

**AMA/Specialty RVS Update Committee
Meeting Minutes
January 29-31, 2009**

I. Welcome and Call to Order

Doctor William Rich called the meeting to order on Friday, January 30, 2009, at 9:00 am. The following RUC Members were in attendance:

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| William Rich, MD (Chair) | Allan Anderson, MD* |
| Bibb Allen, MD | Dennis M. Beck, MD* |
| Michael D. Bishop, MD | Edward Bentley, MD* |
| James Blankenship, MD | Jonathan Berlin, MD* |
| R. Dale Blasier, MD | Manuel D. Cerqueira, MD* |
| Joel Bradley, MD | Bruce Deitchman, MD* |
| Ronald Burd, MD | James Denny, MD* |
| Thomas Cooper, MD | Verdi DiSesa, MD* |
| Thomas A. Felger, MD | Emily Hill, PA-C* |
| John Gage, MD | Allan Inglis, Jr., MD* |
| David Hitzeman, DO | Walter Larimore, MD* |
| Peter Hollmann, MD | M. Douglas Leahy, MD* |
| Charles F. Koopmann, Jr., MD | William J. Mangold, Jr., MD* |
| Gregory Kwasny, MD | Daniel McQuillen, MD* |
| Brenda Lewis, DO | Terry L. Mills, MD* |
| J. Leonard Lichtenfled, MD | Scott D. Oates, MD* |
| Barbara Levy, MD | Julia Pillsbury, MD* |
| Lawrence Martinelli, MD | Sandra B. Reed, MD* |
| Bill Moran, Jr., MD | Chad Rubin, MD* |
| Marc Raphaelson, MD | Steven Schlossberg, MD* |
| Gregory Przybylski, MD | Holly Stanley, MD* |
| Daniel Mark Siegel, MD | Stanley Stead, MD* |
| Lloyd Smith, DPM | Robert Stomel, DO* |
| Peter Smith, MD | J. Allan Tucker, MD* |
| Samuel Smith, MD | George Williams, MD* |
| Susan Spires, MD | |
| Arthur Traugott, MD | *Alternate |
| James Waldorf, MD | |

II. Chair's Report

Doctor Rich made the following general announcements:

- Financial Disclosure Statements for each 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.
- All RUC Advisors are required to sign the attestation statement and submit it with their recommendations to be incorporated into the agenda book.
- 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
- Doctor Rich welcomed the following Medicare Contractor Medical Director:
 - Charles Haley, MD
- Doctor Rich announced the members of the Facilitation Committees:

| <u>Facilitation Committee 1</u> | <u>Facilitation Committee 2</u> | <u>Facilitation Committee 3</u> |
|---------------------------------|----------------------------------|--------------------------------------|
| Bibb Allen, MD (Chairman) | Gregory Kwasny, MD (Chairman) | Katherine Bradley, PhD (Chairman) |
| Joel Bradley, Jr., MD | Michael Bishop, MD | Edward Bentley, MD |
| Ron Burd, MD | James Blankenship, MD | John Gage, MD |
| Thomas Cooper, MD | Dale Blasier, MD | David Hitzeman, DO |
| Emily Hill, PA-C | Thomas Felger, MD | Charles Koopmann, MD |
| Peter Hollmann, MD | Barbara Levy, MD | Brenda Lewis, MD |
| J. Leonard Lichtenfeld, MD | William Mangold, Jr, MD | Lawrence Martinelli, MD |
| Charles Mick, MD | Marc Raphaelson, MD | Bill Moran, MD |
| Gregory Przybylski, MD | Lloyd Smith, DPM | Daniel Mark Siegel, MD |
| Peter Smith, MD | Susan Spires, MD | Arthur Traugott, MD |
| Samuel Smith, MD | James Waldorf, MD | Robert Zwolak, MD |

- Doctor Rich welcomed the following individuals as observers at the January 2009 meeting:
 - Debra Abel – American Academy of Audiology
 - Margie Andreae – American Academy of Pediatrics
 - Brett Baker – American College of Physicians
 - Robert Barr – American Society of Neuroradiology
 - Michael Bigby – American Academy of Dermatology
 - Eileen Brewer, MD – Renal Physicians Association
 - Neil Busis – American Academy of Neurology
 - Scott Collins – American Academy of Dermatology
 - Allan Desmond – American Speech Language Hearing Association
 - Edward Eikman – Society of Nuclear Medicine
 - Jennifer Frazier - American Society for Therapeutic Radiology and Oncology
 - Emily Gardner – American College of Cardiology
 - Denise Garris – American College of Cardiology
 - Richard Gilbert, MD – American Urological Association
 - John Goodson – American College of Physicians
 - Robert Hall – American Association of Hip and Knee Surgeons

- David Han – Society for Vascular Surgery
 - Zachary Hochstetler – Society of Nuclear Medicine
 - Robert Jasak – American Academy of Orthopaedic Surgeons
 - Robert Jones – American College of Cardiology
 - Kendall Kodey – American College of Cardiology
 - Carrie Kovar – American College of Cardiology
 - Katie Kuechemneister – American Academy of Neurology
 - Alex Little, MD – Society of Thoracic Surgeons
 - Kenneth McKusick, MD – Society of Nuclear Medicine
 - Erika Miller – American College of Physicians
 - Lisa Miller-Jones – American College of Surgeons
 - Dewan Naakesh – American Psychiatric Association
 - Gerald Neidzwiecki, MD – Society of Interventional Radiology
 - Dee Nikjeh – American Speech Language Hearing Association
 - Vinita Ollapally – American College of Surgeons
 - Debbie Ramsburg – Society of Interventional Radiology
 - John Ratliff, MD – American Association of Neurological Surgeons
 - David Regan, MD – American Society of Clinical Oncology
 - Paul Rudolf, MD, JD – American Geriatrics Society
 - Matthew Sideman, MD – Society for Vascular Surgery
 - Ezequiel Silva, MD – Society of Interventional Radiology
 - Maurine Spillman-Dennis – American College of Radiology
 - James Startzell, MD – American Association of Oral and Maxillofacial Surgeons
 - Michael Sutherland – Society for Vascular Surgery
 - Tim Tillo – American Podiatric Medical Association
 - William van Decker – American College of Cardiology
 - Edward Vates, MD – American Association of Neurological Surgeons
 - Allison Waxler – North American Spine Society
 - Duane Whitaker, MD – American Academy of Dermatology
 - Joanne Willer – American Academy of Orthopaedic Surgery
 - Kady Williams – American Academy of Audiology
 - Pamela Woodard – American College of Radiology
 - Jennifer Young – American Association of Clinical Endocrinologists
- Doctor Rich and the entire RUC thanked Doctor Thomas Felger for years of service and noted that this is the last meeting for which he will serve on the RUC. Doctor Rich also announced the departure of Doctor James Anthony to whom Doctor Rich wrote a letter thanking him for his service.

