AMA/Specialty RVS Update Committee
Meeting Minutes
April 24-27, 2008

I. Welcome and Call to Order

Doctor William Rich called the meeting to order on Thursday, April 24, 2008, at 9:00 am. The following RUC Members were in attendance:

William Rich, MD (Chair)
Bibb Allen, MD
James Anthony, MD
Michael D. Bishop, MD
James Blankenship, MD
Ronald Burd, MD
Norman A. Cohen, MD
John Derr, Jr., MD
Thomas A. Felger, MD
John Gage, MD
Meghan Gerety, MD
David F. Hitzeman, DO
Peter Hollmann, MD
Charles F. Koopmann, Jr., MD
Gregory Kwasny, MD
Barbara Levy, MD
J. Leonard Lichtenfeld, MD
Bill Moran, Jr., MD
Bernard Pfeifer, MD
Gregory Przybylski, MD
James B. Regan, MD
Daniel Mark Siegel, MD
Lloyd Smith, DPM
Peter Smith, MD
Samuel Smith, MD
Susan Spires, MD
Richard Tuck, MD
Maurits Wiersema, MD
Arthur Traugott, MD
Allan Anderson, MD*
Dennis M. Beck, MD*
Manuel D. Cerqueira, MD*
Scott Collins, MD*
Bruce Deitchman, MD*
James Denneny, MD*
Verdi DiSesa, MD*
Robert S. Gerstle, MD*
Emily Hill, PA-C*
Allan Inglis, Jr., MD*
Walt Larimore, MD*
M. Douglas Leahy, MD*
Brenda Lewis, DO*
William J. Mangold, Jr., MD*
Marc Raphaelson, MD*
Sandra B. Reed, MD*
Chad Rubin, MD*
Steven Schlossberg, MD*
Holly Stanley, MD*
Robert Stomel, DO*
J. Allan Tucker, MD*
James Waldorf, MD*
George Williams, MD*
*Alternate

II. Chair's Report

Doctor Rich made the following general announcements:

- Financial Disclosure Statements for each issue must be submitted to AMA staff prior to its presentation. If a form is not signed prior to the presentation, the individual will not be allowed to present.

- Presenters are expected to announce any conflicts or potential conflicts, including travel reimbursement paid by an entity other than the specialty society, at the onset of their presentation.
- Before a presentation, any RUC member with a conflict must state their conflict and the Chair will rule on recusal.
- RUC members or alternates sitting at the table may not present or advocate on behalf of their specialty.
- All RUC Advisors are required to sign the attestation statement.
- Doctor Rich welcomed the CMS staff and representatives attending the meeting, including:
    - Edith Hambrick, MD, CMS Medical Officer
    - Whitney May, Deputy Director, Division of Practitioner Services
    - Ken Simon, MD, CMS Medical Officer
    - Pam West, PT, DPT, MPH, Health Insurance Specialist
- Doctor Rich welcomed the following Medicare Contractor Medical Director:
    - Richard Whitten, MD
- Doctor Rich welcomed the following Medicare Payment Advisory Commission (MedPAC) staff
    - Kevin Hayes, PhD
- Doctor Rich announced the members of the Facilitation Committees

<u>Facilitation Committee #1</u>
Maurits Wiersema, MD (Chair)
James Anthony, MD
Michael Bishop, MD
James Blankenship, MD
Michael Chaglasian, MD
Norm Cohen, MD
Tom Felger, MD
Meghan Gerety, MD
Gregory Kwasny, MD
Barbara Levy, MD
William Mangold, MD
Eileen Moynihan, MD
Bernard Pfeifer, MD
Gregory Przybylski, MD

<u>Facilitation Committee #2</u>
Samuel Smith, MD (Chair)
Emily Hill, PA-C
John Gage, MD
Peter Hollmann, MD
Leonard Lichtenfeld, MD
Lawrence Martinelli, MD
Bill Moran, MD
Peter Smith, MD
Susan Spires, MD
Richard Tuck, MD

<u>Facilitation Committee #3</u>
Charles Koopman, MD (Chair)
Bibb Allen, MD
Ronald Burd, MD
John Derr, MD
David Hitzeman, MD
James Regan, MD
John Seibel, MD
Daniel Mark Siegel, MD
Lloyd Smith, DPM
Arthur Traugott, MD

- Doctor Rich welcomed the following individuals as observers at the April 2008 meeting:
  - Debra Abel – American Academy of Audiology
  - Margie Andreae – American Academy of Pediatrics
  - Linda Ayers – American Academy of Otolaryngology – Head and Neck Surgery
  - Brett Baker – American College of Physicians
  - William Beach, MD – American Academy of Orthopaedic Surgeons
  - David Beyer - American Society for Therapeutic Radiology and Oncology
  - Michael Bigby – American Academy of Dermatology
  - Michael Bourisaw – American College of Chest Physicians
  - Marla Brichta – American College of Chest Physicians
  - Darryl Bronson, DC – American Academy of Dermatology
  - Leo Bronson - American Chiropractic Association
  - Benjamin Byrd, MD – American College of Cardiology
  - Nicholas Cekosh – American Academy of Sleep Medicine
  - Rhea Cohn, PT, DPT – American Physicial Therapy Association
  - William Creevy, MD – American Academy of Orthopaedic Surgeons
  - Michele Daughrity – American Osteopathic Association Fred Davis - American Academy of Pain Medicine
  - Maurine Dennis – American College of Radiology
  - Octavio Duran – American Academy of Sleep Medicine
  - Michael Ehrenreich – American Academy of Dermatology
  - Thomas Eichler - American Society for Therapeutic Radiology and Oncology
  - Martha Espronceda - American Society for Gastrointestinal Endoscopy
  - Terry Fife, MD – American Academy of Neurology
  - Taylor Frawley – American Academy of Sleep Medicine
  - Emily Gardner – American College of Nuclear Cardiology
  - Richard Gilbert, MD – American Urological Association
  - David Glasser, MD – American Academy of Ophthalmology
  - John Goodson – American College of Physicians
  - Kelly Haenlein – American Academy of Dermatology
  - Bob Hall - American Association of Hip and Knee Surgeons
  - David Han – Society for Vascular Surgery
  - Robert Haralson, MD – American Academy of Orthopaedic Surgeons
  - Kristine Harvey, MD – American Academy of Ophthalmology
  - John Heiner - American Academy of Orthopaedic Surgeons
  - Jenny Jackson - American Society of Plastic Surgeons
  - Rebecca Kelly – American College of Cardiology
  - Cathy Kerr – American Society of Echocardiography
  - Douglas Khoury, MD - American Society of Colon and Rectal Surgeons
  - Katie Kuechenmeister - American Academy of Neurology
  - Debi Lansey – American Academy of Otolaryngology – Head and Neck Surgery
  - Lynne Marcus – American College of Chest Physicians

- Richard Marcus – American Academy of Sleep Medicine
- Alexander Mason, MD - American Association of Neurological Surgeons
- Faith McNicholas – American Academy of Dermatology
- Stephen McNutt - American Society for Therapeutic Radiology and Oncology
- Erika Miller – American College of Physicians
- Lisa Miller-Jones – American College of Surgeons
- David Nace, MD – American Psychiatric Association
- Gerald Neidzwiecki, MD – Society of Interventional Radiology
- Parag Parekh – American Academy of Ophthalmology
- Priyal Patel – American College of Chest Physicians
- Wayne Powell – American College of Cardiology
- Debbie Ramsburg – Society of Interventional Radiology
- Michael Repka, MD – American Academy of Ophthalmology
- Paul Rudolf, MD, JD – American Geriatrics Society
- Thomas Ryan – American College of Cardiology
- Andrew Sloan, MD - American Association of Neurological Surgeons
- James Startzell – American Association of Oral and Maxillofacial Surgeons
- Stan Stead, MD – American Society of Anesthesiologists
- Timothy Tillo – American Podiatric Medical Association
- Edward Vates, MD - American Association of Neurological Surgeons
- Joanne Willer – American Academy of Orthopaedic Surgery
- Kadyn Williams – American Academy of Audiology
- Karin Wittich - American Association of Oral and Maxillofacial Surgeons

- Doctor Rich thanked the following members leaving the RUC for their years of service and noted that this is the last meeting for which they will serve on the RUC:
  - John Derr, MD – American Society of Plastic Surgeons
  - Meghan Gerety, MD – American Geriatrics Society
  - Bernard Pfeifer, MD – American Academy of Orthopaedic Surgeons
  - James Regan, MD – American Urological Association
  - Richard Tuck, MD – American Academy of Pediatrics

III. Director's Report

Doctor Michael Maves, Executive Vice President/CEO of the AMA, addressed the RUC to extend his appreciation for the committee's work.

Sherry Smith made the following announcements:

- The following RUC members have been reappointed by their respective societies: Doctors Thomas Felger, John Gage, David Hitzeman, and Leonard Lichtenfeld.
- AMA staff has distributed a meeting evaluation form to assess the quality of the RUC meeting. Ms. Smith asks all attendees to complete the form at the conclusion of the meeting and to leave it at the registration desk.
- Future RUC meeting locations have been confirmed as follows:

- October 2-5, 2008, RUC Meeting, Renaissance Hotel, Chicago, IL
- Jan 29 – Feb 1, 2009, RUC Meeting, Pointe Hilton at Squaw Peak, Phoenix, AZ
- April 22-26, 2009, RUC Meeting, Swissotel, Chicago, IL
- October 1-4, 2009, RUC Meeting, Hyatt Regency, Chicago, IL
- February 4-7, 2010 RUC Meeting, Hilton Bonnet Creek, Orlando, FL

IV. Approval of Minutes for the February 1-3, 2008 RUC meeting

The RUC approved the minutes without revision.

V. CPT Editorial Panel Update

Doctor Peter Hollmann provided the report of the CPT Editorial Panel:

- The first meeting of the CPT Editorial Panel under new chair, William Thorwarth, Jr., MD took place February 7-10, 2008. The next meeting of the Panel will take place June 5-7, 2008 in Bonita Springs, FL.
- Specialty societies have been notified of the codes referred to the CPT Editorial Panel by the RUC through the bundled code screen of the Five-Year Review Identification Workgroup. Societies will be submitting coding change proposals to address the necessary changes in descriptors at the October 2008 and February 2009 Panel meetings.
- Michael Beebe, the Director of the CPT department of the AMA has resigned.

VI. Centers for Medicare and Medicaid Services Update

Doctor Ken Simon provided the report of the Centers for Medicare and Medicaid Services (CMS):

- Doctor Jeffrey Rich joined the Agency as Director of the Center for Medicare Management in the February 2008. Doctor Rich is a cardiac surgeon and has worked in quality arena for several years, primarily with the Society for Thoracic Surgery in the development of their database.
- The Agency is beginning the process of preparing the 2009 Proposed Rule. The Proposed Rule is scheduled to be published in the early summer of 2008, most likely during the month of June.
- Doctor Simon extended his appreciation to Doctor Hitzeman and the entire RUC Medical Home Workgroup for their efforts in developing a recommendation for the Medicare medical home demonstration project.

James Coan, Project Officer, CMS Office of Research, Development, and Information, made the following personal comments immediately subsequent to the RUC's unanimous approval of the recommendations regarding the Medical Home Demonstration project:

- "I have to congratulate the workgroup for their exceptional work, their time, their dedication, and their frequent comments along the way, which were helpful to say the very least and inspired at the very best. I am particularly pleased to be working on this demonstration from a professional sense. I had no idea what to expect with this particular workgroup. The composition of which was unbelievable – the brain-power, the hours, and the dedication were remarkable to me. I would like to congratulate them and, on behalf of CMS, thank them very much."

VII. Carrier Medical Director Update

Doctor Richard Whitten updated the RUC on several issues related to Medicare Contractor Medical Directors (CMDs).

- Doctor Whitten continued the explanation of the new Medicare Administrative Contracting (MAC) program, established under Section 911 of the Medicare prescription Drug, Improvement, and Modernization Act of 2003 to be completed by October 2011. Doctor Whitten noted that a number of contracts have been awarded since the last meeting of the RUC and provided a presentation highlighting the changes. The presentation is attached to these minutes.
- CMDs are encouraged to retire Local Coverage Determinations (LCDs) that are no longer necessary. That is, where there are no further instances of incorrect coding, CMDs will retire the LCD to avoid costs required to maintain and update the documentation. In the absence of a written LCD, it is the duty of the individual physician to continue to report services appropriately.
- Medicare's transition to the use of National Practitioner Identification (NPI) numbers is continuing. By May 23, 2008 all claims must include only NPIs and no longer use the traditional legacy numbers.

VIII. Washington Update

Sharon McIlrath, AMA Assistant Director of Federal Affairs, provided the RUC with the following information regarding the AMA's advocacy efforts:

- There are only 40 legislative days remaining until the 10.6% cut in the conversion factor is scheduled to occur on July 1, 2008.
- Three bills have been introduced and the Senate Finance Committee is discussing an additional proposal.
    - Sen. Stabenow has introduced a bill that includes continuation of the 0.5% increase throughout the remainder of 2008 and a 1.8% increase in 2009. The bill would fully fund the increase and has a cost of $40 billion.
    - Sens. Burgess and Cornin have introduced a bill that would repeal the SGR in 2010, but it too is very expensive.
    - Rep. Price has introduced a bill that would provide a 1% update for second half of 2008 and a 1.8% increase in 2009. However, this fix is funded through a "bonus" payment that is not funded and will have a negative impact on the SGR in 2010 resulting in estimated cuts of 20% or more.

- Several members of the House of Representatives support using the CHAMP Act as a model and extending the Act through the second half of 2008. The Senate is considering a more drastic change. The Senate Finance Committee is meeting now to discuss the SGR and hope to have a proposal by the end of April. The Committee does not intend to follow the normal order of having a markup session because of the time constraints. The Committee is considering the following factors in their proposal
  - An 18 month package covering the second half of 2008 and all of 2009.
  - Continuing the 0.5% update for 2008 and implementing a 1.1% update in 2009.
  - Funding the increase through a "bonus" payment that will not be funded with new dollars, which will result in an estimated cut of 20% or more in 2010.
  - Extension of the GPCI floor, scarcity bonus, and the PQRI bonus payments of 1.5%.
  - The proposal may also include a budget neutrality provision to increase payments for primary care.
    - Other potential items include electronic prescribing requirements, a ban on specialty hospitals, premium help for low income seniors, imaging accreditation requirements, and reporting of gifts to physicians from device and pharmaceutical manufacturers.
  - The Senate Finance Committee is likely going to pay for these increases by reapportioning money from Medicare Advantage plans, but the shift in money will likely be much smaller than the appropriation that resulted from the CHAMP Act. Specifically, the Senate is discussing the elimination of double payment of IME payments. Currently, Medicare provides payment to both MA plans and hospitals for the provision of IME services. By cutting the payment, $5 billion would be available over 5 years and $13 billion over 10 years. MA Plans are actively lobbying against this proposal on grounds that it will require premium increases or reduction of benefits. MA plans are also appealing to the hospitals to lobby against the reduction claiming that it might reduce MA Plan payments to hospitals.
- The final package is likely to be discussed and put forth by Senators Baucus, Grassley, McConnell, and Reid, with the White House in attendance as well. This may promote compromise and removal of the controversial issues. While Senator Reid has indicated that he would like to have a proposal on the Senate floor by mid-May, this is likely to be another 11th hour decision at the end of June or passed later in the year and made retro-active.

Kurt Gillis, PhD, AMA Principal Economist, provided the RUC with the following analysis of the 2007 volume and expenditure growth of Medicare Part B spending (the presentation is attached to these minutes):

- The information provided represents data from claims processed through December 2007 and is subject to change.
- Volume and intensity growth have been lower than average for evaluation and management, anesthesia, and major procedures. Volume and intensity growth has been higher than average for advanced imaging, tests, minor procedures, and

drugs. Overall, volume and intensity growth for all Medicare Physician Payment Schedule services increased by only 3%, the lowest since 1999.

- Based on these estimates, the first-ever decline in SGR spending is likely. SGR spending is expected to decrease by 0.6%. This is due to the combination of a 2.5% drop in FFS beneficiary enrollment, a 1% drop in Medicare Physician Payment Schedule payment across the board, and lower volume and intensity growth for services and drugs.

Kevin Hayes, PhD of the Medicare Payment Advisory Commission (MedPAC) provided the RUC with the following information regarding the Commission's upcoming report to Congress:

- The Report to Congress will be published on June 15, 2008 and contains several recommendations and informational sections relating to physician services.
- The report will contain two recommendations regarding primary care services:
  - The Commission will recommend to Congress a fee schedule adjustment for primary care services provided by practitioners that have a practice focused in primary care. The services that will receive the higher fee schedule adjustment will include services such as physician office visits, home healthcare visits, nursing home visits and other similar services. The fee schedule adjustment will be recommended to be budget neutral. Eligible practitioners would be defined either by specialty or by billing history. While specialty designation is more direct, MedPAC recognizes that Medicare specialties are self designated and some practitioners may indicate more than one specialty. This creates the possibility for abuse. The alternate methodology would look at the pattern of claims submitted by a single physician and identify patterns of primary care. Physicians that report primary care services beyond a certain threshold would be defined as primary care. MedPAC recognizes that evaluation and management services have seen increases in RVUs, but the Commission is concerned that primary care is in threatened and immediate action is necessary to encourage medical students to enter primary care residencies.
  - MedPAC will also recommend that Congress expand the Medical Home Demonstration project into a pilot project with an expanded nation-wide scope.
- The report will not make a recommendation, but will discuss bundling of payments surrounding a patient hospitalization or episode of care. MedPAC is researching ways to encourage hospitals and physicians to collaborate and to find efficiencies within an episode of care. The discussion will include promotion of gain sharing, reduction of re-admissions, and pilot projects involving bundled payments between physician and hospital payments.
- The report will also discuss public reporting of the conflicts of interest of individual physicians with pharmaceutical companies.
- Lastly, the report will discuss relationships between physicians and hospitals, specifically, joint ventures, hospital recruiting of physicians, and hospital employment of MDs and how it may affect volume.

IX. Relative Value Recommendations for CPT 2009

Intracranial Procedures Anesthesia (Tab 4)
Tripti Kataria, MD, MPH, American Society of Anesthesiologists

Code 00225 *Anesthesia for intracranial procedures; craniotomy or craniectomy for evacuation of hematoma* was created by the CPT Editorial Panel to address concerns expressed regarding the heterogeneity of the surgical procedures within code 00210 *Anesthesia for intracranial procedures; not otherwise specified* (Base Units = 11). The Panel created 00211 to extract the most common anesthesia procedures within 00210, craniotomy or craniectomy for evacuation of a hematoma, into its own code during the RUC's 5-Year review of anesthesia.

The RUC reviewed the survey data for CPT code 00211from 41 anesthesiologists who indicated the complexity/intensity measures for new code 00225 are equal to or slightly less than those for the key reference service 00210 (Base Units = 11). The survey data indicated that the total physician time was less for code 00225 at 175 minutes compared to its key reference code of 268 minutes, yet the specialty maintained the intensity was comparable to 00210. The RUC also reviewed code 00220 *Anesthesia for intracranial procedures; cerebrospinal fluid shunting procedures* (Base units = 10, total physician time = 171.50) in comparison to the new code and agreed that the physician work was similar. The RUC and the specialty society concurred that the value of 00211 should be valued at 10 base units, the 25th percentile of the specialty's survey data. **The RUC recommends a value of 10 Base Units for CPT code 00211.**

Practice Expense:
The RUC recommends the anesthesiology practice expense standard of 8 minutes of clinical labor time consisting of 3 minutes of anesthesia scheduling and 5 minutes of case assignment, scheduling coordination and completion of forms in the facility setting.

CABG Pump Oxygenator Anesthesia (Tab 5)
Facilitation Committee # 2
Tripti Kataria, MD, MPH, American Society of Anesthesiologists

In February 2008 the CPT Editorial Panel revised one CPT code and created a new code to address concerns regarding the heterogeneity of surgical procedures reported under code 00562 (pre CPT Editorial Panel change definition - *Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator* (2008 Base Units = 20).

Code 00562 was developed when the number of cardiac surgery codes was limited. Over the years, this code has been reported for an increasing number of more complex cardiac cases that are performed with pump oxygenator. New code 00567 *Anesthesia for direct coronary artery bypass grafting; with pump oxygenator* was established to encompass surgical CPT codes involving coronary artery bypass with pump oxygenator, preserving code 00562 for more complex surgical procedures including valvular repairs and rework

procedures. To capture the physician anesthesia services for these more complex surgical procedures, CPT code 00562 was revised as; *Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator, age one year or older, for all non-coronary bypass procedures (eg, valve procedures) or for re-operation for coronary bypass more than one month after original operation*.

00562

The RUC reviewed the survey results from 52 anesthesiologists who indicated code 00563 *Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator with hypothermic circulatory arrest* (Base Units = 25) as the key reference in revaluing this service. The specialty survey indicated a median base unit value of 25 however in comparison to its intensity and complexity measures with the key reference service, though high, were not as high as the 00563. The specialty society noted that most of the respondents (78.85%) indicated that they agreed with the typical patient description presented in the survey, those that did not agree with the vignette noted that the patient is usually significantly more complex. It was the survey respondents opinion that the case described in the survey represents the easiest patient and not the typical patient scenario. The specialty society recommended a value of 22 base units which lies between the 25th percentile and the median survey results. RUC disagreed because the survey results appeared overvalued in comparison to the key reference service, code 00563. The RUC concurred that if the value for the code had been 20 base units in the past there was no compelling evidence presented to increase the value as the specialty had recommended for this revised service. **The RUC recommends maintaining the physician work value of CPT code 00562 at 20 Base Units.**

00567

The RUC reviewed the survey results from 50 anesthesiologists who chose code 00566 *Anesthesia for direct coronary artery bypass grafting without pump oxygenator* (Base Units = 25) as the key reference in valuing this service. The specialty society's typical patient listed on their survey instrument was one undergoing direct coronary bypass grafting with pump oxygenator for ischemic heart disease. The specialty noted that coronary artery bypass patients are at greater risk for perioperative myocardial infarction. Anesthesia care must include special attention to maintaining an appropriate myocardial oxygen supply/demand balance and to aggressively treat myocardial ischemia when it occurs.

The specialty survey indicated a median base unit value of 21 Base Units. However, in comparison to its intensity and complexity measures with the key reference service, though high, were not as high as the 00566. The specialty society recommended a base unit value of 20 which was the survey's 25th percentile result. The RUC disagreed with this value, as the survey results were too high in comparison to the key reference service, code 00566. The RUC agreed that code 00566 is a different service than 00567 and the value of code 00567 should be below CPT code 00562 at a value between the specialty society's survey low and its 25th percentile, at a value of 18 base units. The specialty and the RUC agreed on the value of 18 Base Units for 00567 and the rank order base unit increment between 00567 and 00562. **The RUC recommends 18 Base Units for 00567.**

Practice Expense:
The RUC recommends the anesthesiology practice expense standard of 8 minutes of clinical labor time consisting of 3 minutes of anesthesia scheduling and 5 minutes of case assignment, scheduling coordination and completion of forms in the facility setting.

Computer Dependent External Fixation (Tab 6)
Facilitation Committee # 2
R. Dale Blasier, MD and William Creevy, MD, American Academy of Orthopaedic Surgery

The CPT Editorial Panel created two new codes to describe a unique external fixation system that requires specific resources and physician interventions that are not required for standard, non-computer dependent external fixators. The two new codes include one service for the initial application of the fixation system and a second for the replacement of the strut.

20696
The specialty society provided a thorough explanation of the physician work and intensity of computer dependent external fixation services 20696, *Application of multiplane (pins or wires in more than one plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; initial and subsequent alignment, assessment, and computation of adjustment schedule*. The specialty society and the RUC agreed that survey pre-service time was too high and changed the pre-service time to package number 3 (straightforward patient/difficult procedure). The RUC also added 12 minutes of positioning time to the 3 minutes within the package for a total of 15 minutes because the service requires positioning of the patient's thigh and heel to allow for open access. The RUC agreed that the surveyed median intra-service time was too high, and instead found the surveyed 25th percentile intra-service time to be accurate. The RUC compared another reference service, 20692 *Application of a multiplane (pins or wires in more than one plane), unilateral, external fixation system (eg, Ilizarov, Monticelli type)* (work RVU=16.00, IWPUT=.044, intra-service time = 120), to 20696 and agreed that its intra-service work per unit of time (IWPUT) was appropriate to compare to the survey code. In addition, the physician work relative value of 16.00 for 20692 appeared in line for this service except for the intra-service time. The RUC determined that the survey 25th percentile intra-service time of 150 minutes was appropriate and then used a building block methodology to value the service. The RUC began with 16.00 work RVUs from code 20692 and added 30 minutes at an intensity of 0.044 to reflect total 150 minutes of intra service time for 20696. This 1.32 RVU increment was added resulting in a final recommendation of 17.32 RVUs. 17.32 work RVUs for code 20696 was supported through the comparison and review of key reference code 27724 *Repair of nonunion or malunion, tibia; with iliac or other autograft (includes obtaining graft)* (work RVU=19.18), 22554 *Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2* (work RVU=17.54), and 22610 *Arthrodesis, posterior or posterolateral technique, single level; thoracic (with or without lateral transverse technique)* (work RVU=17.08). **The**

RUC recommends an intra-service time of 150 minutes (25th percentile survey) and a relative work value of 17.32 for code 20696.

20697

The specialty society requested and the RUC agreed that 20697, *Application of multiplane (pins or wires in more than one plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; exchange (ie, removal and replacement) of strut, each*, should be assigned a 000 global period. The specialty society presenters discussed the physician work and practice expense involved in code 20697. The presenters and the RUC concurred that the physician work for the change of the strut typically occurs within the 090 day global time period of code 20696 and is performed during one of the follow up visits. If the change of the strut occurs after the 090 day time period an evaluation and management code may be billed along with code 20697. The committee believed the purpose of code 20697 is to provide for the additional practice expense component associated with the change of the strut rather than the physician work. **The RUC, therefore, recommended 0.00 work relative units for 20697.**

Practice Expense

The RUC recommends the standard 090 day global practice expense packages for 20696 as it is only performed in the facility setting. The RUC agreed that the clinical labor time associated with code 20697 should be reduced from a total of 36 minutes to 21 minutes as the service would be reported with an E/M service either as part of a 090 day global or reported separately after 90 days. The RUC further agreed that the time for the equipment should be reduced from 36 minutes to 21 minutes.

New Technology

The RUC recommended that 20696 and 20697 be added to the New Technology list.

<u>Cervical Arthroplasty (Tab 7)</u>

John Wilson, MD, Frederick Boop, MD, Alexander Mason, MD, American Association of Neurological Surgeons/Congress of Neurological Surgeons, Charles Mick, MD, North American Spine Society, Dale Blaiser, MD, American Academy of Orthopaedic Surgery,

Total disc arthroplasty represents a treatment option for patients requiring surgical treatment of symptomatic degerative disc disease which has been refractory to conservative measures. Until this procedure was introduced, open surgical treatments were limited to either decompression or fusion using a variety of techniques. This technique allows for the preservation of nearly normal motion in the operated segment. Cervical arthroplasty received FDA approval last year and in February 2008 the CPT Editorial Panel deleted three and revised six Category III codes, and created three and revised three Category I CPT codes, for cervical total disc arthroplasty (artificial disc), anterior approach. The RUC reviewed the three newly created Category I CPT codes that

involve the total disc arthroplasty, the revision or replacement, and the removal of the disc.

22856 - *Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdisection), single interspace, cervical*
The RUC reviewed the survey results of 92 physicians and viewed them as robust both in physician time, complexity, and intensity for this new service. The RUC also compared three related services in order to value this service: the specialty's key reference service, code 63075 *Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace* (Work RVU = 19.47, 90 minutes intra service time); 22857 *Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), lumbar, single interspace* (work RVU = 26.93, intra-service time = 180 minutes); and 22554 *Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2* (work RVU = 17.54, Intra service time = 90 minutes). The median survey results indicated a intra-service time of 120 minutes for new code 22856. Based on the specialty survey results and these comparison of codes, the RUC and the specialty agreed that the value of 22856 should be between the value of 63075 (19.47) and 22857 (26.93).

The specialty had a good survey response for new code 22856, however they concurred that the respondents had over valued the service at a median survey RVU of 30.00. The RUC understood that the work of new code 22856 consisted of all the work of code 63075 plus the preparation of the end plates and the placement of the device in the spine, for this stand alone co-surgeon code. The complexity and intensity is realized when the surgeon mobilizes the great vessels around the spine and the exact placement of the device. The RUC constructed a work value of 23.90 based on the added time and intensity from its key reference service, 63075. The calculated value is the sum of the work RVU for 63075 plus 30 minutes additional intra-operative time at the same intensity, plus the difference of one post-operative office visit between a 99212 vs. 99213 [19.47 + (30 x 0.132) + 0.47 = 23.90]. The RUC agreed with the specialty's rationale and calculated value. **The RUC recommends a relative work value of 23.90 for code 22856.**

22864 *Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace, cervical*
22864 describes the removal of a previously implanted cervical artificial disc. The RUC and specialty agreed that the value of this code will be inextricably linked to the value of 22856 which is the code for insertion of the cervical artificial disc. With this code as with 22856 the RUC agreed with the specialty's rationale and calculated a value that is lower than the 25 percentile of our survey but is appropriately linked to the recommended value of 22856. The survey indicated 22864 had 30 minutes of additional intra time beyond 22856 and otherwise had essentially identical time and visit data except for one additional level 2 hospital visit. The calculated value is equal to (22856 recommended

RVW) + (30 minutes x IWPUT of base code 63075) + (one additional 99232 hospital visit). [23.90 + (0.132 x 30) + 1.39 = 29.25]

In addition to maintaining appropriate relativity to the base code of 22856, the recommended value also maintains relativity to the key reference code of 22865 Removal of total disc arthroplasty (artificial disc), anterior approach, lumbar, single interspace (work RVU = 31.55, intra service time = 210 minutes) which is also the removal of an artificial disc but in the lumbar spine. This key reference code has a work relative value of 31.55 which is 2.30 RVUs greater than the survey code. Code 22865 has 60 minutes more intra time which is accounted for by the tediousness of dissecting through the previously operated abdominal and retroperitoneal space. However the psychological stress and technical skill was rated higher by the survey respondents than the key reference code within the intra-service period of 150 minutes of new code 22856. **The RUC recommends 29.25 relative value units for code 22864.**

22861 ***Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace, cervical***
Code 22861 is the removal and replacement of a previously implanted cervical artificial disc. The value of this code will be inextricably linked to the value of 22856 which is the code for insertion of the cervical artificial disc and 22864 which is the code for the removal of an artificial cervical disc. With this code, as with 22856 and 22864, the RUC and the specialty agreed in the development of a calculated value that is lower than the 25th percentile of the survey, similar to its key reference service code 22862 *Revision including replacement of total disc arthroplasty (artificial disc) anterior approach, lumbar, single interspace* (work RVU = 32.43, intra-service time = 240). The survey indicated 22861 had 30 minutes of additional intra time beyond 22864 for the revision and replacement rather than just the removal, otherwise the two codes are essentially identical time and visit data. The RUC calculated and recommended relative value is equal to 22864 plus 30 minutes x IWPUT of base code 63075 [29.25 + (0.132 x 30) = 33.21]

In addition to maintaining appropriate relativity to the base code of 22856 and 22864, the recommended value also maintains relativity to the key reference code of 22862) which is also the removal and replacement of an artificial disc, but in the lumbar spine. Code 22862 has 60 minutes more intra time which is accounted for by the tediousness of dissecting through the previously operated and now scarred abdominal and retroperitoneal space. **The RUC recommends a relative work value of 33.21 for CPT code 22861.**

Practice Expense:
The RUC recommends the standard 090 day global practice expense packages for these services as they are only performed in the facility setting.

New Technology:
The RUC recommends that 22856, 22864, and 22861 be added to the new technology list as this procedure utilizes new techniques.

Pelvic Bone Fracture (Tab 8)
R. Dale Blasier, MD and William Creevy, MD, American Academy of Orthopaedic Surgery

In February 2008, the CPT Editorial Panel revised four codes to clarify reporting for pelvic bone fractures as being unilateral and clarification of the nature of ring fractures. These revisions clarify that these treatments pertain to unilateral services and when performed concurrently on the left and right sides of the body, they should be reported with modifier -50.

The RUC reviewed the following pelvic bone fracture codes and agreed with the specialty society that the revisions to the code descriptors were editorial as these services were previously valued as typically unilateral with internal fixation. The RUC recommends maintaining the current work RVUs for codes 27215, 27216, 27217 and 27218. The RUC reviewed the specialty society survey physician times and determined that the pre-, intra-, immediate post-service times and the post-operative visits indicated by the survey respondents were accurate for these revised services.

27215 ***Open treatment of iliac spine(s), tuberosity avulsion, or iliac wing fractures(s), unilateral for pelvic bone fracture patterns which do not disrupt the pelvic ring includes internal fixation, when performed***

The RUC recommends pre-service time package 4 – facility difficult patient/difficult procedure, with an additional 12 minutes of specific positioning time for placing the patient in a lateral decubitus position, support the patient's lower extremities and position fluoroscopic equipment for adequate visualization of the pelvis. Therefore, the pre-service time is 40 minutes evaluation time, 15 minutes positioning time and 20 minutes scrub, dress wait time. The RUC recommends the survey intra-service time of 120 minutes, immediate post service time of 20 minutes, 2-99231 hospital visits, 1-99232 hospital visit, 1-99238 discharge day management, 2-99212 office visits and 1-99213 office visit. **The RUC recommends new physician times and that the work RVU for 27215 be maintained at 10.45.**

27216 ***Percutaneous skeletal fixation of posterior pelvic bone fracture and/or dislocation, for fracture patterns which disrupt the pelvic ring, unilateral, (includes ipsilateral ilium, sacroiliac joint and/or sacrum)***

The RUC recommends pre-service time package 4 – facility difficult patient/difficult procedure, with an additional 22 minutes specific positioning time. Therefore the pre-service time is 40 minutes evaluation time, 25 minutes positioning time and 20 minutes scrub, dress wait time. The RUC recommends the survey intra-service time of 60 minutes, immediate post service time of 25 minutes, 3-99231 hospital visits, 1-99232 hospital visit, 1-99238 discharge day management, 1-99212 office visits and 3-99213

office visit. **The RUC recommends new physician times and that the work RVU for 27216 be maintained at 15.73.**

27217 ***Open treatment of anterior pelvic bone fracture and/or dislocation for fracture patterns which disrupt the pelvic ring, unilateral includes internal fixation when performed (includes ipsilateral pubic symphysis and/or superior/inferior rami)***

The RUC recommends pre-service time package 4 – facility difficult patient/difficult procedure, with an additional 12 minutes specific positioning time. Therefore the pre-service time is 40 minutes evaluation time, 15 minutes positioning time and 20 minutes scrub, dress wait time. The RUC recommends the survey intra-service time of 120 minutes, immediate post service time of 25 minutes, 3-99231 hospital visits, 1-99232 hospital visit, 1-99238 discharge day management, 1-99212 office visits and 3-99213 office visit. **The RUC recommends new physician times and that the work RVU for 27217 be maintained at 14.65.**

27218 ***Open treatment of posterior pelvic bone fracture and/or dislocation, for fracture patterns which disrupt the pelvic ring, unilateral, includes internal fixation, when performed (includes ipsilateral ilium, sacroiliac joint and/or sacrum)***

The RUC recommends pre-service time package 4 – facility difficult patient/difficult procedure, with an additional 37 minutes specific positioning time. Therefore the pre-service time is 40 minutes evaluation time, 40 minutes positioning time and 20 minutes scrub, dress wait time. The RUC recommends the survey intra-service time of 150 minutes, immediate post service time of 30 minutes, 5-99231 hospital visits, 1-99232 hospital visit, 1-99238 discharge day management, 1-99212 office visits and 3-99213 office visit. **The RUC recommends new physician times and that the work RVU for 27218 be maintained at 20.93.**

The RUC noted that the survey respondents indicated higher work RVUs than the current RVUs for each of these codes. The specialty society indicated that they will address the work RVUs at the fourth Five-Year Review.

Practice Expense
The RUC recommends the standard 090-day global direct practice expenses for the facility-setting as modified by the Practice Expense Subcommittee.

<u>Hepatorenal Bypass (Tab 9)</u>
Gary Seabrook MD, David Han MD, Robert Zwolak MD, Society for Vascular Surgery

The CPT Editorial Panel met in February 2008 and created new CPT code 35535 *Bypass graft, with vein; hepatorenal* to provide more specificity to bypass graph, with vein procedures. Currently there are codes for extra-anatomic bypass with vein for the splenic artery to the left renal artery and by direct splenic artery transposition onto the left renal

artery, however a mirror image procedure for the right side had not been addressed. This new service code identifies a similar bypass with vein but this bypass originates on the hepatic artery and ends on the right renal artery. Unlike aorto-renal revascularization, this alternative bypass is performed in patients who have significant cardiac disease and in whom manipulation of the aorta is understood to be inappropriate or excessively morbid.

Hepatorenal bypass with vein conduit is a highly complex renal salvage operation typically performed on patients whose clinical status places them at unacceptably high risk for aortic cross-clamp placement, and therefore not candidates for direct aorto-renal bypass. The typical patient is one with an aorta heavily laden with atherosclerotic plaque that is likely to suffer embolization of shattered plaque if a large vascular clamp were applied to the aorta. Another clinical indication is the patient with advanced coronary artery disease and/or congestive heart failure (CHF) in whom placement of an aortic clamp would pose a major risk for cardiac complications such as myocardial infarction, refractory CHF or cardiac death.

A random survey of 100 vascular surgeons indicated CPT code 35535 is a highly complex, intense, and time consuming procedure. The specialty society's survey results indicated a median relative work value of 35.00, however, due to the time, intensity, and complexity of the procedure the specialty recommended its 75th percentile survey RVU of 38.00. The RUC reviewed the specialty society's key reference service 35536 *Bypass graft, with vein; splenorenal* (work RVU = 33.60, intra-service work time = 240) in relation to this new code, and agreed that new service 35535 involved more physician work and effort. The RUC also reviewed codes 35531 *Bypass graft, with vein; aortoceliac or aortomesenteric* (work RVU = 38.98, intra-service time = 240 minutes, RUC MPC listed) and 35560 *Bypass graft, with vein; aortorenal* (work RVU = 33.90, intra-service time = 200) in relation to this new code. The RUC understood that hepato-renal bypass surgery scores near the top of all intensity and complexity measures and therefore, benchmarked the new code off of code 35536 and 35531.

Both 35536 and 35535 involve operations performed on patients with multiple advanced medical comorbidities typically including hyperlipidemia, coronary artery disease, diffuse atherosclerosis and severe hypertension. The survey code, hepato-renal bypass graft, is a more complex surgical procedure, requiring dangerous dissection in the portal triad just inferior to the liver with risk of injury to neighboring pancreas, common bile duct, portal vein and other vital structures. Arterial blood flow to the liver is interrupted while the proximal anastomosis is being performed and this results in post-operative hepatic dysfunction with LFT elevation, interruption of protein synthetic activity and the potential for post-operative coagulopathy. The intra-service duration of 35535 hepato-renal bypass is also substantially longer than spleno-renal bypass. This is reflected by the additional 60 minutes of intra-service time compared to the reference service. The specialty and RUC recommend a relative work value of 38.00 which is 4.40 RVUs more than the reference service and equates the service to the specialty society's 75th percentile survey result. This increment of 4.40 RVUs is justified by understanding that 60 minutes of intra-service time at an IWPUT of 0.09 would actually result in an intra-service increment of 5.40 RVUs.

Thus, the recommended 4.40 increment is a conservative adjustment for this additional intra-service time.

The RUC also acknowledged the closely related clinical service on the MPC list is CPT 35531, an intra-abdominal visceral revascularization using vein conduit. The relative work value of 35531 is slightly higher than the recommended work value for the 35535 hepatorenal bypass. However, code 35531 has 15 minutes more pre-service time than what the RUC recommends for 35535. The two services have identical intra-service time of 240 minutes. The intra-service work per unit of time (IWPUT) of the MPC reference and 35535 are nearly identical (0.087 and 0.090). Code 35531 has one more hospital visit than 35535, thereby accounting for the 0.98 higher RVW of this MPC reference service. Overall, the RUC concurred that the comparison with this MPC reference service serves to justify an RVW of 38.00 for 35535, hepato-renal bypass.

Code 35560 is another good comparison service from a clinical perspective because it accomplishes the same end-point, revascularization of a severely ischemic kidney. The major clinical differences are two-fold, first the 35560 patient is sufficiently healthy (or at least "less-sick") such that his/her aorta may undergo aortic cross-clamp placement. Second the aorto-renal bypass is 200 minutes in duration, 40 minutes less than the hepato-renal bypass. This reflects the additional time required to safely dissect out the common hepatic / proper hepatic / gastroduodenal artery region required for the hepato-renal bypass graft. This additional 40 minutes of intense intra-service time multiplied by the IWPUT may be considered to reflect 40 x 0.090 = 3.60 additional intra-service work RVUs. Adding the 3.60 intra-service RVUs to the reference service 33.90 RVW results in 37.50, within 2% of the value the RUC recommends for the new service.

The RUC agreed with the specialty society's rationale for choosing its 75th percentile survey results based on comparisons with three clinically-related RUC-surveyed vascular surgical services. **The RUC recommends a work relative value of 38.00 for code 35535.**

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

<u>Tibial-Tibial Bypass with Vein (Tab 10)</u>
Gary Seabrook MD, David Han MD, Robert Zwolak MD, Society for Vascular Surgery

Lower extremity bypass with autogenous conduit has been performed for limb salvage for over twenty years. The lower extremity bypass graft CPT codes are typically described based on inflow artery, outflow artery, and the conduit used. The CPT codes describing lower extremity revascularization with vein as conduit have been systematically described in the CPT manual for the majority of inflow and outflow combinations except tibial artery to tibial artery. The CPT Editorial Panel met in February 2008 and created code 35570

Bypass graft, with vein; tibial-tibial, peroneal-tibial, or tibial/ peroneal trunk-tibial to provide more specificity and to complete the family of lower extremity vein bypass codes.

35570 *Bypass graft, with vein; tibial-tibial, peroneal-tibial, or tibial/peroneal trunk-tibial*

The RUC reviewed the survey results from 39 vascular surgeons regarding new code 35570 and agreed the data was robust and reflected the time, complexity, and intensity of the service provided. In comparison, the RUC reviewed the specialty's key reference code 35671 *Bypass graft, with other than vein; popliteal-tibial or -peroneal artery* (work RVU = 20.64, intra-service time = 130), 44626 *Closure of enterostomy, large or small intestine; with resection and colorectal anastomosis (eg, closure of Hartmann type procedure)* (work RVU = 27.82, intra-service time = 150), and 35523 *Bypass graft, with vein; brachial-ulnar or –radial* (work RVU = 24.00, intra-service time = 180).

In comparison to the specialty's key reference service, both operations are performed on patients with peripheral arterial disease (PAD), but the reference service, because it requires larger size input, and because it uses synthetic conduit, requires much less operating room time than a tibial-tibial bypass graft using vein conduit. Specifically, 35570 has additional 105 minutes of intra-service time (240 minutes vs. 135 minutes) compared to the key reference service. That 105 minutes of additional intra-service time at an intra-service work per unit of time of 0.063 represents an intra-service increment of 6.62 RVUs. In addition, the 35570 patient has an ischemic ulcer, and the tibial-tibial arterial bypass graft patient has a longer and more intensive post-operative course. Inpatient post operative work totals 9.64 RVUs compared to 5.49 for 35671, an incremental difference of 4.15 RVUs. Thus, if one begins with the 20.64 RVW of the key reference, and adds 6.62 RVUs for intra-time, plus 4.15 RVUs of additional post-service time, the cumulative RVW for 35570 would be 31.41. [20.64+6.62+4.15 = 31.41].

The RUC found that CPT code 44626 *Closure of enterostomy, large or small intestine; with resection and colorectal anastomosis (eg, closure of Hartmann type procedure)* (work RVU = 27.28) is the closest 90-day global service (by relative work value ranking) on the RUC's Multi-Specialty Points of Comparison (MPC) list compared to the recommended RVW of new code 35570. 35570 requires much more intra-service time (240 minutes) than this MPC reference service (150 minutes). Additionally even using a conservative intra-service for arterial reconstructions, this increment would add 90 minutes x 0.063 = 5.67 RVUs to the value of the reference to estimate the value of the new service. 44626 has a two-day longer length of stay and a slightly different in-hospital visit profile with a total of 11.64 post-operative in-hospital work RVUs. This is 2.00 RVUs more than 35570, which has 9.64. In contrast, 44626 has one less office visit and 1.31 fewer office visit RVUs compared to 35570. Using these data, the RUC computed a value for 35570 from the MPC service 44626 by starting with the RVW of 44626 and making adjustments for intra and post-service. The calculation is 27.82 + 5.67 – 2.00 + 1.31 = 32.80. However, the RUC and specialty society agreed that the survey median RVU of 29.00 appropriately valued this service in light of the reference services.

Further supporting an RVU recommendation of 29.00 and in comparison to 35523, the RUC concurred that 35523 has a slightly less intense in-hospital and office visit pattern because the upper extremity has fewer wound healing problems and requires a slightly shorter hospital stay. The hospital and office visit pattern are slightly greater magnitude on the leg wherein the foot ulcer is more likely to be infected and requiring attention with antibiotics, etc. Total post-service work for the new code 35570 is 12.40 compared to 7.76 for 35523, an incremental difference of 4.64 in favor of the new service.

The RUC believed that tibial-tibial bypass carries very high intensity and complexity values. Patients who require this vascular reconstruction are elderly and always have many associated medical co-morbidities. After review of the specialty survey results, comparing similar and related codes, and gaining a clear picture of the service, the RUC agreed with the specialty society 's survey median work RVU of 29.00 for new service 35570. **The RUC recommends a relative work value of 29.00 for code 35570.**

Practice Expense:
The RUC recommends the standard 090 day global practice expense packages for these services as they are only performed in the facility setting.

Ilio-celiac Bypass, Ilio-mesenteric Bypass and Ilio-renal Bypasswith (Tab 11)
Gary Seabrook MD, David Han MD, Robert Zwolak MD, Society for Vascular Surgery

The CPT Editorial Panel met in February 2008 and created three new procedure codes that would allow for more specific reporting of vascular bypass operations. Prior to this meeting, procedure codes to report extra-anatomic bypass grafts to route blood around stenotic or occluded mesenteric arteries had not been created, only aortic based procedures using either vein or other than vein for revascularization of the superior mesenteric artery or celiac artery existed. One alternative inflow sources is constructed from the iliac artery, is well established, and available for both mesenteric bypasses. Three new procedure codes were created to allow for this specific reporting of this bypass operation.

35632 *Bypass graft, with other than vein; ilio-celiac*
The specialty society indicated that ilio-celiac bypass with synthetic conduit is a highly complex visceral salvage operation typically performed on patients whose clinical status places them at unacceptably high risk for aortic cross-clamp placement and who are therefore not candidates for direct aorto-celiac bypass. One typical indication is the patient with an aorta aneurysm that might rupture if a large vascular clamp were applied. Other clinical presentations include patients with diffuse aortic atherosclerotic plaque creating a risk for embolization, or patients with advanced coronary artery disease and/or congestive heart failure (CHF) in whom placement of an aortic clamp would pose a major risk for cardiac complications such as myocardial infarction, refractory CHF or cardiac death. All typical patients who undergo this operation were agreed to be significantly malnourished and at increased risk for post-operative infection and wound healing problems.

The RUC reviewed the specialty society's survey results from 33 vascular surgeons who concurred that the key reference service code 35631 *Bypas graft, with other than vein; aortoceliac, aortomesenteric, aortorenal* (work RVU = 35.90) was almost identical in its physician time, intensity, and complexity measures. The specialty and the RUC agreed that both operations had similar risks to the patient and stress placed upon the physician. The new code, ilio-celiac bypass, has 15 more minutes of intra-service time (240 vs. 225), due to the distant dissection of the common iliac artery and all the considerations and work associated with tunneling a longer graft from the pelvis to the upper abdomen, avoiding kinks, creating unusual and dangerous tunnels (e.g. retro-pancreatic), etc. With the established complexity of the intra-service portion of this operation, the 15 minute increment reflecting approximately 1.23 additional RVUs for the new service compared to the reference, and an intensive care visit not present in the reference code, the RUC agreed that the specialty society's recommended work value for code 356X1 of 36.00. The RUC also reviewed physician services 33512 *Coronary artery bypass, vein only; three coronary venous grafts* (work RVU = 43.87) and 43621 *Gastrectomy, total; with Roux-en-Y reconstruction* (work RVU = 39.40) in relation to 35632 for physician time, intra-service work per unit of time, and complexity. The RUC agreed that the specialty society's median survey results as recommended by the specialty provided for the proper rank order between these services and amongst other vascular surgical operations. **The RUC recommends a relative work value for CPT code 35632 of 36.00.**

35633 Bypass graft, with other than vein; ilio-mesenteric

The specialty society indicated that ilio-SMA bypass with synthetic conduit is a highly complex visceral salvage operation typically performed on malnourished patients whose clinical status indicates an unacceptably high risk for aortic cross-clamp placement, thereby excluding them from direct aorto-SMA bypass. One typical clinical indication is the patient with an aorta aneurysm that might rupture if a large vascular clamp were applied. Other clinical settings include patients with diffuse aortic atherosclerotic plaque creating a risk for diffuse embolization if a clamp were placed, or patients with advanced coronary artery disease and/or congestive heart failure (CHF) in whom placement of an aortic clamp would pose a major risk for cardiac complications such as myocardial infarction, refractory CHF, and cardiac death. All typical patients who undergo this operation are significantly malnourished and therefore at increased risk for post-operative infection and wound healing problems.

The RUC reviewed the specialty society's survey results from 33 vascular surgeons who concurred the key reference service code 35631 *Bypas graft, with other than vein; aortoceliac, aortomesenteric, aortorenal* (work RVU = 35.90) was almost identical in its physician time, intensity, and complexity measures. The specialty and the RUC agreed that both operations had similar risks to the patient and stress placed upon the physician. In addition, both operations are performed on malnourished patients with multiple advanced medical comorbidities typically including hyperlipidemia, coronary artery disease, and diffuse atherosclerosis. Both procedures require complex and dangerous dissection in a vascular space rarely approached by surgeons. There is also risk associated with the possibility of injury to neighboring bowels, pancreas, common bile duct, portal vein and

other vital structures. Both procedures carry major risk of hemorrhage, transient post-operative hepatic dysfunction with all the associated sequelae, and in this case there is risk for bowel infarction. The specialty indicated that vascular surgeons often perform 35633 ilio-mesenteric bypass on patients who are even more ill than those who undergo 35631 based on cardiac co-morbidities or the presence of intra-aortic pathology that make it too dangerous to approach the aorta directly, as in 35631.

The RUC and the specialty agreed that new code, ilio-mesenteric bypass, has 15 more minutes of intra-service time (240 vs. 225), due to 1) the dissection of the common iliac artery in the pelvis, 2) the longer graft that must be placed, and 3) all the considerations of graft tunneling, kink avoidance, etc. associated with that longer graft. The intensity of the dissection is the same in both cases, while the intensity of the iliac dissection is slightly less than the intensity of the aortic dissection in 35631. Thus, there is 15 minutes of additional intra-service time, but the overall intra-service intensity is slightly less. It is the hospital visit pattern that makes the primary difference in work values. 35633 includes two intensive care visits that are not present in the reference code. The in hospital post service work RVUs are therefore 14.58 compared to 7.58 in the reference. With the office visit patterns are identical, and beginning with the work value of 35.90 from the reference service, and adding 7.58 RVUs to reflect the additional inpatient post operative care, the RUC estimated the physician work of the new code at 35.90 plus 7.58, or 43.48 RVUs. However, the RUC and the specialty agreed that this work RVU of 43.48 would establish a rank order anomaly with code 33512 *Coronary artery bypass, vein only; three coronary venous grafts* (work RVU = 43.87) and 43621 *Gastrectomy, total; with Roux-en-Y reconstruction* (work RVU = 39.40). Therefore, the RUC and the specialty agreed that the proper valuation and rank order for code 35633 was the 75th percentile specialty survey value of 38.98. **The RUC recommends a relative work value for code 35633 of 38.98.**

35634 Bypass graft, with other than vein; ilio-renal

The specialty society indicated that ilio-renal bypass with synthetic conduit is a highly complex renal salvage operation typically performed on patients with severe hypertension and at least some degree of renal insufficiency whose clinical condition includes an unacceptably high risk for aortic cross-clamp placement, thereby excluding them from direct aorto-renal bypass surgery. One typical indication is the patient with an aorta aneurysm that might rupture if a large vascular clamp were applied. Other clinical settings include patients with diffuse aortic atherosclerotic plaque creating a risk for diffuse embolization if a clamp were placed, or patients with advanced coronary artery disease and/or congestive heart failure (CHF) in whom placement of an aortic clamp would pose a major risk for cardiac complications such as myocardial infarction, refractory CHF, and cardiac death. Virtually all patients who undergo this operation are elderly and have multiple significant medical co-morbidities such as a long history of tobacco abuse, coronary artery disease, COPD, hypertension, and hyperlipidemia.

The RUC reviewed the specialty society's survey results from 33 vascular surgeons who concurred the key reference service code 35631 *Bypas graft, with other than vein; aortoceliac, aortomesenteric, aortorenal* (work RVU = 35.90) was almost identical in its physician time, intensity, and complexity measures to code 35634. The specialty and the

RUC agreed that both operations had similar risks to the patient and stress placed upon the physician. In addition, both operations are performed on patients with multiple advanced medical comorbidities typically including coronary artery disease, hypertension, hyperlipidemia, diffuse atherosclerosis plus all the ravages brought about by decades of tobacco abuse. Both procedures require complex and dangerous arterial dissection. There is risk of injury to neighboring bowels and kidneys. Both procedures carry major risk of hemorrhage and transient post-operative renal dysfunction with all the associated sequelae. In addition to these similarities, vascular surgeons oftentimes perform 35634 ilio-renal bypass on patients who are even more ill than those who undergo 35631 based on cardiac co-morbidities or the presence of aortic pathology.

