

**AMA/Specialty RVS Update Committee
Meeting Minutes
February 1-3, 2008**

I. Welcome and Call to Order

Doctor William Rich called the meeting to order on Friday, February 1, 2008, at 9:00 am.
The following RUC Members were in attendance:

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

*Alternate

II. Chair's Report

Doctor Rich made the following general announcements:

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

- Presenters are expected to announce any conflicts or potential conflicts, including travel reimbursement paid by an entity other than the specialty society, at the onset of their presentation.
- Before a presentation, any RUC member with a conflict must state their conflict and the Chair will rule on recusal.
- RUC members or alternates sitting at the table may not present or advocate on behalf of their specialty.
- For new codes, the Chairman will inquire if there is any discrepancy between submitted PE inputs and PE Subcommittee recommendations or PEAC standards. If the society has not accepted PE Subcommittee recommendations or standardized PE conventions, the issue will be immediately referred to a Facilitation Committee before any work relative value or practice expense discussion.
- RUC advisors and presenters verbally disclose financial conflicts prior to presenting relative value recommendations
- The RUC Chair will ask RUC advisors and presenters to verbally disclose any travel expenses for the RUC meeting paid by an entity other than the specialty society
- The Summary of Recommendation form has been edited and includes a number of new sections, including modifier 51 status, PLI crosswalk. The RUC should provide feedback if sections of the form are incorrect.
- All RUC Advisors are required to sign the attestation statement.
- Doctor Rich thanked Doctor Baldwin Smith from the American Academy of Neurology for his years of service to the RUC and welcomed both Doctor Susan Spires from the College of American Pathologists and Doctor Jim Anthony from the American Academy of Neurology to the RUC.
- Doctor Rich welcomed the CMS staff and representatives attending the meeting, including:
 - Edith Hambrick, MD, CMS Medical Officer
 - Whitney May, Deputy Director, Division of Practitioner Services
 - Ken Simon, MD, CMS Medical Officer
 - Pam West, PT, DPT, MPH, Health Insurance Specialist
 - Carolyn Mullen, Contractor to CMS on Five-Year Review Project
- Doctor Rich welcomed the following Medicare Contractor Medical Director:
 - Charles Haley, MD
- Doctor Rich welcomed the following Medicare Payment Advisory Commission (MedPAC) staff:
 - Kevin Hayes, PhD

- Doctor Rich announced the members of the Facilitation Committees

<u>Facilitation Committee #1</u> Lloyd Smith, DPM James Blankenship, MD Katherine Bradley, PhD, RN John Gage, MD David Hitzeman, DO J. Leonard Lichtenfeld, MD Alan Plummer, MD Samuel Smith, MD Arthur Traugott, MD John Wilson, MD	<u>Facilitation Committee #2</u> Geraldine McGinty, MD James Anthony, MD Joel Brill, MD Ronald Burd, MD Bruce Deitchman, MD Thomas Felger, MD Emily Hill, PA-C Barbara Levy, MD Bernard Pfeifer, MD William Mangold, Jr., MD
<u>Facilitation Committee #3</u> Maurits Wiersema, MD Norman Cohen, MD John Derr, MD Meghan Gerety, MD Peter Hollmann, MD Charles Koopmann, MD Charles Mick, MD Bill Moran, MD Erik van Doorne, DPT	<u>Facilitation Committee #4</u> Peter Smith, MD Michael Bishop, MD Manuel Cerqueira, MD Robert Gerstle, MD Gregory Kwasny, MD Alan Lazaroff, MD James Regan, MD Susan Spires, MD Jane White, PhD, RD
- Doctor Rich welcomed the following individuals as observers at the February 2008 meeting:
 - Debra Abel – American Speech-Language-Hearing Association
 - Margie Andreae – American Academy of Pediatrics
 - Linda Ayers – American Academy of Otolaryngology – Head and Neck Surgery
 - Edward Bentley – American Society for Gastrointestinal Endoscopy
 - Robert Blackburn, MD – American Osteopathic Association
 - Eileen Brewer – Renal Physicians Association
 - Tiffany Brooks – American Society for Therapeutic Radiology and Oncology
 - Janet Conway – American Academy of Orthopaedic Surgeons
 - Thomas Cooper, MD – American Urological Association
 - William Creevy, MD – American Academy of Orthopaedic Surgeons
 - Jeffrey Dann, MD – American Urological Association
 - Meghann Dugan – American Chiropractic Association
 - Cristal Edwards – American College of Surgeons
 - Steve Falcone – American Society of Neuroradiology
 - Robert Fine – American Academy of Orthopaedic Surgeons
 - Mark Friedberg – American College of Physicians
 - Chris Gallagher – Society of Nuclear Medicine
 - Emily Gardner – American College of Nuclear Physicians

- Richard Gilbert, MD – American Urological Association
- Janis Gregory - American Urological Association
- Richard Hamburger, MD – Renal Physicians Association
- Linda Hiddeman – American Geriatrics Society
- Liz Hoy – American College of Surgeons
- Robin Hudson – American Urological Association
- David Jaimovich, MD – American Academy of Pediatrics
- Gayle Lee – American Physical Therapy Association
- Richard Marcus – American Academy of Sleep Medicine
- Alex Mason - American Association of Neurological Surgeons
- Louis McIntyre – American Academy of Orthopaedic Surgeons
- Ericka Miller – American College of Physicians
- Lisa Miller-Jones – American College of Surgeons
- Richard Molteni, MD – American Academy of Pediatrics
- Jeremy Musher – American Psychiatric Association
- Margaret Neal – American Society of Cytopathology
- Nicholas Nickl, MD – American Society for Gastrointestinal Endoscopy
- David Penson, MD – American Urological Association
- Julia Pillsbury, MD – American Academy of Pediatrics
- Kathryn Pontzer – American College of Cardiology
- Debbie Ramsburg – Society of Interventional Radiology
- Paul Rudolf, MD, JD – American Geriatrics Society
- James Scroggs – American College of Obstetricians and Gynecologists
- Maurine Spillman-Dennis – American College of Radiology
- James Startzell – American Association of Oral and Maxillofacial Surgeons
- Stan Stead, MD – American Society of Anesthesiologists
- Timothy Tillo – American Podiatric Medical Association
- Andrea Trescot, MD – American Society of Anesthesiologists
- Sean Tutton, MD – Society of Interventional Radiology
- Bruce Wilkoff – American College of Cardiology
- Joanne Willer – American Academy of Orthopaedic Surgeons
- Kady Williams – American Audiology Association
- Karin Witich – American Association of Oral and Maxillofacial Surgeons

III. Director's Report

Sherry Smith made the following announcements:

- The 2008 RUC Database is available and contains several updates including CMS payment policy indicators and average number of ICD-9 codes per claim.
- Future RUC meeting locations have been confirmed as follows:
 - April 22-26, 2008, RUC Meeting, Renaissance, Chicago, IL
 - October 2-5, 2008, RUC Meeting, Renaissance Hotel, Chicago, IL
 - Jan 29 – Feb 1, 2009, RUC Meeting, Pointe Hilton at Squak Peak, Phoenix, AZ
 - April 22-26, 2009, RUC Meeting, Swissotel, Chicago, IL

- October 1-4, 2009, RUC Meeting, Hyatt Regency, Chicago, IL
- February 4-7, 2010 RUC Meeting, Disney World Swan, Orlando, FL

IV. Approval of Minutes for the September 27-29, 2007 RUC meeting

The RUC approved the minutes and accepted them without revision.

V. CPT Editorial Panel Update

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

- The CPT Editorial Panel has a new chair, William Thorwarth, Jr., MD. Doctor Thorwarth most recently served as a Panel member as well as the Chair of *CPT Assistant Editorial Panel*. Peter Hollmann, MD is the new Vice Chair of the CPT Editorial Panel.
- The next meeting of the CPT Editorial Panel will take place February 7-10, 2008 at the Rancho Las Palmas Resort in Desert Springs, CA. Issues to be discussed at the meeting include, among others:
 - Soft tissue tumor
 - Radical bone resection
 - Stereotactic surgery of brain and spine

VI. Centers for Medicare and Medicaid Services Update

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

- Staff from the Center for Medicare Management are working closely with the Office of Research, Development, and Information to assist in the development of the Medicare medical home demonstration project.
- The Agency is beginning the process of preparing the 2009 Proposed Rule. The Proposed Rule is scheduled to be published later this Summer.
- Doctor Jeffrey Rich will be joining the Agency as Acting Director of the Center for Medicare Management sometime in the month of February. Doctor Rich is a thoracic surgeon and has worked in quality arena for several year, primarily with the Society for Thoracic Surgery.

VII. Carrier Medical Director Update

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

- Doctor Haley continued his explanation of the new Medicare Administrative Contracting (MAC) program, established under Section 911 of the Medicare prescription Drug, Improvement, and Modernization Act of 2003 to be completed

by October 2011. Doctor Haley noted that a number of contracts have been awarded since the last meeting of the RUC and provided a presentation highlighting the changes. The presentation is attached to these minutes.

- Medicare's transition to the use of National Practitioner Identification (NPI) numbers is continuing. By March 31, 2008, NPIs must be included on all claims and by May 23, 2008 claims must include only NPIs.

VIII. Washington Update

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

- In 2007, the AMA continued its efforts to reform the flawed Sustainable Growth Rate (SGR) formula. The AMA maintained a unified message with its partners, including the American Association of Retired Persons, coordinating joint grassroots efforts. Congress also expended roughly \$3.1 billion on another short-term fix. The 2008 fix included a 0.5% increase in the conversion factor, but only for six months. On July 1, 2008, the conversion factor will fall by 10.6%, without legislative action.
- In 2007, the AMA focused its advocacy efforts on several issues in addition to reforming the SGR. Specifically, the AMA addressed insuring the uninsured, mental health parity, antitrust issues, and private fee-for-service plans.
- The legislative environment in 2008 will be challenging. The timetable for passing another fix is compressed. There are 151 days until the cuts take place. Subtracting recesses, weekends, Mondays, and Fridays, there are roughly 60 days with which to pass a fix. Despite talks of compromise on the stimulus package, the current legislature is highly divisive. Aside from the physician payment issue, Congress is focused on the economy, home loan crisis, and the elections. Typically, in election years, Congress will defer difficult issues until after November. Any changes in physician payment in 2008 are required to be "pay as you go," meaning any increase in physician payment must be at the reduction of other health care expenditures. As a result, the health care insurers, hospitals, and other providers are in strong opposition.
- There is an increased opinion in the legislature that health care spending is rising too quickly. Some, including Congressional Budget Office (CBO) Head Peter Orzag, think the solution lies in comparative effectiveness research.
- The President's 2009 budget will be submitted later this month. A story in the New York Times predicts a call for \$91 billion in savings from 2009 to 2013.
- There are also several other factors of concern for physicians in 2008:
 - Quality Reporting: Key House Committees are skeptical, but Senators Baucus and Grassley, chair and co-chair of the Finance Committee, are avid supporters. This year's bill called for a 1.5% increase on all claims for physicians who participate in PQRI. Baucus and Grassley recently sent a letter to CMS indicating that they intend to extend the program this year. They urged the Agency to work with the Consortium, specialty societies and others in developing measures; give priority to measures

- endorsed by the National Quality Forum; target groups of measures focusing on treatment of chronic disease; and post the names of physicians who participate in the PQRI on the Medicare web site.
- Physician Profiling: House committees, particularly Ways and Means, are more interested in using physician profiles, which they believe would address costs as well as quality. MedPAC has recommended that Congress require CMS to develop these profiles and use them to provide confidential feedback to physicians for two years. They have also suggested that after two years, Medicare payment might be tied to the profiles. To that end, MedPAC has been evaluating commercial episode grouper software. Some of the physicians on the MedPAC argued that there are a number of technical issues that must be resolved before the software is tied to payments. Doctor William Rich has attended several MedPAC meetings and warned that the current software is seriously flawed and will penalize the sub-specialists who treat the most complex patients.
 - Health Information Technology and Electronic Prescribing: In 2007, there were over 100 bills that included Health IT provisions. There is mounting pressure to require electronic prescribing as part of any physician payment legislation. A large coalition of consumer groups, including AARP, health plans, and pharmacy benefit managers are pushing very hard on this. CBO believes this could result in savings to the Medicare program.
 - Comparative Effectiveness: There is increasing interest in providing physicians with better information on which treatments work best for which patients. CBO has warned that it may not produce budget savings in the short term.
 - Imaging Cuts and Accreditation Requirements: Accreditation requirements in the CHAMP Bill included commonly used technologies such as ultrasound and x-ray in addition to the advanced technologies of PET, CT and MRI. There is pressure for cuts including the equipment volume and interest assumption changes that the RUC has recommended to CMS.
- Ms. McIlrath noted that many of these issues, despite our best efforts, will likely be implemented in the future. As such, the AMA must avoid the appearance of standing in the way of progress and protecting physician income at the expense of patients and Medicare sustainability. The AMA will continue to improve efforts to show how Medicare pay cuts threaten patient care. Further, AMA will select issues that show promise if done correctly and focus on how they should be done rather than just saying no. Specifically,
 - Health IT and E-Rx: Ideally, the AMA may look to ensure that Congress provides funding and understands that Medicare pay cuts of 40% inhibit physician willingness and ability to make the required investments.
 - Quality Improvement: The AMA will continue work of Consortium. It will make sure reporting is voluntary rather than punitive and ensure that comparative effectiveness research has appropriate role for physicians,

recognizes patient differences, and is not co-opted by insurers who want to use it as quick way to reduce costs.

- In 2008, the AMA will employ a two-step strategy. Immediately, the AMA will focus in the short-term to stop the July 1 cut and address the 2009 cut at the same time. The AMA is organizing the Federation behind a unified message to get a positive update tied to practice cost inflation in 2009. Second, long-term reform will be tabled until the next year.
- The AMA will influence the legislature through elections, which present several possible opportunities and forums, focusing primarily on the Senate Finance Committee. The AMA's National Advocacy Conference, which will bring hundreds of doctors to DC, is conveniently timed for April 1-2. The AMA is also expanding coalitions with patient groups including seniors, disease groups, rural and military.

IX. Relative Value Recommendations for CPT 2009

Computer Dependent External Fixation (Tab 4)

American Academy of Orthopaedic Surgery (AAOS)

Janet Conway, MD was asked by the RUC chair to recuse herself from discussion of the specialty society's recommendation due to a conflict of interest.

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

The specialty society requested and the RUC agreed that 2069X4, *Application of multiplane (pins or wires in more than one plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; exchange (ie, removal and replacement) of strut, each*, should have a 000 global period. The presenters clarified that a strut change may or may not be performed within 90 days of the primary procedure, 2069X3, *Application of multiplane (pins or wires in more than one plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; initial and subsequent alignment, assessment, and computation of adjustment schedule*. There is no typical pattern for strut changes. They most often are required when growth necessitates a longer strut. If a patient requires a strut change during the primary procedure 90-day global period, it would be done at one of the scheduled office visits and an EM would not be billed. If a strut change is required after the 90 days have passed, 2069X4 plus an E/M would be billed. It is most logical that this code should have a 000 day global period. Then, when necessary, the strut change would be billed with or without an EM depending on timing relative to the primary procedure. This is similar to other 000 day global codes that are billed as necessary when performed. The RUC agreed with the specialty society's

recommendation to change 2069X4 to a 000 day global and also agreed with the specialty that 2069X3 should not be presented until it can be surveyed with 2069X4, which will maintain a 090 day global period. Following a recommendation for a change in global period from 090 to 000 for 2069X4, the specialty society will resurvey and present their recommendations at the April 2008 RUC meeting.

The RUC recommends that CMS change the global period of 2069X4 from 090 days to 000 days and that the specialty resurvey for the April 2008 RUC Meeting. CMS has agreed to the 000 day global period.

Buttock Fasciotomy (Tab 5)
Facilitation Committee #4

R. Dale Blasier, MD American Academy of Orthopaedic Surgery (AAOS), William Creevy, MD Occupational Therapy Association (OTA), Charles Mabry, MD, FACS, Christopher Senkowski, MD, FACS American College of Surgeons (ACS)

In June 2008, the CPT Editorial Panel created two new CPT codes for patients who are developing or having compartment syndrome involving one or more of the pelvic compartments. The most commonly recognized compartment, for this syndrome is the buttock compartment as its large muscle mass is confined by the tight inelastic fascia. The most common causes for pelvic compartment syndrome are musculoskeletal pelvic trauma, prolonged immobility with prolonged buttock pressure due to altered level of consciousness, Ehlers-Danlos syndrome, and sickle cell associated muscle infarction. If the compartment syndrome is unrecognized or untreated, it can lead to renal failure, sepsis and death. The treatment for this syndrome had previously been reported using unlisted procedure code 27299 *Unlisted procedure, pelvis or hip joint*.

2699XX5 Decompression fasciotomy(ies), pelvic (buttock) compartment(s) (eg gluteus medius-minimus, gluteus maximus, iliopsoas, and/or tensor fascia lata muscle), unilateral(To report bilateral procedures, report 2699X5 with modifier 50)

The RUC reviewed the specialty society survey data and original recommended work value for code 2699XX5 of 15.92 work RVUs. The RUC believed the pre-service time and post-operative visit time from the survey respondents appeared inaccurate for the service provided. The RUC believed the pre-service package number 3 – Straight forward Patient/Difficult Procedure (total 51 minutes) is appropriate for this service. However because the patient needs to be in a lateral decubitus position, the positioning time required an additional 9 minutes of time. The RUC also believed that an additional reduction in the level of post operative hospital visits was necessary and recommends one 99232 and three 99231 hospital visits. The RUC determined an additional change from the survey results in the level of post operative office visits was also necessary and the RUC recommends one 99213 and three 99212 office visits. Using a building block methodology, the **RUC recommends a work relative value for code 2699XX5 of 12.90.**

These changes and recommendations are shown in the table below. This value was further supported when the RUC reviewed reference codes 27025 *Fasciotomy, hip or thigh, any type* (work RVU 12.66) and code 22010 *Incision and drainage, open, of deep abscess (subfascial), posterior spine; cervical, thoracic, or cervicothoracic* (RUC reviewed April 2005, intra service time = 60 minutes, Work RVU = 12.57 090 global) and determined that code 2699XX5 required more physician work. The RUC understands that the recommended value is slightly lower than the specialty society's 25th percentile survey results of 13.20.

2699XX6 Decompression fasciotomy(ies), pelvic (buttock) compartment(s) (eg gluteus medius-minimus, gluteus maximus, iliopsoas, and/or tensor fascia lata muscle) with debridement of nonviable muscle, unilateral (To report bilateral procedures, report 2699XX6 with modifier 50)

The RUC reviewed the specialty society survey and recommended work value for code 2699XX6 of 18.67. From the specialty society's RUC presentation the specialty and RUC believed the pre-service time and post operative visit time from the survey respondents appeared inaccurate for the service provided. The RUC determined the pre-service package number 3 – Straight forward Patient/Difficult Procedure (total 51 minutes) is appropriate for this service. However because the patient needs to be in a lateral decubitus position, the positioning time required an additional 9 minutes of time. The RUC determined that an additional reduction in the level of post operative hospital visits was necessary and recommends one 99232 and three 99231 hospital visits. The RUC determined an additional change from the survey results in the level of post operative office visits was necessary and recommends one 99213 and three 99212 office visits. After additional discussion of the intensity and complexity of 2699XX6 compared to 2699XX5 *Decompression fasciotomy(ies), pelvic (buttock) compartment(s) (eg gluteus medius-minimus, gluteus maximus, iliopsoas, and/or tensor fascia lata muscle), unilateral* the RUC believed the intra service work per unit of time (IWPUT) should be identical. Using a building block methodology, the **RUC recommends a work relative value for code 2699XX6 of 14.77.**

This value is slightly higher than the 25% percentile specialty survey results and is in proper rank order with the specialty's reference service 25025 *Decompression fasciotomy, forearm and/or wrist, flexor AND extensor compartment; with debridement of nonviable muscle and/or nerve* (work RVU = 17.77). The RUC agreed that 2699XX6 has similar pre and post service work, similar intensities and complexities as code 2699XX5, but has an additional 30 minutes of intra-service work.

	Specialty Original Rec	RUC Recommendation	Specialty Original Rec	RUC Recommendation
Recommended WRVU	15.92	12.90	18.67	14.77
Pre-Evaluation	60	43	60	43
Pre-Positioning	15	12	15	12
Scrub Dress Wait	15	5	15	5
Intra-Service	60	60	90	90
Immediate Post-op	30	30	30	30
99232	3	1	3	1
99231	2	3	3	3
99238	1	1	1	1
99213	2	1	2	1
99212	2	3	2	3
Total Time	456	359	506	389

Practice Expense

The RUC reviewed and agreed the with the facility only practice expense recommendations the specialty had recommended except for the pre-service time for these urgent procedures. The RUC and the specialty agreed that a total of 25 minutes of pre-service time was sufficient for these services rather than the standard 60 minutes for the typical 090 day global service.

End Stage Renal Disease Services (Tab 6)

Facilitation Committee #2

Robert J. Kossmann, MD and Richard J. Hamburger, MD Renal Physicians Association (RPA)

In early 2007, the RUC received a request from CMS to evaluate the End Stage Renal Disease services. CMS states, "As you know, in the physician fee schedule Final Rule for 2007, we did not implement the RUC recommendation to apply the increases in the E/M codes to the G-codes for ESRD physician services. As we stated in the rule, we did not have the information to know what assumptions to make regarding the level of E/M visits to use as part of the building blocks for each of these services. At that time, we also indicated that we would like for the renal physicians to take these G-codes to the RUC, so that we could receive more specific recommendations on the appropriate RVUs for these services. We, therefore, request formally that the RUC review any of the ESRD G-codes that the renal physicians wish to present."

In September 2007, the RUC's Research Subcommittee recommended that the Renal Physicians of America (RPA) review the existing language associated with the temporary ESRD G-codes and submit a coding proposal to the CPT Editorial Panel defining these services and typical patients. Further, the Research Subcommittee reviewed vignettes, proposed educational materials, proposed survey instruments and summary of

recommendation forms. As these services are performed over the course of a month, the Research Subcommittee and the RUC determined that a building block approach using work and time proxies of the evaluation and management services should be utilized to evaluate these services. This approach was reflected on the specialty's survey instruments and their summary of recommendation forms.

RPA submitted a coding proposal to the CPT Editorial Panel for review at its October 2007 meeting, which was very similar in structure to the existing G-codes. This proposal was approved and therefore was forwarded to the RUC for review. The specialty society did utilize the RUC approved modified survey instruments and summary of recommendation forms into their recommendations. As these services are bundled services, the RUC recommended to the society that a building block methodology would be the best manner to evaluate these codes. The RUC recommended that the building block methodology be incorporated into the survey instrument by utilizing a grid that would allow survey respondents to record what services they provide to the typical patient on a daily basis over a month. This grid would allow the respondent to indicate the days in which the patient received dialysis, the additional services performed by the physician (broken down into E/M visit proxies and actual time), additional services performed by the physician extender, i.e. a nurse practitioner or physician assistant (broken down into E/M visit proxies and actual time) and other services not included in these E/M visit proxies such as record review. On the grid, all of the visits and times would be added by the survey respondent. Then, the visits would be multiplied by the associated E/M work RVU proxies. It was determined that the intra-service times for evaluation and management proxies were appropriate as all time in these services are conducted face-to-face with the patient. Finally, all work RVUs were totaled for a recommended work RVU for the particular service being surveyed. This building block methodology utilizing evaluation and management work proxies was deemed to be appropriate because the same approach was utilized to develop RUC recommendations for the adult ESRD services when they were first reviewed in April 1995.

As part of these modified survey instruments and summary of recommendation forms, the RUC had presumed that there was physician extender time associated with these services. Accordingly, the survey instruments and the summary of recommendation forms were modified to try to capture this time. However, in all of the ESRD services, the survey respondents indicated that it was not typical for them to utilize physician extenders i.e. less than 25% of survey respondents indicated that they used physician extenders. Therefore, all of the service time and work discussed in this recommendation are provided by the physician. The RUC in its review of these services assumed the RPA survey times were relatively correct however, made adjustments in the assumed visit intensity.

Adult End Stage Renal Dialysis Services

As the review of these services are considered to be part of the Five-Year Review and the RUC operates with the initial presumption that the current values of existing services is correct, compelling evidence that the existing values for a service(s) are no longer rational or appropriate must be presented to the RUC. The societies did present this compelling

evidence stating that as the existing ESRD G-codes and valuation for these codes were established without the input of organized medicine specifically the nephrologist community, the current methodology used in establishing the valuation for these services was flawed. The RUC agreed with this compelling evidence and continued with their evaluation of these services.

9096X0 End-stage renal disease (ESRD) related services monthly, for patients twenty years of age and over; with 4 or more face-to-face physician visits per month

The RUC reviewed survey data from 55 renal physicians for 9096X0 and determined that a building block methodology should be utilized to evaluate this code. The RUC agreed that this procedure typically has four face-to-face physician visits per month associated with it. The RUC agreed with the specialty societies that the value of this procedure is the equivalent of the following building block:

1 – 99213 Office/Outpt Visit, Est	0.92	15 minutes
3 – 99214 Office/Outpt Visit, Est	(1.42 x 3) 4.26	75 minutes
9096X0	5.18 RVUs	90 minutes

The RUC recommends 5.18 work RVUs and 90 minutes for 9096X0.

9096X1 End-stage renal disease (ESRD) related services monthly, for patients twenty years of age and over; with 2-3 face-to-face physician visits per month

The RUC reviewed survey data from 44 renal physicians for 9096X1 and determined that a building block methodology should be utilized to evaluate this code. The RUC agreed that this procedure typically has three face-to-face physician visits per month associated with it. The RUC agreed with the specialty societies that the value of this procedure is the equivalent of the following building block:

3 – 99214 Office/Outpt Visit, Est	(1.42 x 3) 4.26	75 minutes
9096X1	4.26 RVUs	75 minutes

The RUC recommends 4.26 work RVUs and 75 minutes for 9096X1.

9096X2 End-stage renal disease (ESRD) related services monthly, for patients twenty years of age and over; with 1 face-to-face physician visit per month

The RUC reviewed survey data from 44 renal physicians for 9096X2 and determined that a building block methodology should be utilized to evaluate this code. The RUC agreed that this procedure typically has one face-to-face physician visit per month associated with it however, because it is only one visit, there is significant care plan oversight associated with this service to promote continuity of care. The RUC agreed with the specialty societies that the value of this procedure is the equivalent of the following building block:

1 – G0182 Care Plan Oversight	1.73	38 minutes
1 – 99214 Office/Outpt Visit, Est	1.42	25 minutes
9096X2	3.15 RVUs	63 minutes

The RUC recommends 3.15 work RVUs and 63 minutes for 9096X2.

9096X6 End-stage renal disease (ESRD) related services for home dialysis per full month, for patients twenty years of age and over

The RUC noted that CMS when valuing the associated G-codes determined that the work of 9096X6 and 9096X1 *End-stage renal disease (ESRD) related services monthly, for patients twenty years of age and over; with 2-3 face-to-face physician visits per month* was equivalent. Therefore, the RUC recommends that the value and the times for 9096X6 be directly crosswalked from 9096X1.

3 – 99214 Office/Outpt Visit, Est	(1.42 x 3) 4.26	75 minutes
9096X6	4.26 RVUs	75 minutes

The RUC recommends 4.26 work RVUs and 75 minutes for 9096X6.

The RUC believes that the previous valuations for the adult end stage renal dialysis services are correct. Although these services have had compelling evidence presented that indicates that the existing valuation of the services is flawed because organized medicine specifically the nephrologist community had not been consulted in the existing valuation of these services, the RUC believes that the recommendations for the adult end stage renal dialysis services are essentially work neutral as the RUC recommendations for these services result in only an overall 1% increase in the work RVUs allocated to this family of services.

