AMA/Specialty RVS Update Committee
Meeting Minutes
April 27 – May 1, 2011

I. Welcome and Call to Order

Doctor Barbara Levy called the meeting to order on Thursday, April 28, 2011, at 4:00 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
Scott Collins, MD
John Gage, MD
William Gee, MD
Peter Hollmann, MD
Charles F. Koopmann, Jr., MD
Robert Kossmann, MD
Walt Larimore, MD
Brenda Lewis, DO
J. Leonard Lichtenfeld, MD
Scott Manaker, MD, PhD
Bill Moran, Jr., MD
Guy Orangio, MD
Gregory Przybylski, MD
Marc Raphaelson, MD
Sandra Reed, MD
Lloyd Smith, DPM
Peter Smith, MD
Susan Spires, MD
Arthur Traugott, MD
James Waldorf, MD
George Williams, MD
Allan Anderson, MD*
Margie Andreae, MD*
Gregory Barkley, MD*
Dennis M. Beck., MD*
Gregory DeMeo, DO*
Jane Dillon, MD*
Brian Galinat, MD*
Emily Hill, PA-C*
Mark Kaufmann, MD*
M. Douglas Leahy, MD*
James Levett, MD*
William J. Mangold, Jr., MD*
Daniel McQuillen, MD*
Terry Mills, MD*
Scott D. Oates, MD*
Alan Plummer, MD
Chad Rubin, MD*
Steven Schlossberg, MD*
Eugene Sherman, MD*
Stanley Stead, MD*
Robert Stomel, DO*
J. Allan Tucker, MD*
Edward Vates, 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
  - Elizabeth Truong
  - Ferhat Kassamali
- Doctor Levy welcomed Albert Bothe, MD of the CPT Editorial Panel, who is observing this meeting.

- Doctor Levy announced the following new RUC Alternate Member:
    - George Edward Vates, MD – RUC Alternate Member
- Doctor Levy announced the following departing RUC Members and thanked them for their service to organized medicine:
    - Peter Hollmann, MD
    - Lloyd Smith, DPM
    - Susan Spires, MD
- Doctor Levy welcomed the following MedPAC staff:
    - Kevin Hayes
- Doctor Levy welcomed the following observer:
    - Miriam Laugesen, PhD- Assistant Professor of Health Policy and Management at Columbia University. The Robert Wood Johnson Foundation has provided funding to develop a book that reviews the implementation of the RBRVS and Medicare physician payment.
- Doctor Larimore and Doctor Levy had a positive meeting in March with CMS staff and medical officers
    - CMS staff continues to express appreciation for the RUC's work on misvalued codes.
    - The RUC will continue its work on the MPC and addressing codes identified by CMS in 2010 rulemaking.
- Doctors Larimore and Levy also met with MedPAC in April.
    - The meeting with MedPAC commissioners and staff was productive and conversation centered around articulating the RUC's progress in identifying and addressing misvalued services.
- Doctor Levy also met with several physicians in Congress in April in the continued process of briefing policymakers on the RUC's efforts.
- Congressman Jim McDermott has introduced a bill in the House of Representatives (HR 1256)
    - Would require CMS to use "Analytic Contractors" to identify and analyze misvalued physician services on an annual basis.
    - There are currently only 2 co-sponsors by late April 2011, but has gained attention in the media.
    - On April 14, Doctor Levy met with Congressman McDermott and representatives from AAFP and SGIM in attendance. This meeting will be an opportunity to provide education regarding the RUC process.
    - Doctor Levy stressed that the RUC's role in this discussion is to: 1) continue the efforts of identifying and addressing misvalued services and 2) ensure that clinical expertise is utilized in describing the resources required to provide physician services.
- 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:

- The following RUC members have been reappointed:
  - Robert Blasier, MD – AAOS
  - Joel Bradley, MD – AAP
  - John Gage, MD – ACS
  - David Hitzeman, DO – AOA
  - Brenda Lewis, DO – ASA
  - J. Leonard Lichtenfeld, MD – ACP
  - James Waldorf, MD – ASPS
- The AMA Board of Trustees has also reappointed Doctor Levy for another term as Chair of the RUC.
- The next RUC meeting will be held on September 22 – 25, 2011 at the Hyatt Regency in Chicago, IL.

IV. Approval of Minutes of the February 3-6, 2011 RUC Meeting

The RUC approved the February 2011 RUC Meeting Minutes as submitted.

V. CPT Editorial Panel Update

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

- Again in June 2011, the CPT Editorial Panel will convene, as part of its regular proceedings, a strategic session to discuss potential refinements and look to coordinate large future projects. If any RUC member has any suggestions for the Panel to review please contact Doctor Hollmann for consideration.

VI. Centers for Medicare and Medicaid Services Update

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

- There have been staff changes at CMS since the last RUC meeting. The current Director of Physician Services, Doctor Carol Bazel, has accepted another position within the agency. Currently, John Warren is now the Acting Director of Physician Services.
- The agency is working on implementation of the ACA and publishing the Proposed Rules for the Fourth Five-Year Review and 2012 Payment Schedule in the coming months.

VII. Contractor Medical Director Update

- A Contractor Medical Director was not in attendance to provide an update.

VIII. Washington Update

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

- There are three current plans being circulated concerning the 2012 Federal Budget
    - The Deficit Reduction Commission- Includes a proposal to replace the SGR, but does not have enough approvals to send to Congress
    - The Ryan Plan- This plan would cut Medicare by $30 billion over 10 years. The plan would turn Medicare into a voucher program and reduce individual tax rates.
    - The President's Plan- This plan tightens IPAB target to GDP +0.5%. Also creates new Medicaid matching formula and includes some tax hikes.
- Compromise is critical moving forward. The Budget plan must: reform revenue and entitlements, address demand, not just cut pay, and provide reasonable timelines.
- There are several Medicare reform opportunities, including SGR reform and making beneficiaries more cost-conscious. However, there are risks, including: more formulaic payment cuts, caps upon caps, unrealistic vouchers and divisive redistribution battles.
- The following is the AMA payment reform framework:
    - Repeal the Sustainable Growth Rate
    - Positive statutory updates for five years
    - Start pilot testing ACOs, shared savings, bundled payments, medical home and partial or condition-specific capitation, etc.
    - Reform framework will be adopted in 2015 to implement successful models in 2016.
- The AMA is continuing its aggressive legislative agenda, including:
    - Meetings and written communications with House GOP, Energy and Commerce Committee, Ways and Means Committee and Senate Finance. The goal of these meetings is to provide time and resources for transition and avoid a one-size-fits-all solution.
    - Substantial comments from AMA to CMS on ACP Proposed Rule due in June.

Kevin Hayes, MedPAC Commissioner, provided the RUC with the following information regarding the Commission's report to Congress.

- MedPAC is currently looking at three critical issues surrounding physician payment refinements.
    - Time data- The ACA gives the Secretary the ability to validate physician time and work value data. MedPAC has worked with a contractor and has found that an additional method like the RUC that values physician services by survey and physician expertise is not readily accessible and is not feasible at this time. However, the Commission is focusing on identifying a cohort of physician practices that will participate in regular data collection. This cohort would be big enough that the data will be statistically reliable and could be used for practice expense costs as well as physician time. This will take significant resources and time for CMS to implement.

- In office ancillary services- The Commission is considering policies that will address volume growth in imaging services performed by self referral. MedPAC is looking toward different forms of payment including, ACOs, medical home and bundling, but until these policies are enacted they are recommending the following:
  - The Secretary should accelerate effort to establish comprehensive codes for multiple imaging studies that are commonly performed on the same day, same beneficiary.
  - Account for efficiencies for the work component when multiple imaging studies are performed on the same day, same beneficiary.
  - Establish prior notification for practitioners who order significantly more diagnostic tests than peers.
- Sustainable Growth Rate (SGR)- The Commission is considering several alternatives to the flawed SGR methodology. MedPAC agrees that another short-term fix is not desirable. The Chairman has publicly stated that the goal is to have recommendations on the SGR at the fall MedPAC meeting (September, October) prior to Congress's current temporary SGR fix reaching its horizon.

Kurt Gills, AMA Senior Economist, provided the RUC with the following information regarding the SGR spending and utilization growth for 2010

- The Results for 2010 shows that SGR and Medicare Payment Schedule spending is up 5.6%. Changes were due to:
  - Increase in enrollment (1.1%)
  - Increase in payment schedule pay (2.6%)
  - Increase in volume and intensity per enrollee (2.4%)
- Spending for imaging is down 5%. There is also little to no growth in utilization per enrollee.
- Evaluation and Management services increased $3 billion, about two-thirds of the overall increase in Medicare payment schedule spending.
- Changes to procedures were relatively stable. There were above average pay increases for some categories, such as eye and ambulatory. Also, continuing with recent trends, the data shows a decline in volume and intensity for oncology and some surgical and cardiovascular categories.
- The key results are as follows:
  - No growth in utilization for imaging
  - Overall Medicare Payment Schedule volume and intensity is down
  - $3 billion increase in spending for Evaluation and Management.

IX. Relative Value Recommendations for CPT 2012

<u>Chronic Wound Dermal Substitute (Tab 4)</u>
Seth Rubenstein, DPM (APMA); Timothy Tillo, DPM (APMA); Christopher Senkowski, MD, (ACS); Charles Mabry, MD, (ACS)
Facilitation Committee #1

In October 2009, various Acellular Dermal Allograft and Tissue Cultured Allogeneic Dermal Substitute services were identified as part of the Different Performing Specialty from Survey screen. At that time the specialty societies recommended and the RUC agreed to wait for the work of the CPT Editorial Panel's Chronic Wound Dermal Substitute Workgroup to be completed before the RUC re-considers the work values for these codes.

In February 2011, the CPT Editorial Panel deleted 24 skin substitute codes, including subheading and introductory guidelines, and established a two-tier structure with 8 new codes (15271-15278) to report the application of skin substitute grafts, which are distinguished according to the anatomic location and surface area rather than by product description. The CPT Editorial Panel revised the skin replacement surgery guidelines, including definitions for surgical preparation, autografts, and skin substitute graft and added instructional parenthetical notes to instruct users on the appropriate use of the new codes. Additionally, the CPT Editorial Panel created new add-on code, 15777, to report implantation of biologic implant (et, acellular dermal matrix) for soft tissue reinforcement (eg, breast, trunk).

15271 Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area
The RUC reviewed the survey results from 38 general surgeons and podiatrists and determined that the survey 25th percentile work RVU of 1.50 appropriately accounts for the work required to perform this service. The RUC compared the physician work of 15271 to code 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* (work RVU = 1.44) and agreed with the specialty societies that the surveyed code requires more physician work and more total time than 12004, 45 and 29 minutes respectively. The RUC noted that code 12004 requires significantly less pre-service time than 15271, 7 versus 20 minutes, because it is typically reported with an Evaluation and Management service. Further, the intra-service time for 12004 is slightly greater than 15271, 17 versus 15 minutes, respectively, because it includes local anesthesia and draping time. Therefore, the RUC recommends the survey 25th percentile work RVU. **The RUC recommends a work RVU of 1.50 for CPT Code 15271.**

15272 Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)
The RUC reviewed the survey results from 34 general surgeons and podiatrists and determined that the survey 25th percentile work RVU of 0.59 appropriately accounts for the work required to perform this service. The RUC compared the physician work of 15272 to code 15003 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children (List separately in addition to code for primary procedure)* (work RVU = 0.80) and agreed with the survey respondents that the key reference code requires more physician work and intra-service time than 15272, 15 and 10 minutes respectively. The RUC noted that the recommended work RVU places this service in the proper rank order with base code 15271. Therefore, the RUC recommends the survey 25th percentile work RVU. **The RUC recommends a work RVU of 0.59 for CPT Code 15272.**

15273 ***Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children***

The RUC reviewed the survey results from 35 general surgeons, plastic surgeons and burn surgeons and determined that the survey median work RVU of 3.50 appropriately accounts for the work required to perform this service. The RUC compared the physician work of 15273 to 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) and agreed with the survey respondents that the key reference code requires slightly more physician work to perform. The intra-service time of 20 minutes and immediate post-service time of 20 minutes are the same for both services. For further support, the RUC compared 15273 to 16035 *Escharotomy; initial incision* (work RVU = 3.74) and determined that it also requires the same intra-service and immediate post-service time, but is slightly more intense and complex to perform, typically to avoid nerves and blood vessels. Therefore, the RUC recommends the survey median work value. **The RUC recommends a work RVU of 3.50 for CPT Code 15273.**

15274 ***Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children or part thereof (List separately in addition to code for primary procedure)***

The RUC reviewed the survey results from 30 general surgeons, plastic surgeons and burn surgeons and determined that a work RVU of 0.80, slightly below the survey 25th percentile appropriately accounts for the work required to perform this service. The RUC determined that the survey 25th percentile work RVU of 1.00 overstated the total physician work and the appropriate work RVU should be closer to that of the recommendation for code 15272 in order to maintain rank order within this family of services. The RUC compared code 15274 in relation to 15272 and agreed with the specialty societies that 15274 requires more physician work as it includes a much larger substitute (100 sq cm) and requires meticulous application to avoid wrinkles, application of multiple layers of dressings, dermal replacement and different skin substitute materials. Code 15274 includes application of skin substitutes for a size that is 4 times larger than 15272 and it is important that the graft be secure, requiring fixation often on circumferential anatomical sites. In comparison, the graft for 15272 is more of a delivery system for growth factor. The RUC determined that the physician work required to perform 15274 is equivalent to code 15003 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children* (work RVU = 0.80) as well as similar to 76802 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; each additional gestation* (work RVU = 0.83). **The RUC recommends a work RVU of 0.80 for CPT code 15274.**

15275 ***Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area***
The RUC reviewed the survey results from 38 general surgeons and podiatrists and determined that the survey 25th percentile work RVU of 1.83 appropriately accounts for the work required to perform this service. The RUC compared the physician work of 15275 to 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) and agreed with the survey respondents that the key reference code requires significantly more work and total time, 115 minutes compared to 45 minutes. For further support, the RUC compared 15275 to 12015 *Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm* (work RVU = 1.98) and determined that the surveyed code requires less intra-service time to perform than reference code 12015, 15 and 25 minutes, respectively. The RUC noted that code 12015 requires significantly less pre-service time than 15275, 7 versus 20 minutes, because 12015 is typically reported with an Evaluation and Management service. Further, the intra-service time for 12015 is greater than 15275 because it includes lower intensity local anesthesia and draping time. Therefore, the RUC recommends the survey 25th percentile work RVU. **The RUC recommends a work RVU of 1.83 for CPT Code 15275.**

15276 ***Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 34 general surgeons and podiatrists and determined that although the graft may be placed in cosmetically sensitive areas (ie, face), the typical graft is for the lower extremity (foot and/or multiple digits). The RUC determined 15276 is analogous to code 15272 (recommended work RVU = 0.59) in both physician work and time and should be directly crosswalked. For further support, the RUC compared 15276 to key reference code 15003 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children* (work RVU = 0.80) and determined that 15276 requires 5 minutes less intra-service time, 10 minutes versus 15 minutes, and less physician work to perform. **The RUC recommends a work RVU of 0.59 for CPT code 15276.**

15277 ***Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children***
The RUC reviewed the survey results from 35 general surgeons, plastic surgeons and burn surgeons and agreed that the survey median work RVU of 4.00 appropriately accounts for the work required to perform this service. The RUC noted that 15277 requires more time to perform than the other base codes in this family of services, 25 minutes intra-service time, and is significantly more intense and complex as the site of application requires intricate work to the face, hands, fingers, etc. Dressing and fixation is more difficult on the these body parts and the grafts require sutures and staples just as a regular skin graft. The RUC compared the physician work of 15277 to 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) and determined that the key reference code requires more work and time to perform than 15277, 45 and 25 minutes respectively, and should be valued higher. For further support, the RUC compared 15277 to 16035 *Escharotomy; initial incision* (work RVU = 3.74) and determined 15277 requires more physician work and time to perform, 25 versus 20 minutes intra-service time and 110 minutes versus 70 minutes total time. Therefore, the RUC recommends the survey median work RVU. **The RUC recommends a work RVU of 4.00 for CPT Code 15277.**

15278 ***Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children or part thereof***
The RUC reviewed the survey results from 30 general surgeons, plastic surgeons and burn surgeons for code 15278 and determined the physician time, intensity and complexity is greater than add-on codes 15272, 15274 and 15276 as the surveyed code requires 14 minutes intra-service time compared to 10 minutes, and includes intricate work on the head, neck, face, hands, and fingers, which requires more care in the application and dressing and fixation on these difficult body parts. These grafts require sutures and staples just as a regular skin graft. The RUC disagreed with the specialty society recommendation of the survey 25th percentile work RVU and determined the physician work was equivalent to codes 36148 *Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); additional access for therapeutic intervention* (work RVU = 1.00), 64494 *Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level* (work RVU = 1.00), and 64495 *Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s)* (work RVU = 1.00). The RUC also noted that 15278 is approximately 40% of the work required to perform the key reference service 15116 *Epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof* (work RVU = 2.50 x 0.40 = 1.00). **The RUC recommends a work RVU of 1.00 for CPT code 15278.**

15777 ***Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (eg, breast, trunk) (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 32 general surgeons, plastic surgeons and breast surgeons for code 15777 and disagreed with the specialty society recommendation of the median work RVU in comparison to codes 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) and 57267 *Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach* (work RVU = 4.88). The RUC determined that the physician work required to perform 15777 was less intense than the two aforementioned procedures and determined that the survey 25th percentile work RVU of 3.65 with 45

minutes-intra-service time appropriately accounts for the work required to perform this service. The RUC also referenced the following similar services to support recommended work RVU and intra-service time of 45 minutes: 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), 37222 *Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty* (work RVU = 3.73 and 40 minutes intra-service time) and 93462 *Left heart catheterization by transseptal puncture through intact septum or by transapical puncture* (work RVU = 3.73 and 40 minutes intra-service time). **The RUC recommends a work RVU of 3.65 for CPT code 15777.**

Practice Expense
The RUC reviewed the direct practice expense inputs recommended by the specialty and agreed with minor changes to the clinical labor, supplies, and equipment.

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.

New Technology
The RUC requested that this family of services be placed on the new technology list to review volume in three years to ensure that the utilization assumptions were accurate.

Collagenase Injection (Tab 5)
Daniel Nagle, MD, (ACS); Anne Miller, MD (ASSH); Melissa Crosby, MD, (ASPS); Deborah Bash, MD, (ASPS); William Creevy, MD (AAOS)

In February 2011, the CPT Editorial Panel created two new codes to describe a new technique for treating Dupuytren's contracture by injecting an enzyme (collagenase) into the Dupuytren's cord in order for full finger extension and manipulation.

20527 ***Injection, enzyme (eg, collagenase), palmar fascial cord (ie, Dupuytren's contracture)***
The RUC reviewed the survey results from 30 hand, plastic, and orthopaedic surgeons for code 20527 and agreed with the specialty societies that the survey 25th percentile work RVU of 1.00 appropriately accounts for the physician work required to perform this service. The RUC compared this new injection to the survey's key reference code 20526 *Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel* (work RVU = 0.94). The specialty society explained that multiple injections (typically 3 times) at the site are performed, and extreme care is exercised so that unintended structures (ie, nerves, tendons) are not exposed to the enzyme and destroyed. The physician ensures the enzyme is only injected into the Dupuytren's cord, as it is highly destructive. Given this increased intensity, the surveyed code should be valued slightly greater than the reference code. In addition, the RUC compared 20527 to the CPT code 20551 *Injection(s); single tendon origin/insertion* (work RVU = 0.75) with the understanding that the new code is much more complex, intense, and carries more risk, as the injection of a steroid into a tendon does not include the complexity of avoiding structures to the degree that injecting collagenase includes. The RUC agreed with the specialty's survey results, and recommendation in comparison to CPT codes 20526 and 20551. **The RUC recommends the survey 25th percentile work RVU of 1.00 for CPT code 20527.**

26341 ***Manipulation, palmar fascial cord (ie, Dupuytren's cord), post enzyme injection (eg, collagenase), single cord***
The RUC reviewed the survey results from 30 hand, plastic, and orthopaedic surgeons for code 26341 and agreed with the specialty societies that the survey 25th percentile work RVU of 1.66 appropriately accounts for the physician work required to perform this service. This service is performed the day after the injection of the enzyme. The patient's hand is swollen from the injection and examined to assess for nerve or tendon injury. The hand is prepped, local or regional block anesthesia is applied and the finger is manipulated into full extension assuring disruption of the Dupuytren's cord. Multiple manipulations at 10 minute intervals with a maximum of three manipulations may be required to obtain full extension. The specialty and the RUC considered what the total work would be if the work of Evaluation and Management services were reported, one for the day of the procedure and one for the follow-up visit. The RUC concurred with the specialty that the total work of 26341 would be between two 99213 (RVW = 1.94) and one 99213 plus one 99212 (RVW=1.45). Due to the fact the patient was seen the previous day, the specialty reduced the pre-service evaluation time in Pre-time package 6 (office procedure with anesthesia) by 7 minutes (equal to the survey median time).

The RUC also compared the work of new code 26341 to that of 11421 *Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm* (work RVU = 1.47) and agreed that the work of this new service required more technical expertise and work effort. **The RUC recommends the survey 25th percentile work RVU of 1.66 for CPT code 26341.**

Practice Expense: The RUC carefully reviewed the direct practice expense inputs recommended by the specialty societies and approved the clinical labor, supplies and equipment associated with these services.

SI Joint Injection Revision (Tab 6)
Marc Leib, MD, JD (ASA), Eduardo Fraifeld, MD (AAPM), David Carroway, MD (ASIPP), William Sullivan, MD (NASS), Chris Merifield, MD (ISIS), Scott Horn, DO (ISIS)
Facilitation Committee #2

In October 2009, the Relativity Assessment Workgroup identified CPT code 27096 through the Different Performing Specialty from Survey Screen. The Workgroup asked the specialties to revise the action plan to consider the reporting of multiple codes on the same date of service. In April 2010, the Workgroup referred the service to the CPT Editorial Panel to change the descriptor to include "requiring fluoroscopic guidance." In February 2011, the CPT Editorial Panel changed the descriptor for 27096 to meet the RUC's request to bundle commonly performed services together.

27096 ***Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed***
The RUC reviewed the survey results from 55 pain medicine physicians for CPT code 27096. The RUC analyzed the survey's median physician work value and agreed that the respondents overestimated the physician work involved in the service. The RUC arrived at this conclusion by comparing 27096 to the key reference service 64493 *Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level* (work RVU= 1.52 and total time= 42 minutes). The reference service has greater

intra-service time compared to the surveyed code, 15 minutes compared to 11 minutes, and similar intensity and complexity. In addition, the RUC compared 27096 to CPT code 11980 *Subcutaneous hormone pellet implantation* (work RVU= 1.48) and agreed that the two services are similar in intra-service time, 11 minutes compared to 12.5 minutes, and intensity and the physician work should be directly crosswalked at 1.48 work RVUs. To further justify this work value, the RUC reviewed 65430 *Scraping of cornea, diagnostic, for smear and/or culture* (work RVU= 1.47). These services have analogous physician work and intensity, with similar intra-service time of 10 minutes and 11 minutes, respectively. The RUC recognizes that this value is a significant reduction in work RVUs from the current component billing for the bundled code, 27096 (work RVU= 1.40) and 73542 (work RVU= 0.59) or 77003 (work RVU= 0.60). **The RUC recommends a work RVU of 1.48 for CPT code 27096.**

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 the direct practice expense inputs recommended by the specialty and agreed upon with minor changes to the clinical labor, and equipment. The specialty explained that the performing specialties had changed, along with the standard of care, where pain medicine physicians are more likely to perform the service with the assistance of a nurse and a C-ARM (vs. fluoroscopy room) in the non-facility setting.

Shoulder Arthroscopy - Decompression of Subacromial Space (Tab 7)
William Creevy, MD (AAOS); Louis McIntyre, MD (AANA)

In February 2010, CPT code 29826 was identified by the Relativity Assessment Workgroup through the Codes Reported Together 75% or More Screen. This service is commonly performed with codes 29824, 29827 and 29828. In addition, as part of the Fourth Five-Year Review, CMS identified 29826 as a Harvard reviewed code with utilization over 30,000. Given that the service is rarely performed as a stand alone procedure (less than 1% of the time), the American Academy of Orthopaedic Surgeons (AAOS) sent CMS a request to change the global period from 090 to ZZZ. CMS agreed and CPT code 29826 was surveyed and presented as an add-on service with a ZZZ global period service.

29826 ***Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coraco-acromial ligament (ie, arch) release, when performed***
The RUC reviewed the survey results from 47 orthopaedic surgeons for CPT code 29826. The RUC agreed with the median intra-service time of 40 minutes. The RUC discussed the current value of this add-on service as it will change from a 090 global service and will no longer include the additional approach and closure physician time, or post-operative work. Current reporting of 29826 as a 090-day global code is subject to the multiple endoscopy payment rule, and when reported with another arthroscopy procedure, would have a work RVU of 3.13 under the payment rule. The specialty society did not have compelling evidence to support a change in the work value of the procedure, so the RUC and specialty agreed that a work RVU of 3.00, the survey's 25th percentile, is an accurate value of the physician work for the surveyed procedure.

To further justify this value, the RUC reviewed CPT code 43283 *Laparoscopy, surgical, esophageal lengthening procedure* (work RVU= 2.95). The RUC agreed that the services are similar add-on codes with identical intra-service times, 40 minutes, and should be valued closely. Additionally, the RUC compared 29826 to code 62160 *Neuroendoscopy, intracranial, for placement or replacement of ventricular catheter and attachment to shunt system or external drainage* (work RVU= 3.00) and agreed that the services, with identical intra-service time of 40 minutes and similar intensity and complexity, should be valued identically. **The RUC recommends a work RVU of 3.00 for CPT code 29826.**

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 made no revisions to the direct practice expense inputs recommended by the specialty for these procedures performed in the facility setting.

Arthroscopic Menisectomy of Knee (Tab 8)
William Creevy, MD (AAOS); Louis McIntyre, MD (AANA); Brian Parsley, MD (AAHKS)

In the 4th Five-Year Review of the RBRVS, CMS identified codes 29880 and 29881 through the Harvard-Valued – Utilization over 30,000 screen. CMS requested a review of these codes and the specialty's requested a referral to CPT in order to revise the code descriptors to include chodroplasty in any compartment of the knee as this is typically how the condition is currently treated. In September 2010, the RUC agreed to this code change recommendation and in February 2011 the CPT Editorial Panel changed the code descriptors of 29880 and 29881 to include the work of chodroplasty.

29880 ***Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s) when performed***
The RUC reviewed the survey results from 67 orthopaedic, hip, and knee surgeons who perform these types of services. The current work RVU of 9.45 was supported by the survey. However, the specialty understood the survey results overstated the total physician work of this service in comparison to reference procedures requiring similar work.

The RUC agreed with the physician time components from the specialty survey (pre-service = 58, intra-service = 45, post-service 15, ½ 99238, 2 x 99213, 1 x 99212) with 7 additional minutes necessary for pre-service positioning as the patient is positioned supine in a leg holder with application of a tourniquet.

The RUC, using magnitude estimation, compared 29880 to the recently RUC valued code 23120 *Claviculectomy; partial* (work RVU = 7.39, intra-service time = 45 minutes), as it is a good comparator cross-walk code, requiring similar physician total work. The RUC agreed with the similarity in overall work effort involved in these two services. The RUC agreed that the intensity and complexity of 29880 was higher than 23120, offsetting the one post operative visit differential. **The RUC recommends a work RVU of 7.39 for CPT code 29880.**

29881 ***Arthroscopy, knee, surgical; for infection, with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s) when performed***
The RUC reviewed the survey results from 67 orthopaedic, hip, and knee surgeons who perform these types of services. The current work RVU of 8.71 was supported by the survey. However, the specialty understood the survey results overstated the total physician work of this service in comparison to reference procedures requiring similar work.

The RUC agreed with the physician time components from the specialty survey (pre-service = 58, intra-service = 40, post-service 15, ½ 99238, 2 x 99213, 1 x 99212) with 7 additional minutes necessary for pre-service positioning as the patient is positioned supine in a leg holder with application of a tourniquet.

The RUC. using magnitude estimation compared 29881 to the recently valued code 26715 *Open treatment of metacarpophalangeal dislocation, single, includes internal fixation, when performed* (work RVU = 7.03, intra-service time = 40 minutes), as it is an appropriate cross-walk. The RUC agreed with the similarity in overall work effort involved in these two services. The RUC agreed that the intensity and complexity of 29881 is higher than 29715, offsetting the one post operative visit differential. **The RUC recommends a work RVU of 7.03 for CPT code 29881.**

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 accepted the direct practice expense inputs recommended by the specialty for these procedures performed in the facility setting.

<u>Lung Resection Procedures (Tab 9)</u>
James M. Levett, MD (STS); Keith S. Naunheim; MD (STS); Cameron D. Wright, MD (STS); Francis C. Nichols, MD (STS)
Facilitation Committee #3

The Society of Thoracic Surgeons (STS) brought forward the lung resection codes voluntarily as part of a major re-organization project to ensure accurate coding and reimbursement for these procedures. In February 2011, CPT Editorial Panel deleted 8 codes, revised 5 codes and created 18 new codes to describe new thoracoscopic procedures and to clarify coding confusion between lung biopsy and lung resection procedures. For the wedge resction procedures, the revisions were based on three tiers; first, the approach, thoracotomy or thoracoscopy; second, the target to remove nodules or infiltrates; and lastly the intent, diagnostic or therapeutic (for nodules only, all infiltrates will be removed for diagnostic purposes).

The coding restructuring and clarification for this family of codes is estimated to result in an overall Medicare work savings of 9 percent compared to the current reporting of these services. The RUC intends to re-examine the volume of these services in three years to confirm the frequency estimates.

The specialty society described the typical patient receiving these services, explaining that the sicker and more complicated patient will typically receive a thoracotomy rather than a thoracoscopy because he/she would most likely not tolerate the intentional collapse of one lung, which is required in order to perform a thoracoscopy. The specialty also noted that removing an infiltrate involves the entire lung, but is less difficult than the removal of a nodule. To remove infiltrates the upper and or lower superficial part of the lung is removed and then examined for infiltrates. Removing a nodule is more difficult, because the nodule is invisible, deeper and harder to resect as the physician must search for a "blip" or protrusion on the lung in order to detect and resect.