The RUC and specialty agreed that new code 35634, ilio-renal bypass, has 5 more minutes of intra-service time (230 vs. 225), due to the dissection of the common iliac artery in the pelvis, the longer graft that must be placed, and all the considerations of graft tunneling, kink avoidance, etc. The intensity of the renal dissection is the same in both cases, while the intensity of the iliac dissection is slightly less than that of the aortic dissection in 35631. Thus, there is 5 minutes of additional intra-service time, but the overall intra-service intensity is slightly less for 35634. Although the post operative work is more extensive for 356X3 than for 35631, the RUC and the specialty society agreed in comparison to code 43621 *Gastrectomy, total; with Roux-en-Y reconstruction* (work RVU = 39.40), the physician work of 35634 is slightly less. The RUC agreed with the specialty society's rank order determination and recommendation of 35.20 for code 35634. **The RUC recommends a relative work value of 35.20 for CPT code 35634.**

Practice Expense:
The RUC recommends the standard 090 day global practice expense packages for these services as they are only performed in the facility setting.

<u>Laparoscopic Heller Myotomy (Tab 12)</u>
Michael Edye, MD, FACS; Charles Mabry, MD, FACS; Christopher Senkowski, MD, FACS, American College of Surgeons

Surgical treatment via esophageal myotomy has been widely performed for correction of achalasia. Over the last 10 years practice patterns have changed and the thoracic approach has been largely supplanted by a laparoscopic, trans-abdominal approach. While the work-up and evaluation of the patient with achalasia are essentially unchanged, the operations are dramatically and substantially different in conduct, skill set, and management. Current CPT codes do not precisely describe the laparoscopic approach for an esophageal myotomy, and in February 2008, the CPT Editorial Panel created CPT code 43279 *Laparoscopy, surgical, esophagomyotomy (Heller type), with fundoplasty, when performed* to allow for the proper reporting of this service.

43279
The RUC reviewed specialty society survey results from 117 surgeons who provide this service. The RUC found the survey results to be quite robust given the low median

experience rate as this is a very low volume procedure. The key reference service chosen by those surveyed was 43330 *Esophagomyotomy (Heller type); abdominal approach* (work RVU = 22.06, 2nd Five Year Review RUC reviewed) which is a comparable open procedure but does not include a fundoplasty. The survey median RVW of 25.00 was too high to the RUC and specialty society, although there is more intra service time and work with new code 43279. New code 43279 includes a fundoplasty and survey data confirms additional intra-service time (150 compared to 120 minutes), but since it is laparoscopic there is significantly less post-service time.

The RUC also compared code 43280 *Laparoscopy, surgical, esophagogastric fundoplasty (eg, Nissen, Toupet procedures)* (work RVU = 18.00) to the work of 43279. Code 43280 contains all the elements of 43279 with fundoplasty. Although the total physician time components are similar, the intra-operative intensity of 43279 is greater than 43280. Code 43280 involves the circumferential dissection of the esophagogastric (EG) junction leaving as much tissue on the outside of the esophagus and stomach as is available. The procedure is completed by the reconstructive part of the procedure the fundoplasty. Dissection takes place in gross anatomic planes and although it requires experience and skill to avoid hemorrhage or damage to local structures, the risk of perforation or entry into the lumen of the esophagus is low. On the other hand for new code 43279, between the first step of esophagomyotomy (identical mobilization of the EG junction to give access to the site for myotomy) and the fundoplasty, there is an additional step, the myotomy. The myotomy is very intensive and involves the dissection through the adventitial coat of the esophagus and stomach is performed to expose the submucosa in the floor of the myotomy. To be an effective myotomy, in this delicate step, the surgeon must dissect in a non-anatomic plane, fully divide all overlying smooth muscle for a length of about 8 cm, while preserving the integrity of submucosa and mucosa and the vagus nerves. The layers are often scarred if the patient has had pneumatic dilatation or Botox injections (often tried before surgery), making the dissection even more difficult. This step is fraught with the risk of making a full thickness tear into the esophageal or gastric lumen that could be several cm long requiring extensive repair, or as small as a pin point and difficult to recognize. The clinical implications of any full thickness esophageal injury (that occur in up to 5% of cases) are profound. Thus the intraoperative intensity of work for the myotomy is amongst the most intense a surgeon ever performs. Moreover to optimize identification of tissue planes, the preparatory dissection of the esophagus and stomach for 43279 must be carried out with such precision to avoid bleeding and resultant tissue staining that the intensity of this part of the procedure is higher than for 43280.

The RUC reviewed the specialty survey work RVU statistics and believed that 43279 is essentially equal in total work to the open procedure 43330. The increased intra-time and increased intensity of 43279 balances out the increased post operative hospital work for 43330. The RUC and specialty society concurred that the recommended 25th percentile work RVU of 22.00 (IWPUT = 0.097) provides the correct physician work value and proper rank order amongst similar services. This value is also correspondingly greater than 43280 to account for the increased intra-work and increased intensity as described. **The RUC recommends a relative work value of 22.00 for CPT code 43279.**

Practice Expense:
The RUC recommends the standard 090 day global practice expense packages for these services as they are only performed in the facility setting.

New Technology:
The RUC recommends that 43279 be added to the new technology list as this procedure utilizes new techniques.

Cholangioscopy-Pancreatoscopy (Tab 13)
Joel V. Brill, MD, American Gastroenterological Association, and Klaus Mergener, MD, PhD, American Society for Gastrointestinal Endoscopy

The clinical efficacy of cholangioscopy/pancreatoscopy is well established in the diagnosis and treatment of pancreaticobiliary disease. The CPT Editorial Panel met in February 2008 and agreed that the current endoscopic retrograde cholangiopancreatography (ERCP) codes do not adequately describe a cholangioscopy / pancreatoscopy procedure, which is a distinct and substantially different procedure from ERCP. The cholangioscopy / pancreatoscopy procedure is additive to a variety of ERCP procedures and ERCP codes are inadequate to describe this procedure. The Editorial Panel created CPT code 43273 *Endoscopic cannulation of papilla with direct visualization of common bile duct(s) and/or pancreatic duct(s) (List separately in addition to code(s) for primary procedure)* to accurately report and describe the work associated with this complex procedure. It is estimated that 5-10% of all ERCPs will require this new service 43273.

The RUC reviewed the survey results from 55 practicing gastroenterologists for newly created add-code 43273. The survey respondents reported physician time in the pre and post period. As physician work is typically not performed in the pre and post period for an add-on code, the specialty concluded this was the result of the survey respondents' lack of familiarity with the concept of pre/intra/post time and the survey instrument for an add-on code. The societies concluded it would be appropriate to remove the pre- and post- time and back-out the associated work relative values from the survey median (3.25) to calculate their recommended work value of 2.24. The RUC calculated the work relative value for 43273 by taking the survey median 3.25 – ((25 minutes pre-service time x .0224) + (20 minutes post-service time x .0224)) = 2.24. The value of 2.24 work RVUs lies between the survey median (3.25) and the 25th percentile (2.00).

The RUC compared 43273 to the specialty survey's key reference service code 43235 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* (work RVU = 2.39) and agreed that new service 43273 was similar; however, it is much more intense and requires more skill than code 43235. The RUC also questioned the intra-service time for this new service and was assured by the specialty society and other RUC members that the median survey intra-service time of 45 minutes was reasonable for the service provided. It was

also explained that this new service can only be performed with an ERCP and not separately.

The RUC also compared the code 48400 *Injection procedure for intraoperative pancreatography (List separately in addition to code for primary procedure)* (work RVU = 1.95) and agreed that although both codes involve 45 minutes of intra-service time, a higher work value was justified because endoscopy is a more intense procedure requiring greater technical skill compared to an injection. The RUC agreed that the most accurate work value for new code 43273 is between the specialty's survey 25th percentile (2.00) and its median (3.25). The RUC also believed the specialty calculated value of 2.24 was reasonable and provided for the proper rank order amongst these reviewed services. **The RUC recommends a relative work value of 2.24 for CPT code 43273.**

Practice Expense:
The RUC recommends no direct practice expense inputs for this add-on code.

New Technology:
The RUC recommends that 43273 be added to the new technology list as this procedure utilizes new techniques.

Conscious Sedation
The RUC determined that conscious sedation was only inherent in code 43273.

Hemorrhoidectomy (Tab 14)
Christopher Senkowski, MD, FACS; Charles Mabry, MD, FACS, American College of Surgeons Guy Orangio, MD, FACS, American Society of Colon and Rectal Surgeons

The CPT Editorial Panel met in February 2008 and agreed to delete three codes and create a new code so that the destruction of internal and/or external hemorrhoids in current practice can more accurately be reported. The Panel deleted three CPT codes: 46934 *Destruction of hemorrhoids, any method; internal*, 46935 *Destruction of hemorrhoids, any method; external*, and 46936 *Destruction of hemorrhoids, any method; internal and external* to eliminate ambiguities in coding. The deletion of the three "any method" CPT codes, reference to specific incision and excision codes, and creation of a new code that more precisely describes the non-excisional procedure for internal hemorrhoid(s) was believed to allow for more accurate reporting. The Editorial Panel created 46930 *Destruction of internal hemorrhoid(s) by thermal energy (eg, infrared coagulation, cautery, radiofrequency)* for this purpose.

46930
The RUC reviewed the survey results of 50 colorectal and general surgeons who had indicated a median service performance rate of 15. The survey respondents selected CPT code 46221 *Hemorrhoidectomy, by simple ligature (eg, rubber band)* (work RVU = 2.31, RUC reviewed, MPC listed) as the key reference service for new code 46930. The RUC

compared the two services for physician time, intensity, and complexity. The survey results indicated the physician work effort of 46930 was quite similar however the intra-service time and total physician time was shorter. The RUC also compared the new code to recently RUC reviewed CPT code 46600 *Anoscopy; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* (work RVU = 0.55) which is a similar procedure and has an identical intra-service physician time, but requires much less physician work effort than code 46930. The RUC agreed that the correct physician work relative value was between the survey's key reference code 46221 and 46600.

The RUC and the specialty society concurred that code 46930 is less total work than 46221, yet the intra-service work intensity for both procedures is similar. The specialty and the RUC understood the survey median physician work RVU and 25th percentile RVW resulted in intra-service intensities that are greater than the key reference code. The specialty recommended and the RUC agreed to value new code 46930 at 1.56 relative value units which is supported by taking the value of CPT code 46600 anoscopy (RVW=0.55) plus a 99213 follow-up office visit (0.92) equal 1.47 work RVUs before taking into account the work and increased intra-intensity for the destruction of hemorrhoids. The RUC agreed with the specialty recommended work value of 1.56, which is less than the 25th percentile survey results and places new code 46930 in proper rank order amongst similar procedures. **The RUC recommends a relative work value for CPT code 46930 of 1.56.**

Practice Expense: The RUC reviewed the direct practice expense input recommendation for CPT code 46930 and made minor edits so that the typical patient scenario was captured in the non-facility and facility settings.

Saturation Biopsies (Tab 15)
Facilitation Committee # 3
James G. Giblin, M.D.; Steven M. Schlossberg, M.D.; Richard N. Gilbert, M.D.
American Urological Association

In February 2008, the CPT Editorial Panel transitioned a Category III code (0137T) to a Category I code to capture the increasing utilization of transperineal stereotactic template guided saturation sampling of the prostate. CMS has indicated that they pathology reporting of speciime review still needs to be addressed through the CPT Editorial Board.

The RUC reviewed the specialty society survey results for code 55706 *Biopsies, prostate; needle, transperineal, stereotactic template guided saturation sampling including image guidance* and determined that the survey respondents overestimated the pre-service physician time required. The specialty society and the RUC determined that pre-service package 3 – straightforward patient/difficult procedure with an additional 2 minutes for specific positioning was appropriate. The RUC recommends 33 minutes pre-evaluation time, 5 minutes pre-positioning time and 15 minutes scrub, dress and wait time, totaling 53 minutes.

The survey respondents indicated that the intra-service time is 35 minutes. However, the respondents may have inappropriately allocated the intra-service time under the pre-service time. The RUC agreed with the specialty society recommended intra-service time of 45 minutes. The RUC determined 45 minutes was appropriate because typically 35-60 biopsies are performed to be sure cores are taken at intervals through the template grid. Additionally, each time the biopsy needle is reintroduced through the biopsy template sagittal and transverse ultrasound images are taken to insure precise localization of the biopsy needle. The RUC recommends 45 minutes intra-service time and the survey immediate post-service time of 15 minutes.

The RUC discussed the physician work required to perform 55706 and determined to use a building block approach as this service is a combination of the following: half the work RVU of 51702 *Insertion of temporary indwelling bladder catheter; simple (eg, Foley)* (work RVU = 0.50/2 = 0.25), half the work RVU 76942 *Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation* (work RVU = 0.67/2=0.34), 55700 *Biopsy, prostate; needle or punch, single or multiple, any approach* (work RVU = 2.58), 99213 *Office visit* (work RVU = 0.92) and 99214 Office visit (Work RVU = 1.42) and a half day discharge day 99238 (work RVU = 0.64) to arrive at the appropriate work RVU of 6.15 (0.25+0.34+2.58+0.64+0.92+1.42 = 6.15). The RUC determined a 99214 was appropriate because of the severity of the problems these patients are presenting post-procedure. These patients have typically had 2-3 biopsies before this procedure, are anxious and require a high level visit. The RUC also compared 55706 to code 49322 *Laparoscopy, surgical; with aspiration of cavity or cyst (eg, ovarian cyst) (single or multiple)* (work RVU=5.96, pre-service time 45 minutes, intra-service time 45 minutes, immediate post-service 20 minutes and 1-99213). **The RUC recommends a work RVU of 6.15 for 55706.**

Building Block:

CPT Code			**RVU**
51702 (RVU=0.50)	Insertion of temporary indwelling bladder catheter; simple (eg, Foley)	Half the RVU	0.25
76942 (RVU=0.67)	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	Half the RVU	0.34
55700	Biopsy, prostate; needle or punch, single or multiple, any approach	1	2.58
99238 (RVU=1.28)	Hospital discharge day management	Half of a discharge day	0.64
99213	Evaluation and management of established patient, level 3, 15 minutes face-to-face	1	0.92
99214	Evaluation and management of established patient, level 4, 25 minutes face-to-face	1	1.42
		Total RVU =	**6.15**

Practice Expense
The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

New Technology
The RUC recommends that code 55706 be added to the new technology list.

Stereotactic Radiosurgery (Tab 16)
Facilitation Committee # 3
John Wilson, MD, Frederick Boop, MD, Alexander Mason, MD, American Association of Neurological Surgeons/Congress of Neurological Surgeons

The CPT Editorial Panel deleted one code, renumbered one code and added seven new codes to report frame/frameless, simple/complex and cranial/spine stereotactic radiosurgery. Additionally, previous codes did not allow for reporting multiple cranial lesions. These services were previously reported with one code which was created when the technology and technique of stereotactic radiosurgery was first emerging. Since then technology has allowed for broader indications for stereotactic radiosurgery and one code no longer adequately described these services. The specialty society indicated that 61793 had previously been reported with the -51 modifier for additional lesions. The specialty societies noted that any implantation of fiducial markers are inherent to this service and are not reported separately.

61800
The RUC reviewed code 61800 *Application of stereotactic headframe for stereotactic radiosurgery* and determined that there is pre- and post-service time associated with this add-on code. In this procedure typically the patient must be moved from the room in which the headframe is applied to the radiosurgery unit. The RUC determined additional pre-service time is required in order to check local anesthetic and equipment, prep the patient's skin, check preoperative radiographic images to assure the appropriate placement of the head ring and then take the patient to the radiosurgery unit for the scan. Additionally, pre-time is appropriate because these services are not part of the intensity for the entire intra-service time of the procedure.

The RUC reviewed the physician time and work required to perform this procedure from the specialty society survey. The RUC agreed with the specialty society and the survey respondents that pre-service package 1A – straightforward patient/procedure (no sedation/anesthesia) with a three minute decrement in evaluation time and no scrub dress and wait time is appropriate. The RUC determined that 20 minutes intra-service time is appropriate when compared to key reference code 61517 *Implantation of brain intracavitary chemotherapy agent* (work RVU = 1.38) as well as 20660 *Application of cranial tongs, caliper, or stereotactic frame, including removal (separate procedure)* (work RVU = 4.00, intra-service time = 30 minutes). The RUC determined 10 minutes of immediate post-service time is required to place the patient on a stretcher, take him/her back to the separate room and remove the headframe.

The RUC determined that the physician work for 61800 is significantly less than 20660 but the intra service time is similar. The RUC also compared the physician work for 61800 to key reference service code 61517 and determined that the correct work RVU for 61800 is between the work RVUs of reference codes 20660 and 61517, 4.00 and 1.38 respectively. The RUC determined that the survey 25th percentile work RVU of 2.25 placed this service in the proper rank order for this family of codes as well as relative to other services. **The RUC recommends the survey 25th percentile work RVU of 2.25 for code 61800.**

61796

The RUC reviewed code 61796 *Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); 1 simple cranial lesion*
and determined that the physician work required would be the same as previously reported code 61793 *Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator), one or more sessions* (work RVU= 17.75) minus the application of the head frame which was included in 61793. Therefore, the RUC determined the work for 61796 should be 15.50 (17.75-2.25 = 15.50), which is below the specialty society's survey 25th percentile. The specialty society clarified the physician work involved for this procedure indicating that the neurosurgeon targets the lesion and reviews the scan to view the lesions, whereas the radiation oncologist adjusts the dosimeter and confirms the dose.

The RUC reviewed the physician time required to perform 61796 and determined the pre-service package 2A - Facilitation difficult patient/straightforward procedure (no sedation/anesthesia) was appropriate. The RUC compared the intra-service time required for this procedure with the key reference code 61751 *Stereotactic biopsy, aspiration, or excision, including burr hole(s), for intracranial lesion; with computed tomography and/or magnetic resonance guidance* (work RVU = 18.64, intra-service = 90 minutes) and determined it was exactly the same. The RUC agreed with the specialty society that the survey immediate post-time was appropriate at 15 minutes. Additionally, a half day discharge day and 2- 99213 office visits are required to review post-operative reports and conduct neurological exams. **The RUC recommends a work RVU of 15.50 for code 61796.**

61797

The RUC reviewed the specialty society survey results for code 61797 *Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); each additional cranial lesion, simple* determined that an additional lesion requires less physician work than the initial lesion. The RUC compared 61797 to the key reference service 63048 *Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar* (work = 3.47, intra-service = 45 minutes) and determined that 61797 required slightly less work, but similar intensity as the physician is required to be attentive to the surround structure for each additional lesion. The RUC determined the survey 25th percentile work RVU of 3.48 and survey intra-service time of 30 minutes appropriate accounts for the physician work required to perform code 61797.

The specialty society indicated that the typical number of lesion is 2 and the maximum number of lesions is 5. The RUC determined that this procedure was previously valued at 50% of code 61793 *Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator),* one or more sessions, with the use of modifier -51. However, the previous coding was specified per sessions and did not address the number of lesions. The recommended work RVU of 3.48 is a much lower RVU and is therefore work neutral. **The RUC recommends the survey 25th percentile work RVU of 3.48 for code 61797.**

61798

The RUC reviewed code 61798 *Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); one complex cranial lesion* and determined this procedure is more complex than the previously reported code 61793 as it did not account for complexity or number of lesions. The RUC also determined that 61798 is appropriately more complex than 61796. The RUC examined the survey results and determined that the respondents may have included the physician work required to apply the headframe when valuing 61798. The RUC determined the survey 25th percentile minus the value proposed value for the application of the head frame, 61800 (22.00-2.25 = 19.75) was appropriate. The RUC determined the increments recommended place this family of codes in the appropriate rank order.

The RUC determined that pre-service package 2A – facility difficult patient/straightforward procedure (no sedation/anesthesia), 120 minutes of intra-service time and 15 minutes immediate post-service time are required to perform this service. Additionally, a half day discharge day and 2- 99213 office visits are required to review post-operative reports and conduct neurological exams. A work RVU of 19.75 for 61798 appropriately places this service less than the key reference service 61510 *Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma* (work RVU = 30.63), which requires 80 additional minutes of intra-service time and an increased number of hospital visits. **The RUC recommends a work RVU of 19.75 for code 61798.**

61799

The RUC reviewed code 61799 *Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); each additional cranial lesion, complex* and determined that the additional complex lesion was less complex than the initial complex lesion. The RUC compared 61799 to the key reference 61864 *Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; each additional array* (work RVU= 4.49, intraserice = 68 minutes) and determined that although 61799 requires 8 less minutes of intra-service time, it is more intense as the neurosurgeon is required to be attentive to the surround structure for each additional lesion. **The RUC recommends the survey 25th percentile work RVU of 4.81 for code 61799.**

63620
The RUC reviewed code 63620 *Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); one spinal lesion* and determined that it is appropriate to crosswalk this code to code 61796 *Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); one simple cranial lesion* (proposed work RVU = 15.50) as these single lesion stereotactic services are analogous. The RUC determined that the physician times are exactly the same for 63620 and 61796, 25 minutes pre-service time, 90 minutes intra-service time and 15 minutes immediate post-service time. The post-operative visits are the same for both codes with a half day discharge day and two-99213 visits. Additionally, the physician work required to perform both of these services is similar. **The RUC recommends a work RVU of 15.50 for code 63620.**

63621
The RUC reviewed the specialty society survey results for add-on code 63621 *Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); each additional spinal lesion (List separately in addition to code for primary procedure)*. To be consistent with accepting the survey 25th percentile work RVUs as the RUC recommended for the other stereotactic radiosurgery ZZZ codes (61797 and 61799) at this meeting, the Committee determined that the survey 25th percentile work RVU of 4.00 was appropriate for code 61798. The survey respondents clearly indicated that an additional lesion requires less physician work than the first lesion. This work RVU of 4.00 is slightly higher than the key reference service 63048 *Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar* (work RVU=3.47) which is appropriate as 61798 requires 15 minutes more intra-service time than 63048. **The RUC recommends the survey 25th percentile work RVU of 4.00 for code 63621.**

Practice Expense
The RUC recommends the standard 090-day direct practice expense inputs and zero inputs for the ZZZ codes as these services are always performed in the facility setting.

New Technology
The RUC requests that the spinal stereotactic radiosurgery codes 63620 and 63621 be placed on the new technology list.

Interdiscal Percutaneous Aspiration (Tab 17)
Charles Mick, MD, North American Spine Society, Dale Blasier, MD, American Academy of Orthopaedic Surgery, Geraldine McGinty, MD, American College of Radiology, Robert Barr, MD, American Society of Neuroradiology, John Wilson, MD, American Association of Neurological Surgeons/Congress of Neurological Surgeons, Frederick Boop, MD, American Association of Neurological Surgeons/Congress of Neurological Surgeons, Jonathan Berlin, MD, American College of Radiology, Alexander Mason, MD, American Association of Neurological Surgeons/Congress of Neurological Surgeons

In February 2008, the CPT Editorial Panel created a new code to report a percutaneous disc, nucleus pulpous or paravertebral aspiration of fluid and/or cells for diagnostic purposes.

The RUC reviewed the specialty society survey results for code 62267 *Percutaneous aspiration within the nucleus pulposus, intervertebral disc, or paravertebral tissue for diagnostic purposes* and compared it to key reference service 62290 *Injection procedure for discography, each level; lumbar* (work RVU = 3.00). The RUC determined that the physician work required to perform these services are similar in that they both involve inserting a needle into a disc, 62290 is for the injection of contrast and 62267 is for the aspiration of the disc. Additionally, both services' intra-service times are similar, 35 and 30 minutes respectively. The RUC recommends the survey 25th percentile work RVU of 3.00 for code 62267.

The RUC reviewed the physician time required to perform this service as indicated by the specialty society and survey respondents and determined that the specialty society recommended pre-service pack 1B – straightforward patient procedure (with sedation/anesthesia) is appropriate. The specialty society recommends a decrement of 5 minutes evaluation time as moderate sedation is not inherent in this procedure, an additional 9 minutes for specific positioning of the patient to the prone position and an additional scrub, dress, wait time of 5 minutes. The RUC recommends 14 minutes evaluation time, 10 minutes positioning time and 10 minutes scrub, dress, wait time. The RUC determined that the survey intra-service time of 30 minutes and survey immediate post-service time of 15 minutes adequately represented the time required to perform this service.
The RUC recommends the survey 25th percentile work RVU of 3.00 for code 62267.

Practice Expense
The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

Intermetatarsal Neuroma Injections(s) and Destruction by a Neurolytic Agent (Tab 18)

Facilitation Committee # 2

Tye Ouzounian, MD, American Orthopaedic Foot and Ankle Society, Frank Spinosa, DPM, American Podiatric Medical Association, Robb Mothershed, DPM, American Podiatric Medical Association, Dale Blasier, MD, American Academy of Orthopaedic Surgery

In February 2008, the CPT Editorial Panel created two new codes to report injection(s) of an anesthetic agent and destruction by neurolytic agent of the plantar common digital nerve.

64455*, Injection(s), anesthetic agent and/or steroid; plantar common digital nerve(s) (eg, Morton's neuroma)*

The specialty society presenters articulated for the RUC that the physician work involved in the injection of an anesthetic agent and/or steroid and distinguished the work from other injection services. Based on this explanation, the RUC agreed that the survey median intra-service time of three minutes was inappropriate and inaccurate. They agreed with the specialty societies' expert panel consensus of 5 minutes of intra-service time. The RUC concluded that the survey respondents most likely included within the pre-service time, two additional minutes of intra-service time involved for the actual injection. This was supported by several reference services that the specialty societies agreed were very similar, but none had intra-service times less than five minutes. To account for this shift in intra-service time, the RUC agreed that the pre-service time should be reduced. The RUC did so by reducing the survey median pre-time from 19 minutes to 10 minutes. These 10 minutes consist of pre-service time package #5 (7 minutes) plus 3 additional minutes. These additional 3 minutes include 1 minute to account for communication with other healthcare professionals; 1 minute for check/set-up room; and 1 minute for preparing for the procedure.

The RUC agreed that the survey median work RVU of 0.80 was too high. The specialty society and the RUC agreed that the survey 25th work RVU of 0.75 appropriately values the physician work required for this service and places it in the correct order with other injection services. The physician work required for code 64455 was compared to the work of code 20550, *Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")* (work RVU = 0.75, intra-service time = 5 minutes), the key reference service. Code 20550 involves injection into a muscle, which the RUC determined is less difficult than the work involved in injecting anesthetic directly into a nerve. When injecting a nerve, the physician must first find the nerve and second, be very aware not to damage it. Neither of these concerns is present in the injection into muscle, making a nerve injection more difficult and more intense. Code 20550 was valued by the RUC in 2002 along with several other injection services. The RUC extensively reviewed the injection services and took significant steps to ensure that there were no rank order anomalies. Code 64455, which previously was reported using 20550, was created to account for the additional work involved in injecting a nerve rather than muscle. The

committee agreed that to recommend a work RVU of any less than 0.75 would create a rank order anomaly.

To further support a work RVU of 0.75 for code 64455, the committee reviewed the respective IWPUTs of several injection services: 64614, 20550, 20553, 20551 and 20526. With a work RVU of 0.75, the IWPUT for code 64455 (0.083) falls right in the middle of the IWPUT for the injection services indicated.

Code	Short Descriptor	wRVU	Pre	Intra	Post	IWPUT
64614	Destroy nerve	2.20	15	20	15	0.076
20550	Inj. tendon, sheath/lig	0.75	10	5	5	0.083
64455	**Inj digital nerve**	**0.75**	**10**	**5**	**5**	**0.083**
20553	Inj. trigger point	0.75	7	10	5	0.094
20551	Inj. tendon, sheath/lig	0.75	10	5	5	0.098
20526	Ther. inj.; carp. tun.	0.94	6	5	5	0.139

Thus, the RUC determined that the appropriate work RVU for 64455 is 0.75 with an adjusted intra-service time of 5 minutes, which results in an IWPUT directly in line with other injection services and maintain proper rank order.

The RUC recommends a work RVU of 0.75, amended pre-service package #5 with an additional three minutes (10 minutes pre-service time) and intra-service time of 5 minutes for 64455.

64632, ***Injection, anesthetic agent; other peripheral nerve or branch***
The specialty society presenters articulated for the RUC that the physician work involved in the injection of an anesthetic agent and/or steroid and distinguished the physician work required for other injection services. Based on this explanation, the RUC agreed that the survey median intra-service time of five minutes was appropriate. Additionally, the RUC determined that the survey respondents overstated the pre-service time. As such, the RUC agreed that the pre-service time is only 10 minutes. These 10 minutes consist of pre-service time package #5 (7 minutes) plus 3 additional minutes. The additional 3 minutes include 1 minute to account for communication with other healthcare professionals; 1 minute for check/set-up room; and 1 minute for preparing for the procedure. The RUC determined that the specialty society recommended post-service office of a single 99212 was appropriate.

The RUC determined that the survey median work RVU of 1.80 was too high, but that the survey 25th percentile work RVU of 0.95 was too low. The work of this service is nearly identical to that of the 64455, but includes a single 99212 office visit within its 010 day global period. As such, the committee based its recommendation on the recommended valuation of 64455 and added the work of a 99212 (0.75+0.45 = 1.20). The RUC noted that the resulting IWPUT is 0.083, identical to 64455 and in line with the range of the key reference service, 64614, *Chemodenervation of muscle(s); extremity(s) and/or trunk muscle(s) (eg, for dystonia, cerebral palsy, multiple sclerosis)* (work RVU = 2.20, intra-service time = 20 minutes) and the entire family. The survey code requires

greater mental effort and judgment, technical skill, and physical effort, but requires less intra-service time. As such, the IWPUT for 64632 (0.083) is incrementally higher than those services: 64612 (IWPUT=0.059), 64613 (IWPUT=0.056) and 64614 (IWPUT=0.076).

Code	Short Descriptor	wRVU	Pre	Intra	Post	IWPUT
64612	Chemodenervation, face muscle	1.98	10	20	6	0.059
64613	Chemodenervation, neck muscle	1.98	10	21	16	0.056
64614	Chemodenervation, extremity muscle	2.20	15	20	15	0.076
64632	**Destroy digital nerve**	**1.20**	**10**	**5**	**5**	**0.083**

The RUC recommends a work RVU of 1.20 for 64632.

Practice Expense
The RUC recommends the direct practice expense inputs for the non-facility setting as modified by the Practice Expense Subcommittee.

Anesthetic Agent Nerve Injection (Tab 19)
Facilitation Committee # 2
Tripti Kataria, MD, American Society of Anesthesiologists

CPT code 64416 *Injection, anesthetic agent; trigeminal nerve, any division or branch brachial plexus, continuous infusion by catheter (including catheter placement)* was identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated for physician work.

Because the descriptor originally stated "including daily management for anesthetic agent administration" it could not logically be assigned a 000-day global period. The RUC requested that CMS assign a 000-day global period to code 64416 and that the specialty society resurvey this service with the revised descriptor. CMS notified the RUC that a 000-day global period would be acceptable and assigned code 64416 a 00-day global period. Additionally, the specialty society indicated that this descriptor discrepancy would be applicable to three other codes within this family. Therefore, the specialty society also requested revision to the descriptors and global periods for codes 64446, 64448 and 64449. In February 2008, the CPT Editorial Panel revised the descriptors to eliminate this language. The specialty society resurveyed codes 64416, 64446, 64448 and 64449 and presented recommendations to the RUC at the April 2008 meeting.

64416, 64446 and 64449
The RUC obtained a clear understanding of the services described by these revised codes as well as the correct rank order. The RUC reviewed the survey results from 36-44 physicians who perform these services and found that the survey respondents indicated that these services required more technical skill, mental effort and present more psychological stress upon the physician in comparison to the key reference codes 62318 *Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic* (work RVU = 2.04, total physician time = 120 minutes) and 62319 *Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)* (work RVU = 1.87, total physician time = 108 minutes). Although the reference codes require more overall time, the intensity and complexity measures indicated a higher level of work per unit of time.

Therefore, while understanding the intensity and complexity of the services, the RUC developed a building block type approach to establish appropriate values for this family of codes by comparing them to the following single injection codes:

64415 *Injection, anesthetic agent; brachial plexus, single* (work RVU= 1.48)
64445 *Injection, anesthetic agent; sciatic nerve, single* (work RVU= 1.48)

The increment between the single injection service 62311 *Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)* (work RVU=1.54) and the continuous injection code 62319 *Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)* (work RVU = 1.87) is 0.33 work RVUs (1.87-1.54 = 0.33). To develop the appropriate work RVUs for codes 64416, 64446 and 64449, the RUC used codes 64415 and 64445 (each has a work RVU = 1.48) as the base code and added the single injection increment of 0.33 RVUs to account for the catheter placement and continuous injection (1.48 + 0.33 = 1.81). **The RUC recommends a work RVU of 1.81 for codes 64416, 64446 and 64449.**

64448
The RUC determined that although the surveyed key reference code 62319 *Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography),*

of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal) (work RVU = 1.87, total physician time = 108 minutes) requires more overall time, the intensity and complexity measures indicated a higher level of work per unit of time.

To develop the appropriate work RVU for code 64448 the RUC used the same building block methodology except that the incremental difference added to its base single shot injection was 0.13. The RUC established this increment by taking the difference between codes 62310 *Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic* (work RVU=1.91) and the key reference service 62318 *Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic* (work RVU = 2.04) (2.04-1.91=0.13). To develop the appropriate work RVU for 64448, the RUC used the single injection base code 64447 *Injection, anesthetic agent; femoral nerve, single* (work RVU= 1.50) and added the increment of 0.13 to account for the catheter placement and continuous injection (1.50 + 0.13 = **1.63**). The specialty society indicated and the RUC agreed that the catheter placement is less difficult for 64448 than the other three continuous infusion codes 64416, 64446 and 64449. The RUC determined that these values established the correct rank order among this family of revised codes. **The RUC recommends a work RVU of 1.63 for code 64448.**

Practice Expense:
CPT Codes 64416, 64446, 64448 and 64449 are typically performed in the facility setting, therefore the RUC does not recommend any direct practice expense inputs at this time.

<u>Endothelial Keratoplasty (Tab 20)</u>
Facilitation Committee # 2
David Glasser, MD, American Academy of Ophthalmology, Stephen Kamenetzky, MD, American Academy of Ophthalmology

In February 2008, the CPT Editorial Panel created two CPT codes to describe the physician service of endothelial keratoplasty, which is a new surgical method of repairing some diseased corneas that in the past would have required a full thickness corneal transplant (also called penetrating keratoplasty). Rather than perform a classical transplant with donor tissue replacing the full-thickness of the cornea, the surgeon replaces only the innermost layer of the cornea containing the corneal endothelium. The surgical procedure is radically different from the full-thickness procedure and requires different surgical skills.

65756 ***Keratoplasty (corneal transplant); endothelial***
The RUC reviewed specialty society surveyed physician work data from 51 corneal surgeons. The survey respondents chose its key reference service code 65750 *Keratoplasty (corneal transplant); penetrating (in aphakia)* (work RVU = 16.60),which was compared to new code 65756. The RUC recognized that the largest mean differences were in the areas of technical skill required, outcome depending on the skill and judgment of the physician, and the intensity of the intra-service time.

The RUC agreed that the technical skill required for this procedure was significantly greater than that for the standard full-thickness keratoplasty because the procedure requires extensive manipulation of the transplanted material in the anterior chamber through small incisions. The reduced intra-service time when compared with the reference code is due to the fact that an endothelial graft does not have to be sutured in place. This suturing process in the reference procedure requires more time, but less physician effort and technical skill. Post operatively, code 65756 and 65750 include six post operative visits within the global period, although the level of some of the visits for 65756 are lower than for the reference code. Considering the higher intra service intensity of 65756 and the lower post operative visit levels compared to 65750, the RUC and specialty society agreed that the overall physician work values were quite similar.

The RUC also compared the physician work of codes 44310 *Ileostomy or jejunostomy, non-tube* (work RVU = 17.49) and 49002 *Reopening of recent laparotomy* (work RVU = 17.55) to new code 65756. The RUC and specialty concurred that the physician work for new code 65756 is not as high as these services, however it is highly intense and complex. The RUC agreed with the specialty society that a reasonable physician work RVU for code 65756 is below the survey median of 18.00 and more in line with its key reference service code. The specialty and RUC agreed that the 25th percentile survey work RVU of 16.60 provides an accurate value for code 65756. **The RUC recommends a work relative value of 16.60 for CPT code 65756.**

65757 - ***Backbench preparation of corneal endothelial allograft prior to transplantation (List separately in addition to code for primary procedure)*** (Use 65757 in conjunction with 65756)

The specialty society provided a description of the work and effort involved in preparing a corneal endothelial allograft. The RUC believed that the survey respondents valued the service too high at 2.75 work RVUs and an intensity of 0.183. The RUC reviewed backbench work service 50327 *Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation; venous anastomosis, each* (work RVU=4.00, intra-service time = 44 minutes, IWPUT = .091, XXX global), and the dermal autograph work of 15136 *Dermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 1.50, intra-service time = 15 minutes, IWPUT = 0.010, ZZZ global). The RUC agreed that the intensity of new code 65757 should be between these

two services. The RUC also compared 65757 to 13122 *Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (List separately in addition to code for primary procedure)* (work RVU = 1.44, intra-service time = 23 minutes, global period = ZZZ) and understood the intensity per minute of 6577X2 exceeded that of 13122. The RUC agreed with the physician time of 15 minutes from the survey results. Although the RUC concurred that this service has a high level of intensity, the committee believed that the intra-service work intensity should be about half of what was originally proposed by the specialty. The committee believed the physician work was lower than code 50327 and 15136 yet its intensity was between the two at approximately 0.096. The RUC calculated a work RVU for new code 65757 based on the agreed upon intensity of 0.096 and the 15 minutes of survey intra service time. **The RUC recommends a work relative value of 1.44 for 65757.**

Practice Expense: The RUC recommends the standard 090 day global direct practice expense inputs for new code 65757 as they apply to the facility setting only, as these procedures will typically be performed in the hospital setting. New code 65757 does not require direct practice expense inputs and the RUC recommends none.

New Technology:
The RUC recommends that 65756 and 65757 be added to the new technology list as this procedure utilizes new techniques.

<u>High Dose Rate Brachytherapy (Tab 21)</u>
Facilitation Committee # 2
Michael Kuettel, MD, American Soceity for Therapeutic Radiology and Oncology,
Thomas Eichler, MD, American Soceity for Therapeutic Radiology and Oncology,
David Beyer, MD, American Soceity for Therapeutic Radiology and Oncology,
Najeeb Mohideen, MD, American Soceity for Therapeutic Radiology and Oncology

In February 2008, the CPT Editorial Panel met and agreed that the existing CPT codes for High Dose Rate (HDR) brachytherapy no longer reflect the most current practice. The process of care for HDR brachytherapy has evolved over the past decade and they believed the present descriptors did not optimally discriminate physician work. The number of dwell positions as described in the current codes is a poor surrogate for physician work and changing the code to reflect the number of channels used better describes the physician work. In addition the existing codes were originally valued as 090 day global service codes, but in 2007 were converted to XXX global codes. Thus a more up to date evaluation of the entire work process was required and the CPT Editorial Panel deleted four existing and created three new brachytherapy procedure codes that more accurately described the services provided. The three new procedure codes are:

The RUC reviewed the specialty society's survey results for each of the three new procedure codes and obtained a better understanding of the physician work, intensity, risk factors, and rank order of high dose rate brachytherapy services. The RUC and the specialty agreed that it was difficult for the specialty and survey respondents to select

reference services for these procedures while deleting similar procedure codes, however the survey results did provide a good starting point at obtaining the relative work values. The RUC and specialty society agreed to use a building block approach to establish the values for each code.

77785 - *Remote afterloading high dose rate radionuclide brachytherapy; 1 channel*
RUC members reviewed the key reference service, 77315 *Teletherapy, isodose plan (whether hand or computer calculated); complex (mantle or inverted Y, tangential ports, the use of wedges, compensators, complex blocking, rotational beam, or special beam considerations)* (work RVU = 1.56), in relation to new code 77785. The RUC determined that the intra service work intensity for code 77785 was too high. They agreed that the intensity of code 77785 was equivalent to the intensity of an established patient level two evaluation and management office code (99212, IWPUT= 0.0316) and that its value be equivalent to a E/M code 99214 (work RVU=1.42), by using a building block approach using the specialty society's recommended physician time components (shown below). In addition, the RUC agreed the relative work value lies between two multi-specialty points of comparison codes 11755 *Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds) (separate procedure)* (work RVU=1.31), and 29445 *Application of rigid total contact leg cast* (work RVU=1.78). **The RUC recommends a work relative value of 1.42 for new code 77785.**

77786 - *Remote afterloading high dose rate radionuclide brachytherapy; 2-12 channels*
RUC members reviewed the key reference service, 19296 *Placement of radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy* (work RVU = 3.63) and its intra service work intensity to the survey results and specialty recommendation for code 77786. The RUC determined that the recommended value of 3.10 was too low for the service provided in relation to code 77785. They agreed that the intensity of code 77786 was equivalent to the intensity of an established patient level four evaluation and management office code (99214, IWPUT= 0.0434). It was understood that the surveyed typical number of catheter placements for the code is eight each placement escalates the physician work and risk of error. If any of the catheters are misplaced, significant patient harm would result. The committee also agreed that key reference code 19296 *Placement of radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy* (work RVU=3.63), is more intensive and more work than 777X2, and that the relative work value also lies between codes 79101 *Radiopharmaceutical therapy, by intravenous administration* (work RVU=1.96), 45380 *Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple* (work RVU=4.43). The RUC used a building block approach using the specialty society's recommended physician time components (as shown below) to establish a work value of 3.25 for code 77785. **The RUC recommends a work relative value of 3.25 for new code 77786.**

77787 - Remote afterloading high dose rate radionuclide brachytherapy; over 12 channels

RUC members reviewed the key reference service, 19298 *Placement of radiotherapy afterloading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, includes imaging guidance* (work RVU = 6.00) in relation to code 77787. The RUC determined that with the specialty recommended value of 5.60 the intra service work intensity is too high for the service provided. They agreed that the intensity of code 77786 was equivalent to the intensity of an established patient level five evaluation and management office code (99215, IWPUT= 0.0443). It was understood that with each catheter placement the physician work and risk of error escalates as the physician is repeating the procedures steps and if any of the catheters are misplaced, significant patient harm would result. The committee also agreed that key reference code 19298 *Placement of radiotherapy afterloading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, includes imaging guidanc*e (work RVU=6.00), is more intensive and more work than 777X3, and that the relative work value lies between codes 43260 *Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* (work RVU=5.96) and 95810 *Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist* (work RVU=3.52). The RUC used a building block approach using the intra service work intensity of a 99213 to establish a work relative value of 4.89 for code 77787 (as shown below). **The RUC recommends a work relative value of 4.89 for new code 77787.**

Building Block Methodology using Evaluation and Management Code Intensities

CPT Code	Pre Time	Pre Service IWPUT	Pre Serv RVU	Intra Time	Intra Service IWPUT	Intra Serv RVU	Post Time	Post IWPUT	Post Serv RVU	Total Building Block Values
777X1	11	0.0224	0.246	30	0.0316	0.947	10	0.0224	0.224	**1.42**
777X2	14	0.0224	0.310	60	0.0434	2.602	15	0.0224	0.336	**3.25**
777X3	20	0.0224	0.448	90	0.0443	3.991	20	0.0224	0.269	**4.89**

Practice Expense: The RUC reviewed the direct practice expense inputs for each new code and made minimal edits from the specialty recommendation as they were similar to the deleted codes they replaced. In addition, since conscious sedation was not inherent in procedure code 777X3, although frequently used, the Registered Nurse clinical labor time, medical supplies, and equipment associated with conscious sedation was eliminated.

Radiopharmaceutical Localization Injection (Tab 22)
Jonathan Berlin, MD, American College of Radiology, Kenneth McKusick, MD, Society of Nuclear Medicine/American College of Nuclear Physicians, Geraldine McGinty, MD, American College of Radiology, Gary Dillehay, MD, Society of Nuclear Medicine/American College of Nuclear Physicians

Non-imaging gamma probe procedures are now commonly performed, for which a radiopharmaceutical must be prepared, injected, and handled in accordance with acceptable regulatory and safety requirements. Those gamma probe procedures are performed during surgery as part of and during neck exploration for parathyroid tumors or for sentinel nodes in cancer patients (usually breast and melanoma).

The CPT Editorial Panel developed a diagnostic radiopharmaceutical injection procedure code in order to reflect the resources used for the procedure in February 2008. Previously, there had been no codes specifically for provision of those radioactive drugs when unaccompanied by a procedure performed in nuclear medicine. New code 78808 *Injection procedure for radiopharmaceutical localization by non-imaging probe study~~;~~, intravenous (eg, parathyroid adenoma)* reflects the resources required to provide required for the handling and provision of radioactive drugs by intravenous routes prior to gamma probe localization (eg. parathyroid tumors).

The American College of Nuclear Physicians, American College of Radiology and the Society of Nuclear Medicine conducted a joint survey with 38 respondents. The survey results indicated a procedure that lasted 20 minutes with a median physician work RVU of 0.40. The specialty concluded that the survey median data overestimated the physician work of the procedure, and recommended an RVU of 0.18 which was the 25th percentile. That value is consistent with the key reference service that was most frequently selected by the survey participants, which was CPT code 90774 *Therapeutic, prophylactic or diagnostic injection (specify substance or drug), intravenous push, single or initial substance/drug* (work RVU = 0.18). The society noted that the descriptions of the physician work for both codes are similar in that both require that the physicians provide and confirm orders, interact and review plan with staff, assure that the injection/dose is correctly administered and provide direct physician supervision. The physician work is dissimilar in that it is unlikely that the physician will need to assess the patient during the radiopharmaceutical injection procedure, however the physician provides nuclear regulatory oversight and control, dictates and signs a report of the procedure and coordinates the procedure with the surgeon for whom the radiopharmaceutical is being given. The intra-service time of CPT code 90774 is 5 minutes and the RUC agreed that this would also be the typical time for new code 78808. The RUC agreed with the 25th percentile survey estimate for intra-service time of 5 minutes, and total time of 13 minutes. **The RUC recommends a work relative value of 0.18 for CPT code 78808.**

Practice Expense: The RUC reviewed the direct practice expense inputs for new code 78808 and made minor edits to the specialty recommendation.

Cardiac Device Monitoring (Tab 23)
Bruce Wilkoff, MD and Rich Fogel, MD, American College of Cardiology

The CPT Editorial Panel created 23 new codes to distinguish the work of a programming evaluation from an interrogation evaluation, in person or remotely, performed with different modern devices such as pacemakers and implantable cardioverter defibrillators. Since the first pacemaker implantation in 1958, tremendous advances have occurred in pacemaker and monitoring technology. Similarly, since the first human implant of an implantable cardioverter defibrillator (ICD) in 1980 at the Johns Hopkins Hospital, the indications for ICD therapy have broadened from secondary to primary prevention. Recently, implantable cardiovascular monitor (ICM) technology, incorporated into ICDs, measure and record physiologic cardiovascular data such as intracardiac pressure and thoracic impedance allowing response to hemodynamic changes prior to symptom onset. In addition, long distance telemetry and remote interrogation network systems have become integral to current practice. This technology merges outpatient monitoring, device and arrhythmia detection, wireless communications, and the internet to allow device and cardiac rhythm related problems to be quickly identified, analyzed and communicated to the prescribing physician. When a device event or arrhythmia is detected, it is transmitted via wireless technology and over the Internet to a monitoring station where it is received and reviewed by a monitoring specialist who according to physician prescription notifies the treating physician. This new technology and patient care paradigm was not correctly described by the current AMA CPT code selections. Correctly describing and valuing the work provided by the physician including complex data collection and the collective efforts of the physician, independent testing facilities (IDTF) and office personnel requires a new strategic approach to coding.

The current coding convention does not recognize the value of the information obtained and presented for physician review independent of whether it is derived directly from the implanted device or from remote sensors in contact with the device and its telemetry system. Physiologic monitoring reflecting evidence of volume overload through measurements of intrathoracic impedance, left atrial pressure, weight, and or blood pressure from sensors provide data separate from heart rhythm data. This required codes that clearly distinguish the unique services performed by electrophysiologists from heart failure and other physicians. Codes are required to describe the work done in reference to the implantable cardiovascular monitors and to distinguish the work done in regard to the heart rhythm by the electrophysiologist to the physiologic data usually interpreted and reported by the heart failure or general cardiologist.

Coding options were not available that account for the work performed when preparing an ICD or pacemaker patient for a procedure or surgery. This periprocedural device assessment and programming is a common and necessary service for ICD patients to turn the devices off and back on again to avoid unexpected ICD shocks and to prevent undesirable inhibition or tachycardia in pacemaker patients during delicate operations. This entails identifying the precise device manufacturer and model, retrieving and reviewing the historical records and collecting the appropriate equipment.

The current CPT terminology also did not appropriately distinguish the work of a programming evaluation from an interrogation evaluation performed in modern devices and in practice. These devices are both more complex. It is appropriate to do a substantial evaluation of both pacemakers and ICDs with a full interrogation of the programmed and measured data from the device. The data collected is no different for these evaluations than when the interrogation is done remotely or in person. However, a much more complex and customized programming evaluation is required periodically to prescribe the appropriate behavior of the device for the patient and to evaluate both the patient's condition and the device's function. This iterative temporary and sometimes permanent adjustment of the device's function is increasingly important and intensive paralleling the complexity of both the patients and the devices.

Twenty new implantable device codes and 3 new wearable device codes were developed to: 1) Establish consistency in code descriptions; 2) Simplify code language; 3) Establish uniform frequency standards and eliminated the potential for inappropriate billing; 4) Update codes to reflect remote monitoring service components; 5) Maintain budget neutrality; and 6) Update codes to reflect current technology. For the implantable device and wearable defibrillator codes, the major changes from current to proposed codes provide for work currently not represented in current CPT codes, including complete device analysis without parameter change, remote or in-person interrogation follow-up, biventricular device analysis differentiated, perioperative limited programming, limitations on frequency of follow-up interrogations to include transtelephonic pacemaker monitoring (90 days), parallel codes for wearable defibrillator and implantable pacemaker/ICD, provides physician and service center components and incorporates codes for implantable cardiovascular monitor technology.

Physician work for the interrogation device codes (remote) was predicated on the preparation of the report covering the specified time period, no many how many transmissions are received. If during the specified interrogation period a programming evaluation is needed, the codes can be billed concurrently. Definitions for the new codes are provided in the introductory language to avoid ambiguity. For example, the number of leads will be based on the number of active leads and the number of chambers paced. Single is defined as a pacemaker or ICD with pacing and sensing function in only one chamber of the heart (e.g., an atrial pacemaker only, a ventricular pacemaker only). Dual is defined as a pacemaker or ICD with pacing and sensing function in only two chambers of the heart (e.g., leads in the atrium and ventricle, leads in both atria, leads in both ventricles). Multiple leads are defined as pacemaker or ICD with pacing and sensing function in three or more chambers of the heart as would be seen in a biventricular device with a lead in the atria. Separate codes were established between implantable and wearable defibrillators to capture the difference in work for evaluation and frequency distinguished by the device technology.

The RUC deliberated over the values for these cardiac device monitoring services for three days throughout the duration of the April 2008 RUC meeting.

Pacemaker Services

93288 ***Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; single, dual or multiple lead pacemaker system***

The RUC first reviewed specialty society survey data for pacemaker codes 93288, 93279, 93280 and 93281. In order to develop a work RVU for 93288 the RUC reviewed the two codes in which this code is currently being reported. The specialty society is estimating that 40% of code 93734 *Electronic analysis of single chamber pacemaker system (includes evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); without reprogramming* (work RVU = 0.38, 2006 frequency = 95,862) and 40% of code 93731 *Electronic analysis of dual-chamber pacemaker system (includes evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); without reprogramming* (work RVU=0.45, 2006 frequency = 329,529) will be coded under 93288 once this code is developed. By calculating for work neutrality the RUC developed a work RVU of 0.43 for code 93288.

The RUC reviewed the physician time required to perform this procedure and determined that the survey physician time was appropriate. The RUC recommends 5 minutes pre-service time, 10 minutes intra-service time and 5 minutes immediate post-service time.

Additionally, the RUC compared code 93288 to the following codes which involve similar levels of physician work, time and intensity:
99212 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU=0.45, 2 minutes pre-service, 10 minutes intra-service and 4 minutes immediate post-service time)
75902 *Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen, radiologic supervision and interpretation* (work RVU=0.39, 5 minutes pre-service, 10 minutes intra-service and 5 minutes immediate post-service time)

The RUC recommends a work RVU of 0.43 for 93288.

