AMA/Specialty RVS Update Committee
Meeting Minutes
February 2-5, 2006

I. Welcome and Call to Order

Doctor William Rich called the meeting to order on Friday, February 3, 2006, at 8:00 am. The following RUC Members were in attendance:

William Rich, MD (Chair)
Bibb Allen, Jr., MD
James Anthony, MD*
Michael D. Bishop, MD
James Blankenship, MD
Dale Blasier, MD*
Ronald Burd, MD*
Norman A. Cohen, MD
Bruce Deitchman, MD*
James Denneny, MD*
John Derr, Jr., MD
Verdi DiSesa, MD*
Thomas A. Felger, MD
Mary Foto, OTR
John O. Gage, MD
William F. Gee, MD*
Robert S. Gerstle, MD*
David F. Hitzeman, DO
Peter Hollmann, MD
Charles F. Koopmann, Jr., MD
George F. Kwass, MD*
Walt Larimore, MD*
M. Douglas Leahy, MD*
Barbara Levy, MD
Brenda Lewis, DO*
J. Leonard Lichtenfeld, MD
Charles D. Mabry, MD*
James D. Maloney, MD*
Scott Manaker, MD
Charles Mick, MD
Bill Moran, Jr., MD
Bernard Pfeifer, MD
Aland Plummer, MD*
Gregory Przybylski, MD
Sandra Reed, MD*
David Regan, MD
James B. Regan, MD
Chester W. Schmidt, Jr., MD
Daniel Mark Siegel, MD
Samuel Silver, MD*
J. Baldwin Smith, III, MD
Peter Smith, MD
Clair Tibiletti, MD*
Trexler Topping, MD
Arthur Traugott, MD*
Richard Tuck, MD
James C. Waldorf, MD*
Richard W. Whitten, MD

*Alternate

II. Chair's Report

Doctor Rich made the following announcements:

- Doctor Rich discussed the following:
  - Financial Disclosure Statements must be submitted to AMA staff prior to presenting. If a form is not signed prior to your presentation, you will not be allowed to present.

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

- Doctor Rich announced that this will be the last meeting for one of the original RUC members, Chester W. Schmidt, Jr., MD, from the American Psychiatric Association, and thanked him for all his years of contributing his expertise and time to the RUC.

- Doctor Rich welcomed Ronald Burd, MD, as a new RUC member from the American Psychiatric Association.

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

- Doctor Rich welcomed the following Medicare Payment Advisory Commission (MedPAC) staff:
  - Kevin Hayes
  - Nancy Ray
  - Ariel Winter

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

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

- Doctor Rich welcomed Keun-Young Lee, MD, PhD, from the Korean Medical Association (Korean Society of Obstetrics and Gynecology).

- Doctor Rich announced the members of the Facilitation Committees:

<u>Facilitation Committee #1</u>
Bernard Pfeifer, MD (Chair)
Michael D. Bishop, MD
Keith Brandt, MD
Norman A. Cohen, MD
Thomas A. Felger, MD
Anthony Hamm, DC
Charles F. Koopmann, Jr., MD
Scott Manaker, MD
James B. Regan, MD
Chester W. Schmidt, Jr., MD
Richard W. Whitten, MD

<u>Facilitation Committee #2</u>
Peter Smith, MD (Chair)
Mary Foto, OTR
John O. Gage, MD
Robert Kossmann, MD
Charles Mick, MD
David Regan, MD
Daniel Mark Siegel, MD
J. Baldwin Smith, MD
Richard H. Tuck, MD
Trexler Topping, MD
Arthur Traugott, MD

<u>Facilitation Committee #3</u>
J. Leonard Lichtenfeld, MD (Chair)
Bibb Allen, Jr., MD
James Blankenship, MD
John Derr, MD
Emily H. Hill, PA-C
David Hitzeman, DO
Barbara Levy, MD
Terry M. Mills, MD
Willard Moran, MD
Gregory Przybylski, MD
Susan Strate, MD

- The following individuals were observers at the September 2005 meeting:
  - Savonne Alford - American College of Obstetricians and Gynecologists
  - David Beyer, MD - American Society for Therapeutic Radiology and Oncology
  - Michael Bigby - American Academy of Dermatology
  - James Christmas, MD - American College of Obstetricians and Gynecologists
  - Scott Collins – American Academy of Dermatology
  - Scott Faro – American Society of Neuroradiology
  - Hal Folander – Society of Interventional Radiology
  - James Giblin, MD – American Urological Association
  - John Hart, MD – American Academy of Neurology
  - Alyssa Herman, MD – American Academy of Dermatology
  - Pat Jacob, MD – American Association of Neurological Surgeons
  - Kirk Kanter - American Association for Thoracic Surgery
  - Michael Kuettel, MD – American Society for Therapeutic Radiology and Oncology
  - Debra Lansey – American Society for Therapeutic Radiology and Oncology
  - Alex Mason, MD – American Association of Neurological Surgeons
  - Christina Metzler – American Occupational Therapy Association
  - Stephen Rao, PhD – American Psychological Association
  - Michael Repka, MD – American Academy of Ophthalmology
  - Koryn Rubin – American Academy of Ophthalmology
  - Chad Rubin, MD – American College of Surgeons
  - James Scroggs – American College of Obstetricians and Gynecologists
  - Craig Sobolewski, MD – American College of Obstetricians and Gynecologists
  - Anthony Spina – American Association of Oral and Maxillofacial Surgeons
  - Ron Szabat – American Society of Anesthesiologists
  - Clare Thompson-Smith – American Nurses Association
  - Vince Traynelis, MD – American Association of Neurological Surgeons
  - Chris Welch – American Association of Clinical Endocrinologists
  - Franklin West – Society for Vascular Surgery
  - Kadyn Williams – American Academy of Audiology

III. Directors Report

Sherry Smith made the following announcements:

- We have had a series of organizational changes at the AMA. Lee Stillwell the Senior Vice President of Advocacy for the AMA has retired in the fall and Richard Deem has been promoted to fill that position.
- Kathy Kuntzman, Vice President of Health Policy at the AMA will be retiring at the end of February. Ms. Smith thanked her for her twenty-three years of service.
- Patrick Gallagher has left the AMA and is now Vice President of Government Affairs for the Illinois State Medical Society (ISMS). Sherry will be the Director of the Department of Physician Payment Policy and Systems.
- Ruby-Overton Bridges is the new staff assistant for the Department of Physician Payment Policy and Systems.
- Farewell and thanks to specialty society staff, Mike Mabry on all his work with the RUC since its inception. He started with the American

College of Radiology, moved to the Society of Interventional Radiology, and will now be the Executive Director of Radiology Business Management Association.

- The next RUC meeting will be in Chicago, April 27-20, 2006, at the Hyatt Regency. The September 2006 meeting location is not finalized but will most likely be held in Washington, DC. The February 2007 meeting will be held in San Diego at the Omni Hotel.
- RUC Database is available with all the 2006 information. An improvement that we would like to add to the database, which will need to be discussed, is to add data from Medicare's five percent sample file. This may include the associated diagnosis, number of diagnoses, patient age, etc. Unfortunately, we will not be able to obtain the date of service data due to privacy issues.
- The 2006 Physician's Guide and CPT 2006 books will be mailed out the week of February 6-10, 2006, to all RUC members and alternates.
- RUC voting is not saved electronically and is usually not stated at the RUC meeting. The votes were in the E/M minutes because this was verbally requested and stated at the last meeting.

IV. Approval of Minutes for the September 29-October 2, 2005, RUC meeting:

The RUC reviewed the minutes and made an editorial change, to the rationale for the Doppler Color Flow Add-On.

(Page 25)
Doppler Color Flow Add-On – 93325

~~Workgroup Four had come to no consensus for code 93325 *Doppler echocardiography color flow velocity mapping* (21005 Work RVU = 0.07) during its discussions, and the RUC then reviewed the code in relation to coes 93307 *Echhocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode regording; complete* (2005 Work RVU = 0.92) and 99320 *Doppler echocardiography, pulsed wave and/or continuous wave with spectral display* (2005 Work RVU = 0.38). The RUC noted that these three codes are frequently billed together over 92% of the time, and believed that all three codes should be repackaged into one code.~~ **~~The RUC referred code 933525 to the CPT Editorial Panel for review.~~**

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

V. CPT Editorial Panel Update

Doctor Peter Hollmann informed the RUC that:

- Most of the issues from the Five-Year Review have made there way to the CPT Editorial Panel, those that have not are indicated in a list prepared by AMA staff in the agenda book as not on the CPT agenda. In some cases there are codes that CMS requested for review.
- CPT and the RUC has formed a group to review all the modifiers in CPT and part of the origin is to review the modifier -51 exempt list that appears in CPT.
- CPT will begin the open meeting format at the June 2006 CPT Editorial Panel meeting. The movement of the meetings to this format was encouraged by the AMA Board of Trustees, and would allow attendance and inclusion of both presenters and registered guests during the entire meeting, with the exclusion of the Executive Session.
- There will be an Editorial Board established for CPT Assistant so that this publication is authoritative.

VI. CMS Update

- Doctor Ken Simon briefed the RUC on CMS' focus on quality. CMS is currently developing a voluntary reporting system, and has been working closely with the CPT Editorial Panel on CPT Category II codes. The Physician Voluntary Reporting Program (PVRP) became operational in 2006.
- Doctor Simon announced that CMS is developing the infrastructure for ASC Prospective Payment System which will become operational in spring 2008.
- Carolyn Mullen announced that CMS is holding an open town hall meeting on practice expense methodology at CMS headquarters on February 15, 2006. The meeting intends to clarify what was in the 2005 *Proposed Rule* (which CMS withdrew in the *Final Rule*) and to discuss improvements in practice expense methodology.
- A RUC member questioned Doctor Simon regarding the decision to carrier price moderate sedation. Ms. Smith indicated that she believes CMS wanted to collect utilization prior to making a decision on what would be the appropriate valuation. Doctor Simon indicated that once the data is collected and analyzed, CMS can then make determinations on whether the services will be continue to be carrier priced or whether they will price them. Doctor Simon indicated that any changes will be listed in the Proposed Rule.
- A RUC member requested that CMS publish RUC recommendations even if CMS does not reimburse these services under the Physician Payment Schedule. Doctor Simon indicated that this has been under discussion for some time and CMS has published some recommendations for services not covered by the Medicare program,

however, this is still under discussion. It was noted that the RUC has made this request to CMS many times in the past.

VII. CMD Update

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

- Medicare Administrative Contracting (MAC) process is currently in progress. The first region, region three, will be awarded June 1, 2006 and the subsequent parts of the country will follow over the next two years.
- Durable Medical Equipment (DME) contracts have been awarded already, two months ago. One of the regions has been protested by the previous incumbent.
- In the HCPAC meeting on February 2, 2006, a couple of issues arose (regarding the reporting of the psychological, neurobehavioral and neuropsychological testing codes) that involved incorrect processing determinations by contractors. Doctor Mangold has begun discussions with two contractors and this issue will be clarified soon.

VIII. Washington Update

Sharon McIlrath updated the RUC on the issues included in the Deficit Reduction Act (DRA), which was approved on February 1, 2006. The DRA replaced the 4.4% cut to the Medicare conversion factor that took effect on January 1, 2006, with a payment freeze. It may take until July 2006 for everyone to be properly reimbursed for their claims from January. The AMA is pleased that we were able to halt the cut to the conversion factor, however we continue our campaign to fix the SGR. The multiple procedure reductions savings will not be redistributed among all other practice expenses as CMS has done in the past. The DRA states that starting in 2007, budget neutrality will not apply and instead any savings will go to the government.

A RUC member questioned if the new and revised codes that went through the RUC in 2005, will be valued at CMS' recommended value, since there is no 2005 precedent, if the freeze is signed by the president? Ms. McIlrath responded that this law effects the conversion factor, everything else in the 2006 Final Rule applies. Therefore the new RVUs apply and the conversion factor would be the 2005 conversion factor.

Ms. McIlrath also stated that the bill indicated:

- Ambulatory Surgical Center (ASC) payments will be held to no higher than the Hospital Outpatient Prospective System rate.
- Therapy caps will apply, but there will be some sort of exception process for medically necessary services.
- The Medicaid provisions were extremely controversial, allowing states to increase co-payments.

Ms. McIlrath noted that the pay for performance provisions that were in the Senate package were not included in the final legislation.

MedPAC Update:
Kevin Hayes, from the Medicare Payment Advisory Commission (MedPAC), provided the RUC with an update on the Commission's activities regarding valuing physician services and ways to improve the Five-Year Review. The Commission's report that will address these matters will be submitted to Congress on March 1, 2006, includes four recommendations. There is a focus on identifying potentially overvalued services in the Medicare Physician Payment Schedule. The Commission sees that the process currently appears to do a good job identifying undervalued services, but there is some potential to look further at overvalued services. The report includes recommendations such as CMS' use of an expert panel to help with identifying overvalued services, greater use of data on volume growth, changes in site of service, and a focus on new services. The Commissioners developed an appreciation for the hard work that the RUC and CMS exert. Meetings with the various specialty societies, CMS staff, and a letter from Doctor Rich in September, and meetings with Doctor Rich and Sherry all helped the Commissioners to understand the RUC process better and provide recommendations. The Commissioners have an understanding that much of what they are proposing involves an additional burden on CMS and calls for Congress to give the agency the resources needed and administrative flexibility to address these issues.

MedPAC will also be working on issues regarding primary care and medical student choices about their careers. Additionally, MedPAC will be preparing a report on the sustainable growth rate (SGR) mechanism and alternatives to it. Those alternatives will require MedPAC to review ways to reconfigure the mechanism to look at payment adjustments and updates.

IX. Relative Value Recommendations for the Five-Year Review

Destruction of Lesions (Tab 4)
Bruce Deitchman, MD, American Academy of Dermatology (AAD)
Terri Mills, MD, American Academy of Family Physicians (AAFP)
Facilitation Committee #1

The RUC discussed 17004 *Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), all benign or premalignant lesions (eg, actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions, 15 or more lesions* as it is a rank order anomaly issue created by the Five-Year Review. The RUC addressed several issues regarding this procedure including the difference in work between the 17000

family of codes (17000, 17003 and 17004) and the 17110 family of codes (17110 and 17111). It was determined that all procedures performed on pre-malignant lesions would be addressed in the 17000 family of codes while all procedures performed on benign lesions (other than skin tags or cutaneous vascular lesions) would be addressed in the 17110 family of codes. **The RUC recommends that this issue be referred to the CPT Editorial Panel so that this action will be reflected in the corresponding CPT coding descriptors. Furthermore, the RUC recommends to the CPT Editorial Panel that these changes in the descriptors are editorial in nature. The RUC recommends the editorial changes in the following CPT Code descriptors.**

17000 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), ~~all benign or~~ premalignant lesions (eg, actinic keratoses) ~~other than skin tags or cutaneous vascular proliferative lesions~~; first lesion
17003 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), ~~all benign or~~ premalignant lesions (eg, actinic keratoses) ~~other than skin tags or cutaneous vascular proliferative lesions~~; second through 14 lesions, each (List separately in addition to code for first lesion)
(Use 17003 in conjunction with code 17000)
17004 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), ~~all benign or~~ premalignant lesions (eg, actinic keratoses) ~~other than skin tags or cutaneous vascular proliferative lesions~~, 15 or more lesions
(For destruction of common or plantar warts, see 17110, 17111)
17110 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular lesions ~~flat warts, molluscum contagiosum, or milia~~; up to 14 lesions
17111 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular lesions 15 or more lesions
~~(For destruction of common or plantar warts, see 17000, 17003, 17004)~~
The RUC discussed these changes and how they would impact the work associated with 17004. The RUC agreed that these editorial changes would allow for differences within the description of work of these two code families to be greater defined. The RUC charged the specialty society to create changes to the intra-service description of service of 17000-17004 to accurately reflect the additional work of 17000-17004 as compared to 17110-17111.

The RUC recommends the following description of intra-service for 17000-17004:

Inspect and palpate lesions for size, location, functional risks, depth. Administer local anesthetic, if needed. Destruction of lesions to include multiple freeze/thaw cycles with appropriate lateral margins and depth into papillary dermis, or similar margins via other destructive modalities. Control of bleeding as needed.

The RUC recommends the following description of intra-service for 17110-17111:

Inspect and palpate lesion for size, location, functional risks, depth. Administer local anesthetic, if needed. Destruction of lesion by chosen modality. Control of bleeding as needed.

Due to the changes in the intra-service work descriptions, the RUC discussed the intra-service time that should be associated with 17004 and compared this time to the intra-service time of 17111. The RUC felt that due to the recommended changes made to the descriptors, that the 75th percentile of intra-service time for 17004, 20 minutes, was appropriate when compared to the intra-service time of 17111, 10 minutes. **The RUC recommends the 75th percentile of intra-service time, 20 minutes, for 17004.**

Due to the clarification of descriptors, description of intra-service time and adjusted intra-service work, the RUC felt that the specialty society recommended 1.80 work RVUs, half way between the 25th and median survey percentile for 17004, was appropriate. In addition, the RUC noted that the surveyed code 17004 requires greater mental effort and judgment, technical skill, intensity and time in comparison to the reference code 17111 (Work RVU=0.92) and felt that the value of 1.80 work RVUs appropriately values the surveyed code in relation to the reference code. Furthermore, the RUC agreed that 17004 indeed had slightly less work associated with it than 11750 *Excision of nail and nail matrix, partial or complete, (eg, ingrown or deformed nail) for permanent removal;* (Work RVU=1.86) with 10 minutes pre-service time, 15 minutes of intra-service time, 10 minutes of post service time and 2-99213 office visits. **The RUC recommends 1.80 work RVUs for 17004.**

<u>Cardiothoracic Surgery (Tab 5)</u>
James Levett, MD, Society of Thoracic Surgeons (STS)

The RUC received materials for this tab from STS after the due date. The RUC approved by two-thirds vote to allow consideration of this issue.

The RUC, during the third Five Year Review reviewed various cardiothoracic surgery procedures. In their review of these codes, the RUC determined that several of the reference service codes (33506, 33660, 33670, 33770 and

33780) used in the analysis of surveyed codes had inaccurate physician times associated with them. Some of these codes were reviewed in the second Five Year Review and were assigned time based on crosswalking the pre and post-service inputs to a reference procedure because it was felt that the survey times were inaccurate due to a very low response rate. The remainder of the codes had their times calculated using small sample sizes which presently seem to be potentially inaccurate. Therefore the RUC instructed the specialty society to conduct a survey of time for these reference codes, however, these times could not be used to justify new relative values. The RUC reviewed the specialty society's proposed times for these codes and felt that they accurately reflected the times it takes to perform the procedure as attached to this summary. **The RUC recommends amended physician times for the following cardiothoracic surgery procedures: 33506, 33660, 33670, 33770 and 33780**.

