AMA/Specialty RVS Update Committee
Meeting Minutes
February 1-4, 2007

I. Welcome and Call to Order

Doctor William Rich called the meeting to order on Friday, February 2, 2007, at 10:00 am. The following RUC Members were in attendance:

William Rich, MD (Chair)
Bibb Allen, Jr., MD
Dennis M. Beck, MD*
Michael D. Bishop, MD
James Blankenship, MD
Ronald Burd, MD
Norman A. Cohen, MD
Bruce Deitchman, MD*
James Denneny, MD*
John Derr, Jr., MD
Thomas A. Felger, MD
Robert C. Fifer, PhD*
Mary Foto, OTR
John O. Gage, MD
Meghan Gerety, MD
Robert S. Gerstle, MD*
James Giblin, MD*
David F. Hitzeman, DO
Peter Hollmann, MD
Charles F. Koopmann, Jr., MD
Gregory Kwasny, MD
Walt Larimore, MD*
M. Douglas Leahy, MD*
Barbara Levy, MD
Brenda Lewis, DO*
J. Leonard Lichtenfeld, MD
William J. Mangold, Jr., MD
Charles Mick, MD
Bill Moran, Jr., MD
Bernard Pfeifer, MD
Gregory Przybylski, MD
Sandra B. Reed, MD*
David Regan, MD
James B. Regan, MD
Chad Rubin, MD*
J. Baldwin Smith, III, MD
Peter Smith, MD
Susan Spires, MD*
Holly Stanley, MD*
Robert J. Stomel, MD*
Arthur Traugott, MD
Richard Tuck, MD
James Waldorf, MD*
George Williams, MD*
John A. Wilson, MD*

*Alternate

II. Chair's Report

Doctor Rich made the following general announcements:

- 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.
- Presenters are expected to announce any conflicts or potential conflicts, including travel reimbursement paid by an entity other than the specialty society, at the onset of their presentation.

- Before a presentation, any RUC member with a conflict must state their conflict and the Chair will rule on recusal.
- RUC members or alternates sitting at the table may not present or advocate on behalf of their specialty.
- 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 standardized PE conventions, the tab will be immediately referred to a Facilitation Committee before any work relative value or practice expense discussion.
- The Summary of Recommendation form has been edited and includes a number of new questions, including modifier 51 status, PLI crosswalk and others. The RUC should provide feedback if sections of the summary are incorrect.
- All RUC Advisors presenting survey data are required to sign the attestation statement at the bottom of the Summary of Recommendation form.

- Doctor Rich welcomed the CMS Staff attending the meeting, including:
    - Edith Hambrick, MD, CMS Medical Officer
    - James Hart
    - Carolyn Mullen, Deputy Director of the Division of Practitioner Services
    - Ken Simon, MD, CMS Medical Officer
    - Pam West, PT, DPT, MPH, Health Insurance Specialist

- Doctor Rich welcomed the following Medicare Payment Advisory Commission (MedPAC) staff:
    - Kevin Hayes, PhD

- Doctor Rich welcomed the following Medicare Contractor Medical Director:
    - Charles Haley, MD

- Doctor Rich welcomed the following representatives from the Gallup Organization:
    - Michael Ellrich
    - Catherine Strahan

- Doctor Rich welcomed additional staff from the AMA:
    - Thomas P. Healy, Jr., JD, Vice President of Corporate Law

- Doctor Rich welcomed the Practice Expense Review Committee (PERC) Members attending. The members in attendance for this meeting were:
    - Bill Moran, MD (Chair)
    - Katherine Bradley, PhD, RN

- Joel Brill, MD
- Manuel D. Cerqueria, MD
- Neal Cohen, MD
- Thomas Felger, MD
- Gregory Kwasny, MD
- Tye Ouzounian, MD
- James Regan, MD
- Anthony Senagore, MD

- Doctor Rich announced the members of the Facilitation Committees:

Facilitation Committee #1	Facilitation Committee #3
James Blankenship, MD (Chair)	Thomas Felger, MD (Chair)
Michael D. Bishop, MD	Joel Brill, MD
Mary Foto, OTR	James Denneny, MD
Charles Koopmann, MD	John Derr, MD
Barbara Levy, MD	Emily H. Hill, PA-C
William Mangold, MD	David Hitzeman, DO
Bernard Pfeifer, DC	Charles Mick, MD
Susan Strate, MD	J. Baldwin Smith, MD
Richard Tuck, MD	Peter Smith, MD

Facilitation Committee #2	Facilitation Committee #4
Bibb Allen, MD (Chair)	David Regan, MD (Chair)
Bruce Deitchman, MD	Katherine Bradley, PhD, RN
Robert Fifer, PhD, CCC-A	Ronald Burd, MD
Peter Hollmann, MD	Norman Cohen, MD
Walt Larimore, MD	John O. Gage, MD
J. Leonard Lichtenfeld, MD	Meghan Gerety, MD
Gregory Przybylski, MD	Gregory Kwasny, MD
James Regan, MD	Willard Moran, MD
Robert Zwolak, MD	Arthur Traugott, MD

- Doctor Rich welcomed the following individuals as observers at the April 2006 meeting:
  - Michael Albo, MD, American Urology Association
  - Allan Anderson, American Psychiatric Association
  - Anne Marie Bicha, American Gastroenterological Association
  - Robert Blaser, Renal Physicians Association
  - Dawn Brennaman, North American Spine Society
  - Antanya Chung, American College of Rheumatology
  - Charles A. Crecelius, MD, PhD, CMD, American Medical Directors Association
  - Scott Collins, MD, American Academy of Dermatology
  - William Creevy, MD, Orthopaedic Trauma Association
  - Alan Desmond, American Academy of Audiology

- Sheila Dwyer, American Optometric Association
- Robert Fine, American Academy of Orthopaedic Surgeons
- Megan Fogelson, American Association of Neuromuscular and Electrodiagnostic Medicine
- Edward Fry, MD, American College of Cardiology
- Richard Gilbert, MD, American Urological Association
- Allan E. Inglis, Jr, MD, American Academy of Orthopaedic Surgeons
- Robert Jasak, American Academy of Orthopaedic Surgeons
- Stephanie Kutler, The Endocrine Society
- Andrew Laster, American College of Rheumatology
- Alan Lazaroff, MD, American Geriatrics Society
- Mahesh Mansukhani, MD, College of American Pathologists
- Gilbert Martin, American Academy of Pediatrics
- Jennifer Medicus, American Academy of Child and Adolescent Psychiatry
- Erika Miller, American College of Physicians
- Richard Molteni, American Academy of Pediatrics
- Eileen Moynihan, American College of Rheumatology
- Michael Murro, MD, American College of Cardiology
- Nicolas Nickl, MD, American Society of Gastrointestinal Endoscopy
- Michael Picard, MD, American College of Cardiology
- Wayne Powell, American College of Cardiology
- Thomas Rees, American Speech-Language-Hearing Association
- Thomas Ryan, MD, American College of Cardiology
- Charles A. Scott, MD, FAAP, American Academy of Pediatrics
- James Scroggs, American College of Obstetricians and Gynecologists
- John Seibel, MD, American Association of Clinical Endocrinologists
- Christine Sinsky, American College of Physicians
- Maurine Spillman-Dennis, American College of Radiology
- Eric Tangalos, American Medical Directors Association
- Holly Whelan, The Endocrine Society
- Kadyn Williams, American Audiology Association
- Karin Wittich, American Association of Oral and Maxillofacial Surgeons

III. Director's Report

Sherry Smith made the following announcements:

- The revised RUC database for 2007 is now available and includes additional Medicare claims data regarding utilization percentages for male

versus female patients, most common diagnosis codes reported with each service, and other information regarding utilization.

- AMA staff has distributed a meeting evaluation form to assess the quality of the RUC meeting. Ms. Smith asks all attendees to complete the form at the conclusion of the meeting and to leave it at the registration desk.

IV. Approval of Minutes for the October 5-7, 2006 RUC meeting

The RUC noted that on page 10, code 61923 is incorrectly listed. The correct code is code 61623.

The RUC reviewed the minutes and accepted them as amended.

V. CPT Editorial Panel Update

Doctor Peter Hollmann made the following announcements:

- The February 2007 CPT Editorial Panel meeting has more than 100 issues and expects many of the issues to be referred to the RUC.
- At the last meeting of the CPT Editorial Panel, the Panel finished reviewing the majority the modifier 51 issues. The Panel expects to complete is review at its February 2007 meeting. The majority of the remaining modifier 51 exempt codes will be removed from the list and become either add-on codes or be referred to the RUC for valuation.
- In February, the Panel will also be reviewing the guidelines for documenting consultation versus the transfer of a patient as well as continuing to review appropriate use of CPT modifiers.
- The Panel is considering a number of issues from the Five-Year Review including soft tissue tumors and bone tumors.
- The Panel is developing a more efficient way to report Category II codes to report performance measurements. Currently, other organizations create the measures, such as the Physicians' Consortium, while CPT facilitates the creation of a Category II code. With the initiation of the Physician Quality Reporting Initiative (PQRI) bonus payment for 2007, work on this has increased significantly. CPT is endeavoring to ensure that there are CPT codes for all CMS approved performance measures and that CPT Category II codes remain the preferred reporting method.
- Doctor Hollmann indicated that the Panel would likely be spending more time and effort on the development of Category II codes.
- Doctor Hollmann explained that the turn-around time for a performance measure to become a Category II code is currently relatively brief. Often the Panel will pre-review a measure before approved and, if pre-approved, they are reviewed and approved at the following CPT meeting. In order to expedite the process, the Panel has held numerous conference calls to

approve codes so that no specialty is set back because of lack of a code for a performance measure.

VI. Centers for Medicare and Medicaid Services Update

Doctor Ken Simon made the following announcements:

- Since the last meeting, CMS has published the fee schedule in November.
- The Tax Relief and Healthcare Act of 2006 was enacted on December 8, 2006. The Act provides a one-year freeze on the Medicare conversion factor. Additionally, the Act provides for a 1.5% bonus payment for providers that participate in the Physician Quality Reporting Initiative (PQRI), formerly the Physicians Voluntary Reporting Program (PVRP). The reporting period for the PQRI extends from July 1 through December 31, 2007. The bonus is based on 100% of allowed charges during the six-month period. CMS has created a new office, led by Doctor Tom Valuk, and five new workgroups to facilitate the changes mandated by the Act. The program is still in its infancy and there are many questions that remain to be answered. Two of the most pertinent questions are in regards to the bonus payment cap and the facilitation of payment through tax ID number or through NPI. These two issues have not, at the time of this meeting, been decided. Doctor Simon commented that he expects much more information to be available by the next meeting of the RUC.

VII. Contractor Medical Director Update

Doctor Charles Haley provided an extensive presentation updating the RUC on Medicare contracting reform, jurisdiction changes, and other changes. A copy of the presentation is attached to these minutes.

VIII. Washington Update

Sharon McIlrath, AMA Assistant Director of Federal Affairs provided the RUC with the following announcements of the AMA's lobbying efforts:

- The Democratic takeover of the Congress will shift our legislative opportunities. The possibility of presidential veto and the 2008 presidential race may also make things slow to move in the near future.
- Within Congress, there is a movement for budget deficit relief. Congress is requiring a "pay as you go rule" for new initiative. There is also a growing realization in Washington that entitlement programs such as Social Security and Medicare are unsustainable as currently structured
- The AMA feels that it has a reduced opportunity to promote nationalized medical liability reform. The AMA will continue to support MICRA-like reforms, but will also advocate for other reforms such as health courts. State level liability reform remains a priority, including complete reforms as well as rules on expert witness and other incremental reforms.

- The AMA feels that there is an increased opportunity to advocate for managed care reform. These reforms are likely to include anti-trust relief with larger insurers. Congress is also interested in reviewing the practices of Medicare Advantage contractors.
- There is an improved legislative climate for increasing health care coverage for the uninsured. The AMA is currently participating in the Healthcare Coverage of the Uninsured Coalition, which is developing a plan to incrementally increase coverage. Coverage would first be extended to children through increasing the number covered through SCHIP and Medicare and creating tax credits for child health insurance for families with low incomes.
- Medicare payment reform remains a priority for the AMA. Ms. McIlrath noted that the Tax Relief and Healthcare Act of 2006 includes a one-year extension of 1.0 floor for the GPCIs and support for medical home trials in eight states. Funding for conversion factor freeze and the bonus payment are temporary. Congress approved a one-year fix only. January 1, 2008, the conversion factor will be adjusted to account for the cuts for 2008 as well as the cuts that were avoided in 2007. It is estimated that the reduction will be approximately 10%. The legislation accounted for an additional $1.35 billion to be used at the discretion of CMS. The AMA requests that it be used to reduce the projected cuts in 2008. MedPAC agrees and supports a full inflation update in 2008 of approximately 1.7%.
- Performance measures available for reporting in 2007 may be modified through April 2007. The AMA is working with the CPT Editorial Panel to ensure that Category II codes are developed to report the approved measures. CMS is likely to require use of CPT category II codes rather than the G codes.
- The 2008 President's budget will likely include significant cuts for Medicare. Even if cuts are avoided, there will be few places for surplus money to come from in order to support a positive update.
- The AMA is in the process of developing both a long-term and a short-term plan to fix the flawed Medicare payment system. The include proposals to incrementally phase out the SGR, breaking down the Part A and Part B silos, and modifying cost sharing with beneficiaries.

Kevin Hayes, PhD, MedPAC Senior Advisor, provided the RUC with the following announcements regarding the upcoming MedPAC report:

- MedPAC is completing a report regarding potential alternatives to the sustainable growth rate (SGR) formula, including how it relates to issues the RUC is addressing, and information about the CMS resources to make such changes. The report was mandated by Congress through provisions within the Deficit Reduction Act of 2005. Congress asked that MedPAC consider alternates including ways of removing or re-configuring the SGR to take into consideration one or more of the following: type of service, geographic location, practice size and type, and/or providers with significantly high utilization.

- MedPAC will recommend two paths for Congress to follow in resolving the SGR update:
    1. Repealing SGR and developing approaches, such as rewarding quality, continuity of care, tying payment to episodes of care, and promoting and rewarding efficiency.
    2. Retaining some form of expenditure target. Different from SGR, a target would consider all of Medicare spending, not just physician payment. It would extend to hospitals, drugs, etc. The target could differentiate between geographic areas. There would also be a way to try and allow physicians to share in any savings that occurred due to increased efficiencies, using accountable healthcare organizations.
- MedPAC is also concerned regarding the accuracy of Medicare's prices. In physicians services, MedPAC has reviewed the Five-Year Review process, equipment utilization rates and geographic differences in resource costs and utilization. Specifically there is a continuing concern in the growth of volume of some services and differentials among growth rates by geography and service. MedPAC has discussed a two-step approach to dealing with volume issues: 1) Look for rapid growth rates and assess whether that means that the prices are too high. 2) Propose and conduct a review system to ensure that the incorrect payments are corrected.

Dr. Hayes answered a number of specific questions:

- *What kind of information will convince MedPAC that utilization growth is not a result of mis-valuation for some services?* There is no automatic assumption that such services are overpriced, but it is a potential indicator that there could be an incorrect value associated with that service. It will be necessary to assess other factors that drive growth, such as changes in technology and patient population before concluding that the service is mis-valued.
- *Why is it such a political problem to endorse specialty specific conversion factors to control specialty specific volume growth? Only a single specialty can control its own volume. Why can there not be different conversion factors?* One of the many alternatives considered was creation of a specialty specific payment systems and changes to improve efficiency and quality by specialty. Specialties have shown a lot of promise for self regulation by creating databases, maintenance of certification, etc. MedPAC was heartened by these efforts, but there is a need for the health care system to achieve a better level of coordination among all stakeholders involved. Specialty-specific expenditure targets would detract from this cohesion and cooperation.
- *What about the responsibilities of the patients? How do you explain the role of beneficiaries in the payment system?* There is plenty of work left to be done in the area. Beneficiary responsibility is a hot-button issue and

no conclusions have been made. MedPAC would perhaps address these concerns by revising the beneficiary cost-sharing system.

- *To the extent that there needs to be cohesion among all providers and players, is there any chance of breaking down the Part A and B silos?* Yes there is an understanding of those issues involved by MedPAC. If there is an expenditure target in the future, parts A, B, and potentially D would be considered together as a single pool of expenditures. The divisions would be more appropriately broken down by geographic regions, than by provider type.
- *What evidence could RUC supply to resolve the over-valuation and/or rising utilization issue? Would a resurvey be necessary?* MedPAC recognizes that RVU setting is CMS' responsibility alone, but recommends that the Five-Year Review process be better facilitated. MedPAC is heartened to see that the RUC's Five-Year Review Identification Workgroup is making strides. There is some potential to identify mis-valued services and develop a process for reconsideration of RVUs when necessary.

IX. Relative Value Recommendations for CPT 2008

Internal or External Fixation – Shoulder/Elbow (Tab 4)
Dan Nagle, MD, American Society for Surgery of the Hand (ASSH), Dale Blaiser, MD, American Academy of Orthopaedic Surgery (AAOS), Richard Friedman, MD, American Shoulder and Elbow Society (ASES), William Creevy, MD, Orthopaedic Trauma Association (OTA)

As part of the 2005 Five Year Review Process, the American Academy of Orthopaedic Surgery (AAOS) commented that the compelling evidence rationale for examining the work RVU for the fracture treatment codes is that there is evidence that incorrect assumptions were made in the valuation of these codes due to lack of clarity of the CPT descriptor. In particular, the CPT descriptor states "with or without internal or external fixation." However, it is unclear whether the previous valuation for the code included the situation when internal and external fixation is applied to a fracture site. Therefore, the RUC recommended that these codes be referred to the CPT Editorial Panel for further clarification.

At the October 2007 CPT Editorial Panel Meeting, the AAOS recommended to the CPT Editorial Panel that the identified fracture treatment codes in the musculoskeletal section of CPT that include the nomenclature "internal or external" fixation should be clarified to state that external fixation should be an adjunctive procedure to these procedures. The CPT Editorial Panel agreed with the specialty that these codes needed to be clarified and removed reference to external fixation from 68 CPT codes. These 68 codes were divided into four categories based on location: Shoulder/Elbow, Elbow/Hand, Hip/Knee and Foot/Ankle. At the February 2007 RUC Meeting, three of these categories were discussed:

Shoulder/Elbow, Elbow/Hand and Foot/Ankle. The Hip/Knee codes will be discussed at the April 2007 RUC Meeting.

The specialty engaged in a major survey effort to properly value these services. Between 225 and 450 orthopaedic surgeons participated in each of the surveys. These respondents included physicians from general orthopaedic surgery, shoulder and elbow surgery and orthopaedic trauma surgery. After the results from all of these groups were tablulated, a consensus committee of physicians representing general orthopaedic surgery, hand surgery, traumatologists, podiatrists, foot/ankle surgeons, and hip/knee surgeons met to discuss the survey data for the revised orthopaedic codes. During this review, the specialties first reviewed the survey medians for each service. The 25th percentile was often recommended instead as a means to maintain rank order. IWPUT was reviewed, but only to validate the recommendations resulting from the survey.

The RUC reviewed the compelling evidence for these procedures. The specialty societies claimed that because the CPT descriptors originally contained the phrase "with or without internal or external fixation," it is difficult to imagine what the original Harvard survey data actually represented. Furthermore, an Abt study was performed in 1992 for RUC consideration. This study produced percentage relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down but no changes were made to the Harvard time and visit data, if available. Therefore, the specialty society believes that there is little, if any, relationship between the Harvard database time and visit information and the current work RVUs.

Furthermore, the specialty societies stated that there was a significant change in the technology for how these procedures are performed. The surgical treatments use open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as computed tomography which allows better detection of the fracture pathology and provides the basis for new surgical strategies. There are also new internal fixation devices which require more work. Further, the patient population has changed, as women over 50 are a fast growing segment of the population. A huge percentage of these patients are osteoporatic – making fracture fixation and maintenance of fixation far more difficult. Also, for several of the identified procedures, the provider of the services have changed and were not a part of the original Harvard studies such as the American Shoulder and Elbow Surgeons. The specialty societies conducted a full RUC survey of all codes, and for almost all of the codes, recommended the 25th percentile or the median RVU of the specialty survey data. It should also be noted that the RUC is recommending reductions in work RVUs for three codes of the codes in this family, 23616 and 24575.

The RUC thoroughly reviewed these codes, and as part of this review, the specialties explained that they felt strongly that a 99214 office visit was appropriate

for two of the codes within this family and however, based on discussions at the RUC meeting the specialty agreed to lower the intensity of this visit to a 99213 office visit. The RUC reviewed CPT code 20690 *Application of a uniplane (pins or wires in one plane), unilateral, external fixation system* (Work RVU=3.67) and 20692 *Application of a multiplane (pins or wires in more than one plane), unilateral, external fixation system (eg, Ilizarov, Monticelli type)* (Work RVU=6.40). It is the RUC's understanding that the utilization for these two procedures will not change with this coding change made by the CPT Editorial Panel. Therefore, the RUC believes that there will be no budget neutrality impact for these recommendations. However, the RUC welcomes a retrospective review of this issue in the future.

The detailed recommendations are attached to these minutes

Internal or External Fixation – Elbow/Hand (Tab 5)
Dan Nagle, MD, American Society for Surgery of the Hand (ASSH), Dale Blaiser, MD, American Academy of Orthopaedic Surgery (AAOS), Richard Friedman, MD, American Shoulder and Elbow Society (ASES), William Creevy, MD, Orthopaedic Trauma Association (OTA)

As part of the 2005 Five Year Review Process, the American Academy of Orthopaedic Surgery (AAOS) commented that the compelling evidence rationale for examining the work RVU for the fracture treatment codes is that there is evidence that incorrect assumptions were made in the valuation of these codes due to lack of clarity of the CPT descriptor. In particular, the CPT descriptor states "with or without internal or external fixation." However, it is unclear whether the previous valuation for the code included the situation when internal and external fixation is applied to a fracture site. Therefore, the RUC recommended that these codes be referred to the CPT Editorial Panel for further clarification.

At the October 2007 CPT Editorial Panel Meeting, the AAOS recommended to the CPT Editorial Panel that the identified fracture treatment codes in the musculoskeletal section of CPT that include the nomenclature "internal or external" fixation should be clarified to state that external fixation should be an adjunctive procedure to these procedures. The CPT Editorial Panel agreed with the specialty that these codes needed to be clarified and removed reference to external fixation from 68 CPT codes. These 68 codes were divided into four categories based on location: Shoulder/Elbow, Elbow/Hand, Hip/Knee and Foot/Ankle. At the February 2007 RUC Meeting, three of these categories were discussed: Shoulder/Elbow, Elbow/Hand and Foot/Ankle. The Hip/Knee codes will be discussed at the April 2007 RUC Meeting.

The specialty engaged in a major survey effort to properly value these services. Between 225 and 450 orthopaedic surgeons participated in each of the surveys. These respondents included physicians from general orthopaedic surgery, shoulder

and elbow surgery and orthopaedic trauma surgery. After the results from all of these groups were tablulated, a consensus committee of physicians representing general orthopaedic surgery, hand surgery, traumatologists, podiatrists, foot/ankle surgeons, and hip/knee surgeons met to discuss the survey data for the revised orthopaedic codes. During this review, the specialties first reviewed the survey medians for each service. The 25th percentile was often recommended instead as a means to maintain rank order. IWPUT was reviewed, but only to validate the recommendations resulting from the survey.

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The RUC thoroughly reviewed these codes, and as part of this review, the specialties explained that they felt strongly that a 99214 office visit was appropriate for two of the codes within this family and however, based on discussions at the RUC meeting the specialty agreed to lower the intensity of this visit to a 99213 office visit. The RUC also reviewed CPT code 20690 *Application of a uniplane (pins or wires in one plane), unilateral, external fixation system* (Work RVU=3.67) and 20692 *Application of a multiplane (pins or wires in more than one plane), unilateral, external fixation system (eg, Ilizarov, Monticelli type)* (Work

RVU=6.40). It is the RUC's understanding that the utilization for these two procedures will not change with this coding change made by the CPT Editorial Panel. Therefore, the RUC believes that there will be no budget neutrality impact for these recommendations. However, the RUC welcomes a retrospective review of this issue in the future.

