incorporated into CMS' practice expense calculations as soon as possible.

CMS Town Hall Meeting Questions
CMS developed a set of questions for the medical community on February 15, 2006 at its Town Hall Meeting. In an effort to assist CMS with these issues, the Practice Expense RUC discussed each item and provided the following comments to CMS.

Equipment Assumptions
CMS currently utilizes an interest rate of 11% in pricing medical equipment. CMS has acknowledged that this rate is too high and has requested comments regarding the appropriate interest rate.

The RUC discussed and agreed that the interest rate currently was too high and that it should fluctuate according to market conditions, rather than a fixed rate and made the following recommendation to the RUC:

The RUC recommends that CMS adjust the 11% cost of capital rate to a market competitive rate.

CMS asked how it should reflect the utilization rate, particularly for high cost equipment? Currently, they use a 50% utilization rate for all equipment. The RUC discussed whether there should be a different rate for all equipment or just for the equipment set by specific cost thresholds. RUC members discussed whether consideration should be given to impacts on rural payment, as utilization rates may not be as high as urban areas. In addition, there are some specialties where their utilization rates are far lower than others.

The RUC made the following recommendation to the RUC:

The RUC believes that the 50% utilization rate is too low and CMS should consider using a higher rate for all equipment, providing an opportunity to specialty societies to provide data to support lower utilization rates, if appropriate, based on clinical or geographical considerations

Allocations of Indirect Practice Expense Inputs
The allocation of indirect expense is inherently an arbitrary decision based upon judgments regarding how overhead costs (rent, administrative staff, office supplies and equipment) may be attributed to specific services. There was no consensus amongst the RUC regarding the use of direct expense inputs, physician work, or physician time as an allocation method of indirect costs. The RUC, however again stressed the need for a new multi-specialty practice expense data collection and reaffirmed its recommendation for CMS to work with the AMA, specialty societies, and health care professional organizations to initiate this survey process.

<u>Treatment of Administrative Costs: Direct verse Indirect Expense</u>
The American Osteopathic Association (AOA) has developed an idea to simplify the indirect expense portion of CMS's practice expense methodology. The specialty presented the idea of extracting the clerical administrative staff cost from the total indirect costs and instead include this cost as direct practice expenses. The RUC discussed the proposal and understood its benefit in theory. However, as the RUC understands that the only way to incorporate this cost in direct expense would be at the code level, which would be quite difficult to manage. In addition, it may be impossible to distinguish between all the tasks the administrative staff does and allocate them to the procedural CPT code level. The RUC believed if there was a way to efficiently capture this data in the future, the issue should be revisited.

Work Proxies

CMS has proposed to eliminate the NPWP which may have a significant unfavorable impact upon some NPWP specialties (up to 70%). ASHA and ADA representatives presented their concept of assigning "proxy" work values as an interim solution for the allocation of indirect costs for services without a work value. ASHA and ADA believe a work proxy could be established through the use of existing clinical labor time and creation of an intra-service work per unit of time (IWPUT), for some codes. Indirect costs could then be allocated on the sum of direct costs and the proxy work value.

The RUC recognized that these groups may be unfavorably impacted by the elimination of the NPWP. In addition, the RUC understood that CMS is considering the development of proxy work relative values in order to lesson this impact and made the following recommendation to the RUC:

CMS should examine alternatives to prevent these large decreases in practice expense payments to those health care professionals whose services are currently included in the non-physician work pool. If CMS employs "work proxies" to resolve this issue, the RUC emphasizes that the proxy is for mathematical purposes of recalculating practice expense only.

The RUC approved the Practice Expense Subcommittee report and it is attached to these minutes.

XIV. Research Subcommittee (Tab M)

Doctor Cohen presented the Research Subcommittee Report to the RUC. The Research Subcommittee, at this time, does not wish to comment on the suggestion from the AGA and the ASGE for the RUC to recognize the discharge day planning activities for 000 day global periods and will consider this issue if CMS changes its payment policy.

Doctor Cohen discussed the proposed generic descriptions of service for XXX global procedures. **The Research Subcommittee recommends and the RUC approved generic descriptions to be incorporated into the XXX Pathology, Imaging and Diagnostic and Therapy RUC Survey Instruments as described in the Research Subcommittee report.**

Furthermore, Doctor Cohen reviewed the proposed RUC survey instrument and summary form for all global periods and one modification was made to the summary of recommendations forms: the addition of a space to record the tracking number of the new/revised codes. **The Research Subcommittee recommends and the RUC accepts the revised summary of recommendation**

forms with a modification to add the tracking number. The RUC will refer to this number in its discussions.

Doctor Cohen also described the several modifications the Research Subcommittee made and the RUC approved to the survey instruments including:

- All Global Survey Instruments – Question 2C: To make consistent with other descriptions of post-procedure services, the prolonged services will read:

	Physician Total Time	**Typical Physician face-to-face time**
99354	30-74	30-74
Performed in the office or other outpatient setting		
99355		
Ea. Addtl 30, Use multiples added to 99354, as needed		
99356	30-74	30-74
Performed in the inpatient setting		
99357		
Ea. Addtl 30, Use multiples added to 99356, as needed		

- 000 Day Global Survey Instrument - Question 2B: Under Question 2B, the term "immediate" was removed from immediate post-service time and the background for question two should read:
  Post-operative care on day of the procedure, includes non "skin-to-skin" work in the OR, patient stabilization in the recovery room or special unit and communicating with the patient and other professionals (including written and telephone reports and orders), and patient visits on the day of the operative procedure. These actions more accurately reflect 000 day global procedures.

- All Global Survey Instruments - Question 6: To add extra clarity and ensure an accurate response, Question 6 will read:

  Based on your review of all previous steps, please provide your estimate work RVU (to the hundredth decimal point) for the new/revised CPT code:

  _____

  For example, if the new/revised code involves the same amount of physician work as the reference service you choose, you would assign the same work. If the new or revised code involves less work than the reference service, you would estimate a work RVU value that is less than the work RVU of the reference service and vice versa. This methodology attempts to set the work RVU of the new or revised service "relative" to the work RVU of comparable and established reference services.

In addition, Doctor Cohen reviewed the guidelines for specialty societies developing reference service lists and expressed concern that they are not comprehensive and need to be strengthened. **The Research Subcommittee will solicit comments from specialty societies regarding their recommended additions to the existing reference service list guidelines. These comments will be reviewed by the Research Subcommittee at the October 2006 RUC Meeting. After these comments have been complied and approved by the Research Subcommittee and the RUC, a request will be made to AMA Legal Counsel to review these new guidelines. Furthermore, the Research Subcommittee recommends that the RUC, as part of its discussion for new and revised codes, should review each reference service list and acknowledge whether it meets the RUC policy guidelines.**

Doctor Cohen then described the American College of Surgeons request for a historical analysis on the RUC recommendation. The College expressed concern that the specialty survey process be studied to ensure that it remains based on magnitude estimation and not merely a "social survey" collecting the specialties' "wish list." The RUC recommended that as a first step, AMA Staff prepare an analysis of survey medians and CMS' final implemented relative values to see if the relationship between the survey medians and the final value have changed throughout the process.

Factoring in budget neutrality adjustments and Evaluation and Management visits in the global period increase from the 1997 Five-Year Review, on average 61% of the time the survey medians are equal to the 2006 published Work RVUs. This relationship has remained relatively consistent throughout this time period. After reviewing this data the Research Subcommittee recommends as a second step, AMA Staff prepare an analysis of survey medians, specialty society recommendations and RUC recommendations to see if the relationship between these has changed throughout the process.

Doctor Cohen updated the RUC about the status of the Modifer -51 Workgroup. The Workgroup did briefly meet during the February CPT Meeting and the Chair of the Workgroup Doctor Tucker has assigned Doctor Hollmann to review this issue for the CPT Editorial Panel. After a brief discussion, Doctor Hollmann has suggested the following process to review these codes. The first task will be for Doctor Hollmann and RUC staff to draft suggested inclusion criteria and review codes on and off the list to see if they should be considered. This preliminary review may help articulate additional suggested inclusion/exclusion criteria. Doctor Hollmann and RUC staff will take this list and draft criteria to present at the October 2006 RUC meeting for review by the Research Subcommittee. Based upon input from the Research Subcommittee and the RUC, Doctor Hollmann will ask CPT to convene a conference call to finalize the criteria. RUC Staff will run a second review of codes (if necessary) against the final criteria for the joint group to approve as being 51 exempt. Final recommendations will go to the February 2007 CPT Panel meeting.

XV. Pre-Time Workgroup (Tab N)

The Pre-Time Workgroup is charged with making a recommendation to the RUC regarding the standardization of physician pre-service time. For this meeting the workgroup had directed AMA staff to develop a listing of unique pre-time tasks through solicitation from specialty societies. AMA staff received several unique pre-service tasks from specialties and also took a random sample of RUC database records and synthesized the listing into 16 pre-service tasks, that Workgroup members reviewed. The workgroup believed the 16 tasks could still be reduced to a smaller number and perhaps then be packaged into different levels of service and time increments.

The workgroup believed that the variance in the levels of pre- service times for most tasks is dependent upon the characteristics of both patients and procedures. Further, the workgroup agreed that different types of patients and procedures could be packaged into straightforward patients and procedures and difficult patients and difficult procedures. In addition there could be facility and non-facility procedures with anesthesia and without anesthesia.

For the next meeting Pre-Service Workgroup members are asked to consolidate and evaluate the current 16 tasks and slot them into the different packages listed in the tables above. AMA staff will facilitate the refinement and present the findings at the next meeting. The Workgroup will review and correlate the PEAC standard times for clinical labor time with the pre-service physician time. In addition, the definitions of clinical and physician pre-service times will be clarified through the assistance of CMS representatives.

The RUC approved the Pre-Service Workgroup report and it is attached to these minutes.

XVI. Administrative Subcommittee (TAB O)

Doctor Richard Tuck briefed the RUC on the Administrative Subcommittee meeting. Doctor Tuck announced the Administrative Subcommittee had reviewed and approved revisions to the Structure and Functions and Rules and Procedures documents. Primary changes included documenting the change of the Practice Expense Advisory Committee (PEAC) to the Practice Expense Review Committee (PERC) and adding descriptions of the subcommittees and workgroups of the RUC. The Administrative Subcommittee approved the changes made to the Structure and Functions, and Rules and Procedures documents as amended.

Composition of the RUC

Doctor Tuck then reviewed the Administrative Subcommittees' discussion of the composition of the RUC and continued this discussion with the RUC. The RUC Chair, Doctor William Rich, requested that the Administrative Subcommittee initiate a discussion pertaining to the RUC's composition at their April 28, 2006 meeting. This was an initial discussion which will continue at the October 5-8, 2006 meeting. The RUC Chair indicated that the Administrative Subcommittee should consider changes in the Medicare payment system and changes in the RUC's role in the RBRVS over the past 15 years, as well as changes in determining potential modifications to the criteria for permanent seat, composition changes and changes to the rotating seats.

Doctor Tuck informed the RUC that the current Structure and Functions document section on RUC composition was provided for review. The Administrative Subcommittee also reviewed the 2006 MedPAC report related to the RUC composition. The Commission "calls on CMS to request that the medical community propose changes in the composition of the RUC" pointing out concerns that physicians who furnish primary care services are not represented adequately on the RUC.

The Subcommittee members understood that MedPAC's position regarding determination and review of potentially overvalued codes significantly changed after the Commission had the opportunity to review and understand the RUC process. The Subcommittee expressed that it may also be beneficial to continue to provide the opportunity for MedPAC to observe the RUC. A suggestion was made to invite MedPAC Commissioners and/or staff to observe the October RUC meeting in DC. It was noted that MedPAC was primarily concerned that medicine was not doing an effective job at identifying potentially overvalued services.

Doctor Tuck reiterated that the members of the Administrative Subcommittee discussed the several topics related to composition of the RUC, which were comments only not specific actions, and are outlined in the Administrative Subcommittee report which is attached to these minutes.

The Administrative Subcommittee discussed what data and other information is needed for the October meeting to discuss this issue. The information on the history of the RUC composition and Medicare charges data to be gathered prior to the October 2006 meeting is outlined in the attached Administrative Subcommittee report. Additionally, specific items for discussion at the October 2006 Administrative Subcommittee meeting are outlined on the attached report.

The Administrative Subcommittee acknowledged that the RUC composition review may be carried over into 2007, and it should not be anticipated that all issues will be resolved in October 2006.

Re-review of RUC recommendations – new technology/services
Doctor Tuck announced that at the February 2006 RUC meeting, the RUC determined that all new technology/ services identified from September 2005 forward, would be placed in the new technology/services list and would be reviewed again at some time certain. The Administrative Subcommittee agreed to discuss a timeline and other processes related to reviewing new technology and services at the April 2006 meeting.

The Administrative Subcommittee indicated in its timeline that three years of data would be collected prior to re-review of any new technology/services.

The Administrative Subcommittee recommends the process as outlined in the flowchart to implement the review of new technology/services, which is in the Administrative Subcommittee report which is attached to these minutes.

RUC Database Product
Doctor Tuck informed the RUC that the Administrative Subcommittee reviewed the information which will be included in the RUC database as a product for the public. Most of this information is currently available to the public via CMS Web site, AMA product, or Federal Registers. Information that is not available to the public which will be added to the RUC database is pre-service and post-service description of physician work, RUC rationale and pre-service, intra-service and post-service physician time (however total physician times are publicly available).

The Administrative Subcommittee understands that this is an update from staff concerning the release of the RUC data, following the RUC action to call for a symmetrical distribution of this information.

Election of Rotating Seat Rules
Doctor Tuck informed the RUC that the Administrative Subcommittee reviewed the election of the rotating seat rules to have the rules fresh in everyone's mind since there will be an election for the Internal Medicine rotating seat on Saturday, April 29, 2006.

Other Issues
Doctor Tuck also stated that at the February 2006 Administrative Subcommittee meeting the Subcommittee recommended that the Conflict of Interest Policy Statement include "or any family member" to ensure that those signing this statement disclose any potential conflicts of financial interest that his or her family member may have, which was added to the Statement.

Doctor Tuck discussed referring to the Research Subcommittee a RUC policy regarding changes in global visits that the RUC makes during its discussions and backing out time and RVUs commensurate with those changes. The topic will be placed on the Research Subcommittee's agenda for the February 2006 meeting.

Additionally, a RUC member suggested that the Administrative Subcommittee discuss whether each RUC member, alternate and advisor should submit a listing of all their potential conflicts of interest. **The Subcommittee recommends that AMA staff examine a more detailed disclosure statement for RUC members, RUC alternates, Advisors and presenters. The Subcommittee also recommends that AMA staff research options to implementing an on-line conflict of interest disclosure**.

The Administrative Subcommittee report was accepted by the RUC and is attached to these minutes.

XVII. Election of Rotating Seat (Tab P)

The RUC considered the election of the internal medicine rotating seat. The term for the seat is two years, beginning with the September 2006 RUC meeting and ending in May 2008, with the provision of final recommendations to the Centers for Medicare and Medicaid Services.

The RUC elected Meghan Gerety, MD, representing the American Geriatrics Society.

XVIII. New Business

During its discussions, the RUC asked staff to automatically include codes with conscious sedation inherent in the code to the conscious sedation list in its report to CPT.

The RUC requests that where a code has been brought forward and presented as having conscious sedation inherent in the code; where it has been discussed on that basis; and then established a valuation for the RUC; staff would include in its report of the code notification to CPT to add that code to the conscious sedation list.

Doctor Rich and the entire RUC thanked Doctor Scott Manaker for his service to the RUC as his term concludes at this meeting.

Doctor Richard Whitten addressed the RUC as his term expired at the end of the meeting. Doctor Whitten recognized and thanked the RUC for its service to medicine and the Medicare payment system. His comments to the RUC are attached.

Doctor Rich and the entire RUC thanked Doctor Whitten for his service to the RUC.

Doctor Rich announced that Doctor Charles Koopman was appointed to serve on the newly formed Editorial Board of the AMA publication, *CPT Assistant*.

Doctor Rich reminded the RUC that based on previous MedPAC discussions and recommendations to Congress, CMS-led initiatives to identify misvalued services, and its own mission to ensure correct valuation of all codes, the RUC has approved the establishment of a new subcommittee to identify potentially misvalued codes. This committee will convene in October 2006. At this meeting, the RUC has also adopted a process to identify codes that represent new technology or services that have the potential to change in value. First, a code is identified as a new technology/service at the RUC meeting in which it is initially reviewed. Second, the code is flagged in the next version of the RUC database with the date it is to be reviewed. Lastly, the code will be reviewed in 5 years (depending on what meeting in the CPT/RUC cycle it is initially reviewed) after at least three years of data are available. Doctor Rich requested that the new subcommittee begin to develop objective measures to identify misvalued services.

The meeting adjourned on Sunday, April 30, 2006 at 10:45 a.m.

AMA/Specialty Society RVS Update Process
Practice Expense Review Committee
April 26, 2006

The following PERC members participated in the discussions: Doctors Moran (Chair), Anthony, Brill, Cerqueira, Cohen, Felger, McCreight, J. Regan, and Ouzonian.

Doctor Moran welcomed and informed the group and asked CMS staff for an update. Doctor Ken Simon from CMS provided an update of the agency's recent activities. Doctor Simon stated that the agency is working with the AMA in developing category II codes for pay for performance initiatives that will expand in 2007. Carolyn Mullen stated that the agency has been working on the practice expense methodology and the results from the last Five Year Review. In addition, Ms. Mullen stated that the impacts from the practice expense methodology change should look quite different from what was displayed at its Town Hall meeting last February.

Doctor Moran stated that when a code or set of codes is discussed at the PERC, there should be a physician or staff presenter that is empowered to make decisions for the specialty to assist with any questions or clarifications that may be needed to assist the PERC in its activities. In addition, if the PERC does make any changes to the recommendation, the specialty is obligated to present these revisions to AMA staff by 10:00am the next day. In addition, the PERC discussed and agreed upon the proper protocol going forward for any existing codes that are ultimately reviewed by the PERC. Whereas the specialty should inform CMS of their requested revision and act as a gatekeeper who may then pass the existing codes request AMA staff by a specific date determined by AMA staff that will coincide with the new and revised code time table and its level of interest process.

The following existing code issues were addressed by the PERC as requested by CMS.

1) The American Gastroenterology Association Institute requested equipment related changes to CPT codes 91010, 91034, 91037 and 91038. The requested change were in response to information obtained from the equipment manufacturer which indicates that in some instances equipment pricing is incorrect, or equipment needs to be added or deleted from certain codes. The PERC reviewed each of the modifications requested by the specialty and considered them reasonable and accepted the recommendation without modification. AMA staff also asked the specialty to supply invoice information for the equipment items.
2) The American College of Obstetricians and Gynecologists (ACOG) requested that three codes (58558, 58562, and 59812) should be priced in the non-facility setting and additional supplies and equipment be added to 58120. The PERC made minor modifications to the recommendations and compared the inputs to other codes within their families to come up with the final recommendation. The PERC required the specialty to display all inputs for the codes to be for RUC members in the final recommendations.
3) The American Urological Association brought forward the following issues for review:

1. The addition of scope cleaning to six cystoscopy procedures
2. The addition of a uretheral stent supply item for 52332
3. New direct inputs for code 51715
4. Revision of the direct inputs of codes 52647 and 52648

The PERC initially reviewed and accepted the specialty's clinical labor recommendations in the non-facility setting that included addition of scope cleaning time for the following cystoscopy procedures: 52000, 52001, 52005, 52281, 52283, 52285, and 52647, the facility clinical labor inputs did not change The standard clinical labor scope cleaning and set up time was added (set up time of 5 minutes each and 30 and 10 minutes for flexible and rigid scopes respectively) (52000 receives flexible scope time, and all others receive rigid scope time). In addition, each code requires a cleaning and disinfecting, endoscope (CMS code: SA042). No other supplies or equipment items were altered.

The PERC also recommended non-facility input for code 51715, the addition of a ureteral stent for 52332 and the revision of the direct inputs of code 52647 and 52648. The PERC could not determine the correct level of anesthesia for codes 52647 and 52648. The group recognized the appearance of a change in the site of service, but at this point was not clear as to the relations between the anesthesiologist and the surgeon, and how to apply the costs. The members of the PERC believed that CMS and the PERC should review the codes and address them again at its next meeting. In addition, the PERC recommended that a workgroup be established to review new developments in patient care involving anesthesia and sites of service.

