AMA/Specialty RVS Update Committee
Meeting Minutes
April 28 - May 2, 2010

I. Welcome and Call to Order

Doctor Barbara Levy called the meeting to order on Thursday, April 29, 2010, at 1:00 pm. The following RUC Members were in attendance:

Barbara Levy, MD (Chair)
Bibb Allen, MD
Michael D. Bishop, MD
James Blankenship, MD
R. Dale Blasier, MD
Joel Bradley, MD
Ronald Burd, MD
Thomas Cooper, MD
John Gage, MD
David Hitzeman, DO
Peter Hollmann, MD
Charles F. Koopmann, Jr., MD
Robert Kossmann, MD
Walt Larimore, MD
Brenda Lewis, DO
J. Leonard Lichtenfeld, MD
Lawrence Martinelli, MD
Bill Moran, Jr., MD
Guy Orangio, MD
Gregory Przybylski, MD
Marc Raphaelson, MD
Sandra Reed, MD
Daniel Mark Siegel, MD
Lloyd Smith, DPM
Peter Smith, MD
Susan Spires, MD
Arthur Traugott, MD
James Waldorf, MD
George Williams, MD
Allan Anderson, MD*
Gregory Barkley, MD*
Dennis M. Beck., MD*
Manuel Cerqueira, MD*
Bruce Deitchman, MD*
Gregory DeMeo, DO*
Jane Dillon, MD*
Verdi DiSesa, MD*
Jeffrey Paul Edelstein, MD*
Emily Hill, PA-C*
Allan E. Inglis, Jr., MD*
Robert Jansen, MD*
M. Douglas Leahy, MD*
William J. Mangold, Jr., MD*
Daniel McQuillen, MD*
Terry Mills, MD*
Scott D. Oates, MD*
Julia Pillsbury, DO*
Chad Rubin, MD*
Steven Schlossberg, MD*
Stanley Stead, MD*
J. Allan Tucker, MD*
*Alternate

II. Chair's Report

- Doctor Levy welcomed the CMS staff and representatives attending the meeting, including:
  - Edith Hambrick, MD, CMS Medical Officer
  - Ken Simon, MD, CMS Medical Officer
  - Ryan Howe
  - Ferhat Kassamali
- Doctor Levy welcomed Kevin Hayes of the Medicare Payment Advisory Commission. (MedPAC).
- Doctor Levy welcome Doctor Rebecca J. Patchin Chair of the AMA Board of Trustees

- Doctor Levy welcomed the following Contractor Medical Directors:
  - Doctor Charles Haley, MD
- Doctor Levy welcomed Doctor Kenneth Brin from the Joint CPT/RUC Workgroup.
- Doctor Levy was invited by the National Health Policy Forum to provide an overview of the RUC process to health policy leaders on Friday, March 5. Doctor Levy was joined by Jonathan Blum, Director of the the Center for Medicare Management, in discussing the progress to identify and address misvaluations within the Medicare Physician Payment Schedule. The panel of participants included several members of the Medicare Payment Advisory Commission (MedPAC), senior legislative staff, and other health care economists and policy experts. Mr. Blum and others acknowledged the significant progress of the RUC and national medical specialties in improving relativity within the RBRVS.
- The AMA recently hosted a briefing for the health insurers that participate in the AMA's National Health Insurer Report Card. The purpose of the briefing was to explain the open nature of the CPT process and the RUC process and how health insurers and other payer can participate. Doctors Levy and Thorwarth, Jr attended to present these processes. The health insurers were encouraged to work with their representatives to the CPT Editorial Panel and the RUC so that we can work together to provide consistent application of CPT codes, guidelines and conventions across payers.
- Doctor Levy made clear to the RUC that the IWPUT materials found in the Research Subcommittee is information only. The Research Subcommittee will discuss IWPUT in depth in February 2011. At this time the RUC policy remains in place- IWPUT should not be used as the sole basis for recommendations.
- Before a presentation, any RUC member with a conflict will state their conflict. That RUC member will not discuss or vote on the issue and it will be reflected in the minutes.
- RUC members or alternates sitting at the table may not present or debate for their specialty. The RUC is an expert panel and individuals are to exercise their independent judgment and are not advocates for their specialty.

III. Director's Report

Sherry Smith made the following announcement:

- There will not be a separate 4th Five-Year Review meeting scheduled. All the codes identified through the Five-Year Review process will be reviewed at the September 29-October 3, 2010 RUC meeting.

IV. Approval of Minutes of the February 4-7, 2010 RUC Meeting

The RUC approved the February 2010 RUC Meeting Minutes with the addition of adding DoctorTerry Mills as a RUC Alternate in attendance.

V. CPT Editorial Panel Update

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

- The next scheduled CPT Editorial Panel meeting takes place June 3-5, 2010 at the Grand Hyatt in Washington, DC. The Panel has a light agenda with a strategic issues session scheduled.
- Doctor Kenneth Brin, Chair of the Joint CPT/RUC Workgroup and member of the CPT Editorial Panel is observing this meeting.

VI. Centers for Medicare and Medicaid Services Update

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

- President Obama has nominated Doctor Donald Berwick to be the next CMS Administrator and is waiting Congressional confirmation.
- Carol Bazell is now the Director of the Division of Practitioner Services
- CMS is still working to implement many of the initiatives from the health system reform legislation.

VII. Contractor Medical Director Update

Doctor Charles Haley provided the report of the Contractor Medical Directors:

- No additional A/B MAC Jurisdictions had been awarded as of the date of the meeting and that the nine jurisdictions that had been awarded were all fully operational. Six jurisdictions are awaiting final action (J2, J6, J7, J8, J11, J15).
- Under the previous contracting authority, facilities that sent their claims to a Part A contractor (fiscal intermediary [FI]) were allowed to choose either the state-based FI or one of the commercial FIs. Mutual of Omaha, the last of these commercial FIs, left the business. Their clients, currently handled by Wisconsin Physician Services, are being transitioned to the A/B MACs starting with Jurisdiction 1 in April 2010 followed by Jurisdiction 4 in October 2010.

VIII. Washington Update

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

- The AMA supports elements of the health system reform legislation including: reducing uninsured to 23 million by 2019, enhancing competition through exchanges in 2014 and investing in comparative effectiveness research and prevention and wellness.
- The AMA achieved several improvements to the final health system reform including: eliminating a Medicare/Medicaid enrollment fee for physicians, postponing PQRI penalties for 2 years and eliminating the budget neutrality offset for primary care bonus payments.
- The AMA remains concerned about the following issues concerning the reform legislation: the scope of the Independent Payment Advisory Board, medical liability, data disclosure, cost-quality value index and the lack of a permanent solution to eliminate the SGR payment formula.
- The reform legislation offers many key changes to Medicare physician payment including: extension of the work GPCI floor through 2010, 5% Psych bonus

extended through 2010, a 10% bonus for most office visits billed by primary care physicians is at least 60% of Medicare pay is for these visits and a 10% General Surgery bonus for major procedures in shortage areas.

- One of the AMA's essential elements of health system reform is the elimination of the SGR and opposition to another short-term fix. The legislation passed in December, March, mid-April provided temporary reprieves from a 21% cut. Absent comprehensive reform, health care policy will risk being dictated solely by budget imperatives.
- As Congress continues to delay permanent repeal of the SGR, the cost of not fixing the SGR formula continues to rise. A permanent repeal would cost currently cost just over $200 billion, in three years it will cost almost $400 billion and in five years a fix would cost over $500 billion.
- The AMA's message on the SGR remains that Congress must honor its commitment to seniors and military families and that health system improvement goals cannot be achieved on the back of a broken Medicare program.

Kurt Gillis, PhD, AMA Senior Economist, provided the RUC with the analysis of SGR spending and utilization growth in 2009:

- In the 2010 Final Rule, CMS removed drugs from SGR spending retroactive to base year 1996.
- The impacts of this change are large:
    - Cumulative SGR deficit is cut by $50 billion (from $70b to $20b through 2009)
    - 10 year cost of replacing SGR is reduced by $87.5 billion
- Overall, SGR spending for 2009 is up 4.8% along with the Medicare Fee Schedule spending, which is up 4.4%
- Imaging continues to see moderation in utilization growth and is similar to that for all services.
- Volume growth for new patient office visits is at 4% and critical care utilization has stabilized with 6% growth (down from 10% average in recent years).
- There was also an uptick in utilization growth for some major procedure categories, and minor procedures (physician therapy) and laboratory tests continued to have above-average utilization growth.

IX. Relative Value Recommendations for CPT 2011

<u>Excision and Debridement (Tab 4)</u>
Charles Mabry, MD, ACS, Christopher Senkowski, MD, ACS

CPT Codes 11043 and 11044 were identified by the RUC's Five Year Review Identification Workgroup through the Site of Service Anomaly Screen in September 2007. The specialty recommended and the RUC agreed that codes 11043 and 11044, along with family codes 11040-11042, should be reviewed by CPT because they may describe work that is too variable (ie, bi-modal). These codes were included with many other codes under review by the CPT Excision and Debridement Workgroup.

11010 Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin and subcutaneous tissues

11011 skin, subcutaneous tissue, muscle fascia, and muscle
11012 skin, subcutaneous tissue, muscle fascia, muscle, and bone

CPT codes 11010, 11011 and 11012 were revised at the October 2009 CPT Editorial Panel meeting to state, "Debridement including removal of foreign material at the site of an open fracture(s) and/or an open dislocation(s) (eg, excisional debridement);" The intent of this revision was to clarify to payors and providers that these codes describe debridement of a single traumatic wound caused by an open fracture which creates a single exposure, despite the number of fractures or dislocations in the same anatomic site. The CPT Editorial Panel and the RUC representative at that meeting were unsure if these changes were editorial and therefore requested further information from the specialty societies who perform these services. The specialties indicated that the intra-service work descriptors and the typical patient vignette used for all three codes when these codes were surveyed in 1996 are all quite specific that the typical patient and work involved are for a single traumatic wound from a single bon exposure. The typical patient vignette as societies who perform these services indicated that the original valuation of this service from a survey conducted in 1996 was based on a single fracture as clearly stated in their vignettes. **Based on this rationale, the RUC agreed with the specialty society that the revisions made to these descriptors were editorial and the current work RVUs for these services correctly relate to the typical patient and should be maintained.**

11042 Debridement subcutaneous tissue (includes epidermis and dermis, if performed); first 20 square centimeters or less

CPT Code 11042 was revised by the CPT Editorial Panel to Debridement subcutaneous tissue (includes epidermis and dermis, if performed); first 20 square centimeters or less skin, and subcutaneous tissue. The RUC reviewed the recommended work RVU for this service, 1.12 Work RVUs, and noted that it is higher than the current value for this service. The RUC reviewed the compelling evidence provided by the specialty that this service was originally surveyed by podiatry only and while they represent the dominant providers of the service (40%), general surgery (18%) was not represented in the 2005 survey of this service. Additionally, the RUC reviewed the RBRVS history of this code, including the fact that Harvard surveyed plastic surgeons (who represent a small fraction of the utilization); and that Harvard surveyed the codes with a 10-day global and then CMS (then HCFA) subsequently over several years reduced the work RVUs and changed the global period through the refinement process. The RUC agreed that there was compelling evidence to consider a new work RVU for this service.

The RUC reviewed the survey data for 11042 and made slight modifications to the pre-service time adjusting it to 11 minutes and agreed that 15 minutes of intra-service time and 10 minutes of post-service time were representative of the service. The specialty societies agreed that the survey median of 1.30 work RVUs was not an appropriate value for this service based on comparisons of time and intensity to the key reference code 16020 *Dressings and/or debridement of partial-thickness burns, initial or subsequent; small (less than 5% total body surface area*) (Work RVU=0.80). The specialty societies agreed that an appropriate recommendation would be to reaffirm the previous RUC HCPAC recommendation for this code, 1.12 work RVUs, as valued during the 2005 Five-Year Review. The RUC agreed that this was an appropriate valuation as it maintains relativity between the reference code and the surveyed code as the surveyed code has more intra-service time as compared to the reference code (15 minutes and 10 minutes,

respectively). Further, the surveyed code requires more psychological stress, physical effort and mental effort and judgment to perform than the reference code. An additional reference code that the RUC agreed validated this recommended work RVU is MPC code 56605 *Biopsy of vulva or perineum (separate procedure); 1 lesion* (Work RVU=1.10) as this reference code requires a similar amount of work to perform and has the same intra-service time, 15 minutes. **Based on these comparisons, the RUC recommends 1.12 Work RVUs for 11042.**

11045 Debridement subcutaneous tissue (includes epidermis and dermis, if performed); each additional 20 square centimeters, or part thereof (List separately in addition to code for primary procedure)

Based on the compelling evidence discussed and accepted by the RUC for code 11042, the RUC agreed that the work RVUs for 11045 did not require work neutrality. The specialties estimated that 20% of wounds reported with 11042 will be large enough or extensive enough (ie, trauma) to report one or more units of 11045. The specialty societies agreed that to appropriately value this service, the relativity of the survey data collected between 11042 and 11045 should be maintained. The recommended work RVU for 11042 (1.12 Work RVUs) was 14% less than the survey median work RVU (1.30 Work RVUs). Therefore, the specialty societies will maintain the percent difference by applying a 14 percent reduction to the median work value of 11045 (0.80 Work RVUs) resulting in a recommendation of 0.69 work RVUs for 11045. This value is further supported by reference code 36575 *Repair of tunneled or non-tunneled central venous access catheter, without subcutaneous port or pump, central or peripheral insertion site* (Work RVU=0.67) as this service and the surveyed code have similar work RVUs and the same intra-service time, 15 minutes**. Based on these comparisons, the RUC recommends 0.69 Work RVUs for 11045.**

11043 Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 square centimeters or less

In February 2010, the specialty societies surveyed 11043 and 11044 and found considerable disagreement with the survey vignettes and the new global period (090 days), along with wide variation in surveyed facility length of stay. Per the CPT revised introduction, these debridements may be reported for injuries, infections, wounds, or chronic ulcers. Although the breadth and depth of the debridement for each of these conditions may be similar, the pre-work and especially the post-work will be considerably different and widely variable. Additionally, the patient will be widely variable. The specialties recommended and the RUC agreed to request that CMS change the global period to 000. CMS agreed and codes 11043 and 11044 were re-surveyed as 000-day global codes.

Based on the compelling evidence discussed and accepted by the RUC for code 11042 as well as the change in global period, the RUC agreed that the work RVU for 11043 did not require work neutrality. At the April 2010 RUC meeting, the RUC reviewed the survey data from 54 general surgeons and podiatrists and compared the surveyed code to the key reference code 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). The RUC noted that the reference code had significantly more total service time as compared to the surveyed code, 115 minutes and 86 minutes respectively. Further, the RUC noted that the surveyed code was a less intense service to perform in comparison to the reference code. The RUC, based on this comparison,

agreed that 3.00 Work RVUs, the survey 25th percentile, accurately reflects the relative physician work to perform this service. **The RUC recommends 3.00 Work RVUs for 11043.**

11046 Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); each additional 20 square centimeters, or part thereof (List separately in addition to code for primary procedure)
Based on the compelling evidence discussed and accepted by the RUC for code 11042, the RUC agreed that the work RVU for 11046 did not require work neutrality. The RUC assessed the survey results from 30 general surgeons. The RUC reviewed the specialty's recommended service times and agreed that because this service has a ZZZ global period, that the post-service time should be reduced from 5 minutes to 1 minute to account for additional monitoring for infection; additional discussion about ongoing care with facility staff and patient/family; and additional application of dressings/padding. This reduction to the immediate post-service time also makes this service consistent with other ZZZ global codes which have very minimal or no pre and post service times associated with them. The RUC compared the surveyed code to the key reference code 15005 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children* (Work RVU=1.60). The RUC noted that with the change in post-service time for the surveyed code, both 11046 and 15005 require the same amount of time to perform, 21 minutes. However, the RUC noted that the reference code requires greater technical skill, physical effort and psychological stress to perform in comparison to the surveyed code because of the surgical site, eg, face, eyelids, mouth and/or genitalia. Based on this comparison, the RUC agreed that 1.29 RVUs, the survey's 25th percentile, accurately reflects the relative physician work to perform this service. **The RUC recommends 1.29 Work RVUs for 11046.**

11044 Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 square centimeters or less
In February 2010, the specialty societies surveyed 11043 and 11044 and found considerable disagreement with the survey vignettes and the new global period (090 days), along with wide variation in surveyed facility length of stay. Per the CPT revised introduction, these debridements may be reported for injuries, infections, wounds, or chronic ulcers. Although the breadth and depth of the debridement for each of these conditions may be similar, the pre-work and especially the post-work will be considerably different and widely variable. Additionally, the patient will be widely variable. The specialties recommended and the RUC agreed to request that CMS change the global period to 000. CMS agreed and codes 11043 and 11044 were re-surveyed as 000-day global codes.

Based on the compelling evidence discussed and accepted by the RUC for code 11042 as well as the change in global period, the RUC agreed that the work RVU for 11044 did not require work neutrality. At the April 2010 meeting, the RUC reviewed the survey data from 48 general surgeons and podiatrists and compared the surveyed code to the reference code 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). The RUC noted that the reference code had the same intra-service time, 45 minutes. Further, the RUC noted that the surveyed code and the reference code required similar mental effort and judgment to perform. The RUC, based on this comparison, agreed that 4.56 Work RVUs, the survey 25th percentile, accurately reflects the relative physician work to perform this service and maintains proper rank order with 11042 and 11043. **The RUC recommends 4.56 Work RVUs for 11044.**

11047 Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); each additional 20 square centimeters, or part thereof
Based on the compelling evidence discussed and accepted by the RUC for code 11042, the RUC agreed that the work RVU for 11047 did not require work neutrality. The RUC reviewed the survey data from 30 general surgeons. The RUC agreed with the specialty's recommended service times as this service has a ZZZ global period, the post-service time should be reduced from 5 minutes to 1 minute to account for the additional monitoring time for infection, additional application of dressing/padding and additional discussion about ongoing care with facility staff as well as to make consistent with other ZZZ global codes which have very minimal or no pre and post service times associated with them. The RUC compared the surveyed code to the reference code 15005 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children* (Work RVU=1.60). The RUC noted that the surveyed code has more intra-service time as compared to the reference code, 30 minutes and 20 minutes, respectively. Further, the RUC noted that the surveyed code requires greater mental effort and judgment, psychological stress as well as overall is a more intense procedure to perform in comparison to the reference code. Based on this comparison, the RUC agreed that 2.00 work RVUs, the survey's median, accurately reflects the relative physician work to perform this service. **The RUC recommends 2.00 Work RVUs for 11047.**

Practice Expense
The RUC reviewed and accepted the direct practice expense inputs for 11042-11047 in the non-facility and facility settings.

<u>Hip Arthroscopy (Tab 5)</u>
William Creevy, MD, AAOS, Louis McIntyre, MD, AAOS
Facilitation Committee #1

The CPT Editorial Panel created three new codes to report arthroscopic hip reconstructive procedures. Several hundred procedures are expected to be provided to the Medicare population.

29914 Arthroscopy, hip, surgical; with femoroplasty (ie, treatment of cam lesion)

The RUC reviewed the surveyed physician time data from 75 orthopaedic surgeons for 29914 and agreed with the specialty society that they were reflective of service including the additional 17 minutes of pre-service positioning time. This additional time is consistent with the RUC approved pre-service lateral positioning time as established for spinal surgery procedures and therefore determined to be appropriate for this service. The RUC reviewed 29914 and compared it to 29888 *Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction* (Work RVU =14.30). While

these services have similar total time 280 minutes and 283 minutes, respectively, the RUC agreed that 29914 should be valued higher because the arthroscopy of the hip is a more intense procedure that requires the physician to cut deeper to reach the joint, while operating in a more confined space compared to other arthroscopy services (knee and shoulder). Further, the RUC compared the surveyed service to 29807 *Arthroscopy, shoulder, surgical; repair of SLAP lesion* (Work RVU =14.67, intra time = 90 minutes). The RUC agreed that this service is similar to the surveyed service with analogous total times (280 minutes and 288 minutes respectively) and comparable work RVUs. Finally, the RUC considered the greater intensity and complexity of 29914 compared with other services and agreed that any work RVU lower than that of 29807 would create a rank order anomaly among the arthroscopy family of codes. **Based on this comparison the RUC recommends that the work of 29914 be crosswalked to 29807, Work RVU of 14.67, a value lower than the survey's 25th percentile.**

29915 Arthroscopy, hip, surgical; acetabuloplasty (ie, treatment of pincer lesion) and 29916 Arthroscopy, hip, surgical; labral repair

The RUC reviewed the surveyed physician time from 75 orthopaedic surgeons for 29915 and 29916 and agreed with the specialty society that they were reflective of the services including the additional 17 minutes of pre-service positioning time. This additional time is consistent with the RUC approved pre-service lateral positioning time as established for spinal surgery procedures and therefore determined to be appropriate for these services. The RUC reviewed 29915 *Arthroscopy, hip, surgical; acetabuloplasty (ie, treatment of pincer lesion)* and 29916 *Arthroscopy, hip, surgical; labral repair*. The RUC compared these services to 29914 and the other arthroscopy services with RUC-approved times including 29806 *Arthroscopy, shoulder, surgical; capsulorrhaphy* (Work RVU=15.14). The RUC noted that the surveyed codes have less total service time in comparison to 29806, 270 minutes and 298 minutes, respectively. Additionally, the RUC compared these services to 29914 to ensure rank order in the family. The RUC noted that while 29915 and 29916 have less intra-service time, 90 minutes respectively, compared with 100 minutes for 29914, the intensity and complexity is greater and these two services should be valued higher than 29914. The RUC agreed that these two services are more intense than 29914 because of a number of additional elements including: suture anchor placement, additional portals and arthroscopic suture passing and knot tying. **Considering all of these points of comparison, the RUC recommends a Work RVU of 15.00 for both 29915 and 29916, a value lower than the surveys' 25th percentile.**

In addition, the RUC discussed at length the issue of high IWPUTs for these services and agree that the recommended times accurately reflect reasonable IWPUTs. With the recommended work RVUs, 29914 has an IWPUT of .094. This value is comparable to the IWPUTs of the other RUC-approved reference services (29888= .089 and 29807= .097). The RUC reviewed the IWPUTs for the more intense procedures 29915 and 299146 (IWPUT = .108) and agreed that they were reasonable as these services are the most intense arthroscopic procedures currently being performed by physicians.

Practice Expense: The specialty recommended and the RUC recommends standard 090 day global practice expense inputs, for these are provided only in the facility setting.

New Technology: As the technology to perform these services is new and to ensure that the utilization estimates provided by the specialty are accurate, **the RUC recommended that 29914, 29915 and 29916 be added to the New Technology/Service List.**

Lung Resection Procedures (Tab 6)
Keith Naunheim, MD, STS, Francis Nichols, MD, STS
Facilitation Committee #2

The Society of Thoracic Surgeons (STS) requested that the lung resection codes be deferred from publication until CPT 2012. STS brought forward these codes voluntarily as part of a major re-organization project to ensure accurate coding and reimbursement for these procedures. STS requested deferment to address a number of issues with this series of codes, requiring additional time to work with CMS on the global fee periods for the identified procedures as well as to get additional data to help address the discrepancies in the magnitude estimations from the survey data. The RUC supports the specialty society request to defer these codes from publication until CPT 2012. The CPT Executive Committee deferred this issue.

Endovascular Revascularization (Tab 7)
Joseph Babb, MD, ACC, David Han, MD, SVS, Clifford Kavinsky, MD, ACC, Arthur Lee, MD, ACC, Geraldine McGinty, MD, ACR, Gerald Niedzwiecki, MD, SIR, Gary Seabrook, MD, SVS, Mathew Sideman, MD
Facilitation Committee #2

The RUC identified the endovascular revascularization procedures as potentially misvalued based on the recommendation of the Five-Year Review Identification Workgroup. These codes were referred to the Workgroup for review via the CMS Fastest Growing Screen and High Volume Growth Screen. The specialty societies explained to the RUC that these services need to be clarified through the CPT Editorial Panel process to clearly define the four treatment modalities (angioplasty, stenting, arthrectomy, and stenting plus arthrectomy) that are applied in three different arterial beds (iliac, femoropopiteal and tibial). Further, all of the percutaneous vascular intervention procedures are currently reported with the component coding approach, meaning that at least three codes are used to report each treatment at any single level in the arterial tree. The three codes currently reported include: 1.) a selective catheterization code, plus 2.) a radiological supervision and interpretation code and 3.) a treatment code. The new structure bundles these three services into one code.

37205 Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; initial vessel, **37206** Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; each additional vessel, **37207** Transcatheter placement of an intravascular stent(s) (non-coronary vessel other than iliac and lower extremity arteries), open; initial vessel, **37208** Transcatheter placement of an intravascular stent(s) (non-coronary vessel other than iliac and lower extremity arteries), open; each additional vessel, **75960** Transcatheter introduction of intravascular stent(s) (except coronary, carotid, and, iliac, and lower extremity artery), percutaneous and/or open, radiological supervision and interpretation, each vessel, **75962** Transluminal balloon angioplasty, peripheral artery other than iliac or lower extremity, radiological supervision and interpretation and **75964** Transluminal balloon angioplasty, each

additional peripheral artery other than iliac and lower extremity, radiological supervision and interpretation
The specialty societies have requested that the full RUC survey and RUC review of these services be postponed until after the family of new lower extremity interventional codes has been implemented and the societies have a better estimate of the volume shifts and definition of the typical patient for these remaining procedures. **The RUC recommends the postponement of the review of 37205, 37206, 37207, 37208, 75960, 75962 and 75964 until after the new lower extremity interventional codes has been implemented. The RUC recommends that the current values be maintained.**

37220 Revascularization, iliac artery, unilateral, initial vessel; with transluminal angioplasty
The RUC reviewed the survey data from 129 cardiologists, vascular surgeons and radiologists for the new bundled code, 37220. This code describes a service that was previously reported with the existing iliac angioplasty code (35473 = 6.03 RVUs) plus the existing radiological S&I code for balloon angioplasty (75962 = 0.54 RVUs) plus a catheterization code, either 36200, 36245 or 36246 for this procedure depending on the access site chosen and the exact target vessel. To best estimate the work of the catheterization code selected, the specialty society took an average of these three codes (4.32 RVUs) and reduce that value by 50% for the multiple procedure reduction (thus, 4.32 x 0.5=2.16) resulting in an estimate of 8.73 RVUs for the typical iliac angioplasty case.

The RUC agreed with the specialty societies' recommended physician time components for this service. The specialty society explained that 7 minutes of evaluation time was added to account for selection and verification of numerous supplies and devices, review and set-up of significant imaging equipment, and the coordination of all technical staff. The 2 additional minutes of positioning time were added for appropriately positioning and securing the patient on the angiographic table including the placement of bolsters to protect the arms and placement of rulers underneath the patient to make sure that there is a reference for the physician during the deployment of the devices as well as other activities which are required in order to be able to obtain all necessary views to treat the lesion. The RUC compared this service to reference code 36478 *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated* (Work RVU=6.72). The RUC noted that the surveyed code has more intra-service work as compared to the reference code, 60 minutes and 55 minutes respectively. Further, the RUC noted that the surveyed code requires significantly more mental effort and judgment, technical skill, and results in more psychological stress as compared to the reference code. Based on these comparisons to the reference code, the specialty societies recommend and the RUC agreed that the survey median, 8.15 RVUs, accurately reflects the work required to perform this service. **The RUC recommends 8.15 Work RVUs for 37220.**

37221 Revascularization, iliac artery, unilateral, initial vessel; with transluminal stent placement(s)
The RUC reviewed the survey data from 126 cardiologists, vascular surgeons and radiologists for new bundled code, 37221. This code describes a service that was previously reported with the existing stent code (37205 = 8.27 RVUs) plus the existing radiological S&I code for stent (75960 = 0.82 RVUs) plus one catheterization code, either 36200, 36245 or 36246 depending on the access site chosen and the exact target vessel. To best estimate the work of the catheterization code selected, the specialty

society took an average of these three codes (4.32 RVUs) and reduce it by 50% for multiple procedure reduction (thus, 2.16 Work RVUs). In addition, many current providers additionally report a balloon angioplasty and angioplasty S&I code during an iliac stent procedure (balloon is 35473 = 6.03 RVUs cut by 50% for multiple procedure = 3.02, and angioplasty S&I is 0.54). This component coding resulted in an estimate of 14.81 work RVUs for placement of an iliac stent. The RUC agreed with the specialty societies' recommended physician time components for this service. The specialty society explained that 7 minutes of evaluation time was added to account for selection and verification of numerous supplies and devices, review and set-up of significant imaging equipment, and the coordination of all technical staff. The 2 additional minutes of positioning time were added for appropriately positioning and securing the patient on the angiographic table including the placement of bolsters to protect the arms and placement of rulers underneath the patient to make sure that there is a reference for the physician during the deployment of the devices as well as other activities which are required in order to be able to obtain all necessary views to treat the lesion. The RUC compared this service to reference code 92980 *Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel* (Work RVU=14.82). The RUC noted that the surveyed code has less intra-service work as compared to the reference code, 90 minutes and 120 minutes respectively. Further, the RUC noted that the reference code requires more medical decision making, physical effort, and results in more psychological stress as compared to the surveyed code. Based on these comparisons to the reference code, the specialty societies recommend and the RUC agreed that the survey median, 10.00 RVUs, accurately reflects the work required to perform this service. **The RUC recommends 10.00 Work RVUs for 37221.**

37222 Revascularization, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty (List separately in addition to code for primary procedure
The RUC reviewed the survey data from 79 cardiologists, vascular surgeons and radiologists for the new bundled code, 37222. This code describes a service that was previously reported with the iliac angioplasty code (35473 = 6.03 RVUs) plus the existing radiological S&I code for balloon angioplasty (75962 = 0.54 RVUs) resulting in an estimate of 6.57 RVUs for the typical iliac angioplasty patient. The RUC agreed with the specialty societies' recommended physician time components for this service. The specialty society explained that the additional minute of pre-service time represents the time required for the physician to consider the additional site of treatment, size of necessary devices for the second site, availability of those devices, the order to proceed, the approach to use and the impact the second site will have on the potential use of an embolic protection device. The specialty society explained that the additional minute of post-service time represents the additional time to review extra films and dictating extra procedural details in the interpretation. Patients with more than one treatment site require longer discussion and explanation. Additionally, more attention is required for the limb that has multiple treatment sites to ensure absence of embolization and adequacy of perfusion. The RUC reviewed the physician work of CPT Code 60512 *Parathyroid autotransplantation (List separately in addition to code for primary procedure)* (ZZZ global, 45 minutes intra-service time, Work RVU = 4.44) and agreed this service was more intense and has more overall physician work than the new code. The RUC also reviewed CPT Code 49329 *Laparoscopy, surgical; with omentopexy (omental tacking procedure) (List separately in addition to code for primary procedure)* (ZZZ Global, 45 minute intra-service time, Work RVU = 3.50) and agreed this service was less intense and contains less physician work per minute than the new code. The specialty societies

indicated that CPT Code 14302 *Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)* (ZZZ Global, 40 minutes intra-service time, Work RVU = 3.73) is very similar in overall physician work and intensity to new code 37222. The RUC concurred that the physician work value for the new code should be below the specialty's 25th percentile survey work value of 4.12 and relative to other ZZZ global codes with similar intra-service time. The RUC agreed that the value of 37222 should be directly crosswalked from 14302. **The RUC recommends 3.73 Work RVUs for 37222, a value just below the 25th percentile.**

37223 Revascularization, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s)

The RUC reviewed the survey data from 79 cardiologists, vascular surgeons and radiologists for the new bundled code, 37223. This code describes a service that was previously reported with add-on stent code (37206 = 4.12 RVUs) and its associated S&I code (75960 = 0.82) resulting in an estimate of 4.94 Work RVUs. In some instances, providers will report only these two codes, while others will additionally report a iliac angioplasty code (35473 = 3.02 RVUs after 50% reduction) plus the existing radiological S&I code for balloon angioplasty (75962 = 0.54 RVUs) for a total of 8.50 work RVUs. The RUC agreed with the specialty societies' recommended physician time components for this service. The specialty society explained that the additional minute of pre-service time represents the time required for the physician to consider the additional site of treatment, size of necessary devices for the second site, availability of those devices, the order to proceed, the approach to use and the impact the second site will have on the potential use of an embolic protection device. The specialty society explained that the additional minute of post-service time represents the additional time to review extra films and dictating extra procedural details in the interpretation. Patients with more than one treatment site require longer discussion and explanation. Additionally, more attention is required for the limb that has multiple treatment sites to ensure absence of embolization and adequacy of perfusion. The RUC reviewed the surveyed code in comparison to the reference code 34826 *Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; each additional vessel* (Work RVU=4.12). The RUC noted that the surveyed code has more intra-service time as compared to the reference code, 45 minutes and 30 minutes, respectively. Further, the RUC noted that the surveyed code was a slightly more intense procedure to perform in comparison to the reference code. Based on these comparisons, the specialty societies agree that 4.25 work RVUs, the survey's 25th percentile, accurately reflects the work required to perform the service. **The RUC recommends 4.25 Work RVUs for 37223.**

37224 Revascularization, femoral/popliteal artery(s), unilateral; with transluminal angioplasty

The RUC reviewed the survey data from 89 cardiologists, vascular surgeons and radiologists for new bundled code. 37224. This code describes a service that was previously reported with the existing fem-pop angioplasty code (35474 = 7.35 RVUs) plus the existing radiological S&I code for balloon angioplasty (75962 = 0.54 RVUs) plus one catheterization code that would be used for this procedure, typically 36247 (6.29 RVUs), resulting in 11.04 RVUs. The RUC agreed with the specialty societies' recommended physician time components for this service. The specialty society explained that 7 minutes of evaluation time was added to account for the selection and verification of numerous supplies and devices, review and set-up of significant imaging

equipment, and the coordination of all technical staff. The 2 additional minutes of positioning time were added for appropriately positioning and securing the patient on the angiographic table including the placement of bolsters to protect the arms and placement of rulers underneath the patient to make sure that there is a reference for the physician during the deployment of the devices as well as other activities which are required in order to be able to obtain all necessary views to treat the lesion. The RUC compared this service to reference code 61640 *Balloon dilatation of intracranial vasospasm, percutaneous; initial vessel* (Work RVU=12.32). The RUC noted that although the survey respondents indicated that the surveyed code and 92980 are similarly intense services, the reference code has significantly more total physician time as compared to the surveyed code, 227 minutes and 158 minutes, respectively. The specialty societies addressed the high intensity of this service by explaining that 37224 represents the bundling of services which includes the removal of duplicative pre- and post-service time, lower intense activities, and leaves only the higher intense components, the intra-service time, bundled 37224. The RUC agrees that the high intensity of this service is appropriate in comparison to the reference code and maintains rank order with the intensities associated with the endovascular aneurysm codes. Based on these comparisons to the reference code, the specialty societies recommend and the RUC agrees that the survey median, 9.00 RVUs, accurately reflects the work required to perform this service. **The RUC recommends 9.00 Work RVUs for 37224.**

37225 Revascularization, femoral/popliteal artery(s), unilateral; with atherectomy
The RUC reviewed the survey data from 82 cardiologists, vascular surgeons and radiologists for new bundled code, 37225. This code describes a service that was previously reported with the existing atherectomy code (35493 = 8.09 RVU) plus the existing radiological S&I code for atherectomy (75992 = 0.54 RVU) plus one catheterization code, typically 36247 (3.15 RVUs after 50% payment reduction), resulting in 11.78 Work RVUs. In addition, many providers additionally report a balloon angioplasty and balloon angioplasty S&I during an atherectomy procedure (35474 = 7.35 RVUs cut by 50% for multiple procedure = 3.68, plus 0.54 for the angioplasty S&I), resulting in 16.00 work RVUs. The RUC agreed with the specialty societies' recommended physician time components for this service. The specialty society explained that 7 minutes of evaluation time was added to account for the selection and verification of numerous supplies and devices, review and set-up of significant imaging equipment, and the coordination of all technical staff. The 2 additional minutes of positioning time were added for appropriate positioning and securing the patient on the angiographic table including the placement of bolsters to protect the arms and placement of rulers underneath the patient to make sure that there is a reference for the physician during the deployment of the devices as well as other activities which are required in order to be able to obtain all necessary views to treat the lesion. The RUC compared this service to reference code 37184 *Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel* (Work RVU=8.66). The RUC noted that the surveyed code has more intra-service work as compared to the reference code, 118 minutes and 90 minutes, respectively. Further, the RUC noted that the surveyed code requires more mental effort and judgment, physical effort, and results in more psychological stress as compared to the surveyed code. Based on these comparisons to the reference code, the specialty societies recommend and the RUC agrees that the survey median, 12.00 RVUs, accurately reflects the work required to perform this service. **The RUC recommends 12.00 Work RVUs for 37225.**

37226 Revascularization, femoral/popliteal artery(s), unilateral; with transluminal stent placement(s)

The RUC reviewed the survey data from 89 cardiologists, vascular surgeons, and radiologists for new bundled code, 37226. This code describes a service that was previously reported with the existing stent code (37205 = 8.27 RVU) plus the existing radiological S&I code for peripheral stent (75960 = 0.82 RVU) plus one catheterization code (36247 = 3.15 RVUs after the 50% multiple procedure reduction), resulting in 12.24 Work RVUs. In addition, many providers also report a balloon angioplasty (35474, 7.35 RVU) and balloon angioplasty S&I (75962, 0.54 RVU) during a fem/pop stent procedure, resulting in 16.46 Work RVUs. The RUC agreed with the specialty societies' recommended physician time components for this service. The specialty society explained that 7 minutes of evaluation time was added to account for the selection and verification of numerous supplies and devices, review and set-up of significant imaging equipment, and the coordination of all technical staff. The 2 additional minutes of positioning time were added for appropriate positioning and securing the patient on the angiographic table including the placement of bolsters to protect the arms and placement of rulers underneath the patient to make sure that there is a reference for the physician during the deployment of the devices as well as other activities which are required in order to be able to obtain all necessary views to treat the lesion. The RUC compared this service to reference code 92980 *Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel* (Work RVU=14.82). The RUC noted that although the survey respondents indicated that the surveyed code was overall a more intense service to perform in comparison to 92980, the reference code has significantly more intra-service time as compared to the surveyed code, 120 minutes and 90 minutes, respectively. The specialty societies addressed the high intensity of this service by explaining that 37226 represents the bundling of services which includes the removal of duplicative pre- and post-service time, lower intense activities, and leaves only the higher intense components, the intra-service time, bundled 37226. The RUC agrees that the high intensity of this service is appropriate in comparison to the reference code and maintains rank order with the intensities associated with the endovascular aneurysm codes. Based on these comparisons to the reference code, the specialty societies recommend and the RUC agrees that the survey median, 10.49 RVUs, accurately reflects the work required to perform this service. **The RUC recommends 10.49 Work RVUs for 37226.**

37227 Revascularization, femoral/popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy

The RUC reviewed the survey data from 83 cardiologists, vascular surgeons an radiologists for new bundled code, 37227. This code describes a service that was previously reported with the existing stent code (37205 = 8.27 RVU) plus the existing radiological S&I code for peripheral stent (75960 = 0.82 RVU) plus one catheterization code, typically 36247 (3.15 Work RVUs after the 50% multiple procedure reduction) plus one atherectomy code (35493 = 4.05 Work RVUs after the 50% multiple procedure reduction) plus one atherectomy S&I (75992 = 0.54 RVU), resulting in 16.83 work RVUs. In addition, many providers additionally report a balloon angioplasty and balloon angioplasty S&I during this procedure (35474 = 7.35 RVUs cut by 50% for multiple procedure = 3.66 plus 0.54 for the angioplasty S&I), resulting in 21.03 Work RVUs. The RUC agreed with the specialty societies' recommended physician time components for this service. The specialty society explained that 7 minutes of evaluation time was added to account for the selection and verification of numerous supplies and devices, review and set-up of significant imaging equipment, and the coordination of all

technical staff. The 2 additional minutes of positioning time were added for appropriate positioning and securing the patient on the angiographic table including the placement of bolsters to protect the arms and placement of rulers underneath the patient to make sure that there is a reference for the physician during the deployment of the devices as well as other activities which are required in order to be able to obtain all necessary views to treat the lesion. The RUC compared this service to reference code 37182 *Insertion of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract formation/dilatation, stent placement and all associated imaging guidance and documentation)* (Work RVU=16.97). The RUC noted that the surveyed code has less intra-service work as compared to the reference code, 125 minutes and 150 minutes, respectively. Further, the RUC noted that the surveyed code requires more mental effort and judgment, physical effort, resulting in more psychological stress as compared to the surveyed code. Based on these comparisons to the reference code, the specialty societies recommend and the RUC agrees that the survey median, 14.50 RVUs, accurately reflects the work required to perform this service. **The RUC recommends 14.50 Work RVUs for 37227.**

37228 Revascularization, tibial/peroneal artery, unilateral, initial vessel; with transluminal angioplasty

The RUC reviewed the survey data from 74 cardiologists, vascular surgeons and radiologists for new bundled code, 37228. This code describes a service that was previously reported with the existing tibial peroneal angioplasty code (35470 = 8.62 RVUs) plus the existing radiological S&I code for balloon angioplasty (75962 = 0.54 RVUs) plus one catheterization code that would be used for this procedure, typically 36247 (3.15 RVUs after 50% multiple procedure reduction), resulting in 12.31 RVUs. The RUC agreed with the specialty societies' recommended physician time components for this service. The specialty society explained that 7 minutes of evaluation time was added to account for the selection and verification of numerous supplies and devices, review and set-up of significant imaging equipment, and the coordination of all technical staff. The 2 additional minutes of positioning time were added for appropriate positioning and securing the patient on the angiographic table including the placement of bolsters to protect the arms and placement of rulers underneath the patient to make sure that there is a reference for the physician during the deployment of the devices as well as other activities which are required in order to be able to obtain all necessary views to treat the lesion. The RUC compared this service to reference code 61640 *Balloon dilatation of intracranial vasospasm, percutaneous; initial vessel* (Work RVU=12.32). The RUC noted that the reference code has more total physician time in comparison to the surveyed code (227 minutes and 168 minutes, respectively). Further, the RUC noted that the reference code requires more technical skill, urgency of decision making and overall is a more intense service to perform in comparison to the surveyed code. However, the specialty societies agreed that the median value of 12.00 over-estimated the amount of work for this service and did not maintain rank order between 37228 and 37226 *Revascularization, femoral/popliteal artery(s), unilateral; with transluminal stent placement(s)*. The specialty societies explained that although 37228 and 37226 have the same total service time, they are performed in different vascular beds and as the vessels get smaller the intensity of the work is greater. Based on this explanation, 37228 should be valued higher than 37226. Therefore, the specialty societies agree that 11.00 Work RVUs, a value slightly less than the survey median, adequately reflects the work being performed and preserves the increment of work between 37226 and 37228. **The RUC recommends 11.00 Work RVUs for 37228.**

37229 Revascularization, tibial/peroneal artery, unilateral, initial vessel; with atherectomy

The RUC reviewed the survey data from 68 cardiologists, vascular surgeons and radiologists for new bundled code, 37229. This code describes a service that was previously reported with the existing stent code (35495 = 9.48 RVUs) plus the existing radiological S&I code for peripheral atherectomy. (75992 = 0.54 RVUs) plus the catheterization code that would be used for this procedure (36247 = 3.15 after 50% multiple procedure reduction), resulting in 13.17 RVUs. In addition, we believe many of today's providers will additionally report a balloon angioplasty and balloon angioplasty S&I during an iliac stent procedure (35470 = 4.31 RVUs after 50% multiple procedure reduction) plus the angioplasty S&I (75962 = 0.54), resulting in 18.02 Work RVUs. The RUC agreed with the specialty societies' recommended physician time components for this service. The specialty society explained that 7 minutes of evaluation time was added to account for the selection and verification of numerous supplies and devices, review and set-up of significant imaging equipment, and the coordination of all technical staff. The 2 additional minutes of positioning time were added for appropriate positioning and securing the patient on the angiographic table including the placement of bolsters to protect the arms and placement of rulers underneath the patient to make sure that there is a reference for the physician during the deployment of the devices as well as other activities which are required in order to be able to obtain all necessary views to treat the lesion. The RUC compared this service to reference code 92980 *Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel* (Work RVU=14.82). The RUC noted that although the survey respondents indicated that the surveyed code was overall a more intense service to perform in comparison to 92980, the reference code has significantly more total physician time as compared to the surveyed code, 225 minutes and 198 minutes, respectively. Overall, 92980 is a good reference code as it describes, access, catheterization of a remote vascular bed (100-120 cm) with selection across stenoses of small caliber 2-4 mm vessels, followed by angioplasty and stent placement. However, the vessels and treatment zones are shorter in the coronary bed (92980), and longer in the tibial bed (37229) with same obligate catheter exchanges, long length guidewires, multiple and sometimes prolonged inflations of the angioplasty balloon, stent deployment, pressure measurements, and follow-up angiography, hence the survey median value for 37229 maintains proper rank order with 92980. Based on these comparisons to the reference code, the specialty societies recommend and the RUC agrees that the survey median, 14.05 RVUs, accurately reflects the work required to perform this service. **The RUC recommends 14.05 Work RVUs for 37229.**