Pediatric End Stage Renal Disease Services

As the review of these services are considered to be part of the Five-Year Review and the RUC operates with the initial presumption that the current values of existing services is correct, compelling evidence that the existing values for a service(s) are no longer rational or appropriate must be presented to the RUC. The societies did present this compelling evidence stating that as the existing pediatric ESRD G-codes and valuation for these codes were established without the input of organized medicine, specifically the pediatric nephrologist community, who would be the providers of these services, the current methodology used in establishing the valuation for these services was flawed. The RUC agreed with this compelling evidence and continued with their evaluation of these services.

9095X1 End-stage renal disease (ESRD) related services monthly, for patients under two years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month

The RUC reviewed the survey data provided by the specialty and were concerned about the low survey response rate, 3 survey respondents. The specialty society explained that the survey response rate was so low because these services are rarely performed, less than 10-15 infants in the country require this service. The specialty society also indicated that the typical number of face-to-face physician visits for this service is at least 13-17 visits. The pediatric nephrologists typically attend each of the dialysis sessions. Therefore, the specialty society recommends that this service be crosswalked to 99295 *Initial inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or less* (Work RVU=18.46, 274 minutes) as this service requires extensive and intensive physician work. Furthermore, the RUC noted that this value is further supported by a building block approach. Assuming 13 visits is typical of this service and that they all were at a 99214 Office/Outpt Visit, Est visits level of service, the physician work from that building block approach is the same as crosswalking 9095X1 to 99295. **Therefore, the RUC recommends 18.46 work RVUs and 274 minutes for 9095X1.**

9095X2 *End-stage renal disease (ESRD) related services monthly, for patients under two years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face physician visits per month* and 9095X3 *End-stage renal disease (ESRD) related services monthly, for patients under two years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face physician visit per month*

The specialty society stated that there were zero survey respondents for these services because these services are so infrequently performed. It is rare that these patients with this chronic illness at this age would be seen 2-3 times per month or once per month as again the pediatric nephrologist would typically attend all dialysis sessions. Therefore, because of the rareness of these services and the zero response rate, the RUC recommends that these service be carrier priced. **The RUC recommends that 9095X2 and 9095X3 are carrier priced.**

9095X4 *End-stage renal disease (ESRD) related services monthly, for patients two to eleven years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month*

The RUC reviewed the survey data provided by the specialty and were concerned about the low survey response rate, 7 survey respondents. The specialty society explained that the survey response rate was so low because these services are rarely performed, less than 10-15 patients in the country require this service. The specialty society also indicated that the typical number of face-to-face physician visits for this service is at least 13-17 visits. The pediatric nephrologist typically attends each dialysis session. Therefore, the specialty society recommends that this service be crosswalked to 99293 *Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age* (Work RVU=15.98, 240 minutes) as this service requires extensive and intensive physician work and properly reflects the relativity between

9095X4 and 9095X1 *End-stage renal disease (ESRD) related services monthly, for patients under two years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month* (RUC recommended RVU=18.46). **Therefore, the RUC recommends 15.98 work RVUs and 240 minutes for 9095X4.**

9095X5 *End-stage renal disease (ESRD) related services monthly, for patients two to eleven years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face physician visits per month*

The RUC reviewed 9095X5 and determined that a building block methodology should be utilized to evaluate this code. The RUC agreed that this procedure typically has three visits, of which one visit is a prolonged visit and significant care plan oversight, which includes assessing nutritional needs associated with it. The RUC agreed with the specialty societies that the value of this procedure is the equivalent of the following building block:

1 – 99215 Office/Outpt Visit, Est	2.00	35 minutes
2 – 99214 Office/Outpt Visit, Est	(1.42 x 2) 2.84	50 minutes
1 – 99354 Prolonged Service, Office	1.77	60 minutes
1 – G0182 Care Plan Oversight	1.73	38 minutes
1 – 97802 Medical Nutrition, Indiv	0.45	15 minutes
9095X5	8.79 RVUs	198 minutes

The RUC recommends 8.79 work RVUs and 198 minutes for 9095X5.

9095X6 *End-stage renal disease (ESRD) related services monthly, for patients two to eleven years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face physician visit per month*

The RUC reviewed 9095X6 and determined that a building block methodology should be utilized to evaluate this code. The RUC agreed that this procedure typically has one prolonged service visit and significant care plan oversight, which includes assessing nutritional needs associated with it. The RUC agreed with the specialty societies that the value of this procedure is the equivalent of the following building block:

1 – 99215 Office/Outpt Visit, Est	2.00	35 minutes
1 – 99354 Prolonged Service, Office	1.77	60 minutes
1 – G0182 Care Plan Oversight	1.73	38 minutes
1 – 97802 Medical Nutrition, Indiv	0.45	15 minutes
9095X6	5.95 RVUs	148 minutes

The RUC recommends 5.95 work RVUs and 148 minutes for 9095X6.

9095X7 End-stage renal disease (ESRD) related services monthly, for patients twelve to nineteen years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month

The RUC reviewed 9095X7 and determined that a building block methodology should be utilized to evaluate this code. The RUC agreed with the specialty society that this procedure typically has seven visits of which one is a prolonged visit and significant care plan oversight associated with it. The RUC agreed with the specialty societies that the value of this procedure is the equivalent of the following building block:

1 – 99215 Office/Outpt Visit, Est	2.00	35 minutes
3 – 99214 Office/Outpt Visit, Est	(1.42 x 3) 4.26	75 minutes
3 – 99213 Office/Outpt Visit, Est	(0.92 x 3) 2.76	45 minutes
1 – 99354 Prolonged Service, Office	1.77	60 minutes
1 – G0182 Care Plan Oversight	1.73	38 minutes
9095X7	12.52 RVUs	253 minutes

The RUC recommends 12.52 work RVUs and 253 minutes for 9095X7.

9095X8 End-stage renal disease (ESRD) related services monthly, for patients twelve to nineteen years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face physician visits per month

The RUC reviewed 9095X8 and determined that a building block methodology should be utilized to evaluate this code. The RUC agreed that this procedure typically has three visits of which one visit is a prolonged visit and significant care plan oversight associated with it. The RUC agreed with the specialty societies that the value of this procedure is the equivalent of the following building block:

1 – 99215 Office/Outpt Visit, Est	2.00	35 minutes
2 – 99214 Office/Outpt Visit, Est	(1.42 x 2) 2.84	50 minutes
1 – 99354 Prolonged Service, Office	1.77	60 minutes
1 – G0182 Care Plan Oversight	1.73	38 minutes
9095X8	8.34 RVUs	183 minutes

The RUC recommends 8.34 work RVUs and 183 minutes for 9095X8.

9095X9 End-stage renal disease (ESRD) related services monthly, for patients twelve to nineteen years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face physician visit per month

The RUC reviewed 9095X9 and determined that a building block methodology should be utilized to evaluate this code. The RUC agreed that this procedure typically has one prolonged service visit and significant care plan oversight associated with it. The RUC

agreed with the specialty societies that the value of this procedure is the equivalent of the following building block:

1 – 99215 Office/Outpt Visit, Est	2.00	35 minutes
1 – 99354 Prolonged Service, Office	1.77	60 minutes
1 – G0182 Care Plan Oversight	1.73	38 minutes
9095X9	5.50 RVUs	133 minutes

The RUC recommends 5.50 work RVUs and 133 minutes for 9095X9.

Pediatric Home Dialysis

9096X3 End-stage renal disease (ESRD) related services for home dialysis per full month, for patients under two years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents

The RUC noted that they could not apply the methodology used in 9096X4 or 9096X5 because the RUC recommended that 9095X2 *End-stage renal disease (ESRD) related services monthly, for patients under two years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face physician visits per month* be carrier priced as the volume of this procedure is very low (Medicare Utilization=19 for 2006). Therefore, the RUC tried to determine the relativity in work and time between 9096X3 and 9096X4 *End-stage renal disease (ESRD) related services for home dialysis per full month, for patients two to eleven years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents* (RUC Recommended Value=9.14). The RUC determined that for the under two patient population there would be more time required to manage fluids and nutritional concerns as well as make changes to their dialysis programs and prescriptions as compared to the two to eleven patient population. Therefore, to account for this increased amount of time, the RUC recommends to begin with the recommended value/building block of 9096X4 and add the equivalent of a 99214 Office Visit (Work RVU=1.42) as demonstrated below:

1 – 99215 Office/Outpt Visit, Est	2.00	35 minutes
2 – 99214 Office/Outpt Visit, Est	(1.42 x 2) 2.84	50 minutes
2 – 99354 Prolonged Service, Office	(1.77 x 2) 3.54	120 minutes
1 – G0182 Care Plan Oversight	1.73	38 minutes
1 – 97802 Medical Nutrition, Indiv	0.45	15 minutes
9096X3	10.56 RVUs	258 minutes

The RUC recommends 10.56 work RVUs and 258 minutes for 9096X3.

9096X4 End-stage renal disease (ESRD) related services for home dialysis per full month, for patients two to eleven years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents

The RUC noted that when the RUC reviewed the adult ESRD codes, 9096X1 *End-stage renal disease (ESRD) related services monthly, for patients twenty years of age and over; with 2-3 face-to-face physician visits per month* was recommended to be crosswalked to 9096X6 *End-stage renal disease (ESRD) related services for home dialysis per full month, for patients twenty years of age and over* due to the fact when valuing the associated G-codes, CMS determined that the work of these two codes was equivalent. However, the RUC determined that the pediatric patient population requires additional time and work as compared to 9095X5 *End-stage renal disease (ESRD) related services monthly, for patients two to eleven years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face physician visits per month*. Therefore, the RUC recommends modifying the building block associated with 9095X5 to account for the additional time and physician work associated with 9096X4, as follows:

1 – 99215 Office/Outpt Visit, Est	2.00	35 minutes
1 – 99214 Office/Outpt Visit, Est	1.42	25 minutes
2 – 99354 Prolonged Service, Office	(1.77 x 2) 3.54	120 minutes
1 – G0182 Care Plan Oversight	1.73	38 minutes
1 – 97802 Medical Nutrition, Indiv	0.45	15 minutes
9096X4	9.14 RVUs	233 minutes

The RUC recommends 9.14 Work RVUs and 233 minutes for 9095X4.

9096X5 End-stage renal disease (ESRD) related services for home dialysis per full month, for patients twelve to nineteen years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents.

The RUC noted that when the RUC reviewed the adult ESRD codes, 9096X1 *End-stage renal disease (ESRD) related services monthly, for patients twenty years of age and over; with 2-3 face-to-face physician visits per month* was recommended to be crosswalked to 9096X6 *End-stage renal disease (ESRD) related services for home dialysis per full month, for patients twenty years of age and over* due to the fact when valuing the associated G-codes, CMS determined that the work of these two codes was equivalent. However, the RUC determined that the pediatric patient population requires additional time and work as compared to 9095X8 *End-stage renal disease (ESRD) related services monthly, for patients twelve to nineteen years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face physician visits per month*. Therefore, the RUC recommends modifying the building block associated with 9095X8 to account for the additional time and physician work associated with 9096X5, as follows:

1 – 99215 Office/Outpt Visit, Est	2.00	35 minutes
1 – 99214 Office/Outpt Visit, Est	1.42	25 minutes
2 – 99354 Prolonged Service, Office	(1.77 x 2) 3.54	120 minutes
1 – G0182 Care Plan Oversight	1.73	38 minutes
9096X5	8.69 RVUs	218 minutes

The RUC recommends 8.69 Work RVUs and 218 minutes for 9096X5.

Per Day Services

9096X7 End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients under two years of age

The current methodology for how the G0324 *End stage renal disease (ESRD) related services for home dialysis (less than full month), per day; for patients under two years of age* is valued is by taking the current G0320 *End stage renal disease (ESRD) related services for home dialysis patients per full month; for patients under two years of age to include monitoring for adequacy of nutrition, assessment of growth and development, and counseling of parents* and dividing it by 30 as these services are valued on a per day basis. Therefore, the RUC recommends that 9096X7 be valued using the same methodology as follows taking 9096X3 *End-stage renal disease (ESRD) related services for home dialysis per full month, for patients under two years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents* (RUC Recommended Value=10.56) and dividing it by 30 resulting in a value of 0.35 RVUs. **The RUC recommends 0.35 work RVUs for 9096X7.**

9096X8 End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients two to eleven years of age

The current methodology for how the G0325 *End stage renal disease (ESRD) related services for home dialysis (less than full month), per day; for patients between two and eleven years of age* is valued is by taking the current G0321 *End stage renal disease (ESRD) related services for home dialysis patients per full month; for patients for patients between two and eleven years of age to include monitoring for adequacy of nutrition, assessment of growth and development, and counseling of parents* and dividing it by 30 as these services are valued on a per day basis. Therefore, the RUC recommends that 9096X8 be valued using the same methodology as follows taking 9096X4 *End-stage renal disease (ESRD) related services for home dialysis per full month, for patients two to eleven years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents* (RUC Recommended Value=9.14) and dividing it by 30 resulting in a value of 0.30 RVUs. **The RUC recommends 0.30 work RVUs for 9096X8.**

9096X9 End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients twelve to nineteen years of age

The current methodology for how the G0326 *End stage renal disease (ESRD) related services for home dialysis (less than full month), per day; for patients between twelve and nineteen years of age* is valued is by taking the current G0322 *End stage renal disease (ESRD) related services for home dialysis patients per full month; for patients for patients between twelve and nineteen years of age to include monitoring for adequacy of nutrition, assessment of growth and development, and counseling of parents* and dividing it by 30 as these services are valued on a per day basis. Therefore, the RUC recommends that 9096X9 be valued using the same methodology as follows taking 9096X5 *End-stage renal disease (ESRD) related services for home dialysis per full month, for patients twelve to nineteen years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents* (RUC Recommended Value=8.69) and dividing it by 30 resulting in a value of 0.29 RVUs. **The RUC recommends 0.29 work RVUs for 9096X9.**

9097X0 End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients twenty years of age and over

The current methodology for how the G0327 *End stage renal disease (ESRD) related services for home dialysis (less than full month), per day; for patients twenty years of age and over* is valued is by taking the current G0323 *End stage renal disease (ESRD) related services for home dialysis patients per full month; for patients for patients twenty years of age and over* and dividing it by 30 as these services are valued on a per day basis. Therefore, the RUC recommends that 9097X0 be valued using the same methodology as follows taking 9096X6 *End-stage renal disease (ESRD) related services for home dialysis per full month, for patients twenty years of age and older* (RUC Recommended Value=4.26) and dividing it by 30 resulting in a value of 0.14 RVUs. **The RUC recommends 0.14 work RVUs for 9097X0.**

The RUC recommends that all of the ESRD services be flagged in the RUC database to state that these services should not be used to validate the work or times of other services.

Practice Expense

The RUC reviewed the practice expense inputs for the adult ESRD services and determined that the inputs recommended by the specialty societies was appropriate – a direct practice expense input crosswalk from 99375 *Care Plan Oversight*, 36 minutes of RN/LPN/MTA time and two follow-up phone calls, 6 minutes of RN/LPN/MTA time to account for the complete assessment which is performed in the office for the adult ESRD services. Further, the RUC reviewed the practice expense inputs for the pediatric ESRD services and determined that the inputs recommended by the specialty societies was appropriate – a direct practice expense input crosswalk from 99375 *Care Plan Oversight*, 36 minutes of RN/LPN/MTA time.

Pediatric Intensive Care (Tab 8)

Facilitation Committee #1

Steve Krug, MD and David Jaimovich, MD American Academy of Pediatrics (AAP)

In June 2007, the CPT Editorial Panel created new global bundled critical care codes for children over the age of 2 years who meet the definition of critically ill or injured with single or multiple organ failure where physician presence is required to reassess the patient frequently and supervise the health care team over a 24 hour period. These new CPT codes capture the repetitive evaluation of the patient's status, adjustments to therapy, review of laboratory results, monitoring and review of imaging data as well as the supervision of the health care team. These services are bundled critical care codes because these evaluations occur in brief and longer encounters throughout the day and cannot reasonably be counted or documented at each patient contact, which often represents a dozen or more per day.

The RUC reviewed the specialty society's survey of over 50 pediatric specialists regarding the physician work valuation for neonatal and pediatric intensive care codes 993XX1 and 993XX2.

993XX1 Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 25 months through 71 months of age

The RUC reviewed the specialty society survey work RVU for 993XX1 and determined that the specialty recommended RVU of 15.00 was too high compared to the reference service code 99293 *Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age* (work RVU=15.98) as 99293 requires more time and physician work (240 total minutes).

The RUC used a building block of the adult critical care codes 99291 *Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes* (work RVU = 4.50) and 99292 *Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes* (work RVU = 2.25) to develop the appropriate work RVU for code 993XX1. The RUC equated the physician work of this new code to one 99291 and three 99292 [$4.50 + (2.25 \times 3) = 11.25$]. The maximum total physician time for this building block approach is 164 minutes (74+30+30+30). The building block derived adult critical care total physician time is similar to the specialty society survey total time of 165 minutes, which further supports the building block method approached used by the RUC. The RUC also believed that the intensity of this service is slightly higher than that for the adult critical care codes and that the service is provided throughout the day.

The RUC recommends a work RVU of 11.25 for code 993XX1 and the specialty society surveyed physician time of 30 minutes pre-service, 105 intra-service and 30 minutes post-service.

993XX2 Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 25 months through 71 months of age

The RUC reviewed the specialty society survey work RVU for 993XX2 and determined that the specialty recommended RVU of 7.77 was too high compared to the reference service code 99294 *Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age* (work RVU = 7.99 and 140 minutes total physician time), as 99294 requires more time and physician work.

The RUC used a building block approach of the adult critical care codes 99291 *Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes* (work RVU = 4.50) and 99292 *Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes* (work RVU = 2.25) to develop the appropriate work RVU for code 993XX1. The RUC believed the physician work equated to one 99291 and one 99292 ($4.50 + 2.25 = 6.75$). The total physician time for these blended codes is 104 minutes (74 + 30). The blended adult critical care total physician time is similar to the specialty society survey time of 105 minutes, which further supports the building block approach as proposed by the RUC. The RUC also believed that the intensity of this service is slightly higher than that for the adult critical care codes and that the service is provided throughout the day.

The RUC recommends a work RVU of 6.75 for code 993XX2 and the specialty society surveyed physician times of 20 minutes pre-service, 65 intra-service and 20 minutes post-service.

Practice Expense:

The specialty and the RUC recommend no direct practice expense inputs for codes 993XX1 and 993XX2, since these services are provided only in the facility setting.

X. CMS Requests – Site of Service Anomalies

Bone Graft Procedures (Tab 9)

American Academy of Orthopaedic Surgery (AAOS), American Orthopaedic Foot and Ankle Society (AOFAS)

CPT code 20900, *Bone graft, any donor area; minor or small (eg, dowel or button)* was identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the

service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated. In tandem with the RUC's request to CMS that the service be resurveyed as potentially misvalued, the RUC requested that the global period be changed to 000. Additionally, the specialty society requested that 20902, *Bone graft, any donor area; major or large*, be included with 20900. CMS agreed. However, the specialty society requested that 20900 and 20902 not change to 000 day global periods, but remain 090 day global periods. The RUC did not agree with the specialty's request as the services are commonly performed with other services and there may be duplicative work if 20900 and 20902 remain 090 day global periods. **The RUC reaffirmed its recommendation that the services be surveyed with 000 day global periods and asked that the specialties present survey data in April 2008.**

Excision of Bone - Mandible (Tab 10)

Facilitation Committee #4

Timothy S. Shahbazian, DDS and James M. Startzell, DMD, MS American Association of Oral and Maxillofacial Surgeons (AAOMS), American Dental Association (ADA)

Code 21025 *Excision of bone (eg, for osteomyelitis or bone abscess); mandible* was brought under RUC review from the RUC's Five Year Identification Workgroup's efforts to address site of service anomalies. The specialty's original survey data from August 1995 indicated the service was performed in the facility setting whereas recent Medicare Utilization data indicated the service was typically performed in the non-facility setting. RUC had requested the specialty to resurvey this service.

The specialty agreed with the anomaly although its survey data from 61 oral and maxillofacial surgeons indicated a median length of stay of two days in the hospital (or at least overnight). The specialty society consensus panel recommended to remove all hospital visits and half a day discharge day management to arrive at its recommendation of 11.07 work RVUs.

The RUC reviewed the specialty society survey data and original recommended work value and obtained a clear explanation of the procedure from the specialty. From the specialty recommendation, the RUC agreed the pre-service time from the survey respondents was excessive for the service provided. Acknowledging the importance of accurate pre-service time and the new pre-service time standard packages, the RUC adjusted the pre-service time to reflect Pre-Service Time Package 3-Straightforward Patient/Difficult Procedure of 51 minutes with an additional 9 minutes of positioning time for nasotracheal intubation and airway protection.

The RUC agreed that reducing the specialty recommended work relative value by the difference in the pre-service time ($11.07 - .56 = 10.51$) was appropriate. The RUC also agreed that given the Medicare Utilization data for 2006 indicated that the service was provided over 50% of the time in the physician's office, an additional reduction in work RVUs with respect to eliminating the specialty recommended one-half discharge day

management was necessary ($10.51 - .64 = 9.87$) to arrive at its final recommended value of 9.87.

The RUC also reviewed seven RUC reviewed services with similar physician work, identical intra-service time, and similar post-operative work. The committee reviewed these codes for intra-service work intensities, physician work and time and found that the original specialty work recommendation reflected similarities with these Orthopedic and General Surgery codes. The RUC noted that three of the codes were reviewed by the RUC in the past two years and all since August 2000. In addition, the list contains two multi-specialty points of comparison codes. These seven services are listed below.

38745 *Axillary lymphadenectomy; complete* (Work RVU = 13.71)
49560 *Repair initial incisional or ventral hernia; reducible* (Work RVU = 11.84)
28299 *Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy* (Work RVU = 11.39)
25608 *Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments* (Work RVU = 10.86)
25394 *Osteoplasty, carpal bone, shortening* (Work RVU = 10.71)
29891 *Arthroscopy, ankle, surgical, excision of osteochondral defect of talus and/or tibia, including drilling of the defect* (Work RVU = 9.47)
40840 *Vestibuloplasty; anterior* (Work RVU = 9.02)

The RUC compared the physician work of code 21025 to code 29891 and agreed that more time pre-operatively and intra-operatively is necessary for code 21025 for patient airway protection and infection control. The RUC considered the overall physician work for code 21025 to be greater than code 29891. Based on this agreement and the other reference points and adjustments made to the work relative value to reflect the service's typical site of service, the RUC agreed that a work value of 9.87 would provide for accurate rank order relativity of this service among procedures with similar work..

The RUC recommends a physician work relative value of 9.87 for code 21025.

Practice Expense:

The RUC recommends an adjustment in the direct practice expense inputs for code 21025 to reflect the change in physician time and office visits associated with this service. These changes will be provided separately.

Claviclectomy (Tab 11)

American Academy of Orthopaedic Surgery (AAOS)

CPT code 23120, *Claviclectomy; partial*, was identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an outpatient

setting. CMS agreed with the RUC that this service should be evaluated. At the February 2008 RUC meeting, the RUC established a series of procedural rules to guide the reevaluation of Site of Service Anomalies. Included in these procedural guidelines is the necessity of compelling evidence for any specialty society recommendation to increase work RVU for a Site of Service Anomaly. The RUC deferred consideration of all recommendations for increases to work RVUs until April to allow specialty societies to conform to these rules and alter their recommendations as necessary.

Rotator Cuff (Tab 12)

Dale Blasier, MD and Louis McIntyre, MD American Academy of Orthopaedic Surgery (AAOS)

23410

CPT code 23410, *Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute*, was identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated. The specialty society presenters agreed that the site of service for this code has shifted from predominantly inpatient to outpatient. The presenters did not agree that the current work RVU was incorrect, but did agree that the current time and post-service hospital and office visits were no longer accurate and appropriate adjustments to the work RVU were appropriate. Based on the specialty society survey, the RUC agreed that the median time was appropriate. The recommended physician time is, pre-service evaluation = 40, pre-service scrub, dress and wait = 15, pre-service positioning = 15, intra-service = 90, and immediate post-service = 20. The specialty recommended and the RUC agreed that the reductions in office and hospital visits based on the survey data be adjusted to obtain a new work RVU. The survey data showed that four office visits including two 99212 visits and two 99213 visits were associated with this service. The specialty recommended that the full 99238 discharge day management service be reduced to one-half visit with a reduction in work RVU of 0.64 and the 99231 hospital visit be removed with a reduction in work RVU of 0.76. Subtracting these values from the current work RVU of 12.63 results in a work RVU of 11.23, which the RUC agreed was appropriate. **The RUC recommends a work RVU of 11.23.**

23412

CPT code 23412, *Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; chronic*, was identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated. CPT code 23412 was identified by the RUC for potential

misvaluation based on the Site of Service Anomaly list. The specialty society presenters agreed that the site of service for this code has shifted from predominantly inpatient to outpatient. The presenters did not agree that the current work RVU was incorrect, but did agree that the current time and post-service hospital and office visits were no longer accurate and appropriate adjustments to the work RVU are necessary. Based on the specialty society survey, the RUC agreed that the survey median time was appropriate. The recommended physician time is, pre-service evaluation = 40, pre-service scrub, dress and wait = 15, pre-service positioning = 15, intra-service = 100, and immediate post-service = 20. Further, the specialty recommended and the RUC agreed that the reductions in office and hospital visits based on the survey data be adjusted to obtain a new work RVU. The survey data showed that four office visits including two 99212 visits and two 99213 visits were associated with this service. The specialty recommended that the full 99238 discharge day management service be reduced to one-half with a reduction in work RVU of 0.64 and the one and one-half 99231 hospital visit be removed with a reduction in work RVU of 1.14. Subtracting these values from the current work RVU of 13.55 results in a work RVU of 11.77, which the RUC agreed was appropriate. **The RUC recommends a work RVU of 11.77.**

23420

CPT code 23420, *Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)*, was identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated. The specialty society presenters agreed that the site of service for this code has shifted from predominantly inpatient to outpatient. The presenters did not agree that the current work RVU was incorrect, but did agree that the current time and post-service hospital and office visits were no longer accurate and appropriate adjustments to the work RVU are necessary. Based on the specialty society survey data, the RUC agreed that the survey median time was appropriate. The recommended physician time is pre-service evaluation = 40, pre-service scrub, dress and wait = 15, pre-service positioning = 15, intra-service = 120, and immediate post-service = 20. Further, the specialty recommended and the RUC agreed that the reductions in office and hospital visits based on the survey be adjusted to the work RVU. The survey data showed that five office visits including three 99212 visits and two 99213 visit were associated with this service. The specialty recommended that the full 99238 discharge day management service be reduced to one-half visit with a reduction in work RVU of 0.64 and the one 99231 hospital visit be removed with a reduction in work RVU of 0.76. Subtracting these values from the current work RVU of 14.75 results in a work RVU of 13.35, which the RUC agreed was appropriate. **The RUC recommends a work RVU of 13.35.**

Practice Expense

The RUC recommends an adjustment in the direct practice expense inputs for these codes to reflect any change in office visits associated with this service.

Shoulder Ligament Release (Tab 13)

Dale Blasier, MD and Louis McIntyre, MD American Academy of Orthopaedic Surgery (AAOS)

CPT code 23415, *Coracoacromial ligament release, with or without acromioplasty*, was identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated. The specialty society presenters agreed that the site of service for this code has shifted from predominantly inpatient to outpatient. The presenters did not agree that the current work RVU was incorrect, but did agree that the current time and post-service hospital and office visits were no longer accurate and appropriate adjustments to the work RVU were necessary. Based on the specialty society survey, the RUC agreed that the median time was appropriate. The recommended physician time is, pre-service evaluation = 40, pre-service scrub, dress and wait = 15, pre-service positioning = 15, intra-service = 60, and immediate post-service = 20. The specialty recommended and the RUC agreed that the reductions in office and hospital visits based on the survey data be adjusted to obtain a new work RVU. The survey data showed that four office visits including two 99212 visits and two 99213 visits were associated with this service. The specialty recommended that the full 99238 discharge day management service be reduced to one-half visit with a reduction in work RVU of 0.64 and the one-half 99231 hospital visit be removed with a reduction in work RVU of 0.38. Subtracting these values from the current work RVU of 10.09 results in a work RVU of 9.07, which the RUC agreed was appropriate and is slightly less than the new survey median. **The RUC recommends a work RVU of 9.07.**

Practice Expense

The RUC recommends an adjustment in the direct practice expense inputs for these codes to reflect any change in office visits associated with this service.