32096 ***Thoracotomy, with diagnostic biopsy(ies) of lung infiltrate(s) (eg, wedge, incisional), unilateral***
The RUC reviewed the survey results from 84 thoracic surgeons and determined that the survey 25th percentile work RVU of 17.00 and the specialty society recommended time appropriately account for the work and physician time required to perform this procedure. The RUC compared the physician work of 32096 to 32662 *Thoracoscopy, surgical; with excision of mediastinal cyst, tumor, or mass* (work RVU = 14.99) and determined that 32096 is more intense and complex to perform and requires more total time to complete than 32662, 436 and 350 minutes total time, respectively. For further support, the RUC referenced similar services, 45160 *Excision of rectal tumor by proctotomy, transsacral or transcoccygeal approach* (work RVU = 16.33 and 342 minutes total time) and 61154 *Burr hole(s) with evacuation and/or drainage of hematoma, extradural or subdural* (work RVU = 17.07 and 447 minutes total time). **The RUC recommends a work RVU of 17.00 for CPT code 32096.**

32097 ***Thoracotomy, with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral***
The RUC reviewed the survey results from 83 thoracic surgeons and determined that the survey 25th percentile work RVU of 17.00 and specialty society recommended time appropriately account for the work and physician time required to perform this procedure. The RUC compared the physician work 32097 to 32662 *Thoracoscopy, surgical; with excision of mediastinal cyst, tumor, or mass* (work RVU = 14.99) and determined that 32097 is more intense and complex to perform and requires more total time to complete than 32662, 401 and 350 minutes total time, respectively. For further support the RUC referenced similar services, MPC codes 43832 *Gastrostomy, open; with construction of gastric tube (eg, Janeway procedure)* (work RVU = 17.34 and 417 minutes total time) and 44700 *Exclusion of small intestine from pelvis by mesh or other prosthesis, or native tissue (eg, bladder or omentum)* (work RVU = 17.48 and 402 minutes total time). The specialty society indicated that 32097 is slightly more intense and complex than 32096 however, the survey 25th percentile work RVU was 17.00 for both. **The RUC recommends a work RVU of 17.00 for CPT code 32097.**

32098 ***Thoracotomy, with biopsy(ies) of pleura***
The RUC reviewed the survey results from 84 thoracic surgeons and determined that the survey 25th percentile work RVU of 14.99 and specialty society recommended time appropriately accounts for the physician work and time required to perform this procedure. The RUC compared 32098 to key reference service 32651 *Thoracoscopy, surgical; with partial pulmonary decortication* (work RVU = 18.78) and determined that the key reference service requires more physician work and significantly more total time, 341 and 502 minutes, respectively. The RUC then compared 32098 to 32662 *Thoracoscopy, surgical; with excision of mediastinal cyst, tumor, or mass* (work RVU =

14.99) and determined that 32098 requires the same work and similar time to perform, 341 and 350 minutes total time, respectively. For further support the RUC referenced similar service, 58260 *Vaginal hysterectomy, for uterus 250 g or less;* (work RVU = 14.15 and 311 minutes total time) and 27216 *Percutaneous skeletal fixation of posterior pelvic bone fracture and/or dislocation, for fracture patterns that disrupt the pelvic ring, unilateral (includes ipsilateral ilium, sacroiliac joint and/or sacrum)* (work RVU = 15.73 and 393 minutes total time). **The RUC recommends a work RVU of 14.99 for CPT code 32098.**

32100 ***Thoracotomy; with exploration***
The specialty society indicated and the RUC agreed that the patient population and technology has changed for this service since it was last reviewed 10 years ago. Patients for this procedure include those in which perioperative imaging does not delineate if the patient has a resectable central lung cancer. An exploratory thoracotomy is carried out with intraopertive findings that deem the patient unresectable. The RUC reviewed the survey results from 85 thoracic surgeons and determined that a work RVU of 17.00 and specialty society recommended intra time of 90 minutes, total time of 411 minutes, appropriately account for the work and physician time required to perform this procedure. The RUC determined that 32100 is similar to new codes 32096 and32097, which the RUC is recommending 17.00 for each of these services. The RUC noted that the survey 25th percentile work RVU of 17.50 is similar but could not justify a higher value for 32100. The RUC also compared 32100 to 32662 *Thoracoscopy, surgical; with excision of mediastinal cyst, tumor, or mass* (work RVU = 14.99) and determined that 32100 requires more work and time to perform, 411 and 350 minutes total time, respectively. The RUC noted that it did not consider there to be a rank order anomaly between 32100 and 32140 *Thoracotomy; with cyst(s) removal, includes pleural procedure when performed* (work RVU = 16.66) because the physician work required to perform 32100 has increased due to the change in the patient population as indicated above. For further support, the RUC referenced similar services, 27236 *Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement* (work RVU = 17.61 and 433 minutes total time) and 46710 *Repair of ileoanal pouch fistula/sinus (eg, perineal or vaginal), pouch advancement; transperineal approach* (work RVU = 17.14 and 370 minutes total time). **The RUC recommends a work RVU of 17.00 for CPT code 32100.**

32505 ***Thoracotomy; with therapeutic wedge resection (eg, mass, nodule), initial***
The RUC reviewed the survey results from 91 thoracic surgeons and determined that the survey 25th percentile work RVU of 18.79 and specialty society recommended time appropriately account for the work and physician time required to perform this procedure. The RUC compared 32505 to 32662 *Thoracoscopy, surgical; with excision of mediastinal cyst, tumor, or mass* (work RVU = 14.99) and determined that 32505 is more intense and complex to perform and requires more total time to complete than 32662, 427 and 350 minutes total time, respectively. For further support the RUC referenced similar services, 61751 *Stereotactic biopsy, aspiration, or excision, including burr hole(s), for intracranial lesion; with computed tomography and/or magnetic resonance guidance* (work RVU = 18.79 and 395 minutes total time) and 44188 *Laparoscopy, surgical, colostomy or skin level cecostomy (separate procedure)* (work RVU = 19.35 and 407 minutes total time). **The RUC recommends a work RVU of 18.79 for CPT code 32505.**

32506 ***Thoracotomy; with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 42 thoracic surgeons and agreed with the survey median intra-service time of 25 minutes, and agreed with the specialty society that the survey respondents overestimated the work associated with this service compared to this family of services. Therefore, the specialty society indicated, and the RUC agreed, that the physician work required to perform this service is equivalent to 35697 *Reimplantation, visceral artery to infrarenal aortic prosthesis, each artery* (work RVU= 3.00 and 30 minutes intra-service time). The RUC recommends a direct crosswalk for physician work and the survey median intra-service time of 25 minutes. **The RUC recommends a work RVU of 3.00 for CPT code 32506.**

32507 ***Thoracotomy; with diagnostic wedge resection followed by anatomic lung resection (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 43 thoracic surgeons and determined that the survey 25th percentile work RVU of 3.78 and specialty society recommended time of 30 minutes intra-service, appropriately account for the work and physician time required to perform this procedure. The RUC compared 32507 to the key reference service 32501 *Resection and repair of portion of bronchus (bronchoplasty) when performed at time of lobectomy or segmentectomy (List separately in addition to code for primary procedure)* (work RVU = 4.68) and agreed with the survey respondents that although 32507 requires 5 more minutes of intra-service time, 30 versus 25 minutes, 32507 is less intense and complex to perform, requiring less technological skill, physical effort and psychological stress. For further support, the RUC referenced similar services, 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 (List separately in addition to code for primary procedure)* (work RVU = 4.12 and 30 minutes total time) and 33572 *Coronary endarterectomy, open, any method, of left anterior descending, circumflex, or right coronary artery performed in conjunction with coronary artery bypass graft procedure, each vessel (List separately in addition to primary procedure)* (work RVU = 4.44 and 30 minutes total time). **The RUC recommends a work RVU of 3.78 for CPT code 32507.**

32601 ***Thoracoscopy, diagnostic, (separate procedure); lung, pericardial sac, mediastinal or pleural space, without biopsy***
The RUC reviewed the survey results from 50 thoracic surgeons and agreed with the survey median intra-service time of 60 minutes. However, the RUC concurred with the specialty society that the survey respondents overestimated the work associated with this service compared to this family of services. Therefore, the specialty society indicated, and the RUC agreed, to crosswalk 32601 to 43257 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease* (work RVU = 5.50, intra-service time = 60 and total time = 114). For further support, the RUC also referenced similar service, 52342 *Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)* (work RVU = 5.85 and intra-service time 60 minutes and total time = 140 minutes). **The RUC recommends a work RVU of 5.50 for CPT code 32601.**

32607 ***Thoracoscopy; with diagnostic biopsy(ies) of lung infiltrate(s) (eg, wedge, incisional), unilateral***
The RUC reviewed the survey results from 50 thoracic surgeons and agreed with the survey median intra-service time of 45 minutes. However, the RUC agreed with the specialty society that the survey respondents overestimated the work associated with this service compared to this family of services. Therefore, the specialty society indicated and the RUC agreed to crosswalk 32607 to 52301 *Cystourethroscopy; with resection or fulguration of ectopic ureterocele(s), unilateral or bilateral* (work RVU = 5.50, intra-service time = 45 and total time = 183). For further support, the RUC also referenced similar service, 52341 *Cystourethroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)* (work RVU = 5.35 and intra-service time 45 minutes). **The RUC recommends a work RVU of 5.50 for CPT code 32607.**

32608 ***Thoracoscopy; with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral***
The RUC reviewed the survey results from 50 thoracic surgeons and agreed with the survey median intra-service time of 60 minutes. In addition, the RUC agreed with the specialty society that the survey respondents overestimated the work associated with this service compared to this family of services. The RUC agreed that 32608 requires more work to biopsy the lung nodules compared to biopsy lung infiltrates in code 32607 (RUC recommended work RVU = 5.50). The RUC compared 32608 to key reference service 31600 *Tracheostomy, planned (separate procedure);* (work RVU = 7.17) and agreed with the survey respondents that the surveyed code is more intense and complex and requires more time to perform than the reference code, 60 and 40 minutes intra-service time, respectively. The RUC compared the incremental differences between the two surveys for 32607 and 32608 and although the work RVUs were overstated (12.50 and 14.00, respectively) the incremental difference was appropriate and maintained rank order between these two services. The RUC recommends a work RVU of 6.84 for code 32608 which maintains rank order among this family of services. For further support, the RUC referenced similar services 58560 *Hysteroscopy, surgical; with division or resection of intrauterine septum (any method)* (work RVU = 6.99) and 36475 *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated* (work RVU = 6.72), both which have the same intra-service time of 60 minutes as surveyed code 32608. **The RUC recommends a work RVU of 6.84 for CPT Code 32608.**

32609 ***Thoracoscopy; with biopsy(ies) of pleura***
The RUC reviewed the survey results from 50 thoracic surgeons and agreed with the survey median intra-service time of 45 minutes. However, the RUC concurred with the specialty society that the survey respondents overestimated the work associated with this service compared to this family of services. Therefore, the specialty society indicated, and the RUC agreed, that the physician work required to perform this service is equivalent to 15004 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children* (work RVU 4.58, intra-time = 45 minutes and total time = 150 minutes). Codes 32609 and 15004 have the same intra-service time of 45 minutes and similar total time, 178 and 150 minutes, respectively. Additionally, the RUC agreed that a work RVU of 4.58 maintains

the proper rank order with 32607 and 32608. For further support the RUC referenced code 20902 *Bone graft, any donor area; major or large* (work RVU = 4.58 and intra-service time of 45 minutes). **The RUC recommends a work RVU of 4.58 for CPT code 32609.**

32663 ***Thoracoscopy, surgical; with lobectomy (single lobe)***
The RUC reviewed the survey results from 55 thoracic surgeons and determined that the current work RVU of 24.64, lower than the survey 25th percentile work RVU of 27.23, appropriately accounts for the physician work required to perform this service. The RUC compared 32663 to codes 35351 *Thromboendarterectomy, including patch graft, if performed; iliac* (work RVU = 24.61 and intra-service time = 150 minutes) and 34802 *Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (1 docking limb)* (work RVU = 23.79 and intra-service time = 150 minutes) and determined that 32663 requires similar intra-service time, 155 and 150 minutes, respectively, as well as similar intensity and complexity to perform. The RUC recommends maintaining the current work RVU of 24.64 for code 32663. **The RUC recommends a work RVU of 24.64 for CPT code 32663.**

32666 ***Thoracoscopy, surgical; with therapeutic wedge resection (eg, mass, nodule), initial unilateral***
The RUC reviewed the survey results from 55 thoracic surgeons and determined that the survey 25th percentile work RVU of 14.50 and specialty society recommended intra-service time of 75 minutes appropriately account for the work and physician time required to perform this procedure. The RUC compared 32666 to 32662 *Thoracoscopy, surgical; with excision of mediastinal cyst, tumor, or mass* (work RVU = 14.99) and determined that 32666 requires less time to perform, 317 and 350 minutes total time, respectively. For further support the RUC referenced similar service, 21685 *Hyoid myotomy and suspension* (work RVU = 15.26 and 75 minutes intra-service time) and 52601 *Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)* (work RVU = 15.26 and 75 minutes intra-service time). **The RUC recommends a work RVU of 14.50 for CPT code 32666.**

32667 ***Thoracoscopy, surgical; with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 44 thoracic surgeons and agreed with the survey median intra-service time of 25 minutes. However, the RUC concurred with the specialty society that the survey respondents overestimated the work associated with this service compared to this family of services. Therefore the specialty society indicated, and the RUC agreed, that the physician work required to perform this service is equivalent to codes 32506 (RUC recommended work RVU = 3.00 and intra-service time = 25 minutes), 35697 *Reimplantation, visceral artery to infrarenal aortic prosthesis, each artery* (work RVU 3.00 and 30 minutes intra-service time) and 15157 *Tissue cultured epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (*work RVU 3.00 and 30 minutes intra-service time). The RUC recommends a direct crosswalk for physician work to the aforementioned codes and the survey median intra-service time of 25 minutes. **The RUC recommends a work RVU of 3.00 for CPT code 32667.**

32668 ***Thoracoscopy, surgical; with diagnostic wedge resection followed by anatomic lung resection (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 44 thoracic surgeons and determined that the survey 25th percentile work RVU of 4.00 and 30 minutes intra-service time appropriately accounts for the physician work and time required to perform this service. The RUC compared 32668 to code 32507 *Thoracotomy; with diagnostic wedge resection followed by anatomic lung resection* (RUC recommended work RVU = 3.78) and determined that the additional work for 32668 accounts for the increased intensity and complexity to perform the thoracoscopy and maintains the proper rank order among these services. For further support the RUC referenced codes 33572 *Coronary endarterectomy, open, any method, of left anterior descending, circumflex, or right coronary artery performed in conjunction with coronary artery bypass graft procedure, each vessel (List separately in addition to primary procedure)* (work RVU = 4.44) and 61641 *Balloon dilatation of intracranial vasospasm, percutaneous; each additional vessel in same vascular family (List separately in addition to code for primary procedure)* (work RVU = 4.33) both of which have the same time of 30 minutes as surveyed code 32668. **The RUC recommends a work RVU of 4.00 for CPT code 32668.**

32669 ***Thoracoscopy, surgical; with removal of a single lung segment (segmentectomy)***
The RUC reviewed the survey results from 54 thoracic surgeons and agreed with the specialty society that the survey respondents overestimated the work associated with this service compared to this family of services. Therefore, the specialty society indicated and the RUC agreed that the physician work and intra-service time of 150 minutes required to perform this service is equivalent to 22612 *Arthrodesis, posterior or posterolateral technique, single level; lumbar (with or without lateral transverse technique)* (work RVU=23.53 and intra-time = 150 minutes). The RUC also agreed that a work RVU of 23.53 maintains the appropriate rank order and incremental difference between the 25th percentile survey results for 32669 and 32663 (26.00 divided by 27.23 work RVUs x 24.64 work RVUs for 32663 = 23.53). For further support, the RUC referenced similar service 58200 *Total abdominal hysterectomy, including partial vaginectomy, with para-aortic and pelvic lymph node sampling, with or without removal of tube(s), with or without removal of ovary(s)* (work RVU = 23.10 and intra-service time = 150 minutes). **The RUC recommends a work RVU of 23.53 for CPT code 32669.**

32670 ***Thoracoscopy, surgical; with removal of two lobes (bilobectomy)***
The RUC reviewed the survey results from 55 thoracic surgeons and agreed with the survey median intra-service time of 180 minutes. However, the RUC concurred with the specialty society that the survey respondents overestimated the work associated with this service compared to this family of services. Therefore, the specialty society indicated and the RUC agreed that the physician work required to perform this service is equivalent to 34451 *Thrombectomy, direct or with catheter; vena cava, iliac, femoropopliteal vein, by abdominal and leg incision* (work RVU = 28.52 and 180 minutes intra-service time). The RUC recommends a direct crosswalk to code 34451 for physician work. **The RUC recommends a work RVU of 28.52 for CPT code 32670.**

32671 ***Thoracoscopy, surgical; with removal of lung (pneumonectomy)***
The RUC reviewed the survey results from 55 thoracic surgeons and determined that the survey 25th percentile work RVU of 31.92 and 180 minutes intra-service time appropriately accounts for the physician work and time required to perform this service. The RUC compared 32671 to code 32652 *Thoracoscopy, surgical; with total pulmonary*

decortication, including intrapleural pneumonolysis (work RVU = 29.13) and determined that 32671 is more intense and complex and requires more physician time to perform than 32652, 180 and 160 minutes intra-service time, respectively. For further support the RUC referenced codes 35251 *Repair blood vessel with vein graft; intra-abdominal* (work RVU = 31.91) and 33507 *Repair of anomalous (eg, intramural) aortic origin of coronary artery by unroofing or translocation* (work RVU = 31.40) both of which have the same intra-service time as surveyed code 32671, 180 minutes. **The RUC recommends a work RVU of 31.92 for CPT code 32671.**

32672 ***Thoracoscopy, surgical; with resection-plication for emphysematous lung (bullous or non-bullous) for lung volume reduction (LVRS), unilateral includes any pleural procedure, when performed***

The RUC reviewed the survey results from 54 thoracic surgeons and determined that the survey 25th percentile work RVU of 27.00 and 120 minutes intra-service time appropriately accounts for the physician work and time required to perform this service. The RUC compared 32672 to key reference code 32141 *Thoracotomy, major; with excision-plication of bullae, with or without any pleural procedure* (work RVU = 27.18) and determined that 32672 requires similar physician work and time to perform, 116 and 120 minutes, respectively. For further support, the RUC referenced codes 43880 *Closure of gastrocolic fistula* (work RVU = 27.18) and 43502 *Gastrotomy; with suture repair of pre-existing esophagogastric laceration (eg, Mallory-Weiss)* (work RVU = 25.69) both of which have the same intra-service time as surveyed code 32672, 120 minutes. **The RUC recommends a work RVU of 27.00 for CPT code 32672.**

32673 ***Thoracoscopy, surgical; with resection of thymus, unilateral or bilateral***

The RUC reviewed the survey results from 54 thoracic surgeons and determined that the survey 25th percentile work RVU of 21.13 and 150 minutes intra-service time appropriately accounts for the physician work and time required to perform this service. The RUC compared 32673 to codes 35302 *Thromboendarterectomy, including patch graft, if performed; superficial femoral artery* (work RVU = 21.35) and 22905 *Radical resection of tumor (eg, malignant neoplasm), soft tissue of abdominal wall; 5 cm or greater* (work RVU = 21.58) and determined that 32673 requires the same intra-service time of 150 minutes and similar intensity and complexity to perform. **The RUC recommends a work RVU of 21.13 for CPT code 32673.**

32674 ***Thoracoscopy, surgical; with mediastinal and regional lymphadenectomy (List separately in addition to code for primary procedure)***

The RUC reviewed the survey results from 44 thoracic surgeons and agreed with the survey median intra-service time of 30 minutes. However, the RUC concurred with the specialty society that the survey respondents overestimated the work associated with this service compared to this family of services. Therefore, the specialty society indicated and the RUC agreed that the physician work required to perform this service is equivalent to 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 and 30 minutes intra-service time). The RUC recommends a direct crosswalk to code 34826 for physician work. **The RUC recommends a work RVU of 4.12 for CPT code 32674.**

38746 ***Thoracic lymphadenectomy by thoracotomy, mediastinal and regional lymphadenectomy (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 44 thoracic surgeons and agreed with the survey median intra-service time of 30 minutes. However, the RUC concurred with the specialty society that the survey respondents overestimated the work associated with this service compared to this family of services. Therefore the specialty society indicated and the RUC agreed that the physician work required to perform this service is equivalent to 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 and 30 minutes intra-service time). The RUC recommends a direct crosswalk to code 34826 for physician work. **The RUC recommends a work RVU of 4.12 for CPT code 38746.**

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 the direct practice expense inputs recommended by the specialty society for these procedures performed in the facility setting.

Pacemaker or Pacing Cardioverter-Defibrillator (Tab 10)
Richard Wright, MD (ACC); Robert Kowal, MD (HRS); Bruce Wilkoff, MD (HRS)
Facilitation Committee #3

In February 2010, the Pacemaker and Pacing Cardioverter-Defibrillator series of CPT codes (33207, 33208, 33212, 33213, 33240 and 33249) were identified by the Relativity Assessment Workgroup through the Codes Reported Together 75% or More Screen. These insertion codes were commonly billed with the removal codes (33233, 33241 and 71090) or the device evaluation code (93641). In February 2011, the specialties submitted a code change proposal to the CPT Editorial Panel to bundle the services commonly reported together. A total of 12 codes were created or significantly revised, mandating a RUC survey in April 2011.

The RUC and specialties determined that only 1 level three office visit (99213) and a half discharge day management service are typical for the wound care management for each of the services in this family. Additionally, the RUC discussed the problematic survey data and found consistency in the relationship between the physician time and work values within the family of insertion only codes (33212, 33213, 33221, 33240, 33230 and 33231). However, for the removal and replacement series of codes (33227, 33228, 33229, 33262, 33263, 33264) the survey data was inconsistent in both physician time and work value. Given this understanding, the RUC and specialties agreed that the recommended work RVUs for these services be interim and a comprehensive RUC survey be presented at the September 2011 RUC Meeting.

Pacemaker Services
33212 ***Insertion of pacemaker pulse generator only with existing; single lead***
The RUC reviewed the survey results from 36 cardiologists for CPT code 33212. The RUC and specialties agreed that the post-service time should be lowered from the survey median time of 27.5 minutes to 20 minutes to align itself with the other pacemaker family of services. The RUC reviewed the survey work values and agreed that the 25th percentile

work RVU of 5.39 is a reasonable interim value for this service. To further justify this value, the RUC reviewed code 36571 *Insertion of peripherally inserted central venous access device, with subcutaneous port; age 5 years or older* (work RVU= 5.34) and agreed that the physician work of this service is analogous to the work of 33212 and should be valued similarly due to similar intra-service time, 45 minutes and 50 minutes, respectively, and intensity and complexity. **The RUC recommends an interim work RVU of 5.39 for CPT code 33212.**

33213 ***Insertion of pacemaker pulse generator only with existing; dual leads***
The RUC reviewed the survey results from 32 cardiologists for CPT code 33213. The RUC reviewed the survey work values and agreed that the 25th percentile work RVU of 5.61 is a reasonable interim value for this service. To further justify this value, the RUC compared this service to the single lead insertion base code 33212 and agreed that there is more physician work involved in 33213 given the greater total time, 50 minutes, compared to 33212 with 45 minutes. Also, the RUC compared the surveyed code to CPT code 36571 *Insertion of peripherally inserted central venous access device, with subcutaneous port; age 5 years or older* (work RVU= 5.34) to 33213 and agreed that the surveyed code is a more intense and complex procedure than the reference code. **The RUC recommends an interim work RVU of 5.61 for CPT code 33213.**

33221 ***Insertion of pacemaker pulse generator only with existing; multiple leads***
The RUC reviewed the survey results from 33 cardiologists for CPT code 33221. The RUC reviewed the survey work values and agreed that the 25th percentile work RVU of 6.00 is a reasonable interim value for this service. To further justify this value, the RUC compared this service to the dual lead insertion base code 33213 and agreed that there is more physician work involved in 33221 given the greater total time, 60 minutes, compared to 33212 with 50 minutes. Also, the RUC compared the surveyed code to the reference code 36571 *Insertion of peripherally inserted central venous access device, with subcutaneous port; age 5 years or older* (work RVU= 5.34) and agreed that the physician work between the services are similar and the surveyed code should be valued higher due to greater total time, 60 minutes compared to 50 minutes, and intensity. **The RUC recommends an interim work RVU of 6.00 for CPT code 33221.**

33227 ***Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; single lead system***
The RUC reviewed the survey results from 39 cardiologists for CPT code 33227. The RUC reviewed the survey work values and agreed that the respondents overestimated the work involved in this procedure. The RUC, based on expert opinion, agreed 33227, a removal and replacement service, is likely to have a final work value lower than the value for the analogous insertion-only code, 33212, because a mature pocket is available when a unit is removed and replaced, whereas a pocket has to be created when a unit is initially inserted. Additionally, the RUC concurred that the relationship between 33212 and 33227 is uniform, along with the entire family. Thus, a 10% decrement, deemed reasonable on an interim basis given the relationship in physician work and intensity between the services, was applied to code 33212 to obtain the work value of 4.85 for 33227. To further justify a work RVU of 4.85, the RUC compared the surveyed service to CPT code 49441 *Insertion of duodenostomy or jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report* (work RVU= 4.77 and total time= 133) and agreed that the two services, with identical intra time, 45 minutes, and analogous intensity, should be valued similarly. **The RUC recommends an interim work RVU of 4.85 for CPT code 33227.**

33228 ***Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; dual lead system***
The RUC reviewed the survey results from 36 cardiologists for CPT code 33228. The RUC reviewed the survey work values and agreed that the respondents overestimated the work involved in this procedure. The RUC, based on expert opinion, agreed 33228, a removal and replacement service, is likely to have a final work value lower than the value for the analogous insertion-only code, 33213, because a mature pocket is available when a unit is removed and replaced, whereas a pocket has to be created when a unit is initially inserted. Additionally, the RUC concurred that the relationship between 33213 and 33228 is uniform, along with the entire family. Thus, a 10% decrement, deemed reasonable on an interim basis given the relationship in physician work and intensity between the services, was applied to code 33213 to obtain the work value of 5.05 for 33228. To further justify a work RVU of 5.05, the RUC compared the surveyed service to the single lead system code, 33227, and agreed that the dual lead system should be valued greater due to greater intensity and complexity. Additionally, the RUC compared the surveyed code to CPT code 49441 *Insertion of duodenostomy or jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report* (work RVU= 4.77 and total time= 133) and the surveyed code should be valued higher due to greater total time compared to the reference code, 148 minutes and 133 minutes, respectively. **The RUC recommends an interim work RVU of 5.05 for CPT code 33228.**

33229 ***Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; multiple lead system***
The RUC reviewed the survey results from 31 cardiologists for CPT code 33229. The RUC reviewed the survey work values and agreed that the respondents overestimated the work involved in this procedure. The RUC, based on expert opinion, agreed 33229, a removal and replacement service, is likely to have a final work value lower than the value for the analogous insertion-only code, 33221, because a mature pocket is available when a unit is removed and replaced, whereas a pocket has to be created when a unit is initially inserted. Additionally, the RUC concurred that the relationship between 33221 and 33229 is uniform, along with the entire family. Thus, a 10% decrement, deemed reasonable on an interim basis given the relationship in physician work and intensity between the services, was applied to code 33221 to obtain the work value of 5.40 for 33229. To further justify a work RVU of 5.40, the RUC compared the surveyed service to the dual lead system code, 33228, and agreed that the dual lead system should be valued greater due to greater intensity and intra-service time, 50 minutes compared to 45 minutes. Additionally, the RUC compared the surveyed code to CPT code 36571 *Insertion of peripherally inserted central venous access device, with subcutaneous port; age 5 years or older* (work RVU= 5.34 and total time= 140) and agreed that the two services, with identical intra time, 50 minutes, and analogous intensity, should be valued similarly. **The RUC recommends an interim work RVU of 5.40 for CPT code 33229.**

Cardio-defibrillator Pulse Generator Services
33240 ***Insertion of pacing cardioverter-defibrillator pulse generator only with existing; single lead***
The RUC reviewed the survey results from 30 cardiologists for CPT code 33240. The RUC reviewed the survey work values and agreed that the 25th percentile work RVU of 7.00 is a reasonable interim value for this service. To ensure the value is relative across the family of services, the RUC compared 33240 to the pacemaker insertion-only, single

lead code, 33212, and noted that 33240 should be valued higher because defibrillators are larger devices compared to pacemakers, requiring a larger pocket dissection and greater risk of bleeding and tissue injury. Also, patients receiving a defibrillator have either prior lethal arrhythmia or severe heart failure and are sicker than patients receiving a pacemaker. For additional justification, the RUC compared the surveyed code to CPT code 49325 *Laparoscopy, surgical; with revision of previously placed intraperitoneal cannula or catheter, with removal of intraluminal obstructive material if performed* (work RVU= 6.82) and agreed that the two services have identical intra-service time, 60 minutes, with analogous intensity and should be valued similarly. **The RUC recommends an interim work RVU of 7.00 for CPT code 33240.**

33230 ***Insertion of pacing cardioverter-defibrillator pulse generator only with existing; dual leads***
The RUC reviewed the survey results for CPT code 33230. The RUC reviewed the survey work values and agreed that the 25th percentile work RVU of 7.00 is a reasonable interim value of the physician work involved in this service. The RUC agreed that the insertion of a dual lead pulse generator is slightly more intense than the placement of a single lead defibrillator, but the intensity was not captured in the survey. The RUC compared 33230 to the base code 33240 and noted that both have identical median survey intra-service time, 60 minutes, and identical 25th percentile work values at 7.00 work RVUs. For additional justification, the RUC compared the surveyed code to CPT code 49325 *Laparoscopy, surgical; with revision of previously placed intraperitoneal cannula or catheter, with removal of intraluminal obstructive material if performed* (work RVU= 6.82) and agreed that the two services have identical intra-service time, 60 minutes, with analogous intensity and should be valued similarly. **The RUC recommends an interim work RVU of 7.00 for CPT code 33230.**

33231 ***Insertion of pacing cardioverter-defibrillator pulse generator only with existing; multiple leads***
The RUC reviewed the survey results for CPT code 33231. The RUC reviewed the survey work values and agreed that the 25th percentile work RVU of 7.25 is a reasonable interim value for the physician work involved in this service. The RUC compared 33231 to the dual lead defibrillator code, 33230, and agreed that while the times are identical, the insertion of a multiple lead generator is a more intense procedure compared to the insertion of a single lead defibrillator. For additional justification, the RUC compared the surveyed code to CPT code 63650 *Percutaneous implantation of neurostimulator electrode array, epidural* (work RVU= 7.20) and agreed that the two service have identical intra-service time, 60 minutes, with analogous intensity and should be valued similarly. **The RUC recommends an interim work RVU of 7.25 for CPT code 33231.**

33262 ***Removal of pacing cardioverter-defibrillator pulse generator with replacement of pacing cardioverter-defibrillator pulse generator; single lead system***
The RUC reviewed the survey results from 39 cardiologists for CPT code 33262. The RUC reviewed the survey work values and agreed that the respondents overestimated the work involved in this procedure. The RUC, based on expert opinion, agreed 33262, a removal and replacement service, is likely to have a final work value lower than the value for the analogous insertion-only code, 33240, because a mature pocket is available when a unit is removed and replaced, whereas a pocket has to be created when a unit is initially inserted. Additionally, the RUC concurred that the relationship between 33240 and 33262 is uniform, along with the entire family. Thus, a 10% decrement, deemed reasonable on an interim basis given the relationship in physician work and intensity between the

services, was applied to code 33240 to obtain a work value of 6.30 for 33262. To further justify a work RVU of 6.30, the RUC compared the surveyed service to CPT code 36560 *Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; younger than 5 years of age* (work RVU= 6.29) and agreed that the services have identical intra-service time, 45 minutes, with analogous intensity and should be valued similarly. **The RUC recommends an interim work RVU of 6.30 for CPT code 33262.**

33263 ***Removal of pacing cardioverter-defibrillator pulse generator with replacement of pacing cardioverter-defibrillator pulse generator; dual lead system***
The RUC reviewed the survey results from 33 cardiologists for CPT code 33263. RUC reviewed the survey work values and agreed that the respondents overestimated the work involved in this procedure. The RUC, based on expert opinion, agreed 33263, a removal and replacement service, is likely to have a final work value lower than the value for the analogous insertion-only code, 33230, because a mature pocket is available when a unit is removed and replaced, whereas a pocket has to be created when a unit is initially inserted. Additionally, the RUC concurred that the relationship between 33230 and 33263 is uniform, along with the entire family. Thus, a 10% decrement, deemed reasonable on an interim basis given the relationship in physician work and intensity between the services, was applied to code 33230 to obtain a work value of 6.30 for 33263. To justify a work RVU of 6.30, the RUC compared 33263 to the single lead defibrillator base code 33262 and agreed that while the intra time is greater for the dual lead system, the intensity relationship is comparable throughout the family and should be maintained. Additionally, the RUC compared the surveyed code to CPT code 62362 *Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming* (work RVU= 6.10) and agreed that the services, with identical intra-service time of 60 minutes, and analogous work and intensity, should be valued similarly. **The RUC recommends an interim work RVU of 6.30 for CPT code 33263.**

33264 ***Removal of pacing cardioverter-defibrillator pulse generator with replacement of pacing cardioverter-defibrillator pulse generator; multiple lead system***
The RUC reviewed the survey results from 37 cardiologists for CPT code 33264. The RUC reviewed the survey work values and agreed that the respondents overestimated the work involved in this procedure. The RUC, based on expert opinion, agreed 33264, a removal and replacement service, is likely to have a final work value lower than the value for the analogous insertion-only code, 33231, because a mature pocket is available when a unit is removed and replaced, whereas a pocket has to be created when a unit is initially inserted. Additionally, the RUC concurred that the relationship between 33231 and 33264 is uniform, along with the entire family. Thus, a 10% decrement, deemed reasonable on an interim basis given the relationship in physician work and intensity between the services, was applied to code 33231 to obtain a work value of 6.53 for 33264. To justify a work RVU of 6.53, the RUC compared 33264 to the dual lead generator base code 33263 and agreed that with the increase in intra-service time, 65 minutes and 60 minutes, respectively, for the multiple lead system, 33264 should be valued slightly higher than 33231. Additionally, the RUC compared the surveyed code to CPT code 62362 *Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming* (work RVU= 6.10) and agreed while the services are similar in intensity and physician work, the surveyed code should be valued higher due to greater intra-service time, 65 minutes compared to 60 minutes for the reference code. **The RUC recommends an interim work RVU of 6.53 for CPT code 33264.**

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 accepted the direct practice expense inputs recommended by the specialty for these procedures performed in the facility setting.