The detailed recommendations are attached to these minutes

Internal or External Fixation – Foot/Ankle (Tab 6)
Dan Nagle, MD, American Society for Surgery of the Hand (ASSH), Dale Blaiser, MD, American Academy of Orthopaedic Surgery (AAOS), Richard Friedman, MD, American Shoulder and Elbow Society (ASES), William Creevy, MD, Orthopaedic Trauma Association (OTA)

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means to maintain rank order. IWPUT was reviewed, but only to validate the recommendations resulting from the survey.

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Furthermore, the specialty societies stated that there was a significant change in the technology for how these procedures are performed. The surgical treatments use open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as computed tomography which allows better detection of the fracture pathology and provides the basis for new surgical strategies. There are also new internal fixation devices which require more work. Further, the patient population has changed, as women over 50 are a fast growing segment of the population. A huge percentage of these patients are osteoporatic – making fracture fixation and maintenance of fixation far more difficult. Also, for several of the identified procedures, the provider of the services have changed and were not a part of the original Harvard studies such as the American Podiatric Medical Association. The RUC agreed that there was an abundant amount of compelling evidence to review these codes with the exception of CPT codes 27822 *Open treatment of trimalleolar ankle fracture, with internal fixation, when performed, medial and/or lateral malleolus; without fixation of posterior lip* (Work RVU=12.12), 27823 *Open treatment of trimalleolar ankle fracture, with internal fixation, when performed, medial and/or lateral malleolus; with fixation of posterior lip* (Work RVU=14.26) and 28445 *Open treatment of talus fracture, includes internal fixation, when performed* (Work RVU=17.07). These three identified codes were not reviewed by the RUC because the RUC agreed that the nature of the work involved in providing these services has not substantially changed since the RUC last reviewed them in 2000. The specialty societies conducted a full RUC survey of all codes, and for almost all of the codes, recommended the 25th percentile or the median RVU of the specialty survey data. It should also be noted that the RUC is recommending a slight reduction in work RVUs for one code in this family, 27766 and maintain the work RVUs for four codes, 27822, 27823, 28445 and 28415.

The RUC thoroughly reviewed these codes, and as part of this review, the specialties explained that they felt strongly that a 99214 office visit was appropriate for two of the codes within this family and however, based on discussions at the

RUC meeting the specialty agreed to lower the intensity of this visit to a 99213 office visit. The RUC reviewed CPT code 20690 *Application of a uniplane (pins or wires in one plane), unilateral, external fixation system* (Work RVU=3.67) and 20692 *Application of a multiplane (pins or wires in more than one plane), unilateral, external fixation system (eg, Ilizarov, Monticelli type)* (Work RVU=6.40). It is the RUC's understanding that the utilization for these two procedures will not change with this coding change made by the CPT Editorial Panel. Therefore, the RUC believes that there will be no budget neutrality impact for these recommendations. However, the RUC welcomes a retrospective review of this issue in the future.

The detailed recommendations are attached to these minutes

Transuretheral Ureteral Stent Tube Exchange and Removal (Tab 7)
Robert L. Vogelzang, MD, Society of Interventional Radiology (SIR) and Geraldine McGinty, MD, American College of Radiology (ACR)

The CPT Editorial Panel created two new codes to accurately describe the removal or removal and exchange of a ureteral stent, using radiological guidance methods.

5038X1
The RUC reviewed the specialty society survey median RVU and physician time for code 5038X1 *Removal (via snare/capture) and replacement of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation.* The specialty society indicated that the key reference service, code 50382 *Removal (via snare/capture) and replacement of internally dwelling ureteral stent via percutaneous approach, including radiological supervision and interpretation* (work RVU=5.50, 50 minutes pre-, 60 minutes intra-, and 15 minutes post-service time), has more physician time involved, however the intensity of the two procedures is very similar. The specialty society indicated that the survey median RVU for 5038X1 was too high and recommend a building block approach to develop an RVU of 4.44.

The building block RVU is calculated by taking the reference service code's intra-service intensity measure of 0.06978, multiplied to the intra-service time of 45 minutes for code 5038X1 (0.07 x 45 = 3.15). Then add the pre-service (29 minutes evaluation, 10 minutes positioning and 10 minutes scrub, dress, wait = 49 minutes) and post-service (15 minutes) RVUs (0.95+0.34) to intra service RVU (3.15) to establish a total work RVU of 4.44 for 5038X1.

Additional reference service codes with comparable physician intra-service time and work RVUs are 52315 *Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure);*

complicated (RVU=5.20, 43 minutes intra-service) and 36360 *Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; younger than 5 years of age* (RVU=6.26, intra-service time 45 minutes). The RUC determined this aforementioned building block approach along with the additional reference services supported a work RVU of 4.44, which is below the survey 255h percentile. **The RUC recommends a work RVU of 4.44 for code 5038X1.**

5038X2
The RUC reviewed the survey median RVU and physician time for code 5038X2 *Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation.* The specialty society indicated that the key reference service, code 50384 *Removal (via snare/capture) of internally dwelling ureteral stent via percutaneous approach, including radiological supervision and interpretation* (work RVU=5.00, 55 minutes intra-service) has more physician time and intensity than 5038X2. The specialty society indicated that the survey median RVU of 5.00 for 5038X2 was too high and recommend a building block approach to develop a recommended work RVU of 3.30.

The building block RVU is calculated by taking the reference service code's intra-service intensity measure of 0.07029, multiplied to the intra-service time of 30 minutes for 5038X2 (0.07 x 30 = 2.10). Then add the pre-service (25 minutes evaluation, 10 minutes positioning and 10 minutes scrub, dress, wait = 45 minutes) and post-service (15 minutes) RVUs (0.87+0.33) to intra service RVU (2.10) to establish a total work RVU of 3.30 for 5038X2.

Additional reference service codes with comparable physician intra-service time and work RVUs are 36581 *Replacement, complete, of a tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access* (RVU=3.45, 30 minutes intra-service) and 36590 *Removal of tunneled central venous access device, with subcutaneous port or pump, central or peripheral insertion* (RVU=3.32, 30 minutes intra-service). The RUC determined the aformentioned building block approach along with the additional reference services supported a work RVU of 3.30. **The RUC recommends a work RVU of 3.30 for code 5038X2.**

Practice Expense
The PERC and RUC reviewed and refined the joint specialty recommendation for the direct inputs for codes 5038X1 and 5038X2 during its February 2007 meeting. **The RUC recommends the attached direct practice expense inputs.**

Intra-Abdominal Voiding Pressure (Tab 8)
American Urological Association (AUA)

The CPT Editorial Panel changed CPT code, 51797, *Voiding pressure studies (VP); intra-abdominal voiding pressure (AP) (rectal, gastric, intraperitoneal)*, from a stand-alone service to an add-on service. The Panel agreed that the service should be an add-on service as it is virtually always performed with CPT code, 51795, *Voiding pressure studies (VP); bladder voiding pressure, any technique*, (work RVU = 1.53). The intra-abdominal voiding pressure is done after the bladder study during the same session and involves inserting a rectal catheter and performing an additional calculation.

The RUC considered the specialty society's recommendations for code 51797. While this service is currently valued at 1.60 work RVUs, when it is performed in combination with code 51795, the service is subject to the multiple procedure reduction of 50% and valued appropriately at 0.80 work RVUs (1.60 x 50% = 0.80). The specialty society has recommended a work RVU of 1.00 based on a survey of 32 urologists. The RUC has informed the specialty society that if it wishes to recommend a work RVU different than 0.80, it must provide compelling evidence to do so. The RUC has requested that the specialty provide its recommendation and rationale, including compelling evidence for a change, if warranted, at the April 2007 RUC meeting.

Vitrectomy with Epiretinal Membrane Stripping (Tab 9)
Stephen Kamenetzky, MD and Trex Topping, MD, American Academy of Ophthalmology (AAO)

CPT code 67038, *Vitrectomy, mechanical, pars plana approach; with epiretinal membrane stripping*, was identified by CMS in 2005 as a potentially mis-valued service and placed in the Five-Year Review. The code was referred to CPT for refinement because the code was being used to report several dinstinct procedures which had evolved over the past decade for treatment of retinal-vitreal disease. The CPT Editorial Panel deleted code 67038 and created four new codes to describe the work performed in code 67038. The new codes are:

- Code 6703X, V*itrectomy, mechanical, pars plana approach; with removal of preretinal cellular membrane (eg, macular pucker)*, which describes vitrectomy surgery to remove a cellular membrane from the anterior surface of the macula (center of the retina), e.g. macular pucker.
- Code 670X1, *Vitrectomy, mechanical, pars plana approach; with removal of internal limiting membrane of retina (eg, for repair of macular hole, diabetic macular edema), includes, if performed, intraocular tamponade (ie, air, gas or silicone oil)*, which describes vitrectomy with removal of the internal limiting membrane (non-cellular, very adherent and microscopically thin) from the surface of the macula requiring greater time

and skill and with considerable risk of damaging the macula. This procedure is performed for the repair of macular holes and for treatment of diabetic macular edema. This service may include the injection of therapeutic intraocular gas for macular hole repair.

- Code 670X2, V*itrectomy, mechanical, pars plana approach; with removal of subretinal membrane (eg, choroidal neovascularization), includes, if performed, intraocular tamponade (ie, air, gas or silicone oil) and laser photocoagulation,* which describes vitrectomy for the repair of complex retinal detachment combined with code 67108. The typical patient has proliferative vitreoretinopathy or diabetic traction producing a retinal detachment, which may be performed for management of a giant retinal tear.
- Code 6711X *Repair of complex retinal detachment (eg, proliferative vitreoretinopathy, stage C-1 or greater, diabetic traction retinal detachment, retinopathy of prematurity, retinal tear of > 90 degrees), with vitrectomy and membrane peeling, may include air, gas or silicone oil tamponade, cryotherapy, endolaser photocoagulation, drainage of subretinal fluid, scleral buckling, and/or removal of lens,* which describes vitrectomy with the removal of a neovascular membrane from the subretinal space. The procedure requires a vitrectomy and a retinotomy. Currently no single CPT procedure accurately describes the surgical repair of complex retinal detachment using this technique, so surgeons used codes 67038, (work RVU = 23.30) and 67108, *Repair of retinal detachment; with vitrectomy, any method, with or without air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique* (work RVU = 22.49). CMS has expressed concern that the combination of the retinal detachment repair and vitrectomy codes resulted, even with a multiple procedure modifier, in a total work RVU that was overvalued.

The RUC considered new code 6703X and discussed the survey results in comparison with the key reference service code, 67108, *Repair of retinal detachment; with vitrectomy, any method, with or without air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique*, (work RVU = 22.49, pre-service time = 65, intra-service time = 191, post-service time = 34). The reference service code has a significantly higher intra-service time as compared to the surveyed code, 191 minutes and 62.50 minutes, respectively. While the physician time differed, the RUC agreed that although the reference code has more time than the surveyed code, both codes have similar mental effort and judgment, identical psychological stress and increased technical skill and physical effort of the surveyed code made it a suitable reference service. Due to the difference in total time, the RUC agreed with the specialty society recommendation of 19.00 work RVUs. The RUC considered an additional reference service, 67218, *Destruction of localized lesion of retina (eg, macular*

edema, tumors), one or more sessions; radiation by implantation of source (includes removal of source) (work RVU = 20.22, intra-service time = 60 minutes). Additionally, the recommendation maintains appropriate rank order within the family of services. **The RUC recommends a work RVU of 19.00 pre-service time of 35 minutes, intra-service time of 62.50 minutes, and post-service time of 17.50 minutes for code 6703X.**

The RUC discussed new code 670X1 and reviewed the survey results in comparison with the key reference service code, 67108 *Repair of retinal detachment; with vitrectomy, any method, with or without air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique*, (work RVU = 22.49, pre-service time = 65, intra-service time = 191, post-service time = 34). The key reference service has significantly higher intra-service time than 670X1 survey results, 191 minutes and 85 minutes, respectively. However, the reference service code requires less technical skill, physical effort, and psychological stress. The RUC also noted that the use of vitreous substitute results in a 30 to 40 percent incidence of post-operative elevated intraocular pressure requiring treatment with topical and systemic medications, and in some instances code 65805, *Paracentesis of anterior chamber of eye (separate procedure); with therapeutic release of aqueous* (work RVU = 1.91) or code 67015, *Aspiration or release of vitreous, subretinal or choroidal fluid, pars plana approach (posterior sclerotomy)* (work RVU = 7.00) are required. Neither of these procedures related to the initial surgery, which are performed in the office and would be billable during the global period, but both have significant physician work associated with them. The reference service work RVU of 22.49 is significantly higher than the surveyed median, therefore the RUC agreed that the 25th percentile of the survey results was appropriate. **The RUC recommends a work RVU of 22.13, pre-service time of 35, intra-service time of 85, and post-service time of 15 for code 670X1.**

The RUC considered new code 670X2 and discussed the survey results in comparison with the key reference service code, 67108 *Repair of retinal detachment; with vitrectomy, any method, with or without air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique*, (work RVU = 22.49, pre-service time = 65, intra-service time = 191, post-service time = 34). The key reference service has contains more intra-service time than the surveyed code, 191 minutes and 90 minutes, respectively. However, because of the patient expectation of perfect vision, the surveyed code requires greater mental effort and judgment, technical skill, psychological stress, and intensity and complexity. The RUC agreed that the 25th percentile of the survey results was too low. Because the service is more complex and contains one additional post-operative visit than 670X1, which also relied on 67108 as the key reference service, the RUC added 0.94 RVUs to the survey median, commensurate with one 99213, to account for additional work and to maintain rank order within the family. **The RUC**

recommends a work RVU of 22.94, pre-service time of 35, intra-service time of 90, and post-service time of 20 for code 670X2.

The RUC discussed new code 6711X and reviewed the survey results in comparison with the key reference service code, 67108 *Repair of retinal detachment; with vitrectomy, any method, with or without air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique*, (work RVU = 22.49, pre-service time = 65, intra-service time = 191, post-service time = 34). This service is the most complex of the four codes in the series of vitrectomy procedures and is performed only by fellowship trained retina surgeons. Code 6711X combines pars plana vitrectomy with a number of other surgical procedures that may include scleral buckling, dissection of periretinal scar tissue, retinal repositioning, retinopexy with laser or cryopexy, cataract extraction and installation of a vitreous substitute, either an expansible gas or silicon oil. The survey found a median wRVU of 27.00 and a 25th percentile of 25.00. The median intra-service time was 130 minutes. All of the intensity complexity measures were higher than to perform this procedure than the surveyed reference code. The need for retinal tamponade with a vitreous substitute results in a 30% incidence of elevated intraocular pressure requiring treatment with topical and systemic medications or in some cases the in-office removal of fluid from the eye by paracentesis (65805) or by vitreous tap (67015). Neither of these procedures, would be billable during the global period, but both have significant physician work associated with them. Based on survey responses, seven 99213 post-operative visits are required. The surveyed code requires greater mental effort, judgment, technical skill, physical effort, and psychological stress than reference code 67108, which has a value of 22.49. As such, the RUC agreed that the 25th percentile of the survey results was appropriate. **The RUC recommends a work RVU of 25.00, pre-service time of 35, intra-service time of 130, and post-service time of 20 for code 6711X.**

The coding changes do not represent new work and the RUC sought to maintain work neutrality within the family. Therefore, the RUC reviewed an analysis of its recommended work RVUs and projected Medicare utilization to assure that the changes are work neutral.

Practice Expense
The RUC reviewed the practice expense and recommended the standard 090 day global inputs.

Retinopathy Treatment (Tab 10)
Stephen Kamenetzky, MD and Trex Topping, MD, American Academy of Ophthalmology (AAO)

CPT code 67228, *Treatment of extensive or progressive retinopathy; (eg, diabetic retinopathy), photocoagulation; single session,* was originally referred to the third Five-Year Review by CMS. At that time, the RUC referred the code to the CPT Editorial Panel for revisions because there were difficulties in reviewing the physician work due to a lack of uniformity between the vignette and the descriptor. It was unclear whether or not the work being described was for a single session or the typical number of treatments during the global period (between 2 and 3). The Panel removed the "one or more sessions" language, replaced it with "single session," and the specialty society recommended that the code be changed from a 90 day global to a 10 day global period. CMS did not approve a change in the global period. This action created difficulty in assessing whether the work within the code should include a single session or the typical multiple sessions. In addition to these changes, the Panel created one new code in the family, 6722X, *Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage, one or more sessions; photocoagulation (laser or xenon arc); preterm infant (less than 37 weeks gestation at birth), performed from birth up to 1 year of age (eg, retinopathy of prematurity), photocoagulation or cryotherapy, one or more sessions,* to describe retinopathy treatment in pre-term infants performed in the first year of life.

The specialty society noted that the changes to the global period were assumed within the vignette and description for the edits approved by the CPT Editorial Panel. However, they were not approved by CMS and the service remains a 90 global and accounts for only one procedure. The procedure is typically performed between two and three times, as reflected in the specialty society survey, with an average of 2.4. The survey respondents assumed the inclusion of multiple treatments when the code was surveyed and the recommended values are based on this assumption.

The RUC recommends that the CPT Editorial Panel remove "single session" from the CPT descriptor for code 67228. [Staff note: The CPT Editorial Panel accepted this recommendation at its February 2007 meeting.]

The RUC discussed the survey data for 67228 in comparison with the reference service code, 67145, *Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage, one or more sessions; photocoagulation (laser or xenon arc),* (work RVU = 6.17, pre-service time = 24, intra-service time = 25, post-service time = 11). The reference service is considerably lower in nearly every measure of intensity and complexity for the pre-, intra-, and post-service periods. The surveyed code requires greater mental effort, complexity, technical skill, physical effort, and risk than the reference service. The reference service which has a work RVU of 6.17, when multiplied by 2.4 is 14.81, which is very

similar to the current work RVU of 13.76. Based on the similarity to the reference service and the average of 2.4 treatments within the global period, the RUC recommends maintaining the current work RVU of 13.76, which includes the updates to the E/M services inherent in the global period of the procedure. Further the RUC recommends adjusting the mean pre-, intra-, and post-service physician times by 2.4 times the median survey times to appropriately account for the performing the procedure 2.4 times. **The RUC recommends a work RVU of 13.67, pre-service time of 48 minutes, intra-service time of 60 minutes, and post-service time of 12 minutes for 67228.**

The RUC considered the specialty society survey data for code 6722X, *Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage, one or more sessions; photocoagulation (laser or xenon arc); preterm infant (less than 37 weeks gestation at birth), performed from birth up to 1 year of age (eg, retinopathy of prematurity), photocoagulation or cryotherapy, one or more sessions* and agreed that the median work RVU was appropriate when compared to the reference service code 67145, *Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage, one or more sessions; photocoagulation (laser or xenon arc),* (work RVU = 6.17). The RUC agreed that the work involved in code 6722X is far more intense and complex than the reference service. The intra-service time is exactly three times that of 67145, and the RUC concurred that the median work RVU of 16.00 is appropriate as it is slightly less than three times the reference service work RVU of 6.17. The RUC also discussed the service in comparison with 67107, *Repair of retinal detachment; scleral buckling (such as lamellar scleral dissection, imbrication or encircling procedure), with or without implant, with or without cryotherapy, photocoagulation, and drainage of subretinal fluid* (work RVU = 16.35), which was the second most commonly selected reference service from the survey results. The intra-service time is slightly greater in the reference service than the surveyed code, 107 minutes and 75 minutes, respectively. However, the surveyed code is more extensive and carries a greater risk of unfavorable visual outcome. The RUC considered one additional reference service, code 65782, Ocular surface reconstruction; limbal conjunctival autograft (includes obtaining graft) (work RVU = 15.16), but has a far more similar intraservice time, 83 minutes. **The RUC recommends a work RVU of 16.00, pre-service time of 45 minutes, intra-service time of 75 minutes, and post-service time of 17.50 minutes for code 6722X.**

Practice Expense

The RUC accepted the practice expense inputs as amended by the PERC and as adjusted for the change in intra-service time for 67228.

Brain and Cerebrospinal Fluid Imaging (Tab 11)
American College of Radiology (ACR), Society of Nuclear Medicine (SIR)

The CPT Editorial Panel edited the Nervous System Section, CPT codes 78600-78699, to provide a clearer description of the services describing the number of views captured in various brain imaging services based on current medical practice. The CPT Editorial Panel edited five codes and deleted one code. The CPT Editorial Panel made editorial changes to the descriptors, which did not impact the physician work, however the specialty society recommended edits to the practice expense inputs.

Practice Expense:
The RUC recommends modifications to the practice expense for CPT codes 78600 *Brain imaging, less than four static views*, 78606 *Brain imaging, minimum four static views; with vascular flow* and 78610 *Brain imaging, vascular flow only*. After review of the number of films for the following brain imaging procedures, the RUC recommends the following changes to the direct practice expense inputs:

CPT 78600 reduce the number of films and developer from (2) in to (1)
CPT 78606 reduce the number of films and developer from currently listed (4) to (2)
CPT 78610 reduce the number of films and developer from currently listed (2) to (1)

All other practice expense inputs for this family of codes are consistent with the revised descriptors.

The rationale for these changes is:
- Less than or greater than four views would require (1) one film and developer
- Adding flow to images requires one additional film and developer and is consistent with other nuclear medicine SPECT single study procedures where two (2) films and developer are required.

Manual Microdisection (Tab 12)
Jonathan L. Myles, MD and Mahesh Mansukhani, MD, College of American Pathology (CAP)

The CPT Editorial Panel created two new codes to differentiate manual and laser microdissection, which was previously captured in one microdissection code, regardless of the method used.

The RUC reviewed the survey data for codes 8838X1 *Microdissection (ie, sample preparation of microscopically identified target); manual* and 8838X2 *Microdissection (ie, sample preparation of microscopically identified target); laser capture* and determined that the median work relative value units and

physician times were appropriate. The RUC compared code 8838X1 to the survey reference code 88360 *Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; manual* (RVU= 1.10, intra-service time = 35 minutes) and determined that the physician work involved, the intensity and complexity, technical skill and physical effort was slightly higher to perform 8828X1 compared to the reference service. Code 8838X1 is more intense than the reference service due to the precise dissection of tissue required and the avoidance of contamination with other DNA during dissection. Additionally, the RUC determined that although the intra-service time is slightly lower for 8838X1 compared to the reference service, the intensity and complexity of the dissection involved in the procedure is higher. The RUC recommends an intra-service time of 30 minutes for code 8838X1. **The RUC recommends a work RVU of 1.18 for code 8838X1.**

The RUC compared code 8838X2 to the survey reference code 88368 *Morphometric analysis, in situ hybridization, (quantitative or semi-quantitative) each probe; manual* (work RVU=1.40, intra-service time = 45 minutes) and determined that the physician work involved, the intensity and complexity, technical skill and physical effort was slightly higher to perform 8828X2 compared to the reference service because the laser capture requires more precision than manual microdissection. Additionally, the RUC determined that the survey median intra-service time of 45 minutes is the same as reference code 88368 and is comparably appropriate for code 8838X2. Although the intra-service times for 8838X2 and 88368 are identical, the intensity and complexity, mental effort and judgment and technical skill involved to perform the precise dissection of 8838X2 is higher. Therefore the RUC recommends a slightly higher work RVU for code 8838X2. **The RUC recommends a work RVU of 1.56 for code 8838X2.**

Practice Expense
The RUC reviewed the direct practice expense inputs for these codes and made minor modifications to the clinical labor time for the lab tech and histotech, the number of sterile gloves used and equipment utilized. The final direct practice inputs are attached to this recommendation.

New Technology
Codes 8838X1 and 8838X2 represent new technology and the RUC agreed that these codes should be placed on the new technology list to review potential changes in its valuation. **The RUC recommends that codes 8838X1 and 8838X2 be added to the list of new technology codes.**

Electronic Analysis of Implanted Neurostimulator Pulse Generator System (Tab 13)
American College of Gastroenterology (ACG), American Gastroenterological Association (AGA), American Motility Society (AMS), American Society of Gastrointestinal Endoscopy (ASGE)

The specialties requested that this issue be deferred until the April 2007 RUC meeting.