Forearm Excision (Tab 14)

American Academy of Orthopaedic Surgery (AAOS), American Society for Surgery of the Hand (ASSH)

25116, *Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); extensors, with or without transposition of dorsal retinaculum*, was identified by the RUC for potential misvaluation based on the Site of Service Anomaly list. At the February 2008 RUC meeting, the RUC established a series of procedural rules to guide the reevaluation of Site of Service Anomalies. Included in these procedural guidelines is the necessity of compelling evidence for any specialty society recommendation to increase work RVU for

a Site of Service Anomaly. The RUC deferred consideration of all recommendations for increases to work RVUs to April to allow specialty societies to conform to these rules and alter their recommendations as necessary.

Forearm Repair (Tab 15)

Daniel Nagle, MD American Society for Surgery of the Hand (ASSH), Dale Blasier, MD American Academy of Orthopaedic Surgery (AAOS)

CPT code 25310, *Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single; each tendon*, was identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated. The specialty society presenters agreed that the site of service for this code has shifted from predominantly inpatient to outpatient. The presenters did not agree that the current work RVU was incorrect, but did agree that the current time and post-service hospital and office visits were no longer accurate and appropriate adjustments to the work RVU are necessary. Based on the specialty society survey, the RUC agreed that the survey median times were appropriate. The physician time agreed to is pre-service evaluation = 40, pre-service scrub, dress and wait = 15, pre-service positioning = 10, intra-service = 60, and immediate post-service = 20. Further, the specialty recommended and the RUC agreed that the changes in office and hospital visits based on the survey be adjusted to the work RVU, using a building block method. The survey data showed that four office visits including two 99212 visits and two 99213 visits were associated with this service, however, the presenters agreed that one 99213 visit should be reduced to a 99212 visit. The specialty recommended one-half 99238 discharge day management. To find an appropriate value, the specialty society reduced the current work RVU, assumed to be correct, to account for the removal of one-half 99238 (0.64 work RVUs), one-half 99231 (0.38 work RVUs), and one-half 99212 (0.22 work RVUs). This accounted for a total reduction in work RVU of 1.24. The specialty then added the work associated with one 99213 visit (0.92 work RVUs). The resulting value is 7.94, which the RUC agreed was appropriate and in proper rank order with its reference service 25275, *Repair, tendon sheath, extensor, forearm and/or wrist, with free graft (includes obtaining graft) (eg, for extensor carpi ulnaris subluxation)*, (work RVU = 8.81). The RUC also verified the value by calculating the intra-service work intensity for 25310 (0.05568) and comparing it to the IWPUT of the other code in the family, 25312, *Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single; with tendon graft(s) (includes obtaining graft), each tendon*, (work RVU = 9.70, IWPUT = 0.05099). **The RUC recommends a work RVU of 7.94.**

Practice Expense

The RUC recommends an adjustment in the direct practice expense inputs for these codes to reflect any change in office visits associated with this service.

Finger Arthrotomy (Tab 16)

American Academy of Orthopaedic Surgeons (AAOS), American Society for Surgery of the Hand (ASSH)

CPT code 26080, *Arthrotomy, with exploration, drainage, or removal of loose or foreign body; interphalangeal joint, each*, was identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated. The specialty society presenters were unable to make a recommendation for work RVU on this service because the Medicare claims data and survey responses indicate a vast discrepancy in the use of the code. The Medicare Utilization database indicates that the majority of these services are performed in the out-patient hospital setting, though the survey respondents overwhelmingly state that the service is always performed as an in-patient procedure. The only variance among respondents was the length of stay which was estimated to be between one and six days. Based on these differences, the specialty society concluded and the RUC agreed that there is no appropriate typical patient for the code as currently described. The specialty society presenters suggested that the RUC recommend to CMS that 26080 be changed from a 090 day global to a 000 day global. The RUC did not agree that changing the global period would rectify this anomaly. Rather, the RUC concurred that greater granularity of the CPT descriptor is a more appropriate path.

The RUC recommends that 26080 be referred to the CPT Editorial Board to edit the descriptor to differentiate between the services currently described in the code.

Trochanteric Bursa Excision (Tab 17)

American Academy of Orthopaedic Surgery (AAOS)

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

Closed Treatment of Hip Dislocation (Tab 18)

Dennis Beck, MD American College of Emergency Physicians (ACEP)

CPT code 27250, *Closed treatment of hip dislocation, traumatic; without anesthesia*, was identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. It was also identified in the High IWPOT screen. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an the emergency department. CMS agreed with the RUC that this service should be evaluated. The specialty society presenters agreed that the site of service for this code is the emergency department. CMS agreed with the RUC that this service should be assigned a 000 day global rather than a 090 day global period.

The specialty society conducted a survey of thirty-six emergency medicine physicians and recommended and the RUC agreed with the following current median survey physician time: pre-service evaluation = 15 minutes, pre-service positioning = 5, pre-service scrub, dress and wait = 5, intra-service = 15, and immediate post-service = 13. The survey respondents indicated a median work RVU of 3.82. The RUC agreed the median survey work value appropriate considering the reduction of relative value units associated with the elimination of physician time components that were originally established through the Harvard studies. The Harvard studies had valued this service with an overnight hospital stay, discharge day management, and 4.5 post operative office visits. The RUC also compared the recommended value to the key reference service, 32551, *Tube thoracostomy, includes water seal (eg, for abscess, hemothorax, empyema), when performed (separate procedure)*, (work RVU = 3.29) and, while the surveyed service's and key reference service's intra-service times are different, 15 and 24 minutes, respectively, the survey respondents indicated that 27250 requires substantially greater physician effort and intensity. **The RUC recommends 3.82 work RVUs for 27250.**

CPT Referral

The RUC also noted that this service should be placed on Appendix G of the CPT book, as conscious sedation is inherent. **The RUC recommends that the CPT Editorial Panel add 27250 to Appendix G, the summary of CPT codes that include moderate (conscious) sedation, within the CPT book.**

Practice Expense

The RUC recommends an adjustment in the direct practice expense inputs for these codes to reflect any change in office visits associated with this service.

Leg Bone Resection Partial (Tab 19)

American Academy of Orthopaedic Surgeons (AAOS), American Orthopaedic Foot and Ankle Society (ASSH)

Code 27640 *Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis or exostosis); tibia* and 27641 *Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis or exostosis); fibula* were brought under RUC review from the RUC's Five Year Identification Workgroup's efforts to address site of service anomalies. The services were valued through the Harvard studies with a 090 day global period and physician time components indicating the services were performed in an hospital inpatient setting. Recent Medicare Utilization data indicated the service was typically performed in the hospital outpatient setting. The specialty provided survey results however because the CPT descriptors were imprecise and represent different work than the typical patient encounter, the specialty recommended that both codes be corrected at CPT and surveyed. RUC had requested the specialty to resurvey these two codes as 000 day global services. CMS did not agree that the global period should be changed.

At the February 2008 RUC meeting the specialty requested that codes 27640 and 27641 be referred to the CPT Editorial Panel for revision as various services are described within the same code. **The RUC recommends CPT code 27640 and 27641 be referred to the CPT Editorial Panel for revision**

Achilles Tendon Repair (Tab 20)

Facilitation Committee #3

R. Dale Blasier, MD, American Academy of Orthopaedic Surgeons (AAOS), Tye Ouzounian, MD; Frank Spinosa, DO; Robb Mothershed, DO American Orthopaedic Foot and Ankle Society (AOFAS), American Podiatric Medical Association (APMA)

27650

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

The specialty society provided a detailed explanation of the work involved in providing 27650. Based on the explanation, the RUC agreed that the survey pre-service time is too high and recommended reducing it to 19 minutes of pre-service evaluation time, 15 minutes of positioning time, and 5 minutes of scrub, dress, and wait time. This is slightly higher than the survey key reference service, 28289, *Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint*

(work RVU = 8.10, pre-service time = 30, intra-service time = 45, post-service time = 30). The specialty society also discussed the number and intensity of the post-operative visits associated with this service and the RUC agreed that three 99213 visits and two 99212 visits are necessary due to the highly vascularized area, potential for wound complications, reduced patient mobility following the procedure, and the need for physical therapy. The typical patient requires post-operative visits once every two weeks for twelve weeks, resulting in at least five visits and no more than six visits. Because of the intensity of the service, the RUC agreed that the specialty's recommendation of 9.00 work RVUs appropriately values the service. The key reference service has a nearly identical intensity, however, it contains fifteen minutes less intra-service time. Further, the key reference service is performed in the out-patient setting, but does not contain the RUC-standard one-half of a 99238 visit. If 28289 did contain one-half of a 99238, its IWPOT would be to 0.054 which is very similar to the IWPOT of 0.057 of the survey code with a work RVU of 9.00. The RUC also identified several other reference services to serve as references for the recommended work RVU of 9.00 for 27650. Specifically, the RUC looked to 24359, *Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); debridement, soft tissue and/or bone, open with tendon repair or reattachment*, (work RVU = 8.85, pre time = 50, intra-service = 60, and post-service = 20) and 29905, *Arthroscopy, subtalar joint, surgical; with synovectomy*, (work RVU = 9.00, pre-time = 65, intra-service = 60, and post-service = 15), which also contains one fewer 99212 visits.

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

27654

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

Practice Expense

The RUC recommends an adjustment in the direct practice expense inputs for these codes to reflect any change in office visits associated with this service.

Tendon Transfer (Tab 21)

American Academy of Orthopaedic Surgeons (AAOS), American Orthopaedic Foot and Ankle Society (AOFAS), American Podiatric Medical Association (APMA)

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

Foot Bone Resection Partial (Tab 22)

American Academy of Orthopaedic Surgeons (AAOS), American Orthopaedic Foot and Ankle Society (AOFAS), American Podiatric Medical Association (APMA)

CPT code 28120, *Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); talus or calcaneus*, and 28122, *Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); tarsal or metatarsal bone, except talus or calcaneus*, were identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated. At the February 2008 RUC meeting, the RUC established a series of procedural rules to guide the reevaluation of Site of Service Anomalies. Included in these procedural guidelines is the necessity of compelling evidence for any specialty society recommendation to increase work RVU for a Site of Service Anomaly. The RUC deferred consideration of all recommendations for increases to work RVUs until April to allow specialty societies to conform to these rules and alter their recommendations as necessary.

Hallus Valgus Correction (Tab 23)**Facilitation Committee #3**

R. Dale Blasier, MD, American Academy of Orthopaedic Surgeons (AAOS), Tye Ouzounian, MD; Frank Spinoso, DO; Robb Mothershed, DO American Orthopaedic Foot and Ankle Society (AOFAS), American Podiatric Medical Association (APMA)

CPT code 28296, *Correction, hallux valgus (bunion), with or without sesamoidectomy; with metatarsal osteotomy (eg, Mitchell, Chevron, or concentric type procedures)*, was identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated. The specialty society presenters provided a highly detailed explanation of the work involved in providing CPT code 28296. Based on the specialty society's explanation, the RUC agreed that the survey pre-service time is too high and recommends reducing it to 30 minutes of pre-service evaluation time, 5 minutes of positioning time, and 10 minutes of scrub, dress, and wait time. These time increments are slightly higher than the key reference service, 28750, *Arthrodesis, great toe; metatarsophalangeal joint* (work RVU = 8.37, pre-service time = 40, intra-service time = 75, post-service time = 30). The RUC recommended a change to the pre-service time because the 70 minutes identified in the survey incorporated 5 minutes more scrub, dress and wait time and 5 minutes more positioning time than necessary. Following the explanation of the service, the RUC agreed with the specialty that the number of post-operative visits (two 99213 and three 99212) is appropriate. This is different from the reference service code, which includes four 99213 visits. The reason for this change is that the typical patient requires weekly visits for the first six weeks following the procedure and two additional visits spaced farther apart. Therefore, the typical patient requires at least five visits and no more than seven. The RUC next considered the work RVU of 28296 and agreed that the specialty's recommendation was too high. The service has a nearly identical intensity to the key reference service 28750 according to the survey data. However, the slightly lower intra-service time of the survey code merits a slightly lower work RVU. As such, the RUC recommends the survey 25th percentile work RVU of 8.16. Given the similar intensities, slightly less intra-service time, and higher number of visits, the RUC agreed that a work RVU of 8.16 is an appropriate valuation and in proper rank order with 28750.

The RUC recommends pre-service evaluation time of 30 minutes, pre-service positioning time of 5 minutes, pre-service scrub, dress and wait time of 10 minutes, intra-service time of 60 minutes, immediate post-service time of 15 minutes, two 99213, three 99212, one-half 99238, and the 25th percentile work RVU of 8.16 for 28296.

Practice Expense

The RUC recommends an adjustment in the direct practice expense inputs for these codes to reflect any change in office visits associated with this service.

Foot Arthrodesis (Tab 24)

American Academy of Orthopaedic Surgeons (AAOS), American Orthopaedic Foot and Ankle Society (AOFAS), American Podiatric Medical Association (APMA)

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

Toe Amputation at IP Joint (Tab 25)

American Academy of Orthopaedic Surgeons (AAOS), American College of Surgeons (ACS), American Orthopaedic Foot and Ankle Society (AOFAS), American Podiatric Medical Association (APMA), American Society of General Surgeons (ASGS), Society for Vascular Surgery (SVS)

CPT code 28825, *Amputation, toe; interphalangeal joint*, was identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated. The specialty societies commented that the typical patient for this service is bi-modal. Based on the 2006 Medicare utilization data, the service is performed approximately 46% in the in-patient hospital setting, 46% in the out-patient hospital and ambulatory surgery center settings, and about 7% in the physician office. The service is performed by a wide variety of specialties including podiatry, orthopaedic surgery, vascular surgery and general surgery, further supporting a bi-modal distribution. The typical patient is bi-modal and requires amputation because of either diabetes or gangrene resulting from peripheral vascular disease. The specialties, based on their own survey data which indicated a bi-modal distribution and the Medicare utilization data, recommended that the service be resurveyed with a 000 day global period to more

accurately include the work given the bi-modal distribution. The RUC agreed and further noted that a change in CPT descriptor will not resolve the issue, but a change in global period would.

The RUC recommends that CMS change the global period for 28825 to 000 day global period and the specialty societies to resurvey for the April 2008 RUC meeting. CMS has responded that the 090 day global be maintained. The specialty should determine how to resolve the valuation of this service

ACL Repair (Tab 26)

American Academy of Orthopaedic Surgeons (AAOS), American Orthopaedic Foot and Ankle Society (AOFAS)

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

Arteriovenous Procedures (Tab 27)

Facilitation Committee #3

Robert Zwolak, MD, PhD, Society for Vascular Surgery (SVS), Christopher Senkowski, MD, Charles Mabry, MD, Matthew Sideman, MD, American College of Surgeons (ACS)

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

36820

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

Furthermore, the RUC was compelled to maintain the inpatient hospital visit and full discharge day management of the code based on the following information supplied to the RUC. Although the CMS database has this procedure posted as being performed 34% as hospital inpatient and 63% as hospital outpatient, the majority of survey respondents (56%) reported at least one inpatient visit. The specialty society believes the discrepancy lies in coding of patients who remain in hospital for 23-hour stays. These patients undergo 20 minutes of immediate post-service care. The physician then rounds on them late in the day, and for most, the decision is made that the patient needs to stay in a monitored hospital setting overnight, (some may need post-operative hemodialysis). The associated work is reported as a 99231 visit. The patients are then evaluated the next morning and discharged. A full discharge day management visit (99238) is required for this service because the typical patient goes home on the day after the service. Discharge work includes a full neurovascular evaluation of the extremity, incision exam for potential hemorrhage, fistula evaluation to ensure patency, acceptable discharge glycemic control, physical exam to ensure the IV fluid administered by anesthesia has not pushed the renal failure patient into CHF, provision of wound care instructions, provision of warnings for steal syndrome and vascular compromise of the hand, ensuring arrangements are made to reestablish outpatient hemodialysis, and finalization of many other details for this very sick subset of typically diabetic renal failure patients. Although the RUC “convention” is ½ discharge day for “outpatient” services, the RUC stated very clearly that if a full discharge day is justified, it can and should be assigned. The typical patient for this service goes home the day after surgery, and the 99238 is the only visit assigned to the physician work on that day.

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

services has increased. Therefore the RUC determined based on all of this evidence to maintain the current value of this 36820. **The RUC recommends 14.39 RVUs for 36820.**

36821 and 36825

The specialty society requested that the presentation for these two services be postponed until the April 2008 RUC Meeting.

Practice Expense:

The practice expense inputs, specifically for the assist physician time, discharge day management and the number and level of office visits for 36820 are recommended to be modified to reflect the current survey data.

Jugular Node Dissection (Tab 28)

**American Academy of Otolaryngology - Head and Neck Surgery (AAO-HNS),
American College of Surgeons (ACS)**

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

Palatopharyngoplasty (Tab 29)

American Academy of Otolaryngology - Head and Neck Surgery (AAO-HNS)

CPT code 42145, *Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)*, was identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated. At the February 2008 RUC meeting, the RUC established a series of procedural rules to guide the reevaluation of Site of Service Anomalies. Included in these procedural guidelines is the necessity of compelling evidence for any specialty society recommendation to increase work RVU for a Site of Service Anomaly. The RUC deferred consideration of all recommendations for

increases to work RVUs until April to allow specialty societies to conform to these rules and alter their recommendations as necessary.

Parotid Tumor Excision (Tab 30)

**American Academy of Otolaryngology - Head and Neck Surgery (AAO-HNS),
American College of Surgeons (ACS)**

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

Submandibular Gland Excision (Tab 31)

Jane T. Dillon, MD, American Academy of Otolaryngology - Head and Neck Surgery (AAO-HNS), Charles Mabry, MD, Christopher Senkowski, MD, American College of Surgeons (ACS)

CPT code 42440, *Excision of submandibular (submaxillary) gland*, was identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated.

The specialty society presenters agreed that the site of service for this code has shifted from predominantly inpatient to outpatient. Based on a survey of twenty-five surgeons, the presenters recommended the following median survey times, pre-service evaluation = 30, pre-service positioning = 10, pre-service scrub, dress, and wait = 15, intra-service = 60, immediate post-service = 20. The specialty society presenter and the RUC agreed that the median survey physician time was appropriate. The specialty society recommended two post-service office visits, one 99212, one 99213, and one-half 99238 discharge day management visits. The specialty society presenter clarified the increase in

intensity of office visits, noting that rather than an overnight stay in the hospital, the typical patient is discharged the same day with tubes in their neck and a more intense office visits is needed to remove the tube and check the other dressings. There is also a slightly less intense service for general follow-up care with the patient regarding this service. The specialty society did not agree with the survey median of 12.00 or the 25th percentile of 10.00, but rather recommended maintaining the current RVU of 7.05.

Further, this recommendation was further supported when the RUC considered another reference service, 38520, *Biopsy or excision of lymph node(s); open, deep cervical node(s) with excision scalene fat pad*, (work RVU = 6.95, intra-service time = 60 minutes), which was reviewed by the RUC in the second Five-Year Review. This service contains the same number and level of office visits as the surveyed code. The RUC also compared the intra-service work intensity between the two codes and noted that the IWPUT of the survey code was 0.0596 and for 38520, the IWPUT was nearly identical at 0.0560. The RUC agreed and noted that while the hospital visits were removed, the intensity of the office visits increased significantly and the pre- and post-service times increased slightly. In consideration of the similarity to the reference service, 38520, and the RUC agreed that 7.05 is an appropriate valuation. **The RUC recommends a work RVU of 7.05.**

Practice Expense

The RUC recommends an adjustment in the direct practice expense inputs for these codes to reflect any change in office visits associated with this service.

Rectal Tumor Excision (Tab A)

American College of Surgeons (ACS), American Society of Colon and Rectal Surgeons (ASCRS), American Society of General Surgeons (ASGS)

CPT code 45170 *Excision of rectal tumor, transanal approach* was identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated.

The specialty society requested that this service be referred to the CPT Editorial Panel to distinguish the size of the tumor as the removal of different size tumors would reflect different patient populations and different physician work. Further the descriptor should be clarified to indicate that this service represents a full thickness excision of the rectal wall which can result in several patient complications including pelvic sepsis, urinary retention, hemorrhage and rectal/vaginal fistulas. **For these reasons, the RUC recommends that 45170 be referred to the CPT Editorial Panel.**

It should be noted that this code was also identified in the high intra-service work per unit of time (IWPUT) screen and this action will be reflected in that analysis.

Hernia Repair (Tab B)

American College of Surgeons (ACS), American Society of General Surgeons (ASGS)

CPT codes Repair *initial inguinal hernia, age 5 years or older; incarcerated or strangulated*, 49521 *Repair recurrent inguinal hernia, any age; incarcerated or strangulated* and 49587 *Repair umbilical hernia, age 5 years or older; incarcerated or strangulated* were identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomalies utilizing information from the current physician time data and the Medicare claims data. The physician time data for these codes currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that these services are typically performed in an outpatient setting. CMS agreed with the RUC that these services should be evaluated.

The specialty societies requested that the presentation for these three services be postponed until the April 2008 RUC Meeting.

Urological Procedures (Tab C)

Thomas P. Cooper, MD, Jeffrey A. Dann, MD, James G. Giblin, MD, Richard N. Gilbert, MD American Urological Association (AUA), George A. Hill, MD American College of Obstetricians and Gynecologists (ACOG)

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

51102

The RUC reviewed the specialty society recommendation for code 51102 *Aspiration of bladder; with insertion of suprapubic catheter* and determined that the vignette may have misled survey respondents to inappropriately conclude there are certain post-operative visits because it included "is admitted to the ICU". The RUC also determined that this service should have a 000-day global period instead of a 010-day global period because the post-operative period is variable. **The RUC requests that CMS assign a 000-day global period to code 51102 and that the specialty society resurvey this service with the revised vignette. CMS has notified the RUC that a 000-day global period would be acceptable.**

52341, 52342, 52343, 52344, 52345, 52346, 52400, 52500, 52640 and 54405

At the February 2008 RUC meeting, the RUC established a series of procedural rules to guide the reevaluation of Site of Service Anomalies. Included in these procedural guidelines is the necessity of compelling evidence for any specialty society recommendation to increase work RVU for a Site of Service Anomaly. The RUC deferred consideration of all recommendations for increases to work RVUs until April to allow specialty societies to conform to these rules and alter their recommendations as necessary.

53445

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

54410

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

The RUC was compelled to maintain full discharge day management of the code based on the following information supplied to the RUC. Although the CMS database has this procedure posted as being performed 32% as hospital inpatient and 67% as hospital outpatient, the majority of survey respondents reported a full discharge day and at least one hospital visit. The specialty society believes the discrepancy lies in coding of patients who remain in hospital for 23-hour stays. These patients undergo 30 minutes of immediate post-service care. The physician then rounds on them late in the day, and for most, the decision is made that the patient needs to stay in a monitored hospital setting overnight. The patients are then evaluated the next morning and discharged. A full discharge day management visit (99238) is required for this service because the typical patient goes home on the day after the service. Although the RUC “convention” is ½ discharge day for “outpatient” services, the RUC stated very clearly that if a full discharge day is justified, it can and should be assigned. The typical patient for this service goes home the day after surgery, and the 99238 is the only visit assigned to the physician work on that day.

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

54530

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

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

57287

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

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

Additionally, the RUC compared this service to code 53852 *Transurethral destruction of prostate tissue; by radiofrequency thermotherapy* (work RVU = 10.68, intra-service time

= 58 minutes) as a reference to further support the recommendation of 10.97 for code 57287. **The RUC recommends a work RVU of 10.97 for code 57287.**

Practice Expense

Services for 53445, 54530 and 57287 are typically performed in the facility setting. The practice expense inputs, specifically for the assist physician time and the number of post-operative visits for codes 53445, 54530 and 57287 are recommended to be modified to reflect the current survey data.

Partial Removal of Vulva (Tab D)

George A. Hill, MD American College of Obstetricians and Gynecologists (ACOG)

CPT code 56620 *Vulvectomy simple; partial* was brought under RUC review from the RUC's Five Year Identification Workgroup's efforts to address site of service anomalies. The service was valued through the Harvard studies as a 090 day global period and physician time components indicating the service was performed in a hospital inpatient setting. Recent Medicare Utilization data indicated the service was typically performed in the outpatient hospital setting. RUC had requested the specialty to resurvey this service for presentation at the February 2008 RUC meeting.

The RUC reviewed the specialty society's survey results which were quite similar to the survey's reference code, 57106 *Vaginectomy, partial removal of vaginal wall*; (Work RVU = 7.35). The survey of 500 obstetricians and gynecologists indicated the physician time, intensity and complexity within the pre-service, intra-service, and post service periods for 56620 were slightly higher yet almost identical to 57106. From the survey results the specialty recommended a decrease in the pre-service time of 5 minutes in positioning time and 5 minutes in scrub dress and wait time and believed the respondents underestimated the immediate post service time by 10 minutes. In addition, since the majority of the survey respondents indicated a one day hospital stay (99231) was typical, and Medicare data indicated otherwise, the specialty recommended eliminating the (99231) hospital stay, and ½ day discharge day management. An additional 99213 office visit was added to capture some of the work that was previously performed in the inpatient setting. The RUC agreed with these modifications of physician time from the survey results.

The RUC also reviewed two RUC reviewed codes currently listed on the RUC's multi-specialty points of comparison list to compare the relativity across specialties. Codes 30520 *Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft* (Work RVU = 6.85) and 49505 *Repair initial inguinal hernia, age 5 years or older; reducible* (Work RVU = 7.88) were reviewed in relation to code 56620 and believed that proper rank order would be established with the specialty recommended work value of 7.35.

The RUC recommends a work relative value of 7.35 for CPT code 56620.

Total Thyroid Lobectomy (Tab E)

American Academy of Otolaryngology - Head and Neck Surgery (AAO-HNS), American College of Surgeons (ACS), American Society of General Surgeons (ASGS)

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

The specialty societies requested that the presentation for these two services be postponed until the April 2008 RUC Meeting.

Neurosurgical Procedures (Tab F)

American Association of Neurological Surgeons/Congress of Neurological Surgeons (AANS/CNS), American Urological Association (AUA)

CPT codes: 61885 *Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array*; 64573 *Incision for implantation of neurostimulator electrodes; cranial nerve* and 64581 *Incision for implantation of neurostimulator electrodes; sacral nerve (transforaminal placement)* were identified by the RUC's Five-Year Review Identification Workgroup as having site of service anomalies in recent Medicare claims data. These services were initially priced in the facility setting, i.e. have hospital visits and full discharge management services associated with them, are now being performed in the outpatient setting more than 50% of the time, according to the Medicare Claims data. CMS had requested the RUC review these site of service anomalies.

61885 and 64573

The specialty society had requested that its presentation of codes 61885 and 64573 be postponed until the April 2008 RUC meeting due to its difficulty encountered when they considered their reference service list, the global periods, and timing issues. The RUC granted the specialty's request to postpone and reviewed the survey results of code 64581. **The RUC recommends that the specialty recommendations for CPT codes 61885 and 64573 be presented at the April 2008 RUC meeting.**

64581

The RUC reviewed the survey results from 58 respondents and the specialty recommendation which eliminated inpatient hospital physician activities, as they agreed that the site of service had changed, and added additional post-operative office visits.