37230 Revascularization, tibial/peroneal artery, unilateral, initial vessel; with transluminal stent placement(s)

The RUC reviewed the survey data from 72 cardiologists, vascular surgeons and radiologists for new bundled code, 37230. This code describes a service that was previously reported with the existing stent code (37205 = 8.27 RVUs) plus the existing radiological S&I code for peripheral stent (75960 = 0.82 RVUs) plus selective catheterization (36247 = 3.15 RVUs after 50% multiple procedure reduction), resulting in 12.24 RVUs. In addition, we believe many of today's providers will additionally report a balloon angioplasty and balloon angioplasty S&I during a tibial stent procedure as stenting is often a bailout for failed angioplasty thus (35470 = 4.31 RVUs after 50% multiple procedure reduction) plus the angioplasty S&I (75962 = 0.54 RVUs), resulting in 17.09 RVUs. The RUC agreed with the specialty societies' recommended physician

time components for this service. The specialty society explained that 7 minutes of evaluation time was added to account for the selection and verification of numerous supplies and devices, review and set-up of significant imaging equipment, and the coordination of all technical staff. The 2 additional minutes of positioning time were added for appropriate positioning and securing the patient on the angiographic table including the placement of bolsters to protect the arms and placement of rulers underneath the patient to make sure that there is a reference for the physician during the deployment of the devices as well as other activities which are required in order to be able to obtain all necessary views to treat the lesion. The RUC compared this service to reference code 92980 *Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel* (Work RVU=14.82). The RUC noted that although the survey respondents indicated that the surveyed code was overall a more intense service to perform in comparison to 92980, the reference code has significantly more total physician time as compared to the surveyed code, 225 minutes and 195 minutes, respectively. Overall, 92980 is a good reference code as it describes, access, catheterization of a remote vascular bed (100-120 cm) with selection across stenoses of small caliber 2-4 mm vessels, followed by angioplasty and stent placement. However, the vessels and treatment zones are shorter in the coronary bed (92980), and longer in the tibial bed (37230) with same obligate catheter exchanges, long length guidewires, multiple and sometimes prolonged inflations of the angioplasty balloon, stent deployment, pressure measurements, and follow-up angiography, hence the survey median value for 37230 maintains proper rank order with 92980. Based on these comparisons to the reference code, the specialty societies recommend and the RUC agrees that the survey median, 13.80 RVUs, accurately reflects the work required to perform this service. **The RUC recommends 13.80 Work RVUs for 37230.**

37231 Revascularization, tibial/peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy

The RUC reviewed the survey data from 67 cardiologists, radiologists and vascular surgeons for new bundled code, 37231. This code described a service that was previously reported with the existing atherectomy code 35495 = 9.48 RVUs reported with its radiological S&I code (75992 = 0.54 RVUs) in addition to the stent code (37205 = 4.14 RVUs after 50% multiple procedure reduction) plus the existing radiological S&I code for peripheral stent (75960 = 0.82 RVUs) plus the catheterization code (36247 = 3.15 RVUs after the 50% multiple procedure reduction), resulting in 18.13 RVUs. In addition, we believe many of today's providers will additionally report a balloon angioplasty and balloon angioplasty S&I during an iliac stent procedure (35473 = 3.02 RVUs after the 50% multiple procedure reduction) plus angioplasty S&I (75962 = 0.54 RVUs), resulting in 21.69 RVUs. The RUC agreed with the specialty societies' recommended physician time components for this service. The specialty society explained that 7 minutes of evaluation time was added to account for the selection and verification of numerous supplies and devices, review and set-up of significant imaging equipment, and the coordination of all technical staff. The 2 additional minutes of positioning time were added for appropriate positioning and securing the patient on the angiographic table including the placement of bolsters to protect the arms and placement of rulers underneath the patient to make sure that there is a reference for the physician during the deployment of the devices as well as other activities which are required in order to be able to obtain all necessary views to treat the lesion. The RUC compared this service to reference code 92980 *Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel*

(Work RVU=14.82). The RUC noted that the surveyed code has more intra-service work as compared to the reference code, 135 minutes and 120 minutes, respectively. Further, the RUC noted that the surveyed code requires more mental effort and judgment, physical effort, and results in more psychological stress as compared to the surveyed code. Based on these comparisons to the reference code, the specialty societies recommend and the RUC agrees that the survey median, 15.00 RVUs, accurately reflects the work required to perform this service and maintains rank order with 37231. **The RUC recommends 15.00 Work RVUs for 37231.**

37232 Revascularization, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty

The RUC reviewed the survey data from 64 cardiologists, vascular surgeons and radiologists for the new bundled code, 37232. This code describes a service that was previously reported with the existing tibial angioplasty code (35470 = 4.31 RVUs after 50% multiple procedure reduction) plus its radiological S&I code (75964 = 0.36 RVUs), plus the catheterization of each additional tibial artery (36248 = 1.01 RVUs), resulting in 5.68 RVUs. The RUC agreed with the specialty societies' recommended physician time components for this service. The specialty society explained that the additional minute of pre-service time represents the time required for the physician to consider the additional site of treatment, size of necessary devices for the second site, availability of those devices, the order to proceed, the approach to use and the impact the second site will have on the potential use of an embolic protection device. The specialty society explained that the additional minute of post-service time represents the additional time to review extra films and dictating extra procedural details in the interpretation. Patients with more than one treatment site require longer discussion and explanation. Additionally, more attention is required for the limb that has multiple treatment sites to ensure absence of embolization and adequacy of perfusion. The RUC understood that this was a rarely performed service when reviewing the surveyed code in comparison to the reference code 34826 *Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; each additional vessel* (Work RVU=4.12). The RUC noted that the surveyed code had more intra-service time in comparison to the reference code, 40 minutes and 30 minutes, respectively. The RUC also noted that the reference 34826 is analogous to the surveyed service. Intra-service time of the reference is less, but the work itself is similar to 37232 in that during an ongoing complex endovascular intervention (aortic endografting) an additional procedure is done with already existing catheters in place. Compared to placement of an aortic cuff, tibial intervention involves considerably more superselective catheter work (as opposed to nonselective placement of a stent-graft extension) with greater lengths of diseased vessel and longer catheters. Tibial intervention involve the complexity of multiple lesions treated with a greater possibility of distal embolization and/ or vascular occlusion. Based on these comparisons, the specialty societies agreed that the service should be valued higher than the reference code. However, the specialty societies explained that for this service it is much more difficult to deliver the first stent than the second stent. After reviewing the intensities of the base codes: 37228, 37230 and 37231, the specialty societies agreed that to maintain relativity with the base codes, 4.00 work RVUs, the survey's 25th percentile, accurately reflects the work required to perform the service. **The RUC recommends 4.00 Work RVUs for 37232.**

37233 Revascularization, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy

The RUC reviewed the surveyed data from 58 cardiologists, radiologists and vascular surgeons for the new bundled code, 37233. This code describes a service that was previously reported with the existing tibial angioplasty and atherectomy codes (35470 = 4.31 RVUs after the 50% multiple procedure reduction) and the tibial atherectomy (35495 = 4.74 RVUs after the 50% multiple procedure reduction), reported with the PTA radiological S&I code (75964 = 0.36 RVUs) and additional peripheral atherectomy S&I code (75993 = 0.36 RVUs), plus the catheterization of each additional tibial artery would be reported (36248 = 1.01 RVUs), resulting in 10.78 RVUs. The RUC agreed with the specialty societies' recommended physician time components for this service. The specialty society explained that the additional minute of pre-service time represents the time required for the physician to consider the additional site of treatment, size of necessary devices for the second site, availability of those devices, the order to proceed, the approach to use and the impact the second site will have on the potential use of an embolic protection device. The specialty society explained that the additional minute of post-service time represents the additional time to review extra films and dictate extra procedural details in the interpretation. Patients with more than one treatment site require longer discussion and explanation. Additionally, more attention is required for the limb that has multiple treatment sites to ensure absence of embolization and adequacy of perfusion. The RUC reviewed the surveyed code in comparison to the reference code 34826 *Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; each additional vessel* (Work RVU=4.12). The RUC noted that the surveyed code has more intra-service time as compared to the reference code, 60 minutes and 30 minutes, respectively. Further, the RUC noted that the surveyed code required more mental effort and judgment, technical skill and physical effort to perform in comparison to the reference code. Based on these comparisons, the specialty societies agree that 6.50 work RVUs, the survey's median, accurately reflects the work required to perform the service. **The RUC recommends 6.50 Work RVUs for 37233.**

37234 Revascularization, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s)

The RUC reviewed the survey data from 59 cardiologists, radiologists and vascular surgeons for the new bundled code, 37234. This code describes a service that was previously reported with the existing tibial angioplasty and stent codes (35470 = 4.31 RVUs after the 50% multiple procedure reduction), plus the additional intravascular stent (37206 = 4.12 RVUs) with the PTA radiological S&I code (75960 = 0.82 RVUs), plus the catheterization of each additional tibial artery would be reported (36248 = 1.01 RVUs) resulting in 10.26 RVUs. The RUC agreed with the specialty societies' recommended physician time components for this service. The specialty society explained that the additional minute of pre-service time represents the time required for the physician to consider the additional site of treatment, size of necessary devices for the second site, availability of those devices, the order to proceed, the approach to use and the impact the second site will have on the potential use of an embolic protection device. The specialty society explained that the additional minute of post-service time represents the additional time to review extra films and dictating extra procedural details in the interpretation. Patients with more than one treatment site require longer discussion and explanation. Additionally, more attention is required for the limb that has multiple treatment sites to ensure absence of embolization and adequacy of perfusion. The RUC reviewed the surveyed code in comparison to the reference code 34826 *Placement of*

proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; each additional vessel (Work RVU=4.12). The RUC noted that the surveyed code has more intra-service time as compared to the reference code, 60 minutes and 30 minutes, respectively. Further, the RUC noted that the surveyed code required more mental effort and judgment, technical skill and physical effort to perform in comparison to the reference code. Based on these comparisons, the specialty societies agree that 5.50 work RVUs, the survey's median, accurately reflects the work required to perform the service and maintains rank order with 37233 and 37235. **The RUC recommends 5.50 Work RVUs for 37234.**

37235 Revascularization, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy
The RUC reviewed the survey data from 57 cardiologists, radiologists and vascular surgeons for the new bundled code, 37235. This code describes a service that was previously reported with the existing tibial atherectomy and stent codes (35470 tibial atherectomy = 4.74 RVUs after 50% multiple procedure reduction), the additional peripheral atherectomy S&I code (75993 = 0.36 RVUs), the additional intravascular stent code (37206 = 4.12 RVUs), the stent placement radiological S&I code (75960 = 0.82 RVUs), plus the catheterization of each additional tibial artery would be reported (36248 = 1.01 RVUs), resulting in 11.05 RVUs. The RUC agreed with the specialty societies' recommended physician time components for this service. The specialty society explained that the additional minute of pre-service time represents the time required for the physician to consider the additional site of treatment, size of necessary devices for the second site, availability of those devices, the order to proceed, the approach to use and the impact the second site will have on the potential use of an embolic protection device. The specialty society explained that the additional minute of post-service time represents the additional time to review extra films and dictating extra procedural details in the interpretation. Patients with more than one treatment site require longer discussion and explanation. Additionally, more attention is required for the limb that has multiple treatment sites to ensure absence of embolization and adequacy of perfusion. The RUC reviewed the surveyed code in comparison to the reference code 34826 *Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; each additional vessel* (Work RVU=4.12). The RUC noted that the surveyed code has more intra-service time as compared to the reference code, 60 minutes and 30 minutes, respectively. Further, the RUC noted that the surveyed code required more mental effort and judgment, technical skill and physical effort to perform in comparison to the reference code. Based on these comparisons, the specialty societies agree that 7.80 work RVUs, the survey's median, accurately reflects the work required to perform the service and maintains rank order with 37233 and 37234. **The RUC recommends 7.80 Work RVUs for 37235.**

Moderate Sedation: The RUC after reviewing the survey data for all of the endovascular revascularization procedures noted the moderate sedation was inherent. **Therefore, the RUC recommends that all of the endovascular revascularization procedures be added to Appendix G in the CPT 2011 Book and each code be designated with a ◎.**

Work Neutrality
The RUC's recommendation for this family of codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Practice Expense
The RUC reviewed and accepted the practice expense inputs for 37220-37235 as approved by the PE Subcommittee.

Sentinel Lymph Node Mapping (Tab 8)
Eric Whitacre, MD, ACS, Christopher Senkowski, MD, ACS, Charles Mabry, MD, ACS

The CPT Editorial Panel created a new add-on code to report sentinel lymph node mapping technique which has become the standard of care for initial regional lymph node assessment, replacing complete regional lymph node dissection for most patients. Analysis of regional lymph nodes in breast cancer is the single most important prognostic factor and is essential in determining the appropriate adjuvant treatment. CPT code 38792 *Injection procedure; for identification of sentinel node,* only describes injection of dye. There is no current code to describe the work related to mapping, after dye is injected. New code 38900 represents a new surgical technique that has develeoped over the past 5-10 years. This technique, when performed, requires additional physician work compared with simple dissection of palpable nodes.

The RUC reviewed the survey data for 38900 *Intraoperative sentinel lymph node(s) identification (eg, mapping), includes injection of non-radioactive dye, when performed* and agreed that the recommended service times were appropriate including the additional 2 minutes of pre-service time for the physician to review the risks with the patient including lymphedema, numbness and pain as the search for the sentinel node means additional dissection. The RUC compared the surveyed code to key reference code 19126 *Excision of breast lesion identified by preoperative placement of radiological marker, open; each additional lesion separately identified by a preoperative radiological marker* (Work RVU=2.93). The RUC noted that although 38900 required more mental effort and judgment to perform as compared to the reference code, 19126 had more intra-service time, 60 minutes and 45 minutes, respectively. Based on this comparison, the RUC agreed with the specialty society that 2.50 work RVUs, the survey's 25th percentile, accurately reflects the relative physician work being performed. **The RUC recommends 2.50 Work RVUs for 38900.**

New Technology
As the technique to perform this service is new, and to ensure that the utilization estimates provided by the specialty are accurate, **the RUC recommends that 38900 be added to the New Technology/Service List.**

Further, the RUC recommends that a CPT Assistant Article be written to accurately describe how this service is reported with other services.

Practice Expense: The RUC reviewed and agreed with the specialty recommendation for no direct practice expense inputs for these services as this service is an add-on in the facility setting.

Paraesophageal Hernia Repairs (Tab 9)
Keith Naunheim, MD, ACS, Francis Nichols, MD, ACS, Christopher Senkowski, MD, ACS, Charles Mabry, MD, ACS
Facilitation Committee #2

In February 2010, the CPT Editorial Panel deleted six existing codes and created ten new codes to remove obsolete and duplicative codes and add new codes to report current surgical techniques for paraesophageal hernia repair.

The specialty societies indicated and the RUC agreed that there is compelling evidence that technology has changed the physician work to repair esophageal hernias. When the original paraesophageal hernia repair codes were introduced, they were meant to report anatomic defects within the diaphragm. Thus for many years, paraesophageal hernias were repaired by simply reducing the hernia contents below the diaphragm and narrowing the diaphragmatic crura with sutures to prevent re-herniation. These repairs were performed in an open fashion by either a transabdominal or transthoracic approach. Sometimes tacking sutures were used to fix the stomach to the abdominal wall or occasionally a gastrostomy tube was placed to fix the stomach in place so it would not re-herniate. Occasionally, strictures were dilated or concomitant ulcer disease was treated by vagotomy and pyloroplasty.

Because this was the era prior to modern anti-acid treatment with H2 histamine blockers and PPIs, esophageal strictures requiring treatment were frequent occurrences in paraesophageal hernia patients. In addition, ulcer disease of the stomach and duodenum was also commonly treated because H. pylori had not yet been recognized as an etiologic agent. It was therefore frequent to find giant paraesophageal hernias associated with concomitant strictures and/or ulcer disease. For these reasons, the diaphragmatic hernia repair codes were written to include concomitant treatment for strictures (with and without dilation) and ulcer disease (with or without vagotomy and pyloroplasty). However, in 2010, these treatments (dilation, V&P) are virtually never performed concomitant with paraesophageal hernia repair, and thus the codes as written do not reflect current therapy.

Modern investigation has emphasized the importance of the lower esophageal sphincter's ability to generate pressure to prevent gastroesophageal reflux and the need to augment sphincter pressure with fundoplication, typically a 360 degree full wrap (Nissen) or a partial wrap (Belsey, Mark IV, Toupet). With this further understanding of the pathophysiology, these defects have now been reclassified as variants of hiatal hernia. The current coding schema is in direct opposition to this modern classification. The adjunctive surgical procedures of intraoperative dilatation, vagotomy, and pyloroplasty are now virtually never concomitantly performed with paraesophageal hernia repair; however, fundoplasty is almost always performed. Esophageal dilatation, if needed, is now done by gastroenterologists before any surgical procedure.

In summary, the work described by the current (to-be-deleted) codes was intended for patients with acid reflux (chemical symptoms) or blockage (mechanical symptoms). With the advent of medical management and less invasive treatments, the patients currently undergoing surgery are symptomatic, typically with blockage. The typical patient has more advanced disease and requires more complex repair.

BB1 - 43327 ***Esophagogastric fundoplasty partial or complete; laparotomy***
The RUC reviewed survey results from 64 cardiothoracic and general surgeons for code 43327 and compared it to key reference service 43280 *Laparoscopy, surgical, esophagogastric fundoplasty (eg, Nissen, Toupet procedures)* (work RVU = 18.10 and 150 minutes intra-service time). The RUC determined that 43327 required comparable mental effort, technical skill and psychological stress to perform as key reference service 43280 and therefore recommends the same work RVU of 18.10. The RUC determined that the survey physician time of 63 minutes pre-service, 120 minutes intra-service, and 30 minutes immediate post-service time appropriately accounts for the time required to perform this service. For additional support, the RUC compared 43327 to similar service 38100 *Splenectomy; total* (work RVU = 19.55), which requires the same intra-service time (120 minutes) to perform as 43327, minus two 99231 hospital visits associated with 38100 (19.55 - 1.42 = 18.13), which results in a work RVU of 18.13. **The RUC recommends a work RVU of 18.10 for code 43327.**

BB2 – 43328 ***Esophagogastric fundoplasty partial or complete; thoracotomy***
The RUC reviewed the survey results from 47 cardiothoracic and general surgeons for code 43328. The specialty societies selected and modified pre-service package 4 – Facility-Difficult Patient/Difficult Procedure, adding 17 minutes positioning time to account for placing the patient in the lateral decubitus position with specific attention to padding to protect the nerves throughout the procedure. The RUC agreed that the additional pre-service positioning time is appropriate to position the patient. The RUC reviewed the surveyed intra-service time of 150 minutes for 43328 compared to the key reference service 43282 *Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh* (work RVU = 30.10 and 210 minutes intra-service time). The RUC determined that 43328 required more mental effort, technical still and was more intense and complex than 43282, however, required less physician time to perform. The RUC also compared the thoracic approach to the laparoscopic approach (43327) and determined that 43328 would require more intra-service time. Therefore, 150 minutes intra-service time and a work RVU of 27.00, the survey median, for 43328 appropriately places this service in proper rank order. **The RUC recommends the survey median work RVU of 27.00 for code 43328.**

BB3 – 43332 ***Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; without implantation of mesh or other prosthesis***
The RUC reviewed the survey results from 64 cardiothoracic and general surgeons for code 43332 and compared it to key reference code 43281 *Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh* (work RVU = 26.60). The specialty society indicated and the RUC agreed that the open abdominal approach 43332, would require less intra-service time than the laparoscopic approach, 43281, 150 minutes and 180 minutes, respectively, but more post-service work. Additionally, the mental effort and technical skill required to perform these services are comparable. The RUC agreed that total physician work was the same for 43332 and 43281. **The RUC recommends the survey median work RVU of 26.60 for code 43332.**

BB4 – 43333 ***Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; with implantation of mesh or other prosthesis***
The RUC reviewed the survey results from 63 cardiothoracic and general surgeons for 43333 and compared it to key reference service 43282 *Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of*

mesh (work RVU = 30.10 and 210 minutes intra-service time) and determined it required similar mental effort, technical skill and psychological stress to perform. The RUC determined that the survey physician time of 63 minutes pre-service, 180 minutes intra-service, and 30 minutes immediate post-service time appropriately account for the time required to perform this service.. The RUC agreed that the survey median work RVU of 30.00 appropriately accounted for the physician work required to perform 43333. The RUC compared 43333 to the "without mesh" code 43332 *Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; without implantation of mesh or other prosthesis* and determined that the incremental difference 3.40 work RVUs (30.00 – 26.60 = 3.40) for implantation of mesh was appropriate and would maintain correct rank order.

The RUC compared the "with" and "without mesh" paraesophageal laparotomy codes 43332 and 43333 to "with" and "without mesh" paraesophageal laparoscopic codes 43281 *Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mes*h (work RVU = 26.60 and 180 minutes intra-service time) and 43282 *Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh* (work RVU = 30.10 and 210 minutes intra-service time) which accounts for an incremental difference of 3.50 work RVUs for the implantation of mesh. Additionally, the RUC compared the incremental work related to mesh for 43333 to code 49568 *Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair)* (work RVU = 4.88, ZZZ global period). Based on these comparisons, the RUC determined that the implantation of mesh incremental difference of 3.40 for 43332 and 43333 is appropriate. **The RUC recommends the survey median work RVU of 30.00 for code 43333.**

BB5 – 43334 *Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; without implantation of mesh or other prosthesis*
The RUC reviewed the survey results from 46 cardiothoracic and general surgeons for code 43334. The specialty societies selected and modified pre-service package 4 – Facility-Difficult Patient/Difficult Procedure, adding 17 minutes positioning time to account for placing the patient in the lateral decubitus position with specific attention to padding to protect the nerves throughout the procedure. The RUC agreed that the additional pre-service positioning time is appropriate to position the patient. The RUC compared 43334 to key reference code 43281 *Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh* (work RVU = 26.60 and 180 minutes intra-service time) and determined that the physician intra-service time required to perform these services are the same. However, the RUC agreed that the transthoracic approach for 43334 is more intense and complex, requires greater post-operative care (two additional hospital visits) and requires slightly more pre-service time (10 additional minutes) than 43281 and therefore should be valued higher than 43281 to maintain appropriate rank order. **The RUC recommends the survey median work RVU of 30.00 for code 43334.**

BB6 43335 *Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; with implantation of mesh or other prosthesis*
The RUC reviewed the survey results from 47 cardiothoracic and general surgeons for code 43335. The specialty societies selected and modified pre-service package 4 – Facility-Difficult Patient/Difficult Procedure, adding 17 minutes positioning time to

account for placing the patient in the lateral decubitus position with specific attention to padding to protect the nerves throughout the procedure. The RUC agreed that the additional pre-service positioning time is appropriate to position the patient. The RUC compared 43335 to the key reference code 43282 *Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh* (work RVU = 30.10) and determined that the physician intra-service time required to perform 43335 is slightly less than 43282, 200 minutes and 210 minutes, respectively. However, the RUC agreed that the transthoracic approach for 43335 is more intense and complex, requires greater post-operative care (two additional hospital visits) and requires slightly more pre-service time (10 additional minutes) than 43282. Additionally, the RUC reviewed the intra-service time for without mesh code 43334 and determined that 20 additional minutes for intra-service time and 3.00 more work RVUs for the "with mesh" code 43335 appropriately place these services in the proper rank order. **The RUC recommends the survey median work RVU of 33.00 for code 43335.**

BB7 – 43336 ***Repair, paraesophageal hiatal hernia, (including fundoplication), via thoracoabdominal incision, except neonatal; without implantation of mesh or other prosthesis***

The RUC reviewed the survey results from 39 cardiothoracic and general surgeons for code 43336. The specialty societies selected and modified pre-service package 4 – Facility-Difficult Patient/Difficult Procedure, adding 17 minutes positioning time to account for placing the patient in the lateral decubitus position with specific attention to padding to protect the nerves throughout the procedure. The RUC agreed that the additional pre-service positioning time is appropriate to position the patient. The RUC compared 43336 to the key reference code 43632 *Gastrectomy, partial, distal; with gastrojejunostomy* (work RVU = 35.14 and 225 minutes intra-service time) and determined that 43336 required comparable physician time (240 minutes intra-service time), intensity and complexity to perform. **The RUC recommends the survey median work RVU of 35.00 for code 43336.**

BB8 – 43337 ***Repair, paraesophageal hiatal hernia, (including fundoplication), via thoracoabdominal incision, except neonatal; with implantation of mesh or other prosthesis***

The RUC reviewed the survey results from 39 cardiothoracic and general surgeons for code 43337. The specialty societies selected and modified pre-service package 4 – Facility-Difficult Patient/Difficult Procedure, adding 17 minutes positioning time to account for placing the patient in the lateral decubitus position with specific attention to padding to protect the nerves throughout the procedure. The RUC agreed that the additional pre-service positioning time is appropriate to position the patient. The RUC also compared 43337 to the key reference code 43632 *Gastrectomy, partial, distal; with gastrojejunostomy* (work RVU = 35.14 and 225 minutes intra-service time) and determined that 43337 required more physician time (260 minutes intra-service time), intensity and complexity to perform. Additionally, the RUC reviewed the intra-service time for "without mesh" code 43336 and determined that 20 additional minutes for intra-service time and 2.50 more work RVUs (as indicated by those physicians performing this service in the last year) for "with mesh" code 43337 appropriately place these services in the proper rank order. **The RUC recommends the survey median work RVU of 37.50 for code 43337.**

BB9 – 43338 ***Esophageal lengthening procedure (eg Collis gastroplasty or wedge gastroplasty)***
The RUC reviewed the survey results from 43 cardiothoracic and general surgeons for code 43338 compared to key reference code 44121 *Enterectomy, resection of small intestine; each additional resection and anastomosis (List separately in addition to code for primary procedure)* (work RVU = 4.44 and 60 minutes intra-service time) and agreed with the specialty society that the survey median work RVU of 5.00 and 25th percentile work RVU of 4.50 were too high, as the key reference service requires twice the physician time compared to 43338, 60 minutes versus 30 minutes respectively. However, 43338 requires more mental effort and judgment, technical skill/physical effort and psychological stress than 44121. The specialty society indicated and the RUC agreed that 3.00 work RVUs results in an intensity which is consistent with the intensity of the primary procedures in this family and consistent with other ZZZ add-on MPC codes (22525, 35600, 60512, 63295). **The RUC recommends the survey low response work RVU of 3.00 for code 43338.**

BB10 – 43283 ***Laparoscopy, surgical, esophageal lengthening procedure (eg Collis gastroplasty or wedge gastroplasty)***
The RUC reviewed the survey results from 43 cardiothoracic and general surgeons for code 43283 compared them to key reference code 44121 *Enterectomy, resection of small intestine; each additional resection and anastomosis* (work RVU = 4.44 and 60 minutes intra-service time) and agreed with the specialty society that the survey 25th percentile work RVU of 4.80 was too high, as the key reference service requires more physician time to perform than 43283, 60 minutes versus 40 minutes respectively. The specialty society indicated and the RUC agreed that 4.00 work RVUs results in an intensity which is consistent with the intensity of the primary procedures in this family and consistent with other ZZZ add-on MPC codes (22525, 35600, 60512, 63295). For further support the RUC also compared 43283 to similar service, 14302 *Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof* (work RVU = 3.73 and 40 minutes intra-service time). **The RUC recommends a work RVU of 4.00 for code 43283.**

Practice Expense
The RUC reviewed and recommend the standard 090 global direct practice expense inputs for CPT codes 43327 – 43338 performed only in the facility setting. In addition, the RUC recommends no direct practice expense inputs for add-on codes 43338 and 43283.

<u>Fiducial Marker Placement (Tab 10)</u>
Christopher Senkowski, MD, ACS, Charles Mabry, ACS

The CPT Editorial Panel approved two new add-on codes to report placement of fiducial marker(s) at the time of a primary open or laparoscopic abdominal, pelvic, or retroperitoneal procedure for later stereotactic radiation therapy.

49327 ***Laparoscopy, surgical; with biopsy (single or multiple); with placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), intra-abdominal, intra-pelvic, and/or retroperitoneum, including image guidance, if performed, single or multiple (List separately in addition to code for primary procedure)***

The RUC reviewed the specialty society's survey results and recommendation for new code 49327. The RUC understood the specialty's difficulty in surveying physicians who perform this service, as it is new technology and will be rarely performed. The RUC agreed with the specialty recommended median survey work RVU of 2.38 and median survey intra-service time of 30 minutes, as compared to the key reference service 49326 *Laparoscopy, surgical; with omentopexy (omental tacking procedure) (List separately in addition to code for primary procedure)* (Work RVU = 3.50, ZZZ global period, 45 minutes of intra-service time). Further, as reported in the survey statistics, the RUC noted that 4932X requires more mental effort and judgment, technical skill and overall is a more intense procedure compared with the reference code. Based on these comparisons, the RUC agreed that 2.38 work RVUs accurately reflects the relative physician work required to perform this service. **The RUC recommends a work RVU of 2.38 for CPT code 49327.**

49412 ***Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), open, intra-abdominal, intra-pelvic, and/or retroperitoneum, including image guidance, if performed, single or multiple (List separately in addition to code for primary procedure)***

The RUC reviewed the specialty society's survey results and recommendation for new code 49412. The RUC understood the specialty's difficulty in surveying physicians who perform this service, as it is new technology and will be rarely performed. The RUC compared the specialty recommended survey 25th percentile work RVU of 1.50 and survey median intra-service time of 20 minutes to the key reference service 44139 *Mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy (List separately in addition to primary procedure)* (Work RVU = 2.23, ZZZ global period, 30 minutes of intra-service time). Further, as reported in the survey statistics, the RUC noted that 49412 requires more mental effort and judgment, technical skill and overall is a more intense service to perform in comparison to the reference code. Additionally, the RUC agreed that code 49412 would require similar intensity and complexity compared with code 55876 *Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, prostate, single or multiple* (Work RVU = 1.73, 000 day global, 20 minutes of intra-service time). Based on these comparisons, the RUC agreed that 1.50 work RVUs, the survey's 25th percentile, accurately reflects the relative physician work required to perform this service. **The RUC recommends a work RVU of 1.50 for CPT code 49412.**

New Technology: The RUC recommends that CPT codes 49327 and 49412 be placed on the new technology list.

Practice Expense: The RUC recommends no direct practice expense inputs. These services are add-on and will only be performed in a facility setting.

Intraperitoneal Catheter Codes (Tab 11)
Geraldine McGinty, MD, ACR, Ezequiel Silva, MD, ACR, Sean Tutton, MD, SIR, Robert Vogelzang, MD, SIR, Gerald Niedzwiecki, MD, SIR, Christopher Senkowski, MD, ACS, Charles Mabry, MD, ACS
Facilitation Committee #1

CPT code 49421 *Insertion of tunneled intraperitoneal or catheter for dialysis; open* was identified through a site-of-service anomaly screen by the RUC Five-Year Review Identification Workgroup. Subsequent to that identification, CMS added the related code 49420 *Insertion of intraperitoneal cannula or catheter for drainage or dialysis; temporary* for review and agreed that both codes should have a global period of 000 because of the wide variation in post-procedure work. At the April 2008 RUC meeting, the specialty requested that both codes 49420 and 49421 be referred to the CPT Editorial Panel for investigation and clarification of the history of the codes and the inclusion of the terms temporary and permanent. The belief was that the original intention of the descriptors had changed over time because of the addition of new catheter codes - for approach, diagnosis, and treatment.

The CPT Editorial Panel agreed to delete code 49420 based on the specialty presentation that there may be inadvertent miscoding because the descriptor is vague with respect to catheter placement for drainage. Additionally, temporary "rigid" cannulas are no longer manufactured or utilized. CPT code 49421 was revised to clearly indicate it was an open procedure. A new CPT code 49418 *Insertion of tunneled intraperitoneal catheter (eg, dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological supervision and interpretation; percutaneous* was approved to describe percutaneous procedures.

49421
Before reviewing the specialty's survey and physician time data, the RUC discussed the original valuation of this Harvard valued service and how its previous valuation as a 090 day global service relates to the current valuation with a 000 day global. When the Harvard study was conducted, surveyees were asked to provide estimated minutes for pre, intra and post service physician time. As there were no standard evaluation and management visits when this code was originally valued, visits were arbitrarily assigned based on the surveyees' time estimates. The RUC agreed that compelling evidence is not necessary and the assigned post-operative visits should not be backed out of the current valuation, due to the change in global periods, because they were not part of the original Harvard work, but were assigned by a CMS contractor for the purpose of calculating practice expense RVUs.

The RUC reviewed the survey results from 34 general surgeons for code 49421 and agreed with the specialty that the survey respondents accurately captured the physician work and time necessary to complete this procedure. The RUC agreed that pre-service time package 3 (Facility: Straightforward Patient/Difficult Procedure) was accurate with the deletion of 5 minutes for scrub, dress and wait time to accurately reflect the time required to perform the pre-service activities (pre-service time= 46 minutes). The RUC agreed that the survey median intra-service time of 45 minutes and post service time of 20 minutes accurately reflects the physician time required to perform this service.

The RUC compared code 49421 to the Key Reference Service 32550 *Insertion of indwelling tunneled pleural catheter with cuff* (Work RVU= 4.17 and intra-service time= 30 minutes). The RUC agreed that although these procedures are similar, code 49421 requires more intra-service time and should be valued higher than 32550. Also, the RUC reviewed the survey intensity and complexity measures which indicated code 49421 requires greater intensity and complexity to perform as compared to the reference code 32550. Finally, the RUC reviewed MPC code 45380 *Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple* (Work RVU= 4.43 and intra-service time= 51.5 minutes) in relation to the surveyed code and agreed that 49421 should be valued lower than 45380 to reflect less intra-service time. This comparison further substantiated the specialty's median survey physician work RVU of 4.21 and ensures reflects appropriate relativity. **The RUC recommends 4.21 work RVUs for 49421.**

49418
The RUC reviewed the survey results from 31 radiologists for code 49418 and agreed with the specialties that the survey respondents accurately captured the physician time necessary to compete this procedure, but overestimated the physician work involved. The RUC agreed that pre-service time package 2b (Facility: Difficult Patient/Straightforward Procedure (with sedation/anesthesia) was accurate with the addition of 5 minutes to the positioning time to accommodate ultrasound which is necessary to identify the location for initial access. The survey median intra-service time of 40 minutes and post service time of 20 minutes also accurately accounted for the physician time involved in performing the procedure.

The RUC compared code 49418 to the Key Reference Service code *36558 Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; age 5 years or older* (Work RVU= 4.84 and total time= 116 minutes). The RUC agreed that the reference service, which has a 010 day global period and more total work, should be valued higher than 49418. In addition, the RUC reviewed 49418 in comparison to a 000-day global code 31571 *Laryngoscopy, direct, with injection into vocal cord(s), therapeutic; with operating microscope or telescope* (Work RVU= 4.26, intra-service time= 40 minutes and total time= 129 minutes). The RUC agreed that these services should be valued similarly. Given that the physician time and work for the open procedure (49421) is very similar to the percutaneous procedure 49418, the RUC agreed that a value of 4.21 work RVUs, lower than the survey's 25th percentile and the same as the recommendation for 49421, maintains appropriate relativity. **The RUC recommends 4.21 work RVUs for 49418.**

Moderate Sedation:
The RUC, after reviewing the survey data for procedure 49418, noted that moderate sedation is inherent. **Therefore, the RUC recommends that CPT code 49418 be added to Appendix G in the CPT 2011 Book and the moderate sedation symbol "◎"** be added to 49418.

Practice Expense
The RUC reviewed the direct practice expense inputs and modified the medical supplies and equipment to reflect what is used to perform the typical service.

Transurethral Radiofrequency Bladder Neck and Urethra (Tab 12)
James Giblin, MD, AUA, Richard Gilbert, MD, AUA, Lora Plaskon, MD, AUA, George Hill, MD, ACOG
Facilitation Committee #2

In February 2010, the CPT Editorial Panel converted a Category III code to a Category I code to describe minimally invasive treatment for individuals with stress urinary incontinence due to hypermobility who have failed conservative non-surgical alternatives and/or who are not viable candidates for surgery.

53860 ***Transurethral radiofrequency micro-remodeling of the female bladder neck and proximal urethra for stress urinary incontinence***
The RUC reviewed code 53860 and compared it to three similar services 57522 *Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; loop electrode excision* (work RVU = 3.67 and 20 minutes intra-service time), 17106 *Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm* (work RVU = 3.69 and 30 minutes intra-service time), and 64626 *Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, single level* (work RVU = 3.92 and 30 minutes intra-service time). The RUC determined the surveyed intra-service time of 30 minutes and a work RVU of 3.97 for code 53860 appropriately accounts for the work required to perform this service and appropriately places this service in the proper rank order relative to similar services. **The RUC recommends a work RVU of 3.97 for 53860.**

For further support, the RUC compared 53860 to MPC code 64721 *Neuroplasty and/or transposition; median nerve at carpal tunnel* (work RVU = 4.97 and 25 minutes intra-service time) and determined 53860 required similar intensity and complexity to perform as 64721. However, code 64721 includes a half discharge day and one more 99213 office visit than 53860. The RUC removed the associated half discharge day and hospital visit and then added 0.12 RVUs associated with the additional 5 minutes of intra-service time for 53860 (30 minutes intra-service time) to arrive at a work RVU of 3.97.

64721	4.97
- half 99238	-0.64
- 99212	-0.48
	3.85
+ 5 minutes x (0.0239 IWPUT) =	+ 0.12
Recommended work RVU for 53860	**3.97**

The specialty society indicated and the RUC agreed that two 99213 offices visits are required for this service as the patient needs to be seen once in the first two weeks to assess any complications and again 2 weeks to 1 month later to evaluate the efficacy of the treatment.

New Technology
The RUC recommends that 53860 be placed on the new technology/new service list.

Practice Expense
The RUC reviewed the direct inputs for 53860 and recommends the modified clinical labor time, medical supplies and equipment.

Posterior Tibial Nerve Stimulation (Tab 13)
James Giblin, MD, AUA, Richard Gilbert, MD, AUA, Lora Plaskon, MD, AUA
George Hill, MD, ACOG, Roger Goldberg, MD, ACOG

In February 2010, the CPT Editorial Panel created a new code to report posterior tibial neurostimulation as a treatment for urinary incontinence.

64566
The RUC reviewed the survey results from 39 gynecologists and urologists for 64566. The specialty society indicated and the RUC agreed that the survey respondents overestimated the total time and work required for this service. The specialty society indicated that the placement of the needle by the physician takes 5 minutes and this service is typically performed once a week, for 12 weekly treatments. The RUC agreed with the following modified physician time for each encounter of: 5 minutes pre-service, 5 minutes intra-service and 5 minutes post-service time. The RUC compared 64566 to 20552 *Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)* (work RVU = 0.66 and 5 minutes pre, 5 minutes intra and 3.5 minutes post-time) and 64455 *Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (eg, MortonÆs neuroma)* (work RVU = 0.75 and 10 minutes pre, 5 minutes intra and 5 minutes post-time) and determined that the physician work, time and complexity required to perform these services is similar. With these references the RUC determined that the specialty society building block recommended work RVU of 0.60 was supported. The IWPUT for 64566 if 0.0662 is less than that for reference codes 20552 (0.0939) and 64455 (0.0828). **The RUC recommends a work RVU of 0.60 for code 64566.**

New Technology
The RUC recommends that 64566 be placed on the new technology/new service list.

Practice Expense
The RUC reviewed the direct inputs for 64566 and recommends the modified clinical labor time, medical supplies and equipment.

Iridotomy (Tab 14)
Stephen A. Kamenetzky, MD, AAO, Cindie Mattox, MD, AAO
Facilitation Committee #1

In February 2008, CPT code 66761 *Iridotomy/iridectomy by laser surgery (eg, for glaucoma) (per session)* was identified by the RUC's Five-Year Identification Workgroup through the CMS High IWPUT Screen. The Workgroup determined that although the RUC had reviewed this service at the 2005 Five-Year Review, it required further analysis, specifically addressing a change in number of sessions. At the April 2009 RUC meeting, the Workgroup agreed with the specialty that the service was difficult to survey for physician work with a 090-day global period and the descriptor of one or more sessions. The RUC requested consideration of valuing this procedure as a single surgical session with a 010-day global period. In February 2010, the CPT Editorial Panel revised code 66761 to state "per session" instead of "1 or more sessions" to address the Five-Year Review Identification Workgroup's determination and CMS's consent that this procedure be valued as a single surgical session with a 010-day global.

66761
The RUC reviewed the survey results from 62 ophthalmologists for physician work, time, and intensity recognizing the descriptor and the global period changes and the current work value of 5.02. The 25th percentile survey results were recommended by the specialty (3.99), however the RUC disagreed with the survey respondents choice of reference code 65855 *Trabeculoplasty by laser surgery, 1 or more sessions (defined treatment series)* (Work RVU = 3.99) as its intra-service time was one third higher than 88761 and includes an additional office visit. 65855 is also used to report one or more sessions, while 66761 is reported per session. The RUC agreed a better reference service was 12052 *Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm* (Work RVU = 2.87, 28 minutes intra-service time, 010 global. The RUC compared this reference code to 66761 and noted that the surveyed code is a more intense service to perform, despite the similar total service time. a). Based on this comparison, the specialty society recommends and the RUC agrees that the low of the specialty's survey results of 3.00 RVUs (IWPUT = 0.1169) most accurately represents the work associated with this service. **The RUC recommends a relative work value of 3.00 for 66761.**

Work Neutrality
The RUC's recommendation for this code will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Practice Expense: The RUC recommends the reduced direct practice expense inputs that reflect the typical patient scenario with the change in the CPT descriptor and global period for code 66761.

Open Angle Glaucoma Procedures (Tab 15)
Stephen A. Kamenetzky, MD, AAO, Michael Stiles, MD, AAO
Facilitation Committee #1

In February 2010, the CPT Editorial Panel converted two Category III codes to Category I codes that describe a new technique for the surgical treatment of glaucoma that is unresponsive to medical therapy.