III. Director's Report

Sherry Smith made the following announcements:

- Future RUC meeting locations have been confirmed as follows:
 - April 23-26, 2009, RUC Meeting, Swissotel, Chicago, IL
 - October 1-4, 2009, RUC Meeting, Hyatt Regency, Chicago, IL
 - February 4-7, 2010 RUC Meeting, Hilton Bonnet Creek, Orlando, FL

IV. Approval of Minutes for the October 2-5, 2008 RUC Meeting

The RUC approved the minutes without revision.

V. CPT Editorial Panel Update

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

- The CPT Editorial Panel will be holding its next meeting in Phoenix, AZ February 5-8, 2009. The Panel will be addressing several issues first raised by the RUC's Five Year Review Identification Workgroup.
- Doctor Hollmann reported that the CPT Editorial Panel has begun preliminary discussions to assess the feasibility of creating an on-going process to improve the data for each service. Rather than address services only during one of the three Panel meetings per cycle, the proposed process would allow Panel members to approve editorial revisions and other minor changes outside of Panel meetings. Such a process would help to facilitate editorial changes as well as improve and add clinical vignettes where they are lacking.

VI. Centers for Medicare and Medicaid Services Update

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

- Doctor Simon reported that all political employees of the Agency have departed. CMS is awaiting appointment of the Secretary of Health and Human Services as well as the CMS Administrator.

VII. Carrier Medical Director Update

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

- Doctor Haley reported that MAC contracts have been announced for the remaining five contracts on January 7, 2009. The losing bidders have opportunity to protest the awards, therefore the final contractors not yet finalized. The protest period will postpone the final awards for approximately two to three months.
- Doctor Haley also made several comments regarding the inpatient and outpatient issues recently discussed at the RUC meeting. Doctor Haley noted that the place of service field within the RUC database reflects the site of service as indicated on the physician bill. In Medicare Part B, place of service has no real impact on physician work reimbursement or the facility reimbursement. However, in the Part A setting, the difference between inpatient and outpatient status is significant. A change in status incurs different liabilities and rights for the patients as well as the hospitals. By Medicare rules, the decision to admit is determined by the physician order. A hospital review committee can change from inpatient to outpatient based on whatever criteria they establish. Such a change, changes the claim from a Part A to a Part B payment. Hospitals are supposed to submit the changed claim with a "condition code 44," which notifies CMS that the status has changed. Additionally, the hospital is required to notify a physician of the change. The physician need not be the admitting physician.

VIII. Washington Update

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

- Ms. McIlrath reported that Tom Daschle has been nominated to serve as the Secretary for Health and Human Services. It is still too soon to predict the next administrator of CMS.
Staff Note: Tom Daschle subsequently withdrew from consideration. Kathleen Sebelius is the current nominee.
- The AMA has met with Mr. Daschle, in addition to the entire Obama transition team and the new administration's CMS transition team. Thus far, the new administration has listened to the AMA's requests and has shown a willingness to cooperate.
- The new administration has already begun to act on some of its healthcare initiatives as evidence by the recent SCHIP reauthorization bill and the economic stimulus bill. The SCHIP bill reauthorizes SCHIP spending for five years and increases funding by \$35 billion. The increase is paid for by increases in tobacco tax. The bill also prohibits SCHIP payment to physician owned hospitals that do not have a Medicare ID number. The AMA does not support this provision.
- The House has recently passed the Economic Recovery and Financial Stability Act. The bill includes \$150 billion in healthcare spending. The bill includes provisions to help extend and subsidize COBRA insurance as well provide new money for wellness, prevention, flu pandemic, and primary care services. The bill identifies health information technology as a focus of the new administration, providing \$20 billion in spending to help transition to HIT. The bill provides for a five-year period, in which physicians could receive significant monetary incentives to transition to HIT. At the end of five years, those who are not using HIT will have a 1% penalty on Medicare and Medicaid reimbursement. Despite concerns about the punitive incentives and about the use of a PQRI-based format for demonstrating meaningful use of the HIT, the AMA is supporting the bill's HIT provisions because it provides significant funding to support the transition to HIT.
- With the current economic climate, discussion of healthcare reform has increased. The AMA has remained highly active in these discussions and has insisted that the replacing the SGR is of paramount importance. The AMA has been active with legislators and is working to reach a consensus with other interest groups. Early indications point to a large scale reformation of physician payment reform in 2010. The AMA anticipates another fix late this calendar year to forego the impending 21% cut in physician payment. The current administration and Congress understand that the cost of stop gap fixes has become extremely high. According to the Congressional Budget Office, replacing the SGR will cost \$439 billion and freezing the SGR for 10 years will cost \$318 billion.
- Some lawmakers and the AMA are pushing for a "re-basing" of the Medicare physician payment system. This would eliminate the accumulated cost of all the previous unfunded SGR fixes, wiping out a 21% cut in 2010 and projected cuts of 40% or more over the next several years.
- Lastly, the Acute Care Episode Demonstration project, which combines payment for hospitals and physicians, has awarded demonstration sites. This project will include major cardiac procedures and knee / hip replacement only.