4) The American Psychological Association Practice Organization brought a per procedure cost item involving licensing fees that are incurred on a per-test basis for tests administered via computer. The PERC reviewed the expense and determined that it was a direct practice expense to the clinician and that this cost should be added to codes 96103 and 96120.
5) During their review of the 090 day global standard PEAC recommendation which will be implemented by CMS in 2007, the American Academy of Ophthalmology identified an error where the wrong Ophthalmology visit packages were applied to the wrong codes or more than one package was applied. The society developed listings of the errors and corrections which were approved by the PERC.
6) Other societies identified supplies and equipment that were scheduled for deletion when the 090 day global standard would be applied. These inputs listed by CPT Code were recommended to be retained by the PERC: The following specialty's recommendations were accepted and will be forwarded to CMS by AMA staff;
    1. The American Podiatric Medical Association
    2. American Urological Association
    3. American College of Obstetricians and Gynecologists
    4. American Association of Oral and Maxillofacial Surgeons
    5. The Society of Thoracic Surgeons
    6. American College of Surgeons, American Society of General Surgeons, and the American College of Colon and Rectal Surgeons, and American Society for Surgery of the Hand.

7. The American Academy of Orthopedic Surgeons (will be forwarded upon receipt of proper code set listings)

7) CMS requested the PERC discuss the appropriateness of direct practice expense of clinical labor employed by the physician as a cost in the facility setting. The PERC carefully discussed the recommendation by the American Society of Anesthesiology of 11 minutes and agreed that this was a direct practice expense however 8 minutes of clinical labor time was more appropriate. The PERC recommends 8 minutes of clinical labor time for all anesthesia codes consisting of 3 minutes of anesthesia scheduling and 5 minutes of case assignment, scheduling coordination, and completion of forms.

New and Revised PE Input Recommendations

The PERC reviewed all the direct practice expense inputs for the new and revised codes brought forward for RUC review at this meeting, provided there was a representative from the society available for comment. Most issues involving codes performed only in the facility setting, where the standard 090 day package was recommended, and the PERC was able to accept the recommendation. Codes where the specialty had recommended non-facility inputs and there was no specialty representative or where there was difficulty assessing the practice expense inputs were recommended for facilitation for physician work and practice expense.

The following issues and related practice expense inputs were reviewed and are recommended by the PERC:

RUC Tab

Removal of Pelvis Contents (58240) 4

The PERC and specialty agreed on the standard 090 day global package for these codes.

Standard Backbench Procedures (32855, 32856, 33933, 44715, 47143, 47144, 47145 48551, 50323, 50325) 5

The PERC and specialty agreed on the standard 090 day global package for these codes.

Relative Value Recommendations for *CPT 2007*:

Auditory Brainstem Implant Programming K

The PERC reviewed the direct inputs and made its recommendations to the HCPAC who made their final recommendation for this issue

Anterior Spine Anesthesia (0062X1-0062X2) 6

There are no direct practice expense inputs for this issue.

Skin Graft Recipient Site Preparation (1500X2-1500X5) 7

The PERC reviewed the practice expense inputs for the non-facility and facility settings for these codes and made minor changes to the inputs.

Axial Pattern Forehead Flap (1573X) 8
The PERC made minor changes to the direct inputs for this code and recommends the amended inputs.

Panniculectomy (15830X, 15831) 9
The PERC and specialty agreed on the standard 090 day global package for these codes.

Mohs Surgery (1730X1-1730X5) 10
The PERC reviewed the direct practice expense for these codes and made minor changes. These inputs were then referred to the issue's Pre-Facilitation committee.

Fibroadenoma Cryoablation (191X1) 11
These codes were referred to a facilitation panel for discussion.

Breast Reconstruction (19361) 12
The PERC and specialty agreed on the standard 090 day global package for these codes.

Percutaneous Intradiscal Annuloplast (IDET) 13
(225X1-225X2) These codes were referred to a facilitation panel for discussion.

Excision of Tendon (2510X1) 14
The PERC and specialty agreed on the standard 090 day global package for these codes.

Percutaneous RF Pulmonary Tumor Ablation (32XXX) 15
The PERC discussed the non-facility and facility inputs, made minor modifications and accepted the specialty recommendation.

Initial Epicardial Electrode Insertion (3320X-3320X1) 16
The PERC and specialty agreed on the standard 090 day global package for these codes.

Atrial Tissue Ablation and Reconstruction 17
(3325X, 3325X1-3325X4) The PERC and specialty agreed on the standard 090 day global package for these codes.

Multiple Ventricular Septal Defect Corrections 18
(3368X, 3368X1-3368X2) The PERC and specialty agreed on the standard 090 day global package for these codes.

Venous Anomalies (3373X, 3373X1-3373X3) 19
The PERC and specialty agreed on the standard 090 day global package for these codes.

Thromboendarterectomy (3538A-3538E) 20
The PERC and specialty agreed on the standard 090 day global package for these codes.

Carotid Bypass (35501-35509) 21
The PERC and specialty agreed on the standard 090 day global package for these codes.

Aortobifemoral-Aortofemoral Bypass (3554Y1-3554Y2) 22
The PERC and specialty agreed on the standard 090 day global package for these codes.

Aortobiliac-Aortoiliac Bypass 23
(3554X1-3554X2; 3563X1-3563X2)
The PERC and specialty agreed on the standard 090 day global package for these codes.

Carotid Bypass Graft (35601) 24
The PERC and specialty agreed on the standard 090 day global package for these codes.

Femoral Anastomosis Revision (3587X1-3587X2) 25
The PERC and specialty agreed on the standard 090 day global package for these codes.

Gastric Antrum Neurostimulation (436X1 – 439X4; 64590, 64595 26
(95970 – 95973) The specialty believes that the changes in these codes are editorial, and no practice expense recommendation was received as it is expected to be discussed at the next RUC meeting.

Laparoscopic Permanent Intraperitoneal Catheter Insertion 27
(493X1-493X5) These codes were referred to a facilitation panel for discussion.

Uterine Fibroid Embolization (5XXXX) 28
The PERC discussed the non-facility and facility inputs, made modifications and accepted the specialty recommendation..

Circumcision (54150-54152; 54160-54161) 29
These codes were referred to a facilitation panel for discussion.

Laparoscopic Radical Hysterectomy (5855X) 30
The PERC and specialty agreed on the standard 090 day global package for these codes.

Tumor Debulking (58950-58952; 5895X, 5895X1) 31
The PERC and specialty agreed on the standard 090 day global package for these codes.

Nerve Repair Grafting (649X1-649X2) A
The PERC and specialty agreed on the standard 090 day global package for these codes.

Stereotactic Body Radiation Therapy B
(774XX1-774XX2) The PERC discussed the non-facility and facility inputs, made minor modifications and accepted the specialty recommendation.

Urinary Bladder Residual Study (78730) C
The PERC discussed the non-facility and facility inputs, made minor modifications and accepted the specialty recommendation.

Esophageal Capsule Endoscopy (9111X1) D
The PERC discussed the non-facility and facility inputs, made minor modifications and accepted the specialty recommendation. The PERC asked for clarification of the 21 minutes of pre-procedure time from the specialty and this is listed below:

- Initialize Data Recorder 7 minutes
- Setup sensor array with sleeves 10 minutes
- Set up Data Recorder with sensors 2 minutes
- Initialization of Workstation \2 minutes

Surfactant Administration (946XX) E
The specialty and the PERC recommends no direct inputs for this code.

Ventilator Management (9400X2-9400X5) F
The specialty and the PERC recommended that 9400X2 – 9400X2 to have no direct inputs and that 9400X5 be discussed at the Pre-Facilitation committee meeting on Friday.

Home Apnea Monitoring (9477X1-9477X4) G
These codes were referred to a facilitation panel for discussion.

Allergy Test Interpretation (95004, 95024, 95027) H
Deferred to the next RUC meeting

Physician Anticoagulant Management Services I
(9936X1-9936X2)
Practice Expense will be reviewed at Pre-Facilitation

The PERC meeting was adjourned at 7:15pm

AMA/Specialty Society RVS Update Committee
RUC HCPAC Review Board Meeting
April 26, 2006

Members Present:

Richard Whitten, MD, Chair	Anthony Hamm, DC
Mary Foto, OTR, Co-Chair	Emily H. Hill, PA-C
Katherine Bradley, PhD, RN	Christopher Quinn, OD
Jonathan Cooperman, MS, PT, JD	Lloyd Smith, DPM
Thomas Felger, MD	Doris Tomer, LCSW
Robert Fifer, PhD	Arthur Traugott, MD
James Georgoulakis, PhD, JD	Jane White, PhD, RD, FADA

I. Welcome

Mary Foto, OTR, welcomed the HCPAC and introduced new AMA staff member, David Barrett.

II. CMS Update

Edith Hambrick, MD, provided a CMS update, informing the HCPAC that the agency anticipates to release the a *Proposed Rule* for the Five-Year Review of the RBRVS and the new practice expense methodology, in May 2006. Doctor Hambrick noted that there will be a 60 day comment period for this rule. In addition, CMS will release the *Proposed Rule* on the 2007 Medicare Physician Payment Schedule with other policy proposals later this summer, which will have its own, separate, comment period.

Doctor Hambrick informed the HCPAC that the non-physician work pool is anticipated to be eliminated, as indicated at the February 15, 2006 town hall meeting on practice expense refinement. In addition, the AMA noted that CMS has received letters from the American Dietetic Association and the American Speech-Language-Hearing Association suggesting methods to develop work proxies to utilize in allocation of indirect practice expense for their specific services.

III. Practice Expense Recommendations for CPT 2007

Auditory Brainstem Implant Programming (926XX)

Robert Fifer, PhD, American Speech-Language-Hearing Association (ASHA), presented practice expense recommendations for code 926XX *Diagnostic analysis with programming of auditory brainstem implant, per hour*. **The HCPAC reviewed and modified the practice expense inputs so that the clinical labor time equals 60 minutes. The HCPAC modified medical supplies by adding toupee tape and a disposable razor. Additionally, a cochlear implant programming system was added to the equipment expenses.**

Psychological and Neuropsychological Testing – Licensing Fee (96103 and 96120)

James Georgoulakis, PhD, JD, American Psychological Association (APA), informed the HCPAC that when codes 96103 *Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg,*

MMPI), administered by a computer, with qualified health care professional interpretation and report (Work RVU=0.51) and 96120 *Neuropsychological testing (eg, Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report* (Work RVU=0.51) were valued by the HCPAC in April 2005, APA overlooked that a licensing fee should be added to the medical supply direct inputs. **The HCPAC recommends that the licensing fee be added to the direct practice expense inputs for codes 96103 and 96120.**

IV. Non-Physician Work Pool – Practice Expense Methodology/Work Proxies

The American Dietetic Association (ADA) and American Speech-Language-Hearing Association (ASHA) discussed alternate methodologies on how to stabilize payment for dieticians, speech language pathologists (SLPs) and audiologists once the non-physician work pool is eliminated. ADA and ASHA have written letters to CMS outlining alternate methodologies on how to develop "proxy" work values as an interim solution for the allocation of indirect costs for services without a work value. However, ADA and ASHA believe that the assignment of professional work values for their services is equitable and consistent with the approaches taken with other similar non-physician professional services including physical therapy, occupational therapy and psychological testing services.

In July 2000 the HCPAC submitted work recommendations for the ADA's medical nutrition therapy (MNT) codes (97802-97804). However, work values were not implemented by CMS for the MNT codes. The HCPAC recognizes dieticians, SLPs and audiologists perform professional clinical services that stand alone. Additionally, that the knowledge, skills and judgments that must be made by dieticians, SLPs and audiologists are from a clinical process viewpoint the same as those of physical therapists, occupational therapists and psychologists. **The HCPAC will write a letter to CMS recommending that CMS designate work RVUs for the MNT codes and recommending work values be developed and implemented for speech language pathologists and audiologists.**

V. Other Issues

Pre-Service Time

The HCPAC identified that the Pre-Time Workgroup is currently discussing the standardization of physician pre-service time. The HCPAC acknowledged that there may be unique activities that may impact pre-service work provided by non-physician practitioners. The HCPAC confirmed that they contributed to the Pre-Time Workgroup's request of identifying such activities.

HCPAC Chair

This meeting ends Doctor Whitten's term as the HCPAC Chair. On behalf of the HCPAC Mary Foto, OTR, thanked Doctor Whitten for his years of service and significant contributions he has provided to the HCPAC.

AMA Specialty Society RVS Update Committee
Research Subcommittee
April 27, 2006

Members Present:
Doctors Cohen (Chair), Allen, Derr, DiScesa, Koopman, Hitzeman, Manaker, Przybylski, Siegel, J. B. Smith, L. Smith, Waldorf

I. AGA/ASGE's Request – Adding Discharge Day Planning Activities for 000 Day Global Procedures

A suggestion from the AGA and the ASGE was made that the RUC needs to recognize the discharge day planning activities for 000 day global periods. The current survey and summary of recommendation forms used for 000 day global services do not recognize that physicians who perform endoscopy procedures involving anesthesia/conscious sedation typically perform the same discharge day management activities that are done for 10 and 90 day global services.

It should be noted that the current CMS policy for 000 day global codes is that these discharge day planning activities are captured in the immediate post time. Therefore, first, this request would have to be approved by CMS, as this addition of discharge day planning activities to 000 day global procedures would affect their PE methodology and could potentially affect their payment policy. Second, if CMS did approve this request, all 000 day global procedures would have to be reviewed to assess for duplication in time. The Research Subcommittee, at this time, does not wish to comment on this request and will consider this issue if CMS changes its payment policy.

II. Review of Proposed Generic Descriptions of Service for XXX Global Procedures

The XXX survey requires specialties to develop generic descriptions of pre-service, intra-service and post-service. Several societies have developed generic descriptions for all of their new or revised XXX global codes. The Research Subcommittee has determined that generic description of service periods for the XXX global procedures should be developed. Currently, there are generic descriptions of service for Evaluation and Management codes.

There was some concern that after the third Five Year Review, Emergency Medicine services' service period should be no longer treated as a whole. This service period for the Five Year Review was broken into pre-, intra- and post-service periods. Generic language, based on the Emergency Medicine's Five-Year Review survey instrument, was drafted by AMA Staff to be incorporated into the E/M Survey instrument. A representative from Emergency Medicine requested that this issue be postponed until the October 2006 RUC Meeting for further review by the American College of Emergency Physicians.

AMA Staff has drafted generic descriptions of service for three other types of XXX global procedures including: 1.) Pathology, 2.) Imaging and Diagnostic and 3.) Therapy. The Research Subcommittee reviewed these proposed generic descriptions and made some modifications. **The Research Subcommittee recommends the following generic descriptions be incorporated into the XXX RUC Survey Instruments:**

Pathology:
Pre-Service: Review of literature or research and communication with other professionals prior to interpretation of the material.

Intra-Service: Obtaining and reviewing the history and results of other diagnostic studies, including examination of previous/additional slides and/or reports, during the gross and microscopic interpretation of the histologic specimen and/or cellular material; comparison to previous study reports; identification of clinically meaningful findings; consultation with other pathologists regarding the specimen; any review of literature or research during examination of the specimen; any dictation, preparation and finalization of the report..

Post-Service: Written and telephone communications with patients and/or referring physician and arranging for further studies or other services.

Imaging and Diagnostic:
Pre-Service Period: The pre-service period includes physician work provided before the onset of the procedure and may include review of records and any discussions with other physicians or the clinical staff.

Intra-Service Period: The intra-service period begins at the onset of the examination and ends after the examination is interpreted. Activities in the intra-service period may include performing the procedure; communications with the clinical staff performing the examination; review of preliminary images or data and/or processing of images and data; and interpretation and report of the examination. Only the physician's time spent during the procedure should be considered. Time spent by the technologist and other clinical staff is NOT included.

Post-Service Period: Activities in the post-service period may include signing off on the report for the medical record, and discussions with the patient and referring physician if performed.

Therapy:
Pre-Service Period: Preparing to see the patient, reviewing records, and communicating with other professionals.

Intra-Service Period: Intra-service period includes treatment/therapy and documentation of services which may include written report.

Post-Service Period: Post-service period includes arranging for further services communicating (written or verbal) with the patient, family, and other professionals.

III. Review of Proposed RUC Survey Instrument and Summary Form

RUC staff has drafted new Summary of Recommendation Forms, new Survey Instruments for all global periods and revised the instruction document to reflect the RUC's previous actions. These documents were reviewed by the Research Subcommittee.

One modification was made to the summary of recommendations forms: the addition of a space to record the tracking number of the new/revised codes. **The Research Subcommittee recommends the revised summary of recommendation forms with a modification to add the tracking number. The RUC will refer to this number in its discussions.**

Several modifications were made to the survey instruments including:

- **All Global Survey Instruments – Question 2C**: To make consistent with other descriptions of post-procedure services, the prolonged services will read:

	Physician Total Time	**Typical Physician Face-to-Face Time**
99345	30-74	30-74 - Performed in the office or other outpatient setting
99355	Ea. Addtl 30, Use multiples added to 99354, as needed	
99356	30-74	30-74 - Performed in the inpatient setting
99357	Ea. Addtl 30, Use multiples added to 99356, as needed	

- **000 Day Global Survey Instrument - Question 2B:** Under Question 2B, the term "immediate" was removed from immediate post-service time and the background for question two should read:

  Post-operative care on day of the procedure, includes non "skin-to-skin" work in the OR, patient stabilization in the recovery room or special unit and communicating with the patient and other professionals (including written and telephone reports and orders), and patient visits on the day of the operative procedure. These actions more accurately reflect 000 day global procedures.

- **All Global Survey Instruments - Question 6**: To add extra clarity and ensure an accurate response, Question 6 will read:

  Based on your review of all previous steps, please provide your estimate work RVU (to the hundredth decimal point) for the new/revised CPT code: _____

For example, if the new/revised code involves the same amount of physician work as the reference service you choose, you would assign the same work. If the new or revised code involves less work than the reference service, you would estimate a work RVU value that is less than the work RVU of the reference service and vice versa. This methodology attempts to set the work RVU of the new or revised service "relative" to the work RVU of comparable and established reference services.

IV. Reference Service List Policy

The Research Subcommittee reviewed the guidelines for specialty societies developing reference service lists and expressed concern that they are not comprehensive and need to be strengthened. The current guidelines are as follows:

- *Include a broad range of services and work RVUs for the specialty. Select a set of references for use in the survey that is not so narrow that it would appear to compromise the objectivity of the survey result by influencing the respondent's evaluation of a service.*
- *Services on the list should be those which are well understood and commonly provided by physicians in the specialty.*
- *Include codes in the same family as the new/revised code. (For example, if you are surveying minimally invasive procedures such as laparoscopic surgery, include other minimally invasive services.)*
- *If appropriate, codes from the MPC list may be included.*
- *Include RUC validated codes.*
- *Include codes with the same global period as the new/revised code.*
- *Include several high volume codes typically performed by the specialty.*

The Research Subcommittee will solicit comments from specialty societies regarding their recommended additions to the existing reference service list guidelines. These comments will be reviewed by the Research Subcommittee at the October 2006 RUC Meeting. After these comments have been complied and approved by the Research Subcommittee and the RUC, a request will be made to AMA Legal Counsel to review these new guidelines. Furthermore, the Research Subcommittee recommends that the RUC, as part of its discussion for new and revised codes, should review each reference service list and acknowledge whether it meets the RUC policy guidelines.

V. ACS Request – Historical RUC Recommendation Analysis

During the discussion of the survey instruments, summary of recommendations forms and corresponding instruction document, the American College of Surgeons discussed a letter they had submitted outlining a general discussion of the RUC survey process. The College expressed concern that the specialty survey process be studied to ensure that it remains based on magnitude estimation and not merely a "social survey" collecting the specialties' "wish list." The RUC

recommended that as a first step, AMA Staff prepare an analysis of survey medians and CMS' final implemented relative values to see if the relationship between the survey medians and the final value have changed throughout the process.

Factoring in budget neutrality adjustments and Evaluation and Management visits in the global period increase from the 1997 Five-Year Review, on average 61% of the time the survey medians are equal to the 2006 published Work RVUs. This relationship has remained relatively consistent throughout this time period. After reviewing this data the Research Subcommittee recommends as a second step, AMA Staff prepare an analysis of survey medians, specialty society recommendations and RUC recommendations to see if the relationship between these has changed throughout the process.