Colectomy (Tab 6)
Charles Mabry, MD, American College of Surgeons (ACS)
Guy Orangio, MD, American Society of Colon and Rectal Surgeons (ASCRS)
Charles Shoemaker, MD, American Society of General Surgeons (ASGS)

Upon reviewing the partial colectomy codes 44140 *Colectomy, partial; with anastomosis* and 44143 *Colectomy, partial; with end colostomy and closure of distal segment* as part of the Five Year Review, it was determined that several codes also needed to be reviewed in order to avoid rank order anomalies including 44141, 44144, 44145, 44146 and 44147.

44141 *Colectomy, partial; with skin level cecostomy or colostomy*
In contrast to key reference code 44140 *Colectomy, partial; with anastomosis* (Work RVU = 20.97), code 44141 *Colectomy, partial; with skin level cecostomy or colostomy* is emergent in high risk patients. The intra-operative intensity, complexity, and physician work for 44141 is greater than code 44140 because these cases are usually urgent or emergent procedures and the area of the colon involved is usually associated with inflammation or obstruction. The RUC observed that the dissection is made more difficult because the surgeon does not have the advantage of the normal anatomical planes of dissection and isolation of other organs becomes more difficult (i.e. the ureters). Because the bowel is not properly prepped preoperatively, the associated inflammation or chronic dilatation of the colon prohibits construction of an anastomosis. Pre-operative and post-operative work for 44141 is greater than 44140 because of the colostomy. The RUC felt that the survey median RVW of 27.00 is appropriate for 44141 as this value accounts for the additional work (both time and intensity) compared with 44140. **The RUC recommends 27.00 RVUs for 44141.**

44144 *Colectomy, partial; with resection, with colostomy or ileostomy and creation of mucofistula*
In contrast to key reference code 44140 *Colectomy, partial; with anastomosis* (Work RVU = 20.97), code 44144 *Colectomy, partial; with resection, with colostomy or ileostomy and creation of mucofistula* is emergent in high risk patients. The intra-operative intensity, complexity, and physician work for 44144 is greater than code 44140 because these cases are usually urgent or emergent procedures and the area of the colon involved is usually associated with inflammation or obstruction. The RUC observed that the dissection is made more difficult because the surgeon does not have the advantage of the normal anatomical planes of dissection and isolation of other organs becomes more difficult (i.e. the ureters). Because the bowel is not properly prepped preoperatively, the associated inflammation or chronic dilatation of the colon prohibits construction of an anastomosis. The mucus fistula is constructed because of concern for a possible "blow out "of the stump or distal colon. Also, the mucous fistula may be utilized for easier access when the patient is returned to the operating room at a later date for reconstruction of normal gastrointestinal continuity. Pre-operative and postoperative work for 44144 is greater than 44140 because of the colostomy. The RUC felt that the survey median RVW of 27.00 is appropriate for 44144. This value accounts for the additional work (both time and intensity) compared with 44140. **The RUC recommends 27.00 RVUs for 44144.**

44145 *Colectomy, partial; with coloproctostomy (low pelvic anastomosis)*
Code 44145 *Colectomy, partial; with coloproctostomy (low pelvic anastomosis)* describes an operation that occurs within the pelvis and may involve radiated tissues. It also refers to two sets of patients, one with malignancy (more typically) and one with a chronic inflammatory process, such as diverticulitis. Both types of patients involve operative mobilization of the entire left colon. The RUC observed that the intra-operative work and post-operative care is greater for 44145, compared with 44140 *Colectomy, partial; with anastomosis* (Work RVU = 20.97), because there is an addition of the pelvic dissection for mobilization of the rectum. This includes careful dissection for isolation of both ureters, and isolation and salvaging of the hypogastric plexus in order to prevent injury to sexual function and urinary bladder function. Care must be taken not to injure the presacral veins. When an anastomosis is constructed in the pelvis there is an increased incidence of anastomotic leak there by increasing the post-operative morbidity. Although the intra-operative intensity/complexity and time is greater than 44141 and 44144, the post-op work for 44145 is slightly less. Therefore, the RUC recommends maintaining the current RVW of 26.38 for 44145, instead of the survey median RVW. The current RVW of 26.38 accounts for the additional work necessary compared with 44140 and the slightly less total work compared with 44141 and 44145. Along with the recommendation to maintain the current RVW of 26.38 for 44145, the RUC recommends the new

survey time and visit data to correctly reflect current practice. **The RUC recommends to maintain the value of 26.38 work RVUs for 44145.**

44146 *Colectomy, partial; with coloproctostomy (low pelvic anastomosis), with colostomy*
Code 44146 *Colectomy, partial; with coloproctostomy (low pelvic anastomosis), with colostomy* represents a difficult cancer operation deep within the pelvis. The low pelvic anastomosis is often subject to complications and commonly involves pre-operatively radiated tissues. The risks of complication are significant due to the lateral pelvic sidewall dissection, the low anastomosis and the radiation- related confounding factors. The RUC observed that the pre-operative and postoperative work for 44146 is greater than 44207 *Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis)* (Work RVU=29.96) because of the colostomy. The RUC recommends the survey median RVW of 33.00 for 44146 as this value results in an IWPUT of 0.088 which is correctly less than the laparoscopic reference code 44207 (0.104), but takes into account the additional intra-operative time, greater length of stay, and additional work related to the stoma. **The RUC recommends 33.00 work RVUs for 44146.**

44147 *Colectomy, partial; abdominal and transanal approach*
Code 44147 *Colectomy, partial; abdominal and transanal approach* is a transanal resection of the rectosigmoid colon that requires intussusception of the rectosigmoid and then a resection of the procidentia through a dissection at the level of the anal sphincters. The complex areas involve preserving remaining sphincter function, securing the mesenteric vasculature through the anus, and blindly "yanking" down the sigmoid to reach the anal verge without tearing the colon or injuring the spleen. The RUC observed that the key reference code, 45112 *Proctectomy, combined abdominoperineal, pull-through procedure (eg, colo-anal anastomosis)* (Work RVU=30.49) requires mobilization of the entire rectum from its attachments, including both ureters, bladder, hypogastric plexus, nervi erecti in the prostate bed and the presacral veins; prolapsing the distal rectum and then bringing the proximal colon through the anus; performing a colorectal anastomosis; and placing the anastomosis back through the anus. Although the technical aspect of 44147 and 45112 is different, the total work (pre, intra, and post) is very similar. The RUC recommends the survey median RVW of 31.00 for 44147 as this value appropriately places this procedure among its family. **The RUC recommends 31.00 work RVUs for 44147.**

Practice Expense
The RUC noted that the only practice expense input changes for these codes, being part of the Five Year Review Process, will be changes in physician assist time if the service is priced in the non-facility and the number and level of office visits. For these codes, as they are only priced in the facility, changes were made only to the number and level of office visits. The RUC

has made these changes to the preceding codes and these changes are reflected in the summary forms as attached. However, the RUC wanted to further emphasize that for these codes, the RUC, when initially reviewing the practice expense inputs, recommended to have an additional 7 minutes for the first post-operative office visit for the extra time required to care for stomas, to ensure that this time is not lost during this review of the codes. The practice expense summary form and spreadsheets are attached to this recommendation.

Evaluation and Management (Tab 7)
Douglas Leahy, MD, American College of Physicians (ACP)
Walt Larimore, MD, American Academy of Family Physicians (AAFP)
Edward Diamond, MD, American College of Chest Physicians (ACCP)
James Anthony, MD, American Academy of Neurology (AAN)
Alan Plummer, MD, American College of Chest Physicians (ACCP)
Larry Martinelli, MD, Infectious Diseases Society of America (IDSA)
Joseph Schledt, DO, American Osteopathic Association (AOA)

The following members of the Evaluation and Management (E/M) Workgroup participated in four conference calls (October 19, November 28, December 14, and January 5) to consider interim and postponed actions related to E/M services in the third, Five-Year Review of the RBRVS: Doctors Norman Cohen, Chairman, John Derr, William Gee, David Hitzeman, George Kwass, Doug Leahy, Charles Mabry, Greg Przybylski, J. Baldwin Smith, and Maurits Wiersema.

The Workgroup concluded that all survey data collected by the medical specialties and the surgical specialties should be collated and weighted by Medicare utilization data, similar to the process utilized in the first, Five-Year Review of the RBRVS. The complete analysis of the weighted survey data is included within the attachments to this recommendation. **The RUC concluded that the collated weighted survey data from all survey respondents should be utilized in determining physician time on an interim basis.** This recommended time is included in the spreadsheet attached to these minutes. The RUC agreed that the physician time related to E/M service will continued to be studied when the RUC engages in a long-term review of E/M services.

After considering the extensive discussions of the E/M Workgroup, the RUC completed its review of CPT codes 99213, 99214, 99215, 99222, 99223, 99232, 99233, 99291, and 99292. The final recommendations for each individual E/M code are listed below:

99213
The RUC agreed that the compelling evidence to review this E/M service is that incorrect assumptions were made in the previous valuation of the service

in that the assumptions made by Harvard and CMS are flawed. The RUC extensively discussed 99213 and agreed that 99213 (pre = 3, intra = 15, and post = 5) is slightly more work than 99202 (recommended work RVU = 0.88, pre = 2, intra = 15, and post = 5). It was noted the content for 99213 represents a higher level of intensity as the medical decision making is "low" for 99213, versus "straightforward" for 99202. CMS also provided utilization data that indicated that diagnosis and number of diagnoses were more significant for 99213 than 99202. Finally, the survey respondents agreed with this relationship, as the survey median work RVU for "all" survey respondents was 1.10 for 99213 and 1.05 for 99202. Utilizing this relationship and the recommended work RVU of 0.88 for 99202, the RUC determined that a work RVU of 0.92 for 99213 is appropriate. In addition, the RUC agreed that 99213 is similar in work to 93307 Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete (work relative value = 0.92, pre = 5, intra = 18, and post = 5), which is a code included on the RUC's Multi-Specialty Points of Comparison (MPC). It was also noted that the 25th percentile of the "all" survey respondent, weighted survey data was 0.95. **The RUC recommends a work RVU of 0.92 for 99213, and physician times of pre = 3, intra = 15, and post = 5.**

99214

The RUC agreed that the compelling evidence to review this E/M service is that incorrect assumptions were made in the previous valuation of the service in that the assumptions made by Harvard and CMS are flawed. The RUC compared 99214 (time: pre = 5, intra = 25, post = 10, total = 40) to 99309 Subsequent nursing facility care (work RVU = 1.42, time: pre = 10, intra = 20, post = 10, total = 40). Both services require 2 out of 3 of a detailed history, detailed physical, and moderate decision-making. The 25th percentile of the "all" survey respondent weighted data was 1.50 for 99214. The RUC also agreed that 99214 should be valued higher than 99203. **The RUC recommends a work RVU of 1.42 for 99214 and times: pre = 5, intra = 25, and post =10.**

99215

The RUC agreed that the compelling evidence to review this E/M service is that incorrect assumptions were made in the previous valuation of the service in that the assumptions made by Harvard and CMS are flawed. The RUC did not agree with the key reference service selected by the survey respondents. Reference service 99350 Home Visit (work RVU = 3.03, pre = 15, intra = 72, post = 20) is not appropriate as the time is much greater than 99215 (pre = 5, intra = 35, and post = 15). A more appropriate reference service is 99349 (work RVU = 2.02, pre = 10 , intra = 40 , and post = 15). The work of 99215 is also similar to 99233 Subsequent hospital visit (recommended work RVU = 2.00, pre = 10, intra = 30, and post = 15). The 25th percentile of the medical society survey data was also 2.00. **The RUC recommends a work RVU of 2.00 for 99215 and time of pre = 5, intra = 35, and post = 15.**

99222
The RUC agreed that the compelling evidence to review this E/M service is that incorrect assumptions were made in the previous valuation of the service in that the assumptions made by Harvard and CMS are flawed. The reference service selected was not appropriate as 99235 Observation Care (work RVU = 3.41, time: pre = 10, intra = 75, post = 15) requires 100 minutes of total time, compared to a total survey time of 75 minutes for 99222. A more appropriate reference service is 99234 Observation Care (work RVU = 2.56; time: pre = 10, intra = 60, post = 15). 99222 requires more work than the following services: 90847 Family psychotherapy (work RVU = 2.21; time: pre = 5, intra = 50, post = 21); 99343 Home visit (work RVU = 2.27 ; time: pre = 15, intra = 50 , post = 17); and 99299 Subsequent ICU care for low birth weight newborn (work RVU = 2.50; time: pre = 10, intra = 30, post = 15). 99222 is more intense that 99204 New Office Visit, Level 4 (recommended work RVU = 2.30, time: pre = 5, intra = 30, post = 10). Considering all of these comparisons, it appears that a crosswalk to 99234 is most appropriate. **A work relative value of 2.56 and times of pre = 15, intra = 40, and post = 20 minutes are recommended for 99222.**

99223
The RUC agreed that the compelling evidence to review this E/M service is that incorrect assumptions were made in the previous valuation of the service in that the assumptions made by Harvard and CMS are flawed. More than ninety percent of the survey respondents indicated that the work in performing this service had changed. However, the reference service selected was not appropriate as 99236 Observation Care (work RVU = 4.26) as this code includes an admission and discharge. A more appropriate reference service is 99345 Home Visit (work RVU = 3.78; time: pre = 50, intra = 90, post = 30). A work RVU of 3.78 would be between the 25th percentile and the survey median. **A work relative value of 3.78 and times of pre = 15, intra = 55, and post = 20 minutes are recommended for 99223.**

99232
The RUC agreed that the compelling evidence to review this E/M service is that incorrect assumptions were made in the previous valuation of the service in that the assumptions made by Harvard and CMS are flawed. The RUC agreed that as the average length of hospital stay has declined, the subsequent hospital visits have become more intense. The reference service (99235 Observation Care, work RVU = 3.41; time: pre = 10, intra = 75, and post = 15) selected is also not appropriate as this code includes an admission and discharge and requires significantly more time than 99232 (40 minutes total). In the first, Five-Year Review of the RBRVS, the RUC recommended 1.30 for this service. CPT code 99348 Home visit (work RVU = 1.26; time: pre = 9,

intra = 30, post = 10) is a more appropriate reference service. The work of 99232 is similar to 99214 (recommended work RVU = 1.42; time: pre = 5, intra = 25, post = 10), while 99232 reflects greater intensity, 99214 requires more intra-service time. The RUC also agreed that 99232 should be valued higher than 99203. **A work relative value of 1.39 and times of pre = 10, intra = 20, and post = 10 minutes are recommended for 99232.**

99233

The RUC agreed that the compelling evidence to review this E/M service is that incorrect assumptions were made in the previous valuation of the service in that the assumptions made by Harvard and CMS are flawed. The RUC agreed that as the average length of hospital stay has declined, the subsequent hospital visits have become more intense. The reference service (99236 Observation Care, work RVU = 4.26; total time = 110 minutes) selected is also not appropriate as this code includes an admission and discharge and requires significantly more time than 99233 (55 minutes total). A more appropriate reference service is 99349 Home visit (work RVU = 2.02; time: pre = 10, intra = 40, post = 15. The work of 99233 is similar to 99215 (recommended work RVU = 2.00; time: pre = 5, intra = 35, post = 15). The 25th percentile and median of the survey are both 2.00 and this appears to be the appropriate relative value for this service. **A work relative value of 2.00 and times of pre = 10, intra = 30, and post = 15 minutes are recommended for 99233.**

99291

Unlike other E/M services under review, an argument that the current valuation of critical care was based on a flawed assumption was not presented. In fact, these services have been reviewed by the RUC on a number of occasions. It was noted that the specialty has presented survey data beyond the 4.00 on numerous occasions. The rationale that the patient population is more complex does not meet the compelling evidence standards as one could argue that services provided to patients as a whole have become more complex. No evidence was presented that critical care services differ greatly in their increased complexity from other services. However, in order to prevent a rank order anomaly, it is recommended that 99291 be increased to the 25th percentile (work RVU = 4.50) of those 80 respondents who indicated that the vignette was typical. The increase in a work to 4.50 will retain its relationship to 99255 Inpatient Consultation (recommended work RVU = 4.00). The recommended time is pre = 15, intra = 40, and post = 15. It should be noted that there was a great deal of discussion regarding the CPT definition of time and the RUC survey instrument definition of time. The two descriptions appear consistent as any time spent on the floor, including time spent with the patient's family and other activities more typically thought of as pre and post service work, are included in the intra-service time. Time away from the patient's floor could be captured as pre and post time. **A work**

relative value of 4.50 and times of pre = 15, intra = 40, and post = 15 minutes are recommended for 99291.

99292

Unlike other E/M services under review, an argument that the current valuation of critical care was based on a flawed assumption was not presented. In fact, these services have been reviewed by the RUC on a number of occasions. The rationale that the patient population is more complex does not meet the compelling evidence standards as one could argue that services provided to patients as a whole have become more complex. No evidence was presented that critical care services differ greatly in their increased complexity from other services. However, in order to prevent a rank order anomaly, it is recommended that 99291 be increased to the 25th percentile of 4.50 to retain its relationship to 99255 Inpatient Consultation (recommended work RVU = 4.00). 99292 should also then be increased to be reflective of 50% of the work of 99291, or 2.25 work RVUs. Time: 30 minutes of intra-service time is recommended for this add-on code. **A work relative value of 2.25 and times of intra=30 minutes are recommended for 99292.**

Finally, the RUC recommends that the full increase of the E/M be incorporated into the surgical global periods for each CPT code with a global of 010 and 090. The RUC agrees that E/M work is equivalent and a crosswalk of 100% of the E/M valuation should be bundled into the codes with global periods of 010 and 090 days, with appropriate documentation. In addition, the RUC recommends that the maternity codes (global MMM) also be increased to incorporate the E/M increases, as CMS did in the first, Five-Year Review of the RBRVS (page 59534, November 22, 1996 *Federal Register*). A spreadsheet will be submitted to CMS that itemizes the recommended physician time and work relative value for each CPT code to incorporate the E/M increases.

X. Relative Value Recommendations for CPT 2007

Lumbar Arthroplasty (Tab 8)

Dale Blasier, MD, American Academy of Orthopaedic Surgeons (AAOS)
Claire Tibiletti, MD, North American Spine Society (NASS)
John Wilson, MD, American Association of Neurological Surgeons (AANS)

The CPT Editorial Panel created three new codes to report lumbar arthroplasty, a new treatment option for patients requiring surgical treatment of symptomatic degenerative disc disease which has been refractory to conservative measures. Total disk arthroplasty is an important alternative form of open surgical treatment in patients who wish to avoid fusion and have failed non-operative therapy.