93279 ***Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with report; single lead pacemaker system (Do not report 93279 in conjunction with 93286 or 93288)***

The RUC examined the increment between the base code 93288 (recommended RVU=0.43) and code 93279 (recommended RVU=0.65) and determined the intensity increment was appropriate. The RUC reviewed the specialty society survey data for code

93279 and compared it to a similar service, code 95937 *Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any one method* (work RVU=0.65, 5 minutes pre-service, 12 minutes intra-service and 5 minutes immediate post-service time). The RUC determined that 0.65 work RVUs for 93279 and the survey physician times of 5 minutes pre-, 10 minutes intra- and 5 minutes immediate post-service time are appropriate. **The RUC recommends a work RVU of 0.65 for 93279.**

93280 ***Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with report; dual lead pacemaker system***

The RUC examined the increment between the code 93279 (recommended RVU=0.65) and code 93280 (recommended RVU=0.77) and determined the intensity increment was appropriate. The RUC reviewed the specialty society survey data for code 93280 and compared it to similar services, codes 95971 *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple spinal cord, or peripheral (ie, peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming* (work RVU=0.77, 3 minutes pre-service, 20 minutes intra-service and 3 minutes immediate post-service time) and 93015 *Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report* (work RVU=0.75, 2 minutes pre-service, 15 minutes intra-service and 4 minutes immediate post-service time). The RUC determined that 0.77 work RVUs for 93280 and the physician time components of 5 minutes pre-, 17 minutes intra- and 5 minutes immediate post-service time are appropriate. The RUC removed 2 minutes of immediate post-service time and added it to the intra-service time as the RUC determined that the survey respondents incorrectly placed some interpretation and report time for this XXX global code in the immediate post-service time. **The RUC recommends a work RVU of 0.77 for 93280.**

93281 ***Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with report; multiple lead pacemaker system***

The RUC determined that the intensity for 93279, 93280 and 93281 have progressively higher intensity across these services. The RUC reviewed the specialty society survey results for code 93281 and compared it to similar services, codes 92002 *Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient* (work RVU = 0.88, 5 minutes pre-, 15 minutes intra- and 5 minutes post-service time) and 95921 *Testing of autonomic nervous system function; cardiovagal innervation (parasympathetic function), including two or more of the following: heart rate response to deep breathing with recorded R-R interval, Valsalva ratio, and 30:15 ratio* (work RVU = 0.90, 10 minutes

pre-, 15 minutes intra- and 10 minutes post-service time). The RUC determined that 0.90 work RVUs for 93281 and the physician times of 5 minutes pre-, 20 minutes intra- and 5 minutes post-service time are appropriate. **The RUC recommends a work RVU of 0.90 for 93281.**

Implantable Cardiovertor Defibrillator (ICD)

93289 ***Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; single, dual or multiple lead implantable cardioverter defibrillator system, including analysis of heart rhythm derived data elements***

The RUC reviewed the specialty society survey results for code 93289 and determined that the survey 25th percentile work RVU of 1.00 was slightly high for this service. The RUC crosswalked 93289 to a 99213 office visit (work RVU=0.92, 3 minutes pre-, 15 minutes intra- and 5 minutes post-service time) and determined the physician work is comparable, both with 15 minutes of intra-service time. The RUC determined that the surveyed physician time was appropriate with 5 minutes pre-, 15 minutes intra- and 5 minutes post-service time). **The RUC recommends a work RVU of 0.92 for code 93289.**

93282 ***Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with report; single lead implantable cardioverter defibrillator system***

The RUC reviewed the specialty society survey results for code 93282 and determined that the survey 25th percentile work RVU of 0.85 and survey physician time of 8 minutes pre-, 15 minutes intra- and 5 minutes post-service time appropriate represent the physician work, time and intensity required to perform this procedure. Additionally, recommending the survey 25th percentile work RVU for 93282 appropriately places this service in the proper rank order for this family of services. The RUC also compared code 93282 to a 99213 office visit (work RVU=0.92, 3 minutes pre-, 15 minutes intra- and 5 minutes post-service time) and determined the physician work was comparable. **The RUC recommends the survey 25th percentile work RVU of 0.85 for code 93282.**

93283 ***Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with report; dual lead implantable cardioverter defibrillator system***

The RUC reviewed the specialty society survey results for code 93283 and determined that the survey 25th percentile work RVU of 1.18 and survey physician times of 8 minutes pre-, 15 minutes intra- and 10 minutes post-service time appropriately represents the physician work, time and intensity required to perform this procedure. The RUC also compared code 93283 to code 70544 *Magnetic resonance angiography, head; without contrast material(s)* (work RVU= 1.20, 5 minutes pre-, 10 minutes intra- and 10 minutes post-service time) and determined the physician work was comparable. The RUC

identified that the work RVU increment between 93289 and 93283 was 0.26 and determined that this increment is appropriate to account for the physician work required for reprogramming and the dual lead. **The RUC recommends the survey 25th percentile work RVU of 1.18 for code 93283.**

93284 ***Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with report; multiple lead implantable cardioverter defibrillator system***

The RUC reviewed the specialty society survey results for code 93284 and determined that the survey 25th percentile work RVU of 1.25 and survey physician times of 8.5 minutes pre-, 15 minutes intra- and 10 minutes post-service time appropriately represents the physician work, time and intensity required to perform this procedure. The RUC also compared code 93284 to a 99214 office visit (work RVU = 1.42, 5 minutes pre-, 25 minutes intra- and 10 minutes post-service time). The RUC determined that 93284 would be appropriately valued at 1.25 work RVUs relative to 99214 as 99214 requires 10 minutes more intra-service time. **The RUC recommends the survey 25th percentile work RVU of 1.25 for code 93284.**

Implantable Loop Recorder

93291 ***Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; implantable loop recorder system, including heart rhythm data derived analysis***

The RUC reviewed the specialty society survey results for code 93291 and determined that this service is parallel to the pacemaker interrogation device evaluation, code 93288. Therefore the RUC recommends to crosswalk the work RVU of 93288 (recommended work RVU=0.43) to 93291. However, the RUC recommends the survey physician times of 5 minutes pre-, 12 minutes intra- and 5 minutes for 93291 as these patients are more complicated than the typical patient for 93288, having syncope episodes and many arrhythmia episodes. The RUC also determined that 93291 would be appropriately valued at 0.43 relative to a 99212 office visit (work RVU=0.45). **The RUC recommends a work RVU of 0.43 for 93291.**

93285 ***Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with report; implantable loop recorder system***

The RUC reviewed the specialty society survey results for code 93285 and determined that the survey 25th percentile work RVU of 0.52 and survey physician times of 5 minutes pre-, 12 minutes intra- and 5 minutes post-service time appropriately represent the physician work, time and intensity required to perform this procedure. The RUC determined that although the recommended physician times for 93291 and 93285 are identical, the work for 93285 is slightly higher because this service detects different rhythm disturbances and includes interrogation and programming. Since 93285 is not a

therapeutic device the RUC determined that the increment should be smaller and the intensity slightly higher to account for the softer programming required which detects different rhythm disturbances. The RUC also referenced 93285 to code 76820 *Doppler velocimetry, fetal; umbilical artery* (work RVU = 0.50, 5 minutes pre-, 10 minutes intra- and 5 minutes post-service time) to support a value of 0.52. **The RUC recommends the survey 25th percentile work RVU of 0.52 for code 93285.**

Implantable Cardiovascular Monitor

93290 ***Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; implantable cardiovascular monitor system, including analysis of one or more recorded physiologic cardiovascular data elements from all internal and external sensors***

The RUC reviewed the specialty society survey results for code 93290 and determined that this service is parallel to the other interrogation codes 93288 and 93291 (recommended work RVU = 0.43). The RUC recommends the survey physician times of 5 minutes pre, 12 minutes intra- and 8 minutes post-service time. The RUC also determined that 93291 would be appropriately valued at 0.43 relative to a 99212 office visit (work RVU = 0.45). **The RUC recommends a work RVU of 0.43 for 93290.**

Wearable Defibrillator

93292 ***Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; wearable defibrillator system***

The RUC reviewed the specialty society survey results for code 93292 and determined that this service is parallel to the other interrogation codes in this family, 93288 (recommended work RVU = 0.43). The RUC recommends the survey physician times of 5 minutes pre-, 10 minutes intra- and 5 minutes post-service time. The RUC also determined that 93292 would be appropriately valued at 0.43 relative to a 99212 office visit (work RVU = 0.45). **The RUC recommends a work RVU of 0.43 for 93292.**

93286 ***Peri-procedural device evaluation and programming of device system parameters before or after a surgery, procedure or test with report; single, dual or multiple lead pacemaker system***

The RUC reviewed the specialty society survey results for code 93286 and determined that this service is similar to 93279 (recommended work RVU = 0.65) but should be valued at approximately half the work RVU of 93279 because 93286 will be reported peri-procedurally, once before the procedure and once after the procedure. Additionally, code 93286 and 93279 are comparable because both involve interrogation and programming of a pacemaker device. The RUC determined a lesser relative value for 93286 is appropriate because this service involves only interrogating certain parameters and programming certain parameters. Therefore, the RUC recommends a work RVU of

0.30 for code 93286. The RUC reviewed the physician time required to perform this service and determined that the survey times of 5 minutes pre-, 12 minutes intra-, and 5 minutes post-service time are appropriate. **The RUC recommends a work RVU of 0.30 for code 93286.**

93287 ***Peri-procedural device evaluation and programming of device system parameters before or after a surgery, procedure or test with report; single, dual or multiple lead implantable cardioverter defibrillator system***

The RUC reviewed the specialty society survey results for code 93287 and determined that this service is similar to 93282 (recommended work RVU = 0.85) but should be valued at approximately half the work RVU of 93282 because 93287 will be reported peri-procedurally, once before the procedure and once after the procedure. Additionally, code 93287 and 93282 are comparable because both involve interrogation and programming of a defibrillator device. The RUC determined a lesser relative value for 93287 is appropriate because this service involves only interrogating certain parameters and programming certain parameters. Therefore, the RUC recommends a work RVU of 0.45 for code 93287. The RUC reviewed the physician time required to perform this service and determined that the survey times of 7.5 minutes pre-, 13.5 minutes intra-, and 5 minutes post-service time are appropriate. **The RUC recommends a work RVU of 0.45 for code 93287.**

Trans Telephonic Monitoring

93293 ***Transtelephonic rhythm strip pacemaker evaluation(s) single, dual or multiple lead pacemaker system, includes recording with and without magnet application with report(s) up to 90 days***

The RUC reviewed the specialty society survey results for code 93293 and determined that the average number of transmissions per patient per 90 days is 1.9. The RUC determined that other than the physician work associated with the transmissions, the physician work for 93293 is similar to 93010 *Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only* (work RVU = 0.17, 4 minutes intra- and 1 minute post-service time). The RUC derived at an appropriate work RVU by taking the frequency of reporting this service multiplied by the work RVU for 93010 (1.9 x 0.17 = 0.32 work RVUs). The RUC determined that the physician time required to perform this service is the survey physician time multiplied by the frequency of reporting this service (5/10/5 x 1.9 = 9.5 minutes pre-, 19 minutes intra-, and 7.5 minutes post-service time. **The RUC recommends a work RVU of 0.32 for 93293.**

Wearable Mobile Cardiovascular Telemetry

93228 ***Mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient***

selected events transmitted to a remote attended surveillance center for up to 30 days; physician review and interpretation with report

The RUC reviewed specialty society survey data for code 93228 and determined that the physician work required to perform this service is comparable to 93014 *Telephonic transmission of post-symptom electrocardiogram rhythm strip(s), 24-hour attended monitoring, per 30 day period of time; physician review with interpretation and report only* (work RVU = 0.52 and 10 minutes pre-, 20 minutes intra- and 12 minutes post-service time). The RUC recommends the survey physician time of 5 minutes pre- 12 minutes intra- and 8 minutes post-service time. The RUC also referenced code 99212 office visit (work RVU=0.45) to further support the recommended physician work and time. **The RUC recommends a work RVU of 0.52 for code 93228.**

Remote Interrogation

93294 ***Interrogation device evaluation(s) (remote), up to 90 days; single, dual or multiple lead pacemaker system with interim physician analysis and physician review and report(s)***

The RUC reviewed code 93294 and determined that the average number of transmissions per patient per 90 days is 1.5. The RUC determined that other than the physician work associated with transmissions, the physician work for 93294 is parallel to 93288 (recommended work RVU = 0.43). The RUC derived an appropriate work RVU by taking the frequency of reporting this service multiplied by the work RVU for 93288 (1.5 x 0.43 RVU = 0.65 work RVUs). The RUC determined that the physician time required to perform this service was also 1.5 multiplied by the service times for 93288 (1.5 x 5/10/5 = 7.5 minutes pre-, 15 minutes intra-, and 7.5 minutes post-service time. **The RUC recommends a work RVU of 0.65 for 93294.**

93295 ***Interrogation device evaluation(s) (remote), up to 90 days; single, dual or multiple lead implantable cardioverter defibrillator system with interim physician analysis and physician review and report(s)***

The RUC reviewed code 93295 and determined that the average number of transmissions per patient per 90 days is 1.5. The RUC determined that other than the physician work associated with transmissions, the physician work for 93295 is parallel to 93289 (recommended work RVU = 0.92). The RUC derived at an appropriate work RVU by taking the frequency of reporting this service multiplied by the work RVU for 93289 (1.5 x 0.92 RVU = 1.38 work RVUs). The RUC noted that the physician work and time for 93295 is also similar to a 99214 visit (work RVU = 1.42). The RUC determined that the physician time required to perform this service was also 1.5 multiplied by the service times for 93289, 1.5 x 5/15/5 = 7.5 minutes pre-, 22.5 minutes intra-, and 7.5 minutes post-service time. **The RUC recommends a work RVU of 1.38 for 93295.**

93297 ***Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system, including analysis of one or more recorded physiologic***

cardiovascular data elements from all internal and external sensors, physician analysis, review(s) and report(s)

The RUC reviewed code 93297 and determined that the average number of transmissions per patient per 30 days is 2. The RUC determined that other than the physician work associated with transmissions, the physician work for 93297 is parallel to 93290 (recommended work RVU = 0.43). The RUC discussed taking the frequency of reporting this service and multiplying it by the work RVU for 93290 (2 x 0.43 RVU = 0.86 work RVUs) to develop a work RVU for 93297. However, recognizing that the value for 93228, which requires similar physician work and time, is 0.52 RVUs, the RUC determined to alleviate any rank order anomaly and recommended a work RVU of 0.52 for code 93297. The RUC determined that the physician time required to perform this service was the service times for 93290 multiplied by 2 (2 x 5/12/8 = 10 minutes pre-, 24 minutes intra-, and 16 minutes post-service time). **The RUC recommends a work RVU of 0.52 for 93297.**

93298 ***Interrogation device evaluation(s), (remote) up to 30 days; implantable loop recorder system, including analysis of recorded heart rhythm data, physician analysis, review(s) and report(s)***

The RUC reviewed code 93298 and determined that the average number of transmissions per patient per 30 days is 2. The RUC determined that other than the physician work associated with transmissions, the physician work for 93298 is parallel to 93291 (recommended work RVU = 0.43). The RUC discussed taking the frequency of reporting this service and multiplying it by the work RVU for 93290 (2 x 0.43 RVU = 0.86 work RVUs) to develop a work RVU for 93298. However, recognizing that the value for 93228, which requires similar physician work and time, is 0.52 RVUs, the RUC determined to alleviate any rank order anomaly and recommended a work RVU of 0.52 for 93298. The RUC determined that the physician time required to perform this service was the service times for 93290 multiplied by 2 (2 x 5/12/5 = 10 minutes pre-, 24 minutes intra-, and 10 minutes post-service time). **The RUC recommends a work RVU of 0.52 for 93298.**

93296, 93299 and 93229 (All PE Only)
The RUC recommends the revised direct practice expense inputs for the practice expense only codes 93296, 93299 and 93229.

Practice Expense:
The RUC reviewed the direct practice expense inputs and determined that for 93294, 93295, 93297, 93298 and 93228 there should be zero clinical labor time. The RUC determined any information collected for physician review is performed by administrative staff and not an RN/LPN/MTA. All other practice expense inputs as revised by the Practice Expense Subcommittee were appropriate.

New Technology
The RUC requests that this family of codes 93279 – 93229 be placed on the new technology list. The RUC determined this family will need to be revisited, especially the volume data for codes that may be reported every 90 or 30 days in which RVUs were calculated by the frequency in which the service is performed. The RUC specifically requests that codes 93299 and 93229 be brought back from review in 2 years. Data will need to be collected from the vendors/manufactures because the frequency of the reports will not be apparent in the Medicare frequency data as they may only be reported once every 30 or 90 days. However, the specialty society indicated that each physician practice will have this data available.

Database Notation
The RUC recommends that the RUC database note that physician times for codes 93286, 93287, 93293, 93294, 93295, 93297 and 93298 should not be used for comparison as these times were calculated from crosswalks and are not specialty society survey data.

Work Neutrality
The RUC noted that with the Medicare frequency data available the family of codes appears to be work neutral. The work RVUs for most of these codes which have been previously reported with a current code have decreased. Additionally, now that the remote codes may only be reported once every 30 or 90 days, the frequency is expected to decrease.

Cardiac Device Monitoring RUC Recommendations:

Code	RVU	Pre	Intra	Post	Reference	Ref RVU	Ref Pre	Ref Intra	Ref Post
93288	0.43	5	10	5	99212 75902	0.45 0.39	2 5	10 10	4 5
93279	0.65	5	10	5	95937	0.65	5	12	5
93280	0.77	5	17	5	95971 93015	0.77 0.75	3 2	20 15	3 4
93281	0.90	5	20	5	92521 92002	0.90 0.88	10 5	15 15	10 5
93289	0.92	5	15	5	99213	0.92	3	15	5
93282	0.85	8	15	5	99213	0.92	3	15	5
93283	1.18	8	15	10	70544	1.20	5	10	10
93284	1.25	8.5	15	10	99214	1.42	5	25	10
93291	0.43	5	12	5	93288 99212	0.43 0.45	5 2	10 10	5 4
93285	0.52	5	12	5	76820	0.50	5	10	5
93290	0.43	5	12	8	93288 93291 99212	0.43 0.43 0.45	5 5 2	10 10 10	5 5 4
93292	0.43	5	10	5	99212	0.45	2	10	4
93286	0.30	5	12	5	93279 / 2	0.65	5	12	5
93287	0.45	7.5	13.5	5	93282 / 2	0.85	8	15	5
93293	0.32	9.5	19	9.5	93010 x 1.9	0.17	0	4	1
93294	0.65	7.5	15	7.5	93288 x 1.5	0.43	5	10	5
93295	1.38	7.5	22.5	7.5	93289 x 1.5 99214	0.92 1.42	5 5	15 25	5 10
93297	0.52	10	24	16	93290	0.43	5	12	8
93298	0.52	10	24	10	93291	0.43	5	12	5
93228	0.52	5	12	8	93014 99212	0.52 0.45	10 2	20 10	12 4

<u>Stress Echo with ECG Monitoring (Tab 24)</u>
Facilitation Committee # 1
Bruce Wilkoff, MD and Rich Fogel, MD, American College of Cardiology

The CPT Editorial Panel created two new codes to describe continuous electrocardiographic monitoring and the use of contrast agents for left ventricular opacification for endocardial border visualization with stress echocardiography.

93351 *Echocardiography, transthoracic, real-time with image documentation (2D), with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with physician supervision, with interpretation and report*

The RUC reviewed the specialty society survey physician time for code 93351. The RUC determined that 5 minutes pre-time, 20 minutes intra-service time and 10 minutes post service time for 93351 is appropriate to perform this service.

This RUC determined that the physicians' mental effort, judgment and technical skill required to perform this service is similar to the physician work required to perform 70496 *Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU = 1.75; 8 minutes pre-time, 20 minutes intra-service time, 10 minutes post-service time) and recommends a work RVU of 1.75 for 93351. Additionally, code 70496 is on the RUC's Multi-Specialty Points of Comparison list.

The RUC agreed that a work RVU of 1.75 appropriately takes into account that this service was previously reported with codes 93350 *Echocardiography, transthoracic, real-time with image documentation (2D), with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report* (work RVU =1.48) and 93015 *Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report* (work RVU = 0.75). The RUC agreed that an increment of work above 93350 is appropriate to maintain rank order among this family of codes. A work RVU of 1.75 is the mid-point between the survey 25th percentile of 1.50 and the median of 2.00. **The RUC recommends a work RVU of 1.75 for code 93351.**

The RUC recognizes that the physician time for 93350 (40 minutes) is currently higher than the new survey data for 93351 (37 minutes). There are potential anomalies in the work and/or time data for 93350. **The RUC recommends that 93350 be surveyed and reviewed at the October 2008 RUC meeting.**

93352 *Use of echocardiographic contrast agent during stress echocardiography (List separately in addition to codes for stress echocardiography)*

The RUC agrees with the survey median physician intra-service time and recommends 5 minutes for this add-on service, code 93352. The RUC determined that the 25th percentile work RVU of 0.19 from the specialty society survey is appropriate as it is similar to CPT code 90774 *Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU = 0.18). **The RUC recommends a work RVU of 0.19 for 93352.**

Practice Expense
The direct practice expense inputs have been modified to address concerns of the RUC and practice expense subcommittee and the RUC agrees that the inputs are appropriate.

PLI Crosswalk
The PLI for 93352 has been corrected to be cross walked to the reference service 90774.

Actigraphy Sleep Assessment (Tab 25)
Sam Fleishman, MD, American Academy of Sleep Medicine, Gregory Barkley, MD, American Academy of Neurology, Burt Lesnick, MD, American College of Chest Physicians/American Thoracic Society, Terry Fife, MD, American Academy of Neurology, Scott Manaker, MD, American College of Chest Physicians, Gerald Rich, MD, American Academy of Sleep Medicine

Actigraphy was given a Category III CPT tracking code, 0089T, for new technology in 2004. Since 2004 there has been increased documentation in peer reviewed literature as well as development of a new standard of practice parameter paper that supports the change to a Category I CPT code. In February 2008, the CPT Editorial Panel agreed that a category I CPT code was warranted and created code 95803 *Actigraphy testing, recording, analysis, interpretation and report (minimum of 72 hours to 14 consecutive days of recording).*

The RUC reviewed the survey results from 93 physicians regarding the physician work, time, intensity, and complexity of code 95803, in comparison to the survey's key reference procedure code 95806 *Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, unattended by a technologist* (work RVU = 1.66). The survey results indicated the total work of code 95803 was similar in physician intensity and complexity to 95806, but required less time, urgency, and stress. However, the physician time in the pre-service and post-service periods in the survey data appeared high for the work described and the RUC agreed with the specialty society's downward adjustments (from 15 minutes to 5 in both pre and post service time periods). The RUC the typical intra-service time would be 20 minutes and that the survey median of 1.00 reflected the work value for 95803.

The RUC also reviewed the physician work of a level three (99213 (work value = 0.92)) and level four (99214 (work value = 1.42)) established office visits in relation to new code 95803 and agreed that a 95803 should be valued between the two services. In addition, although code 95806 required more overall physician time (45 minutes for 95806 vs. 30 minutes for 95803), 95803 typically is more complex and requires more physician technical skill. The RUC agreed with the specialty society's median survey results and work relative value recommendation. **The RUC recommends a relative work value of 1.00 for CPT code 95803.**

Practice Expense: The RUC reviewed the direct practice expense inputs for new code 95803 and made minor edits from the specialty recommendation.

New Technology:
The RUC recommends that code 95803 be added to the new technology list as this procedure utilizes new techniques.

Canalith Repositioning (Tab 26)
Facilitation Committee # 1
Jane Dillon, MD, American Academy of Otolaryngology-Head and Necy Surgery, Leo Bronston, DC, American Chiropractic Association, Erik van Doorne, American Physical Therapy Association, Robert Fifer, PhD, American Speech-Language-Hearing Association, Gregory Barkley, MD, American Academy of Neurology, Anthony Hamm, DC, American Chiropractic Association, Terry Fife, MD, American Academy of Neurology

The CPT Editorial Panel created a new code to describe therapeutic maneuvering of the patients' body and head designed to use the force of gravity. By using this type of maneuvering, the calcium crystal debris that is in the semi-circular canal system is re-deposited into a neutral part of the end organ where it will not cause vertigo.

95992 ***Canalith repositioning procedure(s) (eg, Epley maneuver, Semont maneuver), per day***
The specialty society indicated that the vast majority of patients do not have this treatment repeated. The RUC reviewed the survey results for code 95992 in which 101 respondents indicated a median performance rate of 55 times in the last year. The RUC determined that the median physician time from the specialty society survey was appropriate. The specialty societies indicated that the physician or qualified health care professional will spend 30 minutes total with the patient: 20 minutes has been defined to be in the intra-service period, while 10 minutes has been defined to be in the post-service period.

This service is currently reported with two units of 97112 *Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities* (work = 0.90 [0.45 x 2]; total time = 36 minutes [18 x 2]). Therefore, the RUC agreed that the survey median of 0.75 was appropriate. **The RUC recommends a work RVU of 0.75 for 95992.**

Practice Expense
The RUC determined that the direct practice expense inputs, as revised, are appropriate.

PLI Crosswalk
The PLI crosswalk was revised to 99213.

Gastric Neurostimulator Reprogramming (Tab 27)
Joel Brill, MD, American Gastroenterological Assocation

In February 2008, the CPT Editorial Panel deleted temporary Category III code 0162T *Electronic analysis and programming, reprogramming of gastric neurostimulator (ie,*

morbid obesity). As a result of this deletion, it has been assumed that those reporting this procedure would now use CPT codes 95980 – 95982. Code 0162T had been typically non-covered by most Medicare contractors and its deletion will shift the reporting to codes 95980 – 95982 and initiate coverage by Medicare. The specialty society indicated that gastric neurostimulators received FDA approval as a humanitarian use device that may make patients feel full with less food. Small clinical trials have reported positive outcomes in weight loss and maintenance of weight loss along with minimal complications. However, due to the lack of long term outcomes from well-designed randomized clinical trials, conclusions cannot be made concerning the safety and efficacy of chronic gastric stimulation in morbidly obese individuals. While the use of gastric pacing has been proposed for use in morbidly obese patients, the use of a gastric pacing device for this indication remains under investigation. The specialty society and the RUC agreed that the projected volume for these services was unlikely to change at this time and for the foreseeable future, but should be reviewed as planned under the RUC's new technology list.

The RUC agreed that the physician work relative values for codes 95980 – 95982 be maintained and that these services remain on the RUC's new technology list.

X. CMS Requests – Re-Review of Services

<u>Dermatology and Plastic Surgery Procedures (Tab 28)</u>
Facilitation Committee # 2
Michael Bigby, MD, American Academy of Dermatology, Jay Gregory, MD, American Society of General Surgeons, Jane Dillon, MD, American Academy of Otolaryngology-Head and Necy Surgery, Bruce Deitchman, MD, American Academy of Dermatology

Code Family 14000 - 14300
CPT codes 14000, 14001, 14020, 14021, 14040, 14041, 14060, 14061, and 14300 were identified by the RUC's Five-Year Review Identification Workgroup as site of service anomalies in September 2007. This family of services are currently designated as 090 day global day procedures that are typically performed in the outpatient setting or physician office. Codes 14001, 14021, and 14041, were originally valued as inpatient hospital procedures. As part of the RUC's Five-Year Review Identification Workgroup's mission, the entire family of codes are to be resurveyed for physician work based on the new practice pattern of being performed in the outpatient or physician's office setting. The RUC acknowledged that dermatologists predominately perform these services in the physician office or outpatient hospital setting and plastic surgeons predominately perform them in the inpatient or outpatient hospital setting. This bimodal site of service initial caused disagreement between the two specialties on how to survey these services. After much discussion, the RUC and specialty societies agreed that the solution was to change the global period of the codes from 090 day to 000 day. **The RUC recommends CMS change codes 14000, 14001, 14020, 14021, 14040, 14041, 14060, 14061, and 14300 from 090 day to 000 day global services.** After this global period change is made the

specialty will conduct RUC surveys for each code and present recommendations to the RUC for review.

> **** CMS did not approve the recommendation to survey these services with a 000 day global period and directed the specialty to survey the service with a 090 day global period.***

15740 ***Flap; island pedicle***
CPT code 15740 was identified through the RUC's Five Year Review Identification Workgroup as a site of service anomaly in September 2007. After discussion amongst the specialty's that provide the service, there was confusion as to how this service, as described, was performed in the office and hospital setting. All societies agreed that this service needed clarification and recommended forward the code to CPT to better delineate instructions as to how to code this service properly, and develop a CPT assistant article to assist in coding properly. The society plans to create a code change proposal for introductory language to be published in the CPT, and provide its membership with instructions and clarification in coding as well. **The RUC recommends CPT code 15740 be referred to the CPT Editorial Panel for instructional language development to be submitted by July 23, 2008. The physician time will be reverted back to its original physician time components in place prior to the RUC's Five Year Review Identification Workgroup's site of service anomalies activities.**

15570 – 15576
CPT Codes 15570-15576 were identified as a family of codes for which two codes were identified by the RUC's Five-Year Review Identification Workgroup as site of service anomalies. The specialty agreed to survey this family of codes for presentation to the RUC at its October 2008 meeting.

The specialties shall survey codes 15570, 15572,15574, and 15576 and present a recommendation to the RUC at its next meeting.

<u>Bone Graft Procedures (Tab 29)</u>
Dale Blasier, MD, American Academy of Orthopaedic Surgery, William Creevy, MD, American Academy of Orthopaedic Surgery, Tye Ouzounian, MD, American Orthopaedic Foot and Ankle Society

CPT code 20900, *Bone graft, any donor area; minor or small (eg, dowel or button)* was identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicates that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated for physician work. In tandem with the RUC's request to CMS that the service be resurveyed as potentially misvalued, the RUC requested that the global period be changed to 000. Additionally, the specialty society requested that

20902, *Bone graft, any donor area; major or large*, be reviewed with 20900. CMS agreed. However, at the February 2008 RUC meeting, the specialty society requested that 20900 and 20902 not change to 000 day global periods, but remain 090 day global periods. The RUC did not agree with the specialty's request as the services are commonly performed with other services and there may be duplicative work if 20900 and 20902 remain 090 day global periods. The RUC recommended and CMS agreed that the services be surveyed with 000 day global periods.

20900

The specialty society provided the RUC with the survey data for 20900. The survey received 50 responses and the median service performance rate was 5. The specialty society noted that the services when reported with the 000 day global will be subject to the modifier-51 50% reduction when reported in conjunction with another procedure. The specialty society also noted that the procedure is typically, though not always, reported with another service. The specialty society expert panel changed the surveyed pre-service time to pre-service time package number 3 (straightforward patient/difficult procedure) with no modifications. The respondents also indicated a median intra-service time of 30 minutes and immediate post-service time of 15 minutes, which the RUC agreed was appropriate in order to perform this service. The survey respondents indicated a median work RVU of 4.75, which the specialty society and the RUC agreed was too high. The key reference service was 11012, *Debridement including removal of foreign material associated with open fracture(s) and/or dislocation(s); skin, subcutaneous tissue, muscle fascia, muscle, and bone,* (work RVU = 6.87, intra-service time = 90 minutes). The specialty society noted that this is an inappropriate reference service because of the significant difference in time. Rather, the specialty society provided 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 1% of body area of infants and children,* (work RVU = 3.65, intra-service time = 20 minutes), which the RUC agreed was more appropriate. Because of the work involved and the similarity to the reference code 15002, the RUC agreed that the survey 25th percentile work RVU of 3.00 was appropriate.

The specialty society also noted that, as is typical with this service, when reported with another procedure, modifier-51 will apply. This will effectively bring the work RVU to 1.50 at the recommended value. Calculating the intra-service work RVUs, through an IWPUT calculation, results in intra-service work value of 1.74. As such, the resulting work RVU with the modifier-51 reduction will result in a work RVU slightly lower than the intra-service work (1.50 vs. 1.74).

To further support the recommended physician time and work RVU for 20900, the RUC also considered two additional reference codes with 000 day global periods, 19296, *Placement of radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy* (work RVU = 3.63, intra-service time = 30 minutes) and 31240, *Nasal/sinus endoscopy, surgical; with concha bullosa resection* (work RVU =

2.61, intra-service time = 30 minutes) and agreed that the surveyed code was appropriately valued between the two services.

The RUC recommends the survey 25th percentile work RVU of 3.00 for 20900.

20902

The specialty society provided the RUC with the survey data for 20902. The survey received 50 responses and the median service performance rate was 10. The specialty society presenters noted that the services when reported with the 000 day global will be subject to the modifier-51 50% reduction when reported in conjunction with another procedure. The specialty society also noted that the procedure is typically, though not always, reported with another service. The specialty society expert panel changed the surveyed pre-service time to pre-service time package number 3 (straightforward patient/difficult procedure) and added 7 minutes to the positioning time. The RUC determined that the positioning time is slightly higher because the patient must be turned from the supine to a lateral position. A pad must be inserted below the hip and the patient's upper arm must be raised and placed out of the way of the surgical area. The respondents also indicated a median intra-service time of 45 minutes and immediate post-service time of 20 minutes, which the RUC agreed was appropriate in order to perform this service. The key reference service was 11012, *Debridement including removal of foreign material associated with open fracture(s) and/or dislocation(s); skin, subcutaneous tissue, muscle fascia, muscle, and bone,* (work RVU = 6.87, intra-service time = 90 minutes). The specialty society noted that this is an inappropriate reference service because of the significant difference in intra-service time. Rather, the specialty society provided 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 1% of body area of infants and children,* (work RVU = 4.58, intra-service time = 45 minutes), which the RUC agreed was more appropriate. The survey respondents indicated a median work RVU of 7.00, which the specialty society and the RUC agreed was too high. Further, the 25th percentile work RVU 6.56 was also overstated. The specialty society recommended and the RUC agreed that given the similarity between the reference service 15004 and 20902, the physician work required to perform these services is identical. The RUC agreed that a work RVU of 4.58 for 20902 is appropriate.

The RUC also considered an additional reference code with a 000 day global period, 11011, *Debridement including removal of foreign material associated with open fracture(s) and/or dislocation(s); skin, subcutaneous tissue, muscle fascia, and muscle* (work RVU = 4.94, intra-service time = 60 minutes).

In order to confirm the value, the RUC also compared 20902 to two codes with 090 day global periods, including 27720, *Repair of nonunion or malunion, tibia; with iliac or other autograft (includes obtaining graft),* and 27724, *Repair of nonunion or malunion, tibia; with iliac or other autograft (includes obtaining graft)*. Code 27724 is essentially code 27720 with a bone graft procedure very similar to 20902. The difference in work RVUs

between the two codes (19.18 – 12.22 = 6.96) is 6.96. Therefore, the appropriate value of 20902 should be less than 6.96.

The RUC recommends 4.58 work RVUs for 20902.

Claviculectomy (Tab 30)

William Beach, MD, American Academy of Orthopaedic Surgery, William Creevy, MD, American Academy of Orthopaedic Surgery, Dale Blasier, MD, American Academy of Orthopaedic Surgery

CPT code 23120, *Claviculectomy; partial*, was identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicates that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated for physician work. At the February 2008 RUC meeting, the RUC established a series of procedural rules to guide the reevaluation of Site of Service Anomalies. Included in these procedural guidelines is the necessity of compelling evidence for any specialty society recommendation to increase work RVU for a Site of Service Anomaly.

At the April 2008 RUC meeting, the specialty society agreed that there was not compelling evidence to support of a review of the physician work in order to recommend a higher work RVU than is currently assigned to 23120. However, the specialty society noted that current data for 23120 is based on a Harvard survey for intra-service time only and the post-op visits in the database were predicted by CMS using an algorithm rather than a survey. While the specialty agreed that there was no compelling evidence to increase the value of the service, they also agreed that there was no evidence that the service was misvalued. The specialty society conducted a survey of 36 orthopaedic surgeons to validate physician work, physician time components, and post-operative office visits. The survey resulted in a median pre-service evaluation time of 40 minutes, pre-service positioning time of 15 minutes, pre-service scrub, dress and wait time of 15 minutes, intra-service time of 45 minutes, and immediate post-service time of 15 minutes. The survey respondents also indicated that the outpatient procedure includes one-half 99238 discharge management service, two 99212 office visits, and two 99213 office visits within its 090 day global period. Further, the survey resulted in a median work RVU of 8.82 and 25th percentile work RVU of 7.94. The survey respondents indicated the key reference service 29824, *Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure),* (work RVU = 8.82, intra-service time = 60 minutes). The key reference service requires greater intra-service time and should, therefore, be slightly higher than the surveyed code. Further supporting the current work RVU for 23120, the calculated intra-service work per unit of time (IWPUT) with the surveyed times and post-operative visits is 0.043, which is relatively low compared to the key reference service IWPUT of 0.065.

The RUC recommends that the work for 23120 be maintained at remain 7.23 work RVUs with the new surveyed times and post-operative visits.

Forearm Excision (Tab 31)
Daniel Nagle, MD, American Society for Surgery of the Hand, Dale Blasier, MD, American Academy of Orthopaedic Surgery

CPT code 25116, *Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); extensors, with or without transposition of dorsal retinaculum,* was identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicates that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated for physician work. At the February 2008 RUC meeting, the RUC established a series of procedural rules to guide the reevaluation of Site of Service Anomalies. Included in these procedural guidelines is the necessity of compelling evidence for any specialty society recommendation to increase work RVU for a Site of Service Anomaly.

At the April 2008 RUC meeting, the specialty society agreed that there was no compelling evidence to support of a review of the physician work in order to recommend a higher work RVU than is currently assigned to 25116. However, the specialty society noted that current data for 25116 is based on a Harvard survey for intra-service time only and the post-op visits in the database were predicted by CMS using an algorithm rather than a survey. While the specialty society agreed that there was no compelling evidence to increase the value of the service, they also agreed that there was no evidence that the service is misvalued. The specialty society conducted a survey of 55 orthopaedic surgeons to validate physician work, physician time components, and post-operative office visits. The survey resulted in a median pre-service evaluation time of 40 minutes, pre-service positioning time of 10 minutes, pre-service scrub, dress and wait time of 15 minutes, intra-service time of 60 minutes, and immediate post-service time of 20 minutes. The survey respondents also indicated that the outpatient procedure includes one-half 99238 discharge management service, one 99212 office visit, and three 99213 office visits within its 090 day global period. Further, the survey resulted in a median work RVU of 9.89 and 25th percentile work RVU of 9.08. Sixty-nine percent of survey respondents indicated the key reference service 25115, *Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); flexors,* (work RVU = 9.89, intra-service time = 90 minutes). The key reference service requires greater intra-service time and, therefore, the RUC agreed that it should be valued slightly higher than the surveyed code. Further supporting the current work RVU for 25116, the calculated intra-service work per unit of time (IWPUT) with the surveyed times and post-operative visits is 0.031, which is lower than the key reference service IWPUT of 0.050. The RUC concluded that the incremental difference in IWPUT between the survey code and reference code and the difference between the

current work RVU of 25116 and 25115 are appropriate to maintain proper rank order between the services.

The RUC recommends that the work RVU of 7.38 for code 25116 be maintained and recommends that new surveyed times and post-operative visits.

Trochanteric Bursa Excision (Tab 32)
William Creevy, MD, American Academy of Orthopaedic Surgery

CPT code 27062, *Excision; trochanteric bursa or calcification*, was identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated for physician work. At the February 2008 RUC meeting, the RUC established a series of procedural rules to guide the reevaluation of Site of Service Anomalies. Included in these procedural guidelines is the necessity of compelling evidence for any specialty society recommendation to increase work RVU for a Site of Service Anomaly.

At the April 2008 RUC meeting, the specialty society commented that there was no compelling evidence to recommend an increase in the work RVU for 27062. With no compelling evidence, the review was limited to determining whether the current value of 5.66 work RVUs is appropriate or whether they should be adjusted downward. The specialty society provided the RUC with the survey data from 32 orthopaedic surgeons to support their recommendations. The specialty society agreed that the site of service had changed and the patient is typically discharged on the day of the procedure. Based on the survey data, the specialty society recommended pre-service time package number 3 with 2 additional minutes for positioning. The extra time is necessary to place the patient in a lateral position. The RUC also agreed with the specialty society's recommendation to include one-half 99238 discharge day management service and three 99212 office visits within the 090 day global period. The survey respondents indicated that one of the three office visits was a 99213, but the specialty society and the RUC agreed that this was overstated and all three visits are the same lower intensity.

The specialty society noted that the median service performance rate is zero. Given the low utilization rate in 2006 (1,033), a low performance rate is expected. To support the recommendations, the specialty society expert panel divided the survey results into two groups, those with a performance rate of zero and those with one or more. The presenters found that the median intra-service time of 45 minutes was the same for both groups. However, the groups differed in their median work RVU. The group with a performance rate of zero resulted in a lower median work RVU than the group with a service performance rate greater than zero. The overall median work RVU was 6.79 and the 25th percentile was 6.00.

The RUC recommends maintaining the current work RVU of 5.66 and the recommended times and post-operative visits.

Achilles Tendon Repair (Tab 33)

Dale Blasier, MD, American Academy of Orthopaedic Surgery, Robb Mothershed, American Podiatric Medical Association, Frank Spinosa, DPM, American Podiatric Medical Association, Tye Ouzounian, MD, American Orthopaedic Foot and Ankle Society

27650

CPT code 27650, *Repair, primary, open or percutaneous, ruptured Achilles tendon* was identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated for physician work.

At the February 2008 RUC meeting, the specialty society provided a detailed explanation of the work involved in providing 27650. Based on the explanation of the physician work and the specialty society survey results, the RUC agreed that the survey pre-service time is too high and recommended reducing it to 19 minutes of pre-service evaluation time, 15 minutes of positioning time, and 5 minutes of scrub, dress, and wait time. This is slightly higher than the survey key reference service, 28289, *Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint* (work RVU = 8.10, pre-service time = 30, intra-service time = 45, post-service time = 30). The specialty society also discussed the number and level of the post-operative visits associated with this service and the RUC agreed that three 99213 visits and two 99212 visits. The visits are necessary due to the highly vascularized surgical area, potential for wound complications, reduced patient mobility following the procedure, and the need for physical therapy. The typical patient requires post-operative visits once every two weeks for twelve weeks, resulting in at least five visits and no more than six visits. Because of the intensity of the physician work required, the RUC agreed that the specialty's recommendation of 9.00 work RVUs, which is lower than the current work RVU, is appropriate. The key reference service has a nearly identical intensity, however, it contains fifteen minutes less intra-service time. Further, the key reference service is performed in the outpatient setting, but does not contain a 99238 discharge day management visit. If 28289 did contain one-half of a 99238, its IWPUT would be to 0.054 which is very similar to the IWPUT of 0.057 of the survey code with a work RVU of 9.00. The RUC also identified several other reference services to serve as references for the recommended work RVU of 9.00 for 27650. Specifically, the RUC looked to 24359, *Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); debridement, soft tissue and/or bone, open with tendon repair or reattachment*, (work RVU = 8.85, intra-service = 60) and 29905, *Arthroscopy, subtalar joint, surgical;*

with synovectomy, (work RVU = 9.00, intra-service = 60), which also contains one fewer 99212 visits.

The RUC recommends pre-service evaluation time of 19 minutes, pre-service positioning time of 15 minutes, pre-service scrub, dress and wait time of 5 minutes, intra-service time of 60 minutes, immediate post-service time of 20 minutes, three 99213, two 99212, one-half 99238, and the survey median work RVU of 9.00, which is lower than the current work RVU for 27650.

27654

CPT code 27654, *Repair, secondary, Achilles tendon, with or without graft,* was identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated for physician work. At the February 2008 RUC meeting, the RUC established a series of procedural rules to guide the reevaluation of Site of Service Anomalies. Included in these procedural guidelines is the necessity of compelling evidence for any specialty society recommendation to increase work RVU for a Site of Service Anomaly.

At the April 2008 RUC meeting, the specialty society commented that the current physician time and work RVU data for 27654 is based on a Harvard survey of 9 orthopaedic surgeons. Podiatrists were not included in the Harvard study. Additionally, Harvard only surveyed intra-service time (of orthopaedic surgeons) and the post-operative visits were predicted by CMS using an algorithm rather than a survey. The specialty society noted that one of the RUC's compelling evidence standards is that "a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data." Current Medicare utilization data indicate that orthopaedic surgery is the primary provider for 27654 (61%) compared with podiatry (38%). For the current RUC survey, both orthopaedic surgeons and podiatrists were surveyed and the response distribution approximates the Medicare specialty distribution. The survey statistics for all surveys and by specialty are presented below.

Specialty	n	IWPUT	Median RVU	Eval	Posit	Scrub	Med Intra	99238	99213	99212
All	31	0.054	**11.11**	45	15	15	90	0.5	3	2
Ortho	17	0.054	**10.50**	40	15	10	90	0.5	3	1
Podiatry	14	0.063	**12.10**	50	10	15	85	0.5	3	3

Although there are slight differences for some of the statistics, they are not compelling enough to indicate that the incorrect specialty was surveyed in the Harvard study. Consequently, though the survey median data would support an increased work RVU, the

specialty did not recommend an increase. However, the specialty society commented and the RUC concurred that the data also do not support a reduction in the work RVU.

Based on the survey data and the specialty societies' expert consensus panel, the specialty society recommended the following pre-service time increments: pre-service evaluation = 33 minutes; pre-service positioning = 15 minutes; and pre-service scrub, dress, and wait = 5 minutes. These times reflect a reduction from the times indicated by survey respondents, which estimated pre-service evaluation time at 45 minutes and scrub, dress and wait time to be 15 minutes. The specialty societies commented that these times were overstated and appropriately adjusted them downward. The RUC agreed with the specialty societies' recommended pre-service times.

The median survey intra-service time was 90 minutes, which given the increased difficulty of the procedure compared to 27650, the RUC agreed was appropriate for 27654. The intra-service time was also identical to the survey key reference service 28114, *Ostectomy, complete excision; all metatarsal heads, with partial proximal phalangectomy, excluding first metatarsal (eg, Clayton type procedure)*, (work RVU = 11.61, intra-service time = 90 minutes).

Therefore, the RUC recommends maintaining the current work RVU of 10.32, pre-service evaluation time of 33 minutes, pre-service positioning time of 15 minutes, pre-service scrub, dress and wait time of 5 minutes, intra-service time of 90 minutes, immediate post-service time of 20 minutes, three 99213, two 99212, one-half 99238 for code 27654.

<u>Tendon Transfer (Tab 34)</u>
Robb Mothershed, American Podiatric Medical Association, Frank Spinosa, DPM, American Podiatric Medical Association, Tye Ouzounian, MD, American Orthopaedic Foot and Ankle Society, Dale Blasier, MD, American Academy of Orthopaedic Surgery

CPT code 27690, *Transfer or transplant of single tendon (with muscle redirection or rerouting); superficial (eg, anterior tibial extensors into midfoot)*, and 27691, *Transfer or transplant of single tendon (with muscle redirection or rerouting); deep (eg, anterior tibial or posterior tibial through interosseous space, flexor digitorum longus, flexor hallucis longus, or peroneal tendon to midfoot or hindfoot)*, were identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated for physician work . At the February 2008 RUC meeting, the RUC established a series of procedural rules to guide the reevaluation of Site of Service Anomalies. Included in these procedural guidelines is the necessity of compelling

evidence for any specialty society recommendation to increase work RVU for a Site of Service Anomaly.

27690

At the April 2008 RUC meeting, the specialty society commented that the current physician time and work RVU data for 27690 is based on a Harvard survey of 7 orthopaedic surgeons. Podiatrists were not included in the Harvard study. Additionally, Harvard only surveyed intra-service time (of orthopaedic surgeons) and the post-operative visits were predicted by CMS using an algorithm rather than a survey. The specialty society noted that one of the RUC's compelling evidence standards is that "a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data." Current Medicare utilization data indicate that orthopaedic surgery is the primary provider for 27690 (52%) compared with podiatry (47%). For the current RUC survey, both orthopaedic surgeons and podiatrists were surveyed and the response distribution approximates the Medicare specialty distribution. The survey statistics for all surveys and by specialty are presented below.

SPEC	Resp	IWPUT	Median RVW	EVAL	POSIT	SDW	Med Intra	99238	99213	99212
ALL	30	0.059	**9.50**	40	10	15	60	0.5	3	2
ORT	17	0.074	**9.75**	30	10	15	60	0.5	3	1
POD	13	0.051	**9.30**	50	10	15	60	0.5	3	2

Although there are slight differences for some of the statistics, they are not compelling enough to indicate that the incorrect specialty was surveyed in the Harvard study. Consequently, though the survey median data would support an increased work RVU, the specialty did not recommend an increase. However, the specialty society commented and the RUC concurred that the data also do not support a reduction in the work RVU.

Based on the survey data and the specialty societies' expert consensus panel, the presenters recommended the following pre-service time increments: pre-service evaluation = 33 minutes; pre-service positioning = 10 minutes; and pre-service scrub, dress, and wait = 15 minutes. These times reflect a reduction from the times indicated by survey respondents, which estimated pre-service evaluation time at 40 minutes. The specialty society commented that these times were overstated and appropriately adjusted them downward. Further, this was made so that the pre-service evaluation time is consistent with other foot/ankle codes in the site-of-service review. The RUC agreed with the specialty societies' recommended pre-service times.

With respect to the number and intensity of the post-operative visits associated with this service the RUC noted that the median survey data indicate three 99213 and two 99212 office visits. This level and intensity of visits are necessary due to the highly vascularized area, potential for wound complications, reduced patient mobility following

the procedure, and especially the need for physical therapy. Further, this is consistent with other foot and ankle procedures.

The survey median intra-service time for 27690 was 60 minutes, which the specialty societies and the RUC agreed was appropriate. The median work RVU was 9.50 and the 25th percentile work RVU was 9.00. By comparison, the survey code to the key reference code 28740, *Arthrodesis, midtarsal or tarsometatarsal, single joint*, (work RVU = 9.09, intra-service time = 80 minutes), has less intra-service time, but requires less mental effort and judgment, technical skill, physical effort, and psychological stress. Therefore, the RUC agreed that the work RVU for 27690 should be slightly less than the key reference service. The RUC agreed with the specialty societies' presenters that the current value of 8.96 work RVUs for 27690 is appropriate.

The RUC recommends maintaining the current work RVU of 8.96, pre-service evaluation time of 33 minutes, pre-service positioning time of 10 minutes, pre-service scrub, dress and wait time of 15 minutes, intra-service time of 60 minutes, immediate post-service time of 20 minutes, three 99213, two 99212, one-half 99238 for 27690.

27691

At the April 2008 RUC meeting, the specialty society commented that the current physician time and work RVU data for 27691 is based on a Harvard survey of 7 orthopaedic surgeons. Podiatrists were not included in the Harvard study. Additionally, Harvard only surveyed intra-service time (of orthopaedic surgeons) and the post-operative visits were predicted by CMS using an algorithm rather than a survey. The specialty society noted that one of the RUC's compelling evidence standards is that "a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data." Current Medicare utilization data indicate that orthopaedic surgery is the primary provider for 27691 (81%) compared with podiatry (19%).

Based on the survey data and the specialty societies' expert consensus panel, the specialty society recommended the following pre-service time increments: pre-service evaluation = 33 minutes; pre-service positioning = 10 minutes; and pre-service scrub, dress, and wait = 15 minutes. These times reflect a reduction from the times indicated by survey respondents, which estimated pre-service evaluation time at 45 minutes. The specialty societies commented that this time was overstated and appropriately adjusted it downward. Further, this was made so that the pre-service evaluation time consistent with other foot/ankle codes in the site-of-service review. The RUC agreed with the specialty societies' recommended pre-service times.

With respect to the number and intensity of the post-operative visits associated with this service the RUC noted that the median survey data indicate three 99213 and two 99212 office visits. This level and intensity of visits are necessary due to the highly vascularized area, potential for wound complications, reduced patient mobility following the procedure, and especially the need for physical therapy. Further, this is consistent

with other foot and ankle procedures. Furthermore, the RUC agreed that a full 99238 discharge day management service is appropriate. Although the CMS utilization data indicate this procedure is performed 31% as hospital inpatient and 53% as hospital outpatient, the specialty noted that an overnight hospital stay is typical. The specialty society believes the discrepancy lies in coding of patients who remain in hospital for 23-hour stays. A full discharge day management visit (99238) is required for this service because the typical patient goes home on the day after the service. Although the RUC "convention" is one-half discharge day for "outpatient" services, the RUC stated very clearly that if a full discharge day is justified, it can and should be assigned. The typical patient for this service goes home the day after surgery, and the 99238 is the only visit assigned to the physician work on that day.

The survey median intra-service time for 27691 was 75 minutes, which the specialty societies and the RUC agreed was appropriate. The median work RVU was 11.75 and the 25th percentile work RVU was 10.13. By comparison, the survey code to the key reference code 28309, *Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; multiple (eg, Swanson type cavus foot procedure)*, (work RVU = 13.96, intra-service time = 110 minutes), has less intra-service time, but requires slightly less mental effort and judgment, technical skill, physical effort, and psychological stress. Therefore, the RUC agreed that the work RVU for 27691 should be slightly less than the key reference service. The RUC agreed with the specialty societies' presenters that the current value of 10.28 work RVUs for 27691 is appropriate.

The RUC recommends maintaining the current work RVU of 10.28, pre-service evaluation time of 33 minutes, pre-service positioning time of 10 minutes, pre-service scrub, dress and wait time of 15 minutes, intra-service time of 75 minutes, immediate post-service time of 20 minutes, three 99213, two 99212, one 99238 for 27691.

<u>Foot Bone Resection Partial (Tab 35)</u>
Facilitation Committee # 3
Robb Mothershed, American Podiatric Medical Association, Frank Spinosa, DPM, American Podiatric Medical Association, Tye Ouzounian, MD, American Orthopaedic Foot and Ankle Society, Dale Blasier, MD, American Academy of Orthopaedic Surgery

CPT code 28120, *Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); talus or calcaneus*, and 28122, *Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); tarsal or metatarsal bone, except talus or calcaneus*, were identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this

service should be evaluated for physician time. At the February 2008 RUC meeting, the RUC established a series of procedural rules to guide the reevaluation of Site of Service Anomalies. Included in these procedural guidelines is the necessity of compelling evidence for any specialty society recommendation to increase work RVU for a Site of Service Anomaly.

At the April 2008 RUC meeting, the specialty society presented compelling evidence to the RUC in support of a review of the physician work in order to recommend a higher work RVUs than are currently assigned to 28120 and 28122. The specialty society stated that the wrong specialty was originally surveyed in the Harvard studies for both services. Podiatrists were not included in the Harvard study and only orthopaedic surgeons were surveyed for these services. Additionally, Harvard only surveyed intra-service time of orthopaedic surgeons and the post-operative visits were predicted by a CMS contractor using an algorithm rather than a survey. The current Medicare utilization data for 28120 indicate that podiatry is the primary provider (51%) followed by orthopaedic surgery (37%). The Medicare utilization data for 28122 indicate that podiatry is the primary provider (74%) followed by orthopaedic surgery (21%).

The RUC reviewed this evidence and agreed that it was compelling to justify a complete review of the service.