The RUC and the presenters had trouble understanding the sequence of events for the service and the all the component coding typically performed. The specialty indicated that the programming was performed postoperatively within the 090 day global period however it was learned that programming and the insertion of the electrodes may also be billed separately. The RUC also had difficulty with the vignette used for the survey as the implantation and programming services were not excluded and may have skewed the survey results. Considering these issues the RUC could not adequately value this physician service and recommended that the specialty resurvey with a more specific vignette and present their results at the next meeting. **The RUC recommends the specialty re-survey 64581 with an accurate vignette and present their recommendations at the April 2008 RUC meeting.**

Epidural Lysis (Tab G)

Eduardo Fraifeld, MD American Academy of Pain Medicine (AAPM), Alexander Mason, MD, Andrea Trescot, MD American Association of Neurological Surgeons/Congress of Neurological Surgeons (AANS/CNS), Tripti Kataria, MD, MPH, American Society of Anesthesiologists (ASA), Charles Mick, MD, North American Spine Society (NASS)

CPT code 62263 Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days

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

The RUC reviewed 62263 *Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days*. The specialty societies presented data from 19 pain medicine physicians, neurosurgeons, aesthesiologists and spine surgeons. The RUC compared the survey code to the reference code, 62264 *Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day* (Work RVU=4.42). The RUC reviewed the survey data presented by the specialty societies and determined that the surveyed code in comparison to the reference code had considerably longer total service time, 194 minutes and 109 minutes respectively. Further, the RUC noted that the surveyed code required greater mental effort, physical effort and judgment in comparison to the reference code. In addition, the RUC noted that the survey data supported that this service is now more frequently being performed in the ASC or outpatient setting as the 2-99231 hospital visits have been

removed and the full discharge day management service has been reduced to half a discharge day management service. The RUC determined that after an analysis of the survey intensity measures as compared with the reference code and of the calculated IWPUT of 62263 using the specialties recommended values and times (Current IWPUT=0.046, New IWPUT=0.043), the current work RVU for this service is correct. Therefore, given the comparison to the reference code and the survey data, the RUC determined that the current work RVU for this service was appropriate. **The RUC recommends 6.41 RVUs for 62263.**

Practice Expense:

The practice expense inputs, specifically for the assist physician time, discharge day management and the number and level of office visits for 62263 are recommended to be modified to reflect the current survey data.

Intrathecal/Epidural Catheters/Pumps (Tab H)

Eduardo Fraifeld, MD, American Academy of Pain Medicine (AAPM), American Academy of Physical Medicine and Rehabilitation (AAPMR), Alexander Mason, MD, American Association of Neurological Surgeons/Congress of Neurological Surgeons (AANS/CNS), Tripti Kataria, MD, MPH, American Society of Anesthesiologists (ASA), David Bagnall, MD, International Spine Intervention Society (ISIS), Charles Mick, MD North American Spine Society (NASS)

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

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

The specialty societies presented data from 58 pain medicine physicians, neurosurgeons, anesthesiologists and spine surgeons. The RUC compared the surveyed code to the reference code, 64561 *Percutaneous implantation of neurostimulator electrodes; sacral nerve (transforaminal placement)* (Work RVU=7.07). The RUC reviewed the survey data presented by the specialty societies and determined that the surveyed code in comparison to the reference code had less total service time, 170 minutes and 204 minutes respectively. In addition, the RUC noted that the survey data supported that this service is now more frequently being performed in the outpatient setting as the 2-99233 and 1-99231 hospital visits have been removed and the full discharge day management service has been reduced to half a discharge day management service. Therefore, given the comparison to the

reference code, the RUC determined that the median work RVU, 6.00 was appropriate. **The RUC recommends 6.00 RVUs for 62350.**

62355 Removal of previously implanted intrathecal or epidural catheter

The specialty societies presented data from 58 pain medicine physicians, neurosurgeons, anesthesiologists and spine surgeons. The RUC compared the survey code to the reference code, 36589 *Removal of tunneled central venous catheter, without subcutaneous port or pump* (Work RVU=2.27). The RUC reviewed the survey data presented by the specialty societies and determined that the surveyed code in comparison to the reference code had considerably longer total service time, 140 minutes and 79 minutes respectively. Further, the RUC noted that the surveyed code required greater mental effort, physical effort and judgment in comparison to the reference code. In addition, the RUC noted that the survey data supported that this service is now more frequently being performed in the outpatient setting as the 2-99233 and 1-99231 hospital visits have been removed and the full discharge day management service has been reduced to half a discharge day management service. However, the specialty societies determined that the survey median was not an appropriate value for the service as it would cause rank order anomalies with codes in the family. Therefore, the specialty societies recommend 4.30 work RVUs, or approximately half-way between the median and the 75th percentile of the survey data as this value maintains rank order within the family. This value is further supported by another reference code, 44391 *Colonoscopy through stoma; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)* (work RVU=4.31) as this code and the surveyed code have similar work and total service times, 141 minutes and 140 minutes, respectively. Therefore, given the comparison to the reference codes, the RUC determined that 4.30 work RVUs was appropriate and maintained rank order within the family of codes. **The RUC recommends 4.30 RVUs for 62355.**

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

The specialty societies requested that the presentation for this services be postponed until the April 2008 RUC Meeting.

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

The specialty societies presented data from 37 physicians from pain medicine physicians, neurosurgeons, anesthesiologists and spine surgeons. The RUC compared the survey code to the reference code, 61888 *Revision or removal of cranial neurostimulator pulse generator or receiver* (Work RVU=5.20). The RUC reviewed the survey data presented by the specialty societies and determined that the surveyed code in comparison to the reference code had similar total service time, 170 minutes and 171 minutes respectively. However, the RUC noted that the surveyed code required greater mental effort, physical effort and judgment in comparison to the reference code. In addition, the RUC noted that

the survey data supported that this service is now more frequently being performed in the outpatient setting as the 2-99233 and 1-99231 hospital visits have been removed and the full discharge day management service has been reduced to half a discharge day management service. However, the specialty societies determined that the survey median was not an appropriate value for the service as it would cause rank order anomalies with codes in the family. Therefore, the specialty societies recommend 5.60 work RVUs, a value between the median and the 75th percentile of the survey data as this value appropriately maintains rank order within the family. This value is further supported by another reference code, 53853 *Transurethral destruction of prostate tissue; by water-induced thermotherapy* (work RVU=5.54) as this code and the surveyed code have similar work and intra-service times, 60 minutes. Therefore, given the comparison to the reference codes, the RUC determined that 5.60 work RVUs was appropriate and maintained rank order within the family of codes. **The RUC recommends 5.60 RVUs for 62361.**

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

The specialty societies presented data from 37 pain medicine physicians, neurosurgeons, anesthesiologists and spine surgeons. The RUC compared the survey code to the reference code, 61888 *Revision or removal of cranial neurostimulator pulse generator or receiver* (Work RVU=5.20). The RUC reviewed the survey data presented by the specialty societies and determined that the surveyed code in comparison to the reference code had similar total service time, 170 minutes and 171 minutes respectively. However, the RUC noted that the surveyed code required greater mental effort, physical effort and judgment in comparison to the reference code. In addition, the RUC noted that the survey data supported that this service is now more frequently being performed in the outpatient setting as the 3-99233 hospital visits have been removed and the full discharge day management service has been reduced to half a discharge day management service. However, the specialty societies determined that the survey median was not an appropriate value for the service as it would cause rank order anomalies with codes in the family. Therefore, the specialty societies recommend 6.05 work RVUs, a value between the median and the 75th percentile of the survey data as this value appropriately maintains rank order within the family. This value is further supported by another reference code, 49570 *Repair epigastric hernia (eg, preperitoneal fat); reducible (separate procedure)* (work RVU=5.97) as this code and the surveyed code have similar work and intra-service times, 60 minutes. Therefore, given the comparison to the reference codes, the RUC determined that 6.05 work RVUs was appropriate and maintained rank order within the family of codes. **The RUC recommends 6.05 RVUs for 62362.**

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

The specialty societies requested to re-survey this service as they believe the vignette associated with this service may have caused inaccurate survey data as it refers to the removal and replacement of the reservoir or pump. The specialty societies will present this code at the April 2008 RUC meeting.

Practice Expense:

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

Neurostimulators (Tab I)

Eduardo Fraifeld, MD, American Academy of Pain Medicine (AAPM), American Academy of Physical Medicine and Rehabilitation (AAPMR), Alexander Mason, MD, American Association of Neurological Surgeons/Congress of Neurological Surgeons (AANS/CNS), Tripti Kataria, MD, MPH, American Society of Anesthesiologists (ASA), David Bagnall, MD, International Spine Intervention Society (ISIS), Charles Mick, MD North American Spine Society (NASS)

CPT codes describing neurostimulators (63650, 63660, 63685 and 63688) were identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomalies utilizing information from the current physician time data and the Medicare claims data. The physician time data for these codes currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that these services are typically performed in an outpatient setting. CMS agreed with the RUC that these services should be evaluated.

63650 Percutaneous implantation of neurostimulator electrode array, epidural

The specialty societies presented data from 45 pain medicine physicians, neurosurgeons, anesthesiologists, spine surgeons and physical medicine and rehabilitation physicians. The RUC compared the surveyed code to the reference code, 64561 *Percutaneous implantation of neurostimulator electrodes; sacral nerve (transforaminal placement)* (Work RVU=7.07). The RUC reviewed the survey data presented by the specialty societies and determined that the surveyed code in comparison to the reference code had similar intra-service time, 60 minutes and 70 minutes respectively. However, the surveyed code requires slightly more mental effort and judgment, technical skill and physical effort and overall is a more intense service to perform in comparison to the reference code due to the positioning and needle placement into the thoracic or cervical spine which has significant risk of spinal cord injury. In addition, the RUC noted that the survey data supported that this service is now more frequently being performed in the outpatient setting as the 2.5-99231 hospital visits have been removed and the full discharge day management service has been reduced to half a discharge day management service. Therefore, given the comparison to the reference code intensity analysis and IWPOT comparisons, the RUC determined that the median work RVU, 7.15 was appropriate. **The RUC recommends 7.15 RVUs for 63650.**

63660 Revision or removal of spinal neurostimulator electrode percutaneous array(s) or plate/paddle(s)

The specialty societies recommend that this code be referred to the CPT Editorial Panel to more clearly define the service as the current CPT descriptor makes this code difficult to survey and value, i.e. remove or revise. **The RUC recommends that 63660 be referred to the CPT Editorial Panel.**

63685 Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling

The specialty societies presented data from 36 pain medicine physicians, neurosurgeons, anesthesiologists, spine surgeons and physical medicine and rehabilitation physicians. The RUC compared the surveyed code to the reference code, 61888 *Revision or removal of cranial neurostimulator pulse generator or receiver* (Work RVU=5.20). The RUC reviewed the survey data presented by the specialty societies and determined that the surveyed code in comparison to the reference code had significantly more intra-service time, 60 minutes and 34 minutes respectively. In addition, the surveyed code requires more mental effort and judgment, technical skill and physical effort and overall is a more intense service to perform in comparison to the reference code. In addition, the RUC noted that the survey data supported that this service is now more frequently being performed in the outpatient setting as the 2.5-99231 hospital visits have been removed and the full discharge day management service has been reduced to half a discharge day management service. Therefore, given the comparison to the reference code, the RUC determined that the median work RVU, 6.00 was appropriate. **The RUC recommends 6.00 RVUs for 63685.**

63688 Revision or removal of implanted spinal neurostimulator pulse generator or receiver

The specialty societies presented data from 35 pain medicine physicians, neurosurgeons, anesthesiologists, spine surgeons and physical medicine and rehabilitation physicians. The RUC compared the surveyed code to the reference code, 61888 *Revision or removal of cranial neurostimulator pulse generator or receiver* (Work RVU=5.20). The RUC reviewed the survey data presented by the specialty societies and determined that the surveyed code in comparison to the reference code had similar total service time, 165 minutes and 171 minutes respectively. In addition, the surveyed code and the reference code require similar technical skill, physical effort and overall intensity to perform. In addition, the RUC noted that the survey data supported that this service is now more frequently being performed in the outpatient setting as the 1.5-99231 hospital visits have been removed and the full discharge day management service has been reduced to half a discharge day management service. Therefore, given the comparison to the reference code, the RUC determined that the median work RVU, 5.25 was appropriate. **The RUC recommends 5.25 RVUs for 63688.**

Practice Expense:

The practice expense inputs, specifically for the discharge day management and the number and level of office visits for 63650, 63685 and 63688 are recommended to be modified to reflect the current survey data.

Neuroplasty - Leg or Arm (Tab J)

American Academy of Orthopaedic Surgeons (AAOS), American Orthopaedic Foot and Ankle Society (AOFAS), American Society of Plastic Surgeons (ASPS), American Society for Surgery of the Hand (ASSH)

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

Neurorrhaphy – Finger (Tab K)

Dale Blasier, MD, American Academy of Orthopaedic Surgeons (AAOS), American Orthopaedic Foot and Ankle Society (AOFAS), Scott Oates, MD, American Society of Plastic Surgeons (ASPS), Daniel Nagle, MD, American Society for Surgery of the Hand (ASSH)

CPT code 64831, *Suture of digital nerve, hand or foot; one nerve*, was identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated.

The specialty society presenters agreed that the site of service for this code has shifted from predominantly inpatient to outpatient. The presenters did not agree that the current work RVU was incorrect, but did agree that the current time and post-service hospital and office visits were no longer accurate and appropriate adjustments to the work RVU are necessary. Based on the specialty society survey, the RUC agreed that the survey median

time was appropriate. The recommended physician times are pre-service evaluation = 40, pre-service scrub, dress and wait = 15, pre-service positioning = 10, intra-service = 60, and immediate post-service = 15. Further, the specialty recommended and the RUC agreed that the changes in office and hospital visits based on the survey be adjusted to the work RVU, using a building block method. The survey data showed that four office visits including two 99212 and two 99213 were associated with this service. The specialty also recommended one-half 99238 discharge day management visit. To find an appropriate value, the specialty society reduced the current work RVU, assumed to be correct, to account for the removal of one-half 99238 (0.64 work RVUs), one 99231 (0.76 work RVUs), and one-half 99213 (0.46 work RVUs). This accounted for a total reduction in work RVU of 1.86. The specialty then added the work associated with two 99212 (0.90 work RVUs). The resulting value is 9.27, which the RUC agreed was too high, considering the survey results. The RUC agreed that the surveyed 25th percentile RVU of 9.00 was more appropriate. The RUC referred to the key reference service, 64910, Nerve repair; with synthetic conduit or vein allograft (eg, nerve tube), each nerve, (work RVU = 11.21). The key reference service has slightly less pre-service time (50 minutes and 65 minutes, respectively), but considerably more intra-service time (90 minutes and 60 minutes, respectively). However, survey respondents indicated that the intensity and complexity of the services are very similar. The RUC further validated the 25th percentile RVU by calculating the IWPUR for both the surveyed code (0.06738) and the key reference service (0.06674) and found that they were very similar. **The RUC recommends the survey 25th percentile work RVU of 9.00.**

Ophthalmological Procedures (Tab L)

Stephen A. Kamenetzky, MD, American Academy of Ophthalmology (AAO)

Codes 65285 Repair of laceration; cornea and/or sclera, perforating, with reposition or resection of uveal tissue and 68810 Probing of nasolacrimal duct, with or without irrigation; were identified by the RUC's Five-Year Review Identification Workgroup as having site of service anomalies in recent Medicare claims data. These services were initially priced in the facility setting, i.e. have hospital visits and full discharge management services associated with them, are now being performed in the outpatient setting more than 50% of the time, according to the Medicare Claims data. CMS had requested the RUC review these site of service anomalies.

65285

The RUC had indicated that compelling evidence was necessary if the specialty believed the site of service should remain the same for a particular service, despite recent Medicare claims data. The specialty presented a recent journal article that described the service, its complexity, and necessity of being performed in the facility setting. The specialty explained that many of the services in the Medicare data are coding errors and that the service should be removed from the ambulatory service center listing because it requires an overnight hospital stay. The RUC agreed that the procedure is typically provided within the facility inpatient setting.

The RUC agreed with the compelling evidence presented and recommends code 65285 be removed the Site of Services Anomalies list and the physician time be reverted back to its original Harvard determined physician time. It was suggested by the specialty that this service not be included on the ASC list. In addition, a CPT Assistant article should be written to describe appropriate use of this code.

68810

The RUC and specialty society agreed with the site of service anomaly for code 68810 and presented survey results from 33 ophthalmologists that supported the Medicare claims data. The specialty explained and the RUC agreed that reference code 68811 *Probing of nasolacrimal duct, with or without irrigation; requiring general anesthesia* (Work RVU = 2.39) was essentially the same service however typically performed on children. When code 68810 was originally reviewed by the RUC survey data indicated an overnight hospital stay, full discharge day management, and two post operative office visits. The current work relative value for the year 2008 is 2.63. Current survey data indicates the typical patient is an adult with unilateral obstruction with no overnight hospital stay, no discharge day management, and two post operative office visits. The RUC reviewed the specialty survey results and agreed that although the hospitalization and discharge day management is not now the typical patient scenario, the two post operative visits still apply in order tend to the wound. The procedure involves poking a hole into the lacrimal sac to reconnect it the lacrimal duct. After this is done the wound tends to fibrinase over, two post operative office visits allow for the irrigation of the wound to maintain patency in the duct. With the understanding of the change in the typical site of service and that 68810 is typically performed in adults and requires less work to perform than in children, the RUC believed a value of 2.09, which is between the specialty survey median and its 25th percentile survey results, was an accurate relative work value.

The RUC also compared the physician work of code 68840 *Probing of lacrimal canaliculi, with or without irrigation* (Work RVU = 1.27, 10 minutes intra-service time) and agreed that physician work is greater than that of code 68840 as it involves more probing and an additional follow up office visit. **The RUC recommends a relative work value for code 68810 of 2.09.**

Practice Expense

There is no change to the direct practice expense inputs recommended for code 65285. The RUC recommends an adjustment in the direct practice expense inputs for code 68810 to reflect the change in physician time and office visits associated with this service.

Cochlear Device Implantation (Tab M)

Jane T. Dillon, MD, American Academy of Otolaryngology - Head and Neck Surgery (AAO-HNS)

CPT code 69930, *Cochlear device implantation, with or without mastoidectomy*, was identified by the RUC's Five-Year Review Identification Workgroup as a site of service

anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated. The specialty society presenting compelling evidence that the current work is insufficient, due to changes in knowledge, technology, and patient population. The patient pool has expanded at both ends of the spectrum. When the code was new in 1995, the typical patient was three to five years old. Today, the procedure is performed on children less than one year old as well as patients well into their eighties and nineties. The typical patient has also become more complex. This procedure is performed on patients has also been an expansion in the candidate pool for this code. The patients have poorer hearing than before and this is the last option they have. **The RUC did not agree that the compelling evidence standard had been met.**

In line with RUC convention for reviewing the site of service anomalies, the RUC asked the specialty society presenters to present evidence that the current value of 17.60 should be maintained. The specialty society presenters agreed that the site of service had changed from predominantly inpatient when the code was first reviewed by the RUC in 1995, but is now typically performed in the outpatient setting with patients going home the same day. The presenters turned to the results of their survey of 21 otolaryngologists. The respondents have a median service performance rate of 40 and indicated a median RVU of 28.00, which the presenters agreed was too high. The median specialty surveyed physician time was, pre-service evaluation = 60, pre-service positioning = 15, pre-service scrub dress and wait = 20, intra-service time = 180, and immediate post-service time = 30. This is slightly different from the results of the 1995 survey which showed 25 fewer minutes of pre-service time, but identical intra-service and immediate post-service times. The current survey results also showed an increase in the intensity of post-service office visits. The presenters indicated that while one 99231 visit and one-half 99238 visit were unnecessary, one 99213 and one 99214 office visits are required. The intensity increased due to the difficulty of communication with patients and the more complicated patients and a greater length of time spent with the patient. The RUC discussed the high pre-service time. The presenters responded that because of the shift towards a patient population with greater hearing loss, patients have very high expectations that must be addressed during the consent process. The RUC compared the surveyed code to the key reference service, 69714, *Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy*, (work RVU = 14.31). The key reference service has identical intra-service time of 180 minutes. The respondents stated that the surveyed code required greater mental effort and judgment, technical skill and physical effort, and psychological stress, which justifies the current work RVU for the surveyed code. **The RUC recommends maintaining the current work RVU of 17.60.**

Practice Expense

The RUC recommends an adjustment in the direct practice expense inputs for these codes to reflect any change in office visits associated with this service.

XI. CMS Requests – Re-Review of Services

Laparoscopic Radical Prostatectomy (Tab N) **American Urological Association (AUA)**

CPT code 55866 *Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing* was flagged by the RUC in 2003 to be brought forward at the next Five-Year Review for review of its physician time components. This code was recently identified as requiring re-review.

The RUC reviewed the specialty society recommendation for code 55866 and determined that further coding language clarification was needed. The RUC referred code 55866 back to the CPT Editorial Panel to determine if two codes should be developed, one to describe laparoscopy and another code to describe robotic laparoscopy. After CPT evaluation and clarification is received the specialty society will resurvey both services. **The RUC recommends that code 55866 be referred to the CPT Editorial Panel for new code(s).**

Sling Operation for Stress Incontinence (Tab O) **Facilitation Committee #3**

Thomas P. Cooper, MD, Jeffrey A. Dann, MD, James G. Giblin, MD, Richard N. Gilbert, MD American Urological Association (AUA), George A. Hill, MD American College of Obstetricians and Gynecologists (ACOG)

CPT code 57288 *Sling operation for stress incontinence (eg, fascia or synthetic)* (Work RVU=14.01, IWPUT of 0.135) was brought forward as a new technology reassessment. At the August 2005, third Five-Year Review meeting, the specialty society requested and the RUC recommended that this procedure be reviewed again in two years.

The RUC reviewed the specialty society survey data and original specialty society recommended work value for code 57288 of 14.08, with an intra-service time of 60 minutes. The RUC compared 57288 to a similar service 58700 *Salpingectomy, complete or partial, unilateral or bilateral (separate procedure)* (Work RVU = 12.84 and total physician time = 321 minutes with 60 minutes intra-service time). The RUC recommends decreasing the survey pre-service time by 20 minutes to that of the existing pre-service times to more accurately reflect the pre-time involved to perform this service, as well as reflect comparable pre-service time relative to other similar services. **The RUC recommends pre-evaluation time of 35 minutes, pre-positioning time of 15 minutes and scrub, dress, wait time of 10 minutes. The RUC recommends the specialty society recommended post-operative visits: one 99232, one 99238, one 99212 and two 99213 visits.** The RUC determined that one 99232 was necessary because changing packs, Foley catheters, and checking wounds are required.

The RUC determined total physician time of 280 minutes for code 57288 was appropriate when compared to code 58700. Code 57288 is appropriately 41 minutes less than 58700 due to the lower pre-service and post-operative visits required to perform this service. The RUC recommends the 25th percentile RVW of 12.00 for code 57288 instead of the survey median because it appropriately places this service relative to other services with a 090-day global period and an intra-service time of 60 minutes.

All the above recommended revisions give code 57288 an IWPUT of 0.0899, which the RUC determined was appropriate. This IWPUT and recommended work value are further supported by the fact that, if the 41 minutes of pre- and post-service work is backed out of code 58700, the result is a similar RVW of 12.00. Code 57288 was then compared with other services with 60 minutes of intra-service work and a 90 day global period. In addition to code 58700 as described which has an IWPUT of .085, the RUC also referenced code 34825 *Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; initial vessel* (Work RVU = 12.72 and an IWPUT .091) which as a vascular procedure, which appropriately has a higher work RVU and higher intensity than 57288.

The RUC recommends the specialty society survey 25th percentile work RVU of 12.00 and total physician time of 280 minutes for code 57288.

Practice Expense

This service is typically performed only in the facility setting. Therefore, the RUC recommends the standard 090-day global direct practice expense inputs.

CPT Code 57288	RUC Recommendation
Recommended WRVU	12.00
Pre-Evaluation Time	35
Pre-Positioning Time	15
Scrub Dress Wait Time	10
Intra-Service Time	60
Immediate Post Time	20
99232 Post-Op Visit	1
99238 Post-Op Visit	1
99212 Post-Op Visit	1
99213 Post-Op Visit	2
Total Physician Time	280

Photodynamic Therapy of the Eye (Tab P)

Stephen A. Kamenetzky, MD, American Academy of Ophthalmology (AAO)

Code 67225 *Destruction of localized lesion of choroid (eg, choroidal neovascularization); photodynamic therapy, second eye, at single session (List separately in addition to code for primary eye treatment)* was identified by the RUC's Five-Year Review Identification Workgroup as a service in which when initially developed, was

considered new technology. The RUC asked the specialty to re-survey the service since the technology is now considered widespread.

The RUC reviewed the specialties survey results of 14 ophthalmologists which indicated a median physician work RVU of 5.95. The specialty society considered this value too high and believed the survey results were invalid because of the low response rate and a misunderstanding that this is an add on service. The specialty developed its own building block methodology based on the RUC rationale for code 67221 *Destruction of localized lesion of choroid (eg, choroidal neovascularization); photodynamic therapy (includes intravenous infusion)* which resulted in a specialty recommended physician work value of 1.10. The RUC agreed with the specialty that the survey results were invalid and could not agree with the specialty society's building block methodology to support the physician work value recommendation of 1.10.

The specialty society then provided the RUC with a clearer understanding of the physician work performed in this service. The RUC agreed that there was minimal intra-service work associated with the service. However the RUC also believed the typical patient service would not have pre or post service physician time for this add-on code. The RUC agreed that there no evidence to change the existing physician work value of 0.47. The RUC believed it would be inappropriate to recommend a lower value than its existing value without a proper rationale and agreed to maintain the code's current value at 0.47 work RVUs. The RUC also agreed that the total physician time should be maintained at 3 minutes intra service time.

The RUC recommends to maintain the relative work value of 0.47 for code 67225 and its total and intra-service time of 3 minutes.

Practice Expense:

The RUC reviewed the practice expense inputs for code 67225 and agreed that the clinical labor assist physician time should be maintained at 3 minutes.

XII. HCPAC Review Board

Emily Hill, PA-C, HCPAC Alternate Co-Chair, informed the RUC that the HCPAC met on January 31, 2008 for an informational meeting only, no codes were reviewed and no action items were assigned. Ms. Hill indicated one correction to the HCPAC report: Jeffrey Rich, MD is actually the new Director for the Center for Medicare Management, not the administrator. The HCPAC report was filed by the RUC.

XIII. Practice Expense Subcommittee

Doctor Greg Kwasny presented the report for Doctor Moran. AMA staff director Sherry Smith provided a slideshow update on the AMA/Specialty Society Practice Information

Survey. This slideshow provided members with an update to the survey processes and a copy is attached to the Practice Expense Subcommittee minutes.

The Practice Expense Subcommittee reviewed several direct practice expense recommendations for new, revised, and existing CPT codes . During the Subcommittee's discussion of the new code set for Computer Dependent External Fixation (2069X3-2069X4), the Subcommittee made the following recommendation concerning high priced medical supplies:

High cost disposable medical supplies (priced at or above \$200) should either be reported separated with HCPCS II codes or individually identified within the payment bundle and then re-priced on an annual basis.

During the Subcommittee's initial discussion, it had agreed with the 5 minutes of assist physician time for Photodynamic Therapy of the Eye, CPT code 67225. However during the full RUC's discussion of the issue, the physician intra-service time was maintained at 3 minutes which also maintains the intra-service clinical labor time for this service to be 3 minutes.

In addition, the Subcommittee made recommendations for Chemotherapy Administration (96440) and Immunization Administration (90465-90474). The RUC agreed with these recommendations, however it was clarified that for these Immunization Administration codes the recommendations are to be added to any existing direct practice expense inputs within CMS' database, as they pertain to newly mandated regulations. It was also clarified that the use of either the refrigerator or freezer is required, but not both. These recommendations were approved by the RUC and are attached to the Practice Expense Subcommittee minutes.