Renal Angiography (Tab 11)
Sean Tutton, MD (SIR), Robert Vogelzang, MD (SIR), Jerry Niedzwiecki, MD (SIR), Michael Hall, MD (SIR), Gerladine McGinty, MD (ACR), Zeke Silva, MD (ACR), Gary Seabrook, MD (SVS), Robert Zwolak, MD (SVS), David Han, MD (SVS), Michael Sutherland, MD (SVS), Mathew Sideman, MD (SVS)

In February 2010, CPT codes 75722 and 75724 were identified by the Relativity Assessment Workgroup through the Codes Reported Together 75% or More Screen. These supervision and interpretation codes were commonly billed with the catheter placement code 36245. In February 2011, the specialties submitted a code change proposal to the CPT Editorial Panel to bundle the services commonly reported together. The panel deleted 75722 and 75724 and created four bundled services for RUC review in April 2011.

36251 ***Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiologic supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral***
The RUC reviewed the survey results from 70 physicians for CPT code 36251. The RUC reviewed the survey work values and agreed that the respondents overestimated the physician work value at the median level. The RUC compared the surveyed code to the recently valued reference code 31267 *Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus* (work RVU= 5.45) and agreed that the physician work and intensity is comparable with similar intra-service time of 45 minutes and 50 minutes, respectively. Given this, the RUC agreed that the work value for 36251 should be directly cross-walked to the work RVU of 5.45 for CPT code 31267. To further justify this value, the RUC compared the physician work of 36251 to the work of 52341 *Cystourethroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)* (work RVU= 5.35 and intra time= 45 minutes) and agreed that while the surveyed code has less total time, 116 minutes compared to 135 minutes, 36251 is a more intense procedure and should be valued slightly higher than 52341. **The RUC recommends a work RVU of 5.45 for CPT code 36251.**

36252 ***Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiologic supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; bilateral***

The RUC reviewed the survey results from 72 physicians for CPT code 36252. RUC reviewed the survey work values and agreed that the respondents overestimated the physician work value at the median level. The RUC compared the surveyed code to the reference code 43272 *Endoscopic retrograde cholangiopancreatography (ERCP); with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique* (work RVU= 7.38) and agreed that the physician work and intensity is comparable with similar intra-service time of 53 minutes and 60 minutes, respectively. Given this, the RUC agreed that the work value for 36252 should be directly crosswalked to the work RVU of 7.38 for the CPT code 43272. To further justify this value, the RUC compared the surveyed code to MPC code 58560 *Hysteroscopy, surgical; with division or resection of intrauterine septum (any method) (*work RVU= 6.99) and agreed that while the reference code has greater intra-service time compared to 36252, 60 minutes and 53 minutes, the intensity and complexity of the physician work for the surveyed code is greater and should be valued higher than 58560. **The RUC recommends a work RVU of 7.38 for CPT code 36252.**

36253 ***Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiologic supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral***

The RUC reviewed the survey results from 66 physicians for CPT code 36253. The RUC reviewed the survey work values and agreed that the respondents overestimated the physician work value at the median level. The RUC compared the surveyed code to the reference code 52345 *Cystourethroscopy with ureteroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)* (work RVU= 7.55) and agreed that the two services have comparable total time of 135 minutes and should be valued identically. Given this, the RUC recommends the physician work for 36253 be directly crosswalked to reference code 52345 for a work RVU of 7.55. To further justify this value, the RUC compared the surveyed code to the bilateral selective catheter placement code, 36252, and agreed that the increase in intensity and intra-service time, 60 minutes compared to 53 minutes, for code 36253 is accurately captured with a work RVU of 7.55 compared to 7.38 for 36252. **The RUC recommends a work RVU of 7.55 for CPT code 36253.**

36254 ***Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiologic supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; bilateral***

The RUC reviewed the survey results from 66 physicians for CPT code 36253. The RUC reviewed the survey work values and agreed that the respondents overestimated the physician work value at the median level. The RUC compared the surveyed code to the recently reviewed reference code 37220 *Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty* (work RVU= 8.15) and agreed that the two services are comparable in physician work and intensity, with almost identical total time, 139 minutes and 138 minutes, respectively. Given this, the RUC recommends the physician work for 36254 be directly crosswalked to reference code 37220 for a work RVU of 8.15. To further justify this value, the RUC

compared the surveyed code to the key reference service code 37183 *Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS)* (work RVU= 7.99) and agreed that while the reference code has greater intra-service time, 77.5 minutes compared to 68 minutes, the respondents rated 36254 as a more intense procedure in the intensity and complexity measures. **The RUC recommends a work RVU of 8.15 for CPT code 36254.**

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 the direct practice expense inputs recommended and made a few minor changes to them to reflect the typical patient service. The RUC also noted that the standard of care now requires moderate sedation, which is inherent in the procedure. Apart from the additional RN time required to administer the moderate sedation, the practice expense recommendations create efficiencies.

IVC Transcatheter Procedure (Tab 12 and 13)
Sean Tutton, MD (SIR), Robert Vogelzang, MD (SIR), Jerry Niedzwiecki, MD (SIR), Michael Hall, MD (SIR), Gerladine McGinty, MD (ACR), Zeke Silva, MD (ACR), Gary Seabrook, MD (SVS), Robert Zwolak, MD (SVS), David Han, MD (SVS), Michael Sutherland, MD (SVS), Mathew Sideman, MD (SVS)

In February 2010, CPT code 37620 *Interruption, partial or complete, of inferior vena cava by suture, ligation, plication, clip, extravascular, intravascular (umbrella device)* was identified by the Relativity Assessment Workgroup through the Codes Reported Together 75% or More Screen. This code has been billed commonly with 75940 and 36010. In February 2011, the specialties submitted a code change proposal to the CPT Editorial Panel to bundle the services commonly reported together. The Panel created four new codes for RUC review in April 2011.

36010 ***Introduction of catheter, superior or inferior vena cava***
The RUC agreed with the specialties to delay review of this service until the September 2011 RUC meeting. The specialty societies explained that the top five diagnoses for this service are related to conditions that are now reported by the new IVC filter codes. Therefore, the utilization for 36010 is expected to drop significantly. In addition, the typical vignette and dominant provider may change. **The RUC recommends to delay the review of CPT code 36010 until the September 2011 RUC meeting.**

37191 ***Insertion of intravascular vena cava filter, endovascular approach inclusive of vascular access, vessel selection, and all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy)***
The RUC reviewed the survey results from 90 physicians for CPT code 37191. The RUC reviewed the survey's estimated work values and agreed with the specialties that the respondents overestimated the work value of this service. In order to accurately value this procedure, the RUC compared the surveyed code to an analogous percutaneous procedure CPT code 32550 *Insertion of indwelling tunneled pleural catheter with* cuff (work RVU= 4.17) and agreed that these procedures are similar in both physician work and intra-service time, 30 minutes, respectively. However, 32550 does not include supervision and interpretation which is inherent in 37191. Adding the reported S&I code, 75940

Percutaneous placement of IVC filter, radiological supervision and interpretation, to the base code work value (4.17 + 0.54) equals a total value of 4.71. The RUC agreed that a work RVU of 4.71 is an accurate value for 37191. To further justify this value, the RUC compared 37191 to CPT code 52275 *Cystourethroscopy, with internal urethrotomy; male* (work RVU= 4.69) and agreed that the services have similar physician work with identical intra-service time of 30 minutes and should be valued similarly. **The RUC recommends a work RVU of 4.71 for CPT code 37191.**

37192 ***Repositioning of intravascular vena cava filter, endovascular approach inclusive of vascular access, vessel selection, and all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy)***
The RUC reviewed the survey results from 69 physicians for CPT code 37192. The RUC discussed and agreed with the specialties that the 75% percentile intra-service time of 60 minutes more accurately described the physician work involved in the service because removing a filter is more challenging than replacement because the filters are fixed to the wall and can be tilted. Also, the median survey service performance rate was 2 per year, suggesting that the survey respondents do not have great familiarity performing this service. The RUC reviewed the survey's estimated work values and agreed that the 25th percentile work RVU of 8.00 is an appropriate value for this service. To further justify this value, the RUC compared 37192 to the key reference service 37183 *Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS)* (work RVU= 7.99) and agreed that while the reference code has greater intra-service time compared to 37192, 77.5 minutes compared to 60 minutes, the survey respondents consistently rated the surveyed code's physician work more intense in the intensity/complexity measures due to the risk of tearing the cava during the procedure. **The RUC recommends a work RVU of 8.00 for CPT code 37192.**

37193 ***Retrieval (removal) of intravascular vena cava filter, endovascular approach inclusive of vascular access, vessel selection, and all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy)***
The RUC reviewed the survey results from 74 physicians for CPT code 37193. The RUC discussed and agreed with the specialties that the 75% percentile intra-service time of 60 minutes more accurately described the physician work involved in the service because taking out a filter is more challenging than placing them because the filters are fixed to the wall and can be tilted. Also, the median survey service performance rate was 6 per year, suggesting that the survey respondents do not have great familiarity performing this service. The RUC reviewed the survey's estimated work values and agreed that the 25th percentile work RVU of 8.00 is an appropriate value for this service. To further justify this value, the RUC compared 37192 to the key reference service 37183 *Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS)* (work RVU= 7.99) and agreed while the reference code has greater intra-service time compared to 37193, 77.5 minutes compared to 60 minutes, the survey respondents consistently rated the surveyed code's physician work more intense in the intensity and complexity measures due to the risk of tearing the cava during the procedure. **The RUC recommends a work RVU of 8.00 for CPT code 37193.**

37619 ***Ligation of inferior vena cava***
The RUC reviewed the survey results from 41 vascular and general surgeons and agreed with the specialties that the survey respondents underestimated the total physician work for this rarely performed service, by underestimating the significant post-operative work.

The RUC concurred with the specialties that the 75th percentile work RVU of 37.60 is an accurate value for this intense procedure. To further justify this value, the RUC compared 37619 to the key reference service 35082 *Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta* (work RVU= 42.09) and agreed that these two services are analogous, intense procedures, requiring significant post-operative work, including ICU care. Bleeding from a ruptured major vein in the abdomen or pelvis is one of a surgeon's most difficult injuries to control. Ligation of the vena cava is only performed as a last effort to save a patient with massive venous bleeding, most often from trauma. Given these complexities, the key reference code is a suitable comparison, but with greater intra-service time compared to 37619, 180 minutes and 150 minutes, respectively. **The RUC recommends a work RVU of 37.60 for CPT code 37619.**

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 the direct practice expense inputs recommended and made a few minor changes to them to reflect the typical patient service.

New Technology
The RUC requested that CPT codes 37192 and 37193 be placed on the new technology list to review the volume of this service in three years to ensure that the utilization assumptions were accurate.

Destruction by Neurolytic Agent (Tab 14)
Marc Leib, MD, JD (ASA), Eduardo Fraifeld, MD (AAPM), David Carroway, MD (ASIPP), William Sullivan, MD (NASS), Chris Merifield, MD (ISIS), Scott Horn, DO (ISIS)
CPT code 64626, *Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, single level* was identified by the RUC's Five-Year Review Identification Workgroup in April 2008 as potentially misvalued through the Site-of-Service Anomaly screen. In April 2010, the specialty society requested and the RUC agreed that 64622, 64623, 64626, 64627 be referred to CPT to clarify that imaging is required. In February 2011, the CPT Editorial Panel deleted four codes and created four new codes to describe neurolysis reported per joint (2 nerves per each joint) instead of per nerve under image guidance. This level of specificity allowed for the codes to better reflect current practice and the bundling of components. The panel also editorially revised codes 77003 and 77012 to no longer separately report fluoroscopic guidance and localization.

64633 ***Destruction by neurolytic agent, paravertebral facet joint nerve(s); cervical or thoracic, with image guidance (fluoroscopy or CT), single facet joint***
The RUC reviewed the specialty society's survey results of CPT code 61633X from 58 physicians who provide these services. An additional 4 minutes for proper prone positioning is important for these procedures, similar to other facet joint injection procedure positioning. The RUC compared the specialty recommended 25th percentile work RVU of 3.84 to the work of its key reference service 64681 *Destruction by neurolytic agent, with or without radiologic monitoring; superior hypogastric plexus* (work RVU = 3.78, intra time= 30 minutes). The RUC agreed that these two services

have similar physician work with identical intra-service time, 30 minutes. The RUC concurred that the technical skill, stress, and intensity of 61633X is greater than that of 64681. The RUC agreed that the survey's 25th percentile work value is appropriate given the time, skill, and intensity required to perform this service. **The RUC recommends a work RVU of 3.84 for CPT code 61633X.**

64634 ***Destruction by neurolytic agent, paravertebral facet joint nerve(s); cervical or thoracic, with image guidance (fluoroscopy or CT), each additional facet joint (List separately in addition to code for primary procedure)***
The RUC discussed the specialty society's survey results of CPT code 61634X from 39 physicians who provide these services. The RUC compared the specialty recommended 25th percentile work RVU of 1.32 to the work of its key reference service 64491*Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure)* (work RVU = 1.16) and 13122 *Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (List separately in addition to code for primary procedure)* (work RVU = 1.44). The RUC concurred that the technical skill, stress, and intensity of add on code 616334X is greater than that of 64491 and less than 13122. The RUC agreed that the survey's 25th percentile work value was appropriate given the time, skill, and intensity of the service. **The RUC recommends a work RVU of 1.32 for CPT code 61634X.**

64635 Destruction by neurolytic agent, paravertebral facet joint nerve(s); lumbar or sacral, with image guidance (fluoroscopy or CT), single facet joint
The RUC discussed the specialty society's survey results of CPT code 61635X from 42 physicians who provide these types services. An additional 4 minutes for proper prone positioning is important for these procedures, similar to other facet joint injection procedure positioning. The RUC compared the specialty recommended 25th percentile work RVU of 3.78 to the work of its key reference service 64681 *Destruction by neurolytic agent, with or without radiologic monitoring; superior hypogastric plexus* (work RVU = 3.78, intra time = 30 minutes). The RUC agreed that these two services have similar physician work with identical intra-service times 30 minutes. The RUC concurred that the technical skill, stress, and intensity of 61635X can be equated to that of 64681. The RUC agreed that the specialty's 25th percentile survey work value was appropriate given the time, skill, and intensity of the service and noted that this service is less intense and complex in comparison to the cervical service 64633. **The RUC recommends a work RVU of 3.78 for CPT code 64635.**

64636 Destruction by neurolytic agent, paravertebral facet joint nerve(s); lumbar or sacral, with image guidance (fluoroscopy or CT), each additional facet joint (List separately in addition to code for primary procedure)
The RUC discussed the specialty society's survey results of CPT code 61636 from 37 physicians who provide these types services. The RUC compared the specialty recommended 25th percentile work RVU of 1.16to the work of its key reference service 64494 *Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in addition to code for primary procedure)* (work RVU = 1.00, intra time= 15 minutes) and 13122 *Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (List separately in addition to code for primary procedure)* (work RVU = 1.44). The RUC concurred that the technical skill, stress, and

intensity of add on code 61636X is greater than that of 64494 and less than 13122. The RUC agreed that the survey's 25th percentile work value is appropriate given the time, skill, and intensity of the service. In addition, the RUC agreed that this add on service is less intense and complex than that of the cervical add-on service 64634. **The RUC recommends a work RVU of 1.16 for CPT code 61636.**

Practice Expense: The RUC reviewed the direct practice expense inputs for these new destruction by neurolytic agent services and reduced the clinical labor time recommended by the specialty to reflect the typical patient service for all four codes. The RUC made edits to the equipment recommended and agreed that the typical service was performed within a C-Arm room rather than a radiographic fluoroscopic room.

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.

Molecular Pathology - Tier 1 (Tab 15)
Jonathan L. Myles, MD, (CAP), Roger D. Klein, MD, JD, (CAP)

The CPT Editorial Panel has developed a new coding structure to describe molecular pathology services, based on the efforts and recommendations of the Molecular Pathology Coding Workgroup convened beginning in October 2009. In October 2010 and February 2011, the Panel accepted 92 Tier 1 codes, which are a list of gene-specific and genomic analysis CPT codes for high-volume molecular pathology services. These services were previously reported with a series of "stacking codes." The RUC understands that payment for these services is currently based on a mixture of payment methodologies, including the physician fee schedule and the clinical lab fee schedule. CMS has requested that the RUC review data provided by the College of American Pathologists to provide the agency with more information as a policy is developed to determine which payment schedule is appropriate for these services. In April 2011, the specialty presented information on 18 Tier I codes, with the intent to provide data on additional 52 services in September 2011. At this time, the specialty indicated that physician interpretation is not typically required for the remaining 22 Tier I codes.

81206 ***BCR/ABL1 (t[9;22]) (eg, chronic myelogenous leukemia) translocation analysis; major breakpoint, qualitative or quantitative***
A survey of 62 pathologists indicated that the median time for 81206 was 15 minutes, however, the specialty recommended that the work valuation was overstated by these respondents. The RUC agreed with the specialty that the work is similar to 86320 *Immunoelectrophoresis; serum* (total time = 17 minutes, work RVU = 0.37). **The RUC recommends a work RVU of 0.37 for CPT code 81206**.

81207 ***BCR/ABL1 (t[9;22]) (eg, chronic myelogenous leukemia) translocation analysis; minor breakpoint, qualitative or quantitative***
A survey of 30 pathologists indicated that the median time for 81207 was 11 minutes, however, the specialty recommended that the work valuation was overstated by these respondents. The RUC agreed with the specialty that the work is slightly more work and reflects higher intensity than 88302 Level II – *Surgical pathology, gross and microscopic examination* (time = 11 minutes, work RVU = 0.13). **The RUC recommends a work RVU of 0.15 for CPT code 81207.**

81208 ***BCR/ABL1 (t[9;22]) (eg, chronic myelogenous leukemia) translocation analysis; other breakpoint, qualitative or quantitative***
A survey of 16 pathologists indicated that the median time for 81208 was 18 minutes and the specialty recommended work value reflects a 25th percentile work RVU of 0.46. The RUC noted that less than 30 pathologists responded to the survey for this code. This code is rarely performed (estimated 1,000 annually in the Medicare population) and few pathologists are currently performing this test. However, the RUC agreed that work RVU of 0.46 fairly values this service relative to 81206 and 81207. In addition, 81208 requires slightly more physician work and time to perform compared to 88141 *Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician* (total time = 16 minutes, work = 0.42). **The RUC recommends a work RVU of 0.46 for CPT code 81208.**

81220 ***CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; common variants (eg, ACMG/ACOG guidelines)***
A survey of 32 pathologists indicated that the median time for 81211 was 10 minutes, however, the specialty recommended that the work valuation was overstated by these respondents. The RUC agreed with the specialty that81211 requires slightly more work to perform and is more intense than 88302 Level II – *Surgical pathology, gross and microscopic examination* (total time = 11 minutes, work RVU = 0.13). **The RUC recommends a work RVU of 0.15 for CPT code 81220**.

81221 ***CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis;*** **known familial variants**
A survey of 13 pathologists indicated that the median time for 81212 was 20 minutes and the specialty recommended work value reflects a 25th percentile work RVU of 0.40. The RUC noted that less than 30 pathologists responded to the survey for this code. This code is rarely performed (estimated 1,000 annually in the Medicare population) and few pathologists are currently performing this test. However, the RUC agreed that work RVU of 0.40 fairly values this service relative to 81211 and 81213. In addition, 81212 requires less work and intensity to perform compared to 88291 *Cytogenetics and molecular cytogenetics, interpretation and report (*total time = 20 minutes, work = 0.52). **The RUC recommends a work RVU of 0.40 for CPT code 81221.**

81222 ***CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis;*** **duplication/deletion variants**
A survey of 6 pathologists indicated that the median time for 81213 was 13 minutes and reflects a median work RVU of 0.22. The RUC noted that less than 30 pathologists responded to the survey for this code. This code is rarely performed (estimated 1,000 annually in the Medicare population) and few pathologists are currently performing this test. The RUC compared 81213 to 88304 *Level III Surgical pathology, gross and microscopic examination* (total time = 15 minutes, work = 0.22) and determined the physician work required to perform these services are equal. The RUC recommends the physician work for 81213 be crosswalked to 88304. In addition the RUC agreed that a work RVU of 0.22 places this service in the proper rank order relative to 81211 and 81212. **The RUC recommends a work RVU of 0.22 for CPT code 81222.**

81223 ***CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis;*** **full gene sequence**
A survey of 9 pathologists indicated that the median time for 81214 was 20 minutes, however, the specialty recommended that the work valuation was overstated by these respondents. The RUC noted that less than 30 pathologists responded to the survey for this code. This code is rarely performed (estimated 1,000 annually in the Medicare population) and few pathologists are currently performing this test. However, the RUC agreed that a work RVU of 0.40 is appropriate as 81214 requires the same physician work to perform as 81212. In addition, 81214 requires less physician work and intensity to perform compared to 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work = 0.52), therefore places the surveyed service in the proper rank order. **The RUC recommends a work RVU of 0.40 for CPT code 81223.**

81224 ***CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis;*** **intron 8 poly-T analysis (eg, male infertility)**
A survey of 14 pathologists indicated that the median time for 81215 was 10 minutes, however, the specialty recommended that the work valuation was overstated by these respondents. The RUC noted that less than 30 pathologists responded to the survey for this code. This code is rarely performed (estimated 1,000 annually in the Medicare population) and few pathologists are currently performing this test. The RUC agreed with the specialty that 81215 requires slightly more physician work to perform and is more intense compared to 88302 Level II – *Surgical pathology, gross and microscopic examination* (total time = 11 minutes, work RVU = 0.13). **The RUC recommends a work RVU of 0.15 for CPT code 81224**.

81240 F2 (prothrombin, coagulation factor II) (eg, hereditary hypercoagulability) gene analysis; 20210G>A variant
A survey of 42 pathologists indicated that the median time for 81216 was 7 minutes, however, the specialty recommended that the work valuation was overstated by these respondents. The RUC agreed with the specialty that the physician work required to perform 81216 is equivalent to 88302 Level II *Surgical pathology, gross and microscopic examination* (total time = 11 minutes, work RVU = 0.13) and should be crosswalked. **The RUC recommends a work RVU of 0.13 for CPT code 81240.**

81241 F5 (coagulation Factor V) (eg, hereditary hypercoagulability) gene analysis; Leiden variant
A survey of 41 pathologists indicated that the median time for 81217 was 8 minutes, however, the specialty recommended that the work valuation was overstated by these respondents. The RUC agreed with the specialty that the physician work required to perform 81217 is equivalent to 88302 Level II *Surgical pathology, gross and microscopic examination* (total time = 11 minutes, work RVU = 0.13) and should be crosswalked. **The RUC recommends a work RVU of 0.13 for CPT code 81241.**

81243 FMR1 (Fragile X mental retardation 1) (eg, fragile X mental retardation) gene analysis; evaluation to detect abnormal (eg, expanded) alleles
A survey of 13 pathologists indicated that the median time for 81243 was 15 minutes and the specialty recommended work value reflects a 25th percentile work RVU of 0.37. The RUC noted that less than 30 pathologists responded to the survey for this code. This code is rarely performed (estimated 900 annually in the Medicare population) and few pathologists are currently performing this test. The RUC compared 81243 to 86320

Immunoelectrophoresis; serum (total time = 17 minutes, work = 0.37) and determined 81243 requires the same physician work to perform, which is supported by the survey 25th percentile work RVU of 0.37. **The RUC recommends a work RVU of 0.37 for CPT code 81243.**

81244 FMR1 (Fragile X mental retardation 1) (eg, fragile X mental retardation) gene analysis; characterization of alleles (eg, expanded size and methylation status)
A survey of 11 pathologists indicated that the median time for 81244 was 20 minutes and the specialty recommended work value reflects a 25th percentile work RVU of 0.51. The RUC noted that less than 30 pathologists responded to the survey for this code. This code is rarely performed (estimated 100 annually in the Medicare population) and few pathologists are currently performing this test. However, the RUC agreed that work rvu of 0.51 fairly values this service relative to the work and intensity of 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work RVU = 0.52). **The RUC recommends a work RVU of 0.51 for CPT code 81244.**

81256 HFE (hemochromatosis) (eg, hereditary hemochromatosis) gene analysis; common variants (eg, C282Y, H63D)
A survey of 18 pathologists indicated that the median time for 81256 was 7 minutes, however, the specialty recommended that the work valuation was overstated by these respondents. The RUC agreed with the specialty that the physician work is equivalent to 88302 *Level II Surgical pathology, gross and microscopic examination* (total time = 11 minutes, work RVU = 0.13) and therefore should be crosswalked. **The RUC recommends a work RVU of 0.13 for CPT code 81256**.

81270 JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis; V617F variant
A survey of 46 pathologists indicated that the median time for 81270 was 10 minutes, however, the specialty recommended that the work valuation was overstated by these respondents. The RUC agreed with the specialty that 81270 requires slightly more physician work and is more intense to perform compared to 88302 Level II – *Surgical pathology, gross and microscopic examination* (total time = 11 minutes, work RVU = 0.13). **The RUC recommends a work RVU of 0.15 for CPT code 81270.**

81275 KRAS (v-Ki-ras2 Kirsten rat sarcoma viral oncogene) (eg, carcinoma) gene analysis; variants in codons 12 and 13
A survey of 43 pathologists indicated that the median time for 81275 was 20 minutes and reflects a 25th percentile work RVU of 0.50. The RUC agreed that survey 25th percentile work RVU of 0.50 fairly values this service relative to the work and intensity required to perform 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work = 0.52). **The RUC recommends a work RVU of 0.50 for CPT code 81275.**

81291 MTHFR (5,10-methylenetetrahydrofolate reductase) (eg, hereditary hypercoagulability) gene analysis; common variants (eg, 677T, 1298C)
A survey of 16 pathologists indicated that the median time for 81291 was 10 minutes, however, the specialty recommended that the work valuation was overstated by these respondents. The RUC noted that less than 30 pathologists responded to the survey for this code. This code is rarely performed (estimated 5,000 annually in the Medicare population) and few pathologists are currently performing this test. The RUC agreed with the specialty that 81291 requires slightly more physician work to perform than 88302 Level II – *Surgical pathology, gross and microscopic examination* (total time = 11 minutes, work RVU = 0.13). **The RUC recommends a work RVU of 0.15 for CPT code 81291.**

81315 PML/RARalpha, (t(15;17)), (PML-RARA regulated adaptor molecule 1) (eg, promyelocytic leukemia) translocation analysis; common breakpoints (eg, intron 3 and intron 6), qualitative or quantitative
A survey of 27 pathologists indicated that the median time for 81243 was 15 minutes, however, the specialty recommended that the work valuation was overstated by these respondents. The RUC noted that less than 30 pathologists responded to the survey for this code. This code is rarely performed (estimated 1,000 annually in the Medicare population) and few pathologists are currently performing this test. The RUC compared 81315 to 86320 *Immunoelectrophoresis; serum* (total time = 17 minutes, work = 0.37) and determined that the surveyed code requires the same physician work to perform and therefore should be crosswalked. **The RUC recommends a work RVU of 0.37 for CPT code 81315.**

81316 PML/RARalpha, (t(15;17)), (PML-RARA regulated adaptor molecule 1) (eg, promyelocytic leukemia) translocation analysis; single breakpoint (eg, intron 3, intron 6 or exon 6), qualitative or quantitative
A survey of 15 pathologists indicated that the median time for 81316 was 12 minutes, however, the specialty recommended that the work valuation was overstated by these respondents. The RUC noted that less than 30 pathologists responded to the survey for this code. This code is rarely performed (estimated 1,000 annually in the Medicare population) and few pathologists are currently performing this test. The RUC compared 81316 to 88304 *Level III Surgical pathology, gross and microscopic examination (*total time = 15 minutes, work = 0.22) and determined that the surveyed code requires the same physician work to perform and therefore should be crosswalked. **The RUC recommends a work RVU of 0.22 for 81316.**

Practice Expense
The specialty provided data based on assumed batch sizes and modified these batch size estimates to ensure maximum efficiency for today's practice. However, these assumptions should be re-examined when greater experience is available for these services.

Work Neutrality
Reviewing the Medicare utilization data for 83912 *Molecular diagnostics; interpretation and report* (work RVU = 0.37) and the specialty's estimate of utilization of these individual services, the RUC understands that these recommendations will be work neutral to the family.

New Technology
The entire set of molecular pathology codes should be re-reviewed after claims data are available and there is experience with the new coding system. The time, work valuation, codes reported together by the same provider and practice expense inputs should all be reviewed again in the future as these estimates are based on a good faith effort using available information in 2011.

Molecular Pathology - Tier 2 (Tab 16)
Jonathan L. Myles, MD, (CAP), Roger D. Klein, MD, JD, (CAP)

The CPT Editorial Panel has developed a new coding structure to describe molecular pathology services, based on the efforts and recommendations of the Molecular Pathology Coding Workgroup convened beginning in October 2009. In October 2010, the Panel accepted 9 Tier 2 codes, which are a list of codes to be reported when the service is not listed in the Tier 1 codes. The Tier 2 codes are arranged by the level of technical resources and interpretive professional work required. The RUC understands that these services will be rarely reported and represent tests that are largely under development and unlikely to be automated at this time. Once a test has matured, utilization increases, and efficiencies are created, the RUC understands that the test will be assigned a Tier 1 code. These services were previously reported with a series of "stacking codes." The RUC understands that payment for these services is currently based on a mixture of payment methodologies, including the physician fee schedule and the clinical lab fee schedule. CMS has requested that the RUC review data provided by the College of American Pathologists to provide the agency with more information as a policy is developed to determine which payment schedule is appropriate for these services.

Overall, the RUC found it difficult to appropriately assign a work valuation to these services. The number of survey respondents for each code ranged from 11 to 26, all below the RUC's required minimum of thirty respondents. The recommendations submitted by the specialty did not reflect appropriate valuation given the corresponding time recommendations. **The RUC proposes the following recommendations as interim. The specialty will re-survey these codes in Summer 2011 and present new data at the September 2011 RUC meeting.**

81400 ***Molecular pathology procedure, Level 1 (eg, identification of single germline variant [eg, SNP] by techniques such as restriction enzyme digestion or melt curve analysis)***
The RUC reviewed the median survey time of 10 minutes and recommends the median survey work RVU of 0.37. The RUC agreed that this placed the service in appropriate rank order with a 99212 *Office Visit, Level II* (total time =16 minutes; work RVU = 0.48). For further support, the RUC also determined that this service is similar to 80500 *Clinical pathology consultation; limited, without review of patient's history and medical records* (total time = 13 minutes, work RVU = 0.37). **The RUC recommends an interim work RVU of 0.37 for CPT code 81400.**

81401 ***Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat)***
The RUC reviewed the median survey time of 13 minutes and recommends the median survey work RVU of 0.55. The RUC agreed that this placed the service in appropriate rank order with a 99212 *Office Visit, Level II* (total time =16 minutes; work RVU = 0.48). For further support, the RUC referenced similar service 88387 *Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); each tissue preparation (eg, a single lymph node*) (total time = 20 minutes, work RVU = 0.62). **The RUC recommends an interim work RVU of 0.55 for CPT code 81401.**

81402 ***Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants 1 exon)***
The RUC reviewed the median survey time of 18 minutes and recommends the median survey work RVU of 0.68. The RUC agreed that this placed the service in appropriate rank order with a 99212 *Office Visit, Level II* (total time =16 minutes; work RVU = 0.48). For further support the RUC referenced similar service 88387 *Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); each tissue preparation (eg, a single lymph node*) (total time = 20 minutes, work RVU = 0.62). **The RUC recommends an interim work RVU of 0.68 for CPT code 81402.**

81403 ***Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)***
The RUC reviewed the median survey time of 30 minutes and recommends the median survey work RVU of 0.85. The RUC agreed that this placed the service in appropriate rank order with a 99213 *Office Visit, Level II* (total time =23 minutes; work RVU = 0.97). For further support the RUC referenced similar service 88342 *Immunohistochemistry (including tissue immunoperoxidase), each antibody* (total time = 27 minutes, work RVU = 0.85). **The RUC recommends an interim work RVU of 0.85 for CPT code 81403.**

81404 ***Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis)***
The RUC reviewed the median survey time of 45 minutes and recommends the median 75th percentile work RVU of 1.30. The RUC agreed that this placed the service in appropriate rank order with a 99214 *Office Visit, Level II* (total time = 40 minutes; work RVU = 1.50). For further support the RUC referenced similar service 80502 *Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records* (total time = 42 minutes, work RVU = 1.33). **The RUC recommends an interim work RVU of 1.30 for CPT code 81404.**

81405 ***Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons)***
The RUC reviewed the median survey time of 45 minutes and recommends the median 75th percentile value of 1.33. The RUC agreed that this placed the service in appropriate rank order with a 99214 *Office Visit, Level II* (total time = 40 minutes; work RVU = 1.50). For further support the RUC referenced similar service 80502 *Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records* (total time = 42 minutes, work RVU = 1.33). **The RUC recommends an interim work RVU of 1.33 for CPT code 81405.**

81406 ***Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons, cytogenomic array analysis for neoplasia)***
The RUC reviewed the median survey time of 60 minutes and recommends the median 75th percentile work RVU of 1.55. The RUC agreed that this placed the service in appropriate rank order with a 99214 *Office Visit, Level II* (total time = 40 minutes; work RVU = 1.50). For further support the RUC referenced similar service 88307 *Level V Surgical pathology, gross and microscopic examination* (total time = 47 minutes, work RVU = 1.59). **The RUC recommends an interim work RVU of 1.55 for CPT code 81406.**

81407 ***Molecular pathology procedure, Level 8 (eg, analysis of 26-50 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of >50 exons, sequence analysis of multiple genes on one platform)***
The RUC reviewed the median survey time of 63 minutes. The RUC agreed that the service should be directly crosswalked to 88307 *Level V Surgical pathology, gross and microscopic examination* (total time = 47 minutes, work RVU = 1.59). The RUC agreed that this placed the service in appropriate rank order with a 99214 *Office Visit, Level II* (total time = 40 minutes; work RVU = 1.50). **The RUC recommends an interim work RVU of 1.59 for CPT code 81407.**

81408 ***Molecular pathology procedure, Level 9 (eg, analysis of >50 exons in a single gene by DNA sequence analysis)***
The RUC reviewed the median survey time of 73 minutes and recommends the median 75th percentile work RVU of 1.75. The RUC agreed that this placed the service in appropriate rank order with a 99214 *Office Visit, Level II* (total time = 40 minutes; work RVU = 1.50) and 88307 *Level V Surgical pathology, gross and microscopic examination* (total time = 47 minutes, work RVU = 1.59). Additionally, the RUC agreed that the surveyed service requires more physician work to perform compared to 88188 *Flow cytometry, interpretation; 9 to 15 markers* (total time = 43 minutes, work RVU = 1.69). **The RUC recommends an interim work RVU of 1.75 for 81404.**

Practice Expense
The specialty provided data based on assumed batch sizes and modified these batch size estimates to ensure maximum efficiency for today's practice. However, these assumptions should be re-examined when greater experience is available for these services.