28120
Although the Medicare claims data in the RUC database indicate that 28120 is performed 40% in the inpatient hospital, the presenting specialty society's expert consensus panel commented that these patients require close monitoring on the day of the procedure and are typically admitted for continued monitoring overnight. The typical patient is kept overnight and is admitted for at least 23 hours, which may be reported as an outpatient procedure, but inclusive of at least some inpatient physician work. Without RUC policy or rules regarding acceptable coding for this work in the survey or on the summary of recommendation forms, the specialty had difficulty developing a work recommendation. The specialty recommended that a submission of a recommendation for this code is dependent upon the timeline the RUC established to resolve the issue of physician work related to a 23-hour stay. The RUC agreed with the specialty society recommendation for codes 28120

The RUC recommends the current work RVU for 28120 and physician time components for code 28120 be maintained while the RUC develops a process of addressing 23-hour stay services. After a process is developed, the specialty will survey code 28120 and present its findings to the RUC.

28122
Although the Medicare claims data in the RUC database indicate that 28122 is performed 25% in the inpatient hospital, the presenting specialty society's expert consensus panel commented that these patients require close monitoring on the day of the procedure and are typically admitted for continued monitoring overnight. The typical patient is kept overnight and is admitted for at least 23 hours, which may be reported as an outpatient

procedure, but inclusive of at least some inpatient physician work. Without RUC policy or rules regarding acceptable coding for this work in the survey or on the summary of recommendation forms, the specialty had difficulty developing a work recommendation. The specialty recommended that a submission of a recommendation for this code is dependent upon the timeline the RUC established to resolve the issue of physician work related to a 23-hour stay. The RUC agreed with the specialty society recommendation for code 28122.

The RUC recommends the current work RVU for 28122 and physician time components for code 28122 be maintained while the RUC develops a process of addressing 23-hour stay services. After a process is developed, the specialty will survey code 28122 and present its findings to the RUC.

Foot Arthrodesis (Tab 36)

Robb Mothershed, American Podiatric Medical Association, Frank Spinosa, DPM, American Podiatric Medical Association, Tye Ouzounian, MD, American Orthopaedic Foot and Ankle Society, Dale Blasier, MD, American Academy of Orthopaedic Surgery

CPT code 28725, *Arthrodesis; subtalar*, and 28730, *Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse*; were identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated. At the February 2008 RUC meeting, the RUC established a series of procedural rules to guide the reevaluation of Site of Service Anomalies. Included in these procedural guidelines is the necessity of compelling evidence for any specialty society recommendation to increase work RVU for a Site of Service Anomaly.

Although the Medicare claims data in the RUC database indicate that 28725 is performed 41% inpatient hospital and 28730 is performed 38% in the inpatient hospital, the presenting specialty society's expert consensus panel commented that these patients require close monitoring on the day of the procedure and are typically admitted for continued monitoring overnight for pain control, drain management, and to monitor lower extremity neurovascular status. The typical patient is kept overnight and is admitted for at least 23 hours, which may be reported as an outpatient procedure, but inclusive of at least some inpatient physician work. Without RUC policy or rules regarding acceptable coding for this work in the survey or on the summary of recommendation forms, the specialty had difficulty developing a work recommendation. The specialty recommended that a submission of a recommendation for this code is dependent upon the timeline the RUC established to resolve the issue of physician work related to a 23-hour stay. The RUC agreed with the specialty society recommendation for codes 28725 and 28730.

The RUC recommends the current work RVU for 28725 and 28730 and physician time components for code 28725 and 28730 be maintained while the RUC develops a process of addressing 23-hour stay services. After a process is developed, the specialty will survey code 28725 and 28730 and present its findings to the RUC.

Toe Amputation at IP Joint (Tab 37)

Robb Mothershed, American Podiatric Medical Association, Charles Mabry, MD, American College of Surgeons, Frank Spinosa, DPM, American Podiatric Medical Association, Dale Blasier, MD, American Academy of Orthopaedic Surgery, Christopher Senkowski, MD, American College of Surgeons, Tye Ouzounian, MD, American Orthopaedic Foot and Ankle Society, Jay Gregory, MD, American Society of General Surgeons, Robert Zwolak, MD, Society for Vascular Surgery, David Han, MD, Society for Vascular Surgery

CPT code 28825, *Amputation, toe; interphalangeal joint,* was identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated. The specialty societies commented that the typical patient for this service is bi-modal. Based on the 2006 Medicare utilization data, the service is performed approximately 46% in the inpatient hospital setting, 46% in the outpatient hospital and ambulatory surgery center settings, and about 7% in the physician office. The service is performed by a wide variety of specialties including podiatry, orthopaedic surgery, vascular surgery and general surgery, further supporting a bi-modal distribution. The typical patient is bi-modal and requires amputation because of either diabetes or gangrene resulting from peripheral vascular disease. The specialties, based on their own survey data which indicated a bi-modal distribution and the Medicare utilization data, recommended that the service be resurveyed with a 000 day global period to more accurately include the work given the bi-modal distribution. The RUC agreed and further noted that a change in CPT descriptor will not resolve the issue, but a change in global period would. The RUC recommended that CMS change the global period for 28825 to 000 day global period and the specialty societies to resurvey for the April 2008 RUC meeting. CMS has responded that the 090 day global will be maintained.

At the April 2008 RUC meeting, the specialty society presented compelling evidence to the RUC in support of a review of the physician work in order to recommend a higher work RVU than is currently assigned to 28825. The specialty society stated that the wrong specialty was originally surveyed in the Harvard study. Podiatrists, orthopaedic surgeons, and vascular surgeons were not included in the Harvard study. Additionally, Harvard only surveyed intra-service time (of general surgeons) and the post-op visits were predicted by a CMS contractor using an algorithm rather than a survey. The current work RVU and Harvard time/visit data result in an negative IWPUT of -0.013. Current

Medicare utilization data indicate that podiatry is the primary provider for 28825 (46%) followed by orthopaedic surgery (18%), vascular surgery (16%), and general surgery (14%).

The RUC reviewed this evidence and agreed that it was compelling to justify a complete review of the service.

At the April 2008 RUC meeting, the specialty society presented data from a survey of 44 specialists with a mean service performance rate of 6 for code 28825. The survey results showed that the median intra-service time was 30 minutes. The specialty society expert panel reduced the survey respondents' estimation of pre-service evaluation time from 45 minutes to 33 minutes, consistent with pre-service package number three. The specialty recommended that an additional seven minutes be added to the pre-service positioning time to account for additional time required to position the foot and the toe for amputation. The pre-service scrub, dress and wait time of 15 minutes allotted within package number three is appropriate for this service.

The specialty society presenters commented that the survey median RVU was 6.11 and the 25th percentile work RVU was 5.89. Both the RUC and the specialty society agreed that the survey median was too high. However, the survey 25th percentile work RVU provided an appropriate ceiling for the service. The specialty society and the RUC agreed that the most accurate way to value the physician work is to consider key reference service, 28288, *Ostectomy, partial, exostectomy or condylectomy, metatarsal head, each metatarsal head* (work RVU = 5.81, intra-service time = 30 minutes). However, 28288 is typically performed in an office, whereas 28825 is typically performed in the facility setting. Total time and work for the 28825 will therefore typically be greater than 28288. The RUC agreed that the appropriate work RVU for 28825 is higher than 5.81, but lower than 5.89. The survey respondents indicated that 28825 requires greater mental effort and technical skill as well as greater psychological stress than the key reference service. Therefore, the RUC recommended a calculated work RVU for 28825 halfway between the two of 5.85. The RUC calculated the IWPUT noting that the intensity was only 0.010. The RUC also noted another reference service, 26951, *Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with direct closure* (work RVU = 5.85, intra-service time = 30 minutes) to support the recommended value, which was reviewed by the RUC in the Third Five-Year Review.

Further, there is extreme variability of the patient, diagnoses, and providers, resulting in variability in site of service and length of hospital stay. The specialty society expert panel and the RUC agreed that the majority of patients will be admitted to a hospital at least overnight (i.e., 23-hr stay), but probably for several days. Therefore, the RUC agreed that a full 99238 discharge day management service is warranted for 28825.

The RUC recommends 5.85 work RVUs for 28825.

ACL Repair (Tab 38)

Dale Blasier, MD, American Academy of Orthopaedic Surgery, William Creevy, MD, American Academy of Orthopaedic Surgery, William Beach, MD, American Academy of Orthopaedic Surgery

CPT code 29888, *Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction*, was identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated for physician work. At the February 2008 RUC meeting, the RUC established a series of procedural rules to guide the reevaluation of Site of Service Anomalies. Included in these procedural guidelines is the necessity of compelling evidence for any specialty society recommendation to increase work RVU for a Site of Service Anomaly.

The specialty society agreed that there was not compelling evidence to support of a review of the physician work in order to recommend a higher work RVU than is currently assigned to 29888. However, the specialty society noted that current data for 29888 is based on a Harvard survey for intra-service time only and the post-op visits in the database were predicted by CMS using an algorithm rather than a survey. While the specialty agreed that there was not compelling evidence to increase the value of the service, they also agreed that there was no evidence that the service was misvalued. The specialty society conducted a survey of 66 orthopaedic surgeons to validate physician work, physician time components, and post-operative office visits. The survey resulted in a median pre-service evaluation time of 45 minutes, pre-service positioning time of 15 minutes, pre-service scrub, dress and wait time of 15 minutes, intra-service time of 98 minutes, and immediate post-service time of 25 minutes. The survey respondents also indicated that the outpatient procedure includes one-half 99238 discharge management service. The survey respondents indicated that one 99212 office visit, and three 99213 office visits are included within its 090 day global period, but the specialty society expert consensus panel felt the intensity of one of the services was overstated and recommended two 99212 and two 99213 office visits. Further, the survey resulted in a median work RVU of 21.00 and 25th percentile work RVU of 16.50. The survey respondents indicated the key reference service 27447, *Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)*, (work RVU = 23.04, intra-service time = 124 minutes). The key reference service requires greater intra-service time and should, therefore, be higher than the surveyed code. The RUC also agreed that a more appropriate reference code, given the similarity in intra-service time and site of service, is 29866, *Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the autograft[s])*, (work RVU = 14.48, intra-service time = 100 minutes). Additionally, the RUC compared the IWPUTs for 29888 and 29866 and noted that with the surveyed times and visits, the IWPUT for 29888 is 0.089 while the IWPUT for 29866 is 0.087, placing 29888 at its current value of 14.14 work RVUs directly in line with the reference service.

The RUC recommends that the work RVU remain 14.14 with the new surveyed times and post-operative visits for 29888.

Arteriovenous Procedures (Tab 39)

David Han, MD, Society for Vascular Surgery, Gary Seabrook, MD, Society for Vascular Surgery, Robert Zwolak, MD, Society for Vascular Surgery, Charles Mabry, MD, American College of Surgeons, Christopher Senkowski, MD, American College of Surgeons

CPT code 36820 *Arteriovenous anastomosis, open; by forearm vein transposition*, 36821 *Arteriovenous anastomosis, open; direct, any site (eg, Cimino type)* and 36825 *Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); autogenous graft* were identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomalies utilizing information from the current physician time data and the Medicare claims data. The physician time data for these codes currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that these services are typically performed in an outpatient setting. CMS agreed with the RUC that these services should be evaluated for physician work.

36820

The RUC reviewed 36820 *Arteriovenous anastomosis, open; by forearm vein transposition*. The specialty society presented data from 32 vascular surgeons. The specialty society explained that the survey they conducted for this procedure resulted in a median RVU of 14.40 and which supports their recommendation of maintaining the current value of 14.39 for 36820. This value was further justified by comparison to the key reference service, 36819 *Arteriovenous anastomosis, open; by upper arm basilic vein transposition* (Work RVU=14.39). The specialty society made the argument that these two services are comparable in work based on similar intra-service times (120 minutes, each) and similar intensity and complexity measures.

Furthermore, the RUC was compelled to maintain the inpatient hospital visit and full discharge day management of the code based on the following information supplied to the RUC. Although the CMS database has this procedure posted as being performed 34% as hospital inpatient and 63% as hospital outpatient, the majority of survey respondents (56%) reported at least one inpatient visit. The specialty society believes the discrepancy lies in coding of patients who remain in hospital for 23-hour stays. These patients undergo 20 minutes of immediate post-service care. The physician then rounds on them late in the day, and for most, the decision is made that the patient needs to stay in a monitored hospital setting overnight, (some may need post-operative hemodialysis). The associated work is reported as a 99231 visit. The patients are then evaluated the next morning and discharged. A full discharge day management visit (99238) is required for this service because the typical patient goes home on the day after the service. Discharge work includes a full neurovascular evaluation of the extremity, incision exam for potential hemorrhage, fistula

evaluation to ensure patency, acceptable discharge glycemic control, physical exam to ensure the IV fluid administered by anesthesia has not pushed the renal failure patient into CHF, provision of wound care instructions, provision of warnings for steal syndrome and vascular compromise of the hand, ensuring arrangements are made to reestablish outpatient hemodialysis, and finalization of many other details for this very sick subset of typically diabetic renal failure patients. Although the RUC "convention" is one-half discharge day for "outpatient" services, the RUC stated very clearly that if a full discharge day is justified, it can and should be assigned. The typical patient for this service goes home the day after surgery, and the 99238 is the only visit assigned to the physician work on that day.

In addition, the specialty society presented data that the work of the native fistula creation has changed. Although the survey respondents did not identify a change in physician work for this code compared to the reference service, this represents only pseudo-stability because the entire field of hemodialysis access is increasing in complexity. Numerous publications have identified native autogenous hemodialysis access (such as 36820) to provide superior patency and greater protection against infection in these very sick dialysis patients. This has become so important to CMS that the Agency created the "Fistula First Breakthrough Initiative" (FFBI), an entity that has been extremely influential in urging surgeons to perform native autogenous access in an increasing percentage of dialysis patients. What this means is that surgeons are performing more and more complex operations to meet the CMS FFBI mandate. Therefore, while surgeons in this survey equated the work of 36820 to that of 36819, the fact is that the technical complexity of both services has increased.

The RUC recommends 14.39 RVUs for 36820.

36821

The specialty society presented compelling evidence for revaluation of 36821 to the RUC. The basis of the compelling evidence argument was three-fold. First, the specialty presented evidence that the original Harvard valuation of 36821 was incorrect because the wrong type of specialists were surveyed. The physician work RVUs for 170 vascular surgery codes were extrapolated from surveys of only two peripheral vascular operations in Harvard Phase 1 (infrarenal aortic aneurysm repair and carotid endarterectomy). Upon thorough analysis of these extrapolations it became clear that physicians evaluating the vascular surgery services were not obligated to have a working knowledge of the services as a condition for participation. The lack of an adequate basis for setting relative values for vascular services has resulting in reconsideration of hundreds of vascular services during the first three five-year reviews. Second, the specialty argued that the work involved in providing 36821 has evolved. Numerous scientific publications have identified native autogenous hemodialysis access (such as 36821) as providing superior patency and greater protection against infection in ESRD patients. This has become so important to CMS that the Agency created the Fistula First Breakthrough Initiative (FFBI), an entity that has been extremely influential in urging surgeons to perform native autogenous access in an increasing percentage of dialysis patients. The end result is that surgeons are performing more and more complex fistula operations to meet the CMS FFBI mandate. In earlier times, surgeons would perform native dialysis fistulas only in the

healthiest patients who were found to have large veins and normal arteries. Currently, smaller and more diseased veins and arteries are being used to create native fistulas. This is reflected in greater skin-to-skin operative times and greater levels of complexity. Lastly, the specialty presented evidence that fistula performance is now a Quality Performance Indicator. This will push surgeons even more towards performing an increasing percentage of native fistulas with greater emphasis on functionality of the finished product, which results in greater time, intensity, and work.

The RUC agreed that compelling evidence to review 36821 exists.

The RUC reviewed 36821 *Arteriovenous anastomosis, open; direct, any site (eg, Cimino type) (separate procedure)*. The specialty society presented data from 32 vascular surgeons. The survey respondents indicated pre-service times of 45 minutes for evaluation, 10 minutes for positioning, and 15 for scrub, dress and wait. The specialty presenters reduced the pre-service evaluation time to 33 minutes to comport with package 2B, difficult patient/straightforward procedure. However, the specialty recommended and the RUC agreed that the positioning and scrub, dress and wait times should be slightly higher than the package to account for the additional time required to position and prepare for the procedure. The RUC agreed that the procedure requires 10 minutes of pre-service positioning time and 10 minutes of pre-service scrub dress and wait time. The survey respondents also indicated that a two 99212 office visits and one 99213 office visit is included within the service's 090 day global period, with which the RUC agreed. Further, the survey respondents indicated that a full 99238 discharge day management service is included, despite the fact that a slim majority of 53% of survey respondents indicated that the service was performed in the out-patient setting. The specialty society also noted that many outpatient facilities will keep these patients for an overnight 23-hour stay. A full discharge visit is required for this service regardless of whether the patient goes home on the day of service, or the day afterwards. Discharge work includes a full neurovascular evaluation of the extremity, wound examination for potential hemorrhage, fistula evaluation to ensure patency, acceptable discharge glycemic control, physical exam to ensure the IV fluid administered by anesthesia has not pushed patient into CHF, provision of wound care instructions, provision of warnings for steal syndrome and vascular compromise of the hand, ensuring arrangements are made to reestablish outpatient hemodialysis, and finalization of many other details for this very sick typical diabetic renal failure patient. A full 99238 is appropriate given the intensity of the discharge duties.

Lastly, the survey median work RVU is 12.00, which the specialty and the RUC agreed was appropriate given the survey median intra-service time of 90 minutes. This value was justified by comparison to the key reference service, 36819 *Arteriovenous anastomosis, open; by upper arm basilic vein transposition* (Work RVU=14.39, intra-service time = 120 minutes). The survey respondents noted that the intensities and complexities of the key reference service and the surveyed code are nearly identical. The RUC agreed that the difference in intra-service times between the two services is appropriately accounted for in the 2.39 work RVU difference between them. To further support this conclusion, the RUC considered a building block methodology by calculating the IWPUT of 36819 (0.081) and multiplying it by 30 minutes of intra-service time. This results in 2.43 work RVUs.

Subtracting 2.43 work RVUs from 14.39 equals 11.96, which confirms the survey median RVU of 12.00.

The RUC recommends the survey median work RVU 12.00 for 36821 and recommends the new physician times.

36825

The specialty society commented that following a 36825, *Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); autogenous graft*, patients typically stay in the hospital for continued monitoring overnight for hemodynamic stability, homeostasis at the surgical site, and patency of the new dialysis access. Close attention is paid to assuring adequate blood flow to the hand beyond the new access and provide adequate pain management, neurovascular checks of the hand, and wound care. However, the 2006 Medicare utilization data indicate that 36825 is performed in the inpatient setting only 38% of the time. After hearing a more complete description of the service and the typical patient, the RUC agreed with the specialty society that the typical patient stays overnight and that this service should not be valued as an outpatient procedure. It was agreed that the Medicare utilization data do not comport with either the specialty society survey or the RUC's analysis of the procedure and that the valuation of this service, without consideration of a hospital stay, is inappropriate.

The RUC recommends that 36825 be deferred until the RUC has established a policy regarding services related to the 23 hour stay issue.

<u>Jugular Node Dissection (Tab 40)</u>
Facilitation Committee # 2
Jane Dillon, MD, American Academy of Otolaryngology - Head and Neck Surgery, Christopher Senkowski, MD, American College of Surgeons, Charles Mabry, MD, American College of Surgeons

CPT code 38542, *Dissection, deep jugular node(s)*, was identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated for physician work. At the February 2008 RUC meeting, the RUC established a series of procedural rules to guide the reevaluation of Site of Service Anomalies. Included in these procedural guidelines is the necessity of compelling evidence for any specialty society recommendation to increase work RVU for a Site of Service Anomaly.

At the April 2008 RUC Meeting, the specialty society provided compelling evidence to the RUC revaluation of the work RVU for 38542. The specialty society commented that when 38542 was first valued through the Harvard study, the wrong specialty was surveyed.

Only 11 general surgeons and no otolaryngologists were surveyed for intra-operative time, even though otolaryngologists are the primary providers of this service (52% otolaryngology vs 23% general surgery). The specialty commented that the methodology used to calculate the post-operative work was flawed. The Harvard study used an algorithm to predict pre- and post-work based on an intra-service time estimated by general surgeons rather than by conducting a survey. The prediction of pre/post work and survey of general surgeons resulted in data that underestimated the levels of post-operative care and the intensity of the intra-service work.

The RUC agreed that compelling evidence to review 38542 exists.

The specialty society provided survey data that indicated the median physician work value for code 38542 is 10.00. However, the specialty society agreed that this was too high and recommended a work value of 8.00 (25th percentile survey result) that resulted in an intra-service work per unit of time (IWPUT) of 0.066. The RUC agreed that the specialty recommended value of 8.00 was too high for the service provided, but that the IWPUT was appropriate in relation to other similar procedures. The RUC obtained a clearer understanding of the physician work and intensity of code 38542 from the specialty society and reviewed codes 46262 *Hemorrhoidectomy, internal and external, complex or extensive; with fistulectomy, with or without fissurectomy* (work RVU=7.80, IWPUT=0.070, Intra-service time = 45 minutes) and 49587 *Repair umbilical hernia, age 5 years or older; incarcerated or strangulated* (work RVU=7.96, IWPUT=0.048, Intra-service time = 60) for similar physician work and intensity. The committee believed that this service should comply with the RUC's pre-service standard time package # 3 (Facility straightforward patient-difficult procedure) and took off 7 minutes of pre-service evaluation time, however the survey positioning time was maintained at 10 minutes as these types of procedures require careful positioning so that the physician may obtain proper leverage and angling.

The RUC agreed that the value of the service was greater than the work of 46262 and less than 49587 and should be valued between the two services, as such the survey 25th percentile RVU of 8.00 was too high. The RUC calculated the IWPUT for the 7 minutes of pre-service evaluation time (7 x 0.0224 = 0.1568 RVUs) and reduced the work RVU by 0.15 to account for the difference in time, but maintaining the same IWPUT of 0.066. Therefore, the RUC agreed that the appropriate relative work value for 38542 is 7.85, which also places it between 46262 and 49587.

The RUC recommends a work relative value of 7.85, and a reduction in pre-service evaluation time of 7 minutes.

<u>Palatopharyngoplasty (Tab 41)</u>
Jane Dillon, MD, American Academy of Otolaryngology - Head and Neck Surgery

CPT code 42145, *Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty),* was identified by the RUC's Five-Year Review Identification

Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated for physician work. At the February 2008 RUC meeting, the RUC established a series of procedural rules to guide the reevaluation of Site of Service Anomalies. Included in these procedural guidelines is the necessity of compelling evidence for any specialty society recommendation to increase work RVU for a Site of Service Anomaly. The RUC deferred consideration of all recommendations for increases to work RVUs until April to allow specialty societies to conform to these rules and alter their recommendations as necessary.

The specialty society provided evidence that there has been a change in the patient population since the service was reviewed in the first Five-Year Review. The specialty society explained to the RUC that patients undergoing a 42145 are diagnosed with obstructive sleep apnea and are not candidates for the primary treatment of continuous positive airway pressure. These patients are typically overweight or morbidly obese, often with a BMI greater than 35. The presenters noted and the RUC concurred that patients with a BMI greater than 35 will typically spend the night in a hospital following any surgical procedure. Given the diagnosis and the type of patient, the specialty's expert consensus panel indicated these patients require close monitoring and are kept in the hospital for blood oxygen saturations, tachycardia or brachycardia, airway patency, problems with swallowing such as handling secretions, pain, and poor oral intake. Further, the American Society of Anesthesiologists (ASA) guidelines state that continued monitoring is necessary for patients following a palatopharyngoplasty. The ASA states that all palatopharyngoplasty patients have sleep apnea, sometimes severe. All have oropharyngeal/airway abnormalities, and palatopharyngoplasty targets these abnormalities. Coexisting obesity, other airway abnormalities, difficult intubation, hypertension, and GERD are all common. These patients also have an increased risk of cardiovascular disease. Palatopharyngoplasty is airway surgery with a risk of post-operative bleeding into airway and swelling of airway. Palatopharyngoplasty requires general anesthesia with intubation. Separate from the sleep apnea and airway concerns, all patients have severe throat pain limiting swallowing acutely, so an inpatient stay is appropriate for intravenous hydration and more aggressive pain management (eg, IV opiods with close airway observation). Lastly, all palatopharyngoplasty patients require post-operative opiods which elevate risk of worsening sleep apnea while used. Therefore, these patients must be monitored overnight.

The RUC agreed with this explanation of the changing patient population and considered the specialty society's survey data to verify physician times and post-operative visits. However, the RUC did not consider the evidence compelling to warrant a review of the work RVU with consideration for an increase. The specialty society presented survey data from 71 otolaryngologists with a mean service performance rate of 15. The survey respondents indicated that the pre-service evaluation time is 40 minutes, the pre-service positioning time is 10 minutes, and the pre-service scrub, dress and wait time is 15 minutes. The survey respondents also indicated that there is 60 minutes of intra-service

time and the specialty society recommended 30 minutes of immediate post-service time. Despite the fact that the Medicare claims data state that only 12% of 42145s are reported in the inpatient facility, the RUC agreed that the typical patient stays overnight, typically as a 23-hour out-patient. Because of the overnight stay and the extensive work involved in discharging the typical patient, the RUC agreed that a full 99238 post-service discharge day management procedure is warranted. Further, the survey data supported the specialty society's recommendation for continuing to include three 99213 office visits within the service's 090 day global period.

The RUC recommends that the work RVU for 42145 be maintained at 9.63, but that the survey times and post-operative visits, including a full 99238 discharge day management service be accepted.

Parotid Tumor Excision (Tab 42)
Charles Mabry, MD, American College of Surgeons, Christopher Senkowski, MD, American College of Surgeons, Jane Dillon, MD, American Academy of Otolaryngology - Head and Neck Surgery

CPT codes 42415, *Excision of parotid tumor or parotid gland; lateral lobe, with dissection and preservation of facial nerve,* and 42420, *Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve,* were identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated. At the February 2008 RUC meeting, the RUC established a series of procedural rules to guide the reevaluation of Site of Service Anomalies. Included in these procedural guidelines is the necessity of compelling evidence for any specialty society recommendation to increase work RVU for a Site of Service Anomaly. The RUC deferred consideration of all recommendations for increases to work RVUs until April 2008 to allow specialty societies to conform to these rules and alter their recommendations as necessary.

42415
Although the Medicare claims data in the RUC database indicate that 42415 is performed 33% in the inpatient hospital, the presenting specialty society's expert consensus panel commented that these patients require close monitoring on the day of the procedure and are typically admitted for continued monitoring overnight. The typical patient is kept overnight and is admitted for at least 23 hours, which may be reported as an outpatient procedure, but inclusive of at least some inpatient physician work. Without RUC policy or rules regarding acceptable coding for this work in the survey or on the summary of recommendation forms, the specialty had difficulty developing a work recommendation. The specialty recommended that a submission of a recommendation for this code is dependent upon the timeline the RUC established to resolve the issue of physician work

related to a 23-hour stay. The RUC agreed with the specialty society recommendation for code 42415.

The RUC recommends the current work RVU for 42415 and physician time components for code 42415 be maintained while the RUC develops a process of addressing 23-hour stay services. After a process is developed, the specialty will survey code 42415 and present its findings to the RUC.

42420
Although the Medicare claims data in the RUC database indicate that 42420 is performed 40% in the inpatient hospital, the presenting specialty society's expert consensus panel commented that these patients require close monitoring on the day of the procedure and are typically admitted for continued monitoring overnight. The typical patient is kept overnight and is admitted for at least 23 hours, which may be reported as an outpatient procedure, but inclusive of at least some inpatient physician work. Without RUC policy or rules regarding acceptable coding for this work in the survey or on the summary of recommendation forms, the specialty had difficulty developing a work recommendation. The specialty recommended that a submission of a recommendation for this code is dependent upon the timeline the RUC established to resolve the issue of physician work related to a 23-hour stay. The RUC agreed with the specialty society recommendation for code 42420.

The RUC recommends the current work RVU for 42420 and physician time components for code 42420 be maintained while the RUC develops a process of addressing 23-hour stay services. After a process is developed, the specialty will survey code 42420 and present its findings to the RUC.

Insertion of Intraperitoneal Cannula or Catheter (Tab 43)
Charles Mabry, MD, American College of Surgeons

CPT code 49421 *Insertion of intraperitoneal cannula or catheter for drainage or dialysis; permanent* was identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated as it is potentially misvalued. CMS initially added code 49420 *Insertion of intraperitoneal cannula or catheter for drainage or dialysis; temporary* and proposed that these services both to 010-day global periods. However, after further research CMS indicated that code 49421 should have its global period changed from a 090-day to a 000-day and code 49420 would remain at its current global period of 000-day status. This global period change and any changes to post-service work will be deferred pending CPT Editorial Panel revisions.

At the April 2008 RUC meeting, the specialty society requested that codes 49420 and 49421 be referred to the CPT Editorial Panel for clarification. The specialty society is concerned that the original intention of these descriptors has changed over time because of the addition of new catheter codes. Additionally, the specialty society indicated that some inadvertent miscoding may be occurring because the descriptor is vague with respect to catheter placement for "drainage" and whether the code is meant for open or percutaneous placement. **The RUC recommends that codes 49420 and 49421 be referred to the CPT Editorial Panel for clarification and that the current time components be maintained.**

Hernia Repair (Tab 44)
Charles Mabry, MD, American College of Surgeons, Jay Gregory, MD, American Society of General Surgeons, Christopher Senkowski, MD, American College of Surgeons

CPT codes 49507, *Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated*, 49521, *Repair recurrent inguinal hernia, any age; incarcerated or strangulated*, and 49587, *Repair umbilical hernia, age 5 years or older; incarcerated or strangulated*, were identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for these codes currently include hospital visits and discharge management services, however, the Medicare claims data indicate that the services are typically performed in an outpatient setting. CMS agreed with the RUC that the services should be evaluated. At the February 2008 RUC meeting, the RUC established a series of procedural rules to guide the reevaluation of Site of Service Anomalies. Included in these procedural guidelines is the necessity of compelling evidence for any specialty society recommendation to increase work RVU for a Site of Service Anomaly. The RUC deferred consideration of all recommendations for increases to work RVUs until April 2008 to allow specialty societies to conform to these rules and alter their recommendations as necessary.

49507
Although the Medicare claims data in the RUC database indicate that 49507 is performed 47% in the inpatient hospital, the presenting specialty society's expert consensus panel commented that these patients require close monitoring on the day of the procedure and are typically admitted for continued monitoring overnight. The typical patient is kept overnight and is admitted for at least 23 hours, which may be reported as an outpatient procedure, but inclusive of at least some inpatient physician work. Without RUC policy or rules regarding acceptable coding for this work in the survey or on the summary of recommendation forms, the specialty had difficulty developing a work recommendation. The specialty recommended that a submission of a recommendation for this code is dependent upon the timeline the RUC established to resolve the issue of physician work related to a 23-hour stay. The RUC agreed with the specialty society recommendation for code 49507.

The RUC recommends the current work RVU for 49507 and physician time components for code 49507 be maintained while the RUC develops a process of addressing 23-hour stay services. After a process is developed, the specialty will survey code 49507 and present its findings to the RUC.

49521

Although the Medicare claims data in the RUC database indicate that 49521 is performed 43% in the inpatient hospital, the presenting specialty society's expert consensus panel commented that these patients require close monitoring on the day of the procedure and are typically admitted for continued monitoring overnight. The typical patient is kept overnight and is admitted for at least 23 hours, which may be reported as an outpatient procedure, but inclusive of at least some inpatient physician work. Without RUC policy or rules regarding acceptable coding for this work in the survey or on the summary of recommendation forms, the specialty had difficulty developing a work recommendation. The specialty recommended that a submission of a recommendation for this code is dependent upon the timeline the RUC established to resolve the issue of physician work related to a 23-hour stay. The RUC agreed with the specialty society recommendation for code 49521.

The RUC recommends the current work RVU for 49521 and physician time components for code 49521 be maintained while the RUC develops a process of addressing 23-hour stay services. After a process is developed, the specialty will survey code 49521 and present its findings to the RUC.

49587

Although the Medicare claims data in the RUC database indicate that 49587 is performed 37% in the inpatient hospital, the presenting specialty society's expert consensus panel commented that these patients require close monitoring on the day of the procedure and are typically admitted for continued monitoring overnight. The typical patient is kept overnight and is admitted for at least 23 hours, which may be reported as an outpatient procedure, but inclusive of at least some inpatient physician work. Without RUC policy or rules regarding acceptable coding for this work in the survey or on the summary of recommendation forms, the specialty had difficulty developing a work recommendation. The specialty recommended that a submission of a recommendation for this code is dependent upon the timeline the RUC established to resolve the issue of physician work related to a 23-hour stay. The RUC agreed with the specialty society recommendation for code 49587.

The RUC recommends the current work RVU for 49587 and physician time components for code 49587 be maintained while the RUC develops a process of addressing 23-hour stay services. After a process is developed, the specialty will survey code 49587 and present its findings to the RUC.

Urological Procedures (Tab 45)
Facilitation Committee # 3
Steven Schlossberg, MD, Richard Gilbert, MD, James Giblin, MD, American Urological Association, George Hill, MD, American College of Obstetricians and Gynecologists

The following urological procedures were identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for these code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an outpatient setting. CMS agreed with the RUC that these services should be evaluated because they are potentially misvalued.

51102 (renumbered, previously code 51010)
At the February 2008 meeting the RUC reviewed the specialty society recommendation for code 51102 *Aspiration of bladder; with insertion of suprapubic catheter* and determined that the vignette may have misled survey respondents to inappropriately conclude there are certain post-operative visits because it included "is admitted to the ICU". The RUC also determined that this service should have a 000-day global period instead of a 010-day global period because the post-operative period is variable, meaning there is no typical standard regarding the number post-operative office visits. The RUC requested that CMS assign a 000-day global period to code 51102 and that the specialty society resurvey this service with the revised vignette. CMS notified the RUC that a 000-day global period would be acceptable.

In April 2008, the RUC reviewed the new survey results and specialty society recommendation for code 51102 and determined that the pre-service time package 1B – straightforward patient procedure (w/sedation/anesthesia) of 25 minutes, the survey intra-service time of 20 minutes and the survey immediate post-service time of 15 minutes appropriately demonstrated the physician time required to perform this procedure. The RUC determined that the specialty society's survey 25th percentile work RVU of 2.70 appropriately accounted for the intensity and complexity of physician work required to perform this 000-day global procedure. The RUC also compared code 51102 to a similar service, code 36556 *Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older* (work RVU=2.50, 25 minutes pre-service time, 15 minutes intra-service time and 10 minutes immediate post-service time) and determined that 51102 work RVU was slightly higher as a longer intra-service and immediate post-service time is required to perform this procedure. **The RUC recommends the specialty society's survey 25th percentile work RVU of 2.70 for code 51102.**

52341, 52342, 52343, 52344, 52345, 52346, 52400, 52500, 52640 and 54405
At the February 2008 RUC meeting, the RUC established a series of procedural rules to guide the reevaluation of Site of Service Anomalies. Included in these procedural guidelines is the necessity of compelling evidence for any specialty society recommendation to increase work RVU for a Site of Service Anomaly. The RUC

deferred consideration of all recommendations for increases to work RVUs until April 2008 to allow specialty societies to conform to these rules and alter their recommendations as necessary. The following codes were then reviewed at the April 2008 RUC meeting: 52341, 52342, 52343, 52344, 52345, 52346, 52400, 52500, 52640 and 54405. In April, the specialty society indicated that compelling evidence would not be provided to increase the valuation of these services. The specialty recommended that the work of previously indicated hospital visits would be removed.

52341
In April 2008, the RUC received notification that the specialty society determined that there was not sufficient evidence to support an increase in RVUs for code 52341 *Cystourethroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)* (2008 work RVU = 6.11). The specialty society recommended and the RUC agreed that since this service is typically performed in an outpatient setting, the physician work value of a 99231 *Subsequent hospital care visit* (work RVU = 0.76) should be removed. The RUC deleted the value of a 99231 visit from the current value for code 52341 (6.11-0.76 = 5.35) resulting in a work RVU of 5.35. **The RUC recommends a work RVU of 5.35 and the specialty society surveyed physician times for code 52341.**

52342
In April 2008, the RUC received notification that the specialty society determined that there was not sufficient evidence to support an increase in RVUs for code 52342 *Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)* (2008 work RVU = 6.61). The specialty society recommended and the RUC agreed that since this service is typically performed in an outpatient setting, the physician work value of a 99231 *Subsequent hospital care visit* (work RVU = 0.76) should be removed. The RUC deleted the value of a 99231 visit from the current value for code 52342 (6.61-0.76 = 5.85) resulting in a work RVU of 5.85. **The RUC recommends a work RVU and the specialty society surveyed physician times of 5.85 for code 52342.**

52343
In April 2008, the RUC received notification that the specialty society determined that there was not sufficient evidence to support an increase in RVUs for code 52343 *Cystourethroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)* (2008 work RVU = 7.31). The specialty society recommended and the RUC agreed that since this service is typically performed in an outpatient setting, the physician work value of a 99231 *Subsequent hospital care visit* (work RVU = 0.76) should be removed. The RUC deleted the value of a 99231 visit from the current value for code 52343 (7.31-0.76 = 6.55) resulting in a work RVU of 6.55. **The RUC recommends a work RVU of 6.55 and the specialty society surveyed physician times for code 52343.**

52344
In April 2008, the RUC received notification that the specialty society determined that there was not sufficient evidence to support an increase in RVUs for code 52344 *Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)* (2008 work RVU = 7.81). The specialty society recommended and the RUC agreed that since this service is typically performed in an outpatient setting, the physician work value of a 99231 *Subsequent hospital care visit* (work RVU = 0.76) should be removed. The RUC deleted the value of a 99231 visit from the current value for code 52344 (7.81-0.76 = 7.05) resulting in a work RVU of 7.05. **The RUC recommends a work RVU of 7.05 and the specialty society surveyed physician times for code 52344.**

52345
In April 2008, the RUC received notification that the specialty society determined that there was not sufficient evidence to support an increase in RVUs for code 52345 *Cystourethroscopy with ureteroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)* (2008 work RVU = 8.31). The specialty society recommended and the RUC agreed that since this service is typically performed in an outpatient setting, the physician work value of a 99231 *Subsequent hospital care visit* (work RVU = 0.76) should be removed. The RUC deleted the value of a 99231 visit from the current value for code 52345 (8.31-0.76 = 7.55) resulting in a work RVU of 7.55. **The RUC recommends a work RVU of 7.55 and the specialty society surveyed physician times for code 52345.**

52346
In April 2008, the RUC received notification that the specialty society determined that there was not sufficient evidence to support an increase in RVUs for code 52346 *Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)* (2008 work RVU = 9.34). The specialty society recommended and the RUC agreed that since this service is typically performed in an outpatient setting, the physician work value of a 99231 *Subsequent hospital care visit* (work RVU = 0.76) should be removed. The RUC deleted the value of a 99231 visit from the current value for code 52346 (9.34-0.76 = 8.58) resulting in a work RVU of 8.58. **The RUC recommends a work RVU of 8.58 and the specialty society surveyed physician times for code 52346.**

52400
In April 2008, the RUC received notification that the specialty society determined that there was not sufficient evidence to support an increase in RVUs for code 52400 *Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds* (2008 work RVU = 10.06). The specialty society recommended and the RUC agreed that since this service is typically performed in an outpatient setting, the physician work value of a 99231 *Subsequent hospital care visit* (work RVU = 0.76) should be removed and the physician work for half of a 99238 *Hospital discharge day management* (work RVU = 1.28) should be removed as well. The RUC deleted the value of a 99231 visit and deleted the value for

half a discharge day management from the current value for code 52400 (10.06-0.76-0.64 = 8.66) resulting in a work RVU of 8.66. **The RUC recommends a work RVU of 8.66 and the specialty society surveyed physician times for code 52400.**

52500
In April 2008, the RUC received notification that the specialty society determined that there was not sufficient evidence to support an increase in RVUs for code 52500 *Transurethral resection of bladder neck (separate procedure)* (2008 work RVU = 9.39). The specialty society recommended and the RUC agreed that since this service is typically performed in an outpatient setting, the physician work value of a 99231 *Subsequent hospital care visit* (work RVU = 0.76) should be removed and the 99238 *Hospital discharge day management* (work RVU = 1.28) should be reduced to a half discharge day. The RUC deleted the value of a 99231 visit and deleted the value for half a discharge day management from the current value for code 52500 (9.39-0.76-0.64 = 7.99) resulting in a work RVU of 7.99. **The RUC recommends a work RVU of 7.99 and the specialty society surveyed physician times for code 52500.**

52640
In April 2008, the RUC received notification that the specialty society determined that there was not sufficient evidence to support an increase in RVUs for code 52640 *Transurethral resection; of postoperative bladder neck contracture* (2008 work RVU = 6.89). The specialty society recommended and the RUC agreed that since this service is typically performed in an outpatient setting, the physician work value of any 99231 *Subsequent hospital care visit* (work RVU = 0.76) should be removed and the 99238 *Hospital discharge day management* (work RVU = 1.28) should be reduced to a half discharge day. The RUC deleted the value of two 99231 visits and deleted the value for half a discharge day management from the current value for code 52640 (6.89-0.76-0.76-0.64 = 4.73) resulting in a work RVU of 4.73. **The RUC recommends a work RVU of 4.73 and the specialty society surveyed physician times for code 52640.**

54405
In April 2008, the RUC received notification that the specialty society determined that there was not sufficient evidence to support an increase in RVUs for code 54405 *Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir* (2008 work RVU = 14.39). The specialty society indicated that this service is a 23-hour stay that usually requires patients to spend at least one night in the hospital. The specialty society requested that review of code 54405 be deferred until after the RUC develops the specific 23 hour service survey instrument and/or a process to address these 23-hour services. **The RUC recommends that the current work RVU of 14.39 and physician times for code 54405 be maintained and that the specialty society resurvey this code after the development of the process to handle specific 23 hour services.**

53445
In February 2008, the RUC discussed code 53445 *Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff* and determined that it

should be removed from the site-of-service screen and that the current work RVU of 15.21 be maintained. The specialty society indicated that although the Medicare data indicates this service is predominately performed in the outpatient setting (54% outpatient hospital and 45% inpatient hospital), survey respondents indicated this service is typically performed in the facility setting. The specialty society indicated that these patients typically have had a radical prostatectomy and are admitted for 24 hours in order to administer intravenous antibiotics and manage urethral catheters post-operatively. The RUC recommends maintaining the existing work RVU for 53445, however recommends using the new survey data for physician time and post-operative visits. The RUC recommends 1-99232, 1-99233, 1-99238, 1-99212, and 3-99213 post-operative visits. **The RUC recommends removing this service from the site-of-service screen and recommends maintaining the work RVU of 15.21 for code 53445.**

54410
In February 2008, the RUC reviewed specialty society survey results for code 54410 *Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session* and determined that after removing the appropriate post-operative visits the surveyed 25th percentile work RVU of 15.00 was appropriate. The RUC recommends 1-99238, 1-99212 and 3-99213 post-operative visits for this service.

The RUC was compelled to maintain full discharge day management of the code based on the following information supplied by the specialty society. Although the CMS database has this procedure posted as being performed 32% as hospital inpatient and 67% as hospital outpatient, the majority of survey respondents reported a full discharge day and at least one hospital visit. The specialty society believes the discrepancy lies in coding of patients who remain in hospital for 23-hour stays. These patients undergo 30 minutes of immediate post-service care. The physician then rounds on them late in the day, and for most, the decision is made that the patient needs to stay in a monitored hospital setting overnight. The patients are then evaluated the next morning and discharged. A full discharge day management visit (99238) is required for this service because the typical patient goes home on the day after the service. Although the RUC may typically assign a half discharge day for outpatient services, the RUC stated very clearly that if a full discharge day is justified, it can and should be assigned. The specialty society indicated that the typical patient for this service goes home the day after surgery, and the 99238 is the only visit assigned to the physician work on that day.

Additionally, the RUC determined that the survey pre-service evaluation time was slightly high compared to the pre-service evaluation time for reference service 54411 *Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue (pre-service evaluation = 50 minutes)* and other similar procedures. The RUC recommends pre-service evaluation time of 40 minutes, pre-service positioning time of 10 minutes and pre-service scrub, dress, wait time of 15 minutes. **The RUC recommends the 25th percentile work RVU of 15.00 for code 54410.**

54530
In February 2008, the RUC reviewed and agreed with the specialty society survey recommendation for code 54530 *Orchiectomy, radical, for tumor; inguinal approach.* The survey median RVU was 10.38. However, since this service is predominantly performed in the hospital outpatient setting, the specialty society recommended and the RUC agreed to start with the survey median value of 10.38 and delete one 99323 visit, reduce the discharge day to a half-day and remove the associated RVUs with these post-operative visit deletions, (10.38 – 1.39 – 0.64 = 8.35). The RUC recommends the surveyed physician times and a half day-99238, 2-99212 and 1-99213 post-operative visits.

Additionally, the RUC compared this service to codes 37650 *Ligation of femoral vein* (work RVU = 8.41, intra-service time = 60 minutes) and 53505 *Urethrorrhaphy, suture of urethral wound or injury; penile* (work RVU = 8.16, intra-service time = 59 minutes) to further support the recommendation of 8.35 for code 54530. **The RUC recommends a work RVU of 8.35 for code 54530.**

57287
In February 2008, the RUC reviewed code 57287 *Removal or revision of sling for stress incontinence (eg, fascia or synthetic)*. The RUC reviewed the pre-service times and immediate post-service physician times. The RUC determined that the survey respondents over-estimated the pre- and immediate post-service times as they indicated significantly higher times compared to the current physician time associated with this service and physician times for similar services. The RUC recommends 40 minutes pre-evaluation, 10 minutes pre-positioning, 10 minutes scrub, dress, wait time and 20 minutes immediate post-service time.

The survey median RVU for 57287 was 13.00. However, since this service is predominantly performed in the hospital outpatient setting, the specialty society recommended starting with the survey median of 13.00 and delete one 99323 visit, reduce the discharge day to a half-day and remove the associated RVUs with these post-operative visit deletions, (13.00 – 1.39 – 0.64 = 10.97). The RUC recommends a half day 99238, 1-99212 and 3-99213 post-operative visits.

Additionally, the RUC compared this service to code 53852 *Transurethral destruction of prostate tissue; by radiofrequency thermotherapy* (work RVU = 10.68, intra-service time = 58 minutes) as a reference to further support the recommendation of 10.97 for code 57287. **The RUC recommends a work RVU of 10.97 for code 57287.**

Practice Expense
These services are typically performed in the facility setting. The direct practice expense inputs, specifically for the assist physician time and the number of post-operative visits for codes 51102, 53445, 54410, 54530 and 57287 are recommended to be modified to reflect the current survey data. The practice expense inputs for the number of post-operative visits for codes 52341, 52342, 52343, 52344, 52345, 52346, 52400, 52500 and 52640 are

recommended to be modified as revised above. The RUC recommends the practice expense for code 54405 be maintained.

Total Thyroid Lobectomy (Tab 46)
Charles Mabry, MD, American College of Surgeons, Jane Dillon, MD, American Academy of Otolaryngology - Head and Neck Surgery, Christopher Senkowski, MD, American College of Surgeons, Jay Gregory, MD, American Society of General Surgeons

CPT codes 60220 *Total thyroid lobectomy, unilateral; with or without isthmusectomy* and 60225 *Total thyroid lobectomy, unilateral; with contralateral subtotal lobectomy, including isthmusectomy* were identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated for physician work.

The specialty societies noted that while the Medicare utilization data indicate 43% inpatient hospital, the specialties' expert consensus panel believes that these patients require close monitoring on the day of the procedure and are typically kept in the hospital for continued monitoring overnight for airway patency and for development of cervical hematoma. Further, for code 60225, the 2006 Medicare utilization data indicate that this service is performed greater than 50% in the inpatient setting.

Therefore, the RUC agreed that these services are typically performed in the inpatient setting and recommends that they be removed from the site of service anomaly list. Further, the RUC recommends that for 60220, the one 99231 hospital visit and the full 99238 discharge day management service be added back into the 090 day global period of 60220. The RUC recommends that for 60225, the three and-a-half 99231 hospital visits and the full 99238 discharge day management service be added back into the 090 day global period of 60225.

Neurosurgical Procedures (Tab 47)
John Wilson, MD, American Association of Neurological Surgeons/Congress of Neurological Surgeons

The following neurosurgical procedures were identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for these codes currently include hospital visits and discharge day management services, however, the Medicare claims data indicate that the service is typically performed in the outpatient setting. CMS agreed with the RUC that these services should be evaluated.

61885 *Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array*
Medicare claims data in the RUC database indicates that 61885 is performed 30.37% of the time in the inpatient hospital and 68.21% in the outpatient hospital setting. The specialty society believed these patients require close monitoring on the day of the procedure and are typically kept in the hospital for continued monitoring overnight. The typical patient is an elderly debilitated individual with severe Parkinson's Disease. They are usually observed as a 23 hour overnight stay to make sure they tolerate having their stimulator activated. There will be one or more visits on the day of the procedure to check on the progress of the patient. Without RUC policy and/or rules regarding acceptable coding for this work on the summary of recommendation forms, the specialty had difficulty developing a work recommendation. The specialty recommended that a submission of a recommendation for this code is dependent on the timeline the RUC establishes to resolve the issue of physician work related to a 23-hour stay. The RUC agreed with the specialty recommendation. **The RUC recommends the current work RVU of 7.37 and physician time components for code 61885 be maintained while the RUC develops a process of handling specific 23 hour stay services. After a process is developed the specialty will survey code 61885 and present its findings to the RUC.**

64573
Medicare claims data in the RUC database indicate that 64573 is performed 23.90% of the time in the inpatient hospital setting and 74.15% of the time in the outpatient hospital setting. The specialty society believed these patients require close monitoring on the day of the procedure and are typically kept in the hospital for continued monitoring overnight for seizures. The specialty explained that the patients have end stage epilepsy and being on high doses of several anticonvusants often makes them coagulopathic. The surgery itself requires dissection of a long segment of the vagus nerve within the carotid sheath, dissecting between the carotid artery and the jugular vein. This places the patient at risk for a deep neck hematoma. Furthermore, if they awake from anesthesia with nausea and cannot keep their anticonvulsants down, they are at risk for status epilepticus. Finally, the metabolism of their anesthetic drugs often interferes with their anticonvulsant metabolism, again placing them at risk for a flurry of seizures within the first 24 hours after an anesthetic. There will be one or more visits on the day of the procedure to check on the progress of the patient as well as a full discharge day management the day following the procedure. The specialty maintains that the typical patient is a hospital patient, and without RUC policy and/or rules regarding acceptable coding for this work on the summary of recommendation forms, they are unable submit a work recommendation. The specialty requested to defer their recommendation of a work RVU and maintain the current work RVU until the RUC approves a policy and/or rules regarding reporting of physician work performed on the day of a procedure relative to 23-hour stay status. The RUC agreed with this request. **The RUC recommends the current work RVU of 8.14 and physician time components for code 64573 be maintained while the RUC develops a process of handling specific 23 hour stay services. After a process is developed the specialty will survey code 61885 and present its findings to the RUC.**

Intrathecal/Epidural Catheters/Pumps (Tab 48)
Charles Mick, MD, North American Spine Society, Eduardo Fraifeld, MD, American Academy of Pain Medicine, Frederick Boop, MD, American Association of Neurological Surgeons/Congress of Neurological Surgeons, Alexander Mason, MD, American Association of Neurological Surgeons/Congress of Neurological Surgeons, Tripti Kataria, MD, American Society of Anesthesiologists

CPT codes describing intrathecal/epidural catheters/pumps (62350,62360, 62361, 62362 and 62365) were identified by the RUC's Five-Year Review Identification Workgroup as site of service anomalies utilizing information from the current physician time data and the Medicare claims data. The physician time data for these codes currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that these services are typically performed in an outpatient setting. CMS agreed with the RUC that these services should be evaluated for physician work.

62350 ***Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy***

At the February 2008 RUC meeting, the specialty societies presented survey data from 58 pain medicine physicians, neurourgeons, anesthesiologists and spine surgeons. The RUC compared the surveyed code to the reference code, 64561 *Percutaneous implantation of neurostimulator electrodes; sacral nerve (transforaminal placement)* (Work RVU=7.07) and determined that the surveyed code in comparison to the reference code had less total service time, 170 minutes and 204 minutes respectively. In addition, the RUC noted that the survey data supported that this service is now more frequently being performed in the outpatient setting. The respondents indicated that the two 99233 and one 99231 hospital visits, which were previously included in the service's global period, are not included and the full discharge day management service has been reduced to half a discharge day management service. Therefore, given the comparison to the reference code, the RUC determined that the median work RVU, 6.00 was appropriate. **The RUC recommends 6.00 RVUs for 62350.**

62355 ***Removal of previously implanted intrathecal or epidural catheter***

At the February 2008 RUC meeting, the specialty societies presented data from 58 pain medicine physicians, neurourgeons, anesthesiologists and spine surgeons. The RUC compared the survey code to the reference code, 36589 *Removal of tunneled central venous catheter, without subcutaneous port or pump* (Work RVU=2.27). The RUC reviewed the survey data presented by the specialty societies and determined that the surveyed code in comparison to the reference code had considerably longer total service time, 140 minutes and 79 minutes respectively. Further, the RUC noted that the surveyed code required greater mental effort, physical effort and judgment in comparison to the reference code. In addition, the RUC noted that the survey data supported that this service is now more frequently being performed in the outpatient setting. The respondents indicated that the

two 99233 and one 99231 hospital visits, which were previously included in the service's global period, are not included and the full discharge day management service has been reduced to half a discharge day management service. However, the specialty societies determined that the survey median was not an appropriate value for the service as it would cause rank order anomalies with codes in the family. Therefore, the specialty societies recommend 4.30 work RVUs, or approximately half-way between the median and the 75th percentile of the survey data as this value maintains rank order within the family. This value is further supported by another reference code, 44391 *Colonoscopy through stoma; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)* (work RVU=4.31) as this code and the surveyed code have similar work and total service times, 141 minutes and 140 minutes, respectively. Therefore, given the comparison to the reference codes, the RUC determined that 4.30 work RVUs was appropriate and maintained rank order within the family of codes. **The RUC recommends 4.30 RVUs for 62355.**

62360 ***Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir***

At the April 2008 RUC meeting, the specialty society presented compelling evidence to the RUC in order to consider recommendations to increase the work RVU for 62360. The compelling evidence consists of the change from a 090 global period to a 010 day global considering that the service with the original times and work RVU results in a negative IWPUT. The RUC agreed that compelling evidence to consider a change in the work RVU existed because backing out the work associated with the EM services could result in a negative work valuation. Additionally, the specialty noted that incorrect assumptions were made during the original valuation of work by the RUC in 1995, which created a rank order anomaly within the family.