66174 ***Transluminal dilation of aqueous outflow canal; without retention of device or stent***

The RUC reviewed the survey results from 42 physicians familiar with this new surgical treatment, and gained insight from the specialty regarding the typical patient service for CPT code 66174. The RUC agreed with the specialty with the reduction of 9 minutes of evaluation time from the RUC standard pre-service package of a facility based straightforward patient and procedure with sedation and anesthesia to reflect the typical patient service. The RUC determined the typical physician time for CPT code 66174 would have a total of 16 minutes pre-service, 60 minutes intra-service, and total time of 215 minutes. The RUC also agreed that the physician work value must be between the specialty's 25th percentile survey result of 14.00 work RVUs and its low of 8.00 work RVUs to place it in the proper rank order amongst similar services. The RUC reviewed the following services while valuing 66174:

27027 *Decompression fasciotomy(ies), pelvic (buttock) compartment(s) (eg, gluteus medius-minimus, gluteus maximus, iliopsoas, and/or tensor fascia lata muscle), unilateral* (Work RVU = 13.04, 60 minutes intra-service time, total time 359)
38745 *Axillary lymphadenectomy; complete* (Work RVU = 13.87, intra-service time 90 minutes, total time 270.5 minutes)
44300 *Placement, enterostomy or cecostomy, tube open (eg, for feeding or decompression) (separate procedure)* (Work RVU = 13.75), 60 minutes intra-service, total time 389 minutes)
59100 *Hysterotomy, abdominal* (eg, for hydatidiform mole, abortion) (Work RVU = 13.37, 60 minutes of intra-service, total time 329)
65850 *Trabeculotomy ab externo* (Work RVU = 11.39, 60 minutes intra-service, total time 233)

The RUC agreed that new code 66174 was similar to code 65850 in its complexity, however 66174 requires more time and intensity. A building block valuation was developed beginning with the physician work of 65850 of 11.39 work RVUs and then adjusted for the level and number of post operative visits to arrive at a relative work value of 12.85. The RUC reviewed the reference codes above and agreed that 27027, with identical intra-time and analogous physician work, should be valued higher due to the total time disparities. This recommended value, when compared with these references, provides proper rank order. **The RUC recommends a relative work value of 12.85 for 66174.**

66175- ***Transluminal dilation of aqueous outflow canal; with retention of device or stent***

The RUC reviewed the survey results from 46 physicians familiar with this new surgical treatment. The RUC reviewed code 66175 in relation to 66174 and agreed that proper rank order would necessitate 66175 to be greater than 66174, as 66175 requires the retention of a device or stent. The RUC agreed with the specialty with the reduction of 9 minutes of evaluation time from the RUC standard pre-service package of a facility based straightforward patient and procedure with sedation and anesthesia to reflect the typical patient service. The RUC determined the typical physician time for CPT code 66174 would have a total of 16 minutes pre-service, 60 minute intra-service, and total time of 222.5 minutes. The RUC agreed that an additional increment of work added to the work of 66174 would provide for the proper value for 66175. The RUC added the additional 8 minutes of intra-service work required for 66175 to arrive at a work RVU of 13.60 (intra-service work per unit of time of 0.10 x 7.5 minutes = 0.75 RVUs), (12.85 + 0.75 = 13.60). In addition, the RUC reviewed two additional services which have similar work and physician time, these codes are:

38760 *Inguinofemoral lymphadenectomy, superficial, including Cloquets node (separate procedure)* (Work RVU = 13.62, intra-service time 70 minutes, total time 271 minutes)
43605 *Biopsy of stomach; by laparotomy* (Work RVU = 13.72, intra-service time 60 minutes, total time 402 minutes) and agreed that each service has analogous physician work and intensity and should be valued similarly.

The RUC recommends a relative work value of 13.60 for 66175.

New Technology
The RUC recommends that 66174 and 66175 be placed on the new technology/new service list.

Practice Expense: The RUC recommends the standard 090 global direct practice expense inputs for CPT codes 66174 and 66175 as they are services performed only in the facility setting.

Labrinthotomy (Tab 16)
Peter Weber, MD, AAO-HNS, Wayne Koch, MD, AAO-HNS

CPT codes 69801 *Labyrinthotomy, with perfusion of vestibuloactive drug(s); transcanal* and 69802 *Labyrinthotomy, with perfusion of vestibuloactive drug(s); with mastoidectomy* were identified for review through both the CMS Fastest Growing and Site of Service Anomaly Screens. The specialty acknowledged that 69801 is performed entirely in the outpatient setting. After its initial identification in September 2007, the specialty society attempted to survey 69801 and 69802 in October 2009 but found that the survey respondents were confused by the ambiguity of the CPT descriptors and found it difficult to value the services as a single or series of perfusions. The services were referred to the CPT Editorial Panel, and in February 2010 the CPT codes were revised to indicate a single perfusion. Therefore, the specialty suggested that a change from a 090 day global to a 000 day global was necessary to accurately capture the physician work. CMS agreed with a change in the global period from 090 to 000.

69801
The RUC reviewed the survey results from 30 otolaryngologists for code 69801 and agreed with the specialty that the survey respondents accurately captured the physician intra-service and post service time necessary to complete this procedure, but overestimated the pre-service time. The RUC agreed that pre-service time package 6 (Non-facility procedure with sedation/anesthesia care) was accurate for this procedure because local anesthesia is necessary and the procedure would typically be performed in an office. The pre-service time package was then reduced by 5 minutes in the evaluation time, for a total of 18 pre-service minutes, to more accurately reflect the typical interpretation and discussion of previous evaluations that the physician is having with the patient. In addition, the RUC agreed that the survey median intra-service time of 15 minutes and post service time of 10 minutes accurately accounted for the physician time involved in performing the service.

The RUC compared code 69801 to the Key Reference Service 31579 *Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy* (Work RVU= 2.26 and intra-service time= 15 minutes). The RUC agreed that the services are analogous in both physician work and total time, with 43 minutes for 69801 and 45 minutes for 31579. The RUC also agreed that the surveyed service should be slightly lower than the reference service to account for the slight difference in intensity. Finally, the RUC compared the surveyed code to MPC code 52000 *Cystourethroscopy* (Work RVU= 2.23, intra-service time= 15 minutes) and determined that the reference code, while having similar total time, 43 minutes and 42 minutes, respectively, should be valued relatively higher than CPT code 69801 to account for increased intensity and complexity. Given this information, the RUC agreed with the survey's 25th percentile of 2.06 work RVUs, ensuring appropriate relativity. **The RUC recommends 2.06 work RVUs for 69801.**

69802
Prior to surveying this service for RUC valuation, the specialty society determined that this service is outdated and infrequently performed, with only 13 claims submitted in 2008. Therefore, the RUC agreed that the specialty should request this code be deleted by the CPT Editorial Panel. **The RUC recommends 69802 be referred to the CPT Editorial Panel for deletion.**

Practice Expense
The RUC reviewed the direct practice expense for 69801 and 69802 and recommends minor modifications to the clinical labor inputs.

Work Neutrality
The RUC's recommendation for this family of codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Ultrasound of Extremity (Tab 17)
Geraldine McGinty, MD, ACR, Ezequiel Silva, MD, ACR, Imran Omar, MD, ACR, Timothy Tillo, DPM, APMA, Seth A Rubenstein, DPM, APMA, Joseph Zuhosky, MD, AAPMR, Phillip Marion, MD, AAPMR
Facilitation Committee #3

In October 2008, CPT code 76880 *Ultrasound, extremity, nonvascular, real time with image documentation* (Work RVU = 0.59) was identified through the RUC's Five-Year Identification Workgroup's CMS Fastest Growing Screen had never been surveyed by the RUC. The specialty societies explained that the large growth in utilization was caused by physicians' reporting a focused anatomic-specific ultrasound exam and a comprehensive diagnostic exam using the same CPT code, 76880, despite significant differences in physician work and pratice expense costs. In February 2009, the CPT Editorial Panel deleted 76880 and created two new codes to distinguish between the comprehensive diagnostic ultrasound and the focused anatomic-specific ultrasound.

The specialty provided a clear understanding of each service regarding the physician work, time, and intensity. The RUC recognized and agreed with the compelling evidence that there had been a change in the typical provider, the site of service, and the ultrasound technology had changed due to the advent of portable ultrasound devices. Further, the RUC agreed that the patient population is different, whereas there are more evaluations of musculoskeletal pathology using more advanced ultrasound technology rather than magnetic resonance imaging. Ultrasound provides a high level of diagnostic accuracy as well as the potential for dynamic evaluation while at the same time being a non-invasive modality that involves no radiation.

76881 ***Ultrasound, extremity, nonvascular, real-time with image documentation; complete***
The RUC reviewed the survey results from 42 radiologists for CPT code 76881. The RUC agreed with the specialty society's recommendation for physician time of 5 minutes pre-service, 15 minutes intra-service, and 5 minutes post service, as typical of the service provided. These time components maintain appropriate rank order with codes such as the following for 76881:

76856 *Ultrasound, pelvic (nonobstetric), real time with image documentation; complete* (Work RVU=0.69, intra-service time = 20 minutes)
76885 *Ultrasound, infant hips, real time with imaging documentation; dynamic (requiring physician manipulation)* (Work RVU= 0.74, intra-service time = 20 minutes)
76830 *Ultrasound, transvaginal* (Work RVU = 0.69, intra-service time=20 minutes, total time 28 minutes)
99231 *Subsequent hospital care, per day* (Work RVU = 0.76, intra-service time = 10 minutes, total time 20 minutes)
99307 *Subsequent nursing care, per day* (Work RVU = 0.76, intra-service time = 10 minutes, total time 20 minutes)

The RUC, based on an understanding of the physician work, time, and intensities of each of the comparison codes, agreed that the specialty's 25th percentile survey results reflected the work required to perform 76881. The RUC also agreed on the rank order amongst these other services with the new code and agreed that the work value for 76881 should be 0.72. **The RUC recommends a relative work value for CPT code 76881 of 0.72.**

CPT code 76882 *Ultrasound, extremity, nonvascular, real-time with image documentation;* limited anatomic specific
The RUC reviewed the survey results from 44 radiologists and podiatrists for CPT code 76882. The RUC recognized that there had been a change in the typical patient, site of service, provider, and the ultrasound technology had changed due to the advent of portable ultrasound devices. The RUC also concurred with the specialty society's recommendation for physician time of 5 minutes pre-service, 11 minutes intra-service, and 5 minutes post service, as typical of the service provided. These time components maintain appropriate rank order with codes such as the following for 76882:

93228 *Wearable mobile cardiovascular telemetry with electrocardiographic recording,*…(Work RVU = 0.52, intra-service = 12 minutes, total time = 25 minutes)
93285 *Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device…(Work RVU = 0.50, intra-service time* (Work RVU = 0.50, intra-service time = 12 minutes, total time = 22 minutes)
99212 *Office or other outpatient visit for the evaluation and management of an established patient* (Work RVU = 0.48, 10 minutes intra-service time, total time 16 minutes)
99407 *Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes* (Work RVU = 0.50, intra-service time = 15 minutes)

Based on the comparison of physician work of the above codes, the proper rank order, and differences in intensity between 76881 and 76882, the RUC agreed that the physician work value of 76882 should be 0.50. **The RUC recommends a relative work value of 76882 of 0.50.**

CPT *Assistant* Article
The RUC recommends a CPT *Assistant* article be written to ensure the proper reporting of these two services. It was noted by the RUC that these services should not typically be reported more than once per day.

Work Neutrality
The RUC's recommendation for these two codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

New Technology: The RUC recommends that CPT codes 76881 and 76882 be placed on the new technology list and to review utilization data assumptions

Practice Expense: The RUC reviewed the direct practice expense inputs for 76881 and 76882 and edited the typical equipment used for each service. The RUC understands that 76882 is performed with mobile ultrasound, however the RUC was not able to obtain an invoice for the typical mobile ultrasound unit typically purchased by podiatry. The RUC recommends that AMA staff assist in facilitating this discussion between radiology, podiatry, and CMS.

Evaluation of Fine Aspirate (Tab 18)
Jonathan L. Myles, MD, CAP, Margaret Havens Neal, MD, CAP, W. Stephen Black-Shaffer, MD, CAP
Facilitation Committee #2

Due to confusion amongst payers and providers, in February 2010 the CPT Editorial Panel revised the descriptor for 88172 and created a new code, 88177, to report the first evaluation episode and each additional episode of cytopathology evaluation of fine needle aspirate.

88172 Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site
The RUC reviewed the specialty survey results from 107 pathologists for revised code 88172 and agreed with the specialty that the survey respondents overestimated the work value with a median work RVU of 1.20. The RUC compared the physician work to the survey's key reference code 88333 *Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), initial* (Work RVU = 1.20, intra-service = 25 minutes) and concurred that although they have similar physician work, the intensity of mental effort, judgment required, and the psychological stress in evaluating specimen adequacy of diagnosis is less in 88172 than in 88333. In addition, the RUC compared the work of the surveyed service to reference code 99408 *Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes* (Work RVU= 0.65 and total time= 20 minutes) and agreed that the services have analogous total time and should be valued similarly. Finally, the RUC looked at 88334 *Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site* (Work RVU= 0.73 and total time= 20 minutes) and the RUC agreed that 88172 is a slightly less intense service to perform in comparison to the surveyed code and thereby should be valued slightly lower than this reference code. Considering these comparisons, and in order to maintain work neutrality between 88172 and 88177 the RUC agreed that 0.69 RVUs accurately reflects the amount of work required to perform this service. **The RUC recommends a relative work RVU of 0.69 for CPT code 88172.**

88177 ***Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, each separate additional evaluation episode, same site***
The RUC reviewed the specialty survey results from 126 pathologists for new code 88177 and agreed that the survey respondents misunderstood the service being examined as the median work RVU of 1.20 RVUs was not reflective of the service and did not maintain rank order with other pathology services. The RUC compared the work of CPT codes 88333 (Work RVU= 1.20) and 88334 (Work RVU = 0.73). The RUC agreed with the specialty that the ratio in physician work between 88333 and 88334 may be applied to the ratio of work between 88172 and 88177. This methodology results in a relative work value of 0.42 for CPT code 88177 ((0.73/1.20) x 0.69 = 0.42. The RUC noted that the value of 0.42 for 88177 maintains work neutrality with the base code, 88172. **The RUC recommends a relative work value of 0.42 for CPT code 88177.**

Practice Expense: The RUC reviewed the direct practice expense inputs for these services and made minor edits to the clinical labor time to reflect the typical patient service.

CPT Assistant Referral: The RUC recommended that a *CPT Assistant* article be published to educate users on the appropriate reporting of codes 88172 and 8817X. The article should also provide 1) a definition of the term "evaluation episode"; 2) vignettes; and 3) discussion of the unique situation when the pathologist is both performing the FNA and making the interpretation.

Transcranial Magnetic Stimulation (Tab 19)
Naakesh Dewan, MD, APA, Patrick Marsh, MD, APA, Shirlene Sampson, APA

Pre-Facilitation Committee #1

The CPT Editorial Panel created two new Category I codes to replace two existing Category III codes to report transcranial magnetic stimulation (TMS). TMS represents a new treatment for patients with depression. The American Psychiatric Association (APA) requested pre-facilitation of this issue prior to RUC review as the specialty noted issues with the survey data collection effort. During the pre-facilitation committee meeting, participants noted issues in differentiating between the physician work and the service provided by nurses or other clinical staff. The specialty society representatives acknowledged the need to describe the service to better define the physician activity.

Based on feedback from the pre-facilitation discussion, the APA presented a recommendation to the RUC that these codes be withdrawn and referred back to the CPT Editorial Panel. **The RUC supported the specialty society's recommendation to refer transcranial magnetic stimulation to the CPT Editorial Panel.**

Note following RUC meeting: In early May, the CPT Executive Committee reviewed the letter from the APA noting their conclusion that the new codes (approved at the February 2010 Panel meeting) do not adequately describe the physician service and that they intend to submit a new proposal for the CPT 2012 cycle to more clearly define the services performed. The CPT Executive Committee accepted the specialty recommendation to rescind these codes and restore the Category III codes during the refinement of the proposal for the CPT 2012 publication. On May 24, the APA submitted a new letter to the CPT Editorial Panel revoking their earlier recommendation and

requested that CPT proceed with the new Category I codes in 2011. At a July 2010 meeting, the CPT Editorial Panel supported the APA request to retain the Category 1 codes.

Esophageal Motility High Resolution Esophageal Pressure Topography (Tab 20)
Nicholas Nickl, MD, ASGE, Edward Bentley, MD, ASGE

In February, the CPT Editorial Panel combined two CPT codes and created one Category I and two Category III codes to describe two dimensional esophageal motility with stimulation and high resolution esophageal motility, also known as, high resolution esophageal pressure topography [HREPT]. HREPT provides comprehensive and concurrent information regarding the contractility of the upper esophageal sphincter, the esophageal body and the lower esophageal sphincter, as well as flow patterns within the esophagus in three dimensions.

91010 ***Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report; 2-dimensional data***
The RUC reviewed and accepted compelling evidence from the surveying specialty society regarding the change in physician work for code 91010. When first valued during the Harvard studies the physician work was valued at 1.65 RVUs, subsequently during the RUC's first Five-Year Review in August 1995, CMS lowered the work value to 1.25 based on the incorrect assumption that an upper gastrointestinal endoscopy would be co-reported with 91010. CMS claims data for 2008 demonstrates that 91010 is reported with 43200 *Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* (Work RVU = 1.59) less than one percent of the time. It was further explained that advancements in technology have had an impact on the physician work. The manometry catheters and recording systems currently available provide more comprehensive data including multiple line tracings representing pressure change verse time at several discrete esophageal loci, which has added time and complexity to the physician's assessment of the data, and the performance of the service. Esophageal manometry is now a much more comprehensive and complex study than it was years ago. **The RUC agreed that there was compelling evidence to change the work relative value associated with this service.**

The RUC reviewed the specialty society's survey results from 59 gastroenterologists who were familiar with this service. The specialty added 2 minutes of evaluation time to the pre-service time package and deleted 7 minutes from the positioning/scrub, dress, wait time to more accurately describe the physician work involved in prepping and positioning the patient on the examination table. The RUC agreed with the specialty's adjustments and recommends the following physician time: 15 minutes of pre-service time, 20 minutes of intra-service time and 15 minutes of post service time for CPT code 91010.

The RUC also agreed with the specialty's relative work value recommendation for CPT Code 91010 as the 25th percentile work relative value of 1.50 was appropriate for this service. The also RUC compared the surveyed service to the Key Reference Service 91122 *Anorectal manometry* (Work RVU = 1.77) and agreed that the services are similar in physician work but the reference service entails more overall physician work and time than the surveyed code. The RUC also compared 91010 to 91022 *Duodenal motility (manometric) study* (Work RVU = 1.44 and total time= 61 minutes) and agreed that the physician work inherent in the services are analogous and should be valued similarly. Given these reference codes, and the specialty's strong survey results, the RUC

recommends the survey 25th percentile work RVU of 1.50 for code 91010, placing this service in proper rank order with the reference codes. **The RUC recommends a relative work value of 1.50 for CPT code 91010.**

91013 ***Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report; with stimulation or perfusion (eg, stimulant, acid or alkali perfusion) (List separately in addition to code for primary procedure)***

The RUC reviewed the specialty society's survey results from 36 gastroenterologists who were familiar with this service. The RUC agreed with the specialty that there should be no pre-service time in this ZZZ global period service. The RUC also agreed with the specialty society recommendation to reduce the intra-service time to 14 minutes, the survey's 25th percentile for intra-service time. Finally, the RUC determined that no post service time was required in this service as the physician interpretation is all included in the intra-service work. The specialty indicated and the RUC agreed that the survey median of 1.00 RVU was excessive for this add-on procedure and agreed the work value should be the current increment of work between codes 91010 (2010 Work RVU =1.25) and deleted code 91012 *Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study; with acid perfusion studies* (2010 Work RVU = 1.46), (1.46-1.25 = 0.21).

The RUC also compared the surveyed service to the Key Reference Service, 43760 *Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance* (Work RVU = 0.90) and agreed with the specialty that this reference service has much greater total time in comparison to the surveyed code, 32 minutes and 14 minutes, respectively. The RUC also compared the service to 75565 *Cardiac magnetic resonance imaging for velocity flow mapping (List separately in addition to code for primary procedure)* (Work RVU = 0.25, 10 minutes intra-service, ZZZ global period) and 96365 *Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour* (Work RVU = 0.21, 9 minutes total time, XXX global period) and determined that these services provide analogous multi-specialty reference points. Finally, the RUC looked at reference code 96413 *Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug* (Work RVU= 0.28, total time= 13 minutes) and agreed that new service 91013 should be valued similarly and further substantiated that the physician work RVU of 0.21 provides proper rank order among and across specialties. **The RUC recommends a relative work value for CPT code 91013 of 0.21.**

Practice Expense: The RUC reviewed the specialty recommended direct practice expense inputs for 91010 and 91013 and made minor modifications for the typical patient service.

Colon Motility (Tab 21)
Nicholas Nickl, MD, ASGE, Edward Bentley, MD, ASGE

In February 2010, the CPT Editorial Panel created a new CPT code for the assessment of colon muscle function. Analysis of the peristalsis and tone is important in the evaluation of complex and clinically poorly responsive colonic dysfunction, pseudo-obstruction, and severe symptomatic constipation and diarrhea in pediatric and adult populations. This new study accurately describes the assessment of the muscle function, peristalsis, and the tone of the entire colon.

91117 ***Colon motility (manometric) study, minimum 6 hours continuous recording (including provocation tests, eg meal, intracolonic balloon distension, pharmacologic agents, if performed), with interpretation and report***
The RUC reviewed the survey results from 33 gastroenterologists for CPT code 91117. Although the RUC concurred that the survey results were strong, they agreed with the specialty that the respondents reported duplicative time in the pre-service and post service periods related to separately reported fluoroscopic or endoscopic procedures. The RUC agreed with the specialty recommendation to eliminate this duplication in time by reducing the total pre-service time from 35 to 15 minutes and reducing the immediate post time from 60 minutes to 30 minutes. By reducing these physician time components the recommended physician time for CPT code 91117 accurately reflects the typical service being performed (15 minutes pre-service. 60 minute intra-service, and 30 minutes post-service)

The RUC compared the physician work, time, intensity, and complexity with the survey's Key Reference service, 91022 *Duodenal motility (manometric) study* (Work RVU = 1.44, 15 minutes pre, 60 minutes intra-service, and 16 minutes immediate post), 91122 *Anorectal manometry* (Work RVU = 1.77, 20 minutes pre, 60 minutes intra-service, and 15 minutes immediate post), and 99222 *Initial hospital care, per day,…*(Work RVU 2.61, 15 minutes pre, 40 minutes intra-service, and 20 minutes immediate post) in relation to 91117. The RUC agreed that the overall physician work for 91117 was greater in intensity and complexity than 91022 and 91122. However in comparison to 99222 the RUC concurred that 91117 was slightly less intense and complex. Given these comparisons, the RUC agreed that the specialty's 25th percentile, 2.45 work RVUs, most appropriately places these services in proper rank order, as it is less than the work value for 99222, and greater than the work value for 91022 and 91122. **The RUC recommends a relative work value of 2.45 for CPT code 91117.**

New Technology: The RUC recommends that CPT code 91117 be placed on the new technology list.

Practice Expense: The RUC recommends direct practice expense inputs in the facility only as they are only performed in the facility setting.

Anterior Segment Imaging (Tab 22)
Stephen A. Kamenetzky, MD, AAO, Cindie Mattox, MD, AAO, Michael Chaglasian, OD, AOA
Facilitation Committee #1

In February 2010, the CPT Editorial Panel deleted a Category III code and created a Category I code to describe anterior segment imaging with optical coherence tomography. This medical diagnostic imaging technology allows for the high resolution cross-sectional or tomographic imaging in biologic tissues, typically for evaluating narrow angle glaucoma patients.

92132 ***Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral.***
The RUC reviewed the survey results from 30 ophthalmologists and optometrists for new code 92132 and agreed with the physician time components of 3 minutes pre-service and 10 minutes intra-service work. The RUC also noted that this service is typically billed

with an evaluation and management service on the same date of service, but agreed that the service should have 3 minutes of pre-service time to accurately reflect the physician work involved to prepare the machine, examine the patient to ensure ability to fixate the eye and describe the test to the patient and to bring the pre-service time components closer in line with the survey respondents' estimation of the pre-service physician time. The RUC compared the surveyed services to the Key Reference Service 76513 *Ophthalmic ultrasound, diagnostic; anterior segment ultrasound, immersion (water bath) B-scan or high resolution* biomicroscopy (Work RVU= 0.66, total time= 19 minutes) and agreed that the reference code has greater total time and intensity as compared to the surveyed code. In addition,92132 was compared to 92025 *Computerized corneal topography, unilateral or bilateral, with interpretation and report* (Work RVU = 0.35, intra-service time = 12) and agreed that this service is similar in physician work, time, and intensity to this new service. The RUC agreed that the relative work value of 92132 should be the same as 92025. **The RUC recommends a relative work value for 92132 of 0.35.**

New Technology
The RUC recommends that 92132 be placed on the new technology/new service list.

Practice Expense: The RUC reviewed the direct practice expense inputs for new code 92132 and reduced the clinical labor time and supplies for the typical patient service, as an evaluation and management service is typically provided on the same day, and agreed to by the specialty.

<u>Computerized Scanning Ophthalmology Diagnostic Imaging (Tab 23)</u>
Stephen A. Kamenetzky, MD, AAO, Cindie Mattox, MD, AAO, Michael Chaglasian, OD, AOA
Facilitation Committee #1

In October 2008, CPT code 92135 *Scanning computerized ophthalmic diagnostic imaging, posterior segment, (eg, scanning laser) with interpretation and report, unilateral* was identified by the RUC through the CMS Fastest Growing Screen. Following further review, the specialties decided to send this code, in October 2009, to the CPT Editorial Panel to delete CPT code 92135 and create two new codes, 92133 *Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve* and 92134 *Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina* to more accurately describe current clinical practices.

The RUC discussed the utilization assumptions for these new services and agreed that compelling evidence was not needed, as there is a calculated work RVU savings. The deleted code, 92135, describes an imaging service that can be used both unilaterally and bilaterally on patients. For 2010, 0.35 work RVUs were assigned when the service was performed unilaterally and 0.70 work RVUs when the services was performed bilaterally. Under current reporting, 92135 is typically reported bilaterally. Utilizing the newly created codes the following utilization assumptions are understood to be correct: 92133 will gather 35% of the total utilization from 92135, 95% of which will be billed bilaterally, and 92134 will gather the remaining 65% of the total utilization from 92135, 75% of which will be billed bilaterally. Given these assumptions, the resulting RUC recommendations will result in a net 27% reduction in work RVU expenditures.

92133
The RUC reviewed the survey results from 47 ophthalmologists and optometrists for code 92133 and agreed with the specialties that adjustments to the survey physician time components was needed to accurately reflect the surveyed service and the previously RUC valued Key Reference Service, CPT code 92083 *Visual field examination, unilateral or bilateral, with interpretation and report; extended examination* (Work RVU=0.50). The RUC agreed that 3 minutes should be added to the standard XXX pre-service time package to accurately account for the physician time required to position the patient, prepare the computer database for the examination and to reflect the pre-service time indicated by the survey respondents. In addition, 2 minutes were added to the survey's median intra-service time for a total of 10 minutes intra-service physician time. This addition accounts for the physician's interpretation and report of the exam results, which is considered intra-service time, not post service time, which explains the inflated surveyed post service time. The recommended physician times are as follows: 3 minutes pre-service time and 10 minutes intra-service time.

The RUC compared CPT code 92133 to the Key Reference Service 92083 (Work RVU = 0.50, pre-service time= 3 minutes and intra-service time= 10 minutes) and agreed that the two services are similar in physician work and have identical total time of 13 minutes. With this comparison, the RUC agreed that the physician work of 92133 should be valued at 0.50 work RVUs, the survey's 25th percentile. **The RUC recommends 0.50 work RVUs for 92133.**

92134
The RUC reviewed the survey results from 49 ophthalmologists and optometrists for 92134 and agreed with the specialties that adjustments to the survey physician time data was needed to accurately reflect the previously RUC valued visual field examination, CPT code 92083 *Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30°, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)* (Work RVU=0.50). The RUC agreed that 7 minutes should be added to the standard XXX pre-service time package to accurately account for the physician time required to position the patient, prepare the computer database for the examination and to reflect the pre-service time indicated by the survey respondents. In addition, the post service time was negated as the survey's median intra-service time of 10 minutes accurately reflects the physician work of interpreting and reporting the examination results and should not be included as post service time. The recommended physician times are as follows: 7 minutes pre-service time and 10 minutes intra-service time.

The RUC compared CPT code 92134 to the Key Reference Service 92235 *Fluorescein angiography (includes multiframe imaging) with interpretation and report* (Work RVU= 0.81 and total time= 28 minutes) and agreed that these services were different in physician work and the reference code should be valued higher due to the additional total physician time involved in the reference code as compared to the surveyed code,28 minutes and 17 minutes, respectively. The RUC also compared the surveyed service to 92083 and agreed that the two services are similar in physician work. The RUC also discussed that 92134 has very similar physician work compared to 92133 and should be

valued the same. Given these comparisons, the RUC agreed that 92134 should have a physician work RVU of 0.50, identical to 92133, and slightly below the survey's 25th percentile. **The RUC recommends 0.50 work RVUs for 92134.**

Practice Expense
Minor changes to the clinical labor were made and accepted by the RUC.

New Technology
The RUC recommends that CPT codes 92133 and 92134 be placed on the new technology list.

Work Neutrality
The RUC's recommendation for this family of codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Diabetic Retinopathy Imaging (Tab 24)
Stephen A. Kamenetzky, MD, AAO, Michael Chaglasian, OD, AOA

In February, 2010 the CPT Editorial Panel established two codes for reporting remote imaging for screening retinal disease and management of active retinal disease. CPT code 92227 *Remote imaging for detection of retinal disease (eg, retinopathy in a patient with diabetes) with analysis and report under physician supervision, unilateral or bilateral* has no physician work and has practice expense inputs only. CPT code 92228 *Remote imaging for monitoring and management of active retinal disease (eg, diabetic retinopathy) with physician review, interpretation and report, unilateral or bilateral* has both physician work and practice expense inputs.
The RUC reviewed the specialty survey results from 33 ophthalmologists and optometrists for new code 92228 *Remote imaging for monitoring and management of active retinal disease (eg, diabetic retinopathy) with physician review, interpretation and report, unilateral or bilateral*. The RUC agreed with 5 minutes pre-service time accurately reflects the typical patient scenario involving positioning of the patient before the retinal camera. The RUC recommends the following physician time for this service: pre-service time of 5 minutes, intra-service time of 8 minutes and 0 minutes post service. The respondents indicated, and the RUC agreed, that CPT code 92250 *Fundus photography with interpretation and report* (Work RVU = 0.44, 9 minutes of intra-service time and 5 minutes immediate post), was virtually identical in physician work, time, and intensity as new code 92228 and should be valued the same. A value of 0.44 is also the 25th percentile survey work value. **The RUC recommends a work relative value of 0.44 for CPT code 92228.**

New Technology: The RUC recommends that 92228 be placed on the new technology/new service list.

Practice Expense: The RUC reviewed the typical practice expense inputs for codes 92227 and 92228 and agreed upon recommendations for both the non-facility and the facility settings.

External Cardiovascular Device Monitoring (Tab 25)
R. Christopher Jones, MD, ACC, Gregory S. Thomas, MD, MPH, ACC

CPT Codes 93224, 93227, 93230, 93233 and 93237 were identified by the Five-Year Review Identification Workgroup's Harvard Valued – Utilization over 100,000 Screen. Further, CMS in the 2009 Final Rule asked the RUC to assess the work valuation of CPT code 93230 and 93233, which are used to report 24 hours of cardiac monitoring, because these services have the same work RVU of 0.52 as codes 93268 and 93272, which are used to report 30 days of cardiac event monitoring. To address the Five-Year Review Identification Workgroup's Screen and the CMS request, the specialty society submitted a coding proposal to address the ambiguity in the current family of external monitoring codes by adding introductory language, deleting codes, revising the current descriptors to reflect the new technology utilized and grouping the family of codes into three families: 1.) Holter monitoring codes for recording up to 48 hours (93224-93227), 2.) Mobile cardiovascular telemetry codes (93228-93229) and 3.) Event monitoring codes (93268-93272).

Holter Monitoring Codes
The descriptors of the holter monitoring codes were changed to reflect 48 hours of monitoring rather than 24 hours of monitoring to reflect the current practice of the physician being able to select a 24 hour monitor and a 48 hour monitor. The specialty society estimates that the 48 hour monitor will be selected one-third of the time by the physician. There is only one work Summary of Recommendation form for this family of four codes, one which describes the global, one which describes the professional, and two which describe components of the technical component.

93224 External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; includes recording, scanning analysis with report, physician review and interpretation

93227 physician review and interpretation

The RUC reviewed the survey data from 49 cardiologists and electrophysiologists for 93224 and agreed that the service times are appropriate. The RUC reviewed the surveyed code in comparison to the reference code 93283 *Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; dual lead implantable cardioverter-defibrillator system* (Work RVU=1.15) and noted that the surveyed code has less total service time associated with it as compared to the reference code 24 minutes and 33 minutes respectively. Further, the RUC agreed that the reference code requires significantly more mental effort and judgment, technical skill and physical effort to perform in comparison to the surveyed code. Although the survey median for this service is 0.75 work RVUs, the specialty society agreed that there was no compelling evidence to change the value of this service. Therefore, the specialty recommends and the RUC agrees 0.52 Work RVUs accurately reflects the amount of work it requires to perform this service. **The RUC recommends 0.52 Work RVU for 93224 and 93227.**

Mobile Cardiovascular Telemetry Codes
The mobile cardiovascular telemetry codes (93228-93229) were created and valued in 2008 and there was only a single word changed from "wearable" to "external" in the work descriptor. **The specialty agrees and the RUC recommends that the changes made to these services are editorial.**

Event Monitoring Codes
The event monitoring codes, 93268-93272, describe 30 day cardiac event monitoring. The revisions made to the descriptors for these codes are quite extensive and effectively clarify the reporting of the codes. Although a far less commonly used set of codes (93012 and 93014) was folded into this family of codes, 93012 and 93014 had the same values as the codes in the family. The specialty believes that the changes are editorial in nature. However, since the specialty did complete a survey, they have included the data as it is more current than that from the original valuation in 1994. There is only one work Summary of Recommendation form for this family of four codes, one which describes the global, one which describes the professional, and two which describe components of the technical component.

93268 External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with
symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; includes transmission, physician review and interpretation

93272 physician review and interpretation
The RUC reviewed the survey data for 93268 and agreed that the service times are appropriate. The RUC reviewed the surveyed code in comparison to the reference code 93283 *Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; dual lead implantable cardioverter-defibrillator system* (Work RVU=1.15) and noted that the surveyed code has less total service time associated with it as compared to the reference code 30 minutes and 33 minutes, respectively. Further, the RUC agreed that the reference code requires significantly more mental effort and judgment, technical skill and physical effort to perform in comparison to the surveyed code. Although the survey median for this service is 1.00 work RVUs, the specialty society agreed that there was no compelling evidence to change the value of this service and agreed that the modifications to this service were editorial. Therefore, the specialty recommends and the RUC agrees 0.52 Work RVUs accurately reflects the amount of work it requires to perform this service. **The RUC recommends 0.52 Work RVU for 93268 and 93272.**

Work Neutrality: The RUC's recommendation for this family of codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Practice Expense – The specialty society recommends and the RUC agrees that the current inputs for these services be maintained.

Diagnostic Cardiac Catheterization (Tab 26)
Gregory S. Thomas, MD, MPH, ACC, Clifford Kavinsky, MD, SCAI, Joseph Babb, MD, SCAI
Facilitation Committee #3

The RUC identified the cardiac catheterization services as potentially misvalued through its Codes Frequently Reported Together screen as combinations of these codes are reported together more than 95% of the time on the same date of service by the same physician. To address any potential duplication in either work or practice expense, the RUC recommended that the services be referred to the CPT Editorial Panel for development of code change proposals to condense code pairs into a single code and create new coding structure for reporting cardiac catheterization. The specialty submitted a code change proposal for the June 2009 CPT meeting, however, the Panel postponed review until October 2009 to provide the Panel with additional time to review. In October 2009, the CPT Editorial Panel approved the addition of 20 codes, introductory language and deletion of 19 codes to accurately report diagnostic cardiac catheterization and injection services where imaging supervision and intra-procedural injection(s) have been bundled into the cardiac catheterization services.

The RUC reviewed these services in families: Coronaries, Coronaries and Grafts, Non-Coronaries, Injection-Imaging Add-on Codes, Congenital Add-on Codes and Procedural Add-on Codes.

Coronaries:

93458 Catheter placement in coronary artery(s) including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed
The RUC reviewed the survey data from 108 cardiologists for the new bundled service, 93458. This code describes a service that was previously reported with coronary injection (93545 = 0.40 Work RVUs), S&I coronary injection (93556 = 0.83 Work RVUs), left heart catheterization (93510= 4.32 Work RVUs), left ventricular injection (93543=0.15 after 50% multiple procedure reduction) plus S&I for ventricular angiography (93555=0.81Work RVUs), resulting in 6.51 Work RVUs. The RUC agrees that the recommended service times are reflective of this service. The specialty society explained that they selected pre-service time package 2B Difficult Patient/Straightforward Procedure (with sedation) and added 7 minutes of pre-service evaluation time and 2 minutes of positioning time as these time modifications most accurately reflect the survey data. The specialty society explained and the RUC agreed that these adjustments were appropriate as the cardiologist is not only performing the cardiac catheterization but also is providing the moderate sedation as well as using imaging equipment. Further, the specialty society explained and the RUC agreed that there is additional time required for positioning as although the patient is supine, the physician must consider the sedation lines, and catheters, imaging equipment and contrast-injection equipment in relation to the patient. The RUC compared the surveyed code to reference code 93619 *Comprehensive electrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording, including insertion and repositioning of multiple electrode catheters, without induction or attempted induction of arrhythmia* (Work RVU=7.31). The RUC noted that the surveyed code has significantly less intra-service time as compared to the reference

code, 45 minutes and 90 minutes, respectively. Further, the RUC noted that the reference code requires more mental effort and judgment and technical skill as compared to the surveyed code. Although the survey median for this service was 8.03 Work RVUs, the specialty society recommended and the RUC agreed that there was no compelling evidence to change the current value for this service, 6.51 work RVUs. **Therefore, the RUC recommends 6.51 Work RVUs for 93458.**

93454 Catheter placement in coronary artery(s) including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation;
The RUC reviewed the survey data from 48 cardiologists for the new bundled service, 93454. This code describes a service that was previously reported with coronary angiography (93508=4.09 Work RVUs), coronary injection (93545=0.40 Work RVUs), plus S&I for coronary injection (93556=0.83 Work RVUs), resulting in 5.32 Work RVUs. The RUC agrees that the recommended service times are reflective of this service. The specialty society explained that they selected pre-service time package 2B Difficult Patient/Straightforward Procedure (with sedation) and added 7 minutes of pre-service evaluation time and 2 minutes of positioning time as these time modifications most accurately reflect the survey data. The specialty society explained and the RUC agreed that these adjustments were appropriate as the cardiologist is not only performing the cardiac catheterization but also is providing the moderate sedation as well as using imaging equipment. Further, the specialty society explained and the RUC agreed that there is additional time required for positioning as although the patient is supine, the physician must consider the sedation lines, and catheters, imaging equipment and contrast-injection equipment in relation to the patient. The RUC compared the surveyed code to reference code 93619 *Comprehensive electrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording, including insertion and repositioning of multiple electrode catheters, without induction or attempted induction of arrhythmia* (Work RVU=7.31). The RUC noted that the surveyed code has significantly less intra-service time as compared to the reference code, 30 minutes and 90 minutes, respectively. Further, the RUC noted that the reference code requires more mental effort and judgment and technical skill as compared to the surveyed code. After reviewing the these comparisons the RUC agreed that the 25th percentile, 4.95 Work RVUs accurately reflects the work it requires to perform this service. This value represents a decrease in the current valuation of this service, 5.32 work RVUs. **Based on this information, the RUC recommends 4.95 Work RVUs for 93454.**

93456 Catheter placement in coronary artery(s) including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right heart catheterization
The RUC reviewed the survey data from 48 cardiologists for the new bundled service, 93456. This code describes a service that was previously reported with coronary angiography (93508=4.09 Work RVUs), coronary injection (93545=0.40 Work RVUs), S&I for coronary injection (93556=0.83) plus right heart catheterization (93501=1.51 Work RVU after the 50% multiple procedure reduction), resulting in 6.83 Work RVUs. The RUC agrees that the recommended service times are reflective of this service. The specialty society explained that they selected pre-service time package 2B Difficult Patient/Straightforward Procedure (with sedation) and added 7 minutes of pre-service evaluation time and 2 minutes of positioning time as these time modifications most accurately reflect the survey data. The specialty society explained and the RUC agreed that these adjustments were appropriate as the cardiologist is not only performing the

cardiac catheterization but also is providing the moderate sedation as well as using imaging equipment. Further, the specialty society explained and the RUC agreed that there is additional time required for positioning as although the patient is supine, the physician must consider the sedation lines, and catheters, imaging equipment and contrast-injection equipment in relation to the patient. The RUC compared the surveyed code to reference code 37187 *Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance* (Work RVU=8.03). The RUC noted that although the intensity/complexity measures for this service are similar, the reference code requires significantly more intra-service time as compared to the surveyed code, 85 minutes and 40 minutes, respectively. After reviewing the these comparisons, the RUC agreed that the 25th percentile, 6.00 Work RVUs accurately reflects the work it requires to perform this service. This value reflects a decrease in the current valuation of this service, 6.83 work RVUs. **Based on this information, the RUC recommends 6.00 Work RVUs for 93456.**

93460 Catheter placement in coronary artery(s) including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed

The RUC reviewed the survey data from 48 cardiologists for the new bundled service, 93460. This code describes a service that was previously reported with coronary injection (93535=0.40 Work RVUs), S&I for coronary injection (93556=0.83 Work RVUs), left ventricular injection (93543=0.15 after 50% multiple procedures reduction), S&I for ventricular angiography (93555=0.81 Work RVUs) plus 93526=5.98 Work RVUs), resulting in 8.17 Work RVUs. The RUC agrees that the recommended service times are reflective of this service. The specialty society explained that they selected pre-service time package 2B Difficult Patient/Straightforward Procedure (with sedation) and added 7 minutes of pre-service evaluation time and 2 minutes of positioning time as these time modifications most accurately reflect the survey data. The specialty society explained and the RUC agreed that these adjustments were appropriate as the cardiologist is not only performing the cardiac catheterization but also is providing the moderate sedation as well as using imaging equipment. Further, the specialty society explained and the RUC agreed that there is additional time required for positioning as although the patient is supine, the physician must consider the sedation lines, and catheters, imaging equipment and contrast-injection equipment in relation to the patient. The RUC compared the surveyed code to reference code 37184 *Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel* (Work RVU=8.66). The RUC noted that although the intensity/complexity measures for this service are the same, the reference code requires significantly more intra-service time as compared to the surveyed code, 90 minutes and 50 minutes, respectively. After reviewing these comparisons, the RUC agreed that the 25th percentile, 7.88 Work RVUs, accurately reflects the work it requires to perform this service. This value represents a decrease in the current valuation of this service, 8.17 work RVUs. **Based on this information, the RUC recommends 7.88 Work RVUs for 93460.**

Coronaries and Grafts:

93455 Catheter placement in coronary artery(s) including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography
The RUC reviewed the survey data from 48 cardiologists for the new bundled service, 93455. This code describes a service that was previously reported with coronary angiography (93508=4.09 Work RVUs), coronary injection (93545=0.40 Work RVUs), S&I for coronary injection (93556=0.83 Work RVUs), cardiac catheterization injection arterial conduits (93539=0.40 Work RVUs) plus cardiac catheterization injection aortocoronary venous bypass grafts (93540=0.43 Work RVUs), resulting in 6.15 Work RVUs. The RUC agrees that the recommended service times are reflective of this service. The specialty society explained that they selected pre-service time package 2B Difficult Patient/Straightforward Procedure (with sedation) and added 12 minutes of pre-service evaluation time and 2 minutes of positioning time as these time modifications most accurately reflect the survey data. The specialty society explained and the RUC agreed that these adjustments were appropriate as the cardiologist is not only performing the cardiac catheterization but also is providing the moderate sedation as well as using imaging equipment and additionally for this service the physician must review additional films as the patient had prior bypass grafts. Further, the specialty society explained and the RUC agreed that there is additional time required for positioning as although the patient is supine, the physician must consider the sedation lines, and catheters, imaging equipment and contrast-injection equipment in relation to the patient. The RUC compared the surveyed code to reference code 93619 *Comprehensive electrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording, including insertion and repositioning of multiple electrode catheters, without induction or attempted induction of arrhythmia* (Work RVU=7.31). The RUC noted that the surveyed codes requires less intra-service time as compared to the reference code, 40 minutes and 90 minutes, respectively. Further, the RUC noted that the reference code requires has more psychological stress associated with it as compared to the surveyed code. Although the survey median for this service was 8.00 Work RVUs, the specialty society recommended and the RUC agreed that there was no compelling evidence to change the current value for this service, 6.15 work RVUs. **Therefore, the RUC recommends 6.15 Work RVUs for 93455.**