XIV. Five-Year Review Identification Workgroup

Doctor Norm Cohen provided the report of the Five-Year Review Identification Workgroup. Doctor Cohen reported that the Workgroup agreed, in order to more easily facilitate the review process and in consideration of the gravity of the issues, the potentially misvalued services should be reviewed by the RUC on an ongoing basis rather than during the upcoming Five-Year Review. **The RUC recommends that the codes identified as potentially misvalued be reviewed by the RUC on an ongoing basis rather than at the upcoming Five-Year Review.**

Before the Workgroup discussed the individual services identified with high volume growth, it discussed its procedural methodology. The Workgroup agreed that in the future, representatives of the specialty societies submitting comments to the Workgroup be present to answer questions. **The RUC recommends that representatives of the specialty societies submitting comments to the Workgroup be present to answer questions.**

Doctor Cohen reported that the Workgroup reviewed the High Volume Growth codes along with the specialty society feedback. The RUC considered the recommendations and, after corrected typographical errors on two services, approved the recommendations as follows:

Code	RUC Recommendation and Comments
01930	No action and remove the service from the screen
11982	Request for interested specialty societies to submit an action plan for further review of the code and recommend inclusion of the entire family of services.
15401	No action at this time and review the change in utilization after two years of additional data.
27370	Request for interested specialty societies to submit an action plan for further review of the code
29220	Request for interested specialty societies to submit an action plan for further review of the code. The specialty should consider the impact of the April 2002 CPT Assistant on the utilization of this service.
35493	Request for interested specialty societies to submit an action plan for further review of the code. The entire family of codes should be considered. The specialty should address how often the service is reported with other services. It was also noted that the volume of this service has increased as the volume of more invasive procedures has declined.
35495	Request for interested specialty societies to submit an action plan for further review of the code. The entire family of codes should be considered. The specialty should address how often the service is reported with other services. It was also noted that the volume of this service has increased as the volume of more invasive procedures has declined.
37765	No action at this time and review the change in utilization after two years of additional data.
37766	No action at this time and review the change in utilization after two years of additional data.
44207	No action and remove the service from the screen. It was also noted that the volume of this service has increased as the volume of more invasive procedures has declined.
52224	Request for interested specialty societies to submit an action plan for further review of the code. It was noted that a large increase in practice expense valuation occurred at the time of the volume increase.
52648	Request for interested specialty societies to submit an action plan for further review of the code. It was noted that a large increase in practice expense valuation occurred at the time of the volume increase.
55866	No action and remove the service from the screen
64446	Referral to CPT for deletion, clarification, or revision. The specialty noted that they have already submitted a CPT proposal for this service.
64448	Referral to CPT for deletion, clarification, or revision. The specialty noted that they have already submitted a CPT proposal for this service.
64472	Request for interested specialty societies to submit an action plan for further review of the code. It was noted that 64470 should also be reviewed.

Code	RUC Recommendation and Comments
64555	Referral to CPT for deletion, clarification, or revision. This may also include the development of a CPT Assistant article or review of the impact of previous CPT Assistant articles on volume. No other action at this time and review the change in utilization after two years of additional data.
64623	Request for interested specialty societies to submit an action plan for further review of the code and recommend inclusion of the entire family of services. It was noted that other codes that are done at the same time.
67028	Request for interested specialty societies to submit an action plan for further review of the code.
68040	No action at this time and review the change in utilization after two years of additional data.
70496	Referral to CMS for further analysis and review of practice expense.
70498	Referral to CMS for further analysis and review of practice expense.
72191	Referral to CMS for further analysis and review of practice expense.
73580	Request for interested specialty societies to submit an action plan for further review of the code.
73706	Referral to CMS for further analysis and review of practice expense.
75635	Referral to CMS for further analysis and review of practice expense.
75992	Request for interested specialty societies to submit an action plan for further review of the code
75993	Request for interested specialty societies to submit an action plan for further review of the code
76513	Request for interested specialty societies to submit an action plan for further review of the code. It was noted that the AAO explanation that the code was new in 2005 is incorrect.
76970	Request for interested specialty societies to submit an action plan for further review of the code.
77782	Referral to CPT for deletion, clarification, or revision. The specialty indicated that a proposal is under consideration at the February 2008 CPT meeting.
78483	Referral to CPT for deletion, clarification, or revision.
90471	No action and remove the service from the screen.
90472	No action and remove the service from the screen.
92270	Request for interested specialty societies to submit an action plan for further review of the code. The Workgroup recommends that the specialty proceed with their suggestion to pursue a CPT Assistant article, while engaging in the development of a plan of action.
93005	No action and remove the service from the screen. It was noted that the complete ECG (93000) is declining, while the separate tracing and S/I codes have increased.
93017	Also review the change in utilization after two years of additional data.

Code	RUC Recommendation and Comments
93236	Referral to CPT for deletion, clarification, or revision. This may also include the development of a CPT Assistant article or review of the impact of previous CPT Assistant articles on volume. Also review the change in utilization after two years of additional data.
93662	No action at this time and review the change in utilization after two years of additional data.
94014	Request for interested specialty societies to submit an action plan for further review of the code.
94015	Request for interested specialty societies to submit an action plan for further review of the code.
94450	Request for interested specialty societies to submit an action plan for further review of the code.
94681	Request for interested specialty societies to submit an action plan for further review of the code.
94770	Request for interested specialty societies to submit an action plan for further review of the code.
95922	Request for interested specialty societies to submit an action plan for further review of the code.
95954	No action and remove the service from the screen.
95991	No action at this time and review the change in utilization after two years of additional data. This is a new CPT code.
96567	Request for interested specialty societies to submit an action plan for further review of the code – practice expense inputs only.
96921	No action at this time and review the change in utilization after two years of additional data.
97755	No action and remove the service from the screen.
G0202	AMA staff to discuss the practice expense methodology for this service and report back to the Five-Year Review Identification Workgroup. Specifically, direct practice expense inputs have not been developed for this service. A review of legislative language is necessary to understand if CMS has instead developed a practice expense payment to comply with specific legislation.
G0204	AMA staff to discuss the practice expense methodology for this service and report back to the Five-Year Review Identification Workgroup. Specifically, direct practice expense inputs have not been developed for this service. A review of legislative language is necessary to understand if CMS has instead developed a practice expense payment to comply with specific legislation.
G0206	AMA staff to discuss the practice expense methodology for this service and report back to the Five-Year Review Identification Workgroup. Specifically, direct practice expense inputs have not been developed for this service. A review of legislative language is necessary to understand if CMS has instead developed a practice expense payment to comply with specific legislation.
G0237	Request for interested specialty societies to submit an action plan for further review of the code – practice expense only.

Code	RUC Recommendation and Comments
G0238	Request for interested specialty societies to submit an action plan for further review of the code – practice expense only.
G0249	Request for interested specialty societies to submit an action plan for further review of the code. The workgroup questioned why this service was on the Physician Payment Schedule as this appears to be durable medical equipment.
G0250	Request for interested specialty societies to submit an action plan for further review of the code.
G0270	CMS recently requested review of this service for the April 2008 RUC/HCPAC meeting.

Doctor Cohen reported that the Workgroup reviewed the High IWPOT codes along with the specialty society feedback. The RUC considered the recommendations and approved them as follows:

Code	RUC Recommendations and Comments
15330	No action. The code was recently reviewed by the RUC as a new service and there is too little data to provide any rationale for review of the service.
17106	Request for interested specialty societies to submit an action plan for further review of the code.
17107	Request for interested specialty societies to submit an action plan for further review of the code.
17108	Request for interested specialty societies to submit an action plan for further review of the code.
21935	This service was identified as a part of the Site of Service Anomalies and is currently under review by the CPT Editorial Panel's Soft Tissue Tumor Workgroup.
27245	Request for interested specialty societies to submit an action plan for further review of the code. Other codes in the family should also be considered.
27250	This service was identified as a part of the Site of Service Anomalies and is currently under review by the RUC.
33430	No action. This service was recently reviewed by the RUC during the Third Five-Year Review.
33863	No action. This service was recently reviewed by the RUC during the Third Five-Year Review.
45170	This service was identified as a part of the Site of Service Anomalies and is currently under review by the RUC.
47525	Recommend to CMS that this service be given a new global period of 000. Request for interested specialty societies to submit an action plan for further review of the code.
59400	Request for interested specialty societies to submit an action plan for further review of the code.
59409	Request for interested specialty societies to submit an action plan for further review of the code.

Code	RUC Recommendations and Comments
59410	Request for interested specialty societies to submit an action plan for further review of the code.
59510	Request for interested specialty societies to submit an action plan for further review of the code.
66761	This service was recently reviewed by the RUC and requires further analysis from staff, specifically addressing changes in visits, before any definitive action may be taken. Staff will look at original summary forms to determine if the discharge work was removed from the valuation when the time was reduced. Reassess at the April RUC meeting.
66982	Request for interested specialty societies to submit an action plan for further review of the code. Specialty action plan to specifically address the existing post service visits and work neutrality issues with 66984. The specialty should also review the 2003 CPT Assistant article to determine if this clarification impacted the reporting of this service.
66984	Request for interested specialty societies to submit an action plan for further review of the code. Specialty action plan to specifically address work neutrality issues with 66982.
67210	Request for interested specialty societies to submit an action plan for further review of the code. Specialty action plan to specifically address potential coding changes to resolve “one or more session” language.
67220	Request for interested specialty societies to submit an action plan for further review of the code. Specialty action plan to specifically address potential coding changes to resolve “one or more session” language.
67228	Request for interested specialty societies to submit an action plan for further review of the code. Specialty action plan to specifically address potential coding changes to resolve “one or more session” language.

Two additional services originally included in the Site of Service Anomaly review in September 2007, were referred back to the specialty societies for further information. Following the submission of additional information, the RUC approved the workgroup recommendations. **The RUC requests interested specialty society(s) to submit an action plan for reviewing the value of 77427. The RUC recommends that 0.5 99238 be removed with no change in work RVU.**

Doctor Cohen reported that Doctor Ken Brin provided the Workgroup with a report via teleconference outlining the progress of the joint CPT/RUC workgroup regarding the services reported together by the same physician on the same date of service. The Workgroup agreed with the report and recommends that the RUC approve the report in its entirety. **The RUC approved the report of the joint CPT/RUC workgroup.**

XV. Administrative Subcommittee

Confidentiality Statement

James Blankenship, MD, presented the Administrative Subcommittee report to the RUC. Doctor Blankenship indicated that first the Administrative Subcommittee considered a confidentiality statement which would be signed by all RUC participants. The RUC approved the Confidentiality Statement as indicated in the Administrative Subcommittee report attached to these minutes.

Financial Disclosure Statement/Recourse

Secondly, Doctor Blankenship indicated that in an effort improve the financial disclosure form, the Administrative Subcommittee and the RUC recommend revisions to this form.

The RUC recommends that an individual's cumulative lifetime material contributions received be disclosed. The RUC recommends that the financial disclosure form include a bullet to capture any material income which may be received via stock options currently or in the future.

RUC members questioned if these disclosures are required of the RUC members. Doctor Rich indicated that indeed a conflict of interest statement must be signed by all RUC members and alternates annually or more frequently if an individual's status has changed.

Doctor Blankenship indicated currently the financial disclosure forms are submitted with the specialty society recommendations by the specified due dates. Therefore, they will be available for review prior to the meeting. The Administrative Subcommittee discussed what recourse may occur if a significant conflict is discovered or disclosed. The RUC recommended:

- 1. The RUC Chair assigns a sub-group of the Administrative Subcommittee to review all financial disclosures prior to each RUC meeting.**
- 2. During the course of a RUC meeting the RUC Chair has the authority to determine specific recourse him/herself.**

Doctor Blankenship continued that the Administrative Subcommittee discussed what action is taken if an Advisor or presenter falsely discloses or fails to disclose a financial interest and recommended:

- 1. The advisor/presenter must immediately leave the RUC meeting room,**
- 2. Further recourse will be discussed after the RUC meeting, and**
- 3. The remaining presenters continue with presentation**

A RUC member commented that according to CPT criteria to develop a Category I code for a specific procedure, it should be commonly formed. If a specialty society is not able to find a physician who commonly performs such procedure to present in front of the RUC, then perhaps a specific code should not be a Category I code. Therefore, any individuals with a financial interest should not present and should not be present in the meeting room during deliberations on that issue.

The Administrative Subcommittee discussed what action to take if the RUC discovers that an advisor/presenter falsely disclosed or failed to disclose a material financial interest after a RUC meeting. The Administrative Subcommittee will consider and develop recommendations at the next RUC meeting. In addition, the Administrative Subcommittee will discuss the appropriateness of attending the meeting if a significant conflict is discovered.

Mission Statement

Doctor Blankenship indicated that the AMA directed the RUC to develop a mission statement. The Administrative Subcommittee reviewed mission statements of other organizations and a draft of a RUC mission statement prepared by AMA staff. The RUC approved the following mission statement:

American Medical Association/Specialty Society Relative Value Update Committee (RUC)

Mission Statement

The AMA/Specialty Society RVS Update Committee (RUC) is a private volunteer committee comprised of physicians and other health care professionals. The RUC's mission is to make recommendations to the Centers for Medicare and Medicaid Services (CMS) regarding the Medicare Resource-Based Relative Value Scale.

RUC Procedures for Interim Value Recommendations

Doctor Blankenship indicated that at the September 2007 RUC meeting, the issue of interim values arose when the RUC discussed a family of codes of which one code was assigned an interim value. A RUC member suggested that if one code in a family is valued on an interim basis then the entire family should be valued as interim, allowing the RUC to review the entire family at once.

The Administrative Subcommittee considered whether an entire family of codes should be recommended as interim if one code in the family was recommended as interim. There was no support for this action amongst the Subcommittee or from the RUC participants in the audience.

AGA/ASGE Request to Review ABMS Correspondence

Doctor Blankenship indicated that the Administrative Subcommittee reviewed the American Board of Medical Specialties (ABMS) March 13, 2007, letter to Mark Donowitz, MD, the AGA President, as requested by the American Gastroenterological Association (AGA) and the American Society for Gastrointestinal Endoscopy (ASGE).

The ABMS letter supported the concept that ABMS subspecialties should in fact have the status of specialties. The Administrative Subcommittee briefly reviewed the history of the

criteria for membership in the RUC, summarized in the AMA/Specialty Society RVS Update Process manual, Tab P, pages 78-80.

However, the request from AGA/ASGE was simply that the RUC consider this letter. On January 31, 2008, the Administrative Subcommittee reviewed the March 13, 2007, letter from ABMS to AGA. The Administrative Subcommittee recommends that the RUC accept the letter for filing. No further action is recommended. The AGA/ASGE did not request any reconsideration of the RUC permanent seat criteria, but just that the letter is reviewed by the RUC.

XVI. Extant Data Workgroup

Doctor Hitzeman delivered the Extant Data Workgroup report. He discussed several issues including the review of Inclusionary/Exclusionary Criteria for Extant Database Use in the RUC Process. **The Workgroup and the RUC made the following recommendations:**

The Extant Data Workgroup approved the Inclusionary/Exclusionary Criteria for Extant Database Use as listed below:

- Databases must collect time data for the procedures, at a minimum the skin-to-skin or intra-service time and length of stay. Additional time elements may include ICU LOS, and other specialty specific time factors (i.e. phone calls, ventilator hours)
- Databases must have data integrity/reliability
 - Must collect data prospectively,
 - Should have the ability to identify and assess outliers – multiple procedures resulting in greater LOS; diseases with high mortality rate (LOS=0) or extended recovery (LOS>90); age variance (bi-modal)
 - Should have the ability to have transparency of data to compare to other databases including the RUC database
 - Should have the ability to audit the database
 - Should have the ability to track the data/changes over time
 - Should have the ability to collect data on all cases done by participants or for large volume procedures or E/M encounters, should have sampling criteria that are statistically valid to eliminate sampling bias
 - Should have current data, preferably from the last three to five years, although older sets can be used for comparison purposes
- Must have the ability to unequivocally map the procedure to a CPT code and isolate the procedure from associated physician work that is otherwise billable in the same setting

- Databases must list their limitations – include what is provided and not provided with respect to the RUC database
- Databases must be representative
 - The data should be geographically representative eg, regionally and nationally for the specialty,
 - The data should have various levels of patient severity
 - The data should have adequate practice site representation and sample size – practice sites and rural and urban representation
 - The data should be from various practice types – representative of the academic, non-academic and other types of practices for the specialty
 - The data should be collected from the majority specialties (including subspecialties) that perform the procedure or encounter
 - The data should be collected from either hospital/institution or individual physician.

However, during the RUC discussion, it was recommended that the first bullet, *Databases must collect time data for the procedures, at a minimum the skin-to-skin or intra-service time and length of stay. Additional time elements may include ICU LOS, and other specialty specific time factors (i.e. phone calls, ventilator hours)* should be moved under the second bullet *Databases must have data integrity/reliability* modified to read:

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

Doctor Hitzeman then explained some informational items that the Extant Data Workgroup reviewed including the identification of existing extant databases and a review of the statistical difference between mean and median. Further information on these informational items are available in the Extant Data Workgroup Report attached to these minutes.

Finally, Doctor Hitzeman discussed the identification of potential uses of the extant data in the RUC process. The Extant Data Workgroup and the RUC made the following recommendation:

Extant data could be incorporated into the RUC process as supplementary data to the RUC survey in the new and revised process when that extant database meets all approved Inclusionary/Exclusionary Criteria for Extant Database Use

Extant data could be incorporated into the RUC process as primary data in various collected components within the Five Year Review Process when that extant database meets all approved Inclusionary/Exclusionary Criteria for Extant

Database Use, as in the approved alternative methodologies used in previous Five Year Reviews.

Further, the Workgroup and the RUC agreed that a specialty society, that has an extant database, should not be required to present data from the extant database for all procedures it presents to the RUC.

XVII. Research Subcommittee

Doctor Cohen delivered the Research Subcommittee report. He discussed several policy issues including the development of RUC policy pertaining to RUC surveys with a median service performance rate of zero, pre-service time package implementation into the summary of recommendation forms, modifications to the anesthesia survey instrument and summary of recommendation forms and the creation of a workgroup to address the Medicare medical home demonstration project. The Research Subcommittee and the RUC made the following recommendations:

The RUC recommends that the following language be added to the instruction document for specialties developing primary RUC recommendations:

The RUC considers performance rate to be a key component of the work evaluation process. If a specialty society determines that after surveying, the survey data results in a median service performance rate of zero the specialty society has the following options:

- 1.) The specialty society can re-survey the code;**
- 2.) The specialty society can refer the code to the CPT Editorial Panel for further clarification on the code;**
- 3.) The specialty society can use a RUC-approved alternative method to value the survey;**
- 4.) The specialty society can present the survey data to the RUC with separate summary of recommendation forms summarizing the data for those who have performed the service, those who have not performed the service and the aggregate data. If this option is selected, the specialty society must report the performance rate of the reference code on their aggregate summary of recommendation form in the additional rationale section.**

The RUC recommended the pre-services times associated with the RUC approved packages be allocated on the summary of recommendation as indicated in the attachments.

The RUC recommends that given the ruling from CMS via communication to AMA Staff, the time allocated to Subsequent to Decision for Surgery be modified to read: *Day before the Operative Procedure Until the Time of Operative Procedure* to be consistent with the current CMS definition of pre-service time. However, before this

recommendation is implemented the Research Subcommittee will establish a Workgroup to consult with Doctor Barbara Levy, Chair of the Pre-Service Time Workgroup and to review the Pre-Service Time Workgroup's recommendations at the February 2008 RUC Meeting to ensure they are consistent with this modification.

It is the intent of this workgroup as well as the Research Subcommittee to implement these per-service times by inserting additional instructions into the specialty societies instruction document and modifying the summary of recommendation form. These changes will be implemented for the April 2008 RUC Meetings.

The Research Subcommittee approved the modifications to the Anesthesia Survey Instrument and the Anesthesia Summary of Recommendation Form as proposed by the specialty society. These modified documents have been attached to the report at the end of the RUC minutes.

The Research Subcommittee recommends that Doctor Rich appoint members of the RUC to a Medicare Medical Home Workgroup to review the information regarding Medicare Medical Home as provided by CMS and RUC participants and determine the input the RUC will be able to deliver to CMS.

Ad Hoc Pre-Time Workgroup:

Doctor Cohen delivered the Ad Hoc Pre-Time Workgroup report. Doctor Cohen explained that the Research Subcommittee established a Workgroup to consult with Doctor Barbara Levy, Chair of the Pre-Service Time Workgroup and to review the Pre-Service Time Workgroup's recommendations at the February 2008 RUC Meeting to ensure they are consistent with this modification.

The Workgroup reviewed the times allocated to the "Day Before the Operative Procedure Until the Time of Operative Procedure" column for each Pre-Service Time Package to ensure that these times would be consistent with CMS' definition of pre-service time. **The Workgroup and the RUC recommend the following time for the pre-service packages:**

Package	Day Before the Operative Procedure Until the Time of Operative Procedure
Package 1A	5 minutes
Package 1B	5 minutes
Package 2A	10 minutes
Package 2B	10 minutes
Package 3	10 minutes
Package 4	15 minutes

These per-service time standards will be implemented by inserting additional instructions into the specialty societies instruction document and modifying the summary of

recommendation form as previously recommended by the Research Subcommittee and subsequently the RUC. These changes will be implemented for the April 2008 surveys.

In addition, the Workgroup and the RUC recommend that the following question be added to the RUC Member Discussion Checklist:

Does the typical patient, procedure and type of anesthesia care provided justify the pre-service package recommended by the specialty society?

XVIII. MPC Workgroup

Doctor Thomas Felger provided the report of the meeting of the MPC Workgroup. The RUC considered the MPC Workgroup recommendation to add 94002, *Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day*, (Work RVU = 1.99) and 94003, *Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, each subsequent day*, (Work RVU = 1.37) to the MPC list at the request of the American College of Chest Physicians and the American Thoracic Society. **The RUC approved the addition of both 94002 and 94003 to the MPC list.**

XIX. Other Issues

Medical Home Demonstration Project

James Coen of the Office of Research, Development, and Information of CMS provided an overview of the Medical Home Demonstration Project mandated by the Tax Relief and Healthcare Act of 2006. The Act requires that valuation of the project be vetted through the RUC process. CMS has asked that the RUC develop a description of the services involved in the medical home demonstration and provide a recommendation for valuation no later than May 1, 2008. To meet this deadline, the RUC established a workgroup to facilitate a recommendation for the full RUC's consideration by the April 2008 meeting. The members of the Medical Home Workgroup are: David Hitzeman, DO (Chair), Joel Brill, MD, Tom Felger, MD, Meghan Gerety, MD, Charles Koopmann, MD, Barbara Levy, MD, Leonard Lichtenfeld, MD, Chester Schmidt, Jr., MD, Bill Thorwarth, MD, Richard Tuck, MD, John Wilson, MD, and Bob Zwolak, MD.

ASHA Request

The American Speech-Language-Hearing Association requested that the remaining eight audiology procedures that were submitted to the RUC Five-Year Review Identification Workgroup be considered during the October 2008 meeting of the RUC. The procedure codes are:

- 92620, *Evaluation of central auditory function, with report; initial 60 minutes,*
- 92621, *Evaluation of central auditory function, with report; each additional 15 minutes,*
- 92625, *Assessment of tinnitus (includes pitch, loudness matching, and masking),*
- 92626, *Evaluation of auditory rehabilitation status; first hour,*
- 92627, *Evaluation of auditory rehabilitation status; each additional 15 minutes (List separately in addition to code for primary procedure),*
- 92630, *Auditory rehabilitation; prelingual hearing loss*
- 92633, *Auditory rehabilitation; postlingual hearing loss*
- 92640, *Diagnostic analysis with programming of auditory brainstem implant, per hour*

ASHA and the American Academy of Otolaryngology–Head and Neck Surgery (AAOHNS) presented the initial group of audiology procedures in September and may use some or all of the newly valued procedures in the reference list for these codes. ASHA and the American Academy of Audiology (AAA) will invite AAO-HNS members in completing a joint online survey of the eight codes. **The RUC agreed with the request from ASHA and will ask CMS to include 92620, 92621, 92625, 92626, 92627, 926230, 92633, and 92640 on the agenda for the October 2008 RUC meeting.**

Subcommittee and Workgroup Referrals

Several RUC members commented with respect to post-service visits within surgical global periods noting a tendency to group visits into either hospital visit, office visit, or discharge day management codes. However, sometimes the appropriate service to assign may be an observation service or any one of another E/M services. This is particularly poignant in services with overnight hospital stays or 23 hour admissions. The Research Subcommittee is asked to consider this issue.

Another RUC member noted that there is often a discrepancy between the Medicare database and specialty society perception of the site of service. Several times during this meeting, presenters have disagreed with the information in the database and much of this was attributed to overnight stays and 23 hour admissions. This is exacerbated by an inference on the part of the specialty societies and RUC that hospital visits on a RUC survey directly correspond to in-patient admission. The RUC agreed that the Research Subcommittee should review this issue in greater depth and develop a common policy for addressing such differences. This may include revising the survey to ask whether a hospital stay, overnight stay, or 23 hour admission is typical.

The RUC reiterated to the Research Subcommittee that the survey instrument will continue to ask for pre-service time from survey respondents. The specialty society making the recommendation will infer the package based on the survey times and the complexity of the service and typical patient. The RUC also reiterated that any difference between the survey time and the specialty society recommended pre-service time package should not be used to adjust the work RVU. Lastly, the RUC requested that

the Research Subcommittee consider whether pre-service time packages will be retroactively applied to services within the Medical Physician Payment Schedule.

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

The meeting adjourned on Sunday, February 3, 2007 at 9:30 a.m.

**AMA/Specialty Society RVS Update Committee
RUC HCPAC Review Board Meeting
January 31, 2008**

Tab Q

Members Present:

Arthur Traugott, MD, Chair
Lloyd Smith, DPM, Co-Chair
Katherine Bradley, PhD, RN
Michael Chaglasian, OD
Robert Fifer, PhD
Mary Foto, OTR
James Georgoulakis, PhD, JD

Emily H. Hill, PA-C
Anthony Hamm, DC
William J. Mangold, Jr., MD
Doris Tomer, LCSW
Erik van Doorne, PT, DPT
Jane White, PhD, RD, FADA
Maurits Wiersema, MD

I. CMS Update

Edith Hambrick, MD, provided a CMS update and informed the HCPAC that Jeffrey Rich, MD, is the new Director for the Center for Medicare Management.

The HCPAC requested that Doctor Hambrick clarify why the team conference codes were indicated as a bundled service in the November 1, 2007, Final Rule. Doctor Hambrick indicated CMS' decision was that the services described in the team conference codes are included in current codes and therefore designated it as a bundled service. Doctor Hambrick indicated that the values for the team conference codes were published but are not services covered by Medicare.

The HCPAC requested that Doctor Hambrick review the refinement panel process. Doctor Hambrick indicated that when there are specific concerns or disagreement with a RUC or HCPAC recommendation a multi-specialty panel of physicians is formed to review the physician work RVU. RUC or HCPAC members are invited to participate and provide any detail needed to recount the RUC or HCPAC recommendation rationale. As indicated in the *Federal Register* Vol. 72, No. 227, page 66360, the voting members of the refinement panel are clinicians representing the commenting specialties, primary care clinicians nominated by the AAFP and ACP, Contractor Medical Directors and clinicians who practice in related specialties and have knowledge of the services under review.

A HCPAC member questioned why nurses and advanced practitioners are not currently included on the refinement panel. Doctor Hambrick indicated the best avenue would be to write a letter to CMS requesting that advanced practitioners be included in the refinement panel.

II. HCPAC Member Organization's Backgrounds

Backgrounds on each HCPAC member organization were provided to AMA staff and were distributed in the HCPAC agenda materials.

III. Other Issues

HCPAC Recommendations

Following up from the previous meeting regarding why CMS rejected HCPAC recommendations, AMA staff reviewed the rationale and summarized the three main reasons. Lloyd Smith, DPM, HCPAC Co-Chair, reiterated the main reasons why previous HCPAC recommendations were rejected by CMS:

1. The recommended value was considered to be too high and CMS assigned an RVU using the same RVU of a similar service.
2. The new code(s) originated from a deleted code and CMS assigned a different value than the HCPAC recommendation in order to maintain budget neutrality.
3. For some Five-Year Review codes, CMS indicated that lower survey times did not warrant an increase in RVUs even though the initial time may have been Harvard time.