Initial Day Hospital Neonate Care (Tab 14)
Steve Krug, MD, FAAP, Gil Martin, MD, FAAP, and Rich Molteni, MD, FAAP, American Academy of Pediatrics (AAP)

The CPT Editorial Panel created a new inpatient neonate code, 99477X *Initial hospital care, per day, for the evaluation and management of the neonate, 28 days of age or less, who requires intensive observation, frequent interventions, and other intensive care services* to describe the initial day hospital evaluation and management services provided to a sick newborn patient (28 days or less) who requires intensive observation and monitoring, but is not a normal newborn nor meets the CPT definition of critically ill newborn.

The RUC reviewed code 99477X and determined that the survey median work RVU of 7.00 and physician times of 30 minutes pre-service, 77.50 minutes intra-service and 40 minutes post-service were reflect the accurate time spent by the physician. The RUC examined the reference code 99255 *Inpatient consultation for a new or established patient* (work RVU=4.00, physician times = 30 pre, 60 intra, and 25 post) and determined that this reference was appropriate as it was the reference code with the highest RVU and closest comparison offered on the reference service list. The RUC further examined procedures frequently performed during this initial day hospital neonate care service and used a building block analysis to support the survey median of 7.00 RVUs. By adding the reference service code 99255 work RVUs (4.00) and the increments of work for the procedures usually performed in 99477X (2.73, as shown in the calculation below) the total work RVU (6.73) is relative to the survey median 7.00 for 99477X. The RUC clarified that typically there are no other services reported with 99477X.

Procedures usually performed within 99477X are:
62270 *Spinal puncture, lumbar, diagnostic*
36510 *Catheterization of umbilical vein for diagnosis or therapy, newborn*
36600 *Arterial puncture, withdrawal of blood for diagnosis*
51000 *Aspiration of bladder by needle*
43752 *Naso- or oro-gastric tube placement, requiring physician's skill and fluoroscopic guidance (includes fluoroscopy, image documentation and report)*

90744 *Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug*

The RUC recommends a work RVU of 7.00 for 99477X.

Building Block Analysis for 99477X

Code	*Pre-Service Time*	*Intra-Service Time*	*Post-Service Time*	*Total Time*	*RVW*	*Total IWPUT*	*Intra-Service IWPUT*
62270	15.00	20.00	10.00	45.00	1.37	0.0405	0.8100
36510	12.00	20.00	10.00	42.00	1.09	0.0299	0.5972
36600	0.00	8.00	0.00	8.00	0.32	0.0400	0.3200
51000	10.00	13.00	10.00	33.00	0.77	0.0248	0.3220
43752	5.00	20.00	5.00	30.00	0.81	0.0293	0.5860
90774	2.00	5.00	2.00	9.00	0.18	0.0181	0.0904
						Total	2.7256

99255 (4.00) + 2.7256 = 6.73

Practice Expense
The RUC recommends no direct practice expense inputs for code 99477X because this service is typically performed in the facility setting.

Team Conference (Tab 15)
American Academy of Child and Adolescent Psychiatry (AACAP), American Academy of Pediatric (AAP), American Academy of Physical Medicine and Rehabilitation (AAPMR),American Psychiatry Association (APA), American Geriatrics Society (AGS)

The specialties requested that this issue be deferred until the April 2007 RUC meeting.

Non Face-to-Face Services (Tab 16)
Lee Mills, MD, American Academy of Family Physicians (AAFP), Charles Scott, MD, American Academy of Pediatrics (AAP), Eileen Moynihan, MD, American College of Rheumatology (ACRh), and Robert Stomel, DO, American Osteopathic Association (AOA)

The CPT Editorial Panel created four new codes describing Evaluation and Management services performed by a physician via telephone or on-line. Typically these calls involve the physician obtaining a history of the patient, assessing the patient's condition, making a medical decision and communicating that decision via the phone/e-mail to the patient. Over the last two decades

medicine has seen the rapid increase of medical information and communications technology. Combined with changing consumer and health plan expectations for enhanced access to care, a new focus on chronic disease management and continued pressure to reduce the codes of medical services, physicians are providing more care to patients in a "non-face-to-face" manner. Additionally, these services describe physician work that is currently not captured in any other CPT codes.

The RUC reviewed the specialty societies survey results for codes 993XX1-993XX4 *Telephone and Online Evaluation and Management services.* These services are performed by a physicians from various specialties. Therefore, seven different specialties were involved in surveying these services to appropriately capture the typical physician time and work involved. Approximately 500 physicians completed the surveys for 993XX1-993XX3, with median annual service performance rates of 190, 100, and 35, respectively. Additionally, 150 physicians completed the survey for code 993XX4 *Online Evaluation and Management,* indicating a median annual performance rate of 10.

993XX1

The RUC reviewed the specialty societies survey results for code 993XX1 *Telephone Evaluation and Management, 5-10 minutes of medical discussion* and thoroughly discussed the physician time and work involved in this service. The RUC determined that the physician time for 993XX1 was slightly lower than the survey reference service code 99212 *Office or other outpatient visit for the Evaluation and Management of an established patient* (RVU = 0.45, 2 minutes pre-, 10 minutes intra-, and 4 minutes post-service time). The presenting specialty societies and the RUC agreed that the physician work for code 993XX1 should be lower than the survey reference code 99212 but slightly higher than 99211 *Office or other outpatient visit for the Evaluation and Management of an established patient, that may not require the presence of a physician* (RVU=0.17, 5 minutes intra-service and 2 minutes post-service time). The RUC determined that using a magnitude estimation of 150% of the work RVUs for code 99211 would appropriately place 993XX1 in the proper rank order within the Evaluation and Management services family (0.17 x 150% = 0.25**). The RUC recommends a work RVU of 0.25 for code 993XX1. The RUC recommends 1 minute pre-service, 8 minutes intra-service and 4 minutes post-service time for code 993XX1.**

993XX2 and 993XX3

The RUC reviewed the specialty societies survey results for codes 993XX2 *Telephone Evaluation and Management, 11-20 minutes of medical discussion* and 993XX3 *Telephone Evaluation and Management, 21-30 minutes of medical discussion* and thoroughly discussed the physician time and work involved in these services. The RUC determined that the RVU presented by the specialty societies for 993XX2, the 25th percentile work relative value of 0.60, was slightly high in relation to the RUC recommended value for 993XX1 (0.25 RVUs). The

presenting specialty societies and the RUC agreed using a magnitude estimation for 993XX2 and 993XX3 would be appropriate to properly values these services within the Evaluation and Management family of services. The RUC determined that 993XX2 would be twice the recommended value for 993XX1 (0.25 x 2 = 0.50). Additionally, the RUC determined that 993XX3 would be three times the recommended value for 993XX1 (0.25 x 3 = 0.75). **The RUC recommends a work RVU of 0.50 for code 993XX2 and 1 minute pre-service, 15 minutes intra-service and 5 minutes post-service physician time. The RUC recommends a work RVU of 0.75 for code 993XX3 and 1 minute pre-service, 20 minutes intra-service and 10 minutes post-service physician time.**

993XX4

The RUC discussed code 993XX4 *Online Evaluation and Management* and concluded that the definition of work and physician time and complexity involved in this service were unclear, therefore making it difficult to recommend a specific work relative value. The specialty societies agreed and recommended that code 993XX4 be carrier-priced. The specialty societies indicated that they will bring this code back to CPT in order to develop a clearer definition of this service. **The RUC recommends that code 993XX4 be carrier-priced for CY 2008.**

Practice Expense

The PERC and RUC reviewed the direct practice expenses for 993XX1-993XX3 and slightly modified the conduct phone calls/call in prescriptions by the RN/LPN/MTA from 4 to 3 minutes and "other clinical activity" to zero. The presumption was that the typical service would include the clinical staff calling in a prescription. **The RUC recommends the modified practice expense as attached.**

New Technology and New Physician Work

The RUC recommends that codes 993XX1-993XX3 be added to the new technology list to review potential changes in valuation after experience in reporting of these services has occurred. Additionally, the RUC recommends that these services involve new physician work not currently compensated within the physician payment system.

X. Relative Value Recommendations for Five-Year Review

<u>Partial Mastectomy (Tab 17)</u>

Charles Mabry, MD, FACS, American College of Surgeons (ACS), Eric Whitacre, MD, FACS, American Society of Breast Surgeons (ASBS), and Christopher Senkowski, MD, FACP, ACP

As part of the 2005 Five Year Review, CPT code 19303 *Mastectomy, simple, complete* (renumbered from 19180) (Work RVU=15.67) was reviewed. CMS in the *Final Rule* published on December 1, 2006, stated that the new value for 19303

would create a rank order anomaly with CPT code 19301 *Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy* (renumbered from 19160) as 19301 was not part of the 2005 Five Year Review. Therefore, CMS requested that this code be reviewed by the RUC.

The RUC reviewed this historical valuation of 19301 and believed that the compelling evidence presented by the specialty society was sufficient as this code was based on the original Harvard data and in the past five years there has been changes in the patient population and in the technology used to perform this procedure. The RUC agreed that a rank order anomaly was created when 19303 was reviewed without review of 19301.

The RUC reviewed the survey data for 19301 and compared it to the reference service code 19303 *Mastectomy, simple, complete* (Work RVU=15.67). The specialty society explained that the survey respondents overstated the pre-service time and recommend 55 minutes of pre-service time which is slightly less than the pre-service time associated with the reference code, 19303 (60 minutes). The RUC reviewed the intra-service time for 19301 and noted that the intra-service time for 19303 was greater, 60 minutes and 90 minutes, respectively. The RUC reviewed the intensity/complexity measures for both codes and determined that 19301 requires more mental effort and judgment and greater technical skill than the reference code. Therefore, the RUC determined that although the pre-service and intra-service times were lower for the surveyed code, the intensity/complexity measures were greater. The appropriate value for 19301 is the 25th percentile of the survey data, 10.00 RVUs. The RUC believes this value appropriately places 19301 in relation to 19303. **The RUC recommends 10.00 work RVUs for 19301.**

Anoscopy and Proctosigmoidoscopy (Tab 18)

Guy Orangio, MD, FACS, American Society of Colon and Rectal Surgeons (ACRS) and Charles Mabry, MD, FACS American College of Surgeons (ACS)

In CMS' *Proposed Rule* published on June 29, 2006, responding to the RUC recommendations made for the Five-Year Review, CMS proposed to maintain the current work RVUs for the proctoscopy-anoscopy families of codes 45300-45327 and 46600-46615 because the method used by the RUC to develop work RVUs for these services was flawed and that the calculation of the recommended work RVUs depended solely on applying workgroup-derived IWPUT to the surveyed physician time from surveys that were considered otherwise unusable. CMS indicated that it would be willing to consider recommendations generated from a survey process and reviewed by the RUC.

The RUC believed that the compelling evidence presented by the specialty society was sufficient and agreed that these services have values that were based on incorrect assumptions as there was some confusion regarding data for 45300 during

the Harvard study. At the time of the study, there were two codes surveyed 45300 and 45302, which were changed at CPT to one code before the implementation of the Medicare Fee schedule. Specifically, code 45300 was surveyed as "rigid sigmoidoscopy without biopsy, in office" and code 45302 was surveyed as "proctosigmoidoscopy, collect specimen brush/wash." Prior to the implementation of the Fee Schedule, these codes were combined to one code and it appears that the Harvard "total work" value for 45300 was reduced by 50%. The specialty society believes that is is possible that rather than adding the work for the two codes and dividing by two, the work for the original code was simply divided in half. Furthermore, the RUC agreed that the previous evaluation of these procedures was conducted by a specialty who is no longer the dominant provider of that service. The RUC noted that Harvard surveyed gastroenterologists for all anoscopy and proctosigmoidscopy codes, however, in current practice colon and rectal surgeons and general surgeons are the primary providers for these procedures.

The specialty society followed CMS' instructions and established two anchor codes in the anoscopy family (46600 *Anoscopy; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* and 46606 *Anoscopy; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure); with biopsy, single or multiple)* and two codes in the proctosigmoidoscopy family (45300 *Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* and 45305 *Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure); with biopsy, single or multiple*. The specialty society utilized mini-surveys to develop their recommendations for the remainder of the codes in each family as these procedures have low utilization. Further, it should be noted that for the majority of these codes the RUC accepted the median RVU of the survey data and for a few of the services, the RUC accepted the 25th percentile RVU of the survey data.

Proctosigmoidoscopy:
45300 *Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)*

For the first anchor code in the proctosigmoidoscopy family, the RUC reviewed the full survey data for 45300 and compared it to its reference service 45330 *Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* (work RVU=0.96). The specialty society explained that the survey respondents overstated the pre-service time associated with this procedure as it is typically performed in the office setting and recommend 7 minutes of pre-service time which is the same amount of pre-service time associated with the reference code. The RUC reviewed the intra-service time for 45300 and determined that the reference code 45330 had significantly more intra-service time associated with it, 10 minutes and 17 minutes respectively. The RUC reviewed the intensity and complexity measures associated with the surveyed and the reference code and determined that 45330 required significantly more

technical skill and physical effort and was deemed to be a more intense procedure to perform than 45300. Therefore, the RUC determined that because of the lower amount of total service time and the lower intensity complexity measures of the surveyed code as compared to the reference code, the appropriate value for 45300 would be the 25th percentile of the survey data, 0.80 RVUs. The RUC believes this value appropriately places it in relation to 45330. **The RUC recommends 0.80 work RVUs for 45300.**

45305 ***Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure); with biopsy, single or multiple***

For the second anchor code in the proctosigmoidoscopy family, the RUC reviewed the full survey data for 45305 and compared it to its reference service 45330 *Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* (work RVU=0.96). The specialty society explained that the survey respondents overestimated the pre-service time associated with this procedure and recommend 25 minutes of pre-service time which is consistent with standard pre-service times being developed by the RUC for outpatient procedures performed in a facility under anesthesia. This is different than the pre-service time associated with the base code (7 minutes), which is an office based procedure associated with an E/M service, where brief additional time (after the E/M service) is required for positioning and a brief explanation of the procedure. These times are also consistent with standard pre-service times being devleoped by the RUC. The RUC reviewed the total service time for 45305 and determined that the reference code 45330 had significantly less total service time associated with it, 45 minutes and 32 minutes respectively. The RUC reviewed the intensity and complexity measures for both codes and determined that 45305 required significantly more mental effort and judgment and was deemed to be a more intense procedure to perform than 45330. Therefore, the RUC determined that because of the higher amount of total service time and the higher intensity complexity measures of the surveyed code as compared to the reference code, the appropriate value for 45300 would be the median value of the survey data, 1.25 work RVUs. The RUC believes this value appropriately places it in relation to 45330. **The RUC recommends 1.25 work RVUs for 45305.**

45303 ***Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure); with dilation (eg, balloon, guide wire, bougie)***

The RUC reviewed the mini-survey data for 45303 and compared it to the two anchor codes 45300 and 45305. The specialty society explained that the survey respondents overestimated the pre-service time associated with this procedure and recommend 25 minutes of pre-service time which is the same amount of pre-service time associated with the 45305. In addition, the intra-service time for this procedure (15 minutes) has 5 additional minutes associated with it as compared to

both 45300 and 45305 (10 minutes for both procedures). The post-service time is the same for all three codes, 10 minutes. The intensity of 45303 (Recommended IWPUT=0.053) is higher than the intensity of 45300 (Recommended IWPUT=0.042) and comparable to the intensity of 45305 (Recommended IWPUT=0.054). Therefore, due to the longer intra-service time of the surveyed code in comparison to the intra-service times of 45300 and 45305 time and comparable intensity of the surveyed code to 45305, the RUC determined the appropriate value of this code to be the median value of the survey data, 1.50 work RVUs. The RUC believes this value appropriately place this procedure in relation to the anchor codes 45300 and 45305. **The RUC recommends 1.50 RVUs to 45303.**

45307 ***Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure); with removal of foreign body***

The RUC reviewed the mini-survey data for 45307 and compared it to the two anchor codes 45300 and 45305. The specialty society explained that the survey respondents overestimated the pre-service time associated with this procedure and recommend 25 minutes of pre-service time which is the same amount of pre-service time associated with the 45305. In addition, the intra-service time for this procedure (15 minutes) has 5 additional minutes associated with it as compared to both 45300 and 45305 (10 minutes for both procedures). The post-service time is the same for all three codes, 10 minutes. The intensity of 45307 (Recommended IWPUT=0.066) is higher than the intensity of 45300 (Recommended IWPUT=0.042) and the intensity of 45305 (Recommended IWPUT=0.054). Therefore, due to the longer intra-service time and the higher intensity of the surveyed code in comparison to 45300 and 45305 time, the RUC determined the appropriate value of this code to be the median value of the survey data, 1.70 RVUs. The RUC believes this value appropriately place this procedure in relation to the anchor codes 45300 and 45305. **The RUC recommends 1.70 RVUs to 45307.**

45308 ***Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure); with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery***

The RUC reviewed the mini-survey data for 45308 and compared it to the two anchor codes 45300 and 45305. The specialty society explained that the survey respondents overestimated the pre-service time associated with this procedure and recommend 25 minutes of pre-service time which is the same amount of pre-service time associated with the 45305. In addition, the intra-service time for this procedure (15 minutes) has 5 additional minutes associated with it as compared to both 45300 and 45305 (10 minutes for both procedures). The post-service time is the same for all three codes, 10 minutes. The intensity of 45308 (Recommended IWPUT=0.046) is higher than the intensity of 45300 (Recommended

IWPUT=0.042) and lower than the intensity of 45305 (Recommended IWPUT=0.054). Therefore, due to the longer intra-service time of the surveyed code in comparison to the intra-service times of 45300 and 45305 time and the higher intensity of the surveyed code as compared to the 45300, the RUC determined the appropriate value of this code to be the median value of the survey data, 1.40 RVUs. The RUC believes this value appropriately place this procedure in relation to the anchor codes 45300 and 45305. **The RUC recommends 1.40 RVUs to 45308.**

45309 ***Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure); with removal of single tumor, polyp, or other lesion by snare technique***

The RUC reviewed the mini-survey data for 45309 and compared it to the two anchor codes 45300 and 45305. The specialty society explained that the survey respondents overestimated the pre-service time associated with this procedure and recommend 25 minutes of pre-service time which is the same amount of pre-service time associated with the 45305. In addition, the intra-service time for this procedure (15 minutes) has 5 additional minutes associated with it as compared to both 45300 and 45305 (10 minutes for both procedures). The post-service time is the same for all three codes, 10 minutes. The intensity of 45309 (Recommended IWPUT=0.053) is higher than the intensity of 45300 (Recommended IWPUT=0.042) and comparable to the intensity of 45305 (Recommended IWPUT=0.054). Therefore, due to the longer intra-service time of the surveyed code in comparison to the intra-service times of 45300 and 45305 time and comparable intensity of the surveyed code to 45305, the RUC determined the appropriate value of this code to be the median value of the survey data, 1.50 RVUs. The RUC believes this value appropriately place this procedure in relation to the anchor codes 45300 and 45305. **The RUC recommends 1.50 RVUs to 45309.**

45315 ***Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure); with removal of multiple tumors, polyps, or other lesions by hot biopsy forceps, bipolar cautery or snare technique***

The RUC reviewed the mini-survey data for 45315 and compared it to the two anchor codes 45300 and 45305. The specialty society explained that the survey respondents overestimated the pre-service time associated with this procedure and recommend 25 minutes of pre-service time which is the same amount of pre-service time associated with the 45305. In addition, the intra-service time for this procedure (20 minutes) has 10 additional minutes associated with it as compared to both 45300 and 45305 (10 minutes for both procedures). The post-service time is the same for all three codes, 10 minutes. The intensity of 45315 (Recommended IWPUT=0.054) is higher than the intensity of 45300 (Recommended IWPUT=0.042) and has the same intensity as 45305 (Recommended

IWPUT=0.054). Therefore, due to the longer intra-service time of the surveyed code in comparison to the intra-service times of 45300 and 45305 time and the same intensity as the intensity associated with 45305, the RUC determined the appropriate value of this code to be the median value of the survey data, 1.80 RVUs. The RUC believes this value appropriately place this procedure in relation to the anchor codes 45300 and 45305. **The RUC recommends 1.80 RVUs to 45315.**

45317 ***Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure); with control of bleeding (eg, injection bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)***

The RUC reviewed the mini-survey data for 45317 and compared it to the two anchor codes 45300 and 45305. The intra-service time for this procedure (20 minutes) has 10 additional minutes associated with it as compared to both 45300 and 45305 (10 minutes for both procedures). The post-service time is the same for all three codes, 10 minutes. The intensity of 45317 (Recommended IWPUT=0.064) is higher than the intensity of 45300 (Recommended IWPUT=0.042) and the intensity of 45305 (Recommended IWPUT=0.054). Therefore, due to the longer intra-service time of the surveyed code in comparison to the intra-service times of 45300 and 45305 time and the higher intensity of the surveyed code as compared to 45305 and 45300, the RUC determined the appropriate value of this code to be the median value of the survey data, 2.00 RVUs. The RUC believes this value appropriately place this procedure in relation to the anchor codes 45300 and 45305. **The RUC recommends 2.00 RVUs to 45317.**

45320 ***Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure); with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique (eg, laser)***

The RUC reviewed the mini-survey data for 45320 and compared it to the two anchor codes 45300 and 45305. The specialty society explained that the survey respondents overestimated the pre-service time associated with this procedure and recommend 25 minutes of pre-service time which is the same amount of pre-service time associated with the 45305. In addition, the intra-service time for this procedure (23 minutes) has 13 additional minutes associated with it as compared to both 45300 and 45305 (10 minutes for both procedures). The post-service time is the same for all three codes, 10 minutes. The intensity of 45320 (Recommended IWPUT=0.047) is higher than the intensity of 45300 (Recommended IWPUT=0.042) and lower than the intensity of 45305 (Recommended IWPUT=0.054). Therefore, due to the longer intra-service time of the surveyed code in comparison to the intra-service times of 45300 and 45305 time and the higher intensity of the surveyed code as compared to the 45300, the RUC

determined the appropriate value of this code to be the median value of the survey data, 1.78 RVUs. The RUC believes this value appropriately place this procedure in relation to the anchor codes 45300 and 45305. **The RUC recommends 1.78 RVUs to 45320.**

45321 ***Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure); with decompression of volvulus***

The RUC reviewed the mini-survey data for 45321 and compared it to the two anchor codes 45300 and 45305. The specialty society explained that the survey respondents overestimated the pre-service time associated with this procedure and recommend 20 minutes of pre-service time. As this procedure is deemed to be emergent, there would be less pre-service time associated with it. The intra-service time for this procedure (20 minutes) has 10 additional minutes associated with it as compared to both 45300 and 45305 (10 minutes for both procedures). The post-service time is the same for all three codes, 10 minutes. The intensity of 45321 (Recommended IWPUT=0.057) is higher than the intensity of 45300 (Recommended IWPUT=0.042) and the intensity of 45305 (Recommended IWPUT=0.054). Therefore, due to the longer intra-service time of the surveyed code in comparison to the intra-service times of 45300 and 45305 time and the higher intensity of the surveyed code as compared to 45305 and 45300, the RUC determined the appropriate value of this code to be the median value of the survey data, 1.75 RVUs. The RUC believes this value appropriately place this procedure in relation to the anchor codes 45300 and 45305. **The RUC recommends 1.75 RVUs to 45321.**

45327 ***Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure); with transendoscopic stent placement (includes predilation)***

The RUC reviewed the mini-survey data for 45327 and compared it to the two anchor codes 45300 and 45305. The specialty society explained that the survey respondents overestimated the pre-service time associated with this procedure and recommend 20 minutes of pre-service time. As this procedure is deemed to be emergent, there would be less pre-service time associated with it. In addition, the intra-service time for this procedure (28 minutes) has 18 additional minutes associated with it as compared to both 45300 and 45305 (10 minutes for both procedures). The intensity of 45327 (Recommended IWPUT=0.049) is higher than the intensity of 45300 (Recommended IWPUT=0.042) and lower than the intensity of 45305 (Recommended IWPUT=0.054). Therefore, due to the longer intra-service time of the surveyed code in comparison to the intra-service times of 45300 and 45305 time and the higher intensity of the surveyed code as compared to the 45300, the RUC determined the appropriate value of this code to be the median value of the survey data, 2.00 RVUs. The RUC believes this value appropriately

place this procedure in relation to the anchor codes 45300 and 45305. **The RUC recommends 2.00 RVUs to 45327.**

Anoscopy:
46600 ***Anoscopy; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)***

For the first anchor code in the anoscopy family, the RUC reviewed the full survey data for 46600 and compared it to its reference service 99212 *Office or other outpatient visit for the evaluation and management of an established patient*, (work RVU=0.45). The specialty society explained that the survey respondents overstated the pre-service time associated with this procedure as it is typically performed in the office setting and recommend 7 minutes of pre-service time which is the same amount of pre-service time currently associated with this procedure. The RUC reviewed the intra-service times for 46600 and the reference code 99212 and determined that 99212 had twice the amount of intra-service time associated with it, 5 and 10 minutes, respectively. However, due to the increased amount of post-operative activities including the discussion with the patient about the procedure's outcome and future plans for diet and activities, there is more post-operative time associated with the surveyed code in comparison to the reference code, 10 and 4 minutes, respectively. The RUC reviewed the intensity and complexity measures for both codes and determined that 46600 required significantly more technical skill and physical effort than 99212. Therefore, the RUC determined that because of the higher amount of total service time and the higher intensity complexity measures of the surveyed code as compared to the reference code, the appropriate value for 46600 would be the 25th percentile of the survey data, 0.55 RVUs. The RUC believes this value appropriately places it in relation to 99212. **The RUC recommends 0.55 work RVUs for 46600.**

46606 ***Anoscopy; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure); with biopsy, single or multiple***

For the second anchor code in the anoscopy family, the RUC reviewed the full survey data for 46606 and compared it to its reference service 99203 *Office or other outpatient visit for the evaluation and management of a new patient*, (work RVU=1.34). The RUC reviewed the intra service times for 46606 and the reference code 99203 and determined that the surveyed code has significantly less time associated with it as compared to the reference code, 11 and 20 minutes, respectively. The RUC reviewed the intensity and complexity measures for both codes and determined that they were very similar. Therefore, the RUC determined that because of the lower amount of total service time of the surveyd code as compared to the reference code and the similar intensity complexity measures of the surveyed code and the reference code, the appropriate value for 46606 would be the median value of the survey data, 1.20 RVUs. The RUC believes this value appropriately places it in relation to 99203. **The RUC recommends 1.20 work RVUs for 46606.**

46604 ***Anoscopy; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure); with dilation (eg, balloon, guide wire, bougie)***

The RUC reviewed the mini-survey data for 46604 and compared it to the two anchor codes 46600 and 46606. The specialty society explained that as this procedure is primarily performed in the office setting that the survey respondents overestimated the pre-service time associated with this procedure. To account for this site of service, the RUC agreed with the specialty's recommendation that 8 minutes should be removed from the pre-service evaluation survey data time and 5 minutes should be removed from the scrub, dress and wait time. This adjustment in pre-service time results in 7 minutes of evaluation time, 5 minutes of positioning and no time for scrub, dress and waiting. The RUC believed that this difference in the pre-service time should be reflected in the work RVU for this procedure.