93457 Catheter placement in coronary artery(s) including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography and right heart catheterization
The RUC reviewed the survey data from 38 cardiologists for the new bundled service, 93457. This code describes a service that was previously reported with coronary angiography (93508=4.09 Work RVUs), coronary injection (93545=0.40 Work RVUs), S&I for coronary injection (93556=0.83 Work RVUs), cardiac catheterization injection arterial conduits (93539=0.40 Work RVUs) plus cardiac catheterization injection aortocoronary venous bypass grafts (93540=0.43 Work RVUs) plus right heart catheterization (93501=1.51 after 50% multiple procedure reduction), resulting in 7.66 Work RVUs. The RUC agrees that the recommended service times are reflective of this service. The specialty society explained that they selected pre-service time package 2B Difficult Patient/Straightforward Procedure (with sedation) and added 12 minutes of pre-

service evaluation time and 2 minutes of positioning time as these time modifications most accurately reflect the survey data. The specialty society explained and the RUC agreed that these adjustments were appropriate as the cardiologist is not only performing the cardiac catheterization but also is providing the moderate sedation as well as using imaging equipment. Additionally for this service the physician must review additional films as the patient had prior bypass grafts. Further, the specialty society explained and the RUC agreed that there is additional time required for positioning as although the patient is supine, the physician must consider the sedation lines, and catheters, imaging equipment and contrast-injection equipment in relation to the patient. The RUC compared the surveyed code to reference code 37184 *Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel* (Work RVU=8.66) The RUC noted that the reference code required more intra-service time in comparison to the surveyed code 90 minutes and 50 minutes, respectively. Further, the RUC acknowledged that the reference code required a higher urgency of medical decision making and had a higher risk of significant complications, morbidity and mortality as compared to the surveyed code. Although the surveyed 25th percentile for this service was 8.00 Work RVUs, the specialty society recommended and the RUC agreed that there was no compelling evidence to change the current value for this service, 7.66 work RVUs. **Therefore, the RUC recommends 7.66 Work RVUs for 93457.**

93459 Catheter placement in coronary artery(s) including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right heart catheterization with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography

The RUC reviewed the survey data from 38 cardiologists for the new bundled service, 93459. This code describes a service that was previously reported with coronary injection (93545=0.40 Work RVUs), S&I coronary injection (93556=0.83 Work RVUs), left heart catheterization (93510=4.32 Work RVUs), left ventricular injection (93543=0.15 Work RVUs after 50% multiple procedure reduction), S&I for ventricular angiography (93555=0.81 Work RVUs), cardiac catheterization injection arterial conduits (93539=0.40 Work RVUs) plus cardiac catheterization injection aortocoronary venous bypass grafts (93540=0.43 Work RVUs), resulting in 7.34 Work RVUs. The RUC agrees that the recommended service times are reflective of this service. The specialty society explained that they selected pre-service time package 2B Difficult Patient/Straightforward Procedure (with sedation) and added 12 minutes of pre-service evaluation time and 2 minutes of positioning time as these time modifications most accurately reflect the survey data. The specialty society explained and the RUC agreed that these adjustments were appropriate as the cardiologist is not only performing the cardiac catheterization but also is providing the moderate sedation as well as using imaging equipment. Additionally for this service the physician must review additional films as the patient had prior bypass grafts. Further, the specialty society explained and the RUC agreed that there is additional time required for positioning as although the patient is supine, the physician must consider the sedation lines, and catheters, imaging equipment and contrast-injection equipment in relation to the patient. The RUC compared the surveyed code to reference code 37184 *Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s);*

initial vessel (Work RVU=8.66) The RUC noted that the reference code required more intra-service time in comparison to the surveyed code 90 minutes and 60 minutes, respectively. Further, the RUC acknowledged that the reference code was a more intense service to perform as compared to the surveyed code. Although the surveyed 25th percentile for this service was 8.00 Work RVUs, the specialty society recommended and the RUC agreed that there was no compelling evidence to change the current value for this service, 7.34 work RVUs. **Therefore, the RUC recommends 7.34 Work RVUs for 93459.**

93461 Catheter placement in coronary artery(s) including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography
The RUC reviewed the survey data from 38 cardiologists for the new bundled service, 93461. This code describes a service that was previously reported with coronary injection (93545=0.40 Work RVUs), S&I coronary injection (93556=0.83 Work RVUs), left ventricular injection (93543=0.15 Work RVUs after 50% multiple procedure reduction), S&I for ventricular angiography (93555=0.81 Work RVUs), combined right and retrograde left heart catheterization (93526=5.98 Work RVUs), cardiac catheterization injection arterial conduits (93539=0.40 Work RVUs) plus cardiac catheterization injection aortocoronary venous bypass grafts (93540=0.43 Work RVUs), resulting in 9.00 Work RVUs. The RUC agrees that the recommended service times are reflective of this service. The specialty society explained that they selected pre-service time package 2B Difficult Patient/Straightforward Procedure (with sedation) and added 12 minutes of pre-service evaluation time and 2 minutes of positioning time as these time modifications most accurately reflect the survey data. The specialty society explained and the RUC agreed that these adjustments were appropriate as the cardiologist is not only performing the cardiac catheterization but also is providing the moderate sedation as well as using imaging equipment. Additionally for this service the physician must review additional films as the patient had prior bypass grafts. Further, the specialty society explained and the RUC agreed that there is additional time required for positioning as although the patient is supine, the physician must consider the sedation lines, and catheters, imaging equipment and contrast-injection equipment in relation to the patient. The RUC compared the surveyed code to reference code 93620 *Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording* (Work RVU=11.57). The RUC noted that the reference code has significantly more intra-service time as compared to the surveyed code, 120 minutes and 65 minutes, respectively. Further, the RUC acknowledged that the reference code requires more physical effort to perform and has more risk of significant complication, morbidity and mortality as compared to the surveyed code. Although the surveyed median for this service was 11.25 Work RVUs, the specialty society recommended and the RUC agreed that there was no compelling evidence to change the current value for this service, 9.00 work RVUs. **Therefore, the RUC recommends 9.00 Work RVUs for 93461.**

Non-Coronaries:

93451 Right heart catheterization including measurement(s) of oxygen saturation and cardiac output, when performed
The RUC reviewed the survey data from 68 cardiologists for the new code, 93451. This code describes a service that was previously reported with right heart catheterization (93501=3.02 Work RVUs). The RUC agrees that the recommended service times are reflective of this service. The specialty society explained that they selected pre-service time package 2B Difficult Patient/Straightforward Procedure (with sedation) and added 7 minutes of pre-service evaluation time and 2 minutes of positioning time as these time modifications most accurately reflect the survey data. The specialty society explained and the RUC agreed that these adjustments were appropriate as the cardiologist is not only performing the cardiac catheterization but also is providing the moderate sedation as well as using imaging equipment. Further, the specialty society explained and the RUC agreed that there is additional time required for positioning as although the patient is supine, the physician must consider the sedation lines, and catheters, imaging equipment and contrast-injection equipment in relation to the patient. The RUC compared the surveyed code to the reference code 93503 *Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes* (Work RVU=2.91). The RUC noted that the surveyed code had significantly more intra-service time as compared to the reference code 30 minutes and 15 minutes, respectively. The RUC noted that the surveyed code required more mental effort and judgment to perform in comparison to the reference code. Although the surveyed median for this service was 4.00 Work RVUs, the specialty society recommended and the RUC agreed that there was no compelling evidence to change the current value for this service, 3.02 work RVUs. **Therefore, the RUC recommends 3.02 Work RVUs for 93451.**

93452 Left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed
The RUC reviewed the survey data from 68 cardiologists for the new bundled service, 93452. This code describes a service that was previously reported with left heart catheterization (93510=4.32 Work RVUs), left ventricular injection (93543 =0.15 Work RVUs after 50% multiple procedure reduction) plus S&I for ventricular angiography (93555=0.81 Work RVUs), resulting in 5.28 Work RVUs. The RUC agrees that the recommended service times are reflective of this service. The specialty society explained that they selected pre-service time package 2B Difficult Patient/Straightforward Procedure (with sedation) and added 7 minutes of pre-service evaluation time and 2 minutes of positioning time as these time modifications most accurately reflect the survey data. The specialty society explained and the RUC agreed that these adjustments were appropriate as the cardiologist is not only performing the cardiac catheterization but also is providing the moderate sedation as well as using imaging equipment. Further, the specialty society explained and the RUC agreed that there is additional time required for positioning as although the patient is supine, the physician must consider the sedation lines, and catheters, imaging equipment and contrast-injection equipment in relation to the patient. The RUC compared the surveyed code to the reference code 93624 *Electrophysiologic follow-up study with pacing and recording to test effectiveness of therapy, including induction or attempted induction of arrhythmia* (Work RVU=4.80). The RUC noted that the reference code had more intra-service time as compared to the surveyed code, 68 minutes and 30 minutes, respectively. Further, the RUC agreed that the reference code was a more intense procedure to perform as compared to the surveyed code. Although the surveyed 25th percentile was 4.00 Work RVUs, the specialty society

recommended and the RUC agreed that in order to maintain relativity to the other codes within this family, the work for 93452 should be crosswalked to 93510 (4.32 Work RVUs). **Therefore, the RUC recommends 4.32 Work RVUs for 93452.**

93453 Combined right and left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed

The RUC reviewed the survey data from 68 cardiologists for the new bundled service, 93452. This code describes a service that was previously reported with combined right and retrograde left heart catheterization (93526=5.98 Work RVUs), left ventricular injection (93543 =0.15 Work RVUs after 50% multiple procedure reduction) plus S&I for ventricular angiography (93555=0.81 Work RVUs), resulting in 6.94 Work RVUs. The RUC agrees that the recommended service times are reflective of this service. The specialty society explained that they selected pre-service time package 2B Difficult Patient/Straightforward Procedure (with sedation) and added 7 minutes of pre-service evaluation time and 2 minutes of positioning time as these time modifications most accurately reflect the survey data. The specialty society explained and the RUC agreed that these adjustments were appropriate as the cardiologist is not only performing the cardiac catheterization but also is providing the moderate sedation as well as using imaging equipment. Further, the specialty society explained and the RUC agreed that there is additional time required for positioning as although the patient is supine, the physician must consider the sedation lines, and catheters, imaging equipment and contrast-injection equipment in relation to the patient. The RUC compared the surveyed code to the reference code 31600 *Tracheostomy, planned (separate procedure);* (Work RVU=7.17). The RUC noted that the surveyed code has more intra-service time as compared to the reference code, 45 minutes and 40 minutes, respectively. Although the surveyed 25th percentile was 5.44 Work RVUs, the specialty society recommended and the RUC agreed that in order to maintain relativity to the other codes within this family, the work for 93453 should be crosswalked to 93526 (5.98 Work RVUs). **Therefore, the RUC recommends 5.98 Work RVUs for 93453.**

Injection – Imaging Add-on Codes

93566 Injection procedure during cardiac catheterization including image supervision, interpretation, and report; for selective right ventricular or right atrial angiography

The RUC reviewed the survey data from 57 cardiologists for new bundled service, 93566. This code represents a service that was previously reported with right ventricular injection (93542=0.15 Work RVUs after 50% multiple procedure reduction) and S&I for ventricular angiography (93555=0.81Work RVUs), resulting in 0.96 Work RVUs. The RUC had concerns about the recommended post-service time of 5 minutes. The specialty societies explained that this additional time was needed to review the additional images obtained. The RUC agreed that this work was better represented in the intra-service time and makes the service time consistent with other ZZZ global codes. The RUC agrees that the modified service time accurately reflects the service. The RUC compared this service to reference code 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 noted that the surveyed code has more intra-service time as compared to the reference code, 20 minutes and 15 minutes, respectively. Further, the RUC agreed that the surveyed code is a more intense service to perform in comparison to

the reference code. Although the surveyed median for this service was 2.00 Work RVUs, the specialty society recommended and the RUC agreed that there was no compelling evidence to change the current value for this service, 0.96 work RVUs. **Therefore, the RUC recommends 0.96 Work RVUs for 93566.**

93567 Injection procedure during cardiac catheterization including image supervision, interpretation, and report; for supravalvular aortography
The RUC reviewed the survey data from 66 cardiologists for new bundled service, 93567. This code represents a service that was previously reported with aortography (93544=0.25 Work RVUs) and S&I coronary injection (93556=0.83 Work RVUs), resulting in 1.08 Work RVUs. The RUC had concerns about the recommended post-service time of 5 minutes. The specialty societies explained that this additional time was needed to review the additional images obtained. The RUC agreed that this work was better represented in the intra-service time and makes the service time consistent with other ZZZ global codes. The RUC agrees that the modified service time accurately reflects the service. The RUC compared this service to reference code 92978 *Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel* (Work RVU=1.80). The RUC noted that the surveyed code has less intra-service time as compared to the reference code, 15 minutes and 25 minutes, respectively. Further, the RUC agreed that the reference code is a more intense service to perform in comparison to the surveyed code. Although the surveyed 25th percentile for this service was 1.10 Work RVUs, the specialty society recommended and the RUC agreed that the current value for this service, 1.08 Work RVUs, creates a rank order anomaly with this service and 93566 and 93568. Therefore, the RUC directly crosswalked the value of this service to 99213 *Office or other outpatient visit for the evaluation and management of an established patient,* (Work RVU=0.97) as both of these services are similarly intense and both have 15 minutes of intra-service time. This recommended value also maintains rank order with 93566 and 93568. **The RUC recommends 0.97 Work RVUs for 93567.**

93568 Injection procedure during cardiac catheterization including image supervision, interpretation, and report; for pulmonary angiography
The RUC reviewed the survey data from 58 cardiologists for the new bundled service, 93568. This code represents a service that was previously reported with pulmonary angiography (93541=0.15 after 50% multiple procedure reduction) and S&I coronary injection (93556=0.83 Work RVUs), resulting in 0.98 Work RVUs. The RUC had concerns about the recommended post-service time of 5 minutes. The specialty societies explained that this additional time was needed to review the additional images obtained. The RUC agreed that this work was better represented in the intra-service time and makes the service time consistent with other ZZZ global codes. The RUC agrees that the modified service time accurately reflects the service. The RUC compared this service to reference code 92978 *Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel* (Work RVU=1.80). The RUC noted that the surveyed code has slightly less intra-service time as compared to the reference code, 20 minutes and 25 minutes, respectively. Further, the RUC agreed that the reference code requires the same amount of intensity to perform as the surveyed code. Although the surveyed 25th percentile for this service was 1.80 Work RVUs, the specialty society recommended and the RUC agreed that there was no compelling evidence to change the current value for this service, 0.98 work RVUs. **Therefore, the RUC recommends 0.98 Work RVUs for 93568.**

Congenital Add-On Codes:

The RUC expressed concern about the response rate of these three services. The specialty society explained that these are very low volume services and therefore it was difficult to get a robust survey response. The RUC acknowledged that this rationale was appropriate and reasonable.

93563 Injection procedure during cardiac catheterization including image supervision, interpretation, and report; for selective coronary angiography during congenital heart catheterization
The RUC reviewed the survey data for the new bundled service, 93563. This code represents a service that was previously reported with coronary injection (93545=0.40 Work RVUs) and S&I coronary injection (93556=0.83 Work RVUs), resulting in 1.23 Work RVUs. The RUC had concerns about the recommended post-service time of 5 minutes. The specialty societies explained that this additional time was needed to review the additional images obtained. The RUC agreed that this work was better represented in the intra-service time and makes the service time consistent with other ZZZ global codes. The RUC agrees that the modified service time accurately reflects the service. The specialty societies also explained that they had compelling evidence to support their recommendation that the current value for this service, via component coding, is incorrect. The specialty societies stated and the RUC agreed that there is evidence that the patient population has changed as the current typical patient has congenital heart disease which was not true of this service when originally reviewed.

The RUC compared this service to reference code 92978 *Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel* (Work RVU=1.80). The RUC noted that although the surveyed code has the same intra-service time as compared to the reference code, 25 minutes, the RUC agreed that the surveyed code is a more intense service to perform in comparison to the reference code. Further, the RUC compared the surveyed code to MPC code 13133 *Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less* (Work RVU=2.19). The RUC noted that 13133 has more intra-service time as compared to the surveyed code, 30 minutes and 25 minutes respectively**. Based on these comparisons, the RUC recommends 2.00 Work RVUs, the survey median, for 93563.**

93564 Injection procedure during cardiac catheterization including image supervision, interpretation, and report; for selective opacification of aortocoronary venous or arterial bypass graft(s) (eg, aortocoronary saphenous vein, free radial artery, or free mammary artery graft) to one or more coronary arteries and in situ arterial conduits (eg, internal mammary), whether native or used for bypass to one or more coronary arteries during congenital heart catheterization, when performed
The RUC reviewed the survey data for the new bundled service, 93564. This code represents a service that was previously reported with coronary injection (93540=0.43 Work RVUs) and S&I coronary injection (93556=0.83 Work RVUs), resulting in 1.26 Work RVUs. The RUC had concerns about the recommended post-service time of 5 minutes. The specialty societies explained that this additional time was needed to review the additional images obtained. The RUC agreed that this work was better represented in the intra-service time and makes the service time consistent with other ZZZ global codes.

The RUC agreed that the modified service time accurately reflects the service. The specialty societies also explained that they had compelling evidence to support their recommendation that the current value for this service, via component coding, is incorrect. The specialty societies stated and the RUC agreed that there is evidence that the patient population has changed as the current typical patient has congenital heart disease which was not true of this service when originally reviewed.

The RUC compared this service to the reference code 92978 *Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel* (Work RVU=1.80). The RUC noted that although the surveyed code has the same intra-service time as compared to the reference code, 25 minutes, the RUC agreed that the surveyed code is a more intense service to perform in comparison to the reference code. Further, the RUC compared the surveyed code to MPC code 13133 *Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less* (Work RVU=2.19). The RUC noted that 13133 has more intra-service time as compared to the surveyed code, 30 minutes and 25 minutes respectively. Given these comparisons, the RUC agreed that 2.10 work RVUs, the survey median, accurately reflects the amount of work it requires to perform this service as well as maintain rank order between this service and 93563 and 93565. **The RUC recommends 2.10 Work RVUs for 93564.**

93565 Injection procedure during cardiac catheterization including image supervision, interpretation, and report; **for selective left ventricular or left atrial angiography**

The RUC reviewed the survey data for the new bundled service, 93565. This code represents a service that was previously reported with left ventricular injection (93543=0.15 Work RVUs after 50% multiple procedure reduction) and S&I for ventricular angiography (93555=0.81 Work RVUs), resulting in 0.96 Work RVUs. The RUC had concerns about the recommended post-service time of 5 minutes. The specialty societies explained that this additional time was needed to review the additional images obtained. The RUC agreed that this work was better represented in the intra-service time and makes the service time consistent with other ZZZ global codes. The RUC agreed that the modified service time accurately reflects the service. The specialty societies also explained that they had compelling evidence to support their recommendation that the current value for this service, via component coding, is incorrect. The specialty societies stated and the RUC agreed that there is evidence that the patient population has changed as the current typical patient has congenital heart disease which was not true of this service when originally reviewed.

The RUC compared this service to the reference code 92978 *Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel* (Work RVU=1.80). The RUC noted that although the surveyed code has less intra-service time as compared to the reference code, 20 minutes and 25 minutes, respectively, the RUC agreed that the surveyed code is a more intense service to perform in comparison to the reference code. Further, the RUC compared the surveyed code to MPC code 13133 *Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less* (Work RVU=2.19). The RUC noted that 13133 has more intra-service time as compared to the surveyed code, 30 minutes and 20 minutes respectively. Given these comparisons, the RUC agreed that 1.90 work RVUs, the

survey median, accurately reflects the amount of work it requires to perform this service as well as maintain rank order between this service and 93563 and 93565. **The RUC recommends 1.90 Work RVUs for 93565.**

Procedural Add-on Codes:

These services represent new technology which were previously reported with unlisted services. Thus, these services do not require compelling evidence to justify their value. **Further, to ensure that the utilization estimates provided by the specialty are accurate, the RUC recommended that 93463, 93464, 93462 be added to the New Technology/Service List.**

93463 Pharmacologic agent administration (eg, inhaled nitric oxide, intravenous infusion of nitroprusside, dobutamine, milrinone, or other agent) and repeat hemodynamic measurements The RUC reviewed the survey data from 40 survey respondents for 93463 and had concerns about the recommended post-service time of 10 minutes. The specialty societies explained that this additional time was needed to review the cardiac output/hemodynamics/blood pressure prior, during and after the service performed. The RUC agreed that this work was better represented in the intra-service time and makes the service time consistent with other ZZZ global codes. Based on this decision, the RUC agreed that the descriptor for this service should be modified to clearly describe the service being performed. **The RUC recommends the following modified descriptor for 93463:**

Pharmacologic agent(s) administration (eg, inhaled nitric oxide, intravenous infusion of nitroprusside, dobutamine, milrinone, or other agent) including assessment of hemodynamic measurements before, during, after and repeat pharmacologic agent administration, when performed and repeat hemodynamic measurements (List separately in addition to code for primary procedure)

The RUC compared this service to the reference code 93571 *Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; initial vessel* (Work RVU=1.80). The RUC noted that 93571 has more intra-service time as compared to the surveyed code, 30 minutes and 20 minutes respectively. Further, the RUC noted that the surveyed code requires more mental effort and judgment than the reference code. Given these comparisons, the RUC agreed that 2.00 work RVUs, the survey's 25th percentile , accurately reflects the amount of work it requires to perform this service. **The RUC recommends 2.00 Work RVUs for 93463.**

93464 Physiologic exercise study (eg, bicycle or arm ergometry, or pharmacologic exercise) and repeat hemodynamic measurements
The RUC reviewed the survey data for 93464 and had concerns about the recommended post-service time of 10 minutes. The specialty societies explained that this additional time was needed to review the cardiac output/hemodynamics/blood pressure prior and after the service performed. The RUC agreed that this work was better represented in the intra-service time and makes the service time consistent with other ZZZ global codes.

The RUC compared the surveyed code to the reference code 93571 *Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced*

stress; initial vessel (Work RVU=1.80). The RUC noted that the surveyed code has more intra-service time as compared to the reference code, 30 minutes and 20 minutes, respectively. However, the RUC noted that the reference code requires more technical skill, physical effort and causes more psychological stress as compared to the surveyed code. Given these comparisons, the RUC agreed that 1.80 work RVUs, the survey's 25th percentile, accurately reflects the amount of work it requires to perform this service as well as maintain rank order between this service and 93462 and 93463. **The RUC recommends 1.80 Work RVUs for 93464. In addition, The RUC recommends that this service be referred to the CPT Editorial Panel to remove "or pharmacologic exercise" be removed from the descriptor to clarify the difference between 93463 and 93464. Further, the RUC requested that the assessing hemodynamic measurements language be added to this descriptor as well resulting in the following modified language:**

Physiologic exercise study (eg, bicycle or arm ergometry, or pharmacologic exercise) and repeat hemodynamic measurements including assessment of hemodynamic measurements before, during, after and repeat pharmacologic agent administration, when performed and repeat hemodynamic measurements (List separately in addition to code for primary procedure)

93462 Left heart catheterization by transseptal puncture through intact septum or by transapical puncture

The RUC reviewed the survey data for 93462 and had concerns about the recommended pre-service time of 10 minutes. The specialty societies explained that this additional time was needed to obtain additional consent with the patient because of the severe risks to the patient and the equipment required this procedure must be set-up by the physician. The RUC agreed that this work was better represented in the intra-service time and makes the service time consistent with other ZZZ global codes.

The RUC agreed that the service should be cross-walked to 14302 *Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof* (Work RVU=3.73, ZZZ Global), which has the same intra-service time, 40 minutes, and requires the same amount of intensity to perform. This value is further supported by an additional reference code 35685 *Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduit* (Work RVU=4.04, ZZZ Global), which has 5 more minutes of intra-service time in comparison to 93462. **The RUC recommends 3.73 Work RVU and 40 minutes of intra-service time for 93462.**

Moderate Sedation: The RUC after reviewing the survey data for all of the diagnostic cardiac catheterization services noted the moderate sedation was inherent. **Therefore, the RUC recommends that all of the diagnostic cardiac catheterization services be added to Appendix G in the CPT 2011 Book and each code be designated with a ◎.**

Work Neutrality

The RUC's recommendation for this family of codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Practice Expense

The RUC reviewed and accepted the practice expense inputs for 93451-93568 as approved by the PE Subcommittee.

Extremity Non-Invasive Arterial Physiologic Studies (Tab 27)
Joseph Babb, MD, ACC, David Han, MD, SVS, Clifford Kavinsky, MD, ACC, Arthur Lee, MD, ACC, Geraldine McGinty, MD, ACR, Gary Seabrook, MD, SVS, Matthew Sideman, MD, SVS, Ezequiel Silva, MD, ACR, Gregory Thomas, MD, ACC, Robert Zwolak, MD, SVS

In June 2008, CPT code 93922 *Noninvasive physiologic studies of upper or lower extremity arteries, single level, bilateral (eg, ankle/brachial indices, Doppler waveform analysis, volume plethysmography, transcutaneous oxygen tension measurement)* (Work RVU = 0.25) was identified through the RUC's Five-Year Review Identification Workgroup CMS Fastest Growing Screen. The RUC agreed that it and other services in the family should be reviewed for physician work and practice expense. In October 2009, the RUC agreed for the specialty to submit a code change proposal to the CPT Editorial Panel to provide more specificity to better define the work required to report the extremity non-invasive arterial physiologic studies. The CPT Editorial Panel revised the noninvasive arterial physiologic study codes 93922-93924 as well as the introductory guidelines for consistency. In April, 2010 RUC reviewed the physician work and practice expense inputs for this family of codes.

93922 ***Limited bilateral noninvasive physiologic studies of upper or lower extremity arteries, (eg for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus bidirectional Doppler waveform recording and analysis at 1-2 levels; or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus volume plethysmography at 1-2 levels; or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries with transcutaneous oxygen tension measurements at 1-2 levels)***

The RUC reviewed the survey results from 40 vascular surgeons, radiologists, and cardiologists for revised CPT code 93922. The RUC agreed with the specialty that this service is similar in intensity and complexity to 99212 *Office or other outpatient visit for the evaluation and management of an established patient,* (Work RVU = 0.48, 10 minutes of intra-service time), however the surveyed code has less intra-service time, 5 minutes and 10 minutes, respectively. The RUC concurred with the specialty that the work value of 93922 should be about half of 99212 considering the similarities in intensity and complexity and the intra-service time of 93922 of 5 minutes. The RUC also compared the overall work of 93922 to 71020 *Radiologic examination, chest, 2 views, frontal and lateral* (Work RVU = 0.22, total time = 5 minutes) and agreed the work RVU for 93922 should be greater. Although the survey results indicated a median relative work RVU of 0.38, the RUC agreed with the specialty societies there is no compelling evidence that the work of this service had changed. The RUC concurred with the specialty society recommendation the survey 25th percentile results of 0.25 RVUs as it provides the proper intensity, complexity, and rank order for 93922 among and across all specialty services. **The RUC recommends a relative work value of 0.25 for revised CPT code 93922.**

93923 ***Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, three or more levels (eg for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental blood pressure measurements with bidirectional Doppler waveform recording and analysis at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental volume plethysmography at 3 or more***

levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental transcutaneous oxygen tension measurements at 3 or more levels), or single level study with provocative functional maneuvers (eg, measurements with postural provocative tests, or measurements with reactive hyperemia or cold stress)

The RUC reviewed the survey results from 40 vascular surgeons, radiologists, and cardiologists for revised CPT code 93923. The RUC agreed with the specialty that this service is similar in intensity and complexity of 99213 *Office or other outpatient visit for the evaluation and management of an established patient* (Work RVU = 0.97), however the surveyed code has less total service time,16 minutes and 23 minutes . (The RUC compared the surveyed code to MPC code 92250 *Fundus photography with interpretation and report* (Work RVU=0.44). The RUC noted that the surveyed code and the reference code have similar intra-service times, 10 minutes and 9 minutes, respectively. Although the survey results and comparisons to 92250 indicate a median relative work RVU of 0.50, the RUC agreed with the specialty societies that there is no compelling evidence that the work of this service had changed therefore, the specialty society and the RUC agreed that the value of this service should be maintained at 0.45 Work RVUs, a value just below the survey median.The specialty also proposed and the RUC accepted the 25th percentile survey result for intra-service time of 10 minutes for proper rank order as 15 minutes was considered overstated. **The RUC recommends a relative work value of 0.45 for revised CPT code 93923.**

93924 ***Noninvasive physiologic studies of lower extremity arteries, at rest and following treadmill stress testing, (ie, bidirectional Doppler waveform or volume plethysmography recording and analysis at rest with ankle/brachial indices immediately after and at timed intervals following performance of a standardized protocol on a motorized treadmill plus recording of time of onset of claudication other symptoms, maximal walking time, and time to recovery) complete bilateral study***

The RUC reviewed the survey results from 40 vascular surgeons, radiologists, and cardiologists for revised CPT code 93924. The survey respondents chose 99213 to be the key reference service and the RUC agreed with the survey respondents who indicated 93924 was less work than a 99213. The RUC agreed with the specialty that this service is similar in overall physician work to 92083 *Visual field examination, unilateral or bilateral, with interpretation and report; extended examination..,* (Work RVU = 0.50, 13 minutes total time). Although the survey results indicated a median relative work RVU of 0.75, the RUC agreed with the specialty societies that there is no compelling evidence that the work of this service had changed and therefore, the specialty society and the RUC agreed that the value of this service should be maintained at 0.50 Work RVUs, a value between the survey's median and 25th percentile results. The specialty also proposed and the RUC accepted the 25th percentile survey result for intra-service time of 13 minutes for proper rank order as 18 minutes was considered overstated. **The RUC recommends a relative work value of 0.50 for revised CPT code 93924.**

Work Neutrality

The RUC's recommendation and code descriptor change for these three codes should result a 20% reduction in Medicare utilization for these services, resulting in an overall work savings that should be redistributed back to the Medicare conversion factor.

Practice Expense
The RUC reviewed and revised the direct practice expense inputs for codes 93922, 93923, and 93924 to reflect lower costs associated with the new descriptor changes and was agreed upon by the specialty.

Sleep Testing (Tab 28)
Marianna Spanaki, MD, AAN, Gerald Rich, MD, AASM, Sam Fleishman, MD, AASM, Baldwin Smith, MD, AAN/AASM/ACNS, Scott Manaker, MD, PhD, ACCP/ATS, Burt Lesnick, MD, ACCP/ATS
Facilitation Committee #3

The RUC identified the sleep testing services as potentially misvalued based on the recommendation of the Five-Year Review Identification Workgroup. These codes were referred to the Workgroup for review via the CMS Fastest Growing Screen. The specialty society identified a number of causes for the rapidly growing volume of these services including increased accessibility, growing awareness of sleep disorders and their impact on patients' health, as well as the growth of the Medicare population. To address these coding issues, separate Category I codes were created to properly code unattended sleep studies. The RUC recommended conversion of the two Category III codes into two Category I codes to report unattended sleep study and concurrent review of the family of sleep codes.

A multi-specialty panel of physicians met to review survey data from more than 50 physicians. The specialties included sleep medicine, neurology, and pulmonary medicine.

95803 Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)
The RUC reviewed the surveyed times associated with this service (pre-service=15, intra-service=20, and post-service=15). The specialty societies explained that sleep physicians must consider all of the tests available and review forms including patient self-report, questionnaires, sleepiness scales, sleep diaries and the physician notes to include a detailed review of the patient's medication regimen to make an assessment of which test is the most appropriate. This assessment is not a face-to-face visit and is not captured by an evaluation and management service and is the standard of care based on the nature of the test. The decision on the type of test is complex as there are multiple new technologies. The RUC agreed, based on this explanation, that 15 minutes of pre-service time was reflective of the service. The RUC compared the surveyed code to the reference code 95816 *Electroencephalogram (EEG); including recording awake and drowsy* (Work RVU=1.08). The RUC noted that the surveyed code had slightly more intra-service time in comparison to the reference code, 20 minutes and 15 minutes. However, the reference code is a more intense service to perform. The RUC also compared the surveyed code to 51700 *Bladder irrigation, simple, lavage and/or instillation* (Work RVU=0.88). The RUC noted that the surveyed code has slightly more total-service time as compared to 51700, 50 minutes and 45 minutes, respectively. Therefore, the RUC based on these two comparisons agreed that the appropriate value for this service is 0.90 work RVUs, the survey's 25th percentile. **The RUC recommends 0.90 Work RVU for 95803.**

95805 Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness

The RUC reviewed the surveyed times associated with this service (pre-service=15, intra-service=20, and post-service=15). (The specialty society explained that the physician is required to provide instructions to the technologist based on a number of conditions that patient has which require clinical judgment. The physician must review patient medications, sleep diaries to include patient sleep patterns the prior evening as well as other activities. Based on the review of this information, the physician is then able to instruct the technologist regarding when to begin the trials and the criteria for cancellation and medications the patient is allowed to take. The RUC agreed, based on this explanation, that 15 minutes of pre-service time was reflective of the service. The RUC compared the surveyed code to the reference code 99204 *Office or other outpatient visit for the evaluation and management of a new patient,* (Work RVU=2.43). The RUC noted that the surveyed code requires less intra-service time as compared to the reference code, 20 minutes and 30 minutes, respectively. However, the surveyed code is a more intense service to perform in comparison to the reference code. In addition, the RUC compared the surveyed code to 51792 *Stimulus evoked response (eg, measurement of bulbocavernosus reflex latency time)* (Work RVU=1.10). The RUC noted that the surveyed code has more total service time in comparison to 51792, 50 minutes and 45 minutes. Based on these comparisons, the RUC agreed that the appropriate work RVU for this service is 1.20, the survey's 25th percentile. **The RUC recommends 1.20 Work RVU for 95805.**

95806 Sleep study, unattended, simultaneous recording of, heart rate, oxygen saturation, respiratory airflow, and respiratory effort (eg, thoracoabdominal movement)

The RUC reviewed the surveyed times associated with this service (pre-service=10, intra-service=25 and post service=15). The specialty societies explained that sleep physicians must consider all of the tests available and review forms including patient self-report, questionnaires, sleepiness scales, sleep diaries and the physician notes to include a detailed review of the patient's medication regimen to make an assessment of which test is the most appropriate. This assessment is not a face-to-face visit and is not captured by an evaluation and management service and is the standard of care based on the nature of the test. The decision on the type of test is complex as there are multiple new technologies. The RUC agreed, based on this explanation, that 10 minutes of pre-service time was reflective of the service. The RUC compared the surveyed code to reference code 99203 *Office or other outpatient visit for the evaluation and management of a new patient,* (Work RVU=1.42). The RUC recognized that although, the surveyed code has 5 additional minutes of intra-service time as compared to 99203, the reference code is significantly more intense procedure to perform. Further, the RUC compared the surveyed code to MPC code 11755 *Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds)* (Work RVU=1.31) The RUC noted that the surveyed code has slightly less total service time as compared to 11755, 50 minutes and 55 minutes respectively. Based on these comparisons, the RUC agrees that the appropriate work RVU for 95806 is 1.28 Work RVUs, the survey's 25th percentile. **The RUC recommends 1.28 Work RVUs for 95806.**

95800 Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (eg, by airflow or peripheral arterial tone), and sleep time

The RUC reviewed the surveyed times associated with this service (pre-service=15, intra-service=20 and post-service=15). The specialty societies explained that sleep physicians must consider all of the tests available and review forms including patient self-report, questionnaires, sleepiness scales, sleep diaries and the physician notes to include a detailed review of the patient's medication regimen to make an assessment of which test is the most appropriate. This assessment is not a face-to-face visit and is not captured by an evaluation and management service and is the standard of care based on the nature of the test. The decision on the type of test is complex as there are multiple new technologies. The RUC agreed, based on this explanation, that 15 minutes of pre-service time was reflective of the service. The RUC compared this service to reference code 95816 *Electroencephalogram (EEG); including recording awake and drowsy* (Work RVU=1.08). The RUC recognized that although the surveyed code has five minutes more of intra-service time as compared to 95816, these services require similar amount of work to perform. Further, the RUC compared the surveyed code to MPC code 11755 *Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds)* (Work RVU=1.31) The RUC noted that the surveyed code has less total service time as compared to 11755, 50 minutes and 55 minutes respectively. Based on these comparisons, the RUC agrees that the appropriate work RVU for 95800 is 1.05 Work RVUs, the survey's 25th percentile. **The RUC recommends 1.05 Work RVUs for 95800.**

95801 Sleep study, unattended, simultaneous recording; minimum monitoring of heart rate, oxygen saturation, and respiratory analysis (eg, by airflow or peripheral arterial tone)

The RUC reviewed the surveyed times associated with this service (pre-service=10, intra-service=15 and post-service=15). The specialty societies explained that sleep physicians must consider all of the tests available and review forms including patient self-report, questionnaires, sleepiness scales, sleep diaries and the physician notes to include a detailed review of the patient's medication regimen to make an assessment of which test is the most appropriate. This assessment is not a face-to-face visit and is not captured by an evaluation and management service and is the standard of care based on the nature of the test. The decision on the type of test is complex as there are multiple new technologies. The RUC agreed, based on this explanation, that 10 minutes of pre-service time was reflective of the service. The RUC compared the surveyed code to reference code 99202 *Office or other outpatient visit for the evaluation and management of a new patient,* (Work RVU=0.93). The RUC noted that the surveyed code requires more total service time to perform in comparison to the reference code 40 minutes and 22 minutes, respectively. Further, the RUC acknowledged that the surveyed code was a slightly more challenging service to perform in comparison to the reference code. The RUC also compared the surveyed code to 58321 *Artificial insemination; intra-cervical* (Work RVU=0.92). The RUC noted that although the surveyed code and the reference code require the same amount of time to perform, 40 minutes, the surveyed code is a more intense procedure. Based on these comparisons, the RUC agrees that the appropriate work RVU for 95801 is 1.00 Work RVUs, the survey's 25th percentile. **The RUC recommends 1.00 Work RVUs for 95801.**

95807 Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, attended by a technologist
The RUC reviewed the surveyed times associated with this service (pre-service=15, intra-service=25 and post-service=15). The specialty societies explained that sleep physicians must consider all of the tests available and review forms including patient self-report, questionnaires, sleepiness scales, sleep diaries and the physician notes to include a detailed review of the patient's medication regimen to make an assessment of which test is the most appropriate. This assessment is not a face-to-face visit and is not captured by an evaluation and management service and is the standard of care based on the nature of the test. The decision on the type of test is complex as there are multiple new technologies. The RUC agreed, based on this explanation, that 15 minutes of pre-service time was reflective of the service. The RUC compared the surveyed code to the reference code 95957 *Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis)* (Work RVU=1.98). The RUC noted that the surveyed code has significantly less intra-service time as compared to the reference code, 25 minutes and 60 minutes, respectively. The RUC also compared the surveyed code to MPC code 11755 *Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds)* (Work RVU=1.31) The RUC noted that the surveyed code and the reference code require the same amount of time to perform, 55 minutes. Based on these comparisons, the RUC agrees that the appropriate work RVU for 95807 is 1.25 Work RVUs, the survey's 25th percentile. **The RUC recommends 1.25 Work RVUs for 95807.**

95808 Polysomnography; sleep staging with 1-3 additional parameters of sleep, attended by a technologist
The RUC reviewed the surveyed times associated with this service (pre-service=15, intra-service=20 and post-service=15). The specialty societies explained that sleep physicians must consider all of the tests available and review forms including patient self-report, questionnaires, sleepiness scales, sleep diaries and the physician notes to include a detailed review of the patient's medication regimen to make an assessment of which test is the most appropriate. This assessment is not a face-to-face visit and is not captured by an evaluation and management service and is the standard of care based on the nature of the test. The decision on the type of test is complex as there are multiple new technologies. The RUC agreed, based on this explanation, that 15 minutes of pre-service time was reflective of the service. The RUC also questioned the number of survey respondents, 27 respondents. The specialty societies explained that this was because these services are performed very rarely, therefore it was challenging to find many physicians who perform the service. The RUC compared the surveyed code to the reference code 99204 *Office or other outpatient visit for the evaluation and management of a new patient,* (Work RVU=2.43). The RUC noted that the surveyed code requires less intra-service time as compared to the reference code, 20 minutes and 30 minutes, respectively. Further, the RUC compared the surveyed code to MPC code 70496 *Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (Work RVU=1.75). The RUC noted that these two services have the same intra-service time, 20 minutes. Based on these comparisons, the RUC agreed that the appropriate work RVU for this service is 1.74, the survey's 25th percentile. **The RUC recommends 1.74 Work RVU for 95808.**

95810 Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist
The RUC reviewed the surveyed times associated with this service (pre-service=15, intra-service=37 and post-service=15 minutes). The specialty societies explained that sleep

physicians must consider all of the tests available and review forms including patient self-report, questionnaires, sleepiness scales, sleep diaries and the physician notes to include a detailed review of the patient's medication regimen to make an assessment of which test is the most appropriate. This assessment is not a face-to-face visit and is not captured by an evaluation and management service and is the standard of care based on the nature of the test. The decision on the type of test is complex as there are multiple new technologies. The RUC agreed, based on this explanation, that 15 minutes of pre-service time was reflective of the service. The RUC compared the surveyed code to the reference code 99204 *Office or other outpatient visit for the evaluation and management of a new patient,* (Work RVU=2.43). The RUC noted that the surveyed code requires more intra-service time as compared to the reference code, 37 minutes and 30 minutes, respectively. Further, the RUC compared the surveyed code to MPC code 88189 *Flow cytometry, interpretation; 16 or more markers* (Work RVU=2.23). The RUC recognized that the surveyed code requires more time to perform than 88189, 67 minutes and 50 minutes, respectively. Based on these comparisons, the RUC agreed that the appropriate work RVU for this service is 2.50 Work RVUs, the survey's 25th percentile. Further, this value maintains rank order with 95808. **The RUC recommends 2.50 Work RVUs for 95810.**

95811 Polysomnography; sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist

The RUC reviewed the surveyed times associated with this service (pre-service=15, intra-service=35 and post-service=15 minutes). The specialty societies explained that sleep physicians must consider all of the tests available and review forms including patient self-report, questionnaires, sleepiness scales, sleep diaries and the physician notes to include a detailed review of the patient's medication regimen to make an assessment of which test is the most appropriate. This assessment is not a face-to-face visit and is not captured by an evaluation and management service and is the standard of care based on the nature of the test. The decision on the type of test is complex as there are multiple new technologies. The RUC agreed, based on this explanation, that 15 minutes of pre-service time was reflective of the service. The RUC compared the surveyed code to the reference code 99205 *Office or other outpatient visit for the evaluation and management of a new patient,* (Work RVU=3.17). The RUC noted that the surveyed code requires less intra-service time to perform than the reference code, 35 minutes and 45 minutes, respectively. Further, the RUC compared the surveyed code to reference code 31235 *Nasal/sinus endoscopy, diagnostic with sphenoid sinusoscopy (via puncture of sphenoidal face or cannulation of ostium)* (Work RVU=2.64). The RUC noted that the surveyed code and the reference code have the same intra-service time, 35 minutes, but that the total service time of the reference code is slightly more than the surveyed code, 75 minutes and 65 minutes. Based on these comparisons, the RUC agreed that the appropriate work RVU for this service is 2.60 RVUs, the survey's 25th percentile. Further, this value maintains rank order with the other polysomnography code. **The RUC recommends 2.60 Work RVUs for 95811.**

New Technology:

As the technology to perform these services is new and to ensure that the utilization estimates provided by the specialty are accurate, **the RUC recommended that 95806, 95800 and 95801 be added to the New Technology/Service List.**

Work Neutrality: The RUC's recommendation for this family of codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Practice Expense: The RUC reviewed and recommend the practice expense inputs as approved by the Practice Expense Subcommittee.

Chemotherapy Administration into Peritoneal Cavity (Tab 29)
Gary Leiserowitz, MD, ACOG, George Hill, MD, ACOG, David Regan, MD, ASCO, William Robinson, MD, ACOG

The CPT Editorial Panel created one code and deleted 96445 *Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis* to provide updated specificity of the standard of practice for chemotherapy administration into the peritoneal cavity. New code 96446 *Chemotherapy administration into the peritoneal cavity via indwelling port or catheter* identifies intraperitoneal chemotherapy performed concurrently with debulking of a cancerous ovary.

The RUC reviewed the specialty society's survey results for new code 96446 and agreed that the survey respondents misunderstood the service being surveyed as the work RVU values were overstated. Survey respondents indicated that current work RVUs and physician time components were similar for surveyed code, 96446 and for the code that it is replacing, 96445 *Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis* (Work RVU = 2.20), even though the original code included peritoneocentisis, which the new code does not. As the survey data did not accurately reflect the physician work for the surveyed code, the RUC agreed to establish work RVU values based on the existing RUC-approved chemotherapy codes.

The RUC reviewed the chemotherapy code that most closely resembles 96446, 96413 *Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug* (Work RVU = 0.28, pre, intra, and post time of 4, 7, and 2 minutes respectively), with an intra-service work intensity of 0.0204. The RUC understood that interperitoneal (IP) chemotherapy administration is more complex than intravenous (IV) administration, and requires additional preparation and post-therapy work. Additional drugs are used with IP chemotherapy, which increases the risk of toxicity and adverse events. Lastly, patients getting IP chemotherapy typically have more severe symptoms, and the additional fluid in the peritoneal cavity often causes shortness of breath and pain that requires the physician's attention.