Work Neutrality
Reviewing the Medicare utilization data for 83912 *Molecular diagnostics; interpretation and report* (work RVU = 0.37) and the specialty's estimate of utilization of these individual services, the RUC understands that these recommendations will be work neutral to the family.

New Technology
The entire set of molecular pathology codes should be re-reviewed after claims data are available and there is experience with the new coding system. The time, work valuation, codes reported for the same beneficiary and practice expense inputs should all be reviewed again in the future as these estimates are based on a good faith effort using available information in 2011.

Contact Lens Fitting (Tab 17)
Stephen Kamenetzky, M.D. (AAO) and Michael Chaglasian, O.D. (AOA)

In the 4th Five-Year Review of the RBRVS, CMS identified code 92070 *Fitting of contact lens for treatment of disease, including supply of lens* (work RVU = 0.70) through the Harvard-Valued – Utilization over 30,000 screen. Upon review of this service, the specialty societies agreed that there are two distinct uses for 92070 that have substantially different levels of work. In February 2011, the CPT Editorial Panel agreed and deleted code 92070 and created two new codes to distinguish reporting of fitting of contact lens for treatment of ocular surface disease and fitting of contact lens for management of keratoconus.

92071 ***Fitting of contact lens for treatment of ocular surface disease***
The RUC reviewed the survey results from 66 ophthalmologists and optometrists who perform this procedure. Eighty-five percent of the survey respondents believed the vignette was typical and the code would typically be used on the same day as an Evaluation and Management visit. This service involves identifying and fitting of the correct therapeutic contact lens for the corneal damaged eye, to facilitate healing. Although the survey respondents indicated the typical physician intra-service work time requires 15 minutes, the specialty society and the RUC agreed that only five minutes was typical in comparison to similar services, with a total time of 15 minutes. The survey respondents chose 65205 *Removal of foreign body, external eye; conjunctival superficial* (000 day global, work RVU = 0.71) as its key reference service and the RUC agreed that this reference code, with identical physician time components, should be valued similarly to 92071. The RUC compared the work of this service to that of code 65778 *Placement of amniotic membrane on the ocular surface for wound healing; self-retaining* (010 day global, work RVU = 1.19) without its follow up visit. Although the survey indicated a median work RVU of 1.11, the specialty recommended, and the RUC agreed, that the original work value of 0.70 for CPT code 92070 was more appropriate. **The RUC recommends a work RVU of 0.70 for CPT code 92071.**

92072 ***Fitting of contact lens for management of keratoconus***
The RUC accepted compelling evidence that this service is separate from the original 92070 service and has never been valued in the past. In addition, the original code 92070 and new code 92071 were valued unilaterally whereas 92072 appropriately has been surveyed as being typically performed bilaterally. In addition, keratoconus is not seen in the Medicare population and it is not covered.

The RUC reviewed the survey results from 61 ophthalmologists and optometrists who perform this procedure. The specialty recommended 10 minutes of pre-service time to account for the review of all referring data on the patient and an extensive educational discussion concerning lens trials with the patient. A reduced immediate post service time from the survey was also recommended by the specialty to be only 10 minutes rather than 20 minutes. The specialty indicated and the RUC agreed that the immediate post service time, 10 minutes, appropriately mirrors the post service time of 92004 *Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits* (work RVU = 1.82). The RUC determined that the surveyed code is more complex, requires more time, 65 total minutes compared to 40 minutes, and is more intense than the work associated with 92004. The intensity and complexity of 92072 requires the physician to manage a warped cornea to get the correct specially designed contact lens fit in each eye. Each eye is pathologically unique and requires evaluating the correct fit with dye and light. Therefore, the RUC determined that the median work RVU of 1.97 appropriately accounts for the work required to perform this service. **The RUC recommends a work RVU of 1.97 for CPT code 92072**

Referral to CPT:
The RUC referred CPT code 92072 to the CPT Editorial Panel to add language to the code to clarify that the service is the initial service for treatment of keratoconus and that subsequent contact lens fittings would be coded with a general ophthalmological exam or Evaluation and Management service.

Practice Expense:
The RUC reviewed and refined the direct practice expense inputs for 92071 and 92072 to reflect the typical patient service.

<u>Tonography (Tab 18)</u>
Stephen Kamenetzky, M.D. (AAO) and Michael Chaglasian, O.D. (AOA)

In the 4th Five-Year Review of the RBRVS, CMS identified codes 92120 and 92130 through the Harvard-Valued – Utilization over 30,000 screen. In April 2010, the specialty societies indicated that an editorial revision of 92120 was necessary to clarify the reporting between tonography and 0198T *Occular blood flow measurement.* In February 2011, the CPT Editorial Panel agreed with the specialty's recommendations. In April 2011, the RUC reviewed 92120 and 92130 and concluded these are low volume services based upon the fact that a survey could not be performed and that virtually all reporting is incorrect coding, as these services should be reported with the Category III code 0198T *Measurement of ocular blood flow by repetitive intraocular pressure sampling, with interpretation and report*. With the support of ophthalmology and optometry the RUC requested that CPT delete these services during the 2012 CPT cycle. **The RUC recommended CPT codes 92120 and 92130 to the CPT Editorial Panel for deletion.**

Subsequent to the RUC's April 2011 recommendation, the CPT Editorial Panel approved the deletion of codes 92120 and 92130 for CPT 2012.

Pulmonary Function Testing (Tab 19)
Burt Lesnick MD, FCCP,(ACCP); Kathrin Nicolacakis, MD, FCCP,(ATS)
Facilitation Committee #2

In February 2010, CPT codes 94240, 94260, 94350, 94360, 94370 and 94725 were identified by the Relativity Assessment Workgroup through the Codes Reported Together 75% or More Screen. These codes are commonly billed together with 94720, 94360, 94240 and 94350. In February 2011, the specialty submitted a code change proposal to the CPT Editorial Panel to bundle the services commonly reported together. The Panel created four bundled services for RUC review in April 2011. The specialty informed the RUC that these tests are not automated.

94726 ***Plethysmography for determination of lung volumes and, when performed, airway resistance***
The RUC reviewed the survey results from 40 pulmonary physicians for CPT code 94726. The RUC recommends pre-service time of 5 minutes, intra-service time of 5 minutes and post-service time of 5 minutes. The RUC reviewed the Medicare claims data for the services that this code is bundling and noted that an Evaluation and Management service is not typically billed on the same date of service. The RUC reviewed the survey work values and agreed with the specialty that the respondents accurately valued the service at the 25th percentile, a work RVU of 0.31. To further justify this value, the RUC compared the physician work of 94726 to the key reference code 94375 *Respiratory flow volume loop* (work RVU= 0.31) and agreed that while the reference code has greater intra-service time compared the surveyed code, 7 minutes compared to 5 minutes, the survey respondents rated 94726 as a more intense and complex procedure. Therefore, the work values should be identical. Also, the RUC compared 94726 to the reference code 93018 *Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; interpretation and report only* (work RVU= 0.30) and agreed that these services have similar intensity and complexity with identical intra-service time of 5 minutes. **The RUC recommends a work RVU of 0.31 for CPT code 94726.**

94727 ***Gas dilution or washout for determination of lung volumes and, when performed, distribution of ventilation and closing volumes***
The RUC reviewed the survey results from 36 pulmonary physicians for CPT code 94727. The RUC recommends pre-service time of 5 minutes, intra-service time of 5 minutes and post-service time of 5 minutes. The RUC reviewed the Medicare claims data for the services that this code is bundling and noted that an Evaluation and Management service is not typically billed on the same date of service. The RUC reviewed the survey's estimated work values and agreed with the specialty that the respondents accurately valued the service at the 25th percentile, a work RVU of 0.31. To further justify this value, the RUC compared 94727 to the key reference code 94375 *Respiratory flow volume loop* (work RVU= 0.31) and agreed that while the reference code has greater intra-service time compared to the surveyed code, 7 minutes and 5 minutes, the survey respondents rated 94727 as a more intense and complex procedure. Therefore, the work values should be identical. Also, the RUC compared 94727 to CPT code 93018 *Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; interpretation and report only* (work RVU= 0.30) and agreed that these services have similar intensity and complexity with identical intra-service time of 5 minutes. **The RUC recommends a work RVU of 0.31 for CPT code 94727.**

94728 ***Airway resistance by impulse oscillometry***
The RUC reviewed the survey results from 31 pulmonary physicians for CPT code 94728. The RUC recommends pre-service time of 5 minutes, intra-service time of 5 minutes and post-service time of 5 minutes. The RUC reviewed the Medicare claims data for the services that this code is bundling and noted that an Evaluation and Management service is not typically billed on the same date of service. In addition, the specialty explained that while 94728 and 94727 can be billed together, this is not typical as the typical scenario for 94728 involves a pediatric patient. The RUC reviewed the survey work values and agreed with the specialty that the respondents accurately valued the service at the 25th percentile, a work RVU of 0.31. To further justify this value, the RUC compared 94728 to the reference code 94375 *Respiratory flow volume loop* (work RVU= 0.31) and agreed that while the reference code has greater intra-service time compared to the surveyed code, 7 minutes and 5 minutes, 94728 is a more intense procedure compared to the reference code. Therefore, the work values should be identical. Also, the RUC compared 94728 to the reference code 93018 *Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; interpretation and report only* (work RVU= 0.30) and agreed that these services have similar intensity and complexity with identical intra-service time of 5 minutes. **The RUC recommends a work RVU of 0.31 for CPT code 94728.**

94729 ***Diffusing capacity (eg, carbon monoxide, membrane)***
The RUC reviewed the survey results from 42 pulmonary physicians for CPT code 94729. The RUC recommends intra-service time of 5 minutes for this ZZZ global code. The RUC reviewed the survey's estimated work values and agreed that the survey respondents overestimated the work value of this procedure. To determine an appropriate work value for this procedure, the RUC reviewed other ZZZ global codes with similar physician work. The RUC reviewed 93352 *Use of echocardiographic contrast agent during stress echocardiography* (work RVU= 0.19) and agreed that this service has comparable physician work and intensity with identical intra-service time of 5 minutes. Therefore, the work value of 94729 should be directly crosswalked to 93352. To further justify a work RVU of 0.19, the RUC compared the surveyed code to the reference code 96415 *Chemotherapy administration, intravenous infusion technique; each additional hour* (work RVU= 0.19) and agreed that the two services have similar physician work and intensity with identical intra-service time of 5 minutes. **The RUC recommends a work RVU of 0.19 for CPT code 94729.**

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 had an extensive discussion concerning the typical patient service and made revisions to the direct practice expense inputs recommended by the specialties. Clinical labor was specifically refined to reflect the typical patient service. It was also recommended and agreed there were no direct inputs in the facility setting for this service.

EMG in Conjunction with Nerve Testing (Tab 20)
Kevin Kerber, MD and Marianna Spanaki, MD (AAN); Marc Nuwer, MD, PhD (ACNS); Benn Smith, MD and Andrea Boon, MD (AANEM); John Palazzo, DSc, PT, ECS (APTA)

In February 2010, CPT codes 95860, 95861, 95863 and 95864 were identified by the Relativity Assessment Workgroup through the Codes Reported Together 75% or More Screen. These codes are billed commonly with 95904. In February 2011, the specialties submitted a code change proposal to the CPT Editorial Panel to bundle the services commonly reported together. The Panel created three new ZZZ global codes to be reviewed at the RUC in April 2011. The CPT Editorial Panel noted, and the RUC agreed, that these three new codes were approved with the intent that the specialties will take additional time and bring forward a more comprehensive coding solution which bundles services commonly performed together during the CPT 2013 cycle.

95885 *Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; limited*
The RUC reviewed the survey results from 88 physicians for CPT code 95885. The RUC reviewed the survey work values and agreed with the specialties that the respondents overestimated the work value of this service. The RUC reviewed CPT code 92621 *Evaluation of central auditory function, with report; each additional 15 minutes* (work RVU= 0.35) and agreed that the two services have comparable physician work and intensity with identical intra-service time of 15 minutes. Given this, the RUC recommends the work value for 95885 be directly crosswalked to the reference code's work RVU of 0.35. To further justify this value, the RUC reviewed another reference code 93320 *Doppler echocardiography, pulsed wave and/or continuous wave with spectral display;* complete (work RVU= 0.38) and agreed that these two analogous services have identical intra-service time, 15 minutes, and should be valued similarly. **The RUC recommends a work RVU of 0.35 for CPT code 95885.**

95886 ***Needle electromyography, each extremity with related paraspinal areas when performed, done with nerve conduction, amplitude and latency/velocity study; complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels***
The RUC reviewed the survey results from 74 physicians for CPT code 95886. The RUC reviewed the survey's estimated work values and agreed with the specialties that the respondents overestimated the work value of this service. The RUC reviewed the reference code 95973 *Electronic analysis of implanted neurostimulator pulse generator system; complex spinal cord, or peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour* (work RVU= 0.92) and agreed that the two services have similar physician work and intensity with identical intra-service time of 30 minutes. Given this, the RUC recommends the work value for 95886 be directly crosswalked to the reference code's work RVU of 0.92. To further justify this value, the RUC reviewed the reference code 17315 *Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s)* (work RVU= 0.87) and agreed that while the two services have identical intra-service time of 30 minutes, the surveyed code is a more complex procedure and should be valued slightly higher than the reference code. **The RUC recommends a work RVU of 0.92 for CPT code 95886.**

95887 ***Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study***
The RUC reviewed the survey results from 63 physicians for CPT code 95887. The RUC reviewed the survey work values and agreed with the specialties that the respondents overestimated the work value of this service. The RUC reviewed the reference code 88334 *Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site* (work RVU= 0.73) and agreed that the two services have similar physician work and identical intra-service time of 20 minutes. Given the similarities, the RUC recommends the work value for 95887 be directly crosswalked to the reference code's work RVU of 0.73. To further justify this value, the RUC reviewed reference code 76885 *Ultrasound, infant hips, real time with imaging documentation; dynamic (requiring physician manipulation)* (work RVU= 0.74) and agreed that the two services have comparable physician work and intensity with identical intra-service time of 20 minutes. **The RUC recommends a work RVU of 0.73 for CPT code 95887.**

95900 ***Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study***
The RUC reviewed the survey results from 64 physicians for CPT code 95900. The RUC recommends maintaining the current RUC reviewed pre-service time of 4 minutes, intra-service time of 6 minutes and post-service time of 4 minutes. The RUC reviewed the survey work values and agreed with the specialties that the respondents overestimated the work value of this service. Given that there is no compelling evidence to suggest the physician work has changed for this service, the RUC recommends the current work RVU of 0.42 for this service. To justify this value, the RUC looked at the MPC code 99212 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU= 0.48) and agreed that these service are comparable but given that the reference code has greater intra-service time, 10 minutes compared to 6 minutes, the surveyed code should be valued lower. **The RUC recommends a work RVU of 0.42 for CPT code 95900.**

95903 ***Nerve conduction, amplitude and latency/velocity study, each nerve; motor, motor, with F-wave study***
The RUC reviewed the survey results from 64 physicians for CPT code 95903. The RUC recommends pre-service time of 4 minutes, intra-service time of 10 minutes and post-service time of 4 minutes. The pre-service and post-service time components were reduced from the survey median values to match the analogous physician work of 95900. The RUC noted there is no compelling evidence to suggest the physician work has changed for this service and recommends the current work RVU of 0.60 for this code. To justify this value, the RUC looked at the key reference service 95937 *Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any 1 method* (work RVU= 0.65) and agreed that these services have analogous physician work and intensity. The RUC determined that 95937 has greater intra-service time compared to the surveyed code, 12 minutes and 10 minutes, respectively, therefore the surveyed code should be valued slightly less. Finally, the RUC noted that the current work RVU of 0.60 is supported by the survey's 25th percentile at the same value. **The RUC recommends a work RVU of 0.60 for CPT code 95903.**

95904 ***Nerve conduction, amplitude and latency/velocity study, each nerve; motor, motor, sensory***
The RUC reviewed the survey results from 66 physicians for CPT code 95904. The RUC recommends maintaining the current RUC reviewed pre-service time of 4 minutes, intra-service time of 5 minutes and post-service time of 3 minutes. The RUC reviewed the survey work values and agreed with the specialties that the respondents overestimated the work value of this service. Given that there is no compelling evidence to suggest the physician work has changed for this service, the RUC recommends the current work RVU of 0.34 for this service. To justify this value, the RUC reviewed CPT code 92081 *Visual field examination, unilateral or bilateral, with interpretation and report; limited examination* (work RVU= 0.30) and agreed that since the surveyed code has greater total time than the reference code, 12 minutes compared to 10 minutes, 95904 should be valued slightly higher than the reference code. **The RUC recommends a work RVU of 0.34 for CPT code 95904.**

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 had an extensive discussion concerning the typical patient service and made revisions to the direct practice expense inputs recommended by the specialties. The direct inputs recommended by the specialty for codes 95900, 95903, and 95904 were not accepted and the existing inputs are to be maintained. In addition, the RUC recommended the codes be sent to CPT for revision. For all other codes the clinical labor was specifically refined to reflect the work of the evaluation and management service typically performed prior to these services. Supplies and equipment were also reviewed carefully and modified where appropriate.

Additional Discussion
The RUC affirmed that the valuation for CPT codes 95900, 95903 and 95904 is appropriate given the current survey data and review. However, if the specialty should obtain compelling evidence through additional data sources they should not be precluded from requesting a review of these services (i.e. Five-Year Review).

Intra-Operative Neurophysiology Monitoring (Tab 21)
Benn Smith, MD (AANEM)

The American Association of Neuromuscular and Electrodiagnostic Medicine (AANEM) has requested that the CPT Editorial Panel readdress several syntax errors prior to the RUC's valuation. Usually CPT codes are created or modified to address current physician practices. In this case, 959X1 identifies a way some believe that practice should be conducted in the future. As discussed during the February 2011 CPT meeting, the current practice for IOM in an operating room differs significantly from the proposed X1 code. The specialty is concerned that if the X1 code does not accurately represent what is done in clinical practice today, it will create skewed reference points during a RUC evaluation process. It will be difficult for survey respondents to identify the items needed in the

RUC surveys. Furthermore, unless significant coding guidelines are provided, the changes may result in inaccurate coding and may increase the complexity of coding. AANEM believes that CPT codes should reflect current practice and not desired practice.

Therefore, the RUC agreed with the specialty and requests further refinement from the CPT Editorial Panel prior to RUC valuation.

Evoked Potentials and Reflex Studies (Tab 22)
Marianna Spanaki, MD, PhD (AAN); Benn Smith, MD and Andrea Boon, MD (AANEM); Marc Nuwer, MD, PhD (ACNS)

CPT code pairs 95925/95926 and 95928/95929 were identified by the Relativity Assessment Workgroup Codes Reported Together 75% or More Screen. At the request of the RUC, the specialty societies submitted a coding proposal which was approved by the CPT Editorial Panel to create two bundled codes which will allow providers to report short latency somatosensory evoked potential studies of the upper and lower limbs and central motor evoked potential study of the upper and lower limbs. At the February 2011 RUC meeting, the RUC reviewed the survey results for new codes 95938 and 95939. The specialty had obtained strong, valid survey results for code 95938 but not for 95939, as only 31% of the respondents indicated the vignette was typical. The RUC and specialty societies agreed that a new survey should be conducted and the survey results presented at the April 2011 RUC meeting with an inpatient vignette scenario.

95938 ***Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs***
The RUC reviewed the survey data from 54 neurologists, neuromuscular and electrodiagnostic physicians, physical medicine and rehabilitation physicians and clinical neurophysiological physicians. The specialty societies explained that the survey respondents accurately represented the physician time required to determine the placement and re-placement of electrodes based on responses, to supervise the patient preparation, stimulation of nerves and/or dermatomes and recording the resulting evoked potentials at several sites. The physician reviews the data from hundreds of trials that are conducted as the test design changes during the course of the study in response to the information obtained. To develop a recommended work RVU, the specialties compared the surveyed code to reference code 95927 *Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in the trunk or head* (work RVU=0.54). The RUC noted that the surveyed code, 95938, requires more total time to perform than the reference code, 95927, 40 minutes and 31.5 minutes, respectively. Further, the RUC noted that the surveyed code requires more mental effort and judgment, technical skill and physical effort and overall is a more intense service to perform in comparison to the reference code. The RUC also compared the surveyed code to reference code 78802 *Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, single day imaging* (work RVU=0.86). The RUC noted that the surveyed code and the reference code have the same total service time, 40 minutes. Based on these comparisons, the specialty society recommends 0.86 work RVUs, a value halfway between the 25th percentile and the median survey value. Further, the RUC understands that this recommended value represents a 20% savings in work RVUs as this new code represents the bundling of two existing services, 95925 and 95926. **The RUC recommends a work RVU of 0.86 for CPT code 95938.**

95939 ***Motor evoked potential study; in upper and lower limbs***
The RUC reviewed the survey results from 43 physicians who perform these types of services. The RUC agreed with the specialty societies that the survey 25th percentile work RVU of 2.25 appropriately accounts for the physician work required to perform this service. After a review of the survey results and the elimination of the outliers, the specialty recommended 2 additional minutes to the intra-service time for a total intra-service time of 30 minutes and added five minutes to the immediate post service time (15 minutes total) to account for more time to generate the report from the analyses of four limbs accounting for the assessment of 12 muscles. In addition, this immediate post time is similar to the specialty's key reference code and to the survey results of the distinct services of 95928 and 95929 which this new code combines. The RUC agreed that these time adjustments would account for the typical patient scenario. Due to the addition of 95939 to CPT, 95928 and 95959 are expected now to be performed predominately in the outpatient setting. The new combined code would typically be performed in the inpatient setting where the overall number of muscle sites tested is lower, accounting for the lower intra-service time and a much greater level of intensity. The existing codes, 95928 and 95929 would continue to shift toward being typically performed in non-facility settings, requiring a greater number of muscle sites tested per limb, requiring more intra-service time and physician work.

The RUC compared this new service to the survey's key reference code 95810 *Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by EEG technologist* (work RVU = 2.50, intra-service time = 36.5 minutes). The RUC agreed that while the surveyed code has less intra-service time compared to the reference code, 30 and 36.5 minutes,95939 was consistently rated by the survey respondents as more difficult through the survey's intensity/complexity measures. The RUC also compared the physician work of 95939 to that of 79403 *Radiopharmaceutical therapy, radiolabeled monoclonal antibody by intravenous infusion* (work RVU = 2.24) and determined that although the time associated with 79403 was greater, 95939 overall required more skill and had more complexity and intensity per minute than 79403. Further, the RUC understands that the work of this new code accounts for the work of two existing codes, 95928 *Central motor evoked potential study (transcranial motor stimulation); upper limbs* (work RVU = 1.50) and 95929 *Central motor evoked potential study (transcranial motor stimulation); lower limbs* (work RVU = 1.50) (currently billed together 70% of the time in the Medicare population). The creation of this code and its value of 2.25 represents a 25% savings in work RVUs and substantial overall savings to the Medicare system. **The RUC recommends the survey 25th percentile work RVU of 2.25 for CPT code 95939.**

Practice Expense: The RUC carefully reviewed the direct practice expense inputs for 95938 and 95939 in the non-facility setting and made minor edits to the specialty recommendation. In addition, the RUC recommends no direct inputs in the facility setting for this service.

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.

X. CMS Requests

CT Head/Brain (Tab 23)
Geraldine McGinty, M.D. (ACR), Zeke Silva, M.D. (ACR), William D. Donovan, M.D. (ASNR), M.P.H., Jacqueline A. Bello M.D. (AUR)

In October 2009, CPT code 70470 was identified through the Relativity Assessment Workgroup's Harvard Valued- Utilization over 100,000 Screen, and the RUC recommended that this service be surveyed.

70470 ***Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections***
The RUC reviewed the survey results from 106 physicians for CPT code 70470 which indicated a median work RVU of 1.40 with total physician work time of 25 minutes. Although the survey median physician service time is greater than the current Harvard time, the specialty noted that there is no compelling evidence to change the current work RVU of 1.27 for this service. The RUC compared the survey results to key reference service 74160 *Computed tomography, abdomen; with contrast material(s)* (work RVU = 1.27, total time = 23 minutes) and 70596 *Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU = 1.75, total time = 38 minutes). The RUC agreed that the comparison codes are similar services, and although the survey results appeared to indicate that 70470 is more work than 74160, the specialty and the RUC agreed the 25th percentile survey work RVU of 1.27 represented an accurate work value for 70470 with regards to time, intensity, and complexity to perform. The RUC also agreed that the survey 25th percentile work RVU of 1.27 appropriately places this service in the proper rank order. **The RUC recommends a work RVU of 1.27 for CPT code 70470.**

X-Ray Exam of Neck/Spine (Tab 24)
Geraldine McGinty, M.D. (ACR), William D. Donovan, M.D. (ASNR), William Sullivan, MD (NASS)

In October 2010, the Relativity Assessment Workgroup identified CPT code 72040 *Radiologic examination, spine, cervical; 2 or 3 views* through the CMS Low Value/High Volume screen. In preparation for surveying this code, the specialty societies identified an issue with a code descriptor for a code in the immediate family of the identified service, CPT code 72052 *Radiologic examination, spine, cervical; complete, including oblique and flexion and/or extension studies*. The RUC agreed with the specialties that the descriptor for 72052 should be revised to specify the number of inherent views so that survey respondents are not confused during the survey process. **The RUC requests that CPT code 72040 will be referred to the October 2011 CPT Editorial Panel meeting with an intended RUC survey for this family at the January 2012 RUC meeting.**

X-Ray Exam of Pelvis (Tab 25)
Geraldine McGinty, M.D. (ACR), Zeke Silva, M.D. (ACR), John Heiner, M.D. (AAOS), and Peter Mangone, M.D. (AAOS)

In October 2010, the Relativity Assessment Workgroup identified CPT code 72170 through the CMS Low Value/High Volume screen. The specialty societies conducted a RUC survey for presentation at the April 2011 RUC meeting.

72170 ***Radiologic examination, pelvis; 1 or 2 views***
The RUC reviewed the survey results from 46 physicians for CPT code 72170. The RUC recommends pre-service time of 1 minute, intra-service time of 4 minutes and post-service time of 2 minutes. The RUC reviewed the survey work values and agreed with the specialties that there is no compelling evidence to change the current work value for this service. To justify the current work RVU of 0.17 for 72170, the RUC reviewed the key reference service 73510 *Radiologic examination, hip, unilateral; complete, minimum of 2 views* (work RVU= 0.21) and agreed that the reference code should be valued higher due to greater intra-service time, 5 minutes compared to 4 minutes, and greater number of views. In addition, the RUC reviewed 72170 in comparison to the analogous code 72190 *Radiologic examination, pelvis; complete, minimum of 3 views* (work RVU= 0.21) and agreed that the reference code should be valued higher due to a greater number of views, 3 compared to 1 or 2. **The RUC recommends a work RVU of 0.17 for CPT code 72170.**

X-Ray Exam of Shoulder (Tab 26)
Geraldine McGinty, M.D. (ACR), Zeke Silva, M.D. (ACR), John Heiner, M.D. (AAOS), and Peter Mangone, M.D. (AAOS)

In October 2010, the Relativity Assessment Workgroup identified CPT code 73030 through the CMS Low Value/High Volume screen. The specialty societies conducted a RUC survey for presentation at the April 2011 RUC meeting.

73030 ***Radiologic examination, shoulder; complete, minimum of 2 views***
The RUC reviewed the survey results from 47 physicians for CPT code 73030. The RUC recommends pre-service time of 1 minute, intra-service time of 4 minutes and post-service time of 2 minutes. The RUC agreed with the specialties that there is no compelling evidence to change the current work value for this service. To justify the current work value of 0.18 for code 73030, the RUC reviewed MPC code 73560 *Radiologic examination, knee; 1 or 2 views* (work RVU= 0.17) and agreed that the surveyed code should be valued slightly higher due to greater intra-service time of 4 minutes compared to 3 minutes. In addition, the RUC compared CPT code 73030 to CPT code 72170 *Radiologic examination, pelvis; 1 or 2 views* (RUC recommended work RVU= 0.17) and agreed that while the two services have the same recommended physician service time, 73030 should be valued slightly higher because the shoulder is typically viewed with internal and external rotations to get difference visualizations of the joint, while the pelvis is a stable joint. Furthermore, 72170 requires 1 to 2 views, while 73030 requires a minimum of 2 views. **The RUC recommends a work RVU of 0.18 for CPT code 73030.**

X-Ray Exam of Foot (Tab 27)
Geraldine McGinty, M.D. (ACR), Zeke Silva, M.D. (ACR), John Heiner, M.D. (AAOS), Peter Mangone, M.D. (AAOS), Seth Rubenstein, DPM (APMA), Timothy Tillo, DPM (APMA)

In October 2010, the Relativity Assessment Workgroup identified CPT code 73620 through the CMS Low Value/High Volume screen. The specialty societies conducted a RUC survey for presentation at the April 2011 RUC meeting.

73620 ***Radiologic examination, foot; 2 views***
The RUC reviewed the survey results from 118 physicians for CPT code 73620. The RUC recommends pre-service time of 1 minute, intra-service time of 3 minutes and post-service time of 1 minute. The RUC reduced the median survey intra-service and post-service time by one minute each to align the intra-service time with previous RUC reviewed x-ray services and to ensure there is no duplication of work with an Evaluation and Management service typically billed on the same day. The RUC reviewed the survey work values and agreed with the specialties that there is no compelling evidence to change the current work value for this service. To justify the current work value of 0.16 for code 73620, the RUC compared 73620 to analogous code 73630 *Radiologic examination, foot; complete, minimum of 3 views* (work RVU= 0.17) and agreed that while the services have the same physician time, the reference code should be valued slightly higher due to a greater number of required views, 3 views compared to 2 views. To ensure the work value is relative across other x-ray services, the RUC compared these two services to analogous x-ray codes in the hand: 73120 *Radiologic examination, hand; 2 views* (work RVU= 0.16) and 73130 *Radiologic examination, hand; minimum of 3 views* (work RVU= 0.17) These similar services have the same physician time components as the x-ray foot codes and are valued the same, with the 3 view x-ray, 73130, valued at a work RVU of 0.17 and the 2 view x-ray, 73120, valued at a work RVU of 0.16. **The RUC recommends a work RVU of 0.16 for CPT code 73620.**

Diagnostic Cardiac Catheterization (Tab 28)

A RUC Workgroup was formed in response to CMS's request that the "AMA RUC reexamine the Diagnostic Cardiac Catheterization codes as quickly as possible, given the significant PFS utilization and spending for cardiac catheterization services, and put forward an alternative approach to valuing these services that would produce relative values that are resource-based and do not rely predominantly on the current component service values in a circular rationale."