228X1

The RUC reviewed the survey data for 228X1 *Total disc arthroplasty (artificial disc), including anterior approach, including diskectomy to prepare interspace (other than for decompression), lumbar, single interspace* in comparison to the reference code 22558 *Arthrodesis, anterior interbody technique, including minimal diskectomy to prepare interspace (other than for decompression); lumbar* (Work RVU=22.25). The RUC noted that the surveyed code had more physician time associated with it than the reference code, 527 minutes and 502 minutes, respectively. In addition, the surveyed code required greater mental effort and judgment to perform and was deemed more intense than the reference code. However, the specialty society, in its recommendation, felt that the level of office visits associated with the surveyed code was inaccurate and replaced a 99214 office visit with a 99213 office visit. Therefore, when making their final recommendation, the specialty society removed the work associated with 99214 office visit and added the work associated with the 99213 office visit to the 25th percentile, 25.50 work RVUs resulting in a value of 25.07. The RUC felt that this value was appropriately supported by the survey data. **The RUC recommends 25.07 work RVUs for 228X1.**

228X2

The RUC reviewed the survey data for 228X2 *Revision including replacement of total disc arthroplasty (artificial disc) including anterior approach, lumbar, single interspace (includes approach)* in comparison to the reference code 63087 *Vertebral corpectomy (vertebral body resection), partial or complete, combined thoracolumbar approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic or lumbar; single segment* (Work RVU=35.52). The RUC noted that the surveyed code had more physician time associated with it than the reference code, 679 minutes and 664 minutes, respectively. In addition, the surveyed code required greater mental effort and judgment to perform and was deemed more intense than the reference code. However, the specialty society, in its recommendation, felt that the level of office visits associated with the surveyed code was inaccurate and replaced a 99214 office visit with a 99213 office visit. Therefore, when making their final recommendation, the specialty society removed the work associated with 99214 office visit and added the work associated with the 99213 office visit to the 25th percentile, 31.00 work RVUs resulting in a value of 30.57. The RUC felt that this value was appropriately supported by the survey data. **The RUC recommends 30.57 work RVUs for 228X2.**

228X3

The RUC reviewed the survey data for 228X3 *Removal of total disc arthroplasty (artificial disc), including anterior approach, lumbar, single interspace* in comparison to the reference code 63087 *Vertebral corpectomy (vertebral body resection), partial or complete, combined thoracolumbar approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic or lumbar; single segment* (Work RVU=35.52). The RUC was informed by the specialty that although the median intra-service time for this procedure was 180 minutes, this value was calculated by physicians who had performed the procedure and those who had not. When the specialty society reviewed the survey data solely from those who had performed the procedure, they observed that the median survey time for this subset was 210 minutes. The specialty society felt that this intra-service time more accurately reflected in the intra-service time for this procedure. The RUC agreed with this recommendation. In addition, the specialty society, in its recommendation, felt that the level of office visits associated with the surveyed code was inaccurate and replaced a 99214 office visit with a 99213 office visit. The RUC noted that the surveyed code, with these changes in the intra-service time and office visit level had less physician time associated with it than the reference code, 617 minutes and 664 minutes, respectively. However, the surveyed code required greater mental effort and judgment to perform and was deemed more intense than the reference code. Therefore, when making their final recommendation, the specialty society removed the work associated with 99214 office visit and added the work associated with the 99213 office visit to the 25th percentile, 30.00 work RVUs resulting in a value of 29.57. The RUC felt that this value was appropriately supported by the survey data and accurately placed this code amongst its family. **The RUC recommends 29.57 work RVUs for 228X3.**

Practice Expense

The RUC carefully reviewed of the inputs for all three procedures and agreed with the specialty society that 75 minutes of pre-service time was deemed appropriate due to the standard set by the spine surgeons at the March 2002 PEAC meeting where the Spine Arthrodesis family of codes 22548 – 22830 were given 75 minutes of pre-service time due to their overall complexity. The RUC also altered the practice expense inputs for all three procedures to reflect the change in the level of office visit from 3-99213 and 1-99214 to 4-99213 office visits. The practice expense inputs were approved as amended.

New Technology

As part of the new process established by the RUC for identifying new technology, this code has been identified as utilizing new technology and will be flagged in the RUC database to return to the RUC for re-review once this technology has become widespread.

Distal Radius Fracture (Tab 9)
Dale Blasier, MD, American Academy of Orthopaedic Surgeons (AAOS)
Daniel Nagle, MD, American Society for Surgery of the Hand (ASSH)

At the 2005 Five-Year Review meeting, the RUC referred code 25620 *Open treatment of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid, with or without internal or external fixation* to the CPT Editorial Panel to create a simpler method of classification to report distal radius fractures. At the October 2005 CPT Editorial Panel, the Editorial Panel deleted code 25620, created four new codes and revised two codes, to precisely describe the variations of total work necessary to repair a fracture of the distal radius and ulnar styloid.

The RUC reviewed codes 25600 and 25605 and agreed that the change was editorial and that the work RVUs remain the same. **The RUC recommends to maintain the work RVU of 2.63 for code 25600 and 5.80 for code 25605.**

The RUC reviewed code 2561X1 *Percutaneous skeletal fixation of distal radial fracture or epiphyseal separation* and compared it to codes 24582 *Percutaneous skeletal fixation of humeral condylar fracture, medial or lateral, with manipulation* (work RVU=8.54) and 25620 *Open treatment of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid, with or without internal or external fixation* (work RVU=8.54). The RUC felt that 2561X1 involved less physician work than codes 24582 and 25620, because code 24582 includes manipulation and 25620 involves open treatment as opposed to 2561X1 which involves percutaneous approach and without manipulation. The RUC thought that the survey results were strong and seemed reasonable for the service provided. However, in order to maintain rank order within this family of codes, the RUC felt that the survey 25th percentile work RVU was more appropriate than the median. **The RUC recommends the survey 25th percentile work RVU of 7.25 for 2561X1.**

The RUC reviewed code 2561X2 *Open treatment of distal radial extraarticular fracture or epiphyseal separation, with internal fixation* and compared it to codes 25622 *Open treatment of ulnar styloid fracture* (work RVU=7.59) and 25620 *Open treatment of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid, with or without internal or external fixation* (work RVU=8.54). The RUC felt that code 2561X2 fell between the two codes referenced by the specialty society and although the survey results seem reasonable for the service

provided, in order to maintain rank order the RUC felt that the survey 25th percentile work RVU was more appropriate. **The RUC recommends the survey 25th percentile work RVU of 8.50 for 2561X2.**

The RUC reviewed code 2561X3 *Open treatment of distal radial intraarticular fracture or epiphyseal separation; with internal fixation of two fragments* and compared it to codes 25431 *Repair of nonunion of carpal bone (excluding carpal scaphoid (navicular)) (includes obtaining graft and necessary fixation), each bone* (work RVU=10.42) and 25620 *Open treatment of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid, with or without internal or external fixation* (work RVU=8.54). The RUC felt that code 2561X3 involved less physician work than code 25431 but more physician work than code 25620. In order to maintain rank order within this family of codes, the RUC felt that the survey 25th percentile work RVU was more appropriate. **The RUC recommends the survey 25th percentile work RVU of 10.01 for 2561X3.**

The RUC reviewed code 2561X4 *Open treatment of distal radial intraarticular fracture or epiphyseal separation; with internal fixation of two fragments with internal fixation of three or more fragments* and compared it to codes 25431 *Repair of nonunion of carpal bone (excluding carpal scaphoid (navicular)) (includes obtaining graft and necessary fixation), each bone* (work RVU=10.42) and 25620 *Open treatment of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid, with or without internal or external fixation* (work RVU=8.54). The RUC felt that code 2561X4 involves more physician work than codes 25431 and 25620. In order to maintain order within this family of codes, the RUC felt that the survey 25th percentile work RVU was more appropriate. **The RUC recommends the survey 25th percentile work RVU of 13.00 for 2561X4.**

Practice Expense
The RUC assessed and accepted the standard practice expense inputs for codes 2561X1, 2561X2, 2561X3 and 2561X4.

Total Colectomy (Tab 11)
Charles Mabry, MD, American College of Surgeons (ACS)
Guy Orangio, MD, American Society of Colon and Rectal Surgeons (ASCRS)
Charles Shoemaker, MD, American Society of General Surgeons (ASGS)

The CPT Editorial Panel deleted two existing codes and created two new codes to accurately describe current practice of performing total colectomy. These modifications to CPT are a result of a comprehensive review made by the

specialty society of all the colon and rectal procedures as part of the Five Year Review.

4415X1
The RUC compared key reference code 44211 *Laparoscopy, surgical; colectomy, total, abdominal, with proctectomy, with ileoanal anastomosis, creation of ileal reservoir (S or J), with loop ileostomy, with or without rectal mucosectomy* (Work RVU=34.95) with new code 4415X1 *Colectomy, total, abdominal, with proctectomy, with ileoanal anastomosis, includes loop ileostomy and rectal mucosectomy, when performed* and noted that the surveyed code requires less intra-operative time than the reference code, 240 minutes and 300 minutes respectively, because the abdominal contents are exposed after laparotomy (ie, laparoscopy requires blind 3-D visualization). However, the length of hospital stay for 4451X1 is greater because open abdominal colon procedures develop a prolonged ileus, requiring nasogastric suctioning, prolonged intravenous fluids and delay in returning to oral intake. Because of the abdominal ileus causing distension and the long abdominal incision, the patient has difficulty with pulmonary function and ambulation. Atelectasis can develop requiring aggressive pulmonary care. In addition, the RUC noted that the surveyed pre-service times were over-estimated by the survey respondents. The RUC recommends that the pre-service evaluation and positioning time for 4415X1 be 30 minutes and 15 minutes, respectively as they felt these times appeared to be more appropriate. The survey median RVW of 33.00 is recommended for 445X1. This value results in an IWPUT of 0.075 that is correctly less than the laparoscopic reference procedure 44211 (IWPUT=0.081). **The RUC recommends 33.00 Work RVUs.**

4415X2
The RUC compared key reference code 44211 *Laparoscopy, surgical; colectomy, total, abdominal, with proctectomy, with ileoanal anastomosis, creation of ileal reservoir (S or J), with loop ileostomy, with or without rectal mucosectomy,* to new code 4415X2 *Colectomy, total, abdominal, with proctectomy, with ileoanal anastomosis, creation of ileal reservoir (S or J), includes loop ileostomy and rectal mucosectomy, when performed* requires less intra-operative time requires less intra-operative time because the abdominal contents are exposed after laparotomy (ie, laparoscopy requires blind 3-D visualization). However, the length of hospital stay for 4451X2 is greater because open abdominal colon procedures develop a prolonged ileus, requiring nasogastric suctioning, prolonged intravenous fluids and delay in returning to oral intake. Because of the abdominal ileus causing distension and the long abdominal incision, the patient has difficulty with pulmonary function and ambulation. Atelectasis can develop requiring aggressive pulmonary care. In addition, the RUC noted that the surveyed pre-service times were over-estimated by the survey respondents. The RUC recommends that the pre-service evaluation and positioning time for 4415X2 be 30 minutes and 15 minutes, respectively as they felt these times appeared to be more appropriate.

The survey median RVW of 34.00 is recommended for 445X2. This value results in an IWPUT of 0.073 that is correctly less than the laparoscopic reference procedure 44211 (IWPUT=0.081). **The RUC recommends 34.00 Work RVUs.**

Practice Expense

The standard inputs for 090 day global period codes only performed in the facility were applied with one exception: an additional 7 minutes was allocated to the first post-operative visit for the extra time required to care for stomas.

Interstitial Fiducial Marker Placement (Tab 12)

Jonathan Berlin, MD, American College of Radiology (ACR)
Thomas Cooper, MD, American Urological Association (AUA)
Geraldine McGinty, MD, American College of Radiology (ACR)
Najeeb Mohideen, MD, American Society for Therapeutic Radiology and Oncology (ASTRO)

The CPT Editorial Panel created a new code to report interstitial fiducial marker placement. Fiducial markers are a safe and appropriate device to verify and correct the position of the target organ and the amount of seed migration and organ deformation is far below current tumor delineation accuracy.

The RUC compared the surveyed code 558XX *Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple* to the reference code 76873 *Ultrasound, transrectal; prostate volume study for brachytherapy treatment planning* (Work RVU=1.55). The specialty society made some revisions to the surveyed time as it was felt that the survey respondents over-estimated the pre-service work associated with this code. The specialty society recommends that the pre-service time inputs should be reduced to 19 minutes of pre-service evaluation time and no time should be allocated to scrub, dress and wait time as these actions do not occur for this procedure. The specialty society recommends that the median intra-service time of 20 minutes and 10 minutes of immediate post-service time is appropriate. Taking into account this modification in recommended physician time, the total service time for the surveyed code is virtually the same as the reference code, 59 minutes and 60 minutes respectively. However, the surveyed code has much higher intensity and complexity measures associated with it when compared to the reference code. Therefore, to account for this difference in intensity and complexity the specialty society recommends the 25th percentile of 1.73 RVUs. The RUC reviewed the survey data and felt that the 25th percentile work RVU, 1.73 RVUs, appropriately places this code in

comparison to the reference code. **The RUC recommends 1.73 work RVUs for 558XX**.

Practice Expense
The RUC reviewed the practice expense inputs recommended by the specialty society. Many of these inputs were amended to reflect standards set by the PEAC.

Laparoscopic Supracervical Hysterectomy (Tab 13)
George A. Hill, MD, American College of Obstetrics and Gynecology (ACOG)
Craig Sobolewski, MD, American College of Obstetrics and Gynecology (ACOG)
Pre-Facilitation Committee#3

The CPT Editorial Panel created four new codes to describe a laparoscopic approach of a total hysterectomy with the removal of the uterine fundus after morcellation.

The RUC reviewed code 585XX3 *Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 grams or less;* and the specialty society indicated that the survey median work RVU appeared to be high, however they felt that the survey appropriately assessed the amount of intra-service physician time associated with this procedure. The RUC reviewed the survey results and agreed that, although the RVU and pre-service time seemed to overestimate the work involved in this procedure, the intra-service physician time of 95 minutes was appropriate. The specialty society used the building block approach by using the low survey RVU of 14.17 or the reference service code, CPT code 58550 *Laparoscopy surgical, with vaginal hysterectomy, for uterus 250 grams or less* (Work RVU= 14.17) minus 5 minutes of intra-service time and proposed a work RVU of 13.77 for code 585XX3 (14.17- 0.40=13.77). **The RUC recommends a work RVU of 13.77 for 585XX3.**

The RUC reviewed codes 585XX4 *Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary(s)*, 585XX1 *Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 grams;* and 585XX2 *Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s)* and felt that the mental effort and judgment, technical skill, physical effort and psychological stress intensity measures were similar to the reference service code 58552 *Laparoscopy surgical, with vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary(s)* (Work RVU=15.98). In order to maintain rank order the RUC felt that the surveys 25th percentile work RVUs were appropriate. **The RUC recommends the 25th percentile survey median work RVUs of 15.63 for code 585XX4, 15.94 for code 585XX1 and 17.44 for 585XX2.**

The specialty society agreed that the pre-service time may have been overestimated by the survey respondents and felt that the post-service physician time should be the same for this family of codes (585XX1-585XX4). However, the specialty society agreed that the survey intra-service time accurately reflected the time involved in this procedure. Therefore, the specialty society adjusted the pre-service, immediate post-service time, and visits to all reflect the similarity of time for this family of codes in order to maintain rank order. The RUC also agreed that the changes in pre- and post-service time were appropriate. Each code in this family will have 45 minutes pre-service evaluation, 10 minutes pre-service positioning, 5 minutes pre-service scrub, dress and wait, 30 minutes immediate post-service time, two 99213 visits, one 99238 visit, one 99212 visit and two 99213 visits. The only variance is the intra-service time. **The RUC recommends the physician time below to maintain rank order in this family of codes.**

CPT Code	Pre-Service Eval	Pre-Service Positioning	Pre-Service Scrub, Dress, Wait	Intra-Service	Immediate Post-Service	Visits
585XX3	45	10	5	95	30	99231 x 2, 99238 x 1, 99212 x 1, and 99213 x 2
585XX4	45	10	5	110	30	99231 x 2, 99238 x 1, 99212 x 1, and 99213 x 2
585XX1	45	10	5	120	30	99231 x 2, 99238 x 1, 99212 x 1, and 99213 x 2
585XX2	45	10	5	135	30	99231 x 2, 99238 x 1, 99212 x 1, and 99213 x 2

Practice Expense

The RUC assessed and accepted the standard practice expense inputs for codes 585XX3, 585XX4, 585XX1 and 585XX2.

New Technology/Services List

As part of the new process established by the RUC for identifying new technology, these codes (585XX3, 585XX3, 585XX1 and 585XX2) have been identified as using new technology and will be flagged in the RUC database to return to the RUC for re-review once this technology has become widespread.

Ophthalmic Endoscope (Tab 14)

Stephen Kamenetzky, MD, American Academy of Ophthalmology (AAO)
Christopher Quinn, OD, American Optometric Association (AOA)

The CPT Editorial Panel requested that the RUC review codes 67036 *Vitrectomy, mechanical, pars plana approach;* and 67112 *Repair of retinal detachment; by scleral buckling or vitrectomy, on patient having previous ipsilateral retinal detachment repair(s) using scleral buckling or vitrectomy*

techniques to determine if separate reporting of 66990 *Use of ophthalmic endoscope (List separately in addition to code for primary procedure)(66990 may be used only with codes 65820, 65875, 65920, 66985, 66986, 67036, 67038, 67039, 67040, 67112)* impacts the work of codes 67036 and 67112. The RUC determined that codes 67036 and 67112 were initially valued prior to the use of an ophthalmic endoscope, therefore these two codes do not already include the use of an ophthalmic endoscope. The RUC determined that reporting 66990 in addition to 67036 or 67112 is appropriate. **The RUC determined that the revision to add-on code 66990 is editorial.**

MRI Functional Cortical and Subcortical Brain Mapping (Tab 15)
James Anthony, MD, American Academy of Neurology (AAN)
Robert Barr, MD American Society of Neuroradiology (ASNR)
Jonathan Berlin, MD, American College of Radiology (ACR)
Scott Faro, MD American Society of Neuroradiology (ASNR)
James Georgoulakis, PhD, American Psychological Association (APA)
John Hart, Jr., MD, American Academy of Neurology (AAN)
Geraldine McGinty, MD, American College of Radiology (ACR)
Stephen Rao, PhD, American Psychological Association (APA) – *disclosed financial interest prior to presentation.*
Pre-Facilitation Committee #2

The CPT Editorial Panel created three new functional MRI codes to describe performing magnetic resonance imaging on an active patient, which allows regional brain mapping of human cognitive functions such as motor skills, vision, language and memory. Functional MR localization of eloquent cortex is accomplished by imaging the active patient during specific task performance.