The RUC agreed with the specialty that these patients need additional management and have additional complications that require additional pre and post service physician time and work. The RUC agreed that the physician time components of 5 minutes pre-service evaluation, 7 minutes intra-service time, and 5 minutes immediate post time were appropriate for this service, resulting in an intra-service work per unit of time of 0.02086. Given these additional minutes of service time of the surveyed code in comparison to the reference code, the RUC added an increment of work RVUs to the reference code to accurately account for these increases in time valuing the surveyed service at 0.37 work RVUs. The RUC also reviewed the specialty's key reference service, 96416 *Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump* (Work RVU = 0.21, total time = 10 minutes) 94453 *High altitude simulation test (HAST), with physician interpretation and report; with supplemental oxygen titration*

(Work RVU = 0.40, 23 minutes total time) and multispecialty points of comparison code 95900 *Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study* (Work RVU = 0.42, 14 minutes total time), in relation to new code 96446, and agreed it that 0.37 work RVUs properly rank orders the surveyed service amongst all physician services. **The RUC recommends a relative work value of 0.37 for CPT code 96446.**

Work Neutrality
The RUC's recommendation for this code will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Practice Expense: The RUC reviewed the direct practice expense inputs for CPT code 96446, made some minor reductions to the specialty recommended clinical labor time and medical supplies to reflect the typical patient service.

Stand by Services (Tab 30)
James Levett, MD, STS, Kirk Kanter, MD, STS
Facilitation Committee #2

The Society of Thoracic Surgeons (STS) requests that the CPT Editorial Panel to rescind the code change request which led to the revision of 99360 and establishment code 9936X from the 2011 CPT book, and revert the standby code 99360 back to its 2010 language. The CPT Executive Committee agreed with the specialty society's request.

X. CMS Requests

Skin Injection Services (Tab 31)
Michael Bigby, MD, SID, Scott Collins, MD, ASDS, Mark Kaufman, MD, AAD

In October 2009, CPT code 11900 *Injection, intralesional; up to and including 7 lesions* was identified by the Harvard Valued- Utilization over 100,000 Screen. In February 2010, this service, along with its family 11901 *Injection, intralesional; more than 7 lesions* was reviewed by the Five-Year Identification Workgroup and a RUC survey was recommended.

11900
The RUC reviewed the survey results from 41 dermatologists for CPT code 11900 and agreed there was no compelling evidence to change the current value of the service. The specialty chose pre-service time package 5 (NF Procedure without sedation/anesthesia care) and subtracted 2 minutes from the pre-service evaluation time, as the specialty societies agreed that the survey respondents inadvertently included intra-service physician work in the allotted pre-service time. To account for this error, the RUC agreed that the intra-service time should be increased from the survey median time of 5 minutes to 8 minutes as this was an accurate estimate of the physician time to anesthetize and inject the typical patient. Finally, the post service time was reduced from the survey median of 7 minutes to 2 minutes in order to reflect current clinical practice. The RUC recommends the following physician times: pre-service time of 5 minutes, intra-service time of 8 minutes and post service time of 2 minutes.

The RUC compared CPT code 11900 to the Key Reference Service 11950 *Subcutaneous injection of filling material (eg, collagen); 1 cc or less* (Work RVU= 0.84 and intra-service time= 15 minutes) and agreed that the surveyed service should be valued lower given the disparity in total time, 15 minutes and 35 minutes, respectively, and the surveyees indication of higher intensity and complexity measures for 11950. The RUC also compared the surveyed service to MPC code 20610 *Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)* (Work RVU= 0.79 and intra-service time= 15 minutes) and again agreed that code 11900 should be valued less than this reference code due to the disparate total time and total times of 15 minutes and 29 minutes, respectively. With these comparisons and no compelling evidence to change the current physician work RVUs, the RUC recommends 0.52 work RVUs, which is the current value and slightly less than the survey's 25th percentile. **The RUC recommends 0.52 work RVUs for 11900.**

11901

The RUC reviewed the survey results from 35 dermatologists for CPT code 11901 and agreed there was no compelling evidence to change the current value of the service. The specialty chose pre-service time package 5 (NF Procedure without sedation/anesthesia care) and subtracted 2 minutes from the pre-service evaluation time, as the specialty societies agreed that the survey respondents inadvertently included intra-service physician work in the allotted pre-service time. To account for this error, the RUC agreed that the intra-service time should be increased from the survey median time of 10 minutes to 13 minutes as this was an accurate estimate of the physician time to anesthetize and inject the typical patient. Finally, the post service time was reduced from the survey median of 7 minutes to 4 minutes in order to reflect current clinical practice.

The RUC compared CPT code 11901 to the Key Reference Service 11950 *Subcutaneous injection of filling material (eg, collagen); 1 cc or less* (Work RVU= 0.84 and intra-service time= 15 minutes) and agreed that the surveyed service should be valued similarly due to the analogous intra-service times of 13 minutes and 15 minutes, respectively. Also, the RUC noted that while the reference service has greater total physician time of 35 minutes compared to 22 minutes for 11901, the survey respondents consistently rated the surveyed service at a higher intensity compared with 11950. With these comparisons and no compelling evidence to change the current physician work RVUs, the RUC recommends 0.80 work RVUs, which is the current value and slightly less than the survey's 25th percentile. **The RUC recommends 0.80 work RVUs for 11901.**

Repair Superficial Wounds (Tab 32)
Jennifer Wiler, MD, MBA, ACEP, Thomas Weida, MD, AAFP
Facilitation Committee #3

In October 2009, CPT codes 12001 and 12002 were identified through the Harvard Valued- Utilization over 100,000 Screen. Upon further review, CMS requested that the entire family of superficial wound repair codes (12001-12018) be surveyed and valued through the RUC process. In addition, CMS requested that these services be surveyed as 000 day global period codes rather than the current 010 day global periods to more accurately reflect the typical services being performed.

12001 ***Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less***
The RUC reviewed the survey results from 60 family medicine and emergency medicine physicians for CPT code 12001. The RUC recommends the following physician time components: 7 minutes pre-service (slightly less than the survey to account for 1 minute only for positioning and scrub, dress and wait), 10 minutes intra-service and 5 minutes post service.

The RUC compared CPT code 12001 to the Key Reference Service 11100 *Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion* (Work RVU= 0.81, pre-service time= 5 minutes, intra-service time= 12 minutes and post service time= 5 minutes) and agreed that the services have comparable physician work and identical total time. Given this comparison, the RUC agreed that the services should be valued similarly and agreed that the survey's 25th percentile of 0.84 work RVUs accurately reflects the physician work involved in the service and maintains relativity amongst all physician services. **The RUC recommends 0.84 work RVUs for CPT code 12001.**

After reviewing the base service (CPT code 12001), the RUC carefully evaluated the survey's physician work and time inherent in the family of services and recommends a consistent, uniform methodology for the valuation of these services. The RUC discussed the survey times and work values across the family and noted that there is an analogous relationship between the surveyed median physician times and median work RVUs, resulting in intensities that create appropriate rank order amongst the entire family. The RUC recommends relative values for the entire family based on the relationship between the RUC approved work value, 0.84, for code 12001 and the survey respondents' relativity within the family.

12002 ***Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm***
The RUC reviewed the survey results from 52 family medicine and emergency medicine physicians for CPT code 12002. The RUC recommends the following physician time components: 7 minutes pre-service (slightly less than the survey to account for 1 minute only for positioning and scrub, dress and wait), 15 minutes intra-service and 5 minutes post service.

The RUC applied the uniform relativity based on the survey median value of 1.89 work RVUs to derive a value of 1.14 work RVUs. To support this value, the RUC compared 12002 to the reference code 96920 *Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm* (Work RVU= 1.15, pre-service time= 5 minutes, intra-service time= 17 minutes and post service time= 5 minutes) and agreed that both services have analogous physician work and should be valued similarly. **The RUC recommends 1.14 work RVUs for CPT code 12002.**

12004 ***Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 7.6 cm to 12.5 cm***
The RUC reviewed the survey results from 49 family medicine and emergency medicine physicians for CPT code 12004. The RUC agreed to add 3 minutes of intra-service time to the survey's median intra-service time to reflect the increase intensity and complexity associated with the increased length of the wound compared to code 12002 and to maintain the uniform relationship of intra-service time within the family. The RUC

recommends the following physician time components: 7 minutes pre-service (slightly less than the survey to account for 1 minute only for positioning and scrub, dress and wait), 20 minutes intra-service and 5 minutes post service.

The RUC applied the uniform relativity based on the survey median value of 2.30 work RVUs to derive a value of 1.44 work RVUs. To support this value, the RUC compared 12004 to the reference code 96920 *Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm* (Work RVU= 1.15, pre-service time= 5 minutes, intra-service time= 17 minutes and post service time= 5 minutes) and agreed that the surveyed service has more physician work and should be valued higher due to the higher intra-service time. **The RUC recommends 1.44 work RVUs for CPT code 12004.**

12005 ***Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 12.6 cm to 20.0 cm***
The RUC reviewed the survey results from 43 family medicine and emergency medicine physicians for CPT code 12005. The specialty added, and the RUC agreed, 1 minute to the positioning time to account for the increased preparation and draping necessary for lacerations of this size, which typically involves multiple lacerations across the body. The RUC recommends the following physician time components: 11 minutes pre-service (slightly less than the survey to account for 2 minutes of positioning and 1 minute of scrub, dress and wait), 25 minutes intra-service and 5 minutes post service.

The RUC applied the uniform relativity based on the survey median value of 2.92 work RVUs to derive a value of 1.97 work RVUs. To support this value, the RUC compared 12005 to the reference code 96922 *Laser treatment for inflammatory skin disease (psoriasis); over 500 sq cm* (Work RVU= 2.10, pre-service time= 5 minutes, intra-service time= 30 minutes and post service time= 5 minutes) and agreed that the surveyed service should be valued slightly less than the reference code due its shorter intra-service physician time. **The RUC recommends 1.97 work RVUs for CPT code 12005.**

12006 ***Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 20.1 cm to 30.0 cm***
The RUC reviewed the survey results from 41 family medicine and emergency medicine physicians for CPT code 12006. The specialty added 1 minute to the positioning time to account for the increased preparation and draping necessary for lacerations of this size, which typically involves multiple lacerations across the body. Further accounting for these multiple laceration sites, the RUC added 1 minute to the survey's post service time as there is additional discharge management including discussion with the patient on proper wound care for these longer lacerations. The RUC recommends the following physician time components: 11 minutes pre-service (slightly less than the survey to account for 2 minutes of positioning and 1 minute of scrub, dress and wait), 30 minutes intra-service and 6 minutes post service.

The RUC applied the uniform relativity based on the survey median value of 3.50 work RVUs to derive a value of 2.39 work RVUs. To support this value, the RUC compared 12006 to the reference code 96922 *Laser treatment for inflammatory skin disease (psoriasis); over 500 sq cm* (Work RVU= 2.10, pre-service time= 5 minutes, intra-service time= 30 minutes and post service time= 5 minutes) and agreed that the surveyed should

be valued higher due to 12006 having more total time, 47 minutes compared to 40 minutes, and increased intensity compared to the reference code. **The RUC recommends 2.39 work RVUs for CPT code 12006.**

12007 ***Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); over 30.0 cm***
The RUC reviewed the survey results from 38 family medicine and emergency medicine physicians for CPT code 12007. The specialty added 1 minute to the positioning time to account for the increased preparation and draping necessary for lacerations of this size, which typically involves multiple lacerations across the body. Further accounting for these multiple laceration sites, the RUC added 3 minutes to the survey's post service time as there is additional discharge management including discussion with the patient on proper wound care for these longer lacerations. The RUC recommends the following physician time components: 11 minutes pre-service (slightly less than the survey to account for 2 minutes of positioning and 1 minute of scrub, dress and wait), 35 minutes intra-service and 8 minutes post service.

The RUC applied the uniform relativity based on the survey median value of 4.21 work RVUs to derive a value of 2.90 work RVUs. To support this value, the RUC compared 12007 to the reference code *62267 Percutaneous aspiration within the nucleus pulposus, intervertebral disc, or paravertebral tissue for diagnostic purposes* (Work RVU= 3.00, pre-service time= 44 minutes, intra-service time= 30 minutes and post service time= 15 minutes) and the RUC agreed that while the services have similar intra-service times and physician work, the surveyed service is a significantly more intense procedure and should be valued similarly to the reference service. **The RUC recommends 2.90 work RVUs for CPT code 12007.**

12011 ***Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less***
The RUC reviewed the survey results from 46 family medicine and emergency medicine physicians for CPT code 12011. The RUC recommends the following physician time components: 7 minutes pre-service (slightly less than the survey to account for 1 minute only for positioning and scrub, dress and wait), 12 minutes intra-service and 5 minutes post service.

The RUC applied the uniform relativity based on the survey median value of 1.79 work RVUs to derive a value of 1.07 work RVUs. To support this value, the RUC compared 12011to the reference code 11730 *Avulsion of nail plate, partial or complete, simple;* single (Work RVU=1.10, pre-service time= 15 minutes, intra-service time= 12 minutes and post service time= 10 minutes) and agreed that the services have analogous physician time and intensities and should be valued similarly. **The RUC recommends 1.07 work RVUs for CPT code 12011.**

12013 ***Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm***
The RUC reviewed the survey results from 43 family medicine and emergency medicine physicians for CPT code 12013. The RUC recommends the following physician time components: 7 minutes pre-service (slightly less than the survey to account for 1 minute only for positioning and scrub, dress and wait), 15 minutes intra-service and 5 minutes post service.

The RUC applied the uniform relativity based on the survey median value of 2.00 work RVUs to derive a value of 1.22 work RVUs. To support this value, the RUC compared 12013 to the reference code 57500 *Biopsy of cervix, single or multiple, or local excision of lesion, with or without fulguration* (Work RVU= 1.20, pre-service time= 9 minutes, intra-service time= 15 minutes and post service time= 5 minutes) and agreed that the services have analogous physician times and intensities and should be valued similarly. **The RUC recommends 1.22 work RVUs for CPT code 12013.**

12014 ***Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 5.1 cm to 7.5 cm***
The RUC reviewed the survey results from 44 family medicine and emergency medicine physicians for CPT code 12014. The RUC recommends the following physician time components: 7 minutes pre-service (slightly less than the survey to account for 1 minute only for positioning and scrub, dress and wait), 20 minutes intra-service and 5 minutes post service.

The RUC applied the uniform relativity based on the survey median of 2.48 work RVUs to derive a value of 1.57 work RVUs. To support this value, the RUC compared 12014 to the reference code 96922 *Laser treatment for inflammatory skin disease (psoriasis); over 500 sq cm* (Work RVU= 2.10, pre-service time= 5 minutes, intra-service time= 30 minutes and post service time= 5 minutes) and agreed that while the physician work is comparable, the surveyed service should be valued lower as it has 10 less minutes in intra-service time. **The RUC recommends 1.57 work RVUs for CPT code 12014.**

12015 ***Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm***
The RUC reviewed the survey results from 39 family medicine and emergency medicine physicians for CPT code 12015. The RUC recommends the following physician time components: 7 minutes pre-service (slightly less than the survey to account for 1 minute only for positioning and scrub, dress and wait), 25 minutes intra-service and 5 minutes post service.

The RUC applied the uniform relativity based on the survey median of 3.05 work RVUs to derive a value of 1.98 work RVUs. To support this value, the RUC compared 12015 to the reference code 96922 *Laser treatment for inflammatory skin disease (psoriasis); over 500 sq cm* (Work RVU= 2.10, pre-service time= 5 minutes, intra-service time= 30 minutes and post service time= 5 minutes) and agreed that the services are analogous in both physician time and intensity and should be valued similarly. **The RUC recommends 1.98 work RVUs for CPT code 12015.**

12016 ***Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 12.6 cm to 20.0 cm***
The RUC reviewed the survey results from 37 family medicine and emergency medicine physicians for CPT code 12016. The specialty added 1 minute to the positioning time to account for the increased preparation and draping necessary for lacerations of this size, which typically involves multiple lacerations across the face. Further accounting for these multiple laceration sites on complex parts of the face, the RUC added 1 minute to the survey's post service time as there is additional discharge management including discussion with the patient on proper wound care for these longer lacerations. The RUC

recommends the following physician time components: 11 minutes pre-service (slightly less than the survey to account for 2 minutes of positioning and 1 minute of scrub, dress and wait), 30 minutes intra-service and 6 minutes post service.

The RUC applied the uniform relativity based on the survey median of 3.90 work RVUs to derive a value of 2.68 work RVUs. To support this value, the RUC compared 12016 to the reference code 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)* (Work RVU=2.78, pre-service time= 20 minutes, intra-service time= 30 minutes and post service time= 15 minutes) and agreed that the services have comparable physician work but the reference service should be valued higher due to a greater total time, 65 minutes and 48 minutes, respectively. **The RUC recommends 2.68 work RVUs for CPT code 12016.**

12017 ***Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 20.1 cm to 30.0 cm***

The RUC reviewed the survey results from 37 family medicine and emergency medicine physicians for CPT code 12017 and agreed with the specialty that adjustments were needed. The specialty reduced the pre-service evaluation and scrub, dress and wait time by 10 minutes from the time package to more accurately reflect the service being performed. In addition, the specialty added 1 minute to the positioning time to account for the increased preparation and draping necessary for lacerations of this size, which typically involves multiple lacerations across the face. Further accounting for these multiple laceration sites on complex parts of the face, the RUC added 3 minutes to the survey's post service time as there is additional discharge management including discussion with the patient on proper wound care for these longer lacerations. The RUC recommends the following physician time components: 11 minutes pre-service (slightly less than the survey to account for 2 minutes of positioning and 1 minute of scrub, dress and wait), 40 minutes intra-service and 8 minutes post service.

The RUC applied the uniform relativity based on the survey median of 4.60 work RVUs to derive a value of 3.18 work RVUs. To support this value, the RUC compared 12017 to the reference code 36595 *Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access* (Work RVU=3.59, pre-service time= 30 minutes, intra-service time= 45 minutes and post service time= 15 minutes) and agreed that while the services have disparate total time, 90 minutes and 56 minutes, respectively, the surveyed service has greater intensity and complexity and its physician work is comparable. **The RUC recommends 3.18 work RVUs for CPT code 12017.**

12018 ***Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; over 30.0 cm***

The RUC reviewed the survey results from 36 family medicine and emergency medicine physicians for CPT code 12018. The specialty added 1 minute to the positioning time to account for the increased preparation and draping necessary for lacerations of this size, which typically involves multiple lacerations across the face. Further accounting for these multiple laceration sites on complex parts of the face, the RUC added 3 minutes to the survey's post service time as there is additional discharge management including discussion with the patient on proper wound care for these longer lacerations. The RUC

recommends the following physician time components: 11 minutes pre-service (slightly less than the survey to account for 2 minutes of positioning and 1 minute of scrub, dress and wait), 45 minutes intra-service and 8 minutes post service.

The RUC applied the uniform relativity based on the survey median of 5.20 work RVUs to derive a value of 3.61 work RVUs. To support this value, the RUC compared 12018 to the reference code 36595 *Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access* (Work RVU=3.59, pre-service time= 30 minutes, intra-service time= 45 minutes and post service time= 15 minutes) and agreed that while the services have disparate total times, 90 minutes and 66 minutes, respectively, the surveyed service has significantly greater intensity and complexity and should be valued similarly. **The RUC recommends 3.61 work RVUs for CPT code 12018.**

Work Neutrality
The RUC's recommendation for this family of codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Upper Eyelid Blepharoplasty (Tab 33)
Stephen A. Kamenetzky, MD, AAO, Robert Weiss, MD, AAO

In October 2009, CPT code 15823 *Blepharoplasty, upper eyelid; with excessive skin weighting down lid* was identified through the Harvard Valued- Utilization over 100,000 Screen. The RUC recommended this service be surveyed under the RUC process. The RUC understands that Medicare covers only functional repair and not cosmetic repair. In addition, it is estimated that 70% of the time both eyelids require surgery.

15823
The RUC reviewed the survey results from 55 ophthalmologists for CPT code 15823 and agreed that the survey respondents accurately assigned the physician time components necessary to complete the service. Pre-service time package 1b (FAC Straightforward Patient Procedure (with sedation/anesthesia) was chosen with a reduction of 9 minutes in the evaluation time to accurately account for current clinical practice and to align itself with the survey's median evaluation time. This change results in pre-service times of: evaluation time of 10 minutes, positioning time of 1 minute and scrub, dress and wait time of 5 minutes. The RUC concurred with the median survey physician time components with intra-service time of 45 minutes, and immediate post service time of 10 minutes.

Furthermore, the RUC discussed the appropriate amount of post operative visits necessary for the service. The specialty indicated that the typical service requires four post operative visits. The first visit occurs shortly after the procedure to check for bleeding of the eyelid. Five to ten days later, a level three visit (99213) is conducted to remove the sutures. The third and fourth office visits are scheduled weeks later and require the physician to ensure proper healing of the patient's eyelid or check the cornea. The RUC agreed that three 99212 visits, one 99213 visit and a half day discharge (99238) accurately reflect the typical service.

The RUC compared CPT code 15823 to the Key Reference Service 67900 *Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)* (Work RVU= 6.82, total time= 177 minutes) and agreed that the two services are analogous in physician work,

with the surveyed service totaling 170 minutes and the reference service totaling 177 minutes, and should be valued similarly. Additionally, it was noted that the two services were rated by the survey respondents as having comparable intensity and complexity in their respective physician work. Given this comparison, the RUC recommends 6.81 work RVUs, the survey's 25th percentile, for CPT code 15823. **The RUC recommends 6.81 work RVUs for 15823.**

Control Nasal Hemorrhage (Tab 34)
Wayne Koch, MD, AAO-HNS

In October 2009, CPT code 30901 *Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method* was identified for review through the Five-Year Review Identification Workgroup screen of Harvard valued codes with Medicare utilization over 100,000. The RUC recommended this service be surveyed under the RUC process.

30901
The RUC reviewed the survey results from 41 otolaryngologists and agreed with the specialty society recommended physician time required to perform this service (6 minutes pre-evaluation, 0 min for positioning, 5 minutes scrub/dress/wait, 10 minutes intra-service, and 5 minutes immediate post-service time). The RUC confirmed that although this service is typically billed with an Evaluation and Management visit, additional pre-service time is necessary to confirm that necessary supplies and equipment are available and to gown/drape the patient for protection as well as allow the physician to put on protective clothing and gloves.

The RUC reviewed the specialty society survey data and agreed with the specialty society that there is no compelling evidence to change the current work RVU of 1.21. To support the current valuation, the RUC compared 30901 to CPT code 36620 *Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous* (work RVU = 1.15) and agreed that 30901 required slightly more total service time to perform, 26 minutes and 22 minutes, respectively and 30901 and required comparable intensity and complexity. The RUC also compared 30901 to the key reference code 31231 *Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure*) (work RVU = 1.10) and agreed that code 30901 would be relatively more intense/complex because it involves an active process requiring immediate therapeutic attention compared with 31231 which is a scheduled diagnostic procedure. **The RUC recommends maintaining the current work RVU of 1.21 for code 30901.**

Venipuncture (Tab 35)
Scott Manaker, MD, PhD, ACP

In October 2009, CPT code 36410 *Venipuncture, age 3 years or older, necessitating physician's skill (separate procedure), for diagnostic or therapeutic purposes (not to be used for routine venipuncture)* was identified through the Harvard Valued- Utilization over 100,000 Screen. The RUC recommended this service be surveyed under the RUC process.

36410
The RUC reviewed the survey results for CPT Code 36410. The RUC discussed the limited amount of pre-service physician work for the typical patient and agreed to reduced the pre-service from the survey median of 3 minutes down to 1 minute. The median survey time of 5 minutes of intra-service physician time and 2 minutes of post service time were accepted as accurately reflecting the typical procedure. The RUC noted that the specialty only garnered 17 complete survey respondents. The specialties indicate that few physicians indicate that they perform or report the service.

Given the low number of survey respondents, the RUC looked at multiple reference codes to ensure appropriate relativity across all physician services. First, the RUC compared CPT code 36410 to the Key Reference Service 93000 *Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report* (Work RVU= 0.17, intra-service time= 5 minutes and post service time= 2 minutes) and agreed that these services are similar in physician work and total time and should be valued similarly. The surveyed service was also compared to 96374 *Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug* (Work RVU= 0.18, pre-service time= 2 minutes, intra-service time= 5 minutes and post service time= 2 minutes) and again agreed that these services have almost identical total time and should have analogous work RVUs. Finally, the RUC compared code 36410 to MPC code 94010 *Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation* (Work RVU= 0.17, intra-service= 5 minutes and post service time= 2 minutes) and again agreed that this was another RUC valued service that has similar total time and physician work and that the surveyed service should be valued similar. Given these comparisons and that the specialty societies presented no compelling evidence to change the current value of the service, the RUC recommends 0.18 work RVUs and physician times of 1 minute of pre-service time, 5 minutes of intra-service time and 2 minutes of post service time for CPT code 36410. **The RUC recommends 0.18 work RVUs for 36410.**

<u>Uroflowmetry (Tab 36)</u>
James Giblin, MD, AUA, Richard Gilbert, MD, AUA, William Gee, MD, AUA

In October 2009, CPT code 51741 *Complex uroflowmetry (eg, calibrated electronic equipment)* was identified through the Harvard Valued - Utilization over 100,000 Screen. In February 2010, the RUC recommended that code 51736 *Simple uroflowmetry (UFR) (eg, stop-watch flow rate, mechanical uroflowmeter)* should be reviewed as part of this code family. The RUC recommended these services be surveyed under the RUC process.

51741
The RUC reviewed the survey results from 35 urologists for code 51741 and agreed with the specialty society that the equipment currently used has made this service much easier to perform and the value should decrease significantly. The previous equipment required calibration before every test, now physician interpretation of the uroflowmetry report is the majority of the physician work required for this service. The specialty society indicated the survey median work RVU overestimated the work required. Therefore, the specialty society recommended and the RUC agreed that the physician time and work should be directly crosswalked to similar service 93000 *Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report* (work RVU = 0.17 and 5 minutes intra-service and 2 minutes immediate post-service time). For further support the RUC also compared 51741 to 94010 *Spirometry, including graphic record, total and timed*

vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation (work RVU = 0.17 and 5 minutes intra-service and 2 minutes immediate post-service time). **The RUC recommends a work RVU of 0.17 for 51741.**

51736
The specialty society indicated that many physicians do not conduct uroflowmetry via stop-watch and those reported using 51736 are most likely miscoded. As stated above, the interpretation is the majority of the physician work, not the method (stop watch v. electronic equipment). Therefore, the specialty society recommends directly crosswalking 51736 to the work RVU and physician time for 51741. **The RUC recommends a work RVU of 0.17 for 51736.**

Global Period
The specialty society recommends and the RUC agreed to request that CMS change the global period for 51736 and 51741 to XXX.

Work Neutrality
The RUC's recommendation for this family of codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Practice Expense
The RUC recommends that the Practice Expense Subcommittee review the direct practice expense inputs for 51736 and 51741 at the October 2010 meeting as the technology has changed.

Cystourethroscopy (Tab 37)
James Giblin, MD, AUA, Richard Gilbert, MD, AUA, William Gee, MD, AUA

A RUC member requested reconsideration of this issue. The RUC reexamined and discussed the recommendation that the RUC passed for code 52281. The RUC clarified that the voted upon work RVU was correct. The RUC reaffirmed its initial recommendation.

In October 2009, CPT codes 52281 *Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female* and 52332 Cystourethroscopy, *with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)* were identified through the Harvard Valued - Utilization over 100,000 Screen. The RUC recommended these services be surveyed under the RUC process.

52281
The RUC reviewed the survey results from 33 urologists for code 52281 and agreed with the specialty society that there is no compelling evidence that the work for this service has changed. The RUC reviewed the survey results for 52281 and determined that the physician time of 16 minutes pre, 20 minutes intra and 10 minutes immediate post-service time and maintaining the current work appropriately accounts for the time and work required to perform this procedure. For additional support to maintain the current work RVU, the RUC compared this service to codes 49452 *Replacement of gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report* (work RVU = 2.86 and 30 minutes pre, 20 minutes intra and 10 minutes immediate post-service time) and 51102 *Aspiration of*

bladder; with insertion of suprapubic catheter (work RVU = 2.70 and 25 minutes pre, 20 minutes intra and 15 minutes immediate post-service time) which require similar physician time, intensity and complexity. **The RUC recommends maintaining the work RVU of 2.80 for code 52281.**

52332
The RUC reviewed the survey results from 39 urologists for code 52332 and agreed with the specialty society that there is no compelling evidence that the work for this service has changed. The RUC reviewed the survey results for 52281 and determined that the physician time of 21 minutes pre, 25 minutes intra and 10 minutes immediate post-service time and maintaining the current work appropriately accounts for the time and work required to perform this procedure. For additional support to maintain the current work RVU, the RUC also compared this service to codes the same reference codes as 52281, codes 49452 *Replacement of gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report* (work RVU = 2.86 and 30 minutes pre, 20 minutes intra and 10 minutes immediate post-service time) and 51102 *Aspiration of bladder; with insertion of suprapubic catheter* (work RVU = 2.70 and 25 minutes pre, 20 minutes intra and 15 minutes immediate post-service time) which require similar physician time, intensity and complexity. **The RUC recommends maintaining the work RVU of 2.83 for code 52332.**

Radiologic Examination (Tab 38)
Geraldine McGinty, MD, ACR, Ezequiel Silva, MD, ACR

In October 2009, CPT code 73080 *Radiologic examination, elbow; complete, minimum of 3 views* was identified through the Harvard Valued- Utilization over 100,000. In February 2010, the specialty presented, to the Five-Year Review Identification Workgroup, their proposed valuation for this service based on a crosswalk methodology that was previously approved by the RUC's Research Subcommittee at the October 2009 RUC meeting. The Five-Year Review Workgroup accepted this initial proposal and requested that the specialty present this crosswalk methodology to the RUC for valuation.

In October 2009, the Research Subcommittee performed a thorough review of the specialty's proposed crosswalk methodology and agreed that this methodology of directly crosswalking radiologic examinations of similar body parts with identical physician work was appropriate for these limited number of codes due to the fact that it would be difficult to differentiate the relatively low work values. It has also been stressed that this methodology, and any other alternative valuation methodology, should not be applied to other codes without full Research Subcommittee review and subsequent RUC approval.

For CPT code 73080, the specialty chose to crosswalk the physician times and values directly to CPT code 73110 *Radiologic examination, wrist; complete, minimum of 3 views* (Work RVU= 0.17, pre-service time= 1 minute, intra-service time= 3 minutes and post service time= 1 minute). This reference service was chosen for multiple reasons including: both codes are exams of upper extremity sites (elbow and writs, respectively), both services require the same minimum number of 3 views, they are similar in both service and time and require the same positioning of the patients. At the RUC's request the specialty societies provided vignettes and descriptions of work for this service. The RUC accepted the new vignettes and descriptions of physician work.

The RUC recommends to maintain the work RVUs of 0.17 for CPT code 73080 and a direct physician time crosswalk from CPT code 73110. This crosswalk is outlined below.

Code	RUC Recommended Work RVU	Cross-walk	Physician Time Cross-walk
73080	**0.17**	73110 (Radiologic examination, wrist; complete, minimum of 3 views), (Work RVU = 0.17) (RUC reviewed August 2005)	1 minute pre-service time, 5 minutes intra service time, 1 minute post service time 5 minutes total time

Pathology Consultation (Tab 39)
Jonathan L. Myles, MD, CAP, George F. Kwass, MD, CAP
Facilitation Committee #2

The pathology consultation services were identified by the RUC's Five-Year Review Identification Workgroup through its CMS screen for Harvard-valued codes with utilization greater than 1 million. At the October 2009 RUC Meeting, the RUC recommended that all of the identified codes in this family be surveyed using the standard RUC survey instrument or present an alternative methodology to the Research Subcommittee for review, or present a code change proposal to the CPT Editorial Panel for their review. The College of American Pathologists conducted a standard RUC Survey for each of the pathology consultation codes and had between 84 and 165 survey respondents for each survey. The survey data from this robust survey demonstrates that the current work associated with these services is accurate and furthermore supports the specialty society's recommendation that there is no compelling evidence to change the current work of these services.

88300 Level I - Surgical pathology, gross examination only
The RUC reviewed the survey data for 88300. The specialty society recommended and the RUC agreed that the surveyed time accurately reflects the service being performed. The RUC reviewed the surveyed code in comparison to 88311 *Decalcification procedure* (Work RVU=0.24). The RUC noted that the surveyed code has slightly more intra-service time as compared to the reference code, 10 minutes and 7 minutes, respectively. Although the survey median for this service was 0.27 Work RVUs, the specialty society recommended and the RUC agreed that there was no compelling evidence to change the current value for this service, 0.08 work RVUs. **Therefore, the RUC recommends 0.08 Work RVUs for 88300.**

88302 Level II - Surgical pathology, gross and microscopic examination
The RUC reviewed the survey data for 88302. The specialty society recommended and the RUC agreed that the surveyed time accurately reflects the service being performed. The RUC reviewed the surveyed code in comparison to 88334 *Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site* (Work RVU=0.73). The RUC noted that the surveyed code had significantly less intra-service time as compared to the reference code, 11 minutes and 20 minutes, respectively. In addition, the RUC agreed that the reference code required more technical skill and

physical effort and cased more psychological stress to perform in comparison to the surveyed code. Although the survey 25th percentile for this service was 0.30 Work RVUs, the specialty society recommended and the RUC agreed that there was no compelling evidence to change the current value for this service, 0.13 work RVUs. **Therefore, the RUC recommends 0.13 Work RVUs for 88302.**

88304 Level III - Surgical pathology, gross and microscopic examination
The RUC reviewed the survey data for 88304. The specialty society recommended and the RUC agreed that the surveyed time accurately reflects the service being performed. The RUC reviewed the surveyed code in comparison to 88334 *Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site* (Work RVU=0.73). The RUC noted that the surveyed code had slightly less intra-service time as compared to the reference code, 15 minutes and 20 minutes, respectively. In addition, the RUC agreed that the reference code required more technical skill, mental effort and judgment and cased more psychological stress to perform in comparison to the surveyed code. Although the survey 25th percentile for this service was 0.45 Work RVUs, the specialty society recommended and the RUC agreed that there was no compelling evidence to change the current value for this service, 0.22 work RVUs. **Therefore, the RUC recommends 0.22 Work RVUs for 88304.**

88305 Level IV - Surgical pathology, gross and microscopic examination
The RUC reviewed the survey data for 88305. The specialty society recommended and the RUC agreed that the surveyed time accurately reflects the service being performed. The RUC reviewed the surveyed code in comparison to 88323 *Consultation and report on referred material requiring preparation of slides* (Work RVU=1.83). The RUC noted that the surveyed code had less intra-service time as compared to the reference code, 25 minutes and 56 minutes, respectively. In addition, the RUC agreed that the reference code was overall a more intense procedure to perform as compared to the surveyed code. Although the survey 25th percentile for this service was 1.50 Work RVUs, the specialty society recommended and the RUC agreed that there was no compelling evidence to change the current value for this service, 0.75 work RVUs. **Therefore, the RUC recommends 0.75 Work RVUs for 88305.**

88307 Level V - Surgical pathology, gross and microscopic examination
The RUC reviewed the survey data for 88307. The specialty society recommended and the RUC agreed that the surveyed time accurately reflects the service being performed. The RUC reviewed the surveyed code in comparison to 88325 *Consultation, comprehensive, with review of records and specimens, with report on referred material* (Work RVU=2.50). The RUC noted that the surveyed code had less intra-service time as compared to the reference code, 47 minutes and 80 minutes, respectively. In addition, the RUC agreed that the reference code was overall a more intense service to perform as compared to the surveyed code. Although the survey 25th percentile for this service was 2.00 Work RVUs, the specialty society recommended and the RUC agreed that there was no compelling evidence to change the current value for this service, 1.59 work RVUs. **Therefore, the RUC recommends 1.59 Work RVUs for 88307.**

88309 Level VI - Surgical pathology, gross and microscopic examination
The RUC acknowledged that 88309 was reviewed during the 2005 Five-Year Review. Based on the review of the other surgical pathology services, the RUC agrees that it would be appropriate that the recommendations from that review be reaffirmed. **The RUC recommends that the current value of 2.80 for 88309 be maintained and that the recommendations from the 2005 Five Year Review be reaffirmed.**

PLI Crosswalks: The RUC recommends that the PLI RVUs be maintained and that the PLI crosswalk for each of these codes be the existing code.

Electroconvulsive Therapy (Tab 40)
Naakesh Dewan, MD, APA, Shirlene Sampson, MD, APA
Facilitation Committee #1

In October 2009, CPT code 90870 *Electroconvulsive therapy (includes necessary monitoring)* was identified through the Harvard Valued- Utilization over 100,000 Screen and the RUC recommended that this service be surveyed and valued through the RUC process.

The RUC discussed compelling evidence for this service, as the specialty is requesting an increase in physician work RVUs. The specialty explained that within the last ten years, the technology for this service has become more sophisticated and requires more treatment options and decision points to be made by the physician. Previously, the treatment for this service was determined solely by the patient's age, now there are a number of new decision points that must be made in determining the treatment dosage, including identifying the seizure threshold and monitoring the response of the patient to the treatment method. In addition, the old technology used only one type of wave (sine) while the new technology uses two types of waves (brief pulse and ultra brief pulse) and multiple monitoring devices, including EEG and ECG. All these new treatment options, stemming from the comprehensive change in technology over the last ten years, have led to an increase in complexity in the physician's decision making process for this service. Given the overwhelming evidence, the RUC agreed that this service meets compelling evidence.

90870
The RUC reviewed the survey results from 77 psychiatrists for CPT Code 90870 and agreed that adjustments were needed in the physician time components. First, the specialty recommended that the pre-service time package 1b (FAC Straightforward Patient Procedure (with Sedation/anesthesia) needed to be reduced. The specialty society recommended that the evaluation time be reduced by 9 minutes resulting in 10 minutes of pre-service evaluation time and reduced the scrub, dress and wait time by 5 minutes resulting in 0 minutes, for a total of 11 minutes pre-service time. These modifications account for what the specialty society agreed was survey error in that the survey respondents accounted for the work of the electrode and EEG lead placement in the pre-service work and this work should be included in the intra-service work. Additionally, to account for this adjustment in intra-service work, the survey's 75th percentile intra-service time of 20 minutes is recommended. Finally, 5 minutes of post service time was agreed upon, over the survey's median time of 10 minutes, as it more accurately reflects the physician work of ensuring the patient is stable and documenting the procedure in the

patient's medical record. The RUC recommends the following physician time components: 11 minutes pre-service time, 20 minutes intra-service time and 5 minutes post service time.

The RUC compared CPT code 90870 to MPC code 99284 *Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function* (Work RVU= 2.56, total time= 40 minutes) and agreed that this service has analogous physician decision making to the surveyed code. In addition, these two services have comparable total times of 36 minutes and 40 minutes, respectively. Given the slight difference in total time and reviewing the survey respondent's estimate of the physician work RVU, the RUC recommends 2.50 work RVUs, the survey's 25th percentile for 90870. **The RUC recommends 2.50 work RVUs for 90870.**

Visual Field Examination (Tab 41)
Stephen A. Kamenetzky, MD, AAO, Cindie Mattox, MD, AAO, Robert Weiss, MD, AAO, Michael Chaglasian, OD, AOA

In October 2009, CPT codes 92081 *Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)* and 92082 *Visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination (eg, at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)* were identified through the Harvard Valued- Utilization over 100,000 Screen and the RUC recommended that this service be surveyed and valued through the RUC process.

92081
The RUC reviewed the survey results from 33 ophthalmologists for code 92081 and agreed with the specialties that adjustments to the survey physician time components were needed to accurately reflect the surveyed procedure and the previously RUC valued visual field examination, CPT code 92083. The RUC agreed that the 3 minutes of pre-service time is sufficient to accurately account for the physician time required to position the patient and instruct the patient how to respond to the stimuli. In addition, 2 minutes was added to the intra-service time for a total of 7 minutes. This addition to the intra-service time accurately accounts for the physician's interpretation and report of the exam results. There would be no additional post-service time. The recommended physician times are as follows: 3 minutes pre-service time, 7 minutes intra-service time and no post service time.

The RUC compared CPT code 92081 to the Key Reference Service 92083 *Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30¦, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)* (Work RVU= 0.50 and pre-service time= 3 minutes and intra-

service time= 10 minutes) and agreed that this procedure is a longer, more intense procedure and should be valued higher than the surveyed service. The RUC also compared 92081 to reference code 92020 *Gonioscopy* (Work RVU= 0.37 and total time= 20 minutes) and agreed that given the greater total time, the reference code should be valued higher than the surveyed code. Given these comparisons, the RUC agreed that the survey's 25th percentile, 0.30 work RVUs, was reflective of the service and appropriately maintains relativity amongst all physician services. **The RUC recommends 0.30 work RVUs for 92081.**

92082
The RUC reviewed the survey results from 37 ophthalmologists for code 92082 and agreed with the specialties that adjustments to the survey physician time components were needed to accurately reflect the surveyed procedure and the previously RUC valued visual field examination, CPT code 92083. The RUC agreed that the 3 minutes of pre-service time is sufficient to accurately account for the physician time required to position the patient and instruct the patient how to respond to the stimuli. In addition, the RUC agreed that a total of 8 minutes intra-service physician time accurately reflects the physician's interpretation and report of the exam results. There would be no additional post-service time. The recommended physician times are as follows: 3 minutes pre-service time, 8 minutes intra-service time and no post service time.

The RUC compared CPT code 92082 to the Key Reference Service 92083 *Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30¦, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)* (Work RVU= 0.50 and pre-service time= 3 minutes and intra-service time= 10 minutes) and agreed that this procedure is a longer, more intense procedure and should be valued higher than the surveyed service. The RUC also compared 92082 to MPC code 92250 *Fundus photography with interpretation and report* (Work RVU= 0.44 and total time= 14 minutes) and agreed that the services have similar physician work and should be valued similarly. Given these comparisons, the RUC agreed that the survey's 25th percentile, 0.40 work RVUs, was reflective of the service and appropriately maintains relativity amongst all physician services. **The RUC recommends 0.40 work RVUs for 92082.**

Work Neutrality
The RUC's recommendation for this family of codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

<u>Binocular Microscopy (Tab 42)</u>
Wayne Koch, MD, AAO-HNS

In October 2009, CPT code 92504 *Binocular microscopy (separate diagnostic procedure)* was identified for review through the Five Year Review Identification Workgroup screen of Harvard valued codes Medicare utilization over 100,000. The RUC recommended this service be surveyed under the RUC process.

This service is reported to capture the extra work of a more sophisticated examination of the tympanic membrane and external auditory canal when otoscopy is not sufficient for diagnosis. After an Evaluation and Management service is performed, the patient is

moved to a room where a microscope is available. The physician explains the procedure, positions the patient and performs the procedure. The RUC noted that code 92504 has Harvard total time of 8 minutes, whereas 31 otolaryngologist survey respondents indicated 9 minutes total time (2 minutes pre-, 5 minutes intra- and 2 minutes post-service time). The RUC agreed that these physician time components accurately reflect the typical service. The RUC compared the surveyed code to reference code 92567 *Tympanometry (impedance testing)* (Work RVU=0.20). The RUC noted that the surveyed code has more total service time compared to the reference code, 9 minutes and 6 minutes respectively. Further, the RUC noted that code 92567 required more mental effort and judgment to perform compared to the reference code. However, the specialty society indicated, and the RUC agreed, that there is no compelling evidence to increase the work RVU for code 92504. **The RUC recommends maintaining the current work RVU of 0.18 for code 92504.**

Needle Electromyography (Tab 43)
Marianna Spanaki, MD, AAN, Benn Smith, MD, AANEM, Marc R. Nuwer, MD, PhD, Joseph Zuhosky, MD, AAPM&R

The specialties societies involved submitted a letter to the RUC prior to the meeting stating that CPT code 95860 was identified by two screens (Harvard Valued, Utilization over 100,000 and the Codes Billed Together 75% or Greater). The specialties contacted the RUC's Research Subcommittee and their reply was to postpone the presentation of survey data for 95860 until the service has been addressed by the Joint CPT/RUC Workgroup.

