

**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)	Walt Larimore, MD*
Bibb Allen, Jr., MD	M. Douglas Leahy, MD*
James Anthony, MD*	Barbara Levy, MD
Dennis M. Beck, MD*	Brenda Lewis, DO*
Michael D. Bishop, MD	J. Leonard Lichtenfeld, MD
James Blankenship, MD	Charles D. Mabry, MD*
Dale Blasier, MD*	Scott Manaker, MD
Ronald Burd, MD*	Charles Mick, MD
Norman A. Cohen, MD	Bill Moran, Jr., MD
Bruce Deitchman, MD*	Bernard Pfeifer, MD
James Denny, MD*	Gregory Przybylski, MD
John Derr, Jr., MD	David Regan, MD
Verdi DiSesa, MD*	James B. Regan, MD
Thomas A. Felger, MD	Daniel Mark Siegel, MD
Mary Foto, OTR	J. Baldwin Smith, III, MD
John O. Gage, MD	Peter Smith, MD
William F. Gee, MD*	Robert J. Stomel, MD*
Robert S. Gerstle, MD*	Susan M. Strate, MD
David F. Hitzeman, DO	Trexler Topping, MD
Peter Hollmann, MD	Arthur Traugott, MD*
Charles F. Koopmann, Jr., MD	Richard Tuck, MD
Michael Kuettel, MD, MBA, PhD*	Richard W. Whitten, MD
Gregory Kwasny, 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:
 - Facilitation Committee #1
 - 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
 - Kady 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

Removal of Pelvis Contents (Tab 4)

**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 for 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 for 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 mammoplasty* (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 that 15831 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	<u>2.64</u>
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 be 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 abdominis 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 annuloplasty 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 minutes 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 malignancies 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.

25 th 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.

25 th 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 (IWPUPUT=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 venous 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 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 (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 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 (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 IWP/UT of 35531 (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 IWPOT 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 agreed they 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 agreed they 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, open*, 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)programming 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 ($10 \times 0.17 = 1.70$) 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 ($4 \times 0.17 = 0.68$) 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 dietitians, SLPs and audiologists perform professional clinical services that stand alone. Additionally, that the knowledge, skills and judgments that must be made by dietitians, 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.

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. 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 lessen 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 compiled 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 Modifier -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 urethral 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 urethral 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.

<u>Axial Pattern Forehead Flap (1573X)</u>	8
The PERC made minor changes to the direct inputs for this code and recommends the amended inputs.	
<u>Panniculectomy (15830X, 15831)</u>	9
The PERC and specialty agreed on the standard 090 day global package for these codes.	
<u>Mohs Surgery (1730X1-1730X5)</u>	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.	
<u>Fibroadenoma Cryoablation (191X1)</u>	11
These codes were referred to a facilitation panel for discussion.	
<u>Breast Reconstruction (19361)</u>	12
The PERC and specialty agreed on the standard 090 day global package for these codes.	
<u>Percutaneous Intradiscal Annuloplast (IDET)</u>	13
(225X1-225X2) These codes were referred to a facilitation panel for discussion.	
<u>Excision of Tendon (2510X1)</u>	14
The PERC and specialty agreed on the standard 090 day global package for these codes.	
<u>Percutaneous RF Pulmonary Tumor Ablation (32XXX)</u>	15
The PERC discussed the non-facility and facility inputs, made minor modifications and accepted the specialty recommendation.	
<u>Initial Epicardial Electrode Insertion (3320X-3320X1)</u>	16
The PERC and specialty agreed on the standard 090 day global package for these codes.	
<u>Atrial Tissue Ablation and Reconstruction</u>	17
(3325X, 3325X1-3325X4) The PERC and specialty agreed on the standard 090 day global package for these codes.	
<u>Multiple Ventricular Septal Defect Corrections</u>	18
(3368X, 3368X1-3368X2) The PERC and specialty agreed on the standard 090 day global package for these codes.	
<u>Venous Anomalies (3373X, 3373X1-3373X3)</u>	19
The PERC and specialty agreed on the standard 090 day global package for these codes.	

<u>Thromboendarterectomy (3538A-3538E)</u>	20
The PERC and specialty agreed on the standard 090 day global package for these codes.	
<u>Carotid Bypass (35501-35509)</u>	21
The PERC and specialty agreed on the standard 090 day global package for these codes.	
<u>Aortobifemoral-Aortofemoral Bypass (3554Y1-3554Y2)</u>	22
The PERC and specialty agreed on the standard 090 day global package for these codes.	
<u>Aortobiliac-Aortoiliac Bypass</u>	23
(3554X1-3554X2; 3563X1-3563X2)	
The PERC and specialty agreed on the standard 090 day global package for these codes.	
<u>Carotid Bypass Graft (35601)</u>	24
The PERC and specialty agreed on the standard 090 day global package for these codes.	
<u>Femoral Anastomosis Revision (3587X1-3587X2)</u>	25
The PERC and specialty agreed on the standard 090 day global package for these codes.	
<u>Gastric Antrum Neurostimulation (436X1 – 439X4; 64590, 64595</u>	26
<u>(95970 – 95973)</u> 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.	
<u>Laparoscopic Permanent Intraperitoneal Catheter Insertion</u>	27
(493X1-493X5) These codes were referred to a facilitation panel for discussion.	
<u>Uterine Fibroid Embolization (5XXXX)</u>	28
The PERC discussed the non-facility and facility inputs, made modifications and accepted the specialty recommendation..	
<u>Circumcision (54150-54152; 54160-54161)</u>	29
These codes were referred to a facilitation panel for discussion.	
<u>Laparoscopic Radical Hysterectomy (5855X)</u>	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