705X54 and 705X55

The RUC reviewed codes 705X54 *Magnetic resonance imaging, brain, functional MRI; including test selection and administration of repetitive body part movement and/or visual stimulation, not requiring physician or psychologist administration* and 705X55 *Magnetic resonance imaging, brain, functional MRI; requiring physician or psychologist administration of entire neurofunctional testing* and discussed that for these procedures a radiologist interprets the brain fMRI. For code 705X54, a technician, non-physician, or non-psychologist is performing the test and the radiologist is supervising the technician and for code 705X55, the radiologist is doing less supervisory work and the reduced amount of work that they are performing on the supervision side is outweighed by the increased number of images. In other words, there is decreased supervision but increased processing involved in the physician performing code 705X55.

In the pre-facilitation meeting the specialty society reduced the immediate post-service time to 10 minutes for code 705X54. The RUC agreed that this was appropriate since the surveyees may have misinterpreted some of the intra-service work as immediate post-service work and this time more accurately represents the physician time associated with this procedure. The RUC carefully reviewed the survey data for 705X54 to code 73223 *Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s), followed by contrast material(s) and further sequences* (work RVU=2.15 and intra-service time of 30 minutes). The RUC felt that the work RVU recommendation and physician time for 705X54 was consistent with the upper extremity joint MRI, code 73223. **The RUC recommends a work RVU of 2.11 for code 705X54.**

The RUC then compared code 705X55 to MRI codes 70553 *Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences* (work RVU=2.36, 43 minutes of total time) and 75635 *Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, radiological supervision and interpretation, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing* (work RVU=2.40, 45 minutes of intra-service time). The work RVUs for code 705X55 are consistent and the recommended work RVU and with the family of MRI codes (neck and brain). When performing code 705X55 the additional images must be taken into account, which would cause the work relative value to be more than the traditional brain MRI codes. In the pre-facilitation meeting the specialty society reduced the pre-service evaluation time to 10 minutes and reduced the immediate post-service time to 10 minutes for code 705X55. The RUC agreed with these changes in pre and post-service time, as this more accurately represents the physician times associated with this procedure. The specialty society computed the value by reducing the survey 25th percentile work RVU of 3.10, subtracted out 25 minutes that were taken out of the pre- and post-service time (0.0224*25=0.56) to come up with a work RVU of 2.54 (3.10-0.56=2.54). Given the relativity of this value to the value of the reference codes, the RUC agreed that the work value was appropriate. **The RUC recommends a work RVU of 2.54 for code 705X55.**

<u>9604X1</u>

The RUC reviewed code 9604X1 *Neurofunctional testing selection and administration during non-invasive imaging functional brain mapping, with test administered entirely by a physician or psychologist, with review of test results and report* and the specialty society indicated that the median survey time appeared to be high. The survey respondents indicated that the physical effort and psychological stress complexity measures were less for 9604X1 than the reference code 95958 *Wada activation test for hemispheric function, including electroencephalographic (EEG) monitoring* (work RVU=4.24). The

RUC then compared 9604X1 to code 95810 *Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist* (work RVU=3.52, intra-service time=60 minutes). The RUC felt that the physician work and time involved to perform code 9604X1 was similar to that to perform code 95810. Therefore, the RUC recommends the 25th percentile work RVU of 3.43. Additionally, in the pre-facilitation meeting the specialty society reduced the pre-service evaluation time to 10 minutes and reduced the immediate post-service time to 10 minutes to accurately reflect the physician time involved in performing this procedure. The RUC agreed that pre- and post-service physician time changes were appropriate. **The RUC recommends the survey 25th percentile work RVU of 3.43 for code 9604X1.**

CPT Code	Pre-Eval	Pre-Positioning	Pre-Scrub	Intra-Service	Immed Post-Service	Work RVU
705X54	15	0	0	35	10	2.11
705X55	10	0	0	45	10	2.54
9604X1	10	0	0	60	10	3.43

Practice Expense

The RUC reviewed, modified and accepted the practice expense inputs for 705X54, 705X55 and 9604X1. A change was made to reduce the metal screening/interview time for code 705X54 from five minutes to two minutes. Another change was made to decrease all the pre-service facility times for code 9604X1, from three minutes to zero minutes because the pre-service activities are performed by the physician and this time is already captured.

New Technology/Services List

As part of the new process established by the RUC for identifying new technology, these codes (705X54, 705X55 and 9604X1) have been identified as utilizing new technology and will be flagged in the RUC database to return to the RUC for re-review once this technology has become widespread.

Sonographic Measurement of Nuchal Translucency (Tab 16)

George A. Hill, MD, American College of Obstetrics and Gynecology (ACOG)
James T. Christmas, MD, American College of Obstetrics and Gynecology (ACOG)

The CPT Editorial Panel created one new code and one add-on code to describe a more efficient and non-invasive risk assessment, which maximizes the detection rate of Down Syndrome and minimizes the screen positive rate at an early gestational age.

768XX1

The RUC reviewed code 768XX1 *Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; single or first gestation* and compared the work involved to that of a standard first trimester ultrasound, code 76801 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (14 weeks 0 days), transabdominal approach; single or first gestation* (work RVU=0.99, global=XXX). The specialty society indicated that when performing a standard first trimester ultrasound, code 76801, in the majority of cases all of the elements are obtained without waiting for any anatomy to change or repositioning of the patient. When performing the standard first trimester ultrasound the crown/rump length is measured in virtually any orientation that the fetus is positioned in and at any magnification. Additionally, with code 76801, there is not a great deal of attention to the gain settings on the ultrasound machine. However, when measuring the nuchal translucency, code 768XX1, the embryo is between 4 to 8 centimeters in length, but the measurement of the nuchal translucency must be down to one-tenth of a millimeter. This precision requires absolutely perfect positioning of the embryo. The embryo must be transverse to the plane of the ultrasound beam, and there must be a perfect midsagittal view. Any movement of the cursors must not be more than a one-tenth millimeter increment and the fetus must be caught in a neutral position. Therefore, code 768XX1 was believed to be more complex than code 76801. The survey respondents supported the higher complexity by indicating that the mental effort and judgment, technical skill/physical effort and psychological stress intensity measures of 768XX1 are more complex than the intensity measures for code 76801. **The RUC recommends the survey median work RVU of 1.18 for code 768XX1.**

768XX2

The RUC reviewed code 768XX2 and the specialty society indicated that the survey median RVU appeared to be high. Therefore, the specialty society proposed the 25th percentile survey work RVU of 0.99 for code 768XX2. The RUC recognized that the intra-service time of 20 minutes for 768XX2 would be the same as the intra-service time for 768XX1, however, since 768XX2 is an add-on code to capture each additional gestation, there would not be any pre- or post-service time. The RUC also compared code 768XX2 to add-on codes 76810 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (or = 14 weeks 0 days), transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)* (work RVU=0.98, intra-service time = 20 minutes, global=ZZZ) and 76802 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (14 weeks 0 days), transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)* (work RVU=0.83, intra-service time = 10 minutes, global=ZZZ) and found the work RVU and intra-service times to be comparable. **The RUC**

recommends the 25th percentile survey work RVU of 0.99 for code 768XX2.

Practice Expense
The RUC assessed and modified the practice expenses for codes 768XX1 and 768XX2 to reflect standard inputs.

Computerized Corneal Topography (Tab 17)
Stephen Kamenetzky, MD, American Academy of Ophthalmology (AAO)
Christopher Quinn, OD, American Optometric Association (AOA)

The CPT Editorial Panel created a new code to describe computerized corneal topography a test which detects and monitors corneal changes due to disease or trauma. An estimate of corneal disease or trauma may be obtained with retinoscopy, which is part of the single eye exam or general ophthalmological services, however this is not similar to the detection provided with computerized corneal topography.

The RUC felt that the survey median times for code 92XXX were comparable to the reference service code 92135 *Scanning computerized ophthalmic diagnostic imaging (eg, scanning laser) with interpretation and report, unilateral* (work RVU=0.35). The RUC also indicated that the specialty society work relative value recommendation and survey median times for code 92XXX is comparable to codes 99260 *Ophthalmodynamometry* (work RVU=0.20) and 92370 *Repair and refitting spectacles; except for aphakia* (work RVU=0.32). **The RUC recommends the survey median work RVU of 0.35 for code 92XXX.**

Practice Expense
The RUC assessed and approved the practice expenses submitted for code 92XXX.

Exhaled Nitric Oxide Measurement (Tab 18)
Edward Diamond, MD American College of Chest Physicians (ACCP)
Alan Plummer, MD American College of Chest Physicians (ACCP)

The CPT Editorial Panel created a new code to report exhaled nitric oxide measurement, a procedure that non-invasively measures airway inflammation, i.e. the main cause of asthma. Exhaled nitric oxide measurement provides the physician with the means of evaluating an asthma patient's inflammatory status and response to anti-inflammatory therapy.

The RUC reviewed the specialty society's recommended practice expense inputs as this procedure has no physician work associated with it. The RUC

learned that this procedure would only be performed in the non-facility setting by a blend of RN/RT. **All of the submitted inputs were reviewed and were approved by the RUC.**

Whole Body Integumentary Photography (Tab 19)
American Academy of Dermatology (AAD)
Facilitation Committee #2

The CPT Editorial Panel created a new code to report whole body integumentary photography for skin cancer detection.

The RUC reviewed the specialty society recommended practice inputs for this procedure as this procedure has no physician work associated with it. The RUC learned that this procedure would be performed in the non-facility setting by a medical photography technician assisted by an MTA. The RUC noted that most of the specialty recommended inputs were PEAC standards. It was explained by the specialty society that positioning the patient required 15 minutes and performing the test required 15 minutes. It was also noted by the RUC that it required 13 minutes to process the images captured during the test. The RUC agreed with all of these time inputs. When reviewing the medical supplies, it was noted that typically the images are printed out on paper as well as on CD. Therefore, the RUC recommended both inputs. The RUC made various other modifications to the practice expense inputs including staff type and various supplies. **The RUC recommends the amended practice expense inputs.**

New Technology
As part of the new process established by the RUC for identifying new technology, this code has been identified as utilizing new technology and will be flagged in the RUC database to return to the RUC for re-review once this technology has become widespread.

XI. Practice Expense Review Committee Report (Tab 20)

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

1) 78350 - Site of Service Recommendation Request.
2) 78481, 78483, and 78465 – Change in Current Direct Inputs Request
3) 36475 and 36476 – Change in Direct Inputs Request
4) 36566 – Change in Current Direct Inputs Request

5) Payment for Splint and Casting Reporting

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

XII. RUC HCPAC Review Board (Tab 21)

Mary Foto, OTR briefed the RUC on the HCPAC Review Board meeting conducted on February 2, 2006. Ms. Foto indicated that CMS provided an informative update on the Physical Therapy (PT)/Speech-Language Pathology (SLP) and outpatient Occupational Therapy (OT) services capitation, the chiropractic demonstration, Medical Nutrition Therapy (MNT) telemedicine codes in effect, and the low vision demonstration.

Ms. Foto informed the RUC that Emily Hill, PA-C, briefed the HCPAC that the NUCC has revised the 1500 Health Insurance Claim Form, primarily to include the National Provider Identifier (NPI) and ensure proper electronic claim submissions. This revised form will be effective February 1, 2007.

Ms. Foto informed the RUC that the PLI premium data collection that the HCPAC has been working on gathering is now complete, since the American Optometric Association has provided the HCPAC with its average annual PLI premium range for optometrists. **The HCPAC will send a letter to CMS providing this PLI premium information.**

Staff Note: A letter was sent on February 27, 2006, and is attached to these minutes.

Ms. Foto stated that the HCPAC discussed the psychological testing codes (96101-96103 and 96116-96120) since there has been some confusion by carriers on the appropriate method to code the technician and computer-administered psychological testing and neuropsychological testing codes. The HCPAC reaffirmed that the supervision as well as interpretation and report, as performed by a qualified health care professional (e.g., a physician or psychologist) are included in the technician and computer administered testing codes. The American Psychological Association indicated that they will submit editorial introductory language for the psychological and neuropsychological testing codes to CPT in order to clarify coding issues with these codes. AMA RUC HCPAC Staff indicated that she will work with CPT Staff to indicate proper coding procedures in the CPT Assistant.

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

XIII. Administrative Subcommittee (Tab 22)

Conflict of Interest/Financial Disclosure Statement
Doctor Richard Tuck briefed the RUC on the issues discussed at the Administrative Subcommittee meeting. Doctor Tuck informed the RUC that the Administrative Subcommittee reviewed the conflict of interest policy and financial disclosure statement. The Subcommittee felt that RUC members, alternates and advisors should indicate a conflict or disclose if a family member has an interest in any issues discussed/presented at the RUC. **The Administrative Subcommittee requested that the conflict of interest policy and statement, as well as the financial disclosure statement include disclosing whether a representative or "family member" has a financial interest.**

Additionally, the Administrative Subcommittee requested that two procedural steps occur in the RUC process to allow conflicts and financial interests to be made apparent to the RUC.

1. **All RUC members' and alternate members' conflict of interest statements should be disclosed in writing prior to RUC meetings and placed in the agenda book.**
2. **Each presenter verbally confirms any financial interests or lack of financial interests prior to the presentation of each issue/tab.**

The RUC discussed whether those with a declared interest should be allowed to continue to present. **The RUC concluded that the Administrative Subcommittee should discuss this issue at the April 2006 meeting.**

Re-review of New Technology/Services
Doctor Tuck informed the RUC that the Administrative Subcommittee determined that new evolving technology/services should be identified and re-reviewed at a time certain. The Subcommittee requested the following:

- **A check box is added to the RUC survey instrument and summary of recommendation form so that specialty societies/survey respondents may indicate if a new or revised code is considered to be a new technology service.**

- **At each RUC meeting there is a vote on each new and revised code to determine if a code is to be considered a new technology service.**
- **All new technology/services will be placed on the "New Technology/Service List" to be collated and maintained by RUC staff.**
- **The RUC would intend that all services on this list would be reviewed again at some time certain.**
- **The Administrative Subcommittee will discuss a timeline and other processes related to this at the April 2006 meeting.**

Confidentiality and Proprietary Rights

Doctor Tuck briefed the RUC that although AMA staff provides the Rules and Procedures document and the RUC Chair, Doctor Rich, reiterates the confidentiality and proprietary rights that all information discussed and materials provided by the AMA or the RUC are proprietary, there continues to be occasional infringements of this rule. Doctor Rich charged the Administrative Subcommittee with reviewing/developing a penalization policy. Discussion ensued as to whether the infraction would be deliberate or inadvertent, with a major or minor consequence. **The Administrative Subcommittee recommends that the RUC follow Section VII. Continued Representation of the Structure and Functions and any enforcement and appropriate penalties on violation of this section are to be determined by the executive committee (i.e., RUC Chair, AMA Representative and Alternate AMA Representative).**

Five-Year Review Subcommittee

Doctor Tuck informed the RUC that based on recent MedPAC discussions and the RUC's mission to ensure correct valuation of all codes, the Administrative Subcommittee discussed that there should be a process to identify potentially misvalued codes. **The Administrative Subcommittee recommended that the RUC develop a new committee to identify potential misvalued codes for the Five-Year Review.**

Definition of Physician Work

Doctor Tuck stated that in discussing the difficulty to value potentially misvalued codes, a Subcommittee member noted that physician time to perform certain services may decrease due to new evolving technology, benefit to the patient, and ultimately provide cost savings to the overall health care system. A discussion then ensued regarding the RBRVS and the definition of physician work. There was general consensus that the RUC should study the current environment regarding quality measures, efficiency, and value to the patient and health care system.

A number of RUC members indicated that although the initial concepts on how to incorporate value to healthcare may be difficult, there is probably no better group than the RUC and CPT physicians to look at how quality

interacts with the payment system. If the RUC does not take part in this there are many other entities that will. This method will not come quickly or easily but the RUC should be involved otherwise we will have to deal with such a system that is inevitable without having a say in it. The RUC should be involved in the beginning framework of such a system. It was discussed that perhaps the RUC should add something in our mission statement to consider these ideas and how we would implement them is what we need to find.

The Administrative Subcommittee recommends that the RUC study additional mechanisms for evaluating physician work to include quality measures, efficiency, and value to the patient and health care system, while recognizing that no metric is currently available.

Verification of Accurate Data

Doctor Tuck informed the RUC that the Administrative Subcommittee discussed that due to various individuals involved in developing specialty society RUC surveys and the summary of recommendation forms submitted to the RUC, verification of the accuracy and integrity of the data to the RUC should occur. **The RUC recommends that RUC Advisors sign a statement to attest that the integrity of the RUC survey and summary of recommendation forms are based on accurate and complete data to the best of the RUC Advisor's knowledge. RUC Advisors acknowledge that violations would be addressed by the executive committee (i.e., RUC Chair, AMA Representative and Alternate AMA Representative).**

The Administrative Subcommittee report was approved and is attached to these minutes.

XIV. Pre-Time Workgroup (Tab 23)

The RUC has created standards to the typical direct practice expense inputs: clinical labor activities, supplies, and equipment. These standards continue to be applied during each PERC meeting, and assist members in the development of direct inputs for the typical patient encounter. The Pre-Time Workgroup had been charged with creating discussion and making a recommendation to the RUC regarding the standardization of physician pre-service time.

The Workgroup members believed that in order to establish some standardization they would have to establish criteria. Benchmarks could be established based on some characteristics of the procedures. In addition, members warned that if a benchmark is developed, as in the PEAC where 090 day global codes were set at 60 minutes of pre-service time, a bar is set, and all codes going forward would likely be set at that time or higher.

The Workgroup and RUC agreed to:

- Establish packages according to the specific details of the services provided
- These details would then make up the services in each package within or among each global period.
- At the next Five Year Review, the RUC may be able to retrospectively slot existing codes into their proper pre-service package with the assistance of the specialty society

The workgroup and RUC believed that small groups of RUC members, representing surgical and non-surgical specialties, could meet to initially establish the packages for each global period. It was suggested that AMA staff send a letter to all specialties requesting a list of what they view as pre-service physician work activities. These lists would be compiled and discussed by the established groups who would then determine the initial packages.

In addition, the workgroup asked for AMA staff to graph the existing time data in order to identify any groupings within the global periods, and report back to the group at the next meeting.

The Pre-Time Workgroup report was approved and is attached to these minutes.

XV. Practice Expense Subcommittee (Tab 24)

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

Indirect Practice Expense Allocation
In the year 2000, the AMA Socioeconomic Monitoring Survey (SMS), which included questions related to physician practice expense, was discontinued. This data are now dated yet still are used by CMS in their practice expense methodology to develop practice expense relative values. The RUC and the AMA's Health Policy Group have continued to seek funding and approval for additional surveys, as there is a significant need for more current data.