XI. Practice Expense Subcommittee Report (Tab 44)

Doctor Moran reported the Subcommittee's recommendations regarding fluoroscopy in the non-facility setting. Doctor Moran stated that the Subcommittee reviewed 76 services performed in the non-facility setting resulting in 15 practice expense direct input changes. He also reported that three services were extracted from the recommendation which would have had the Radiographic-Fluoroscopic room deleted. CPT codes were 62310, 62311, and 62318 were extracted by the North American Spine Society (NASS) as they are within a family of codes (i.e. 62319) where this equipment item is typically utilized.

The Subcommittee created three new workgroups to assist in making recommendations regarding: Non-facility clinical labor "Surgical Time Out" time, the migration from radiological film to digital expenses, and new non-facility regulatory expenses related to moderate sedation. These workgroups will convene over the summer and report back to the Subcommittee.

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

XII. Five Year Identification Workgroup Report (Tab 45)

Review Revised Action Plans
Walt Larimore, MD, informed the RUC that the Five-Year Review Identification Workgroup reviewed specialty society action plans for services identified by the Harvard only codes with utilization over 100,000 and services surveyed by one specialty and now performed by another specialty screens. **The Workgroup recommendations for each family are specified in the report attached to these minutes.**

Codes Performed together 75% of the time (same day/same physician)
Doctor Larimore praised the Workgroup and Doctor Kenneth Brin, Chairman of the Joint CPT/RUC Workgroup on Codes Frequently Reported Together on the outstanding and lengthy work conducted. Doctor Larimore indicated that the Joint Workgroup met via 3 two hour conference calls to carefully review the specialties' action plans pertaining to the 20 code groups, which contained code pairs that are billed together on the same date of service 75% or more of the time, identified by the Workgroup prior to the February RUC meeting.

The Joint CPT/RUC Workgroup analyzed potential duplication in physician work and practice expense values for these 20 code groups. Additionally, the Workgroup members considered how often a service was reported alone as well as clinical scenarios in which specific services are reported together. The Joint Workgroup recommendations include: submission of code change proposals for bundled codes, submission of CPT Assistant articles, deletion of a code, consideration of CCI edits, and referrals to the RUC Practice Expense Subcommittee. These final recommendations were collected and put into a final report for the Five-Year Identification Workgroup to review. Finally, if a specialty has more than two code groups identified in this first review which would lead to a RUC survey, the specialty may elect to address only the top two of those groups in the CPT 2012 cycle and address the remainder in the 2013 CPT cycle.

The RUC reviewed the final recommendations from the Joint CPT/RUC Workgroup on Codes Frequently Reported Together and accepted all 20 of the recommendations.

Fourth Five-Year Review - Specialty Society Level of Interest
Doctor Larimore summarized several specialty society requests regarding the Fourth Five-Year Review. **The RUC approved the following requests:**

CPT Referrals
15365, 92950, 64622, 64623, 64626, 64627, 92070 and 92120
Codes 15365, 95920, 64622, 64623, 64626, 64627, 92070 and 92120
were requested to be referred to the CPT Editorial Panel for clarification and the Workgroup agreed. Codes 15365 and 92950 were requested to be referred because an existing CPT Workgroup is currently addressing these services. Codes 64622, 64623, 64626, 64627 were requested to referred to revise to include that imaging is required. Codes 92070 and 92120 were requested to be referred to change the code descriptors.

99341-99350 Home Visits
The AAFP submitted a comment letter based on action of their Congress of Delegates to have home visits re-evaluated. However, the AAFP and other specialties do not believe that there is compelling evidence to increase the valuation of these services. The specialty

societies indicated that the work for home visits 99341-99350 has not changed since the recent RUC and CMS review. Therefore, the specialty societies determined that there was no compelling evidence and recommends the RUC recommend no change in value for the Fourth Five-Year Review.

15240
This code was identified in error in the CMS site-of-service screen. The RUC database and time file for this service reflected a full discharge day although the rationale clearly indicates that the RUC only considered a half day discharge. Therefore, the RUC should reflect a recommendation of no change and explain the typo in the database that lead to the inappropriate identification.

Site-of-Service/23+ Hour Issue
AMA Staff indicated that the specialties have requested more complete (i.e. final) 2009 claims data and AMA staff will work with CMS to obtain this data. In addition, CMS has requested that codes identified as outpatient services reflect only outpatient visits. CPT and the RUC have worked to address the 23+ hour issue by creating subsequent outpatient observation codes. However, these codes will not be implemented until January 1, 2011. The Research Subcommittee discussed the options regarding an appropriate time/visit valuation methodology of these issues. *Please refer to the Research Subcommittee April 2010 Report (attached to these minutes) for this discussion.*

New Technology: September 2010
Doctor Larimore informed the RUC that in September 2005, February 2006 and April 2006 the RUC began flagging new and revised codes that were identified as new technology or a new service. The RUC agreed that after three years of data had been collected the RUC will assess these services.

In June 2010, AMA Staff will distribute an LOI request for 33 new technology/new services. Interested specialty societies will be required to complete a brief action plan to be reviewed at the October 2010 meeting. The RUC will review 2007-2009 claims data for these 33 new technology/new services. Claims data will include utilization, performing specialties, diagnosis codes reported and site of service information. Specialty societies will have the opportunity to discuss whether there has been a diffusion of technology for these services. The RUC will compare the claims data to the original submission to determine whether or not each service should be evaluated.

The RUC will recommend one of the following actions for codes on the New Technology/New Services List:

1. **The service does not need to be re-evaluated, the code is removed from the New Technology/Services List.**
2. **The service requires additional claims data, more than the first three years. The RUC will determine on a case-by-case basis when the service should be re-reviewed through the New Technology/New Services List process.**
3. **The service needs to be re-evaluated. The specialty society will survey the service and present recommendations at the next RUC meeting. New RVUs will be published January 1 of the next year if approved by the RUC and CMS.**

Other Issues
Doctor Larimore indicated that the following items were provided as informational materials:
CPT Editorial Panel Referrals; CPT Assistant Referrals; and the full status report of the Five-Year Review Identification Workgroup.

The RUC approved the Five-Year Identification Workgroup's report and it is attached to these minutes.

XIII. Research Subcommittee Report (Tab 46)

2010 Five Year Review: Review of Alternative Methodologies
Doctor Lewis announced to the RUC that no alternative methodologies for the 2010 Five-Year Review were submitted to the Research Subcommittee for review.

Establishment of Vignette and Reference Service Lisr Review Process
The RUC approved a new timeline and process for vignette review. **The RUC recommends the following language be added to the instruction document to describe this new process:**

> If a specialty society would like to have the Research Subcommittee review proposed vignettes and reference service lists for the new and revised process or CMS requests, they must adhere to the following process. It should be noted that this process is not a requirement by the RUC. Specialties societies will submit the proposed reference service list which should adhere to the reference service list guidelines and provide the following data points for each service on the reference service list so that the Research Subcommittee can critically review the list:
>
> 1.) The year it was valued
> 2.) Whether the time is based on RUC, Harvard or other
> 3.) The MPC status
> 4.) The Medicare Volume including specialty distribution
> 5.) The intra-service time
> 6.) The total service time
> 7.) The IWPUT calculation

RUC Five Year Review Survey Instrument, Summary of Recommendation Form and Instruction Document for Specialties Developing Work Value Recommendations
In preparation for the Fourth Five-Year Review Process, the RUC recommends the following modifications to the Five-Year Review Survey Instruments and Summary of Recommendation Forms:

> **Background for Question 6**
>
> ---
>
> **The RUC is also interested in determining whether the physician work for the service has changed over the previous five years. Please complete the following questions by circling your response.**

Question 6

Has the work of performing this service changed in the past 5 years?

Yes No

If Yes, please circle your response to questions a-c:

a. Does this service represent new technology?
Yes No

If yes, how has this new technology affected the work of this service?

Less Work Same Work More Work

b. This service represents new technology that has become more familiar (i.e., less work).
I agree I do not agree

c. Patients requiring this service are now:
more complex less complex no change

d. The usual site-of-service has changed:
from outpatient to inpatient from inpatient to outpatient no change

Doctor Lewis briefed that RUC that the Research Subcommittee had considerable discussion about the request made by CMS to include additional statistical data points including the 5th percentile, the 95th percentile and the geometric mean on the RUC's Summary of Recommendation Forms. **The RUC recommends that the 5th percentile, 95th percentile and the geometric mean be included on the Summary of recommendation forms and also would like to provide to CMS other central tendency points including: arithmatic mean and mode (including bimodal distribution, if applicable). Further, the RUC recommends that the RUC send a letter to CMS requesting them to articulate the relevant use of this additional data.**

The RUC reviewed and recommends modifications be made to the instruction document as highlighted in the revised instruction document in the Research Subcommittee Tab of the RUC Agenda Book. In addition to these modifications, the Research Subcommittee made the following recommendations including:

1.) Under Step 2: The following language should be deleted as it is not accurate.

~~A survey must be conducted for all work relative values recommendations presented to the RUC. You must contact the physicians to be surveyed prior to sending the questionnaire and determine that they have agreed to complete it.~~

2.) Under Alternative Ways to Develop Work Relative Value Recommendations Section: Applying Payment Rules, the example of CPT code 61531 *Subdural implantation of strip electrodes through 1 or more burr or trephine hole(s) for long-term seizure monitoring* needs to be replaced as the value and rationale for this code has changed as of the 2005 Five-Year Review.

Re-review of Site of Service Anomalies
Doctor Lewis briefed the RUC that in the 2010 Five-Year Review List, forwarded by CMS to the RUC, CMS included several codes that have already been reviewed by the RUC as identified through the Five-Year Review Identification Workgroup's Site of Service Anomaly Screen. T**he RUC recommends that the re-review of these services should be referred to the February 2011 RUC meeting, so the RUC can review after CMS policy is in place and implemented.**

Review of Extant Data Policy
Doctor Lewis informed the RUC that at the February 2010 RUC Meeting, a RUC member discussed the need for the RUC to begin looking for an external validation of time data. The RUC, through the Extant Data Workgroup, reviewed and developed policy about how extant data should be used in the RUC process. However, **the RUC recommends that at the February 2011 RUC Meeting, the results of a solicitation to the specialty societies to identify any additional extant databases be presented and that the NSQIP and STS Databases be evaluated to determine if they meet the RUC's extant data criteria.**

Specialty Society Requests
Doctor Lewis informed the RUC that the Research Subcommittee reviewed several specialty society requests including a specialty society request from the American Academy of Dermatology pertaining to the Destruction of Malignant Lesion codes. **The RUC recommends a full RUC survey be conducted for the destruction of malignant lesion services.** The Research Subcommittee reviewed a specialty society request from American Academy of Orthopaedic Surgeons, American College of Rheumatology, American Podiatric Medical Association, American Society for Surgery of the Hand pertaining to the Arthrocentesis codes. **The RUC agrees with the specialty societies recommendation of conducting a full RUC survey for the arthrocentesis services.** The Research Subcommittee reviewed a specialty society request from the American Osteopathic Association pertaining to the Osteopathic Manipulative Treatment codes. **The RUC recommends a full RUC survey be conducted for the osteopathic manipulative treatment services.** The Research Subcommittee reviewed a specialty society request from the College of American Pathologists pertaining to the Cytopathology Codes and the Pathology Consultation During Surgery Codes. **The RUC recommends the description of service and modified vignettes for 88104-88108. Further, the RUC recommends the vignettes and description of services for 88329-88332.**

The Research Subcommittee reviewed a request from the *American Psychiatric Association and the American Psychological Association pertaining to the* Psychiatric Diagnostic and Therapeutic Codes. After review, the Research Subcommittee provided the following guidance to the specialty societies: 1.) the vignettes should not list patient multiple co-morbities unless absolutely typical, 2.) where appropriate, the reference services list should be combined, particularly in instances where there may be only one or two codes differences within the lists.

Doctor Lewis announced that the discussion of the American Academy of Ophthalmology's IWPUT Research would be discussed at the full RUC, per the request of the RUC Chair.

The RUC approved the Research Subcommittee report, with editorial changes, and it is attached to these minutes.

XIV. Administrative Subcommittee (Tab 47)

RUC Confidentiality
Dale Blasier, MD, indicated that at the February 2010 RUC meeting, individual RUC members requested that the RUC strengthen its confidentiality provisions to ensure that consultants who attend the RUC meetings are not sharing information with clients inappropriately.

The AMA's Office of General Counsel proposed revisions to the RUC's Confidentiality Agreement. **The Administrative Subcommittee recommended and the RUC agreed with the revisions to the attached Confidentiality agreement which will be signed by each meeting attendee.**

The Administrative Subcommittee also recommended and the RUC agreed that when consultants are present and speaking at a meeting, the RUC Chair require consultants to identify themselves, indicate which specialty society(ies) or health care professional organization(s) they represent and their relationship/role to the specialty society(ies) or health care professional organization(s). The confidentiality agreement itself provides the clear instruction that information obtained during the meeting may not be shared with other clients.

Financial Disclosure Clarification: Stock Options
Doctor Blasier indicated that the Administrative Subcommittee, with the guidance from AMA Legal Counsel, made minor revisions to the RUC Survey Instrument Financial Disclosure section in order to clearly convey what disclosures are requested. The revisions are as indicated:

Do you or a family member* have a direct financial interest in this procedure, other than providing these services in the course of patient care? For purposes of this Survey "direct financial interest" means:

- A financial ownership interest in an organization** of 5% or more: Yes/No
- A financial ownership interest in an organization** which contributes materially*** to your income: Yes/No
- **Ability to exercise Ownership of** stock options in an organization** **now or in the future**: Yes/No
- A position as proprietor, director, managing partner, or key employee in an organization**: Yes/No
- Serve as a consultant, researcher, expert witness (excluding professional liability testimony), speaker or writer for an organization**, where payment contributes materially*** to your income: Yes/No

*Family member means spouse, domestic partner, parent, child, brother or sister. Disclosure of family member's interest applies to the extent known by the survey respondent.

** Organization means any entity that makes or distributes the product that is utilized in performing the service, and not the physician group or facility in which you work or perform the service.
***Materially means $10,000 or more in income (excluding any reimbursement for expenses) for the past twenty-four months.

If you have answered yes to any of the above questions, do not complete this survey.

Financial Disclosure Consistency: RUC Survey and Disclosure Statement
Doctor Blasier informed the RUC that at the February 2010 RUC meeting, a member asked if the changes made most recently to the RUC Survey disclosure section should also be made to the RUC Conflict of Interest Policy and Advisory Committee Member Financial Disclosure to ensure consistency. **The Administrative Subcommittee recommended and the RUC agreed that current RUC Conflict of Interest Policy and Advisor Financial Disclosure be revised to be the same as the indicated in the survey instrument.**

The RUC approved the Administrative Subcommittee's report and it is attached to these minutes.

XV. HCPAC Review Board Report (Tab 48)

Emily Hill, PA-C, Alternate Co-Chair of the HCPAC reported to the RUC that the HCPAC reviewed the work relative values for Strapping Lower Extremity services and the direct practice expense for Speech Language Pathology and Debridement services.

Strapping Lower Extremity (29540, 29550 & 29590)
In October 2009, CPT code 29540 *Strapping; ankle and/or foot* was identified through the Harvard Valued - Utilization over 100,000 Screen. The RUC recommended this family of services be surveyed.

29540
The HCPAC reviewed code 29540 *Strapping; ankle and/or foot* and compared it to key reference service 29580 *Strapping; Unna boot* (Work RVU=0.55). The HCPAC compared the total time required for 29540 to 29580, 18 and 27 minutes, respectively and noted that 29540 required less time, mental effort/judgment, technical skill and psychological stress than 29580. The HCPAC determined that 29540 was approximately 30% less intense and complex than 29580, resulting in a work RVU of 0.39, which appropriately places this service in proper rank order relative to other similar services. For further support, the HCPAC also compared 29540 to 97116 *Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)* (work RVU = 0.40, 15 minutes total time) which requires similar intensity and complexity and time to perform. **The HCPAC recommends a work RVU of 0.39 for code 29540.**

29550
The HCPAC reviewed code 29550 and compared it 97762 *Checkout for orthotic/prosthetic use, established patient, each 15 minutes* (work RVU = 0.25) which requires the same intensity and complexity to perform as 29550. The HCPAC recommends crosswalking the work RVU for 29550 to reference code 97762. The HCPAC reviewed the survey time and determined that 7 minutes pre-service, 5 minutes intra-service and 1 minute immediate post-service time was appropriate to perform this procedure. **The HCPAC recommends a work RVU of 0.25 for 29550.**

29590
The American Podiatric Medical Association (APMA) indicated that 29590 Denis-Browne splint strapping technique is no longer used. Additionally, the survey response had a zero median performance rate for this service. **APMA requested and the HCPAC agreed that code 29590 be referred to the CPT Editorial Panel for deletion.**

Work Neutrality
The HCPAC's recommendation for this family of codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Speech-Language Pathology Services – Practice Expense Review Only
The HCPAC reviewed the speech language pathology services 92507, 92508, 92606, 92607, 92608 & 92609 at the February 2010 meeting as part of the transition of work from practice expense. At that time, the HCPAC met prior to the PE Subcommittee review of these services. **The American Speech-Language-Hearing Association recommended and the HCPAC agreed to remove the clinical labor inputs as this is now captured in the work, and maintaining the supplies and equipment.** ASHA indicated that they will petition CMS to update the supplies and equipment for these services at a later date to reflect the change in technology.

Debridement – Practice Expense Review Only (97597 & 97598)
At the February 2010 meeting the HCPAC met prior to the PE Subcommittee review of these services. The PE Subcommittee reviewed and modified the practice expense inputs. **The HCPAC approves the modified practice expense input for codes 97597 and 97598.**

Incision and Drainage of Abscess (10060 & 10061)
Code 10061 was identified through the Harvard Valued – Utilization Over 100,000 *Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple* was identified through the Harvard Valued – Utilization Over 100,000. The American Podiatric Medical Association (APMA) informed the HCPAC that they wish to extract code 10061 to resurvey and allow other specialties, such as General Surgery that perform this service, conduct surveys as well. APMA indicated that they will revise the vignette and resurvey with other specialties that perform this service. The HCPAC supports this proposal and added that 10060 be surveyed at the same time.

The RUC filed the HCPAC Review Board report which is attached to these minutes.

XVI. Other Issues

Other:

- There were was no further business brought forward.

The meeting adjourned on Saturday, May 1, 2010 at 3:00 pm.

AMA/Specialty Society RVS Update Committee **TAB 44**
Practice Expense Subcommittee Report
Wednesday-Thursday, April 28-29, 2010

Members present: *Doctors Bill Moran (Chair), Joel Brill (Vice Chair), Joel Bradley, Ron Burd, Manuel Cerqueira, Neal Cohen, Thomas Cooper, Peter Hollmann, Terry Mills,Guy Orangio, Tye Ouzounian, John Seibel, Anthony Senagore, Susan Spires, and Katherine Bradley, PhD, RN.*

Doctor Moran welcomed the attendees and reminded the participants that when presenting a code it is very important to adhere to the established standards where possible and to provide cross reference code direct inputs side by side where appropriate. He also told informed specialties that if the group can't get through a particular issue quickly and easily the entire tab will be revisited at the end of the subcommittee's agenda.

Radiographic - Fluoroscopy Workgroup Discussion
The Chair of the Fluoroscopy Workgroup, Doctor Tye Ouzounian, provided the Subcommittee with a summarization of its work and recommendation to the Subcommittee. Doctor Ouzounian stated that the Workgroup discussions were open to all specialties and CMS representatives. The Workgroup functioned as an expert panel and utilized input from specialty societies and Medicare claims data to inform their decision making. The members of the group were advisors and were limited to comment on codes that their specialty performed. **The Subcommittee accepted the Fluoroscopy Workgroup recommendations without modification and provides them to the RUC for approval.**

A summarization of these 76 recommendations follows for the non-facility setting:

- **60 services were recommended to have the EL014 Room, Radiographic-Fluoroscopic room be maintained**
- **7 services were recommended to have a C-Arm (codes: 49400, 50684, 62281, 62319, 64561, 74430, 76000)**
- **5 services were recommended to have no non-facility inputs, as the service is typically performed in the facility setting. (codes: 62268, 62269, 63610, 64508, 70010)**
- **4 was recommended to have the fluoro room deleted (codes: 50590, ~~62310, 62311, 62318~~)***

16 of the 76 were also considered services where miscoding was suspected and that a CPT Assistant article is recommended to be written with input from each of the specialties who have Medicare utilization. The codes for these services are: 21116, 27093, 27095, 27648, 43761, 49400, 62280, 62281, 62282, 62290, 62291, 70332, 70370, 72275, 74283, and 75901.

Codes 62310, 62311, and 62318 were extracted for additional review from this recommendation at the full RUC.

Equipment Time
At its meeting in February 2010, the Subcommittee discussed a request from CMS to provide time elements for each equipment item on the practice expense spreadsheet. In the past, this information was determined by CMS staff. The Subcommittee requested that CMS outline instructions for equipment time determination. Between the February and April RUC meetings, the RUC requested and received direction from CMS that could be used by specialties in making its equipment time recommendations. This direction was discussed and edited based on specialty input, and agreed upon by the Subcommittee. The following guidance will be supplied to specialties and provided as a reference for all practice expense recommendations to CMS for CPT 2011 and beyond:

1. Service Period: Equipment time is the sum of specific line item activities on the PE worksheet where a labor category is using the piece of equipment, plus any additional time the piece of

equipment is not available for use with another patient due to its use during the procedure in question. If more than one labor category uses equipment, do not multiple count overlapping times – e.g. if a nurse and a tech both use a piece of equipment for 10 minutes, 5 minutes of which it is used by both together, the 5 minutes of overlapping time should be counted only once – total equipment time would be 15 minutes, not 20 minutes. Cleaning time for scopes and/or instruments should only be applied to the scope and/or instrument pack listed, not to all equipment listed.

2. Post-Service Period: For the standard equipment used during office visits included in a code's global period, equipment time should be the sum of the office visit times where the equipment is used. When scope and/or instruments are including in post-procedure office visits, the cleaning time for scopes and/or instruments should only be applied to the scope and/or instrument pack listed, not to all equipment listed.

Time Out Clinical Labor Time

Within the specialty's original practice expense recommendation for Tab 7 clinical labor time was allocated to a "Time Out", to confirm orders, patient identity and mandatory time out prior to the procedure initiation. The Subcommittee agreed that this time would need to be discussed separately in a Workgroup to determine its validity and whether the time should be applied to other procedure codes and by what method. This Workgroup will meet over the summer of 2010 and report back to the Subcommittee.

Migration of radiologic images from film to digital

Subcommittee members have struggled during several meetings with identifying the direct practice expense inputs necessary to capture the now obvious migration taking place from radiologic film imaging inputs to the appropriate digital images and data storage inputs. The Subcommittee agreed that a workgroup should be formed to research and discuss the method and inputs to capture the technology change.

Direct Input Expense of Sedation in the Non-Facility Setting

At its meeting in February 2010, the Subcommittee discussed current regulations and standards for sedation (and the appropriate related practice expense inputs) in the non-facility setting. It was agreed that a workgroup should be formed to research and discuss the issue and report back to the Subcommittee.

CMS Equipment – Room Contents.

The North American Spine Society and AMA staff have requested details of several rooms that are listed under CMS's equipment listing. The Subcommittee agreed with this request and supports AMA staff, CMS, and the specialty's research in identifying the contents of these rooms for future reference for the Subcommittee and for specialty reference for future recommendations.

New and Revised Direct Practice Expense Input Recommendations
Wednesday, April 28, 2010

Endovascular Revascularization (378XX-372X11) – Clinical labor, medical supplies, and equipment were all edited for the typical patient service. The clinical labor "Time Out" time of 3 minutes was extracted to a workgroup.

Intraperitoneal Catheter Codes (494XX)*- This service was reviewed for practice expense inputs for the typical dialysis patient. All direct inputs were reviewed and medical supplies and equipment were edited for the typical service.

Ultrasound of Extremity Limited (7688X1 & 7688X2)*-The direct inputs were reviewed carefully and the equipment was discussed thoroughly. It was the subcommittee's understanding that a specific equipment device was to be used for code 7688X2, and while the specialty provided a much different device and

maintained it was the typical equipment item. Because of the impasse with the choice of equipment for 7688X2 the Subcommittee could not agree on the type of equipment typically used. The society and CMS with AMA staff assistance, will work toward identifying this equipment item to be implemented for 2011.

External Cardiovascular Device Monitoring (93224-93229, 93268-93272)* - The Subcommittee agreed the current existing direct inputs are still applicable and typical and recommends their maintenance.

Diagnostic Cardiac Catheterization (93XX11-93XX20)* - The direct inputs for these codes were fully reviewed and edits to clinical labor time, medical supplies, and equipment were made.

Extremity Non-invasive Arterial Physiologic Studies (93922-93924)*- The direct inputs for these codes were fully reviewed and edits to clinical labor time, medical supplies, and equipment were made.

New and Revised Direct Practice Expense Input Recommendations
Thursday, April 29, 2010

Excision and Debridement (11043, 11046X, 11044, 11047X)*- A minor edit to the clinical labor time was made and the other direct inputs were reviewed and accepted as presented.

Sentinel Lymph Node Mapping (389XX)- The Subcommittee agreed there would be no direct inputs for this service.

Fiducial Marker Placement (4932X & 494X1)- The Subcommittee agreed there would be no direct inputs for this service.

Intraperitoneal Catheter Codes (49421)*- A minor edit to the clinical labor time was made and the other direct inputs were reviewed and accepted as presented.

Posterior Tibial Nerve Stimulation (PTNS) (645XX) - The direct inputs for these codes were fully reviewed and edits to clinical labor time, medical supplies, and equipment were made.

Iridotomy (66761)* -Minor changes to the clinical labor and supplies were made and accepted by the Subcommittee.

Labrinthotomy (69801 & 69802)*- Minor changes to the clinical labor were made and accepted by the Subcommittee.

Evaluation of Fine Aspirate (8817X & 88172)- Minor changes to the clinical labor were made and accepted by the Subcommittee.

Transcranial Magnetic Stimulation (9086X7 & 9086X8) - The direct inputs for these codes were fully reviewed and edits to clinical labor time, medical supplies, and equipment were made. In addition, the specialty and CMS will work together toward the possibility of developing a new CMS equipment room for these types of procedures.

Esophageal Motility (91010 & 9101X1)- The direct inputs for these codes were fully reviewed and edits to clinical labor time, medical supplies, and equipment were made.

Colon Motility (9112X1) –No changes were made to the recommended direct inputs and it was accepted by the Subcommittee

Anterior Segment Imaging (9213X)- Minor changes to the clinical labor were made and accepted by the Subcommittee.

Computerized Scanning Ophthalmology Diagnostic Imaging (921X1 & 921X2)- Minor changes to the clinical labor were made and accepted by the Subcommittee.

Diabetic Retinopathy Imaging (922X1 & 922X2)- No changes were made to the recommended direct inputs and it was accepted by the Subcommittee

Sleep Testing (9580X, 9580X1, 95803, 95805, 95806, 95807, 95808, 95810 & 95811)*- The direct inputs for these codes were fully reviewed and edits to clinical labor time, medical supplies, and equipment were made.

Chemotherapy Administration Into Peritoneal Cavity (9644X)- Minor changes to the clinical labor were made and accepted by the Subcommittee.

Stand-by Services (99360 & 9936X)- The clinical labor time was reduced for the typical patient service and all other inputs were accepted as presented.

Breast reconstruction (19357) - Minor changes to the clinical labor were made and accepted by the Subcommittee.

Speech-Language Pathology Services (92507, 92508, 92606, 92607, 92608 & 92609)*- All clinical labor time was eliminated from these servicews and it was accepted by the Subcommittee

090 Day Global Services

Hip Arthroscopy (2986X4, 2986X5 & 2986X6)- *090 day global-* Minor changes to the clinical labor were made and accepted by the Subcommittee.

Lung Resection Procedures (32095X-32095X2, 32100, 3250X-3250X2, 32601, 3260X-3260X2, 3266X-3266X4, 32663, 3266X3-3266X8 & 38746) - *090 day global-* Minor changes to the clinical labor were made and accepted by the Subcommittee.

Paraesophageal Hernia Repairs (4332X-4332X5 & 4328X)- *090 day global-* Minor changes to the medical supplies were made and the Subcommittee accepted the recommendation.

Transurethral Radiofrequency Bladder Neck and Urethra (5386X)- *090 day global-* The direct inputs for these codes were fully reviewed and edits to clinical labor time, medical supplies, and equipment were made.

Open Angle Glaucoma Procedures (66XX1-66XX2) - *090 day global -* No changes were made to the recommended direct inputs and it was accepted by the Subcommittee

The Practice Expense Subcommittee was adjourned at 1:05 pm Thursday.

AMA/Specialty Society RVS Update Committee **Tab 45**
Five-Year Review Identification Workgroup
April 29, 2010

Members: Doctors Walt Larimore *(Chair),* Robert Zwolak *(Vice-Chair)*, Bibb Allen, Michael Bishop, James Blankenship, Dale Blasier, John Gage, Stephen Levine, Brenda Lewis, William Mangold, Larry Martinelli, Marc Raphaelson, George Williams

I. Review Revised Action Plans

The Five-Year Review Identification Workgroup reviewed specialty society action plans for services identified by the Harvard only codes with utilization over 100,000 and services surveyed by one specialty and now performed by another specialty screens. **The Workgroup recommendations for each family of codes are as follows:**

CPT Code family	Screen	Recommendation
12031, 12032*, 12034, 12035, 12036, 12037, 12041, 12042, 12044, 12045, 12046, 12047, 12051, 12052, 12053, 12054, 12055, 12056, 12057	Harvard Valued-Utilization over 100,000	Survey – RUC Oct 2010 (specialty society will not survey or use 12052 on its reference service list).
16020, 16025*, 16030	Different Performing Specialty from Survey	16020 & 16025 – Survey RUC Oct 2010 16030 - Refer to CPT Assistant, site-of-service clarification
27096*	Different Performing Specialty from Survey	Refer to CPT Editorial Panel to change descriptor to include "requiring fluoroscopic guidance"
36000*	Harvard Valued-Utilization over 100,000	Refer to CPT Editorial Panel to delete
62290*	Different Performing Specialty from Survey	Refer to CPT Assistant to address the proper use of 62290, 72285 and 72295 and specifically include clarification that code 77003 (fluoroscopy) should not be reported with these codes.
62367, 62368*, 95990, 95991	Different Performing Specialty from Survey	Refer to CPT Editorial Panel to delete 62368 and separate into 3 codes and PE review Oct 2010 to remove duplication
70470*	Harvard Valued-Utilization over 100,000	Survey
72100, 72110*, 72114, 72120	Harvard Valued-Utilization over 100,00	Refer to CPT Editorial Panel to revise 72120 to accurately reflect the work performed and then survey family (family of codes as determined by specialty society)
73542*	Different Performing	Refer to CPT Editorial Panel to revise

	Specialty from Survey	existing parenthetical to clarify to use 27096 for the injection procedure which includes fluoroscopic guidance for sacroiliac joint injections. Refer to CPT Assistant for further clarification.
95971*, 95972	Different Performing Specialty from Survey	Refer to CPT Editorial panel to address neurostimulator programming for incontinence as a separate new code. In addition, the Committee may wish to consider the number of channels as a determinant of code clarification between 95971/95972 rather than simple and complex.
**code identified by screen*		

II. Codes Performed together 75% of the time (same day/same physician)

Doctor Kenneth Brin, Chairman of the Joint CPT/RUC Workgroup on Codes Frequently Reported Together, shared with the Workgroup the Joint Workgroup's official recommendations. The Joint Workgroup met via 3 two hour conference calls to carefully review the specialties' action plans pertaining to the 20 code groups, which contained code pairs that are billed together on the same date of service 75% or more of the time, identified by the Workgroup prior to the February RUC meeting.

The Joint CPT/RUC Workgroup analyzed potential duplication in physician work and practice expense values for these 20 code groups. Additionally, the Workgroup members considered how often a service was reported alone as well as clinical scenarios in which specific services are reported together. The Joint Workgroup recommendations include: submission of code change proposals for bundled codes, submission of CPT Assistant articles, deletion of a code, consideration of CCI edits, and referrals to the RUC Practice Expense Subcommittee. These final recommendations were collected and put into a final report for the Five-Year Identification Workgroup to review. Finally, if a specialty has more than two code groups identified in this first review which would lead to a RUC survey, the specialty may elect to address only the top two of those groups in the CPT 2012 cycle and address the remainder in the 2013 CPT cycle.

The Workgroup reviewed the final recommendations from the Joint CPT/RUC Workgroup on Codes Frequently Reported Together and accepted all 20 of the recommendations.

III. Fourth Five-Year Review - Specialty Society Level of Interest

Specialty Society Requests:

CPT Referrals
15365, 92950, 64622, 64623, 64626, 64627, 92070 and 92120
Codes 15365, 95920, 64622, 64623, 64626, 64627, 92070 and 92120 were requested to be referred to the CPT Editorial Panel for clarification and the Workgroup agreed. Codes 15365 and 92950 were requested to be referred because an existing CPT Workgroup is currently addressing these services. Codes 64622, 64623, 64626, 64627 were requested to referred to revise to include that imaging is required. Codes 92070 and 92120 were requested to be referred to change the code descriptors.

99341-99350 Home Visits
The AAFP submitted a comment letter based on action of their Congress of Delegates to have home visits re-evaluated. However, the AAFP and other specialties do not believe that there is compelling evidence to increase the valuation of these services. The specialty societies indicated that the work for home visits 99341-99350 has not changed since the recent RUC and CMS review. Therefore, the specialty societies determined that there was no compelling evidence and recommends the RUC recommend no change in value for the Fourth Five-Year Review.

15240
This code was identified in error in the CMS site-of-service screen. The RUC database and time file for this service reflected a full discharge day although the rationale clearly indicates that the RUC only considered a half day discharge. Therefore, the RUC should reflect a recommendation of no change and explain the typo in the database that lead to the inappropriate identification.

Site-of-Service/23+ Hour Issue
AMA Staff indicated that the specialties have requested more complete (i.e. final) 2009 claims data and AMA staff will work with CMS to obtain this data. In addition, CMS has requested that codes identified as outpatient services reflect only outpatient visits. CPT and the RUC have worked to address the 23+ hour issue by creating subsequent outpatient observation codes. However, these codes will not be implemented until January 1, 2011. The Research Subcommittee discussed the options regarding an appropriate time/visit valuation methodology of these issues. *Please refer to the Research Subcommittee April 2010 Report for this discussion.*

IV. New Technology: September 2010

The Workgroup discussed that in September 2005, February 2006 and April 2006 the RUC began flagging new and revised codes that were identified as new technology or a new service. The RUC agreed that after three years of data had been collected the RUC will assess these services.

In June 2010, AMA Staff will distribute an LOI request for 33 new technology/new services. Interested specialty societies will be required to complete a brief action plan to be reviewed at the October 2010 meeting. The RUC will review 2007-2009 claims data for these 33 new technology/new services. Claims data will include utilization, performing specialties, diagnosis codes reported and site of service information. Specialty societies will have the opportunity to discuss whether there has been a diffusion of technology for these services.

The RUC will compare the claims data to the original submission to determine whether or not each service should be evaluated.

The Workgroup discussed and recommends the possible RUC action that will occur upon review of the action plans for the New Technology/New Services codes. The RUC will recommend one of the following actions for codes on the New Technology/New Services List:

1. **The service does not need to be re-evaluated, the code is removed from the New Technology/Services List.**
2. **The service requires additional claims data, more than the first three years. The RUC will determine on a case-by-case basis when the service should be re-reviewed through the New Technology/New Services List process.**
3. **The service needs to be re-evaluated. The specialty society will survey the service and present recommendations at the next RUC meeting. New RVUs will be published January 1 of the next year if approved by the RUC and CMS.**

IV. Other Issues

The following items were provided as informational materials:

- CPT Editorial Panel Referrals
- CPT Assistant Referrals
- Full status report of the Five-Year Review Identification Workgroup

Joint CPT/RUC Workgroup on Codes Reported Together Frequently
Recommendations Report
April 28, 2010

Workgroup Members: Doctors Kenneth Brin (Chair); Bibb Allen; Peter Hollmann; Walt Larimore; Steve Levine; Mark Synovec and Robert Zwolak

Background

As was reported at the Five-Year Review Identification Workgroup meeting in February 2010, the Joint CPT/RUC Workgroup reconvened, in October 2009, to review the set of code pairs identified through the newly established Codes Reported Together 75% or More screen. Through multiple conference calls in January and February of this year, the Workgroup synthesized the code pair data into groups of related codes, rank ordered the groups as described in the February report, and prioritized for review the top 20 "groups" identified. Level of Interest Forms (LOI) were then distributed to all specialty societies on February 15, 2010, with action plans requested by March 31,2010.

Joint Workgroup Recommendation Process:

Through three 2 hour conference calls on April 8, 12 and 21, the Workgroup carefully reviewed the specialty societies' action plans and recommendations. The Workgroup analyzed potential duplication in physician work and practice expense values through the attached detailed spreadsheets. In addition, the Workgroup members considered how often a service was reported alone as well as clinical scenarios in which specific services are reported together, facilitating the comprehensive evaluation of these groups of services. In cases where the Workgroup members felt that additional information or an alternative action plan should be considered, the specialties involved were contacted and responses to the Workgroup's questions were received either by specialty participation on a Workgroup conference call or via email.

The attached Final Workgroup Report represents the Joint Workgroup's final recommendations for the 20 groups identified in the LOI. For each recommendation there is a corresponding entry detailing the response of the specialty societies involved in that set of services as well as the Workgroup's recommendation, together with the Workgroup's rationale when appropriate. The Workgroup's recommendations include: submission of code change proposals for bundled codes, submission of CPT Assistant articles, deletion of a code, consideration of CCI edits, and referrals to the RUC Practice Expense Subcommittee. In addition, the Workgroup has identified codes in which the volume has increased without specialty explanation and the Workgroup is requesting clarification of clinically appropriate reporting scenarios. In cases where an action is expected, a specific timeline is provided in the report. Finally, if a specialty has more than two code groups identified in this first review which would lead to a RUC survey, the specialty may elect to address only the top two of those groups in the CPT 2012 cycle and address the remainder in the 2013 CPT cycle.

TAB 45

Codes Reported Together 75% of More Screen
Joint CPT/RUC Workgroup Recommendation Summary Table

Issue	Code	Specialty Action and Notes	Specialties Involved in Action Plan	Workgroup Recommendation with Timeline*
Group 1	94240, 94720 94240-26, 94720-26 94240-TC, 94720-TC 94260, 94720 94260, 94360 94260-26, 94720-26 94350, 94720 94350, 94240 94360, 94720 94360-26, 94720-26 94370, 94240 94725, 94240 94725, 94350	Specialties acknowledge duplication in clinical labor and supplies and request a PE review to remove the duplicative inputs. **Revised Action Plan:** Specialty will develop CPT code proposal to bundle services always reported together on the same date of service.	ACCP ATS	The Workgroup accepts the specialties' recommendation to submit a code change proposal to bundle services always reported together on the same date of service. The Workgroup agreed with the specialties that duplication exists between these code pairs when they are reported on the same date of service by the same physician. Given that claims data indicate that each of these codes is reported as a stand alone service less than 1% of all reporting of the service, the specialties agreed to submit a proposal for bundling these services. **Timeline**: No later than the February 2011 CPT Editorial Panel meeting **Update:** *Specialties have submitted a code change proposal to be addressed at the Oct 2010 CPT Editorial Panel Meeting*
Group 2	77421, 77418	The frequency in which the two codes are reported together is appropriate as 77421 is a guidance code. 77418 has no work assigned, so the specialty argues that there is no duplication in resources.	ACRO ASTRO	The Workgroup accepts the specialties' recommendation that there is no duplication in the physician work because 77418 is a guidance code with no physician work. To assure there is no duplication in PE, the Workgroup will refer the PE components to the PE Subcommittee for review to check for potential duplication, as the services were reviewed at separate meetings. **Timeline**: PE review in September 2010
Group 3	93016, 93018 93017, 93016 93018, 93016	These coding scenarios represent proper component coding and do not represent any overlap in physician work or PE. A CPT Assistant article can be created to address any coding issues.	ACC ACNM AAFP SNM	Both reporting structures result in the same total work RVU of 0.75. Thus, the Workgroup accepts the specialties' recommendation that these codes represent proper component coding and does not feel that a CPT Assistant article is necessary. Individuals are appropriately instructed to report 93015 when performed in office and 93016 and 92018 when professional component is performed in the facility. **Timeline**: Complete
Group 4	97016, 97110 97018, 97110 97116, 97110	There is no duplication in work because 1) the services are timed in separate 15 minute units and 2) the codes have limited pre/post times reflecting that more than one service would be billed together; and 3) the services were created and valued with the assumption that they would be reported together on the same date by the same therapist.	AOTA APTA AAPM&R	The Workgroup accepts the specialties' recommendation that these services include no duplication in physician work and PE components as these services were valued with limited pre and post time because it was assumed that they would be reported together on the same date by the same physician. **Timeline**: Complete

*If a specialty has more than two code groups identified in this first review which would lead to a RUC survey, the specialty may elect to address only the top two of those groups in the CPT 2012 cycle and address the remainder in the 2013 CPT cycle.

TAB 45

Codes Reported Together 75% of More Screen
Joint CPT/RUC Workgroup Recommendation Summary Table

Issue	Code	Specialty Action and Notes	Specialties Involved in Action Plan	Workgroup Recommendation with Timeline*
Group 5	93350, 93015 93350-26, 93018	Wait for more data from new coding structure. With the creation of 93351 in 2009, combining a complete stress test and stress echo, these coding instances should be reduced. The specialty also commented that CMS created 93351-26 to describe the professional component when the combined code is performed in the facility setting.	ACC	The Workgroup accepts the specialty's recommendation that, with the creation of 93351 combining a complete stress test and stress echo, the utilization should be reduced in the 2009 claims data. Given the specialty's comment relating to 93351-26, the Workgroup recommends that a CPT Assistant article be developed stating that when a complete stress test is performed with a complete echo in the facility setting, 93351-26 should be reported. This would also require a code change proposal to modify the introductory language and the cross reference foot note in CPT as the current introductory language directs the reporting of 93350 and the appropriate stress test codes (93016 and 93018). **Timeline**: No later than the October 2010 CPT Editorial Panel meeting. 2010- Review 2009 claims data to monitor if code pairs are still reported together at a high rate. **Update:** *Specialty has submitted a code change proposal to be addressed at the Oct 2010 CPT Editorial Panel Meeting*
Group 6	95860, 95904 95860-26, 95904-26 95861, 95904 95863, 95904 95864, 95904	There is not substantial duplication in work or practice expense when the code sets are reported together. **Revised Action**: Specialties, after discussing with the Workgroup, agreed to submit a code change proposal that decreases duplication when the typical scenario is performed.	AAN AANEM ACNS NASS AAPM&R	The Workgroup, accepts the specialties' revised recommendation to submit a code change proposal to decrease duplication when these services are reported together on the same day by the same physician. The Workgroup reviewed the recommended number of units for 95904 located in Appendix J of the CPT book and found that up to 6 units can be reported per diagnosis. Given this, the specialties agree that duplication could be minimized with a new coding structure. *Note: EMGs are reported 1% of the time as stand-alone services and nerve conduction studies are reported as stand alone services less than 1% of the time.* **Timeline**: No later than the February 2011 CPT Editorial Panel meeting

*If a specialty has more than two code groups identified in this first review which would lead to a RUC survey, the specialty may elect to address only the top two of those groups in the CPT 2012 cycle and address the remainder in the 2013 CPT cycle.