In January 2011, the Workgroup reviewed the RUC recommendations for Diagnostic Cardiac Catheterization Services that were sent to CMS in May 2010.

- For the 20 codes in the series, RUC recommended values were at the survey 25th percentile for 5 codes, below the 25th percentile for 8 codes, and between the 25th and 50th percentile for 7 codes.
- For the 20 codes in the series, RUC recommended values were at current values for 11codes, below the current values for 3 codes, and above current values for 3 codes. Three codes were newly evaluated and did not have current value assignments for comparison.
- The Workgroup noted that neither CMS nor specialty societies challenged the RVUs or times during the first three 5-year reviews.

Medicare Budget impact estimations demonstrated an overall savings of about 3.7% for work RVUs for the entire series. The Workgroup reached consensus that these recommendations were resource based and followed the RUC's current process and policies of establishing RVUs for new/revised services as they were based on magnitude estimation and building block and were reviewed for potential rank order anomalies.

The Workgroup reviewed the CMS assumption that when services are bundled together, there should be substantial efficiencies in total work RVUs and times. The Workgroup, through its review of the valuation history of the Diagnostic Cardiac Catheterization services, respectfully disagreed with this assumption for these services. The RUC reviewed the detailed valuation history (detailed in the attached report) for these services and agreed that this history suggests that CMS concluded that there should be no duplication in the valuation of these services when reported by component coding as opposed to bundled coding in the initiation of the RBRVS. The RUC's recommendations for these services in 2010, reaffirm this conclusion.

The Workgroup was charged with addressing CMS' concerns with the RUC recommended work RVUs for Diagnostic Cardiac Catheterization Services through a re-review of RUC recommendations. Based on historical analysis of work RVUs and times, on evidence that the work of cardiac catheterization services has not decreased, and on comparisons to services requiring similar work, the Workgroup submits that the RUC recommendations for each of these services were derived through magnitude estimation, are resource-based and support the CMS conclusion from 1993 that there is negligible duplication in work or valuation, whether these services are reported as individual component codes or as a bundle. **The Workgroup reaffirms the RUC's recommended values for the diagnostic cardiac catheterization services.**

Extremity Study (Tab 29)
Gerladine McGinty, MD (ACR), Zeke Silva, MD (ACR), Gary Seabrook, MD (SVS), Robert Zwolak, MD (SVS), David Han, MD (SVS), Michael Sutherland, MD (SVS), Mathew Sideman, MD (SVS)
Facilitation Committee #2

In October 2010, the RUC identified CPT code 93971 *Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study* as part of the Low Value-High Volume screen and requested that it be surveyed.

The RUC reviewed the survey results from 67 radiologists and vascular surgeons and recommends that the current work RVU of 0.45 be maintained as it appropriately accounts for the work required to perform this service. The RUC compared 93971 to key reference code 93923 *Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, 3 or more levels* (work RVU = 0.45) and determined these services required the same intra-service time of 10 minutes and similar intensity and complexity to perform. The RUC noted that the current value is supported by the survey median work RVU of 0.47. **The RUC recommends a work RVU of 0.45 for CPT code 93971.**

Evaluation of Wheezing (Tab 30)
Burt Lesnick MD, FCCP (ACCP); Kathrin Nicolacakis, MD, FCCP (ATS)

In July 2010, CMS identified code 94060 *Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration* as part of the MPC List screen. In February 2011, the RUC recommended that this service be surveyed.

The RUC reviewed the survey results from 48 pulmonary physicians and determined that the current work RVU of 0.31 be maintained as it appropriately accounts for the work required to perform this service. This value is further supported by the survey 25th

percentile work RVU of 0.31. The RUC compared 94060 to key reference service 94375 *Respiratory flow volume loop* (work RVU = 0.31) and determined that the surveyed time and that of the key reference service were the same, requiring similar intensity and complexity to perform. However, 94060 is typically billed with an Evaluation and Management service. Therefore, the RUC recommends reducing the pre-service time to 3 minutes, maintaining the survey respondents intra-service time of 7.5 minutes and reducing the immediate post-service time to 3 minutes. For further support the RUC referenced similar service 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)* (work RVU = 0.30), which has similar intra-service time of 7 minutes and analogous intensity. **The RUC recommends a work RVU of 0.31 for CPT code 94060.**

Percutaneous and Intracutaneous Allergy Tests (Tab 31)
Donald W. Aaronson, MD, JD, MPH (JCAAI) and Gary Gross, MD (JCAAI)
Facilitation Committee #3

In July 2010, CMS identified code 95010, 95015 and 95024 as part of the Low Value-Billed in Multiple Units screen. In February, 2011, the RUC requested that the specialty societies resurvey codes 95010 and 95015 as the physician time for these codes were not representative of the number of units typically performed and to review the practice expense inputs only for code 95024 as the assumed typical number of tests was 12 at the time of valuation, and is now 16. The RUC agreed that a review of physician work for code 95024 was not necessary because, an RVU of 0.17 would similarly be established for the battery of tests still resulting in a work RVU of 0.01 (0.17 divided by 16). Additionally, the RUC appropriately divided the physician time by the typical number of units.

95010 ***Percutaneous tests (scratch, puncture, prick) sequential and incremental, with drugs, biologicals or venoms, immediate type reaction, including test interpretation and report by a physician, specify number of tests***
The RUC reviewed the survey results from 32 allergy and immunology physicians and determined that although the current value of 0.15 is overvalued, the service is intense as a significant reaction may occur. A work RVU of 0.11 appropriately accounts for the physician work required to perform this service. The specialty society indicated and the RUC agreed that this service is typically reported with an Evaluation and Management service on the same date by the same provider as part of counseling the patient on the use of the epinephrine auto injector following the tests. Therefore, the RUC reduced the pre-service time to 7 minutes, agreed with the survey median intra-time of 10 minutes, and reduced the immediate post-service time to 2 minutes. When divided by 7 (the typical number of tests/codes reported on the same date) the time is converted to 1 minute pre-service time, 1.43 intra-service time and 0.29 immediate post service time. Therefore, the RUC took the crosswalk work RVU of 0.76 divided by 7, the typical number of tests, equaling 0.11 to arrive at an accurate work RVU per test. For further support the RUC referenced similar services 20553 *Injection(s); single or multiple trigger point(s), 3 or more muscle(s)* (work RVU = 0.75), which has the same intra-service time, 10 minutes, as the surveyed code and 99231 *Subsequent hospital care, per day, for the evaluation and management of a patient* (work RVU = 0.76 and intra-service time = 10 minutes), which requires similar intensity and complexity as 95010. **The RUC recommends a work RVU of 0.11 for CPT Code 95010.**

95015 ***Intracutaneous (intradermal) tests, sequential and incremental, with drugs, biologicals, or venoms, immediate type reaction, including test interpretation and report by a physician, specify number of tests***
The RUC reviewed the survey results from 32 allergy and immunology physicians and determined that the current value of 0.15 is overvalued. The median work RVU of 1.25 divided by 20, the typical number of tests, equaling 0.06 appropriately accounts for the physician work required to perform this service. The specialty society indicated and the RUC agreed that this service is typcially reported with an Evaluation and Management service on the same date by the same provider as part of counseling the patient on the use of the epinephrine auto injector following the tests. Therefore, the RUC reduced the pre-service time to 7 minutes, agreed with the survey median intra-time of 15 minutes and reduced the immediate post-service time to 3 minutes, when divided by 20, the number of tests this becomes 0.35 pre-service time, 0.75 intra-service time and 0.15 immediate post service time per test. The RUC also compared 95015 to 96920 *Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm* (work RVU = 1.15 and intra-service time = 17 minutes) and 36620 *Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous* (work RVU 1.15 and intra-service time = 10 minutes) and determined the physician work required to perform these services are similar. **The Committee recommends a work RVU of 0.06 for CPT Code 95015.**

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.

CPT Referral
The specialty societies indicated that codes 95010 and 95015 are almost always billed together. The RUC recommends that these services be referred to the CPT Editorial Panel to bundle. The RUC also recommends a CPT Assistant article be created for 95010 on how to correctly report this service as many radiologists are currently reporting this service.

Practice Expense
The RUC had an extensive discussion concerning the typical patient service and made revisions to the direct practice expense inputs recommended by the specialties. The RUC refined the clinical labor of codes 95010, 95015, and 95024 to reflect the work of the Evaluation and Management service typically performed with these services. The specialty societies recommended and the RUC agreed that there were no direct inputs in the facility setting for this service.

XI. Practice Expense Subcommittee Report (Tab 32)

Doctor Joel Brill reported that the Practice Expense Subcommittee reviewed direct practice expense inputs and made recommendations for over 100 CPT codes.

The Subcommittee's discussion on the report submitted by the migration of radiologic images from film to digital Workgroup and individual code recommendations can be found in the attached Subcommittee report.

The Subcommittee also recommends that when newly bundled codes are brought forth to this Subcommittee, the existing practice expense inputs for both codes be provided in spreadsheet form along with the proposed (bundled) code and direct inputs. This will allow for a more efficient review of the inputs. This direction will be placed in the practice expense instructions and will be required from specialties for all future recommendations.

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

XII. Multi-Specialty Points of Comparison Workgroup (Tab 33)

Doctor Burd discussed the results of the MPC Workgroup meeting and presented the Workgroup's report. The purpose of the report is to outline the revised summary of processes for the MPC Workgroup to establish as it undergoes a comprehensive restructuring. Some RUC members voiced trepidation about voting to approve this document given that there are fundamental differences between these new processes and the current ones. The key distinction is that the new processes will allow the MPC Workgroup, with RUC approval, to place a code on the list without the specialty society submitting it. In response, the Chair noted that the document states that the specialty, CMS and RUC have to first agree that a work value is valid for the service to be placed on the list. This will preclude codes that the specialty believes to be misvalued from being included on the final MPC list. Other members stated that while the process of creating a list of multi-specialty services is a difficult one, CMS and other outside stakeholders are requesting such a list. It is important that the RUC continue to move forward and evolve so that a multi-specialty list of codes is available to establish a better reference for relativity of services both within and outside each specialty. The MPC Workgroup will continue its process of defining the multi-specialty MPC list and present it for the RUC's approval when complete.

The RUC approved the MPC Workgroup report and it is attached to these minutes.

XIII. Relativity Assessment Workgroup (Tab 34)

MPC List Screen

Walt Larimore, MD, informed the RUC that the Workgroup reviewed the action plans submitted for the remaining 9 codes identified by the MPC List screen and recommended the following:

- 11056 (APMA) – resurvey for October 2011
- 11721 (APMA) – resurvey with 11719 and 11720 for October 2011
- 31231 (AAO-HNS) – resurvey for October 2011
- 43239 (AGA, ASGE) – resurvey for October 2011
- 45380 (AGA, ASGE) – resurvey for October 2011
- 45385 (AGA, ASGE) – resurvey for October 2011
- 73721 (AAOS, ACR) – resurvey for February 2012 in order to include appropriate codes with 2012 final RVUs on the reference service list (ultrasound and CT of extremity).
- 77003 (AAOS, AAPM, AAPMR, ASA, ISIS, NASS) – resurvey for October 2011
- 92980 (ACC) – refer to CPT Editorial Panel, specialty society to submit coding proposal by November 2, 2011 for review at CPT February 2012.

Review Action Plan
Doctor Larimore indicated that the Workgroup reviewed the action plan for code 64450 *Injection, anesthetic agent; other peripheral nerve or branch*, which was identified by the Harvard Valued – Utilization Over 100,000 screen. At the February 2010 meeting, the Workgroup tabled the action plan and noted that this service should be reviewed in a year. When the 2009 5% claims data are available to identify which diagnoses are typical, a survey vignette can be developed and identify which services are reported in conjunction with 64450 on the same date.

In CPT 2009, codes 64455 and 64632 were created and it was expected that podiatrists would frequently use these codes instead of 64450. In February 2010, the action plan from the specialty societies indicated that a significant drop in the frequency for 64450 was to be expected. The data from 2009 and 2010 indicate that 64450 is steadily increasing as well as additional reporting of 64455 and 64632. However, the increased reporting of 64450 is primarily from primary care.

The Workgroup recommended that 64450 be resurveyed for October 2011. Also, AMA staff will request the top diagnosis codes 2010 data from CMS to assist the specialties in developing a vignette. A CPT Assistant article should be developed to clarify the appropriate reporting of this service.

CMS Request
Doctor Larimore indicated that CMS requested that the RUC consider and make recommendations as to whether CPT code 46930 should be assigned a 010-day global (vs. a 090-day global) and be reevaluated. This code was reviewed by the RUC in 2008 and activated on the Medicare Physician Fee Schedule on 1/1/2009 as a 90-day global service. This code was surveyed by the American College of Surgeons and the American Society of Colorectal Surgery who agreed a that 90-day global designation was appropriate.

Since that time, CMS received numerous inquiries from primary care physicians, AGS, and ASGE requesting a change in the global designation from a 90-day designation to a 10-day global service. CMS has not received any clinical evidence from the requestors supporting the need for multiple treatments within a 90-day time period and the corresponding interval required to safely destroy one internal hemorrhoid before proceeding to destroy a second hemorrhoid if clinically warranted.
ASGS, ASCRS and ACS recommended that CPT code 46930 remain a 090-day global. ACG, AGA and ASGE recommended CPT code 46930 be changed to a 010-day global period. ACP and AAFP did not submit a recommendation regarding the global period for this service. It was noted that there are only 2 years of claims data for this code. **The Workgroup determined that there is not enough data to recommend a change in the global period at this time. However, if CMS determines that a change in the global period is warranted the service should be resurveyed.** The Workgroup also noted that this service may be addressed in the future at the fifth Five-Year Review, in 2015, if a comment is submitted to CMS.

CMS/Other Codes
At the February 2011 RUC meeting, a Relativity Assessment Workgroup member noted that any "CMS/Other" source codes would not have been flagged in the Harvard only screens, therefore the Workgroup recommended that a list of all "CMS/Other" codes be developed and reviewed at the April 2011 meeting. CMS/Other codes are services which were not reviewed by either Harvard or the RUC and were either gap filled (most likely by crosswalk) by CMS or were part of radiology schedule.

The Workgroup identified 410 codes with a source of CMS/Other. **The Workgroup requests that specialty societies submit an action plan that articulates how the code values and times were originally developed for CMS/Other codes with Medicare utilization 500,000 or more (18 codes) for review at the October 2011 meeting. The Workgroup will review these action plans and determine how to proceed.**

Harvard Valued Codes
Doctor Larimore indicated that the Workgroup identified 35 remaining Harvard codes with utilization over 30,000 that were not originally identified by CMS. **The Workgroup determined that the specialty societies should survey the remaining 35 Harvard codes with utilization over 30,000 for October 2011. If other codes in the family are appropriate to review at the same time, to avoid rank order anomalies, the specialty should identify them during the Level of Interest process.**

The Workgroup also noted that the RUC has reviewed 153 Harvard valued codes identified by the Relativity Assessment Workgroup. The RUC supported Harvard valuation for approximately half of the codes reviewed. For codes that the RUC believed to be misvalued, nearly an equal number of codes were increased as were decreased. There is no compelling argument that Harvard as a source leads to an assumption regarding misvaluation of a code. **The Workgroup recommends that Harvard-valued codes with utilization below 30,000 do not need to be surveyed at this time related to a "Harvard Only-Volume" screen. However, these codes may be eligible under other screens or for identification in a future Five-Year Review.**

CPT Referrals

The following 12 codes were identified by a Relativity Assessment Workgroup screen and subsequently referred to the CPT Editorial Panel. These codes were identified a year ago and have not been addressed. AMA staff requested that the dominant specialties performing these services provide notification to the Workgroup indicating why these codes have not been through the CPT process and when CPT should expect to receive a Coding Change Proposal. The Workgroup was notified that the following codes will be addressed at a time certain.

- 29590 – CPT June 2011 – deletion
- 37201 – CPT October 2011
- 37203 – CPT June 2011
- 37204 – CPT October 2012
- 75894– CPT October 2012
- 75896– CPT October 2011
- 75960– CPT February 2013
- 75961– CPT June 2011

- 92506– CPT October 2011

- 36000
  The Workgroup reviewed code 36000, which was identified by the Harvard Valued – Utilization Over 100,000 screen in April 2010. In April 2010, the specialty societies indicated they could not determine situations in which cardiologists are reporting this service. The specialty societies recommended referral to the CPT Editorial Panel for deletion.

  To date, no coding proposals for deletion were received. The Workgroup further discussed the use of this service. The specialty societies who typically perform this service, based on Medicare data, indicated that it is not appropriate to separately report 36000 as it is a component of other services. However, the pediatricians had commented, in writing only, that the code was needed for the pediatric population. **The Workgroup recommends that CMS consider a bundled status for this code so that it is not separately reportable by Medicare.**

- 95921 & 95922
  Codes 95921 and 95922 were identified by the Different Performing Specialty from Survey and Codes Reported Together 75% or More screens. In April 2010, the Workgroup acknowledged that the rationale for increased utilization was unclear, thus, the dominant specialties for these two codes (Family Medicine and Internal Medicine) were requested to provide information. AAFP and ACP indicated that they do not have an explanation for the increased utilization as their physicians indicated that they do not perform these services.

  In 2008, a CPT Assistant article was published to correct inappropriate reporting by clarifying that a tilt table is required in the provision of the service. However, Medicare claims data indicate that the attempted coding education was not effective. **The Workgroup determined that this code be referred to CPT to revise the descriptor to include the use of a tilt table and refer those who do not use a tilt table in autonomic testing to use an unlisted code.**

  Doctor Allan Glass, RUC Advisor, The Endocrine Society, announced that he looks forward to providing more information to the CPT Editorial Panel regarding this issue. Doctor Larimore welcomed any additional information when CPT reviews this issue.

New Business
Doctor Larimore indicated that the RUC flags some codes to be re-reviewed, in which utilization assumptions for the purpose of budget neutrality calculations were difficult to predict. For example: in March 2003, a presenting specialty presented work neutrality calculations for 64415, 64445 and 64450. However, utilization from 2002 to 2005 has increased from about 247,000 to 320,000 per year (a 30% increase over 3 years). **The Workgroup recommends that all codes that have budget neutrality assumptions be evaluated three years later to assess the utilization assumptions.**

Other Issues
The following were included as informational items:

- CPT Editorial Panel Referrals
- CPT Assistant Referrals
- Progress of Relativity Assessment Workgroup of Potentially Misvalued Services
- Full status report of the Relativity Assessment Workgroup
- Letter to CMS Re: RUC Recommendations and attachments

The RUC approved the Relativity Assessment Workgroup report and it is attached to these minutes.

XIV. Health Care Professional Advisory Committee (Tab 35)

Lloyd Smith, DPM, thanked the RUC and HCPAC for being able to serve as the RUC HCPAC Co-Chair for the last four years. Dr. Smith announced that Anthony W. Hamm, DC, FACO, American Chiropractic Association was elected to serve as the HCPAC Co-Chair. Jane V. White, PhD, RD, FADA, American Dietetic Association, was elected as the Alternate Co-Chair.

Dr. Smith informed the RUC that the HCPAC reviewed and developed recommendations for three otoaucoustic emissions measurement codes, two evaluation for prescription of non-speech generating-augmentive and alternative communication device codes. The rationale for these recommendations are detailed in the HCPAC report attached to these minutes.

Dr. Smith noted that the HCPAC will identify specific concerns and possible solutions on how to address how specialties who report a minimal number of CPT codes develop a reference service list for discussion at the Research Subcommittee.

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

XV. Research Subcommittee (Tab 36)

Doctor Lewis reviewed the items that need RUC approval from the last two Subcommittee conference calls.

Online Survey Update
The Research Subcommittee has been working with AMA Market Research staff to finalize a survey product that will be piloted this summer for codes on the September 2011 RUC meeting agenda. In September, the developers will be onsite to conduct a orientation for interested specialty societies.

Observation discharge 99217 service time
As the Research Subcommittee agreed that the introduction of the subsequent observation codes into the Fee Schedule in 2011 allow for a more accurate measure of work for these 23+ hour stay services, the Research Subcommittee recommends that the appropriate proxy for a separate evaluation and management visit performed later on the same day of surgery is the subsequent observation codes, 99224-99226.

Further, the Research Subcommittee discussed the appropriate proxies for discharge management. At the October 2010, RUC Meeting, the RUC approved the following policy pertaining to discharge service code assignments, **0.5 x 99238 (or 0.5 x 99217) for same-day discharge and 1.0 x 99238 (or 1.0 x 99217) for discharge on a day subsequent to the day of a procedure. The Research Subcommittee recommends that the 99217 service be added to the survey instrument and summary of recommendation form.**

The Research Subcommittee also recommends that the time associated with 99217 be crosswalked from 99238, 38 minutes.

Survey instrument modifications

The Research Subcommittee discussed several changes to the Survey instrument and have outlined them below.

Subsequent Observation Care Question

The Research Subcommittee approved the following proposed modified language to add clarity to the RUC survey instrument:

> **c) Post-Operative Work –** Please respond to the following questions based on your *typical* experience for each survey code. *Typical* for purpose of this survey means more than 50% of the time.

What is "Typical"?		New/Revised Code
	(Check only one row)	
Do you *typically* (>50%) perform this procedure at a hospital, ASC or at your office?	Typically performed at a hospital	
	Typically performed at a ASC	
	Typically performed at my office	
	(Check only one row)	
If you *typically* perform this procedure at a hospital, is your patient discharged the same day, kept overnight but less than 24 hours, or overnight more than 24 hours?	Same-day discharge	
	~~Overnight, but stays less than 24 hrs~~ Overnight stay - less than 24 hrs	
	~~Admitted, stays more than 24 hrs~~ Overnight stay - more than 24 hrs	
	N/A – typically in ASC or office	
	(Check only one row)	
If your patient is *typically* kept overnight at a hospital, will you perform an E&M service later on the same day?	Yes	
	No	

Moderate Sedation Question

The Research Subcommittee approved the following proposed modified language to add clarity to the RUC survey instrument:

Moderate sedation is a service provided by the operating physician or under the direct supervision of the physician performing the procedure to allow for sedation of the patient with or without analgesia through administration of medications via the intravenous, intramuscular, inhalational, oral, rectal, or intranasal routes. For purposes of the following question, sedation and analgesia delivered separately by an anesthesiologist or other anesthesia provider not performing the primary procedure is not considered moderate sedation.

Question 6 ~~**Do you or does someone under your direct supervision typically administer moderate sedation for these procedures when performed in the Hospital/ASC setting or in the Office Setting?**~~

	~~Hospital/ASC Setting~~		~~Office Setting~~	
	~~Yes~~	~~No~~	~~Yes~~	~~No~~
~~New/Revised Code~~				
~~Reference Code~~				

Question 6 **Do you or does someone under your direct supervision typically administer moderate sedation for these procedures when performed in the Hospital/ASC?**

	In the Hospital/ASC		
	Yes	No	N/A, I do not perform this procedure in the Hospital/ASC
New/Revised Code			

Do you or does someone under your direct supervision typically administer moderate sedation for these procedures when performed in the Office?

	In the Office		
	Yes	No	N/A, I do not perform this procedure in the Office
New/Revised Code			

XVI. Election of Rotating Seats (Tab 37)

Administrative Subcommittee
Dale Blasier, MD, informed the RUC that prior to the election of the internal medicine and any other rotating seats, the Administrative Subcommittee reviews the election rules and nominees. The Administrative Subcommittee reviewed the election rules via e-mail and determined that they are appropriate and reviewed the candidates and determined they were appropriately nominated.

The RUC approved the Administrative Workgroup report and it is attached to these minutes.

Election of Rotating Seats
The RUC considered the election of the internal medicine rotating seat and elected Timothy J. Laing, MD, American College of Rheumatology.

The RUC considered the election of the "other" rotating seat. The RUC elected David C. Han, MD, to serve as the "other" rotating seat.

The terms for the rotating seats are two years, beginning with the September 2011 RUC meeting and ending in May 2013, with the provision of final recommendations to the Centers for Medicare and Medicaid Services.

XVII. Other Issues

- There was no other business brought forward.

The meeting adjourned on Saturday, April 30, 2011 at 3:45 pm.

AMA/Specialty Society RVS Update Committee **TAB 32**
Practice Expense Subcommittee Report
Wednesday, April 27 and Thursday April 28, 2011

Members present: *Doctors Bill Moran (Chair), Joel Brill (Vice Chair), Joel Bradley, Ron Burd, Neal Cohen, Bill Gee, Peter Hollmann, Bill Mangold, Lee Mills, Guy Orangio, Tye Ouzonian, Chad Rubin, John Siebel, Robert Stomel, Susan Spires, and Bryan Smith DNPC.*

Migration of Radiologic Images from Film to Digital Workgroup
Doctor Ezequiel Silva of the American College of Radiology provided the Subcommittee with an update of their work on developing direct inputs of digital imaging. As the dominate user of PACS technology he reported that the ACR had been evaluating the migration of film acquisition to PACS through an internal ACR workgroup. Doctor Silva provided the Subcommittee with an update of their progress on defining the direct practice expense inputs of digital imaging. Doctor Silva explained that they have worked hard at understanding what are the typical costs associated, what may be considered direct costs versus indirect costs. There are an array of PACS systems and storage requirement being utilized today within an array of practice settings. These may even differ by state and by hospital system as well. Doctor Silva explained that the next steps will involve surveys and the development of a typical PACS environment across specialties involving other specialty societies and physician input. The Subcommittee looks forward to their next report in September 2011.

Relative Value Recommendations for CPT 2012 New and Revised Services:
Otoacoustic Emissions Measurement (925X1, 92587 & 92588) Tab 35
The Subcommittee reviewed the direct practice expense inputs recommended by the specialty and agreed upon the recommendations.

Evaluation for Prescription of Non-Speech Generating-Augmentive and Alternative Communication Device (92605 & 926XX) Tab 35
The Subcommittee reviewed the direct practice expense inputs recommended by the specialty and agreed upon the recommendations.

Chronic Wound Dermal Substitute (152X1-152X8 & 1577X) Tab 4
The Subcommittee reviewed the direct practice expense inputs recommended by the specialty and agreed upon with minor changes to the clinical labor, supplies, and equipment.

Collagenase Injection (205X1 & 263X1) Tab 5
The Subcommittee made no revisions to the direct practice expense inputs recommended by the specialty for these procedures.

SI Joint Injection Revision (27096) Tab 6
The Subcommittee reviewed the direct practice expense inputs recommended by the specialty and agreed upon with minor changes to the clinical labor, and equipment. The Subcommittee discussed the need for comparison direct inputs for those instances where a new or revised code had been bundled. Code 27096 had been identified through the RUC's Different Performing Specialty from Survey Screen and subsequently bundled by CPT with its radiological examination service CPT code 73542. The specialty explained that the performing specialties had changed where pain medicine physicians are more likely to perform the service with a nurse and a C-ARM (vs. fluoroscopy room) in the non-facility setting. The Subcommittee agreed to a total clinical labor time of 50 minutes verse 44 minutes (27096 (34 minutes) plus 77003 (10 minutes)). In addition, the Subcommittee agreed that a C-ARM room is more typical now than a fluoroscopy room, and the agreed that similar services are performed in a C-ARM room as well (64490 – 64495).

The Subcommittee recommends that when newly bundled codes are brought forth to this Subcommittee, the existing practice expense inputs for both codes be provided in spreadsheet form

along side with the proposed (bundled) code and direct inputs. This will allow for a more efficient review of the inputs. This direction will be placed in the practice expense instructions and will be required from specialties for all future recommendations.

Shoulder Arthroscopy- Decompression of Subacromial Space (29824, 29826, 29827 & 29828) Tab 7
The Subcommittee made no revisions to the direct practice expense inputs recommended by the specialty for these procedures performed in the facility setting.

Arthroscopic Menisectomy of Knee (29880 & 29881) Tab 8
The Subcommittee made no revisions to the direct practice expense inputs recommended by the specialty for these procedures performed in the facility setting.

Lung Resection Procedures (32095X-32095X2, 32100, 3250X-3250X2, 32601, 3260X-3260X2, 3266X-3266X4, 32663, 3266X3-3266X8 & 38746) Tab 9
The Subcommittee made no revisions to the direct practice expense inputs recommended by the specialty for these procedures performed in the facility setting.

Pacemaker or Pacing Cardioverter-Defibrillator (33212, 33213, 3321X, 3323X1-3323X3, 33240, 3324X1-3324X2, 33241, 3324XX1-3324XX3) Tab 10
The Subcommittee made no revisions to the direct practice expense inputs recommended by the specialty for these procedures performed in the facility setting.

Renal Angiography (362X1-362X4) Tab 11
The Subcommittee reviewed the direct practice expense inputs recommended and made a few minor changes to them to reflect the typical patient service.

IVC Transcatheter Procedure (372X1-372X3) Tab 12
The Subcommittee reviewed the direct practice expense inputs recommended and made a few minor changes to them to reflect the typical patient service.

Ligation of Inferior Vena Cava (376XX) Tab 13
The Subcommittee made no revisions to the direct practice expense inputs recommended by the specialty for these procedures performed in the facility setting.

Destruction by Neurolytic Agent (64633X-64636X) Tab 14
The Subcommittee had an extensive discussion concerning the typical patient service and made revisions to the direct practice expense inputs recommended by the specialties. Clinical labor was refined to reflect the work of the evaluation and management service typically performed prior to these services. In addition, the Subcommittee agreed that a C-ARM room is more typical now than a fluoroscopy room, and the agreed that similar services are performed in a C-ARM room as well (64490 – 64495).

Molecular Pathology-Tier 1(88XX1-88XX28) Tab 15
Molecular Pathology-Tier 2 (L2XX1-L2XX9) Tab 16
The Subcommittee met twice via conference call prior to the meeting to discuss the direct practice expense inputs for these codes. Subcommittee members and RUC members participated in the discussions that led to a significant reduction in the clinical labor time on all the codes. The reduction in clinical labor time was reduced when the specialty found additional efficiencies and increased the batch sizes. At this meeting the Subcommittee reviewed the final revised practice expense inputs and unanimously agreed upon them. The specialty is expected to provide additional information regarding the supplies for these services to AMA staff as soon as possible.

Contact Lens Fitting (9207X1-9207X2) Tab 17
Clinical labor was specifically refined to reflect the work of the evaluation and management service typically performed prior to these services.

Tonography (92120 & 92130) Tab 18
Clinical labor was specifically refined to reflect the work of the evaluation and management service typically performed prior to these services.

Pulmonary Function Testing (940X1-940X4) Tab 19
The Subcommittee had an extensive discussion concerning the typical patient service and made revisions to the direct practice expense inputs recommended by the specialties. It was also recommended and agreed there were no direct inputs in the facility setting for this service.

EMG in Conjunction with Nerve Conduction (958XX, 958YY, 958ZZ, 95900, 95903 & 95904) Tab 20
The Subcommittee had an extensive discussion concerning the typical patient service and made revisions to the direct practice expense inputs recommended by the specialties. The direct inputs recommended by the specialty for codes 95900, 95903, and 95905 were not accepted and the existing inputs are to be maintained. In addition, the Subcommittee recommended the does be sent to CPT for revision. For all other codes the clinical labor was specifically refined to reflect the work of the evaluation and management service typically performed prior to these services. Supplies and equipment were also reviewed carefully and modified where appropriate.

Evoked Potentials and Reflex Studies (9592X2, 95928X) Tab 22
The Subcommittee carefully reviewed the direct practice expense inputs recommended by the specialty and agreed with the recommendation in the non-facility setting. There was one minor edit to the supplies which was accepted by the Subcommittee. It was also recommended and agreed there were no direct inputs in the facility setting for this service.

CMS Requests

Percutaneous & Intracutaneous Allergy Tests (95010, 95015, 95024) Tab 31
The Subcommittee had an extensive discussion concerning the typical patient service and made revisions to the direct practice expense inputs recommended by the specialties. Clinical labor was specifically refined to reflect the work of the evaluation and management service typically performed prior to these services. It was also recommended and agreed there were no direct inputs in the facility setting for this service.

AMA/Specialty Society RVS Update Committee
Multi-Specialty Points of Comparison Workgroup
April 28, 2011 **TAB 33**

Members Present: Doctors Ron Burd, (Chair), Susan Spires, (Vice Chair), Scott Collins, Peter Hollmann, J. Leonard Lichtenfeld, Eileen Moynihan, Bill Moran, Guy Orangio, Arthur Traugott, MD

I. Review of January 12, 2011 conference call minutes
The Workgroup reviewed the minutes from the March 24, 2011 conference call and approved the minutes without revision.