Subcommittee members believed that the specialties would be interested in working with the AMA, through the RUC process to design and financially support the survey. It was noted that the survey could be used for not only capturing current practice expense data, but also information on practice liability insurance premiums, and on the overall increase in physician practice expense for use in organized medicine's campaign to replace the SGR.
The Subcommittee and RUC agreed that a multi-specialty survey should be pursued and recommended that: **The RUC reaffirms the RUC's November 3, 2004 letter to Doctor Michael Maves that states "We would offer and**

encourage the AMA to work through the RUC to involve the specialties in both constructing the survey and funding the effort."

Standardized 090 and 010 Day Global Period Codes and Medical Supplies
CMS representatives again informed the RUC that they intend to apply the standard packages associated with 090 day global codes for the 2007 physician fee schedule. The original CPEP data may have contained some specialty-specific supply items but these items would be replaced with the standard packages. In some cases the supplies may be appropriate but since specialties have not asked for any exceptions to standard, CMS has no way of retaining these items. If CMS changes its practice expense methodology from top down to bottom up and applies the RUC's recommendation for these codes, there may be an adverse affect on the RVUs for some specialty specific codes.

The RUC recommended the following:
AMA staff will provide specialties with a list of CPT codes where there may be specialty-specific supply or equipment items earmarked for deletion when the 010 day and 090 day standard packages are applied by CMS.

Future Refinement of Direct Practice Expense
This Subcommittee has discussed the future refinement of direct practice expense inputs regarding mechanisms to review services moving into the office setting and for ideas related to the first 5 Year Review of the direct inputs. The Subcommittee continued to discuss these issues in order to establish future RUC policy.

The RUC should conduct a review of the practice expense direct inputs going forward and will outline a process for such review as CMS determines when such review processes should begin.

Equipment Utilization Assumptions
When CMS developed its practice expense methodology it had to make an assumption of the equipment utilization because the data was not collected in the Abt study. CMS has made blanket equipment assumptions for hundreds of equipment items over the years which either overstates the utilization for some or underestimates equipment costs for others. The Subcommittee discussed whether the RUC is interested in studying equipment utilization in an effort to recommend accurate assumptions to CMS. The Subcommittee discussed the possibility of creating a tiered utilization schedule for the various equipment types but realized the task was overwhelming. The Subcommittee will continue to monitor CMS's equipment utilization assumptions carefully for new methodological approaches and reexamine them at a later date.

XVI. Research Subcommittee (Tab 25)

Doctor Cohen presented the Administrative Subcommittee Report to the RUC. Doctor Cohen announced that at recent RUC meetings there have been several discussions held by RUC members that there was a need for a comprehensive review of the RUC Survey Instrument and Summary of Recommendation Form. Several suggestions were made during these discussions regarding what needed to be reviewed. The following is a list of actions the RUC made to modify the survey instrument, summary of recommendation form and corresponding instruction document:

- **The RUC recommends adding a table to summarize the specialty society recommended data to the summary of recommendation form.**

- **The RUC recommends adding the prolonged services CPT codes to the survey instrument. Doctor Cohen asked Doctors Hollmann, Manaker and Przybylski to review the explanatory note after drafted by RUC Staff.**

- **The RUC recommends that a note be incorporated in the instruction document stating that RUC members and RUC Alternates are prohibited from participating in their associated specialty society's surveys as part of RUC policy that RUC members do not act as advocates for their specialties.**

Furthermore, a suggestion was made to add the percent of respondents who have performed the surveyed procedure in the last 12 months to the summary form. This question is currently on the survey instrument but not on the summary form. The question was originally added to assist specialty societies in developing their recommendations.

The Research Subcommittee discussed this issue and determined that not only is the information provided about a survey respondent's performance of the surveyed procedure within the last 12 months not necessary to include on the summary of recommendation form but because the information provided by this question was not instrumental in valuing a new or revised CPT code this question should be removed from the survey instrument. The Research Subcommittee recommends that the following question be removed from the survey instrument:

QUESTION 5: How many times have you personally performed these procedures in the past year?
New/Revised Code: _____ Reference Service Code: _____

The RUC discussed this issue and disagreed with the Research Subcommittee's action to delete this question entirely from the RUC survey instrument because the specialty societies find the information from this question to be very useful when calculating their specialty society recommendations. **The RUC recommends maintaining Question 5 on the RUC survey instrument.**

In addition to these items, at the request of the Research Subcommittee Chair, an e-mail was sent to RUC participants to provide their input on items to be added to this agenda item. Eight responses were received. The following is a list of actions the RUC made to modify the survey instrument, summary of recommendation form and corresponding instruction document :

- **The RUC recommends placing question 7 *Is your typical patient for this procedure similar to the typical patient described on the cover* directly following the vignette on the RUC survey instruments**
- **The RUC recommends removing from the survey instrument questions regarding, address, fax number and years of practice within a specialty.**
- **The RUC recommends that only the information directly pertaining to the global period of the surveyed code should remain on the associated survey instrument.**
- **The RUC recommends that the term "Conscious Sedation," should be replaced with the current term "Moderate Sedation" on the RUC survey instruments**
- **The RUC recommends that on the summary of recommendation form, a field should be added to designate whether reference codes utilize RUC or Harvard times as this would assist the RUC in its discussions pertaining to physician times.**

Doctor Cohen mentioned that there were several issues that still needed to be addressed by the Research Subcommittee and subsequently by the RUC including 1.) a recommendation from the AGA and the ASGE was that the RUC needs to recognize the discharge day planning activities for 000 day global periods and 2.) standardized descriptions of service for XXX codes. The Research Subcommittee recommended and the RUC agreed these issues be placed on the April 2006 Research Subcommittee Agenda.

Furthermore, there were also various suggestions made by respondents regarding the basic format of the survey instrument and issues concerning the availability of having the survey process completely maintained online. RUC staff will create an entirely new format for the survey instruments based on the discussions held by the Research Subcommittee as well as suggestions and comments received and present this updated survey instrument at the April RUC Meeting. In addition, RUC staff is in communication with the AMA

Surveying Experts to examine the possibilities available to the RUC in conducting its survey process online.

During the discussion of the survey instruments, summary of recommendations forms and corresponding instruction document, the American College of Surgeons discussed a letter they had submitted outlining a general discussion of the RUC survey process. The College expressed concern that the specialty survey process be studied to ensure that it remains based on magnitude estimation and not merely a "social survey" collecting the specialties' "wish list." **The RUC recommends that as a first step, AMA Staff prepare an analysis of survey medians, specialty recommendations, RUC recommendations and CMS' final implemented relative values to see if the relationship between the survey medians and the final value has changed throughout the process.**

In addition to reviewing the summary of recommendation form and the survey instrument, there was also a request to review the current reference service list policy. Doctor Cohen announced that RUC Staff will be providing the Research Subcommittee historical and background documents pertaining to this issue and postponed discussion of this issue to the April RUC Meeting

Doctor Cohen updated the RUC about developments with the Modifer-51 workgroup. At the October 2005 RUC Meeting, there was a discussion related to the processes in place for determining which codes are exempt from the use of Modifier -51 as listed in Appendix E of the CPT book. It was recommended to the CPT Editorial Panel that this issue be discussed to consider establishing a process to allow each of the codes listed in Appendix E to be reviewed for appropriateness using a set of criteria to determine whether the value assigned warrants its exemption from the Modifier -51. The CPT Editorial Panel has created a Modifier Workgroup which will review each code currently given the Modifier -51 exemption to determine its appropriateness of being on the list and to establish criteria that would determine how future codes would be placed on this list i.e., confirming with RUC Staff that pre- and post-service times are not associated with the proposed codes. The Workgroup has asked for RUC participation. Four members of the Research Subcommittee have volunteered to participate in these meetings: Doctors Derr, Hitzeman, Manaker and Peter Smith. The Workgroup will be meeting during the CPT Meeting February 9-12, 2006. RUC members will be able to participate via conference call. The Research Subcommittee requests a report from the Subcommittee members participating on the call as to the actions items taken by the Workgroup.

XVII. Professional Liability Insurance Workgroup (Tab 26)

Doctor Hitzeman provided the RUC with a brief on what was discussed at the PLI Workgroup meeting. Doctor Hitzeman informed the RUC that CMS has agreed to examine specific malpractice premium data for use in the calculation of the Malpractice Geographic Practice Cost Index (GPCI) which will be made available by Doctor Stephen Kamenetzky. Doctor Kamenetzky indicated to AMA staff that he will begin to assemble the data from the Physician Insurers Association of America (PIAA) for the six pilot states (Iowa, Colorado, New York, Florida, Pennsylvania and Texas) that have been chosen. Doctor Kamenetzky indicated that he should be able to obtain this data for CMS in approximately 90 days.

Doctor Hitzeman indicated that the PLI Workgroup felt that the RUC's previous recommendation to CMS regarding low volume codes should be reinforced. Therefore, **the PLI Workgroup recommends that the RUC reaffirm our previous recommendation to CMS that CMS utilize these recommended specialties for low volume codes (ie, fewer than 100 claims per year), rather than rely on claims data.**

Staff Note: A letter was sent to CMS on February 27, 2006, and is attached to these minutes.

Doctor Hitzeman informed the RUC that the PLI Workgroup reviewed the professional liability insurance information section of the Instructions for Specialty Societies Developing Recommendations (page 10). The Workgroup noted that while CMS methodology utilizes physician work and the specialty risk factor to drive PLI relative values, the work RVU may not always be the best surrogate for a crosswalk. Other measures such as intra-service work may be more appropriate. **The PLI Workgroup recommends that the instructions be refined to include "other measures."**

The PLI Workgroup also reviewed the professional liability insurance information section of the summary of recommendation form (page 5). The PLI Workgroup recommends that further directions be provided on the determination of surgical versus non-surgical risk factors so that specialties understand the distinction as defined by CMS.

Doctor Hitzeman informed the RUC that the Workgroup agreed that CMS should request physicians to provide PLI premium information on an annual basis. However, the full RUC did not accept this recommendation.

Doctor Hitzeman informed the RUC that the Workgroup discussed the probability of a multi-specialty endeavor to gather PLI premium information. Specifically, with the implementation of National Provider Identifiers (NPIs) such collection efforts may be possible directly through CMS. The Workgroup continued to discuss that it would be helpful for CMS to identify the key elements CMS would require to use in their PLI methodology.

The PLI Workgroup also discussed the possibility of gathering PLI information as part of the PE multi-specialty survey process if it occurs.

The PLI Workgroup Report was approved and is attached those these minutes.

XVIII. Other Issues

Society of Thoracic Surgeons (STS) Request

The Society of Thoracic Surgeons (STS) requested that the RUC retract their recommendation that a parenthetical be added to the 2006 CPT book indicating that codes 33925 *Repair of pulmonary artery arborization anomalies by unifocalization; without cardiopulmonary bypass* and 33926 *Repair of pulmonary artery arborization anomalies by unifocalization; with cardiopulmonary bypass* should not be reported together with code 33697 *Complete repair tetralogy of Fallot with pulmonary atresia including construction of conduit from right ventricle to pulmonary artery and closure of ventricular septal defect*.

The STS indicated that the parenthetical note included in the 2006 CPT book under codes 33925 and 33926 indicating (Do not report 33925, 33926 in conjunction with 33697) is inappropriate. The parenthetical note did not exist under codes 33918 and 33919, which were deleted and replaced with the new codes due to the descriptor changes to the codes, nor were they previously bundled under the NCCI. As a result of this parenthetical note, CMS had bundled procedures 33925 and 33926 with 33697 with a "0" indicator which means that the codes can never be reported together.

The STS believes that the parenthetical note that does not allow 33697 to be reported in conjunction with code 33925 or 33926 is inappropriate. It is not always necessary to do both procedures. However, if both procedures are performed in the same session, unifocalization requires more work in addition to tetralogy of Fallot repair. The abnormal pulmonary arteries need to be dissected from their source (typically the descending aorta but also the brachiocephalic vessels) and then incorporated with the native pulmonary arteries. Occasionally, this could involve a separate thoracotomy during the same anesthetic with unifocalization, then repair of tetralogy of Fallot through a sternotomy.

In reviewing this issue, **the RUC believes that the parenthetical note under CPT codes 33925 and 33926 should be deleted. The RUC communicated this to the CPT Editorial Panel.**

The meeting adjourned on Saturday, February 4, 2006 at 4:35 p.m.

AMA/Specialty Society RVS Update Process
Practice Expense Review Committee
February 2, 2006

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

Doctor Moran welcomed and informed the group that they were on a tight time schedule. Doctor Ken Simon from CMS provided an update of the agency's recent activities. Doctor Simon stated that the agency is continuing its work on pay for performance initiatives and that it will be a reality in 2007. Doctor Simon stressed the need for medicine to monitor CMS's work on pay for performance. In addition, it was mentioned that CMS will be having a Town Hall meeting on CMS's practice expense methodology on Wednesday, February 15, 2006 in Baltimore. You must register for the meeting, but it is open to all.

The following issues were addressed from CMS's final rule for 2006:

6) <u>78350 - Site of Service Recommendation Request: SNM, ACR, (AAFP to comment):</u>
In November 2006 CMS reported that they had received comments from one specialty society disagreeing with the RUC's recommendation for code 78350, *single photon bone densitometry.* The specialty stated they believed that the procedure is being performed in the office and provided direct inputs for review. The PERC and the specialty society carefully reviewed the inputs, made reductions to the inputs and its reference code, and then accepted the recommendation.

7) <u>78481, 78483, and 78465 – Change in Current Direct Inputs Request: SNM, ACR, ACC</u>
Two years ago at the January 2004 PERC meeting, the PERC made a full review of the direct practice expense inputs of codes 78481 *Cardiac blood pool imaging, (planar), first pass technique; single study, at rest or with stress exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without quantification* and code 78483 *Cardiac blood pool imaging, (planar), first pass technique; single study, at rest or with stress exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without quantification*

In November 2005, CMS reported that they received a comment from an equipment distributor and multiple comments from physicians asking them to add more clinical labor supplies and equipment to codes 78481 and 78483. The commenters emphasized that the labor costs are understated, and that additional supplies and equipment are necessary to perform these services. In particular, the commenters requested" CMS "add a nuclear medicine gamma camera to the equipment inputs or cross-walk the equipment listed for CPT 78465 *Myocardial perfusion imaging;tomographic (SPECT), multiple studies (including attenuation correction when performed), at rest or stress (exercise and/or pharmacologic), with or without quantification.* The nuclear medicine gamma camera distributor presented supply and equipment tables for both codes to CMS, using direct PE inputs currently listed in the PE database, most of these inputs are found in the PE for CPT 78465.

The PERC was informed by the specialty that the codes when first presented to the PEAC the codes were understood to be add on codes, however later they realized that they were more typically performed as stand alone codes. After this was clarified the PERC reviewed the specialty recommendation, made minor changes, and accepted them.

8) 36475 and 36476 – Change in Direct Inputs Request: SIR, ACR, SVS

In February 2004 the RUC made recommendations for physician work and practice expense for the then new CPT codes 36475 *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated* and add on code 36476 *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency;second and subsequent veins treated in a single extremity, each through separate access sites.*

In November 2005, CMS reported that, a manufacturer requested that CMS "add 15 minutes of clinical labor and a tilt table to the PE database for CPT codes 36475 and 36476—both new codes for CPT 2005." The specialty requested to add a tilt table to the entire family of ablation codes (36475, 36476, 36478, 36479), but did not believe an additional 15 minutes was warranted. The PERC concurred and recommends the addition of a tilt table to each code.

9) 36566 – Change in Current Direct Inputs Request: SIR

In April 2003, the RUC made recommendations for physician work and practice expense for the then new code 36566 *Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older* (For peripherally inserted non-tunneled central venous catheter, age 5 years or older, use 36569).

In November, 2005 CMS reported that a specialty society and a manufacturer had asked to replace the supply item, a Tesio type dual catheter, with the Lifesite system. It is explained that the manufacturer asked the CMS for assistance in correcting a "clerical error". The commenters explain that "CPT codes 36565 and 36566 are nearly identical in procedure, although CPT 36566 requires the insertion of "subcutaneous port(s)" and the Tesio-type catheter, priced at $355, is currently listed in both these procedures." The Lifesite system, containing a subcutaneous port, is priced at $1,750. Both commenters noted that 2 Lifesite systems are necessary to perform this procedure instead of one for a total supply cost of $3,500.

At its previous meeting, the RUC had asked CMS to monitor on an annual basis high priced disposable medical supplies, as they continually create disruptions in the PE RVUs of other procedures when applied to CMS's PE methodology. CMS reported that this was on there radar screen but has not implemented any mechanism to review such items. The PERC again stressed the need for such review that only applied to items priced over $200.

The PERC was informed that there is only one manufacturer of the expensive supply being requested for inclusion in code 36566 at this time, but would expect competitors to have another device that may be less expensive in the future. The PERC accepted the recommendation however suggested that this code be re-reviewed at a later date. The PERC also believed that a "tickler file" could be developed and maintained that would keep track of these special procedures with high priced disposables. Who would maintain this file was not determined. Doctor Brill was concerned that if CMS could update current marketplace prices connected with the outpatient prospective payment system, why isn't there a process for updating high priced disposables connected with Part B? The PERC members suggested the RUC's PE Subcommittee develop a formal methodology for this process.

10) 19298 and 19296 – Change in Direct Inputs Request: PERC Review

The Final Rule CMS stated the following, regarding concerning codes 19296 and 19298: "we received comments from a specialty organization citing that the total RVUs for CPT code 19298 are too low in comparison to those for CPT code19296—both new CPT codes for CY 2005. The specialty believes this difference is likely due to the supply PE inputs necessary to perform each procedure. The specialty states that the catheter supply expenses should be similar between the two services, yet the non-facility PE RVUs for CPT code 19298 (39.56 for CY 2005 and 42.28 for CY 2006) are significantly lower than those listed for CPT code19296 (117.96 for CY 2005 and 125.75 for CY 2006). The specialty stated that while the average number of catheters used for CPT code 19298 is 25, ranging from 15–30, this cost should be comparable to the catheter required for CPT code 19296. Finally, the specialty requests that CMS crosswalk the total RVUs for the non-facility setting from CPT code 19296 to CPT code 19298 for 2006 while they gather detailed information to present to them.

This issue was discussed by the PERC as a whole since no specialty had come forward with a formal recommendation. The PERC took no action on this issue.

11) Payment for Splint and Casting Supplies: APMA, AAOS, ASSH (ASPS, AAFP, AADA) to comment.

On November 1, 2000, CMS stated they had removed cast and splint supplies from the PE database for the CPT codes for fracture management and cast/strapping application procedures. Because casting supplies could be separately billed using Healthcare Common Procedure Coding System (HCPCS) codes, CMS did not want to make duplicate payment under for these items. However, in limiting payment of these supplies to the HCPCS codes Q4001 through Q4051, CMS unintentionally prohibited remuneration for these supplies when they are not used for reduction of a fracture or dislocation, but rather, are provided (and covered) as incident to a physician's service.