The RUC approved the compelling evidence to consider a change to the work RVU for 62360.

The specialty society reviewed the results of a survey of 30 neurosurgeons for 62360. The specialty society adjusted the survey pre-service time to package 2B (difficult patient/straightforward procedure) because they agreed the survey respondents may have overstated the pre-service time. The median intra-service time based on the survey was 60 minutes. The survey median work RVU was 5.00, which the specialty society agreed was too high. The specialty society instead recommended the 25th percentile work RVU of 4.28. The RUC found the key reference service 61888, *Revision or removal of cranial neurostimulator pulse generator or receiver* (work RVU = 5.20, intra-service time = 34 minutes) to be similar but commented that it has never been RUC reviewed. The RUC compared the service to another reference service, 36585, *Replacement, complete, of a peripherally inserted central venous access device, with subcutaneous port, through same venous access*, (work RVU = 4.81, intra-service time = 60 minutes) and determined the 25th percentile RVU placed this code in proper rank order.

The RUC recommended the survey 25th percentile RVU of 4.28 work RVUs for 62360.

62361 ***Implantation or replacement of device for intrathecal or epidural drug infusion; non-programmable pump***

At the February 2008 RUC meeting, the specialty societies presented data from 37 physicians from pain medicine physicians, neurourgeons, anesthesiologists and spine surgeons. The RUC compared the survey code to the reference code, 61888 *Revision or removal of cranial neurostimulator pulse generator or receiver* (Work RVU=5.20). The RUC reviewed the survey data presented by the specialty societies and determined that the surveyed code in comparison to the reference code had similar total service time, 170 minutes and 171 minutes respectively. However, the RUC noted that the surveyed code required greater mental effort, physical effort and judgment in comparison to the reference code. In addition, the RUC noted that the survey data supported that this service is now more frequently being performed in the outpatient setting. The respondents indicated that the two 99233 and one 99231 hospital visits, which were previously included in the service's global period, are not included and the full discharge day management service has been reduced to half a discharge day management service. However, the specialty societies determined that the survey median was not an appropriate value for the service as it would cause rank order anomalies with codes in the family. Therefore, the specialty societies recommend 5.60 work RVUs, a value between the median and the 75th percentile of the survey data as this value appropriately maintains rank order within the family. This value is further supported by another reference code, 53853 *Transurethral destruction of prostate tissue; by water-induced thermotherapy* (work RVU=5.54) as this code and the surveyed code have similar work and intra-service times, 60 minutes. Therefore, given the comparison to the reference codes, the RUC determined that 5.60 work RVUs was appropriate and maintained rank order within the family of codes. **The RUC recommends 5.60 RVUs for 62361.**

62362 ***Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming***

At the February 2008 RUC meeting, the specialty societies presented data from 37 pain medicine physicians, neurourgeons, anesthesiologists and spine surgeons. The RUC compared the survey code to the reference code, 61888 *Revision or removal of cranial neurostimulator pulse generator or receiver* (Work RVU=5.20). The RUC reviewed the survey data presented by the specialty societies and determined that the surveyed code in comparison to the reference code had similar total service time, 170 minutes and 171 minutes respectively. However, the RUC noted that the surveyed code required greater mental effort, physical effort and judgment in comparison to the reference code. In addition, the RUC noted that the survey data supported that this service is now more frequently being performed in the outpatient setting. The respondents indicated that the two 99233 and one 99231 hospital visits, which were previously included in the service's global period, are not included and the full discharge day management service has been reduced to half a discharge day management service. However, the specialty societies

determined that the survey median was not an appropriate value for the service as it would cause rank order anomalies with codes in the family. Therefore, the specialty societies recommend 6.05 work RVUs, a value between the median and the 75th percentile of the survey data as this value appropriately maintains rank order within the family. This value is further supported by another reference code, 49570 *Repair epigastric hernia (eg, preperitoneal fat); reducible (separate procedure)* (work RVU=5.97) as this code and the surveyed code have similar work and intra-service times, 60 minutes. Therefore, given the comparison to the reference codes, the RUC determined that 6.05 work RVUs was appropriate and maintained rank order within the family of codes. **The RUC recommends 6.05 RVUs for 62362.**

62365 ***Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion***

At the April 2008 RUC meeting, the specialty societies requested to re-survey this service as they believe the vignette associated with this service may have caused inaccurate survey data as it referred to the removal and replacement of the reservoir or pump. At the April meeting, the specialty society reviewed the results of a survey of 30 neurosurgeons with the revised clinical vignette. The specialty society noted that this service had originally been brought up in a previous Five-Year Review because of a negative intra-service work per unit of time (IWPUT), but that it was removed because there were not enough survey responses. Based on the results of this survey, the specialty society recommended decreasing the pre-service time from 72 minutes to 48 minutes. This includes the time associated with pre-service time package 2B with an additional 9 minutes for positioning the patient. The additional positioning time is needed to move the patient from the supine position to a lateral position. This also required placing a pad between the patient's knees, placing the upper arm on a board away from the surgical area, and inserting a foley catheter. The median intra-service time is 45 minutes. The presenters noted that this time is appropriate. The typical patient for this service is taken to the operating room because of an infection, commonly MRSA, and requires the removal of a pump or reservoir. However, the typical service is removal of a pump, rather than reservoir. While the catheter is sometimes removed at the same time, it is separately reportable. However, it is often left in the patient or externalized in order to deliver antibiotics to fight the infection. The pump that requires removal is most commonly held within a cloth sac within the patient. As such, the cloth becomes attached to the fascia with scar tissue and is difficult to remove. The removal must be performed without damaging the catheter. The survey median work RVU was 4.60, which the RUC agreed was appropriate for this service. The RUC also compared the service to reference service, 61888, *Revision or removal of cranial neurostimulator pulse generator or receiver*, (work RVU = 5.20; intra-time = 34 minutes). **The RUC recommends the survey median work RVU of 4.60 for 62365.**

Practice Expense:
The practice expense inputs, specifically for the discharge day management and the number and level of office visits for 62350, 62355, 62361, 62362, and 62365 are recommended to the modified to reflect the current survey data.

Neuroplasty - Leg or Arm (Tab 49)
Daniel Nagle, MD, American Society for Surgery of the Hand, Dale Blasier, MD, American Academy of Orthopaedic Surgery, Tye Ouzounian, MD, American Orthopaedic Foot and Ankle Society, Scott Oates, MD, American Society of Plastic Surgeons

CPT codes 64708, *Neuroplasty, major peripheral nerve, arm or leg; other than specified*, and 64712, *Neuroplasty, major peripheral nerve, arm or leg; sciatic nerve*, were identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated for physician work. At the February 2008 RUC meeting, the RUC established a series of procedural rules to guide the reevaluation of Site of Service Anomalies. Included in these procedural guidelines is the necessity of compelling evidence for any specialty society recommendation to increase work RVU for a Site of Service Anomaly.

At the April 2008 RUC meeting, the specialty society commented that the current physician time and work RVU data for 64708 is based on a Harvard survey of 7 orthopaedic surgeons. Podiatrists, plastic surgeons, and hand surgeons were not included in the Harvard study. Additionally, Harvard only surveyed intra-service time (from orthopaedic surgeons and the post-operative visits were predicted by CMS using an algorithm rather than a survey. One of the RUC's compelling evidence standards is that "a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data." Current Medicare utilization data indicate that orthopaedic surgery is the primary provider for 64708 (33%), but not the only provider. For the current RUC survey, orthopaedic surgeons and plastic surgeons and their subspecialties were surveyed. Because there is not compelling evidence to review the work RVU with consideration for an increase, the specialty society provided data to support that the service is appropriately valued with its current work RVU of 6.22.

The specialty society provided the results of a survey of 82 orthopaedic, hand, plastic, and foot and ankle surgeons to the RUC. Based on the survey results, the presenters recommended pre-service evaluation time of 35 minutes, pre-service positioning time of 10 minutes, and pre-service scrub, dress and wait time of 10 minutes. The median intra-service time is 60 minutes. The specialty society agreed that the primary site of service is the outpatient setting and that this service would not typically require an overnight stay. The specialty society then recommended and the RUC agreed with one-half 99238 discharge day management service, three 99212, and one 99213 office visits within the 090 day global period of 67408. The survey also resulted in a median work RVU of 10.00 and a 25th percentile work RVU of 8.50. The survey respondents selected 64910, *Nerve repair; with synthetic conduit or vein allograft (eg, nerve tube), each nerve* (work

RVU = 11.21, intra-service time = 90 minutes) as a key reference service. The RUC noted that the intra-service time for 64910 was too high for the RUC to use as a comparison and instead considered several other reference services including, 19298, *Placement of radiotherapy afterloading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, includes imaging guidance*, (work RVU = 6.00, intra-service time = 60 minutes) and 30520, *Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft* (work RVU = 6.85, intra-service time = 60 minutes). Therefore, the RUC agreed that the current value of 6.22 is not overvalued and is an appropriate work RVU for the service.

The RUC recommends maintaining the current work RVU of 6.22 and implementing the recommended times and post-operative visits.

64712

Code 64712 describes a procedure for neuroplasty of the sciatic nerve. The specialty society expert consensus panel noted a significant shift from 1999 to 2005 in the providers reporting this operative procedure. The panel believes there is an issue with reporting (at least in the Medicare database) that erroneously changes the site of service for this code. Literature describes a minimally invasive epidural catheter procedure using a Racz catheter as "epidural neuroplasty" - hypothesized principle of action is local epidural lysis of adhesions, neurolysis of vertebral nerve roots and local lavage of proinflammatory mediators by repeated injection of local anesthetics, corticosteroids, hyaluronidase and hypertonic saline solution. However, neuroplasty is surgery to repair or restore nerve tissue. Neuroplasty of the sciatic nerve requires an incision, exploration/dissection and decompression/repair. This is not the same work as injection by catheter of a neurolytic agent for lysis of adhesions. The specialty society has identified this as a CPT issue requiring new codes for catheter injection, not only of the sciatic nerve, but also of the lumbar plexus (ie, code 64714) which also appears to have the same shift in reporting since the introduction of the Racz catheter. **The RUC agreed and recommended that this service be referred to the CPT Editorial Panel for revision.**

XI. CMS Requests – Other

<u>Medicare Medical Home Demonstration (Tab 50)</u>

Workgroup Members: David Hitzeman, DO (Chairman), Joel Brill, MD, Thomas Felger, MD, Meghan Gerety, MD, Charles Koopman, MD, Barbara Levy, MD, Leonard Lichtenfeld, MD, Chester Schmidt, Jr., MD, Richard Tuck, MD, John Wilson, MD, Robert Zwolak, MD, Alan Lazaroff, MD, (Ex Officio), William L. Rich, III, MD, (Ex Officio), and William Thorwarth, Jr., MD, (Ex Officio),

Introduction

The RUC Medical Home Workgroup was established at the February 2008 RUC Meeting following a request from the Centers for Medicare and Medicaid Services (CMS) based

on a legislative mandate resulting from the Tax Relief and Health Care Act of 2006 (TRHCA). Section 204 of the TRHCA directs CMS to conduct a three-year demonstration project of the medical home concept of patient care. This demonstration is to occur in rural, urban, and underserved areas in up to eight states. The legislation describes the medical home as large or small medical practices where a physician provides comprehensive and coordinated patient centered medical care and acts as the "personal physician" to the patient. Based on this directive, CMS designed a three-tiered system of the medical homes based on the capabilities of the physician office serving as medical home. The differentiation of the tiers is based on capabilities of the physician office as determined by CMS and not based on the severity of patient illness. Further, the TRHCA specifically instructs CMS to set a care management fee using the RUC process. Therefore, CMS asked the RUC to recommend a valuation of a management fee by May 1, 2008. The TRHCA also mandates that this demonstration project be "cost neutral," in the sense that the costs of this project are to be offset by the overall savings it generates. This definition of "cost neutrality" is dissimilar to the ordinary meaning of budget neutrality within the payment policy lexicon. Rather, the cost neutrality of the demonstration project will not affect the payment or valuation of any service in the Medicare physician payment schedule and will result in no adjustment to conversion factor.

The Workgroup was charged with the task of researching and facilitating work relative value recommendations and direct practice expense recommendations for services defined in the Medicare Medical Home demonstration project to the RUC at the April 2008 RUC meeting. Given the brief time in which to develop a recommendation, the Workgroup began immediately by initiating an electronic discussion among its members and facilitating conference call meetings on a weekly basis. The Workgroup met 11 times between February 12 and April 21 by conference call. The Workgroup also met face-to-face on Wednesday April 23 immediately preceding the April 2008 RUC Meeting. Based on these discussions, the Workgroup developed the following recommendations for descriptors, physician work, direct practice expense inputs, and professional liability insurance crosswalks for the Medical Home demonstration project. To the extent practicable, the Workgroup utilized the standard RUC processes. However, based on the information regarding eligibility of beneficiaries and practice requirements, some assumptions were made.

G-Code Descriptors

The Workgroup first worked to develop G code descriptors for each of the three tiers of the Medical Home based on the minimum requirements for inclusions within each tier as provided by Mathematica. Initially, CMS indicated an interest in developing two levels of coding and payment within each of the three tiers based on the complexity and/or number of chronic conditions of eligible beneficiaries. The Workgroup determined that any distinction between complexity of patients and the ability of a practice to designate a beneficiary into one of the categories would be arbitrary. The number of chronic conditions is not a strong indicator for complexity or difficulty of coordinating care. A patient with one chronic condition may require greater intensity of coordination than a patient with several chronic conditions. Therefore, the Workgroup decided, and

Medicare representatives agreed, that a single code per tier describing the work for the typical patient would be most appropriate.

To develop the G codes, the Workgroup turned to the Mathematica proposals for the description of a Tier 3 (the most comprehensive) medical home. After reviewing the list of criteria for a Tier 3 medical home, the Workgroup transposed the requirements into a description of the service provided on a monthly basis. The Workgroup repeated this process for each of the tiers. As CMS made changes to the requirements of each tier of the medical home, the Workgroup appropriately revised the G code descriptors. The proposed descriptors represent the most up-to-date CMS-required components for each tier of the medical home. A Tier 1 Medical Home (entry level) requires ten of the designated core capabilities. A Tier 2 Medical Home (typical) requires sixteen of the designated core capabilities. A Tier 3 Medical Home (optimal) requires eighteen of the designated requirements and three of an additional ten requirements. (See "Table 2. Proposed Method for Tiering Medical Home Qualification"). The CMS demonstration is likely to use a modified version of the NCQA Physician Practice Connection - Patient-Centered Medical Home instrument to determine practice eligibility and tier assignment. **The RUC recommends the attached G Code descriptors for the Tier 1, Tier 2 and Tier 3 Medical Home to CMS for the Medicare Medical Home demonstration project.**

The RUC understands that eligible physicians will be designated into a tier level based on CMS recognition of their office capabilities. These capabilities will be monitored by CMS. Practices may and are encouraged to qualify for a higher tier level during the demonstration, but only upon approval by CMS.

Average Panel Size

The Workgroup next addressed the issue of average panel size per primary care physician in order to assist in the development of work and direct practice expense input recommendations. The Workgroup looked to several sources to define total panel size for a primary care physician, Medicare beneficiary portion of that panel, and the portion of Medicare beneficiaries that would be eligible for the participation in the demonstration project.

- Mathematica provided the Workgroup with a rough estimate of the number of Medicare beneficiaries per primary care physician. They obtained these estimates using 2004-2006 Medicare claims data and the 2000-2002 Community Tracking Study Physician Survey. Mathematica indicated that there are roughly 257 unique Medicare beneficiaries seen by a typical individual primary care physician (family practice, general internal medicine, or general practice) in one year. Mathematica went on to state that a physician typically will not see all patients within a panel in any given twelve months, resulting in a potentially larger total Medicare panel size. They estimate this to be as much as 30% higher, bringing total Medicare panel size 335. CMS has indicated that it will rely on beneficiary eligibility criteria for the demonstration project that will expand inclusion to 86% of all beneficiaries based on the Hwang criteria. Based on this assumption, the panel

size of eligible beneficiaries per primary care physician will be between 221 and 284. Based on all Mathematica assumptions and CMS-stated patient eligibility criteria, a panel size of 250 is a reasonable estimate.

- Staff requested information from the Medical Group Management Association (MGMA) on average total panel size per primary care physician. The MGMA does not benchmark "panel size," primarily because there are many variables that can skew these figures. However, the organization does track one related metric from the "Cost Survey Report" – that of "Patients per Physician," from the data table titled: "Staffing, RVUs, Patients, Procedures and Square Footage." That table reports data for unique patients seen in the previous year. Based on this the "Cost Survey for Single-specialty Practices: 2007 Report Based on 2006 Data," for Family Practice, the average number of patients per FTE physician is 2,362. U.S. Census data indicate that 12% of the population are 65 years of age or older. The number of family medicine patients would therefore be approximately 283. If 86% were eligible for the demonstration (per CMS current criteria), 245 patients per family physician would be eligible. The review of MGMA data, census data, and CMS assumptions again concludes that 250 is a reasonable estimate for eligible patients per physician.
- Lastly, the Workgroup looked to current "medical homes" as a source of information on total panel size and Medicare panel size. Specifically, the Geisinger Health System, very generously shared a wealth of its data with the Workgroup. In January 2007, Geisinger implemented an intensive medical home project in two practice sites. The description of this project resembles a Tier 3 Medical Home. In these two initial sites, the Geisinger representatives indicated that there were 250 Medicare "medical home" patients per physician.

Reviewing all available data and assumptions, the RUC developed recommendations assuming that each physician may have approximately 250 Medicare patients who will be eligible and who will agree to participate in the practice's medical home.

Physician Work

Tier 3 Medical Home

The Workgroup estimates that for the "very sick" patients, the physician will typically spend 15 minutes per patient per month. This estimate is based on two other estimates. One is that the physician will spend approximately 12.5 minutes per patient per month in interaction with the case manager and the rest of the clinical staff team; this estimate is derived from the PACE data previously discussed by the Workgroup.

The 12.5 minutes includes the following coordination of care activities described by Total Longterm Care, a PACE program provider in Denver, CO:

- Intake and Assessment: This occurs twice weekly. 1-2 new participants and 15 reassessments are reviewed at each meeting. (Complete reassessments are done every six months). Each meeting lasts about 2.5 hours.
- Morning meeting: this occurs every morning. About 10-15 patients are discussed. Issues for the day are reviewed, including interim progress reports and care planning and follow-up. Duration about 45 minutes daily.
- Nursing home review meeting. This occurs weekly. The program uses nursing homes (and sends in its own staff to augment the NH services) for short term "medical respite" as an alternative to avoid or shorten hospital stays. The meeting lasts about 30-60 minutes, during which the progress and transition plans for about 10 patients are reviewed and developed.
- End-of-life nurse meeting. The physician meets weekly for about thirty minutes with a nurse whose focus is end-of-life care. This typically involves perhaps 4 patients.
- Ad-hoc family meetings occur irregularly, typically involve multiple staff members including the physician, and generally last more than 30 minutes.

The remaining 2.5 minutes per patient per month is estimated to be the time the physician will spend in other medical home responsibilities not included within the PACE program, such as review of registry information, or other daily interactions with the health care team.

For the blend of other "sick" patients, it is estimated that the physician will spend only 10 minutes per patient per month. This recognizes that these patients will require less physician interaction with the case manager and other members of the clinical staff team and is similar to the reduction in clinical staff time associated with "sick" and "very sick" patients (discussed within practice expense section).

The Workgroup also assumed, based on data from the Wolff study[i] (see page 9-10 for discussion), that the typical patient in the demonstration project will have seven evaluation and management (E/M) visits per year. The Workgroup concluded that 2.8 of these visits will be at the level of 99214 and 4.2 will be at the level of 99213. This assumption is based on the 2007 Medicare utilization data that show a total utilization of 99213 and 99214 with a relationship between them of roughly 1.5 : 1. Extrapolated to the seven E/M visits, this correlates to 4.2 : 2.8. Finally, half of the post-service physician time associated with each of these visits will otherwise duplicate the physician time related to the proposed care management code and, thus, should be deducted from the physician time per patient per month otherwise attributable to the proposed codes. The post-service physician time for 99214 is 10 minutes, and for 99213, it is 5 minutes.

2007 Medicare Utilization Data			
Code	**Family Medicine**	**Internal Medicine**	**Total**
99213	21,382,656	26,581,566	103,587,751
99214	13,467,111	18,564,247	65,129,891

The physician time per patient per month before accounting for the overlap with existing E/M services is 11.25 minutes, which is calculated as a weighted average of the time spent with each patient cohort as follows: (15 minutes x 0.25) + (10 minutes x 0.75) = 11.25 minutes. The overlap with existing E/M services is calculated as 2.1 minutes per patient per month as follows: ((10 minutes x 2.8 99214 visits) + (5 minutes x 4.2 99213 visits)) / 2 = 24.5 minutes per patient per year; 24.5 minutes / 12 months = 2.04 minutes per patient per month. The unduplicated physician time per patient per month is calculated as follows: 11.25 minutes – 2.04 minutes = 9.21 minutes per patient per month.

The RUC recommends an intra-service time per patient per month of 9.2 minutes for a Tier 3 Medical Home.

The Workgroup used a modified building block methodology to develop a recommendation for physician work. Relying on the same ration of 99213 to 99214 visits for this population of patients, the Workgroup agreed that a similar intensity of medical home services was appropriate. The Workgroup instead used a total intensity of the time by calculating the total work per unit of total time. For 99213, the total work per unit of time is equal to 0.92 work RVUs divided by 23 total minutes, resulting in 0.040 work RVUs per minute. For 99214, the total work per unit of time is equal to 1.42 work RVUs divided by 40 total minutes, resulting in 0.0355 work RVUs per minute. The Workgroup then applied the same 4.2 : 2.8 ratio it used to develop physician time overlap from associated E/M work. Thus, 0.040 was multiplied by 4.2 and 0.0355 was multiplied by 2.8 and the sum was divided by 7. This resulted in a weighted work RVU per minute of 0.0382. The Workgroup then multiplied 0.0382 by 9.2 minutes to come to a work RVU recommendation of 0.35144.

The Workgroup noted that 99339, *Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home; 15-29 minutes*, with a work RVU of 1.25 is an appropriate reference service, comparing the 40 minutes of total time with the 9.2 minutes of time in the Tier 3 Medical Home, resulting in a comparable work RVU of .31.

The RUC recommends a work RVU per patient per month of 0.35 for a Tier 3 Medical Home.

Tier 2 Medical Home

The Workgroup estimates that for the "very sick" patients, the physician will spend 12.5 minutes per patient per month. This estimate assumes that, at lower tiers, the physician will spend less time per patient per month consistent with the decreased capability of the practice as a medical home. This estimate is also consistent with assumptions made with respect to clinical staff time (i.e., staff will spend less time per patient per month at lower tiers of the medical home).

For the blend of other "sick" patients, it is estimated that the physician will spend only 9 minutes per patient per month. This recognizes that these patients will require less

physician interaction with the case manager and other members of the clinical staff team and is similar to the reduction in clinical staff time associated with "sick" and "very sick" patients (discussed within practice expense section).

The Workgroup also assumed, based on data from the Wolff study[i] (see page 9-10 for discussion), that the typical patient in the demonstration project will have seven evaluation and management (E/M) visits per year. The Workgroup concluded that 2.8 of these visits will be at the level of 99214 and 4.2 will be at the level of 99213. This assumption is based on the 2007 Medicare utilization data that show a total utilization of 99213 and 99214 with a relationship between them of roughly 1.5 : 1. Extrapolated to the seven E/M visits, this correlates to 4.2 : 2.8. Finally, half of the post-service physician time associated with each of these visits will otherwise duplicate the physician time related to the proposed care management code and, thus, should be deducted from the physician time per patient per month otherwise attributable to the proposed codes. The post-service physician time for 99214 is 10 minutes, and for 99213, it is 5 minutes.

2007 Medicare Utilization Data			
Code	**Family Medicine**	**Internal Medicine**	**Total**
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The physician time per patient per month before accounting for the overlap with existing E/M services is 9.875 minutes, which is calculated as a weighted average of the time spent with each patient cohort as follows: (12.5 minutes x 0.25) + (9 minutes x 0.75) = 9.875 minutes. The overlap with existing E/M services is calculated as 2.1 minutes per patient per month as follows: ((10 minutes x 2.8 99214 visits) + (5 minutes x 4.2 99213 visits)) / 2 = 24.5 minutes per patient per year; 24.5 minutes / 12 months = 2.04 minutes per patient per month. The unduplicated physician time per patient per month is calculated as follows: 9.875 minutes – 2.04 minutes = 7.835 minutes per patient per month.

The RUC recommends an intra-service time per patient per month of 7.8 minutes for a Tier 2 Medical Home.

The Workgroup used a modified building block methodology to develop a recommendation for physician work. Relying on the same ration of 99213 to 99214 visits for this population of patients, the Workgroup agreed that a similar intensity of medical home services was appropriate. The Workgroup instead used a total intensity of the time by calculating the total work per unit of total time. For 99213, the total work per unit of time is equal to 0.92 work RVUs divided by 23 total minutes, resulting in 0.040 work RVUs per minute. For 99214, the total work per unit of time is equal to 1.42 work RVUs divided by 40 total minutes, resulting in 0.0355 work RVUs per minute. The Workgroup then applied the same 4.2 : 2.8 ratio it used to develop physician time overlap from associated E/M work. Thus, 0.040 was multiplied by 4.2 and 0.0355 was multiplied by 2.8 and the sum was divided by 7. This resulted in a weighted work RVU per minute

of 0.0382. The Workgroup then multiplied 0.0382 by 7.8 minutes to come to a work RVU recommendation of 0.29796.

The Workgroup noted that 99339, *Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home; 15-29 minutes*, with a work RVU of 1.25 is an appropriate reference service, comparing the 40 minutes of total time with the 7.8 minutes of time in the Tier 2 Medical Home, resulting in a comparable work RVU of .31.

The RUC recommends a work RVU per patient per month of 0.30 for a Tier 2 Medical Home.

Tier 1 Medical Home

The Workgroup estimates that for the "very sick" patients, the physician will spend 10 minutes per patient per month. This estimate again assumes that, at lower tiers, the physician will spend less time per patient per month consistent with the decreased capability of the practice as a medical home. This estimate is also consistent with assumptions made with respect to clinical staff time (i.e., staff will spend less time per patient per month at lower tiers of the medical home).

For the blend of other "sick" patients, it is estimated that the physician will spend only 8 minutes per patient per month. This recognizes that these patients will require less physician interaction with the case manager and other members of the clinical staff team and is similar to the reduction in clinical staff time associated with "sick" and "very sick" patients (discussed within practice expense section).

The Workgroup also assumed, based on data from the Wolff study[i] (see page 9-10 for discussion), that the typical patient in the demonstration project will have seven evaluation and management (E/M) visits per year. The Workgroup concluded that 2.8 of these visits will be at the level of 99214 and 4.2 will be at the level of 99213. This assumption is based on the 2007 Medicare utilization data that show a total utilization of 99213 and 99214 with a relationship between them of roughly 1.5 : 1. Extrapolated to the seven E/M visits, this correlates to 4.2 : 2.8. Finally, half of the post-service physician time associated with each of these visits will otherwise duplicate the physician time related to the proposed care management code and, thus, should be deducted from the physician time per patient per month otherwise attributable to the proposed codes. The post-service physician time for 99214 is 10 minutes, and for 99213, it is 5 minutes.

2007 Medicare Utilization Data			
Code	**Family Medicine**	**Internal Medicine**	**Total**
99213	21,382,656	26,581,566	103,587,751
99214	13,467,111	18,564,247	65,129,891

The physician time per patient per month before accounting for the overlap with existing E/M services is minutes, which is calculated as a weighted average of the time spent with each patient cohort as follows: (10 minutes x 0.25) + (8 minutes x 0.75) = 8.5 minutes.

The overlap with existing E/M services is calculated as 2.1 minutes per patient per month as follows: ((10 minutes x 2.8 99214 visits) + (5 minutes x 4.2 99213 visits)) / 2 = 24.5 minutes per patient per year; 24.5 minutes / 12 months = 2.04 minutes per patient per month. The unduplicated physician time per patient per month is calculated as follows: 8.5 minutes – 2.04 minutes = 6.46 minutes per patient per month.

The RUC recommends an intra-service time per patient per month of 6.5 minutes for a Tier 1 Medical Home.

The Workgroup used a modified building block methodology to develop a recommendation for physician work. Relying on the same ratio of 99213 to 99214 visits for this population of patients, the Workgroup agreed that a similar intensity of medical home services was appropriate. The Workgroup instead used a total intensity of the time by calculating the total work per unit of total time. For 99213, the total work per unit of time is equal to 0.92 work RVUs divided by 23 total minutes, resulting in 0.040 work RVUs per minute. For 99214, the total work per unit of time is equal to 1.42 work RVUs divided by 40 total minutes, resulting in 0.0355 work RVUs per minute. The Workgroup then applied the same 4.2 : 2.8 ratio it used to develop physician time overlap from associated E/M work. Thus, 0.040 was multiplied by 4.2 and 0.0355 was multiplied by 2.8 and the sum was divided by 7. This resulted in a weighted work RVU per minute of 0.0382. The Workgroup then multiplied 0.0382 by 6.5 minutes to come to a work RVU recommendation of 0.2483.

It was noted that the work RVU for 99441, *Telephone evaluation and management service provided by a physician; 5-10 minutes*, is 0.25, which appeared to the Workgroup to be an appropriate floor for the medical home physician work.

The RUC recommends a work RVU per patient per month of 0.25 for a Tier 1 Medical Home.

Summary

In sum, the following times and work RVUs are proposed for each tier:

Tier	Physician Time	Work RVUs
1	6.5 minutes	0.25
2	7.8 minutes	0.30
3	9.2 minutes	0.35

Direct Practice Expense Inputs

Clinical Staff Type

Based on the G-Code descriptors, the workgroup agreed that the minimum competency for clinical staff should be no less than a registered nurse or licensed practical nurse and recommends using the blended Medicare clinical staff type of registered nurse/licensed

practical nurse (RN/LPN). The clinical staff type is consistent across all tiers and the blended staff type is recommended in each of the three medical home tiers. Although Geinsinger reported that only RNs would be hired, the Workgroup understood that many practiced may not be able to hire RNs. Concurrently, the Workgroup recognized that in some states, medical assistants (MAs) may not be licensed to perform many of the activities inherent in the medical home service. As such, the Workgroup agreed that a RN/LPN blend is appropriate. **The RUC recommend to CMS that it use a clinical staff type of RN/LPN for the practice expense inputs for the Tier 1, Tier 2 and Tier 3 Medical Homes.**

Clinical Staff Time

The Workgroup arrived at a typical amount of staff time by employing both top-down and bottom-up approaches. After an extensive review of medical home and care management literature and discussions with practitioners in the medical home clinical settings, the Workgroup found that the mode for caseload per nurse in a Tier 3 setting is 125, Tier 2 setting is 150, and Tier 1 setting is 200.

The workgroup next arrived at a similar number by dividing patient complexity into two groups, "sick" and "sicker." Rather than split the medical home G codes into two categories as originally recommended, the workgroup noted that patients will move in and out of the two groups regularly and to assign an individual patient to a group is not realistic. However, risk-adjusting the groups under the assumption that at any given time only 25% of an eligible patient mix require extensive care management ("sicker") and the remaining 75% require less extensive care management ("sick") is a more accurate and efficient way to allot clinical staff time. Further, the workgroup assumed that the typical medical home patient in all three tiers will have 7 evaluation and management (E/M) visits per year, based on the Wolff study[i] and summarized below:

Number of Conditions	E/M Visits per Year	% of Medicare population	Visits x Medicare %	Weighted Average
Medicare Pts. with 1 condition	3.5	0.173	0.210976	0.738415
Medicare Pts. with 2 conditions	5.7	0.218	0.265854	1.515366
Medicare Pts. with 3 conditions	7.9	0.188	0.229268	1.81122
Medicare Pts. with 4 or more conditions	9.4	0.241	0.293902	2.762683
Average # of Medicare Visits		0.82		**6.827683**

The workgroup then reduced the clinical staff time by 3 minutes per patient in each of the three tiers to account for overlap of one phone call per month due to the E/M services provided. Each E/M (7 annually) requires 2 nurse follow-up phone calls per the

implemented practice expense input data, leading to approximately 14 calls per year. The Workgroup agreed that these phone calls should not be duplicated and removed one from each month. (14/12 = approximately 1 call or 3 minutes per month.) The clinical staff time based on this methodology for each of the three tiers is included in the attached spreadsheet.

	Pts per RN/LPN	**Time spent per Bene min/mo**	**Sum min/month**
Tier 3			
Sick Patients (75%)	94	60	5625
Very Sick Pts (25%)	31	236	4775
	125	83	10400
Remove 3 minute call		**80**	
Tier 2			
Sick Patients (75%)	112.5	40	4500
Very Sick Pts (25%)	37.5	157	5900
	150	69	10400
Remove 3 minute call		**66**	
Tier 1			
Sick Patients (75%)	150	30	4500
Very Sick Pts (25%)	50	118	5900
	200	52	10400
Remove 3 minute call		**49**	

The RUC recommend to CMS that it use clinical staff time of 80 minutes per patient per month for a Tier 3 medical home, 66 minutes per patient per month for a Tier 2 medical home, and 49 minutes per patient per month for a Tier 1 medical home. The RUC acknowledges that these recommendations are estimates based on information that was available to the Workgroup regarding patient eligibility and nurse case manager caseload. These data may be highly variable by practice. The RUC strongly urges CMS to monitor the actual resource costs during the demonstration project. At a minimum, the RUC recommends that CMS survey participating practices regarding their nurse case manager caseload.

Medical Supplies

Over the course of a complete year, the workgroup agreed that the typical medical home patient will receive three patient education brochures. Divided over twelve months, the total number of booklets per month is 0.25. **The RUC recommend to CMS 0.25 of a patient education booklet as a practice expense input for the Tier 1, Tier 2 and Tier 3 Medical Homes.**

Medical Equipment

The legislation mandating the Medical Home Demonstration Project calls for use of an electronic medical records system. The Tier 3 medical home G-Code includes implementation and use of an EMR system and the workgroup discussed at length the type and capabilities of such a system. Based on these discussions, review of literature, and preliminary findings of the ongoing physician practice information survey, and a detailed invoice, the workgroup has developed a recommendation for the necessary elements of an appropriate EMR system. The system should include the following elements, listed below. For several of these components, CMS currently maintains a pricing input. For those line items that are not included within the CMS list of equipment, a price from the attached invoice has been included.

The RUC recommend to CMS that the Tier 3 Medical Home include direct practice expense inputs for an Electronic Medical Records system consistent with the system element descriptions below.

EMR System Elements for a Tier 3 Medical Home
Software: Comprehensive electronic health record software system that includes the following:

a. Disease Management
b. Point of care evidence-based decision support
c. Electronic prescribing
d. Laboratory test result tracking
e. Automatic problem lists
f. Referral History
g. Diagnostic Imaging Storage
h. Statistical Analysis
i. Patient Registries
j. Medication lists
k. Reporting
l. Patient Education Materials
m. Workflow coordination
n. Secure Electronic Communication with patients

Hardware: Using a server model, the electronic health record would require:

a. One server
b. One desktop computer with monitor
c. Router
d. Firewall
e. Cable/DSL Modem

Other practice expenses related to the electronic health record include:

a. Maintenance/service contract for hardware, software, internal network, and Internet connections (i.e., system support)
b. Training services
c. Data backup and recovery services
d. Interfaces to practice management system, laboratory, etc.

e. Data conversion/migration from existing systems
f. Licensing of commercial databases (e.g., First Data Bank, Multum, CPT)

EMR System Costs for a Tier 3 Medical Home

Element	CMS Code	Time[1]	Life	Price
Software; license	(new)	60 minutes RN/LPN + 4 minutes physician	3 years[2]	$7,995 (per provider)[3]
Software; updates, upgrades, and support	(new)	60 minutes RN/LPN + 4 minutes physician	3 years[2]	$3,198[3]
Computer, server	ED022	60 minutes RN/LPN + 4 minutes physician	5 years[4]	- [4]
Computer, desktop, with monitor	ED021	60 minutes RN/LPN + 4 minutes physician	5 years[4]	- [4]
System support (hardware, network, Internet connection)	(new)	60 minutes RN/LPN + 4 minutes physician	5 years[5]	$1,253[6]
Interfaces	(new)	60 minutes RN/LPN + 4 minutes physician	3 years[7]	$550[3]

Notes

1. Time is assumed equal to seventy-five percent of clinical staff time plus slightly less than half of the estimated physician time, since the EHR is an integral part of care management in the Tier 3 medical home and will be in use whenever the RN/LPN or physician is providing care management for the patient.
2. Based on IRS amortization rules for computer software (see instructions Line 16 on IRS Form 4562 online at http://www.irs.gov/pub/irs-pdf/i4562.pdf)
3. Based on proposal for e-MDs provided by the Oklahoma QIO, attached. E-MDs is one of three systems expected to be capable of meeting the needs of a Tier 3 medical home; the other two are eClinicalWorks and NextGen. An invoice for eClinicalWorks is pending.
4. See CMS equipment list
5. Corresponding to lifetime of hardware
6. Assumed to be 5% of hardware costs
7. Corresponding to lifetime of software

The RUC recommend to CMS the above line items for implementation and use of electronic medical records system within the PE inputs for the Tier 3 medical home. Invoices are attached.

The Workgroup agreed that the Tier 2 Medical Home includes a desktop computer and patient registry software. The medical home practice capabilities required by CMS cannot be implemented by a physician office without the use of a separate dedicated desktop top computer with monitor. Further, the management of a panel of medical home patients at the Tier 2 level of sophistication requires, at the least, the use of a software system to track patient status.

The RUC recommend to CMS that the Tier 2 Medical Home include one ED021 Desk top computer with monitor and patient registry software. For the registry software, the RUC agrees that this software should allow the directing of multiple disease states and allow for the creation of reports to better track patients. DocSite is an example of such a registry. The pricing information for DocSite is available at: http://www.docsite.com/help/pricing.

The Tier 1 medical home contains no medical equipment.

PLI Crosswalk

The Workgroup discussed the professional liability insurance (PLI) crosswalk methodology used by CMS noting that CMS relies on a service within the family or somewhat comparable with a similar work RVU. **The RUC recommends that a suitable service with a similar work RVU is either 92025*, Computerized corneal topography, unilateral or bilateral, with interpretation and report*, which has a work RVU of 0.35 and a PLI RVU of 0.02 or 99441*, Telephone evaluation and management service provided by a physician; 5-10 minutes*, which has a work RVU of 0.25 and a PLI RVU of 0.02.**

Reference

Wolff, JL, Starfield, B, Anderson, G. Prevalence, Expenditures, and Complications of Multiple Chronic Conditions in the Elderly. Arch. Intern. Med. 2002; 162:2269-2276.

<u>Arthroscopy (Tab 51)</u>
Dale Blaiser, MD, American Academy of Orthopaedic Surgeons

Arthroscopy Codes (29805, 29830, 29840, 29870, 29900) were requested by CMS, in the Final Rule published in the November 27, 2007, *Federal Register*, for review by the RUC. CMS requested that the RUC to revisit the non-facility direct practice expense inputs for arthroscopy codes. CMS had requested comments as to the specific non-facility inputs for these codes and received comments in opposition to the establishment of non-facility PE because CMS believed the procedures are not safely performed in the office

setting. CMS also received comments from physicians stating that they are currently performing these procedures in the non-facility setting. CMS stated that the specialty societies and the RUC, should first be given the opportunity to resolve these issues before a final decision is made regarding pricing these services in the non-facility setting.

The RUC carefully discussed this issue and agreed with the specialty that these services, for patient safety reasons, should be priced only in the facility setting. The specialty had spoken with the physicians that claimed that they were providing these services in the office setting and it was revealed that they were actually performing these services in an ambulatory surgical center, not in the physicians office.

The RUC and the specialty agreed and recommend the following:

It is medically inappropriate to perform arthroscopy in a non-facility setting for the following reasons:

- **A full exam of the joint is customarily included in the procedure and may not be done effectively under a local or block anesthesia.**
- **Arthroscopy is an invasive procedure which includes injection of fluids into the patient under pressure which has the potential for serious complications which cannot be effectively managed in the office.**
- **If a lesion, treatable by standard (in-facility) arthroscopy is discovered, it cannot be treated in the office and the patient must undergo a second procedure for treatment.**
- **There is not a supporting body of peer-reviewed literature that documents the safety of effectiveness of non-facility arthroscopy.**
- **A review of the CMS data base suggests that arthroscopy outside the facility is neither customary nor common for any of these five services.**

<u>Left Heart Catheterization (Tab 52)</u>
James Maloney, MD, American College of Cardiology, Benjamin Byrd, MD, American College of Cardiology, Thomas Ryan, MD, American College of Cardiology

In the Final Rule published in the November 27, 2007 *Federal Register*, CMS requested that the RUC to revisit the non-facility direct practice expense inputs for cardiac catheterization codes 93501 through 93556 so that data from the Cardiovascular Outpatient Center Alliance (COCA) Direct Cost Study may be afforded appropriate and adequate consideration. COCA's Direct Cost Study purportedly demonstrated that their 2006 RUC estimates of direct practice expense costs for the non-facility setting did not adequately address direct patient care activities. COCA stated that a significant amount of the data from its Direct Cost Study was then missing from the practice expense recommendations that were jointly prepared and presented at the April 2007 RUC meeting with American College of Cardiology (ACC) and The Society for Cardiac Angiography and Interventions (SCAI). The RUC reviewed and revised these

recommendations in April 2007 and made practice expense recommendations to CMS for the following codes: 93501, 93505, 93508, 93510, 93526, 93539, 93540, 93542, 93543, 93544, 93545, 93555, and 93556.

In January 2008, AMA staff received a letter from CMS stating that they were only concerned about the practice expense inputs for code 93510. AMA staff therefore placed code 95310 on its agenda for April 2008.

The American College of Cardiology commented and recommended to the RUC that they believed there was no need for any practice expense revision to code 93510, as ACC had thoroughly reviewed all data prior to the submission in April 2007. The RUC and members of its practice expense subcommittee discussed and agreed that there was no evidence that would lead the RUC to review and recommend different practice expense inputs for this service. **The RUC recommends the current direct practice expenses for code 93510 should be maintained.**

Medical Nutrition Therapy (Tab 53)
Facilitation Committee # 3
Jane White, PhD, American Dietetic Association, John Seibel, MD, American Association of Clinical Endocrinologists, Joel Brill, MD, American Gastroenterological Association

MNT Background
In July 2000, the Health Care Professionals Advisory Committee (HCPAC) reviewed three medical nutrition therapy (MNT) codes, 97802, 97803 and 97804 and submitted its recommendations to CMS. However, during rulemaking for the CY 2001 Physician Fee Schedule Final Rule, CMS indicated that MNT services were not covered because there was no statutory benefit category that would allow medical nutritionists to bill these services. CMS also did not accept the HCPAC recommendations for work RVUs for these MNT services because the codes were designed for use only by non-physicians. The following year, section 105(c) of the Medicare, Medicaid, and State Child Health Insurance Program Benefits Improvement Protection Act of 2000 (BIPA) provided for the coverage of MNT services when furnished by registered dietitians or nutritional professionals at 85% of the amount a physician would be paid for the same services.

On September 27, 2001, the HCPAC wrote a letter to CMS stating, "the HCPAC evaluated these codes with the understanding that they will be performed almost exclusively by nutritionists (dietitians) and took into consideration the appropriate valuation in comparison to E/M services which are available to other providers but not to nutritionists. Therefore, applying a 15% reduction to these services is inappropriate as the HCPAC already took this into account when developing the recommendations."

CMS established practice expense values for these MNT services for the CY 2002 Physician Fee Schedule. However, the associated value for each code was captured in the

clinical labor time for MNTs as part of the PE component and not the work component. CMS did not accept the July 2000 HCPAC work recommendations for these MNT codes.

In the November 1, 2002 Final Rule, page 55279, CMS responded to public comment which stated that the 15% discount to these services is neither fair nor reasonable. CMS' response was:

> We initially anticipated that physicians would never bill Medicare for medical nutrition therapy services because they generally would not meet the statutory requirements to be considered registered dietitians or nutrition professionals. In this circumstance, we agree that it seems unusual to apply a reduction for a service that seldom would be furnished by a physician. However, we believe that the statute requires that Medicare payment be based on the 85 percent level. We understand that although not common, there are physicians who do meet the statutory requirements to be considered registered dietitians or nutrition professionals. In these circumstances our payment to the physician will be based on 100 percent of the Physician Fee Schedule amount, not the 85 percent that we will pay to a registered dietitian or nutrition professional. We believe the statute would not allow a physician who does not meet the statutory requirements for a registered dietitian or nutrition professional to be paid for a medical nutrition therapy services. If a physician provides medical nutrition counseling as part of a patient encounter that meets the requirements for an E/M service, the physician can bill Medicare for a physician's service.

The HCPAC and the American Dietetic Association (ADA) continued to urge CMS to assign the HCPAC recommended work values for the MNT services. In the December 1, 2006 Final Rule, CMS established work RVUs for the MNT services, as previously recommended by the HCPAC, to be effective January 1, 2007.

In late 2007, ADA met with CMS to discuss their concerns regarding the work RVU of the codes 97802 and 97803. The ADA stated that they believe that the current HCPAC recommended work RVUs represent work values for non-physician practitioners because these were developed by the HCPAC and not the RUC. The ADA believes that a RUC valuation of these MNT services by the physician specialties providing them would more accurately establish physician work values for these MNT services.

In a letter to Doctor William Rich, chairman of the RUC, dated January 28, 2008, CMS requested that the services described by CPT codes 97802 and 97803 be given the opportunity for consideration under the RUC process to help ensure that CMS payment for MNT services to non-physician nutrition professionals is accurate.

97802 ***Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes***

The specialty societies indicated that this service is typically reported with 3-4 units. Accordingly, the committee determined the appropriate time required to perform this service is 1 minute pre-time, 15 minutes intra-time and 1 minute post-time. A number of relevant reference services support a work valuation of 0.53, which would result in the existing work value of 0.45 when the 85% payment policy reduction is applied.

99407 *Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes* (work RVU = 0.50, intra-service time only = 15 minutes)
99401 *Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes* (work RVU = 0.48, intra-service time only = 15 minutes)
96150 *Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment* (work RVU = 0.50, time: pre = 3, intra = 15, post = 5)

The RUC recommends a work RVU of 0.53 for code 97802.

97803 ***Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes***
The specialty society indicated that this service is typically reported with 3 units. Accordingly, the committee determined the appropriate time required to perform this service is 1 minute pre-time, 15 minute intra-time and 1 minute post-time. A number of relevant reference services support a work valuation of 0.45, which would result in a slightly higher adjusted value (0.38) than the existing work value of 0.37 when the 85% payment policy reduction is applied.

97535 *Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes* (work RVU = 0.45, time: pre = 1, intra = 15, post = 2)

99212 *Office Visit, Established* (work RVU = 0.45, time: pre=2, intra = 10, post = 4)

The RUC recommends a work RVU of 0.45 for 97803.

Practice Expense Inputs
The RUC recommends the following direct practice expense inputs for codes 97802 and 97803 in the non-facility setting:

RN/LPN/MA	Greet patient	0.50 minute	2 minute standard /4 units
	Obtain vitals	0.75 minute	3 minute standard/4 units
	Phone call	0.75 minute	3 minute standard/4 units
	Total	2 minutes per 15 minute unit of time	

Supplies:	Patient Education Booklet (patient diary, etc)	0.25 (1/4 units)
	Label for file folders	0.25 (1/4 units)
	Paper laser printing each sheet	2

Equipment:
Food model set
Nutrition therapy software (nutritionist)
Chair, medical recliner
Body analysis machine, bioimpedence
Scale, High capacity (800 lb)
Printer, laser paper
Table, OT `

Professional Liability Insurance
The existing PLI for codes 97802 and 97803 is 0.01. The RUC recommends that the current PLI value is appropriate and is also consistent with the reference services 99407 and 96150.

Ocular Photoscreening (Tab 54)
Stephen Kamenetzky, MD, American Academy of Ophthalmology, Steven Krug, MD, American Academy of Pediatrics, Julia Pillsbury, DO, American Academy of Pediatrics, Guy Orangio, MD, American Society of Cataract and Refractive Surgery, David Glasser, MD, American Academy of Ophthalmology

At the February 2007 CPT Editorial Panel meeting, a pediatric physician provided evidence indicating that since 2003, ocular photoscreening utilization has increased with over 5,000 photoscreening units currently in circulation. The CPT Editorial Panel recognized widespread use of the ocular photo screening Category III code and approved that this code be moved to Category I status.

The RUC initiated the standard Level of Interest process for its April 2007 meeting in which specialty societies may survey physicians performing this procedure and present work relative value recommendations to the RUC. No specialty societies indicated an interest in providing a work relative value recommendation. Ophthalmology and pediatrics specialties both indicated no interest in developing a recommendation for this code. Therefore, the RUC had no recommendation for physician work or practice expense for code 99174 *Ocular photoscreening with interpretation and report, bilateral* at that time.

In early 2008, the American Academy of Pediatrics requested CMS to consider practice expense valuation for ocular photoscreening and CMS asked the RUC to develop inputs. At the RUC's April 2008 meeting ophthalmology and pediatrics submitted direct practice expense input recommendations for code 99174. These recommendations were thoroughly reviewed and revised for the typical patient scenario by the RUC's practice expense subcommittee and approved by the RUC. **The RUC recommends the attached direct practice expense inputs for CPT code 99174.**

Chemotherapy Administration (Tab 55)
American Academy of Dermatology

Throughout the existence of the Practice Expense Advisory Committee, the Practice Expense Review Committee, and the Practice Expense Subcommittee, Chemotherapy Administration codes 96405 and 96406 have never been reviewed for their direct practice expense inputs. Only CPEP data is shown in CMS' direct practice expense database. These codes were identified by AMA staff and CMS as not being refined. At the April 2008 RUC meeting, the American Academy of Dermatology presented a set of direct practice expense inputs which were reviewed and revised to reflect the typical patient services.

The RUC recommends the attached direct practice expense inputs for codes 96405 and 96406.

XII. Practice Expense Subcommittee (Tab 56)

Doctor Moran reported that AMA staff director Sherry Smith provided a Powerpoint presentation update on the AMA/Specialty Society Practice Information Survey. This presentation provided members with an update to the survey progress and Ms. Smith stressed the need for specialties to ramp up communication again, and she encouraged broadcast e-mails and other communications to specialty membership. The survey firm projects that the major data collection effort will be completed by August 31. A detailed listing of the number of responses by specialty to date and the presentation from this update are attached.

The Practice Expense Subcommittee reviewed several direct practice expense recommendations for new, revised, and existing CPT codes. These recommendations were approved by the RUC and are attached to the Practice Expense Subcommittee minutes.

Doctor Moran also reported that the Subcommittee reviewed two other issues that required a different level of review. These involved the refinement of non-facility practice expense inputs of four arthroscopy codes (29805, 29830, 29840 & 29870) and further review of left heart catheterization code (95310). The Subcommittee agreed with the society recommendations for both issues. The Subcommittee agreed that at this time, is was medically inappropriate to perform arthroscopy in the non-facility setting and therefore there was no need to establish and recommend non-facility practice expense inputs for these procedures. In addition, the RUC had previously had an extensive review of the direct practice expense inputs for left heart catheterization and at this time there is no evidence that would lead the group to review and recommend different practice expense inputs for this service.

XIII. Five-Year Review Identification Workgroup (Tab 57)

Doctor Barbara Levy provided the report of the Five-Year Review Identification Workgroup. Doctor Levy reported that the Workgroup heard feedback from Doctor Ken Simon regarding the rolling nature of the Workgroup's actions. CMS will discuss the site-of-service anomalies and the RUC's Five-Year Review Identification and re-valuation progress in the Notice of Proposed Rulemaking (NPRM) this summer. This discussion will articulate the progress that has been made to address the concerns of the Medicare Payment Advisory Commission (MedPAC) and CMS. The RUC's recommendations from the February and April 2008 meetings will be addressed in the Final Rule this November with a 60-day comment period and the values for these services will be published as interim values in 2009. Doctor Simon also stated to the Workgroup that CMS supports the rolling Five-Year Review. Any budget impacts will be addressed on an annual basis (ie, savings from these activities would decrease the existing work adjuster immediately).

Doctor Levy reported that the Workgroup the reviewed the specialty society action plans for recommended action regarding the potentially misvalued services identified at the February 2008 meeting. These services were identified through the High Volume Growth and High IWPUT screens. Additionally, one site-of-service anomaly code was deferred to this meeting and an action plan was accepted and reviewed by the Workgroup.

The RUC discussed the Workgroup's recommendations and took the following actions:

11981, 11982, 11983, 52224, 52648
The RUC agreed that the specialty should convene its expert panel to discuss the growth in volume prior to the next Workgroup meeting in order to maintain the original timetable for all specialty societies. **The RUC recommends that the specialty society convene an expert panel and report its action plan to the Workgroup via conference call prior to the October 2008 LOI deadline (June 1) for action during the October RUC or CPT Editorial Panel Meetings.**

The Five-Year Review Workgroup met via conference call following the RUC meeting to discuss these services and presented its recommendations to the RUC via email in June.