Audiology Code Review Update

Robert Fifer, PhD, from the American Speech-Language-Hearing Association (ASHA), updated the HCPAC that the remaining 8 audiology codes, which will capture work in the physician work RVU as opposed to the PE RVU, will be reviewed at the October 2008 RUC meeting.

MNT Code Review

Jane White, PhD, RD, American Dietetic Association (ADA), informed the HCPAC that ADA placed a request to CMS that MNT codes 97802 and 97803 be re-reviewed. ADA believes that a RUC valuation of these MNT services by the physician specialties providing them would more accurately establish physician work values for these MNT services. CMS sent a letter to Doctor Rich requesting that the services described in 97802 and 97803 be given the opportunity for consideration under the RUC process to ensure that CMS payment for MNT services to non-physician nutrition professionals is accurate. These codes will be placed on the level of interest form for review in April 2008.

Local Coverage Determinations (LCD)

A HCPAC member requested clarification from the Contractor Medical Directors at the meeting, on CMS' currently ongoing process of replacing all Part A Fiscal Intermediaries and all Part B Carriers with 15 Medicare Administrative Contractors (MACs). MAC Jurisdiction 3 (J3) was awarded last year and J4 and J5 awarded this year, all of which have transitions underway. J1 and J12 had awards announced but protests were filed in each of these, and final decisions are being delayed. J2, J7 and J13 will be awarded in the next few months with the remaining seven MAC scheduled to be announced at the end of this year.

All specialties are alerted that shortly after the award of each MAC contract, the new contractor must consolidate all Part B LCDs (and also all Part A LCDs) for the new MAC. This is an important opportunity to have input into what will become the new MAC's LCD. Existing LCDs for each state incorporated into a MAC may be obtained at: http://www.cms.hhs.gov/mcd/index_lmrp_bystate.asp

**AMA/Specialty Society RVS Update Committee
Practice Expense Subcommittee Minutes
Thursday, January 31, 2008**

Tab R

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

Doctor Moran first welcomed the committee members and AMA staff director Sherry Smith provided a slideshow update on the AMA/Specialty Society Practice Information Survey. Ms. Smith mentioned that the AMA had terminated contract with the Gallup Organization and contracted with Dmrkynetec in November 2007. The survey will begin today within the remaining budget and the AMA will not solicit additional funding from specialty societies. Ms. Smith's full set of slides are attached to these minutes.

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

RUC TAB

Relative Value Recommendations for CPT 2009:

Computer Dependent External Fixation (2069X3-2069X4)

4

Subcommittee members discussed the specialty recommendation whereas X3 is typically performed in the facility setting and X4 is performed in the non-facility setting. Subcommittee members expressed concern about the possible overlap in office visits among the two services and deferred to the RUC regarding its validity. In addition, the specialty and Subcommittee believed that the code's global periods were incorrect and had recommended 2069X4 to be 000 day global code. It was also felt appropriate that the inserted struts be separately billable through a HCPCs code. CMS had rejected the establishment of a new HCPCs code and assigned the globals. Therefore the subcommittee reviewed the codes as 090 day global services. The subcommittee believed the 090 standard was appropriate for 2069X3 and a less than recommended pre-service clinical labor time component recommendation regarding code 2069X3. These recommendations are attached.

At the full RUC these codes were referred to CPT for revision. From Subcommittee's discussion of high priced disposable medical supplies the Subcommittee makes the exact same recommendation it made previously:.

High cost disposable medical supplies (priced at or above \$200) should either be reported separated with HCPCS II codes or individually identified within the payment bundle and then re-priced on an annual basis.

It was suggested by the Subcommittee and at Doctor Moran's meeting with CMS, that the RUC assist CMS in collecting invoices and provide them to CMS on an annual basis.

Buttock Fasciotomy (2699X5-2699X6)

5

The subcommittee reviewed the recommended standard 090 day global practice expense recommendations and understood that these codes were urgent and that the pre-service time should be reduced below the standard 60 minutes. The subcommittee reviewed other emergent practice expense recommendations such as Internal. External Fixation - Hip and Knee (CPT cycle 2008) recommendations which indicated zero pre-service time as well as the Colon and Rectal urgent service 44143 *Colectomy, partial; with end colostomy and closure of distal segment (Hartmann type procedure)*(15 minutes in pre-service) reviewed by the PEAC in January 2002. The subcommittee agreed that there should be zero clinical labor time in the pre-service time period and the remaining 090 day standard package be applied for codes 2699XX5 and 2699X6. ***At the full RUC pre-service time clinical labor time of 25 was recommended.***

End Stage Renal Disease Services (9095X1-X9 & 9096X0-X9, 9097X0)

6

The Subcommittee reviewed a new set of recommendations from the specialty society. There are several age based series and the subcommittee felt the methodology should be consistent across series. The Subcommittee

started with the high volume Adult ESRD codes 90906X0 – 9096X6. These services are always “facility” even though some of the E/M that occurs within the monthly management may occur in the physician’s office. Based on personal experiences and discussions from the presenters the Subcommittee members had difficulty understanding the length of clinical staff time needed to provide these services and where they were typically provided. The presenters indicated that each month includes a “complete” assessment that they cross-walked to a 99215. They indicated that adult patients typically receive this in the office, not the dialysis center. The other visits (number as required by the code descriptors) typically are in the dialysis center. The Subcommittee concluded the monthly service related to clinical staff could be considered as two components: non face to face care management and the “complete” visit. The Subcommittee believed the complete visit was appropriately cross-walked to a 99214, but could not attribute clinical staff time to the service without knowing the actual site of service. With respect to the care management, the subcommittee selected 99375 as being a good comparator. It has 18 minutes pre-service and 18 minutes intra-service staff time. While the time allocation is somewhat unusual for a non face to service it was believed that the 18 minutes pre-service time was appropriate for the ESRD service. The total clinical staff time is 18+53 when the “complete” visit service is in the office. It is 18 minutes when that visit occurs in the dialysis center. A coding or payment policy solution may be required to establish reporting of the “complete” assessment by site of service. The pediatric/adolescent codes assume the site of the complete visit to be the dialysis center and therefore only the care management aspect is applicable. The PE Subcommittee deferred this discussion to the Pre-Facilitation committee on Friday morning. ***At the full RUC the pediatric ESRD codes were cross-walked to home health supervision code 99375 with a total clinical labor time of 36 minutes. The adult ESRD codes were also cross-walked to 99375 and additional time was added for two phone calls totaling 42 minutes of clinical labor time.***

Cardiac Device Monitoring (93XX1-X9 & 93X10-X23)

7

The cardiac device Monitoring codes were deferred to the April 2008 meeting and were not discussed.

Neonatal and Pediatric Intensive Care (993XX1-X2)

8

The Subcommittee agreed with the specialty that there should be no direct practice expense inputs for these codes.

Sling Operation for Stress Incontinence (57288), Laparoscopic Radical Prostatectomy (55866)

N, O

Both codes 55866 and 57288 are facility only 090 day global codes and were not altered by this Subcommittee

Photodynamic Therapy of the Eye (67225)

P

The Subcommittee agreed with the minor direct practice expense inputs recommended by the society. ***At the full RUC physician intra-service time was maintained at 3 minutes which changes the intra-service clinical labor time for this recommendation to be 3 minutes.***

CMS Requests - Existing Codes

Chemotherapy Administration (96440)

R

The Subcommittee and specialty reviewed this never reviewed service carefully to determine the typical direct practice inputs. The Subcommittee reduced and added inputs necessary to provide this service. These recommendations are attached. ***These recommendations were approved by the RUC.***

PE Review Process & Immunization Administration (Indirect to Direct PE for 90465-90474)

The Subcommittee first discussed and agreed to continue with its current process of making recommendations on existing codes. This involves the specialties contacting AMA staff and CMS staff and requesting a change in existing direct practice inputs. CMS acting as a gatekeeper regarding these requests may then request the issue be brought to the RUC for discussion. CMS would provide a list of codes for future RUC meeting with a rationale to RUC staff, and then RUC staff would begin a level of interest process and allocate time on the Practice Expense Subcommittee’s agenda for the issue’s discussion.

The Subcommittee then considered the request from the American Academy of Pediatrics to move specific items currently considered in CMS' PE methodology as indirect practice expenses to direct practice expenses. This movement of indirect expenses to direct expenses has never been recommended by the RUC in the past and members believed this would set a precedent for the future if recommended. The issue involves only the pediatrics vaccine codes (90465-8, 90471-4). The PE changes, the specialty explained, are due to new regulations that require specific additional equipment such as: a dedicated full size vaccine refrigerator, a dedicated under counter freezer, temperature control devices and alarms, as well as a dedicated back-up generator. The specialty also explained additional clinical labor time was needed for ordering and managing the inventory of the vaccines, vaccine registry input and audits.

Recommended Additional Clinical Labor to Existing Practice Expense Inputs

Subcommittee members and a CMS representative initially were uncomfortable with the inputs requested, however then made some modification to the original specialty recommendation of clinical staff time allowing registry data entry. Members agreed with some of the additional clinical labor requested and referenced the regulatory clinical labor time allotted for MQSA by this committee in August 2003 for screening mammography code 77057, 4 minutes for the initial first injection code and 1 minute for any additional injection.

Recommended Additional Equipment to Existing Practice Expense Inputs

The Subcommittee agreed to the specialty requested refrigerators and freezer and not the backup generator. These costs were explained not to be indirect but specific to these vaccine procedures. The Subcommittee and the CMS representative considered how to allocate the refrigerator/freezer expense per vaccine administrative service. It considered the minutes of refrigerator/freezer expense per vaccine and recommends the total vaccine clinical staff time as the time of refrigerator/freezer use, rather than just the intra-service clinical staff time used in CMS' PE methodology. Only one control device is used per vaccine. ***These additions to the direct practice expense inputs for these immunization administration codes presented were approved by the RUC.***

These additions to the existing clinical labor time and equipment PE direct inputs that are recommended by this Subcommittee are attached.

These minutes were approved by the RUC on February 3, 2008.

Physician Practice Information Survey

RUC Meeting – January 31, 2008



Survey Firm Selection

- Terminated contract with the Gallup Organization and Contracted with **Dmrkynetec** in November 2007
- All 51 physician specialties and other health care professionals continue to be included in the survey effort
- Survey will be conducted within remaining budget. AMA will not solicit additional funding from specialty societies





Data available from Gallup

- Final Data from Gallup Effort:
 - 13,336 sample in field
 - 1,454 at least partially completed (11%)
 - 807 financial sections completed (6%)
 - Disparate results by specialty (0 completes for Interventional Radiology; 45 completes for Colon and Rectal Surgery; median # completes = 15)
- **Dmrkynetec** re-contacting physicians from Gallup survey in January and February to increase the number of useable completes



CMS Discussions

- AMA has finalized contract with CMS regarding CMS contribution to purchase data computations from survey
- CMS agreed to stronger language within the survey communication tools (cover letter, uniform announcement)
- November 1, 2007 Final Rule included discussion – Data will be helpful in determining practice costs and MEI.



New Timeframe

- Initial effort designed to field survey through December 2007 and submit data to CMS by March 31, 2008
- Will need to field survey throughout 2008
- Contracted with CMS to provide data no later than March 31, 2009
- CMS will consider in rulemaking for the 2010 Medicare Physician Payment Schedule.



Response Rate/Precision Criteria/Number of Completes

- 50% response rate overly aggressive
- 20% response rate now desired, but may still be difficult to achieve
- Top priority – 100 completes per specialty
- Supplemental surveys – designed to meet CMS precision criteria, required 100 completes on average



Incentives

- Will continue \$50 incentive
- A \$75 incentive will be offered to those who complete the survey on-line



Communication

- Specialty societies have been cooperative: websites, e-mails, newsletters, membership lists, etc.
- AMA: AMAVoice; AMNews; CPT Assistant; PAHCOM; MGMA; Morning Rounds; etc.
- Uniform Announcement has been updated – we request that all specialty societies post the revised document on their website.





Survey Re-launch

- **Dmrkynetec** will mail survey packets in three waves from mid-January through mid-March.
- All sample for each specialty (1,000 per specialty) will be released at once.
- More than 19,000 physicians received the survey packet this week.
- 100 interviewers began calling the first wave today (January 31).





Reporting Results

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

**AMA/Specialty Society RVS Update Committee
Five-Year Review Identification Workgroup
January 31, 2008**

Tab S

Members Present: 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, Allan Inglis, MD, James J. Anthony, MD, Maurits Weirsema, MD, Robert Zwolak, MD

Doctor Levy initiated the meeting of the Five-Year Review Identification Workgroup by thanking the members for their efforts from the previous meeting as well as their work prior to this meeting. Doctor Levy also discussed one of the over-arching issues engaging the Workgroup in a discussion of whether the Workgroup should recommend a rolling “five-year review” process for potentially misvalued services identified through these screens or recommend that codes identified in these screens be referred to the upcoming Five-Year Review. The Workgroup agreed that, in order to more easily facilitate the review process and in consideration of the gravity of the issues, the potentially misvalued services should be reviewed by the RUC on an ongoing basis rather than during the upcoming Five-Year Review. **The Workgroup recommends to the RUC that the codes identified as potentially misvalued be reviewed by the RUC on an ongoing basis rather than at the upcoming Five-Year Review.**

The Workgroup acknowledged that this may put considerable pressure upon specialty societies and is a change in RUC methodology. Because of this, the Workgroup agrees that if the review is ongoing, the RUC should be flexible with specialty societies. The Workgroup agreed that specialty societies should be given the opportunity to establish a plan for review of potentially misvalued services and present this to the workgroup for recommendation to the RUC before the RUC makes recommendations to CMS to request review of services.

I. Review of Specialty Society Comments Regarding Services with High Volume Growth

Before the Workgroup discussed the individual services identified with high volume growth, it discussed its procedural methodology. The Workgroup agreed that in the future, representatives of the specialty societies submitting comments to the Workgroup be present to answer questions. **The Workgroup recommends that the RUC request representatives of the specialty societies submitting comments to the Workgroup be present to answer questions.**

The Workgroup created several categories of actions for the services with high volume increases, including:

- Request for interested specialty societies to submit an action plan for further review of the code including, but not limited to, more in depth analysis of the service and applicable policies and/or a schedule for survey (or some other methodology presented to and approved by the Research Subcommittee) and valuation recommendation to the RUC.

Approved by the RUC on February 3, 2008

- Referral to CPT for deletion, clarification, or revision. This may also include the development of a CPT Assistant article or review of the impact of previous CPT Assistant articles on volume.
- Referral to CMS for further analysis and review of practice expense.
- No action and remove the service from the screen
- No action at this time and review the change in utilization after two years of additional data.

The Workgroup also asked that the members consider not only the code under review, but also other services that may impact the service in question. Where there is a shift from one service to another less invasive and potentially less costly procedure, the workgroup should note that within its recommendations to the RUC.

For any future iterations of this screen, the Workgroup asked that staff include the historic dominant specialty and ICD-9 code information for the years under review.

Code	Workgroup Recommendation and Comments
01930	No action and remove the service from the screen
11982	Request for interested specialty societies to submit an action plan for further review of the code and recommend inclusion of the entire family of services.
15401	No action at this time and review the change in utilization after two years of additional data.
27370	Request for interested specialty societies to submit an action plan for further review of the code
29220	Request for interested specialty societies to submit an action plan for further review of the code. The specialty should consider the impact of the April 2002 CPT Assistant on the utilization of this service.
35493	Request for interested specialty societies to submit an action plan for further review of the code. The entire family of codes should be considered. The specialty should address how often the service is reported with other services. It was also noted that the volume of this service has increased as the volume of more invasive procedures has declined.
35495	Request for interested specialty societies to submit an action plan for further review of the code. The entire family of codes should be considered. The specialty should address how often the service is reported with other services. It was also noted that the volume of this service has increased as the volume of more invasive procedures has declined.
37765	No action at this time and review the change in utilization after two years of additional data.
37766	No action at this time and review the change in utilization after two years of additional data.
44207	No action and remove the service from the screen. It was also noted that the volume of this service has increased as the volume of more invasive procedures has declined.

Code	Workgroup Recommendation and Comments
52224	Request for interested specialty societies to submit an action plan for further review of the code. It was noted that a large increase in practice expense valuation occurred at the time of the volume increase.
52648	Request for interested specialty societies to submit an action plan for further review of the code. It was noted that a large increase in practice expense valuation occurred at the time of the volume increase.
55866	No action and remove the service from the screen
64446	Referral to CPT for deletion, clarification, or revision. The specialty noted that they have already submitted a CPT proposal for this service.
64448	Referral to CPT for deletion, clarification, or revision. The specialty noted that they have already submitted a CPT proposal for this service.
64472	Request for interested specialty societies to submit an action plan for further review of the code. It was noted that 64470 should also be reviewed.
64555	Referral to CPT for deletion, clarification, or revision. This may also include the development of a CPT Assistant article or review of the impact of previous CPT Assistant articles on volume. No other action at this time and review the change in utilization after two years of additional data.
64623	Request for interested specialty societies to submit an action plan for further review of the code and recommend inclusion of the entire family of services. It was noted that other codes that are done at the same time.
67028	Request for interested specialty societies to submit an action plan for further review of the code.
68040	No action at this time and review the change in utilization after two years of additional data.
70496	Referral to CMS for further analysis and review of practice expense.
70498	Referral to CMS for further analysis and review of practice expense.
72191	Referral to CMS for further analysis and review of practice expense.
73580	Request for interested specialty societies to submit an action plan for further review of the code.
73706	Referral to CMS for further analysis and review of practice expense.
75635	Referral to CMS for further analysis and review of practice expense.
75992	Request for interested specialty societies to submit an action plan for further review of the code
75993	Request for interested specialty societies to submit an action plan for further review of the code
76513	Request for interested specialty societies to submit an action plan for further review of the code. It was noted that the AAO explanation that the code was new in 2005 is incorrect.
76970	Request for interested specialty societies to submit an action plan for further review of the code.
77782	Referral to CPT for deletion, clarification, or revision. The specialty indicated that a proposal is under consideration at the February 2008 CPT meeting.
78483	Referral to CPT for deletion, clarification, or revision.

Code	Workgroup Recommendation and Comments
90471	No action and remove the service from the screen.
90472	No action and remove the service from the screen.
92270	Request for interested specialty societies to submit an action plan for further review of the code. The Workgroup recommends that the specialty proceed with their suggestion to pursue a CPT Assistant article, while engaging in the development of a plan of action.
93005	No action and remove the service from the screen. It was noted that the complete ECG (93000) is declining, while the separate tracing and S/I codes have increased.
93017	Also review the change in utilization after two years of additional data.
93236	Referral to CPT for deletion, clarification, or revision. This may also include the development of a CPT Assistant article or review of the impact of previous CPT Assistant articles on volume. Also review the change in utilization after two years of additional data.
93662	No action at this time and review the change in utilization after two years of additional data.
94014	Request for interested specialty societies to submit an action plan for further review of the code.
94015	Request for interested specialty societies to submit an action plan for further review of the code.
94450	Request for interested specialty societies to submit an action plan for further review of the code.
94681	Request for interested specialty societies to submit an action plan for further review of the code.
94770	Request for interested specialty societies to submit an action plan for further review of the code.
95922	Request for interested specialty societies to submit an action plan for further review of the code.
95954	No action and remove the service from the screen.
95991	No action at this time and review the change in utilization after two years of additional data. This is a new CPT code.
96567	Request for interested specialty societies to submit an action plan for further review of the code – practice expense inputs only.
96921	No action at this time and review the change in utilization after two years of additional data.
97755	No action and remove the service from the screen.
G0202	AMA staff to discuss the practice expense methodology for this service and report back to the Five-Year Review Identification Workgroup. Specifically, direct practice expense inputs have not been developed for this service. A review of legislative language is necessary to understand if CMS has instead developed a practice expense payment to comply with specific legislation.

Code	Workgroup Recommendation and Comments
G0204	AMA staff to discuss the practice expense methodology for this service and report back to the Five-Year Review Identification Workgroup. Specifically, direct practice expense inputs have not been developed for this service. A review of legislative language is necessary to understand if CMS has instead developed a practice expense payment to comply with specific legislation.
G0206	AMA staff to discuss the practice expense methodology for this service and report back to the Five-Year Review Identification Workgroup. Specifically, direct practice expense inputs have not been developed for this service. A review of legislative language is necessary to understand if CMS has instead developed a practice expense payment to comply with specific legislation.
G0237	Request for interested specialty societies to submit an action plan for further review of the code – practice expense only.
G0238	Request for interested specialty societies to submit an action plan for further review of the code – practice expense only.
G0249	Request for interested specialty societies to submit an action plan for further review of the code. The workgroup questioned why this service was on the Physician Payment Schedule as this appears to be durable medical equipment.
G0250	Request for interested specialty societies to submit an action plan for further review of the code.
G0270	CMS recently requested review of this service for the April 2008 RUC/HCPAC meeting.

II. Review of Specialty Society Comments Regarding Services with High IWPOT

The Workgroup next discussed the specialty society comments regarding services with high IWPOT. Similar to the review of the high volume growth services, the Workgroup recommended that any service for which a resurvey or referral to CPT is recommended, that the interested specialty societies be given the opportunity to establish a work plan to do so. The Workgroup reviewed the specialty society feedback and made the following recommendations and comments to the RUC:

Code	Workgroup Recommendations and Comments
15330	No action. The code was recently reviewed by the RUC as a new service and there is too little data to provide any rationale for review of the service.
17106	Request for interested specialty societies to submit an action plan for further review of the code.
17107	Request for interested specialty societies to submit an action plan for further review of the code.
17108	Request for interested specialty societies to submit an action plan for further review of the code.
21935	This service was identified as a part of the Site of Service Anomalies and is currently under review by the CPT Editorial Panel's Soft Tissue Tumor Workgroup.
27245	Request for interested specialty societies to submit an action plan for further review of the code. Other codes in the family should also be considered.

Code	Workgroup Recommendations and Comments
27250	This service was identified as a part of the Site of Service Anomalies and is currently under review by the RUC.
33430	No action. This service was recently reviewed by the RUC during the Third Five-Year Review.
33863	No action. This service was recently reviewed by the RUC during the Third Five-Year Review.
45170	This service was identified as a part of the Site of Service Anomalies and is currently under review by the RUC.
47525	Recommend to CMS that this service be given a new global period of 000. Request for interested specialty societies to submit an action plan for further review of the code.
59400	Request for interested specialty societies to submit an action plan for further review of the code.
59409	Request for interested specialty societies to submit an action plan for further review of the code.
59410	Request for interested specialty societies to submit an action plan for further review of the code.
59510	Request for interested specialty societies to submit an action plan for further review of the code.
66761	This service was recently reviewed by the RUC and requires further analysis from staff, specifically addressing changes in visits, before any definitive action may be taken. Staff will look at original summary forms to determine if the discharge work was removed from the valuation when the time was reduced. Reassess at the April RUC meeting.
66982	Request for interested specialty societies to submit an action plan for further review of the code. Specialty action plan to specifically address the existing post service visits and work neutrality issues with 66984. The specialty should also review the 2003 CPT Assistant article to determine if this clarification impacted the reporting of this service.
66984	Request for interested specialty societies to submit an action plan for further review of the code. Specialty action plan to specifically address work neutrality issues with 66982.
67210	Request for interested specialty societies to submit an action plan for further review of the code. Specialty action plan to specifically address potential coding changes to resolve “one or more session” language.
67220	Request for interested specialty societies to submit an action plan for further review of the code. Specialty action plan to specifically address potential coding changes to resolve “one or more session” language.
67228	Request for interested specialty societies to submit an action plan for further review of the code. Specialty action plan to specifically address potential coding changes to resolve “one or more session” language.

III. Specialty Society Feedback Regarding Site of Services Anomalies

The Workgroup reviewed the comments submitted by ASTRO regarding the site of service anomaly with 77427. ASTRO commented that this code has an “implied” 090 day global period associated with it. In the CMS 2005 MFS Proposed Rule CMS proposed to change the global period for the weekly treatment management code from XXX to 090. Such a change would not have recognized the nature of this procedure. If CMS changed the global period from XXX to 090, the carriers’ claims processing systems would have rejected all claims submitted within 90 days of the first date of service for code 77427. Based on the concerns raised by the commenters, CMS retained the global period of XXX for CPT code 77427 and the implied 090 day global following the end of treatment and did not change the global period for this service as proposed. In response to the comments, the Workgroup noted that the service had not been reviewed by the RUC since 1998 and the methodology for deriving the visits and value was very confusing. The Workgroup agreed that the best way to resolve this issue is to ask the specialty society to come back to the RUC with an action plan to review 77427. The Workgroup also requests that ASTRO consider potential coding solutions for this service, consistent with other radiation oncology services. **The Workgroup recommends that the RUC request interested specialty society(s) to submit an action plan for reviewing the value of 77427.**

The Workgroup next discussed the specialty society comments regarding 31611. In its original comments, the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) indicated that 31611 is typically performed in the outpatient setting when not performed in conjunction with a laryngectomy, but is typically performed in the inpatient setting when performed in conjunction with a laryngectomy. Following further discussions with AAO-HNS, the society indicates that 31611 may or may not be reported with a laryngectomy and it is unable to state with any certainty which method is typical. As such, the AAO-HNS does not object to changes recommended by the workgroup with respect to hospital visits in light of the Medicare utilization data, provided the work RVU is not affected. **As such, the Workgroup recommends that 0.5 99238 be removed with no change in work RVU.**

IV. Progress Report of Joint CPT / RUC Workgroup

Doctor Ken Brin provided the Workgroup with a report outlining the progress of the joint CPT/RUC workgroup regarding the services reported together by the same physician on the same date of service. The Workgroup agreed with the report and thanked the joint workgroup for their excellent work thus far. **The Workgroup recommends that the RUC approve the report of the joint CPT/RUC workgroup attached to this report.** Also attached to this report is the list of the 23 Type A code pairs referred to in Doctor Brin’s report.

V. Additional Criteria for Identification of Potentially Misvalued Services

Doctor Levy asked that Workgroup members review the criteria for identification of potentially misvalued services that have been presented to the Workgroup at previous meetings. At the Workgroup’s next meeting, it will begin to prioritize the next tier of criteria for identification of potentially misvalued services.

VI. Other Issues

The workgroup entertained a brief discussion regarding the IWPUT as a screening tool for potentially misvalued services. The workgroup concluded that it is an appropriate screen.

Joint CPT/RUC Workgroup – Progress Report

Background

A joint CPT/RUC workgroup has been formed to review code pairs that are reported together very frequently, consider whether some duplication in work valuation occurs under those circumstances, and make recommendations to address the potential misvaluation of work when the codes are reported together. The workgroup recommends: (a) a process to determine when code pairs are submitted together on a frequent basis (Step 1); (b) a process to determine how these code pairs should be evaluated for modification or revision (Step 2).

Identification and Prioritization of Code Pairs Types (Step 1)

Analysis of the CMS Five Percent Sample File has been utilized to identify code pairs which are very frequently reported together, i.e., when Code 1 is submitted, what is the percent occurrence that the same physician also reports Code 2. The initial threshold utilized to identify these was 90%, however, the workgroup agrees that the 90% threshold should be raised to 95% to account for any coding errors and/or sample errors in the CMS Five Percent Sample File. In addition, analysis of the data will be performed to determine the inverse—when Code 2 is submitted, what is the percent occurrence of the same physician also reporting Code 1. This will identify four possible conditions for joint utilization of the two codes as identified in the table below.