In June 2005, CMS proposed to eliminate the separate HCPCS codes for these casting supplies and to again include these supplies in the PE database. This would allow for payment for these supplies while ensuring that no duplicate payments are made. In addition, by bundling the cost of the cast and splint supplies into the PE component of the applicable procedure codes under the PFS, physicians would no longer need to bill Q-codes in addition to the procedure codes to be paid for these materials. Because these supplies were removed from the PE database prior to the refinement of these services by the PEAC, CMS proposed to add back the original CPEP supply data for casts and splints to each applicable CPT code and CMS requested that the relevant medical societies review the direct practice expense inputs and provide feedback regarding the appropriateness of the type and amount of casting and splinting supplies. CMS also requested specific information about the amount of casting supplies needed for the 10-day and 90-day global procedures, because these supplies may not be required at each follow-up visit; therefore, the number of follow-up visits may not reflect the typical number of cast changes required for each service.

The cast and splint supplies were added, where applicable, to the following CPT codes:
23500 through 23680
24500 through 24685,
25500 through 25695
26600 through 26785
27500 through 27566

27750 through 27848
28400 through 28675
29000 through 29750.

In CY 2007, CMS will pay for splint and cast through the PE component of the PFS and no longer make separate payment for these items using the HCPCS Q-codes.

The PERC held a conference call for Thursday, January 26th and discussed the direct inputs for these codes. On the conference call and at the PERC meeting, Doctor Ouzounian led the group discussion and presented the specialty's recommendation. The PERC understood the specialty's recommendation methodology and agreed with the recommended inputs.

New and Revised PE Input Recommendations
The PERC reviewed all the direct practice expense inputs for the new and revised codes brought forward for RUC review at this meeting. For a few issues involving codes performed only in the facility setting, where the standard 090 day package was recommended, there was no specialty representation. The PERC requests that in the future if there will be no specialty representation, that this is communicated to staff and written in the cover of the specialty's practice expense recommendations. The following issues and related practice expense inputs were reviewed and are recommended by the PERC:

Relative Value Recommendations for *CPT 2007*:

Lumbar Arthoroplasty (228X1 – 228X5)
The PERC and specialty agreed on the standard 090 day global package for these codes.

Distal Radius Fracture (2561X1-2561X4)
The PERC and specialty agreed on the standard 090 day global package for these codes.

Gastric Antrum Neurostimulation (436X1 – 439X4; 64590, 64595; 95970 – 95973)
The specialty indicated that there were only editorial changes to these codes and that the current practice expense inputs should be maintained. The specialty did not provide a listing of the current inputs however the PERC on this understanding, approved no change in the current inputs for these codes. *Tab 10 code was referred to CPT for further discussion.*

Total Colectomy (4415X1 – 4415X2)
The PERC and specialty agreed on the standard 090 day global package for these codes.

Interstitial Fiducial Marker Placement (558XX)
The PERC and the specialty agreed on several reductions to the recommended practice expense inputs for these codes. CMS representatives stated that they were considering a global period change for this code to a 010 day global designation.

Laparoscopic Supracervical Hysterectomy (585XX3-585XX4; 58XX1, and 58XX2)
The PERC and specialty agreed on the standard 090 day global package for these codes.

Ophthalmic Endoscope (66990)
This code was removed from the agenda by the specialty.

MRI Functional Cortical and Subcortical Brain Mapping (705X54, 705X55, and 9604X1)
The PERC and specialty agreed to make minor changes to the clinical labor direct inputs for these codes.
Sonographic Measurement of Nuchal Translucency (768XX1 – 768XX2)
The PERC and specialty agreed to make minor changes to the clinical labor and equipment direct inputs for these codes.
Computerized Corneal Topography (92XXX)
The PERC accepted the recommended direct practice expense inputs for this code without modification.
Exhaled Nitric Oxide Measurement (950XX)
The PERC accepted the recommended direct practice expense inputs for this code without modification.

Whole Body Integumentary Photography (969XX)
The PERC and the specialty agreed to make minor changes in clinical labor and several changes to the equipment for this code.

The PERC meeting was adjourned at 10:50 am

AMA/Specialty Society RVS Update Committee
RUC HCPAC Review Board Meeting
February 2, 2006

Members Present:

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

I. Welcome

Mary Foto, OTR, welcomed Thomas Felger, MD, who will serve as the RUC representative on the HCPAC.

II. CMS Update

Pam West, PT, DPT, MPH, provided a CMS update, informing the HCPAC on the following:

- *Physical Therapy (PT)/Speech-language pathology (SLP) and outpatient occupational therapy (OT) services capitation.* Dr. West informed the HCPAC that the PT/SLP and OT therapy capitation of $1,740 went into effect January 1, 2006. Dr. West also indicated that CMS is considering mechanisms to promptly implement a provision of the Deficit Reduction Act (DRA) that permits medically necessary therapy services exemptions from the therapy capitations.

- *Chiropractic demonstration.* Dr. West indicated that SLP/PT services performed by chiropractors under the demonstration will be included under the SLP/PT capitation, as appropriate. Dr. West and Anthony Hamm, DC, American Chiropractic Association, have indicated that the Chiropractic demonstration is currently running smoothly.

- *Medical Nutrition Therapy (MNT) telemedicine.* Dr. West informed the HCPAC that CMS has added three MNT codes (G0270 *Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face- to- face with the patient, each 15 minutes*, 97802 *Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes* and 97803 *Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes*) to the list of Medicare telehealth services, which went into effect January 1, 2006. Dr. West indicated that contractors have until April 3, 2006, to ensure that the GT modifier, which identifies telehealth services, is processed correctly.

- *Low vision demonstration.* Dr. West informed the HCPAC that the low vision demonstration is slated to begin April 3, 2006, which will involve payment to three types

of low vision specialists and occupational therapists. These demonstration services will not be subject to the OT therapy capitation.

III. Update on National Uniform Claim Committee (NUCC) Issues

Emily Hill, PA-C, American Academy of Physician Assistants, briefed the RUC that the NUCC has revised the 1500 Health Insurance Claim Form primarily to include the National Provider Identifier (NPI) and ensure proper electronic claim submissions. The form may undergo minor revisions and will be effective February 1, 2007.

IV. Other Issues

PLI Premium Data

Ms. Foto informed the HCPAC that the American Optometric Association has provided the HCPAC with its average annual PLI premium range for optometrists, which is $500 to $2,000. Previously, CMS indicated in the 2004 November 15 *Final Rule* that the agency was interested in RUC input on the appropriateness of the PLI crosswalk assumptions. The risk factors are currently set at the all physician risk factor for the professions indicated below. The RUC requested the PLI risk factor be set to 1.00 ($6,100) for the following eight health professionals and that CMS investigate other data as $6,100 most likely over estimates the PLI premium for these professions. The RUC also invited these professions to present evidence that their annual PLI premiums are greater than $6,100. These professions include:

- Clinical Psychologist
- Licensed Clinical Social Worker
- Occupational Therapist
- Psychologist
- Optician
- Optometry
- Chiropractic
- Physical Therapist

At the September 2005 meeting, the HCPAC professions submitted PLI premium data to the HCPAC, except opticians/optometry. Subsequently, at the September 2005 HCPAC meeting the dieticians also shared their PLI premium data. **The HCPAC believes that the yearly average PLI premium data per profession is accurate and will submit new premium data for opticians/optometry to CMS.**

Specialty Society	Average Yearly Premium	Yearly Premium Range
American Chiropractic Association	$1,870 (in 2005)	Up to $4,000 - $6,000 (New York averages $4,000 and Florida $6,000)
American Occupational Therapy Association		$250 - $1,000 (in 2004/2005)
American Psychological Association	$1,500	
American Physical Therapy Association	$1,100 (2005) $1,500 (projected for 2006)	

American Speech-Language-Hearing Association	$700 (Typical private practice with hearing aid dispensing capabilities)	$62 (Individual) $167 (Group)
National Association of Social Workers	$500	
American Optometric Association		$500 to $2,000
American Dietetic Association		$118-$144 (hospital facility) $900 (small practice)

Psychological Testing Codes

Richard W. Whitten, MD, informed the HCPAC that there has been confusion by carriers on the appropriate method to code the technician and computer administered psychological testing and neuropsychological testing codes. The HCPAC reaffirmed that supervision as well as interpretation and report, as performed by a qualified health care professional (e.g. a physician or psychologist) are included in the technician and computer administered testing codes (96102, 96103, 96119 and 96120). **The American Psychological Association indicated that they will submit editorial introductory language for the psychological and neuropsychological testing codes to CPT (by March 8, 2006 to be reviewed at the June 8-11, 2006, CPT Editorial Panel meeting) in order to clarify coding issues with these codes.**

AMA RUC HCPAC Staff will work with CPT Staff to indicate proper coding procedures in the CPT Assistant.

Additionally, William Mangold, MD, Contractor Medical Director, expressed willingness to explore payment policy concerns with carriers.

96101 *Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report (*work RVU=1.86)

96102 *Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI and WAIS), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face* (work RVU=0.50)

96103 *Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI), administered by a computer, with qualified health care professional interpretation and report* (work RVU=0.51)

96116 *Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report* (work RVU=1.86)

96118 *Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report* (work RVU=1.86)

96119 *Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face* (work RVU=0.55)

96120 *Neuropsychological testing (eg, Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report* (work RVU=0.51)

AMA/Specialty Society RVS Update Committee
Administrative Subcommittee Report
February 2, 2006

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

I. Review conflict of interest policy and financial disclosure statement

Doctor Tuck reviewed the current conflict of interest policy to determine if the existing policy was comprehensive in identifying all types of conflict of interests/financial interests. The Administrative Subcommittee identified that family relationships may constitute a conflict or financial interest. **Therefore, the Administrative Subcommittee requests that the conflict of interest policy and statement, as well as the financial disclosure statement include disclosing whether a representative or "family member" has a financial interest.**

In further review of the conflict of interest policy, the Administrative Subcommittee requests that "RUC alternate members" be included in the policy.

The Administrative Subcommittee requests the following changes:

AMA/Specialty Society RVS Update Committee
Conflict of Interest Policy

No RUC **member, RUC alternate member** or other Committee or Subcommittee representative will vote or participate in any deliberation on a specific issue in the event the representative **or a representative's family member** has a financial interest in the outcome of the vote or deliberation other than the representative in the course of their practice performing the procedure or service at issue. Every RUC or other Committee or Subcommittee representative shall disclose his or her potential interest prior to any vote or deliberation and shall not vote or participate in the deliberation. Any individual who is presenting or discussing relative value recommendations before the RUC shall disclose his or her potential interest prior to any presentations.

Statement of Compliance with the RUC Conflict of Interest Policy

I understand that I am expected to comply with the Conflict of Interest Policy of the RUC. To my knowledge and belief, I am in compliance with the Conflict of Interest Policy. I have disclosed any financial interests in specific issues considered by RUC, and I have excused myself from deliberation and vote on any issue in which I **or any family member** have a financial interest. I understand that I have a continuing responsibility to comply with the Conflict of Interest Policy, and I will promptly disclose my interests required to be disclosed under the Policy.

Financial Disclosure Statement

For purposes of this Disclosure, "direct financial interest" means:

- A financial ownership interest of 5% or more, or
- A financial ownership interest which contributes materially to your income, or
- A position as proprietor, director, managing partner, key employee or consultant

I certify that any personal **or family member's** direct financial interest, and any affiliations with or involvement in any organization or entity with a direct financial interest, in the relative value recommendations are noted below. Otherwise, my signature indicates that I have no such financial interest, other than in the provision of these services.

Statement of Financial Interest (If more space is needed, submit a signed attachment)

_____
_____
_____
_____

Signature

_____

Date

_____

Print Name

_____

Additionally, the Administrative Subcommittee requests that two procedural steps occur in the RUC process to allow conflicts and financial interests to be made apparent to the RUC.

3. **All RUC members' and alternate members' conflict of interest statements should be disclosed in writing prior to RUC meetings and placed in the agenda book.**
4. **Each presenter verbally confirms any financial interests or lack of financial interests prior to the presentation of each issue/tab.**

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

At the February 2005 RUC meeting, the Administrative Subcommittee determined that new technology codes should be identified, and approved the following process for formalized review:

The codes that are identified during the RUC review as codes to be re-reviewed in the future will be maintained on a formal list. This list will be placed on a RUC agenda for discussion just prior to the following Five-Year Review. AMA staff would

provide information pertaining to the frequency, expenditures, sites of service, lengths of stay, numbers and types of providers and scientific information for the code and the RUC will then review this information and determine whether the procedure has indeed achieved widespread use of the new technology. If the RUC deems that this procedure has achieved this status, the specialty society will be asked to re-present these codes with information pertaining to the newly achieved wide-spread use of new technology and how this information affects their original RUC recommendation as a part of the Five Year Review. If the RUC deems that wide-spread use of the new technology has not been achieved, the code will go back on the formal list and will be presented at the next Five Year Review.

Recently, the Medicare Payment Advisory Commission (MedPAC) has expressed interest in the identification of new services likely to experience reductions in value. Doctor Rich charged the Administrative Subcommittee with determining:

1. How many years should pass until a new technology code is re-reviewed and if this should be determined on an individual basis or should a set number of years be established.
2. How the RUC should determine whether a particular code reflects new technology.

To address the issue of identifying new evolving technology codes and re-reviewing them, **the Administrative Subcommittee requests:**

- **A check box is added to the RUC survey instrument and summary of recommendation form so that specialty societies/survey respondents may indicate if a new or revised code is considered to be a new technology service.**
- **At each RUC meeting there is a vote on each new and revised code to determine if a code is to be considered a new technology service.**
- **All new technology/services will be placed on the "New Technology List" to be collated and maintained by RUC staff.**
- **The RUC would intend that all services on this list would be reviewed again at some time certain.**
- **The Administrative Subcommittee will discuss a timeline and other processes related to this at the April 2006 meeting.**

III. Confidentiality and Proprietary Rights

Although AMA staff provides the Rules and Procedures document and the RUC Chair, Doctor Rich, reiterates the confidentiality and proprietary rights that all information discussed and materials provided by the AMA or the RUC are proprietary, there continues to be occasional infringements of this rule. Doctor Rich charged the Administrative Subcommittee with developing a penalization reviewing and policy. Discussion ensued as to whether the infraction would be deliberate or inadvertent, with a major or minor consequence.

The Administrative Subcommittee recommends that the RUC follow Section VII. Continued Representation of the Structure and Functions and any enforcement and appropriate penalties on violation of this section are to be determined by the executive committee (i.e., RUC Chair, AMA Representative and Alternate AMA Representative).

Section VII. Continued Representation

A. A representative's continued participation on the RUC and/or any other Committee or Subcommittee is contingent upon the representative complying with the representative complying with the requirements of this Structure and Organization document and the Rules and Procedures adopted by the RUC.

IV. Other Issues

Five-Year Review Subcommittee
Based on recent MedPAC discussions and the RUC's mission to ensure correct valuation of all codes, the Administrative Subcommittee discussed that there should be a process to identify potentially misvalued codes **The Administrative Subcommittee recommends that the RUC develop a new committee to identify potential misvalued codes for the Five-Year Review.**

Definition of Physician Work
In discussing the difficulty to value potentially misvalued codes, a Subcommittee member noted that physician time to perform certain services may decrease due to new evolving technology, benefit to the patient, and ultimately provide cost savings to the overall health care system. A discussion then ensued regarding the RBRVS and the definition of physician work. There was general consensus that the entire issue of how quality, benefit to patients, and overall health care savings could contribute to the physician payment schedule.

The Administrative Subcommittee recommends that the RUC study additional mechanisms for evaluating physician work to include quality measures, efficiency, and value to the patient and health care system, while recognizing that no metric is currently available.

Verification of Accurate Data
Due to various individuals involved in developing specialty society RUC surveys and the summary of recommendation forms submitted to the RUC, verification of the accuracy and integrity of the data to the RUC should occur. **The RUC recommends that RUC Advisors sign a statement to attest that the integrity of the RUC survey and summary of recommendation forms are based on accurate and complete data to the best of the RUC Advisor's knowledge. RUC Advisors acknowledge that violations would be addressed by the executive committee (i.e., RUC Chair, AMA Representative and Alternate AMA Representative).**

AMA/Specialty Society RVS Update Committee
Pre-Time Workgroup
February 2, 2006

The following members participated in the discussion: Doctors Barbara Levy, (Chair), Norman Cohen, MD, Thomas Felger, MD, Emily Hill, PA-C, Charles Mick, MD, Tye Ouzounian, MD, James Regan, MD, J. Baldwin Smith, MD, Trexler Topping, MD, Maurits Wiersema, MD

Doctor Levy provided the group with background information stating that the RUC has created standards to the typical direct practice expense inputs: clinical labor activities, supplies, and equipment. These standards continue to be applied during each PERC meeting, and assist members in the development of direct inputs for the typical patient encounter. The Pre-Time Workgroup had been charged with creating discussion and making a recommendation to the RUC regarding the standardization of physician pre-service time.

Workgroup members first had a general discussion of when the pre-service period starts, the current CMS definition of pre-time, and what services are necessary for hospital admission that is not separately billable as an E/M service. The Workgroup members believed that in order to establish some standardization they would have to establish some sort of criteria. Benchmarks could be established based on some characteristics of the procedures. In addition, members warned that if a benchmark is developed, as in the PEAC where 090 day global codes were set at 60 minutes of pre-service time, a bar is set, and all codes going forward would likely be set at that time or higher.

The Workgroup acknowledged that the easiest way to create standards would be to create packages based on global periods and the site of service. Members also believed that it may be appropriate to have more than one package per global period depending on the number of services provided in the pre-service time period.

The Workgroup members agreed that the RUC should:

- Establish packages according to the specific details of the services provided
- These details would then make up the services in each package within or among each global period.
- At the next Five Year Review, the RUC may be able to retrospectively slot existing codes into their proper pre-service package with the assistance of the specialty society

In an effort to move this process forward, the workgroup thought that small groups of RUC members, representing surgical and non-surgical specialties, could meet to initially establish the packages for each global period. It was suggested that AMA staff send a letter to all specialties requesting a list of what they view as pre-service physician work activities. These lists would be compiled and discussed by the established groups who would then determine the initial packages.

In addition, the workgroup asked for AMA staff to graph the existing time data in order to identify any groupings within the global periods, and report back to the group at the next meeting.

AMA Specialty Society RVS Update Committee
Practice Expense Subcommittee
Thursday, February 02, 2006

Doctors Topping (Chair), Anthony, Gage, Lichtenfeld, D. Regan, Mick, Moran, and Zwolak met after lunch to discuss the following practice expense Subcommittee items.