IX. Relative Value Recommendations for CPT 2010

Subcutaneous Excision of Soft Tissue Tumor (Tab 4), Subfascial Excision of Soft Tissue Tumor (Tab 5), Radical Excision of Soft Tissue Tumor (Tab 6), New Excision of Soft Tissue Tumor (Tab 7)

Jane Dillon, MD, American Academy of Otolaryngology – Head and Neck Surgery, Christopher Senkowski, MD, American College of Surgeons, Martha Matthews, MD, American Society of Plastic Surgeons, Dan Nagle, MD, American Society for Surgery of the Hand, William Creevy, MD, American Academy Orthopaedic Surgeons, Tye Ouzonian, MD, American Orthopaedic Foot and Ankle Society, Daniel Nagle, MD, American Society for Surgery of the Hand, Frank Spinosa, DPM, American Podiatric Medical Association

Background:

The American Academy of Orthopaedic Surgery (AAOS) and the Musculoskeletal Tumor Society (MSTS) responded to the Centers for Medicare and Medicaid Services' (CMS) Five-Year Review request for comment on misvalued codes in 1995, arguing that the Hsaio survey had misvalued these services. During the course of this first Five-Year Review process, it became evident that coding changes would be necessary prior to revaluing these services. From 1995-2005, MSTS and AAOS drafted CPT proposals to address issues within the soft tissue tumor excision family and bone tumor family codes but these proposals were rejected by the CPT advisors and/or the CPT Editorial Panel. For the 2005 Five-Year Review, MSTS and AAOS submitted 14 soft tissue tumor codes and 12 bone tumor codes which were ultimately referred again to the CPT Editorial Panel for clarification and creation of new codes to differentiate the codes based on the size and depth of the tumor. In February 2009, the CPT Editorial Panel approved the coding proposal submitted by the Soft Tissue Tumor and Bone Workgroup which revised and expanded the soft tissue tumor and bone tumor sections to more accurately describe the services being provided and address the concerns raised by the RUC during the Third Five-Year Review.

Subcutaneous Excision of Soft Tissue Tumor Codes

There are currently 10 CPT codes that describe subcutaneous excision of soft tissue tumors. For CPT 2010, these 10 codes have been split into 20 codes differentiated by the size of the excised lesion. These codes were never part of a Five-Year Review Process, however, the societies agreed that these codes needed to be consistent with the new coding convention of the subfascial and radical soft tumor excision codes. Between 75-150 general surgeons, otolaryngologists, orthopaedic surgeons, general and orthopaedic surgical oncologists, hand surgeons, plastic surgeons, foot and ankle orthopaedic surgeons, and podiatrists participated in the some or all of the surveys. All of the specialty societies met several times by conference call to discuss the survey statistics. During this review, the societies indicated that they discussed the survey results noting similarities and differences in type of anesthesia positioning, intra-operative time and follow-up care. Several of the codes had exactly the same components which resulted in a recommendation for the same RVU. The specialty societies also indicated that the recommended work RVUs for these codes were correctly ranked. In addition to this analysis, the specialty societies noted that because these codes were never part of a Five-Year Review Process, they recommended and the RUC agreed that the recommendations for this family of codes should be work neutral. To account for this decision, the specialty societies reduced their recommendations by 2.88%.

Subfascial Excision of Soft Tissue Tumor Codes

There are currently 10 CPT codes that describe subfascial excision of soft tissue tumors. For CPT 2010, these 10 codes have been split into 20 codes differentiated by size of excised lesion. Nine of

these 10 original codes were part of one or more Five-Year Review Processes. The single code not originally identified has very low volume. The RUC sympathized with the argument that there should be work valuation changes but requested that codes first be reviewed by the CPT Editorial Panel. Between 75-150 general surgeons, orthopaedic surgeons, general and orthopaedic surgical oncologists, foot and ankle surgeons, podiatrists, otolaryngologists, hand surgeons and plastic surgeons participated in some or all of the surveys. All of the specialty societies met several times by conference call to discuss the survey statistics. During this review, the societies indicated that they discussed the survey results noting similarities and differences in type of anesthesia positioning, intra-operative time and follow-up care. Several of the codes had exactly the same components which resulted in a recommendation for the same RVU. The specialty societies also indicated that the recommended work RVUs for these codes were correctly ranked. In addition to this analysis, the societies noted that 18 of the 20 codes were part of a previous Five-Year Review. The societies presented significant compelling evidence as to why these recommendations should not be work neutral. This compelling evidence includes: 1.) Evidence that incorrect assumptions were made in the previous valuation of the service because the Harvard review of these codes did not survey all of the specialties, especially the primary providers, who currently perform these services; and 2.) evidence that technology has changed the physician work because over the past 10 years significant advances have been made which allow for greater imaging and thus more precise understanding of anatomic location and extent of tissue involvement. Based on this compelling evidence and so not to create rank order anomalies, the RUC agreed that the recommendations for the subfascial excision of soft tissue tumor codes did not have to be work neutral. The RUC reviewed the site of service for this family of codes and agreed with the specialty societies data which supported an overnight hospital stay for seven of the large subfascial codes and three of the small subfascial codes. However, to ensure proper rank order across all of the soft tissue tumor codes, the small subfascial excision of soft tissue tumor codes were reduced by 2.88%. Additionally, the RUC recommended significant decreases to the specialty societies' recommendations for the large subfascial tissue tumor codes to ensure proper rank order with the small subfascial excision services, as a primary difference between the small and large subfascial tumor codes was the difference in the intra-service time. The RUC agrees that this adjustment to the large subfascial tissue tumor codes accounts for the 2.88% reduction and maintains the appropriate relativity to the rest of the tumor excision codes.