8 x 0.0224 = 0.1792
5 x 0.0081 = 0.0405
0.2197 ~ 0.22 RVUs

In addition, the intra-service time for this procedure (12 minutes) has more time associated with it as compared to 46600 (5 minutes) and 46606 (11 minutes). The post-service time is the same for all three codes, 10 minutes. The intensity of 46604 (Recommended IWPUT=0.045) is higher than the intensity of 46600 (Recommended IWPUT=0.034) and has comparable intensity as 46606 (Recommended IWPUT=0.044). Therefore, due to the longer intra-service time of the surveyed code in comparison to the intra-service times of 46600 and 46606 and the comparable intensity as the intensity associated with 46606, the RUC determined the appropriate value of this code to be the median value of the survey data (1.25 RVUs) minus the work associated with the time removed from the pre-service period (0.22 RVUs), resulting in 1.03 RVUs. The RUC believes this value appropriately places this procedure in relation to the anchor codes 46600 and 46606. **The RUC recommends 1.03 RVUs to 46604.**

46608 ***Anoscopy; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure); with removal of foreign body***

The RUC reviewed the mini-survey data for 46608 and compared it to the two anchor codes 46600 and 46606. The intra-service time for this procedure (15 minutes) has more time associated with it as compared to the intra-service times of both 46600 and 46606 (5 minutes and 11 minutes, respectively). The post-service time is the same for all three codes, 10 minutes. The intensity of 46608 (Recommended IWPUT=0.039) is higher than the intensity of 46600 (Recommended IWPUT=0.034) and lower than the intensity of 46606 (Recommended IWPUT=0.044). Therefore, due to the longer intra-service time of the surveyed code in comparison to the intra-service times of 46600 and 46606 and

the higher intensity of the surveyed code as compared to the 46600, the RUC determined the appropriate value of this code to be the median value of the survey data, 1.30 RVUs. The RUC believes this value appropriately place this procedure in relation to the anchor codes 46600 and 46606. **The RUC recommends 1.30 RVUs to 46608.**

46610 ***Anoscopy; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure); with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery***

The RUC reviewed the mini-survey data for 46610 and compared it to the two anchor codes 46600 and 46606. The intra-service time for this procedure (15 minutes) has more time associated with it as compared to the intra-service times of both 46600 and 46606 (5 minutes and 11 minutes, respectively). The post-service time is the same for all three codes, 10 minutes. The intensity of 46608 (Recommended IWPUT=0.038) is higher than the intensity of 46600 (Recommended IWPUT=0.034) and lower than the intensity of 46606 (Recommended IWPUT=0.044). Therefore, due to the longer intra-service time of the surveyed code in comparison to the intra-service times of 46600 and 46606 and the higher intensity of the surveyed code as compared to the 46600, the RUC determined the appropriate value of this code to be the median value of the survey data, 1.28 RVUs. The RUC believes this value appropriately place this procedure in relation to the anchor codes 46600 and 46606. **The RUC recommends 1.28 RVUs to 46610.**

46611 ***Anoscopy; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure); with removal of single tumor, polyp, or other lesion by snare technique***

The RUC reviewed the mini-survey data for 46611 and compared it to the two anchor codes 46600 and 46606. The intra-service time for this procedure (15 minutes) has more time associated with it as compared to the intra-service times of both 46600 and 46606 (5 minutes and 11 minutes, respectively). The post-service time is the same for all three codes, 10 minutes. The intensity of 46611 (Recommended IWPUT=0.039) is higher than the intensity of 46600 (Recommended IWPUT=0.034) and lower than the intensity of 46606 (Recommended IWPUT=0.044). Therefore, due to the longer intra-service time of the surveyed code in comparison to the intra-service times of 46600 and 46606 and the higher intensity of the surveyed code as compared to the 46600, the RUC determined the appropriate value of this code to be the median value of the survey data, 1.30 RVUs. The RUC believes this value appropriately place this procedure in relation to the anchor codes 46600 and 46606. **The RUC recommends 1.30 RVUs to 46611.**

46612 ***Anoscopy; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure); with removal of multiple tumors, polyps, or other lesions by hot biopsy forceps, bipolar cautery or snare technique***

The RUC reviewed the mini-survey data for 46612 and compared it to the two anchor codes 46600 and 46606. The intra-service time for this procedure (15 minutes) has more time associated with it as compared to the intra-service times of both 46600 and 46606 (5 minutes and 11 minutes, respectively). The post-service time is the same for all three codes, 10 minutes. The intensity of 46611 (Recommended IWPUT=0.049) is higher than the intensity of 46600 (Recommended IWPUT=0.034) and 46606 (Recommended IWPUT=0.044). Therefore, due to the longer intra-service time and higher intensity of the surveyed code in comparison to the intra-service times and intensities of 46600 and 46606, the RUC determined the appropriate value of this code to be the median value of the survey data, 1.50 RVUs. The RUC believes this value appropriately place this procedure in relation to the anchor codes 46600 and 46606. **The RUC recommends 1.50 RVUs to 46612.**

46614 ***Anoscopy; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure); with control of bleeding (eg, injection bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)***

The RUC reviewed the mini-survey data for 46614 and compared it to the two anchor codes 46600 and 46606. The specialty society explained as this procedure is primarily performed in the office setting that the survey respondents overestimated the pre-service time associated with this procedure. To account for this site of service, the specialty society recommends that 8 minutes be removed from the pre-service evaluation survey data time and 7 minutes be removed from the scrub, dress and wait time. This adjustment in pre-service time results in 7 minutes of evaluation time, 5 minutes of positioning and no time for scrub, dress and waiting. In addition, the intra-service time for this procedure (15 minutes) has more time associated with it as compared to 46600 (5 minutes) and 46606 (11 minutes). The post-service time is the same for all three codes, 10 minutes. The intensity of 46614 (Recommended IWPUT=0.034) has the same intensity as 46600 (Recommended IWPUT=0.034) and has lower intensity than 46606 (Recommended IWPUT=0.044). Therefore, due to the longer intra-service time of the surveyed code in comparison to the intra-service times of 46600 and 46606 and the comparable intensity as the intensity associated with 46600, the RUC determined the appropriate value of this code to be the 25 percentile of the survey data, 1.00 RVUs which accounts for the time removed from the pre-service period. The RUC believes this value appropriately place this procedure in relation to the anchor codes 46600 and 46606. **The RUC recommends 1.00 RVUs to 46614.**

46615 ***Anoscopy; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure); with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique***

The RUC reviewed the mini-survey data for 46615 and compared it to the two anchor codes 46600 and 46606. The specialty society explained that the survey respondents overestimated the pre-service time associated with this procedure and recommend 25 minutes of pre-service time. The intra-service time for this procedure (20 minutes) has more time associated with it as compared to the intra-service times of both 46600 and 46606 (5 minutes and 11 minutes, respectively). The intensity of 46615 (Recommended IWPUT=0.037) is higher than the intensity of 46600 (Recommended IWPUT=0.034) and lower than the intensity of 46606 (Recommended IWPUT=0.044). Therefore, due to the longer intra-service time of the surveyed code in comparison to the intra-service times of 46600 and 46606 and the higher intensity of the surveyed code as compared to the 46600, the RUC determined the appropriate value of this code to be the median value of the survey data, 1.50 RVUs. The RUC believes this value appropriately place this procedure in relation to the anchor codes 46600 and 46606. **The RUC recommends 1.50 RVUs to 46615.**

Eye Exams (Tab 19)

Stephen Kamenetzky, MD, American Academy of Ophthalmology (AAO), George Williams, MD, American Society of Cataract and Refractive Surgery (ACRCS), and Michael Chaglasian, OD, American Optometric Association (AOA)

Prior to the Third Five-Year Review, the American Academy of Ophthalmology (AAO) submitted a March 31, 2005, letter to the Five-Year Review Workgroup requesting action related to the Eye Exam codes. AAO provided documentation that in the 1995 Five-Year Review process, the RUC recommended that a "permanent link" be established between the eye exam codes and the office visit codes. The Workgroup noted that it is not possible to automatically determine at this point in time that any rationale in the office visit codes would automatically apply to the eye exam codes. The Workgroup offered that AAO may wish to solicit CMS to add the eye exam codes to the Five-Year Review process. If CMS agreed to this request, these codes would be included in a level of interest process and then assigned to Workgroup 5 Evaluation and Management Services to review survey data presented by the specialty.

AAO requested that CMS maintain the "permanent" link previously established between the eye exam codes and the office visit codes. In the December 1, 2006 Federal Register, Vol. 71, No. 231, Page 69732, AAO commented and expressed disappointment in CMS' decision to not maintain the link in RVUs between the Ophthalmology Examination codes (92002-92014) to the E/M codes. The AAO

urged CMS to reaffirm this linkage and increase those values to reflect the proposed increases in E/M services. CMS responded:

We acknowledge that currently the work RVUs for ophthalmology examination services are linked to the work RVUs for certain E/M codes. However, the work RVUs for the E/M codes are being increased based on our acceptance of the rationale that the work required to furnish these services has itself changed. This increase in work RVUs also implies that the E/M services today are not exactly the same services to which we initially linked the eye examination services. Unfortunately, because the specialty did not bring the ophthalmology examination codes to the Five-Year Review for evaluation of any change in the work of furnishing these services, it is not known to what extent, if at all, the work for the ophthalmology examination codes would have mirrored the change in the work of the E/M codes. We note that the E/M increases have been added to other services only when the E/M codes were clearly used as the building blocks for valuing the services, for example, for global surgical services with post-operative visits. Therefore, we will implement the work RVUs for CPT codes 92002–92014 as proposed. However, if received in time for next year's proposed rule, we would be willing to consider any RUC recommendations for work RVUs for these services for implementation in FY 2008 and would consider this as part of the Third Five-Year Review.

The four ophthalmology examination codes were brought back to the RUC for review at the February 2007 meeting, which will be considered as part of the Third Five-Year Review.

February 2007
The eye exam codes were previously linked to specific E/M office visit codes prior to the Third Five-Year Review. At the 2005 Five-Year Review the compelling evidence to review E/M services was that incorrect assumptions were made when in the previous valuation of these services. The RUC discussed the compelling evidence to review the eye exam codes. Since the eye exam codes were linked to the Evaluation and Management codes which were based on incorrect assumptions when they were initially valued, the RUC determined that the eye exam codes were based on incorrect assumptions as well.

The AAO and American Optometric Association (AOA) provided detailed information that there are only two levels of service, an intermediate level and a comprehensive level, for both the new and established ophthalmological service patients. The RUC discussed the fact that the survey recommended work RVUs are higher for the established patient code 92012 *Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient* compared to the new patient code, 92002 *Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient*. The RUC noted that this reflects a lack of granularity in ophthalmology

visit codes, specifically because there are only two ophthalmology visit code levels in contrast to five general office visit codes. In addition, intensity measures in the surveys were lower for the new patient code (relative to a level 2 new patient general visit code) than for the established visit code (relative to a level 3 general established visit code).

92002 and 92004

The RUC noted that code 92002 was previously linked to 99202 *Level 2 New Patient Office Visit* (Work RVU=0.88, 2 minutes pre-service, 15 minutes intra-service and 5 minutes post-service time) and survey respondents indicated that the technology, physician work, patient complexity and site of service have not changed for 92002. The survey 25th percentile work RVU was 0.91, which is similar to 0.88, the 2007 work RVU for code 92002. **The RUC recommends that the work RVU of 0.88 for code 92002 be maintained.**

The RUC noted that code 92004 was previously linked to the mean of 99203 *Level 3 New Patient Office Visit* and 99204 *Level 4 New Patient Office Visit* [(1.34+2.30)/2=1.82]. The majority of the survey participants indicated that the work had increased because the patients had become more complex. The survey 25th percentile work RVU was 2.16, which falls between the work values for 99203 and 99204, but is higher than the mean work RVU (1.82) of 99203 and 99204. The RUC determined that a work RVU of 1.82 is appropriate for code 92004 relative to the Evaluation and Management office visit new patient codes. **The RUC recommends a work RVU of 1.82 for 92004.**

92012 and 92014

The RUC reviewed the survey data and determined that CPT code 92012 corresponds to reference service code 99213 *Level 3 Established Patient Office Visit* (RVU=0.92, 3 minutes pre-service, 15 minutes intra-service and 5 minutes post-service time) in terms of the vignette, physician time and physician work. Likewise, CPT code 92014 *Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, one or more visits* corresponds to reference service 99214 *Level 4 Established Patient Office Visit* (RVU=1.42, 5 minutes pre-service, 25 minutes intra-service and 10 minutes post-service time) by the vignette, physician time and physician work. The RUC determined that the surveyed times and work RVUs appropriately captured the physician work and time to perform these services. The specialty societies explained the survey data for eye exam codes 92012 and 92014 supports the link to reference services 99213 and 99214, respectively. The RUC agreed that the survey data validates the 25th percentile work RVUs of 0.92 for code 92012 and 1.42 for code 92014. **The RUC recommends a work RVU of 0.92 for code 92012 and a work RVU of 1.42 for code 92014.**

The survey results validated that the work RVU link between the eye exam services to the Evaluation and Management services was appropriate and remains appropriate. However, the physician times differ slightly.

The RUC recommends the following physician times:

Code	Pre-Service Time	Intra-Service Time	Immediate Post-Service Time	Work RVU	Work RVU E/M Link
92002	5 minutes	15 minutes	5 minutes	**0.88**	99202
92004	5 minutes	25 minutes	10 minutes	**1.82**	Mean of 99203 and 99204
92012	5 minutes	15 minutes	5 minutes	**0.92**	99213
92014	5 minutes	24 minutes	8 minutes	**1.42**	99214

Doppler Color Flow (Tab 20)
Michael Picard, MD American College of Cardiology (ACC) and Thomas Ryan, MD, ACC

For the 2005 Five Year Review, CMS originally requested review of CPT Code 93325 *Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)* (work RVU = 0.07, ZZZ global) as it had not been reviewed by the RUC. The American College of Cardiology (ACC) surveyed the code and recommended an increased work RVU to the RUC. During that meeting, the RUC reviewed the specialty's survey results and rationale and noted that code 93307 *Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete* (work RVU = 0.92, XXX global period) was almost always billed with 93325. The RUC could not recommend a change in the value of the code without CPT review of the code. The RUC recommended code 93325 be referred to the CPT Editorial Panel for consideration.

During the October 2006 RUC meeting, the RUC was informed that CPT code 93325, had not yet been reviewed by the CPT Editorial Panel following the most recent Five-Year Review. The specialty society had indicated to CPT that it did not intend to submit a CPT code proposal. Although the RUC indicated an interest in bundling the service with other cardiology services, ACC argued that bundling is inappropriate due to the service's varied utilization pattern with a wide variety of other services. Since ACC had not addressed the concerns in a coding proposal, the RUC would need to examine the code again.

The specialty presented their 2005 survey data results for 93325 at the February 2007 RUC meeting. The RUC also reviewed data from the 2005 Medicare Utilization files for 93325 and other services in this family of codes. The RUC discussed the inherent nature of providing the services described in 93325, 93307, and 93320 *Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic*

imaging); complete on the same day by the same physician, as illustrated in the following table:

Same Day Occurrences for 93325 with Codes Billed Together at Least 90% of the Time

Produced from the 2005 5% Sample File

CPT Code 1	CPT Code 2	Code 1 Services	Same Day Billed Occurrences	% of Time Code 1 Billed with Code 2
93325	93320	138,398	136,433	98.58%
93325-TC	93320-TC	23,039	22,645	98.29%
93325-26	93320-26	211,640	206,755	97.69%
93325	93307	13,8398	130,949	94.62%
93325-TC	93307-TC	23,039	22,298	96.78%
93325-26	93307-26	211,640	197,093	93.13%

The RUC discussed its policy for other services that are inherent in the provision of physician services. For example, when conscious sedation is inherent to procedures it is included within the valuation of the procedure and not reported separately. Likewise, the CPT Editorial Panel has moved to an approach of including radiological guidance within a new CPT code if it is inherent to the procedure. The RUC understands that the American College of Cardiology is taking a long-term, broad review of their services and welcomes this approach. However, the data for 93320, 93325, and 93307 are clear and a coding proposal should be prepared by the specialty society to immediately address this as one service versus three distinct services.

The RUC recommends referral of this issue to the CPT Editorial Panel

Allergy Test Interpretation (Tab 21)
Donald Aaronson, MD, Joint Council of Allergy, Asthma and Immunology (JCAAI) and Paul Fass, MD, American Academy of Otolaryngic Allergy (AAOA)

At the 2005 Five Year Review, the Joint Council of Allergy, Asthma & Immunology commented that there is physician work involved in allergy test interpretation services that is not being recognized and not reimbursed through any other codes. The specialty society came to the RUC 2005 Five Year Review and presented physician work values for these allergy codes. At the meeting, the specialty presented each code with physician work representing staff supervision and the interpretation of the tests results. The codes are typically billed with an E/M service which, according to CPT, the "actual performance and/or interpretation of diagnostic tests/studies ordered during a patient encounter are not included in the level of E/M services." The RUC, at the time could not value the

codes based upon the CPT descriptor and the survey results and referred the specialty to the CPT Editorial Panel for clarification and possible revision of the codes to include physician work. In February 2006, the CPT Editorial Panel made modifications to these allergy testing codes in order to include the test interpretation and report provided by a physician (pending RUC survey which would prove that physician work was associated with these services).

For the February 2007 RUC meeting, the specialty surveyed over 100 physicians and provided new survey data with "test interpretation and report by a physician" included in the descriptors. The survey respondents indicated that there is physician work in the three services. The RUC believed that there is physician work in these allergy services and understood that the surveys were based on a battery of tests that are typically performed. The physician work and time is computed to be a small fraction of the surveyed results based on the total service. The survey for CPT code 95004 *Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, including test interpretation and report by a physician, specify number of tests* was based on a battery of 40 tests; 95024 *Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, including test interpretation and report by a physician, specify number of tests* was based on a battery of 12 tests, and 95027 *Intracutaneous (intradermal) tests, sequential and incremental, with allergenic extracts for airborne allergens, immediate type reaction, including test interpretation and report by a physician, specify number of tests* was based on a battery of 45 tests. Surveyed physician time and work was then divided by these typical number of tests and modified for the typical patient encounter.

Physician work for these services were compared to the level two office visit code 99212 (work RVU = 0.45) for time and intensity comparisons based on the three batteries of tests. The RUC believed that this "battery of tests" comparison with the Evaluation and Management codes was valid and established relativity between code families. In addition, the RUC and the specialty agreed that code 95024 was typically billed subsequent to 95004 and thus there would be some overlap in physician time. The RUC therefore agreed that there would be zero pre-service time for 95024 and the post service physician time for code 95004 should more appropriately be 5 minutes, rather than 10 from the survey results with the battery of 40 tests. The RUC agreed that although physician work for each of the single tests was minimal, as a battery of tests, the rank order between each of the codes and the relativity with Evaluation and Management codes is established when the work RVUs are all equal to 0.01. The below chart shows the rank order and relativity based on the battery of tests.

CPT Code	Work RVU	Number of Tests	Work RVU for Battery
95004	**0.01**	40	0.40
95024	**0.01**	12	0.12
95027	**0.01**	45	0.45
99212	0.45		0.45

The RUC recommends work relative values of 0.01 for revised CPT codes 95004, 95024, and 95027.

Practice Expense
The RUC agreed that the existing practice expense inputs that were reviewed in September 2002 were inappropriate and needed to be revised now that the code values were now based on a number of tests rather than on the number of antigens. The RUC reviewed and revised practice expense inputs based on the following batteries of tests; 95002 – 40 tests, 95024 – 12 tests, and 95027 – 45 tests. The RUC eliminated overlapping clinical labor time among the code set and altered the medical supplies and equipment to reflect the number of tests for each allergy code. The RUC agreed that these revisions now reflected the resources used during the typical patient encounter.

Nursing Facility Care (Tab 22)
Dennis Stone, MD, American Medical Directors Association (AMDA) and Eric Tangalos, MD, AMDA

In 2004, the CPT Editorial Panel replaced the existing family of codes for nursing facility services with a new family of services, representing a greater range in the complexity of medical decisions making. The Panel also created a new CPT code, 99310, *Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a comprehensive interval history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention.* In April 2005, a survey was conducted for these services, however, the most appropriate reference services were being considered within the third Five-Year Review and could not be used as a reference service. Consequently, the RUC reviewed the survey data and found it to be unacceptable and recommended that the services be re-surveyed following the Five-Year Review.