11982
The RUC recognized that the implant used has one-year duration. According to the specialty, physicians used the one-year implant to make the procedure more convenient for patients than the one-month implant. However, for some patients, this therapy resulted in unacceptable side effects and required removal of the implant (reported using 11982). In addition, since the implant only had one-year duration, the implant had to be removed at the end of twelve months. The RUC agreed that the growth in utilization of 11982 was appropriate

The RUC recommends that 11981, 11982, 11983 be removed from this screen with no further action at this time.

52224

The RUC agreed that the increase in utilization may be partly due to instances of miscoding. There may have been some incorrect reporting of 52224 in that some physicians were reporting this code numerous times during the same procedure based on the number of lesions fulgurated. The RUC agreed that publication of a CPT Assistant article as well as a review of utilization in two years is appropriate.

The CPT descriptors for 52214 and 52224 indicate that the procedure includes cryosurgery or laser surgery, yet the direct practice expense inputs appear to include inputs for both electrosurgery and laser surgery. The RUC agreed that a review of the direct practice expense inputs is appropriate.

The RUC recommends that CPT Assistant publish an article to clarify appropriate reporting of 52224. The RUC recommends that the code be reviewed again for utilization growth in two years to assess the impact of the CPT Assistant article.

The RUC also recommends that 52224 and 52214 be reviewed by the Practice Expense Subcommittee in October 2008 for direct practice expense inputs.

52648

The RUC agreed with the specialty society that 52601, *Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (TURP),* used to be considered the "gold standard" for the operative treatment of BPH. As new technologies are evolving, this procedure is no longer being performed as frequently. The results of these operative treatments are equal to 52601 in reducing the symptoms of BPH with lower morbidity and complications (eg, less bleeding, catheterization time, hospital stay, etc.). Therefore, as utilization of 52648 and 52647 has increased, utilization for 52601 has decreased proportionately.

The RUC recommends that 52648 be removed from this screen with no further action at this time.

27370, 73580

In 2004, Medicare issued a national coverage decision that clarified correct coding and reimbursement for knee examinations and concurrently issued a non-coverage determination for arthroscopic lavage and arthroscopy debridement of the knee. As a result, physicians began to use injection procedures for knee arthrography. The Workgroup agreed with the specialty society that the increase in utilization reflects a shift

away from arthroscopic lavage and arthroscopic debridement after the 2004 Medicare NCD decision. The Workgroup also agreed that this is the appropriate way to report such procedures and does not reflect any misvaluation of the service. **The RUC recommends that 27370 and 73580 be removed from this screen with no further action at this time.**

29220
The specialty society was unable to identify any physician that performs this service and recommended to the Workgroup that the service be referred to the CPT Editorial Panel for deletion. **The RUC recommends that 29220 be referred to the CPT Editorial Panel for possible deletion.**

35490, 35491, 35492, 35493, 35494, 35495, 75992, 75993, 75994, 75995, 75996
The specialty societies find that the technology and use of percutaneous atherectomy has changed significantly. The presenters informed the Workgroup that there are several new atherectomy devices that they believe to have changed the clinical application of these services in a significant enough way to warrant the creation of new codes to report these services. The Workgroup agreed with the specialties' recommendation to refer the services to the CPT Editorial Panel for possible deletion or other coding change. **The RUC recommends that 35490-35495 and 75992-75996 be referred to the CPT Editorial Panel for possible deletion or other coding change.**

64470, 64472, 64475, 64476
When the services were first reviewed by the RUC, the relationship between the base code and the add-on code was approximately one to one. However, in recent years, that relationship has changed dramatically with the add-on code reported roughly two times as often as the base code. The Workgroup agrees that this affects the valuation of the service and believes that the family of services is potentially misvalued. However, the services may be appropriately addressed through a coding change proposal to clarify the description of the service provided.

The RUC discussed this issue at length and agreed that the increase in utilization of the add-on code may be indicative of misvaluation or an outdated coding descriptor. As such, the RUC agreed that the specialty society should have the opportunity to consider a coding change proposal include work that was once a part of the add-on service but is now typically performed with the base code within the base code. **The RUC recommends that this service be referred to the CPT Editorial Panel for possible revisions in the coding descriptor.**

64622, 64623, 64626, 64627
The Workgroup expressed concerns that pulsed radiofrequency is currently being reported with these services inappropriately. A cross-reference needs to be added to indicate appropriate reporting for pulsed radiofrequency as an unlisted code. **The RUC recommends that this service be referred to the CPT Editorial Panel to create a parenthetical to describe appropriate coding of pulsed radiofrequency.**

67028
The specialty society noted that there are new pharmacological treatments for AMD that are sight saving treatments. These drugs are delivered via an injection into the vitreous. The treatments require repeated injections at monthly intervals for an indefinite period, which is causing an increase in the use of 67028. However, the surgical treatments for AMD neovascularization have and will continue to decrease accordingly. As such, code 67221 had utilization of 126,894 in 2004 but has decreased to 43,733 in 2006, evidencing this shift in service. **The RUC recommends that 67028 be removed from this screen with no further action at this time.**

70496, 70498, 72191, 73706, 75635
The RUC recognized that the technology for these services has been changing over the last several years and that some practices have migrated to more advanced CT scanners. However, during this time of transition, there is not sufficient information to be able to determine the typical scanner that is in use. While the cost of equipment is generally increasing, it is in flux. The specialty society requested and the Workgroup agreed that until there is more definitive data on the typical scanner utilized, the practice expense should not be reviewed. **The RUCrecommends that 70496, 70498, 72191, 73706 and 75635 be removed from this screen with no further action at this time.**

76513
The specialty society commented that the increase in utilization is due to new technology being developed and 76513 was being used incorrectly to bill for some of those services. Recently a new technology for anterior segment imaging that uses light rather than ultrasound to generate the images was developed, but did not, until July 1, 2007 have an appropriate CPT code. The new technology of imaging the anterior segment with optical coherence tomography was given its own code, 0187T, *Scanning computerized ophthalmic diagnostic imaging, anterior segment*, last year. The Workgroup agreed that proper coding education and a CPT parenthetical instructing physicians to correctly report 0187T when appropriate. **The RUC recommends that 76513 be removed from this screen. Further, the RUC recommends that CPT Assistant publish an article to clarify proper coding of this service and recommends to the CPT Editorial Panel that a parenthetical be added instructing physicians not to report 76513 where 0187T is appropriate.**

76970
The American College of Surgeons indicated that 76970 is reported as a follow-up for abnormal areas in the breast that are typically first seen on a screening annual mammography. The abnormal areas, if believed to be benign (such as a small cyst), are then followed-up with an ultrasound as opposed to repeating a unilateral mammogram for the follow-up study. Frequency for 77055 (Mammography; unilateral) has decreased over the same referenced years. Further, the ACS also indicated that the reported increase in frequency is almost exclusively due to reporting by general practice physicians (non-surgeons). **The RUC recommends that CMS investigate these claims for appropriateness.**

92270
The specialty society commented that the increase in utilization for service may reflect miscoding. This service should be reported only for retina tests, which are often used in conjunction with ERG to diagnose retina disorders. Some physicians may be using this service to report vestibular testing, which is inappropriate. This service should be used primarily by ophthalmologists and particularly by retina specialists. **The RUC recommends that CPT Assistant publish an article to clarify appropriate reporting of 92270.**

94014, 94015, 94016
The specialty society noted correctly that the primary provider for these services is independent diagnostic testing facilities (IDTFs). The specialty commented that it is most likely that these services are used most often for post-lung transplant, cycstic fibrosis, near fatal asthma patients and the increase is appropriate. However, 94014 is a global service, 94015 is used to report only the technical component of the service, and 94016 is used only to report the physician interpretation of the service. Intuitively, the Workgroup concluded that there should be roughly the same frequency for 94015 as 94016, but the actual frequencies differ significantly. 94016 was reported 26,662 times and 94015 was reported only 8,659 times in 2006. The Workgroup has concerns that the code is being improperly reported and needs more information. **The RUC requests that CMS reach out to the IDTF organization for clarification and assessment regarding use of this service and provide some feedback to the RUC.** The RUC also agreed that once it receives information from CMS that is must take some action on recommending a plan to review the values for these services.

94450
Neither the specialty society's panel of experts nor any member of the Workgroup is aware of who is reporting this service based on the information available. **The RUC recommends that CMS investigate these claims for appropriateness.**

94681
The specialty society was unable to identify any practitioners that utilize this service. However, the Workgroup located device manufacturers that recommend use of this service for their products, which may or may not be appropriate for this service. (See http://www.oxigraf.com/orca/cpt_codes.html). Based on this information, the RUC agrees that the technology has changed since this service was first valued by the Harvard studies. **The RUC recommends that 94681 be referred to CPT Editorial Panel for revisions of the descriptor to reflect changes in technology.**

94770
The Workgroup noted that the utilization of this service increased dramatically after it was priced in the office setting. The Workgroup and the specialty society agreed that this service should never be performed in the office setting. **The RUC recommends that the office-based practice expense inputs be removed from 94770 and that it be priced only in the facility setting.**

95922
The Workgroup is concerned that the increase in utilization of this service is closely relate to a proliferation of device manufacturers with newer technology that may not have been taken into consideration of this service when it was first valued. (See: http://www.drgaelriverz.com/DPA.htm and http://www.greathealth-tour.com/dpa.php). These manufacturers may be inappropriately recommending use of this code. However, more information is needed before any action should be taken on this service. **The RUC recommends that CPT Assistant publish an article to clarify coding and ask that this service be reviewed by the Workgroup again in two years (April 2010).**

96567
At its previous meeting, the Workgroup requested that the specialty society provide clarification of the history of fluctuations in practice expense relative values for 96567. The specialty noted that aminolevulineic acid (Levulin) was added then later removed as a medical supply. **The RUC recommends that 96567 be removed from this screen with no further action at this time.**

G0202, G0204, G0206
Staff provided the Workgroup with the background information regarding CMS's methodology for establishing the practice expense for these services. **The RUC recommends that these services be removed from this screen with no further action at this time.**

G0237 and G0238
The specialty society reported that historically these services were reported and paid within Medicare Part A through CORFs. Now that CMS has established a separate G code to describe this service, volume is increasing. The Workgroup agrees that the increase in utilization for these services is appropriate considering the shift in the site of service due to the development of the G code. In light of this change, the Workgroup notes that CMS should fund the SGR to account for the reporting and payment for this service because the change in the site of service was mandated by administrative regulation.

The change in site of service is a result of administrative regulations made by CMS and is not potentially misvalued based on this screen. The RUC recommends that CMS review the current status of the impact on the SGR from G0237 and G0238 and make any necessary changes to ensure that the service is funded.

G0249and G0250
The RUC agreed that this should be flagged and brought back to the Workgroup as part of an expanded review of all anticoagulation management service in one year (April 2009). At that time, the interested specialty societies may consider a CPT coding change proposal at that time or a survey and work RVU recommendation to the RUC.

17106, 17107, 17108
The specialty society commented to the Workgroup that this service should not be provided to the Medicare population and the increase in utilization is inappropriate. The Workgroup agreed that the current values resulted in an excessively high IWPUT and the amount of physician time was either too low or the RVU was too high. In addition, the services may have changed since the first Five-Year Review, when the RUC reviewed them. Therefore, the Workgroup agreed that a resurvey would be appropriate. The specialty society commented and the Workgroup agreed that the number of dermatologists qualified to perform such procedures is very small and that a standard RUC survey may either skew data or result in an unacceptable service performance rate. The specialty requested that it be allowed to consult with the Research Subcommittee to develop a recommendation based on an expert panel rather than survey. **The RUC recommends that 17106, 17107, and 17108 be reviewed by the RUC at the October 2008 RUC meeting. The RUC referred the development of expert panel recommendations rather than a survey-based recommendations of this issue to the Research Subcommittee. The Research Subcommittee should meet via conference call to discuss this prior to the October 2008 RUC meeting so the specialty may present its data to the RUC at its October 2008 meeting.**

27244 and 27245
The Workgroup agreed with the specialty society that both 27244 and 27245 should be valued the same as they are essentially similar procedures. In addition to these assumptions, the specialty society noted that neither 27245 nor 27244 have been surveyed by the RUC. The Workgroup agreed with the specialty society that a RUC survey is necessary. **The RUC recommends that 27244 and 27245 be surveyed and presented to the RUC at the October 2008 meeting.**

47525
The specialty society commented that this procedure typically requires only a one-day hospital stay. Further, the patient may receive follow up care by a general surgeon rather than the radiologist. The specialty society recommends and the Workgroup agrees that a change in the global period from 000 to 090 would be most appropriate for this service. Following any change in the global period, the service should be surveyed and presented to the RUC. **The RUC recommends that 46525 be changed to a 000 day global and resurveyed and presented to the RUC at the October 2008 meeting.**

59400, 59409, 59410, 59412, 59414, 59425, 59426, 59430, 59510, 59515, 59610, 59612, 59614, 59618, 59620, 59622
The specialty society originally requested that MMM global period codes be changed to a 000 day global code. The Workgroup expressed reservations, but entertained discussion. Following the discussion, representatives from CMS indicated that the likelihood of the Agency unbundling the services was very small. Based on this, the Workgroup and the specialty society agreed that the current coding structure was inaccurate and, given the wide variance in child birth scenarios, it is very difficult to define a typical patient and recommend appropriate intra-service time based on the typical patient. **The RUC referred development of an MMM survey instrument to the Research Subcommittee**

with input from the specialty society at its October 2008 meeting and that these services then be surveyed and reviewed by the RUC. The RUC recommends that AAFP and ACOG work together on this issue.

66982 and 66984

The specialty society recognized the high IWPUT of these services as not unusual for cataract surgery and noted that this specific issue has been discussed on multiple occasions at the RUC. They agreed that the service was appropriately valued, but that the level and number of post-service visits were higher than typically performed. The Specialty society recommended and the Workgroup agreed that the post-service visits for 66982 should change from five 99213 office visits to two 99213 and three 99212 visits. The workgroup also noted that at the time this service was reviewed, the specialty society estimated that approximately 1.5% of cataract operations would be reported using 66982 and the remaining 98.5% would be reported using 66984. This ratio was accurate for the first two years of the code's existence. However, that ratio has changed in more recent years. In 2003, 66982 jumped to 2.5% and has climbed to 5.3% in 2006. The specialty society notes that this increase coincides with the increase use of the drug Flomax (tamsulosin hydrochloride) and other alpha adrenergic antagonists for the treatment of prostate disease. The use of these drugs cause the iris of the eye to become atonic which makes cataract surgery more technically difficult and requires special techniques and devices to overcome. The condition, called "floppy iris syndrome" has increased in frequency to such a degree that it was actually given its own ICD-9 code in October 2007, 364.81. The Workgroup agreed with the specialty society that the majority of carriers have not developed clear criteria for the use of 66982 and the most efficient way to address the issue to clarify the requirements for use of the 66982 code and disseminate this information through appropriate educational activity. **The RUC recommends that the post-service office visits be redistributed to two 99213 to three 99212 office visits with no reduction in the RVU. The WoRUCrkgroup recommends that the specialty society work with CMS to develop better-defined criteria for accurate reporting of 66982. Lastly, the RUC recommends that 66982 be reviewed again by the Workgroup in two years (April 2010) to assess the distribution ratio between 66982 and 66984.**

The Workgroup commented that 66984 was recently reviewed at the Third Five-Year Review. At that time, the RUC noted the high IWPUT in its rationale. The Workgroup agrees with the RUC's rationale. **The RU recommends that 66984 be removed from this screen with no further action at this time. In concordance with the recommendation for 66982, the Workgroup recommends that 66984 be reviewed again by the Workgroup in two years (April 2010) to assess the distribution ratio between the two services.**

67210, 67220, 67228

The Workgroup noted that the CPT descriptor for each of these services contains "one or more sessions," the physician time includes the appropriate time for only one session, and the work RVU contains the work of the typical number of sessions: 2.5. As such, the work and time are not correlative, which significantly skews the IWPUT. To resolve this

issue, the workgroup agrees with the specialty society that the services should be changed from 90 day globals to a 010 day globals and after CMS concurrence referred to the CPT Editorial Panel to change the descriptor. **The RUC recommends that a CPT coding change proposal be developed when the global periods for 67210, 67220, and 67228 change to 010 days. The specialty society will report back to Workgroup at the October meeting with a more definite work plan following CMS's decision.**

77427

77427 was originally identified in the site of service anomaly screen and deferred for discussion to this meeting to provide the specialty an opportunity to clarify the reasons for the anomaly. The specialty society clarified that current CMS policy precludes separate payments for evaluation and management services, including those provided during the 90 day period following the last treatment of this multi-treatment service. Therefore, the service, while officially an XXX global period is treated in the RBRVS much like a 90 day global. The Workgroup recognizes the inconsistency of the site of service and recommended conducting a mini-survey to address post radiation follow up care. The American Society for Therapeutic Radiation Oncology will draft a survey and methodology to present to the Research Subcommittee for their comment following the April RUC meeting. The specialty plans to finalize the survey instrument at the October 2008 meeting and present recommendations to the RUC at the February 2009 meeting. **The RUC recommends that the specialty work with the Research Subcommittee to develop a survey instrument to assess post radiation follow-up care for 77427.**

The report of the Workgroup was approved and is attached to these minutes.

XIV. Election of Internal Medicine Rotating Seat (Tab 58)

The RUC considered the election of the internal medicine rotating seat. The following individuals were nominated:

- Scott Manaker, MD, PhD – American College of Chest Physicians/American Thoracic Society
- Lawrence Martinelli, MD – Infectious Diseases Society of America
- Eileen Moynihan, MD – American College of Rheumatology
- John Seibel, MD – American Association of Clinical Endocrinologists

The term for the seat is two years, beginning with the September 2008 RUC meeting and ending in May 2010, with the provision of final recommendations to the Centers for Medicare and Medicaid Services.

The RUC elected Lawrence Martinelli, MD, representing the Infectious Diseases Society of America.

XV. Other Issues

Moderate Sedation (Tab 59)

In May 2005, the RUC submitted work relative value and direct practice expense recommendations for moderation sedation services. Rather than publish the RUC recommendations, CMS chose to carrier price these services in 2006. The RUC repeatedly commented that CMS should reconsider this decision. Volume data is now available to indicate that CMS is paying many claims for moderate sedation.

CMS has requested that the RUC discuss the reporting of moderate sedation services by Anesthesiologists. Further, the American Academy of Pediatrics has requested that CMS consider a non-coverage policy for these services so that relative values could be published for private payor use in 2009. **To that end, the RUC will establish a joint CPT/RUC workgroup to discuss the issue completely and submit a recommendation to CMS regarding how best to proceed. Doctors Rich and Thorwarth nominated the following individuals to serve on the Workgroup: Stanley Stead, MD (Chair), Edward Bentley, MD, Katherine Bradley, PhD, RN, Michael Bishop, MD, Charles Haley, MD, MS, FACP, Rodney Lee Jones, MD, Charles Koopman, MD, Steve Krug, MD, FAAP, Brenda Lewis, DO, Geraldine McGinty, MD, Andrea H. McGuire, MD, Charles Mick, MD, Tim Shahbazian, DDS, Ken Simon, MD.**

XVI. New Business

- A RUC member reiterated previous RUC recommendations to CMS to publish all work RVUs despite CMS coverage policy.

- A member of the RUC commented on the RUC policies to review and question the financial disclosures of presenters. Doctor Rich referred the issue to the Administrative Subcommittee and noted that members of the RUC should maintain the opportunity to query presenters at the table and review their financial disclosures even if more stringent standards are implemented.

- The CPT Editorial Panel representative, Doctor Hollmann, commented that the service descriptions on the SORs have gradually increased in length, with some as long as five pages. Doctor Hollmann questioned the need for such lengthy descriptors. Several members of the RUC concurred and Doctor Rich agreed to refer this issue to the Administrative Subcommittee.

- During the review of the potentially misvalued services identified through the Site of Service Anomaly screening mechanism, the RUC uncovered several services that are reported in the outpatient setting, but where the patient is kept overnight and, on occasion, several nights. The RUC referred to these issues as 23-Hour Stay services. Rather than apply a methodology to review the services during this meeting, the RUC referred the issue to the Research Subcommittee to develop a survey question or other

methodology to appropriately account for the physician work related to overnight stays for services that are reported primarily in the outpatient setting.

- A RUC member requested that the RUC consider whether a code can be referred for review in the next Five-Year Review, not because of potential misvaluation, but because of the specialty's desire to place the service on the Multi-Specialty Points of Comparison list. The issue was referred to the Five Year Review Identification Workgroup for consideration during its October 2008 meeting.

- A RUC member requested that the RUC reconsider the pre-service time packages to ensure that the packages accurately reflect the typical time involved for the delivery of the associated services. The issue was referred to the Practice Expense Subcommittee for consideration during its October 2008 meeting.

The meeting adjourned on Sunday, April 27, 2008 at 10:00 a.m.

AMA/Specialty Society RVS Update Committee **Tab 57**
Five-Year Review Identification Workgroup
April 24, 2008

Members Present: Barbara Levy, MD (Chair), Michael Bishop, MD, James Blankenship, MD, Norm Cohen, MD, Thomas Felger, MD, Holly Stanley, MD, Gregory Kwasny, MD, William J. Mangold, Jr., MD, Bibb Allen, MD, Allan Inglis, MD, James J. Anthony, MD, Maurits Weirsema, MD, Robert Zwolak, MD

Report from CMS on "Rolling Five-Year Review"
Doctor Levy welcomed the Workgroup and began the meeting by inviting Doctor Ken Simon to provide a brief overview of CMS's response to the RUC's recommendation to initiate a "rolling Five-Year Review" for potentially misvalued services.

Doctor Simon reported that CMS has had internal discussions regarding the Five-Year Review Identification Workgroup. CMS will discuss the site-of-service anomalies and the RUC's Five-Year Review Identification and re-valuation progress in the Notice of Proposed Rulemaking (NPRM) this summer. This discussion will articulate the progress that has been made to address the concerns of the Medicare Payment Advisory Commission (MedPAC) and CMS.

The RUC's recommendations from the February and April 2008 meetings will be addressed in the Final Rule this November with a 60-day comment period and the values for these services will be published as interim values in 2009.

CMS supports the rolling Five-Year Review. Any budget impacts will be addressed on an annual basis (ie, savings from these activities would decrease the existing work adjuster immediately).

Review of Action Plans for Potentially Misvalued Services
The Workgroup next turned its attention to the review of the specialty society action plans for recommended action regarding the potentially misvalued services identified at the February 2008 meeting. The Workgroup reviewed each service individually and submits the following actions to the RUC for consideration

High Volume Growth	
11981 11982 11983 52224 52648	The Workgroup recognized that there was a misunderstanding of the specialty society regarding the mandate following the last meeting. The Workgroup agreed that the specialty should convene its expert panel to discuss the growth in volume prior to the next Workgroup meeting in order to maintain the original timetable for all specialty societies. **The Workgroup recommends that the specialty society convene an expert panel and report its action plan to the Workgroup via conference call prior to the October 2008 LOI deadline (June 1) for action during the October RUC or CPT Editorial Panel Meetings for codes 11981, 11982, 11983, 52224, and 52648.**
27370 73580	In 2004, Medicare issued a national coverage decision that clarified correct coding and reimbursement for knee examinations and concurrently issued a non-coverage determination for arthroscopic lavage and arthroscopy debridement of the knee. As a

	result, physicians began to use injection procedures for knee arthrography. The Workgroup agreed with the specialty society that the increase in utilization reflects a shift away from arthroscopic lavage and arthroscopic debridement after the 2004 Medicare NCD decision. The Workgroup also agreed that this is the appropriate way to report such procedures and does not reflect any misvaluation of the service. **The Workgroup accepts the action plan of the specialty society and recommends that 27370 and 73580 be removed from this screen with no further action at this time.**
29220	The specialty society was unable to identify any physician that performs this service and recommended to the Workgroup that the service be referred to the CPT Editorial Panel for deletion. **The Workgroup accepts the action plan of the specialty society and recommends that 29220 be referred to the CPT Editorial Panel for possible deletion.**
35490 35491 35492 35493 35494 35495 75992 75993 75994 75995 75996	The specialty societies find that the technology and use of percutaneous atherectomy has changed significantly. The presenters informed the Workgroup that there are several new atherectomy devices that they believe to have changed the clinical application of these services in a significant enough way to warrant the creation of new codes to report these services. The Workgroup agreed with the specialties' recommendation to refer the services to the CPT Editorial Panel for possible deletion or other coding change. **The Workgroup accepts the action plan of the specialty societies and recommends that 35490-35495 and 75992-75996 be referred to the CPT Editorial Panel for possible deletion or other coding change.**
64470 64472 64475 64476	The Workgroup noted several issues of concern related to these codes. When the services were first reviewed by the RUC, the relationship between the base code and the add-on code was approximately one to one. However, in recent years, that relationship has changed dramatically with the add-on code reported roughly two times as often as the base code. The Workgroup agrees that this affects the valuation of the service and believes that the family of services is potentially misvalued. However, the services may be appropriately addressed through a coding change proposal to clarify the description of the service provided. The RUC discussed this issue at length and agreed that the increase in utilization of the add-on code may be indicative of misvaluation or an outdated coding descriptor. As such, the RUC agreed that the specialty society should have the opportunity to consider a coding change proposal include work that was once a part of the add-on service but is now typically performed with the base code within the base code. **The Workgroup recommends that this service be referred to the CPT Editorial Panel for possible revisions in the coding descriptor.**

64622 64623 64626 64627	The Workgroup expressed concerns that pulsed radiofrequency is currently being reported with these services inappropriately. A cross-reference needs to be added to indicate appropriate reporting for pulsed radiofrequency as an unlisted code. **The Workgroup recommends that this service be referred to the CPT Editorial Panel to create a parenthetical to describe appropriate coding of pulsed radiofrequency.** The CPT Executive Committee addressed this issue on May 1 and added parenthetical to instruct use of unlisted code for pulsed radiofrequency.
67028	The specialty society noted that there are new pharmacological treatments for AMD that are sight saving treatments. These drugs are delivered via an injection into the vitreous. The treatments require repeated injections at monthly intervals for an indefinite period, which is causing an increase in the use of 67028. However, the surgical treatments for AMD neovascularization have and will continue to decrease accordingly. As such, code 67221 had utilization of 126,894 in 2004 but has decreased to 43,733 in 2006, evidencing this shift in service. The Workgroup agreed with the specialty's comments. **The Workgroup accepts the action plan of the specialty society and recommends that 67028 be removed from this screen with no further action at this time.**
70496 70498 72191 73706 75635	The Workgroup recognized that the technology for these services has been changing over the last several years and that some practices have migrated to more advanced CT scanners. However, during this time of transition, there is not sufficient information to be able to determine the typical scanner that is in use. While the cost of equipment is generally increasing, it is in flux. The specialty society requested and the Workgroup agreed that until there is more definitive data on the typical scanner utilized, the practice expense should not be reviewed. **The Workgroup accepts the action plan of the specialty society and recommends that 70496, 70498, 72191, 73706 and 75635 be removed from this screen with no further action at this time.**
76513	The specialty society commented that the increase in utilization is due to new technology being developed and 76513 was being used incorrectly to bill for some of those services. Recently a new technology for anterior segment imaging that uses light rather than ultrasound to generate the images was developed, but did not, until July 1, 2007 have an appropriate CPT code. The new technology of imaging the anterior segment with optical coherence tomography was given its own code, 0187T, *Scanning computerized ophthalmic diagnostic imaging, anterior segment*, last year. The Workgroup agreed that proper coding education and a CPT parenthetical instructing physicians to correctly report 0187T when appropriate. **The Workgroup accepts the action plan of the specialty society and recommends that 76513 be removed from this screen. Further, the Workgroup recommends that CPT Assistant publish an article to clarify proper coding of this service and**

	recommends to the CPT Editorial Panel that a parenthetical be added instructing physicians not to report 76513 where 0187T is appropriate. The CPT Executive Committee addressed this issue on May 1 and added parenthetical to instruct not to report 76513 where 0187T is appropriate. Specialty to develop CPT Assistant article.
76970	The American College of Surgeons indicated that 76970 is reported as a follow-up for abnormal areas in the breast that are typically first seen on a screening annual mammography. The abnormal areas, if believed to be benign (such as a small cyst), are then followed-up with an ultrasound as opposed to repeating a unilateral mammogram for the follow-up study. Frequency for 77055 (Mammography; unilateral) has decreased over the same referenced years. Further, the ACS also indicated that the reported increase in frequency is almost exclusively due to reporting by general practice physicians (non-surgeons). **The Workgroup recommends that CMS investigate these claims for appropriateness.**
92270	The specialty society commented that the increase in utilization for service may reflect miscoding. This service should be reported only for retina tests, which are often used in conjunction with ERG to diagnose retina disorders. Some physicians may be using this service to report vestibular testing, which is inappropriate. This service should be used primarily by ophthalmologists and particularly by retina specialists. **The Workgroup agrees with the action plan and recommends that CPT Assistant publish an article to clarify appropriate reporting of 92270.**
94014 94015 94016	The specialty society noted correctly that the primary provider for these services is independent diagnostic testing facilities (IDTFs). The specialty commented that it is most likely that these services are used most often for post-lung transplant, cycstic fibrosis, near fatal asthma patients and the increase is appropriate. However, 94014 is a global service, 94015 is used to report only the technical component of the service, and 94016 is used only to report the physician interpretation of the service. Intuitively, the Workgroup concluded that there should be roughly the same frequency for 94015 as 94016, but the actual frequencies differ significantly. 94016 was reported 26,662 times and 94015 was reported only 8,659 times in 2006. The Workgroup has concerns that the code is being improperly reported and needs more information. **The Workgroup requests that CMS reach out to the IDTF organization for clarification and assessment regarding use of this service and provide some feedback to the RUC.** The Workgroup also agreed that once it receives information from CMS that is must take some action on recommending a plan to review the values for these services.

94450	Neither the specialty society's panel of experts nor any member of the Workgroup is aware of who is reporting this service based on the information available. **The Workgroup recommends that CMS investigate these claims for appropriateness.**
94681	The specialty society was unable to identify any practitioners that utilize this service. However, the Workgroup located device manufacturers that recommend use of this service for their products, which may or may not be appropriate for this service. (See http://www.oxigraf.com/orca/cpt_codes.html). Based on this information, the Workgroup agrees that the technology has changed since this service was first valued by the Harvard studies. **The Workgroup recommends that 94681 be referred to CPT Editorial Panel for revisions of the descriptor to reflect changes in technology.**
94770	The Workgroup noted that the utilization of this service increased dramatically after it was priced in the office setting. The Workgroup and the specialty society agreed that this service should never be performed in the office setting. **The Workgroup recommends that the office-based practice expense inputs be removed from 94770 and that it be priced only in the facility setting.**
95922	The Workgroup is concerned that the increase in utilization of this service is closely relate to a proliferation of device manufacturers with newer technology that may not have been taken into consideration of this service when it was first valued. (See: http://www.drgaelriverz.com/DPA.htm and http://www.greathealth-tour.com/dpa.php). These manufacturers may be inappropriately recommending use of this code. However, more information is needed before any action should be taken on this service. **The Workgroup recommends that CPT Assistant publish an article to clarify coding and ask that this service be reviewed by the Workgroup again in two years (April 2010).**
96567	At its previous meeting, the Workgroup requested that the specialty society provide clarification of the history of fluctuations in practice expense relative values for 96567. The specialty noted that aminolevulineic acid (Levulin) was added then later removed as a medical supply. **The Workgroup recommends that 96567 be removed from this screen with no further action at this time.**

G0202 G0204 G0206	Staff provided the Workgroup with the background information regarding CMS's methodology for establishing the practice expense for these services.
G0237 G0238	The specialty society reported that historically these services were reported and paid within Medicare Part A through CORFs. Now that CMS has established a separate G code to describe this service, volume is increasing. The Workgroup agrees that the increase in utilization for these services is appropriate considering the shift in the site of service due to the development of the G code. In light of this change, the Workgroup notes that CMS should fund the SGR to account for the reporting and payment for this service because the change in the site of service was mandated by administrative regulation. **The change in site of service is a result of administrative regulations made by CMS and is not potentially misvalued based on this screen. The Workgroup recommends that CMS review the current status of the impact on the SGR from G0237 and G0238 and make any necessary changes to ensure that the service is funded.**
G0249 G0250	The Workgroup agreed that this should be flagged and brought back to the Workgroup as part of an expanded review of all anticoagulation management service in one year (April 2009). At that time, the interested specialty societies may consider a CPT coding change proposal at that time or a survey and work RVU recommendation to the RUC.
High IWPUT	
17106 17107 17108	The specialty society commented to the Workgroup that this service should not be provided to the Medicare population and the increase in utilization is inappropriate. The Workgroup agreed that the current values resulted in an excessively high IWPUT and the amount of physician time was either too low or the RVU was too high. In addition, the services may have changed since the first Five-Year Review, when the RUC reviewed them. Therefore, the Workgroup agreed that a resurvey would be appropriate. The specialty society commented and the Workgroup agreed that the number of dermatologists qualified to perform such procedures is very small and that a standard RUC survey may either skew data or result in an unacceptable service performance rate. The specialty requested that it be allowed to consult with the Research Subcommittee to develop a recommendation based on an expert panel rather than survey. **The Workgroup recommends that 17106, 17107, and 17108 be reviewed by the RUC at the October 2008 RUC meeting. The Workgroup asks that the RUC refer the development of expert panel recommendations rather than a survey-based recommendations of this issue to the Research Subcommittee. The Research Subcommittee should meet via conference call to discuss this prior to the October 2008 RUC meeting so the specialty may present its data to the RUC at its October 2008 meeting.**

27244 27245	The Workgroup agreed with the specialty society that both 27244 and 27245 should be valued the same as they are essentially similar procedures. In addition to these assumptions, the specialty society noted that neither 27245 nor 27244 have been surveyed by the RUC. The Workgroup agreed with the specialty society that a RUC survey is necessary. **The Workgroup accepts the action plan of the specialty society and recommends that 27244 and 27245 be surveyed and presented to the RUC at the October 2008 meeting.**
47525	The specialty society commented that this procedure typically requires only a one-day hospital stay. Further, the patient may receive follow up care by a general surgeon rather than the radiologist. The specialty society recommends and the Workgroup agrees that a change in the global period from 000 to 090 would be most appropriate for this service. Following any change in the global period, the service should be surveyed and presented to the RUC. **The Workgroup accepts the action plan of the specialty society and recommends that 46525 be changed to a 000 day global and resurveyed and presented to the RUC at the October 2008 meeting.**
59400 59409 59410 59412 59414 59425 59426 59430 59510 59515 59610 59612 59614 59618 59620 59622	The specialty society originally requested that MMM global period codes be changed to a 000 day global code. The Workgroup expressed reservations, but entertained discussion. Following the discussion, representatives from CMS indicated that the likelihood of the Agency unbundling the services was very small. Based on this, the Workgroup and the specialty society agreed that the current coding structure was inaccurate and, given the wide variance in child birth scenarios, it is very difficult to define a typical patient and recommend appropriate intra-service time based on the typical patient. **The Workgroup recommends that the RUC refer development of an MMM survey instrument to the Research Subcommittee with input from the specialty society at its October 2008 meeting and that these services then be surveyed and reviewed by the RUC. The Workgroup recommends that AAFP and ACOG work together on this issue.**
66982 66984	The specialty society recognized the high IWPUT of these services as not unusual for cataract surgery and noted that this specific issue has been discussed on multiple occasions at the RUC. They agreed that the service was appropriately valued, but that the level and number of post-service visits were higher than typically performed. The Specialty society recommended and the Workgroup agreed that the post-service visits for 66982 should change from five 99213 office visits to two 99213 and three 99212 visits. The workgroup also noted that at the time this service was reviewed, the specialty society estimated that approximately 1.5% of cataract operations would be reported using 66982 and the remaining 98.5% would be reported using 66984. This ratio was accurate for the first two years of the code's existence. However, that ratio has changed in more recent years. In 2003, 66982 jumped to 2.5% and has climbed to 5.3% in 2006. The specialty society notes that this increase coincides with the increase

	use of the drug Flomax (tamsulosin hydrochloride) and other alpha adrenergic antagonists for the treatment of prostate disease. The use of these drugs cause the iris of the eye to become atonic which makes cataract surgery more technically difficult and requires special techniques and devices to overcome. The condition, called "floppy iris syndrome" has increased in frequency to such a degree that it was actually given its own ICD-9 code in October 2007, 364.81. The Workgroup agreed with the specialty society that the majority of carriers have not developed clear criteria for the use of 66982 and the most efficient way to address the issue to clarify the requirements for use of the 66982 code and disseminate this information through appropriate educational activity. **The Workgroup accepts the specialty society's action plan and recommends that the post-service office visits be redistributed to two 99213 to three 99212 office visits with no reduction in the RVU. The Workgroup recommends that the specialty society work with CMS to develop better-defined criteria for accurate reporting of 66982. Lastly, the Workgroup recommends that 66982 be reviewed again by the Workgroup in two years (April 2010) to assess the distribution ratio between 66982 and 66984.** The Workgroup commented that 66984 was recently reviewed at the Third Five-Year Review. At that time, the RUC noted the high IWPUT in its rationale. The Workgroup agrees with the RUC's rationale. **The Workgroup recommends that 66984 be removed from this screen with no further action at this time. In concordance with the recommendation for 66982, the Workgroup recommends that 66984 be reviewed again by the Workgroup in two years (April 2010) to assess the distribution ratio between the two services.**
67210 67220 67228	The Workgroup noted that the CPT descriptor for each of these services contains "one or more sessions," the physician time includes the appropriate time for only one session, and the work RVU contains the work of the typical number of sessions: 2.5. As such, the work and time are not correlative, which significantly skews the IWPUT. To resolve this issue, the workgroup agrees with the specialty society that the services should be changed from 90 day globals to a 010 day globals and after CMS concurrence referred to the CPT Editorial Panel to change the descriptor. **The Workgroup recommends that a CPT coding change proposal be developed when the global periods for 67210, 67220, and 67228 change to 010 days. The specialty society will report back to WG at the October meeting with a more definite work plan following CMS's decision.**
Other Issues	
77427	77427 was originally identified in the site of service anomaly screen and deferred for discussion to this meeting to provide the specialty an opportunity to clarify the reasons for the anomaly. The specialty society clarified that current CMS policy precludes separate payments for evaluation and management services, including those provided during the 90 day period following the last treatment of this multi-treatment service. Therefore, the service, while officially an XXX global period is treated in the RBRVS much like a 90 day global. The Workgroup recognizes the inconsistency of the site of

	service and recommended conducting a mini-survey to address post radiation follow up care. The American Society for Therapeutic Radiation Oncology will draft a survey and methodology to present to the Research Subcommittee for their comment following the April RUC meeting. The specialty plans to finalize the survey instrument at the October 2008 meeting and present recommendations to the RUC at the February 2009 meeting. **The Workgroup accepts the action plan of the specialty society and recommends that the specialty work with the Research Subcommittee to develop a survey instrument to assess post radiation follow-up care for 77427.**

AMA/Specialty Society RVS Update Committee **Tab 56**
Practice Expense Subcommittee Minutes
Wednesday – Thursday, April 24, 2008

Participating Members: Bill Moran, MD (Chair), Bibb Allen, MD, Katherine Bradley, PhD, RN, Joel Brill, MD, Manuel D. Cerqueira, MD, Thomas Felger, MD, David Hitzeman, DO , Peter A. Hollmann, MD, William J. Mangold, Jr., MD, Gregory Kwasny, MD, MD, Tye Ouzounian, MD, and John A. Seibel, MD

Doctor Moran first welcomed the committee members and reminded the group that there was a considerable amount of information to review and that it important that specialty recommendations reflect accurate typical direct practice inputs, standard inputs where they apply, and well formatted submissions. If the committee believes that the submissions are poorly presented and do not reflect typical procedure, the Chair will ask the specialty to revise their recommendations and present after all other business is presented.

Update on AMA/Specialty Society Practice Information Survey
AMA staff director Sherry Smith provided a slideshow update on the AMA/Specialty Society Practice Information Survey. Ms. Smith informed the committee that Dmrkynetec has begun the resurvey process and has mailed survey packets in three waves with more than 50,000 physicians receiving survey packets. This project is currently 30% complete with a total of 1,735 completed surveys. Specialty societies have been cooperative in their communications efforts, whereas all specialties have information about the survey on their websites, and some specialties have sent e-mails and newsletters to their membership. Ms. Smith stressed the need for specialties to ramp up communication again, and she encouraged broadcast e-mails and other communications to specialty membership. The AMA is will also be sending emails and postcards reminding physicians of the survey effort and to check their mail for the survey. The survey firm projects that the major data collection effort will be completed by August 31. A detailed listing of the number of responses by specialty and all of the slides from this update are attached.

The Practice Expense Subcommittee reviewed the following new, revised, and current issues and make the following recommendations to the RUC:

Relative Value Recommendations for *CPT 2009*:

The Practice Expense Subcommittee reviewed the following direct practice expense inputs recommendations, and either agreed with the recommendations or made minor edits and corrections based on the typical service provided and were approved:

Tab 4: Intracranial Procedures Anesthesia (0021)
Tab 5: CABG Pump Oxygenator Anesthesia (00562 & 0056X)
Tab 7: Cervical Arthroplasty (228XX1-228XX3
Tab 8: Pelvic Bone Fracture (27215-27218)
Tab 6: Computer Dependent External Fixation (2069X3-2069X4)
Tab 9: Hepatorenal Bypass (3553X)
Tab 10: Tibial-Tibial Bypass with Vein (3557X)
Tab 11: Ilio-celiac Bypass, Ilio-mesenteric Bypass and Ilio-renal Bypass with Other than Vein (3563X1-3563X3)
Tab 12: Laparoscopic Heller Myotomy (432X1)
Tab 14: Hemorrhoidectomy (4693X)
Tab 15: Saturation Biopsies (5570X)
Tab 16: Stereotactic Radiosurgery (61XX0-61XX4, 61795, 636X1-636X2)
Tab 17: Interdiscal Percutaneous Aspiration (6226X)
Tab 18: Intermetatarsal Neuroma Injections(s) and Destruction by a Neurolytic Agent (644XX & 646XX)
Tab 20: Endothelial Keratoplasty (65710, 65730, 65750, 65755, 6575X1 & 6575X2)

Tab 21: High Dose Rate Brachytherapy (77XX1-77XX3)
Tab 22: Radiopharmaceutical Localization Injection (788X1)
Tab 23: Cardiac Device Monitoring (93XX1-X9 & 93X10-X22) (93X21 and 93X23 were reviewed and recommended by the RUC separately)
Tab 24: Stress Echo with ECG Monitoring (93350, 933X1-933X2)
Tab 25: Actigraphy Sleep Assessment (9580X)Tab 26: Canalith Repositioning (959XX)
Tab 53: Medical Nutrition Therapy (97802 & 97803)
Tab 54: Ocular Photoscreening (99174)
Tab 55: Chemotherapy Administration (96405-6)

The following issues required a different level of review and the recommendations follow:
Tab 51: Arthroscopy (29805, 29830, 29840 & 29870)
CMS asked the RUC to revisit the non-facility direct practice expense inputs for arthroscopy codes; 29805, 29830, 29840, 29870, and 29900. CMS had requested comments as to the specific non-facility inputs for these codes and received comments in opposition to the establishment of non-facility PE because they believe the procedures are not safely performed in the office setting. CMS also received comments from physicians stating that they are currently performing these procedures in the non-facility setting. CMS stated that the specialty societies and the RUC, should first be given the opportunity to resolve these issues before a final decision is made regarding pricing these services in the non-facility setting.

The Subcommittee carefully discussed this issue and agreed with the specialty that these services be priced only in the facility setting as it was medically necessary for the patient safety. After speaking with the physicians that claimed that they were providing these services in the office setting it was revealed that they were really performing them in an Ambulatory Surgical Center. The specialty stated and the Subcommittee agrees with the following: "We continue to feel that it is medically inappropriate to perform arthroscopy in a non facility setting for the following reasons:

1) A full exam of the joint is customarily included in the procedure and may not be done effectively under a local or block anesthesia.
2) Arthroscopy is an invasive procedure which includes injection of fluids into the patient under pressure which has the potential for serious complications which cannot be effectively managed in the office
3) If a lesion treatable by standard (in-facility) arthroscopy is discovered, it cannot be treated in the office and the patient must undergo a second procedure for treatment

There is not a supporting body of peer-reviewed literature which documents the safety of effectiveness of non-facility arthroscopy. Review of the CMS data base suggests that arthroscopy outside the facility is neither customary nor common for any of these five codes." The committee also believed that if necessary category III codes may be developed to account for these services being provided in the non-facility setting.

Tab 52: Left Heart Catheterization (93510)
CMS asked the RUC to revisit the non-facility direct practice expense inputs for cardiac catheterization codes 93501 through 93556 so that data from the Cardiovascular Outpatient Center Alliance (COCA) Direct Cost Study be afforded appropriate and adequate consideration. COCA's Direct Cost Study purportedly demonstrated that the 2006 RUC's estimates of direct PE costs for the non-facility setting did not adequately address direct patient care activities. COCA contends that a significant amount of the data from its Direct Cost Study were not incorporated into the PE recommendations that were jointly prepared and presented at the April 2007 RUC meeting with ACC and SCA&I. In January 2008, AMA staff received a letter from CMS stating that they were only concerned about the PE inputs for code 93510. The American College of Cardiology commented and recommended to the Subcommittee, that they believed there was no need for a revision to code 93510. The Subcommittee discussed and agreed that there was no evidence that would lead the group to review and recommend different practice expense inputs for this service. The Subcommittee recommends the direct practice expenses for code 93510 not be altered at this time.

Chairman's Report
RUC

April 23-27, 2008

Chicago, IL

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Procedural Issues

Advisors:

- Financial Disclosure Forms-must be on file prior to presentation – no forms are accepted at the meeting.
- Attestations of Survey data should be signed with or after the submission of the SOR. AMA had received statements from Advisors prior to submission of any recommendations
- Before the presentation of a new code, the Chairman will ask presenters to declare any conflicts




Procedural Issues

- October 2006 – The RUC reaffirmed that RUC advisors and presenters verbally disclose financial conflicts prior to presenting relative value recommendations
- The RUC also recommended that the RUC Chair ask RUC advisors and presenters to verbally disclose any travel expenses for the RUC meeting paid by an entity other than the specialty society




Procedural Issues

RUC Members:

- Before a presentation, any RUC member with a conflict will state their conflict and the Chair will rule on recusal.
- RUC members or alternates sitting at the table may not present or debate for their society




Procedural Issues

- For **new** codes, the Chairman will inquire if there is any discrepancy between submitted PE inputs and PE Subcommittee recommendations or PEAC standards.
- If the society has not accepted PE Subcommittee recommendations or PEAC conventions, the tab will be immediately referred to a Facilitation Committee before any WRVU discussion.




Summary of Recommendation Form

- Please note the new summary of recommendations forms
- The RUC should provide any feedback if sections of the summary are incorrect (pre-service times, modifier – 51, PLI crosswalk, etc.)
- RUC Members and Alternates should carefully review frequency information per new or revised code




RUC Meeting

- **Cell phones!!!**




CMS Representatives

- Edith Hambrick, MD – CMS Medical Officer
- Whitney May – Deputy Director, Division of Practitioner Services
- Ken Simon, MD – CMS Medical Officer
- Pam West, DPT, MPH – Health Insurance Specialist




Medicare Contractor Medical Directors

- Charles Haley, MD




MedPAC Staff

- Kevin Hayes




Facilitation Committee #1

Cardiac Device Monitoring, Tab 23
Conference Call

- Maurits Wiersema, MD (Chairman)
- James Anthony, MD
- Michael Bishop, MD
- James Blankenship, MD
- Michael Chaglasian, OD
- Norman Cohen, MD
- Thomas Felger, MD
- Meghan Gerety, MD
- Gregory Kwasny, MD
- Barbara Levy, MD
- William Mangold, Jr, MD
- Eileen Moynihan, MD
- Bernard Pfeifer, MD
- Gregory Przybylski, MD




Facilitation Committee #2

Resection of Soft Tissue Bone Tumors

Preliminary Discussion

Thursday, April 24, 7:00 am – 8:00 am

- Samuel Smith, MD (Chairman)
- Emily Hill, PA-C
- John Gage, MD
- Peter Hollmann, MD
- J. Leonard Lichtenfeld, MD
- Lawrence Martinelli, MD
- Bill Moran, MD
- Peter Smith, MD
- Susan Spires, MD
- Richard Tuck, MD

Facilitation Committee #3

- Charles Koopmann, MD (Chairman)
- Bibb Allen, MD
- Ronald Burd, MD
- John Derr, MD
- David Hitzeman, DO
- James Regan, MD
- John Seibel, MD
- Daniel Mark Siegel, MD
- Lloyd Smith, DPM
- Arthur Traugott, MD




RUC Observers

- Debra Abel – American Academy of Audiology
- Margie Andreae – American Academy of Pediatrics
- Linda Ayers – American Academy of Otolaryngology – Head and Neck Surgery
- Brett Baker – American College of Physicians
- Jerome Barrett – American Academy of Sleep Medicine
- William Beach, MD – American Academy of Orthopaedic Surgeons
- David Beyer - American Society for Therapeutic Radiology and Oncology
- Michael Bigby – American Academy of Dermatology




RUC Observers

- Michael Bourisaw – American College of Chest Physicians
- Marla Brichta – American College of Chest Physicians
- Darryl Bronson, DC – American Academy of Dermatology
- Leo Bronson - American Chiropractic Association
- Benjamin Byrd, MD – American College of Cardiology
- Nicholas Cekosh – American Academy of Sleep Medicine
- Rhea Cohn, PT, DPT – American Physicial Therapy Association
- William Creevy, MD – American Academy of Orthopaedic Surgeons




RUC Observers

- Trisha Crishock - American Society for Therapeutic Radiology and Oncology
- Michele Daughrity – American Osteopathic Association Fred Davis - American Academy of Pain Medicine
- Bruce Deitchman, MD – American Academy of Dermatology
- Maurine Dennis – American College of Radiology
- Octavio Duran – American Academy of Sleep Medicine
- Michael Ehrenreich – American Academy of Dermatology
- Thomas Eichler - American Society for Therapeutic Radiology and Oncology




RUC Observers

- Martha Espronceda - American Society for Gastrointestinal Endoscopy
- Terry Fife, MD – American Academy of Neurology
- Taylor Frawley – American Academy of Sleep Medicine
- Emily Gardner – American College of Nuclear Cardiology
- Richard Gilbert, MD – American Urological Association
- David Glasser, MD – American Academy of Ophthalmology
- John Goodson – American College of Physicians




RUC Observers

- Kelly Haenlein – American Academy of Dermatology
- Bob Hall - American Association of Hip and Knee Surgeons
- David Han – Society for Vascular Surgery
- Robert Haralson, MD – American Academy of Orthopaedic Surgeons
- Kristine Harvey, MD – American Academy of Ophthalmology
- John Heiner - American Academy of Orthopaedic Surgeons
- Jenny Jackson - American Society of Plastic Surgeons
- Rebecca Kelly – American College of Cardiology
- Cathy Kerr – American Society of Echocardiography




RUC Observers

- Douglas Khoury, MD - American Society of Colon and Rectal Surgeons
- Katie Kuechenmeister - American Academy of Neurology
- Debi Lansey – American Academy of Otolaryngology – Head and Neck Surgery
- Lynne Marcus – American College of Chest Physicians
- Richard Marcus – American Academy of Sleep Medicine
- Alexander Mason, MD - American Association of Neurological Surgeons
- Kenneth McKusick, MD – Society of Nuclear Medicine




RUC Observers

- Faith McNicholas – American Academy of Dermatology
- Stephen McNutt - American Society for Therapeutic Radiology and Oncology
- Erika Miller – American College of Physicians
- Lisa Miller-Jones – American College of Surgeons
- David Nace, MD – American Psychiatric Association
- Gerald Neidzwiecki, MD – Society of Interventional Radiology
- Parag Parekh – American Academy of Ophthalmology




RUC Observers

- Priyal Patel – American College of Chest Physicians
- Julia Pillsbury, DO – American Academy of Pediatrics
- Wayne Powell – American College of Cardiology
- Debbie Ramsburg – Society of Interventional Radiology
- Michael Repka, MD – American Academy of Ophthalmology
- Paul Rudolf, MD, JD – American Geriatrics Society
- Thomas Ryan – American College of Cardiology
- Andrew Sloan, MD - American Association of Neurological Surgeons




RUC Observers

- James Startzell – American Association of Oral and Maxillofacial Surgeons
- Stan Stead, MD – American Society of Anesthesiologists
- Timothy Tillo – American Podiatric Medical Association
- Edward Vates, MD - American Association of Neurological Surgeons
- Joanne Willer – American Academy of Orthopaedic Surgery
- Kadyn Williams – American Academy of Audiology
- Karin Wittich - American Association of Oral and Maxillofacial Surgeons




Au Revoir

- John Derr, MD – American Society of Plastic Surgeons
- Meghan Gerety, MD – American Geriatrics Society
- Bernard Pfeifer, MD – American Academy of Orthopaedic Surgeons
- Richard Tuck, MD – American Academy of Pediatrics

Physician Practice Information Survey

RUC Meeting – April 23, 2008

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Survey Re-launch

- **Dmr**kynetec mailed survey packets in three waves from late January through late March.
- All sample for each specialty (1,000 per specialty) was released.
- More than 50,000 physicians received the survey packet.
- 100 interviewers began calling the first wave on January 31. All physicians should have received at least one phone call. Some physicians have received as many as 15 calls.




Expectations

- 1,000 new completes by April 30.
- 3,000 completed surveys by August 31
- 4,000 completed surveys by October 31
- 100 useable completes per specialty (5,000 overall) by December 31, 2008
- PE/Hour computations to be delivered to CMS by March 31, 2009.