VI. Modifier -51 Exempt Workgroup Update

At the October 2005 RUC Meeting, there was a discussion related to the processes in place for determining which codes are exempt from the use of Modifier -51 as listed in Appendix E of the CPT book. It was recommended to the CPT Editorial Panel that this issue be discussed to consider establishing a process to allow each of the codes listed in Appendix E to be reviewed for appropriateness using a set of criteria to determine whether the value assigned warrants its exemption from the Modifier -51.

The CPT Editorial Panel has created a Modifier Workgroup which will review the codes currently given the Modifier -51 exemption to determine its appropriateness of being on the list and to establish criteria that would determine how future codes would be placed on this list i.e., confirming with RUC Staff that pre- and post-service times are not associated with the proposed codes. The Workgroup has asked for RUC participation. Four members of the Research Subcommittee have volunteered to participate in these meetings: Doctors Derr, Hitzeman, Manaker and Peter Smith.

The Workgroup did briefly meet during the February CPT Meeting and the Chair of the Workgroup Doctor Tucker has assigned Doctor Hollmann to review this issue for the CPT Editorial Panel. After a brief discussion, Doctor Hollmann has suggested the following process to review these codes. The first task will be for Doctor Hollmann and RUC staff to draft suggested inclusion criteria and review codes on and off the list to see if they should be considered. This preliminary review may help articulate additional suggested inclusion/exclusion criteria. Doctor Hollmann and RUC staff will take this list and draft criteria to present at the October 2006 RUC meeting for review by the Research Subcommittee. Based upon input from the Research Subcommittee and the RUC, Doctor Hollmann will ask CPT to convene a conference call to finalize the criteria. RUC Staff will run a second review of codes (if necessary) against the final criteria for the joint group to approve as being 51 exempt. Final recommendations will go to the February 2007 CPT Panel meeting.

AMA/Specialty Society RVS Update Committee
Pre-Time Workgroup
Thursday, April 27, 2006

The following RUC and PERC members participated in the pre-service workgroup discussion: Barbara Levy, MD (Chair), James Anthony, MD, Norman Cohen, MD, Thomas Felger, MD, Emily Hill, PA-C, Charles Mick, MD, James Regan, MD, Gary Seabrook, MD, Baldwin Smith, MD, Trexler Topping, MD, and Richard Tuck, MD.

The Pre-Time Workgroup is charged with making a recommendation to the RUC regarding the standardization of physician pre-service time. At its meeting in February 2006, the workgroup directed AMA staff to develop a listing of unique pre-time tasks through solicitation from specialty societies. AMA staff received several unique pre-service tasks from specialties and also took a random sample of approximately 2,000 RUC database records and synthesized the listing of approximately 215 tasks that were reviewed for additional commonality resulting in the following 16 pre-service tasks:
Draft Summarized Universe of Pre-Service Tasks

1 Subsequent to Decision for Surgery: Problem Focused History & Exam
2 Subsequent to Decision for Surgery: Detailed History & Exam
3 Subsequent to Decision for Surgery: Comprehensive History & Exam
4 Order, perform and review appropriate pre-tests
5 Prepare for Procedure (Check lab results, plan, assess risks, review procedure), Level 1
6 Prepare for Procedure (Check lab results, plan, assess risks, review procedure), Level 2
7 Prepare for Procedure (Check lab results, plan, assess risks, review procedure), Level 3
8 Communicate with patient and/or family (Discuss procedure/obtain consent etc.)
9 Communicate with other professionals (Staff or other physicians)
10 Check/set up room, supplies, and equipment
11 Dress and scrub for procedure
12 Check/prepare patient readiness (Gown, drape, prep, mark)
13 Perform/Supervise Patient Positioning
14 Prepare/review/confirm procedure (including "time out" and other regulatory compliance)
15 Administer/supervise local or general anesthesia
16 Other Procedure Specific Pre-Service Time

At this meeting, the workgroup members reviewed the tasks and agreed that there may be varying levels of service for most tasks, and for others there may be fixed times that could be allotted for the task (e.g. scrub and dress). The workgroup believed the 16 tasks could still be reduced to a smaller number and perhaps then be packaged into different levels of service and time increments.

The workgroup believed that the variance in the levels of pre- service times for most tasks is dependent upon the characteristics of both patients and procedures. Further, the workgroup agreed that different types of patients and procedures could be packaged into straightforward patients and procedures and difficult patients and difficult procedures. In

addition there could be facility and non-facility procedures with anesthesia and without anesthesia. Factors that might determine into what pre-service time package a procedure would be placed could include: technical features of the work, logistics of positioning the patient, complexity of required equipment, and monitoring, and risks associated with the procedure.

These sectors could be developed with the patient type indicated by columns and the type of procedure as a row, so that:

Facility Procedure

		Patient Type	
Procedure Type		**Straightforward**	**Difficult**
	Straightforward	Package 1	Package 2
	Difficult	Package 3	Package 4

Non-Facility

No Anesthesia	**Anesthesia**
Package 5	Package 6

For the next meeting Pre-Service Workgroup members were asked to consolidate and evaluate the current 16 tasks and slot them into the different packages listed in the tables above. AMA staff will facilitate the refinement and present the findings at the next meeting. The Workgroup will review and correlate the PEAC standard times for clinical labor time with the pre-service physician time. In addition, the definitions of clinical and physician pre-service times will be clarified through the assistance of CMS representatives.

AMA/Specialty Society RVS Update Committee
Administrative Subcommittee Report
April 28, 2006

Members Present: Doctors Richard Tuck (Chair), Michael D. Bishop, James Blankenship, Mary Foto, OTR, Peter Hollmann, Barbara Levy, Lawrence Martinelli, Bernard Pfeifer, James Regan, Chester Schmidt, Jr., and Arthur Traugott.

I. Approval of Revisions to the Structure and Functions Document and Rules and Procedures Document

The Administrative Subcommittee reviewed changes to the Structure and Functions and Rules and Procedures documents, which were made by RUC members, AMA staff and AMA legal counsel. Primary changes included documenting the change of the Practice Expense Advisory Committee (PEAC) to the Practice Expense Review Committee (PERC) and adding descriptions of the subcommittees and workgroups of the RUC. **The Administrative Subcommittee approved the changes made to the Structure and Functions, and Rules and Procedures documents as amended.**

II. Composition of the RUC

The RUC Chair, Doctor William Rich, requested that the Administrative Subcommittee initiate a discussion pertaining to the RUC's composition at their April 28, 2006 meeting. This was an initial meeting and this discussion will continue at the October 5-8, 2006 meeting. The Administrative Subcommittee was charged to take a step back on this issue and "think outside the box" regarding the RUC composition. The RUC Chair indicated that the Administrative Subcommittee should consider changes in the Medicare payment system and changes in the RUC's role in the RBRVS over the past 15 years, as well as changes in determining potential modifications to the criteria for permanent seat, composition changes and changes to the rotating seats.

The current Structure and Functions document section on RUC composition was provided for review. The Administrative Subcommittee also reviewed the MedPAC discussion related to the RUC composition. The Commission "calls on CMS to request that the medical community propose changes in the composition of the RUC" pointing out concerns that physicians who furnish primary care services are not represented adequately on the RUC.

The Subcommittee members understood that MedPAC's position regarding determination and review of potentially overvalued codes significantly changed after the Commission had the opportunity to review and understand the RUC process. The Subcommittee expressed that it may also be beneficial to continue to provide the opportunity for MedPAC to observe the RUC. A suggestion was made to invite MedPAC Commissioners and/or staff to observe the October RUC meeting in DC. It was noted that MedPAC was primarily concerned that medicine was not doing an effective job at identifying potentially overvalued services.

Members of the Administrative Subcommittee discussed the following topics related to composition of the RUC:

1. The RUC is an expert panel and the intent of this self-examination is not to change this core principle.
2. Physicians on the RUC are not representing their specialty, but rather all of medicine and providing expertise to develop recommendations to improve the Medicare Physician Payment Schedule.
3. The RUC is a deliberative and not a representative body.
4. Several individuals stated that the RUC consider the issue of fairness as a key principle, making sure that all specialties are able to have their issues addressed in a fair and consistent process.
5. The RUC should consider what other expertise would be helpful to process (eg, economists, statisticians, etc).
6. A suggestion was made that staff review with legal staff whether private payors could have input through an advisory committee to the RUC.
7. When the RUC was established, it was charged with reviewing physician work relative values. The committee's scope has expanded to include a review of practice expense and professional liability insurance (PLI). The Committee should consider this expanded scope to ensure that all expertise is available to address these issues.
8. The RUC's mission continues to evolve and it is an appropriate time to review the mission due to pay-for-performance, cost effectiveness issues, etc. The Subcommittee should consider whether the RUC is equipped to handle these issues.
9. The HCPAC should be included in these discussions.
10. Several members noted that the RUC should welcome outside observation and suggestions to continue to evolve and remain credible.
11. The work of the RUC extends beyond Medicare as many private payors use the RBRVS, and this should be considered as the RUC discusses its composition.

The Administrative Subcommittee discussed what data and other information is needed for the October meeting to discuss this issue. The following information will be gathered prior to the October 2006 meeting:

1. History of the original development of the structure and composition of the RUC.
2. History of the requests for RUC composition changes.
3. Medicare charges by each society for the last ten years including:
    a. Percentage of E/M
    b. Percentage of surgery
    c. Percentage of procedures
    d. Estimation of global E/M for surgery

The following will be discussed at the October 2006 Administrative Subcommittee meeting:

1. History of the composition of the RUC, including current guidelines and development of an outline on future issues
2. Potential modifications to the criteria for permanent seats, composition changes and changes to the rotating seats
3. The issue of term limits are to be reviewed

The Administrative Subcommittee acknowledges that this review may be carried over into 2007, and it should not be anticipated that all issues will be resolved in October 2006.

III. Re-review of RUC recommendations – new technology/services

At the February 2006 RUC meeting, the RUC determined that all new technology/ services identified from September 2005 forward, would be placed in the new technology/services list and would be reviewed again at some time certain. The Administrative Subcommittee agreed to discuss a timeline and other processes related to reviewing new technology and services at the April 2006 meeting.

The Administrative Subcommittee indicated in its timeline that three years of data would be collected prior to re-review of any new technology/services.

The Administrative Subcommittee recommends the process as outlined in the attached flowchart to implement the review of new technology/services.

IV. RUC Database Product

The Administrative Subcommittee reviewed the information which will be included in the RUC database as a product for the public. Most of this information is currently available to the public via CMS Web site, AMA product, or Federal Registers. Information that is not available to the public which will be added to the RUC database is pre-service and post-service description of physician work, RUC rationale and pre-service, intra-service and post-service physician time (however total physician times are publicly available).

The Administrative Subcommittee understands that this is an update from staff concerning the release of the RUC data, following the RUC action to call for a symmetrical distribution of this information.

V. Election of Rotating Seat Rules

The election of the rotating seat rules were provided to the Administrative Subcommittee for information only since there will be an election for the Internal Medicine rotating seat on Saturday, April 29, 2006.

VI. Other Issues

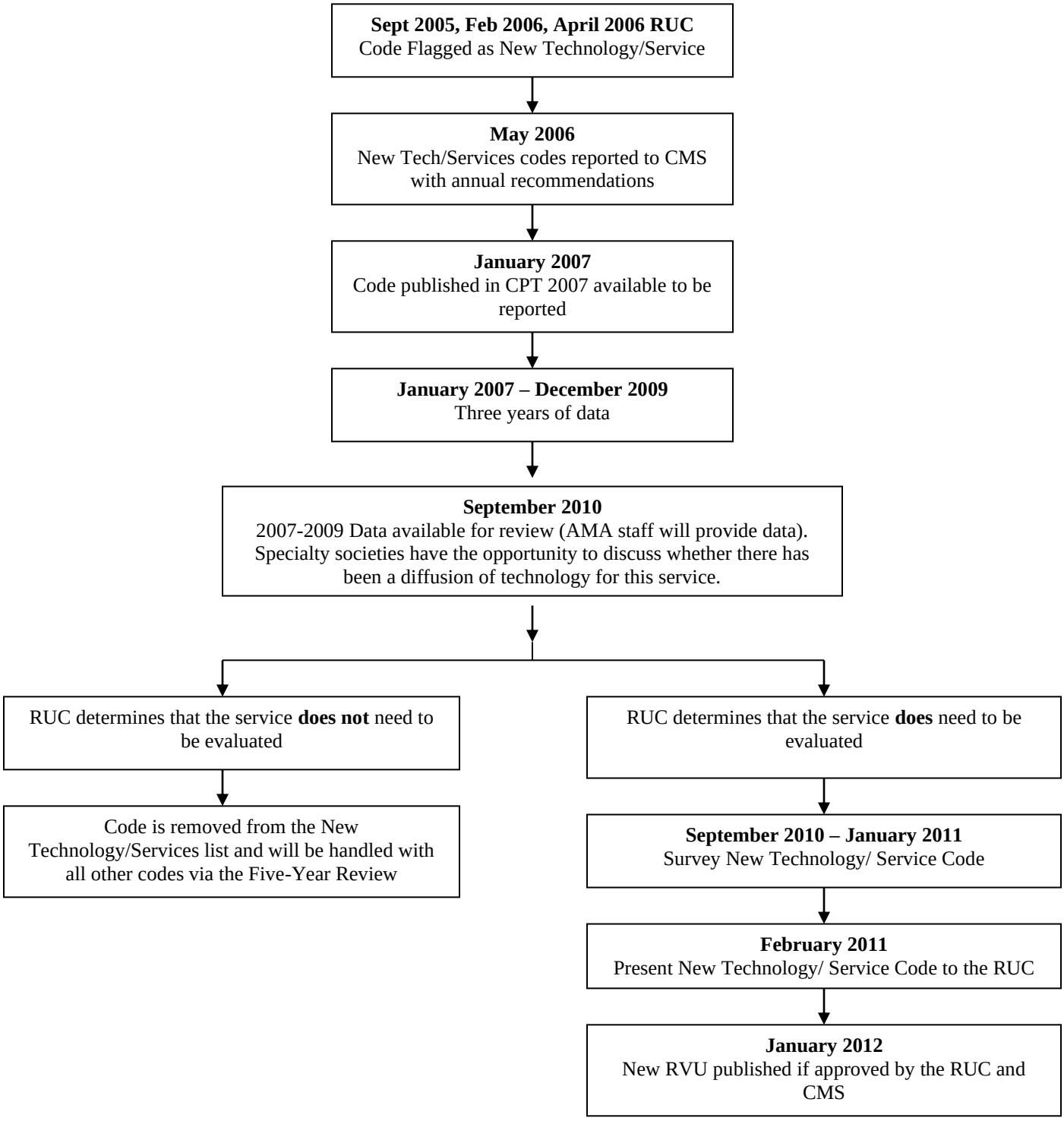
Conflict of Interest
At the February 2006 Administrative Subcommittee meeting the Subcommittee recommended that the Conflict of Interest Policy Statement include "or any family member" to ensure that those signing this statement disclose any potential conflicts of financial interest that his or her family member may have.

A RUC member suggested that the Administrative Subcommittee discuss whether each RUC member, alternate and advisor should submit a listing of all their potential conflicts of interest. **The Subcommittee recommends that AMA staff examine a more detailed disclosure statement for RUC members, RUC alternates, Advisors and presenters. The Subcommittee also recommends that AMA staff research options to implementing an on-line conflict of interest disclosure**.

New Technology/Services Timeline

1. Code is identified as a new technology/service at the RUC meeting in which it is initially reviewed.
2. Code is flagged in the next version of the RUC database with date to be reviewed
3. Code will be reviewed in 5 years (depending on what meeting in the CPT/RUC cycle it is initially reviewed) after at least three years of data are available.

Example


Sept 2005, Feb 2006, April 2006 RUC
Code Flagged as New Technology/Service
May 2006
New Tech/Services codes reported to CMS with annual recommendations
January 2007
Code published in CPT 2007 available to be reported
January 2007 – December 2009
Three years of data
September 2010
2007-2009 Data available for review (AMA staff will provide data). Specialty societies have the opportunity to discuss whether there has been a diffusion of technology for this service.
RUC determines that the service **does not** need to be evaluated
Code is removed from the New Technology/Services list and will be handled with all other codes via the Five-Year Review
RUC determines that the service **does** need to be evaluated
September 2010 – January 2011
Survey New Technology/ Service Code
February 2011
Present New Technology/ Service Code to the RUC
January 2012
New RVU published if approved by the RUC and CMS

AMA/Specialty Society RVS Update Process
Practice Expense Subcommittee
April 27, 2006

1. Update on Multi-Specialty Practice Expense Survey

CMS currently utilizes practice expense data and physician hours from the 1995-1999 AMA Socioeconomic Monitoring System (SMS) survey to calculate a "practice expense per hour" estimation for each specialty. At several meetings the RUC has recognized that these data are outdated and that there is a significant need for new survey data. On March 24, 2006, a multi-specialty sign-on letter (signed by more than 70 organizations) was sent to CMS with the following recommendation: *We are all in agreement, however, that moving forward, it is imperative that a multi-specialty practice expense survey be conducted to collect recent, reliable, consistent practice expense data for all specialties and health care professionals. We urge CMS to work with the AMA and other physician and health professions organizations to achieve this goal.*

AMA staff updated the Subcommittee on the status of the multi-specialty survey. During the week of May 9th AMA staff is scheduled to meet with CMS to discuss a potential survey. The previous SMS survey data was performed over multiple years, however there is a current need for a large sample size of data in the first year and therefore will lead to a higher cost initially. AMA staff has already received a financial commitment from one specialty and will send out a letter requesting each specialty's contribution in this survey effort.

In addition, AMA staff has received funds from management for design and pre-testing in 2006. AMA staff foresees that the survey would be fielded for at least 9 months starting in the second quarter of 2007 and continuing through the year. The data would be compiled in the first quarter of 2008 and submitted to CMS in the spring of 2008 for implementation for the 2009 fee schedule. The intent is to bring the RUC into the process through the Practice Expense Subcommittee and the Research Subcommittees.

The Subcommittee members reviewed the importance of the immediate data collection need. The Subcommittee made the following recommendation to the RUC:

The Practice Expense Subcommittee reiterates the importance of a new multi-specialty practice expense data collection process and requests that it be incorporated into CMS' practice expense calculations as soon as possible.

2. CMS Town Hall Meeting Questions

CMS developed a set of questions for the medical community on February 15, 2006 at its Town Hall Meeting. In an effort to assist CMS with these issues, the Practice Expense Subcommittee discussed each item and provided the following comments to CMS.

i. Equipment Assumptions

a) Cost of Capital Assumptions

CMS currently utilizes a interest rate of 11% in pricing medical equipment. CMS has acknowledged that this rate is too high and has requested comments regarding the appropriate interest rate.

The Subcommittee discussed and agreed that the interest rate currently was too high and that it should fluctuate according to market conditions, rather than a fixed rate. The cost of capital is a legitimate cost of a physician's office and it should be linked to prevailing rates. One RUC member questioned why CMS would pay for physicians' decisions to finance equipment. The Subcommittee made the following recommendation to the RUC:

The Practice Expense Subcommittee recommends that CMS adjust the 11% cost of capital rate to a market competitive rate.

b) Equipment Utilization Data

CMS asked how it should reflect the utilization rate, particularly for high cost equipment? Currently, they use a 50% utilization rate for all equipment. The Subcommittee discussed whether there should be a different rate for all equipment or just for the equipment set by a specific cost thresholds. Subcommittee members indicated that the cost of capital may not have a direct linear relationship with equipment utilization Some Subcommittee members discussed whether consideration should be given to impacts on rural payment, as utilization rates may not be as high as urban areas.

CMS representatives reminded the group that ABT Associates originally recommended the utilization rate to be 70% and after reviewing comments from specialty societies, CMS lowered the utilization rate to 50%. MedPAC has conducted a study of the utilization rates of MRI and CT that will be published in their June report, and their results so far indicate mean utilization rates of approximately 75% for CT and 90% for MRI. Representatives from radiology indicated that the MedPAC study may be flawed due to the nature of their survey. After much discussion, the Subcommittee made the following recommendation to the RUC: Some Subcommittee members suggested that the CMS set a higher utilization rate for all equipment and provide specialties with an opportunity to present data if certain equipment items should have a lower utilization rate.