99304, 99305 and 99306
In February 2007, the RUC discussed the initial nursing facility care codes, 99304 – 99306. The RUC discussed 99304 and clarified information regarding the typical patient, the differences between the 2005 survey data and the current survey data, as well as the differences and similarities between providing evaluation and management (E/M) services in a hospital, office and nursing home. Following this discussion and with a clear understanding of the work involved in the services, the RUC reviewed the survey data and agreed that the median work RVUs were too high. The RUC then compared 99304 to a new reference code, 99203, *Office or other outpatient visit for the evaluation and*

management of a new patient, (work RVU = 1.34). The RUC noted that the service descriptions are the same, each consisting of a detailed history, detailed examination and medical decision-making of low complexity. Further, the intra-service time is relatively similar, 22.5 minutes and 20 minutes, respectively. However, 99203 contains less total time than 99304 (29 minutes and 42.50 minutes, respectively) and the RUC agreed that 99203 does not adequately provide for care plan oversight, which is inherent in 99304 and accounts for this difference in total time. As such, the RUC considered 99374, *Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes*, (work RVU = 1.10). Code 99374 includes 30 days of service. In order to adjust for this difference in days of service, the RUC applied an increment of one-fourth of the work RVU (0.27) to 99203 and reached a work RVU of 1.61 (0.27 + 1.34 = 1.61). **The RUC recommends a work RVU of 1.61, pre-service time of 10, intra-service time of 23, and post-service time of 10 for 99304.**

In order to add justification this rationale, the RUC arrived at very similar work RVUs for 99304-99306 by comparing the nursing facility care codes to the hospital visit codes and adjusting for differences in time and care plan oversight. The supporting justification divided the intra-service time of the nursing facility care code by the equivalent subsequent hospital care codes (99221-99223, respectively) multiplied by the hospital care code work RVU and then added the one-fourth care plan oversight work RVUs (0.27) to the total. The resulting work RVUs for 99304, 99305, and 99306 were 1.68, 2.35, and 3.36, respectively. Calculations are shown below. The RUC felt that this proximity to the recommended values adds validity to its work RVU recommendation for the services.

Calculation of additional support for 99304, 99305, and 99306

[(Intra-service time of nursing facility code / intra-service time of subsequent care hospital visit) x Subsequent care hospital visit RVU] + [one-fourth of the work RVU of 99374, *Home health care supervision* (wRVU = 1.10) = 0.27]

99304 = [(22.50 / 30.00) x 1.88] + 0.27 = wRVU of 1.68
99305 = [(32.50 / 40.00) x 2.56] + 0.27 = wRVU of 2.35
99306 = [(45.00 / 55.00) x 3.78] + 0.27 = wRVU of 3.36

The RUC discussed 99305 and clarified information regarding the typical patient, the differences between the 2005 survey data and the current survey data, as well as the differences and similarities between providing evaluation and management (E/M) services in a hospital, office and nursing home. Following this discussion and with a clear understanding of the work involved in the services, the RUC reviewed the survey data and agreed that the median work RVUs were too high. The RUC then compared the service to a new reference service, 99204, *Office or other outpatient visit for the evaluation and management of a new patient,* (work RVU = 2.30, pre-time = 5, intra-service time = 30, post-service time = 10). The RUC noted that the descriptions of the codes are similar, including comprehensive history, comprehensive examination, and moderate complexity medical decision-making. The intra-service work time of 99204 is similar to 99305 (intra-service time = 32.50). The RUC agreed that the physician work involved within both services is very similar. **The RUC recommends a work RVU of 2.30, pre-service time of 11, intra-service time of 33, and post-service time of 13 for 99305.**

The RUC discussed 99306 and clarified information regarding the typical patient, the differences between the 2005 survey data and the current survey data, as well as the differences and similarities between providing evaluation and management (E/M) services in a hospital, office and nursing home. Following this discussion and with a clear understanding of the work involved in the services, the RUC reviewed the survey data and agreed that the median work RVUs were too high. The RUC then compared the service to a new reference service, 99205, *Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity* (work RVU = 3.00, pre-service time = 7, intra-service time = 45, post-service time = 15). The descriptions of the services each include a comprehensive history, comprehensive examination, and high complexity medical decision-making. The intra-service time for 99205 is identical to 99306 (intra-service time = 45). The RUC agreed that the physician work involved within both services is very similar. **The RUC recommends a work RVU of 3.00, pre-service time of 15, intra-service time of 45, and post-service time of 20 for 99306.**

99307, 99308, 99309, 99310, and 99318

In February 2007, the RUC discussed the subsequent nursing facility care codes, 99307 – 99310 and 99318, *Annual nursing facility assessment*. The RUC reviewed the specialty society's survey results for 99307 including the time and intensity in comparison to the key reference service, 99231, *Subsequent hospital care,* (work RVU = 0.76). The RUC agreed that due to the similar history, examination, medical decision-making, time, and intensity, the services were comparable. The RUC reviewed the survey data and noted that the 25th percentile work RVU was 0.75, median was 0.77, the and the 75th percentile was 0.95. The tight distributions of survey work RVUs supported a recommended work RVU of

0.76. **The RUC recommends a work RVU of 0.76, pre-service time of 5, intra-service time of 10, and post-service time of 5 for 99307.**

The RUC reviewed the specialty society's survey results for 99308 including the time and intensity in comparison to the key reference service 99232, *Subsequent hospital care*, (work RVU = 1.39). The RUC agreed that the median survey work RVU of 1.40 was too high and agreed that the 25th percentile of 1.16 work RVUs was appropriate due to the similar history, examination, medical decision-making, time, and intensity with the reference service. **The RUC recommends 25th percentile work RVU of 1.16, pre-service time of 7, intra-service time of 15, and post-service time of 9 for 99308.**

The RUC reviewed the specialty society's survey results for 99309 including the time and intensity in comparison to the key reference service 99233, *Subsequent hospital care*, (work RVU = 2.00, pre-service time = 10, intra-service time = 30, post-service time = 15). The RUC agreed that the median survey work RVU of 2.00 was too high and agreed that the 25th percentile of 1.55 work RVUs was appropriate due to the similar history, examination, medical decision-making and the slightly lesser time and intensity with the reference service. **The RUC recommends 25th percentile work RVU of 1.55, pre-service time of 10, intra-service time of 25, and post-service time of 10 for 99309.**

The RUC reviewed the specialty society's survey results for 99310 including the time and intensity in comparison to the key reference service, 99233, (work RVU = 2.00, pre-service time = 10, intra-service time = 30, post-service time = 15). The RUC agreed that due to the similar history, examination, medical decision-making as well as the greater time and intensity of 99310, the services were very similar. The RUC reviewed the survey data and noted that the 25th percentile work RVU was 2.10, median work RVU was 2.35, and the 75th percentile was 3.00. The tight distributions of survey work RVUs supported a recommended work RVU of 2.35. **The RUC recommends the median work RVU of 2.35, pre-service time of 15, intra-service time of 35, and post-service time of 20 for 99310.**

The RUC reviewed the specialty society's survey results for 99318 including the time and intensity in comparison to the key reference service 99397, *Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; 65 years and older* (work RVU = 1.71 pre-service time = 5, intra-service time = 35, post-service time = 10). The RUC agreed that the median survey work RVU of 1.88 was too high and agreed that the 25th percentile of 1.71 work RVUs was appropriate due to a more involved history, examination, medical decision-making, greater intensity and complexity, and the slightly lesser time than the reference service. **The RUC recommends 25th percentile work**

RVU of 1.71, pre-service time of 10, intra-service time of 27, and post-service time of 10 for 99309.

Home Care (Tab 23)
George Taler, MD, American Academy of Home Care Physicians (AAHCP) and American Geriatrics Society (AGS)

The family of Home Care codes was not identified for inclusion in the third Five-Year Review, however, in the 2007 Final Rule at the behest of the specialty society, CMS recommended that these services be reviewed and valued by the RUC following the review of Evaluation and Management services.

99343, 99344, 99345, 99347, 99348, 99349, and 99350
The RUC reviewed the specialty's request during its February 2007 meeting and agreed that there was not compelling evidence to review 99343 – 99350, Home Care visits The nature of the work involved in providing these services has not substantially changed since the RUC last reviewed and substantially increased the valuation in 1997. **The RUC recommends that the work RVUs for 99343, 99344, 99345, 99347, 99348, 99349 and 99350 be maintained at their current values.**

Domiciliary Care (Tab 24)
George Taler, MD, American Academy of Home Care Physicians (AAHCP) and American Geriatrics Society (AGS)

The family of Domiciliary Care codes was identified for inclusion in the third Five-Year Review. The specialty first sought CPT changes to mirror the Domiciliary codes with the Home Care codes (99343 – 99350) and then surveyed the new descriptors to convince the RUC and CMS that the Domiciliary Care codes be valued equivalent to the Home Care codes. In the 2007 Final Rule at the behest of the specialty society, CMS recommended that these services be reviewed again and valued by the RUC following the review of Evaluation and Management services.

99326, 99327, 99328, 99334, 99335, 99336, and 99337
The RUC reviewed the specialty's request during its February 2007 meeting and agreed that there was not compelling evidence to review the Domiciliary Care codes (99326 – 99337). The nature of the work involved in providing these services has not substantially changed since the RUC last reviewed the services in 2005. The RUC had recommended significant increases that were implemented by CMS in 2006. Additionally, CMS has maintained and the RUC and specialty society agree that Domiciliary Care services include similar work to Home Care services and the work RVUs for corresponding services should be valued the

same. **The RUC recommends that the work RVUs for 99326, 99327, 99328, 99334, 99335, 99336 and 99337 be maintained at their current values.**

XI. Direct Practice Expense Input Recommendation – CMS Requests:

Gynecologic Oncology (Tab 25)
American College of Obstetricians and Gynecologists

In the November 1, 2006 Final Rule, CMS stated, "A society representing gynecologic oncologists recommended that the standard supplies for their procedures should be modified to include additional supplies that are associated with their procedures such as a pelvic exam kit and a patient drape….With respect to the comments about the absence of specific supplies in gynecologic oncology procedures, we would note that the 90 day CPT codes identified by the specialty for gynecology and obstetrics all contain these specific items as part of the standard packages, as approved by the RUC and accepted by CMS. We would again suggest that the commenter work through the RUC process to assure that the necessary inputs are included in these services."

At the February 2007 RUC meeting, the Practice Expense Review Committee (PERC) and the specialty determined that the gynecologic oncology code supplies referred to in CMS' ruling were all included in the direct practice expense and the Society of Gynecologic Oncologists and the American College of Obstetricians and Gynecologists agree that there is no further action needed by CMS on this particular issue.

Computer-Aided Detection (CAD) Breast Mammography (Tab 26)
American College of Radiology

In the November 1, 2006 Final Rule, CMS stated, CMS received several comments that expressed concern about the decrease in payment for computer-aided detection (CAD) services, CPT codes, 76082 and 76083 (renumbered to 77051 and 77052, respectively), both add-on procedures that are billed in combination with an appropriate mammography service. The commenters stressed that CAD systems for mammography are diagnostic tools that can increase breast cancer detection rates, especially in the early stages…. We understand the concern expressed by all of these commenters. However, payments made for services on the PFS (physician fee schedule) can only reflect, in a budget neutral manner, the relative resources required to perform the service. We will request that the RUC review again the PE inputs for the DXA and the CAD services to ensure that the direct inputs associated with these services are accurately reflected in the database"

At the February 2007 RUC meeting the PERC found that the American College of Radiology (ACR) had reviewed the direct practice expense inputs for the two Computer-Aided Detection codes, 77051 and 77052 and did not wish to propose any changes at this time. Attached is a letter by the ACR from with this explanation.

Dual-Energy X-Ray Absorptiometry (Tab 27)
American Association of Clinical Endocrinologists, American College of Radiology, American College of Rheumatology, The Endocrine Society

In the November 1, 2006 Final Rule, CMS stated, "We received many comments regarding the proposed decrease in PE RVUs for either specific services or for given specialties…. Commenters opposed the proposed decrease in payment for the axial bone density testing (DXA) service, CPT Code 76075 (renumbered to 77080) which is used for detection and quantification of osteoporosis, and CPT codes 76077 (renumbered to 77082), which is used for vertebral fracture assessment. The commenters raised the concern that the proposed decrease in payment for these services would severely restrict patient access to bone density testing thereby undermining our effort to effectively screen Medicare beneficiaries for osteoporosis and vertebral fractures. These commenters identified what they believed to be flaws in the direct input and with the utilization rate applied to the DXA machine. We will request that the RUC review again the practice expense inputs for the DEXA services to ensure that the direct inputs associated with these services are accurately reflected in the database"

AMA staff, accordingly, initiated the Level of Interest Process so that all interested parties would be able to address CMS' request for presentation at the February 2007 RUC meeting. The following specialties provided a joint recommendation to the PERC and RUC; American College of Rheumatology, The Endocrine Society, The International Society for Clinical Densitometry, American Association of Clinical Endocrinologists, and the American College of Radiology.

The PERC and RUC reviewed and refined the joint specialty recommendation for the direct inputs for codes 77080, 77081, and 77082 during its February 2007 meeting. During the RUC review, RUC members questioned if the provision for vital signs is typical for these services. Unfortunately, the presenters had already departed the meeting. The RUC then deferred the vote on the DEXA services until representatives were present in April 2007 to address this one specific issue.

Cardiac Catheterization (Tab 28)

The specialties request that this issue be deferred until the April 2007 RUC meeting.

XII. Practice Expense Review Committee

Doctor Moran summarized the work of the PERC whereas the committee successfully reviewed all the practice expense items on its agenda and made its recommendations to the RUC. Doctor Moran also acknowledged Doctor James Anthony as one of the original members and significant contributor to the process. He explained that Doctor Anthony no longer will be part committee due his increased involvement in his own medical practice and will be missed. Doctor Rich agreed and mentioned the RUC will send a letter of appreciation to Doctor Anthony. Doctor Levy and other RUC members questioned a line item (line 15, Obtain vital signs) on the practice expense recommendation for Dual-Energy X-Ray Absorptiometry (DEXA), CPT code 77080. RUC members questioned if the provision for vital signs is typical for these services and recommended the direct practice expense input to be reconsidered at the April 2007 PERC and RUC meeting. The RUC then deferred the vote on the DEXA services until representatives were present in April 2007 to address this one specific issue. The remainder of the PERC report was approved without discussion.

The RUC approved the Practice Expense Review Committee report and it is attached to these minutes.

XIII. Extant Data Workgroup

Doctor David Hitzeman presented the Extant Data Workgroup's Report to the RUC. Doctor Hitzeman apprised the RUC of the Workgroup's overall agenda; the Workgroup's review of extant data use in the 2005 Five Year Review, specifically NSQIP and the STS Database; and CMS' concerns with the RUC's potential use of extant data. Doctor Hitzeman informed the RUC that the workgroup's future actions will include:

1.) AMA staff will solicit specialty societies' input in the Workgroup's development of inclusionary and exclusionary criteria for extant database review and in the Workgroup's project of identifying any existing extant databases
2.) A report from the American College of Surgeons which details the components of an extant database
3.) Communication with the developers of the NSQIP database and the STS database to determine the availability of this data to the RUC for internal review and to determine the extent of the data collected in these databases

4.) Communication with the Surgical Quality Assurance Workgroup to be apprised of the work they are conducting relating to their review of extant databases

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

XIV. MPC Workgroup

Doctor Derr informed the RUC that the MPC Workgroup met and discussed a number of pertinent issues. The Workgroup has developed a complete and insightful history of the MPC list and recommends that it be included as a foreword in all future publications of the MPC list. **The RUC approved the inclusion of the MPC History in all future publications of the MPC list**.

Doctor Derr also informed the RUC that the MPC Workgroup believed that the MPC list was not entirely effective in creating cross-specialty comparisons. The MPC Workgroup will begin to create a more effective system of comparing values across specialties. The first step to be taken is asking each specialty to consider all of their codes on the MPC as well as the two highest utilization codes within their specialty, identified by CMS in the most recent 5 year review, and inform the MPC whether there is a good measure of relativity among the specialty's codes. Once intra-specialty relativity is confirmed, the Workgroup will recommend subsequent actions to assess cross-specialty relativity.

The MPC Workgroup also discussed the MPC list changes that required concurrence from the dominant specialty. **The RUC considered these changes and made the following changes to the MPC list:**

20973 – Removed
22842 – Removed
23395 – Removed
29075 – Added
29848 – Removed
59400 – Removed
78315 - Added

The RUC approved the Multi-Specialty Points of Comparison Workgroup report and it is attached to these minutes.

XV. HCPAC Review Board

Mary Foto, OTR, informed the RUC that the HCPAC developed recommendations for the Team Conference Non-Physician codes 9936X2 and

9936X4. Ms. Foto indicated that the HCPAC did not make recommendations regarding the Non Face-to-Face Qualified Healthcare Professional Services, codes 989X1-989X4. The American Physical Therapy Association (APTA) tabled these codes from review at this meeting until a better sense of the total issue, specifically the vignettes, is reached. The APTA noted that additional non-physician groups should also survey these services prior to April 2007.

Ms. Foto indicated that the HCPAC discussed the following "other issues" as specified in the full HCPAC Review Board Report attached to these minutes: HCPAC member recusal from voting, reduced services, the HCPAC Co-Chair and Alternate Co-Chair elections at the April 2007 meeting and an update on the Multi-Specialty Practice Information Survey.

The Health Care Professionals Advisory Committee report was filed and is attached to these minutes.

XVI. Research Subcommittee

Doctor Norman Cohen presented the Research Subcommittee Report to the RUC. Doctor Cohen informed the RUC members about the Research Subcommittee's recommendations pertaining to how to incorporate the Pre-Time Workgroup's recommendations into the survey instruments and summary of recommendation forms. The Research Subcommittee recommended and the RUC approved the following actions:

1.) **The pre-services times associated with the RUC approved packages be allocated on the summary of recommendation as indicated in the February 2007 RUC agenda book.**

2.) **A new field will be added titled, "Additional Pre-Service Time," to reflect this additional pre-service time.**

3.) **The following language will be added to the instruction document to assist specialty society staff in its completion of the summary of recommendation form:**

Please review the following pre-service time packages and determine which package best corresponds to the data which was collected in the survey process. Once the selection is made, the pre-service evaluation, pre-service positioning and pre-service scrub, dress and wait fields will be pre-populated with the corresponding times. Additionally, in the "Additional Pre-Service Time," field please reflect the additional pre-service time that is potentially associated with the procedure. Examples of additional time would include the time associated with TEE, invasive monitoring or complex positioning. The rationale for

this additional time should be explained in the summary of recommendation form under description of pre-service work.

4.) CMS modify its current definition of pre-service time from beginning 24 hours prior to surgery to beginning immediately after making the decision for surgery.

5.) All the aforementioned pre-service time recommendations be implemented into the summary of recommendation form and instruction document, pending CMS' response to this change in policy request which will be published in the 2007 *Final Rule.*

Doctor Cohen informed the RUC about the Research Subcommittee's recommendations pertaining to the AMA's Legal Counsel's recommendations to be incorporated into the instruction document where it details how societies should develop their reference service lists. **The Research Subcommittee recommends and the RUC approved the following changes be made to the instruction document:**

The following is an approved list of guidelines for developing reference service lists. ~~There may be circumstances in which it may not be possible or appropriate to follow one or more guidelines.~~

The specialty may ask AMA ~~staff~~ and the RUC's Research Subcommittee to evaluate a reference service list in advance of the specialty sending the survey out for completion.

(It should be noted that the term "physician" in this context includes both physician and non-MD/DO providers)

- **Include a broad range of services (i.e. 10-20 services) and their 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.**
- **Include codes that represent ~~S~~services on the list ~~should be those~~ which are well understood and commonly provided by physicians in the specialty or subspecialty. Accordingly, a specialty society's reference service list may vary based on the new/revised code being surveyed.**
- **Include similar or related codes ~~in~~ from the same family or CPT section 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, i~~Include codes from ~~on~~ the MPC list, if appropriate ~~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 <u>if appropriate.</u>**

Doctor Cohen reviewed the proposed RUC rationale for 22840, 22842, 22843, 22845, 22846 and 22847 as it was determined at a previous RUC meeting that these rationales needed to reflect the valuation history of these codes. **The Research Subcommittee recommends and the RUC approved incorporating the amended rationales for CPT codes 22840, 22842, 22843, 22844, 22845, 22846 and 22847 as listed in the February 2007 RUC agenda book into the RUC database.**

Doctor Cohen also informed the RUC about several specialty society requests that the Research Subcommittee reviewed. The Research Subcommittee reviewed and the RUC recommended that:

1.) American Speech-Language and Hearing Association should develop their recommendations for their procedures utilizing a standard RUC survey instrument and at ASHA's request, their reference service list for these procedures will be reviewed by the Research Subcommittee. Additionally, upon the submission of these recommendations to CMS, a request should be made that CMS should transition the relative values that it currently utilized for these services from the practice expense pool to the work RVU pool to account for this change in policy.

2.) A new XXX-Radiation Oncology survey instrument be created which will reflect the following description of service and otherwise match the XXX-Therapy survey instrument:

Pre-Service Period: Preparing to see the patient/start procedure, reviewing records and communicating with other professionals

Intra-Service Period: Activities in the intra-service period may include performing the procedure, communications with the clinical staff, review and interpretation of images or data, when acquired and documentation of services.

Only the physician's time spent during the procedure should be considered. Time spent by the technologist and other clinical staff is NOT included.

Post-Service Period: Post-Service period includes arranging for further services, communicating (written or verbal) with the patient, family and other professionals

3.) The two proposed base codes, 585XX1 *Laparoscopy, surgical, with total hysterectomy for uterus 250 grams or less* and *585XX3 Laparoscopy, surgical,*

with total hysterectomy for uterus greater than 250 grams **be surveyed utilizing a standard RUC survey instrument and an incremental add-on approach be used to develop RVU recommendations for the subsequent two codes in the family which both include the removal of tube(s) and/or ovary(s).**

Doctor Cohen explained that the Research Subcommittee reviewed the recommendation process for specialty frequency estimates and determined that this process could be strengthened. **The Research Subcommittee recommends and the RUC approved that the following language be added to the existing queries of frequency estimates on the summary of recommendation form:**

1.) **Estimate the number of times the service might be provided nationally in one year and if the service is performed by multiple specialties, then all societies must provide their frequency and their percentage of performing this service. Please explain the rationale for this estimate;**

2.) **Estimate the number of times the service might be provided to Medicare patients in one year and if the service is performed by multiple specialties, then all societies must provide their frequency and their percentage of performing this service. Please explain the rationale for this estimate.**

Doctor Cohen completed his report the Extant Data Policy Workgroup update. Minutes from the Extant Data Policy Workgroup Update are attached to these minutes. **The RUC approved the Research Subcommittee report and it is attached to these minutes.**

The RUC approved the Research Subcommittee report and it is attached to these minutes.

XVII. PE/Research Subcommittee - Multi-Specialty Survey

Mike Ellrich and Catherine Strahan of the Gallup Organization presented the preliminary results of the pilot study of the Multi-Specialty Physician Practice Information Survey, projected to be completed by mid-February. Their PowerPoint presentation is attached to these minutes.

The RUC approved the following, as suggested by Gallup and the joint meeting of the Practice Expense Subcommittee and Research Subcommittee:

- **Send "call to action" letter (attached to these minutes) from relevant specialty society 7-10 days prior to Gallup advance packet mailing**

- **Combat discard rate by adding specialty society branding and/or printed message prominently on envelope**

- **Calculate expenses for employed physicians by collecting the specialty practice level costs and then allocate based on the physician's patient care hours compared to practice's patient care hours.**

- **Condense the medical equipment utilization series of questions within the survey.**

A report of the discussion related to the Mutli-Specialty Physician Practice Information Survey is attached to these minutes.

The RUC approved the Practice Expense / Research Subcommittee joint report and it is attached to these minutes.