II. Discuss and approve Chair suggested changes to absolute criteria for MPC acceptance

The Workgroup had significant discussion concerning the verbiage of the MPC Summary of Processes document that will be sent to the RUC for approval. The document was created by the MPC Workgroup to be used as a reference/guidance document for specialty societies and the MPC Workgroup as the process of systematically restructuring the MPC list into a cross-specialty list continues. The members discussed that the new MPC list will include codes both identified in the Workgroup's objective screening mechanisms and those added by the specialty societies which meet, at a minimum, the absolute inclusionary criteria. The Workgroup members made significant revisions to the document and the final document is attached to this report for RUC acceptance.

III. Review approved cross-specialty codes and determine gaps in codes representing the spectrum of work RVUs and globals

The Workgroup discussed several next steps in refining the new MPC list to identify and fill gaps in the data. First, the members discussed the redundancies that exist in the newly created cross-specialty MPC list. Due to the screening criteria, a majority of the services on the cross-specialty MPC list have relatively low work values. **The MPC Workgroup agreed that services with similar work values and performing specialties will be grouped together and reviewed by the Workgroup prior to the next RUC meeting.** It was also discussed that these services should be sent to the specialty societies to solicit input as to which services should or should not be removed in the redundant code groups. Second, the Workgroup discussed the process that should be enacted regarding the current MPC codes that were not included in the cross-specialty MPC screening criteria. The members noted that the significant and/or predominant specialty societies should be notified of these services so that a specialty review process can occur to develop cogent arguments as to whether or not these codes should be included in the new MPC list. The Workgroup discussed that the codes currently on the MPC list that are not cross-specialty should be reviewed for continuation on the revised MPC list. Date of last RUC review may be a relevant factor to ensure the process moves forward efficiently. **AMA staff will provide the Workgroup with the list of current MPC codes left off the cross-specialty MPC list and a priority system will be put into place for specialty society review.**

IV. Develop maintenance processes to ensure MPC codes are accurately valued and relevant

The Workgroup discussed that as the cross-specialty MPC list is developed it may be beneficial to separate those codes that were determined to be definite cross-specialty (eg four or more performing specialties) from other services on the MPC list. This could be accomplished by adding an asterisk or other identifier next to the codes with four or more performing specialty codes. The Workgroup agreed that a tiered system of cross-specialty codes would be valuable to both the specialties and the RUC as the services on the MPC list will be under heavier scrutiny in regards to correction of valuation within the RUC process and outside stakeholders.

V. Approve and submit for RUC approval the MPC Summary of Processes document

The MPC Workgroup approved the MPC Summary of Processes document and will present the final document to the RUC for approval and adoption.

The MPC Workgroup will continue the systematic review of the MPC list as described above on conference calls and email review, as necessary, leading up to the October 2011 RUC meeting.

MPC Summary of Processes

In the Medicare Physician Payment Schedule Proposed and Final Rule for 2011, CMS indicated that they believe the entire MPC list should be assessed to ensure that these important services are valued appropriately under the RBRVS. CMS prioritized the review of the MPC list to 33 codes. The MPC Workgroup met via conference call in August 2010 and agreed that a systematic restructuring of the MPC list into a list of cross-specialty services would be more useful to the RUC in the valuation process. The MPC Workgroup's tasks are to determine that the MPC list is correct, accurate and useful.

The systematic restructuring of the MPC list will contain 7 steps:

1) Define the purposes of the MPC list
2) Add codes objectively identified as performed by multiple specialties to the list
3) Review the current inclusion criteria for the MPC list and consider revisions
4) Review the process of list maintenance, including the identification of gaps in codes listed (eg inadequate spectrum of RVUs or global periods, specialty specific deficiencies), frequency of confirmation of values and times, and processes required when MPC list codes undergo revaluation
5) Review the current codes on the MPC list according to new criteria
6) Review the MPC list for deficiencies or problems, then craft strategies to resolve.
7) Continued maintenance of MPC list

1) Review and revision of Purpose:

The Multi-Specialty Points of Comparison (MPC) list exists to serve as a resource in the RBRVS valuation processes. These codes are used to create a framework that links all specialties so that cross specialty relativities can be established. The MPC list as in existence in 2011 reflects codes with accepted values that create a ladder of services within a specialty so that a specialty can accomplish appropriate rank order valuations. The goal of the revised MPC list is to create a cross specialty reference where each ladder is linked to all other ladders and a multispecialty framework is created.

The Multi-Specialty Points of Comparison (MPC) Workgroup will strive to maintain a list that achieves these purposes. The MPC list will include codes selected by the specialty societies or identified by other means such as objective screens. Codes are on the list for either valuation of services by a specific society, or for the purpose of cross-specialty comparison. Societies may be asked to further identify codes for inclusion in the MPC list so that deficiencies (gaps) can be addressed. Codes on the list shall meet the criteria articulated below. This requires that each specialty have a list of codes with the following characteristics:

- Codes for every specialty that represent a range of low to high work RVUs within the specialty.
- Codes for every specialty that include the range of global periods for services provided by the specialty.
- Codes that are reflective of the entire spectrum of services provided by a specialty
- Codes that reflect the range of intensities

2) Add codes identified by objective screens

AMA staff has applied several screens to the codes, seeking services provided by more than one specialty at a significant level. "Significant" currently is defined as either 10% or an absolute number of 10,000.

Through these screens, 373 codes were identified. These codes have further been classified according to numbers of specialty societies providing the service- 4 or more, 3 or 2. Over multiple conference calls, face-to-face meetings and email review, the MPC Workgroup carefully reviewed all the services to determine if the services should be included as part of the revised MPC list.

- 92 of these codes are already on the MPC list, the Workgroup agreed that these services will be added to the new MPC list.
- 130 of these codes have 4 or more performing specialties.
- 81 of these codes have 3 performing specialties.
- 138 of these codes have 2 performing specialties.

The MPC Workgroup also proposes additions to the MPC list be on a "Consent Calendar", ie that the specialty(ies) may make the case the codes should not be added to the list. The MPC will consider their comments and make a recommendation to the RUC.

3) Current Criteria Review the current inclusion criteria for the MPC list and consider revisions

Absolute Criteria:

- The codes should have current work RVUs that the specialty(s), RUC and CMS accept as valid.
- Any specialty(s) that perform(s) greater than 10% of the total utilization or greater than 10,000 billing instances of the service should have the right to consider the appropriateness of the inclusion of the service on the MPC list. The MPC Workgroup will review that request in consultation with the performing specialty(s), which shall be offered the opportunity to comment, and make a recommendation to the RUC for final determination.
- Any code included in the MPC list should have gone through the RUC survey process and have RUC approved time.

Suggested Criteria (not Absolute Requirements):

- Codes should represent a spectrum of low to high work RVUs.
- The codes should span the range of global periods for services
- Codes should be reflective of the entire spectrum of services provided by specialty societies.
- Codes that are frequently performed should be reflected on the MPC list.
- To the maximum extent possible, the MPC list should include codes that are performed by multiple specialties.
- Codes on the MPC list should be understood and familiar to most physicians.
- Codes with utilization of less than 1,000 should not be included on the MPC list without justification by a specialty society.

MPC Summary of Processes

4) Review the process of list maintenance, identify gaps in RVUs and globals and consider revisions

The MPC Workgroup shall review the Criteria, objective screens and MPC list annually, but particularly following the Five-Year Review of the RBRVS. (It is important to note that inclusion on the MPC list does not preclude a specialty from commenting on that code in a future Five-Year Review.) The Workgroup recognizes that MPC services will continue to be under scrutiny and is considering a valuation/time review process for codes that are maintained on the MPC list.

5) Review the codes on the current MPC list and identify those to be retained according to the new criteria

Ask each society to specifically review those codes currently on the MPC list which they perform (and not added through the MPC Workgroup's defined screen) and identify those which they wish to see retained on the list and their rationale for their recommendation.

6) Review MPC list for deficiencies or problems, then craft strategies to resolve.

Following adoption by the RUC of the above and subsequent implementation, the Workgroup members shall consider how to further improve the function of the MPC Workgroup and list, including processes for adding additional services. The Workgroup will review the list to determine gaps in order to make the MPC list relevant to all specialty societies and over a wide range of services.

7). Continued maintenance of MPC list

The MPC list will require continuous review and refinement with codes added and deleted.

<u>Confirmation of Valuations and Times of MPC Codes:</u>
Selected codes may be designated as critical anchor codes. These may need regular review of times and valuations. All MPC codes require periodic confirmation of appropriateness of continuance on the list, but should not require formal revaluations. The RUC may wish to consider mechanisms to update times on well accepted codes to permit use of standard packages in pre time or post operative E/M services within the global period.

AMA/Specialty Society RVS Update Committee **Tab 34**
Relativity Assessment Workgroup
April 28, 2011

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

I. Review Actions Plans for services identified through the MPC List screen

In the Medicare Physician Payment Schedule *Proposed Rule* and *Final Rule for 2011 (Table 9)*, CMS indicated that they believe the entire MPC list should be assessed to ensure that services are paid appropriately under the Physician Payment Schedule. CMS prioritized the review of the MPC list to 33 codes, ranking the codes by allowed service units and charges based on CY 2009 claims data.

The RAW reviewed this list at the October 2010 meeting and noted that 6 of the 33 codes have been identified by another screen and have been re-reviewed by the RUC in the last two years, leaving 27 newly identified codes. In the *Final Rule for 2011,* CMS indicated that one of the rationales for review of MPC services was that the code was not reviewed by the RUC in the last 6 years. The Workgroup noted that 17 of the 27 services have been reviewed by the RUC in the last 6 years. In February 2011, the Workgroup reaffirmed the RUC recommendation for the 17 MPC codes that were reviewed by the RUC in the last 6 years. For the remaining 10 MPC codes identified, the Workgroup requested that the specialty societies submit an action plan or survey for April 2011. One code, 94060, will be surveyed and reviewed by the RUC at this meeting.

The Workgroup reviewed the action plans submitted for the remaining 9 codes and recommends the following:

- 11056 (APMA) – resurvey for October 2011
- 11721 (APMA) – resurvey with 11719 and 11720 for October 2011
- 31231 (AAO-HNS) – resurvey for October 2011
- 43239 (AGA, ASGE) – resurvey for October 2011
- 45380 (AGA, ASGE) – resurvey for October 2011
- 45385 (AGA, ASGE) – resurvey for October 2011
- 73721 (AAOS, ACR) – resurvey for February 2012 in order to include appropriate codes with 2012 final RVUs on the reference service list (ultrasound and CT of extremity).
- 77003 (AAOS, AAPM, AAPMR, ASA, ISIS, NASS) – resurvey for October 2011
- 92980 (ACC) – refer to CPT Editorial Panel, specialty society to submit coding proposal by November 2, 2011 for review at CPT February 2012.

II. Review Action Plan

Code 64450 *Injection, anesthetic agent; other peripheral nerve or branch* was identified by the Harvard Valued – Utilization Over 100,000 screen. At the February 2010 meeting the action plan was tabled and noted that this service should be reviewed in a year when the 2009 5% claims data are available to identify which diagnosis are typical so a survey vignette can be developed and which services are reported in conjunction with 64450 on the same date.

In CPT 2009, codes 64455 and 64632 were created and it was expected that podiatrists would frequently use these codes instead of 64450. In the February 2010, the action plan from the specialty societies indicated that a significant drop in the frequency for 64450 was to be expected. The data from 2009 and

2010 indicate that 64450 is steadily increasing as well as additional reporting of 64455 and 64632. However, the increased reporting of 64450 is primarily from primary care.

The Workgroup recommended that 64450 be resurveyed for October 2011. Also, AMA staff will request the top diagnosis codes 2010 data from CMS to assist the specialties in developing a vignette. A CPT Assistant article should be developed to clarify the appropriate reporting of this service.

III. CMS Request

CMS requested that the RUC consider and make recommendations to CMS as to whether CPT code 46930 *Destruction of internal hemorrhoid(s) by thermal energy (eg, infrared coagulation, cautery, radiofrequency)* should be assigned a 010-day global (vs. a 090-day global) and be reevaluated. This code was reviewed by the RUC in 2008 and activated on the Medicare Physician Fee Schedule on 1/1/2009 as a 90-day global service. This code was surveyed by the American College of Surgeons and the American Society of Colorectal Surgery who agreed a that 90-day global designation was appropriate.

Since that time CMS received numerous inquiries from primary care physicians, AGS, and ASGE requesting a change in the global designation from a 90-day designation to a 10-day global service. CMS has not received any clinical evidence from the requestors supporting the need for multiple treatments within a 90-day time period and the corresponding interim interval required to safely destroy one internal hemorrhoid before proceeding to destroy a second hemorrhoid if clinically warranted. Given the breadth of specialties participating on the RUC, CMS is interested in the following.

1. Would the AMA RUC recommend that the global designation be changed from a 90-day to a 10-day designation and, if so, on what basis;
2. Should this service be resurveyed since it has developed increasing utilization by primary care physicians and gastroenterologists; and
3. If the AMA RUC considers a 10-day global designation appropriate, does the service require revaluation?

ASGS, ASCRS and ACS recommended that CPT code 46930 remain a 090-day global. ACG, AGA and ASGE recommended CPT code 46930 be changed to a 010-day global period. ACP and AAFP did not submit a recommendation regarding the global period for this service. It was noted that there are only 2 years of claims data for this code. **The Workgroup determined that there is not enough data to recommend a change in the global period at this time. However, if CMS determines that a change in the global period is warranted the service should be resurveyed.** The Workgroup also noted that this service may be addressed in the future at the fifth Five-Year Review, in 2015, if a comment is submitted to CMS.

IV. CMS/Other Codes

At the February 2011 RUC meeting, a Relativity Assessment Workgroup member noted that any "CMS/Other" source codes would not have been flagged in the Harvard only screens, therefore the Workgroup recommended that a list of all "CMS/Other" codes be developed and reviewed at the April 2011 meeting. CMS/Other codes are services which were not reviewed by either Harvard or the RUC and were either gap filled (most likely by crosswalk) by CMS or were part of radiology schedule.

The Workgroup identified 410 codes with a source of CMS/Other. **The Workgroup requests that specialty societies submit an action plan that articulates how the code values and times were originally developed for CMS/Other codes with Medicare utilization 500,000 or more (18 codes) for review at the October 2011 meeting. The Workgroup will review these action plans and determine how to proceed.**

V. Harvard Valued Codes

In February 2011, the Relativity Assessment Workgroup noted that the Harvard Valued screen started with a utilization of 1 million or more, then was expanded to 100,000 or more and most recently by CMS through the 4th Five-Year Review to 30,000 or more. Currently, there are remaining Harvard codes with utilization over 30,000 that were not originally identified by CMS. CMS identified Harvard codes with utilization of 30,000 or more in the 4th Five-Year Review, but that list was not all-inlcusive of all Harvard codes with utilization over 30,000. **The Workgroup determined that the specialty societies should survey the remaining 35 Harvard codes with utilization over 30,000 for October 2011. If other codes in the family are appropriate to review at the same time, to avoid rank order anomalies, the specialty should identify them during the Level of Interest process.**

The Workgroup also noted that the RUC has reviewed 153 Harvard valued codes identified by the Relativity Assessment Workgroup. The RUC supported Harvard valuation for approximately half of the codes reviewed. For codes that the RUC believed to be misvalued, nearly an equal number of codes were increased as were decreased. There is no compelling argument that Harvard as a source leads to an assumption regarding misvaluation of a code. **The Workgroup recommends that Harvard-valued codes with utilization below 30,000 do not need to be surveyed at this time related to a "Harvard Only-Volume" screen. However, these codes may be eligible under other screens or for identification in a future Five-Year Review.**

VI. CPT Referrals

The following 12 codes were identified by a Relativity Assessment Workgroup screen and subsequently referred to the CPT Editorial Panel. These codes were identified a year ago and have not been addressed. AMA staff requested that the dominant specialties performing these services provide notification to the Workgroup indicating why these codes have not been through the CPT process and when CPT should expect to receive a Coding Change Proposal. The Workgroup was notified that the following codes will be addressed at a time certain.

- 29590 – CPT June 2011 – deletion
- 37201 – CPT October 2011
- 37203 – CPT June 2011
- 37204 – CPT October 2012
- 75894– CPT October 2012
- 75896– CPT October 2011
- 75960– CPT February 2013
- 75961– CPT June 2011
- 92506– CPT October 2011

- 36000

The Workgroup reviewed code 36000 *Introduction of needle or intracatheter, vein*, which was identified by the Harvard Valued – Utilization Over 100,000 screen in April 2010. In April 2010, the specialty societies indicated they could not determine situations in which cardiologists are reporting this service. The specialty societies recommended referral to the CPT Editorial Panel for deletion.

To date, no coding proposals for deletion were received. The Workgroup further discussed the use of this service. The specialty societies who typically perform this service, based on Medicare data, indicated that it is not appropriate to separately report 36000 as it is a component of other services. However, the pediatricians had commented, in writing only, that the code was needed for the pediatric population. **The Workgroup recommends that CMS consider a bundled status for this code so that it is not separately reportable by Medicare.**

- 95921 & 95922

Codes 95921 *Testing of autonomic nervous system function; cardiovagal innervation (parasympathetic function), including 2 or more of the following: heart rate response to deep breathing with recorded R-R interval, Valsalva ratio, and 30:15 ratio* and 95922 *Testing of autonomic nervous system function; vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and R-R interval changes during Valsalva maneuver and at least 5 minutes of passive tilt* were identified by the Different Performing Specialty from Survey and Codes Reported Together 75% or More screens. In April 2010, the Workgroup acknowledged that the rationale for increased utilization was unclear, Thus, the dominant specialties for these two codes (Family Medicine and Internal Medicine) were requested to provide the following information: 1. what are the clinically appropriate scenarios for reporting each service? 2. What is the description of service? 3. What are the clinically appropriate scenarios when these services are reported on the same date? AAFP and ACP indicated that they do not have an explanation for the increased utilization as their physicians indicated that they do not perform these services.

In 2008, a CPT Assistant article was published to correct inappropriate reporting by clarifying that a tilt table is required in the provision of the service. However, Medicare claims data indicate that the attempted coding education was not effective. **The Workgroup determined that this code be referred to CPT to revise the descriptor to include the use of a tilt table and refer those who do not use a tilt table in autonomic testing to use an unlisted code.**

VII. New Business

The Workgroup Chair indicated that the RUC flags some codes to be re-reviewed, in which utilization assumptions for the purpose of budget neutrality calculations were difficult to predict. **The Workgroup recommends that all codes that have budget neutrality assumptions be evaluated three years later to assess the utilization assumptions.**

For example: in March 2003, a presenting specialty presented work neutrality calculations for 64415, 64445 and 64450. However, utilization from 2002 to 2005 has increased from about 247,000 to 320,000 per year (a 30% increase over 3 years).

VIII. Other Issues

The following were included as informational items:

- CPT Editorial Panel Referrals
- CPT Assistant Referrals
- Progress of Relativity Assessment Workgroup of Potentially Misvalued Services
- Full status report of the Relativity Assessment Workgroup
- Letter to CMS Re: RUC Recommendations and attachments

Members Present
Members: Arthur Traugott, MD (Chair), Lloyd Smith, DPM (Co-Chair), Emily Hill, PA-C (Alt. Co-Chair), Eileen Carlson JD, RN, Michael Chaglasian, OD, Robert Fifer, PhD, CCC-A, 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 the CMS Update. Doctor Hambrick indicated the Agency is currently preparing the Proposed Rule for 2012. She noted that the Agency appreciates all the work the HCPAC has contributed thus far and looks forward to working together in the future.

II. HCPAC Co-Chair and Alternate Co-Chair Elections

Anthony W. Hamm, DC, FACO, American Chiropractic Association was elected to serve as the HCPAC Co-Chair. Jane V. White, PhD, RD**,** FADA, American Dietetic Association, was elected as the Alternate Co-Chair.

III. Relative Value Recommendations for CPT 2012:

Otoacoustic Emissions Measurement (925X1, 92587 & 92588)
925X1
The American Speech-Language-Hearing Association and American Audiology Association presented code 925X1 *Evoked otoacoustic emissions; screening (qualitative measurement of distortion product or transient evoked otoacoustic emissions), automated analysis.* The HCPAC reviewed the survey results from 111 audiologists and compared the surveyed code to the key reference code 92567 *Tympanometry (impedance testing)* (work RVU = 0.20). The survey respondents indicated and the HCPAC agreed that overall the surveyed code requires less intensity and complexity to perform than the key reference code. The HCPAC compared 925X1 to other services that require the same time and work to perform, such as 93000 *Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report* (work RVU = 0.17 and 5 minutes intra-time and 2 minutes immediate post-service time), 90471 *Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)* (work RVU = 0.17 and 7 minutes intra-service time) and 11719 *Trimming of nondystrophic nails, any number* (work RVU = 0.17 and 2 minutes pre-service, 2 minutes intra-service and 5 minutes immediate post-service time). The HCPAC noted that this service is automated but unlike 76977 *Ultrasound bone density measurement and interpretation, peripheral site(s), any method* (work RVU = 0.05) and 95905 *Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report* (work RVU = 0.05), code 925X1 requires continual placement of the probe and the application of the test for a baby by a qualified health care professional. **The HCPAC recommends 5 minutes intra-service time and 2 minutes immediate post-service time and a work RVU of 0.17 for CPT code 925X1.**

92587
The HCPAC reviewed the survey results from 186 audiologists for code 92587 *Distortion product evoked otoacoustic emissions; limited evaluation to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report* and determined that 92587 was less intense and complex for all measures compared to key reference code 92570 *Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing* (work RUC = 0.55 and 3 minutes pre, 15 minutes intra and 3 minutes immediate post-service time). The HCPAC agreed that 3 minutes pre, 12 minutes intra and 3 minutes immediate post-service time appropriately account for the time required to perform this evaluation. The audiologist is not only constantly monitoring the positioning of the patient and placement of the probe, but is making clinical observations of the patient through out the test to identify any false positives from the automated examination. The HCPAC determined that the work required to perform 92587 falls between the survey 25th percentile and median, 0.35 and 0.55, respectively. The HCPAC determined that 0.45 work RVUs appropriately accounts for the work required to perform this service. The HCPAC indicated that the recommended work RVU of 0.45 appropriately places this service relative to other similar services, 92250 *Fundus photography with interpretation and report* (work RVU = 0.35) and key reference service 92570 (work RVU = 0.55). For additional support the HCPAC also compared 92587 to 97110 *Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility* (work RVU = 0.45). **The HCPAC recommends a work RVU of 0.45 for CPT code 92587.**

92588
The HCPAC reviewed the survey results of 96 audiologists for code 92588 *Distortion product evoked otoacoustic emissions; comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation* compared 92588 to key reference service 92570 *Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing* (work RUC = 0.55 and 3 minutes pre, 15 minutes intra and 3 minutes immediate post-service time. The survey respondents indicated and the HCPAC agreed that 92588 is more intense and complex to perform than the reference service code 92570. The HCPAC agreed that 3 minutes pre, 16.5 minutes intra and 3 minutes immediate post-service time appropriately account for the time required to perform this evaluation. The HCPAC also compared 92558 to 92557 *Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)* (work RVU = 0.60) and determined that 92558 required the same work, which was supported by the survey median of 0.62. **The HCPAC recommends a work RVU of 0.60 for CPT code 92588.**

Evaluation for Prescription of Non-Speech Generating-Augmentive and Alternative Communication Device (92605 & 926XX)
The American Speech-Language-Hearing Association presented code 92605 *Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient;* each additional 30 minutes (List separately in addition to code for primary procedure). The HCPAC reviewed the survey results from 42 speech language pathologists and compared 92605 to the key reference service 92607 *Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour* (work RVU = 1.85). The HCPAC determined that the intensity and complexity for the surveyed code is slightly lower than the key reference code and agreed that survey median work RVU of 1.75 and pre-time of 10 minutes, intra-time of 60 minutes and 20 minutes of immediate post-service work

appropriately accounts for the work and time required to perform this evaluation. The qualified health care professional is evaluating the patient by interacting with patient and caregiver to appropriately interpret feedback/communication from the patient. **The HCPAC recommends a work RVU of 1.75 for CPT code 92605.**

926XX

The American Speech-Language-Hearing Association presented code 92605 *Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure).* The HCPAC reviewed the survey results from 32 speech language pathologists and compared 926XX to the key reference service 92608 *Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure)* (work RVU = 0.70). The HCPAC determined that the intensity and complexity for the surveyed code is slightly lower than the key reference code and agreed that survey 25th percentile work RVU of 0.65 and 30 minutes of intra-service work appropriately accounts for the work and time required to perform these additional minutes of evaluation. The qualified health care professional is evaluating the patient by interacting with patient and caregiver to appropriately interpret feedback/communication from the patient. **The HCPAC recommends a work RVU of 0.65 for CPT code 926XX.**

IV. Development of Reference Service Lists

The HCPAC questioned how to develop a reference service list when most of a societies codes are being surveyed. AMA staff referred the HCPAC members to the instructions document which outlines how to develop a reference service list as well as utilize the Research Subcommittee to assist in development and review of a reference service list. AMA staff indicated if a specialty wishes to deviate from the standard RUC survey process they must bring forth their alternate survey or methodology to the Research Subcommittee for approval. **The HCPAC indicated that they will identify specific concerns and possible solutions on how to address how specialties who report a minimal number of CPT codes develop a reference service list for discussion at the Research Subcommittee.**

AMA/Specialty Society RVS Update Committee
Administrative Subcommittee
April 2011 – via e-mail

Members: Doctors Dale Blasier (Chair), David Hitzeman (Vice Chair), Michael Bishop, James Blankenship, Emily Hill, PA-C, Robert Kossmann, Walt Larimore, Scott Manaker, Sandra Reed, Arthur Traugott, James Waldorf, and George Williams.

Prior to the election of the internal medicine and any other rotating seats, the Administrative Subcommittee reviews the election rules and nominees. The Administrative Subcommittee reviewed the election rules via e-mail and determined that they are appropriate and reviewed the candidates and determined they were appropriately nominated.

AMA/Specialty Society RVS Update Committee
Research Subcommittee Conference Call
Monday, April 4, 2011

Members Present: Brenda Lewis, DO (Chair), Bibb Allen, MD, Scott Collins, MD, Charles Koopmann, Jr, MD, Marc Raphaelson, MD, Sherry Barron-Seabrook, MD, Peter Smith, MD

I. Survey Instrument Modifications

A. Subsequent Observation Care Question

During the March 18th Research Subcommittee Conference Call, a Subcommittee member requested that the Research Subcommittee review the language for question 2C at the April Research Subcommittee conference call.

The Research Subcommittee approved the following proposed modified language to add clarity to the RUC survey instrument:

> **c) Post-Operative Work** – Please respond to the following questions based on your *typical* experience for each survey code. *Typical* for purpose of this survey means more than 50% of the time.

What is "Typical"?		New/Revised Code
		(Check only one row)
Do you *typically* (>50%) perform this procedure at a hospital, ASC or at your office?	Typically performed at a hospital	
	Typically performed at a ASC	
	Typically performed at my office	
		(Check only one row)
If you *typically* perform this procedure at a hospital, is your patient discharged the same day, kept overnight but less than 24 hours, or overnight more than 24 hours?	Same-day discharge	
	~~Overnight, but stays less than 24 hrs~~ Overnight stay - less than 24 hrs	
	~~Admitted, stays more than 24 hrs~~ Overnight stay - more than 24 hrs	
	N/A – typically in ASC or office	
		(Check only one row)
If your patient is *typically* kept overnight at a hospital, will you perform an E&M service later on the same day?	Yes	
	No	

B. Moderate Sedation Question

AMA RUC Staff received a proposed modification to the moderate sedation question on the survey instrument. The proposed modification addresses the concern that when specialty society staff are currently tabulating results from the moderate sedation question it is unclear whether a no response means moderate sedation was not typical in the office or whether the respondent did not perform the procedure in the office.

Further, the proposed modification, eliminates the portion of the question ascertaining whether moderate sedation in inherent in the reference code. The data for whether the reference code has moderate sedation has already been determined so this data is deemed to be superfluous.

The Research Subcommittee approved the following proposed modified language to add clarity to the RUC survey instrument:

Moderate sedation is a service provided by the operating physician or under the direct supervision of the physician performing the procedure to allow for sedation of the patient with or without analgesia through administration of medications via the intravenous, intramuscular, inhalational, oral, rectal, or intranasal routes. For purposes of the following question, sedation and analgesia delivered separately by an anesthesiologist or other anesthesia provider not performing the primary procedure is not considered moderate sedation.

Question 6

~~**Do you or does someone under your direct supervision typically administer moderate sedation for these procedures when performed in the Hospital/ASC setting or in the Office Setting?**~~

	~~Hospital/ASC Setting~~		~~Office Setting~~	
	~~Yes~~	~~No~~	~~Yes~~	~~No~~
~~New/Revised Code~~				
~~Reference Code~~				

Question 6

Do you or does someone under your direct supervision typically administer moderate sedation for these procedures when performed in the Hospital/ASC?

	In the Hospital/ASC		
	Yes	No	N/A, I do not perform this procedure in the Hospital/ASC
New/Revised Code			

Do you or does someone under your direct supervision typically administer moderate sedation for these procedures when performed in the Office?

	In the Office		
	Yes	No	N/A, I do not perform this procedure in the Office
New/Revised Code			

II. RUC Online Survey

In February 2011, the RUC was appraised of efforts made by RUC staff in coordination with AMA Market Research Staff, Sara Thran and Joanna Wicher, to create a centralized website to be made available for specialties to voluntarily conduct online RUC surveys.

The Research Subcommittee received a presentation of the planned tool in late February. The Subcommittee offered a number of suggestions, many editorial in format, but others requesting improvements such as roll over pop-up instructions to provide added directions/definitions and a summary screen at the end to compare the input for multiple codes. After this presentation, the Research Subcommittee was provided the survey website address to review the survey website and provided input directly to the AMA RUC Staff.

In Mid-March 2011, the specialty societies received a demonstration of the website and were given the opportunity to comment to AMA RUC Staff, both during the demonstration and in review of survey link following the call. The specialty society staff editorial changes were incorporated into the survey website as well.

On April 4, the Research Subcommittee reviewed the revised online survey instrument and was pleased to see the new functionality, including the ability to make side-by-side corrections at the end of the survey when comparing multiple codes. Additional editorial comments will be implemented into the survey instrument and approved the survey instrument to be used in a pilot by a specialty society this Summer.

The estimated timeline of this project is:

June 2011	One specialty will pilot test the website for presentation at the September 2011 RUC Meeting
September 2011	Piloting specialty society to provide feedback to the Research Subcommittee on their experience using RUC Online Survey Tool Education session at the September 2011 RUC Meeting to specialty societies on use of the website
November 1, 2011	Full implementation of the website is scheduled to be complete in time for surveys used to collect data for the January 2012 RUC Meeting.
Ongoing	Education and improvements will be ongoing as specialties voluntarily use the online survey tool.

AMA/Specialty Society RVS Update Committee
Research Subcommittee Conference Call
Tuesday, March 8, 2011

Members Present: Brenda Lewis, DO (Chair), Greg Przybylski, MD (Vice Chair), Bibb Allen, MD, Scott Collins, MD, John Gage, MD, Charles Koopmann, Jr, MD, J. Leonard Lichtenfeld, MD, Marc Raphaelson, MD, Sherry Barron-Seabrook, MD, Lloyd Smith, DPM, Peter Smith, MD

I. RUC Online Survey

In February 2011, the RUC was appraised of efforts made by RUC staff in coordination with AMA Market Research Staff, Sara Thran and Joanna Wicher, to create a centralized website for specialties to conduct online RUC surveys.

Per the timeline of implementation of this centralized website, the Research Subcommittee received a presentation on the editorially revised survey instrument which has been programmed into the survey software. The Subcommittee's initial suggestions included: 1.) for places within the survey instrument where definitions of terms are available, a roll-over pop-up should be incorporated, 2.) a summary screen following Step 7 summarizing all the data that the survey respondent provided prior to submitting data to internet server and 3.) removal of the AMA Logo from online survey with the exception of first page. Further, a Subcommittee member requested that the Research Subcommittee review the language for question 2C at the April Research Subcommittee conference call.

After this presentation, the Research Subcommittee was provided the survey website address to review the survey website and provide input directly to the AMA RUC Staff by March 16th.