Radical Excision of Soft Tissue Tumor Codes

There are currently 11 codes that describe radical excision of soft tissue tumors. For CPT 2010, these 11 codes have been split into 22 codes differentiated by size of excised lesion. Six of these 11 codes were part of one or more Five-Year Review Processes. The RUC sympathized with the argument that there should be work valuation changes but requested that codes first be reviewed by the CPT Editorial Panel. The other five codes have very low volume and are either not performed or rarely performed by orthopaedic surgeons and thus were not included in their comment letters to CMS during the Five-Year Reviews. Between 100-120 general surgeons, otolaryngologists, plastic surgeons, orthopaedic surgeons, orthopaedic and surgical oncologists participated in some or all of the surveys. All of the specialty societies met several times by conference call to discuss the survey statistics. During this review, the societies indicated that they discussed the survey results noting similarities and differences in type of anesthesia positioning, intra-operative time and follow-up care. Several of the codes had exactly the same components which resulted in a recommendation for the same RVU. The specialty societies also indicated that the recommended work RVUs for these codes were correctly ranked. Further, the societies presented and the RUC agreed that there is significant compelling evidence as to why these recommendations should not be work neutral. This compelling evidence includes: 1.) Evidence that incorrect assumptions were made in the previous valuation of the service because the Harvard review of these codes did not survey all of the specialties who currently perform these services and 2.) Evidence that technology has changed the

physician work because over the past 10 years significant advances have been made which allow for greater imaging and thus more precise understanding of anatomic location and extent of tissue involvement. Further, for malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This advancement has allowed for increased ability to kill tumors in situ at a higher level. These tumors are typically asymptomatic and therefore attain large size before being excised. Resecting these lesions with a wide margin in adjacent tissues routinely requires meticulous dissection around major nerves and blood vessels. Based on this compelling evidence and so not to create rank order anomalies, the RUC agreed that the recommendations for the radical excision of soft tissue tumor codes did not have to be work neutral. However, to ensure proper rank order across all of the soft tissue tumor codes, the radical excision of soft tissue tumor codes were reduced by 2.88%.

New Codes for Excision of Soft Tissue Tumor Codes

In addition to these revisions to the existing code set, the CPT Editorial Panel created 4 new subcutaneous, 4 new subfascial and 2 new radical excision codes. These codes were created to fill in anatomic gaps in the coding convention for excision of soft tissue tumors. The specialty societies noted that CPT Assistant indicated excision of subcutaneous soft tissue tumors may be reported with benign or malignant lesion codes which have a 10 day global period or an unlisted services code. The specialty societies also noted that excision of deep subfascial tumors or radical soft tissue excision procedures would currently be reported with the unlisted code. However, to ensure proper rank order across all of the soft tissue tumor codes, these new excision of soft tissue tumor codes were reduced by 2.88%. In addition to this reduction, the RUC determined that further reductions should be made to two of the four new subfascial codes to keep in rank order with the recommendations from the other subfascial codes.

Frequency and Impact

The specialties had difficulty in estimating the frequency split for current codes and frequency estimates for new codes but made a best faith effort. The specialties stated that they made several assumptions given the fact that this section has been completely revised including new guidelines and instructions. The RUC appreciated the difficulty of this task and agreed with the specialties recommended utilization. **However, the RUC recommended that these services should be re-reviewed to determine the accuracy of these utilization assumption in three years at the September 2012 RUC meeting to allow for time to obtain two years of frequency data from Medicare (2010 and 2011).** The overall increased work impact of the RUC recommendations for these services, given the society recommended utilization assumptions, is minor.

Repairs Resulting from Excisions

The RUC discussed the issue of separately reporting complex wound repair when performing an excision of a tumor, as the current introductory language states including simple or intermediate repair is included. The representatives from American Academy of Orthopaedic Surgeons (AAOS) stated that they have a coding program called *Code X* and it instructs its users about the intra-operative services included in the global service package for specific codes and lists the CCI edits associated with these codes as well. When reviewing how these procedures were originally reported, *Code X* says that either there are currently CCI edits in place which do not allow closure of wound and repair of tissues provided for surgical exposure -12001 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less*, which is the first code for a simple repair through 13153 *Repair, complex, eyelids, nose, ears and/or lips; each additional 5 cm or less (List separately in addition to code for primary procedure)*, which is the last code for a complex repair to be billed separately and/or instructs the user that CPT codes 12001-13153 are included in the global service package when performing these procedures. Therefore, the AAOS states and the RUC agrees that simple,

intermediate and even complex wound closures by these instructions and the CCI edits are considered to be an integral part of the operation for resecting the tumor and are not to be reported separately. The RUC recommends that the introductory language for these codes be modified to reflect this coding convention.

Staff Note: At the February 2009 RUC Meeting, during the presentation of the Excision of Soft Tissue Tumors, a RUC member posed a question to the sponsoring specialty societies regarding complex closures. The following is a transcript of that discussion:

36:57

Siegel: Vignettes state that medial or lateral flaps are made but the intro language states that simple or intermediate repair is included. Is the assumption that a separate flap, a 14000 procedure is being billed for the repair on these

Presenter(Heiner): No, when I wrote the vignettes I had no idea that people would think that it was a separate thing, you know b/c I tried to make it fairly simple there shouldn't be any additional... it should be a simple opening. So, there shouldn't be any complex closure associated with any of these.

Siegel So, can we make an editorial change that states that the repair for the most part is usually included b/ I see this as a loop hole for separate repairs being built with these

Presenter: That is totally a reasonable suggestion

45:12

Hollmann: On the repairs, the codes all have in the introduction, simple and intermediate repairs are inclusive in the procedures so one would expect that there would be CCI edits probably on that anyway. You were only referring to those types of repairs not complex repairs or any reconstructive things?