Mary Foto, OTR, Co-Chair

Katherine Bradley, PhD, RN

Jonathan Cooperman, MS, PT, JD

Thomas Felger, MD

Robert Fifer, PhD

James Georgoulakis, PhD, JD

Anthony Hamm, DC

Emily H. Hill, PA-C

Christopher Quinn, OD

Lloyd Smith, DPM

Doris Tomer, LCSW

Arthur Traugott, MD

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 dietitians, 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 dietitians, SLPs and audiologists perform professional clinical services that stand alone. Additionally, that the knowledge, skills and judgments that must be made by dietitians, 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 compiled 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
Prepare/review/confirm procedure (including "time out" and other regulatory
- 14 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	
		Straightforward	Difficult
Procedure Type	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

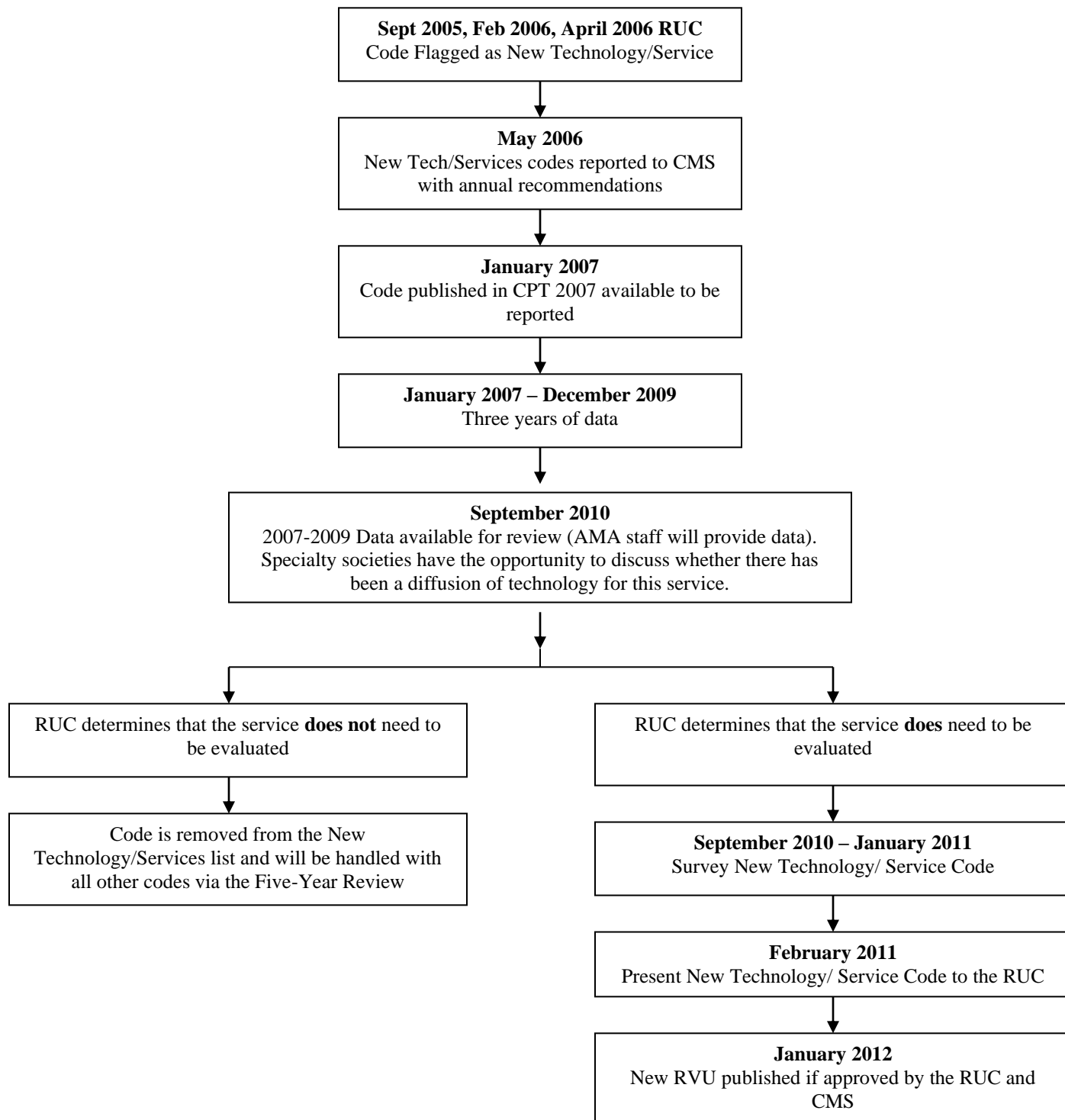
At the February 2006 Administrative Subcommittee meeting the Subcommittee recommended that the Conflict of Interest Policy Statement include “or any family member” to ensure that those signing this statement disclose any potential conflicts of financial interest that his or her family member may have.

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



**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.