The Practice Expense Subcommittee believes that the 50% utilization rate is too low and CMS should consider using a higher rate for all equipment, providing an opportunity to specialty societies to provide data to support lower utilization rates, if appropriate, based on clinical or geographical considerations

ii. Allocations of Indirect Practice Expense Inputs

The allocation of indirect expense is inherently an arbitrary decision based upon judgments regarding how overhead costs (rent, administrative staff, office supplies and equipment) may be attributed to specific services. CMS requested specific comments on a number of these "judgments". CMS staff stated that of the four options and impacts that were presented at its Town Hall meeting, none would be implemented as shown. There was no consensus amongst the Subcommittee regarding the use of direct expense

inputs, physician work, or physician time as an allocation method of indirect costs. The Subcommittee did agree however that indirect costs have increased significantly throughout the medical profession, as demonstrated by the recent supplemental surveys. The Subcommittee again stressed the need for a new multi-specialty practice expense data collection and reaffirmed its recommendation for CMS to work with the AMA, specialty societies, and health care professional organizations to initiate this survey process.

3. Treatment of Administrative Costs: Direct verse Indirect Expense

The American Osteopathic Association (AOA) has developed an idea to simplify the indirect expense portion of CMS's practice expense methodology. The specialty presented the idea of extracting the clerical administrative staff cost from the total indirect costs and instead include this cost as direct practice expenses. Clerical administrative staff is the largest cost component of the indirect portion of the total practice expense inputs. The Subcommittee discussed the proposal and understood its benefit in theory. However, as the Subcommittee understands that the only way to incorporate this cost in direct expense would be at the code level, which would be quite difficult to manage. In addition, it may be impossible to distinguish between all the tasks the administrative staff does and allocate them to the procedural CPT code level. CMS representatives believed that the PEAC did great job at the clinical labor, but agreed that it would be a difficult task to gather the information. The Subcommittee members agreed that the AOA suggestion had merit, however actual application of this method is not currently realistic. If there was a way to efficiently capture this data in the future, the issue should be revisited.

4. Work Proxies

The American Speech-Language-Hearing Association (ASHA) and the American Dietetic Association (ADA) have sent letters to CMS urging them to have their services recognized under the professional component of the resource-based relative value scale. Currently, these non-physician practitioners receive their reimbursement for Medicare services through the practice expense component only.

CMS has proposed to eliminate the NPWP which may have a significant unfavorable impact upon some NPWP specialties (up to 70%). ASHA and ADA representatives presented their concept of assigning "proxy" work values as an interim solution for the allocation of indirect costs for services without a work value. ASHA and ADA believe a work proxy could be established through the use of existing clinical labor time and creation of an intra-service work per unit of time (IWPUT), for some codes. Indirect costs could then be allocated on the sum of direct costs and the proxy work value.

ASHA and ADA believe that the assignment of professional work values for their services is equitable and consistent with the approaches taken with other similar non-physician professional services including physical therapy (PT), occupational therapy (OT) and psychological testing services.

The Subcommittee recognized that these groups may be unfavorably impacted by the elimination of the NPWP. The Subcommittee understands that CMS is considering the development of proxy work relative values in order to lesson this impact. The Subcommittee recommends the following recommendation to the RUC:

CMS should examine alternatives to prevent these large decreases in practice expense payments to those health care professionals whose services are currently included in the non-physician work pool. If CMS employs "work proxies" to resolve this issue, the RUC emphasizes that the proxy is for mathematical purposes of recalculating practice expense only.

April 2006 RUC Physician Time File

CPT Code	Pre Evaluation Time	Pre Positioning Time	Pre Service Scrub Dress Wait Time	Median Intra Service Time	Immediate Post Service Time	99291	99292	99231	99232	99233	99238	99211	99212	99213	99214	99215	99296	Unadjusted Total Time
00625	30			240	30													300
00626	40			300	30													370
15002	45	15	15	20	20													115
15003				15	1													16
15004	45	15	15	45	30													150
15005				20	1													21
15731	50	10	15	120	30						0.5		1	3	1			365
15830	50	15	15	120	30			1	1		1		2	3				414
17311	8	6	6	110	8													138
17312		8		65														73
17313	8	6	6	100	8													128
17314		8		60														68
17315				30														30
19105	30	5	10	45	15													105
19361	35	20	15	240	30			2	1		1		3	2				535
22526	30	15	15	45	15						1		1					153
22527				45														45
25109	25	10	15	40	20						1		1	2				189
32998	15	15	15	60	30													135
33202	55	15	15	65	30			1	1		1			1				329
33203	55	15	15	90	30			1	1		1			1				313
33254	60	15	20	120	40			1	1		1			1	1			442
33255	60	15	20	180	40			1	2		1			1	1			532
33256	60	15	20	200	40	1		1	3		1			1	1			604
33265	60	15	20	150	40			1	1		1			1	1			472
33266	60	15	20	200	40			1	2		1			1	1			552
33675	70	15	15	180	60	1		3	2		1				1			594
33676	70	15	15	210	60	1		3	2		1				1			624
33677	70	15	15	240	60	1		3	2		1				1			654
33724	60	15	20	183	53	1		2	1		1				1			536
33726	60	15	20	240	60	1		3	1		1				1			660
35302	40	15	20	150	30			1	1		1		1	1				419
35303	40	15	20	150	30			1	1		1		1	1				419
35304	40	15	20	180	30			1	1		1		1	1				449
35305	40	15	20	160	30			1	1		1		1	1				429

April 2006 RUC Physician Time File

CPT Code	Pre Evaluation Time	Pre Positioning Time	Pre Service Scrub Dress Wait Time	Median Intra Service Time	Immediate Post Service Time	99291	99292	99231	99232	99233	99238	99211	99212	99213	99214	99215	99296	Unadjusted Total Time
35306				90														90
35501	40	15	20	200	30			1	1		1			2				477
35509	40	15	20	190	30			1	1		1			2				467
35537	50	15	20	288	40	1		1	2		1		1	2				734
35538	50	15	20	360	43	1		1	2		1		1	2	1			847
35539	60	20	20	300	30	1		2	2		1		1	2				770
35540	60	20	20	360	30	1		2	2		1		1	2				830
35601	40	15	20	180	30			1	1		1			2				457
35637	40	15	20	210	30	1		2	2		1		1	2				614
35638	40	15	20	240	30	1		2	2		1		1	2				644
35883	50	15	20	170	30			1	2		1		1	1				438
35884	50	15	20	190	30			1	2		1		1	1				458
37210	25	10	10	90	25													160
49324	20	10	10	60	20						1			1				161
49325	20	10	10	60	20						1			1				161
49326				45														45
49435				30														30
49436	15	5	10	15	13						1		1					91
54150	15	5	5	15	5													45
58548	60	10	5	240	45			2	1		1			2	1			548
58957	65	10	15	180	45			2	2		1		1	1	1			566
58958	65	10	15	210	45			2	2		1		1	1	1			596
64910	25	10	15	90	20						1		1	1				216
64911	25	10	15	120	20						1		1	3				292
77435	20			230	20													270
78730				5														5
91111	5			15	15													35
94002	15			30	15													17
94003	10			20	10													40
94004	10			15	10													35
94005	15			25	15													55
94610				20														20
99363				50														50
99364				20														20

AMA
AMERICAN
MEDICAL
ASSOCIATION

May 25, 2006

Terry Kay
Deputy Director
Hospital and Ambulatory Policy Group
Center for Medicare and Medicaid Services, C4-01-26
7500 Security Blvd.
Baltimore, MD 21244

Dear Mr. Kay:

It is with pleasure that I submit to the Centers for Medicare and Medicaid Services (CMS), on behalf of the American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC), work relative value and direct practice expense inputs for new and revised codes for CPT 2007. Also included in this submission are the practice expense refinement recommendations for existing CPT 2006 codes and RUC recommendations on the practice expense methodology developed by CMS. The RUC Health Care Professionals Advisory Committee (HCPAC) Review Board is separately forwarding its recommendations to CMS.

CPT 2007 New and Revised Codes

Enclosed are two binders of RUC recommendations for new and revised codes. The total number of coding changes for CPT 2007 is 350, including 171 additions, 84 revisions, and 95 deletions. Twenty-four of these new and revised codes are not payable on the RBRVS (eg, laboratory services and vaccines), and accordingly, the RUC does not submit any information on these codes. In addition, one of the new codes was reviewed by the RUC HCPAC Review Board as it describes services provided by non-MD/DO health professionals. Of the remaining 230 new and revised codes, the RUC submits 230 recommendations at this time.

The RUC is recommending that nine codes be carrier-priced in 2007. The summary table in the attached binder and in the enclosed CD, specifically identifies CPT code 37210 *Uterine fibroid embolization (UFE, embolization of the uterine arteries to treat uterine fibroids, leiomyomata), percutaneous approach inclusive of vascular access, vessel selection, embolization, and all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the procedure* to be re-reviewed at the September 2006 RUC meeting. We will send any new information related to this service to CMS immediately following the meeting. Furthermore, 58 new/revised codes were identified through the Five Year Review Process. For these codes, the RUC during its Five-Year review Process discovered an issue with existing coding language and referred these

codes to the CPT Editorial Panel for review. The Panel deleted, revised and created new codes to address the concerns of the RUC and these coding changes emerged in the new and revised process for CPT 2007.

Also included in these binders and on the enclosed CD, are physician time data for each of the CPT codes reviewed at the September 2005, February 2006, and April 2006 RUC meetings. The RUC continues to review the physician time data to ensure that the most accurate data is utilized in the CMS practice expense methodology. The CD also includes a table summarizing the current physician time for all CPT codes.

Practice Expense Refinements

Also enclosed in this submission are two additional binders which detail the practice expense refinement recommendations to existing codes resulting from the efforts of the RUC's Practice Expense Review Committee (PERC) over the past year. This information is also included on the aforementioned CD. The RUC is submitting recommendations on the direct practice expense inputs for 2,783 existing CPT codes. We understand that the practice expense direct inputs for all existing CPT codes is complete. If CMS identifies any services that have not been refined, please contact AMA staff so that we may schedule those codes for review at an upcoming RUC meeting.

Cost estimates for medical supplies and equipment not listed on "CMS's Labor, Supply, and Equipment List for the Year 2006" are based on provided source(s) as noted, such as manufacturer's catalogue prices and may not reflect the wholesale prices, quantity or cash discounts, prices for used equipment or any other factors which may alter the cost estimates.

Practice Expense Methodology Recommendations

CMS currently utilizes practice expense data and physician hours from the 1995-1999 AMA Socioeconomic Monitoring System (SMS) survey to calculate a "practice expense per hour" estimation for each specialty. At several meetings the RUC has recognized that these data are outdated and that there is a significant need for new survey data. On March 24, 2006, a multi-specialty sign-on letter (signed by more than 70 organizations) was sent to CMS with the following recommendation: *We are all in agreement, however, that moving forward, it is imperative that a multi-specialty practice expense survey be conducted to collect recent, reliable, consistent practice expense data for all specialties and health care professionals. We urge CMS to work with the AMA and other physician and health professions organizations to achieve this goal.* **The RUC would like to take this opportunity to reiterate the importance of a new multi-specialty practice expense data collection process and request that it be incorporated into CMS' practice expense calculations as soon as possible.**

CMS developed a set of questions for the medical community on February 15, 2006 at its Town Hall Meeting. In an effort to assist CMS with these issues, the RUC discussed each item and provides the following comments to CMS.

Equipment Assumptions - Cost of Capital Assumptions
CMS currently utilizes an interest rate of 11% in pricing medical equipment. CMS has acknowledged that this rate is too high and has requested comments regarding the appropriate interest rate. The RUC discussed and agreed that the interest rate currently was too high and that it should fluctuate according to market conditions, rather than a fixed rate. The cost of capital is a legitimate cost of a physician's office and should be linked to prevailing rates. **The RUC makes the following recommendation: CMS should adjust the 11% cost of capital rate to a market competitive rate.**

Equipment Assumptions - Equipment Utilization Data
CMS requested information on how it should reflect the utilization rate, particularly for high cost equipment. Currently, CMS uses a 50% utilization rate for all equipment. The RUC discussed whether there should be a different rate for all equipment or just for the equipment set by specific cost thresholds. The RUC indicated that the cost of capital may not have a direct linear relationship with equipment utilization. Further, the RUC discussed whether consideration should be given to impacts on rural payment, as utilization rates may not be as high as urban areas. **As a result of this discussion the RUC makes the following recommendation: The existing CMS standard of 50% utilization rate for all equipment is not an accurate measure. CMS should consider using a higher rate for all equipment, providing an opportunity to specialty societies to provide data to support lower utilization rates, if appropriate, based on clinical or geographic considerations.**

Allocations of Indirect Practice Expense Inputs
The allocation of indirect expense is inherently an arbitrary decision based upon judgments regarding how overhead costs (rent, administrative staff, office supplies and equipment) may be attributed to specific services. CMS requested specific comments on a number of these "judgments". The RUC agrees that indirect costs have increased significantly throughout the medical profession, as demonstrated by the recent supplemental surveys. **The RUC again stresses the need for a new multi-specialty practice expense data collection and reaffirmed its recommendation for CMS to work with the AMA, specialty societies, and health care professional organizations to initiate this survey process.**

Work Proxies
The American Speech-Language-Hearing Association (ASHA) and the American Dietetic Association (ADA) have sent letters to CMS urging that their services be recognized under the professional component of the resource-based relative value scale. Currently, these non-physician practitioners receive their reimbursement for Medicare services through the practice expense component only.

CMS has proposed to eliminate the NPWP which may have a significant unfavorable impact upon some NPWP specialties (up to 70%). ASHA and ADA representatives presented their concept of assigning "proxy" work values as an interim solution for the allocation of indirect costs for services without a work value. ASHA and ADA suggested that a work proxy be established through the use of existing clinical labor time and creation of an intra-service

work per unit of time (IWPUT), for some codes. Indirect costs could then be allocated on the sum of direct costs and the proxy work value.

The RUC recognized that these groups may be unfavorably impacted by the elimination of the NPWP. The RUC understands that CMS is considering the development of proxy work relative values in order to lesson this impact. **The RUC recommends that CMS should examine alternatives to prevent these large decreases in practice expense payments to those health care professionals whose services are currently included in the non-physician work pool. If CMS employs "work proxies" to resolve this issue, the RUC emphasizes that the proxy is for mathematical purposes of recalculating practice expense only.**

Five Year Review Subcommittee & New Technology/Services Identification/Review Process

Based on previous MedPAC discussions and recommendations to Congress, CMS-led initiatives to identify misvalued services, and its own mission to ensure correct valuation of all codes, the RUC concurred that there should be a process to identify potentially misvalued codes. The RUC approved the establishment of a new subcommittee to identify such codes. This committee will initially convene in October 2006. In addition, the RUC has begun to identify services incorporating new technology, which are likely to change in value, for subsequent review in order to minimize future misvaluation. The RUC is also developing other objective measures to identify misvalued services.

At its April 2006 meeting, the RUC adopted a process to identify and review codes that represent new technology or services that have the potential to change in value. First, a code is identified as a new technology/service at the RUC meeting in which it is initially reviewed. Secondly, the code is flagged in the next version of the RUC database with the date it is to be re-reviewed. Lastly, the code will be reviewed according to this schedule (depending on what meeting in the CPT/RUC cycle it is initially reviewed) after at least three years of data are available. A flow chart providing a detailed description of this process is below. The RUC has already identified 29 of these procedures through its new and revised process. A table of these codes identified as being new technology/services has been attached.

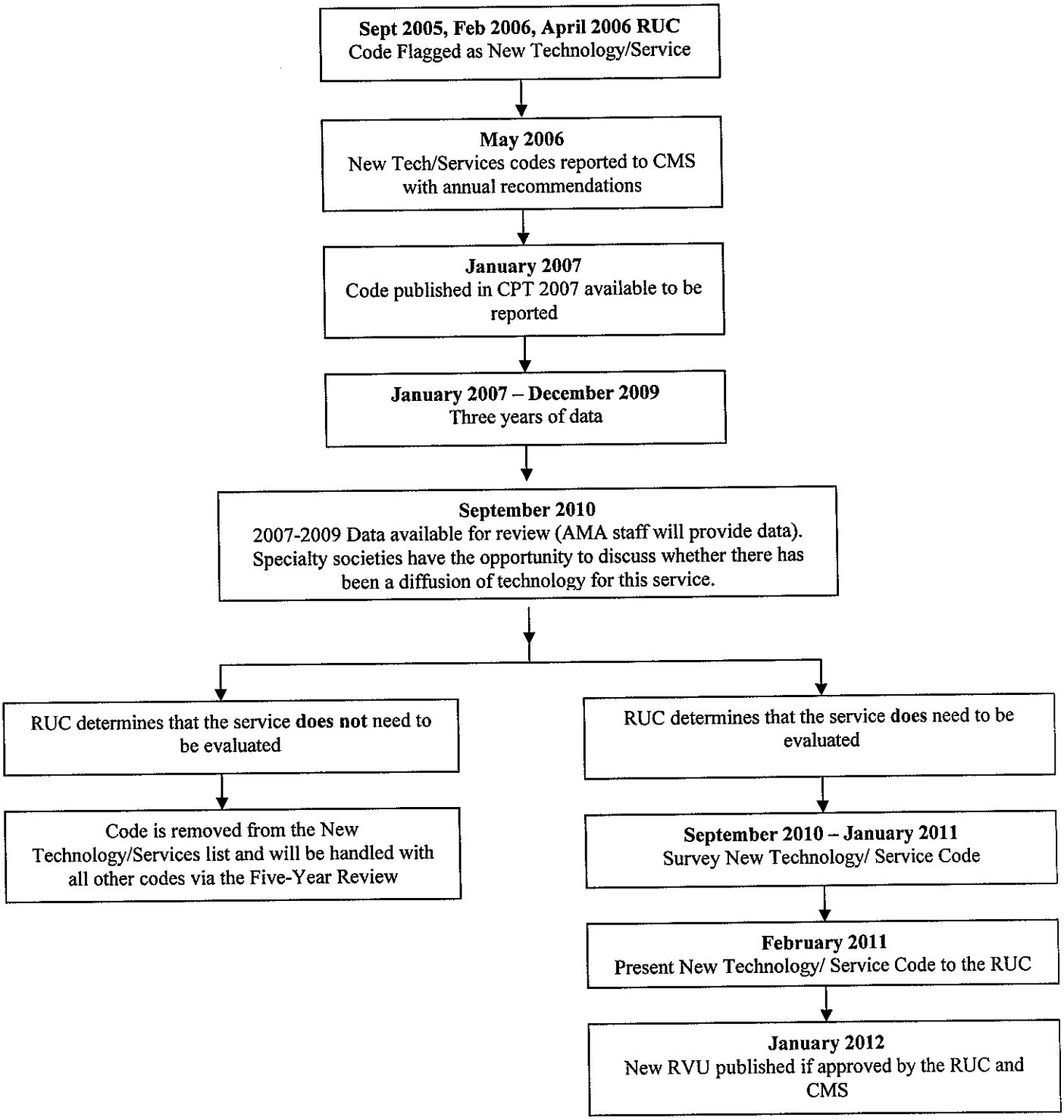
We appreciate your consideration of the RUC's recommendations. You may contact Sherry Smith with any questions regarding this submission.

Sincerely,

William Rich, MD

cc:
Ken Simon, MD
Rick Ensor
Edith L Hambrick MD
Carolyn Mullen
Pam West, DPT
RUC Participants

Chart: Flow Chart of RUC Process to Identify/Review New Technology/Services



AMA
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August 17, 2006

Mark McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard., C4-26-05
Baltimore, MD 21244-1850

Subject: CMS-1512-PN Medicare Program; Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule; Proposed Notice

Dear Doctor McClellan:

The American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) Proposed Notice on the Five-Year Review of the Work Relative Value Units (RVUs) under the Physician Payment Schedule, published in the June 29, 2006 Federal Register.

In October 2005, the RUC submitted recommendations on work relative values for 723 CPT codes culminating in the results of the third Five Year Review of the RBRVS. This submission was the result of significant effort and experience of the volunteer physicians who participate in the RUC Process. Of these 723 CPT codes, CMS published recommendations for 715 CPT codes, while the remaining 8 CPT codes were inadvertently not included in Table 1: Five-Year Review of Work Relative Value Units (p.24). The eight codes have been identified and are listed in a table in Appendix 1, which is appended to this letter. Of the 723 codes in this review, the RUC recommended:

- Increases in work RVUs for 266 CPT codes
- Decreases in work RVUs for 30 CPT codes
- Maintained the work RVUs for 288 CPT codes
- Referred to the CPT Editorial Panel 139 CPT codes

CMS has proposed to:

- Increase the work RVUs for 225 CPT codes
- Decrease the work RVUs for 29 CPT codes
- Maintained the work RVUs for 330 CPT codes
- Referred to the CPT Editorial Panel 139 CPT codes

We appreciate the participation and diligent review conducted by CMS staff during the course of the past two years. However, we are disappointed that you did not accept the

RUC recommendations for certain services. In this letter, the RUC will respond to issues where CMS has asked for specific comments or recommendations. We urge you to accept all of the RUC recommendations.