The survey website will be modified to reflect the Research Subcommittee's potential comments/changes. In late March 2011, the specialty societies will receive a demonstration of the website and given the opportunity to comment to AMA RUC Staff as well. Again, the estimated timeline of this project is:

Late March 2011	The specialty societies would be given a demonstration of the centralized website for comment
Early April 2011	Research Subcommittee to approve on-line surveys and report to RUC
June 2011	One specialty will pilot test the website for presentation at the September 2011 RUC Meeting
September 2011	Education session at the September 2011 RUC Meeting to specialty societies on use of the website
November 1, 2011	Full implementation of the website is scheduled to be complete in time for surveys used to collect data for the January 2012 RUC Meeting.

II. Specialty Society Requests for Review of Survey Instruments and Reference Service Lists

Lung Resection Procedures (32095X-32095X2, 32100, 3250X-3250X2, 32601, 3260X-3260X2, 3266X-3266X4, 32663, 3266X3-3266X8 & 38746)
Society of Thoracic Surgeons

Using a fax back ballot, the CPT Editorial Panel approved revisions made to the Lung Resection codes. As you will recall in April 2010, 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 supported the specialty society request to defer these codes from publication until CPT 2012.

At this time, STS is requesting to have a modified survey instrument and reference service list be reviewed and approved by the Research Subcommittee. There is one survey instrument for the 90 day global codes, one survey instrument for the 0 day global codes, and one survey instrument for the XXX codes. Specialty society staff highlighted the added instructions in yellow and used track changes to identify any changes to the instructions. The other major change is how the survey is laid out. The STS is looking to have the surveyee fill out the typical RUC survey for one code and then the time and visit data will be completed for all the other codes using the table, the intensity measure will also be completed for all the codes using a table format, then the rest of the data on the typical survey will be collected for each code at the end of the survey. So all of the data that is usually collected is still being collected for each code, it is just in a different format.

The main changes are in the instructions for selecting the reference code. STS would like to have survey respondents select only one reference code per survey for all of the codes being surveyed in that survey, so the wording has been changed in the instructions to reflect this.

The Research Subcommittee reviewed the proposed survey instruments and agreed that it would be inappropriate for the survey respondents to select only one reference code for all of the codes with the same global period. Therefore, the Research Subcommittee recommends that all language pertaining to this proposed change be removed from the specialty society's survey instrument. The Research Subcommittee agreed that 1.) the specialty society could use their proposed Tables for Step 2 and Step 3; 2.) the specialty society, as requested, could remove the subsequent observation care codes and observation discharge codes from their survey instrument and 3.) the 000 day global survey instrument could include critical and non-critical care visits. **As amended, the Research Subcommittee recommends the specialty society's proposed survey instruments. Further, the Research Subcommittee also reviewed and recommend the 3 reference service lists as presented by the specialty society.**

Injection - Anesthetic Agent (64450)
American Academy of Pain Medicine
American Podiatric Medical Association
American Society of Anesthesiologists
American Society of Interventional Pain Physicians

In February 2010, the specialties made a presentation to the Relativity Assessment Workgroup. They stated that Podiatry had used this code to report injections for which specific CPT codes have now been established. These codes were new to CPT in 2009: 64455: *Injection(s), anesthetic agent and or steroid, plantar common digital nerve(s) (eg, Morton's neuroma)* and 64632: *Destruction by neurolytic agent; plant common digital nerve*.

The specialties anticipated that there would be a significant drop in the frequency of code 64450 subsequent to use of these new codes. With this information, the RUC tabled the specialty

societies action plan pending receipt of further information from the 2009 5% claims data to identify which diagnoses are typical so a survey vignette can be developed. The 2009 5% claims data did not show a significant decrease in the utilization of 64450. The specialty societies stated that they were unable to develop a vignette that could be agreed upon by all providers of the service and require more data. AMA Staff announced that the 2010 5% claims data should be available in the next week and will provide the specialties more data pertaining to typical diagnosis. **Therefore, the Research Subcommittee recommends that the specialty societies review this 2010 data and develop an Action Plan for the review by the Relativity Assessment Workgroup at the April 2011 RUC Meeting.**

Evaluation for Prescription of Non-Speech Generating-Augmentive and Alternative Communication Device (92605, 926XX)
American Speech-Language and Hearing Association

The American Speech-Language and Hearing Association has requested review of a proposed reference service list. The Research Subcommittee reviewed the proposed reference service list and recommended that 92608 *Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure)* and 90801 *Psychiatric diagnostic interview examination* be deleted as not performed by the survey respondents. Further, the Research Subcommittee recommended that 92626 *Evaluation of auditory rehabilitation status; first hour* and 92620 *Evaluation of central auditory function, with report; initial 60 minutes* be added to the reference service list to fill in a current work RVU gap between 1.30 and 1.70 Work RVUs. **As modified, the Research Subcommittee recommends the proposed reference service list for 90605.**

Further, the Research Subcommittee recommends that a separate reference service list be developed for 926XX, as this is a ZZZ global code and its reference service list should comprise more codes with ZZZ global assignments. The Research Subcommittee offered that they would review the proposed reference service list for 926XX via e-mail after the Research Subcommittee call, if the specialty societies desired.

Percutaneous Allergy Tests (95010 & 95015)
Joint Council of Allergy, Asthma and Immunology
American Academy of Allergy, Asthma and Immunology

The Joint Council of Allergy, Asthma and Immunology and the American Academy of Allergy, Asthma and Immunology have requested review of the two vignettes and a proposed reference service list. **The Research Subcommittee recommend the two vignettes and proposed reference service list as presented by the specialty societies.**

EMG in Conjunction with Nerve Conduction (958XX, 958YY, 958ZZ, 95900, 95903 and 95904)
American Academy of Neurology
American Association of Neuromuscular and Electrodiagnostic Medicine
American Academy of Physical Medicine and Rehabilitation
American Clinical Neurophysiology Society
American Physical Therapy Association

The American Academy of Neurology, American Association of Neuromuscular and Electrodiagnostic Medicine, American Academy of Physical Medicine and Rehabilitation,

American Clinical Neurophysiology Society and the American Physical Therapy Association have requested review of several vignettes and a reference service list. **The Research Subcommittee recommend the vignettes as proposed by the specialty societies.**

The Research Subcommittee reviewed the proposed reference service list and agreed that the specialty societies should develop two separate reference service lists for Needle EMG codes (ZZZ global) and for the Nerve Conduction Codes (XXX global). The Research Subcommittee offered that they would review the proposed reference service lists via e-mail after the Research Subcommittee call, if the specialty societies desired. Per the request of the Research Subcommittee, the specialty societies submitted two reference service lists for review. These lists have been circulated to the Subcommittee members and feedback will be provided to the specialties in a timely fashion.

Evoked Potentials and Reflex Studies (9592X2)
American Academy of Neurology
American Association of Neuromuscular and Electrodiagnostic Medicine
American Academy of Physical Medicine and Rehabilitation
American Clinical Neurophysiology Society

At the February 2011 RUC Meeting, the American Academy of Neurology, American Association of Neuromuscular and Electrodiagnostic Medicine, American Academy of Physical Medicine and Rehabilitation and the American Clinical Neurophysiology Society requested that only 95928X be reviewed by the RUC and that 95929X be withdrawn from consideration as only 31% of survey respondents found the outpatient vignette to be typical. The societies indicated that they would develop a vignette based on an inpatient scenario, re-survey the code and present recommendations at the April 2011 RUC Meeting. The specialty societies request review of the 95929X vignette and the proposed reference service list. **The Research Subcommittee recommends the vignette and reference service list as proposed by the specialty society.**

III. Observation Discharge 99217 Service Time

At the February 2011 RUC Meeting, the Research Subcommittee, during its discussion about the 23+ Hour E/M Proxy discussion, approved the following policies:

As the Research Subcommittee agreed that the introduction of the subsequent observation codes into the Fee Schedule in 2011 allow for a more accurate measure of work for these 23+ hour stay services, the Research Subcommittee recommends that the appropriate proxy for a separate evaluation and management visit performed later on the same day of surgery is the subsequent observation codes, 99224-99226.

Further, the Research Subcommittee discussed the appropriate proxies for discharge management. At the October 2010, RUC Meeting, the RUC approved the following policy pertaining to discharge service code assignments**, 0.5 x 99238 (or 0.5 x 99217) for <u>same-day</u> discharge and 1.0 x 99238 (or 1.0 x 99217) for discharge on a day <u>subsequent</u> to the day of a procedure. The Research Subcommittee recommends that the 99217 service be added to the survey instrument and summary of recommendation form.**

Since these codes were reviewed in 1993, the RUC has taken the position that the physician work provided to a patient whether being discharged from the hospital or from observation status is the same. This position is recognized as 99217 *Observation Care Discharge* and 99238 *Hospital Discharge* have the same work RVUs associated with them, 1.28 Work RVUs. However, upon

further research into this issue, AMA Staff recognized that these two services have different total service times, 99217=55 minutes and 99238=38 minutes. AMA Staff believes this to be an error within the physician time. The Research Subcommittee reviewed the times associated with these services and determined that the total service time for 99217 should be altered to reflect the current RUC position on inpatient and observation services (i.e., 99217 should be assigned 38 minutes). **The Research Subcommittee recommends that the time associated with 99217 be crosswalked from 99238, 38 minutes.**

AMA/Specialty Society RVS Update Committee **Tab 28**
Diagnostic Cardiac Catheterization Report
Monday, March 29, 2011

Members Present
Marc Raphaelson, MD (Chair) Michael Bishop, MD, Scott Collins, MD, Brenda Lewis, DO, Douglas Leahy, MD, Scott Manaker, MD, Lawrence Martinelli, MD, Peter Smith, MD, Arthur Traugott, MD

The Workgroup met several times via conference call and face-to-face to discuss the request made by CMS pertaining to the Diagnostic Cardiac Catheterization Services. As stated in the *Final Rule* published on November 29, 2010,

> To develop the RVUs for comprehensive diagnostic cardiac catheterization services, the AMA RUC generally recommended the lower of either the sum of the current RVUs for the component services or the physician survey 25th percentile value. In most cases, the AMA RUC's recommendation for the comprehensive service was actually the sum of the current work RVUs for the component services and we are unsure how this approach is resource-based with respect to physician work. We are also concerned that the physician survey appears to have overstated the work for these well established procedures so significantly that the 25th percentile value was usually higher than the sum of the current RVUs for the component services. Under this methodology, the AMA RUC-recommended RVUs for the comprehensive codes for diagnostic cardiac catheterization are an average of only one percent lower than the sum of the RVUs for the component services (taking into consideration any MPPR that would currently apply) included in the bundle. We do not find the AMA RUC's methodology or the resulting values in this case to be acceptable for a major code refinement exercise of this nature.
>
> If we were to accept the AMA RUC's recommended values for these cardiac catheterization codes, we essentially would be agreeing with the presumption that there are negligible work efficiencies gained in the bundling of these cardiac catheterization services. On the contrary, we believe that the AMA RUC did not fully consider or account for the efficiency gains when the component services are furnished together, including the significant reduction in service time. Rather, the AMA RUC appears to have considered only the summation of the component services to the comprehensive service. **Therefore, we are requesting that the AMA RUC reexamine these codes as quickly as possible, given the significant PFS utilization and spending for cardiac catheterization services, and put forward an alternative approach to valuing these services that would produce relative values that are resource-based and do not rely predominantly on the current component service values in a circular rationale.**
>
> Since we believe that the new comprehensive diagnostic cardiac catheterization codes would be overvalued under the AMA RUC's CY 2011 recommendations, we have employed an interim methodology to determine alternative values for these services which we are assigning as the interim final work RVUs for CY 2011. To account for efficiencies inherent in bundling, we set the work RVUs for

> all of the CY 2011 cardiac catheterization codes for which we received AMA RUC recommendations to 10 percent less than the sum of the current work RVUs for the component codes, taking into consideration any MPPR that would apply under current PFS policy. We recognize that this interim methodology is not highly specific and further acknowledge that the use of another approach by the AMA RUC may have differential effects on the values of the new comprehensive services compared to the proportionate reduction on the sum of the RVUs for the component services that we have adopted as a temporary methodology.
>
> However, given the complexity of the component code combinations that contribute to the comprehensive cardiac catheterization codes and the apparent overstatement of physician work from the physician survey, we are unable to present a more refined, code-specific methodology for the interim final values. Instead, based upon a very conservative estimate of the work efficiencies we would expect to be present when multiple component services are bundled together into a single comprehensive service, we have set interim final work values for the cardiac catheterization codes using a 10 percent reduction on the current values.
>
> As points of comparison, we note that the current MPPR policies under the PFS for imaging and surgical services reduce payment for the second and subsequent procedures by 50 percent on the TC and complete service, respectively, and, as discussed in detail in section II.C.4. of this final rule with comment period, we are adopting a 25 percent MPPR on the PE component of payment for therapy services in CY 2011. We further note that the service specific work efficiencies for the other two major categories of new bundled codes for CY 2011, specifically endovascular revascularization and CT, are generally between 20 and 35 percent.

In January 2011, the Workgroup reviewed the RUC recommendations for Diagnostic Cardiac Catheterization Services that were sent to CMS in May 2010.

- For the 20 codes in the series, RUC recommended values were at the survey 25th percentile for 5 codes, below the 25th percentile for 8 codes, and between the 25th and 50th percentile for 7 codes.
- For the 20 codes in the series, RUC recommended values were at current values for 11codes, below the current values for 3 codes, and above current values for 3 codes. Three codes were newly evaluated and did not have current value assignments for comparison.
- The Workgroup noted that neither CMS nor specialty societies challenged the RVUs or times during the first three 5-year reviews.

Medicare Budget impact estimations demonstrated an overall savings of about 3.7% for work RVUs for the entire series. The reference service list supported these valuations, but the list was somewhat limited, because a number of comparative services were then under RUC review. The Workgroup reached consensus that these recommendations were resource based and followed the RUC's current process and policies of establishing RVUs for new/revised services as they were based on magnitude estimation and building block and were reviewed for potential rank order anomalies. To address the concerns raised by CMS, the Workgroup requested the following information from the specialty society:

1. The Workgroup requests that the specialty society provide the Workgroup the valuation history for all of the new bundled cardiac catheterization services utilizing the above format. Further, the Workgroup requests that the specialty society provide the Workgroup the historical service times for the bundled cardiac catheterization services.
2. The Workgroup requests that the specialty societies provide information supporting this shift in patient population to the Workgroup to further validate the RUC recommended values for these services.
3. The Workgroup requests that the specialty societies review pre, post and intraservice work for each of the bundled codes, to help determine what duplication might be present when services are bundled.
4. The Workgroup requests that the specialty societies provide alternative reference codes to support the RUC recommended values for each of the bundled diagnostic cardiac catheterization services.

During the March 2011 conference call, the specialty society presented the data requested by the Workgroup.

First, the Workgroup reviewed the CMS assumption that when services are bundled together, there should be substantial efficiencies in total work RVUs and times. The Workgroup, through its review of the valuation history of the Diagnostic Cardiac Catheterization services, respectfully disagreed with this assumption for these services.

The valuation history for the diagnostic cardiac catheterization codes begins in 1993. In 1993, several of the high volume diagnostic cardiac catheterization codes could be reported either through a bundled mechanism or a component coding mechanism. Component coding allowed a radiologist to bill for supervision and interpretation of the procedure, while the cardiologist billed for the catheterization. CMS valuation for the service was virtually identical whether services were reported as a single code or as components. In 1994, the bundled diagnostic cardiac catheterization codes were deleted and a new component coding structure was designed. Between 1994 and 2010, the valuation for the component coding for these services were subject to minor adjustments that were applied to all values within the RBRVS. Modifications in multiple procedure payment policy also affected valuation of these codes. The following is an example of the valuation history for a left heart catheterization combination service between 1993 and 2010:

93458	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation;with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed			
	1993 Bundled RVUs	6.32	1993 Bundled Physician Time	151
	1993 Component RVUs	6.31	1993 Component Physician Time	223
	1994 Component RVUs	6.62	1994 Component Physician Time	245
	2010 Component RVUs	6.51*	2010 Component Physician Time	210
	2011 Bundled RVUs (RUC recommended)	6.51	2011 Bundled Physician Time	123

*Valuation subject to Multiple Procedure Reduction Policy which went into effect in 1995

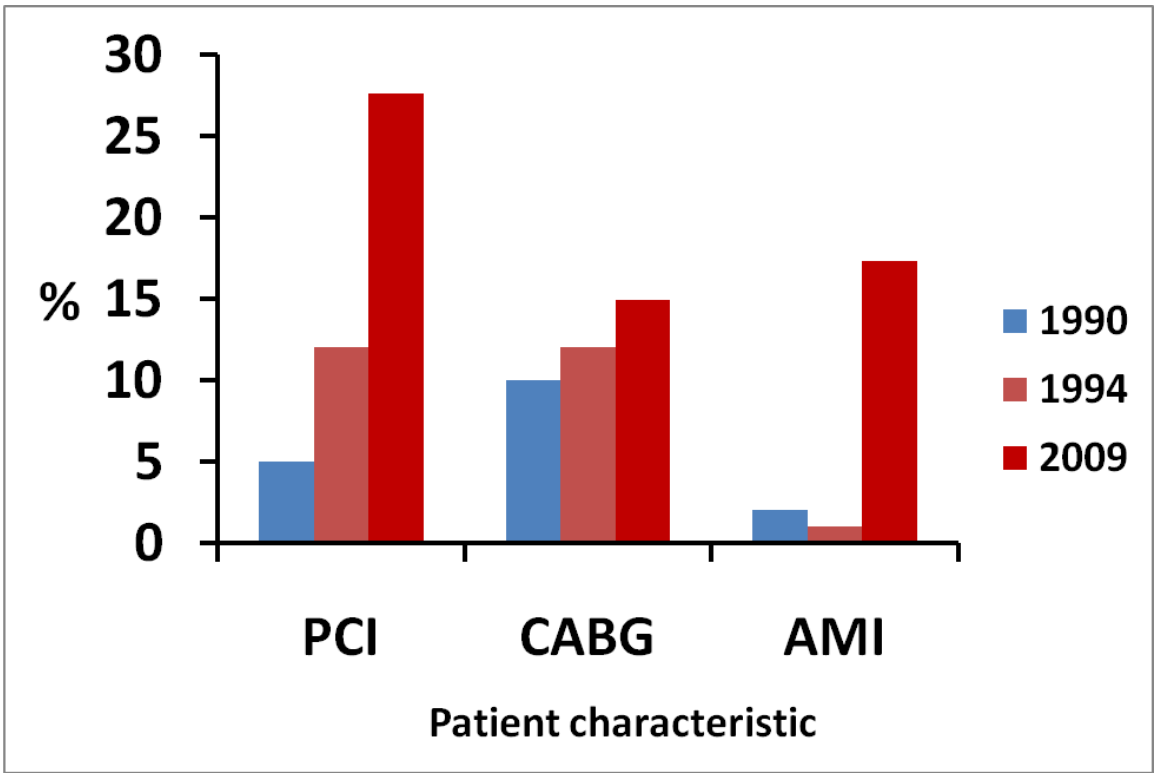
Utilizing the data from the example above, the Workgroup noted that whether the left heart catheterization combination of services was reported as a bundled service or as component services the work RVU was relatively constant over 18 years, despite the variations in service times assigned by CMS without RUC survey. The Workgroup reviewed similar specific historic data for each of the diagnostic cardiac catheterization services that had bundled and component coding in 1993 [Attachment #1]. Each demonstrated stable RVU valuation whether reported as a bundled code or multiple codes in 1993 and stable valuation when reported as multiple codes thereafter, even when assigned times were altered. The Workgroup agrees with CMS that any excessive valuation introduced in the 1994 unbundling should be subtracted in the 2010 rebundling. However, since no excessive valuation was assigned when component coding was introduced, there is no obvious excessive valuation to remove while rebundling the same codes for the same procedures.

The Workgroup agreed that this valuation history suggests that CMS concluded that there should be no duplication in the valuation of these services when reported by component coding as opposed to bundled coding in the initiation of the RBRVS. The RUC's recommendations for these services in 2010, reaffirm this conclusion.

RUC valuation for a number of the cardiac catheterization codes include stable RVUs with lower total and intra-service times. The Workgroup reviewed the historical times for these services as provided by the specialty society [attachment #1] and made several observations. First and foremost, the Workgroup agreed that the source of the historical times may be inaccurate, as these service times were derived from Harvard times and CMS estimates rather than physician surveys. The Workgroup noted that RUC surveys are deemed by CMS to be more accurate than older methods; indeed, absence of RUC valuation is now a sufficient reason for CMS to request RUC evaluation of codes commonly performed. Additionally, the Workgroup acknowledged that currently there is much more empahsis on accuracy of physician time than at the beginning of the RBRVS. Finally, the Workgroup notes that subsequent to the adoption of standard pre-service time packages, pre-service time often has decreased for RUC valued services. This standardization further contributed to reduced preservice times for the current valuation of the cardiac catheterization codes. The Workgroup contends that the times originally assigned to these services were incorrect and that the time collected from the physicians who participated in the 2010 RUC surveys is more accurate.

Second, the Workgroup discussed the change in the intensity of providing cardiac catheterization. The specialty societies provided evidence that the typical patient currently is more likely to be an inpatient and is more likely to have suffered a heart attack than the patients in the past. Expert opinion is supplemented by data from the *Registry of the Society for Cardiac Angiography and Interventions*, which demonstrates that the percentage of patients receiving diagnostic cardiac catheterization services, had undergone previous PCI or CABG or had an AMI within the past 24 hours is higher in 2009 than in the early 90's. [Figure A]

Figure A: Data from the Registry of the Society for Cardiac Angiography and Interventions



Further, a peer reviewed publication, *Chest*, in 2007, found that patients having coronary angioplasty in 2005 are older and have a higher prevalence of diabetes, hypertension and higher BMI than those in 1996. Additionally, the specialty society indicated that the work of the procedure has become more complex, partly because current catheters are smaller and more difficult to manipulate in comparison to the larger catheters used in the early 90's. The Workgroup agrees with the specialty society that the work of diagnostic cardiac catheterization has not decreased. that the RUC recommendations for cardiac catheterization are appropriate and no further decreases to the RUC recommended work RVUs could be substantiated.

Third, the Workgroup reviewed a revised and expanded list of reference codes document [attachment #2] as provided by the specialty societies. This list includes codes valued by RUC while the cardiac catheterization codes were under review, codes whose values are now published by CMS. Valuation for each code in this family is supported by values of other RUC surveyed codes requiring similar work. This method of magnitude estimation further supports the RUC recommended values for the diagnostic cardiac catheterization services.

The Workgroup was charged with addressing CMS' concerns with the RUC recommended work RVUs for Diagnostic Cardiac Catheterization Services through a re-review of RUC recommendations. Based on historical analysis of work RVUs and times, on evidence that the work of cardiac catheterization services has not decreased, and on comparisons to services requiring similar work, the Workgroup submits that the RUC recommendations for each of these services were derived through magnitude estimation, are resource-based and support the CMS conclusion from 1993 that there is negligible duplication in work or valuation, whether these services are reported as individual component codes or as a bundle. **The Workgroup reaffirms the RUC's recommended values for the diagnostic cardiac catheterization services.**

93452	Left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed														
1993 Bund codes	**1993 Bund RVUs**	**1993 Bund Times**	**1993 Comp Codes**	**1993 Comp RVUs**	**1993 Comp Times**	**1994 Comp Codes**	**1994 Comp RVUs**	**1994 Comp Times**	**2010 Comp Codes**	**2010 Comp RVUs**	**2010 Comp Times**	**2011 Code**	**2011 RVUs (RUC rec.)**	**2011 times**	
93546	4.68	97	93510	4.38	94	93510	4.38	94	93510	4.32	94	93452	4.32	108	
75523	0.86	22	93543	0.29	32	93543	0.29	32	93543	0.145	16				
			75523	0.86	22	93555	0.82	37	93555	0.81	37				
	5.54	*119*		*5.53*	*148*		*5.49*	*163*		*5.275*	*147*		*4.32*	*108*	*Sum*
75523	Cardiac radiography, left side														
93510	Left heart catheterization, retrograde, from the brachial artery, axillary artery or femoral artery; percutaneous														
93543	Injection procedure during cardiac catheterization; for selective left ventricular or left atrial angiography														
93546	Combined left heart catheterization and left ventricular angiography														
93555	Imaging supervision, interpretation and report for injection procedure(s) during cardiac catheterization; ventricular and/or atrial angiography														

CPT Code		Descriptor	Pre-time	Intra-time	Post-time	Total Time	RVU	Global
31256	Ref	Nasal/sinus endoscopy, w/ max antrostomy	33	45	18	96	3.29	000
77786	Ref	high dose rate radionuclide brachytherapy	14	60	15	89	3.25	000
43458	Ref	Dilate espphagus/30 mm> for achalasia	21	31	30	82	3.06	000
93451	**RUC REC**	**RHC w/wo O2 sat & CO**	**48**	**30**	**30**	**108**	**3.02**	**000**
95974	Ref	neurostimulator pulse gen complex	30	60	20	110	3.00	XXX
62267	Ref (CC)	Interdiscal perq aspir dx	34	30	15	79	3.00	000
93503	SVY Ref Code	Insert Swan-Ganz monitoring	12	15	10	37	2.91	000
31623	Ref	Dx bronchoscope/brush	20	30	20	70	2.88	000
CPT Code	CPT Code	CPT Code	CPT Cod	CPT Cod	CPT Cod	CPT Cod	CPT Code	CPT Code
93624	SVY Ref Code	EP follow up w/pacing inc induct arrhy	30	60	38	128	4.80	000
31288	Ref	Nasal/sinus endoscopy	30	60	30	120	4.57	000
50385	Ref	Rmv/replace of intern ureteral stent	49	45	15	109	4.44	000
93452	**RUC REC**	**LHC for LVG**	**48**	**30**	**30**	**108**	**4.32**	**000**
49418	Ref	tnld intraperitoneal catheter, compl	44	40	20	104	4.21	000
31629	Ref (CC)	Bronchoscopy/needle bx each	30	30	20	80	4.09	000
31634	Ref	Bronchoscopy, including fluor guidance	25	45	20	90	4.00	000
CPT Code	CPT Code	CPT Code	CPT Cod	CPT Cod	CPT Cod	CPT Cod	CPT Code	CPT Code
31600	Ref (CC)	Tracheostomy, planned (sep proc.)	50	40	55	145	7.17	000
52282	Ref	Cystourethroscopy, w/ ins of perm utr stent	40	50	30	120	6.39	000
43261	Ref	(ERCP); with biopsy, single or multiple	20	55	20	95	6.26	000
58563	Ref	Hysteroscopy, surg; w/endometrial abl	40	60	30	130	6.16	000
52277	Ref	Cystourethroscopy, sphincterotomy	45	45	40	130	6.16	000
36561	Ref	Insrt tunel'd CVA device, w/subcu pt	35	45	50	130	6.04	010
93453	**RUC REC**	**R+LHC wo cors eg ped wMR**	**48**	**45**	**30**	**123**	**5.98**	**000**
45387	Ref (CC)	Colonoscopy w/stent	30	45	30	105	5.90	000
31267	Ref	Nasal/sinus endoscopy	30	50	30	110	5.45	000
59074	Ref	Fetal fluid drainage w/us	65	30	30	125	5.24	000
CPT Code	CPT Code	CPT Code	CPT Cod	CPT Cod	CPT Cod	CPT Cod	CPT Code	CPT Code
93619	SVY Ref Code	EP right atrial pacing	60	90	53	203	7.31	000
59074	Ref	Fetal fluid drainage w/us	65	30	30	125	5.24	000
45385	Ref&MPC (CC)	Colonoscopy, flexible	16	43	15	74	5.30	000
45391	Ref	Colonoscopy, with endoscope, us	35	55	20	110	5.09	000
93454	**RUC REC**	**CORS**	**48**	**30**	**30**	**108**	**4.95**	**000**
11011	Ref-New	Debrid rmv foreign OF; subc	45	60	45	150	4.94	000
31288	Ref	Nasal/sinus endoscopy	30	60	30	120	4.57	000
50385	Ref	Rmv/replace of intern ureteral stent	49	45	15	109	4.44	000
31629	Ref	Bronchoscopy/needle bx each	30	30	20	80	4.09	000
CPT Code	CPT Code	CPT Code	CPT Cod	CPT Cod	CPT Cod	CPT Cod	CPT Code	CPT Code
93619	SVY Ref Code	EP right atrial pacing	60	90	53	203	7.31	000
34812	Ref&MPC (CC)	Xpose endoprosth fem, unilateral	75	45	30	150	6.74	000
52282	Ref	Cystourethroscopy, w/ ins of perm utr stent	40	50	30	120	6.39	000
43261	Ref	(ERCP); with biopsy, single or multiple	20	55	20	95	6.26	000
52277	Ref	Cystourethroscopy, sphincterotomy	45	45	40	130	6.16	000
93455	**RUC REC**	**CORS + Grafts**	**53**	**40**	**30**	**123**	**6.15**	**000**
45387	Ref	Colonoscopy w/stent	30	45	30	105	5.90	000
45385	Ref&MPC	Colonoscopy, flexible	16	43	15	74	5.30	000
CPT Code		Descriptor	Pre-time	Intra-time	Post-time	Total Time	RVU	Global
37187	SVY Ref Code	Venous mechanical thrombectomy	40	85	20	145	8.02	000
43261	Ref (CC)	(ERCP); with biopsy, single or multiple	20	55	20	95	6.26	000
93456	**RUC REC**	**RHC + CORS**	**48**	**40**	**30**	**118**	**6.00**	**000**
45387	Ref	Colonoscopy w/stent	30	45	30	105	5.90	000
31267	Ref	Nasal/sinus endoscopy	30	50	30	110	5.45	000
45385	Ref&MPC	Colonoscopy, flexible	16	43	15	74	5.30	000
CPT Code	CPT Code	CPT Code	CPT Cod	CPT Cod	CPT Cod	CPT Cod	CPT Code	CPT Code
37184	SVY Ref Code	Prime Art Mech thrombectomy	40	90	30	160	8.66	000
37183	Ref	Remove Hepatic Shunt (TIPS)	28	78	30	135	7.99	000