TAB 45

Codes Reported Together 75% of More Screen
Joint CPT/RUC Workgroup Recommendation Summary Table

Issue	Code	Specialty Action and Notes	Specialties Involved in Action Plan	Workgroup Recommendation with Timeline*
Group 7	33207, 71090-26 33208, 71090-26 33212, 33233 33213, 33233 33240, 33241 33249, 71090-26 33249, 93641-26	For the code pairs that are subject to the 50% multiple procedure reduction, the reduction sufficiently accounts for any duplication. For the other code pairs, a code change proposal will be created to request an editorial change that states 71090 should not be reported with 33207, 33208, 33249.	ACC	The Workgroup accepts the specialty's recommendation to generate an editorial code change proposal instructing that 71090 not be reported with 33207, 33208, and 33249 as well as to delete the CPT note before 33202 indicating "For radiological supervision and interpretation with insertion of pacemaker, use 71090". In addition, the Workgroup recommends the creation of an add-on code describing the removal of a permanent pacemaker pulse generator (33233) and the subcutaneous removal of a cardioverter-defibrillator pulse generator(33241) when performed with the insertion codes (33207, 33208, 33212, 33213 and 33240) on the same date of service. **Timeline**: No later than the February 2011 CPT Editorial Panel meeting.
Group 8	29824, 29826 29827, 29826 29828, 29826	The total work RVUs for the combined procedures when the endoscopy multiple procedure reduction is applied is appropriate and consistent with the work performed by the surgeon. Also, 29826 is being reviewed during the 4th Five-Year Review as a Harvard valued service with utilization over 30,000.	AAOS	The Workgroup defers review of the group until the RUC reviews 29826 in September 2010 as part of the Harvard valued service with utilization over 30,000. The Workgroup recommends that the RUC consider that 29826 is reported as a stand alone procedure less than 1% of the time per Medicare claims data. The specialty also noted that 29826 should not be converted to a ZZZ global period as the service in the non-Medicare population is typically performed as a stand alone procedure. **Timeline**: September 2010 RUC meeting - 29826
Group 9	72191, 74175 72191-26, 74175-26 72191-TC, 74175-TC	Potential efficiencies may exist and a code change proposal is necessary.	ACR SIR	The Workgroup accepts the specialties' recommendation to submit a code change proposal that addresses any duplication when these services are reported together on the same date by the same physician. **Timeline**: No later than the February 2011 CPT Editorial Panel meeting. **Update:** *Specialties have submitted a code change proposal to be addressed at the Oct 2010 CPT Editorial Panel Meeting*

*If a specialty has more than two code groups identified in this first review which would lead to a RUC survey, the specialty may elect to address only the top two of those groups in the CPT 2012 cycle and address the remainder in the 2013 CPT cycle.

TAB 45

Codes Reported Together 75% of More Screen
Joint CPT/RUC Workgroup Recommendation Summary Table

Issue	Code	Specialty Action and Notes	Specialties Involved in Action Plan	Workgroup Recommendation with Timeline*
Group 10	22630, 22612	A code change proposal will be submitted to create a bundled code to describe the work when both procedures are performed together (same date, same physician)	AANS/CNS AAOS NASS	The Workgroup accepts the specialties' recommendation to submit a code change proposal to create a new code to describe the physician work when the services are performed together on the same date of service by the same physician. Additionally, a parenthetical will be created to indicate that the separate services (22630 and 22612) not be reported together. **Timeline**: No later than the February 2011 CPT Editorial Panel meeting. **Update:** *Specialties have submitted a code change proposal to be addressed at the Oct 2010 CPT Editorial Panel Meeting*
Group 11	96416, 96413	The two services should remain separate and distinct.	ACRh ASCO ASH	The Workgroup requested to meet with the specialties to discuss their concerns about duplication in physician work and PE inputs. The specialties acknowledge that there is duplication in the PE pre time in the greet patient and change gown components when multiple services are provided on the same date of service. The Workgroup has further concerns about duplication in physician work, with both codes having pre and post time. The specialties explained that the services are done sequentially with separate protocols and contain no physician overlap. Given this information, the Workgroup recommends a PE review at the September 2010 PE Subcommittee meeting. *Note: 96416 is reported approximately 7% as a stand alone service.* **Timeline**: PE review in September 2010

*If a specialty has more than two code groups identified in this first review which would lead to a RUC survey, the specialty may elect to address only the top two of those groups in the CPT 2012 cycle and address the remainder in the 2013 CPT cycle.

TAB 45

Codes Reported Together 75% of More Screen
Joint CPT/RUC Workgroup Recommendation Summary Table

Issue	Code	Specialty Action and Notes	Specialties Involved in Action Plan	Workgroup Recommendation with Timeline*
Group 12	75671-26, 36216 75671-26, 75680-26 75671, 75680 75680-26, 36216 75680, 75650 75680, 36215 75680, 36216 75722-26, 36245 75724-26, 36245 75724, 36245	Review additional data sources to accurately determine current practice patterns. It would also be helpful to track these procedures moving forward as there is a large number of potential code pairs that can be reported within this family.	AANS/CNS (75671 & 75680) ACC ACR ASNR AUR SIR SVS	The Workgroup recommends the specialties submit a code change proposal to bundle the set of codes describing unilateral renal angiography (75722 and 36245) as well as those codes describing bilateral renal angiography (75724 and 36245) for submission by the February 2011 CPT meeting. In addition, the Workgroup feels that there is duplication on work among the carotid angiography codes when various carotid angiography services are provided together and that a code change proposal describing the more typical services would be appropriate. This coding solution describing the more common service sets should be completed by the February 2012 CPT Editorial Panel Meeting. *Note: 75671, 75680, 75722, 75724, 75650 have not been RUC or Harvard reviewed.* **Timeline**: No later than the February 2011 CPT Editorial Panel meeting (renal); Initiated no later than February 2012 CPT Editorial Panel meeting (carotid).
Group 13	93651, 93620-26 93652, 93620-26	The 50% multiple procedure reduction sufficiently accounts for any duplication.	ACC	The Workgroup recommends that the specialty submit a code change proposal to create two bundled codes: one code will bundle the work of 93651 when performed on the same day with 93620 and the other code will bundle 93652 when performed on the same day with 93620. The Workgroup discussed whether the 50% multiple procedure reduction sufficiently accounted for duplication when these services are reported together, but agreed that since these services have 000 day globals, the creation of bundled codes is more a comprehensive approach. **Timeline**: No later than the February 2011 CPT Editorial Panel meeting.

*If a specialty has more than two code groups identified in this first review which would lead to a RUC survey, the specialty may elect to address only the top two of those groups in the CPT 2012 cycle and address the remainder in the 2013 CPT cycle.

TAB 45

Codes Reported Together 75% of More Screen
Joint CPT/RUC Workgroup Recommendation Summary Table

Issue	Code	Specialty Action and Notes	Specialties Involved in Action Plan	Workgroup Recommendation with Timeline*
Group 14	93875, 93880 93875-TC, 93880-TC 93886-TC, 93880-TC 93888, 93880 93931-TC, 93880-TC	Separate CPT Assistant articles should be created describing the appropriate use of 93875, 93886, & 93931.	AAN ACC ACR SIR SVS	The Workgroup recommends: A. That the specialties submit a code change proposal to delete 93875. Also, the specialties should take the Doppler ultrasound component "Doppler ultrasound spectral analysis" from code 93875 and place it in the descriptor of 93880 *Duplex scan of extracranial arteries; complete bilateral study*, as there was concern raised with the inclusion of "Doppler ultrasound spectral analysis" in the "eg" after code 93875 given that Doppler ultrasound spectral analysis is a component of 93880; B. A CPT Assistant article should be published to notify providers of the change. C. For code pairs 93886/93880, 93888/93880 and 93931/93880 the Workgroup recommends CCI edits that would preclude the reporting of these code pairs together. An indicator of 1 is recommended to allow for the reporting of these services together on the same date of service under clinically appropriate scenarios. **Timeline**: No later than the October 2010 CPT Editorial Panel meeting. **Update:** *Specialties have submitted a code change proposal to be addressed at the Oct 2010 CPT Editorial Panel Meeting*

*If a specialty has more than two code groups identified in this first review which would lead to a RUC survey, the specialty may elect to address only the top two of those groups in the CPT 2012 cycle and address the remainder in the 2013 CPT cycle.

TAB 45

Codes Reported Together 75% of More Screen
Joint CPT/RUC Workgroup Recommendation Summary Table

Issue	Code	Specialty Action and Notes	Specialties Involved in Action Plan	Workgroup Recommendation with Timeline*
Group 15	95921, 95922 95922, 95921 95925-26, 95926-26 95926-26, 95925-26 95928-26, 95929-26 95929-26, 95928-26	95921-22: Review 2009 utilization to determine if CPT Assistant article changed coding practices for 95922. 95925-26: There is some duplication but not enough to change. 95928-29: There is some duplication but not enough to change.	AAFP AANS/CNS (95928 & 95929) AAN AANEM ACNS AAPM&R	The Workgroup recommends that the specialties submit a code change proposal to create two codes that bundle 95925 with 95926 and 95928 with 95929 when the services are performed on the same date. For code pair 95921/95922, the Workgroup acknowledges that the rational for increased utilization remains unclear. Thus, the dominant specialties for these two codes (Family Medicine and Internal Medicine) are requested to provide the following information regarding 95921 and 95922: A. What are the clinically appropriate scenarios for reporting each service? B. What is the description of service? C. What are the clinically appropriate scenarios when these services are reported on the same date? **Timeline**: Further review by Workgroup, including clinical appropriate scenarios for reporting. No later than February 2011 CPT Editorial Panel meeting for presentation of bundled codes. **Update:** *Specialties have submitted a code change proposal to be addressed at the Oct 2010 CPT Editorial Panel Meeting*
Group 16	76950-TC, 77418 76950, 77418	77418 does not have physician work assigned. Specialty acknowledges duplication in the practice expense inputs for these two codes.	ACRO ASTRO	The Workgroup agrees with the specialties and recommends that the duplication in PE inputs resulting when the two services are reported together on the same date of service by the same physician be reviewed by the PE Subcommittee. **Timeline**: PE review in September 2010
Group 17	75960-26, 37205 75960, 37205	Review should be postponed until the RUC response to the outcome of the lower extremity revascularization recommendations to be presented at the April 2010 RUC meeting.	ACC ACR SIR SVS	The Workgroup acknowledges that it is unclear what volume of services will remain described by these codes given the removal of the lower extremity revascularization services and agrees with the specialties to defer this issue for one year until the RUC has reviewed the lower extremity revascularization codes in April 2010 and the new codes are implemented. Currently, the Workgroup encourages the specialties to consider a bundled code for the 2012 CPT cycle. **Timeline**: Review complete no later than the February 2011 CPT Editorial Panel meeting.

*If a specialty has more than two code groups identified in this first review which would lead to a RUC survey, the specialty may elect to address only the top two of those groups in the CPT 2012 cycle and address the remainder in the 2013 CPT cycle.

TAB 45

Codes Reported Together 75% of More Screen
Joint CPT/RUC Workgroup Recommendation Summary Table

Issue	Code	Specialty Action and Notes	Specialties Involved in Action Plan	Workgroup Recommendation with Timeline*
Group 18	37620, 75940-26 37620, 36010	Potential efficiencies exist and the family will be reviewed by the specialties' coding committees.	ACR SIR SVS	The Workgroup accepts the specialties' recommendation to submit a code change proposal that would address any duplication when these services are reported together on the same date by the same physician. **Timeline**: No later than the February 2011 CPT Editorial Panel meeting.
Group 19	37201, 75896-26 37203, 75961-26 37204, 75894-26	Potential efficiencies exist and the family will be reviewed by the specialties' coding committees.	AANS/CNS (37201) ACC ACR SIR SVS	The Workgroup accepts the specialties' recommendation to submit a code change proposal that would address any duplication when these services are reported together on the same date by the same physician. **Timeline**: No later than the February 2011 CPT Editorial Panel meeting.
Group 20	95990, 62368 95991, 62368	Propose new coding structure: 1) delete 62368 and create three new codes 2) Add CPT parenthetical after 95990-91 to clarify new coding language. PE values for 95990-91 should be reviewed to eliminate duplication with 62368.	AANS/CNS ASA ISIS NASS AAPM&R	The Workgroup accepts the specialties' recommendation to delete 62368 and describe those services with three separate codes (6236X1- with reprogramming; 6236X2- with reprogramming and refill (does not need physician's skill); and 6236X3- with reprogramming (needs physician's skills). In addition, a CPT parenthetical will be added to follow the pump refill codes (95990/95991) to state "When analysis, reprogramming and refill are performed, report only 6235X2 or 6236X3. Additionally, the PE components for both 95990 and 95991 will be reviewed to eliminate any duplication when reported with 62368 on the same sate of service. **Timeline**: No later than the October 2011 CPT Editorial Panel meeting. PE Review in September 2010 **Update:** *Specialties have submitted a code change proposal to be addressed at the Oct 2010 CPT Editorial Panel Meeting*

*If a specialty has more than two code groups identified in this first review which would lead to a RUC survey, the specialty may elect to address only the top two of those groups in the CPT 2012 cycle and address the remainder in the 2013 CPT cycle.

CPT	Long Descriptor	Global	Work RVU	Work Pre	Work Intra	Work Post	Total Phy Work Time	RUC Review	PE Review	PE Pre	PE Intra	PE Post	Volume	Volume billed alone	% billed alone
94240	Functional residual capacity or residual	XXX	0.26	5	5	5	15	Aug-95	Sep-02	0	35	0	610175	540	0.09%
94260	Thoracic gas volume	XXX	0.13				16	No	Sep-02	0	35	0	265613	220	0.08%
94350	Determination of maldistribution of insp	XXX	0.26	5	8	5	18	Aug-95	Feb-05	0	31	0	124623	260	0.21%
94360	Determination of resistance to airflow, c	XXX	0.26	5	10	5	20	Aug-95	Sep-02	0	45	0	299051	340	0.11%
94370	Determination of airway closing volume	XXX	0.26				18	No	Feb-05	0	31	0	58057	180	0.31%
94720	Carbon monoxide diffusing capacity (eg	XXX	0.26	4	9	5	18	Aug-95	Sep-02	0	41	0	865929	6120	0.71%
94725	Membrane diffusion capacity	XXX	0.26	5	8	5	18	Aug-95	Feb-05	0	39	0	28948	80	0.28%

CPT	Long Descriptor	Global	Work RVU	Work Pre	Work Intra	Work Post	Total Phy Work Time	RUC Review	PE Review	PE Pre	PE Intra	PE Post	Volume	Volume billed alone	% billed alone
77418	Intensity modulated treatment deliver	XXX	0.00					Apr-01	Apr-01	0	60	5	1188906	256120	21.54%
77421	Stereoscopic X-ray guidance for local	XXX	0.39	0	9	0	9	Apr-05	Apr-05	0	34	0	753500	297500	39.48%

CPT	Long Descriptor	Global	Work RVU	Work Pre	Work Intra	Work Post	Total Phy Work Time	RUC Review	PE Review	PE Pre	PE Intra	PE Post	Volume	Volume billed alone	% billed alone
93016	Cardiovascular stress test using maxi	XXX	0.45	10	38	10	58	Jun-93	Jan-02	0	0	0	1180090	72460	6.14%
93017	Cardiovascular stress test using maxi	XXX	0.00					No	Feb-09	15	55	0	250860	3780	1.51%
93018	Cardiovascular stress test using maxi	XXX	0.30	2	5	5	12	Aug-05	Jan-02	0	0	0	1349077	120120	8.90%

CPT	Long Descriptor	Global	Work RVU	Work Pre	Work Intra	Work Post	Total Phy Work Time	RUC Review	PE Review	PE Pre	PE Intra	PE Post	Volume	Volume billed alone	% billed alone
97016	Application of a modality to 1 or more	XXX	0.18	2	14	2	18	May-94	Feb-01	0	17	0	200406	1760	0.88%
97018	Application of a modality to 1 or more	XXX	0.06	1	11	1	13	May-94	Mar-01	0	6	0	127229	820	0.64%
97110	Therapeutic procedure, 1 or more are	XXX	0.45	1	15	2	18	May-94	Feb-01	0	15	0	36609136	3159368	8.63%

CPT	Long Descriptor	Global	Work RVU	Work Pre	Work Intra	Work Post	Total Phy Work Time	RUC Review	PE Review	PE Pre	PE Intra	PE Post	Volume	Volume billed alone	% billed alone
93015	Cardiovascular stress test using maxi	XXX	0.75	2	15	4	21	Aug-05	Jan-02	15	55	0	2165186	265600	12.27%
93018	Cardiovascular stress test using maxi	XXX	0.30	2	5	5	12	Aug-05	Jan-02	0	0	0	1349077	120120	8.90%
93350	Echocardiography, transthoracic, real	XXX	1.46	3	20	5	28	Oct-08	Mar-02	3	67	4	417092	14120	3.39%

CPT	Long Descriptor	Global	Work RVU	Work Pre	Work Intra	Work Post	Total Phy Work Time	RUC Review	PE Review	PE Pre	PE Intra	PE Post	Volume	Volume billed alone	% billed alone
95860	Needle electromyography; 1 extremity	XXX	0.96	0	34	0	34	Harvard	Apr-99	0	30	0	260399	3680	1.41%
95861	Needle electromyography; 2 extremiti	XXX	1.54	15	25	10	50	Aug-05	Feb-00	8	24	8	346994	3920	1.13%
95863	Needle electromyography; 3 extremiti	XXX	1.87	0	57	0	57	No	Feb-00	8	34	8	13774	220	1.60%
95864	Needle electromyography; 4 extremiti	XXX	1.99	0	68	0	68	No	Feb-00	8	44	8	16748	300	1.79%
95904	Nerve conduction, amplitude and late	XXX	0.34	4	5	3	12	Aug-05	Apr-99	0	24	0	3367586	86880	0.33%

CPT	Long Descriptor	Global	Work RVU	Work Pre	Work Intra	Work Post	Total Phy Work Time	RUC Review	PE Review	PE Pre Facility	PE Intra Facility	PE Post Facility	Volume	Volume billed alone	% billed alone
33207	Insertion or replacement of permaner	090	8.05	47.5	60	131	238.5	Apr-07	090 std	60	12	36	26540	3840	14%
33208	Insertion or replacement of permaner	090	8.77	45	60	131	236	Aug-05	090 std	60	12	36	120095	14300	12%
33212	Insertion or replacement of pacemake	090	5.52	60	60	67	187	May-94	090 std	60	6	16	13524	1560	12%
33213	Insertion or replacement of pacemake	090	6.37	60	75	67	202	May-94	090 std	60	6	16	48557	3860	8%
33240	Insertion of single or dual chamber pa	090	7.64	38	68	69	175	May-94	090 std	60	12	27	28373	440	2%
33249	Insertion or repositioning of electrode	090	15.17	60	120	69	249	May-99	090 std	60	12	108	62729	1100	2%
33233	Removal of permanent pacemaker pu	090	3.39	45	53	62	160	May-94	090 std	60	6	54	64978	920	1%
33241	Subcutaneous removal of single or du	090	3.29	45	60	76	181	May-94	090 std	60	12	27	33544	180	1%
71090-26	Insertion pacemaker, fluoroscopy and	XXX	0.54				12	No	Mar-04	0	0	0	231034	3400	1%
93641-26	Electrophysiologic evaluation of singl	000	5.92	75	120	60	255	Aug-95	Jan-03	0	0	0	77843	1660	2%

Visits	Office	Hospital	Discharge
33207	99213-1	232-1	238-1
33208	99213-1	232-1	238-1
33212	99211-1		
33213	99211-1		
33240	99212-1		
33249	99213-3		
33233	99212-2		
33241	99212-1		

CPT	Long Descriptor	Global	Work RVU	Work Pre	Work Intra	Work Post	Total Phy Work Time	RUC Review	PE Review	PE Pre	PE Intra	PE Post	Volume	Volume billed alone	% billed alone
29824	Arthroscopy, shoulder, surgical; distal	090	8.98	48	60	20	225	Feb-01	090 standar	60	6	126	29510	140	0.47%
29826	Arthroscopy, shoulder, surgical; deco	090	9.16	49	95	23	242	Sep-10	Apr-01	60	6	95	70905	5320	7.50%
29827	Arthroscopy, shoulder, surgical; with r	090	15.59	75	120	40	334	Apr-02	090 standar	60	6	135	39105	1980	5.06%
29828	Arthroscopy, shoulder, surgical; bicep	090	13.16	70	75	20	262	Apr-07	Apr-07	60	6	126	4376	120	2.74%

Visits	Office	Hospital	Discharge
29824	99212-2, 99213-2		238-0.5
29826	99212-3.5		238-0.5
29827	99212-5		238-0.5
29828	99212-2, 99213-2		238-0.5

CPT	Long Descriptor	Global	Work RVU	Work Pre	Work Intra	Work Post	Total Phy Work Time	RUC Review	PE Review	PE Pre	PE Intra	PE Post	Volume	Volume billed alone	% billed alone
72191	Computed tomographic angiography,	XXX	1.81	9	30	10	49	Feb-01	Feb-01	5	112	5	105805	1300	1%
74175	Computed tomographic angiography,	XXX	1.90	10	30	10	50	Feb-01	Feb-01	5	112	5	172886	39040	23%

CPT	Long Descriptor	Global	Work RVU	Work Pre	Work Intra	Work Post	Total Phy Work Time	RUC Review	PE Review	PE Pre	PE Intra	PE Post	Volume	Volume billed alone	% billed alone
22630	Arthrodesis, posterior interbody techn	090	22.09	85	180	236	501	Apr-95	Mar-02	60	12	144	24667	20	0.08%
22612	Arthrodesis, posterior or posterolatera	090	23.53	95	150	237	482	Sep-05	Mar-02	75	12	108	56075	120	0.21%

Visits	Office	Hospital	Discharge
22630	99213-4		
22612	99213-3	231-1, 232-2	238-1

CPT	Long Descriptor	Global	Work RVU	Work Pre	Work Intra	Work Post	Total Phy Work Time	RUC Review	PE Review	PE Pre	PE Intra	PE Post	Volume	Volume billed alone	% billed alone
96413	Chemotherapy administration, intrave	XXX	0.28	4	7	2	13	Oct-04	Oct-04	6	86	6	2366889	149000	6.30%
96416	Chemotherapy administration, intrave	XXX	0.21	4	4	2	10	Oct-04	Oct-04	6	96	6	118219	8400	7.11%

CPT	Long Descriptor	Global	Work RVU	Work Pre	Work Intra	Work Post	Total Phy Work Time	RUC Review	PE Review	PE Pre	PE Intra	PE Post	Volume	Volume billed alone	% billed alone
75671	Angiography, carotid, cerebral, bilater	XXX	1.66				31	No	Jan-04	6	147	0	38387	240	0.63%
75680	Angiography, carotid, cervical, bilatera	XXX	1.66				31	No	Jan-04	6	110	0	42681	100	0.23%
75722	Angiography, renal, unilateral, selecti	XXX	1.14				22	No	Jan-04	6	86	0	11678	220	1.88%
75724	Angiography, renal, bilateral, selective	XXX	1.49				28	No	Jan-04	6	126	0	46754	320	0.68%
36216	Selective catheter placement, arterial	XXX	5.27		72		72	Sep-10	Jan-04	9	45	3	67466	100	0.15%
75650	Angiography, cervicocerebral, cathete	XXX	1.49				28	No	Jan-04	6	53	0	38269	140	0.37%
36215	Selective catheter placement, arterial	XXX	4.67		61		61	Sep-10	Jan-04	9	45	3	80329	300	0.37%
36245	Selective catheter placement, arterial	XXX	4.67		73		73	Sep-10	Jan-04	0	84	0	165800	1100	0.66%

CPT	Long Descriptor	Global	Work RVU	Work Pre	Work Intra	Work Post	Total Phy Work Time	RUC Review	PE Review	PE Pre	PE Intra	PE Post	Volume	Volume billed alone	% billed alone
93620-26	Comprehensive electrophysiologic ev	000	11.57	60	120	60	240	Yes	Jan-03	27	0	0	51604	5260	10.19%
93651	Intracardiac catheter ablation of arrhy	000	16.23	120	285	60	465	Jun-93	Jan-03	0	0	0	31185	440	1.41%
93652	Intracardiac catheter ablation of arrhy	000	17.65	63	300	60	480	Feb-10	Jan-03	0	0	0	2522	40	1.59%

CPT	Long Descriptor	Global	Work RVU	Work Pre	Work Intra	Work Post	Total Phy Work Time	RUC Review	PE Review	PE Pre	PE Intra	PE Post	Volume	Volume billed alone	% billed alone
93875	Noninvasive physiologic studies of ex	XXX	0.22				11	No	Jan-02	1	30	6	104894	5720	5.45%
93880	Duplex scan of extracranial arteries; c	XXX	0.60				18	No	Jan-02	3	71	8	3006981	1798140	59.80%
93886	Transcranial Doppler study of the intr	XXX	0.94				25	No	Jan-02	3	81	8	72712	16760	23.05%
93888	Transcranial Doppler study of the intr	XXX	0.62				19	No	Jan-02	3	53	8	16860	2880	17.08%
93931	Duplex scan of upper extremity arteri	XXX	0.31				13	No	Jan-02	3	50	8	39524	11040	27.93%

CPT	Long Descriptor	Global	Work RVU	Work Pre	Work Intra	Work Post	Total Phy Work Time	RUC Review	PE Review	PE Pre	PE Intra	PE Post	Volume	Volume billed alone	% billed alone
95921	Testing of autonomic nervous system	XXX	0.90	10	15	10	35	Apr-96	Feb-01	10	49	5	62583	940	1.50%
95922	Testing of autonomic nervous system	XXX	0.96	10	25	10	45	Apr-96	Feb-01	10	77	5	50402	40	0.08%
95925	Short-latency somatosensory evoked	XXX	0.54	6.5	15	10	31.5	Aug-05	Apr-00	14	92	3	42572	1040	2.44%
95926	Short-latency somatosensory evoked	XXX	0.54	6.5	15	10	31.5	Aug-05	Apr-00	14	92	3	49775	1540	3.09%
95928	Central motor evoked potential study	XXX	1.50	15	60	15	90	Feb-04	Feb-04	14	105	0	8638		
95929	Central motor evoked potential study	XXX	1.50	15	55	15	85	Feb-04	Feb-04	14	115	0	8941		

CPT	Long Descriptor	Global	Work RVU	Work Pre	Work Intra	Work Post	Total Phy Work Time	RUC Review	PE Review	PE Pre	PE Intra	PE Post	Volume	Volume billed alone	% billed alone
76950	Ultrasonic guidance for placement of	XXX	0.58				18	No	Mar-04	0	33	0	148518	31011	20.88%
77418	Intensity modulated treatment deliver	XXX	0.00					Apr-01	Apr-01	0	60	5	1188906	256120	21.54%

CPT	Long Descriptor	Global	Work RVU	Work Pre	Work Intra	Work Post	Total Phy Work Time	RUC Review	PE Review	PE Pre	PE Intra	PE Post	Volume	Volume billed alone	% billed alone
37205	Transcatheter placement of an intrava	000	8.27	65	98	35	198	Apr-04	Apr-07	0	98	0	109648	240	0.22%
75960	Transcatheter introduction of intravas	XXX	0.82				17	Apr-04	Apr-07	0	31	0	136293	380	0.28%

CPT	Long Descriptor	Global	Work RVU	Work Pre	Work Intra	Work Post	Total Phy Work Time	RUC Review	PE Review	PE Pre	PE Intra	PE Post	Volume	Volume billed alone	% billed alone
37620	Interruption, partial or complete, of inf	090	11.57	61	69	250	380	No	090 std	60	12	68	65022	1940	3%
36010	Introduction of catheter, superior or in	XXX	2.43	0	26	0	26	No	Jan-04	0	37	0	78381	1480	2%
75940-26	Percutaneous placement of IVC filter,	XXX	0.54				12	No	Jan-04	0	0	0	60504	1300	2%

Visits	Office	Hospital	Discharge
37620	99212-2.5	231-7.5	238-1

CPT	Long Descriptor	Global	Work RVU	Work Pre	Work Intra	Work Post	Total Phy Work Time	RUC Review	PE Review	PE Pre	PE Intra	PE Post	Volume	Volume billed alone	% billed alone
37201	Transcatheter therapy, infusion for thr	000	4.99	65	81	35	181	Aug-95	Mar-01	45	0	0	12480	320	2.56%
37203	Transcatheter retrieval, percutaneous	000	5.02	0	80	61	141	Yes	Jan-04	0	97	0	3324	80	2.41%
37204	Transcatheter occlusion or embolizati	000	18.11	95	240	35	370	Yes	Mar-01	0	0	0	23054	20	0.09%
75896-26	Transcatheter therapy, infusion, any r	XXX	1.31				25	No	Jan-04	0	0	0	19043	180	0.95%
75961-26	Transcatheter retrieval, percutaneous	XXX	4.24				76	No	Jan-04	6	89	0	3172	60	1.89%
75894-26	Transcatheter therapy, embolization,	XXX	1.31				25	No	Jan-04	0	0	0	25234	80	0.32%

CPT	Long Descriptor	Global	Work RVU	Work Pre	Work Intra	Work Post	Total Phy Work Time	RUC Review	PE Review	PE Pre	PE Intra	PE Post	Volume	Volume billed alone	% billed alone
62368	Electronic analysis of programmable,	XXX	0.75		30		30	Apr-95	Mar-03	3	33	3	180026	31380	17.43%
95990	Refilling and maintenance of implanta	XXX	1.51	10	20	10	40	Feb-03	Feb-03	15	32	0	57556	1740	3.02%
95991	Refilling and maintenance of implanta	XXX	0.77	10	20	7	37	Feb-03	Feb-03	0	3	0	81679	6020	7.37%

AMA/Specialty Society RVS Update Committee **Tab 46**
Research Subcommittee
Thursday, April 29, 2010

Members Present
Members: Brenda Lewis, DO (Chair), Greg Przybylski, MD (Vice Chair), Bibb Allen, MD, John Gage, MD, Charles Koopmann, Jr, MD, Douglas Leahy, MD, Marc Raphaelson, MD, Sherry Barron-Seabrook, MD, Daniel Mark Siegel, MD, Lloyd Smith, DPM, Peter Smith, MD

I. 2010 Five Year Review: Review of Alternative Methodologies

No alternative methodologies for the 2010 Five-Year Review were submitted to the Research Subcommittee for review.

II. Establishment of Vignette and Reference Service List Review Process

It was suggested by a Research Subcommittee member to formalize a process for reviewing vignettes and reference service lists proposed by the specialty societies. **The Research Subcommittee recommends the following language be added to the instruction document to describe this new process:**

> If a specialty society would like to have the Research Subcommittee review proposed vignettes and reference service lists for the new and revised process or CMS requests, they must adhere to the following process. It should be noted that this process is not a requirement by the RUC. Specialties societies will submit the proposed reference service list which should adhere to the reference service list guidelines and provide the following data points for each service on the reference service list so that the Research Subcommittee can critically review the list:
>
> 1.) The year it was valued
> 2.) Whether the time is based on RUC, Harvard or other
> 3.) The MPC status
> 4.) The Medicare Volume including specialty distribution
> 5.) The intra-service time
> 6.) The total service time
> 7.) The IWPUT calculation
>
> Further, for a vignette review, the specialty society will submit the proposed vignette which should reflect the typical patient and provide the existing vignette, either approved by the CPT Editorial Panel or the vignette listed in the RUC Database.
>
> These submissions must be made by ____, 2010 (two days after the survey packet is released) to Roseanne.Fischoff@ama-assn.org. These submissions will be forwarded to the Research Subcommittee

members for review with discussion during a conference call the week of ____, 2010. (the week after the survey packet is released) These comments will be shared with the specialty societies on ____, 2010. (the day after the conference call)

For the 2010 Five-Year Review Process, the same process applies:

These submissions must be made by May 20, 2010 to Roseanne.Fischoff@ama-assn.org . These submissions will be forwarded to the Research Subcommittee members for review with discussion during a conference call on May 26, 2010. These comments will be shared with the specialty societies on May 27, 2010.New and Revised CPT Code Timeline

III. RUC Five-Year Review Survey Instrument, Summary of Recommendation Form and Instruction Document for Specialties Developing Work Value Recommendations

For the 2010 Five-Year Review, modified survey instruments, summary of recommendation forms and Instructions for Specialties Developing Work Value Recommendations must be utilized. AMA Staff developed proposed Five-Year Review Survey Instruments, Summary of Recommendation Forms and Instructions for Specialties Developing Work Value Recommendations which have been modified by the Research Subcommittee. **The Research Subcommittee recommends the following modifications to the Five-Year Review Survey Instruments:**

Background for Question 6

The RUC is also interested in determining whether the physician work for the service has changed over the previous five years. Please complete the following questions by circling your response.

Question 6

Has the work of performing this service changed in the past 5 years?

Yes No

If Yes, please circle your response to questions a-c:

a. **Does this service represent new technology?**
Yes No

If yes, how has this new technology affected the work of this service?

Less Work Same Work More Work

b. **This service represents new technology that has become more familiar (i.e., less work).**

I agree I do not agree

c. **Patients requiring this service are now:**

more complex less complex no change

d. **The usual site-of-service has changed:**

from outpatient to inpatient from inpatient to outpatient no change

All other minor changes to the existing survey instruments made by the Research Subcommittee are highlighted in the individual survey instrument documents as reflected in the RUC Agenda Book. **The Research Subcommittee recommends the following modifications to the Five-Year Review Summary of Recommendation forms:**

1.) The frequency information has been deleted, as these are existing codes and the frequency information is established

2.) Addition of a text box for the specialty societies to describe their compelling evidence

3.) Responses fields from Question 6 as stated above have been added to the form as well

4.) Removal of New Technology Box and Modifier -51 Exempt Box as this information has already been established for these services

The Research Subcommittee had considerable discussion about the following request made by CMS:

> For purposes of the fourth Five-Year Review of work RVUs and in order to gain a better understanding of the distribution of data from surveys and other data sources submitted in support of work RVU refinements, we will require that the minimum/maximum values, the 5th, 25th, 50th (median), 75th, and 95th percentiles be reported. In addition, we will require reporting of the geometric mean. This is similar to information currently reported for the specialty surveys, with some additional percentiles and the geometric mean being included. However if the AMA RUC recommendation does not include the information discussed above we may reject the recommendation.

The Research Subcommittee questioned CMS representatives why they were requesting these additional statistical data points. CMS representatives stated that they made this request to get a better understanding of the distribution of the survey data provided by specialties and to have another point of central tendency. **The Research Subcommittee recommends that the 5th percentile, 95th percentile and the geometric mean be included on the Summary of recommendation forms and also would like to provide to CMS other central tendency points including: arithmatic mean and mode (including bimodal distribution, if applicable).** While there is a need for transparency about the survey data collected by specialty societies, the Research Subcommittee is concerned about how these additional data points will be used by CMS. **Therefore, the**

Research Subcommittee recommends that the RUC send a letter to CMS requesting them to articulate the relevant use of this additional data.

The Research Subcommittee reviewed and recommends that the proposed modifications be made to the instruction document as highlighted in the RUC Agenda Book. In addition to these modifications, the Research Subcommittee made the following recommendations including:

1.) Under Step 2: The following language should be deleted as it is not accurate.

> A survey must be conducted for all work relative values recommendations presented to the RUC. ~~You must contact the physicians to be surveyed prior to sending the questionnaire and determine that they have agreed to complete it.~~

2.) Under Alternative Ways to Develop Work Relative Value Recommendations Section: Applying Payment Rules, the example of CPT code 61531 *Subdural implantation of strip electrodes through 1 or more burr or trephine hole(s) for long-term seizure monitoring* needs to be replaced as the value and rationale for this code has changed as of the 2005 Five-Year Review.

IV. Re-Review of Site of Service Anomalies

In the 2010 Five-Year Review List, forwarded by CMS to the RUC, CMS included several codes that have already been reviewed by the RUC as identified through the Five-Year Review Identification Workgroup's Site of Service Anomaly Screen. The RUC recommendations for some of these identified services maintained hospital visits in the post-service time period. The RUC agreed that patients typically remain in the hospital for 23+ hours and included subsequent hospital visits, acknowledging that the Medicare claims data indicate that these services are typically reported as hospital outpatient. CMS has asked for further review of these services.

At the June 2009 CPT Editorial Panel Meeting, three codes were approved to describe subsequent observation care. Per the RUC Process, the RUC recommendations for these codes will be submitted to the Centers for Medicare and Medicaid Services (CMS) in May 2010. These codes will be published in the 2011 Final Rule for use beginning January 1, 2011. These codes are of importance to the RUC process because they address the 23+ hour stay policy issue that the RUC has been discussing. The current RUC policy for a 23+ hour stay code is:

> *If a procedure or service is typically performed in the hospital and the patient is kept overnight and/or admitted, the RUC should evaluate it as an inpatient service or procedure using the hospital visits as a work proxy regardless of any status change made by the hospital.*

However, the introduction of these codes into the Fee Schedule in 2011 will allow for a more accurate measure of work for these 23+ Hour Stay Services assuming they are recognized by CMS.

In light of this information, the Research Subcommittee recommends that the re-review of these services should be referred to the February 2011RUC meeting, so the RUC can review after CMS policy is in place and implemented.

V. Review of Extant Data RUC Policy

At the February 2010 RUC Meeting, a RUC member discussed the need for the RUC to beginning looking for an external validation of time data. Doctor Levy referred this issue to the Research Subcommittee for consideration. The RUC, through the Extant Data Workgroup, reviewed how extant data should be used in the RUC process, due to a query posed by CMS in the *Proposed Rule* published in June 21, 2006. The Workgroup developed an Inclusionary and Exclusionary Criteria List for Extant Database Use which was reviewed by all specialty societies and approved by the RUC in February 2008. This approved list is on pages 2761-2 of the RUC agenda book.

Further the Workgroup discussed how extant data would be optimally incorporated into the RUC process. The Workgroup recommended and the RUC approved that: 1.)Extant data could be incorporated into the RUC process as supplementary data to the RUC survey in the new and revised process when that extant database meets all approved Inclusionary/Exclusionary Criteria for Extant Database Use and 2.) Extant data could be incorporated into the RUC process as primary data in various collected components within the Five Year Review Process when that extant database meets all approved Inclusionary/Exclusionary Criteria for Extant Database Use, as in the approved alternative methodologies used in previous Five Year Reviews.

This historical background demonstrates that the RUC does have a mechanism to use extant data in its new and revised process to validate time data presented to the RUC. **Further, in order to be proactive, the Research Subcommittee recommends that at the February 2011 RUC Meeting, the results of a solicitation to the specialty societies to identify any additional extant databases be presented and that the NSQIP and STS Databases be evaluated to determine if they meet the RUC's extant data criteria which is listed below:**

- Databases must have data integrity/reliability
    - Must collect data prospectively,
    - Should have the ability to identify and assess outliers – multiple procedures resulting in greater LOS; diseases with high mortality rate (LOS=0) or extended recovery (LOS>90); age variance (bi-modal)
    - Should have the ability to have transparency of data to compare to other databases including the RUC database
    - Should have the ability to audit the database
    - Should have the ability to track the data/changes over time

- Should have the ability to collect data on all cases done by participants or for large volume procedures or E/M encounters, should have sampling criteria that are statistically valid to eliminate sampling bias
- Should have current data, preferably from the last three to five years, although older sets can be used for comparison purposes

- Databases should collect time data for the procedures, at a minimum the skin-to-skin or intra-service time and length of stay. Additional time elements may include ICU LOS, and other specialty specific time factors (i.e. phone calls, ventilator hours)

- Must have the ability to unequivocally map the procedure to a CPT code and isolate the procedure from associated physician work that is otherwise billable in the same setting

- Databases must list their limitations – include what is provided and not provided with respect to the RUC database

- Databases must be representative
  - The data should be geographically representative eg, regionally and nationally for the specialty,
  - The data should have various levels of patient severity
  - The data should have adequate practice site representation and sample size – practice sites and rural and urban representation
  - The data should be from various practice types – representative of the academic, non-academic and other types of practices for the specialty
  - The data should be collected from the majority specialties (including subspecialties) that perform the procedure or encounter
  - The data should be collected from either hospital/institution or individual physician.

VI. Specialty Society Requests

Destruction of Malignant Lesion (17261, 17262, 17271, 17272, 17281 & 17282)
American Academy of Dermatology

The specialty society recommended an alternative methodology to value these services which involved the use of anchor codes After reviewing their methodology, the Research Subcommittee agrees that it is not appropriate due to 1.) the anchor codes would not be surveyed at the same time these recommendations would be made, 2.) the anchor codes have not been reviewed in the last five years or were reviewed in Feb 10 and have not been validated by CMS and 3.) the large utilization of the services being surveyed. **The Research Subcommittee recommends a full RUC survey be conducted for the destruction of malignant lesion services.**

Arthrocentesis (20600, 20605 & 20610)
American Academy of Orthopaedic Surgeons
American College of Rheumatology
American Podiatric Medical Association
American Society for Surgery of the Hand

The specialty societies have recommended that they conduct a full RUC survey for the arthrocentesis services. **The Research Subcommittee agrees with the specialty society recommendation of conducting a full RUC survey for the arthrocentesis services.**

Osteopathic Manipulative Treatment (98925-98929)
American Osteopathic Association

The specialty society recommends utilizing data from a survey that was conducted in July 2002 for the purposes of establishing physician intra-service times to develop clinical labor time recommendations. The specialty explained that they would use the intra-service times from these surveys and use an expert panel to develop pre-service time and post-service times. The specialty maintained that the current work RVUs are still valid. After reviewing the proposed methodology, the Research Subcommittee agrees that the data from the survey is outdated and potentially not reflective of the service. **The Research Subcommittee recommends a full RUC survey be conducted for the osteopathic manipulative treatment services.**

Cytopathology (88104, 88106 & 88108) and Pathology Consultation During Surgery (88329-88332)
College of American Pathologists

The specialty society provided proposed vignettes and proposed reference service lists for the cytopathology and pathology consultation during surgery codes to the Research Subcommittee for review which are scheduled to be presented at the October 2010 RUC Meeting. The Research Subcommittee reviewed the recommendations for the cytopathology services and agreed with the specialty society that there be no pre-service time description and no post-service time description, as these activities will be included in the intra-service description. This recommendation is consistent with recent pathology services that have been reviewed by the RUC, where the time allocated for these services have been incorporated into the intra-service time.

The Research Subcommittee reviewed the proposed description of service for the cytopathology services and agreed that they were reflective of these services. **The Research Subcommittee recommends the description of service for 88104-88108 as stated on page 2781 of the RUC Agenda Book. The Research Subcommittee reviewed and modified the vignettes proposed for CPT codes 88104, 88106 and 88108 and recommends the following:**

88104 Bronchoscopic brushings are obtained from a left main stem bronchus mass in a 60 year old male with hemoptysis and cytologic exam is performed

88106 Bladder washings are obtained during cystoscopic examination in a 70 year old male with hematuria and cytologic exam is performed

88108 A voided urine specimen is obtained from a 72 year old male smoker who has the history of urothelial carcinoma of the bladder and cytologic exam is performed

The Research Subcommittee reviewed the proposed vignettes for the pathology consultation during surgery codes and agreed that they were reflective of the typical patients. **The Research Subcommittee recommends the vignettes for 88329-88332 as stated on page 2782 of the RUC Agenda Book.** The Research Subcommittee reviewed and agreed that the description of service for 88329 was reflective of the service being performed. **The Research Subcommittee recommends the description of service for 88329 as stated on page 2782. The Research Subcommittee reviewed and modified the description of service for 88331 and 88332 and recommends the following**

The intra-service work may include (among other activities):
-Performing or directly supervising the specimen preparation
-Gross and microscopic examination is performed
-Discussing the pathologic findings with surgeon
-Documenting pathologic findings
-Performing or directly supervising the disposition of the specimen

Psychiatric Diagnostic and Therapeutic Procedures (90801-90862 & 90870-90880)
American Psychiatric Association
American Psychological Association

The specialty societies have provided proposed vignettes and proposed reference service lists for the psychiatric diagnostic and therapeutic procedures to the Research Subcommittee for review. After review, the Research Subcommittee provided the following guidance to the specialty societies: 1.) the vignettes should not list patient multiple co-morbities unless absolutely typical, 2.) where appropriate, the reference services list should be combined, particularly in instances where there may be only one or two codes differences within the lists.

VII. Other Issues

IWPUT Research – Informational Item Only
American Academy of Ophthalmology

Discussion of this issue was referred to the full RUC, per the request of the RUC Chair.

AMA/Specialty Society RVS Update Committee **Tab 47**
Administrative Subcommittee
April 29, 2010

Members: *Doctors Dale Blasier (Chair), David Hitzeman (Vice Chair), Michael Bishop,Jeffery Edelstein, Emily Hill, PA-C, Robert Kossmann, Walt Larimore, Larry Martinelli, Sandra Reed, Arthur Traugott, and James Waldorf*

I. RUC Confidentiality

At February 2010 RUC meeting, individual RUC members requested that the RUC strengthen its confidentiality provisions to ensure that consultants who attend the RUC meetings are not sharing information with clients inappropriately.