When Code 1 submitted, % Code 2 is > 95%		When Code 2 submitted, % Code 1 is > 95%	
		Yes	No
Yes	Yes	A	B
	No	B	C

Based on this, the workgroup has divided the services into type, Type A and Type B. Any Type C codes would fall outside the parameters of the workgroup's charge. Type A codes are bi-directionally paired. That is, when Code 1 is reported, Code 2 is also reported greater than the threshold % of occurrences and when Code 2 is reported, Code 1 is also reported greater than the threshold % of occurrences. Subsequently, these two codes are submitted independently "rarely".

Type B codes are uni-directional. That is, either when Code 1 is reported, Code 2 is also reported greater than the threshold % of occurrences but when Code 2 is reported, Code 1 is not reported greater than the threshold % of occurrences (i.e., Code 2 is frequently reported separately from Code 1), or the inverse.

Type C codes are reported together with a frequency less than the set threshold and Code 2 is reported together with Code 1 with a frequency less than the set threshold. Type C code pairs need no further investigation unless the threshold utilized to determine their pair utilization status is changed.

Addressing Type A and B Code Pairs (Step 2)

Code pairs classified as Type A and B merit further evaluation to determine whether new codes should be generated. The workgroup recommends that all specialty societies be notified of codes meeting both Type A and Type B in a letter to be sent in February.

Foremost, the workgroup will ask specialties to consider coding change proposals to condense each Type A code pair into a single code and eliminate the original two codes. However, specialties, at this time, may recommend alternate approaches if necessary and if a proper rationale is provided. The period for comment on Type A code pairs will extend through the summer of 2008 with coding change proposals to be submitted in time for the October 2008 CPT meeting.

Specialty societies will also be informed that following the completion of Type A code changes, coding change proposals for Type B codes must be considered. Type B code pairs represent a more complex coding issue and may be resolved in a number of ways. The workgroup envisions comments and coding change proposals from specialties to consider either combining the codes into a single code, combining the codes into a single code while maintaining the original codes, or maintaining the code pairs as is if adequately supported by convincing rationale. The period for coding change proposals for Type B codes will extend beyond the October 2008 CPT meeting, but is requested to be within the CPT 2010 cycle.

Specialty societies, rather than addressing type A and B codes separately, may wish to address them together and/or include a broader range of codes if desired. In addition, specialty societies may wish to propose coding proposals which simplify a family of codes rather than single code pairs, in which case greater time periods for submission of such proposals will be considered.

Same Day Same Provider

Code 1	Mod 1	Global	Date of RUC Review	51 Exempt	Long Descriptor	Code 2	Mod 2	Global	Date of RUC Review	51 Exempt	Long Descriptor	Code 1 Services - From 5% File (2205 data)	Same Day Billed Occurrences - From 5% File (2205 data)	Percentage of Time Code 1 Billed with Code 2 (2205 data)	Code 1 Total Utilization (2205 data)	Code 2 Total Utilization (2205 data)	Code 1 Computed 5% of Total Utilization (2205 data)	Code 2 Computed 5% of Total Utilization (2205 data)	ratio column P/M	ratio column S/Q
78465		XXX	Aug-05	No	Myocardial perfusion imaging; tomographic (SPECT), multiple studies (including attenuation correction when performed), at rest and/or stress (exercise and/or pharmacologic) and redistribution and/or rest injection, with or without quantification	78478		XXX	Aug-05	No	Myocardial perfusion study with wall motion, qualitative or quantitative study (List separately in addition to code for primary procedure)	82,480	79,037	95.8%	1,649,269	1,632,646	82,463	81,632	1.00	1.03
78465		XXX	Aug-05	No	Myocardial perfusion imaging; tomographic (SPECT), multiple studies (including attenuation correction when performed), at rest and/or stress (exercise and/or pharmacologic) and redistribution and/or rest injection, with or without quantification	78480		XXX	Aug-05	No	Myocardial perfusion study with ejection fraction (List separately in addition to code for primary procedure)	82,480	77,913	94.4%	1,649,269	1,608,615	82,463	80,431	1.00	1.03
78465	TC	XXX	Aug-05	No	Myocardial perfusion imaging; tomographic (SPECT), multiple studies (including attenuation correction when performed), at rest and/or stress (exercise and/or pharmacologic) and redistribution and/or rest injection, with or without quantification	78478	TC	XXX	Aug-05	No	Myocardial perfusion study with wall motion, qualitative or quantitative study (List separately in addition to code for primary procedure)	14,238	13,301	92.7%	284,259	278,624	14,213	13,931	1.00	1.05
78478		XXX	Aug-05	No	Myocardial perfusion study with wall motion, qualitative or quantitative study (List separately in addition to code for primary procedure)	78465		XXX	Aug-05	No	Myocardial perfusion imaging; tomographic (SPECT), multiple studies (including attenuation correction when performed), at rest and/or stress (exercise and/or pharmacologic) and redistribution and/or rest injection, with or without quantification	81,469	79,711	97.0%	1,632,646	1,649,269	81,632	82,463	1.00	1.03
78478		XXX	Aug-05	No	Myocardial perfusion study with wall motion, qualitative or quantitative study (List separately in addition to code for primary procedure)	78480		XXX	Aug-05	No	Myocardial perfusion study with ejection fraction (List separately in addition to code for primary procedure)	81,469	79,625	96.9%	1,632,646	1,608,615	81,632	80,431	1.00	1.01
78478	26	XXX	Aug-05	No	Myocardial perfusion study with wall motion, qualitative or quantitative study (List separately in addition to code for primary procedure)	78480	26	XXX	Aug-05	No	Myocardial perfusion study with ejection fraction (List separately in addition to code for primary procedure)	64,704	62,909	96.4%	1,285,566	1,291,108	64,278	64,555	0.99	1.03
78478	TC	XXX	Aug-05	No	Myocardial perfusion study with wall motion, qualitative or quantitative study (List separately in addition to code for primary procedure)	78480	TC	XXX	Aug-05	No	Myocardial perfusion study with ejection fraction (List separately in addition to code for primary procedure)	13,962	13,660	94.6%	278,624	277,004	13,931	13,850	1.00	1.01
78478	TC	XXX	Aug-05	No	motion, qualitative or quantitative study	78465	TC	XXX	Aug-05	No	tomographic (SPECT), multiple studies	13,962	13,647	94.5%	278,624	284,259	13,931	14,213	1.00	1.04
78480		XXX	Aug-05	No	Myocardial perfusion study with ejection fraction (List separately in addition to code for primary procedure)	78478		XXX	Aug-05	No	Myocardial perfusion study with wall motion, qualitative or quantitative study (List separately in addition to code for primary procedure)	80,291	79,658	98.3%	1,608,615	1,632,646	80,431	81,632	1.00	1.02

Same Day Same Provider

Code 1	Mod 1	Global	Date of RUC Review	51 Exempt	Long Descriptor	Code 2	Mod 2	Global	Date of RUC Review	51 Exempt	Long Descriptor	Code 1 Services - From 5% File (2205 data)	Same Day Billed Occurrences - From 5% File (2205 data)	Percentage of Time Code 1 Billed with Code 2 (2205 data)	Code 1 Total Utilization (2205 data)	Code 2 Total Utilization (2205 data)	Code 1 Computed 5% of Total Utilization (2205 data)	Code 2 Computed 5% of Total Utilization (2205 data)	ratio column P/M	ratio column S/Q
78480		XXX	Aug-05	No	Myocardial perfusion study with ejection fraction (List separately in addition to code for primary procedure)	78465		XXX	Aug-05	No	Myocardial perfusion imaging; tomographic (SPECT), multiple studies (including attenuation correction when performed), at rest and/or stress (exercise and/or pharmacologic) and redistribution and/or rest injection, with or without quantification	80,291	78,607	97.0%	1,608,615	1,649,269	80,431	82,463	1.00	1.05
78480	26	XXX	Aug-05	No	Myocardial perfusion study with ejection fraction (List separately in addition to code for primary procedure)	78478	26	XXX	Aug-05	No	Myocardial perfusion study with wall motion, qualitative or quantitative study (List separately in addition to code for primary procedure)	65,026	62,905	96.0%	1,291,108	1,285,566	64,555	64,278	0.99	1.02
78480	TC	XXX	Aug-05	No	Myocardial perfusion study with ejection fraction (List separately in addition to code for primary procedure)	78478	TC	XXX	Aug-05	No	Myocardial perfusion study with wall motion, qualitative or quantitative study (List separately in addition to code for primary procedure)	14,247	14,046	92.7%	277,004	278,624	13,850	13,931	0.97	0.99
78480	TC	XXX	Aug-05	No	Myocardial perfusion study with ejection fraction (List separately in addition to code for primary procedure)	78465	TC	XXX	Aug-05	No	Myocardial perfusion imaging; tomographic (SPECT), multiple studies (including attenuation correction when performed), at rest and/or stress (exercise and/or pharmacologic) and redistribution and/or rest injection, with or without quantification	14,247	13,914	91.8%	277,004	284,259	13,850	14,213	0.97	1.02
92541		XXX	NA	No	Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording	92544		XXX	NA	No	Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording	6,993	6,409	90.0%	139,635	133,175	6,982	6,659	1.00	1.04
92544		XXX	NA	No	Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording	92545		XXX	NA	No	Oscillating tracking test, with recording	6,684	6,475	92.6%	133,175	133,175	6,659	6,659	1.00	1.03
93543		000	NA	No	Injection procedure during cardiac catheterization; for selective left ventricular or left atrial angiography	93555	26	XXX	NA	Yes	Imaging supervision, interpretation and report for injection procedure(s) during cardiac catheterization; ventricular and/or atrial angiography	51,355	47,987	93.4%	1,026,768	986,104	51,338	49,305	1.00	1.03
93545		000	Aug-95	Yes	Injection procedure during cardiac catheterization; for selective coronary angiography (injection of radiopaque material may be by hand)	93556	26	XXX	NA	Yes	Imaging supervision, interpretation and report for injection procedure(s) during cardiac catheterization; pulmonary angiography, aortography, and/or selective coronary angiography including venous bypass grafts and arterial conduits (whether native or use	60,861	56,129	91.8%	1,214,670	1,137,470	60,734	56,874	1.00	1.01
93555	TC	XXX	NA	Yes	Imaging supervision, interpretation and report for injection procedure(s) during cardiac catheterization; ventricular and/or atrial angiography	93556	TC	XXX	NA	Yes	Imaging supervision, interpretation and report for injection procedure(s) during cardiac catheterization; pulmonary angiography, aortography, and/or selective coronary angiography including venous bypass grafts and arterial conduits (whether native or use	1,643	1,632	99.3%	32,569	33,966	1,628	1,698	0.99	1.04

Same Day Same Provider

Code 1	Mod 1	Global	Date of RUC Review	51 Exempt	Long Descriptor	Code 2	Mod 2	Global	Date of RUC Review	51 Exempt	Long Descriptor	Code 1 Services - From 5% File (2205 data)	Same Day Billed Occurrences - From 5% File (2205 data)	Percentage of Time Code 1 Billed with Code 2 (2205 data)	Code 1 Total Utilization (2205 data)	Code 2 Total Utilization (2205 data)	Code 1 Computed 5% of Total Utilization (2205 data)	Code 2 Computed 5% of Total Utilization (2205 data)	ratio column P/M	ratio column S/Q
93555		XXX	NA	Yes	Imaging supervision, interpretation and report for injection procedure(s) during cardiac catheterization; ventricular and/or atrial angiography	93556		XXX	NA	Yes	Imaging supervision, interpretation and report for injection procedure(s) during cardiac catheterization; pulmonary angiography, aortography, and/or selective coronary angiography including venous bypass grafts and arterial conduits (whether native or use	1,616	1,581	97.8%	31,220	32,470	1,561	1,624	0.97	1.03
93555	TC	XXX	NA	Yes	Imaging supervision, interpretation and report for injection procedure(s) during cardiac catheterization; ventricular and/or atrial angiography	93510	TC	000	NA	No	Left heart catheterization, retrograde, from the brachial artery, axillary artery or femoral artery; percutaneous	1,643	1,480	90.1%	32,569	30,688	1,628	1,534	0.99	1.04
93556	TC	XXX	NA	Yes	Imaging supervision, interpretation and report for injection procedure(s) during cardiac catheterization; pulmonary angiography, aortography, and/or selective coronary angiography including venous bypass grafts and arterial conduits (whether native or use	93555	TC	XXX	NA	Yes	Imaging supervision, interpretation and report for injection procedure(s) during cardiac catheterization; ventricular and/or atrial angiography	1,711	1,633	95.4%	33,966	32,569	1,698	1,628	0.99	1.00
93556		XXX	NA	Yes	Imaging supervision, interpretation and report for injection procedure(s) during cardiac catheterization; pulmonary angiography, aortography, and/or selective coronary angiography including venous bypass grafts and arterial conduits (whether native or use	93555		XXX	NA	Yes	Imaging supervision, interpretation and report for injection procedure(s) during cardiac catheterization; ventricular and/or atrial angiography	1,680	1,581	94.1%	32,470	31,220	1,624	1,561	0.97	0.99

**AMA/Specialty Society RVS Update Committee
Administrative Subcommittee Report
January 31, 2008**

Tab T

Members Present: Doctors James Blankenship (Chair), Michael Bishop, Ronald Burd, John Gage, Meghan Gerety, Charles Koopmann, Barbara Levy, Doug Leahy, Lloyd Smith, DPM, Arthur Traugott.

I. Conflict of Interest Policy/Confidentiality Review

A. RUC Confidentiality Notice

At the September 2007 RUC meeting, the Administrative Subcommittee determined that any individual involved in the RUC Process shall sign a RUC Confidentiality Statement. The RUC reviewed a confidentiality statement drafted by AMA staff and approved by AMA General Counsel. The Administrative Subcommittee approved the following RUC confidentiality statement to be signed by all RUC participants:

**AMA/Specialty Society RVS Update Committee (RUC)
Confidentiality Statement**

Current Procedural Terminology (CPT™) five-digit codes, descriptions, and other data only are copyright 2007 by the American Medical Association (AMA). All Rights Reserved. No fee schedules, basic units, relative values or related listings are included in CPT.™ CPT™ is a trademark of the American Medical Association.

All representatives to the RUC, observers and participants in the American Medical Association/Specialty Society Relative Value Update Process ("Process") acknowledge by their participation that any information or materials disclosed during the Process are confidential and/or proprietary and shall be kept confidential and shall only be used and disseminated for internal use within their organization as provided for by the Process. All representatives to the RUC, observers and participants in the Process acknowledge that all RUC deliberations are confidential and shall not be disseminated or discussed with individuals outside of the Process.

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

All representatives to the RUC, observers and participants in the Process acknowledge by their participation that all notices of copyright, confidentiality or other conditions on materials disclosed or distributed during the Process shall not be removed from any materials.

Your signature constitutes an acceptance of all terms described above.

Signature:

Date:

Print Name:

Specialty Society:

B. Financial Disclosure Forms for Advisors/Presenters

At the September 2007 RUC meeting, the Administrative Subcommittee determined that specific financial disclosures for Advisors and presenters are necessary. For example, a Subcommittee member suggested a disclosure form similar to the FDA. However, due to limited time the Administrative Subcommittee was not able to revise the current disclosure forms at the September 2007 meeting.

The Administrative Subcommittee convened by conference call on December 4, 2007, to expedite the development of policies and draft financial disclosure forms. The Administrative Subcommittee discussed any limitations of the current financial disclosure form; reviewed the FDA conflict of interest form as a reference; and revised the current financial disclosure form to be more specific in defining “*material contribution*.”

The AMA General Counsel reviewed the draft financial disclosure statement and suggested minor revisions. At the February 2008 meeting, the Administrative Subcommittee continued discussion of the financial disclosure and discussed what time period of material contribution should be disclosed. **The Administrative Subcommittee recommends that an individual’s cumulative lifetime material contributions received be disclosed. The Administrative Subcommittee also recommends that the financial disclosure form include a bullet to capture any material income which may be received via stock options currently or in the future.**

The Administrative Subcommittee recommends the following revised Financial Disclosure form:

Financial Disclosure Statement

For purposes of this Disclosure, “direct financial interest” means:

- A financial ownership interest of 5% or more, or
- A financial ownership interest which contributes materially* to your income, or
- Ability to exercise stock options now or in the future; or
- A position as proprietor, director, managing partner, or key employee, or
- Serve as a consultant, expert witness, speaker or writer, where payment contributes materially* to your income.

*Please define your cumulative lifetime material interest in the space provided below using the following increments:

\$5,000-\$9,999	\$10,000-\$24,999	\$25,000-\$49,999	\$50,000-\$99,999	> \$100,000
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“Family member” means spouse, domestic partner, parent, child, brother or sister. Disclosure of family member’s interest applies to the extent known by the representative.

I certify that my personal or my family members’ direct financial interest in, and my personal or my family members’ affiliation with or involvement in any organization or entity with a direct financial interest in the development of relative value recommendations in which I am participating are noted below. Otherwise, my signature indicates I have no such direct financial interest or affiliation with an organization with a direct financial interest, other than providing these services in the course of patient care.

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

Signature:

Date:

Print Name:

C. Conflict/Financial Interest Discovery/Disclosure Recourse and Failure/False Disclosure Recourse

The Administrative Subcommittee discussed what recourse may occur if a significant conflict is discovered or disclosed. The Administrative Subcommittee recommends:

1. **The RUC Chair assign a sub-group of the Administrative Subcommittee to review all financial disclosures prior to each RUC meeting.**
2. **During the course of a RUC meeting the RUC Chair has the authority to determine specific recourse him/herself.**

The Administrative Subcommittee discussed what action is taken if an Advisor or presenter falsely discloses or fails to disclose a financial interest and recommends:

1. **The advisor/presenter must immediately leave the RUC meeting room,**
2. **Further recourse will be discussed after the RUC meeting, and**
3. **The remaining presenters continue with presentation**

The Administrative Subcommittee discussed what action to take if the RUC discovers that an advisor/presenter falsely disclosed or failed to disclose a material financial interest after a RUC meeting. The Administrative Subcommittee will consider and develop recommendations at the next RUC meeting. In addition the Administrative Subcommittee will discuss the appropriateness of attending the meeting if a significant conflict is discovered.

II. RUC Mission Statement

The AMA has directed the RUC to develop a mission statement. At the September 2007 RUC meeting, Doctor Rich referred the development of a RUC mission statement to the Administrative Subcommittee. The Administrative Subcommittee reviewed mission statements of other organizations and a draft of a RUC mission statement prepared by RUC staff. The Administrative Subcommittee recommends the following mission statement for the RUC:

**American Medical Association/Specialty Society
Relative Value Update Committee (RUC)**

Mission Statement

The AMA/Specialty Society RVS Update Committee (RUC) is a private volunteer committee comprised of physicians and other health care professionals. The RUC's mission is to make recommendations to the Centers for Medicare and Medicaid Services (CMS) regarding the Medicare Resource-Based Relative Value Scale.

III. RUC Procedures for Interim Value Recommendations

At the September 2007 RUC meeting, the issue of interim values arose when the RUC discussed a family of codes of which one code was assigned an interim value. A RUC member suggested that if one code in a family is valued on an interim basis then the entire family should be valued as interim, allowing the RUC to review the entire family at once.

The Administrative Subcommittee considered whether an entire family of codes should be recommended as interim if one code in the family was recommended as interim. Two Subcommittee members voiced opposition to this idea. No one spoke in favor of it. Members of the audience were invited to comment, and no one commented.

IV. AGA/ASGE Request to Review ABMS Correspondence

The American Gastroenterological Association (AGA) and the American Society for Gastrointestinal Endoscopy (ASGE) requested that the RUC review the American Board of Medical Specialties (ABMS) March 13, 2007, letter to Mark Donowitz, MD the AGA President.

The Administrative Subcommittee briefly reviewed the history of the criteria for membership in the RUC, summarized in the AMA/Specialty Society RVS Update Process manual, Tab P, pages 78-80.

Criteria for membership on the RUC were adopted by the RUC at the April 25-28, 2002, RUC meeting. The five criteria are listed in the “Structure and Functions” section of the AMA/Specialty Society RVS Update Process manual (Tab A, page 3). Number 1 is “The specialty is an ABMS specialty”.

At the September 2002 meeting the RUC determined the following:

“The inclusion of the criteria for permanent membership (eg, ABMS specialty) into the RUC’s Structure and Functions should include specific language that clearly states that these are the criteria to be considered when a new application for a seat on the RUC is received. The current permanent members are not subject to removal from the RUC if they do not meet each specific criteria.

The process for soliciting a permanent seat on the RUC should also be outlined in the RUC’s Structure and Function document. The process will include a written request and will provide for the specialty to make a formal presentation to the full RUC. Data will be prepared by AMA staff to indicate whether the specialty meets each of the eligibility criteria.”

At the February 1-4, 2007 RUC meeting, “*The RUC reaffirmed the five criteria for participation for a permanent seat on the RUC, listed in priority order: (1) The specialty is an ABMS specialty, (2)...*”

The Administrative Subcommittee reviewed correspondence between ABMS and the AGA, including a request from AGA to ABMS on March 7, 2007, to clarify the status of ABMS subspecialties. The President/CEO of the ABMS responded on March 13, 2007, that “...although they [ABMS subspecialties] are referred to as subspecialties, they are nonetheless distinct specialties.” Dr. Rich requested that the Administrative Subcommittee review the letter. This action was delayed until the RUC had voted on whether to add a primary care seat to the RUC, which vote was held in September 2007.

On January 31, 2008, the Administrative Subcommittee reviewed the March 13, 2007, letter from ABMS to AGA. **The Administrative Subcommittee recommends that the RUC accept the letter.** No further action is recommended.

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

I. Review of Inclusionary/Exclusionary Criteria for Extant Database Use in the RUC Process

At the September 2007 RUC Meeting, the Workgroup assessed all of the proposed inclusionary/exclusionary criteria and created a proposed list of criteria. The Workgroup recommended that this inclusionary/exclusionary list be sent to the specialty societies for their review and comments. AMA Staff, at the direction of the Workgroup, solicited comments from the specialty societies via e-mail and received a joint comment letter from several specialty societies, a letter from the American Academy of Orthopaedic Surgeons and a letter from the American Academy of Pain Medicine. The Workgroup made several editorial edits to this list to address several concerns raised in the letters received. **The Extant Data Workgroup approved the Inclusionary/Exclusionary Criteria for Extant Database Use as listed below:**

- Databases must collect time data for the procedures, at a minimum the skin-to-skin or intra-service time and length of stay. Additional time elements may include ICU LOS, and other specialty specific time factors (i.e. phone calls, ventilator hours)
- Databases must have data integrity/reliability
 - Must collect data prospectively,
 - Should have the ability to identify and assess outliers – multiple procedures resulting in greater LOS; diseases with high mortality rate (LOS=0) or extended recovery (LOS>90); age variance (bi-modal)
 - Should have the ability to have transparency of data to compare to other databases including the RUC database
 - Should have the ability to audit the database
 - Should have the ability to track the data/changes over time
 - Should have the ability to collect data on all cases done by participants or for large volume procedures or E/M encounters, should have sampling criteria that are statistically valid to eliminate sampling bias
 - Should have current data, preferably from the last three to five years, although older sets can be used for comparison purposes
- Must have the ability to unequivocally map the procedure to a CPT code and isolate the procedure from associated physician work that is otherwise billable in the same setting

- Databases must list their limitations – include what is provided and not provided with respect to the RUC database
- Databases must be representative
 - The data should be geographically representative eg, regionally and nationally for the specialty,
 - The data should have various levels of patient severity
 - The data should have adequate practice site representation and sample size – practice sites and rural and urban representation
 - The data should be from various practice types – representative of the academic, non-academic and other types of practices for the specialty
 - The data should be collected from the majority specialties (including subspecialties) that perform the procedure or encounter
 - The data should be collected from either hospital/institution or individual physician.

After discussion by the full RUC, it was recommended that the first bullet, *Databases must collect time data for the procedures, at a minimum the skin-to-skin or intra-service time and length of stay. Additional time elements may include ICU LOS, and other specialty specific time factors (i.e. phone calls, ventilator hours)* should be moved under the second bullet *Databases must have data integrity/reliability* modified to read

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

II. Identification of Existing Extant Databases

At the September 2007 RUC Meeting, the Workgroup discussed all of the specialty society identified extant databases and determined that this identification process should continue. Therefore, the Workgroup recommends that the specialty societies be solicited again to identify any extant databases with which they are familiar. AMA Staff, at the direction of the Workgroup, solicited the specialty societies to identify any other extant databases via e-mail and received no additional identified extant databases.

III. Review of Statistical Components Collected in Extant Databases

The Workgroup requested a review of statistical components collected in extant databases, specifically the differences between mean and median. As requested, staff conferred with Kurt Gillis, Senior Economist of the Socioeconomic Policy Development Department of the AMA, to provide the following explanation.

Both are measures of central tendency or the central position. The mean, otherwise called the arithmetic mean or average, is the most commonly used measure of central tendency.

In order to calculate the mean, all values in the group of data are added and divided by the number of values. The median is calculated by ordering the group of data from the lowest to the highest and if there is an odd number of data select the middle data point, if there is an even number of data select the two middle data points and deduce the average of these two data points to determine the median. The median describes the middle position of a frequency distribution for a group of data.

When comparing the mean to the median of a dataset, it is important to note that the principle difference in these statistical tools is that the mean accounts for the entire group of data including the outliers while the median determines the most central value by excluding the outliers. The mean of a dataset can dramatically shift based on the presence of low or high data points while the median of a dataset is far more consistent despite the presence of outliers.

The Workgroup discussed the advantages and disadvantages of using the mean versus the median of a data set and offer no additional comments at this time.

IV. Identification and Approval of Potential Uses of Extant Data in RUC Process

Over the course of the Extant Data Workgroup meeting AMA Staff received multiple letters supporting the use of extant databases and several letters received from specialties that expressed concern with how the RUC was to incorporate the data from the extant databases into the RUC process. The Workgroup discussed how extant data would be optimally incorporated into the RUC process. The Workgroup makes the following recommendation:

Extant data could be incorporated into the RUC process as supplementary data to the RUC survey in the new and revised process when that extant database meets all approved Inclusionary/Exclusionary Criteria for Extant Database Use

Extant data could be incorporated into the RUC process as primary data in various collected components within the Five Year Review Process when that extant database meets all approved Inclusionary/Exclusionary Criteria for Extant Database Use, as in the approved alternative methodologies used in previous Five Year Reviews.

Further, the Workgroup discussed whether a specialty society, that has an extant database, should be required to present data from the extant database for all procedures it presents to the RUC. The Workgroup determined that this should not be a requirement placed on the specialty societies.

**AMA/Specialty Society RVS Update Committee
Research Subcommittee Report
December 11, 2007 and January 21, 2008 – Conference Calls**

Tab V

Members Present: Daniel Mark Siegel, MD (Chair), Dennis Beck, MD, Norman A. Cohen, MD, Emily Hill, PA-C, Eileen M. Moynihan, MD, Greg Przybylski, MD, Peter Smith, MD, Susan Spires, MD, Maurits Wiersema, MD

I. RUC Surveys with a Median Service Performance Rate of Zero– Development of Policy

At the April 2007 RUC meeting, the service performance rate (i.e., number of times performed by the respondent in the last year) for three coding issues was called into question during the RUC's discussion. A few RUC members were concerned that respondents have some defined amount of experience with a service in order to complete the survey. The RUC requested that the Research Subcommittee consider implications and potential guidelines and policies regarding the validity of surveys where the median "Service Performance Rate" is zero.

The RUC has expressed concern about accepting survey data where the median performance rate is zero. Therefore, bearing in mind that there is historical support to suggest that there is no relationship between performance rate and collected work values and the RUC's concern of accepting data where the median performance rate is zero, the Research Subcommittee reviewed several options at the September 2007 RUC Meeting. After a lengthy discussion, *the Research Subcommittee recommended that where the survey data for a new/revised code reflects a median performance rate of zero, the code will be referred back to CPT with the rationale that there are not enough providers with direct expertise in performing the procedure to evaluate the service.*

The RUC discussed this recommendation made by the Research Subcommittee and expressed concern that this recommendation would prohibit some procedures from being valued at the RUC. The RUC recommended that this issue be referred back to the Research Subcommittee for further consideration.