32603	Ref	Thoracoscopy, diagnostic w/o biopsy	83	90	120	293	7.80	000
93457	**RUC REC**	**RHC + CORS + Grafts**	**53**	**50**	**30**	**133**	**7.66**	**000**
52345	Ref (CC)	Cysto/uretero w/up stricture	70	45	20	135	7.55	000
52344	Ref	Cysto/uretero balloon dilation	60	45	20	125	7.05	000
75956	Ref	X Ray Endovascular repair	30	90	20	140	7.00	XXX
43261	Ref	(ERCP); with biopsy, single or multiple	20	55	20	95	6.26	000
CPT Code	**CPT Code**	**CPT Code**	**CPT Cod**	**CPT Cod**	**CPT Cod**	**CPT Code**	**CPT Code**	**CPT Code**
93619	SVY Ref Code	EP right atrial pacing	60	90	53	203	7.31	000
11012	Ref	Deb skin bone at fx site	60	90	60	210	6.87	000
43240	Ref	U GI endoscopy	20	90	20	130	6.85	000
34812	Ref&MPC (CC)	Xpose endoprosth fem, unilateral	75	45	30	150	6.74	000
93458	**RUC REC**	**CORS + LVG**	**48**	**45**	**30**	**123**	**6.51**	**000**
43261	Ref	(ERCP); with biopsy, single or multiple	20	55	20	95	6.26	000
45387	Ref	Colonoscopy w/stent	30	45	30	105	5.90	000
CPT Code	**CPT Code**	**CPT Code**	**CPT Cod**	**CPT Cod**	**CPT Cod**	**CPT Code**	**CPT Code**	**CPT Code**
37184	SVY Ref Code	Prime Art Mech thrombectomy	40	90	30	160	8.66	000
52345	Ref	Cysto/uretero w/up stricture	70	45	20	135	7.55	000
93459	**RUC REC**	**CORS + Grafts + LHC**	**53**	**50**	**30**	**133**	**7.34**	**000**
31600	Ref (CC)	Tracheostomy, planned (sep proc.)	50	40	55	145	7.17	000
52344	Ref	Cysto/uretero balloon dilation	60	45	20	125	7.05	000
75956	Ref	X Ray Endovascular repair	30	90	20	140	7.00	XXX
CPT Code	**CPT Code**	**CPT Code**	**CPT Cod**	**CPT Cod**	**CPT Cod**	**CPT Code**	**CPT Code**	**CPT Code**
37184	SVY Ref Code	Prime Art Mech thrombectomy	40	90	30	160	8.66	000
37183	Ref	Remove Hepatic Shunt (TIPS)	28	78	30	135	7.99	000
37235	Ref	TIB/per Revasc Stnt/Ather	1	80	1	82	7.80	ZZZ
93460	**RUC REC**	**RHC + CORS + LVG**	**48**	**50**	**30**	**128**	**7.88**	**000**
52345	Ref	Cysto/uretero w/up stricture	70	45	20	135	7.55	000
31600	Ref (CC)	Tracheostomy, planned (sep proc.)	50	40	55	145	7.17	000
CPT Code	**CPT Code**	**CPT Code**	**CPT Cod**	**CPT Cod**	**CPT Cod**	**CPT Code**	**CPT Code**	**CPT Code**
93620	SVY Ref MPC	Comp EP w/reposit, induct arrhy RA pac	60	120	60	240	11.57	000
35475	Ref	Transl balloon angioplasty	0	90	121	211	9.47	000
37224	Ref	Endov, fem, unil, w.translum angio	48	80	30	158	9.00	000
93461	**RUC REC**	**R & L CORS & Grafts**	**53**	**65**	**35**	**153**	**9.00**	**000**
59076	Ref (CC)	Fetal Shunt Placement w/us	105	60	0	165	8.99	000
37220	MPC	Revasc, illiac, unil, init ves, w/translum angio	48	60	30	138	8.15	000
CPT Code	**CPT Code**	**CPT Code**	**CPT Cod**	**CPT Cod**	**CPT Cod**	**CPT Code**	**CPT Code**	**CPT Code**
13133	Ref (CC) MPC	Repair, cmplx, head/neck/feet, add <5 cm	0	30	0	30	2.19	ZZZ
15151	Ref (CC)	Tissue epiderm autogft ; add1-75 sq cm	0	20	0	20	2.00	ZZZ
93563	**RUC REC**	**Inj, selective COR Angio**	**0**	**25**	**0**	**25**	**2.00**	**ZZZ**
92978	SVY Ref Code	Intravasc US (cor vessel/graft) init vessel	0	25	0	25	1.80	ZZZ
15005	Ref	Wnd prep F/N/HF/G add on	0	20	1	21	1.60	ZZZ
CPT Code	**CPT Code**	**CPT Code**	**CPT Cod**	**CPT Cod**	**CPT Cod**	**CPT Code**	**CPT Code**	**CPT Code**
13133	Ref (CC) MPC	Repair, cmplx, head/neck/feet, add <5 cm	0	30	0	30	2.19	ZZZ
37250	Ref	IV US 1st Vessel Add on	0	23	0	23	2.10	ZZZ
93564	**RUC REC**	**Inj, selective opac bypass graft**	**0**	**25**	**0**	**25**	**2.10**	**ZZZ**
15151	Ref (CC)	Tissue epiderm autogft ; add1-75 sq cm	0	20	0	20	2.00	ZZZ
92978	SVY Ref Code	Intravasc US (cor vessel/graft) init vessel	0	25	0	25	1.80	ZZZ
CPT Code	**CPT Code**	**CPT Code**	**CPT Cod**	**CPT Cod**	**CPT Cod**	**CPT Code**	**CPT Code**	**CPT Code**
13133	Ref (CC) MPC	Repair, cmplx, head/neck/feet, add <5 cm	0	30	0	30	2.19	ZZZ
15151	Ref (CC)	Tissue epiderm autogft ; add1-75 sq cm	0	20	0	20	2.00	ZZZ
93565	**RUC REC**	**Inj, selective, LV or LAG**	**0**	**20**	**0**	**20**	**1.90**	**ZZZ**
92978	SVY Ref Code	Intravasc US (cor vessel/graft) init vessel	0	25	0	25	1.80	ZZZ
11047	Ref	Debrid Bone Add on	0	30	1	31	1.20	ZZZ
96570	Ref	Photodynamc tx 30 min add-on	0	30	0	30	1.1	ZZZ
CPT Code	**CPT Code**	**CPT Code**	**CPT Cod**	**CPT Cod**	**CPT Cod**	**CPT Code**	**CPT Code**	**CPT Code**
15151	Ref (CC)	Tissue epiderm autogft ; add1-75 sq cm	0	20	0	20	2.00	ZZZ
11047	Ref	Debrid Bone Add on	0	30	1	31	1.20	ZZZ
96570	Ref	Photodynamc tx 30 min add-on	0	30	0	30	1.1	ZZZ
93566	**RUC REC**	**Inj, RV or RT atrial angio**	**0**	**20**	**0**	**20**	**0.96**	**ZZZ**

93015	SVY Ref Code	Stress test	2	15	4	21	0.75	XXX
15301	Ref	Apply sknallogrft t/a/l addl	0	15	0	15	1.00	ZZZ
CPT Code	**CPT Code**	**CPT Code**	**CPT Cod**	**CPT Cod**	**CPT Cod**	**CPT Cod**	**CPT Code**	**CPT Code**
92978	SVY Ref Code	Intravasc US (cor vessel/graft) init vessel	0	25	0	25	1.80	ZZZ
11047	Ref	Debrid Bone Add on	0	30	1	31	1.20	ZZZ
96570	Ref	Photodynamc tx 30 min add-on	0	30	0	30	1.1	ZZZ
93567	**RUC REC**	**Inj, supravalvular aortography**	**0**	**15**	**0**	**15**	**0.97**	**ZZZ**
99213	Ref & MPC(CC)	E&M 2 of 3, 15 min face to face	3	15	5	23	0.97	XXX
15301	Ref	Apply sknallogrft t/a/l addl	0	15	0	15	1.00	ZZZ
CPT Code	**CPT Code**	**CPT Code**	**CPT Cod**	**CPT Cod**	**CPT Cod**	**CPT Cod**	**CPT Code**	**CPT Code**
15151	Ref (CC)	Tissue epiderm autogft ; add1-75 sq cm	0	20	0	20	2.00	ZZZ
92978	SVY Ref Code	Intravasc US (cor vessel/graft) init vessel	0	25	0	25	1.80	ZZZ
11047	Ref	Debrid Bone Add on	0	30	1	31	1.20	ZZZ
96570	Ref	Photodynamc tx 30 min add-on	0	30	0	30	1.1	ZZZ
15301	Ref	Apply sknallogrft t/a/l addl	0	15	0	15	1.00	ZZZ
93568	**RUC REC**	**Inj, Pulm Angio**	**0**	**20**	**0**	**20**	**0.98**	**ZZZ**
11046	Ref	Debride muscle facial add on	0	20	1	21	0.70	ZZZ

Streamlining the claims process: Standard Set of Claims and Payment Rules Initiatives

Tammy Banks
Director, Practice Management Center

AMA
TOGETHER WE ARE STRONGER




Session objectives

- Engage RUC members in the ongoing national effort to streamline the claims process through the establishment of a standard set of claims edits and payment rules to reduce the cost of dealing with the variability and uncertainty that currently permeates the repricing activities of the various third party payers.
- Inform attendees regarding the status of the Colorado initiative. The Colorado Medical Society was instrumental in passing a bill (HB 1332) which mandates the creation of a standard set of claims edits and payment rules.
- Discuss draft principles for standardized claim edits and pricing rules.




2010 AMA National Health Plan Report Card Results for Edits

Visit www.ama-assn.org/go/reportcard

to view a webinar of the complete 2010 NHIRC results

The 2011 NHIRC will be unveiled at the AMA HOD Annual Meeting during the Monday morning education session.

Plan to attend!




National Health Insurer Report Card—What Does It Measure?

- Actionable data:
  - Payment timeliness and type
  - Accuracy
  - Claim edit sources and frequency
  - Denials
  - Improvement of claims cycle workflow

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National Health Insurer Report Card—What data did we use?

Physicians' Electronic Data Interchange (EDI) files (electronic claims and remittance advices)

- Approximately 3.49 million services
- Approximately 2.05 million claims
- February 1, 2010 – March 31, 2010
- 43 states
- 76 specialties
- Over 200 practices




National Health Insurer Report Card

- Payers: Aetna, Anthem BCBS, CIGNA, Coventry, Health Care Services Corporation (HCSC), Humana, UnitedHealthcare (UHG), and Medicare
- 17 metrics reflecting five focus areas:
  - Data for Payment Timeliness and Type, Accuracy, Code Edit Sources and Frequency, and Denials were provided by NHXS.
  - Information on Improvement of Claim Cycle Workflow was self-reported by the payers.




National Health Insurer Report Card– Disclaimer

- Data for this report card was provided by physician groups that have adopted best practices for electronic data interchange and contract compliance.
- NHXS uses information in the standard transaction in ways that are not described within the implementation guide to help improve match rate.
- These results may be better than practices that have not adopted such technologies.




Claim Edits are not Denials

- "Claim edit" means a payment rule to which the provider is obligated by contract that results in an allowed amount of $0.
- Examples include mutually exclusive, or inclusive rules found in CPT Guidelines.
- An edit is not a "denial" where the allowed amount is billed charges and the final adjudication is still uncertain.
- Examples of a denial are non covered services, patient not covered, missing information, duplicate claim.




Claim Edit Sources and Frequency

Metric 8 - Total number of available payer claim edits*

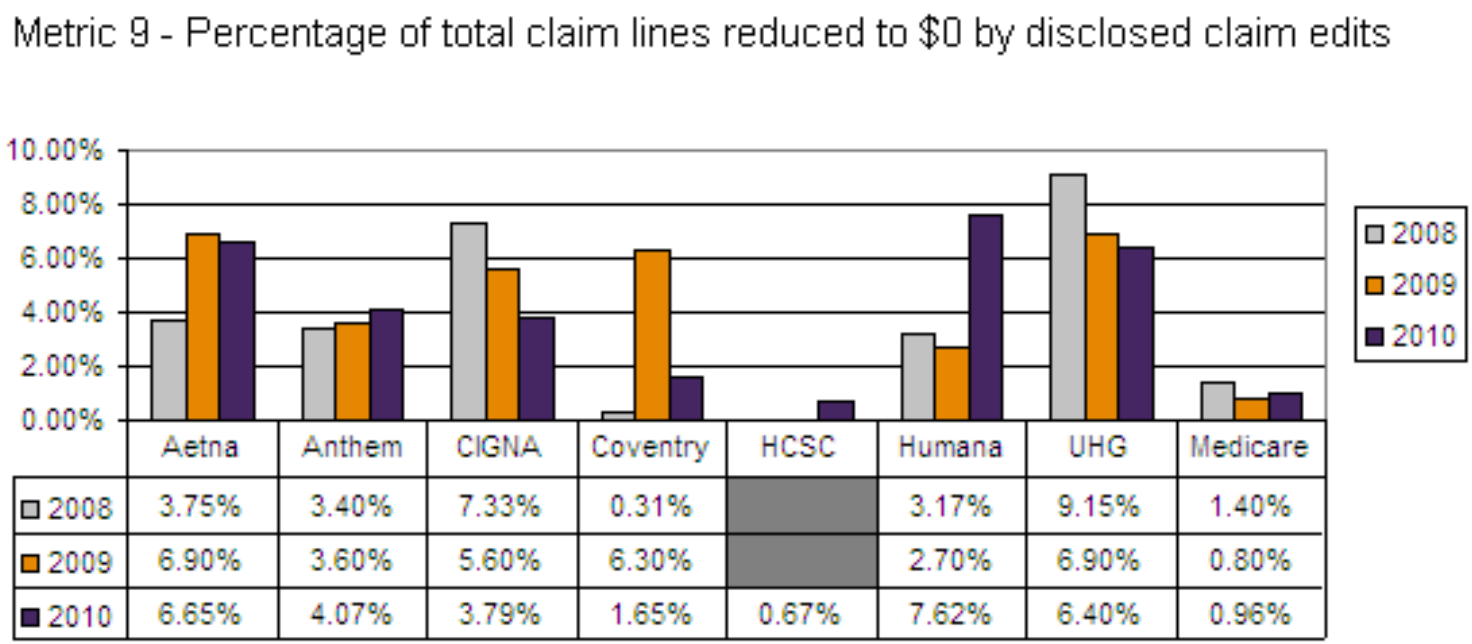
	Aetna	Anthem BCBS	CIGNA	Coventry	HCSC	Humana	UHG	Medicare
CPT	19,802	20,015	19,654	19,710	20,015	20,015	19,919	20,015
ASA	1,070	1,070	1,070	1,064	1,070	1,070	1,070	1,070
NCCI	744,605	744,265	744,678	744,272	744,475	744,678	744,678	744,678
CMS	60,164	45,118	60,420	60,051	43,291	60,420	46,533	60,420
Payer Specific	210,272	64,557	442	0	194,108	5,033	247,961	387,816




Claim Edit Frequency

Metric 9 - Percentage of total claim lines reduced to $0 by **disclosed** claim edits

Aetna	Anthem BCBS	CIGNA	Coventry	HCSC	Humana	UHG	Medicare
6.65%	**4.07%**	**3.79%**	**1.65%**	**0.67%**	**7.62%**	**6.40%**	**0.96%**

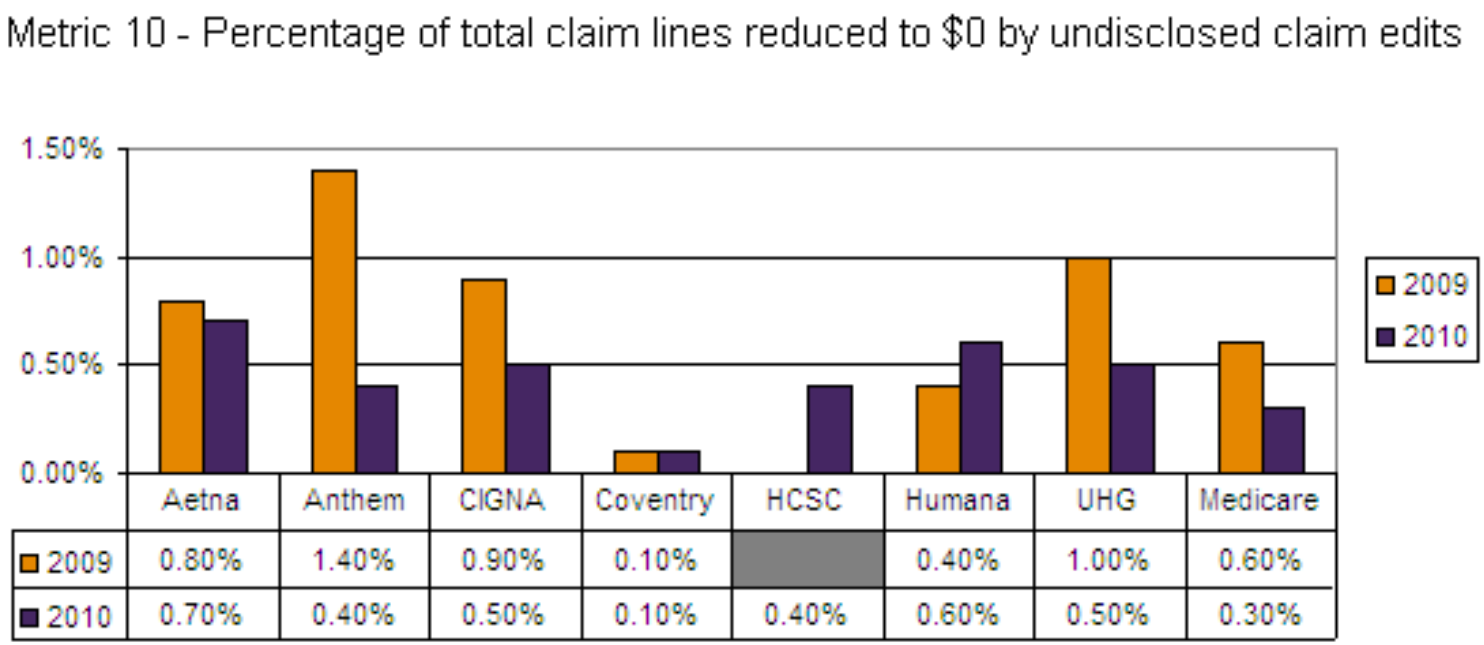


	Aetna	Anthem	CIGNA	Coventry	HCSC	Humana	UHG	Medicare
2008	3.75%	3.40%	7.33%	0.31%		3.17%	9.15%	1.40%
2009	6.90%	3.60%	5.60%	6.30%		2.70%	6.90%	0.80%
2010	6.65%	4.07%	3.79%	1.65%	0.67%	7.62%	6.40%	0.96%

Claim Edit Frequency

Metric 10 - Percentage of total claim lines reduced to $0 by **undisclosed** claim edits

Aetna	Anthem BCBS	CIGNA	Coventry	HCSC	Humana	UHG	Medicare
0.70%	**0.40%**	**0.50%**	**0.10%**	**0.40%**	**0.60%**	**0.50%**	**0.30%**



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Payment policies/ claim edits

- Payers should be completely transparent concerning the payment policies and claim edits that may affect the contracted rate as identified on the fee schedule, including:
  - Clearly stated payment rules and the specific underlying methodology (e.g., multiple procedure reduction logic, assistant at surgeon, co-surgeon, modifier adjustments, global surgery period).
  - All payer applied claim edits (optimally in a downloadable format), as well as the publisher, product name, edition, and model version of the software the payer uses to edit claims submitted by the physician practice.




Standard claims processing platform - Claim edits

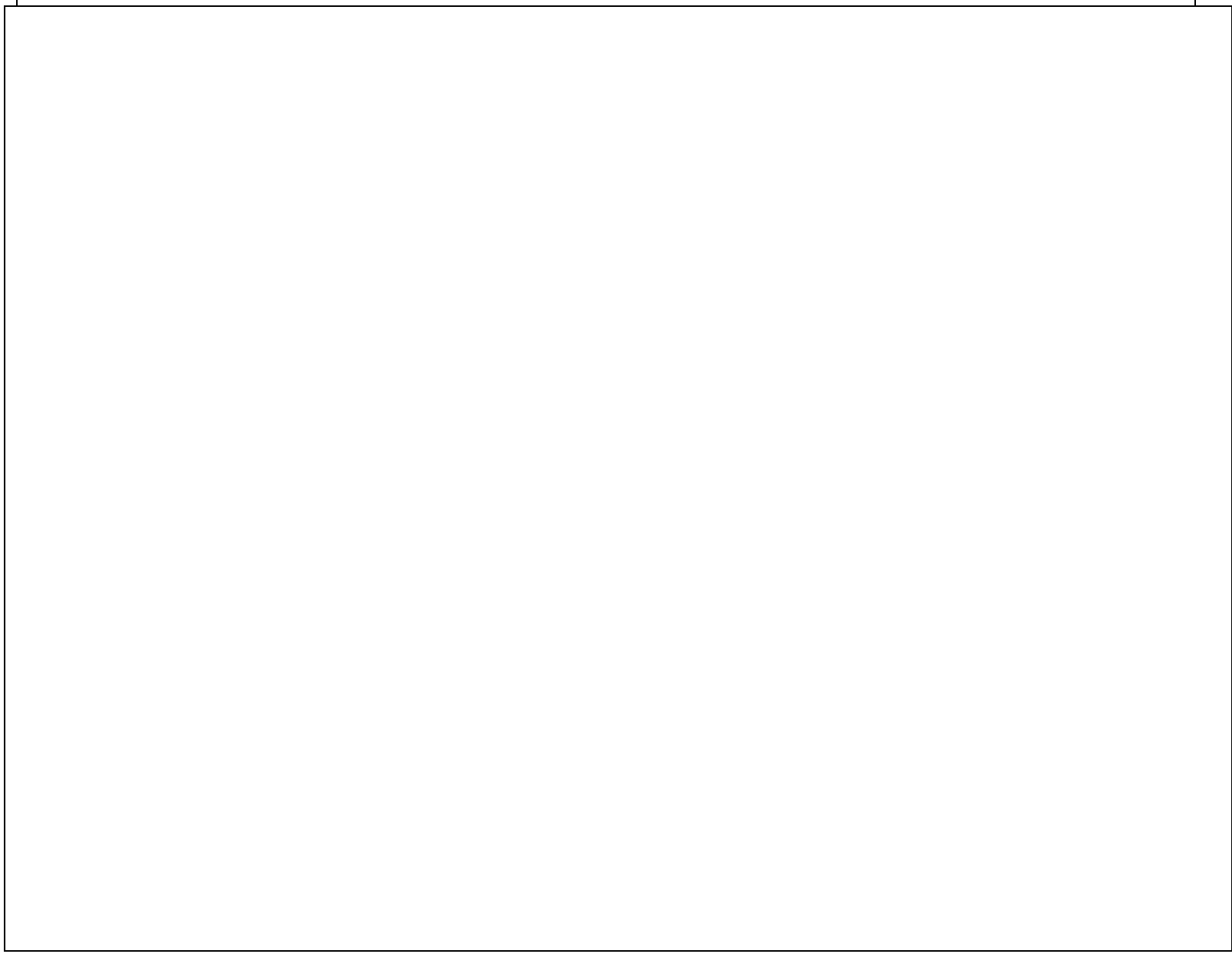
- **Hypothesis – the complexity is costing more than it is saving!**
- Standard claim edits and payment rules are readily available and downloadable through easy online access
- Standard claims processing platform would not dictate:

  payer payment rates,

  medical coverage rules,

  claim review policies, or

  product benefit level or design.






DRAFT: Guiding principles for a standardized code edit set:

The AMA and National Medical Specialty Societies:

- define the term “claim edits” to mean an algorithm programmed into a third party payers claims adjudication system which denies payment for specific services on the grounds that the denied services have already been paid because they were included within other services for which the provider billed on the same claim. Technical definition Claim edit is defined as any claim line edits where the Actual Allowed Amount ([X12 835: AMT02] and the Line Item Provider Payment Amount (X12 835: SVC03) were both equal to $0.
- believe that the purpose of edits is to create a uniform, correct coding practice in the market place and that such edits should be adopted universally by the trading partners as well as provide transparency and simplicity for point of service pricing.

DRAFT: Guiding principles for a standardized code edit set:

The AMA and National Medical Specialty Societies (continued):

- support the development of edits that are consistent with CPT codes, guidelines and conventions and give thoughtful consideration to all AMA and national medical specialty society policy documents, clinical vignettes, comments, etc.
- believe the NCCI review process as it is currently handled, that allows AMA and national medical specialty societies to review, comment and appeal must be retained.
- believe that with health plan benefit coverage or payment policies must not be commingled with claim edits.




DRAFT: Guiding principles for standardized pricing rules:

The AMA and National Medical Specialty Societies:

- define “pricing rules” to mean payment rules (e.g., multiple procedure reduction logic, bilateral modifier payment percentage) additional rules applied to increase or decrease the allowed amount or required to be paid appropriately. Rules applied by a third party payer to increase or decrease the payment amount (but not decreased to $0) in specified circumstances, such as:
  - when several procedures are done at the same time (multiple procedure reduction logic),
  - the procedure is done on both sides of the body (bilateral modifier payment percentage)
  - the service is provided by an assistant surgeon (assistant at surgeon payment percentage), and
  - services are included within a global period or global procedure etc.




DRAFT: Guiding principles for standardized pricing rules:

The AMA and National Medical Specialty Societies (continued):

- believe that the purpose of pricing rules is to create a uniform, transparent practice in the marketplace and that such rules should be adopted universally by the trading partners.
- support the development of pricing rules by an entity free from influence by special interests that gives thoughtful consideration to all AMA and national medical specialty societies policy documents, clinical vignettes, comments, etc.
- The AMA and national medical specialty societies do not support the development of edits or pricing rules by entities that do not give thoughtful consideration to all AMA and National Medical Specialty Societies policy documents, clinical vignettes, comments, etc.

AMA's Administrative Simplification Agenda

We need your help!

Visit www.ama-assn.org/go/simplify

for more information regarding the AMA's Administrative Simplification Agenda including:

Downloadable fee schedule

Streamlining prior authorization for medical services and pharmacy

Full transparency on eligibility and ERA of the funder of the claim (fiduciary), contracting party with the physician and the identification of the specific fee schedule, claim administrator and the identification of the specific patient benefit plan.

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Washington Update

RUC Meeting
April 28, 2011

Sharon McIlrath

BUDGET BATTLES

- Continuing Resolution for 2011
- Debt Ceiling Extension Deadlines
- 2012 Budget Resolution
- President’s Budget Proposal
- Big Budget Deal

The Contenders

- The Deficit Reduction Commission
  - Not enough approvals to send to Congress
  - Others likely to borrow from it
  - Includes proposal to replace SGR
  - Freezes MD fees, cuts GME, strengthens IPAB
- The Ryan Plan
  - 10-year, $30 billion Medicare cut
  - Turns Medicare into voucher program
  - Block Grants Medicaid & cuts $771 billion
  - Medical liability reform said to save $60 billion
  - Reduces individual tax rates
- The President's Plan
  - Tightens IPAB target to GDP+0.5%
  - Creates new Medicaid matching formula
  - Makes automatic cuts to meet deficit targets
  - Includes some tax hikes
  -

Latest Contenders

- Budgetary Cap Proposals
  - Several proposals to cap spending only
  - Corker McCaskill sets cap at 20.6%, others similar or deeper
  - If spending exceeds cap, automatic spending cuts take effect;
  - Unlike Obama plan, revenue not included.
  - Could cut Medicare and Medicaid by 19% over 10 years

Compromise Critical

- Need revenue and entitlement reform
- Must address demand, not just cut pay
- Should provide reasonable timelines
- Potential Dealmakers
  - Senate Gang of 6
  - Biden bipartisan deficit panel

Medicare Reform Opportunities

- Major entitlement reform best option for long-term SGR solution
- Could break down silos that short-change physicians
- Make beneficiaries more cost-conscious

Reform Risks

- More formulaic payment cuts
- Caps upon caps
- Unrealistic Vouchers
- Divisive redistribution battles
  - Geographic
  - Specialty
  - Provider Types

Navigating Through Tricky Waters

- Promote Bipartisan solutions
- Join with other stakeholders to shape policy
- Seek repeal or revision in IPAB
- Oppose one-sided budgetary caps
- Support appropriate entitlement reforms
  - Transitioning to adequate premium supports
  - Revising Medicare eligibility age
  - Combined deductible & restrictions on first dollar coverage
- Encourage liability reform
- Press for SGR solution

Payment Reform Framework

- Repeal SGR
- Positive statutory updates for 5 years
- Pilot test ACOs, shared savings, bundled payments, medical home, independence at home, partial or condition-specific capitation, care warranties (see www.paymentreform.org)
- Adopt legislation in 2015 to implement successful models in 2016

Legislative Status

- House GOP Leadership and Committee staff met with physician groups
- Energy & Commerce
  - sought ideas from 51 organizations
  - will hold hearing on May 5
  - AMA sent letters detailing framework and will testify
- Also talking to Ways & Means staff and members; expect hearing there soon
- Have met with Senate Finance staff as well
- Goal is to provide time and resources for transition and avoid one-size-fits-all solutions
- Status quo is a losing hand

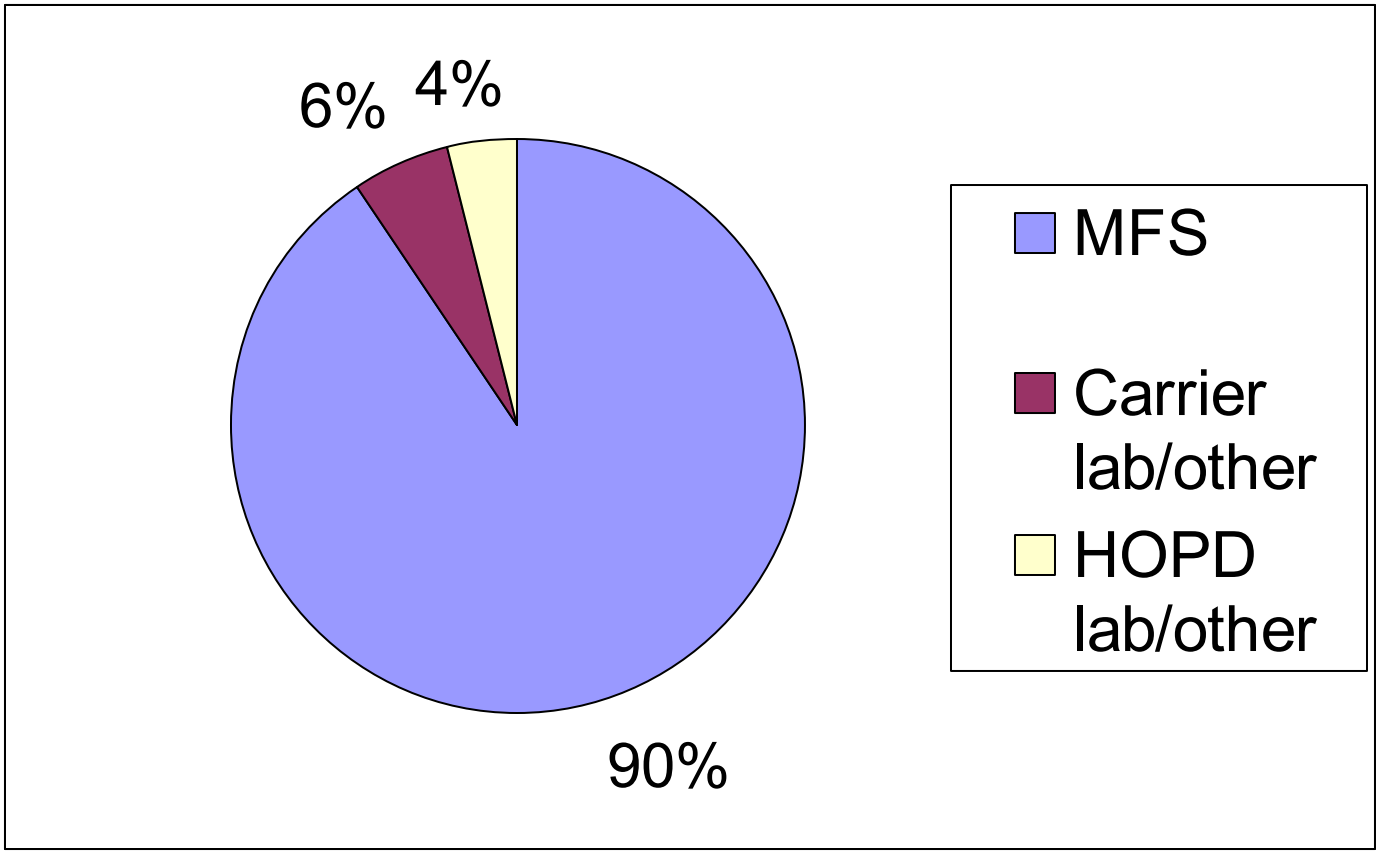
Other Developments

- ACO rule comments due 6-6
- AMA letter on regulatory burden
- Continued discussions on E-Rx Penalties
- Data bills
- Medical Liability Reform
- Medicare Private Contracting

SGR Spending and Utilization Growth for 2010

Estimates based on claims processed through Dec 31, 2010

SGR spending is...



Coding Changes for 2010

- Office consults deleted – affects frequency for 99201-99215
- Inpatient consults deleted – affects frequency for 99221-99223, 99304-99306, and (?)
- 78465 + add-ons replaced with 78452
- Affected codes were not included in pay and volume/intensity estimates

Results for 2010 - Overall

- SGR spending is up 5.6%
- MFS spending up by same amount

- Change in MFS spending was due to:
  - Increase in FFS enrollment (1.1%)
  - Increase in MFS pay (2.6%)
  - V/i growth of 2.4% (down from recent years)

Results for 2010 - Imaging

- Spending for imaging is down 5%
- Pay per service down slightly
- Little to no growth in utilization per enrollee
- Modest shift to facility setting that also reduced spending

Results for 2010 – E&M

- $3 billion increase in spending or 2/3 of the overall increase in MFS spending
- Above average pay increases for many visit categories
- Above average volume/intensity increases

Office Consults + Affected Codes

- 15.2 million office consults in 2009
- Totals for 99241-99245 + 99201-99215:
  - Frequency per enrollee up 1.2%
  - Spending up 7.6%

Inpat Consults + Affected Codes

- 13.1 million inpatient consults in 2009

- Totals for 99251-99255 + 99221-99223 + 99304-99306:
  - Frequency per enrollee down 2.4% (no change if 99231-99233 included)
  - Spending up 2.5% (up 5.2% if 99231-99233 included)

Procedures

- Above average pay increases for some categories (eg, eye, ambulatory)
- Average volume/intensity growth for most broad categories
- Decline in v/i for oncology and some surgical and cardiovascular categories (eg, CABG)

Other Results

- Physical therapy – volume intensity up 3%
- Lab tests – volume intensity up 4% to 5%

Key Results

- No growth in utilization for imaging
- Overall MFS volume/intensity growth is down
- $3 billion increase in spending for E&M