The AMA's Office of General Counsel proposed revisions to the RUC's Confidentiality Agreement. **The Administrative Subcommittee recommends the attached revised Confidentiality agreement which will be signed by each meeting attendee.**

The Administrative Subcommittee recommends when consultants are present and speaking at a meeting, the RUC Chair require consultants to identify themselves, indicate which specialty society(ies) or health care professional organization(s) they represent and their relationship/role to the specialty society(ies) or health care professional organization(s). The confidentiality agreement itself provides the clear instruction that information obtained during the meeting may not be shared with other clients.

II. Financial Disclosure Clarification: Stock Options

AMA Staff received a question about the section in the RUC's financial disclosure section related to stock options, the current language refers to exercising stock options "now or in the future." The question raised was, "how do I know today if five years from now I may not be provided stock options that I exercise six years from now?"

AMA Staff questioned AMA Legal Counsel if it is appropriate to modify the bullet to read "own stock options in an organization", as the fundamental issue in question is that they have obtained stock options that they may exercise if the new device looks promising.

AMA Legal Counsel reviewed and responded "Sometimes you have stock options, but can not exercise them until a future date. It is "the ownership of stock options" that is key. Although the current language is fine, because it reflects the current ownership of options, regardless of when they can be exercised, it would be equally fine to change the language to simply say "ownership of stock options in an organization."

The Administrative Subcommittee recommends revising the RUC Survey Instrument Financial Disclosure section to the following:

> Do you or a family member* have a direct financial interest in this procedure, other than providing these services in the course of patient care? For purposes of this Survey "direct financial interest" means:
>
> · A financial ownership interest in an organization** of 5% or more: Yes / No

- A financial ownership interest in an organization** which contributes materially*** to your income: Yes / No

- ~~**Ability to exercise**~~ **Ownership of** stock options in an organization** ~~**now or in the future**~~: Yes/No

- A position as proprietor, director, managing partner, or key employee in an organization**: Yes / No

- Serve as a consultant, researcher, expert witness (excluding professional liability testimony), speaker or writer for an organization**, where payment contributes materially*** to your income: Yes/No

*Family member means spouse, domestic partner, parent, child, brother or sister. Disclosure of family member's interest applies to the extent known by the survey respondent.

** Organization means any entity that makes or distributes the product that is utilized in performing the service, and not the physician group or facility in which you work or perform the service.

***Materially means $10,000 or more in income (excluding any reimbursement for expenses) for the past twenty-four months.

If you have answered yes to any of the above questions, do not complete this survey.

III. Financial Disclosure Consistency: RUC Survey and Disclosure Statement

At the February 2010 RUC meeting, a member asked if the changes made most recently to the RUC Survey disclosure section should also be made to the RUC Conflict of Interest Policy and Advisory Committee Member Financial Disclosure to ensure consistency. **The Administrative Subcommittee recommends that current RUC Conflict of Interest Policy and Advisor Financial Disclosure be revised to be the same as the indicated in the survey instrument.**

AMA/SPECIALTY SOCIETY RVS COMMITTEE PROCESS CONFIDENTIALITY AGREEMENT

In consideration of permission granted to me to participate at the meetings of the AMA/Specialty Society RVS Update Committee (RUC), the Health Care Professionals Advisory Committee (HCPAC) Review Board, and/or subcommittees/workgroups established by the RUC (collectively, "Committee" and "Committees"), I agree:

1. I will maintain as confidential any and all materials and information I obtain in connection with my participation in the Committees and the RUC process (Process) including but not limited to the following which shall collectively be considered "Confidential Information" and proprietary to the American Medical Association:

- CPT® code change applications;
- pre-publication *Current Procedural Terminology (CPT®)* temporary codes and modifiers, text descriptors, cross references, guideline language;
- any information disclosed or discussed as part of the business or deliberations of the Committees; and
- the names of all individuals including Committee members, private practice physicians, consultants, attorneys, individuals representing companies, payers and others, and their respective associations or corporate affiliations who participate in Committee proceedings and discussions [including but not limited to those regarding the development of recommendations of relative values and resource costs to the Centers for Medicare and Medicaid Services (CMS)].

The foregoing information shall be considered Confidential Information no matter what format it is provided to or obtained by me including but not limited to verbally, electronically or in print media.

2. I will use Confidential Information only in connection with my participation on the Committees and in connection providing assistance to Advisors in developing relative value recommendations to the Centers for Medicare and Medicaid Services. I will not disclose, distribute or publish Confidential Information to any party in any manner whatsoever outside of the Process, other than to disseminate information to my sponsoring organization for internal use within my organization only for use in connection with providing assistance to Advisors in developing relative value recommendations to the Centers for Medicare and Medicaid Services. I specifically acknowledge that I will not publish or authorize anyone else to publish Confidential Information in any Web posting, article, newsletter, press report and release, publication, or any other communication.

3. I will not use any audio or video recording or photographic device in any manner during Committee meetings to record or to copy any Confidential Information. I will not remove any notices of copyright, confidentiality or other conditions on materials disclosed or distributed in connection with the Process or take any other action to circumvent the purpose and intent of this Agreement.

4. The CPT Editorial Panel can modify or eliminate a code or the language or guidelines associated with a code at any time up to the date of publication of the CPT book. CPT Editorial Panel actions are not final until publication of the CPT book. I acknowledge that the early release of CPT Editorial Panel actions and any related information can cause significant problems for physicians, patients, payers and third parties and could cause irreparable injury to the American Medical Association and others.

5. I acknowledge CPT® five-digit codes, descriptions, and other data only are copyright 2009 by the American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values or related listings are included in CPT coding.

6. The AMA, specialty societies or HCPAC organizations may disseminate information and data developed during the Process with the prior written approval by the majority of the RUC. The RUC will consider such requests only after the publication by CMS of interim or final relative values for CPT codes considered under the Process. Any other disclosure or distribution of such materials is strictly prohibited.

7. Violators of this Agreement may be barred from attendance and participation on the Committees.

I represent that I have authority to execute this Agreement on behalf of myself and any organization I represent.

Agreed

Print Name: _____

Affiliation (Organization) _____

Signature _____ Date _____

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Members: *Lloyd Smith, DPM (Co-Chair), Emily Hill, PA-C (Alt. Co-Chair), Eileen Carlson, Charles Fitzgerald, OD, Dee Nikjeh,, Mary Foto, OTR, James Georgoulakis, PhD, Anthony Hamm, DC, Stephen Levine, PT, DPT, MSHA, William Mangold, MD, Doris Tomer, LCSW, Jane White, PhD, RD, FADA, Marc Raphaelson, MD*

I. CMS Update

Edith Hambrick, MD, provided a CMS update and informed the HCPAC that Donald Berwick, MD has been nominated to be the Administrator for CMS, a confirmation hearing will be held at the Senate this summer. Doctor Hambrick also indicated that CMS staff is currently working on the NPRM to be released summer 2010.

II. CMS Request: Relative Value Recommendations for *CPT 2011*:

Incision and Drainage of Abscess* (10060 & 10061)

Code 10061 was identified through the Harvard Valued – Utilization Over 100,000 *Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple* was identified through the Harvard Valued – Utilization Over 100,000. The American Podiatric Medical Association (APMA) informed the HCPAC that they wish to extract code 10061 to resurvey and allow other specialties, such as General Surgery that perform this service, conduct surveys as well. APMA indicated that they will revise the vignette and resurvey with other specialties that perform this service. The HCPAC supports this proposal and added that 10060 be surveyed at the same time.

Strapping Lower Extremity (29540, 29550 & 29590)

29540

These services were identified through the Harvard Valued – Utilization Over 100,000 screen. HCPAC reviewed code 29540 *Strapping; ankle and/or foot* and compared it to key reference service 29580 *Strapping; Unna boot* (work RVU 0.55) and determined that 29540 was approximately 30% less intense and complex than 29580, resulting in a work RVU of 0.39. The HCPAC also compared 29540 to 97116 *Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)* (work RVU = 0.40, 15 minutes total time) which requires similar intensity and complexity and time to perform. **The HCPAC recommends a work RVU of 0.39 for code 29540.**

29550

The HCPAC reviewed 29550 and compared it 97762 *Checkout for orthotic/prosthetic use, established patient, each 15 minutes* (work RVU = 0.25) which requires the same intensity and complexity to perform as 29550. The HCPAC recommends croswalking the work RVU for 29550 to reference code 97762. **The HCPAC recommends a work RVU of 0.25 for 29550.**

29590

The APMA indicated that 29590 Denis-Browne splint strapping technique is no longer used. Additionally, the survey response had a zero median performance rate for this service. **APMA requested and the HCPAC agrees that code 29590 be referred to the CPT Editorial Panel for deletion.**

Speech-Language Pathology Services – Practice Expense Review Only

The HCPAC reviewed the speech language pathology services 92507, 92508, 92606, 92607, 92608 & 92609 at the February 2010 meeting as part of the transition of work from practice expense. At that time, the HCPAC met prior to the PE Subcommittee review of these services. **The American Speech-Language-Hearing Association recommended and the HCPAC agreed to remove the clinical labor inputs as this is now captured in the work and maintaining the supplies and equipment.** ASHA indicated that they will petition CMS to update the supplies and equipment for these services at a later date to reflect the change in technology.

Debridement – Practice Expense Review Only (97597 & 97598)
At the February 2010 meeting the HCPAC met prior to the PE Subcommittee review of these services. The PE Subcommittee reviewed and modified the practice expense inputs. **The HCPAC approves the modified practice expense input for codes 97597 and 97598.**

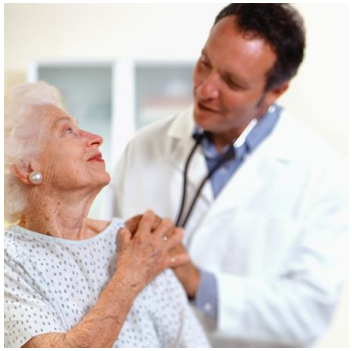
		April 2010 RUC Meeting Physician Time												
CPT Code	Pre Evaluation Time	Pre Positioning Time	Dress scrub and wait Time	Intraservice Time	Immediate post service time	99212	99213	99215	99231	99232	99233	99238	99291	Total Time
11043	33	3	5	30	15									86
11044	33	3	15	45	20									116
11046	0	0	0	20	1									21
11047	0	0	0	30	1									31
29914	33	20	10	100	20	2	2					0.5		280
29915	33	20	10	90	20	2	2					0.5		270
29916	33	20	10	90	20	2	2					0.5		270
37220	40	3	5	60	30									138
37221	40	3	5	90	30									168
37222	1	0	0	40	1									42
37223	1	0	0	45	1									47
37224	40	3	5	80	30									158
37225	40	3	5	118	30									196
37226	40	3	5	90	30									168
37227	40	3	5	125	30									203
37228	40	3	5	90	30									168
37229	40	3	5	120	30									198
37230	40	3	5	120	30									198
37231	40	3	5	135	30									213
37232	1	0	0	40	1									42
37233	1	0	0	60	1									62
37234	1	0	0	60	1									62
37235	1	0	0	80	1									82
38900	2	0	0	45										47
43283	0	0	0	40										40
43327	40	3	20	120	30		2		1	1	1	1		412
43328	40	20	20	150	30		2		1	1	2	1		514
43332	40	3	20	150	30		2		1	2	1	1		482
43333	40	3	20	180	30		2		1	2	1	1		512
43334	40	20	20	180	30		2		2	2	1	1		549
43335	40	20	20	200	30		2		2	2	1	1		569
43336	40	20	20	240	30	1	2		2	2	1	1	1	695
43337	40	20	20	260	30	1	2		2	2	1	1	1	715
43338	0	0	0	30										30
49327	0	0	0	30										30
49412	0	0	0	20										20

		April 2010 RUC Meeting Physician Time												
CPT Code	Pre Evaluation Time	Pre Positioning Time	Dress scrub and wait Time	Intraservice Time	Immediate post service time	99212	99213	99215	99231	99232	99233	99238	99291	Total Time
49418	33	6	5	40	20									104
49421	33	3	10	45	20									111
53860	7	0	0	30	15		2							98
64566	5	0	0	5	5									15
66174	10	1	5	60	10	4	2					0.5		215
66175	10	1	5	67.5	10	4	2					0.5		223
66761	7	0	0	10	10	1	1							66
69801	12	1	5	15	10									43
76881	5	0	0	15	5									25
76882	5	0	0	11	5									21
88172	0	0	0	20										20
88177	0	0	0	15										15
91010	15	0	0	20	15									50
91013	0	0	0	14										14
91117	15	0	0	60	30									105
92132	3	0	0	10										13
92133	2	1	0	10										13
92134	7	0	0	10										17
92228	5	0	0	8										13
93224	2	0	0	15	7									24
93227	2	0	0	15	7									24
93272	5	0	0	15	10									30
93451	40	3	5	30	30									108
93452	40	3	5	30	30									108
93453	40	3	5	45	30									123
93454	40	3	5	30	30									108
93455	45	3	5	40	30									123
93456	40	3	5	40	30									118
93457	45	3	5	50	30									133
93458	40	3	5	45	30									123
93459	45	3	5	50	30									133
93460	40	3	5	50	30									128
93461	45	3	5	65	35									153
93462	0	0	0	40										40
93463	0	0	0	30										30
93464	0	0	0	30										30

		April 2010 RUC Meeting Physician Time												
CPT Code	Pre Evaluation Time	Pre Positioning Time	Dress scrub and wait Time	Intraservice Time	Immediate post service time	99212	99213	99215	99231	99232	99233	99238	99291	Total Time
93563	0	0	0	25										25
93564	0	0	0	25										25
93565	0	0	0	20										20
93566	0	0	0	20										20
93567	0	0	0	15										15
93568	0	0	0	20										20
93922	3	0	0	5	2									10
93923	3	0	0	10	3									16
93924	3	0	0	13	4									20
95800	15	0	0	20	15									50
95801	10	0	0	15	15									40
95803	15	0	0	20	15									50
95805	15	0	0	20	15									50
95806	10	0	0	25	15									50
95807	15	0	0	25	15									55
95808	15	0	0	20	15									50
95810	15	0	0	36.5	15									66.5
95811	15	0	0	35	15									65
96446	5	0	0	7	5									17

Summary of Direct Practice Expense Changes
RUC Recommendations for CMS Requests - April 2010 RUC Meeting

Previous Recommendation									Current Recommendation							Change in Practice Expense Components						
CPT Code	Clinical Labor Assist	intra service time	99238	99212	99213	99214	Meeting Month		Clinical Labor Assist	Intra Service Time	99238	99212	99213	99214		Intra Service Change in Clinical labor Time	99238	99212	99213	99214	Change in Post-Op Visits?	Change in Clinical Labor Time from Change in Post-Op Visits
11900	6	9					April 2010		5	8						-1					No	0
11901	11	16					April 2010		9	13						-2					No	0
12001	13	18		1			April 2010		7	10						-6		-1			No	-27
12002	15	22		1			April 2010		12	15						-3		-1			No	-27
12004	26	37		1			April 2010		14	17						-12		-1			No	-27
12005	38	54		1			April 2010		20	25						-18		-1			No	-27
12006	45	64		1			April 2010		24	30						-21		-1			No	-27
12007	55	78		1			April 2010		28	35						-27		-1			No	-27
12011	25	22		1			April 2010		10	12						-15		-1			No	-27
12013	22	32		1			April 2010		12	15						-10		-1			No	-27
12014	32	45		1			April 2010		16	20						-16		-1			No	-27
12015	47	67		1			April 2010		20	25						-27		-1			No	-27
12016	58	83		1			April 2010		24	30						-34		-1			No	-27
15823	45	45		4			April 2010		45	45	0.5	3	1			0	0.5	-1	1	0	Yes	15
30901	18	21					April 2010		9	10						-9					No	0
36410	16	16					April 2010		5	5						-11					No	0
51736	3	10					April 2010		2	5						-1					No	0
51741	3	28					April 2010		1	5						-2					No	0
52281	22	33					April 2010		13	20						-9					No	0
52332	20	32					April 2010		16	25						-4					No	0
73080	8	5					April 2010		5	3						-3					No	0
88300	3	4					April 2010		8	10						5					No	0
88302	3	7					April 2010		5	11						2					No	0
88304	30	11					April 2010		15	15						-15					No	0
88305	30	24					April 2010		25	25						-5					No	0
88307	8	48					April 2010		8	47						0					No	0
90870	23	23					April 2010		20	20						-3					No	0
92081	30	13					April 2010		16	7						-14					No	0
92082	30	15					April 2010		16	8						-14					No	0
92504	8	8					April 2010		5	5						-3					No	0



RUC Chair Report

April 29, 2010

Chicago, IL

AMA

TOGETHER WE ARE STRONGER

CMS Representatives

- Edith Hambrick, MD – CMS Medical Officer
- Ken Simon, MD – CMS Medical Officer
- Ryan Howe
- Ferhat Kassamali

Medicare Payment Advisory Commission (MedPAC)

- Kevin Hayes

AMA Board of Trustees

- Rebecca J. Patchin, MD, Chair of AMA Board of Trustees

Medicare Contractor Medical Directors

- Charles Haley, MD




Joint CPT/RUC Workgroup

- Kenneth Brin, MD




National Health Policy Forum

- March 5 meeting
- Opportunity to provide Congressional staff, MedPAC Commissioners, and other health policy experts an update on RUC's progress
- Jon Blum, CMS Director of Medicare Management, extremely positive about the RUC's contributions and future activities.




IWPUT

- Research Subcommittee – Information Only
- Invitation to provide perspective on IWPUT when discussed by Research Subcommittee in February 2011
- At this time the RUC policy remains in place - IWPUT not to be used as sole basis for recommendation (magnitude estimation, reference services important).




Confidentiality

- All RUC attendees/participants are obligated to adhere to the RUC confidentiality policy. (All signed an agreement at the registration desk)




Procedural Issues

RUC Members:

- Before a presentation, any RUC member with a conflict will state their conflict. That RUC member will not discuss or vote on the issue and it will be reflected in the minutes
- RUC members or alternates sitting at the table may not present or debate for their society

The RUC is an Expert Panel

- Individuals exercise their independent judgment and are not advocates for their specialty

Always keep your RUC hat on

I am famous for my power red. Now we all have red RUC hats as reminders for us to use our collective power and wisdom to be fair, impartial and equitable as we do our work here.

Source: Logo from American Heart Association

"Always do right. This will gratify some people and astonish the rest."

--Mark Twain

- Test Clickers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Washington Update
April 29, 2010

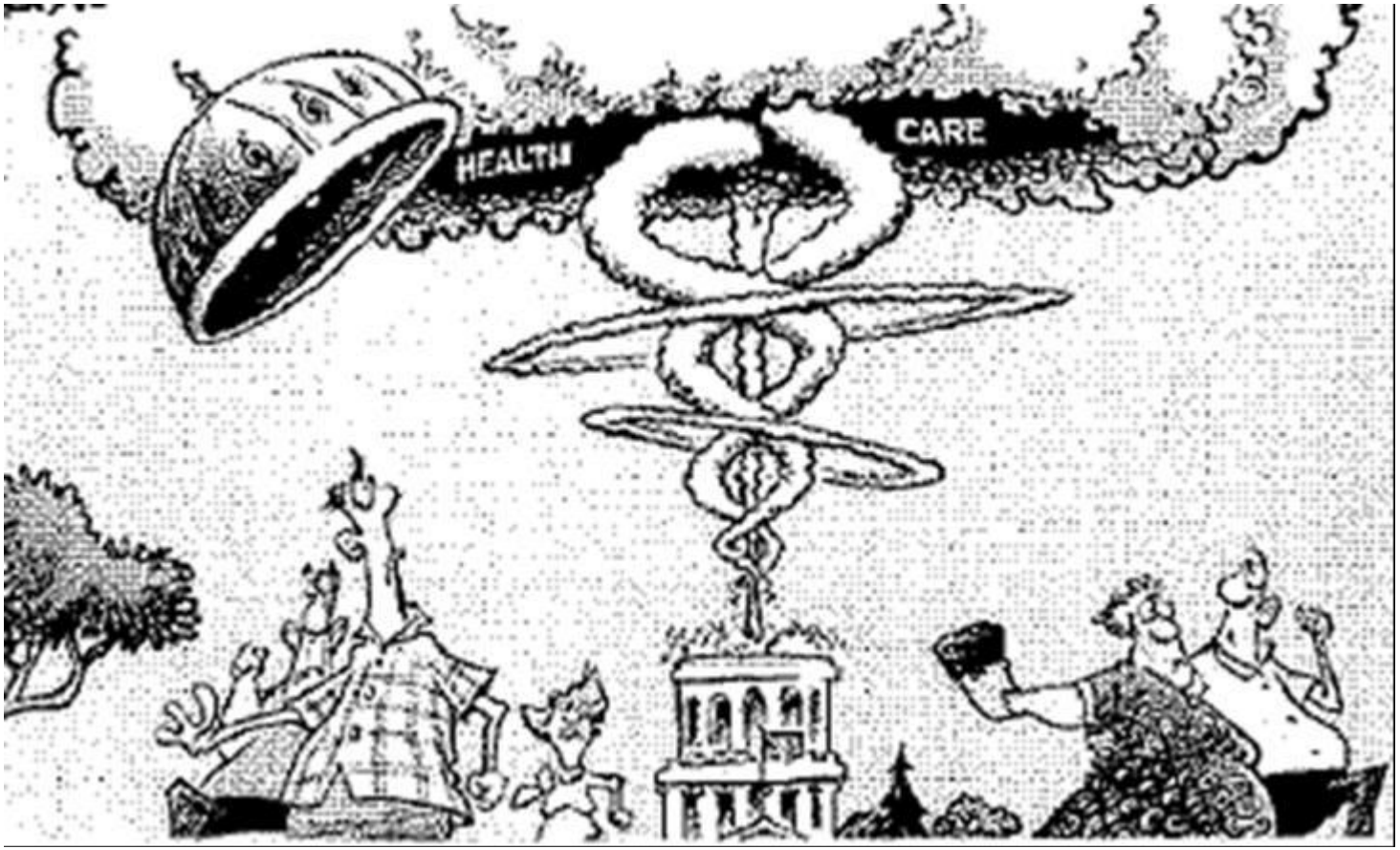
Sharon McIlrath
Asst. Director Federal Affairs

AMA
TOGETHER WE ARE STRONGER

AMA's Two Reform Goals

- Passage of meaningful health system reform legislation consistent with AMA policy
- Permanent repeal of Medicare SGR

3-23-2010



Patient Protection and Affordable Care Act is Born

(3-30 Corrective Surgery via Health Care and Education Reconciliation Act of 2010)

AMA-Supported Elements of Bill

- **Expands coverage**; reduces uninsured to 23 million by 2019.
- **Enhances competition** through exchanges in 2014.
- **Reforms insurance market**: bans rescissions, lifetime limits, pre-existing conditions; requires guaranteed issue; limits waiting periods to 90 days; creates minimum medical loss ratio.
- **Requires administrative simplification**
- **Invests in comparative effectiveness research:** CER Institute to be formed in 2010; findings can't be construed as coverage or payment guidelines.
- **Invests in prevention and wellness** New Council to develop national strategy; funds and grants to support prevention and wellness activities; eliminate M&M cost-sharing for preventive services; new Medicare benefit for personal risk assessment and prevention plan; various incentives for employer wellness programs.

Improvements Achieved by AMA

- 5% payment reduction for high-resource use outliers eliminated
- Medicare/ Medicaid enrollment fee for physicians eliminated
- PQRI penalties postponed 2 years
- Budget neutrality offset for primary care bonus payments eliminated
- Cosmetic surgery tax dropped
- Medicare buy-in proposal for uninsured aged 55-64 stopped

Issues of Continuing Concern

- Using reconciliation process to modify Senate bill limited issues that could be addressed.
- Expect additional corrective legislation will provide opportunity to address some other issues.
- Issues of concern include:
  - Independent Payment Advisory Board
  - Data Disclosure
  - Medical Liability
  - PQRI Penalties
  - Value-Based Physician Payment Adjustment

Quick Start; Key Provisions for 2010

- **Coverage Reforms**: small business tax credits, temporary high-risk pool, dependent coverage to age 26.
- **Market Reforms**: prohibitions on rescissions & lifetime limits and pre-existing condition limits for kids; reporting of medical loss ratios;
- **Physician Pay Changes**: Begins 1-yr Work GPCI floor extension; 2-yr fully-funded PE GPCI change; 1-yr mental health payment add-on; increases multiple imaging discount.
- **Workforce Provisions**: Establishes new Workforce Commission; authorizes changes in GME rules that discourage outpatient training; increases NHSC loan repayment amount to $50,000.
- **Delivery System Reform**: Establishes Comparative Effectiveness Research Institute; new Interagency Health Care Quality Work Group & begins to develop national strategy for performance improvement.
- **Miscellaneous**: Tanning tax, $250 donut hole rebate,

Other Key Dates:

- **Coverage:** Medicaid expansion, insurance exchanges, most premium/cost-sharing subsidies, employer & individual mandates start in 2014.
- **Medicare FFS Savings:** Updates for most other providers reduced by varying amounts 2011 through at least 2015. Productivity adjustment applied to other providers 2011-2013. hospitals. IPAB 2014.
- **Medicare Advantage Savings:** Rates tied to FFS starting in 2012
- **Delivery System Reform:** Accountable Care Organization 2012; Medicare Bundling 2013; Public reporting of physician quality data 2013; Value-based physician payment adjustments 2015..
- **New Revenue:** Tax on drug mfgrs 2011 & device makers 2013; Medicare tax on high earners 2013; tax on health insurers 2014; tax on “Cadillac” plans 2018.
- **Medical Liability Reform:** $50 million in grants for state demos of alternative dispute resolution 2011.

Medicare Physician Payment Changes

- **Physician update**: No provision
- **Imaging Payment:** Multiple imaging discount rises to 50% 7-1-2010; Equipment utilization assumption set at 75% 1-1-2012.
- **Misvalued Services:** Secretary to conduct periodic review 2013.
- **Work GPCI Floor:** Extended through 2010;
- **Psych Bonus:** Extended through 2010.
- **PE GPCI Changes:** Temporary change 2010-11. Permanent budget neutral changes 2012.
- **Primary Care Bonus:** 10% bonus for most visit codes for IM, FP, geriatricians, pediatricians, NPs, PAs if at least 60% of Medicare pay is for these visits. Does not include hospital visits. 2011-2015
- **General Surgery Bonus:** 10% bonus for major procedures in shortage areas.

Delivery System Reform

"I'm afraid you've had a paradigm shift."

Value-Based Purchasing For Physicians

- **PQRI Changes:**
  - Bonus of 1% in 2011, 0.5% 2012-2014
  - Penalties of 1.5% in 2015, 2% thereafter. AMA will work to delay/eliminate.
  - Requires timely feedback and appeals process by 2011.
  - Reporting through maintenance of certification process provides extra 0.5% bonus 2011-2013 and could be mandated after 2014.
- **Physician Compare Website:**
  - By 1-1-11 will include info on PQRI participants;
  - By 1-1-13 HHS must have plan for public reporting of quality and patient experience.
- **Value-Based Payment Modifier:**
  - Adjusts payments based on quality and spending per beneficiary for some physicians in 2015 and all physicians by 2017.
  - AMA will continue to argue for changes/elimination of this provision.

Other Geographic Adjustments

- **PE GPCIs:** Will reflect only 50% of rent & wages differences in 2010 and 2011.
  - Retroactive to 1-1-2010.
  - Increases pay in about half of all payment areas.
  - Losers held harmless.
  - Permanent floor of 1.0 for frontier states 1-1-11. Increases pay in MT, ND, SD, UT, WY by up to 7.7%.
  - HHS study with permanent budget neutral changes in 2012.

More Delivery System Reforms

- **Support for Primary Care**:
  - Medicaid to pay primary care physicians Medicare rates 2013-2015.
  - 5-yr, 10% bonus;
  - Grants to create health teams to support primary care physicians.
  - Various provisions related to GME payments.
- **Medicare Shared Savings Program:**
  - Effective 2012 providers, including group practices or physician networks, that meet HHS-established cost and quality standards to create accountable care organizations and share savings with Medicare.
  - Must have at least 5,000 Medicare patients. Must participate for at least 3 years.
  - Not a pilot.
- **Medicare Bundling Pilot:**
  - 5-yr pilot begins 1-1-2013
  - Single payment for bundle of hospital, physician and post-acute care services from 3 days prior to 30 days after hospital stay for 10 conditions determined by HHS.

More Delivery Reforms Cont.

- **Independence at Home Demo:**
  - Physicians and NP-directed teams that provide home-based primary care and coordinate care for up to 10,000 beneficiaries with specified characteristics may share any savings in excess of 5%.
- **Hospital Payment Modifications:**
  - Effective 2013, DRG payments for certain conditions will be reduced by 1% to 3% for hospitals with "excess, preventable readmissions."
  - Effective 2015, all DRG payments reduced by 1% in hospitals with highest rates of hospital-acquired conditions.
- **Medicare Innovation Center:**
  - Will test innovative payment & delivery models to reduce spending and enhance quality in Medicare, Medicaid, CHIP.
  - Statute names 20 models including use of appropriateness criteria for diagnostic imaging, state all-payer systems, and direct contracting with provider groups paid through salary or global payment.
  - May expand models under certain conditions.

Other High Profile Provisions

- **Independent Payment Advisory Board:**
  - Beginning in 2014, the IPAB develops proposal to reduce Medicare spending by targeted amounts.
  - Unless Congress approves alternative plan to meet targets, IPAB proposal takes effect automatically.
  - IPAB recommendations can't change eligibility, benefits, premiums or cost-sharing and won't affect certain providers, including hospitals, until 2019.
- **Comparative Effectiveness Research:**
  - Creates independent, nonprofit institute.
  - GAO-appointed board members must include 4 practicing physicians.
  - Institute may not issue practice guidelines, coverage recommendations or payment recommendations.

Top Tier AMA Concerns Remaining

- Independent Payment Advisory Board
  - Double-jeopardy for physicians, equitable application across providers, transparent process, Congressional accountability, flexibility
- Cost-quality value index
- Data disclosure
- Medical liability

Eliminating the SGR

- One of AMA's essential elements of health system reform
  - Consistently opposed another short-term fix
- Legislation passed in December, March, mid-April provided temporary reprieves from 21% cut;
- Talk of five-year freeze is not coming from those making decision.
- Medicine must be united on permanent repeal
  - This is not a partisan issue
  - It affects all specialties, all physicians
  - The budgetary cost will only grow if repeal is postponed again

Observations

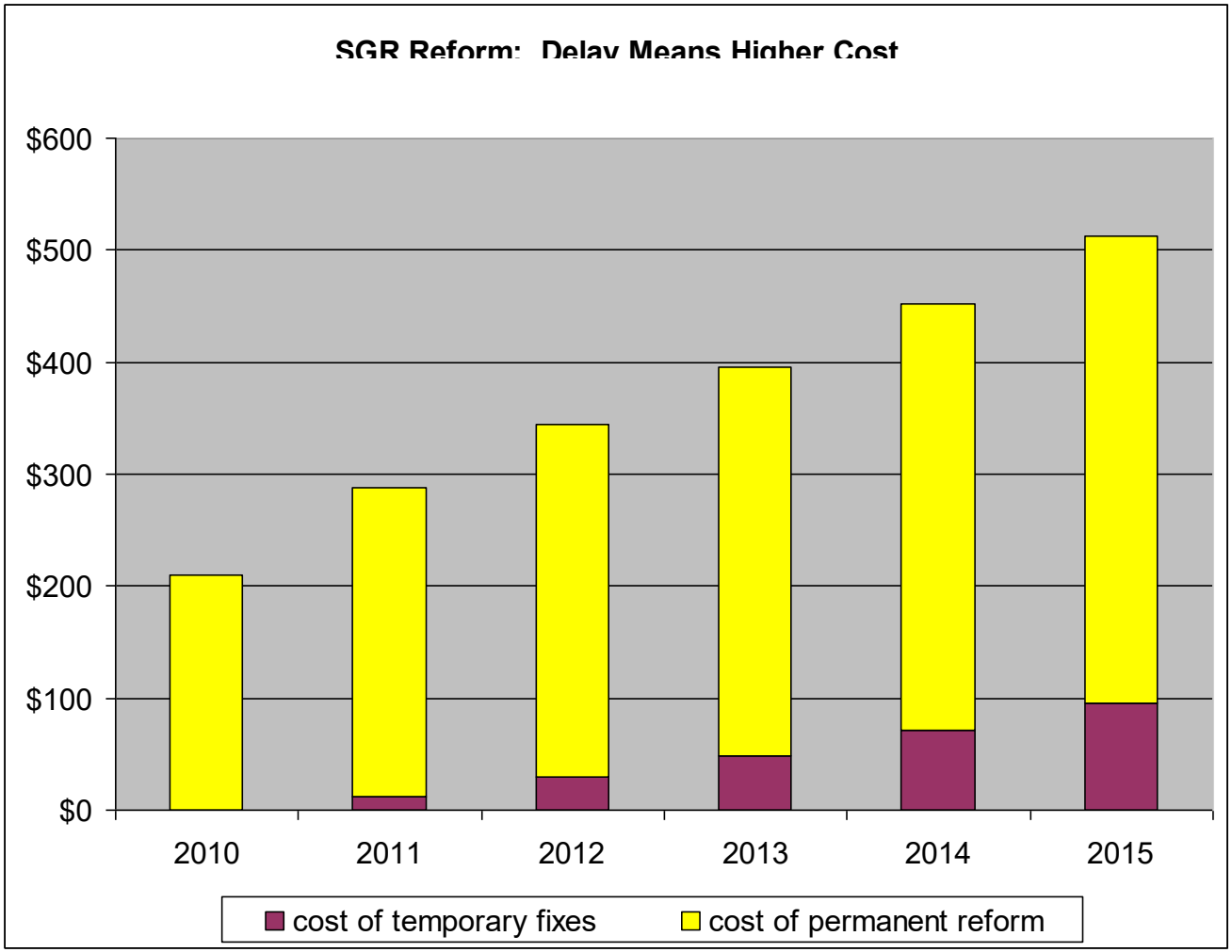
- BOT very cognizant of widespread physician concerns
- There will be opportunities for improvements
  - House leaders share top tier concerns
- Bottom line consideration rooted in ethics
- Can't lose sight of the problems driving reform
  - 46 million uninsured, comparable to total Medicare enrollment
  - Escalating premiums that make insurance unaffordable and raise employer costs
  - Insurers implementing quality improvement and provider ranking programs
  - Health care costs consuming federal and state budgets
- Absent comprehensive reform, we risk returning to health care policy being dictated solely by budget imperatives
  - Price controls vs. policy innovations

Growing Cost of Short-Term Solutions

Date of CBO Score	Freeze – 10 Year Score	MEI – 10 Year Score
February 28, 2002	----------	$126 billion (based upon 2001 and 2002 MedPAC recommendation)
May 5, 2004	----------	$95 billion
March 24, 2005	$48.6 billion	$154.5 billion
March 24, 2006	$127.2 billion	$218.2 billion
January 2007	$170.8 billion	$252.2 billion
March 2007	$177.7 billion	$262.1 billion
March 14, 2008	$220.1 billion	$288.1 billion
May 7, 2009	$285 billion	$344 billion

*After drugs were eliminated from SGR, freeze dropped to $210 billion

SGR Reform: Delay Means More Cuts



SGR Message

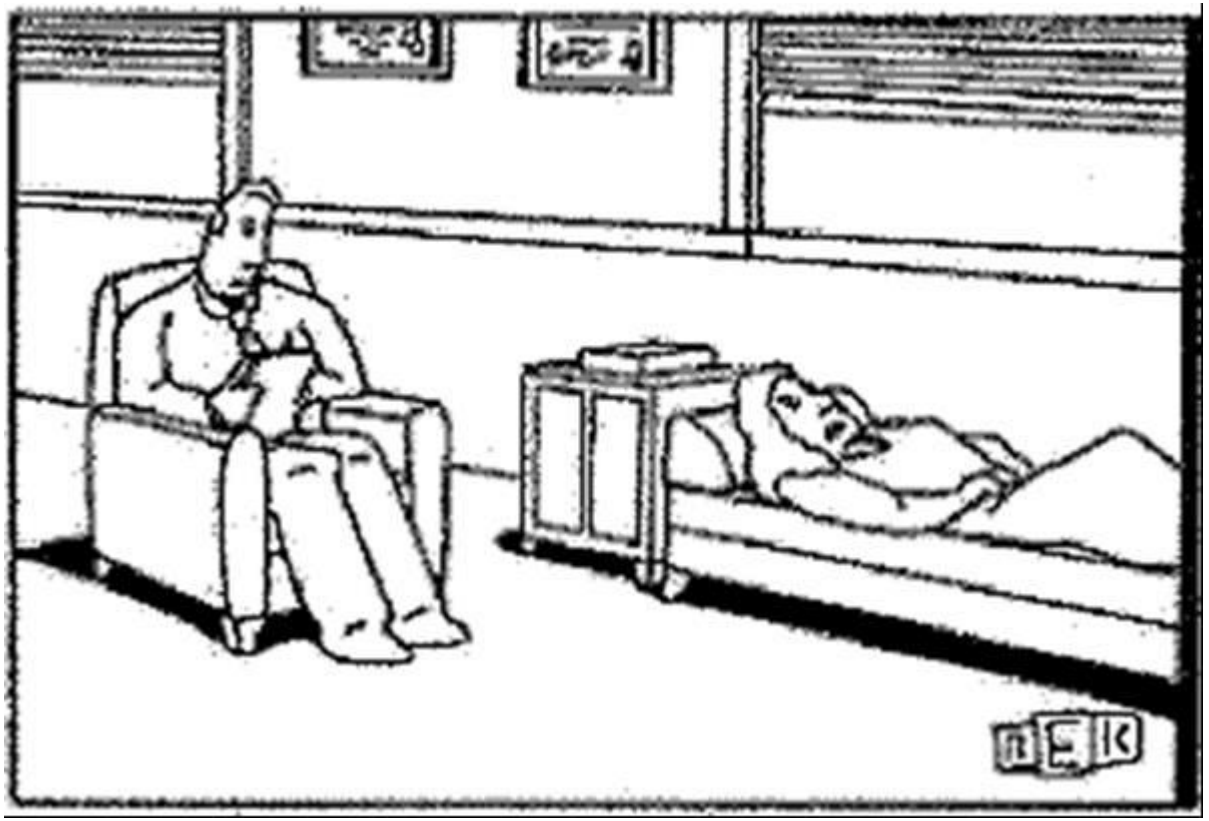
- Congress must honor its commitment to seniors and military families
  - They are worried about losing access and choice of physician
- No more short-term fixes that increase the cuts and grow the cost of reform
- Health system improvement goals cannot be achieved on the back of a broken Medicare program

We Need Your Help

- Call your legislators and explain the need for permanent SGR reform

- Use the AMA Grassroots Hotline

1-800-833-6354



"Well, I do have this recurring dream that one day I might see some results"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SGR Spending and Utilization Growth for 2009

Estimates based on claims processed through Dec 31, 2009

Drugs!

- Drugs had grown from 4% of SGR in 1996 to 10% in 2008
- CMS removed drugs from SGR spending (2010 final rule)
- Drug spending is removed retroactively to base year (1996)

Impacts of Removing Drugs

- Cumulative SGR deficit is cut by $50 billion (from $70b to $20b through 2009)
- Significant reduction in projected CF cuts although 21% cut for 2010 is unchanged
- The 10 year cost of replacing SGR is reduced by $87.5 billion (CBO)

Results for 2009 - Overall

- SGR spending is up 4.8%
- MFS spending also up 4.4%

- Change in MFS spending was due to:
  - Decline in FFS enrollment (-0.9%)
  - Increase in MFS pay (2.0%)
  - V/i growth of 3.6% (same as 2008)

Results for 2009 - Imaging

- Continued moderation in utilization growth
- 2% v/i growth for advanced imaging
- V/i growth for imaging is similar to that for all services

Results for 2009 - Imaging

- v/i growth for:
  - Nuclear Medicine was -2%
  - MRI Brain was -2%
  - MRI Other was 1%

  - Standard Imaging/Breast increase of 31% is due to increased use of G0202, G0204, G0206. Use of 77055-77077 went down (standard imaging/chest).

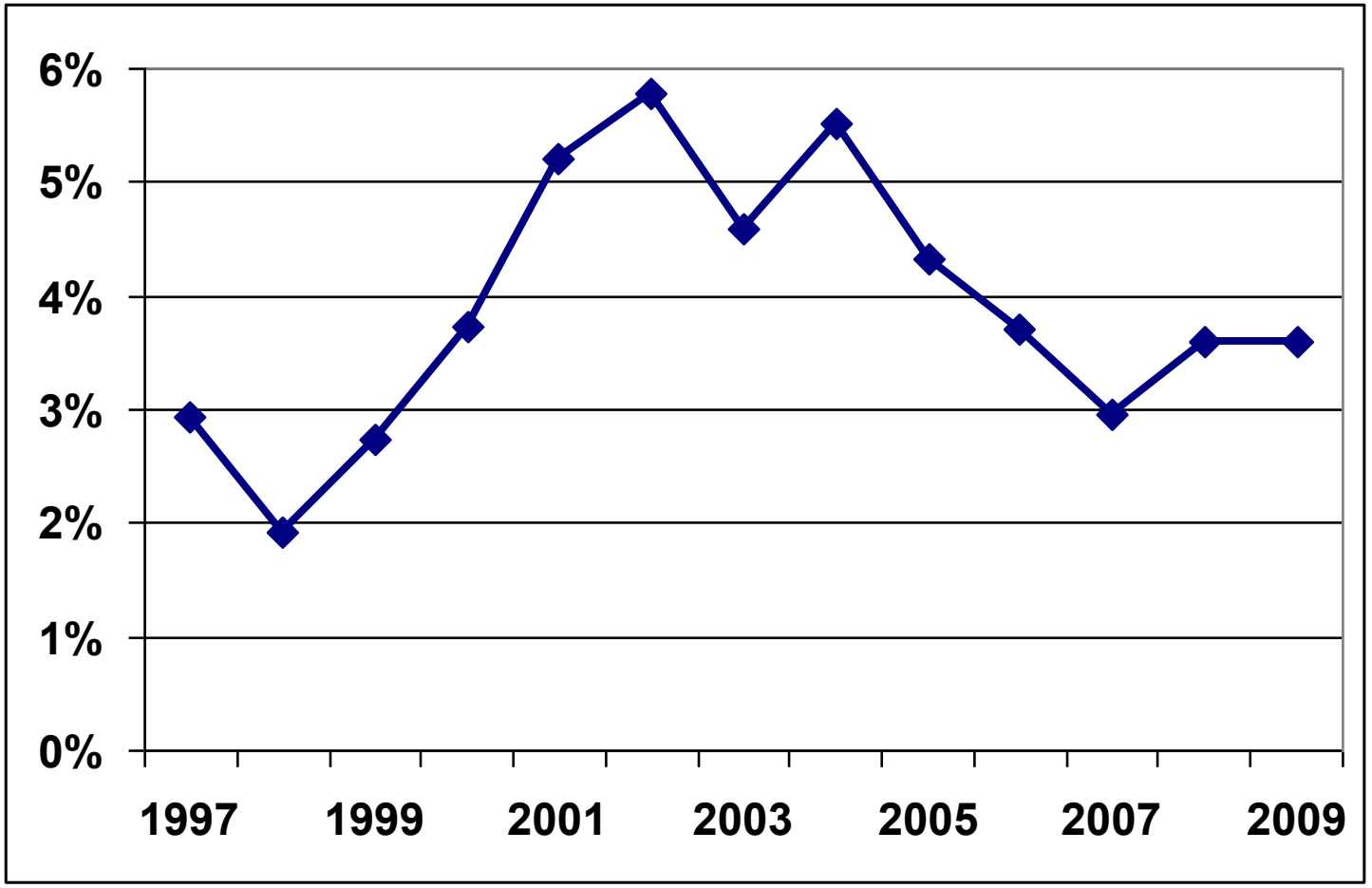
Results for 2009 – E&M

- 4% v/i growth for new patient office visits
- Almost no v/i growth for initial and subsequent hospital visits
- Critical care utilization up 6% (down from 10% average growth in recent years)

Other Results for 2009

- Uptick in utilization growth for major procedures
- Continued above average growth in v/i for minor procedures (physical therapy) and lab tests

Overall MFS v/i growth



Key Results

- Overall MFS v/i growth has stabilized
- v/i growth for imaging is down again
- v/i growth for some E&M and major procedure categories is up

- Uniform growth in utilization across type of service categories