Discussion of Comments by Clinical Area

1. Dermatology and Plastic Surgery (p. 37189)

CMS accepted all but one of the RUC recommendations for the dermatology and plastic surgery codes:

- 17004 *Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), all benign or premalignant lesions (eg, actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions, 15 or more lesions* – CMS proposes to reduce the work RVU for this code from the RUC recommended 1.80 to 1.58 RVUs.

Comments:

The RUC reviewed CPT code 17004 as part of its identification of rank order anomaly process. The RUC identified this procedure as being overvalued after reviewing 17003 *Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), all benign or premalignant lesions (eg, actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions; second through 14 lesions, each (List separately in addition to code for first lesion).* CMS states, "For CPT code 17004, we believe that the work associated with benign and premalignant lesions is comparable and therefore, should be more similar to CPT code 17111 *Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of flat warts, molluscum contagiosum, or milia; 15 or more lesions* (Work RVU=0.92)." In the RUC's review of this procedure, it was evident that that work associated with benign and pre-malignant lesions was not comparable. This notion was reflected in the RUC action of recommending that the CPT Editorial Panel modify the descriptors for these procedures to reflect that all procedures performed on pre-malignant lesions would be addressed in the 17000 family of codes while all procedures performed on benign lesions (other than skin tags or cutaneous vascular lesions) would be addressed in the 17110 family of codes. Furthermore, the RUC noted that the surveyed code 17004 requires greater mental effort and judgment, technical skill, intensity and time in comparison to the reference code 17111).

The RUC reaffirms its recommendation in a decrease in work from 2.79 work RVUs to 1.80 work RVUs for 17004 which appropriately values the surveyed code in relation to the 17111.

2. Orthopedic Surgery (p. 37195)

CMS accepted all but three of the RUC recommendations for the orthopedic surgery codes:

- 27130 *Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft* – CMS proposes to reduce the RUC recommended work RVU of 20.09 to 15.96 RVUs.

- 27236 *Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement* – CMS proposes to reduce the RUC recommended work RVU of 15.58 to 12.77 RVUs.

- 27447 *Arthroplasty, knee, condyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty)* – CMS proposes to reduce the RUC recommended work RVU of 21.45 to 19.30 RVUs.

Comments:

In the Proposed Rule CMS states, "The specialty society did not submit surveys for these codes which is the accepted RUC method, for the RUC's consideration of changes to current work RVUs. Instead the specialty society developed proposed values for these services based on data obtained from the VA National Surgical Quality Improvement Program (NSQIP) database and the Medicare Diagnostic Related Group (DRG) database."

The RUC acknowledges that the specialty society did not present their survey data as originally requested in August 2005. However, the specialty did bring this data to be reviewed at the September 2005 RUC meeting at the RUC's request. It is important to clarify that the specialty society ultimately presented recommendations primarily based on survey data. The intra-service time recommendations were supplemented by NSQIP and DRG data. In addition the specialties then compared the codes with other RUC reviewed codes (i.e. the reference codes) to show that the recommended values and times placed the codes in proper rank order.

The RUC recommended values for these three codes is further supported when compared to other procedures within the associated family:

- CPT code 27130 has similar total service time as CPT code 27147 *Osteotomy, iliac, acetabular or innominate bone; with open reduction of hip* (Work RVU=20.55), 462 minutes and 447 minutes respectively.
- CPT code 27236 has significantly more total time as CPT code 27036 *Capsulectomy or capsulotomy, hip, with or without excision of heterotopic bone,*

with release of hip flexor muscles (i.e., gluteus medius, gluteus minimus, tensor fascia latae, rectus femoris, sartorius, iliopsoas) (Work RVU=12.86), 447 minutes and 376 minutes respectively.

- CPT code 27447 has the same total service times as CPT code 24363 *Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)* (CMS Proposed Work RVU=21.07) 451 minutes.

Consequently, by CMS proposing to decrease the work RVUs associated with these codes, it will create substantial rank order anomalies with the families. In addition, for CPT codes 27130 and 27236, the surveys documented that only half of the survey respondents felt that the work of performing this service has changed since the original Harvard studies due to an increase in the complexity of the patient population.

The RUC reaffirms its recommendations of maintaining the work RVUs for these procedures at 20.09 work RVUs for 27130, 15.58 work RVUs for 27236 and 21.45 work RVUs for 27447.

3. **Gynecology, Urology, Pain Medicine and Neurosurgery** (p. 37200)

CMS accepted all but three of the RUC recommendations for the gynecology, urology, pain medicine and neurosurgery codes:

- 51798 *Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, nonimaging* – CMS proposes to maintain the current work RVU of this code of 0.00 work RVUs, rather than accept the RUC recommendation of 0.38 work RVUs.

- 22612 *Arthrodesis, posterior or posterolateral technique, single level; lumbar (with or without lateral transverse technique)* – CMS proposes to maintain the current work RVU for this code, rather than accept the RUC recommendation of 22.00 work RVUs.

- 63048 *Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), (eg, spinal or lateral recess stenosis)), single vertebral segment; each additional segment, cervical, thoracic, or lumbar*) – CMS proposes to maintain the current work RVU for this code rather than accept the RUC recommendation of 3.55 work RVUs.

Comments:
The RUC wishes to comment on two of these procedures 22612 and 63048.

22612:
The RUC recommended a value of 22.00 for 22612, the survey's 25th percentile value. The survey process yielded well over 200 responses. As part of the rationale for rejecting this value, CMS states that the RUC's recommendation was based largely on a typographical error that listed the primary reference code, 22595 *Arthrodesis, posterior technique, atlas-axis (C1-C2)*, as having a work value of 23.36 instead of the correct value of 19.36 work RVUs. We acknowledge that this typographical error was made on the RUC Summary of Recommendation form, but we do not agree that this impacted the RUC discussion and recommendation. The RUC based its recommendation instead on the validity of the survey data and the building block methodology that was presented in the additional rationale section of the Summary of Recommendation form. The additional rationale explained the results from the survey in detail because the survey methodology was a variation of the standard RUC survey instrument. The RUC understands that the survey respondents compared the current work involved in a spinal fusion to the work involved in a spinal fusion five years ago. Therefore, the typographical error did not affect the way the survey respondents determined the correct value for 22612. The RUC believes then that 22.00 was an appropriate value for 22612 and that it maintained appropriate rank order with not only 22595 but other equally comparable codes from the family of fusion codes. **The RUC recommends that CMS change the value for 22612 from the proposed 20.97 RVUs (current value) to the RUC recommended value of 22.00 RVUs.**

63048:
In changing the recommended value for 63048 from 3.55 to 3.26, the RUC also believes that CMS misinterpreted the survey and presentation process. Again, we appreciate the opportunity to clarify this process for CMS. CMS indicates that no information is given that compares the respondents' estimates of complexity and intensity between CPT code 63048 and the reference code because the summary of recommendation form did not list a reference code. However, this was done because the survey respondents compared the complexity and intensity currently involved in the work of 63048 with the complexity and intensity involved in the work of 63048 five years ago. Just as was done in the summary of recommendation forms for the other six spine surgery codes (22520, 22554, 22612, 22840, 63047 and 63075), this process was outlined in the additional rationale section of the form and also clarified that a value of 3.55 was very near the 25th percentile value from our survey results. Therefore, the RUC agreed that a value of 3.55 as a measurement of the current level of complexity and intensity is an appropriate comparison to the complexity and intensity of performing the work involved in 63048 five or more years ago. **The RUC recommends that CMS change the value of 63048 from the proposed 3.26 work RVUs (current value) to the RUC recommended value of 3.55 work RVUs.**

4. Radiology, Pathology and other Miscellaneous Services (p. 37204)

CMS accepted all but one of the RUC recommendations for the radiology, pathology and other miscellaneous services codes:

- 95872 *Needle electromyography using single fiber electrode, with quantitative measurement of jitter, blocking and/or fiber density, any/all sites of each muscle studied* – CMS proposes to increase the current work RVU for this code to 2.00 work RVUs but not to the level recommended by the RUC at 3.00 work RVUs

Comments:

CMS rejected the RUC recommendation because it was the survey 75 percentile, rather than the survey median. CMS explained that compelling rationale is required to accept the survey 75 percentile. We articulate this rationale in this comment letter. The RUC believes that the proposed work for 95872 of 2.00 RVUs inadequately represents the physician work required to perform the procedure. Single-fiber EMG is one of the most physically demanding and technically difficult studies that electrodiagnostic physicians perform. The study is extremely time-consuming because it not only requires that the physician hold the single fiber needle electrode perfectly still for a minute or more at a time, but also requires the patient to remain very still and continuously activate a single muscle at a very low level of activation. This activation can be difficult for many patients to maintain consistently, making the procedure time, consuming and laborious. If the patient stops activating the muscle while the physician is collecting a sample from a pair of muscle fibers, the entire collection process must be started over for that pair. Many times a patient will move requiring the physician to re-study the same muscle fibers. After collecting each sample from a pair of muscle fibers, the physician has to redirect the needle and search for a new pair of fibers to capture, which in itself can take several minutes at a time. This same process is repeated until the physician has successfully collected at least 20 pairs of technically reliable recordings. Between 1000 and 2000 waveforms must be individually analyzed for one unit of single-fiber EMG. This often takes more time than the actual collection procedure by the physician.

The specialty society survey demonstrated that the procedure takes approximately 95 minutes with large amounts of technical skill and effort. Since this procedure is the most complex that electrodiagnostic physicians perform, a good comparison code in the family does not exist; this procedure is several fold more difficult, stressful and time consuming than any other procedure done in electrodiagnostic medicine. However, looking at other neurology procedures, 95978 *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode*

selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; first hour (Work RVU=3.50) could be reasonably compared to 95872 as they have similar physician time and intensity.

The RUC believes that this justification to increase the RVU of 95872 to 3.00 RVUs is reasonable and outweighs CMS' proposed valuation of 2.00 RVUs which is solely based on IWPUT. The RUC urges CMS to accept the original RUC recommendation of 3.00 work RVUs for 95872.

Additional Comments:

The RUC reviewed the specialty's survey results and rationale for 93325 *Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)*, and understands that code 93307 *Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete* (work RVU = 0.92) is typically billed with 93325. The RUC could not recommend a change in the value of the code without CPT review of the code. The RUC recommends that code 93325 be referred to the CPT Editorial Panel for consideration for inclusion of the work of 93325 in the work of 93307.

The CPT Editorial Panel has not received a Coding Change Proposal for this code. Instead, the American College of Cardiology has sent Doctor Tracy Gordy, the Chair of the CPT Editorial Panel, a letter stating their reasons for not completing a proposal. This letter has been attached for your information

5. Evaluation and Management Services (p. 37209)

CMS accepted all of the RUC recommendations for the Evaluation and Management (E/M) services codes.

Comments:

The RUC would like to take this opportunity to thank CMS for agreeing with the RUC's recommended work RVUs for the Evaluation and Management Services. As you are aware, the RUC and its participants put a great deal of time and effort into developing recommendations that were equitable across all specialties. This arduous task could not have been accomplished without great support of the RUC members, specialty society staff and the input from CMS representatives. We appreciate CMS' validation of these efforts and strongly encourage CMS to finalize these recommendations in its Final Rule.

As part of the recommendation, the RUC recommended that the full increase of the E/M be incorporated into the surgical global periods for each CPT code with a global of 010

and 090. The RUC agrees that the Evaluation and Management work is equivalent and a crosswalk of 100% of the E/M valuation should be bundled into the codes with global periods of 010 and 090 days, with appropriate documentation. It appears from the Proposed Rule that CMS has incorrectly implemented this recommendation. CMS, when calculating the increment to be added to all of the services with post-operative visits in the 010 and 090 global periods, used the non-discounted work RVUs instead of the discounted work RVUs. **The RUC requests that CMS review their calculations and implement the correct work RVUs for all procedures that have a 010 and 090 global period to reflect the RUC recommendation. We understand that your staff has worked with RUC staff to make these corrections.**

6. Cardiothoracic Surgery (p. 37218)

CMS accepted all of the RUC recommendations related to nine congenital cardiac surgery codes. The RUC submitted recommendations related to 72 adult cardiac and general thoracic surgery codes. CMS has proposed to either maintain the current work relative value or adjust the RUC recommendations for all 72 of the adult codes.

The CMS rationale to reject the RUC recommendation is primarily based on the agency's concern that the RUC process was circumvented, stating that "We would not want to see the RUC abandon its survey methodology, unless a better approach can be found than can be applied to all services." We appreciate the expression of confidence in the ongoing RUC process, but urge CMS to consider that a trusted process may sometimes use alternative methods to get to the correct result. The RUC understands that the foundation of the RBRVS is based on magnitude estimation and we have not distorted relativity in our recommendations for these services. CMS' decision to modify the RUC's recommendations is flawed for several reasons. We urge that you reconsider this decision and instead implement the RUC recommendations for all of the cardiothoracic surgery codes.

We understand that this issue has been complex and the process utilized may not have been perfectly articulated. Therefore, we offer the following clarifications regarding the RUC review and other compelling rationale to accept the RUC recommendations as submitted in October 2005:

- CMS has expressed concern that certain families of codes have been reviewed in previous Five-Year Review processes. While it is true that these codes were reviewed in the 2000 Five-Year Review, the specialty argued that the previous review created rank order anomalies in the general thoracic codes and presented data to demonstrate that the patient population for the adult cardiac codes is now more complex. We ask that you consider the RUC recommendations submitted for these services independent of previous less reliable review processes for

cardiothoracic surgery. We acknowledge the CMS concern that the RBRVS is now 15 years old and understand that future Five-Year Reviews may focus on codes in which there has been a change in service and/or have been identified for review by some objective measure that the RUC and CMS agree to in advance.

- The RUC's acceptance of the methodology to review this large number of cardiothoracic surgery does not set new precedent for review of new/revised codes and does not threaten the current survey/magnitude estimation methodology. In each of the previous Five-Year Review processes, the RUC has allowed alternative methodologies to be utilized to review a large number of codes. In 2000, the RUC proposed, and CMS accepted, relative value improvements for vascular surgery based in part on an intensity survey similar to the one utilized by cardiothoracic surgery. The RUC approved the use of this methodology by a 2/3 majority vote for the specific purpose of reviewing established cardiothoracic surgery codes in this Five-Year Review only. If CMS has concerns regarding certain approaches utilized (eg, the RASCH analysis), the RUC will seriously consider those concerns prior to any future application of the method.

- The intensity measures, or IWPUT, proposed by the Society of Thoracic Surgeons and approved by the RUC were developed based on a credible process. A survey process was conducted, utilizing two approaches. There were a total of 533 survey respondents, 168 completed the Intensity survey and 365 completed the RASCH paired comparison analysis. The surveys included established reference IWPUT's that satisfied established RUC criteria for use in standard RUC surveys, and were submitted to RUC staff for review prior to execution. An Expert Panel of 32 cardiac and general thoracic surgeons, with an appropriate geographic and practice mix, reviewed these survey results. This meeting was convened with two proctors from the RUC process: William Moran, MD, RUC Member and Chairman of the Practice Expense Review Committee (PERC) and Patrick Gallagher, former Director of Physician Payment Policy and Systems at the American Medical Association.

- The IWPUT measures (0.0730 – 0.1210) proposed by STS were well within the range of IWPUT utilized for other major surgical procedures. The RUC did examine the IWPUT assigned to each code and did not make any changes because modifications would result in rank order anomalies.

- The CMS method to value these codes (i.e., accepting all of the RUC recommendations for time and changing the IWPUT) has led to a number of rank order anomalies, including:

- 43113 *Total or near total esophagectomy, with thoracotomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)* (CMS proposed work RVU = 40.41) is valued lower than 43112 *Total or near total esophagectomy, with thoracotomy; with pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty* (CMS proposed work RVU = 43.43) even though 43113 requires two additional hours of surgery and the transplant of the interposed colon.

- CPT code 33536 *Coronary artery bypass, using arterial graft(s); four or more coronary arterial grafts* (CMS proposed work RVU = 38.04) is proposed to be valued lower than 33535 *Coronary artery bypass graft, using arterial graft(s);, three* (CMS proposed work RVU = 38.73).

- CMS proposes to accept the RUC recommended time for all of the cardiothoracic surgery codes. However, CMS expresses reservation about the use of extant databases and requests further review of this issue by the RUC. The RUC's Research Subcommittee will initiate discussion regarding extant time data at our October 5 meeting. The RUC will consider issues related to representativeness and any other concerns that CMS and specialty societies wish to address over the course of the next several meetings. However, the RUC did approve the use of the STS database for this Five-Year Review and we urge you to implement the recommendations based on this time data.

- CMS has proposed to reject the RUC recommendations for CPT codes 33517, 33518, 33519, 33521, 33522, and 33523, codes describing coronary surgery bypass using venous and arterial grafts. CMS argues that these are add-on codes, and therefore, do not have any post-service time or work associated with the service. While most add-on codes do not have pre-service or post-service time and work, these codes do as patients receiving multiple grafts are more complex and require longer hospital stays. CMS previously acknowledged that in certain circumstances, add-on codes may indeed have pre-service and post-service work.

> *The definition of a ZZZ global period will be revised as follows: "ZZZ = Code related to another service and is always included in the global period of the other service (Note: Physician work is associated with intra-service time and in some instances the pre- and post-service time)"*
>
> *Federal Register, December 31, 2002*

The RUC acknowledges that the review of the cardiothoracic surgery codes during this Five-Year Review process was complex and similar to the review of the Evaluation and

Management Services, contentious. The RUC engaged in review of these services over a nine month period and spent more than twenty hours in face-to-face review and deliberation prior to finalizing these recommendations by a two-third majority. **We urge you to consider the clarification that we provide in this comment letter and implement the RUC recommendations for all of the cardiothoracic surgery codes.**

7. **General, Colorectal and Vascular Surgery** (p. 37226)

CMS accepted 87 out of 116 RUC recommendations for the general, colorectal and vascular surgery codes excluding the following:

- 44120 *Enterectomy, resection of small intestine; single resection and anastomosis* - CMS proposes to increase the current work RVU for this code but not to the level recommended by the RUC

- 44130 *Enteroenterostomy, anastomosis of intestine, with or without cutaneous enterostomy (separate procedure)* - CMS proposes to increase the current work RVU for this code but not to the level recommended by the RUC

- 47600 *Cholecystectomy* - CMS proposes to increase the current work RVU for this code but not to the level recommended by the RUC

- 45300-45327 and 46600-46615 Proctosigmoidoscopy and Anoscopy Codes – CMS proposes to maintain the current work RVU for these codes.

- 33877 *Repair of thoracoabdominal aortic aneurysm with graft, with or without cardiopulmonary bypass* – CMS proposes to increase the current work RVU for this code but not to the level recommended by the RUC.

- 34201 *Embolectomy or thrombectomy, with or without catheter; femoropopliteal, aortoiliac artery, by leg incision* – CMS proposes to increase the current work RVU for this code but not to the level recommended by the RUC.

- 35102 *Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta involving iliac vessels (common, hypogastric, external)* – CMS proposes to increase the current work RVU for this code but not to the level recommended by the RUC.

- 35556 *Bypass graft, with vein; femoral-popliteal* – CMS proposes to increase the current work RVU for this code but not to the level recommended by the RUC.

- 35566 *Bypass graft, with vein; femoral-anterior tibial, posterior tibial, peroneal artery or other distal vessels* – CMS proposes to increase the current work RVU for this code but not to the level recommended by the RUC.

- 35585 *In-situ vein bypass; femoral-anterior tibial, posterior tibial, or peroneal artery*– CMS proposes to increase the current work RVU for this code but not to the level recommended by the RUC.