Siegel: My concern is that the descriptors it seems that one could do complex repairs or flaps or a variety of creative repairs and the reality is that the subcutaneous tumors one cuts down to the lesion, dissects....as Bill and I both know... you cut out.. you don't have very much of a defect there, its not a very difficult or complex repair at all but the phraseology sets it up that someone would see this vignette and argue that you have created a flap and you can see someone worrying that someone would game the system and essentially taking up more RVUs unnecessarily in a way that would not be appropriate...just trying to stop that before it happens

Hollmann: I wouldn't anticipate CPT putting in language that complex repairs or flap repairs etc, are not allowed to be coded, b/c generally speaking CPT does not get into medical necessity or gaming. We specifically made a point that intermediate and simple repairs are included in all of these things but other things were separately reportable, so I think if there is something very unique about a specific site where one would never clinically see it happening and you want

language..that is something I would need to know because this is not covered in the current language and was not discussed by the Workgroup or CPT.

Siegel: Essentially when you are taking out a subcutaneous lesion, the lesion has acted as a tissue expander, so you have loose skin to work with there..so your repair is often easier than after you had excised skin and it is often a much simpler repair. So something along the lines as repair is not payable separately for this procedure.

49:40

Presenter: Speaking to separately reporting the complex wound closure at the time of excision of the lesion. The Academy has a coding program called *Code X* and it lists the procedures which it considers to be integral to the procedure and which can be reported separately. If you look at the historical code for this, picking the hand one, the excision of a subcutaneous lesion, it says closure of wound and repair of tissues provided for surgical exposure -12001, which is the first code for a simple repair and it goes all the way up to 13153 which is the last code for a complex repair, so it is the Academy's position that even a complex wound closure by its definition in CPT is considered to be an integral part of the operation for resecting the tumor and is not to be reported separately.

Upon further review of the AAOS product, AMA staff learned that *Code X* instructs its users about the intra-operative services included in the global service package for specific codes and lists the CCI edits associated with these codes as well. When reviewing how these procedures were originally reported, *Code X* states that either there are currently CCI edits in place which do not allow closure of wound and repair of tissues provided for surgical exposure -12001 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less*, which is the first code for a simple repair through 13153 *Repair, complex, eyelids, nose, ears and/or lips; each additional 5 cm or less (List separately in addition to code for primary procedure)*, which is the last code for a complex repair to be billed separately and/or instructs the user that CPT codes 12001-13153 are included in the global service package when performing these procedures.

Therefore, based on the information given by the presenters, the RUC recommended that the introductory language for the soft tissue tumor and bone codes include language that simple, intermediate and complex wound repair are considered to be an integral part of the operation for resecting the tumor and are not to be reported separately.

CPT/RUC Discussion Following February 2009 RUC Meeting:

This recommendation was brought to the CPT Executive Committee during their February 2009 Meeting. The CPT Executive Committee agreed with the RUC recommendations, however, when the issue was discussed at the CPT Editorial Panel Meeting, several concerns were raised by the specialties. The Panel requested that this recommendation be referred to the specialties who sponsored this coding change to gain their input and this input would be reported back to the CPT Executive Committee. These specialties agreed that complex repair should be reported separately for the soft tissue and bone tumor codes and thus disagree with the RUC and the presenter's recommendation. Further, the specialties, in their review of the

minutes, requested that the Repairs Resulting from Excision paragraph listed above be removed.

In response to this request selected members of the soft tissue workgroup who had responded to a ballot as requested by the CPT Panel and the Panel representative to the RUC met by teleconference. Panel member Bradford Henley MD indicated that AAOS has undertaken a project to review Code X guidance. AAOS has removed complex repairs from procedures as AAOS indicated complex repairs are generally separately reportable, whether or not CCI edits may exist. The conferees agreed that the intent of the original submission was to allow complex repairs and that as a general rule for procedures, complex repairs, but not simple or intermediate repairs, are separately reported when performed in conjunction with excisions and incisions. The group felt that the point of concern was a potential failure to distinguish between elevating skin flaps to access the tumor (not a complex repair) and extensive undermining required to primarily close a defect after the excision of significant skin. Additionally, it was felt that complex repair would be very infrequent (never typical) and when required may involve a different surgeon in a significant proportion of times. The conferees recommend that the RUC rescind the request for the additional restrictions of reporting of codes 13100-13153 and that CPT insert clarifying introductory language.

Based on this recommendation, AMA Staff proposes the following paragraph to replace the current “Repairs Resulting from Excisions” paragraph:

Repairs Resulting from Excisions

The RUC discussed the issue of separately reporting complex wound repair when performing an excision of a tumor, as the current introductory language states including simple or intermediate repair is included. RUC members expressed concern about complex repair being reported separately with these procedures. After much deliberation, it was determined that these services would rarely require complex repair as defined in CPT codes 13100-13153. However, to alleviate the concern, the CPT Editorial Panel has been requested to add introductory language to this section of codes clarifying the components of complex repair and when it should be reported separately.

The RUC approved this proposal as submitted by AMA Staff and recommends that this aforementioned language be added to the recommendation for these codes.

Practice Expense

The RUC extensively discussed of the clinical labor time associated with the services performed in the non-facility setting and reduced the clinical labor time for several services. In addition, the RUC carefully scrutinized the supplies and equipment and made adjustments to reflect treatment to the typical patient. The practice expense inputs recommended by the specialty in the facility setting were also reviewed and modified. The RUC recommends the attached direct practice expense inputs.

The individual recommendations for this issue have been attached to these minutes.