Therefore, the Research Subcommittee is charged again with developing policy to address RUC surveys with zero median service performance rate. Recognizing that each coding issue that comes before the RUC is unique, the Research Subcommittee recommends a more expansive approach to address this issue. **The Research Subcommittee recommends that the following language be added to the instruction document for specialties developing primary RUC recommendations:**

The RUC considers performance rate to be a key component of the work evaluation process. If a specialty society determines that after surveying, the survey data results in a median service performance rate of zero the specialty society has the following options:

- 1.) The specialty society can re-survey the code;**
- 2.) The specialty society can refer the code to the CPT Editorial Panel for further clarification on the code;**
- 3.) The specialty society can use a RUC-approved alternative method to value the survey;**
- 4.) The specialty society can present the survey data to the RUC with separate summary of recommendation forms summarizing the data for those who have performed the service, those who have not performed the service and the aggregate data. If this option is selected,**

Approved by the RUC on February 3, 2008

the specialty society must report the performance rate of the reference code on their aggregate summary of recommendation form in the additional rationale section.

II. Pre-Service Time Definition

In both March and May of 2007, the RUC requested that CMS consider a modification to the definition of physician pre-service time to be consistent with the pre-service definition utilized for the practice expense methodology. The current CMS definition of pre-service time for physicians is as follows:

Pre-service period:

The pre-service period includes physician services provided from the day before the operative procedure until the time of the operative procedure and may include the following:

- *Hospital admission work-up*
- *The pre-operative evaluation may include the procedural work-up, review of records, communicating with other professionals, patient and family, and obtaining consent*
- *Other pre-operative work may include dressing, scrubbing and waiting before the operative procedure, preparing patient and needed equipment for the operative procedure, positioning the patient and other “non-skin-to-skin” work in OR*

The following services are not included:

- *Consultation or evaluation at which the decision to provide the procedure was made (reported with modifier -57)*
- *Distinct evaluation and management services provided in addition to procedure (reported with modifier -25)*
- *Mandated services (reported with modifier -32)*

The RUC recommended that the physician pre-service period instead begin when the decision for surgery is made, similar to the CMS definition for clinical staff time. Physicians may engage in many of these pre-service activities (eg, review of records, communicating with other professionals) prior to the day before the operative procedure.

However, the RUC operates under the policies and guidelines established for the RBRVS by CMS. In order for the RUC to proceed with this project, CMS must first determine if the agency will revise the pre-service physician time definition. The RUC in its Comment Letter on the *Proposed Rule* to CMS urged CMS to consider including this proposal in the *Final Rule*.

In the *Final Rule* published on November 1, 2007, stated that, “revisions to the definition of pre-service work and time for certain global services... are outside the scope of the issues raised in the CY 2008 PFS proposed rule, we will not respond to these issues in this final rule with comment period.” Therefore, the Research Subcommittee will have to redefine the RUC’s proposed definition of pre-service time given this ruling from CMS.

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 recommended the pre-**

Approved by the RUC on February 3, 2008

services times associated with the RUC approved packages be allocated on the summary of recommendation as indicated in the attachments.

The Research Subcommittee recommends that given the ruling from CMS via communication to AMA Staff, the time allocated to Subsequent to Decision for Surgery be modified to read: *Day before the Operative Procedure Until the Time of Operative Procedure* to be consistent with the current CMS definition of pre-service time. However, before this recommendation is implemented the Research Subcommittee will establish a Workgroup to consult with Doctor Barbara Levy, Chair of the Pre-Service Time Workgroup and to review the Pre-Service Time Workgroup's recommendations at the February 2008 RUC Meeting to ensure they are consistent with this modification.

It is the intent of this workgroup as well as the Research Subcommittee to implement these per-service times by inserting additional instructions into the specialty societies instruction document and modifying the summary of recommendation form. These changes will be implemented for the April 2008 RUC Meetings..

III. Specialty Society Request

American Society of Anesthesiologists – Proposed Changes to the Anesthesia Survey Instrument and Anesthesia Summary of Recommendation Form

AMA Staff received a request from the ASA to review proposed revisions to the Anesthesia Survey Instrument to make it consistent with the RUC review of the anesthesia services during the Five-Year Review. The Research Subcommittee received a brief presentation from ASA regarding their proposed changes to the Anesthesia Survey instrument and Anesthesia Summary of Recommendation form. This issue is being presented at this time because it is the intent of the specialty society to survey codes for the April 2008 RUC meeting and the society wishes to make the changes to the Anesthesia Survey Instrument and Anesthesia Summary of Recommendation Form permanent for all future surveys. The Research Subcommittee reviewed these documents during its conference call on January 21st.

ASA modified the current version of the anesthesia survey instrument and added some of the text from the 2nd and 3rd Five-Year Review survey tool so that the survey captures data for all the components used by the Anesthesia Workgroup at its meeting during the April 2007 RUC meeting (pre-anesthesia exam/eval, equipment and supply prep, induction, PIPPA and post-anesthesia). The results are revisions to questions 2 and 3 and the addition of a new question 5.

In addition, several modifications were made to the Anesthesia Summary of Recommendation form. These modifications included changes to several of the tables and the addition of a table to display quintile assignments. These changes to the Anesthesia Summary of Recommendation form correspond to the changes made in the survey instrument. **The Research Subcommittee approved the modifications to the Anesthesia Survey Instrument and the Anesthesia Summary of Recommendation Form as proposed by the specialty society.** These modified documents have been attached to this report for RUC review.

IV. Medicare Medical Home Demonstration Project

AMA Staff received a request from CMS to provide them with the opportunity to discuss the Medicare Medical Home Demonstration Project during the January 21 Research Subcommittee conference call and subsequently during an education session for the full RUC during its meeting

Approved by the RUC on February 3, 2008

on January 31st. The Research Subcommittee at its September 2007 Meeting received an update from CMS regarding this legislation. The following is an excerpt from that meeting:

In the 2006 Tax Relief and Health Care Act, legislation was enacted to establish a Medicare medical home demonstration project. The law requires, "using the relative value scale update committee (RUC) process under such section, the Secretary shall develop a care management fee code for such payments and a value for such code."

ACP has been working with CMS to develop the codes and descriptors for this demonstration project and would like to update the Research Subcommittee on their preparation for the survey process. CMS has announced that they plan to have the descriptors for these codes ready for review at the February 2008 RUC Meeting, the procedures will be evaluated for work at the April 2008 Meeting and the codes will be implemented in January 2009.

Representatives from American College of Physicians, American Academy of Family Physicians, American Academy of Pediatrics, American Geriatrics Society and American Osteopathic Association were invited to participate in this discussion. Jim Coan, Office of Research Development and Information, CMS gave a brief presentation outlining the legislation and the steps that CMS has taken since the legislation was written including that Mathematica has been contracted to develop the design, which must be approved at three levels CMS, HHS, and Office of Management and Budget (OMB). CMS stated that they were required to get input from the RUC due to their expertise in evaluating services. The Research Subcommittee and other participants asked a series of questions regarding project specifics including questions about funding, how a medical home would be defined, how the coding structure would be organized and who would be eligible to participate. CMS also stated that they were still in the process of developing reports detailing the final design and definitions for this project but stated that they would be willing to share these draft reports with the RUC. Further, CMS stated that they have had communications with United Healthcare about a similar program that they have instituted and would be willing to share this information as well with the RUC. Doctor Gerety also stated that she had some background information on Medical Home that she would make available to the RUC.

CMS stated that the time-frame for this project would be to have RUC input by May 1, 2008 so the project could be implemented on January 1, 2009. RUC members on the call expressed concern regarding this time-frame. **The Research Subcommittee recommends that Doctor Rich appoint members of the RUC to a Medicare Medical Home Workgroup to review the information regarding Medicare Medical Home as provided by CMS and RUC participants and determine the input the RUC will be able to deliver to CMS.**

Doctor Rich has appointed the following members to the Medical Home Workgroup:

- David Hitzeman, DO (Chair)
- Thomas Felger, MD
- Representative to AAP (TBD)
- Meghan Gerety, MD
- F. Leonard Lichtenfeld, MD
- Robert Zwolak, MD
- Barbara Levy, MD
- John Wilson, MD
- Joel Brill, MD
- Chester Schmidt, MD
- Charles Koopmann, MD
- William Rich, MD (Ex Officio)
- William Thorworth, MD (Ex Officio)

Approved by the RUC on February 3, 2008

AMA staff indicated that the first item of business will be a letter to CMS seeking a formal written request to the RUC itemizing the specific issues for which CMS would like addressed pertaining to the Medicare Medical Home Demonstration Project.

Approved by the RUC on February 3, 2008

**AMA/Specialty Society RVS Update Committee
Research Subcommittee – Ad Hoc Pre-Time Workgroup
February 1, 2008**

Tab V

In both March and May of 2007, the RUC requested that CMS consider a modification to the definition of physician pre-service time to be consistent with the pre-service definition utilized for the practice expense methodology. The RUC recommended that the physician pre-service period instead begin when the decision for surgery is made, similar to the CMS definition for clinical staff time. Physicians may engage in many of these pre-service activities (eg, review of records, communicating with other professionals) prior to the day before the operative procedure.

However, the RUC operates under the policies and guidelines established for the RBRVS by CMS. In order for the RUC to proceed with this project, CMS must first determine if the agency will revise the pre-service physician time definition. The RUC in its Comment Letter on the *Proposed Rule* to CMS urged CMS to consider including this proposal in the *Final Rule*.

In the *Final Rule* published on November 1, 2007, stated that, “revisions to the definition of pre-service work and time for certain global services... are outside the scope of the issues raised in the CY 2008 PFS proposed rule, we will not respond to these issues in this final rule with comment period.” Therefore, the Research Subcommittee will have to redefine the RUC’s proposed definition of pre-service time given this ruling from CMS.

During its December 11, 2007 conference call, **the Research Subcommittee recommended that given the ruling from CMS via communication to AMA Staff, the time allocated to Subsequent to Decision for Surgery be modified to read: *Day before the Operative Procedure Until the Time of Operative Procedure* to be consistent with the current CMS definition of pre-service time.** However, before this recommendation is implemented the Research Subcommittee will establish a Workgroup to consult with Doctor Barbara Levy, Chair of the Pre-Service Time Workgroup and to review the Pre-Service Time Workgroup’s recommendations at the February 2008 RUC Meeting to ensure they are consistent with this modification.

The Workgroup reviewed the times allocated to the “Day Before the Operative Procedure Until the Time of Operative Procedure” column for each Pre-Service Time Package to ensure that these times would be consistent with CMS’ definition of pre-service time. The Workgroup determined that the “Day Before the Operative Procedure Until the Time of Operative Procedure” times associated with Package 2A, 2B, 3 and 4 needed to be modified by removing 5 minutes from each of these packages. These packages, under the CMS definition, must describe the time spent in updating a history and physical exam as opposed to initiating a history and physical exam, which was the presumption under the RUC recommended definition of pre-service time. Therefore, the Workgroup recommends the following times:

Package	Day Before the Operative Procedure Until the Time of Operative Procedure
Package 1A	5 minutes
Package 1B	5 minutes
Package 2A	10 minutes
Package 2B	10 minutes
Package 3	10 minutes
Package 4	15 minutes

Approved by the RUC on February 3, 2008

It is the intent of this workgroup as well as the Research Subcommittee to implement these per-service time standards by inserting additional instructions into the specialty societies instruction document and modifying the summary of recommendation form as previously recommended by the Research Subcommittee and subsequently the RUC. These changes will be implemented for the April 2008 surveys.

In addition, the Workgroup recommends that the following question be added to the RUC Member Discussion Checklist:

Does the typical patient, procedure and type of anesthesia care provided justify the pre-service package recommended by the specialty society?

Pre-Service Time Workgroup Recommendations

	Day Before the Operative Procedure Until the Time of Operative Procedure	Order, perform and review appropriate pre-tests	Prepare for Procedure (Check labs, plan, assess risks, review procedure)	Communicate with patient and/or family (Discuss procedure/ obtain consent)	Communicate with other professionals	Check.set-up room, supplies and equipment	Dress and scrub for procedure	Check/ prepare patient readiness (Gown, drape, prep, mark)	Perform/ supervise patient positioning	Prepare/ review/ confirm procedure	Administer anesthesia	Observe (wait anesthesia care)	Total Pre-Service Time Minutes		Pre-Service Evaluation Time (IWPOT =0.0224)	Pre-Service Positioning Time (IWPOT = 0.0224)	Pre-Service Scrub, Dress and Wait Time (IWPOT =0.0081)	Total Pre-Service Time Minutes
Facility Setting																		
Package 1A	5	0	2	3	0	1	5	1	1	1	1	0	20		13	1	6	20
Package 1B*	5	0	2	3	1	1	5	1	1	1	5	0	25		19	1	5	25
Package 2A	10	0	2	0	3	1	5	1	1	1	1	0	25		18	1	6	25
Package 2B*	10	0	2	5	3	1	5	1	1	1	10	0	39		33	1	5	39
Package 3	10	0	2	5	5	5	5	5	3	1	0	10	51		33	3	15	51
Package 4	15	0	4	5	5	5	5	5	3	1	0	15	63		40	3	20	63
Non-Facility Setting																		
Package 5	4	0	1	2									7		7	0	0	7
Package 6	8	1	1	3	2	1		1	1		5		23		17	1	5	23

* Indicates packages that contain moderate sedation

- Package 1A Straightforward Patient/Straightforward Procedure (No sedation/anesthesia care)
- Package 1B Straightforward Patient/Straightforward Procedure (With sedation/anesthesia care)
- Package 2A Difficult Patient/Straightforward Procedure (No sedation/anesthesia care)
- Package 2B Difficult Patient/Straightforward Procedure (With sedation/anesthesia care)
- Package 3 Straightforward Patient/Difficult Procedure
- Package 4 Difficult Patient/Difficult Procedure
- Package 5 Procedure without sedation/anesthesia care
- Package 6 Procedure with sedation/anesthesia care

**AMA/Specialty Society RVS Update Committee
MPC Workgroup Report
December 10, 2007 – Via E-Mail**

Members Present: Thomas Felger, MD (Chair), John Derr, Jr, MD, Anthony Hamm, DC, Peter Hollmann, MD, William Moran, MD, David Regan, MD, James Regan, MD, Samuel Smith, MD, Susan Strate, MD, Richard Tuck, MD.

- I. Specialty Society Request – American College of Chest Physicians (ACCP) and American Thoracic Society (ATS) – Request to add 94002 and 94003 to the MPC List.

The RUC's Multi-Specialty Points of Comparison Workgroup received one additional specialty society request to add services to the MPC for the CPT 2009 RUC cycle. Normally, these requests are reviewed at the Workgroup's one scheduled meeting during the September RUC meeting each year. However, in light of the drastic change to the MPC list (removal of B and C codes) at the previous RUC meeting, the Workgroup considered it appropriate to review this request for an MPC addition by the ACCP and ATS.

The MPC Workgroup considered the request to add the following services to the MPC list:

94002, *Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day*, (Work RVU = 1.99).

94003, *Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, each subsequent day*, (Work RVU = 1.37)

Rather than arrange for a separate meeting of the MPC Workgroup, the Workgroup considered the request via email. The Workgroup was notified via email of the ACCP and ATS request on Tuesday, December 4, 2007. Members of the Workgroup were given until Monday, December 10, 2007 to respond with their vote on the recommendation. Based on this electronic meeting, **the Multi-specialty Points of Comparison Workgroup recommends to the RUC the addition of CPT codes 94002 and 94003 to the MPC List.**

Chairman's Report RUC

Jan. 31 – Feb. 3, 2008

Palm Springs, CA





Procedural Issues

Advisors:

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



Procedural Issues

RUC Members:

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

Procedural Issues

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



Procedural Issues

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



Summary of Recommendation Form

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



RUC Meeting

- **Cell phones!!!**



CMS Representatives

- Edith Hambrick, MD – CMS Medical Officer
- Whitney May – Deputy Director, Division of Practitioner Services
- Carolyn Mullen – contractor to CMS on Five-Year Review
- Ken Simon, MD – CMS Medical Officer
- Pam West, DPT, MPH – Health Insurance Specialist

Medicare Contractor Medical Directors

- Charles Haley, MD





Facilitation Committee #1

Epidural Lysis, Tab G

*Intrathecal/Epidural Catheters/Pumps, Tab H and
Neurostimulators, Tab I*

Friday, February 1, 7:00 am – 9:00 am

Lloyd Smith, DPM (Chair)

James Blankenship, MD

Katherine Bradley, PhD, RN

John Gage, MD

David Hitzeman, DO

J. Leonard Lichtenfeld, MD

Alan Plummer, MD

Samuel Smith, MD

Arthur Traugott, MD

John Wilson, MD





Facilitation Committee #2

End Stage Renal Disease Services, Tab 6
Friday, February 1, 7:00 am – 9:00 am

- Geraldine McGinty, MD (Chair)
- James Anthony, MD
- Joel Brill, MD
- Ronald Burd, MD
- Bruce Deitchman, MD
- Thomas Felger, MD
- Emily Hill, PA-C
- Barbara Levy, MD
- Bernard Pfeifer, MD
- William Mangold, Jr, MD



Facilitation Committee #3

Computer Dependent External Fixation, Tab 4
Friday, February 1, 7:00 am – 9:00 am

- Maurits Wiersema, MD (Chair)
- Norman Cohen, MD
- John Derr, MD
- Meghan Gerety, MD
- Peter Hollmann, MD
- Charles Koopmann, MD
- Charles Mick, MD
- Bill Moran, MD
- Erik van Doorne, PT, DPT, COMT

Facilitation Committee #4

- Peter Smith, MD (Chair)
- Michael Bishop, MD
- Manuel Cerqueira, MD
- Robert Gerstle, MD
- Gregory Kwasny, MD
- Alan Lazaroff, MD
- James Regan, MD
- Susan Spires, MD
- Jane White, PhD, RD, FADA



RUC Observers

- Debra Abel – American Speech-Language-Hearing Association
- Margie Andreae – American Academy of Pediatrics
- Linda Ayers – American Academy of Otolaryngology – Head and Neck Surgery
- Edward Bentley – American Society for Gastrointestinal Endoscopy
- Robert Blackburn, MD – American Osteopathic Association
- Eileen Brewer – Renal Physicians Association
- Tiffany Brooks – American Society for Therapeutic Radiology and Oncology



RUC Observers

- Janet Conway – American Academy of Orthopaedic Surgeons
- Thomas Cooper, MD – American Urological Association
- William Creevy, MD – American Academy of Orthopaedic Surgeons
- Jeffrey Dann, MD – American Urological Association
- Meghann Dugan – American Chiropractic Association
- Cristal Edwards – American College of Surgeons
- Steve Falcone – American Society of Neuroradiology
- Robert Fine – American Academy of Orthopaedic Surgeons
- Mark Friedberg – American College of Physicians
- Chris Gallagher – Society of Nuclear Medicine



RUC Observers

- Emily Gardner – American College of Nuclear Physicians
- Richard Gilbert, MD – American Urological Association
- Janis Gregory - American Urological Association
- Richard Hamburger, MD – Renal Physicians Association
- Linda Hiddeman – American Geriatrics Society
- Liz Hoy – American College of Surgeons
- Robin Hudson – American Urological Association
- David Jaimovich, MD – American Academy of Pediatrics
- Gayle Lee – American Physical Therapy Association



RUC Observers

- Richard Marcus – American Academy of Sleep Medicine
- Alex Mason - American Association of Neurological Surgeons
- Louis McIntyre – American Academy of Orthopaedic Surgeons
- Ericka Miller – American College of Physicians
- Lisa Miller-Jones – American College of Surgeons
- Richard Molteni, MD – American Academy of Pediatrics
- Jeremy Musher – American Psychiatric Association



RUC Observers

- Margaret Neal – American Society of Cytopathology
- Nicholas Nickl, MD – American Society for Gastrointestinal Endoscopy
- David Penson, MD – American Urological Association
- Julia Pillsbury, MD – American Academy of Pediatrics
- Kathryn Pontzer – American College of Cardiology
- Debbie Ramsburg – Society of Interventional Radiology
- Paul Rudolf, MD, JD – American Geriatrics Society



RUC Observers

- James Scroggs – American College of Obstetricians and Gynecologists
- Maurine Spillman-Dennis – American College of Radiology
- James Startzell – American Association of Oral and Maxillofacial Surgeons
- Stan Stead, MD – American Society of Anesthesiologists
- Timothy Tillo – American Podiatric Medical Association
- Andrea Trescot, MD – American Society of Anesthesiologists
- Sean Tutton, MD – Society of Interventional Radiology



RUC Observers

- Bruce Wilkoff – American College of Cardiology
- Joanne Willer – American Academy of Orthopaedic Surgeons
- Kadyn Williams – American Audiology Association
- Karin Wittich – American Association of Oral and Maxillofacial Surgeons



Au Revoir

- J. Baldwin Smith, III, MD - American Academy of Neurology



Welcome

- Susan Spires, MD - College of American Pathologists
- James Anthony, MD - American Academy of Neurology

Physician Time Changes From Feb 2008 Meeting							Post Op Information after Feb 08 RUC											Post Op Visit Information Prior to Feb 08 RUC											Change in Post Op Visit Info																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																														
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Physician Time Changes													
CPT Code	Tab	Physician Intra-Service Change?	Change In Clinical Labor Time from Change in Post Op Visits	CMS Staff Type CL .1	CMS Staff Type CL .2	CL Assist Intra Time 1	CL Assist Intra Time 2	CL Assist Phys % Intra .1	CL Assist Phys % Intra .2	Revised Clinical Labor Time 1	Revised Clinical Labor Time 2	Total Change in Clinical Labor Time 1	Change in Clinical Labor Time 2
21025	10	Yes	-44	RN/LPN/MTA		120		100%		90	-	-74	0
23410	12		12									12	0
23412	12		12									12	0
23420	12		-33									-33	0
23415	13		25.5									26	0
25310	15		16.5									17	0
27250	18		-133.5									-134	0
27650	20		48									48	0
28296	23	Yes	39	RN/LPN/MTA		90		100%		60	-	9	0
36820	27		-75									-75	0
42440	31		16.5									17	0
53445	C		27									27	0
54410	C		10									10	0
54530	C		-6									-6	0
57287	C		30									30	0
56620	D		39	RN/LPN/MTA								39	0
62263	G	Yes	39	RN/LPN/MTA	RN	50	45	67%	60%	30	27	19	-18
62350	H		-78									-78	0
62355	H		-51									-51	0
62361	H		-78									-78	0
62362	H		-78									-78	0
63650	I		-42									-42	0
63685	I		-42									-42	0
63688	I		-42									-42	0
64831	K		30									30	0
68810	L	Yes	-47	COMT/COT/RN/CST		15		100%		10	-	-52	0
69930	M		-50									-50	0
57288	O		0									0	0
67225	P	No	0	COMT/COT/RN/CST		3		100%		3	-	0	0
65285	L		-210									-210	0

RUC Physician Time Recommendation from February 2008 RUC Meeting
(Site of Service Anomalies and other CMS Requested Reviewed Services)

CPT Code	Pre-Evaluation	Pre-Postioning	Pre-Dress Scrub Dress	Intra-Service	Immediate Post Service Time	99231	99232	99233	99238	99239	99211	99212	99213	99214	99215	Total Time
21025	60	10	15	90	30	0	0	0	0	0	0	2	2	0	0	283
23410	40	15	15	90	20	0	0	0	0.5	0	0	2	2	0	0	277
23412	40	15	15	100	20	0	0	0	0.5	0	0	2	2	0	0	287
23415	40	15	15	60	20	0	0	0	0.5	0	0	2	2	0	0	247
23420	45	15	15	120	20	0	0	0	0.5	0	0	3	2	0	0	328
25310	40	10	15	60	20	0	0	0	0.5	0	0	3	1	0	0	235
27250	15	5	5	15	13	0	0	0	0	0	0	0	0	0	0	53
27650	19	15	5	60	20	0	0	0	0.5	0	0	2	3	0	0	239
28296	30	5	10	60	15	0	0	0	0.5	0	0	3	2	0	0	233
36820	45	10	15	120	20	0	0	0	1	0	0	1	1	0	0	307
42440	30	10	15	60	20	0	0	0	0.5	0	0	1	1	0	0	193
53445	50	15	20	90	25	0	1	1	1	0	0	1	3	0	0	418
54410	40	10	15	120	30	0	0	0	1	0	0	1	3	0	0	338
54530	57.5	10	15	60	30	0	0	0	0.5	0	0	2	1	0	0	246.5
56620	45	10	5	45	30	0	0	0	0.5	0	0	1	3	0	0	239
57287	40	10	10	60	20	0	0	0	0.5	0	0	1	3	0	0	244
57288	35	15	10	60	20	0	1	0	1	0	0	1	2	0	0	280
62263	33	10	5	45	20	0	0	0	0.5	0	0	1	2	0	0	194
62350	33	10	5	60	20	0	0	0	0.5	0	0	0	1	0	0	170
62355	33	10	5	30	20	0	0	0	0.5	0	0	0	1	0	0	140
62361	33	10	5	60	20	0	0	0	0.5	0	0	0	1	0	0	170
62362	33	10	5	60	20	0	0	0	0.5	0	0	0	1	0	0	170
63650	33	10	5	60	20	0	0	0	0.5	0	0	0	1	0	0	170
63685	33	10	5	60	20	0	0	0	0.5	0	0	0	1	0	0	170
63688	33	10	5	55	20	0	0	0	0.5	0	0	0	1	0	0	165
64831	40	10	15	60	15	0	0	0	0.5	0	0	2	2	0	0	237
65285	37	0	15	79	32	0.5	0	0	1	0	0	0	5.5	0	0	337.5
67225	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	3
68810	10	5	5	10	5	0	0	0	0	0	0	2	0	0	0	67
69930	60	15	20	180	30	0	0	0	0.5	0	0	0	1	1	0	387

Physician Time Recommendations for New and Revised Codes
February 2008 RUC Meeting

CPT Code	RUC Issue	Tracking Code	Pre-Service Evaluation	Pre-Service Positioning	Scrub Dress and Wait	Intra Service Time	Immediate Post Service Time	99231	99232	99238	99212	99213	RUC Recommended Total Physician Time
2699X5	Buttock Fasciotomy	J1	43	12	5	60	30	3	1	1	3	1	359.00
2699X6	Buttock Fasciotomy	J2	43	12	5	90	30	3	1	1	3	1	389.00
9095X1	End Stage Renal Disease Services	K1				274							274.00
9095X2	End Stage Renal Disease Services	K2											Carrier Priced
9095X3	End Stage Renal Disease Services	K3											Carrier Priced
9095X4	End Stage Renal Disease Services	K4				240							240.00
9095X5	End Stage Renal Disease Services	K5				198							198.00
9095X6	End Stage Renal Disease Services	K6				148							148.00
9095X7	End Stage Renal Disease Services	K7				253							253.00
9095X8	End Stage Renal Disease Services	K8				183							183.00
9095X9	End Stage Renal Disease Services	K9				133							133.00
9096X0	End Stage Renal Disease Services	K10				90							90.00
9096X1	End Stage Renal Disease Services	K11				75							75.00
9096X2	End Stage Renal Disease Services	K12				63							63.00
9096X3	End Stage Renal Disease Services	K13				258							258.00
9096X4	End Stage Renal Disease Services	K14				233							233.00
9096X5	End Stage Renal Disease Services	K15				218							218.00
9096X6	End Stage Renal Disease Services	K16				75							75.00
9096X7	End Stage Renal Disease Services	K17				8.60							8.60
9096X8	End Stage Renal Disease Services	K18				7.77							7.77
9096X9	End Stage Renal Disease Services	K19				7.27							7.27
9097X0	End Stage Renal Disease Services	K20				2.50							2.50
993XX1	Neonatal Pediatric Intensive Care	M1	30			105	30						165.00
993XX2	Neonatal Pediatric Intensive Care	M2	20			65	20						105.00