Comments:

44120 and 44130:

For codes 44120 *Enterectomy, resection of small intestine; single resection and anastomosis* and 44130 *Enteroenterostomy, anastomosis of intestine, with or without cutaneous enterostomy (separate procedure), 44626 Closure of enterostomy, large or small intestine; with resection and colorectal anastomosis (eg, closure of Hartmann type procedure)* (work RVU = 25.32) was cited as a key reference code. For all three operations, there are similarities in the actual conduct of surgery, such as an intestinal anastomosis. However, CPT 44626 is a complex and difficult pelvic operation with challenges that exceed 44120 and 44130. A second reference code discussed was 43631 *Gastrectomy, partial, distal; with gastroduodenostomy* (Work RVU=22.56). Codes 44120, 44130 and 43631 refer to patients who have urgent and emergent needs for surgery. Intra-operatively, the procedures focus on foregut and midgut surgery. Codes 44120 and 44130 typically involve extremely compromised bowel, reactive ascites and patients potentially suffering from bacterial translocation. This is a significant distinction of 44120 and 44130 compared with the gastrectomy. Pre-service and immediate post-service work is very similar for all patients. The LOS is the same for all three codes, however, 44120 and 44130 would require higher level of hospital visits because of issues related to the insult from the underlying intestinal conditions, fluid management, a higher risk of wound problems and the risk of fistula formation. The RUC also considered code 44140 *Colectomy, partial; with anastomosis* (Proposed work RVU = 20.97) as a reference for rank order purposes only, because this code was also under review.

For CPT codes 44120 and 44130, CMS expressed concerns with the RUC methodology to use the NSQIP data to increase the work RVUs above the median from the survey. In disagreeing, CMS is proposing to use the median survey values of 18.00 and 20.00 as the work RVUs for CPT codes 44120 and 44130, respectively. First, we note that the value cited by CMS as median survey value for 44120 is incorrect. The survey median for 44120 is 19.00 work RVUs. The surveyed summary data has been attached in Appendix 2.

However, after discussion of all reference codes, the RUC agreed that the survey medians underestimated total work compared with several other reference codes that are actually anchors for other families of codes. The RUC agreed that the survey medians would create rank order anomalies. The RUC facilitated a recommendation for 44120 that was 1.11 work RVUs greater than the survey median. For 44130, the RUC facilitated a recommendation that was 0.87 work RVUs greater than the survey median. **Therefore, to maintain rank order within the family of code the RUC reaffirms its recommendation of 20.11 RVUs and 20.87 RVUs for 44120 and 44130, respectively.**

47600:

The RUC would also like to respond to CMS' comments regarding 47600 *Cholecystectomy.* The RUC respectfully disagrees with CMS' proposed work RVU for 47600 as it does not accurately reflect the work currently associated with this procedure. CMS' premise is that the work for this procedure was derived through the National Surgical Quality Improvement Program (NSQIP) database. This premise is not accurate. The RUC would like CMS to note that only the intra-service times and post-operative visits from the NSQIP database were accepted as part of the RUC recommendation. The RUC presumes that these time inputs were accepted by CMS. To calculate the work RVU, the RUC reviewed the service times and the post-operative visits for the reference code for this procedure, 47605 *Cholecystectomy; with cholangiography* (Work RVU=14.67). The RUC noted that the reference code has 90 minutes of intra-service time while the surveyed code has 115 minutes of intra-service time. In addition, the RUC noted that the only difference between the post-operative visits between these two codes is that the surveyed code has one additional 99231 hospital visit in comparison to the reference code. To account for these differences, and to maintain rank order between the surveyed and reference code the RUC recommends a value of 15.88 work RVUs for 47600, which is a value slightly above the 75th percentile. **Therefore, the RUC reaffirms its recommendation of 15.88 work RVUs for 47600.**

Proctosigmoidoscopy and Anoscopy codes (45300-45327 and 46600-46615)

For the proctoscopy-anoscopy families of codes 45300-45327 and 46600-46615, CMS is proposing to maintain the current work RVUs because the method used by the RUC to obtain work values for these services was flawed. CMS indicates that the calculation of the recommended work RVUs depended solely on applying a workgroup-derived IWPUT to the surveyed physician time from surveys that were considered otherwise unusable and that the RUC has established rules that state that IWPUT cannot be the sole rationale for valuation. Further, as an example of a better methodology, CMS indicates that there were acceptable surveys that were used as anchors to create the correct rank order for

dermatology codes without adequate surveys and if the specialty society wishes to resurvey these codes and the RUC submits work RVU recommendations to CMS, CMS would be willing to consider them. **The specialty society recommendations for these services are scheduled to be presented at the October 2006 RUC Meeting.**

33877, 34201, 35102, 35556, 35566 and 35585

The RUC would also like to take this opportunity to respond to CMS' proposed values for several vascular surgery procedures including 33877 *Repair of thoracoabdominal aortic aneurysm with graft, with or without cardiopulmonary bypass*, 34201 *Embolectomy or thrombectomy, with or without catheter; femoropopliteal, aortoiliac artery, by leg incision*, 35102 *Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta involving iliac vessels (common, hypogastric, external)*, 35556 *Bypass graft, with vein; femoral-popliteal*, 35566 *Bypass graft, with vein; femoral-anterior tibial, posterior tibial, peroneal artery or other distal vessels* and 35585 *In-situ vein bypass; femoral-anterior tibial, posterior tibial, or peroneal artery.*

For all of these codes, the rationale in the Proposed Rule states, "For these services, the RUC used the NSQIP time data to increase the work values above the survey median, and even for above several codes the 75th percentile." No rationale for comparison services at the proposed work RVU was provided. The RUC acknowledges that its recommendations were not clear in reflecting the rationale for above the median and in some instances above the 75 percentile of the survey data for these services. To assist CMS with the review of these codes the RUC will discuss how the work associated with a given CPT code is analogous to the work in other services and will provide a rationale for recommending the CMS accept the RUC recommendations. The CMS proposed work RVUs will create rank order anomalies. These vascular surgery procedures represent the most difficult and lengthy procedures with a very high risk patient. In the specialty society's recommendations and in its discussions at the RUC, these procedures were compared to other major vascular surgical procedures with similar intensity, complexity and operative times such as 35531 *Bypass graft, with vein; aortoceliac or aortomesentric* (Work RVU = 36.15); 35646 *Bypass graft, with other than vein; aortobifemoral* (Work RVU=30.95) and 35666 *Bypass graft, with other than vein; femoral-anterior tibial, posterior tibial, or peroneal artery* (Work RVU=22.16). The outcome of discussions at the RUC was that the survey median work RVU for these six procedures were underestimated and would create rank order anomalies. For these six codes, the RUC recommended work RVUs would be a better relative value in comparison other major operations performed by vascular surgeons. The detailed rationale for each individual code is attached in Appendix 3. **The RUC reaffirms its recommendations for these vascular surgery procedures.**

8. Otolaryngology and Ophthalmology (p. 37230)

CMS accepted all but fourteen of the RUC recommendations for the otolaryngology and ophthalmology codes:

- 31360-31382 Laryngectomy and Partial Laryngectomy Codes – CMS proposes to increase the current work RVU for this code but not to the level recommended by the RUC.

- 31390 *Pharyngolaryngectomy, with radical neck dissection; without reconstruction* – CMS proposes to increase the current work RVU for this code but not to the level recommended by the RUC.

- 31395 *Pharyngolaryngectomy, with radical neck dissection; with reconstruction* – CMS proposes to increase the current work RVU for this code but not to the level recommended by the RUC.

- 41100 *Biopsy of tongue; anterior two-thirds* – CMS proposes to decrease the current work RVU for this code.

- 41153 *Glossectomy; composite procedure with resection floor of mouth, with suprahyoid neck dissection* – CMS proposes to increase the current work RVU for this code but not to the level recommended by the RUC.

- 41155 *Glossectomy; composite procedure with resection floor of mouth, mandibular resection, and radical neck dissection (Commando type)* – CMS proposes to increase the current work RVU for this code but not to the level recommended by the RUC.

- 42845 *Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; closure with other flap*– CMS proposes to increase the current work RVU for this code but not to the level recommended by the RUC.

Comments:

The RUC wishes to comment on eight of these codes 31360, 31365, 31367, 31368, 31390, 31395, 41155 and 42845 where the CMS disagreed with the RUC recommendation. For all of these codes, the rationale in the Proposed Rule states: "The median values for intra-service times were accepted by the RUC for these services, which is an indication that a value other than the 75th percentile for work also may be

appropriate." No rationale for comparison services at the proposed work RVUs was provided. The RUC acknowledges that its recommendations were not clear in reflecting the rationale for the 75th percentile of the survey data for these services. To assist CMS with the review of these codes the RUC's comments will discuss how the work associated with a given CPT code is analogous to the work in other services and will provide a rationale for recommending that CMS accept the RUC recommendations. Although these procedures are performed at a low frequency, CMS proposed work RVUs will create rank order anomalies. These head and neck oncology procedures represent the most complex, lengthy, and demanding cancer operations performed by otolaryngologists. A standard AMA/RUC survey was utilized for these eight codes, which are all completed by subspecialists with focused expertise. The reference service list that accompanied the survey included procedures that may be familiar to otolaryngologists and head and neck surgeons, however, the majority of codes that would definitely be familiar to head and neck surgeons with a focused expertise were under review and could not be included in the reference list.

In the specialty society's rationale for recommendations for these codes, comparisons to codes on the multispecialty points of comparison (MPC) table were presented. In the specialty society's recommendations and in its discussions at the RUC, these procedures were compared to other major oncologic resections that have similar length, complexity, and impact of decision making, such as 58210 *Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s);* 47120 *Hepatectomy, resection of liver; partial lobectomy*; and 48153 *Pancreatectomy, proximal subtotal with near-total duodenectomy, choledochoenterostomy and duodenojejunostomy (pylorus-sparing, Whipple-type procedure); with pancreatojejunostomy*. In comparison to the cited major oncologic operations, the RUC agreed that the head and neck resections typically require more postoperative care that included management of wound problems in radiated and contaminated fields, and in the recovery of speech, swallowing, airway function and upper extremity usage.

The outcome of discussions at the RUC was that the survey median work RVUs for these eight low volume codes were underestimated and would create rank order anomalies. For these eight codes, the RUC recommended work RVU would be a better relative value in comparison to other head and neck codes and other major operations of other specialties. **The detailed rationale for each individual code is attached in Appendix 4. The RUC reaffirms its recommendations for these otolaryngologic procedures.**

Additional Comments:

For CPT code 69210 *Removal impacted cerumen (separate procedure), one or both ears*, the RUC wishes to express its appreciation to CMS for proposing to accept the RUC's

recommendation to maintain the current work RVU of 0.61. The RUC's recommendation is based on solid data and rationale. However, the RUC would like to address CMS' concern with this valuation for the use of this code for routine removal of ear wax during a physical examination of a patient. CMS states:

"This code is listed with a "separate procedure" designation in the CPT code book, meaning that it is billed most properly when it is the only service provided for a particular date of service. However, Medicare data used for evaluation of codes in the current Five-Year Review indicate that CPT code 69210 was billed with an E/M service 63 percent of the time. It is our understanding that CPT code 69210 is to be used when there is a substantial amount of cerumen in the external ear canal that is very difficult to remove and that impairs the patient's auditory function. We will continue to monitor the use of this code for the appropriate circumstances."

We appreciate CMS's proposal to maintain the current work RVU of this service. We agree with CMS that, per CPT, code 69210 is to be used when there is a substantial amount of cerumen in the external ear canal that is very difficult to remove and that impairs the patient's auditory function. However, we are concerned that CMS is misinterpreting the "separate procedure" designation in this instance. Per the CPT Editorial Panel:

"Some of the procedures or services listed in the CPT codebook that are commonly carried out as an integral component of a total service or procedure have been identified by the inclusion of the term "separate procedure." The codes designated as "separate procedure" should not be reported in addition to the code for the total procedure or service of which it is considered an integral component."

However, when a procedure or service that is designated as a "separate procedure" is carried out independently or considered to be unrelated or distinct from other procedures/services provided at that time, it may be reported by itself, or in addition to other procedures/services by appending modifier 59 to the specific "separate procedure" code to indicate that the procedure is not considered to be a component of another procedure. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries).

The designation of "separate procedure" does not mean "that it is billed most properly when it is the only service provided for a particular date of service." As noted, per CPT, it may be reported by itself or in addition to other procedures/services. As such, the fact that 69210 is billed 63% of the time with an E/M service does not violate its "separate procedure" designation. When 69210 is billed with an E/M service on the same date of

service, modifier 25 should be appended to the E/M service to indicate that it was significant and separately identifiable from the impacted cerumen removal. Assuming both services are accurately documented in this circumstance, then their use is appropriate.

Ophthalmology Services

The RUC recommendations for CPT codes 67228 *Destruction of extensive or progressive retinopathy (eg, diabetic retinopathy), one or more sessions; photocoagulation (laser or xenon arc)* and 67038 *Vitrectomy, mechanical, pars plana approach; with epiretinal membrane stripping,* which were placed into the Five Year Review by CMS and subsequently referred to CPT to address coding concerns were not submitted during the CPT 2007 Cycle. However, Coding Change Proposals were submitted by the American Academy of Ophthalmology (AAO) to the CPT Editorial Panel and will be presented at the October 2006 CPT Panel Meeting. The RUC recommendations for these procedures will be forwarded to CMS for the CPT 2008 Cycle.

Other Issues

Anesthesia (p. 37237)

CMS states, "We are recommending the valuation of anesthesia services, namely the proposed valuation of the post-induction time period, be referred to the RUC for their review and consideration." The RUC will consider any specific CMS request. We ask that CMS articulate the scope of review and specific elements of the anesthesia relativity that is supposed to be addressed.

Budget Neutrality (p. 37241)

The Omnibus Budget Reconciliation Act of 1989 requires that increases or decreases in relative value units (RVUs) for a year may not cause the amount of expenditures for the year to differ by more than $20 million from what expenditures would have been in the absence of these changes. To limit the increases in Medicare expenditures as mandated by the statute, CMS has applied various adjustments to the Medicare Physician Payment Schedule, including re-scaling the RVUs, creating a separate "work adjuster," or applying a budget neutrality adjustment to the Medicare conversion factor. CMS has proposed to create a new "work adjuster" to ensure budget neutrality following the implementation of the improved work RVUs from this Five-Year Review of the RBRVS. **The RUC argues that applying budget neutrality to the work RVUs to offset the improvements in E/M and other services is a step backward and strongly urges CMS to instead apply any necessary adjustments to the conversion factor.**

In 1993 - 1995, CMS achieved budget neutrality by uniformly reducing all work relative values across all services. The RUC strongly objected to using work relative values as a mechanism to preserve budget neutrality. These adjustments to the work relative values caused confusion among the many non-Medicare payers, as well as physician practices, that adopt the RBRVS payment system. The constant re-scaling also impeded the process of establishing work RVUs for new and revised services. The RUC argued that any budget neutrality adjustments deemed necessary should be made to the conversion factor, rather than the work relative values.

In 1997, following the first Five-Year Review of the RBRVS, CMS modified the approach to apply budget neutrality and implemented a separate work adjuster. This approach was short-lived as CMS converted this adjustment to the conversion factor in 1999. CMS later articulated that the creation of the work adjuster was not effective.

> "We did not find the work adjustor to be desirable. It added an extra element to the physician fee schedule payment calculation and created confusion and questions among the public who had difficulty using the RVUs to determine a payment amount that matched the amount actually paid by Medicare." (*Federal Register*, Vol. 68, No. 216, Pg. 63246).

From 1998 to present, CMS has implemented all work neutrality adjustments by adjusting the Medicare conversion factor. CMS does not explain why it proposes to alter this long utilized method and move backward to an approach that the agency itself remarked was inappropriate. In fact, CMS recognizes the current policy on page 37171 of this Proposed Rule, stating that "we must make adjustments to the conversion factors (CFs) to preserve budget neutrality." The RUC requests that CMS consider the history and these additional arguments in its consideration of this issue:

1.) Adjusting the conversion factor does not affect the relativity of services reflected in the recommended RVUs. Adjusting the RVUs has the potential to inappropriately affect relativity. If the work RVUs are adjusted as proposed, it will dampen the improvements to the E/M services valuation. CMS has publicly lauded the RUC for recommending these increases to E/M and we would surmise that the agency would want to achieve the full benefit of these improvements.
2.) An adjustment in the Medicare conversion factor is preferable because it has less impact on other payers who use the Medicare RVUs. That is, an adjustment in the Medicare conversion factor will not necessarily affect the payment rates of other payers who use the Medicare RVUs and their own conversion factors. However, any adjustment in the RVUs will impact the payment rates of such payers. The payment rates of payers who peg their rates to a percentage of Medicare will be affected regardless. The RUC believes that CMS must consider such "ripple effects" as it decides how to adjust for work neutrality.

3.) The RUC believes an adjustment to the conversion factor is preferable because it recognizes that budget neutrality is mandated for monetary reasons. Thus, the conversion factor, as the monetary multiplier in the Medicare payment formula, is the most appropriate place to adjust for budget neutrality

4.) Applying the work neutrality adjustment to the conversion factor would coincide with CMS' current mission of making the Medicare payment transparent.

The methodology of applying the budget neutrality adjustment to the conversion factor could also be applied to the practice expense budget neutrality application, but only after all of the RUC's recommendations related to the methodology have been addressed by CMS. This includes the consideration of the RUC's recommendations related to the equipment utilization rate; interest rate; and implementation of practice expense data from a recent, consistent, reliable multi-specialty physician practice survey to determine indirect practice expenses.

There is a key difference between the work relative values and the practice expense relative values at this point in the RBRVS. The work relativity is based on a long established methodology of magnitude estimation. Changes in the work relative values from year to year, or in the Five-Year Review, are based on changes in the services performed by physicians (eg, a patient population that has become more complex; a procedure that requires less time). These changes do not imply that other physician services have become easier, just that CMS cannot afford to pay for the deserved recognition of work. The practice expense portion of the RBRVS payment, however, is still based on a methodology that is in flux. CMS has moved from "bottom-up" to "top-down" to a proposed blended approach. Until the actual method of practice expense relativity is firmly in place, one may not make assumptions regarding specific services. We envision a point in time in which practice expense for individual services are evaluated in a Five-Year Review and at that point, a similar application for budget neutrality would be appropriate.

Practice Expense Methodology (p. 37241)

CMS has approved a new practice expense methodology, which is in summary, a blend between a "bottom up" approach and a "top down" approach. CMS proposes to calculate direct practice expense RVUs using data refined by the RUC and its Practice Expense Review Committee (PERC) (and formerly the Practice Expense Advisory Committee). The application of this direct practice expense data is straightforward. CMS simply sums the expense of the clinical staff, medical supplies, and medical equipment to determine the cost at the individual CPT code level, in a "bottom up" approach. We note that CMS

has acknowledged that only 2/3 of the direct expenses are recognized due to budget constraints. This provides direct evidence that Medicare payments are not covering physician's practice costs. The indirect practice expenses, making up 60-70% of total payment depending upon specialty, is still based on a "top down" approach, allocating specialty level data from surveys to individual services using work RVUs and direct expenses. The RUC has not had the opportunity to meet and discuss this new methodology. Therefore, we will not comment on the method itself. However, the RUC has remaining concerns regarding the data that is used within the methodology and urges CMS to address each of the following issues:

Multi-Specialty Physician Practice Expense Survey

CMS currently utilizes practice expense data and physician hours from 1995-1999 AMA Socioeconomic Monitoring System (SMS) survey to calculate a "practice expense per hour" estimation for most specialties. A number of other specialties have conducted their own supplemental surveys and CMS proposes to use these new data sources in 2007 The RUC has recognized that the SMS data are outdated and that there is a significant need for new survey data. It is imperative that a multi-specialty practice expense be conducted to collect recent, reliable and consistent practice expense data for all specialties and health care professionals. The RUC is encouraged that the AMA is coordinating a new survey effort. **We urge CMS to work with the AMA and other physician and health professional organizations to fund this multi-specialty survey effort and to ensure that the resulting data is utilized in 2009.**

Equipment Assumptions – Cost of Capital Assumptions

CMS currently utilizes an interest rate of 11% in pricing medical equipment. CMS has acknowledged that this rate is too high and requested comments regarding the appropriate interest rate. The RUC discussed and agreed that the interest rate currently utilized is too high. The RUC agreed that the interest rate should fluctuate according to market conditions, rather than a fixed rate. The cost of capital is a legitimate expense of a physician's office and should be linked to prevailing rates. **CMS should adjust the 11% cost of capital rate to a market competitive rate.**

Equipment Assumptions – Equipment Utilization Data

CMS requested information on how it should reflect the utilization rate, particularly for high cost equipment. Currently, CMS uses a 50% utilization rate for all equipment. The RUC has discussed whether there should be a different rate for all equipment or just for the equipment set by specific cost thresholds. The RUC indicated that the cost of capital may not have a direct linear relationship with equipment utilization. Further, the RUC

discussed whether consideration should be given to impacts on rural payment, as utilization rates may not be as high as in urban areas. **The RUC recommends that the existing CMS standard of 50% utilization rate for all equipment is not an accurate measure. CMS should consider using a higher rate for all equipment, providing an opportunity to specialty societies to provide data to support lower utilization rates, if appropriate, based on clinical or geographic considerations.**

Errors in Data – Practice Expense Methodology

In the course of reviewing the Proposed Rule, AMA RUC staff identified a few errors in the data used to formulate CMS' proposed practice expense relative values. We appreciate that your staff have been responsive in working with AMA staff to correct these errors. We understand that the 2007 Medicare Physician Payment Schedule Proposed Rule, released on August 8, 2006 corrects the following:

- The direct practice expense data has been updated to include adjustments derived from the Five Year Review (i.e. adjustments to the number and level of post-operative visits and the associated clinical staff assist physician time).
- The incorporation of the complete RUC physician time file as resubmitted in June 2006.
- The appropriate inflation of the practice expense/hour data to reflect that the AMA's SMS survey data had been deflated to 1995 dollars and not 1997 dollars.
- The appropriate crosswalk for both interventional pain management and pain medicine should be to the "All Physician" practice expense per hour data.