Bone Tumor (Tab 8)

John Heiner, MD and William Creevy, MD, American Academy Orthopaedic Surgeons, Tye Ouzounian, MD, American Orthopaedic Foot and Ankle Society, and

**Daniel Nagle, MD, American Society for Surgery of the Hand, Frank Spinosa, DPM,
American Podiatric Medical Association**

The American Academy of Orthopaedic Surgery (AAOS) and the Musculoskeletal Tumor Society (MSTS) responded to the Centers for Medicare and Medicaid Services' (CMS) Five-Year Review request for comment on misvalued codes in 1995, arguing that the Hsaio survey had misvalued these services. During the course of this first Five-Year Review process, it became evident that coding changes would be necessary prior to revaluing these services. From 1995-2005, MSTS and AAOS drafted CPT proposals to address issues within the soft tissue tumor excision family and bone tumor family codes but these proposals were rejected by the CPT advisors and/or the CPT Editorial Panel. For the 2005 Five-Year Review, MSTS and AAOS submitted 14 soft tissue tumor codes and 12 bone tumor codes which were ultimately referred again to the CPT Editorial Panel for clarification and creation of new codes to differentiate the codes based on the size and depth of the tumor. In February 2009, the CPT Editorial Panel approved the coding proposal submitted by the Soft Tissue Tumor and Bone Workgroup which revised and expanded the soft tissue tumor and bone tumor sections to more accurately describe the services being provided and address the concerns raised by the RUC during the Third Five-Year Review.

There are currently 20 codes that describe bone tumor codes. All of these codes were part of the one or more Five-Year Review processes. Between 60-100 musculoskeletal orthopaedic surgeons and orthopaedic surgeons, hand surgeons, podiatrists and foot and ankle surgeons participated in all or some of the surveys. After the results of these providers were tabulated, the associated specialty societies met to discuss the data. The societies presented and the RUC agreed that there is significant compelling evidence as to why these recommendations should not be work neutral. This compelling evidence is that there is evidence that technology has changed the physician work as over the past 10 years significant advances have been made which allow for greater imaging and thus more precise understanding of anatomic location and extent of tissue involvement. Further, for malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This advancement has allowed for increased ability to eradicate tumors in situ at a higher level. While 20 years ago amputation was used most commonly to treat these patients, limb preservation resections have now become the standard treatment of care as currently less than 5% of patients with pelvic and extremity sarcomas receiving amputations. The specialty society argued and the RUC agrees that the work associated with soft tissue resection procedures has increased dramatically as these procedures are now more technically demanding, prolonged and involve additional risk.

Pelvis

The RUC reviewed the specialty societies' survey results for the eight pelvis radical resection of tumor codes. The specialty societies indicated and the RUC agreed that 10 years ago patients would undergo total leg amputation in cases of bone sarcomas of the pelvis, whereas now limb salvage is an option. The typical pelvis radical resection of tumor patient is usually in the hospital for 7-10 days.

27077

The RUC reviewed the pelvis anchor codes starting with the largest, most complex procedure of this family, code 27077 *Radical resection of tumor; innominate bone, total*. The RUC reviewed the pre-service time and agreed with the specialty society that pre-time package 4 – Difficult Patient/Difficult Procedure was appropriate as the physician must conduct an additional extensive review of the pathology studies, coordination with radiation therapy, etc. The RUC determined that an additional 17 minutes of pre-positioning time is required to place the patient in the lateral

position after anesthesia is administered. The RUC compared 27077 to key reference service 20956 *Bone graft with microvascular anastomosis; iliac crest* (work RVU = 40.93, intraservice time 400 minutes) and determined that the survey median physician time of 400 minutes and work RVU of 45.00 appropriately accounted for the physician time and work required to perform this service and placed this service in the proper rank order. The RUC noted that the survey respondents indicated that 27077 was much more intense than 20956. The RUC further supported a work RVU of 45.00 for 27077 by comparing it to similar service, 20973 *Free osteocutaneous flap with microvascular anastomosis; great toe with web space* (work RVU = 46.95).

The specialty society indicated and the RUC agreed that four 99231 and four 99232 hospital visits are typical as patients are usually in the hospital for 7-10 days and since limb salvage is possible the patient will need that time to recover in the hospital. The specialty society also indicated and the RUC agreed that one higher level office visit, 99214, was appropriate as the physician will perform an extensive consultation, review of pathology margins, contact 2-3 consulting physicians, oncologists or radiation oncologists and the visit will last one hour to 1.5 hours. Patients typically have sarcomas and aggressive cancer and a 99214 allows for extensive treatment plans. Additionally the RUC determined that 2-99213 office visits are appropriate because typically these extremity related events require significant physical therapy, joint stability examination and range of motion checks. **The RUC recommends the survey median work RVU of 45.00 for code 27077.**

27076

The RUC reviewed code 27076 *Radical resection of tumor; ilium, including acetabulum, both pubic rami, or ischium and acetabulum* and agreed with the specialty societies that there has been a long standing rank order anomaly between codes 27076 and 27077 (approximately 22.00 difference in RVUs). The RUC reviewed the pre-time and agreed with the specialty society that pre-time package 4 – Difficult Patient/Difficult Procedure was appropriate as the physician must conduct an additional extensive review of the pathology studies, coordination with radiation therapy, etc. The RUC determined that an additional 17 minutes of pre-positioning time is required to place the patient in the lateral position after anesthesia is administered. The RUC determined that 27076 required slightly less physician intra-service time than 27077 (360 versus 400, respectively). However, 27076 is slightly more intense than 27077 because of the location and size of large the tumors typically surrounding the areas of the pelvis being removed in this procedure. The RUC compared code 27076 to 27077 and key reference service 20956 *Bone graft with microvascular anastomosis; iliac crest* (work RVU = 40.93, intraservice time 400 minutes). The RUC noted that they survey respondents indicated that 27076 is more intense and complex than 20956. Even though the intra-service time is longer for reference service 20956, more mental effort, technical skill and psychological stress is exerted or occurs when performing 27076. The RUC determined that the survey median physician time of 360 minutes and work RVU of 40.00 appropriately accounted for the physician time and work required to perform this service and placed this service in the proper rank order. The RUC agreed with the specialty society and recommends one less 99231 hospital visit for 27076 than 27077. **The RUC recommends the survey median work RVU of 40.00 for 27076.**