Indirect Practice Expense Allocation
The AMA previously had performed the Socioeconomic Monitoring Survey (SMS), which included questions related to physician practice expense, which is currently being used by CMS in their practice expense methodology to develop practice expense relative values. CMS has utilized older 1995 through 1999 SMS data in the practice expense methodology, as the AMA discontinued its survey in the year 2000. Since that time, the RUC and the AMA's Health Policy Group has continued to seek funding and approval for additional surveys, as there is a significant need for more current data.

As stated in the last Physician Payment Schedule Final Rule, CMS has decided not to accept any more supplemental surveys and is seeking a multi-specialty survey with the hope that it is supported by the RUC and other specialties. CMS may representatives informed the Subcommittee that any support or guidance in the design of the survey would be well received. CMS be able to purchase the data from an umbrella group such as the AMA, therefore providing some offset to the cost of such an effort.

Subcommittee members agreed that one of the reasons the SMS survey was discontinued was that the survey included controversial data on physician income and understands that collection of this data may no longer be necessary. Subcommittee members believed that the specialties would be interested in working with the AMA, through the RUC process to design and financially support the survey. It was noted that the survey could be used for not only capturing current practice expense data, but also information on practice liability insurance premiums. The data could also be used to provide information on the overall increase in physician practice expense for use in organized medicine's campaign to replace the SGR. .
The Subcommittee agreed that a multi-specialty survey should be pursued and recommends that **the RUC reaffirm the RUC's November 3, 2004 letter to Doctor Michael Maves that states "We would offer and encourage the AMA to work through the RUC to involve the specialties in both constructing the survey and funding the effort"**

Standardized 090 and 010 Day Global Period Codes and Medical Supplies
CMS representatives again informed the RUC that they intend to apply the standard packages associated with 090 day global codes for the 2007 physician fee schedule. The original CPEP data may have contained some specialty-specific supply items but these items would be replaced with the standard packages. In some cases the supplies may be appropriate but since specialties have not asked for any exceptions to standard, CMS has no way of retaining these items. If CMS changes its practice expense methodology from top down to bottom up and applies the RUC's recommendation for these codes, there may be an adverse affect on the RVUs for some specialty specific codes.

It was explained by RUC members that specialties have known about this for at least three years and have had many opportunities to refine the data. CMS representatives stated that most of the codes where this situation applies are in dermatology and orthopedic surgery

codes. When the standard was created PEAC members mainly focused on the clinical labor inputs and not medical supplies or equipment.
The RUC recommended the following:
AMA staff will provide specialties with a list of CPT codes where there may be specialty-specific supply or equipment items earmarked for deletion when the 090 day standard packages are applied by CMS.

Future Refinement of Direct Practice Expense
This Subcommittee has discussed the future refinement of direct practice expense inputs regarding mechanisms to review services moving into the office setting and for ideas related to the first 5 Year Review of the direct inputs. The Subcommittee continued to discuss these issues in order to establish future RUC policy.

The Subcommittee first questioned whether the statute requiring the review of relative values applied to all relative values; work, practice expense, and practice liability insurance RVUs. If the statute states that all relative values are to be reviewed every 5 years it would be difficult to review all of them simultaneously.
In addition, the Subcommittee questioned what a 5 year review of practice expense RVUs would entail, and what would be reviewed?

AMA staff confirmed via AMA legislative staff that Section 1848 (C) 2(B) Omnibus Budget Reconciliation Act of 1990 requires CMS to comprehensively review all relative values at least every five years and make any needed adjustments. However, there is no explicit outline detailing such a review and there has been no other legislation superseding the 1990 Act.

One suggestion was to start with the oldest practice expense recommendations first and work forward in time, revisiting each code. The RUC could review the direct inputs and adjust them to reflect current medical practice, including any shift in the site of service. The Subcommittee was also concerned that any review of the direct practice expense inputs may reveal changes in physician work. The Subcommittee understood that any review of practice expense would be a huge task, and any process needs to be effective and efficient.

The RUC should conduct a review of the practice expense direct inputs going forward and will outline a process for such review as CMS determines when such review processes should begin.

Equipment Utilization Assumptions
When CMS developed its practice expense methodology it had to make an assumption of the equipment utilization because the data was not collected in the Abt study. CMS initially made an assumption that all equipment is in use 70% of the time the office is open. This greatly overstated the utilization of most equipment, leading to underestimates of equipment costs in the preliminary relative values. In the 1997 NPRM, CMS reduced the equipment utilization rate to 50%. However, an assumption of 50% equipment utilization may underestimate equipment costs for some codes and overestimate equipment costs for other codes

The Subcommittee discussed whether the RUC is interested in studying equipment utilization in an effort to recommend accurate assumptions to CMS. The Subcommittee discussed the possibility of creating a tiered utilization schedule for the various equipment types but realized the task was overwhelming and may be best conducted by CMS using an outside contractor. The

Subcommittee also considered having specialties generate the utilization information and bring it to the RUC for approval, but again they realized this task was huge and there would likely not be the amount of participation by specialties that is required.

The Subcommittee decided not to pursue a resolution to this problem at this time and look forward to CMS's Town Hall meeting on February 15, 2006 when this and other practice expense methodological issues would be discussed. The Subcommittee will continue to monitor CMS's equipment utilization assumptions carefully for new methodological approaches and reexamine them at a later date.

AMA Specialty Society RVS Update Committee
Research Subcommittee
February 2, 2006

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

I. Comprehensive Review of the RUC Survey Instrument and Summary Form

At recent RUC meetings there have been several discussions held by RUC members that there was a need for a comprehensive review of the RUC Survey Instrument and Summary of Recommendation Form. Several suggestions were made during these discussions regarding what needed to be reviewed. These suggestions and the Research Subcommittee's corresponding actions are as follows:

A) the summary tables in the summary form needed to include a place for the survey time data as well as specialty society recommended time data. The Subcommittee felt this suggestion was valid and would improve the RUC's review of specialty society recommendations. **The Research Subcommittee recommends adding a table to summarize the specialty society recommended data to the summary of recommendation form.**

B) A concern was expressed that the survey instrument allowed multiple E&M procedures to be billed on the same day in the global period, although this was not permissible with CPT coding convention. In addition, there was a suggestion made that prolonged care service codes should be added to the survey instrument to accurately reflect patient care. Doctors Hollmann and Pryzybylski clarified that this discussion centered around an issue from the Five Year Review that the correct method for properly coding a particular code required prolonged care service codes and currently these codes are not a part of the survey instrument. The Research Subcommittee discussed this issue and determined that the prolonged services CPT codes 99354, 99355, 99356 and 99357 should be added to the survey instrument with corresponding explanatory notes to instruct the survey respondent how to appropriately code these procedures. **The Research Subcommittee recommends adding the prolonged services CPT codes to the survey instrument. Doctor Cohen asked Doctors Hollmann, Manaker and Pryzybylski to review the explanatory note after drafted by RUC Staff.**

C) Another concern was expressed about the RUC's current eligible survey respondent policy. The current policy regarding eligible survey respondent is as follows:

The survey should be sent to a sample of physicians from your specialty society. It is also recommended that you survey physicians from a wide array of practice settings: urban vs. rural; solo vs. group practice; and private practice vs. academic setting. Your sample for the mail survey must include a sufficient number of physicians for your society to obtain survey data from 30 respondents. You may choose to survey a larger number of physicians (e.g., 100 or more) to strengthen the rationale for your recommendation and develop estimates that will have greater statistical validity.

The concern expressed is that the existing policy needs to be refined to clearly detail who is able to participate in the survey process without bias. For example, the existing policy does not limit survey participation from various RUC participants.

The Research Subcommittee was reminded by Doctor Rich that RUC members and RUC Alternates are prohibited from participating in their associated specialty society's surveys as part of RUC policy that RUC members do not act as advocates for their specialties. **The Research Subcommittee recommends that this policy be incorporated in the instruction document that is sent with the RUC surveys to specialty society staff to assist specialties in their process of creating their survey sample.**

D) A suggestion was made to add the percent of respondents who have performed the surveyed procedure in the last 12 months to the summary form. This question is currently on the survey instrument but not on the summary form. The question was originally added to assist specialty societies in developing their recommendations.

The Research Subcommittee discussed this issue and determined that not only is the information provided about a survey respondent's performance of the surveyed procedure within the last 12 months not necessary to include on the summary of recommendation form but because the information provided by this question was not instrumental in valuing a new or revised CPT code this question should be removed from the survey instrument. **The Research Subcommittee recommends that the following question be removed from the survey instrument:**

QUESTION 5: How many times have you personally performed these procedures in the past year?
New/Revised Code: _____ Reference Service Code: _____

The RUC discussed this issue and disagreed with the Research Subcommittee's action to delete this question entirely from the RUC survey instrument because the specialty societies find the information from this question to be very useful when calculating their specialty society recommendations. **The RUC recommends maintaining Question 5 on the RUC survey instrument.**

In addition to these items, at the request of the Research Subcommittee Chair, an e-mail was sent to RUC participants to provide their input on items to be added to this agenda item. Eight responses were received. Their comments/suggestions and the Research Subcommittee's corresponding actions are as follows:

- A suggestion from the AGA and the ASGE was that the RUC needs to recognize the discharge day planning activities for 000 day global periods. The current survey and summary of recommendation forms used for 000 day global services do not recognize that physicians who perform endoscopy procedures involving anesthesia/conscious sedation typically perform the same discharge day management activities that are done for 10 and 90 day global services. The Research Subcommittee discussed this issue and determined that this suggestion is a policy issue and needs to be a separate agenda item.

The Research Subcommittee recommends this issue be placed on the April 2006 Research Subcommittee Agenda

- A suggestion was made by multiple respondents to place the following question directly after the vignette within the survey instrument:

  QUESTION 7: Is your typical patient for this procedure similar to the typical patient described on the cover?

  Yes □ No □

  If no, please describe your typical patient for this procedure:

  After some brief discussion the Research Subcommittee agreed that this suggestion would make the survey easier to complete by survey respondents. **The Research Subcommittee recommends placing the aforementioned question directly following the vignette.**

  It was also suggested by respondents to the Research Subcommittee's request that this question should be revised to state, "If no, please do not complete the remainder of the survey." This suggestion was discussed by the Subcommittee and it was decided that even if a survey respondent did not feel the vignette described was typical, the information that he/she could provide the specialty society related to this new or revised service was valuable.

- The existing survey instrument asks the survey respondents for personal information including contact information, specialty, years practicing specialty, geographic information and primary type of practice information. The reason for these questions being on the RUC survey was to allow specialty society staff to be able to contact the survey respondent if they had any further questions regarding their responses; allow them to ensure that a single physician is not completing the same survey more than one time and be certain that their survey sample included responses from various regions and practice types within the country. The Subcommittee discussed this issue and determined that contact information was essential for the specialty society staff to obtain, however, information relating to the survey respondent's address, the fax number and the years of practice within a specialty was superfluous information. **The Research Subcommittee recommends removing from the survey instrument questions regarding, address, fax number and years of practice within a specialty.**

- In the Background for Question 1 of the survey instrument, there are definitions for the various categories of global period. This information was included because survey respondents when reviewing the reference service list, which may include codes of different global periods than the surveyed code, would be able to accurately consider the global period when comparing the surveyed code to the reference code. Several respondents to the Research Subcommittee's request, suggested that for those not familiar with global period descriptors, this information may be confusing and makes the survey instrument less user friendly and recommended that the additional definitions of global periods should be removed from the survey instrument. **The Research Subcommittee agreed with this suggestion and recommends that only the information directly**

pertaining to the global period of the surveyed code should remain on the survey instrument.

- There was a suggestion made by several respondents that the question pertaining to whether someone under the survey respondent's direct supervision typically administers conscious sedation for these procedures should only be placed on surveys where conscious sedation would be inherent when performing the procedure. **The Research Subcommittee before addressing the issue recommended that the term "Conscious Sedation," should be replaced with the current term "Moderate Sedation."** The Research Subcommittee questioned who would determine whether moderate sedation would be inherent in performing the procedure and felt that this question need to be retained to verify through survey responses the inherent or not inherent nature of moderate sedation when performing the surveyed procedure.

- There were several questions that were recommended by respondents to be added to the survey instrument including: whether the survey respondent had completed previous RUC surveys and whether the survey respondent had received instruction from specialty society staff on how to complete the survey. Also, it was suggested that an example should be placed in the survey instrument to demonstrate how to assign physician visits. These suggestions had no support from the Research Subcommittee as the Subcommittee felt that these questions and additions would not assist in valuing the new or revised procedures. **It was also suggested and supported by the Research Subcommittee that on the summary of recommendations, a field should be added to designate whether reference codes utilize RUC or Harvard times as this would assist the RUC in its discussions pertaining to physician times.**

- It was suggested by several respondents that the intensity/complexity measures should be removed. The Research Subcommittee was reminded by RUC Staff that these intensity and complexity measures are an integral part of constructing a rationale to CMS that strongly supports the RUC recommended values. The Research Subcommittee agreed that these intensity/complexity measures were essential to the evaluation process but that the data should be calculated in a more statistically appropriate manner. The Research Subcommittee recommended that RUC Staff obtain guidance from AMA Statisticians on how to best calculate these measures appropriately.

- The American Geriatric Society expressed concern about how effective the survey instruments are for XXX codes and codes where there is no face-to-face time or all face-to-face time. For these procedures, the XXX survey would be utilized which requires specialties to develop generic descriptions of pre-service, intra-service and post-service. Several societies have developed generic descriptions for all of their new or revised XXX global codes. The Research Subcommittee will review these generic description of service periods and further address this issue at the April RUC Meeting.

- There were also various suggestions made by respondents regarding the basic format of the survey instrument and issues concerning the availability of having the survey process completely maintained online. RUC staff will create an entirely new format for the survey instruments based on the discussions held by the Research Subcommittee as well as suggestions and comments received and present this updated survey instrument at the

April RUC Meeting. In addition, RUC staff is in communication with the AMA Surveying Experts to examine the possibilities available to the RUC in conducting its survey process online.

- The American College of Surgeons submitted a letter outlining general discussion of the RUC survey process. The College expressed concern that the specialty survey process be studied to ensure that it remains based on magnitude estimation and not merely a "social survey" collecting the specialties' "wish list." **The Research Subcommittee recommends that as a first step, AMA Staff prepare an analysis of survey medians, specialty recommendations, RUC recommendations and CMS' final implemented relative values to see if the relationship between the survey medians and the final value have changed throughout the process.**

A new draft survey instrument and summary form will be reviewed prior to and finalized at the April 2006 RUC Meeting.

II. Reference Service List Policy

In addition to reviewing the summary of recommendation form and the survey instrument, there was also a request to review the current reference service list policy. The current reference service list policy is as follows:

- *Include a broad range of services and work RVUs for the specialty. Select a set of references for use in the survey that is not so narrow that it would appear to compromise the objectivity of the survey result by influencing the respondent's evaluation of a service.*

- *Services on the list should be those which are well understood and commonly provided by physicians in the specialty.*

- *Include codes in the same family as the new/revised code. (For example, if you are surveying minimally invasive procedures such as laparoscopic surgery, include other minimally invasive services.)*

- *If appropriate, codes from the MPC list may be included.*

- *Include RUC validated codes.*

- *Include codes with the same global period as the new/revised code.*

- *Include several high volume codes typically performed by the specialty.*

Doctor Cohen announced that RUC Staff will be providing the Research Subcommittee historical and background documents pertaining to this issue and postponed discussion of this issue to the April RUC Meeting

III. Modifier -51 Exempt Workgroup Update

At the October 05 RUC Meeting, there was a discussion related to the processes in place for determining which codes are exempt from the use of Modifier -51 as listed in Appendix E of the CPT book. The codes listed in Appendix E are not subject to the multiple procedure Modifier -51 reduction, as the values assigned to these codes were already reduced since they are valued to include intra-service work only, with a small amount if any pre- and post-time added. However, the RUC noted that not all of the Modifier -51 exempt codes are valued in such a manner as some of the codes include pre- and post-time, follow-up visits with global periods.

It was recommended to the CPT Editorial Panel that this issue be discussed to consider establishing a process to allow each of the codes listed in Appendix E to be reviewed for appropriateness using a set of criteria to determine whether the value assigned warrants its exemption from the Modifier -51. The CPT Editorial Panel has created a Modifier Workgroup which will review the codes currently given the Modifier -51 exemption to determine its appropriateness of being on the list and to establish criteria that would determine how future codes would be placed on this list i.e., confirming with RUC Staff that no pre- and post-service times are not associated with the proposed codes. The Workgroup has asked for RUC participation. Four members of the Research Subcommittee have volunteered to participate in these meetings: Doctors Derr, Hitzeman, Manaker and Peter Smith. The Workgroup will be meeting during the CPT Meeting February 9-12, 2006. RUC members will be able to participate via conference call. The Research Subcommittee requests a report from the Subcommittee members participating on the call as to the actions items taken by the Workgroup.

AMA/Specialty Society RVS Update Committee
Professional Liability Insurance Workgroup
February 2, 2006

The following members of the Professional Liability Insurance (PLI) Workgroup met on February 2, 2006, to discuss numerous issues related to the CMS methodology to compute PLI relative values. Doctors David Hitzeman (Chair), Michael D. Bishop, Brenda Lewis, Scott Manaker, Guy Orangio, Gregory Przybylski, Sandra Reed, David Regan and Peter Smith.

PLI Premium Collection Efforts

In a letter dated January 11, 2006, CMS has agreed to examine specific malpractice premium data for use in the calculation of the Malpractice Geographic Practice Cost Index (GPCI) available through Doctor Stephen Kamenetzky. Doctor Kamenetzky indicated to AMA staff that he will begin to assemble the data from the Physician Insurers Association of America (PIAA) for the six pilot states (Iowa, Colorado, New York, Florida, Pennsylvania and Texas) that have been chosen. Doctor Kamenetzky indicated that he should be able to obtain this data for CMS in approximately 90 days.

Low Utilization Services

At the April 2005 RUC meeting, the PLI Workgroup reviewed the dominant specialty of 1,844 CPT codes with Medicare utilization in 2003 of fewer than 100 services reported. For approximately 13% (240 CPT codes) of these low utilization services, the recommended specialty to utilize for PLI purposes differs from the dominant specialty. An additional 152 CPT codes have zero Medicare utilization and in this case specialty was recommended. The PLI Workgroup forwarded these recommendations to CMS for consideration in their 2006 rulemaking process. CMS was not able to incorporate such recommendations in the 2006 Final Rule.

The PLI Workgroup recommends that the RUC reaffirm our previous recommendation to CMS that CMS utilize these recommended specialties for low volume codes (ie, fewer than 100 claims per year), rather than rely on claims data.