We would also note that the application of budget neutrality to the work relative values has been applied in the work RVUs utilized in the indirect practice expense allocation. This is inappropriate and we urge CMS to correct this and use the work RVUs, as approved by the RUC, as the appropriate allocator in the methodology.

The RUC appreciates the opportunity to offer these comments to CMS. We look forward to the work ahead to further improve the RBRVS.

Sincerely,

William L. Rich, III, MD, FACS

Attachments
cc: RUC participants

Appendix 1 - CPT Codes Not Listed in Proposed Rule's Table 1: Five-Year Review of Work Relative Value Units

	Descriptor	Workgroup Number	RUC Action	2006 Work RVU
17000	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), all benign or premalignant lesions (eg, actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions; first lesion	1	Refer to CPT	0.60
17110	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of flat warts, molluscum contagiosum, or milia; up to 14 lesions	1	Refer to CPT	0.65
17111	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of flat warts, molluscum contagiosum, or milia; 15 or more lesions	1	Refer to CPT	0.92
33506	Repair of anomalous coronary artery from pulmonary artery origin; by translocation from pulmonary artery to aorta	6	Maintain the Current RVU	35.45
33660	Repair of incomplete or partial atrioventricular canal (ostium primum atrial septal defect), with or without atrioventricular valve repair	6	Maintain the Current RVU	29.96
33670	Repair of complete atrioventricular canal, with or without prosthetic valve	6	Maintain the Current RVU	34.95
33770	Repair of transposition of the great arteries with ventricular septal defect and subpulmonary stenosis; without surgical enlargement of ventricular septal defect	6	Maintain the Current RVU	36.94
33780	Repair of transposition of the great arteries, aortic pulmonary artery reconstruction (eg, Jatene type); with closure of ventricular septal defect	6	Maintain the Current RVU	41.69

Appendix 2- Survey Data for 44120

GS Final					RVW				
SOURCE	CPT	N	Resp	%	MIN	25TH	MED	75TH	MAX
REF	43631						22.56		
NSQIP	44120		1735				23.43		
SVY	44120	200	46	23%	16.00	18.00	19.00	21.00	35.00
RUC Rec	44120						20.11		

Appendix 3 – Detailed Rationale for Vascular Surgery Codes

33877 *Repair of thoracoabdominal aortic aneurysm with graft, with or without cardiopulmonary bypass*

For CPT code 33877, the RUC agreed that there was compelling evidence that the current relative value is inappropriate due to a change in the patient population, length of stay and evidence that incorrect assumptions were made in the previous valuation of the service. The RUC reviewed the pre-service times and office/hospital visits and made modifications consistent with other codes in this family. The RUC reviewed the recommended work RVU of 64.04 which was the 75th percentile of the survey data. The RUC recognized that due to the complexity of this 6-hour operation which is performed routinely on patients with advanced coronary artery disease and COPD and that patients undergoing thoracoabdominal aortic aneurysm repair require collaboration of many specialists to keep them alive, felt 64.04 RVU was justified and accurately captured the work associated with this code as compared to other codes within the family. The RUC believes that CMS will also be creating a major anomaly with respect to code 43118 *Partial esophagectomy, distal two-thirds, with thoracotomy and separate abdominal incision, with or without proximal gastrectomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)* that the agency has proposed an RVW of 61.08. CPT code 43118 has essentially the same intra-service time and an equivalent in-hospital and post-discharge visit pattern, yet CMS assigned 33877 approximately 8 RVUs less. CPT code 33877 is deemed to be a more intense procedure with a more complex patient when compared with 43118.

Furthermore, the Society of Vascular Surgery (SVS) used database intra-time over survey intra-time whenever it was available because we believed accuracy was a goal of this exercise. In "Additional Rationale" for CPT 33877 thoracoabdominal aneurysm repair, SVS pointed out that it had three different sources for intra-service time for this code:

1. SVS RUC survey of 39 surgeons - skin-to-skin intra-time 360 minutes
2. NSQIP database of 156 accurately recorded operations, intra-time 324 minutes
3. STS database of 108 accurately recorded operations, intra-time 326 minutes

This demonstrates a tight correlation between the two databases (different hospitals, different surgeons). SVS put aside the 360 minutes from the survey data and recommended the lesser value of 324 minutes, representing a mean of the two databases. Intra-service time for major aortic surgery has been valued by the RUC typically at 0.090 to 0.110 over the past 8 years. If SVS were to choose 0.100 RVUs per minute, SVS would reduce the work associated with this service by 3.60 intra-service RVUS by choosing the database time. SVS explained this to the RUC workgroup during its presentation. This explanation constituted part of the rationale for the RUC recommending 64.04 RVUs for this service, a value greater than median survey.

Using 324 minutes for intra-service time, the SVS and RUC recommended RVW of 64.04 results in an IWPUT of 0.114, an appropriate value for one of the most complex open surgical operations.

Instead of accepting the RUC recommendation, CMS proposed 53.00 RVUs for this service. Using an RVW of 53.00, the IWPUT at 324 minutes calculates to only 0.080, lower than any major arterial reconstruction approved by CMS in the last 8 years. It deserves the highest not the lowest IWPUT within the aneurysm repairs of the aorta or peripheral arteries, or other aortic surgery range as demonstrated in the attached excel spreadsheet. At the SVS/RUC recommended RVW of 64.04, this service would be appropriately valued with an IWPUT of 0.114, still substantially below several other RUC-valued high-intensity services.

This additional information provides a compelling argument for the RUC recommended RVW of 64.04 for this service. **The RUC would like to reaffirm its recommendations of 64.04 work RVUs for 33877.**

34201 *Embolectomy or thrombectomy, with or without catheter; femoropopliteal, aortoiliac artery, by leg incision*

For CPT code 34201, the RUC agreed that there was compelling evidence that the current relative value is inappropriate due to a change in the patient population and anomalous relationships within the family of codes. The RUC reviewed the NSQIP data and the survey data in regard to intra-service times. The RUC agreed that the survey data demonstrates physicians underestimating their time and thus the NSQIP time, 128 minutes, was more accurate. Therefore, to derive the recommended work RVU, the RUC determined the difference in time between the NSQIP and the survey, 38 minutes and multiplied this difference by 0.077, the recommended IWPUT for this procedure, which was deemed to be an appropriate intensity, which results in 2.93 work RVUs. The RUC then added this resultant work to the median surveyed RVU, 17.00 which results in 19.93 work RVUs for this procedure. Further adjustments in the resultant work RVU were made based on modifications to the pre-service times and the removal of two hospital visits. With all of these adjustments, the RUC recommended 18.31 work RVUs for this procedure. NSQIP data proved that survey respondents underestimated intra-service time by more than 25%. It is important to know that the specialty society assumed NSQIP time (number of cases >300) to be more accurate than RUC survey time (n = 30 surveys), and used NSQIP time when available whether it increased or reduced the RUC survey times. It is important to note that NSQIP time reduced intra-service times from survey data in several cases, and we used that lower time to construct our recommendations, and the RUC and CMS were more than willing to use NSQIP time when it resulted in a lower RVW recommendation. For this particular code, the RUC agreed that survey intra-times required adjustment. **The RUC would like to reaffirm its recommendations of 18.31 work RVUs for 34201.**

35102 *Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and*

associated occlusive disease, abdominal aorta involving iliac vessels (common, hypogastric, external)

For CPT code 35102, the RUC agreed that there was compelling evidence that the current relative value is inappropriate due to a change in the patient population and anomalous relationships within the family of codes. The RUC reviewed the NSQIP data and the survey data in regard to intra-service times. The RUC agreed that the survey data demonstrates physicians underestimating their time and thus the NSQIP time, 265 minutes, was more accurate. Therefore, to derive the recommended work RVU, the RUC determined the difference in time between the NSQIP and the survey, 25 minutes and multiplied this difference by 0.097, the recommended IWPUT for this procedure, which was deemed to be an appropriate intensity, which results in a 2.43 work RVUs. The RUC then added this resultant work to the median surveyed RVU, 34.00 which results in a 36.43 work RVUs for this procedure. Further adjustments in the resultant work RVU were made based on modifications to the pre-service times. With all of these adjustments, the RUC recommends 36.28 work RVUs for this procedure. This value was further supported by an additional reference code 35531 *Bypass graft, with vein; aortoceliac or aortomesentric* (Work RVU = 36.15) which had similar intensities, work and service times. NSQIP data proved that survey respondents underestimated intra-service time by almost half an hour. It is important to know that the specialty society assumed NSQIP time (number of cases >800) to be more accurate than RUC survey time (n ~ 50 surveys), and the specialty society used NSQIP time when available whether it increased or reduced the RUC survey times. For this particular code, the RUC agreed that survey intra-times required adjustment. The RUC recommendation of 36.28 resulted in an IWPUT of 0.083, a value within the established IWPUT range for aneurysm repairs of the aorta or peripheral arteries, or other aortic surgery as demonstrated in the attached excel spreadsheet. The CMS recommendation of only 34.00 RVUs will establish a totally new low IWPUT benchmark for these services at 0.074. This is a complex operation with an established 30-day mortality of 4-6%. An IWPUT of 0.074 does not account for the true intensity and complexity of the service, and it indicates that the proposed work RVU for this service has been undervalued by CMS. **The RUC would like to reaffirm its recommendations of 36.28 work RVUs for 35102.**

35556 *Bypass graft, with vein; femoral-popliteal*

For CPT code 35556, the RUC agreed that there was compelling evidence that the current relative value is inappropriate due to a change in technology that has resulted in a change in the physician work. The RUC reviewed the NSQIP data and the survey data in regard to intra-service times. The RUC agreed that the survey data demonstrates physicians underestimating their time and thus the NSQIP time, 251 minutes, was more accurate. In addition, adjustments were made to the pre-service times. The RUC reviewed the intensity, mental effort, technological skill associated with this procedure and felt that the 75th percentile of the survey data, 27.25 accurately reflects the work associated with this code. This lower extremity bypass is performed to prevent leg amputation due to ischemic gangrene and non-healing foot ulcers. This bypass in addition to three others in the same family (35566 *Bypass graft, with vein; femoral-anterior tibial, posterior tibial,*

peroneal artery or other distal vessels, 35583 *In-situ vein bypass; femoral-popliteal*, 35585 *In-situ vein bypass; femoral-anterior tibial, posterior tibial, or peroneal artery*) are among the most undervalued services in the Medicare physician fee schedule. The number of physicians willing to perform these operations on Medicare beneficiaries is dwindling, based on the major reduction in frequency documented in the RUC database over the past 10 years. In addition, CMS will be creating a major rank order anomaly if it values 35556 at only 25.00, while at the same time assigning CPT 44150 *Colectomy, total, abdominal, without proctectomy; with ileostomy or ileoproctostomy* an RVW of 27.50. CPT code 44150 is a 180 minute skin-to-skin operation performed in patients with moderate cardiovascular comorbidities. CPT code 35556 is a 251 minute operation performed in patients who typically have advanced cardiovascular comorbidities. **The RUC would like to reaffirm its recommendation of 27.25 RVUs for 35556.**

35566 *Bypass graft, with vein; femoral-anterior tibial, posterior tibial, peroneal artery or other distal vessels*

For CPT code 35566, The RUC agreed that there was compelling evidence that the current relative value is inappropriate due to a change in technology that has resulted in a change in the physician work. The RUC reviewed the NSQIP data and the survey data in regard to intra-service times. The RUC agreed that the survey data demonstrates physicians underestimating their time and thus the NSQIP time, 306 minutes, was more accurate. In addition, adjustments were made to the pre-service times. The RUC reviewed the intensity, mental effort, technological skill associated with this procedure and felt that the 75th percentile of the survey data, 32.00 accurately reflects the work associated with this code. The RUC recommended 32.00 work RVUs for this procedure. This lower extremity bypass is performed to prevent leg amputation due to ischemic gangrene and non-healing foot ulcers. This bypass in addition to three others in the same family (35556 *Bypass graft, with vein; femoral-popliteal*, 35566 *Bypass graft, with vein; femoral-anterior tibial, posterior tibial, peroneal artery or other distal vessels*, 35583 *In-situ vein bypass; femoral-popliteal*, 35585 *In-situ vein bypass; femoral-anterior tibial, posterior tibial, or peroneal artery*) are among the most undervalued services in the Medicare physician fee schedule. The number of physicians willing to perform these operations on Medicare beneficiaries is dwindling, based on the major reduction in frequency documented in the RUC database over the past 10 years. These bypass grafts were undervalued by survey respondents for two reasons. First, the NSQIP data proves that survey respondents underestimated the intra-service time, in this case by 33 minutes. There were almost 1400 of these operations recorded in the NSQIP database, and the intra-time must be more accurate than estimates by ~40 surgeons. In addition, CMS will be creating a major rank order anomaly if it values 35566 at only 30.00, while at the same time assigning CPT 44151 *Colectomy, total, abdominal, without proctectomy; with continent ileostomy* an RVW of 32.00. CPT code 44151 is a 200 minute skin-to-skin operation performed in patients with moderate cardiovascular comorbidities. CPT code 35566 is a 306 minute operation performed in patients who typically have advanced cardiovascular comorbidities. Total time for 44151 is 673 minutes, while total time for 35566 is 693 minutes. **The RUC reaffirms its recommendation of 32.00 Work RVUs for 35566.**

35585 *In-situ vein bypass; femoral-anterior tibial, posterior tibial, or peroneal artery*

For CPT code 35585, the RUC agreed that there was compelling evidence that the current relative value is inappropriate due to a change in technology that has resulted in a change in the physician work. The RUC reviewed the NSQIP data and the survey data in regard to intra-service times. The RUC agreed that the survey data demonstrates physicians underestimating their time and thus the NSQIP time, 305 minutes, was more accurate. In addition, adjustments were made to the pre-service times. The RUC reviewed the intensity, mental effort, technological skill associated with this procedure and felt that the 75th percentile of the survey data, 32.00 accurately reflects the work associated with this code. This lower extremity bypass is performed to prevent leg amputation due to ischemic gangrene and non-healing foot ulcers. This bypass in addition to three others in the same family (35556 *Bypass graft, with vein; femoral-popliteal*, 35566 *Bypass graft, with vein; femoral-anterior tibial, posterior tibial, peroneal artery or other distal vessels*, 35583 *In-situ vein bypass; femoral-popliteal*) are among the most undervalued services in the Medicare physicians fee schedule. The number of physicians willing to perform these operations on Medicare beneficiaries is dwindling, based on the major reduction in frequency documented in the RUC database over the past 10 years. These bypass grafts were undervalued by survey respondents for two reasons. First, 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 by ~40 surgeons. In addition, CMS will be creating a major rank order anomaly if it values 35585 at only 30.00, while at the same time assigning CPT 44151 *Colectomy, total, abdominal, without proctectomy; with continent ileostomy* an RVW of 32.00. 44151 is a 200 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 673 minutes, while total time for 35585 is 715 minutes. **The RUC reaffirms its recommendation of 32.00 RVUs for 35585.**

Established IWPUT Range for Aneurysm Repairs of the Aorta or Peripheral Arteries, or Other Aortic Surgery

Code	Short Descriptor	SVS Rec	RUC Rec	CMS Rec	CMS Year	Survey Intra time	NSQIP Intra Time	SVS Rec Intra Time	RUC Intra Time	SVS Total Time	RUC Total Time	SVS IWPUT	RUC IWPUT	CMS IWPUT
	Disputed 5-Year Review Aortic Aneurysm Repair Codes													
33877	Rep thoraco abd	64.04	64.04	53.00	2007 5yr	360	324	324	324	1085	1005	0.114	0.114	0.080
35102	Rep infrarenal AAA bifurcated	39.8	36.28	34.00	2007 5yr	240	265	265	265	696	685	0.094	0.083	0.074
	RUC Reviewed Elective Aneurysm Repairs and Aortic Surgery, 2000-2006													
35141	Rep femoral an			19.97	2002 5yr	150		150	150	412	412		0.082	0.082
34900	Endovasc Iliac an rep			16.36	2003 new	120		120	120	348	348		0.088	0.088
35646	AortoBiFem BPG			30.95	2002 new	210		210	210	602	602		0.093	0.093
33881	Endovasc rep thoracic aorta			28.00	2006 new	200		200	200	542	527		0.095	0.095
34802	Endovasc AAA 2-piece			22.97	2001 new	150		150	150	448	448		0.101	0.101
34805	Endovasc AAA aorto-uni-iliac			21.85	2004 new	150		150	150	150	408		0.101	0.101
35647	AortoFem BPG			27.97	2002 new	170		179	179	536	536		0.102	0.102
35151	Rep popliteal an			22.61	2002 5yr	150		150	150	456	456		0.094	0.094
35011	Rep Axillary/Brach An			17.97	2002 5yr	120		120	120	352	352		0.099	0.099
35131	Rep Iliac an			24.96	2002 5yr	150		150	150	501	501		0.101	0.101
35045	Rep radial/ulnar an			17.54	2002 5yr	120		120	120	120	326		0.102	0.102
34803	Endovasc AAA 3-piece			24.00	2005 new	165		165	165	448	448		0.104	0.104
35121	Rep mesenteric an			29.96	2002 5yr	190		190	190	535	535		0.105	0.105
33880	Endovasc rep thoracic aorta			33.00	2006 new	225		225	225	587	572		0.105	0.105
35111	Rep splenic an			24.96	2002 5yr	150		150	150	457	457		0.109	0.109
34800	Endovasc AAA 1-piece			20.72	2001 new	120		120	120	413	413		0.109	0.109

Appendix 4 – Detailed Rationale for Otolaryngologic Procedures

31360 *Laryngectomy; total, without radical neck dissection*

For CPT code 31360, the reference code cited most often in the RUC survey was CPT 60252 *Thyroidectomy, total or subtotal for malignancy; with limited neck dissection* (RVW= 20.54). The intra-operative time is only slightly less for 60252, but the LOS is four days shorter. Code 31360 requires more preservice work related to discussing/preparing for emergency airway access and reconstruction as well as patient/family work to discuss voice rehabilitation options. Postoperatively, these patients have a stoma to manage and require monitoring of swallowing and diet after discharge (they are not able to eat by mouth for 7-10 days). The RUC believes the choice of this reference code and the use of magnitude estimation resulted in an underestimation of the total work for 31360. In terms of RVW, time, and post-op work, the RUC recommended work RVU (28.00) is a more reasonable relative value when compared with the three MPC codes and the survey reference code as shown below.

	CPT	Description	RVW	Time	HV	OV
Survey	31360	Laryngectomy; total without radical neck	28.00*	714	8	6
Ref	60252	Thyroidectomy; with limited neck dissection	20.54	446	4	3
MPC	45110	Proctectomy; complete, AP with colostomy	27.96	624	9	4
MPC	61510	Craniectomy, for excision brain tumor	28.41	609	7	4
MPC	27134	Revision total hip arthroplasty	28.48	608	8	3

* RUC recommended value

Additionally, by proposing the median work RVU (24.00) for 31360, CMS has created an anomaly within the families of codes encompassed by our specialty. For example, 31230 *Maxillectomy with orbital exenteration (en bloc)* was approved by the RUC with CMS agreement at a median work RVU of 28.00. The total time and visits for 31230 and 31360 are very similar. Also, 31225 *Maxillectomy without orbital exenteration*, which involves less work, was approved by the RUC with CMS agreement at a median work RVU of 24.00.