27075

The RUC reviewed code 27075 *Radical resection of tumor; wing of ilium, one pubic or ischial ramus or symphysis pubis* and determined that the physician time and work required will be significantly less than 27076 and 27077 as this procedure is the removal of one portion of the pelvis. Additionally, 27075 requires fewer hospital visits (2-99231 and 3-99232 visits) than 27076 and 27077. The RUC reviewed the pre-time and agreed with the specialty society that pre-time package 4 – Difficult Patient/Difficult Procedure was appropriate as the physician must

conduct an additional extensive review of the pathology studies, coordination with radiation therapy, etc. No additional positioning time is required as the typically the patient is in the supine position for this procedure. The RUC compared code 27075 to key reference service 27134 *Revision of total hip arthroplasty; both components, with or without autograft or allograft* (work RVU = 30.13, intra-service time = 240 minutes) and determined that the physician time required to perform 27075 is slightly more than 270134. The survey respondents also responded that 27075 is more intense and complex than 27134. The RUC determined that a work RVU of 32.50 for 27075 appropriately places this service in the proper rank order within this family of services. **The RUC recommends the survey median work RVU of 32.50 for 27075.**

27078

The RUC reviewed 27078 *Radical resection of tumor; ischial tuberosity and greater trochanter of femur* and determined that the physician time, work and intensity required is similar to 27075. The RUC reviewed the pre-time and agreed with the specialty society that pre-time package 4 – Difficult Patient/Difficult Procedure was appropriate, as the physician must conduct an additional extensive review of the pathology studies, coordinate with radiation therapy, etc. The RUC determined that an additional 17 minutes of pre-positioning time is required to place the patient in the prone position after anesthesia is administered. The RUC compared code 27078 to 27075 and to key reference service 27134 *Revision of total hip arthroplasty; both components, with or without autograft or allograft* (work RVU = 30.13, intra-service time = 240 minutes) and determined that the physician intra-service time required to perform these services is the same and the physician work and intensity required is similar. Additionally, 27078 requires the same number of hospital and office visits as 27075. **The RUC recommends the survey median work RVU of 32.00 for 27078.**

Upper Limb

The RUC reviewed the upper limb radical resection of tumor codes. The specialty societies indicated that most patients receiving these procedures have had pre-operative chemotherapy and are catabolic and may have sarcomas pressing on the aortic arch and subclavian. The physician must carefully identify the soft tissue mass as not to damage surrounding viable tissue. Thus, the closer the tumor is to the shoulder the more complex the procedure. The specialty societies indicated that one 99214 office visit is required for each upper limb radical resection of bone tumor codes. The RUC agreed that the number of office visits were appropriate as the physician will discuss pathology, coordinate care, and assess functional rehabilitation and physical therapy.

23200

The RUC reviewed the pre-service time for code 23200 *Radical resection of tumor; clavicle* and agreed with the specialty society that pre-time package 4 – Difficult Patient/Difficult Procedure was appropriate as the physician must conduct an additional extensive review of the pathology studies, coordination with radiation therapy, etc. The RUC determined that an additional 9 minutes of pre-positioning time is required to place the patient in the lateral position. The RUC then compared 23200 to key reference service 27447 *Arthroplasty, knee, condyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty)* (work RVU = 23.04, intra-service time = 124 minutes) and determined that the physician time and intensity was slightly higher for code 23200. The RUC determined the survey median work RVU of 22.50 and median physician time of 155 minutes appropriately places this service in the proper rank order within this family of services. **The RUC recommends the survey median work RVU 22.50 for 23200.**

23210

The RUC reviewed the pre-service time for code 23210 *Radical resection of tumor; scapula* and agreed with the specialty society that pre-time package 4 – Difficult Patient/Difficult Procedure was appropriate as the physician must conduct an additional extensive review of the pathology studies, coordination with radiation therapy, etc. The RUC determined that an additional 17 minutes of pre-positioning time is required to place the patient in the prone or lateral position. The RUC then compared 23210 to key reference service 27134 *Revision of total hip arthroplasty; both components, with or without autograft or allograft* (work RVU = 30.13, intra-service time = 240 minutes) and determined that the physician time, work and intensity was slightly lower for code 23210. The RUC noted that the 23210 has a slightly lower work RVU than 27134, as it has a shorter length of stay requiring only one 99231. The RUC determined the survey 25th percentile work RVU of 27.00 and median intra-service time of 210 minutes appropriately placed 23210 in relativity to 27134. **The RUC recommends the survey 25th percentile work RVU of 27.00 for 23210.**

23220

The RUC reviewed the pre-service time for code 23220 *Radical resection of tumor; proximal humerus* and agreed with the specialty society that pre-time package 4 – Difficult Patient/Difficult Procedure was appropriate as the physician must conduct an additional extensive review of the pathology studies, coordination with radiation therapy, etc. The RUC determined that an additional 9 minutes of pre-positioning time is required to place the patient in the lateral position. The RUC then compared 23220 to key reference service 27134 *Revision of total hip arthroplasty; both components, with or without autograft or allograft* (work RVU = 30.13, intra-service time = 240 minutes) and determined that the physician time, work and intensity was the same for these procedures. The RUC determined the survey 25th percentile work RVU of 30.00 and median physician time of 240 minutes was appropriate to perform this service. **The RUC recommends the survey 25th percentile work RVU of 30.00 for 23220.**