XVIII. Practice Expense Subcommittee

Doctor Katherine Bradley presented the Practice Expense Subcommittee Report to the RUC, and the RUC agreed with the following recommendations and agenda discussions:

The Practice Expense Subcommittee and the RUC reviewed physician services, Endoscopic Enteral Stenting codes (43256, 44370, 44379, and 44383), that had earlier been identified by AMA staff as not having any physician time information. The RUC recommends the following physician time components:

Stent Codes	Pre-Time	Intra Time	Post Time
43256	**28**	**45**	**20**
44370	**31**	**70**	**22**
44379	**30**	**205**	**22**
44383*	**36**	**47**	**18**

Physician Time Component Allocations
Three specialties submitted time components; the American Academy of Dermatology Association (AAD), the American College of Cardiology (ACC), and the Society for Interventional Radiology (SIR). The RUC agreed with all of the specialty physician time components. These recommendations are contained within the Practice Expense Subcommittee Report. The RUC also **recommends that by the April 2007 agenda book publication date, for codes with total time only, if no specialty recommends physician time components, the total time for the code will be recommended by the RUC as having zero physician time.**

The Establishment of Guidelines for Pricing Procedures in Different Sites of Service

In October 2006, the RUC recommended that "*codes 37205, 37206, and 74960 be referred to the Practice Expense Subcommittee in order to establish guidelines for establishing non-facility direct inputs for codes that have historically been performed predominately in facility settings and currently have relative values only in the facility setting."*

Doctor Bradley emphasized and the RUC agreed that CMS should not infer from PERC recommendations that the PERC (or RUC) approves or endorses a site of service for any particular procedure or service. The PERC is merely providing information as to the resources that typically would be used in a particular setting if the physician chooses to provide the service there. The Subcommittee members believed that it is the physician's choice as to where the patient's care may be best provided and up to CMS and the carriers to determine payment policy. The subcommittee believed that the PERC processes and its relationship with CMS works well and should not be altered at this time.

Treatment of Administrative Costs: Direct verse Indirect Expense

The RUC recommends that the **PERC begin discussions about establishing a process for the refinement of administrative practice expenses and report back to the Practice Expense Subcommittee if and when they develop a specific proposed method to identify these costs.**

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

XIX. Five Year Review Identification Workgroup

Doctor Barbara Levy provided the RUC with a report of the discussion and recommendations from the Five-Year Review Identification Workgroup meeting. The Workgroup's discussions are now focused on developing a methodology for identifying potentially mis-valued services.

The Workgroup first reviewed services that potentially have data errors. Specifically services that are primarily performed in the outpatient setting, but contain inpatient hospital visits and/or a full discharge day within their global period were identified. The Workgroup discussed the methodology for analyzing these services and intends to distribute the list of services to all specialties for comment and clarification. Doctor levy explained "comment and clarification" to the RUC as a reason for why the services may legitimately appear on the list. Once the Workgroup has the information, then it will recommend actions for how to deal with the services.

The RUC recommends that the Workgroup identify the services with any inpatient E/M services within their global period, performed less than 50%

in the inpatient hospital setting, and having a utilization greater than or equal to 1,000 to be explored for review by the Workgroup at the September 2007 RUC meeting. Any code containing 99231, 99232, or 99233 hospital E/M services within the global period will be forwarded to the dominant specialty(s) for comment and clarification of the inclusion of such services. Any code containing a full 99238 and meeting the other criteria will be forwarded to the dominant specialty(s) for comment and clarification regarding appropriateness of the discharge service.

Doctor Levy also informed the RUC that the Workgroup is interested in receiving utilization data from private payers to help identify potentially mis-valued services. The RUC recommends **that utilization data from private payers be solicited to aid in the identification of potentially misvalued services.**

Lastly, Doctor Levy informed the RUC that the Workgroup is considering services that are provided by the same provider on the same date of service for identification as potentially mis-valued. The utilization data to conduct this query was provided by CMS from the 2005 five percent sample file. Staff will review these data with the 2007 fee schedule, 51 exempt list and global period (ZZZ) to provide a more accurate list of services that are potentially mis-valued. The RUC recommends that t**he Workgroup identify any service that is reported 90% of the time or more with another service on the same date by the same physician and having a utilization greater than or equal to 1,000. These will be discussed as a concept for identifying potentially misvalued codes at the September 2007 RUC meeting.**

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

XX. Administrative Subcommittee

Doctor Tuck reviewed the items discussed and recommendations from the Administrative Subcommittee meeting. First, the Administrative Subcommittee discussed the level of interest policy, in which **the RUC recommended adding a statement to the LOI instructions that a lack of response by the specified due date indicates forfeiture of participation in developing a recommendation or providing written comment for that specialty society.**

Second, the Administrative Subcommittee discussed the issue of how to alleviate the workload of RUC participants. **The RUC recommended scheduling time-certain presentations on each issue.** The RUC indicated that the Chairman may use his discretion regarding the details of implementing time-certain presentations.

Third, the Administrative Subcommittee discussed the issue of possibly implementing term limits for RUC members. **The RUC reaffirmed the current policy that term limits are at the discretion of the specialty society.**

Lastly, the Administrative Subcommittee discussed the composition of the RUC, specifically the five criteria for participation for a permanent seat on the RUC and the addition of a primary care seat to the RUC. **The RUC reaffirmed the five criteria for participation for a permanent seat on the RUC, listed in priority order.**

1. **The specialty is an American Board of Medical Specialties (ABMS) specialty.**
2. **The specialty comprises 1 percent of physicians in practice.**
3. **The specialty comprises 1 percent of physician Medicare expenditures.**
4. **Medicare revenue is at least 10 percent of mean practice revenue for the specialty.**
5. **The specialty is not meaningfully represented by an umbrella organization, as determined by the RUC.**

The RUC fully discussed adding a primary care seat to the RUC. The RUC agreed that they could not add a primary care seat with out defining who is eligible. Doctor Felger indicated that he believed that the Administrative Subcommittee intended on the initiation of this process and were looking for support of the creation of this seat. Doctor Tuck slightly modified the motion to indicate that the RUC will initiate the process of adding a primary care seat. **The RUC recommended initiating the process of adding a primary care seat to the RUC.**

The RUC discussed that the specialty societies should be solicited on how they would define the primary care seat and who would be eligible. **The RUC recommended that the RUC solicit specialty societies and HCPAC organizations for recommendations to define the primary care seat criteria and type (i.e., permanent or rotating).**

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

XXI. Other Issues – CMS Request – Anesthesia

The RUC addressed to the CMS request to consider the valuation of anesthesia services reported under CPT codes 00100 through 01999 by developing a workgroup to discuss these issues and appointed the following members:

Daniel Mark Siegel, MD (Chair)
John Gage, MD
J. Leonard Lichtenfeld, MD
James Regan, MD
Peter Smith, MD
David F. Hitzeman, DO
Richard Tuck, MD

The meeting adjourned on Sunday, February 4, 2007 at 9:00 a.m.

AMA/Specialty Society RVS Update Committee
Practice Expense Review Committee Report
February 1, 2007

The following PERC members participated in the discussions: Doctors Moran (Chair), Katherine Bradley, PhD, RN, Joel Brill, MD, Manuel D. Cerqueria, MD, MD, Thomas A. Felger, MD, Gregory Kwasny, MD, Peter McCreight, MD, Tye Ouzounian, MD, James Regan, MD, and Anthony Senagore, MD.

Doctor Moran welcomed the group and stressed the need for specialties to be prepared and ready to present when called to the table.

I. Committee Discussion of New and Revised PE Input Recommendations
The following issues and related practice expense inputs for new and revised CPT codes were reviewed, modified slightly, and are recommended by the PERC:

RUC TAB

Team Conference (9936X1-9936X4) A and 15
Although the PERC provided inputs for the physician codes (9936X1 and 9936X3), PERC members expressed concern regarding what staff would be involved in these codes. The final inputs were heavily reduced from what was originally requested and the vote was not unanimous for approval. The PERC also recommends no direct inputs in the facility setting.

Non Face-to-Face Qualified Healthcare Professional Services A and 16
(989X1, 989X2, 989X3 and 989X4) and ((993XX1-993XX4)

Transuretheral Ureteral Stent Tube Exchange and Removal 7
(5038X1 – 5038X2)

Intra-Abdominal Voiding Pressure (51797) 8

Vitrectomy with Epiretinal Membrane Stripping 9
(6703X – 6711X)

Retinopathy Treatment (6722X1-6722X2) 10
The final inputs for these codes are contingent upon the RUC's work recommendations

Brain and Cerebrospinal Fluid Imaging (78600-78607) 11
The PERC accepted all of the specialty recommendations without modification.

Manual Microdisection (8838X1-8839X2) 12

Electronic Analysis of Implanted Neurostimulator 13
Pulse Generator System (9597X1-9597X3)

Initial Day Hospital Neonate Care (992X1) 14
The PERC recommends NO direct inputs for this code.

Allergy Test Interpretation (95027) 21

The direct inputs for this code is due to a methodological change. It was agreed that the direct inputs should be reviewed carefully during the code's pre-facilitation on Saturday morning in relation to physician work.

II. Special Situations for Existing Codes **RUC TAB**

The following issues were mentioned in the November 1, 2006 Final Ruling by CMS and were put on a level of interest for this meeting by AMA staff.

Gynecologic Oncology 25

The American College of Obstetricians and Gynecologists (ACOG) requested that a standard pack be developed for all ob/gyn procedures. The PERC believed this would be appropriate however if this would change any of the existing inputs for any code, the PERC requests these codes be listed for further review. In addition, ACOG requested a light source and a clarification of the type of exam table for some codes. The PERC again requests a code listing be provided for the next meeting.

Computer-Aided Detection (CAD) Breast Mammography 26
(77051-*77052)*

American College of Radiology reviewed this issue did not wish to propose any changes at this time and the PERC had no comment regarding the direct inputs for these codes.

Dual-Energy X-Ray Absorptiometry (77080-77082) 27

The American Association of Clinical Endocrinologists, American College of Radiology, American College of Rheumatology, and The Endocrine Society recommended changes to existing direct inputs which were reviewed and refined by the PERC. The RUC requests reconsideration of the vital signs by the PERC as the RUC questioned whether this is typically performed for this service. The PERC will re-review this issue at the April 2007 PERC meeting.

Cardiac Catheterization (93501-93572) 28

American College of Cardiology

(Per discussions with specialty society, CMS, and other organizations, a decision has been made to defer this issue until the April 2007 PERC/RUC meeting.)

AMA/Specialty Society RVS Update Committee
Extant Data Workgroup Report
February 1, 2007

Members Present: David Hitzeman, DO, (Chair), Bibb Allen, MD, John Derr, MD, Charles Mabry, MD, Scott Manaker, MD, Bernard Pfeifer, MD, and Peter Smith, MD

I. Workgroup's Proposed Overall Agenda

After much discussion, the Workgroup determined that it needed to develop a process for how to make its recommendations on what the RUC's policy should be on extant data use. It should be noted that this process could be altered in the future. However, the following process was proposed and accepted by the Workgroup:

1.) A Review of the Extant Data Use in the 2005 Five Year Review
2.) CMS Discussion/Overview of Specialty Society Concerns
3.) Database Identification Project
4.) Develop Exclusionary/Inclusionary Criteria
5.) Existing Database Analysis
6.) Develop Policy of How Extant Data Could be Used in the New and Revised Process

II. Review of Extant Data Use in 2005 Five Year Review

The Workgroup requested a review of how extant data, specifically NSQIP data and the STS Database, was used in the 2005 Five Year Review. They requested that the specialties who recommended the use of these extant databases give a brief presentation regarding their databases and their use in the 2005 Five Year Review. Both Doctors Mabry and Smith gave a brief presentation about the NSQIP database and the STS database, respectively. They each highlighted how their specialties internally reviewed these databases to determine their validity, discussions that the Research Subcommittee had when reviewing these databases and how these databases were used in the Five Year Review Process.

III. CMS Discussion/Overview of Extant Data Use Concerns

On June 21, 2006, the Centers for Medicare and Medicaid Services (CMS) issued a Proposed Rule indicating various concerns it had with the RUC using extant databases to develop work RVU recommendations. Representatives from CMS stated that they recognize the significant data that can be provided by these extant databases, however, they have concerns about how this data will be implemented in the new and revised process. Their concerns including the following:

1.) How the RUC will construct measures by which all specialty societies' databases will be reviewed;
2.) How will the RUC ensure that no societies will be disadvantaged by using these extant databases; e.g. office-based databases vs. hospital-based databases and who is reporting the procedure;
3.) How the RUC will ensure transparency of data to all parties,
4.) How the RUC will ensure relativity within code families; within a specialty's code set and across all codes and
5.) How the RUC if it determines to use this data to replace the current RUC survey instrument will take into consideration intensity and complexity measures; e.g. IWPUT

III. Future Actions

The workgroup requests the following for its next meeting:

1.) AMA staff will solicit specialty societies' input in the Workgroup's development of inclusionary and exclusionary criteria for extant database review and in the Workgroup's project of identifying any existing extant databases

2.) A report from the American College of Surgeons which details the components of an extant database
3.) Communication with the developers of the NSQIP database and the STS database to determine the availability of this data to the RUC for internal review and to determine the extent of the data collected in these databases
4.) Communication with the Surgical Quality Assurance Workgroup to be apprised of the work they are conducting relating to their review of extant databases

AMA/Specialty Society RVS Update Committee
Multi-Specialty Points of Comparison Workgroup Report
February 1, 2007

The following members were in attendance: John Derr, MD (Chair), Bibb Allen, MD, Ron Burd, MD, Bruce Deitchman, MD, Robert Fifer, PhD, CCC-A, John Gage, MD, Charles Koopmann, MD, Robert Kossmann, MD, Walt Larimore, MD, Douglas Leahy, MD, and Bernard Pfeifer, MD

History of the MPC Report
The MPC Workgroup reviewed and discussed the "History of the MPC" document. The Workgroup agreed with the historical account and made no structural changes to the document. **The MPC Workgroup recommends that the History of the MPC document be included as a reference in future updates of the MPC list.**

The discussion regarding the history of the MPC list also focused on current and potential uses of the list. The Workgroup noted that since its inception, the MPC list has never been used to assess relativity between specialties and is not used by CMS for establishing cross-specialty relativity. The MPC Workgroup discussed potential steps it may take to begin to assess the quality of the list in establishing such relativity. The Workgroup agreed that relativity of MPC codes within the each specialty must first be ensured. Prior to the next solicitation of edits to the MPC list, the workgroup will ask specialties to comment on the overall relativity of its MPC codes (including A, B and C codes, if applicable) to all services performed by the specialties. Further, the Workgroup agreed that specialties will be asked to assess the intra-specialty relativity of the codes identified by CMS for the most recent Five-Year Review, namely the top two utilized services for each specialty. The Workgroup hopes these comments and considerations to result in the development of an MPC list with intra-specialty relativity making it easier to assess and develop cross-specialty relativity. The next opportunity to review the MPC list will be at the September 2007 RUC meeting.

Specialty Society Concurrence of MPC Changes
At the most recent meeting of the MPC Workgroup, a number of requested changes to the MPC list codes were recommended by specialty societies that were not the dominant specialty for those codes. The Workgroup recommended and the RUC denied the requests, pending concurrence by the dominant specialty society. Staff solicited specialty society input for each requested change, identified below, and received the following responses from the dominant specialty society.

CPT	Request	Requesting SS	Dominant SS	Dominant SS Response
20973	Remove	ASSH	AAPM	Concur
22842	Remove	AANS	AAOS	Concur
23395	Remove	ASSH	AAOS	Concur
29075	Add	ASSH	AAOS	Concur
29848	Remove	ASSH	AAOS	Concur
44160	Remove	ASCRS	ACS	Does Not Concur
44202	Remove	ASCRS	ACS	Does Not Concur
59400	Remove	AAFP	ACOG	Concur
78315	Add	SNM	ACR	Concur

The MPC Workgroup recommends that 20973, 22842, 23395, 29848, and 59400 be removed from the MPC list; that 29075 and 78315 be added to the MPC list; and that no action be taken for 44160 and 44202.

AMA/Specialty Society RVS Update Committee
RUC HCPAC Review Board Meeting
February 1, 2007

Members Present:

Arthur Traugott, MD, Chair
Mary Foto, OTR, Co-Chair
Katherine Bradley, PhD, RN
Michael Chaglasian, OD
Thomas Felger, MD
Robert Fifer, PhD
James Georgoulakis, PhD, JD
Anthony Hamm, DC
Emily H. Hill, PA-C
William J. Mangold, Jr., MD
Lloyd Smith, DPM
Doris Tomer, LCSW
Erik Van Doorne, PT
Jane White, PhD, RD, FADA

I. CMS Update

Edith Hambrick, MD, provided a CMS update and informed the HCPAC that the *Final Rule* on the Medicare Physician Fee Schedule was posted on November 1, 2006. Currently, CMS is focusing on the implementation of reporting measures for the Physician Quality Reporting Initiative (PQRI).

II. Relative Value Recommendations for *CPT 2008*

Team Conference

The following specialty societies presented recommendations for the Team Conference Non-Physician codes 9936X2 and 9936X4: American Dietetic Association (ADA), American Physical Therapy Association (APTA), American Psychological Association (APA), American Occupational Therapy Association (AOTA), American Speech-Language-Hearing Association (ASHA), and National Association of Social Workers (NASW). The CPT Editorial Panel created CPT codes 9936X2 *Medical team conference with interdisciplinary team of health care professionals, face to face with patient and/or family, 30 minutes or more; participation by non-physician qualified health care professional* and CPT code 9936X4 *Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by non-physician qualified health care professional* to differentiate team conferences at which the patient is present versus when the patient is not present and differentiate for each of the various healthcare professionals who may participate in the conference.

The HCPAC thoroughly reviewed the specialty societies survey results and recommendations for codes 9936X2 and 9936X4. The HCPAC agreed that 9936X2 would involve slightly more physician work than 9936X4 because there is more involvement when the patient and/or family is present. The HCPAC concluded that the survey results were too high and there was not appropriate rationale for the specialty societies recommended work relative value units. The HCPAC then performed a weighted average based on the survey median work values per specialty, with an intra-service time of 30 minutes. The weighted average produced a work relative value of 0.82. The HCPAC determined that a 0.82 work RVU was appropriate when compared to commonly reported codes by other health care professionals such as occupational therapists, physical therapists and dieticians. For example, code 97110 *Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility* valued at (RVU=0.45) or code 97803 *Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes* valued at (RVU=0.37), both which are valued at 15 minute increments. Therefore, if these services are doubled to 30 minutes, for a comparable reference to code 9936X2, the RVUs equal 0.90 and 0.74 respectively. Thus placing the RVU recommendation of 0.82 for 9936X2 appropriately relative to similar health care professional services.

The HCPAC analyzed the survey pre-, intra-, and post-service survey times and determined that these times were too high, relative to similar services performed by health care professionals. **The HCPAC recommends a pre-service time of 5 minutes, intra-service time of 30 minutes, and immediate post-service time of 5 minutes for 9936X2. The HCPAC recommends a work RVU of 0.82 for code 9936X2.**

The HCPAC analyzed the specialty societies survey data for code 9936X4. The HCPAC determined to crosswalk the percentage difference of the survey recommended RVU with the final recommended RVU for code 9936X2 (0.82/1.25) and apply this percentage difference to the survey recommended RVU to determine an appropriate rank order. The resulting work RVU recommendation is 0.72. **The HCPAC recommends a pre-service time of 5 minutes, intra-service time of 30 minutes, and immediate post-service time of 5 minutes for 9936X4. The HCPAC recommends a work RVU of 0.72 for code 9936X4.**

Practice Expense

The HCPAC reviewed the practice expense associated with 9936X2 and recommend less than one minute (0.33 minutes, 1 minute of meet and greet time divided by 3 health care professionals) of greet the patient. The HCPAC determined that a blended RN/LPN/MTA provides the greeting. Additionally, 1/3 or 0.33 of a patient education booklet is recommended as part of the medical supplies for code 9936X2. The HCPAC recommends that there is no practice expense associated with code 9936X4.

PLI

The HCPAC recommends codes 97110 (x2), 97803 (x2) or a blend of these two codes as the reference codes for the PLI crosswalks for codes 9936X2 and 9936X4.

Non Face-to-Face Qualified Healthcare Professional Services (989X1, 989X2, 989X3 and 989X4)

The CPT Editorial Panel created codes 989X1 *Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion*, 989X2 *11-20 minutes of medical discussion*, 989X3 *21-30 minutes of medical discussion* and 989X4 *Online evaluation and management service provided by a physician to an established patient, guardian or health care provider not originating from a related E/M service provided within the previous 7 days, using the Internet or similar electronic communications network* to capture time spent providing care to patients in a non face-to-face manor and differentiate for each of the various healthcare professionals who may provide non face-to-face services.

The American Physical Therapy Association (APTA) presented the survey results for codes 989X1, 989X2, 989X3 and 989X4. After further examining the CPT code vignettes the HCPAC determined that the latest modifications to the vignettes were not those used on the survey, because the CPT Editorial Panel finalized these after the initiation of the survey process. The specialty society tabled these codes from review at this meeting until a better sense of the total issue is reached, including review of the physician non face-to-face codes. The APTA noted that additional non-physician groups should also survey prior to April 2007.

III. Other Issues

Recusal from Voting

In the executive session of the HCPAC, the issue of conflict of interest was examined. At this particular meeting multiple societies presented the team conference codes and the presenting HCPAC members concluded that they would recuse themselves from voting on these codes. The HCPAC then discussed the issue of making formal changes to the HCPAC Organizational Structure and Processes regarding whether a HCPAC member votes or recuses oneself from voting when his/her specialty society presents an issue. The HCPAC will examine this issue and possibly propose specific changes at the April 2007 HCPAC meeting.

Reduced Services

At the October 2006 RUC HCPAC meeting James Georgoulakis, PhD, asked the HCPAC how a health care professional should report a service when it had been prematurely ended du to the patient's request or sudden departure. AMA staff confirmed that the appropriate action would be to report such codes with a modifier -52.

HCPAC Co-Chair and Alternate Co-Chair

AMA staff indicated that the terms for the HCPAC Co-Chair, Mary Foto, OTR, and HCPAC Alternate Co-Chair, Robert Fifer, PhD, will end after the April 2007 HCPAC meeting. AMA staff will be requesting nominations following this meeting and voting for these chairs will occur at the April 2007 HCPAC meeting.

Multi-Specialty Practice Information Survey

Representatives from the Gallup Organization attended the meeting to discuss sampling issues for non MD/DO participants. The AMA, Lewin and Gallup will follow-up with specific groups to ensure that both organization members and non-members are included in the survey sample.

The meeting adjourned at 12:20 p.m.

AMA/Specialty Society RVS Update Committee
Research Subcommittee Report
February 1, 2007

Members Present: Norman A. Cohen, MD, (Chair), Bibb Allen, MD, John Derr, MD, Charles Koopmann, Jr., MD, David Hitzeman, DO, Scott Manaker, MD, Greg Przybylski, MD, Bruce Deitchman, MD, J. Baldwin Smith, DPM, Lloyd Smith, DPM, Peter Smith, MD, Samuel Smith, MD

I. Recommendations from Pre-Time Workgroup

At the October 2006 RUC Meeting, the Pre-Service Time Workgroup made recommendations to the Research Subcommittee to incorporate the RUC-approved pre-service time packages into the summary of recommendation form**. The Research Subcommittee recommends the pre-services times associated with the RUC approved packages be allocated on the summary of recommendation as indicated on page 1354 of the RUC agenda book.**

These times will be incorporated into the summary of recommendation form in the form of a drop down field which would allow the specialty society to pick the package that best corresponds to the data which was collected in the survey process. Once the selection is made, the pre-service evaluation, pre-service positioning and pre-service scrub, dress and wait fields will be pre-populated with the corresponding times. Additionally, the Research Subcommittee discussed that specialty societies need to be able to reflect the additional pre-service time that is potentially associated with TEE, invasive monitoring or complex positioning as instructed by the Workgroup. **The Research Subcommittee recommends that a new field will be added titled, "Additional Pre-Service Time," to reflect this additional pre-service time.**

Furthermore, the Research Subcommittee recommended that the following language will be added to the instruction document to assist specialty society staff in its completion of the summary of recommendation form:

Please review the following pre-service time packages and determine which package best corresponds to the data which was collected in the survey process. Once the selection is made, the pre-service evaluation, pre-service positioning and pre-service scrub, dress and wait fields will be pre-populated with the corresponding times. Additionally, in the "Additional Pre-Service Time," field please reflect the additional pre-service time that is potentially associated with the procedure. Examples of additional time would include the time associated with TEE, invasive monitoring or complex positioning. The rationale for this additional time should be explained in the summary of recommendation form under description of pre-service work.