CPT	Description	RVW	Time	HV	OV
31360	Laryngectomy; total, without radical neck	28.00*	714	8	6
31225	Maxillectomy without orbital exenteration	24.00	568	5	5
31230	Maxillectomy with orbital exenteration	28.00	647	6	5

* RUC recommended value

Based on these comments, the RUC would like to reaffirm its recommendation of 28.00 work RVUs for code 31360.

31365 *Laryngectomy; total, with radical neck dissection*

Code 31365 adds radical neck dissection to the work of code 31360. The survey median work RVU for 38720 *Cervical lymphadenectomy (complete)* (20.00) was approved by the RUC with CMS agreement. In reviewing 31365, the RUC considered the incremental work of radical neck dissection in its recommended work RVU, as approximately 50 percent of the work RVU for 38720 (i.e., utilization of the multiple procedure payment rule). By proposing the median work RVU (31.50) for 31365, CMS has created an anomaly within the families of codes encompassed by our specialty.

Additionally, the specialty society presented three MPC codes that support the RUC recommendation.

	CPT	Description	RVW	Time	HV	OV
Survey	31367	Laryngectomy; total, with radical neck	37.00*	838	9	6
MPC	19364	Breast reconstruction with free flap	40.94	730	5	6
MPC	33405	Replacement, aortic valve	34.95	567	8	4
MPC	33426	Valvuloplasty, mitral valve	32.95	571	7	3

*RUC recommended value

Based on these comments, The RUC reaffirms its recommendation of 37.00 work RVUs for code 31365.

31367 *Laryngectomy; subtotal supraglottic, without radical neck dissection*

For CPT code 31367, the code cited most often in the specialty society survey as a reference was CPT 60252 *Thyroidectomy, total or subtotal for malignancy; with limited neck dissection* (RVW= 20.54). The intra-operative time is the same for the two procedures, but 31367 requires more preservice work related to discussing/preparing for emergency airway access. LOS is significantly greater for 31367 because these patients will have their airway compromised and need a tracheotomy that will require monitoring for swallowing and diet. The RUC believes the choice of this reference code and the use of magnitude estimation resulted in an underestimation of the total work for 31367. In terms of RVW, time, and post-op work, the RUC recommended work RVU (27.36) is deemed a reasonable relative value when compared with the three MPC codes and the survey reference code as shown below.

	CPT	Description	RVW	Time	HV	OV
Survey	31367	Laryngectomy; supraglottic without radical neck	27.36*	675	7	6
Ref	60252	Thyroidectomy; with limited neck dissection	20.54	446	4	3
MPC	27134	Revision total hip arthroplasty	28.48	608	8	3
MPC	45110	Proctectomy; complete, AP with colostomy	27.96	624	9	4
MPC	61510	Craniectomy, for excision brain tumor	28.41	609	7	4

* RUC recommended value

Additionally, by proposing the median work RVU (24.00) for 31367, CMS has created an anomaly within the families of codes encompassed by our specialty. For example, 31230 *Maxillectomy with orbital exenteration (en bloc)* was approved by the RUC with CMS agreement at a median work RVU of 28.00. The total time for 31230 and 31367 are very similar. Also, 31225 *Maxillectomy without orbital exenteration*, which involves less work, was approved by the RUC with CMS agreement at a median work RVU of 24.00.

CPT	Description	RVW	Time	HV	OV
31367	Laryngectomy; supraglottic without radical neck	27.36*	675	7	6
31225	Maxillectomy without orbital exenteration	24.00	568	5	5
31230	Maxillectomy with orbital exenteration	28.00	647	6	5

* RUC recommended value

Based on these comments, the RUC reaffirms its recommendation of 28.00 work RVUs for code 31367.

31368 *Laryngectomy; subtotal supraglottic, with radical neck dissection*

Code 31368 adds radical neck dissection to the work of code 31367. The survey median work RVU for 38720 *Cervical lymphadenectomy (complete)* (20.00) was approved by the RUC with CMS agreement. In reviewing 31368, the RUC considered the incremental work of radical neck dissection in it's recommended work RVU as approximately 50 percent of the work RVU for 38720 (i.e., utilization of the multiple procedure payment rule). By proposing the median work RVU (30.50) for 31368, CMS has created an anomaly within the families of codes encompassed by our specialty. Additionally, the specialty society presented three MPC codes that support the RUC recommendation.

	CPT	Description	RVW	Time	HV	OV
Survey	31368	Laryngectomy; supraglottic with radical neck	36.00*	804	8	6
MPC	19364	Breast reconstruction with free flap	40.94	730	5	6
MPC	33405	Replacement, aortic valve	34.95	567	8	4
MPC	33426	Valvuloplasty, mitral valve	32.95	571	7	3

*RUC recommended value

Based on these comments, the RUC reaffirms its recommendation of 36.00 work RVUs for code 31368.

42845 *Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; closure with other flap*

For code 42845, the reference code cited most often in the RUC survey was 60254 *Thyroidectomy, total or subtotal for malignancy; with radical neck dissection* (RVW=26.95). Compared with 42845 the intra-op time, LOS, and office visits are all less

for 60254. Patients requiring 42845 remain in the hospital for a long time to monitor the flap, and because their overall health and nutrition are compromised as a result of the large active tumor in the throat, and most often because of previous chemotherapy and radiation. The RUC believes the choice of reference code 60254 and the use of magnitude estimation resulted in an underestimation of the total work for 42845. In terms of RVW, time, and post-op work, the RUC recommended work RVU (32.00) is a more reasonable relative value when compared with the three MPC codes and the survey reference code as shown below.

	CPT	Description	RVW	Time	HV	OV
Survey	42845	Radical resection of tonsil; closure w flap	32.00*	758	10	4
Ref	60254	Thyroidectomy; with radical neck dissection	26.95	476	4	3
MPC	15756	Free muscle/myocutaneous flap	35.18	796	9	6
MPC	33405	Replacement, aortic valve	34.95	567	8	4
MPC	33426	Valvuloplasty, mitral valve	32.95	571	7	3

* RUC recommended value

Compared with the work RVUs for other codes performed by our specialty and surveyed and approved by the RUC with CMS agreement, valuing 42845 at the RUC recommended value of 32.00 maintains rank order.

Based on these comments, the RUC reaffirms its recommendation of 32.00 work RVUs for code 42845.

41155 *Glossectomy; composite procedure with resection floor of mouth, mandibular resection, and radical neck dissection (Commando type)*

For code 41155, the reference code cited most often in the RUC survey was 60254 *Thyroidectomy, total or subtotal for malignancy; with radical neck dissection* (RVW=26.95). The RUC believes the choice of reference code 60254 and the use of magnitude estimation resulted in an underestimation of the total work for 41155. In terms of RVW, time, and post-op work, the RUC recommended work RVU (40.00) is a more reasonable relative value when compared with the three MPC codes and the survey reference code as shown below.

	CPT	Description	RVW	Time	HV	OV
Survey	41155	Glossectomy; composite with RND (Commando)	40.00*	899	10	6
Ref	60254	Thyroidectomy; with radical neck dissection	26.95	476	4	3
MPC	33405	Replacement, aortic valve	34.95	567	8	4
MPC	33426	Valvuloplasty, mitral valve	32.95	571	7	3
MPC	19264	Breast reconstruction with free flap	40.94	730	5	6

* RUC recommended value

Additionally, the RUC recommendation maintains rank order within and between the families of head and neck surgical procedures and with other major oncologic resections

that have similar length, complexity, and impact of decision making, such as 45126, 47120, and 48150, as shown below.

CPT	Description	RVW	Time	HV	OV
41155	Glossectomy; composite with RND (Commando)	40.00*	899	10	6
45126	Pelvic exenteration for colorectal malignancy	45.09	866	9	4
47120	hepatectomy, partial lobectomy	35.45	730	9	4
48150	Pancreatectomy, Whipple	47.93	1078	13	4

Based on these comments, the RUC reaffirms its recommendation of 40.00 work RVUs for code 41155.

31390 *Pharyngolaryngectomy, with radical neck dissection; without reconstruction*

For CPT code 31390, 60254 *Thyroidectomy with radical neck dissection* (RVW=26.95) and CPT 43107 *Total or near total esophagectomy, without thoracotomy; with pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty (transhiatal)* (RVW=39.94) were cited equally as key references. The specialty society believes that 43107 is a better reference code because of its very similar total work. Further, the choice of reference code 60254 and the use of magnitude estimation resulted in an underestimation of the total work for the survey respondents who chose this code. In terms of RVW, time, and post-op work, the RUC recommended work RVU (40.00) is a more reasonable relative value when compared with the three MPC codes and the survey reference codes as shown below.

	CPT	Description	RVW	Time	HV	OV
Survey	31390	Pharyngolaryngectomy, RND, w/o reconstruct	40.00*	920	9	6
Ref	43107	Esophagectomy, total, w/o thoracotomy	39.94	912	11	4
Ref	60254	Thyroidectomy; with radical neck dissection	26.95	476	4	3
MPC	19264	Breast reconstruction with free flap	40.94	730	5	6
MPC	33405	Replacement, aortic valve	34.95	567	8	4
MPC	33426	Valvuloplasty, mitral valve	32.95	571	7	3

* RUC recommended value

Additionally, the RUC recommendation maintains rank order within and between the families of head and neck surgical procedures and with other major oncologic resections that have similar length, complexity, and impact of decision making, such as 45126, 47120, and 48150, as shown below.

CPT	Description	RVW	Time	HV	OV
31390	Pharyngolaryngectomy, RND, w/o reconstruct	40.00*	920	9	6
45126	Pelvic exenteration for colorectal	45.09	866	9	4

	malignancy				
47120	hepatectomy, partial lobectomy	35.45	730	9	4
48150	Pancreatectomy, Whipple	47.93	1078	13	4

Based on these comments, the RUC reaffirms its recommendation of 40.00 work RVUs for code 31390.

31395 *Pharyngolaryngectomy, with radical neck dissection; with reconstruction*

For CPT code 31395, 43107 *Total esophagectomy without thoracotomy; with pharyngogastrostomy* (RVW=39.94) was cited as the key references for 31395. Compared with the reference code, 31395 requires 100 minutes more intra-operative time, two additional office visits, and one less hospital visit. The RUC recommended an incremental value for the additional work of 31395 when compared to 31390 or 43107 as 4.00 work RVUs. The RUC recommendation for 31395 maintains rank order within and between the families of head and neck surgical procedures and with other major oncologic resections that have similar length, complexity, and impact of decision making, such as 45126, 47120, and 48150, as shown below.

CPT	Description	RVW	Time	HV	OV
31395	Pharyngolaryngectomy, RND, with reconstruct	44.00*	979	10	6
31390	Pharyngolaryngectomy, RND, w/o reconstruct	40.00*	920	9	6
43107	Esophagectomy, total, w/o thoracotomy	39.94	912	11	4
45126	Pelvic exenteration for colorectal malignancy	45.09	866	9	4
47120	hepatectomy, partial lobectomy	35.45	730	9	4
48150	Pancreatectomy, Whipple	47.93	1078	13	4

* RUC recommended value

Based on these comments, the RUC reaffirms its recommendation of 44.00 work RVUs for code 31395.

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June 7, 2006

Dr. Tracy R. Gordy, Chair
AMA CPT Editorial Panel
515 N. State Street
Chicago, IL 60610

Dear Dr. Gordy:

On behalf of the American College of Cardiology (ACC) and the American Society of Echocardiography (ASE), we wish to follow up on the Relative Value Update Committee (RUC)'s 5-year Review recommendation that the AMA CPT Editorial Panel consider whether or not CPT Code 93325 (Doppler echocardiography color flow velocity mapping) (add-on code) should be "bundled" into CPT Code 93307 (echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording, complete). After considerable discussion with leadership in the field and in our societies, we would like to take this opportunity to share our concerns with this recommendation.

The RUC's review of CPT code 93325 was requested by the Centers for Medicare and Medicaid Services (CMS) in conjunction with the five year review of work relative value units (W-RVUs) because these W-RVUs had not been subject to RUC review previously. While the ACC conducted a survey of the physician work associated with CPT code 93325 in accordance with established RUC survey procedures, this survey data was not seriously considered by the RUC. Rather, because the number of claims for color Doppler was roughly the same as the number of claims for transthoracic echocardiography (CPT code 93307), the RUC recommended that CPT Code 93325 be referred to the Editorial Panel to consider whether or not it should be "bundled" into CPT Code 93307.

This recommendation was made over the strenuous objection of the ACC and the ASE. In fact, while many transthoracic echocardiograms are (appropriately) performed with color Doppler, about half a million transthoracic echocardiograms are performed without color Doppler, and a stand-alone color Doppler code remains necessary for use with other echocardiography services in order for physicians to accurately report the procedures they perform.

The reasons for the ACC/ASE stance on this matter were set forth at length in correspondence sent to Dr. Ken Simon at CMS in September, 2005. This correspondence was also shared with members of the RUC shortly in advance of its meeting in September 2005. A copy is attached for your review.

The ACC, in conjunction with the ASE, reviewed the issue following the RUC's decision to refer the matter to the Editorial Panel, and reaffirmed its position that the current echocardiography nomenclature should not be modified. For that reason, even though ACC was provided an opportunity to submit a CPT code proposal to "bundling" CPT code 93325 into CPT Code 93307, ACC does not intend to submit a CPT Code proposal. It is our continued strong belief that the current nomenclature facilitates the most accurate reporting of the echocardiography procedures that are actually performed by cardiologists and other physicians.

However, in advance of the February 2006 Editorial Panel meeting, the ACC did follow up with CMS, which had initially submitted CPT Code 93325 for the five year review. In its correspondence with Dr. Ken Simon, the ACC requested clarification of CMS' intent. On behalf of CMS, Dr. Simon indicated to the ACC that CPT Code 93325 would likely not be addressed as part of the five year review. CMS's written reply further states: ***"If we decide to review this code, it will be as part of our usual rule-making process."*** (Emphasis added.) We would be delighted to provide a copy of this correspondence upon request.

We hope that this clarifies the current status of this matter, as we understand it. If you have any further questions regarding our position that are not addressed by this correspondence and the attached letter, please contact us personally on behalf of our organization.

Sincerely yours,

James C. Blankenship

James C. Blankenship, MD, FACC
ACC Representative, AMA/Specialty Society RVS Update Committee

Diane E. Wallis, MD, FACC
ACC Advisory Committee Member, AMA CPT Editorial Panel

CC; William Rich, MD, Chair, AMA/Specialty Society RVS Update Committee
Peter Holmann, MD, AMA CPT Editorial Panel Representative to AMA/Specialty Society RVS Update Committee
Roseanne M. Eagle, MPP, AMA Department of Physician Payment Policy and Systems
Alan Pearlman, MD, ASE Representative to ACC RVS Update Committee
Michael Piccard, MD, President, ASE
Thomas Ryan, MD, Vice President, ASE
Diane Millman, JD, Washington Council, ASE
Janice Brannon, Advocacy Director, ASE

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April 20, 2006

RUC Members, Alternates & Family
c/o AMA Division of Payment Policy
515 North State Street
Chicago, IL 60610 -

Dear Colleagues:

By our RUC *Structure and Functions* there are three of us who have specified term limits. Those are two years for our Chair (renewable for a maximum tenure of six years), and three years (renewable for a maximum tenure of six years) for each of the AMA Member and Alternate. Having reached the end of a twelve year succession, I will finish my term after this meeting. It has been a very great privilege – as well as a personal pleasure - to serve on our AMA/Specialty Society RUC, and with each of you…I think of Baldwin Smith's thoughtful comments in this regard, and agree with them completely.

I wanted to leave with three specific thoughts for the RUC as you go forward. First, per our *Structure and Functions*: "Specialty Society representatives shall execute independent judgment in their deliberations consistent with membership on the RUC."

Many individuals have worked to help the RUC – help all of us, and our specialty members and patients – to keep our proceedings as fair and impartial as possible. I remember numerous occasions with members striving so carefully to keep objective and fair (recalling a few episodes with Jim Moorefield, Chuck Novak and Grant Rodkey, for example) that their own specialties became upset! But it has been a very worthwhile effort. Together, we *are* stronger, if we can maintain our objectivity, our "RUC" hats. Our Chair and AMA member and alternate will work toward this objective, but it is *all* of our responsibility that we, when sitting on the RUC, remain as fair, open, objective and impartial as possible. Please help remind each other – and take pride in – this history and continuing goal.

Secondly, I would like to comment on the recently released MedPAC March Report. Note the appended list of recommendations, and the summary:

> "The Commission evaluated CMS's five-year review process and determined that changes are necessary because previous five-year reviews led to substantially more increases in RVUs than decreases, even though many services are likely to become overvalued over time. Although we recognize the valuable contribution made by the American Medical Association/ Specialty Society Relative Value Scale Update Committee (RUC), we conclude that CMS's five-year review process does not do a good job of identifying services that may be overvalued. CMS has relied too heavily on physician specialty societies to identify services that are misvalued and provide supporting evidence."
>
> (Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2006, Washington DC, p. 134)

This *is* concerning! It is particularly concerning, however, in that there *is* truth here. The RUC process is very good. It has come a long way in developing objective mechanisms to determine relativity. But it *has been* at least to some degree inherently inflationary, and it *has not dealt* as well with identifying and addressing "overvalued" services.

This, however, is also an opportunity. We can correct this from *within* the RUC. Together we *are* stronger, and we need this advantage. I recommend the RUC consider adding two non-voting, liason seats with the specific intent of increasing our communications and our identification and pursuit of what others may feel are misvalued codes; one to be a representative contractor medical director and one a representative Medicare Plus medical director. This will bring these concerns, with data and thoughtful review, right into our RUC processes, while preserving the RUC as the reviewing and deciding body.

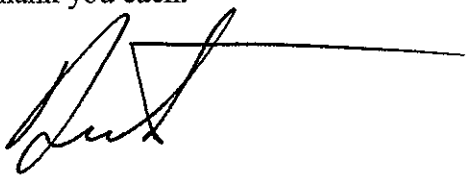
Third, and last, I recommend we aggressively pursue the idea coming from Barb Levy and others on our Administrative Subcommittee that we set up a mechanism for more

continuous identification and tracking of possible misvalued codes. We have been doing this in five-year spurts, waiting on CMS input. We need instead a more continuous mechanism that the RUC itself welcomes, identifies and follows such concerns, working them into our regular RUC processes (whether the ultimate resolution remains at five-year intervals, or some other mechanism we may develop).

It will be fun to watch RUC's continued growth in skill and success. I leave with absolute confidence this will occur, and will welcome any opportunity to continue to help, either as a CMD or personally. I also leave with many friends that will remain life-long. Nancy and I will shortly finish our long-planned home, and now with just the two of us there, will hope folks will find an opportunity to visit the Seattle area.

I'll close with a very special thank you to our AMA staff. Bill Rich and I have the opportunity to see more than most how exceptionally careful, thoughtful, detail-oriented and just all-around wonderful our support is. We are blessed!

Thank you each.



Richard W. Whitten, MD, FACP
Contractor Medical Director AK, HI & WA

RWW:mms
Att.

RUC Members, Alternates & Family
April 20, 2006
Attachment to Letter

RECOMMENDATIONS

3-1 The Secretary should establish a standing panel of experts to help CMS identify overvalued services and to review recommendations from the RUC. The group should include members with expertise in health economics and physician payment, as well as members with clinical expertise. The Congress and the Secretary should ensure that this panel has the resources it needs to collect data and develop evidence.

COMMISSIONER VOTES: YES 15 • NO 0 • NOT VOTING 0 • ABSENT 2

. . . . . .

3-2 The Secretary, in consultation with the expert panel, should initiate the five-year review of services that have experienced substantial changes in length of stay, site of service, volume, practice expense, and other factors that may indicate changes in physician work.

COMMISSIONER VOTES: YES 15 • NO 0 • NOT VOTING 0 • ABSENT 2

. . . . . .

3-3 In consultation with the expert panel, the Secretary should identify new services likely to experience reductions in value. Those services should be referred to the RUC and reviewed in a time period as specified by the Secretary.

COMMISSIONER VOTES: YES 15 • NO 0 • NOT VOTING 0 • ABSENT 2

. . . . . .

3-4 To ensure the validity of the physician fee schedule, the Secretary should review all services periodically.

COMMISSIONER VOTES: YES 15 • NO 0 • NOT VOTING 0 • ABSENT 2

(Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2006, Washington DC, p. 154)