Responses to Date

- 618 useable completes from 2007 Gallup effort. Dmrkynetec continues to work to improve the number of useable Gallup surveys by re-contacting physicians.
- 1,117 Dmrkynetec New Completes
- Total of 1,735 Completed Surveys
- Project is 30% Complete




Groups with 40% Complete +

- Podiatry 95%
- Clinical Social Work 68%
- Optometry 63%
- Osteopathic Manipulative Therapy 62%
- Colon and Rectal Surgery 59%
- Allergy and Immunology 51%




Groups with 40% Complete +

- Oral Surgery (Dentist only) 50%
- Audiologist 48%
- Chiropractor 48%
- Vascular Surgery 42%
- Rheumatology 41%
- Pediatrics 40%




Need to Increase Communication Efforts for These Specialties

• Gastroenterology	19%
• Endocrinology	18%
• Pain Medicine	18%
• Spine Surgery	18%
• Nuclear Medicine	17%
• Otolaryngology	14%
• Medical Oncology	12%
• Cardiology	9%

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Communication

- The AMA has organized e-mail announcements from Professional Association of Health Care Office Management (PAHCOM), Medical Group Management Association (MGMA), Practice Management Center (PMC)
- AMA organized uniform announcement used by each of these groups and the participating specialty societies




Communication

- January 21 edition of *Advocacy Update*
- January 22 edition of *Federation News*
- January 28-31, 5 day run in *Morning Rounds*
- January 28 - AMA Website - Headline Story
- March/April *AMA Voice* Article
- March 20 *eVoice*
- April 1 *Federation Newsletter*




Communication

- Specialty societies have been cooperative: websites, e-mails, newsletters, membership lists, etc.
- Need to ramp up communication again. We encourage broadcast e-mails and will distribute a new message to send out.
- Dmrkynetec just sent 30,000 e-mails and faxes this week.
- AMA will be providing 40,000 postcards for Dmrkynetec to send to the sample.



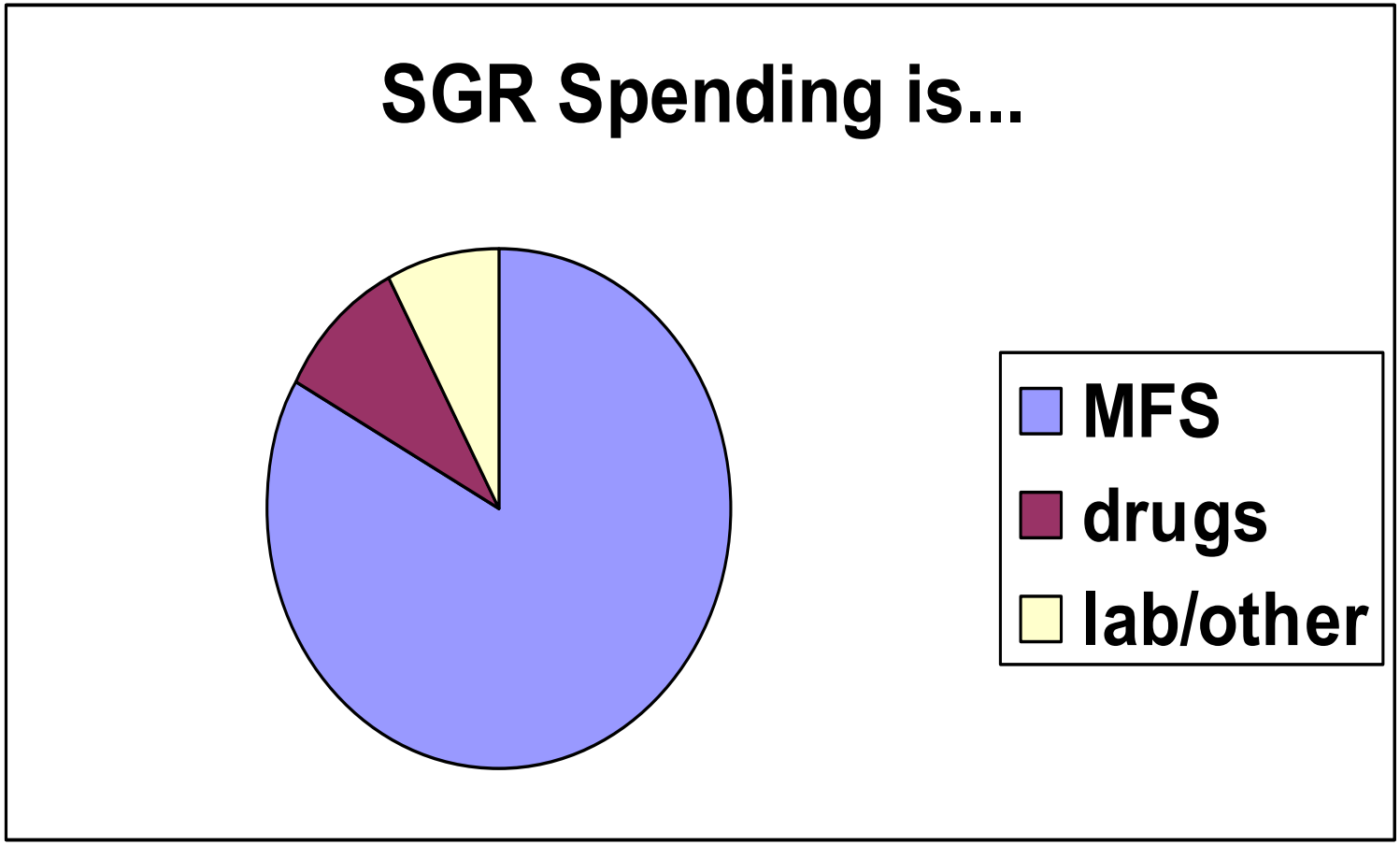

Reporting Results

- Progress reports will be shared on a weekly basis with all specialty societies – beginning May 1st.
- Survey firm projects that major data collection will be completed by August 31
- 4th quarter of 2008 will then be utilized to re-contact physicians with missing responses and to focus on specialties that do not meet the precision criteria.

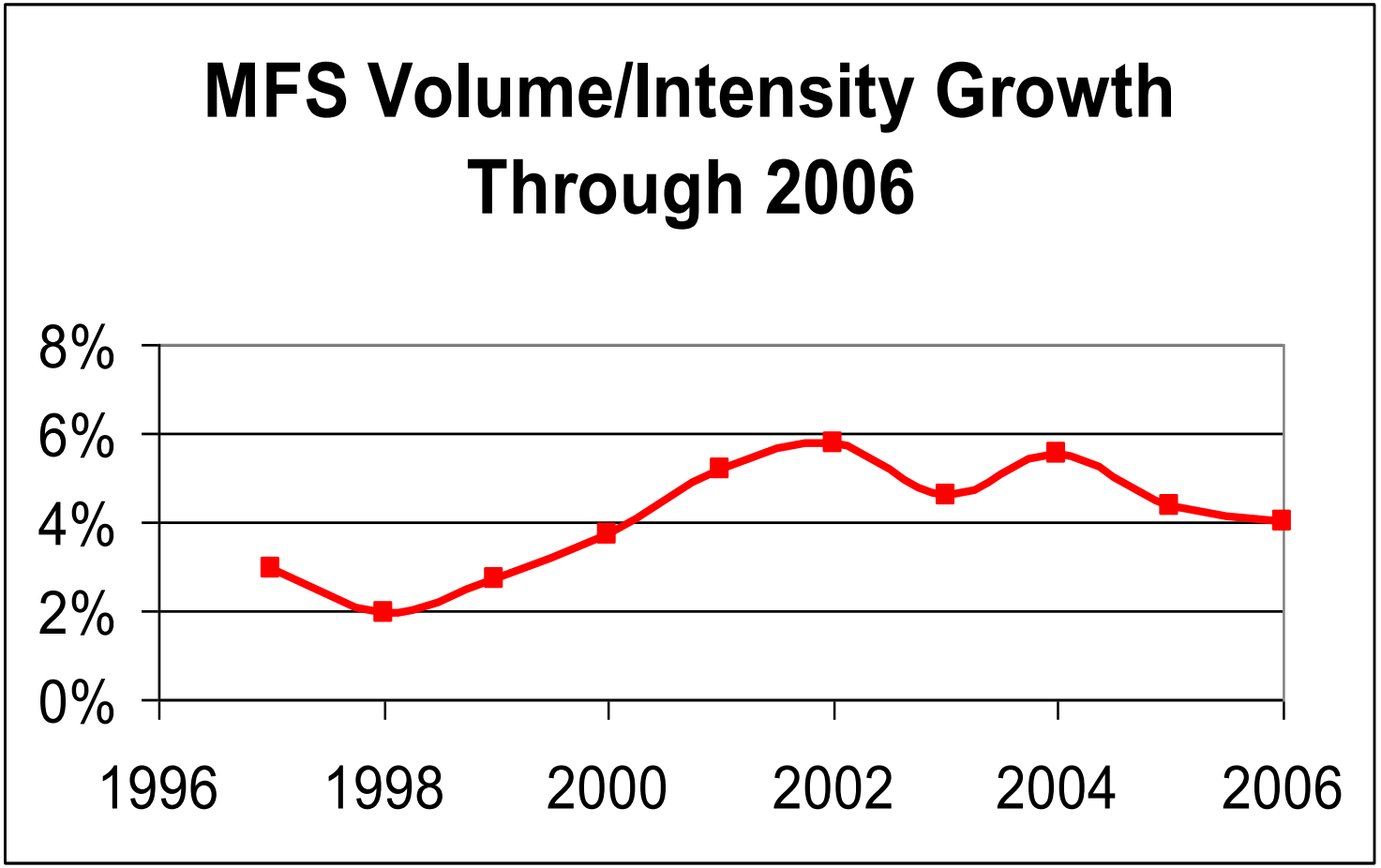
SGR Spending Growth for 2007

Estimates based on claims processed through Dec 31, 2007

Background



Background


MFS Volume/Intensity Growth Through 2006
8%
6%
4%
2%
0%
1996
1998
2000
2002
2004
2006

Background

- V/i growth has been below average for:
  - E&M
  - Major Procedures
  - Anesthesia
- V/i growth has been above average for
  - Advanced Imaging
  - Tests
  - Minor Procedures
  - Drugs

Results for 2007

- First ever decline in SGR spending is likely (-0.6% estimated)

- Decline was due to:
  - Drop in FFS enrollment (-2.5%)
  - Drop in MFS pay (-1%)
  - Low v/i growth for MFS and drugs

Results for 2007

- Some things stayed the same...

- Continued low v/i growth for:
  - E&M
  - Major Procedures
  - Anesthesia

Results for 2007

- Some things changed...

- v/i growth declined for:
  - Advanced imaging
  - Echography
  - Cardiovascular procedures
  - Drugs

Results for 2007

- Within Imaging, v/i growth declined for:
  - Nuclear medicine
  - CAT: Other
  - MRI: Brain
  - Heart echo
  - Other categories too

Other Notable Results for 2007

- v/i for Critical Care keeps growing
- Large reductions in v/i for many major procedures
- Increase in v/i growth for minor procedures (physical therapy rebounds)
- Utilization of Darbepoetin and Epoetin was down sharply (-18% per enrollee)

Key Results

- v/i growth for MFS services was just 3% overall for 2007 – the lowest since 1999
- v/i growth for imaging is down sharply
- No growth in drug utilization

- Will these changes continue for 2008?

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April 29, 2008

Kerry N. Weems
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Resources
Hubert H. Humphrey Building
200 Independence Ave., S.W.
Washington, DC 20201

Dear Mr. Weems,

On behalf of the American Medical Association/Specialty Society RVS Update Committee (RUC), I am pleased to submit work relative value recommendations and direct practice expense inputs specifically for the Medicare Medical Home Demonstration project to the Centers for Medicare and Medicaid Services (CMS).

The RUC's recommendations are enclosed, along with several supporting documents regarding patient eligibility and physician panel size which served as the basis for the physician work and clinical staff time determinations. The attachments also include two price quotes regarding an electronic medical records system for use in the development of medical equipment inputs for the Tier 3 medical home. In addition to the recommended work relative values and direct practice expense inputs, the RUC is submitting its recommended language for the HCPCS G Code descriptors to be used for reporting the three tiers of medical homes. It is the opinion of the RUC that these recommendations are reasonable in light of the information provided by the Agency and its contractor, Mathematica Policy Research.

At the outset of this request, the RUC engaged in an effort to acquire data from CMS regarding the specific eligibility criteria for Medicare beneficiaries who would be eligible to participate in this demonstration project. Initially, the RUC was given a range of 65-86% of all Medicare beneficiaries. Data regarding the average number of Medicare beneficiaries in a typical primary care physician's practice was not readily available. While this made the process of developing recommendations somewhat more challenging, the RUC was able to use several sources to extrapolate an estimate of 250 enrolled patients per primary care physician within this demonstration. The RUC's recommendations are based on these assumptions. These recommendations may be different in the event that CMS changes the eligibility criteria for the demonstration project or the requirements of a medical home.

In addition to changes in eligibility, medical home care coordination, and/or practice capabilities, changes in the actual participation by Medicare beneficiaries or significant differences in practice costs may have an impact on the recommended valuation of these

services. To address these concerns, the RUC recommends that CMS actively monitor the practice inputs of the medical home demonstration on an ongoing basis to verify the recommendations of the RUC. The RUC also recommends that CMS monitor the number of participating Medicare beneficiaries per physician.

Any significant deviation from the RUC's estimated panel size of 250 enrolled beneficiaries per physician may impact the valuation of the medical home services. With this in mind, the RUC also encourages the Agency to track data that may be used by the RUC or CMS in potential future valuation of medical home services, including but not limited to actual staff type, clinical staff time, physician staff time, medical equipment, and medical supplies. The RUC encourages CMS to utilize the RUC Medical Home Workgroup to provide assistance in the development of an evaluation design.

The RUC strongly encourages the Agency to collect clinical as well as fiscal endpoints to measure the success of this demonstration project. As discussed at the onset of this project, CMS has made it clear that success will be at least partly determined by the cost savings generated. With a large panel size as CMS has proposed, the distribution of patients is likely to be bi-modal based on severity of patient illness. For those that are "sicker," cost savings may well be the primary indicator for success. However, in the larger, "less sick" distribution of patients, the cost savings may not be immediately apparent in a three-year demonstration project. These two populations have markedly different needs; while they each will benefit within a medical home, the outcomes and specific benefits may be vastly different. The RUC requests that CMS consider expanding metrics for success to include increases in preventative services such as number of mammograms, colorectal cancer screening, hemoglobin A1C, and others. Similar to any research project or a clinical trial, it is imperative that CMS define success criteria and clarify primary and secondary endpoints before the demonstration begins.

The RUC appreciates the opportunity to participate in the development of these recommendations and looks forward to a successful demonstration project.

Sincerely,

William L. Rich, III, MD, FACS

Cc: Tim Love
James Coan
Jeff Rich, MD
Edith Hambrick, MD
Ken Simon, MD
Whitney May
RUC Participants

AMA/Specialty Society RVS Update Committee
Medicare Medical Home Demonstration Project
April 25, 2008

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Introduction

The RUC Medical Home Workgroup was established at the February 2008 RUC Meeting following a request from the Centers for Medicare and Medicaid Services (CMS) based on a legislative mandate resulting from the Tax Relief and Health Care Act of 2006 (TRHCA). Section 204 of the TRHCA directs CMS to conduct a three-year demonstration project of the medical home concept of patient care. This demonstration is to occur in rural, urban, and underserved areas in up to eight states. The legislation describes the medical home as large or small medical practices where a physician provides comprehensive and coordinated patient centered medical care and acts as the "personal physician" to the patient. Based on this directive, CMS designed a three-tiered system of the medical homes based on the capabilities of the physician office serving as medical home. The differentiation of the tiers is based on capabilities of the physician office as determined by CMS and not based on the severity of patient illness. Further, the TRHCA specifically instructs CMS to set a care management fee using the RUC process. Therefore, CMS asked the RUC to recommend a valuation of a management fee by May 1, 2008. The TRHCA also mandates that this demonstration project be "cost neutral," in the sense that the costs of this project are to be offset by the overall savings it generates. This definition of "cost neutrality" is dissimilar to the ordinary meaning of budget neutrality within the payment policy lexicon. Rather, the cost neutrality of the demonstration project will not affect the payment or valuation of any service in the Medicare physician payment schedule and will result in no adjustment to conversion factor.

The Workgroup was charged with the task of researching and facilitating work relative value recommendations and direct practice expense recommendations for services defined in the Medicare Medical Home demonstration project to the RUC at the April 2008 RUC meeting. Given the brief time in which to develop a recommendation, the Workgroup began immediately by initiating an electronic discussion among its members and facilitating conference call meetings on a weekly basis. The Workgroup met 11 times between February 12 and April 21 by conference call. The Workgroup also met face-to-face on Wednesday April 23 immediately preceding the April 2008 RUC Meeting. Based on these discussions, the Workgroup developed the following recommendations for descriptors, physician work, direct practice expense inputs, and professional liability insurance crosswalks for the Medical Home demonstration project. To the extent practicable, the Workgroup utilized the standard RUC processes. However,

based on the information regarding eligibility of beneficiaries and practice requirements, some assumptions were made.

G-Code Descriptors

The Workgroup first worked to develop G code descriptors for each of the three tiers of the Medical Home based on the minimum requirements for inclusions within each tier as provided by Mathematica. Initially, CMS indicated an interest in developing two levels of coding and payment within each of the three tiers based on the complexity and/or number of chronic conditions of eligible beneficiaries. The Workgroup determined that any distinction between complexity of patients and the ability of a practice to designate a beneficiary into one of the categories would be arbitrary. The number of chronic conditions is not a strong indicator for complexity or difficulty of coordinating care. A patient with one chronic condition may require greater intensity of coordination than a patient with several chronic conditions. Therefore, the Workgroup decided, and Medicare representatives agreed, that a single code per tier describing the work for the typical patient would be most appropriate.

To develop the G codes, the Workgroup turned to the Mathematica proposals for the description of a Tier 3 (the most comprehensive) medical home. After reviewing the list of criteria for a Tier 3 medical home, the Workgroup transposed the requirements into a description of the service provided on a monthly basis. The Workgroup repeated this process for each of the tiers. As CMS made changes to the requirements of each tier of the medical home, the Workgroup appropriately revised the G code descriptors. The proposed descriptors represent the most up-to-date CMS-required components for each tier of the medical home. A Tier 1 Medical Home (entry level) requires ten of the designated core capabilities. A Tier 2 Medical Home (typical) requires sixteen of the designated core capabilities. A Tier 3 Medical Home (optimal) requires eighteen of the designated requirements and three of an additional ten requirements. (See "Table 2. Proposed Method for Tiering Medical Home Qualification"). The CMS demonstration is likely to use a modified version of the NCQA Physician Practice Connection - Patient-Centered Medical Home instrument to determine practice eligibility and tier assignment. **The RUC recommends the attached G Code descriptors for the Tier 1, Tier 2 and Tier 3 Medical Home to CMS for the Medicare Medical Home demonstration project.**

The RUC understands that eligible physicians will be designated into a tier level based on CMS recognition of their office capabilities. These capabilities will be monitored by CMS. Practices may and are encouraged to qualify for a higher tier level during the demonstration, but only upon approval by CMS.

Average Panel Size

The Workgroup next addressed the issue of average panel size per primary care physician in order to assist in the development of work and direct practice expense input recommendations. The Workgroup looked to several sources to define total panel size for a primary care physician, Medicare beneficiary portion of that panel, and the portion

of Medicare beneficiaries that would be eligible for the participation in the demonstration project.

- Mathematica provided the Workgroup with a rough estimate of the number of Medicare beneficiaries per primary care physician. They obtained these estimates using 2004-2006 Medicare claims data and the 2000-2002 Community Tracking Study Physician Survey. Mathematica indicated that there are roughly 257 unique Medicare beneficiaries seen by a typical individual primary care physician (family practice, general internal medicine, or general practice) in one year. Mathematica went on to state that a physician typically will not see all patients within a panel in any given twelve months, resulting in a potentially larger total Medicare panel size. They estimate this to be as much as 30% higher, bringing total Medicare panel size 335. CMS has indicated that it will rely on beneficiary eligibility criteria for the demonstration project that will expand inclusion to 86% of all beneficiaries based on the Hwang criteria. Based on this assumption, the panel size of eligible beneficiaries per primary care physician will be between 221 and 284. Based on all Mathematica assumptions and CMS-stated patient eligibility criteria, a panel size of 250 is a reasonable estimate.
- Staff requested information from the Medical Group Management Association (MGMA) on average total panel size per primary care physician. The MGMA does not benchmark "panel size," primarily because there are many variables that can skew these figures. However, the organization does track one related metric from the "Cost Survey Report" – that of "Patients per Physician," from the data table titled: "Staffing, RVUs, Patients, Procedures and Square Footage." That table reports data for unique patients seen in the previous year. Based on this the "Cost Survey for Single-specialty Practices: 2007 Report Based on 2006 Data," for Family Practice, the average number of patients per FTE physician is 2,362. U.S. Census data indicate that 12% of the population are 65 years of age or older. The number of family medicine patients would therefore be approximately 283. If 86% were eligible for the demonstration (per CMS current criteria), 245 patients per family physician would be eligible. The review of MGMA data, census data, and CMS assumptions again concludes that 250 is a reasonable estimate for eligible patients per physician.
- Lastly, the Workgroup looked to current "medical homes" as a source of information on total panel size and Medicare panel size. Specifically, the Geisinger Health System, very generously shared a wealth of its data with the Workgroup. In January 2007, Geisinger implemented an intensive medical home project in two practice sites. The description of this project resembles a Tier 3 Medical Home. In these two initial sites, the Geisinger representatives indicated that there were 250 Medicare "medical home" patients per physician.

Reviewing all available data and assumptions, the RUC developed recommendations assuming that each physician may have approximately 250 Medicare patients who will be eligible and who will agree to participate in the practice's medical home.

Physician Work

Tier 3 Medical Home

The Workgroup estimates that for the "very sick" patients, the physician will typically spend 15 minutes per patient per month. This estimate is based on two other estimates. One is that the physician will spend approximately 12.5 minutes per patient per month in interaction with the case manager and the rest of the clinical staff team; this estimate is derived from the PACE data previously discussed by the Workgroup.

The 12.5 minutes includes the following coordination of care activities described by Total Longterm Care, a PACE program provider in Denver, CO:

- Intake and Assessment: This occurs twice weekly. 1-2 new participants and 15 reassessments are reviewed at each meeting. (Complete reassessments are done every six months). Each meeting lasts about 2.5 hours.
- Morning meeting: this occurs every morning. About 10-15 patients are discussed. Issues for the day are reviewed, including interim progress reports and care planning and follow-up. Duration about 45 minutes daily.
- Nursing home review meeting. This occurs weekly. The program uses nursing homes (and sends in its own staff to augment the NH services) for short term "medical respite" as an alternative to avoid or shorten hospital stays. The meeting lasts about 30-60 minutes, during which the progress and transition plans for about 10 patients are reviewed and developed.
- End-of-life nurse meeting. The physician meets weekly for about thirty minutes with a nurse whose focus is end-of-life care. This typically involves perhaps 4 patients.
- Ad-hoc family meetings occur irregularly, typically involve multiple staff members including the physician, and generally last more than 30 minutes.

The remaining 2.5 minutes per patient per month is estimated to be the time the physician will spend in other medical home responsibilities not included within the PACE program, such as review of registry information, or other daily interactions with the health care team.

For the blend of other "sick" patients, it is estimated that the physician will spend only 10 minutes per patient per month. This recognizes that these patients will require less physician interaction with the case manager and other members of the clinical staff team and is similar to the reduction in clinical staff time associated with "sick" and "very sick" patients (discussed within practice expense section).

The Workgroup also assumed, based on data from the Wolff study[i] (see page 9-10 for discussion), that the typical patient in the demonstration project will have seven evaluation and management (E/M) visits per year. The Workgroup concluded that 2.8 of these visits will be at the level of 99214 and 4.2 will be at the level of 99213. This assumption is based on the 2007 Medicare utilization data that show a total utilization of

99213 and 99214 with a relationship between them of roughly 1.5 : 1. Extrapolated to the seven E/M visits, this correlates to 4.2 : 2.8. Finally, half of the post-service physician time associated with each of these visits will otherwise duplicate the physician time related to the proposed care management code and, thus, should be deducted from the physician time per patient per month otherwise attributable to the proposed codes. The post-service physician time for 99214 is 10 minutes, and for 99213, it is 5 minutes.

2007 Medicare Utilization Data			
Code	**Family Medicine**	**Internal Medicine**	**Total**
99213	21,382,656	26,581,566	103,587,751
99214	13,467,111	18,564,247	65,129,891

The physician time per patient per month before accounting for the overlap with existing E/M services is 11.25 minutes, which is calculated as a weighted average of the time spent with each patient cohort as follows: (15 minutes x 0.25) + (10 minutes x 0.75) = 11.25 minutes. The overlap with existing E/M services is calculated as 2.1 minutes per patient per month as follows: ((10 minutes x 2.8 99214 visits) + (5 minutes x 4.2 99213 visits)) / 2 = 24.5 minutes per patient per year; 24.5 minutes / 12 months = 2.04 minutes per patient per month. The unduplicated physician time per patient per month is calculated as follows: 11.25 minutes – 2.04 minutes = 9.21 minutes per patient per month.

The RUC recommends an intra-service time per patient per month of 9.2 minutes for a Tier 3 Medical Home.

The Workgroup used a modified building block methodology to develop a recommendation for physician work. Relying on the same ration of 99213 to 99214 visits for this population of patients, the Workgroup agreed that a similar intensity of medical home services was appropriate. The Workgroup instead used a total intensity of the time by calculating the total work per unit of total time. For 99213, the total work per unit of time is equal to 0.92 work RVUs divided by 23 total minutes, resulting in 0.040 work RVUs per minute. For 99214, the total work per unit of time is equal to 1.42 work RVUs divided by 40 total minutes, resulting in 0.0355 work RVUs per minute. The Workgroup then applied the same 4.2 : 2.8 ratio it used to develop physician time overlap from associated E/M work. Thus, 0.040 was multiplied by 4.2 and 0.0355 was multiplied by 2.8 and the sum was divided by 7. This resulted in a weighted work RVU per minute of 0.0382. The Workgroup then multiplied 0.0382 by 9.2 minutes to come to a work RVU recommendation of 0.35144.

The Workgroup noted that 99339, *Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home; 15-29 minutes*, with a work RVU of 1.25 is an appropriate reference service, comparing the 40 minutes of total time with the 9.2 minutes of time in the Tier 3 Medical Home, resulting in a comparable work RVU of .31.

The RUC recommends a work RVU per patient per month of 0.35 for a Tier 3 Medical Home.

Tier 2 Medical Home

The Workgroup estimates that for the "very sick" patients, the physician will spend 12.5 minutes per patient per month. This estimate assumes that, at lower tiers, the physician will spend less time per patient per month consistent with the decreased capability of the practice as a medical home. This estimate is also consistent with assumptions made with respect to clinical staff time (i.e., staff will spend less time per patient per month at lower tiers of the medical home).

For the blend of other "sick" patients, it is estimated that the physician will spend only 9 minutes per patient per month. This recognizes that these patients will require less physician interaction with the case manager and other members of the clinical staff team and is similar to the reduction in clinical staff time associated with "sick" and "very sick" patients (discussed within practice expense section).

The Workgroup also assumed, based on data from the Wolff study[i] (see page 9-10 for discussion), that the typical patient in the demonstration project will have seven evaluation and management (E/M) visits per year. The Workgroup concluded that 2.8 of these visits will be at the level of 99214 and 4.2 will be at the level of 99213. This assumption is based on the 2007 Medicare utilization data that show a total utilization of 99213 and 99214 with a relationship between them of roughly 1.5 : 1. Extrapolated to the seven E/M visits, this correlates to 4.2 : 2.8. Finally, half of the post-service physician time associated with each of these visits will otherwise duplicate the physician time related to the proposed care management code and, thus, should be deducted from the physician time per patient per month otherwise attributable to the proposed codes. The post-service physician time for 99214 is 10 minutes, and for 99213, it is 5 minutes.

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The physician time per patient per month before accounting for the overlap with existing E/M services is 9.875 minutes, which is calculated as a weighted average of the time spent with each patient cohort as follows: (12.5 minutes x 0.25) + (9 minutes x 0.75) = 9.875 minutes. The overlap with existing E/M services is calculated as 2.1 minutes per patient per month as follows: ((10 minutes x 2.8 99214 visits) + (5 minutes x 4.2 99213 visits)) / 2 = 24.5 minutes per patient per year; 24.5 minutes / 12 months = 2.04 minutes per patient per month. The unduplicated physician time per patient per month is calculated as follows: 9.875 minutes – 2.04 minutes = 7.835 minutes per patient per month.

The RUC recommends an intra-service time per patient per month of 7.8 minutes for a Tier 2 Medical Home.

The Workgroup used a modified building block methodology to develop a recommendation for physician work. Relying on the same ration of 99213 to 99214 visits for this population of patients, the Workgroup agreed that a similar intensity of medical home services was appropriate. The Workgroup instead used a total intensity of the time by calculating the total work per unit of total time. For 99213, the total work per unit of time is equal to 0.92 work RVUs divided by 23 total minutes, resulting in 0.040 work RVUs per minute. For 99214, the total work per unit of time is equal to 1.42 work RVUs divided by 40 total minutes, resulting in 0.0355 work RVUs per minute. The Workgroup then applied the same 4.2 : 2.8 ratio it used to develop physician time overlap from associated E/M work. Thus, 0.040 was multiplied by 4.2 and 0.0355 was multiplied by 2.8 and the sum was divided by 7. This resulted in a weighted work RVU per minute of 0.0382. The Workgroup then multiplied 0.0382 by 7.8 minutes to come to a work RVU recommendation of 0.29796.

The Workgroup noted that 99339, *Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home; 15-29 minutes*, with a work RVU of 1.25 is an appropriate reference service, comparing the 40 minutes of total time with the 7.8 minutes of time in the Tier 2 Medical Home, resulting in a comparable work RVU of .31.

The RUC recommends a work RVU per patient per month of 0.30 for a Tier 2 Medical Home.

Tier 1 Medical Home

The Workgroup estimates that for the "very sick" patients, the physician will spend 10 minutes per patient per month. This estimate again assumes that, at lower tiers, the physician will spend less time per patient per month consistent with the decreased capability of the practice as a medical home. This estimate is also consistent with assumptions made with respect to clinical staff time (i.e., staff will spend less time per patient per month at lower tiers of the medical home).

For the blend of other "sick" patients, it is estimated that the physician will spend only 8 minutes per patient per month. This recognizes that these patients will require less physician interaction with the case manager and other members of the clinical staff team and is similar to the reduction in clinical staff time associated with "sick" and "very sick" patients (discussed within practice expense section).

The Workgroup also assumed, based on data from the Wolff study[i] (see page 9-10 for discussion), that the typical patient in the demonstration project will have seven evaluation and management (E/M) visits per year. The Workgroup concluded that 2.8 of these visits will be at the level of 99214 and 4.2 will be at the level of 99213. This assumption is based on the 2007 Medicare utilization data that show a total utilization of 99213 and 99214 with a relationship between them of roughly 1.5 : 1. Extrapolated to the seven E/M visits, this correlates to 4.2 : 2.8. Finally, half of the post-service physician time associated with each of these visits will otherwise duplicate the physician time related to the proposed care management code and, thus, should be deducted from

the physician time per patient per month otherwise attributable to the proposed codes. The post-service physician time for 99214 is 10 minutes, and for 99213, it is 5 minutes.

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Code	**Family Medicine**	**Internal Medicine**	**Total**
99213	21,382,656	26,581,566	103,587,751
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The physician time per patient per month before accounting for the overlap with existing E/M services is minutes, which is calculated as a weighted average of the time spent with each patient cohort as follows: (10 minutes x 0.25) + (8 minutes x 0.75) = 8.5 minutes. The overlap with existing E/M services is calculated as 2.1 minutes per patient per month as follows: ((10 minutes x 2.8 99214 visits) + (5 minutes x 4.2 99213 visits)) / 2 = 24.5 minutes per patient per year; 24.5 minutes / 12 months = 2.04 minutes per patient per month. The unduplicated physician time per patient per month is calculated as follows: 8.5 minutes – 2.04 minutes = 6.46 minutes per patient per month.

The RUC recommends an intra-service time per patient per month of 6.5 minutes for a Tier 1 Medical Home.

The Workgroup used a modified building block methodology to develop a recommendation for physician work. Relying on the same ratio of 99213 to 99214 visits for this population of patients, the Workgroup agreed that a similar intensity of medical home services was appropriate. The Workgroup instead used a total intensity of the time by calculating the total work per unit of total time. For 99213, the total work per unit of time is equal to 0.92 work RVUs divided by 23 total minutes, resulting in 0.040 work RVUs per minute. For 99214, the total work per unit of time is equal to 1.42 work RVUs divided by 40 total minutes, resulting in 0.0355 work RVUs per minute. The Workgroup then applied the same 4.2 : 2.8 ratio it used to develop physician time overlap from associated E/M work. Thus, 0.040 was multiplied by 4.2 and 0.0355 was multiplied by 2.8 and the sum was divided by 7. This resulted in a weighted work RVU per minute of 0.0382. The Workgroup then multiplied 0.0382 by 6.5 minutes to come to a work RVU recommendation of 0.2483.

It was noted that the work RVU for 99441, *Telephone evaluation and management service provided by a physician; 5-10 minutes*, is 0.25, which appeared to the Workgroup to be an appropriate floor for the medical home physician work.

The RUC recommends a work RVU per patient per month of 0.25 for a Tier 1 Medical Home.

Summary

In sum, the following times and work RVUs are proposed for each tier:

Tier	Physician Time	Work RVUs
1	6.5 minutes	0.25
2	7.8 minutes	0.30
3	9.2 minutes	0.35

Direct Practice Expense Inputs

Clinical Staff Type

Based on the G-Code descriptors, the workgroup agreed that the minimum competency for clinical staff should be no less than a registered nurse or licensed practical nurse and recommends using the blended Medicare clinical staff type of registered nurse/licensed practical nurse (RN/LPN). The clinical staff type is consistent across all tiers and the blended staff type is recommended in each of the three medical home tiers. Although Geinsinger reported that only RNs would be hired, the Workgroup understood that many practiced may not be able to hire RNs. Concurrently, the Workgroup recognized that in some states, medical assistants (MAs) may not be licensed to perform many of the activities inherent in the medical home service. As such, the Workgroup agreed that a RN/LPN blend is appropriate. **The RUC recommend to CMS that it use a clinical staff type of RN/LPN for the practice expense inputs for the Tier 1, Tier 2 and Tier 3 Medical Homes.**

Clinical Staff Time

The Workgroup arrived at a typical amount of staff time by employing both top-down and bottom-up approaches. After an extensive review of medical home and care management literature and discussions with practitioners in the medical home clinical settings, the Workgroup found that the mode for caseload per nurse in a Tier 3 setting is 125, Tier 2 setting is 150, and Tier 1 setting is 200.

The workgroup next arrived at a similar number by dividing patient complexity into two groups, "sick" and "sicker." Rather than split the medical home G codes into two categories as originally recommended, the workgroup noted that patients will move in and out of the two groups regularly and to assign an individual patient to a group is not realistic. However, risk-adjusting the groups under the assumption that at any given time only 25% of an eligible patient mix require extensive care management ("sicker") and the remaining 75% require less extensive care management ("sick") is a more accurate and efficient way to allot clinical staff time. Further, the workgroup assumed that the typical medical home patient in all three tiers will have 7 evaluation and management (E/M) visits per year, based on the Wolff study[i] and the Partnership for Solutions report[ii], which relies on the Agency for Healthcare Research and Quality (AHRQ) Medical Expenditure Panel Survey of 2001 summarized below:

Number of Conditions	E/M Visits per Year	% of Medicare population	Visits x Medicare %	Weighted Average
Medicare Pts. with 1 condition	3.5	0.173	0.210976	0.738415
Medicare Pts. with 2 conditions	5.7	0.218	0.265854	1.515366
Medicare Pts. with 3 conditions	7.9	0.188	0.229268	1.81122
Medicare Pts. with 4 or more conditions	9.4	0.241	0.293902	2.762683
Average # of Medicare Visits		0.82		**6.827683**

The workgroup then reduced the clinical staff time by 3 minutes per patient in each of the three tiers to account for overlap of one phone call per month due to the E/M services provided. Each E/M (7 annually) requires 2 nurse follow-up phone calls per the implemented practice expense input data, leading to approximately 14 calls per year. The Workgroup agreed that these phone calls should not be duplicated and removed one from each month. (14/12 = approximately 1 call or 3 minutes per month.) The clinical staff time based on this methodology for each of the three tiers is included in the attached spreadsheet.

	Pts per RN/LPN	**Time spent per Bene min/mo**	**Sum min/month**
Tier 3			
Sick Patients (75%)	94	60	5625
Very Sick Pts (25%)	31	236	4775
	125	83	10400
Remove 3 minute call		**80**	
Tier 2			
Sick Patients (75%)	112.5	40	4500
Very Sick Pts (25%)	37.5	157	5900
	150	69	10400
Remove 3 minute call		**66**	
Tier 1			
Sick Patients (75%)	150	30	4500
Very Sick Pts (25%)	50	118	5900
	200	52	10400
Remove 3 minute call		**49**	

The RUC recommend to CMS that it use clinical staff time of 80 minutes per patient per month for a Tier 3 medical home, 66 minutes per patient per month for a Tier 2

medical home, and 49 minutes per patient per month for a Tier 1 medical home. The RUC acknowledges that these recommendations are estimates based on information that was available to the Workgroup regarding patient eligibility and nurse case manager caseload. These data may be highly variable by practice. The RUC strongly urges CMS to monitor the actual resource costs during the demonstration project. At a minimum, the RUC recommends that CMS survey participating practices regarding their nurse case manager caseload.

Medical Supplies

Over the course of a complete year, the workgroup agreed that the typical medical home patient will receive three patient education brochures. Divided over twelve months, the total number of booklets per month is 0.25. **The RUC recommend to CMS 0.25 of a patient education booklet as a practice expense input for the Tier 1, Tier 2 and Tier 3 Medical Homes.**

Medical Equipment

The legislation mandating the Medical Home Demonstration Project calls for use of an electronic medical records system. The Tier 3 medical home G-Code includes implementation and use of an EMR system and the workgroup discussed at length the type and capabilities of such a system. Based on these discussions, review of literature, and preliminary findings of the ongoing physician practice information survey, and a detailed invoice, the workgroup has developed a recommendation for the necessary elements of an appropriate EMR system. The system should include the following elements, listed below. For several of these components, CMS currently maintains a pricing input. For those line items that are not included within the CMS list of equipment, a price from the attached invoice has been included.

The RUC recommend to CMS that the Tier 3 Medical Home include direct practice expense inputs for an Electronic Medical Records system consistent with the system element descriptions below.

EMR System Elements for a Tier 3 Medical Home
Software: Comprehensive electronic health record software system that includes the following:

a. Disease Management
b. Point of care evidence-based decision support
c. Electronic prescribing
d. Laboratory test result tracking
e. Automatic problem lists
f. Referral History
g. Diagnostic Imaging Storage
h. Statistical Analysis
i. Patient Registries
j. Medication lists

k. Reporting
l. Patient Education Materials
m. Workflow coordination
n. Secure Electronic Communication with patients

Hardware: Using a server model, the electronic health record would require:

a. One server
b. One desktop computer with monitor
c. Router
d. Firewall
e. Cable/DSL Modem

Other practice expenses related to the electronic health record include:

a. Maintenance/service contract for hardware, software, internal network, and Internet connections (i.e., system support)
b. Training services
c. Data backup and recovery services
d. Interfaces to practice management system, laboratory, etc.
e. Data conversion/migration from existing systems
f. Licensing of commercial databases (e.g., First Data Bank, Multum, CPT)

EMR System Costs for a Tier 3 Medical Home

Element	CMS Code	Time[1]	Life	Price
Software; license	(new)	60 minutes RN/LPN + 4 minutes physician	3 years[2]	$7,995 (per provider)[3]
Software; updates, upgrades, and support	(new)	60 minutes RN/LPN + 4 minutes physician	3 years[2]	$3,198[3]
Computer, server	ED022	60 minutes RN/LPN + 4 minutes physician	5 years[4]	-[4]
Computer, desktop, with monitor	ED021	60 minutes RN/LPN + 4 minutes physician	5 years[4]	-[4]
System support (hardware, network, Internet connection)	(new)	60 minutes RN/LPN + 4 minutes physician	5 years[5]	$1,253[6]
Interfaces	(new)	60 minutes RN/LPN + 4 minutes physician	3 years[7]	$550[3]

Notes

1. Time is assumed equal to seventy-five percent of clinical staff time plus slightly less than half of the estimated physician time, since the EHR is an integral part of care management in the Tier 3 medical home and will be in use whenever the RN/LPN or physician is providing care management for the patient.
2. Based on IRS amortization rules for computer software (see instructions Line 16 on IRS Form 4562 online at http://www.irs.gov/pub/irs-pdf/i4562.pdf)
3. Based on proposal for e-MDs provided by the Oklahoma QIO, attached. E-MDs is one of three systems expected to be capable of meeting the needs of a Tier 3 medical home; the other two are eClinicalWorks and NextGen. An invoice for eClinicalWorks is pending.
4. See CMS equipment list
5. Corresponding to lifetime of hardware
6. Assumed to be 5% of hardware costs
7. Corresponding to lifetime of software

The RUC recommend to CMS the above line items for implementation and use of electronic medical records system within the PE inputs for the Tier 3 medical home. Invoices are attached.

The Workgroup agreed that the Tier 2 Medical Home includes a desktop computer and patient registry software. The medical home practice capabilities required by CMS cannot be implemented by a physician office without the use of a separate dedicated desktop top computer with monitor. Further, the management of a panel of medical home patients at the Tier 2 level of sophistication requires, at the least, the use of a software system to track patient status.

The RUC recommend to CMS that the Tier 2 Medical Home include one ED021 Desk top computer with monitor and patient registry software. For the registry software, the RUC agrees that this software should allow the directing of multiple disease states and allow for the creation of reports to better track patients. DocSite is an example of such a registry. The pricing information for DocSite is available at: http://www.docsite.com/help/pricing.

The Tier 1 medical home contains no medical equipment.

PLI Crosswalk

The Workgroup discussed the professional liability insurance (PLI) crosswalk methodology used by CMS noting that CMS relies on a service within the family or somewhat comparable with a similar work RVU. **The RUC recommends that a suitable service with a similar work RVU is either 92025, *Computerized corneal topography, unilateral or bilateral, with interpretation and report*, which has a work RVU of 0.35 and a PLI RVU of 0.02 or 99441, *Telephone evaluation and management service provided by a physician; 5-10 minutes*, which has a work RVU of 0.25 and a PLI RVU of 0.02.**

References

[i] Wolff, JL, Starfield, B, Anderson, G. Prevalence, Expenditures, and Complications of Multiple Chronic Conditions in the Elderly. Arch. Intern. Med. 2002; 162:2269-2276.

[ii] Agency for Healthcare Research and Quality. *Medical Expenditure Panel Survey*. 2001. Cited by Anderson G, Herbert R, Zeffiro T, and Johnson N, for the Partnership for Solutions. *Chronic Conditions: Making the case for ongoing care.* September 2004 Update. Available at: http://www.partnershipforsolutions.org/DMS/files/chronicbook2004.pdf. Accessed January 23, 2008.

Attachments

G Code Tier 1 Descriptors
G Code Tier 2 Descriptors
G Code Tier 3 Descriptors
CMS Method for Tiering Medical Home (Table 2)
Mathematica Eligibility Information
Mathematica Panel Size Information
MGMA Panel Size Information
Geisinger Report
EMR Description Tier 3
EMR Quote Tier 3
EMR Quote2 Tier 3

G Code for Medical Home Demonstration (Tier 1)

This code is to be used for Medicare Fee For Service patients enrolled in Medicare's Medical Home Demonstration Project. Appropriate E/M codes may be also submitted as they occur.

GXXXX1:

Short Description: Coordination of care across all of a patient's healthcare needs, provided in a Tier 1 medical home, per month,

Long Description: Direct physician supervision and management of the comprehensive and coordinated health care of a patient having one or more chronic conditions or prolonged illnesses as included on the CMS eligible disease list. These services are separate from and in addition to those provided as part of E/M services that may occur during the service period. Coordination of care across all of a patient's healthcare needs and responsibilities will occur whether or not an E/M service is provided and reported during the service period. Services include all of the following as necessary within a calendar month:

- Obtains mutual agreement on role of medical home between physician and patient
- Ongoing support, oversight, and guidance by a physician-led health care team
- Integrated coherent planning for ongoing medical care including communication and coordination with other physicians and healthcare professionals furnishing care
- Regular physician development and/or revision of documented care plans, including integration of new information and/or adjustment of medical therapy
- Approval and tracking of medication changes initiated by pharmacy benefit plans
- Medication reconciliation
- Reviews all medications including prescriptions, over the counter medications, and herbal therapies/supplements.
- Use of integrated care plan to plan and guide patient care.
- Review of reports of patient status from other physicians or health care professionals
- Review results of laboratory and other studies
- Seven day per week, 24-hour access to phone triage
- Communication with the patient, family, and caregivers for purposes of assessment or care decisions
- Use of health assessment to characterize patient needs and risks
- Identify age, gender and medical condition appropriate preventive medicine services.
- Organizes and trains staff in roles for coordination of care across all of a patient's healthcare needs. (including staff feedback).

The following services should not be reported in the same month as this reported service for the medical home demonstration.

Anticoagulant Management (CPT Codes 99363 and 99364)
Medical Team Conference (CPT Codes 99366-99368)
Care Plan Oversight (99339-99340, 99374-99380)
Counseling Services (99401-99420)
Telephone Services (99441-99443; 98966-98968)
On-Line Medical Evaluation (99444; 98969)
Education and Training for Patient Self-Management (98960-98962; 99078)
Review of Data/Preparation of Special Reports (99080, 99090, 99091)
Medication Therapy Management Services (99605-99607)

G Code for Medical Home Demonstration (Tier 2)

This code is to be used for Medicare Fee For Service patients enrolled in Medicare's Medical Home Demonstration Project. Appropriate E/M codes may be also submitted as they occur.

GXXXX2:

Short Description: Coordination of care across all of a patient's healthcare needs, provided in a Tier 2 medical home, per month,

Long Description: Direct physician supervision and management of the comprehensive and coordinated health care of a patient having one or more chronic conditions or prolonged illnesses as included on the CMS eligible disease list. These services are separate from and in addition to those provided as part of E/M services that may occur during the service period. Coordination of care across all of a patient's healthcare needs and responsibilities will occur whether or not an E/M service is provided and reported during the service period. Services include all of the following as necessary within a calendar month:

- Obtains mutual agreement on role of medical home between physician and patient
- Ongoing support, oversight, and guidance by a physician-led health care team
- Integrated coherent planning for ongoing medical care including communication and coordination with other physicians and healthcare professionals furnishing care
- Regular physician development and/or revision of documented care plans, including integration of new information and/or adjustment of medical therapy
- Approval and tracking of medication changes initiated by pharmacy benefit plans
- Medication reconciliation
- Reviews all medications including prescriptions, over the counter medications, and herbal therapies/supplements
- Review of reports of patient status from other physicians or health care professionals
- Review results of laboratory and other studies
- Documented use of evidence-based medicine and clinical decision support tools to facilitate diagnostic test tracking, pre-visit planning, and after-visit/test follow-up
- Seven day per week, 24-hour access to phone triage
- Communication (including telephone calls, secure web sites, etc.) with the patient, family, and caregivers for purposes of assessment or care decisions
- Use of patient self-management plan (including end-of-life planning, home monitoring)
- Patient, family, and caregiver education and support

- Use of health assessment to characterize patient needs and risks
- Monitoring, arranging, and evaluating appropriate and/or evidence informed preventive services
- Organizes and trains staff in roles for coordination of care across all of a patient's healthcare needs (including staff feedback)

The following services should not be reported in the same month as this reported service for the medical home demonstration.

Anticoagulant Management (CPT Codes 99363 and 99364)
Medical Team Conference (CPT Codes 99366-99368)
Care Plan Oversight (99339-99340, 99374-99380)
Counseling Services (99401-99420)
Telephone Services (99441-99443; 98966-98968)
On-Line Medical Evaluation (99444; 98969)
Education and Training for Patient Self-Management (98960-98962; 99078)
Review of Data/Preparation of Special Reports (99080, 99090, 99091)
Medication Therapy Management Services (99605-99607)

G Code for Medical Home Demonstration (Tier 3)

This code is to be used for Medicare Fee For Service patients enrolled in Medicare's Medical Home Demonstration Project. Appropriate E/M codes may be also submitted as they occur.

GXXXX3:

Short Description: Coordination of care across all of a patient's healthcare needs, provided in a Tier 3 medical home, per month,

Long Description: Direct physician supervision and management of the comprehensive and coordinated health care of a patient having one or more chronic conditions or prolonged illnesses as included on the CMS eligible disease list. These services are separate from and in addition to those provided as part of E/M services that may occur during the service. Coordination of care across all of a patient's healthcare needs and responsibilities will occur whether or not an E/M service is provided and reported during the service period. Services include all of the following as necessary within a calendar month:

- Obtains mutual agreement on role of medical home between physician and patient
- Ongoing support, oversight, and guidance by a physician-led health care team
- Integrated coherent planning for ongoing medical care including communication and coordination with other physicians and healthcare professionals furnishing care
- Regular physician development and/or revision of documented care plans, including integration of new information and/or adjustment of medical therapy
- Coordinates care and follow-up for patients who receive care in inpatient and outpatient facilities.
- Approval and tracking of medication changes initiated by health plans or pharmacy benefit plans
- Medication reconciliation to avoid interactions or duplications. Reviews all medications including prescriptions, over the counter medications, and herbal therapies/supplements
- Review of reports of patient status from other physicians or health care professionals
- Review results of laboratory and other studies
- Staff monitoring to ensure use of evidence-based medicine and clinical decision support tools to facilitate diagnostic test tracking, pre-visit planning, and after-visit/test follow-up
- Seven day per week, 24-hour access to phone triage
- Communication (including telephone calls, secure web sites, etc.) with the patient, family, and caregivers for purposes of assessment or care decisions

- Use of patient self-management plan (including end-of-life planning, home monitoring)
- Patient, family, and caregiver education and support
- Use of health assessment to characterize patient needs and risks
- Use of health information technologies, such as patient registries, to monitor and track patient health status or generate point of care clinical reminders
- Use of secure systems that provide for patient access to personal health information
- Use of secure electronic communication between the patient and the healthcare team
- Use of an electronic health record
- Use of an electronic prescribing system
- Measuring performance regarding clinical quality and patient experience and taking action to improve care and processes
- Monitoring, arranging, and evaluating appropriate evidence based and/or evidence informed preventive service
- Organizes and trains staff in roles for coordination of care across all of a patient's healthcare needs (including staff feedback)

The following services should not be reported in the same month as this reported service for the medical home demonstration.

Anticoagulant Management (CPT Codes 99363 and 99364)
Medical Team Conference (CPT Codes 99366-99368)
Care Plan Oversight (99339-99340, 99374-99380)
Counseling Services (99401-99420)
Telephone Services (99441-99443; 98966-98968)
On-Line Medical Evaluation (99444; 98969)
Education and Training for Patient Self-Management (98960-98962; 99078)
Review of Data/Preparation of Special Reports (99080, 99090, 99091)
Medication Therapy Management Services (99605-99607)

Table 2. Proposed Method for Tiering Medical Home Qualification 3-25-08

Tier 1: Entry Level	Tier II: Typical	Tier III: Optimal	
All 10 of the Following	All 16 of the Following Requirements (16 Core)	All 18 of the Following Requirements	Three of the 10 Additional Requirements
Continuity			
Obtains mutual agreement on role of medical home between physician and patient	Obtains mutual agreement on role of medical home between physician and patient	Obtains mutual agreement on role of medical home between physician and patient	Uses scheduling process to promote continuity with clinician
Clinical Information Systems			
Uses data to identify and track medical home patients	Uses data to identify and track medical home patients	Uses data to identify and track medical home patients via an EMR	Uses electronic prescribing tools to reduce medication errors, promote use of generics, and assist in medication management Use of secure electronic communication between the patient and the healthcare team Use of secure systems that provide for patient access to personal health information
Delivery System Redesign			
Implements processes to promote access and communication Organizes and trains staff in roles for care management (incl. staff feedback) Organizes clinical data for individual patients (problem lists, medication lists, risk factors, structured progress notes) Uses health assessment to characterize patient needs and risks Uses integrated care plan to plan and guide patient care	Implements processes to promote access and communication Measures implementation of access and communication processes Organizes and trains staff in roles for care management (incl. staff feedback) Organizes clinical data for individual patients (problem lists, medication lists, risk factors, structured progress notes) Provides pre-visit planning and after-visit follow-up for medical home patients Uses health assessment to characterize patient needs and risks Uses integrated care plan to plan and guide patient care	Implements processes to promote access and communication Measures implementation of access and communication processes Organizes and trains staff in roles for care management (incl. staff feedback) Organizes clinical data for individual patients (problem lists, medication lists, risk factors, structured progress notes) Provides pre-visit planning and after-visit follow-up for medical home patients Uses health assessment to characterize patient needs and risks Uses integrated care plan to plan and guide patient care	Measures performance on clinical quality and patient experiences Reports to physicians on performance Uses data to set goals and take action to improve performance

Tier 1: Entry Level	Tier II: Typical	Tier III: Optimal	
All 10 of the Following	All 16 of the Following Requirements (16 Core)	All 18 of the Following Requirements	Three of the 10 Additional Requirements
Decision Support			
	Adopts evidence-based clinical practice guidelines on preventive and chronic care	Adopts evidence-based clinical practice guidelines on preventive and chronic care	Uses searchable electronic data to generate lists of patients and remind patients and clinicians of services needed Implements system to generate reminders (papers based or electronic) about preventive services at the point of care Implements system to generate reminders (paper based or electronic) about chronic care needs at the point of care
Patient/Family Engagement			
	Documents patient self-management plan (including end-of-life planning, home monitoring) Provides patient education and support Encourages family involvement	Documents patient self-management plan (including end-of-life planning, home monitoring Provides patient education and support Encourages family involvement	
Coordination			
Tracks tests and provides follow-up Tracks referrals including referral plan and patient report on self referrals Reviews all medications a patient is taking including prescriptions, over the counter medications and herbal therapies/supplements	Tracks tests and provides follow-up Tracks referrals including referral plan and patient report on self referrals Reviews all medications a patient is taking including prescriptions, over the counter medications and herbal therapies/supplements	Tracks tests and provides follow-up Tracks referrals including referral plan and patient report on self referrals Reviews all medications a patient is taking including prescriptions, over the counter medications and herbal therapies/supplements Coordinates care and follow-up for patients who receive care in inpatient and outpatient facilities Uses medication reconciliation post discharge to avoid interactions or duplications	

From: Mai Pham [mailto:MPham@hschange.org]
Sent: Thursday, April 17, 2008 1:57 PM
To: Deborah Peikes; Myles Maxfield; Coan, James F. (CMS/ORDI); Sherry Smith
Subject: FW: # of benes

just fyi --
for a different project, we checked the average number of Medicare benes treated by CTS PCPs in the year 2005 with new claims data. Updated numbers are higher than in 2000. The avg is 300 (compared to 257 prior). I am cc'ing Sherry Smith at the RUC in case this update is useful in fee setting for the medical home demo.

thanks,
Mai

-----Original Message-----
From: Saiontz-Martinez, Cynthia [mailto:CMartinez@s-3.com]
Sent: Thursday, April 17, 2008 2:02 PM
To: Mai Pham
Subject: RE: # of benes

Hi Mai, this is a proc univariate of the number of bene's for the 2,284 PCPs.