After further discussion of this issue, a RUC member expressed a concern that CMS' current definition of pre-service time does not reflect the pre-service time recommendations as approved by the RUC. Therefore, the Research Subcommittee recommends that CMS modify its current definition of pre-service time which is that the pre-service time begins just 24 hours prior to surgery to pre-service time begins immediately after making the decision to have surgery. This change in CMS policy will be consistent with the existing practice expense definition of pre-service time. **The Research Subcommittee recommends that CMS modify its current definition of pre-service time from beginning 24 hours prior to surgery to beginning immediately after making the decision for surgery.**

Because this recommendation is a CMS policy change, it will require publication within CMS' Final Rule. **Therefore, the Research Subcommittee recommends that all the aforementioned pre-service time recommendations be implemented into the summary of recommendation form and instruction document, pending CMS' response to this change in policy request which will be published in the 2007 *Final Rule.***

II. Reference Service List Policy

At the April 2006 RUC Meeting that this policy of guidelines might not be protecting us from Antitrust violations. Therefore at the October 2006 RUC meeting, the Research Subcommittee reviewed and edited the existing guidelines for the reference service list and requested AMA legal counsel review to inform the RUC if these modifications to the guidelines would be compliant with Antitrust Laws. At the request of the RUC and the Research Subcommittee, AMA Legal Counsel was consulted to determine if these changes to the recommended guidelines were consistent with past anti-trust legal advice. After careful review of the history of this issue as well as the RUC's Standard Methodological Requirements for Specialties Document, AMA Legal Counsel recommended the following changes to the Research Subcommittee's modifications as highlighted. With these changes, the AMA Legal Counsel believes that this policy is consistent with past advice which affords the RUC protection from violating the Antitrust laws. **The Research Subcommittee reviewed the following changes and recommends that they be implemented into the instruction document.**

The following is an approved list of guidelines for developing reference service lists. ~~There may be circumstances in which it may not be possible or appropriate to follow one or more guidelines.~~

The specialty may ask AMA ~~staff~~ and the RUC's Research Subcommittee to evaluate a reference service list in advance of the specialty sending the survey out for completion.

(It should be noted that the term "physician" in this context includes both physician and non-MD/DO providers)

- **Include a broad range of services (i.e. 10-20 services) and their 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.**
- **Include codes that represent ~~S~~services on the list ~~should be those~~ which are well understood and commonly provided by physicians in the specialty or subspecialty. Accordingly, a specialty society's reference service list may vary based on the new/revised code being surveyed.**
- **Include similar or related codes ~~in~~ from the same family or CPT section 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, i~~Include codes from ~~on~~ the MPC list, if appropriate ~~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 if appropriate.**

III. Proposed RUC Rationale for 22840, 22842, 22843, 22845, 22846 and 22847

While conducting research on the codes in the Modifier -51 exempt list, it appeared that 7 spine codes on the list had some interesting valuation history. The RUC had recommended that these procedures (22840, 22842, 22843, 22844, 22845, 22846 and 22847) were originally valued by the RUC through the new and revised process as the global period of these codes were changed from a 000 to a ZZZ. As such the RUC, recommended that the code should no longer be reported with a -51 Modifier and the RVU for these codes should be reduced in some cases by half to reflect this change in global. CMS accepted this recommendation in the Dec 1995 Federal Register. However, the decision was overturned in the Nov 1996 Federal Register due to comments CMS received regarding these codes. The Research Subcommittee discussed this issue and received input from CMS that they would review this issue further. However, at this time the RUC recommends that the rationale in the RUC database for these codes reflect this history. **The Research Subcommittee recommends incorporating the amended rationales for CPT codes 22840, 22842, 22843, 22844, 22845, 22846 and 22847 as listed on page 1360 of the RUC agenda book into the RUC database.**

IV. Specialty Society Request –

- **American Speech-Language and Hearing Association (ASHA) – Review of Survey Issues for Speech-Language and Hearing Codes**

After receiving a letter from CMS stating that they would consider establishing work relative values for Speech-Language Pathology and Audiology Services (SLP/A), ASHA requested guidance from the Research Subcommittee to help them address their potential survey complications and how to develop work RVU recommendations for these services. In addition, the Research Subcommittee received a letter from the American Academy of Otolaryngology and Head-Neck Surgery requesting clarification on CMS' intentions about assigning work RVUs to these codes. After much discussion, the Research Subcommittee dealt only with specific methodological questions posed by ASHA. The Research Subcommittee reviewed the survey proposals made by ASHA. **The Research Subcommittee recommends that ASHA should develop their recommendations for these procedures utilizing a standard RUC survey instrument and at ASHA's request, their reference service list for these procedures will be reviewed by the Research Subcommittee.**

A Subcommittee member suggested and the **Research Subcommittee recommended that upon the submission of these recommendations to CMS, a request should be made that CMS should transition the relative values that it currently utilized for these services from the practice expense pool to the work RVU pool to account for this change in policy.**

- **American Society for Therapeutic Radiology and Oncology (ASTRO) – Survey Instrument Description of Service Revision**

ASTRO anticipates conducting a survey to develop recommendations for some radiation oncology services. After reviewing the current XXX survey instruments, ASTRO determined that none of these survey instruments accurately reflected the description of services for these radiation oncology services. ASTRO suggested and the **Research Subcommittee recommends that a new XXX-Radiation Oncology survey instrument be created which will reflect the following description of service and otherwise match the XXX-Therapy survey instrument:**

Pre-Service Period: Preparing to see the patient/start procedure, reviewing records and communicating with other professionals

Intra-Service Period: Activities in the intra-service period may include performing the procedure, communications with the clinical staff, review and interpretation of images or data, when acquired and documentation of services.

Only the physician's time spent during the procedure should be considered. Time spent by the technologist and other clinical staff is NOT included.

Post-Service Period: Post-Service period includes arranging for further services, communicating (written or verbal) with the patient, family and other professionals.

- **American College of Obstetricians and Gynecologists (ACOG) – Alternative Development of Work RVU Recommendation**

ACOG wishes to utilize an incremental add-on approach in valuing four laparoscopic total hysterectomy codes. ACOG in the last two years has surveyed two families of laparoscopic hysterectomy codes. In the survey process of these two families, there were inconsistencies in the recommended values by the physicians surveyed, between codes without removal of tube(s) and/or ovary(s) and codes in the removal of tube(s) and/or ovary(s). To develop recommendations for these codes a building block methodology was implemented. ACOG suggests and **the Research Subcommittee recommends that the two proposed base codes, 585XX1 Laparoscopy, surgical, with total hysterectomy for uterus**

250 grams or less and 585XX3 Laparoscopy, surgical, with total hysterectomy for uterus greater than 250 grams be surveyed utilizing a standard RUC survey instrument and an incremental add-on approach be used to develop RVU recommendations for the subsequent two codes in the family which both include the removal of tube(s) and/or ovary(s).

V. Review of Recommendation Process for Specialty Frequency Estimates

A specialty society has raised a concern with the RUC staff that some specialties may under appreciate the importance of the specialty-specific frequency data submitted as part of the code valuation process. Therefore, the specialty society suggests and the Research Subcommittee recommends that the following language be added to the existing queries of frequency estimates on the summary of recommendation form:

1.) Estimate the number of times the service might be provided nationally in one year and if the service is performed by multiple specialties, then all societies must provide their frequency and their percentage of performing this service. **Please explain the rationale for this estimate;**

2.) Estimate the number of times the service might be provided to Medicare patients in one year and if the service is performed by multiple specialties, then all societies must provide their frequency and their percentage of performing this service. **Please explain the rationale for this estimate.**

VI. Extant Data Policy Workgroup Update

AMA staff gave an overview of the Extant Data Policy Workgroup's meeting. The Extant Data Policy Workgroup reviewed and approved its proposed overall agenda, reviewed the extant data use in the 2005 Five Year Review, specifically NSQIP data and the STS Database and had a discussion with CMS regarding their concerns as published in its *Proposed Rule*. The Workgroup's future actions include:

1.) AMA staff soliciting specialty societies to develop inclusionary and exclusionary criteria for extant database review and to identify any existing extant databases

2.) Obtaining a report from the American College of Surgeons which details the components of an extant database

3.) Communicating with the developers of the NSQIP database and the STS database to determine the availability of this data to the RUC for internal review and to determine the extent of the data collected in these databases and

4.) Communicating with the Surgical Quality Assurance Workgroup to be apprised of the work they are conducting relating to their review of extant databases.

AMA/Specialty Society RVS Update Committee
Practice Expense Subcommittee/Research Subcommittee
Multi-Specialty Practice Information Survey – Gallup Presentation
February 1, 2007

Practice Expense Subcommittee Members: Katherine Bradley, PhD, RN, (Chair), Joel Brill, MD, Thomas Felger, MD, John Gage, MD, Meghan Gerety, MD, William J. Mangold, Jr, MD, Charles Mick, MD, Bill Moran, MD, David Regan, MD, and Robert Zwolak, MD.

Research Subcommittee Members: Norman A. Cohen, MD, (Chair), Bibb Allen, MD, John Derr, MD, Charles Koopmann, Jr., MD, David Hitzeman, DO, Scott Manaker, MD, Greg Przybylski, MD, J. Baldwin Smith, DPM, Lloyd Smith, DPM, Peter Smith, MD, Samuel Smith, MD

Gallup Presentation

Mike Ellrich and Catherine Strahan of the Gallup Organization presented the preliminary results of the pilot study of the Multi-Specialty Physician Practice Information Survey, projected to be completed by mid-February. The PowerPoint presentation is attached. The preliminary findings of the pilot indicate that the telephone interviews of physicians and non-MD/DO health care professionals are within the 15 minutes in length, which is the maximum recommended length for a physician interview. The practice manager component of the pilot survey, however, is running at approximately 25 minutes for the telephone interview and 3 ½ hours of preparatory work. Gallup recommends that the practice manager interview be condensed to 15 minutes and the advanced preparation require no more than 1 ½ hours of information collection. Mr. Ellrich indicated that upon completion of the pilot, Gallup will be working with the American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS) to finalize the survey prior to its launch in March. The AMA and CMS had desired to pilot an extensive survey to determine what was indeed plausible. The survey will be condensed to eliminate many questions proposed by the AMA and CMS, leaving in place all questions required for the practice expense methodology and specific questions that were critical to certain specialty societies. The final surveys are to be available by March 5th and will be circulated to all participating specialty societies at that time.

Specific Gallup Recommendations:

- **Send "call to action" letter from relevant specialty society 7-10 days prior to Gallup advance packet mailing**

The Subcommittees reviewed the attached letter and agreed that it should be sent by Gallup in advance of the survey packet.

- **Combat discard rate by adding specialty society branding and/or printed message prominently on envelope**

The Subcommittees also agreed that the specialty society logos should be printed on the survey packet envelopes. Ms. Smith indicated that the AMA has collected these logos. Notification will be sent to all survey participants regarding the intention to use the logos and signatures for the new advance letter and the logos on the envelope to ensure that all specialty society questions and concerns may be addressed in advance. It was suggested that umbrella organizations may wish to have their logo added to the subspecialty's envelope. AMA staff will collect these requests and organize this information for the Gallup Organization.

- **Calculate expenses for employed physicians by collecting the specialty practice level costs and then allocate based on the physician's patient care hours compared to practice's patient care hours.**

A few Subcommittee members recommended employed physicians be excluded form this survey project as they were concerned that the practice expenses would be underestimated for these physicians. However, the majority of the Subcommittee members agreed with the Gallup recommendation to collect the practice costs for employed physicians at the practice level to be allocated to that individual based on the overall percentage of that physicians patient care hours to that of the practice's patient care hours. If the physician is employed by a multi-specialty group practice, the practice costs and the patient care hours for the practice would be collected at the specialty level.

- **Condense the medical equipment utilization series of questions within the survey.**

The Subcommittees understood that the listing of 30-35 specific types of medical equipment added to the complexity of the survey instrument. However, it is recommended that the basic question be maintained and only a few (<5) items be listed. Mr. Ellrich did indicate that it would be expected that a small percentage of physicians will have purchased expensive equipment and would be able to respond to this specific question.

[*Insert Applicable Specialty Group Logo*]

(Date/Year)

John Smith, M.D.
1000 Medical Center Drive
New York, New York 20687

Dear Dr. Smith:

I am specifically writing to ask you for your support of a national study about medical practices, currently being co-sponsored by the [*Insert Applicable Specialty Group*] and the American Medical Association. The objective of this study is to help document changes in the U.S. healthcare delivery system that affect your practice every day. During my tenure as *[Insert Title]* of the *[Insert Applicable Specialty Group]*, one of the recurring comments I hear from [*specialty*] is that decision makers and payors are not fully informed about the broad clinical, operational, and financial challenges that face their practices today. This study represents your practice's opportunity to communicate accurate financial and operational information to policy makers including members of Congress and the Centers for Medicare and Medicaid Services. Your participation in this study will ensure that the voice and priorities of our medical specialty are clearly heard.

The Gallup Organization has been retained to administer the survey and will make data collection as convenient for you and your practice as possible. Throughout calendar year 2007, Gallup will contact randomly selected healthcare providers and practice managers/administrators in order to collect their confidential responses. During the next few weeks please let your staff know to anticipate a packet from Gallup and *[Insert Applicable Specialty Group]* containing important information about the study. Some of the more detailed questions may require advance data collection but please afford your staff the necessary time so that your voice may be included in the final study results.

Thank you in advance for your time and I hope that you will take the opportunity to participate in this national study beginning March 2007. Your involvement will make certain that the information collected will accurately represent your practice, patients, and medical specialty.

Sincerely,

[*InsertTitle*]
[*Insert Applicable Specialty Group*]

THE GALLUP ORGANIZATION
PRINCETON

2007 Practice Information Survey - Pilot Study

Review of Findings for: AMA/Specialty Society RVS Update Committee (RUC)

February 1, 2007

I. Study Design

- Three phase pilot
- Advance packet materials
- Executive ownership
- One survey/two component design
- Honorarium
- Letters of support
- “Key items” worksheet with cross walk to survey
- Web survey versions

II. Summary – On-site Visits

- Seven site visits were conducted representing six specialties across three geographic regions
  - Orthopedic Surgery
  - Internal Medicine (2)
  - Physical Therapy
  - Ophthalmology
  - Forensic Psychology
  - Pediatrics
- Avg. reported time to complete provider worksheet was 20-25 minutes
- Avg. reported time to complete expense worksheet estimated as 3-3.5 hours

II. Summary – On-site Visits (cont.)

- **Practice Managers/Administrators interviewed recommended involving them early in the process to intervene and encourage participation, especially among employee providers**
- **Greater affinity to participate found when specialty association endorsement was emphasized**

II. Summary – Pilot Interviews

- **Practice receptivity found to differ dramatically between non-MD/DO vs. MD/DO specialties**
- **Expense detail for requested items requires multiple touch-points**
- **Hospital based practices present greatest challenge in locating correct individual to complete expense portion of the study**
- **Ramp up period to interview is 1-2 weeks longer than typical physician studies based on information flow and advance data collection required**

II. Summary – Cognitive Interviews

- Length of expense survey referenced as “excessive” with few practices likely to complete surveys "as is"
- Detailed level of expense survey raised concerns among respondents about data confidentiality
- Questions largely understood by respondents with exception of expectation to allocate share of expenses for employed providers
- Expense detail determined to be most commonly available at the practice vs. provider level
- Honorarium referenced as unusually low relative to required burden

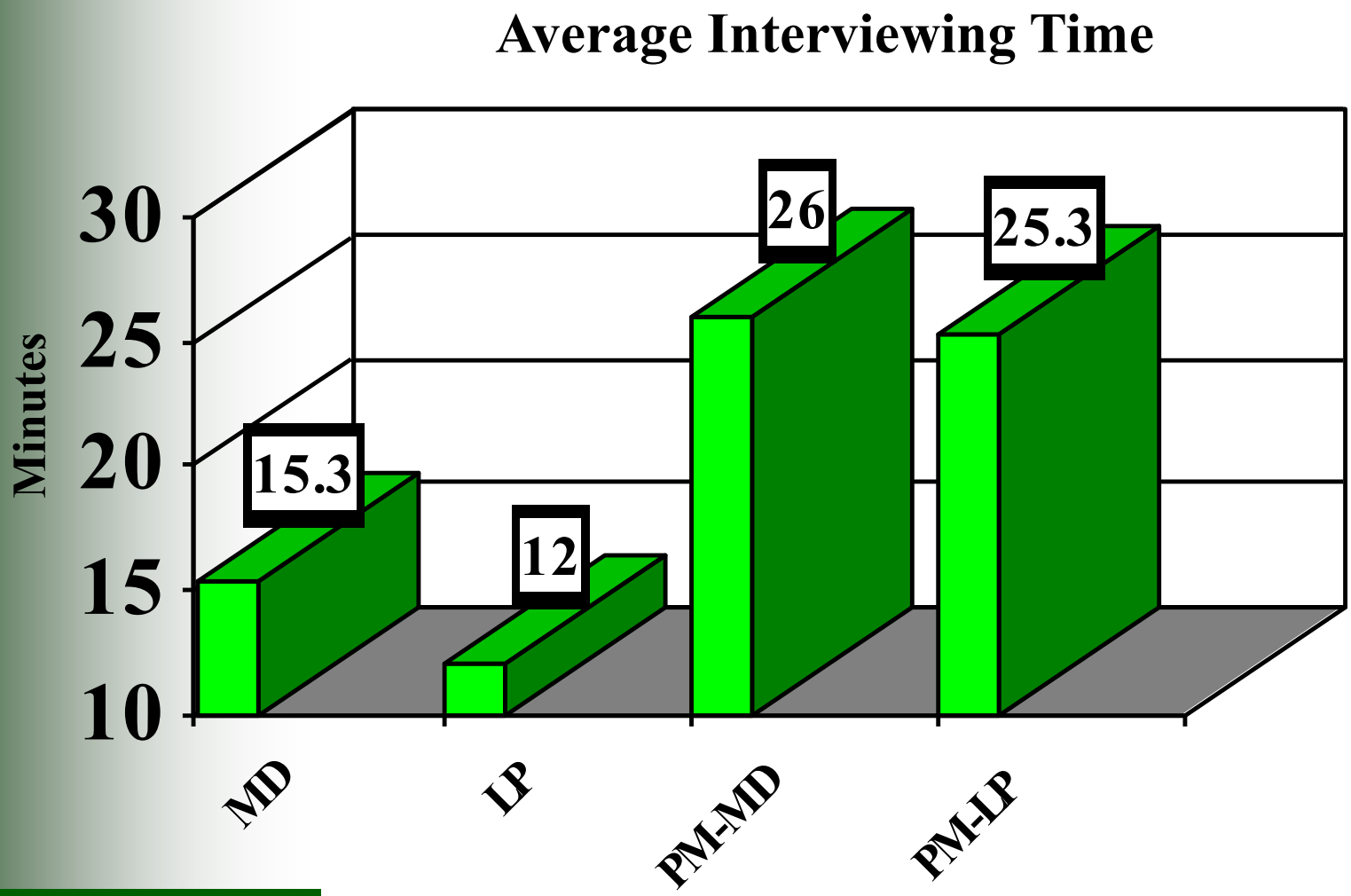
II. Summary – Interviewer Feedback

- Percentage of practices discarding advance Gallup packet estimated at 40% or higher
- Additional skip patterns incorporated into physician survey will reduce burden for solo practitioners
- Observed relationship between practice size and employee provider's influence in getting manager to complete expense portion of survey
- Unusually low number of provider initiated calls in response to advance packet mailing

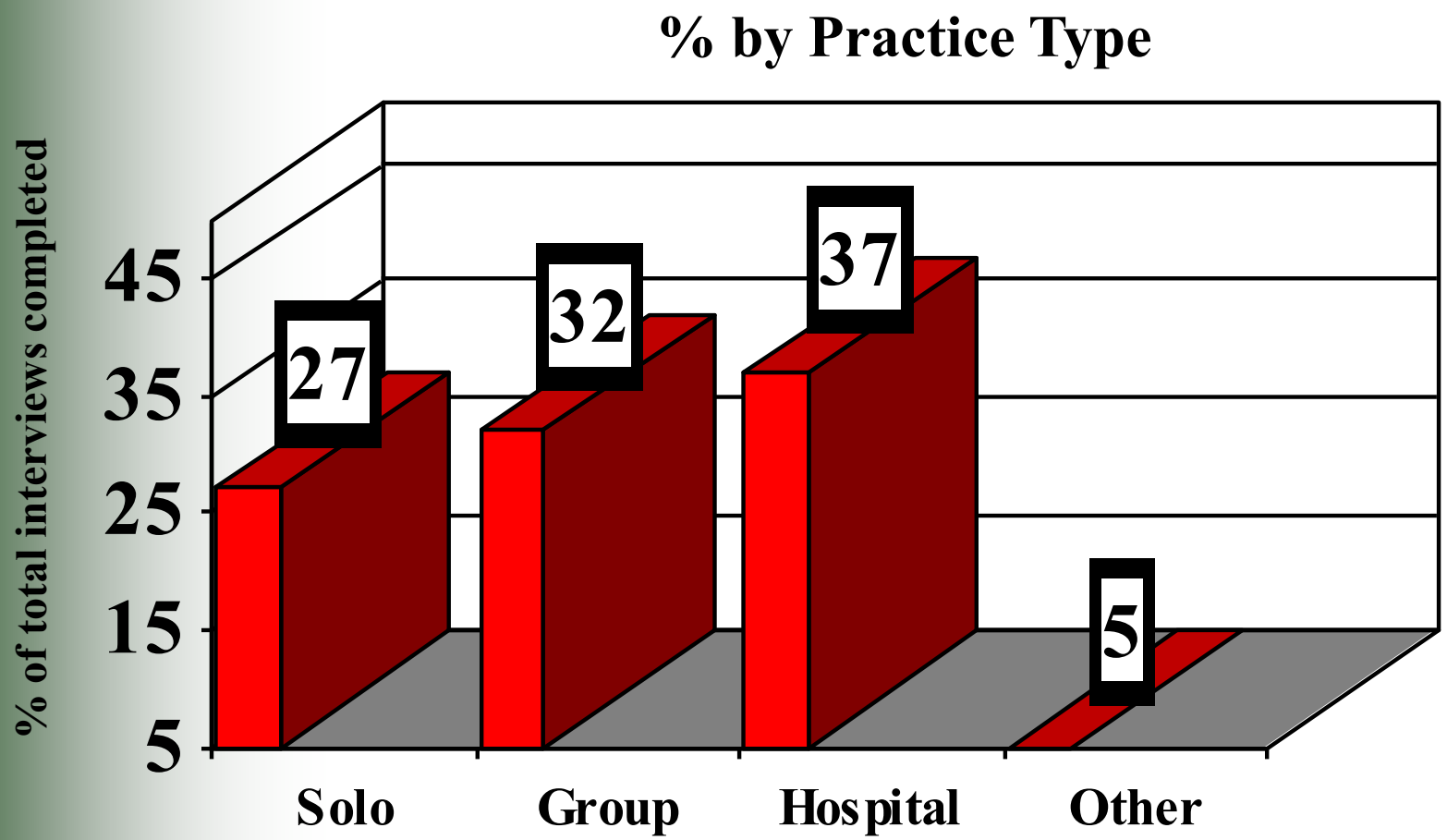
III. Status and Data Highlights

- **RVUs are not known by vast majority of MD/non-MD providers (even when definition is provided)**
- **No completes on the medical equipment utilization section to date**
- **Only 20% of practice managers interviewed to date indicate using one of the pre-specified cost allocation methods, i.e. # of providers, revenue, RVUs, charges, etc., in expense survey**
- **With respect to employee providers sampled, majority of practice managers have indicated "NA" for expense allocation method utilized**

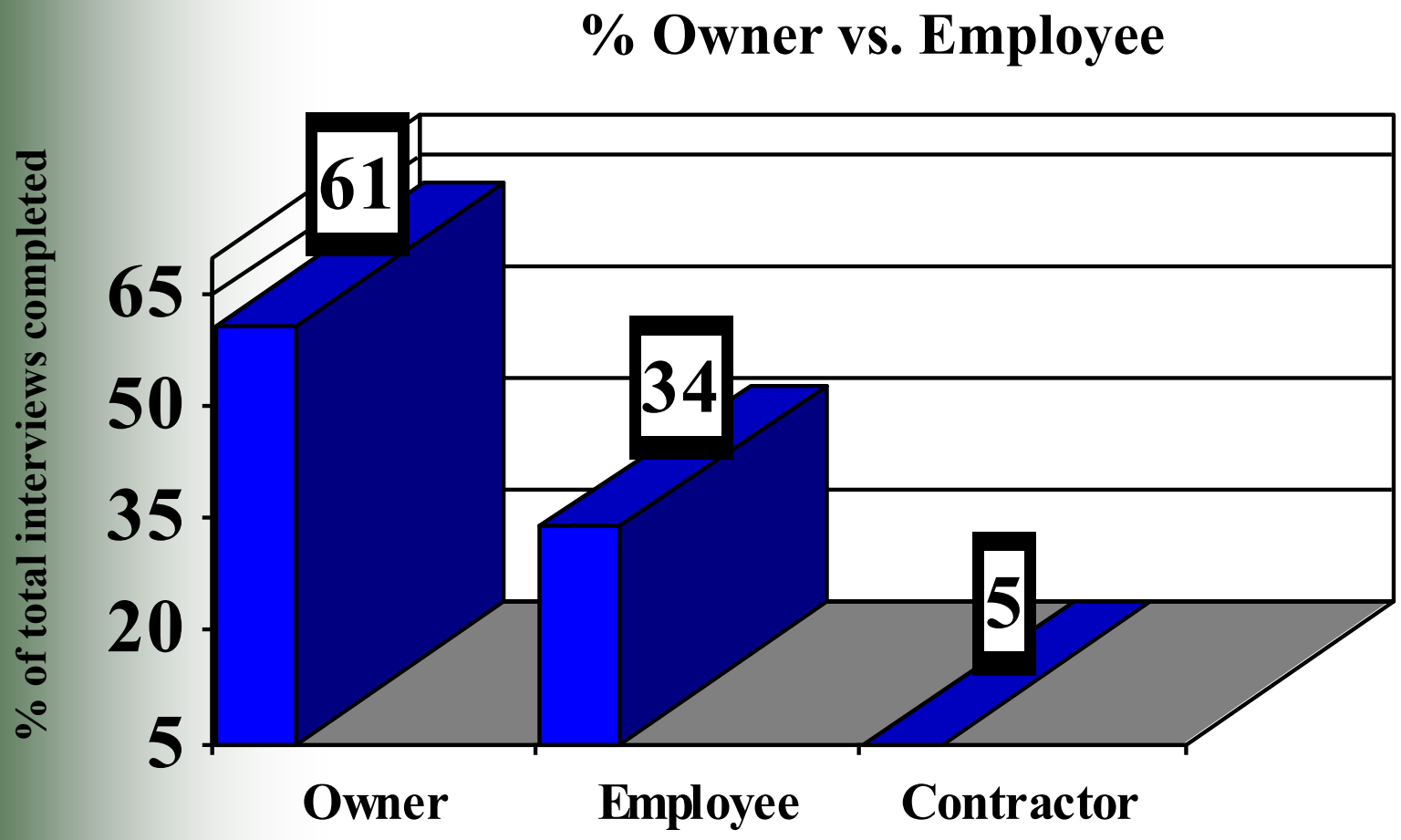
III. Status and Data Highlights (cont.)