Discussion of RUC process PLI crosswalks for new codes

The PLI Workgroup reviewed the professional liability insurance information section of the Instructions for Specialty Societies Developing Recommendations (page 10). Doctor Przybylski noted that while CMS methodology utilizes physician work and the specialty risk factor to drive PLI relative values, however, the work RVU may not always be the best surrogate for a crosswalk. Other measures such as intra-service work may be more appropriate. **The PLI Workgroup recommends that the instructions be refined to include other measures.**

> Professional Liability Insurance Information
> New and revised CPT codes are temporarily assigned a professional liability insurance (PLI) relative value based on CMS staff analysis of an appropriate crosswalk. The crosswalk should represent a code with a similar work RVU **or other appropriate measure** and be performed by the same specialty. The RUC has agreed that specialty input into this crosswalk is important and is providing that opportunity by including a section on the Summary of Recommendation Form to specifically collect this information. Please complete this section of the Summary form with your specialty RVS committee.

The PLI Workgroup also reviewed the professional liability insurance information section of the summary of recommendation form (page 5). The PLI Workgroup recommends that further directions be provided on the determination of surgical versus non-surgical risk factors so that specialties understand the distinction as defined by CMS.

Other Issues

A PLI Workgroup member suggested, and the Workgroup agreed that CMS request physicians to provide PLI premium information on an annual basis. However, the full RUC did not accept this recommendation.

The PLI Workgroup discussed the probability of a multi-specialty endeavor to gather PLI premium information. Specifically, with the implementation of National Provider Identifiers (NPIs) such collection efforts may be possible directly through CMS.

The Workgroup continued to discuss that it would be helpful for CMS to identify the key elements CMS would require to use in their PLI methodology.

The PLI Workgroup also discussed the possibility of gathering PLI information as part of the PE multi-specialty survey process if it occurs.

AMA/Specialty Society RVS Update Committee
E/M Workgroup Report
January 16, 2006

The following members of the Evaluation and Management (E/M) Workgroup participated in four conference calls (October 19, November 28, December 14, and January 5) to consider interim and postponed actions related to E/M services in the third, Five-Year Review of the RBRVS:

Norman Cohen, MD, Chairman
John Derr, MD
William Gee, MD
David Hitzeman, DO
George Kwass, MD
Doug Leahy, MD
Charles Mabry, MD
Greg Przybylski, MD
J. Baldwin Smith, MD
Maurits Wiersema, MD

This report will first summarize the discussions at each conference call and then provide a number of recommendations for full RUC consideration. At the February 2-5, 2006 meeting, the RUC must finalize actions on the following E/M codes:

99213, 99214, 99215 - Postponed until February 2006
99222 - 2.56 (interim)
99223 - 3.78 (interim)
99232 - 1.30 (interim)
99233 - 2.00 (interim)
99291 - 4.29 (interim)
99292 - 2.15 (interim)

October 19, 2005

The E/M Workgroup convened a call to discuss next steps in establishing RUC recommendations for CPT codes 99213, 99214, and 99215 and the process to review the interim recommendations for 99222, 99223, 99322, 99323, 99291, and 99292. Sherry Smith clarified that this E/M Workgroup is charged with the short-term process of developing recommendations for the RUC to review in February 2006. Doctor Rich has proposed development of a long-term review workgroup to study E/M and its placement within the RBRVS that would begin at the conclusion at this Five-Year Review process.

The Workgroup quickly came to consensus that a re-survey of these services would not generate any additional beneficial information to assist the RUC in completing its review of E/M services. However, the Workgroup requested that AMA staff collect the existing survey data from both the medical and surgical specialty societies and analyze this information. AMA staff were to specifically weigh this survey data to the Medicare 2004 utilization data by specialty. This

is consistent to the collation of data from the 1995 Five-Year Review of E/M. Additional regression analysis regarding potential increments between coding content and other elements could also be explored by AMA staff, if the Workgroup finds this necessary.

Workgroup members discussed other approaches to establish the E/M work values, independent of the survey data. For example, one Workgroup member proposed utilizing IWPUT to fill in the gaps for the remaining nine codes. Another Workgroup member proposed utilization of the relative values accepted by the RUC in October for the majority of the E/M codes to determine appropriate increments for the remaining codes to be resolved. A continued comparison of the E/M codes to other imaging and minor procedure codes will also be explored.

November 28, 2005

The primary focus of the second E/M Workgroup conference call was to receive and discuss new data analysis of the raw survey data collected by both the medical specialty societies and the surgical specialty societies. AMA staff compiled several tables (attached) with the weighted survey data utilizing individual survey responses. These tables are presented with data from all surveys (medical and surgical); those where the respondent indicated that the vignette was typical; and medical respondents only. AMA staff provided the following notes regarding this analysis:

Notes Regarding Specialty Representation in the Survey Data:

Although there appears to be a larger number of family medicine respondents than presented in the earlier data, the data is consistent. The August E/M Workgroup had initially requested that the data be supplied by "specialty society." The vast majority of the American Osteopathic Association's respondents indicated family medicine as their specialty, therefore the family medicine number of respondents is more representative than previously indicated by the differentiation by specialty society.

Also, please note that the original medical specialty data included incorrect numbers related to the number of respondents. For example, there is a sharp decline in the number of endocrinologists. This resulted from a misunderstanding that an individual should be counted as a respondent if they initiate the on-line survey, even if they did complete the major portions of the survey. AMA staff removed all survey responses where the individual respondent did not complete the work relative value recommendation question for any of the codes in the family.

Weighting Methodology

The ratio of the percentage of Medicare frequency to the percentage of respondents was used to determine the work relative value weight. The weight for pre, intra, and post-service time was calculated utilizing the percent of respondents for those time elements separately. Note also that separate weights were calculated for the 'typical vignette only' and 'medical specialty only' and 'all specialty' results. The weighted percentiles were calculated using SAS version 8.2, using the UNIVARIATE procedure with a WEIGHT statement. To get the weighted percentile 'p', we

first ranked the (non-missing) responses in ascending order and calculate the sum of the weights, W. The percentile 'p' response is the first observation where the cumulative weight exceeds pW. The methodology is described in the SAS 8 Procedures Guide, UNIVARIATE procedure, under the section titled "weighted quartiles".

New Medical Specialty Society Request and Workgroup Discussion

On this call, the medical specialty societies indicated that they had reviewed the new weighted survey data and wished the Workgroup to consider the following relative value recommendations:

99213 1.00 (August WG - 0.80)
99214 1.50 (August WG - 1.30)
99215 2.00 (August WG - 2.00)
99222 2.56 (August WG - 2.56/RUC - 2.56 (interim))
99223 3.78 (August WG - 3.78/RUC - 3.78 (interim))
99232 1.50 (August WG - 1.30/RUC - 1.30 (interim))
99233 2.00 (August WG - 2.00/RUC - 2.00 (interim))

The Workgroup then discussed three codes (99222, 99223, and 99233) on the conference call. Although, the Workgroup did come to a majority agreement on 99223 and 99233 (vote 6-4), a decision was made to convene a new call in December after the surgeons prepared a written document outlining their continued concerns with the August E/M Workgroup recommendations.

December 14, 2005

The Workgroup initiated the call by discussing a request from the surgeons to utilize the weighted survey time data, rather than the data first presented to the August E/M Workgroup. A clarification in process was made that those codes in which the work relative values and physician time data had been fully approved by the RUC in October would require a request for reconsideration prior to any discussion in regards to modifications to the physician time data. However, the Workgroup can proceed with new recommendations related to physician time for the nine codes that are interim or postponed. The Workgroup then agreed (9 agreed,1 abstained) that the weighted survey time data for those respondents who indicated that the vignette was typical was the most representative time data and agreed that this time data should be recommended for each of the nine codes in question. The weighted survey data is attached to this report. To summarize, the physician time data for the nine codes under review by the Workgroup will be submitted to the RUC as follows:

Code:	Pre/Intra/Post
99213	5/15/5
99214	5/25/10
99215	7/40/15
99222	10/40/15

99223	15/55/20
99232	10/20/10
99233	10/30/15
99291	15/40/15
99292	0/30/0

The Workgroup noted that the representatives of critical care should comment on the time for 99291/99292. However, the weighted typical survey time is the same as the intra-service time data already presented by the specialty.

The Workgroup then re-visited its discussion from the November 28 conference call related to codes 99222 and 99233. The Workgroup was able to come to 100% agreement that the work relative values for two hospital codes should be valued at the August Workgroup and October RUC Interim recommendations, as follows:

99222	2.56 (Original August E/M Workgroup Recommendation - Interim RUC Rec.)
99233	2.00 (Original August E/M Workgroup Recommendation - Interim RUC Rec.)

The Workgroup also agreed that work relative value for 99223 should be valued at the August Workgroup and October RUC Interim recommendations, as follows:

99223	3.78 (Original August E/M Workgroup Recommendation - Interim RUC Rec.)

However, three Workgroup members (vote 7-3) offered a minority report for 99223 (see page 5 of the attached December 13, 2005 memo from the American College of Surgeons for rationale).

E/M in Surgical Global Period

During this conference call, Workgroup members raised the issue of including all E/M increases in the surgical global period. Several Workgroup members argued that it would be appropriate to crosswalk the E/M relative values to the E/M codes included in the surgical global period at 100% of their value. The Workgroup agreed to table this discussion until their next conference call and to review it as the first order of business.

A number of questions were raised during the discussion regarding the previous Five-Year Review and the incorporation of the E/M increases in the global period. Attached is the report generated by Dann Dunn for your review on this topic.

In addition, others raised questions about the global period policy in general. The Omnibus Budget Reconciliation Act of 1989 (OBRA 89, PL 101-239), which established the RBRVS, required CMS to establish a uniform global surgical policy. It appears that any action related to repealing global surgical package policy would require legislative action. If certain specialties are interested in this issue, the best forum to discuss this would be in policy development through the AMA House of Delegates as the Council of Medical Services will be researching and preparing a report on global surgical policies for the Interim 2006 House of Delegates meeting. This report will study the coding rules, payment policies, legal and ethical issues related to reimbursement of

physicians for services rendered in the postoperative global period. The House of Delegates recognized that the contributions of specialty societies would be valuable to the study.

January 5, 2006

In preparation for this final monthly conference call of the E/M Workgroup, a request was made that the medical specialties articulate their recommendations on the remaining codes to be resolved (99213, 99214, 99215, 99232, 99291, and 99291). The medical specialties submitted a memo on January 5th to the E/M Workgroup, with the following recommendations for these six unresolved codes:

99213	1.00
99214	1.50
99215	2.00
99232	1.50
99291	5.00
99292	2.50

E/M in Surgical Global Period

As indicated at the conclusion of the December 14 conference call, the call initiated with a discussion related to the E/M valuation within the surgical global period. Doctor Leahy indicated that the codes with surgical global periods should be increased to incorporate increases in the E/M services as work should be considered equivalent across all specialties and the discounts applied in the first Five-Year Review are not appropriate [see attached summary for codes that are currently discounted within the global]. He also indicated that the MEC agrees with the RUC's March 1997 recommendation to CMS that "the most recent and accurate data should be used to determine the number and level of hospital and office visits in global service work." However, Doctor Leahy indicated that they have a few of concerns that they would request to be addressed. For example, the assumptions regarding the number and level of E/M codes in the global period largely goes untested. Individuals within the MEC have questioned whether these post-operative visits would sustain an audit process if the same 1995/1997 documentation guidelines for stand alone E/M codes were applied to the visits in the global period. These statements engendered a great deal of discussion amongst the Workgroup members.

AMA staff informed the Workgroup that only 32 codes have a 99215 bundled into the service and only 311 codes have a 99214 bundled into the service. The RUC is responsible for ensuring that the number and level of visits in the surgical global period is appropriate. The RUC has made many adjustments to the number and/or level of E/M visits in the global period throughout its review process.

Other discussion focused on whether the post-service work of documentation differed between the stand alone E/M services and the E/M services in the surgical global periods. Some Workgroup members indicated that there is not any difference in the way they handle charting for patients seen post-operatively versus those seen for a service unrelated a surgical procedure. Others on the call indicated that there is a different level of documentation in general between

those services performed independently of procedures and those that are a component of the global surgical period.

The Workgroup agreed (8 agree and 1 abstained) that a crosswalk of 100% of the E/M increases should be bundled into the codes with surgical global periods of 010 and 090 days, with the provision that the 1995/1997 documentation requirements, whether element based or time based, are the same as stand alone E/M. The Workgroup acknowledged that that the RUC is not the appropriate forum to discuss enforcement of documentation requirements. One Workgroup member abstained as he did not feel that the RUC would be the appropriate mechanism to enforce documentation in E/M services performed in the postoperative period, but CMS would be responsible for any such implementation. Another Workgroup member also voiced concern that payors would use an audit process to reduce payment if the number of visits were less than the number captured as "typical" in the global surgical period.

Valuation of 99215

The Workgroup understands from a review of the September 29-October 2, 2005 meeting that 2/3 of the RUC would support a relative value recommendation at or above the August E/M Workgroup recommendation of 2.00. However, at that time several RUC members refused to consider a value below 2.15. The presenting medical specialties have indicated since the November 28, 2005 conference call that they would accept the August E/M Workgroup recommendation of 2.00. The Workgroup agreed that work relative value for 99215 should be valued at the August Workgroup recommendation:

99215 2.00 (Original August E/M Workgroup Recommendation)

However, two Workgroup members (vote 7-2) offered a minority report for 99215 (see page 4 of the attached December 13, 2005 memo from the American College of Surgeons for rationale.)

Valuation of 99213

The E/M Workgroup then attempted to come to consensus on 99213. The Workgroup understands from a review of the September 29-October 2, 2005 meeting that 2/3 of the RUC would support a relative value recommendation at or above the August E/M Workgroup recommendation of 0.80. The Workgroup then reviewed the January 5 memo from the MEC related to their rationale for 99213. In this memo, the MEC recommends a work relative value of 1.00 for 99213. Some Workgroup members offered criticism of comparison to certain reference services discussed in the memo, such as insertion of IUD and nasal endoscopy, as they had not been recently reviewed by the RUC. Others found support in a value between 0.88 - 0.92 for 99213 in the following rationale:

> *As the RUC recommendations for the 1995 Five-Year Review were 0.80 for 99213 and 0.79 for 99202 due to the more complex decision making and higher intensity of 99213, the current RUC recommendation of 0.88 for 99202 should be less than the work relative value for 99213.*

Doctor Mabry argued that the RUC's previous linkage of 99202 and 99213 may indicate that the RUC's recommendation on 99202 in October was too high. Doctor Cohen reminded the Workgroup members that all recommendations submitted to CMS in October are considered final and a formal request for reconsideration would be the appropriate process to re-review any of the previous RUC actions.

To help determine where the Workgroup members were able to vote on at this particular time, Doctor Cohen requested that each of the nine members on the call express their recommendation for 99213. One Workgroup member recommended that 99213 be maintained at 0.67. Two individuals stated that they support the Workgroup recommendation of 0.80. Four individuals stated that they would support a recommendation ranging from 0.88 - 0.92. Two individuals would recommend a work relative value of 1.00. Given the wide range of opinion regarding the valuation of 99213, the Workgroup recommends that the RUC consider the value of 99213 as a committee of the whole.

Valuation of 99214

The Workgroup acknowledges that neither the RUC, nor this Workgroup, have discussed the valuation of 99214. However, the Workgroup believes that the RUC must first resolve 99213. The August E/M Workgroup recommendation for 99214 was 1.30. The MEC is recommended a work relative value of 1.50.

Valuation of 99232

The August E/M Workgroup also recommended a work relative value of 1.30 for 99232 and the RUC approved this as an interim recommendation in October. However, the MEC is recommending a work relative of 1.50. The Workgroup believes that it is appropriate that the RUC, as a committee of the whole, resolve this valuation.

Critical Care

The RUC approved an interim work relative value of 4.29 for 99291 and 2.15 for 99292 to avoid creation of rank order anomalies with other higher level hospital codes. The presenting specialty societies had requested that these recommendations remain interim until all of the other E/M services were resolved. As three codes remain unresolved at this time, the presenting specialties for critical care has requested that they have the opportunity to present at the full RUC meeting, upon completion of the other E/M services. At this point, the specialty societies are requesting that the RUC consider 5.00 for 99291 and 2.50 for 99292.

E/M Workgroup Recommendations for RUC Action

#1 - The E/M Workgroup recommends that the weighted survey time data from those respondents who indicated that the vignette was typical should be utilized as the physician time recommendations for those codes in that E/M Workgroup was charged to review, as follows:

Code:	Pre	Intra	Post	Total
99213	5	15	5	25
99214	5	25	10	40
99215	7	40	15	62
99222	10	40	15	65
99223	15	55	20	90
99232	10	20	10	40
99233	10	30	15	55
99291	15	40	15	70
99292	0	30	0	30

The RUC concluded that the "all" survey respondent median time data should be utilized on an interim basis for all E/M codes under review. The RUC will continue to study the E/M physician time data as it conducts a long-term review of E/M valuation.

#2 - The E/M Workgroup recommends that the RUC approve a work relative value recommendation of 2.56 be approved for 99222. This is the original August E/M Workgroup recommendation and the October Interim RUC recommendation.

#3 - The E/M Workgroup recommends that the RUC approve a work relative value recommendation of 3.78 be approved for 99223. This is the original August E/M Workgroup recommendation and the October Interim RUC recommendation.

#4 - The E/M Workgroup recommends that the RUC approve a work relative value recommendation of 2.00 be approved for 99233. This is the original August E/M Workgroup recommendation and the October Interim RUC recommendation.

#5 - The E/M Workgroup recommends that the RUC approve a work relative value recommendation of 2.00 be approved for 99215. This is the original August E/M Workgroup recommendation.

The RUC approved the E/M Workgroup recommendations for 99222, 99223, 99233, and 99215.

#6 - The Workgroup recommends that a crosswalk of 100% of the E/M increases should be bundled into the codes with surgical global periods of 010 and 090 days, with the provision that the 1995/1997 documentation requirements, whether element based or time based, are the same as stand alone E/M.

The RUC agreed that E/M work is equivalent and a crosswalk of 100% of the E/M valuation should be bundled into the codes with global periods of 010 and 090 days, with appropriate documentation

The full RUC will need to review, discuss, and determine the relative value recommendations for CPT codes 99213, 99214, 99232, 99291, and 99292.

The RUC completed its review of CPT codes 99213, 99214, 99232, 99291, and 99292 and finalized recommendations for each of these codes.

Attachments

- January 16, 2006 minority opinion from Doctors Gage/Mabry
- Spreadsheet summarizing relative values and physician time data
- RUC Recommendations submitted to CMS on October 31, 2005
- Minutes from September 29-October 2, 2005 RUC Meeting
- Weighted survey data prepared by AMA staff
- Suggested valuation approach proposed by David Hitzeman, DO
- January 5, 2006 Memo from Medical Executive Committee
- 1995 RUC E/M Recommendations
- December 13, 2005 Minority Response Memo
- Dan Dunn analysis of E/M in the global period
- One page summary form of current E/M valuation and time in the global period