HSC35.02.9081: Physicians' Peer Networks
Larger 2005 100% Physician Supplier File
Who Age 65 Years or Older as of 01/01/2005, NonESRD/Disablity
CTS PCP (w/ TAXID) - All Visits
Excluding physicians seeing GT 900 pts
Descriptive stats on number of bene's per PCP
Using CTS definition for PCP

The UNIVARIATE Procedure
Variable: BENE_CNT (Number of Benes, all visits)

Weight: PHNATLWT (PH4:CV:Weight, Natl.Est. full sample)

Weighted Moments

N	2284	Sum Weights	100898.667
Mean	300.364474	Sum Observations	30306374.9
Std Deviation	2476.88904	Variance	6134979.33
Skewness	13.6231258	Kurtosis	306.237459
Uncorrected SS	2.31091E10	Corrected SS	1.40062E10
Coeff Variation	824.627831	Std Error Mean	7.7976518

Weighted Basic Statistical Measures

Location		Variability	
Mean	300.3645	Std Deviation	2477
Median	223.0000	Variance	6134979
Mode	1.0000	Range	9498
		Interquartile Range	293.00000

Weighted Tests for Location: Mu0=0

Test	-Statistic-		-----p Value------
Student's t	t 38.51986	Pr > |t|	<.0001

Weighted Quantiles

Quantile	Estimate
100% Max	9499
99%	1290
95%	786
90%	617
75% Q3	395
50% Median	223
25% Q1	102
10%	36
5%	11
1%	1
0% Min	1

Extreme Observations

----Lowest----		----Highest---	
Value	Obs	Value	Obs
1	2150	1865	1823
1	2076	2026	619
1	2048	3099	33
1	2041	4299	698
1	2017	9499	135

Larger 2005 100% Physician Supplier File
Who Age 65 Years or Older as of 01/01/2005, NonESRD/Disablity
CTS PCP (w/ TAXID) - All Visits
Excluding physicians seeing GT 900 pts
Contents

The CONTENTS Procedure

Data Set Name	T9081.PCP_BENE_COUNT_05	Observations	2284
Member Type	DATA	Variables	5
Engine	V9	Indexes	0
Created	Wednesday, April 09, 2008 04:01:18 PM	Observation Length	33
Last Modified	Wednesday, April 09, 2008 04:01:18 PM	Deleted Observations	0
Protection		Compressed	CHAR
Data Set Type		Reuse Space	NO
Label		Point to Observations	YES
Data Representation	WINDOWS_32	Sorted	NO
Encoding	wlatin1 Western (Windows)		

Engine/Host Dependent Information

Data Set Page Size	4096
Number of Data Set Pages	24
Number of Data Set Repairs	0
File Name	\\hsc5\e_hsc5\hsc1\t9081\data\pcp_bene_count_05.sas7bdat
Release Created	9.0101M3
Host Created	XP_PRO

Alphabetic List of Variables and Attributes

#	Variable	Type	Len	Format	Informat	Label
3	BENE_CNT	Num	8			Number of Benes, all visits
4	PCP	Num	3			PH4:CV:Questionnaire def of PCP
5	PHNATLWT	Num	8			PH4:CV:Weight, Natl.Est. full sample
2	PHYSID	Num	8	BEST12.	12.	Physician ID
1	PRF_UPIN	Char	6			Carrier Line Performing UPIN Number

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MEMORANDUM

TO: Jim Coan, Project Officer

FROM: Hoangmai Pham, Deborah Peikes, Myles Maxfield

DATE: 2/21/2008
6245

SUBJECT: Prevalence estimates for medical home design

This memo responds to your request for estimates of the number of patients in a physician's panel likely to be eligible for the Medical Home Demonstration, and the number of eligible physicians. In summary, we estimate that a typical non-pediatrician primary care physician will have between 100-150 FFS Medicare patients who are eligible for the demonstration, and that approximately 102,000 primary care physicians see FFS Medicare patients in a given year. We cannot directly estimate the number of eligible physician practices, but suggest several other potential sources for these data.

A. Number of Eligible Beneficiaries Per Physician

We do not yet know which conditions CMS will include for patient eligibility criteria for the demonstration. Spike Duzer at CMS estimates that 44 percent of FFS Medicare beneficiaries have one or more of 9 conditions among those listed in the Chronic Condition Warehouse (colorectal cancer, breast cancer, chronic kidney disease, COPD, diabetes, heart failure, hip fracture, ischemic heart disease, and stroke). These beneficiaries accounted for 85% of total Medicare expenditures in 2005. We believe they were identified as eligible in 2003 and 2004, but have not confirmed that with Spike.

We examined data from the 2000-2001 Community Tracking Study Physician Survey for a representative sample of non-Federal, non-pediatrician primary care physicians who completed training and were active in patient care at least 20 hours per week, and found that they billed for encounters with an average of 257 unique FFS beneficiaries in one year. However, we expect that their total FFS Medicare panel will be larger (not all patients get seen in the same year), by as much as 30%. We thus made the following calculations based on both the (a) 257 and (b) 335 patients/PCP figures.

Applying Spike Duzer's estimate of 44% above, we estimate that the typical primary care physician will have approximately 100-150 (113-147) FFS Medicare patients eligible for the demonstration. Of course, these figures should be interpreted as lower bounds, and will shift upward with the number of chronic conditions that CMS includes in its patient eligibility criteria.

The attached table provides another indication of the prevalence rates for specific chronic conditions is the attached table, but this table does not take into account that beneficiaries often have more than one condition. We hope to have more information on prevalence of specific conditions within the next two weeks.

B. Number of Eligible Physicians

Based on the 2004-2005 Community Tracking Study Physician Survey, we estimate that there are 113,013 primary care physicians in the U.S., of whom approximately 90% see at least one FFS Medicare patient in a given year, implying that roughly 101,700 primary care physicians may be eligible for the demonstration.

Estimates of the number of physicians in particular primary care specialties follow. We suggest that the RUC ask specialty societies for estimates of the number of physicians in non-primary care specialties who participate in Medicare.

Specialty	Total number of physicians	Number of physicians with Medicare patients
General internal medicine	45,427	40,884
General practice	4,646	4,181
Family practice	60,277	54,249
Geriatrics	2,390	2,151
Internal medicine/pediatrics combined specialty	1,718	1,546

We are not aware of a readily accessible source of data on the number of physician practices participating in Medicare. The Medical Group Management Association may be able to suggest some. It may also be possible to derive these estimates from the National Plan and Provider Enumeration System, based on the number of organizational National Provider Identification (NPIs) numbers that are associated with physician NPIs.

Hi Sherry,

Happy to chat about this and our data. A few points to clarify (I'm cc'ing Jim Coan, Bill Rich, and Myles Maxfield, to close the loop):

1. Please interpret the 257 number as the median number of unique Medicare beneficiaries seen by a typical **individual PCP** (FP/GIM/GP) in **ONE** year. As a physician won't see all of his/her patients in any given 12 months, their total Medicare panel may be larger, by as much as 30% (bringing it to 335). It is possible for us to run numbers for their total Medicare panel over 3 years (for more recent years 2004-06), but not sure if we would need programming support.

2. The typical practice will have several fold this number of beneficiaries, but you can pick the multiplier based on assumptions about the number of docs per practice.

3. The 100-150 number was our early estimate of how many of the 257-335 patients would be eligible for the demo based on prevalence counts for **only 8 chronic conditions**. We therefore strongly suspect that the number of eligibles per PCP will actually be much closer (or higher) than the 200 range, as more conditions are added to the eligibility list.

4. The numbers are from the Community Tracking Study Physician Survey, linked to Medicare claims data for years 2000-2002 for the beneficiaries those physicians treated. We just got the 2004-2006 claims data in hand, and have linked that to our 2005 survey respondents.

Please let me know if helpful to discuss further.

thanks,
Mai

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mpham@hschange.org

From: Devon Broderick [dbroderick@mgma.com]
Sent: Friday, February 15, 2008 11:51 AM
To: David Barrett
Subject: benchmark data for panel size

Hi, David. This is an excerpt of the message sent to the original member who inquired about panel size. Please review it and, if you have any questions, feel free to contact the Information Center at infocenter@mgma.com.

Thanks,

Devon

MGMA's Survey Reports do not benchmark "panel size" benchmarks, primarily because there are many variables that can affect these figures.

Having said that, you may want have in mind one related metric from the "Cost Survey Report" -- that of "Patients per Physician," from the data table titled: "Staffing, RVUs, Patients, Procedures and Square Footage."
That table reports data for unique patients seen in the previous year.

For example, of those respondents to the "Cost Survey for Single-specialty Practices: 2007 Report Based on 2006 Data," for Family Practice, the average number of patients per FTE physician is 2.362; the median is 2,115. The table containing this patient data appears in the survey for each specialty reported.

In addition, the articles listed below provide guidance on how to determine Panel Size. Specifically, from the article reference below, titled: "Panel Size" by Dr. Mark Murray, et.al, (Family Practice Management, Nov 2007), this formula is provided:

"Panel size × visits per patient per year (demand) = visits per provider per day × number of days worked per year (supply).

For example, if a physician provides 20 visits per day, 220 days per year, and his or her patient population averages two visits per patient per year, the ideal panel size would be 2,200."

The article (shown below) provides background context and explanation for the formula.

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These article citations come from the EBSCO Health Business Database, available as a benefit of MGMA membership. The links will take you to article descriptions with the option to download a full-text PDF or HTML version of the article.

PANEL SIZE. By: Murray, Mark; Davies, Mike; Baoshan, Barbara.
Family Practice Management
Nov2007, Vol. 14 Issue 10, p29-32, 4p; (AN 27745524) Persistent link to this record:
http://search.ebscohost.com/login.aspx?direct=true&db=nhh&AN=27745524&site=ehost-live

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PANEL SIZE How Many Patients Can One Doctor Manage?
By: Murray, Mark; Davies, Mike; Baoshan, Barbara.
~~~~~~~~~~

Family Practice Management
Apr2007, Vol. 14 Issue 4, p44-51, 8p; (AN 24908473) Persistent link to this record:
http://search.ebscohost.com/login.aspx?direct=true&db=nhh&AN=24908473&site=ehost-live

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Performance Metrics for Advanced Access.
By: Gupta, Diwakar; Potthoff, Sandra; Blowers, Donald; Corlett, John.
Journal of Healthcare Management
Jul/Aug2006, Vol. 51 Issue 4, p246-258, 13p; (AN 21816928) Persistent link to this record:
http://search.ebscohost.com/login.aspx?direct=true&db=heh&AN=21816928&site=ehost-live

~~~~~~~~~~
I hope these data and articles will be of help. Please let me know if I can assist further.

Thank you!

Marti Cox, MLIS
Information Center
Medical Group Management Association
104 Inverness Terrace East
Englewood, CO 80112
toll-free (877)275-6462, ext. 1887
www.mgma.com

Please take a couple minutes to complete this short questionnaire regarding the Medical Group Management Association (MGMA) Information Center e-mail service. Your input is greatly appreciated to help medical group practice professionals excel in their activities.
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Click on the link below to begin.
http://www.mgma.com/surveypro/content/06SatisfactionQuestions_1.htm

If you have questions about this questionnaire, please call toll-free 877.275.6462, ext. 1887 or e-mail infocenter@mgma.com.

>>> <L.Logel@FMHospital.com> 1/15/2008 12:39 PM >>>
Hi

Recently we developed and implemented a full hospitalist program so our

providers no longer complete hospital rounds. Based on the fact that they are now in the office more hours and not in the hospital I'm wondering

what MGMA data is for best practice panel size for primary care.

Thank you in advance for your help.

Leslie Logel, CMPE
Director of Operations
Department of Primary Care
Frisbie Memorial Hospital

335-8812

RUC Medical Home Workgroup / Geisinger Health System Conference Call

Members of the RUC Medical Home Workgroup met with representatives of the Geisinger Health System on Thursday, April 3, 2008 via conference call to better understand the Geisinger role in the ongoing Medicare Physician Group Practice Demonstration Project and to ascertain any information that would be useful to the Workgroup's ongoing discussion.

Doctors David Hitzeman, Leonard Lichtenfeld, Thomas Felger, and William Rich participated. The Geisinger participants included Doctors Steve Pierdon, Beverly Blaisure, Duane Davis and Janet Tomcavage. Doctor James Blankenship facilitated the meeting and listened in as an observer.

Doctors Rich and Hitzeman summarized the RUC's role in the Medicare Medical Home Demonstration project. The representatives from Geisinger explained their role in current Medicare demonstration projects, however most of the discussion focused on a specific medical home project currently running in two Geisinger practices.

Electronic Health Records and IT Infrastructure

Geisinger fully implemented electronic health records (HER) in 2001. This highly sophisticated system uses EpicCare as a foundation, enhanced with homegrown software and programming. It was acknowledged that the Geisinger model could not be used to predict EHR costs for the typical medical home as their IT costs include all lines of business, including their insurance component. The entire HER system cost $80 million, or $114,000 per individual physician. Geisinger has nearly 700 physicians in their system, of which 200 are primary care focused. Geisinger's ongoing IT budget is 4% of the system's annual revenue. The Geisinger representatives encouraged the Workgroup members to consider other sources to determine the appropriate EHR cost estimate.

Medicare Patient Panel Size

Statistics included on Geisinger's website, www.geisinger.org/about/stats.html, indicate that the system serves more than 2 million patients throughout Pennsylvania, with 210,000 enrolled in the Geisinger health plan. Other relevant statistics:

Clinical Staff Breakdown in 2007

- Physicians/scientists: 679
- Residents/fellows: 257
- Registered nurses: 1,949
- Licensed practical nurses: 316

It is estimated that the 200 Geisinger primary care physicians serve a total of 350,000 patients, which translates to 1,750 patients per physician. Medicare patients represent

25% of this estimated panel size or 440 patients. This varies from the overall Geisinger physician panel sizes. The Geisinger representatives quoted that that their overall average load of patient to physicians is 2,500, of which 700-800 are Medicare.

The RUC participants inquired about whether the system has risk-adjusted data, dependent upon the number of chronic condition or other risk criteria. Geisinger does risk adjust by the number of chronic conditions and also use a 1-5 risk rating, with the highest risk at rated at 5. Approximately 15-20% require intensive case management, as at least 15% of patients are rated at a 5.

Patient Caseload per Nurse Case Manager

In addition to the sophisticated EMR system, Geisinger has utilized a number of medical home concepts across their entire patient population for some time. Patient registries; use of best practices/evidence-based medicine for chronic care and preventive medicine; and patient reminders are already a component of the system.

In January 2007, an intensive medical home project was initiated in two practice sites. The description of this project resembles the Tier 3 medical home. Approximately 3,000 Medicare patients are served by these two practice sites. The program has recently been expanded to 20,000 patients in eleven practice sites.

In these two initial sites, the Geisinger representatives indicated that there were 250 Medicare "medical home" patients per physician. This is lower than the overall Geisinger Medicare patient to primary care physician estimate of 440 described above.

In these two initial practices, four Registered Nurse (RN) case managers were hired to exclusively coordinate the care for the patients. It is estimated that each case manager was able to coordinate the care of 125 high risk patients. LPNs are also involved in this medical home model, as individuals integrating the care coordination input into the practice.

Physician Involvement

The physicians in these two practices attend at least one hour to ninety minute team meeting per month to discuss the sickest patients. In addition, the physicians spend, on average, three hours per week in non face-to-face patient care coordination activities.

PROPOSED ELECTRONIC HEALTH RECORD FOR TIER 3 MEDICAL HOME

System Elements

Software
Comprehensive electronic health record software system that includes the following:

a. Disease Management
b. Point of care evidence-based decision support
c. Electronic prescribing
d. Laboratory test result tracking
e. Automatic problem lists
f. Referral History
g. Diagnostic Imaging Storage
h. Statistical Analysis
i. Patient Registries
j. Medication lists
k. Reporting
l. Patient Education Materials
m. Workflow coordination
n. Secure Electronic Communication with patients

Hardware
Using a server model, the electronic health record would require:

a. One server
b. One desktop computer with monitor
c. Router
d. Firewall
e. Cable/DSL Modem

Other
Other practice expenses related to the electronic health record include:

a. Maintenance/service contract for hardware, software, internal network, and Internet connections (i.e., system support)
b. Training services
c. Data backup and recovery services
d. Interfaces to practice management system, laboratory, etc.
e. Data conversion/migration from existing systems
f. Licensing of commercial databases (e.g., First Data Bank, Multum, CPT)

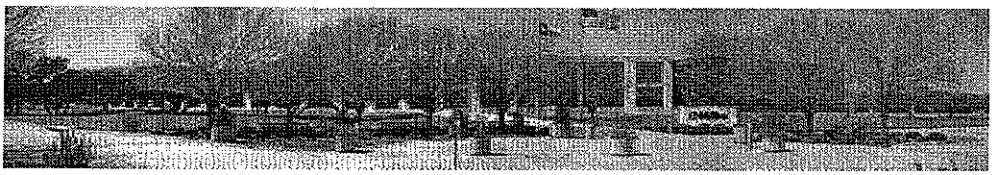
System Costs

Element	CMS Code	Time[1]	Life	Price
Software; license	(new)	80 minutes + physician time	3 years[2]	$7,995 (per provider)[3]
Software; updates, upgrades, and support	(new)	80 minutes + physician time	3 years[2]	$3,198[3]
Computer, server	ED022	80 minutes + physician time	5 years[4]	$22,567[4]
Computer, desktop, with monitor	ED021	80 minutes + physician time	5 years[4]	$2,501[4]
System support (hardware, network, Internet connection)	(new)	80 minutes + physician time	5 years[5]	$1,253[6]
Interfaces	(new)	80 minutes + physician time	3 years[7]	$550[3]
Total				**$38,064**

Notes:

1. Time is assumed equal to clinical staff time plus physician time, since the EHR is an integral part of care management in the Tier 3 medical home and will be in use whenever the RN/LPN or physician is providing care management for the patient.
2. Based on IRS amortization rules for computer software (see instructions Line 16 on IRS Form 4562 online at http://www.irs.gov/pub/irs-pdf/i4562.pdf)
3. Based on proposal for e-MDs provided by the Oklahoma QIO, attached. E-MDs is one of three systems expected to be capable of meeting the needs of a Tier 3 medical home; the other two are eClinicalWorks and NextGen. An invoice for eClinicalWorks is pending.
4. From CMS equipment list
5. Corresponding to lifetime of hardware
6. Assumed to be 5% of hardware costs
7. Corresponding to lifetime of software

e-MDs
P.O. Box 2889
Cedar Park, TX 78630
P: (888) 344-9836
F: (512) 335-4375
www.e-MDs.com



Prepared By: Scott Perkins
Direct Line: (817) 455-1304
e-Mail: sperkins@e-mds.com

Proposal Valid Until: 30-Jan-00
Date Proposal Prepared:

Prepared For: e-MDs quote for a 2 Provider clinic
Address:
City: **ST** **Zip:**
e-Mail: **Tel:** **Fax:**

	Count	Unit Price	Line Total	Totals
Software Licenses Per Provider (MD, DO, PA, NP, etc.)				**15,990.00**
e-MDs Solution Series	2	7,995.00	15,990.00	
Includes: Chart, Bill, DocMan, Schedule, Tracking Board, TaskMan, E&M Coding, ICD Coder, CPT/HCPCS Search, Code Linker, Prescriptions, Order Tracking, Fax Management, Medical Art, Patient Education, Template Editor, Forms, Referrals, Collections Module, CCI Edits, Graphing, Check In Module, etc.				
Updates/Upgrades and Support				**3,198.00**
Annual software updates, upgrades, and support as a % of software licenses (1)				
Third Party Software				**680.00**
MS SQL Server 2005 - Standard Edition (per workstation)	8	65.00	520.00	
AMA CPT Code Files (per workstation)	8	20.00	160.00	
EDI Clearinghouse				**300.00**
Gateway EDI				
Interface setup and registration per site - billed by e-MDs	1	300.00	300.00	
Interface annual support fee billed in year 2	1	250.00		
Training & Implementation - See item (3), (4) and (5) below - **Travel expenses are not included**				**7,455.00**
e-MDs facility for e-MDs Bill - 2 1/2 days - per person	4	495.00	1,980.00	
Bill and Schedule modules taught in a classroom setting (approx. 12 students per class), at the e-MDs corporate headquarters in Austin, Texas. Geared toward Office Managers, Billing and Scheduling Supervisors, and general scheduling/billing staff. Upon completion, participants will be able to schedule, reschedule, and cancel appointments; check in patients; build invoices manually and from Chart; post payments; and send electronic claims.				
e-MDs facility for e-MDs Chart- 2 1/2 days - per person	4	495.00	1,980.00	
Chart, DocMan, Tracking Board, Lab Tracking, Refill Requests, and TaskMan modules taught in a classroom setting (approx. 12 students per class), at the e-MDs corporate headquarters in Austin, Texas. Geared toward Providers, Nursing, and Clinical staff, as the functions of the Classroom participants can be from various medical specialties. Upon completion, participants will be able to track the patient from waiting room to exam room; create doctor's and nurse's notes; enter vitals, past M/F/S history, medications; create and edit templates, pre-clicks, and shortcuts; create, edit, use flow sheets; create, authorize, and deny refill requests; and track send-out labs, tests, and procedures.				
e-MDs QuickStart setup - up to 8 hours	1	995.00	995.00	
QuickStart setup creates a solid foundation for clinic to build their database. A wide variety of information is entered by an e-MDs staff member, including all of the clinic's staff and their logins, providers, internal facilities (if clinic has more than 1 location), and schedules. After the QuickStart is installed and after training has been completed, the clinic's staff will be able to customize the database further to meet the clinic's individual needs.				
On Site Installation Services - per day	1	1,250.00	1,250.00	
An e-MDs IT professional travels to the clinic's location to install e-MDs software and set-up (if available) the Fax Server, scanners, DigiCams, insurance card scanners, tablets, PDAs (if Companion is purchased), and Lab Interfaces. Hardware/Network must be purchased and installed before e-MDS IT tech arrives to install software.				

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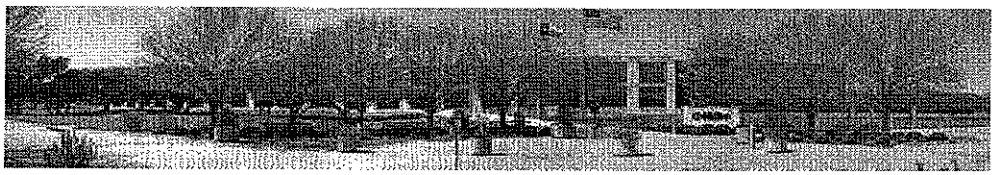

Prepared By: Scott Perkins
Direct Line: (817) 455-1304
e-Mail: sperkins@e-mds.com

Proposal Valid Until: 30-Jan-00
Date Proposal Prepared:

Prepared For: e-MDs quote for a 2 Provider clinic
Address:
City: **ST** **Zip:**
e-Mail: **Tel:** **Fax:**

	Count	Unit Price	Line Total	Totals
Project Management - per hour A dedicated e-MDs Project Manager is assigned to offer guidance, create a custom implementation project plan, and to make recommendations for successful implementation. If needed, clinic will purchase additional hours at $125/hr.	8	125.00	1,000.00	
e-Prescribing (SureScripts) Set-Up Fee Per Database	1	250.00	250.00	
Shipping (3 Day Ground)		25.00		**25.00**
			Total:	**27,648.00**
			***Grand Total:**	**27,648.00**

Financing Options (Through ACI Financial)

Term	3 Year	5 Year
Payment	$1,015	$680
Optional 3 month deferred:	$1,045	$705
Optional 6 month deferred:	$1,067	$722

*** Applicable sales tax will be added at the time of invoicing. If you are exempt from Sales Tax, please provide a valid exemption certificate when submitting your order.**

(1) You must have the ability to download minor updates via the internet
(2) Data Imports require a separate agreement
(3) Related travel expenses including airfare, hotel, rental car, and meals are extra. An estimate will be provided for your approval before any expenses are incurred.
(4) Training cancellation policy: 30 days written notice for onsite training and Go Live cancellations; 15 days written notice for classroom training cancellations; and 10 days written notice for online training cancellations.
(5) Training expiration policy: All training must be scheduled and taken within 12 months of the date of purchase.

Purchase Schedule - Page 1 of 2

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P: (888) 344-9836
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www.e-MDs.com

Prepared By:
Direct Line:
e-Mail:

Proposal Valid Until: 09-Aug-07
Date Proposal Prepared: 10-Jul-07

Prepared For:
Address:
City
e-Mail:
State:
Tel:
Zip:
Fax:

	Count	Unit Price	Line Total	Totals
Software Licenses Per Provider (MD, DO, PA, NP, etc.)				27,982.50
e-MDs Solution Series Includes: Chart, Bill, DocMan, Schedule, Tracking Board, TaskMan, E&M Coding, ICD Coder, CPT/HCPCS Search, Code Linker, Prescriptions, Order Tracking, Fax Management, Medical Art, Patient Education, Template Editor, Forms, Referrals, Collections Module, CCI Edits, Graphing, Check In Module, etc.	3	7,995.00	23,985.00	
e-MDs Solution Series - Part Time Provider (16 hours per week or less)	1	3,997.50	3,997.50	
e-MDs Chart Includes: Chart, DocMan, Schedule, Tracking Board, TaskMan, E&M Coding, ICD Coder, CPT/HCPCS Search, Code Linker, Prescriptions, Order Tracking, Fax Management, Medical Art, Patient Education, Forms, Referrals, Check In Module, Template Editor, etc.	0	4,495.00	0.00	
e-MDs Bill Includes: Bill, Schedule, TaskMan, ICD and CPT/HCPCS Coders, Code Linker, CCI and Other Claim Edits, Forms, Referral Management, Customizable Check In Module, Collections Module, Collections Tickler Notes, Appointment Instructions, Work Lists, Master Person Index, Electronic Claims and Remittances, etc.	0	4,495.00	0.00	
e-MDs Docman Includes: DocMan, TaskMan, Document Filing Cabinet, Document Search, Graphing, Audit Trails, Fax Management, Customizable Folders, etc.	0	1,495.00	0.00	
e-MDs Schedule Includes: Schedule, TaskMan, Forms, Check In Module, Customizable Check In Tasks, Referrals, Appointment Reminders Work List, Daily Work List, Appointment Instructions, etc.	0	695.00	0.00	
e-MDs Companion Mobile Scheduling and Charge Capture Solution	0	395.00	0.00	
Interfaces				0.00
Quest Lab Interface Lab interface between Quest and e-MDs Chart	0	3,000.00	0.00	
Labcorp Lab Interface Lab interface between Labcorp and e-MDs Chart	0	3,000.00	0.00	
Custom Lab Interface Lab interface between Spectrum and e-MDs Chart	0	3,000.00	0.00	

Purchase Schedule - Page 2 of 2

Updates/Upgrades and Support				5596.50
Annual software updates, upgrades, and support as a percentage of software licenses (1)				
Third Party Software - Per Workstation				1,955.00
MS SQL Server 2000 - Standard Edition	23	65.00	1,495.00	
AMA CPT Code Files	23	20.00	460.00	
Dragon Naturally Speaking V.9	0	695.00	0.00	
EDI Clearinghouse				300.00
Gateway EDI				
Interface setup and registration per site - billed by e-MDs	1	300.00	300.00	
Interface annual support fee billed in year 2	1	250.00	250.00	
Conversions (2)				0.00
Basic Conversion - Demographics	0	2,995.00	0.00	
Financial Conversion - Demographics + Balance Forwards	0	4,995.00	0.00	
Training & Implementation - See item (3) below - Travel expenses are not included				12,965.00
On-Site EMR training per instructor - per day	2	1,250.00	2,500.00	
On-Site PM training per instructor - per day	2	1,250.00	2,500.00	
e-MDs facility for e-MDs Bill - 2 1/2 days - per person	2	495.00	990.00	
e-MDs facility for e-MDs Chart- 2 1/2 days - per person	2	495.00	990.00	
e-MDs Internet or telephone training - per hour	8	125.00	1,000.00	
e-MDs QuickStart setup - up to 8 hours	1	995.00	995.00	
On Site Installation Services - per day	1	995.00	995.00	
Go Live Support - per person - per day	1	995.00	995.00	
Project Management - per hour	16	125.00	2,000.00	
e-MDs Portal Set-up	0	495.00	0.00	
e-MDs Portal 12-month Subscription ($75/provider/month)	0	900.00	0.00	
e-Prescribing (SureScripts) Set-Up Fee Per Database	0	250.00	0.00	
Shipping (3 Day Ground)		20.00		20.00
			Total:	48,819.00
MANAGEMENT APPROVAL REQUIRED >>>>>			Approved Discount:	2,798.25
Management Approved Discount				3,000.00
			***Grand Total:**	43,020.75

* Applicable sales tax will be applied at the time of invoice

(1) You must have the ability to download minor updates via the internet

(2) Data imports require a separate agreement

(3) Related travel expenses including airfare, hotel, rental car, and meals are extra. An estimate will be provided for your approval before any expenses are incurred.

Initials_____

AMA/Specialty Society RVS Update Committee Physician Time Recommendations
September 2007, February 2008, and April 2008

CPT Code	Pre-Evaluation Time	Pre-Positioning Time	Pre-Service Scrub, Dress, Wait Time	Intra Service Time	Immediate Post Service Time	99211	99212	99213	99214	99231	99232	99233	99238	99291	Total Time	Time Date
41512	15	15	15	60	30		2	1					0.5		209	September 2007 New/Revised
41530	15	10	15	30	20			1	1				1		167	September 2007 New/Revised
49652	45	15	15	90	30		1	1		1			1		292	September 2007 New/Revised
49653	45	15	15	120	30		2	1		1	1		1		378	September 2007 New/Revised
49654	45	15	15	120	30		1	1		1	1		1		362	September 2007 New/Revised
49655	50	15	15	150	30		2	1		1	1		1		413	September 2007 New/Revised
49656	45	15	15	120	30		1	1		1	1		1		362	September 2007 New/Revised
49657	60	15	15	180	30		2	1		1	2		1		493	September 2007 New/Revised
93306	5			20	6.5										31.5	September 2007 New/Revised
00142	15			38	10										63	September 2007 CMS Request
11043	45			45	20			2					0.5		175	September 2007 Five Year ID WG
11044	60			90	30			3					0.5		268	September 2007 Five Year ID WG
15220	27	15		90	27		4.5						0.5		250	September 2007 Five Year ID WG
15770	28	25		104	23			4.5					0.5		302.5	September 2007 Five Year ID WG
19020	48			48	14		3								158	September 2007 Five Year ID WG
19318	60			150	30	1	2	1					0.5		321	September 2007 Five Year ID WG
19357	65			105	30		5	7					0.5		460	September 2007 Five Year ID WG
20000	14			19	14		1								63	September 2007 Five Year ID WG
20525	20	15		48	18		1						0.5		136	September 2007 Five Year ID WG
20694	15	25		26	15		2.5						0.5		140	September 2007 Five Year ID WG
21015	40			79	30		2	1					0.5		223	September 2007 Five Year ID WG
21557	24	25		128	18		2						0.5		246	September 2007 Five Year ID WG
21935	27	25		104	23		4.5						0.5		270	September 2007 Five Year ID WG
22900	29	25		62	20		2.5						0.5		195	September 2007 Five Year ID WG
23076	25	15	11	75	20		4.5						0.5		237	September 2007 Five Year ID WG
23130	19	25	12	66	18		4.5						0.5		231	September 2007 Five Year ID WG
23405	23	25		47	22		3.5						0.5		192	September 2007 Five Year ID WG
23430	26	25		60	23		4						0.5		217	September 2007 Five Year ID WG
23440	25	25		62	21		3.5						0.5		208	September 2007 Five Year ID WG
25210	21	25		53	20		3.5						0.5		194	September 2007 Five Year ID WG
25260	28	15		50	23		5						0.5		215	September 2007 Five Year ID WG
25280	22	25		53	20		3.5						0.5		195	September 2007 Five Year ID WG
26080	15	15		34	18		3.5						0.5		157	September 2007 Five Year ID WG
26356	45			90	30			8					0.5		368	September 2007 Five Year ID WG
27048	27	25		104	24		4						0.5		263	September 2007 Five Year ID WG
27324	18	25		41	17		3						0.5		168	September 2007 Five Year ID WG
27615	30	25		150	26		4.5						0.5		322	September 2007 Five Year ID WG
27619	25	15		89	23		4						0.5		235	September 2007 Five Year ID WG
27685	17	25		55	20		4						0.5		200	September 2007 Five Year ID WG
27687	21	25		59	19		3.5						0.5		199	September 2007 Five Year ID WG
27818	19	25		54	12		4						0.5		193	September 2007 Five Year ID WG
28111	18	25		44	17		3						0.5		171	September 2007 Five Year ID WG
28118	21	25		56	19		3.5						0.5		196	September 2007 Five Year ID WG
28124	17	15		34	21		4								151	September 2007 Five Year ID WG
28298	24	25		77	22		4						0.5		231	September 2007 Five Year ID WG
28300	25	25		62	23		4						0.5		218	September 2007 Five Year ID WG
28310	19	15		46	18		3						0.5		165	September 2007 Five Year ID WG
28740	45			80	30			4					0.5		266	September 2007 Five Year ID WG
30465	30			120	30		2	2					0.5		277	September 2007 Five Year ID WG
31571	45			40	25								0.5		129	September 2007 Five Year ID WG
31611	19	25		43	18		2.5						0.5		164	September 2007 Five Year ID WG
32421	10			28	10										48	September 2007 Five Year ID WG
32422	15	15		31	14										75	September 2007 Five Year ID WG
32550	15	15	10	30	20										90	September 2007 Five Year ID WG
32551	14	25	7	24	25										95	September 2007 Five Year ID WG
32560	15	15		39	16										85	September 2007 Five Year ID WG
36834	30			73	15		1	1					0.5		176	September 2007 Five Year ID WG
36870	20			60	15		1						0.5		130	September 2007 Five Year ID WG
37609	45			30	20		1						0.5		130	September 2007 Five Year ID WG
37760	30	25	8	133	23		3						0.5		286	September 2007 Five Year ID WG
37785	21	25		63	17		2						0.5		177	September 2007 Five Year ID WG
45170	80			30	45		1	2					0.5		236	September 2007 Five Year ID WG
46200	21	25		31	19		3.5						0.5		171	September 2007 Five Year ID WG
48102	20	15		41	17		0.5						0.5		120	September 2007 Five Year ID WG
51040	16	25		33	14		2						0.5		139	September 2007 Five Year ID WG
51100	10			13	10										33	September 2007 Five Year ID WG

AMA/Specialty Society RVS Update Committee Physician Time Recommendations
September 2007, February 2008, and April 2008

CPT Code	Pre-Evaluation Time	Pre-Positioning Time	Pre-Service Scrub, Dress, Wait Time	Intra Service Time	Immediate Post Service Time	99211	99212	99213	99214	99231	99232	99233	99238	99291	Total Time	Time Date
51101	12	15		18	12										57	September 2007 Five Year ID WG
54520	21	25		40	15		1.5						0.5		144	September 2007 Five Year ID WG
56515	50			45	20			1					0.5		157	September 2007 Five Year ID WG
57155	47.5			55	20		1	1					0.5		180.5	September 2007 Five Year ID WG
58660	47.5			90	30			1					0.5		209.5	September 2007 Five Year ID WG
58661	55			90	30			1					0.5		217	September 2007 Five Year ID WG
60220	62.5			90	25		1	1					0.5		235.5	September 2007 Five Year ID WG
60300	20			15	15										50	September 2007 Five Year ID WG
61793	85			120	18			2					0.5		288	September 2007 Five Year ID WG
62281	50			40	30										120	September 2007 Five Year ID WG
62287	70			60	30			3					0.5		248	September 2007 Five Year ID WG
63660	24	25		64	18			2					0.5		196	September 2007 Five Year ID WG
64581	60			120	30				1				0.5		269	September 2007 Five Year ID WG
64640	20			31	18		1								85	September 2007 Five Year ID WG
64712	25	25		109	19		3						0.5		245	September 2007 Five Year ID WG
65105	24	25		77	21			4.5					0.5		269.5	September 2007 Five Year ID WG
67039	30	25		88	28			7					0.5		351	September 2007 Five Year ID WG
67040	36	25		105	30			7.5					0.5		387.5	September 2007 Five Year ID WG
67107	27	25		107	31				4.5				0.5		389	September 2007 Five Year ID WG
67108	40	25		191	34				5				0.5		509	September 2007 Five Year ID WG
67110	24	25		41	25			4.5							218.5	September 2007 Five Year ID WG
69801	21	25		61	17		3								172	September 2007 Five Year ID WG
27027	43	12	5	60	30		3	1		3	1		1		359	February 2008 New/Revised
27057	43	12	5	90	30		3	1		3	1		1		389	February 2008 New/Revised
90951				274											274	February 2008 New/Revised
90952															carrier pr	February 2008 New/Revised
90953															carrier pr	February 2008 New/Revised
90954				240											240	February 2008 New/Revised
90955				198											198	February 2008 New/Revised
90956				148											148	February 2008 New/Revised
90957				253											253	February 2008 New/Revised
90958				183											183	February 2008 New/Revised
90959				133											133	February 2008 New/Revised
90960				90											90	February 2008 New/Revised
90961				75											75	February 2008 New/Revised
90962				63											63	February 2008 New/Revised
90963				258											258	February 2008 New/Revised
90964				233											233	February 2008 New/Revised
90965				218											218	February 2008 New/Revised
90966				75											75	February 2008 New/Revised
90967				8.6											8.6	February 2008 New/Revised
90968				7.77											7.77	February 2008 New/Revised
90969				7.27											7.27	February 2008 New/Revised
90970				2.5											2.5	February 2008 New/Revised
99475	30			105	30										165	February 2008 New/Revised
99476	20			65	20										105	February 2008 New/Revised
21025	60	10	15	90	30		2	2							283	February 2008 CMS Request
23410	40	15	15	90	20		2	2					0.5		277	February 2008 CMS Request
23412	40	15	15	100	20		2	2					0.5		287	February 2008 CMS Request
23415	40	15	15	60	20		2	2					0.5		247	February 2008 CMS Request
23420	45	15	15	120	20		3	2					0.5		328	February 2008 CMS Request
25310	40	10	15	60	20		3	1					0.5		235	February 2008 CMS Request
27250	15	5	5	15	13										53	February 2008 CMS Request
28296	30	5	10	60	15		3	2					0.5		233	February 2008 CMS Request
42440	30	10	15	60	20		1	1					0.5		193	February 2008 CMS Request
56620	45	10	5	45	30		1	3					0.5		239	February 2008 CMS Request
57288	35	15	10	60	20		1	2			1		1		280	February 2008 CMS Request
62263	33	10	5	45	20		1	2					0.5		194	February 2008 CMS Request
63650	33	10	5	60	20			1					0.5		170	February 2008 CMS Request
63685	33	10	5	60	20			1					0.5		170	February 2008 CMS Request
63688	33	10	5	55	20			1					0.5		165	February 2008 CMS Request
64831	40	10	15	60	15		2	2					0.5		237	February 2008 CMS Request
65285	37		15	79	32			5.5		0.5			1		337.5	February 2008 CMS Request
67225				3											3	February 2008 CMS Request
68810	10	5	5	10	5		2								67	February 2008 CMS Request
69930	60	15	20	180	30			1	1				0.5		387	February 2008 CMS Request

AMA/Specialty Society RVS Update Committee Physician Time Recommendations
September 2007, February 2008, and April 2008

CPT Code	Pre-Evaluation Time	Pre-Positioning Time	Pre-Service Scrub, Dress, Wait Time	Intra Service Time	Immediate Post Service Time	99211	99212	99213	99214	99231	99232	99233	99238	99291	Total Time	Time Date
00225	20		15	120	20										175	April 2007 New/Revised
00562	30		30	270	30										360	April 2007 New/Revised
00567	30		30	247.5	30										337.5	April 2007 New/Revised
20696	33	15	15	180	30		3	3		2			1		468	April 2007 New/Revised
20697																April 2007 New/Revised
22856	40	20	20	120	30			3			1		1		377	April 2007 New/Revised
22861	40	20	20	180	30			3			2		1		477	April 2007 New/Revised
22864	40	20	20	150	40			3			2		1		457	April 2007 New/Revised
27215	40	15	20	120	20		2	1		2	1		1		388	April 2007 New/Revised
27216	40	25	20	60	25		1	3		3	1		1		393	April 2007 New/Revised
27217	40	15	20	120	25		1	3		3	1		1		443	April 2007 New/Revised
27218	40	40	20	150	30		1	3		5	1		1		543	April 2007 New/Revised
35535	40	15	20	240	30		1	2		2	2	1	1	1	690	April 2007 New/Revised
35570	40	15	20	240	30			3		2	3	1	1		667	April 2007 New/Revised
35632	40	15	20	240	30		1	2		2	2	1	1	1	690	April 2007 New/Revised
35633	40	15	20	240	30		1	2		2	2		1	2	705	April 2007 New/Revised
35634	40	15	20	230	30		1	2		2	2	1	1	1	680	April 2007 New/Revised
43273				45											45	April 2007 New/Revised
43279	40	20	20	150	30			2		1	1		1		404	April 2007 New/Revised
46930	8	5		5	5			1							46	April 2007 New/Revised
55706	33	5	15	45	15			1	1				0.5		195	April 2007 New/Revised
61796	18	1	6	90	15			2					0.5		195	April 2007 New/Revised
61797				30											30	April 2007 New/Revised
61798	18	1	6	120	15			2					0.5		225	April 2007 New/Revised
61799				60											60	April 2007 New/Revised
61800	10	1		20	10										41	April 2007 New/Revised
62267	14	10	10	30	15										79	April 2007 New/Revised
63620	18	1	6	90	15			2					0.5		195	April 2007 New/Revised
63621				60											60	April 2007 New/Revised
64416	19	1	5	20	15										60	April 2007 New/Revised
64446	19	5	5	20	15										64	April 2007 New/Revised
64448	19	1	5	15	15										55	April 2007 New/Revised
64449	19	5	5	20	11										60	April 2007 New/Revised
64455	10			5	5										20	April 2007 New/Revised
64632	10			5	5		1								36	April 2007 New/Revised
65756	33	1	5	60	20		3	3					0.5		255	April 2007 New/Revised
65757				15											15	April 2007 New/Revised
77785	10	1		30	10										51	April 2007 New/Revised
77786	13	1		60	15										89	April 2007 New/Revised
77787	19	1		90	20										130	April 2007 New/Revised
78808	5			5	3										13	April 2007 New/Revised
93228	5			12	8										25	April 2007 New/Revised
93279	5			10	5										20	April 2007 New/Revised
93280	5			17	5										27	April 2007 New/Revised
93281	5			20	5										30	April 2007 New/Revised
93282	8			15	5										28	April 2007 New/Revised
93283	8			15	10										33	April 2007 New/Revised
93284	8.5			15	10										33.5	April 2007 New/Revised
93285	5			12	5										22	April 2007 New/Revised
93286	5			12	5										22	April 2007 New/Revised
93287	7.5			13.5	5										26	April 2007 New/Revised
93288	5			10	5										20	April 2007 New/Revised
93289	5			15	5										25	April 2007 New/Revised
93290	5			12	8										25	April 2007 New/Revised
93291	5			12	5										22	April 2007 New/Revised
93292	5			10	5										20	April 2007 New/Revised
93293	9.5			19	9.5										38	April 2007 New/Revised
93294	7.5			15	7.5										30	April 2007 New/Revised
93295	7.5			22.5	7.5										37.5	April 2007 New/Revised
93297	10			24	16										50	April 2007 New/Revised
93298	10			24	10										44	April 2007 New/Revised
93351	5			20	10										35	April 2007 New/Revised
93352				5											5	April 2007 New/Revised
95803	5			20	5										30	April 2007 New/Revised
95992				20	10										30	April 2007 New/Revised
14000	25			64	22			3.5					0.5		210.5	April 2008 CMS Request

AMA/Specialty Society RVS Update Committee Physician Time Recommendations
September 2007, February 2008, and April 2008

CPT Code	Pre-Evaluation Time	Pre-Positioning Time	Pre-Service Scrub, Dress, Wait Time	Intra Service Time	Immediate Post Service Time	99211	99212	99213	99214	99231	99232	99233	99238	99291	Total Time	Time Date
14001	34		15	105	26			4							272	April 2008 CMS Request
14020	29			78	24			4					0.5		242	April 2008 CMS Request
14021	37		15	116	28			4							288	April 2008 CMS Request
14040	15	10	5	90	25		2	2							223	April 2008 CMS Request
14041	34		15	135	27			4							303	April 2008 CMS Request
14060	15	10	5	60	15		2	2							183	April 2008 CMS Request
14061	38		15	157	28			4.5							341.5	April 2008 CMS Request
14300	44		25	102	34			4.5							308.5	April 2008 CMS Request
15570	60			105	30		1	2		2			1		335	April 2008 CMS Request
15572	35			90	30		1	2		1			1		275	April 2008 CMS Request
15574	50			120	30	1	1	1					0.5		265	April 2008 CMS Request
15576	45			90	30		1	2					0.5		246	April 2008 CMS Request
15740	39		15	118	32			4.5		1			1		365.5	April 2008 CMS Request
20900	33	3	15	30	15										96	April 2008 CMS Request
20902	33	10	15	45	20										123	April 2008 CMS Request
23120	40	15	15	45	15		2	2					0.5		227	April 2008 CMS Request
25116	40	10	15	60	20		1	3					0.5		249	April 2008 CMS Request
27062	33	5	15	45	20		3						0.5		185	April 2008 CMS Request
27650	19	15	5	60	20		2	3					0.5		239	April 2008 CMS Request
27654	33	15	5	90	20		2	3					0.5		283	April 2008 CMS Request
27690	33	10	15	60	20		2	3					0.5		258	April 2008 CMS Request
27691	33	10	15	75	20		2	3					1		292	April 2008 CMS Request
28120	22		25	67	21		3.5			1.5			1		259	April 2008 CMS Request
28122	18		25	51	26		5			1.5			1		268	April 2008 CMS Request
28725	25		25	89	22		4			2.5			1		313	April 2008 CMS Request
28730	60			120	30			5		1			1		383	April 2008 CMS Request
28825	33	10	15	30	20		2	2					1		224	April 2008 CMS Request
29888	45	15	15	98	25		2	2					0.5		295	April 2008 CMS Request
36820	45	10	15	120	20		1	1		1			1		307	April 2008 CMS Request
36821	33	10	10	90	20		2	1					1		256	April 2008 CMS Request
36825	23	8	25	81	22		2.5			1			1		257	April 2008 CMS Request
38542	33	10	15	60	15			2					0.5		198	April 2008 CMS Request
42145	40	10	15	60	30			3					1		262	April 2008 CMS Request
42415	30		25	156	37			3.5		1.5			1		396.5	April 2008 CMS Request
42420	32		25	182	22			3.5		3			1		439.5	April 2008 CMS Request
49421	20		25	41	15		1			2.5			1		205	April 2008 CMS Request
49507	45			67.5	30		1	1		1			1		239.5	April 2008 CMS Request
49521	45			90	30		1	1		1			1		262	April 2008 CMS Request
49587	45			60	30		1	1		1			1		232	April 2008 CMS Request
51102	19	1	5	20	15										60	April 2008 CMS Request
52341	45	10	15	45	20										135	April 2008 CMS Request
52342	40	10	10	60	20										140	April 2008 CMS Request
52343	45	10	10	60	25										150	April 2008 CMS Request
52344	40	10	10	45	20										125	April 2008 CMS Request
52345	45	10	15	45	20										135	April 2008 CMS Request
52346	40	10	10	60	20										140	April 2008 CMS Request
52400	72.5	10	15	40	25		1						0.5		197.5	April 2008 CMS Request
52500	45	10	15	45	27.5			3					0.5		230.5	April 2008 CMS Request
52640	40	10	10	30	20		2						0.5		161	April 2008 CMS Request
53445	50	15	20	90	25		1	3			1	1	1		418	April 2008 CMS Request
54405	33		25	115	23					2.5			1		284	April 2008 CMS Request
54410	40	10	15	120	30		1	3					1		338	April 2008 CMS Request
54530	57.5	10	15	60	30		2	1					0.5		246.5	April 2008 CMS Request
57287	40	10	10	60	20		1	3					0.5		244	April 2008 CMS Request
61885	50			60	25			4		1	1		1		325	April 2008 CMS Request
62350	33	10	5	60	20			1					0.5		170	April 2008 CMS Request
62355	33	10	5	30	20			1					0.5		140	April 2008 CMS Request
62360	33	10	5	60	20			1					0.5		170	April 2008 CMS Request
62361	33	10	5	60	20			1					0.5		170	April 2008 CMS Request
62362	33	10	5	60	20			1					0.5		170	April 2008 CMS Request
62365	33	10	5	45	20			1					0.5		155	April 2008 CMS Request
64573	65			90	20			2		1			1		279	April 2008 CMS Request
64708	35	10	10	60	15		3	1					0.5		220	April 2008 CMS Request
66982	40			60	15		3	2					0.5		228	April 2008 CMS Request
97802	1			15	1										17	April 2008 CMS Request
97803	1			15	1										17	April 2008 CMS Request

AMA/Specialty Society RVS Update Committee
Five-Year Review Identification Workgroup
June 3, 2008

Members Present: Barbara Levy, MD (Chair), James Blankenship, MD, Katherine Bradley, PhD, RN, Norm Cohen, MD, Thomas Felger, MD, Gregory Kwasny, MD, William J. Mangold, Jr., MD, Geraldine McGinty, MD, Robert Zwolak, MD.

Discussion of Urology Action Plans

Doctor Levy thanked the Workgroup members on the call and briefly reviewed the Workgroup's discussion regarding the urology codes following the April meeting. At the April meeting, the Workgroup recognized that there was a misunderstanding of the specialty society regarding the mandate following the February meeting for codes 11981, 11982, 11983, 52224, and 52648. The RUC asked that the specialty should convene its expert panel to discuss the growth in volume prior to the next Workgroup meeting in order to maintain the original timetable for all specialty societies. The Workgroup then discussed each action plan individually.

11982

The Workgroup reviewed the action plan for 11982 (and the other codes in the family identified by AUA: 11981 and 11983) and recognized that the implant used has one-year duration. According to the specialty, physicians used the one-year implant to make the procedure more convenient for patients than the one-month implant. However, for some patients, this therapy resulted in unacceptable side effects and required removal of the implant (reported using 11982). In addition, since the implant only had one-year duration, the implant had to be removed at the end of twelve months. The Workgroup agreed that the growth in utilization of 11982 was appropriate

The Workgroup accepts the action plan of the specialty society and recommends that 11981, 11982, 11983 be removed from this screen with no further action at this time.

52224

The Workgroup reviewed the action plan for 52224 and agreed that the increase in utilization may be partly due to instances of miscoding. There may have been some incorrect reporting of 52224 in that some physicians were reporting this code numerous times during the same procedure based on the number of lesions fulgurated. The Workgroup agreed that publication of a CPT Assistant article as well as a review of utilization in two years is appropriate.

While reviewing the procedure, the Workgroup discussed the direct practice expense inputs and noted that 52224 and 52214 were reviewed together. The CPT descriptors for both services indicate that the procedure includes either cryosurgery or laser surgery, yet the direct practice expense inputs appear to include inputs for both electrosurgery and

laser surgery. The Workgroup agreed that a review of the direct practice expense inputs is appropriate.

The Workgroup agrees with the action plan and recommends that CPT Assistant publish an article to clarify appropriate reporting of 52224. The Workgroup recommends that the code be reviewed again for utilization growth in two years to assess the impact of the CPT Assistant article.

The Workgroup also recommends that 52224 and 52214 be reviewed by the Practice Expense Subcommittee in October 2008 for direct practice expense inputs.

52648

The Workgroup reviewed the action plan for 52648 and agreed with the specialty society that 52601, *Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (TURP)*, used to be considered the "gold standard" for the operative treatment of BPH. As new technologies are evolving, this procedure is no longer being performed as frequently. The results of these operative treatments are equal to 52601 in reducing the symptoms of BPH with lower morbidity and complications (eg, less bleeding, catheterization time, hospital stay, etc.). Therefore, as utilization of 52648 and 52647 has increased, utilization for 52601 has decreased proportionately.

The Workgroup accepts the action plan of the specialty society and recommends that 52648 be removed from this screen with no further action at this time.