III. Status and Data Highlights (cont.)



III. Status and Data Highlights (cont.)



III. Status and Data Highlights (cont.)

Specialties Responding in Pilot

- Anesthesiology
- Cardiothoracic Surgery
- Emergency Medicine
- Family Medicine
- General Practice
- General Surgery
- Internal Medicine
- Interventional Radiology
- Nephrology
- Neurology
- Obstetrics/Gynecology
- Ophthalmology
- Orthopedic Surgery
- Pathology
- Pediatrics
- Physical Medicine and Rehab
- Psychiatry
- Urology

III. Status and Data Highlights (cont.)

Specialties Responding in Pilot

- ✓Chiropractor
- ✓Optometry
- ✓Podiatry
- ✓Audiologist
- ✓Physical Therapy
- ✓Dietician-Nutritionist
- ✓Clinical Social Worker

IV. SWOT Assessment

Weaknesses

- Length (25 min. avg. for expense)
- Granular detail (prep. time)
- Ordering of survey (saliency)
- Addition of employed physicians

Strength

- Survey design (provider and manager)
- Preparatory/advance work done for pilot
- Virtually universal support
- On-going provider pressures create opportunity for opinion sharing
- Consistent findings among pilot phases

Opportunities

- Point-in-time update necessary for on-going decision making
- Modify design and questions to address challenges discovered during pilot phase

Threats

- Narrow time window
- Too broad a focus may compromise response rates and efficacy of data

V. Study Timeline

Pilot Data Analysis	February 16*
Final Pilot Recommendations w/Interviewer Feedback	February 21*
Full Study Kick-off/Planning Meeting (discuss findings from pilot study)	February 26
Survey finalization	March 5
Sample received from AMA	March 5
Survey programmed/proofed	March 14
Introductory packets revised/printed/mailed	March 14
Interviewer training	March 16
Interviewing	March 19-December 22
Data analysis/preparation	January 2-9
Data file delivered to AMA	January 10

* Indicates revision from original proposed timeline

VI. Recommendations

1. Conclude pilot during next two weeks and complete final analysis
2. Significantly reduce practice manager portion of survey to 15 minutes or less with 1.5 hour prep. work
3. Tightly control sample wave releases during initial months in field to provide greater flexibility in managing sample size relative to desired response rate
4. Create full paper survey versions available upon request
5. Lead with provider contact vs. current 2 prong provider/manager approach

VI. Recommendations (cont.)

6. **Send "call to action" letter from relevant specialty society 7-10 days prior to Gallup advance packet mailing *(see proposed version)***
7. **Combat discard rate by adding specialty society branding and/or printed message prominently on envelope**
8. **Exclude employed physicians from sample OR calculate expenses for this group based on overall percentage of total practice hours worked**
9. **Remove medical equipment utilization series from Practice Information Survey**

AMA/Specialty Society RVS Update Committee
Practice Expense Subcommittee
Thursday, February 1, 2007

Doctors Katherine Bradley, PhD, RN, (Chair), Joel Brill, MD, Thomas Felger, MD , Douglas M. Leahy, MD, John Gage, MD, Meghan Gerety, MD, William J. Mangold, Jr. MD, Charles Mick, MD, Bill Moran, MD, David Regan, MD, and Robert Zwolak, MD met and discussed the following four issues:

Missing Physician Time for Endoscopic Enteral Stenting Codes
The Practice Expense Subcommittee and the RUC reviewed physician services that had been identified by AMA staff as not having any physician time information (Harvard or RUC) at its October 2006 meeting and recommended the specialty society research and provide an appropriate rationale for Endoscopic Enteral Stenting codes (43256, 44370, 44379, and 44383). The American Gastroenterological Association (AGA) and the American Society for Gastrointestinal Endoscopy (ASGE) presented physician time for these stent codes and the subcommittee members agreed with the time after reviewing the intra-service work per unit of time for each. The Practice Expense Subcommittee recommends the following physician time components*:

Stent Codes	Pre-Time	Intra Time	Post Time
43256	**28**	**45**	**20**
44370	**31**	**70**	**22**
44379	**30**	**205**	**22**
44383*	**36**	**47**	**18**

The specialty noted that for code 44383 *Ileoscopy, through stoma; with transendoscopic stent placement (includes predilation)* the 2005 Medicare Utilization data indicates that Urology is the dominate specialty for this low volume code rather than Gastroenterology (as indicated in 2004) and that the time should be reviewed by this specialty.
*These time components are recommended unless there is a concern from Urology.

Physician Time Component Allocations
At the request of a specialty society, AMA staff compiled list of codes where there are no time components, only total time. On October 27, 2006 AMA staff emailed the list of codes to RUC participants and requested specialties to review the listing and submit time components to AMA staff. Three specialties submitted time components; the American Academy of Dermatology Association (AAD), the American College of Cardiology (ACC), and the Society for Interventional Radiology (SIR). After discussion of each of the submissions, the subcommittee agreed with all of the specialty physician time components and recommends them to the RUC for approval. These recommendations are attached behind this report.

In addition, since this issue of specialties providing missing physician time components has been an standing agenda item for this subcommittee since at least 2002, the subcommittee **recommends that by the April 2007 agenda book publication date, for codes with total time only, if no specialty recommends physician time components, the total time for the code will be recommended by the RUC as having zero physician time.** AMA staff will send a final listing of codes where physician time components are needed to all RUC participants soon after this meeting.

Approved by the RUC February 4, 2007

The Establishment of Guidelines for Pricing Procedures in Different Sites of Service
The RUC continues to review direct practice expense inputs for new/revised codes, following action by the CPT Editorial Panel. In addition, the Centers for Medicare and Medicaid Services (CMS) forwards sets of previously reviewed CPT codes for the Practice Expense Review Committee (PERC)/RUC to review when new issues arise related to practice costs or specialty societies have requested additional review in their comments/discussion with CMS. The general process following a CMS request is to initiate a level of interest process to determine all interested parties. Codes are then placed on a future PERC agenda for review. In general, these requests have largely focused on missing inputs that were not identified during original review and refinement. However, CMS has also referred codes to the PERC/RUC review if individual physicians or specialties have commented that the services have migrated to the physician office, and there is a need for non-facility direct inputs where there had been none. To date, CMS has not directed the PERC/RUC to derive inputs for the non-facility setting, but simply stated that the PERC/RUC review the specialty recommendations.

At the October 2006 PERC meeting, the Society for Interventional Radiology (SIR) and the American College for Radiology (ACR) presented a set of intravascular stent codes to the PERC for the establishment of non-facility practice expense inputs. These codes had been referred by CMS using the process described above. At that meeting, the PERC expressed concern that the committee's recommendation could be misinterpreted by CMS. Whereas CMS may believe that the RUC was endorsing a site of service or the establishment of practice expense RVUs. At that time the RUC recommended that "*codes 37205, 37206, and 74960 be referred to the Practice Expense Subcommittee in order to establish guidelines for establishing non-facility direct inputs for codes that have historically been performed predominately in facility settings and currently have relative values only in the facility setting."*

The Practice Expense Subcommittee discussed the current PERC processes and agreed that CMS should not infer from PERC recommendations that the PERC (or RUC) approves or endorses a site of service for any particular procedure or service. The PERC is merely providing information as to the resources that typically would be used in a particular setting if the physician chooses to provide the service there. The Subcommittee members believed that it is the physician's choice as to where the patient's care may be best provided and up to CMS and the carriers to determine payment policy. The subcommittee believed that the PERC processes and its relationship with CMS works well and should not be altered at this time.

Treatment of Administrative Costs: Direct verse Indirect Expense
At previous meetings the American Osteopathic Association (AOA) proposed the idea of simplifying the indirect expense portion of CMS's practice expense methodology by moving the administrative costs of medical procedures to direct practice expense. The subcommittee had agreed in April 2006 that the "AOA suggestion had merit", and that the issue should be revisited and presented with a more detailed proposal. At this meeting, Doctor Hitzman presented a more detailed proposal for the PERC to begin the process of identifying the administrative costs of the vast array of medical procedures listed in CPT. The subcommittee discussed the idea at length and recommends that the **PERC begin discussions about establishing a process for the refinement of administrative practice expenses and report back to the Practice Expense Subcommittee if and when they develop a specific proposed method to identify these costs.**

Recommended Time Recommendations*

From ACC								
CPT Code	Descriptor	Pre Eval	Pre Positioning	Pre Scrub	intra	post	**Total Rec Time**	**Total Existing Time**
36005	Injection procedure for extremity venography	5	5	5	5	5	25	25
37202	Transcatheter infusion other than for thrombolysis	30	15	20	65	35	165	165
37204	Transcatheter embolization	60	15	20	240	35	370	370
37205	Transcatheter stent, percutaenous	30	15	20	98	35	198	198
93514	Left heart catheterization by left ventricular puncture	53			49	7	109	109
93616	Esophageal recording of atrial electrogram with or without ventricular electrogram(s); with pacing	7			26	5	38	38
From SIR								
CPT Code		Pre Eval	Pre Positioning	Pre Scrub	intra	post		
19290	Preoperative placement of needle localization wire, breast	20	10	5	22	15	72	72
35490	Percutaneous atherectomy renal or other visceral	30	15	20	149	35	249	249
35491	Percutaneous atherectomy aortic	30	15	20	96	35	196	196
35492	Percutaneous atherectomy iliac	30	15	20	78	35	178	178
35493	Percutaneous atherectomy fem-pop	30	15	20	100	35	200	200
35494	Percutaneous atherectomy brachiocephalic trunk or branches	30	15	20	124	35	224	224
35495	Percutaneous atherectomytibioperoneal trunk and branches	30	15	20	124	35	224	224
36005	Injection procedure for extremity venography	5	5	5	5	5	25	25
37200	Transcatheter biopsy	30	15	20	42	35	142	142
37201	Transcatheter infusion for thrombolysis, non-coronary	30	15	20	81	35	181	181
37202	Transcatheter infusion other than for thrombolysis	30	15	20	65	35	165	165
37204	Transcatheter embolization	60	15	20	240	35	370	370
37205	Transcatheter stent, percutaenous	30	15	20	98	35	198	198
43761	Repositioning of gastric feeding tube through the duodenum	10	10	20	35	10	85	85
47505	Injection procedure for cholangiography through an existing ca	5	5	5	36	5	56	56
47556	Biliary endoscopy with dilation of biliary duct stricture(s) (x-ref	30	10	20	89	35	184	184
49427	Injection procedure for eval of previously placed peritoneal-ve	5	5	5	30	5	50	50
61624	Transcatheter occlusion/embo CNS	60	15	20	232	35	362	362
61626	Transcatheter occlusion/embo non-CNS, head or neck	60	15	20	173	35	303	303
From AAD		Pre Eval	Pre Positioning	Pre Scrub	intra	post	**Total Rec time**	**Total Existing Time**
11300	Shave skin lesion, trunk arms legs, 1, < 0.5 cm	5			8	5	18	23
11301	Shave skin lesion, 0.6 to 1.0 cm	5			15	5	25	29
11302	Shave skin lesion, 1.1 to 2.0 cm	7			17	5	29	32
11303	Shave skin lesion, > 2.0 cm	7	3		20	5	35	35
11305	Shave skin lesion, scalp, neck, hand, foot, genitals, < 0.5 cm	5			12	5	22	26
11306	Shave skin lesion, 0.6 to 1.0 cm	5			16	5	26	31
11307	Shave skin lesion, 1.1 to 2.0 cm	7			18	5	30	34
11308	Shave skin lesion, > 2.0 cm	7	3		22	5	37	39
11310	Shave skin lesion, face, ears, eyelids, nose, lips, mucous mer	5			13	5	23	27
11311	Shave skin lesion, 0.6 to 1.0 cm	5			18	5	28	32
11312	Shave skin lesion, 1.1 to 2.0 cm	7			20	5	32	35
11313	Shave skin lesion, > 2.0 cm	7	3		24	5	39	42

These Time Allocations will be flagged within the RUC database with "DO NOT USE TO VALIDATE FOR PHYSICIAN WORK"

AMA/Specialty Society RVS Update Committee
Five-Year Review Identification Workgroup Report
February 1, 2007

The following members were in attendance: Barbara Levy, MD (Chair), Michael Bishop, MD, James Blankenship, MD, Katherine Bradley, PhD, RN, Norm Cohen, MD, Thomas Felger, MD, Meghan Gerety, MD, Gregory Kwasny, MD, William J. Mangold, Jr., MD, Geraldine McGinty, MD, Bernard Pfeifer, MD, Maurits Weiserma, MD, and Robert Zwolak, MD

Doctor Levy opened the meeting by reminding the Five-Year Review Identification Workgroup of its task to identify potentially misvalued services using objective mechanisms for reevaluation during the upcoming Five-Year Review.

Review of Site of Service Anomalies
Following the most recent meeting of the Five-Year Review Identification Workgroup, staff developed a list of all services that include hospital in-patient post-service E/M visits within their global package, yet are performed in the inpatient hospital setting less than 50% of the time. Doctor Levy noted that based on her recommendation, the services listed were limited to those with a utilization of 1,000 or greater, reducing the list from 402 to 152 services. The Workgroup discussed the methodology for analyzing these services and noted that there may be errors on this list of codes that account for the anomaly, there may be coding errors that need to be addressed, and/or the site of service has changed over time and the hospital visits must be reconsidered. Much of the discussion focused on the codes that included a full 99238 as opposed to the usual 0.5 99238 allotted for outpatient procedures. The Workgroup agreed that this potential discrepancy as well as the inclusion of other hospital visits within global periods for outpatient procedures may be inappropriate and, if so, may compromise the integrity of the RUC physician time data. Per the RUC's mandate, these services will be addressed prior to the next Five-Year Review of the RBRVS.

The Workgroup identified the services with any inpatient E/M services within their global period, performed less than 50% in the inpatient hospital setting, and having a utilization greater than or equal to 1,000 to be explored for review by the Workgroup at the September 2007 RUC meeting. Any code containing 99231, 99232, or 99233 hospital E/M services within the global period will be forwarded to the dominant specialty(s) for comment and clarification of the inclusion of such services. Any code containing a full 99238 and meeting the other criteria will be forwarded to the dominant specialty(s) for comment and clarification regarding appropriateness of the discharge service.

Staff noted that it will forward the entire list of codes meeting these criteria with detailed information regarding the original specialty that submitted the recommendation as well as current specialty utilization data to all specialties. Specialties interested in submitting comments and clarification may indicate their interest and do so for review at the September 2007 RUC meeting. It was noted that dependent upon the success of the methodology and effectiveness of a review, the Workgroup may extend its review to the remaining services, regardless of utilization.

Private Payer Data
Doctor Levy asked the Workgroup to consider solicitation of utilization data from payers other than Medicare, for example, Blue Cross Blue Shield. The Workgroup commented that such data would lend the Five-Year Review Identification process added credibility and increased accessibility. The additional data may help to identify potentially misvalued services relying on utilization data for services not typically performed on the Medicare population. Staff noted that

it will consult with general counsel regarding any anti-trust issues. **The Workgroup recommends that utilization data from private payers be solicited to aid in the identification of potentially misvalued services.**

Review of CMS Data of Services Performed on Same Day by Same Provider
As assigned at the most recent RUC meeting, staff solicited data from CMS regarding services commonly billed together. The data provided by CMS included all services reported together 50% of the time or greater. The resulting list contained nearly 1,500 unique code pairing in order to create a more manageable initial work load. **The Workgroup will identify any service that is reported 90% of the time or more with another service on the same date by the same physician and having a utilization greater than or equal to 1,000. These will be discussed as a concept for identifying potentially misvalued codes at the September 2007 RUC meeting.** The Workgroup asked AMA staff to review the procedures on the list and ensure that the services are consistent with CPT 2007. The Workgroup also requested that staff identify the global period associated with each service and its modifier -51 exemption status.

Other Issues
The Workgroup will extend its review of IWPUT anomalies to include services with unusually low IWPUT as well as unusually high IWPUT. The Workgroup selected a low IWPUT of equal to or lesser than .010. Discussion of the IWPUT analysis was tabled until the next meeting.

The Workgroup also found that the review of the PEAC processes was not helpful and will be removed from future agendas.

The Workgroup will continue to consider other objective criteria for the identification of potentially misvalued services discussed at previous Workgroup meetings as well as other additional objective criteria.

AMA/Specialty Society RVS Update Committee **Tab F**
Administrative Subcommittee Report
February 2, 2007

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

I. Level of Interest Policy Clarification

During a facilitation committee discussion at the October 2006 RUC meeting, there was some concern expressed that the policy regarding the level of interest process, reporting and response needs to be strengthened. The facilitation committee requested that the Administrative Subcommittee clarify the RUC's policy when:

1. AMA staff receives an LOI indicating a specialty society's level one interest and the specialty society decides that they no longer wish to participate in developing primary recommendations.
2. AMA staff receives an LOI indicating a specialty society's level two interest and no comment is received from the specialty society.
3. AMA staff receives no level of interest from the specialty society.

The Administrative Subcommittee discussed that a lack of response indicates forfeiture of participation for that specialty society, whether it be failure to develop primary recommendations after indicating an interest to do so, failure to submit comments after indicating an interest to do so, or failure submit a level of interest. **The Administrative Subcommittee recommends adding a statement to the LOI instructions that a lack of response by the specified due date indicates forfeiture of participation in developing a recommendation or providing written comment for that specialty society.**

II. RUC Members, Alternates and Advisors Work Load

The Administrative Subcommittee discussed the issue of how to alleviate the workload of RUC participants. **The Administrative Subcommittee recommends scheduling time-certain presentations on each issue.** The Subcommittee indicated that the Chairman may use his discretion regarding the details of implementing time-certain presentations.

III. RUC Member Term Limits

The Administrative discussed the issue of possibly implementing term limits for RUC members. The RUC's Structure and Functions reads as follows:

III. Organization and Structure
A. RVS Update Committee
(6) Terms of Appointment:
(a) Specialty Society and AOA Representatives and Alternate Representatives: The 20 permanent specialty society representatives, AOA representatives and alternate representatives shall hold terms of three (3) years. Appendix B lists all of the members of the RUC and the term in which each term ends.

The Administrative Subcommittee reaffirmed the current policy that term limits are at the discretion of the specialty society.

IV. Composition of the RUC

Richard Tuck, MD, reiterated the charge of the Administrative subcommittee. The Administrative Subcommittee was charged to "think outside the box" regarding the RUC composition. The RUC Chair indicated that the Administrative Subcommittee should consider changes in the Medicare payment system and changes in the RUC's role in the RBRVS over the past 15 years, as well as changes in determining potential modifications to the criteria for permanent seat, composition changes and changes to the rotating seats.

Approved by the RUC February 4, 2007

Doctor Tuck thoroughly reviewed the data requested at the October 2006 RUC meeting:

1. The summarization of how codes fared when a subspecialty had a rotating seat on the RUC versus when they did not.

The Administrative Subcommittee concluded that the data on how rotating seat codes fared when a subspecialty had a rotating seat on the RUC versus when they did not, demonstrated that the RUC's recommendations did not significantly sway for or against specialty societies, regardless of the specialties rotating seat status.

2. The size of other AMA committees and councils.

3. The poll of all RUC participants (i.e., RUC Members, RUC Alternates and RUC Advisors) asking if they felt that the RUC as it is currently comprised has the expertise to appropriately fulfill its role as a committee dedicated to making relative value recommendations for new and revised codes as well as periodically updating RVUs to reflect changes in medical practice.

The poll of RUC participants indicated that 54% determined the RUC to be appropriately comprised, 46% indicated that the RUC was lacking some expertise. Of the respondents who indicated that the RUC is lacking some expertise, 48% indicated that the addition of one primary care seat would appropriately balance the RUC and the remaining 52% indicated adding specific specialty seats (as indicated in the Administrative Subcommittee agenda materials).

The Administrative Subcommittee extensively discussed the current criteria for participation for a permanent seat on the RUC, specifically the first criteria that the specialty is an American Board of Medical Specialties (ABMS) specialty.

The Administrative Subcommittee reaffirmed the five criteria for participation for a permanent seat on the RUC, listed in priority order.

1. **The specialty is an American Board of Medical Specialties (ABMS) specialty.**
2. **The specialty comprises 1 percent of physicians in practice.**
3. **The specialty comprises 1 percent of physician Medicare expenditures.**
4. **Medicare revenue is at least 10 percent of mean practice revenue for the specialty.**
5. **The specialty is not meaningfully represented by an umbrella organization, as determined by the RUC.**

The Administrative Subcommittee then discussed the current RUC composition. Based on the review of the RUC participant poll on the RUC expertise composition and discussion on the current composition, the Administrative Subcommittee concluded that a primary care seat should be added to the RUC.

The Administrative Subcommittee recommends initiating a process of adding a primary care seat to the RUC.

The Administrative Subcommittee recommends that the RUC solicit specialty societies and HCPAC organizations for recommendations to define the primary care seat criteria and type (i.e., permanent or rotating).

The Administrative Subcommittee will further discuss the definition of and eligibility for the primary care rotating seat at the April 2007 meeting after responses are received from specialty societies. The Administrative Subcommittee will discuss any other rotating seat issues in September 2007.