24150

The RUC reviewed the pre-service time for code 24150 *Radical resection of tumor; shaft or distal humerus* and agreed with the specialty society that pre-time package 4 – Difficult Patient/Difficult Procedure was appropriate as the physician must conduct an additional extensive review of the pathology studies, coordination with radiation therapy, etc. The RUC determined that an additional 9 minutes of pre-positioning time is required to place the patient in the supine position and position the arm and hand correctly. The RUC then compared 24150 to key reference service 24363 *Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)* (work RVU = 22.47, intra-service time = 150 minutes) and determined that the physician time, work and intensity was the similar for these procedures. The RUC agreed that the survey median work RVU of 23.25 and median physician time of 180 minutes was appropriate to perform this service. **The RUC recommends the survey median work RVU of 23.25 for 24150.**

24152

The RUC reviewed the pre-service time for code 24152 *Radical resection of tumor; radial head or neck* and agreed with the specialty society that pre-time package 3 – Straightforward Patient/Difficult Procedure was appropriate. The RUC determined that an additional 9 minutes of pre-positioning time is required to place the patient in the supine position and adjust the arm and hand for a clear operative site. The RUC then compared 24152 to key reference service 24363 *Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)* (work RVU = 22.47, intra-service time = 150 minutes) and determined that the physician time, work and intensity was the similar for these procedures. The RUC determined the survey 25th percentile work RVU of 19.78 and median physician time of 150 minutes was appropriate to

perform this service. **The RUC recommends the survey 25th percentile work RVU of 19.78 for 24152.**

25170

The RUC reviewed the pre-service time for code 24170 *Radical resection of tumor; radius or ulna* and agreed with the specialty society that pre-time package 3 – Straightforward Patient/Difficult Procedure was appropriate. The RUC determined that an additional 9 minutes of pre-positioning time is required to place the patient in the supine position and adjust the arm and hand for a clear operative site. The RUC then compared 24170 to key reference service 24363 *Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)* (work RVU = 22.47, intra-service time = 150 minutes) and determined that the physician time, work and intensity is similar for these procedures. The RUC agreed the survey median work RVU of 22.00 and similar total physician time indicates that the work for these two services are the same. **The RUC recommends the survey median work RVU of 22.00 for 25170.**

26250

The RUC reviewed the pre-service time for code 26250 *Radical resection of tumor; metacarpal* and agreed with the specialty society that pre-time package 2b – Difficult Patient/Straightforward Procedure was appropriate. The specialty society indicated and the RUC agreed that the survey respondents slightly overestimated the pre-service evaluation time and that time is actually captured in the scrub, dress, and wait time. Therefore, the RUC removed 10 minutes of pre-evaluation time from the established package and added it to the scrub, dress, wait pre-time. The RUC determined that an additional 9 minutes of pre-positioning time is required to place the patient in the supine position and adjust the arm and hand for a clear operative site. The RUC then compared 26250 to key reference service 25447 *Arthroplasty, interposition, intercarpal or carpometacarpal joints* (work RVU = 10.95, intra-service time = 100 minutes) and determined that the physician time, work and intensity is higher for 26250. To further support the survey median work RVU of 15.00, the RUC compared 26250 to 24346 *Reconstruction medial collateral ligament, elbow, with tendon graft (includes harvesting of graft)* (work RVU = 14.97, intra-service time = 120 minutes), which requires similar physician work and intra-service time. The RUC determined the survey median work RVU of 15.00 and median physician time of 120 minutes was appropriate to perform this service. **The RUC recommends the survey median work RVU of 15.00 for 26250.**

26260

The RUC reviewed the pre-service time for code 26260 *Radical resection of tumor; proximal or middle phalanx of finger* and agreed with the specialty society that pre-time package 2b – Difficult Patient/Straightforward Procedure was appropriate. The specialty society indicated and the RUC agreed that the survey respondents slightly overestimated the pre-service evaluation time and that time is actually captured in the scrub, dress, and wait time. Therefore, the RUC removed 10 minutes of pre-evaluation time from the established package and added it to the scrub, dress, wait pre-time. The RUC determined that an additional 9 minutes of pre-positioning time is required to place the patient in the supine position and adjust the arm and hand for a clear operative site. The RUC then compared 26260 to key reference service 25447 *Arthroplasty, interposition, intercarpal or carpometacarpal joints* (work RVU = 10.95, intra-service time = 100 minutes) and determined that the physician time, work and intensity is similar for these services. The RUC determined the survey 25th percentile work RVU of 11.00 and median physician time of 90 minutes was appropriate to perform this service. **The RUC recommends the survey 25th percentile work RVU 11.00 for 26260.**

26262

The RUC reviewed the pre-service time for code 26262 *Radical resection of tumor; distal phalanx of finger* and agreed with the specialty society that pre-time package 1b – Straightforward Patient/Straightforward Procedure was appropriate. The specialty society indicated and the RUC agreed that the survey respondents slightly overestimated the pre-service evaluation time and that time is actually captured in the scrub, dress, and wait time. Therefore, the RUC removed 5 minutes of pre-evaluation time from the established package and added it to the scrub, dress, wait pre-time. The RUC determined that an additional 9 minutes of pre-positioning time is required to place the patient in the supine position and adjust the arm and hand for a clear operative site. The RUC agreed that in cases with a malignant bone tumor of the finger, it is usually amputated, but in some cases the thumb may be preserved. The RUC then compared 26262 to key reference service 24685 *Open treatment of ulnar fracture, proximal end (eg, olecranon or coronoid process[es]), includes internal fixation, when performed* (work RVU = 8.21, intra-service time = 60 minutes) and determined that the physician time, work and intensity is similar for these services. The RUC compared 26262 to code 28175 *Radical resection of tumor; phalanx of the toe* and to avoid a rank order anomaly the RUC agreed that the 25th percentile work RVU for of 8.13 for 28175 is appropriate for 26262 as it is similar to the survey 25th percentile work RVU of 8.00. The RUC determined that a work RVU of 8.13 and physician time of 60 minutes is appropriate to perform the work required for this procedure. **The RUC recommends a work RVU of 8.13 for 26262.**

Lower Limb

The RUC reviewed the specialty societies' survey results for the lower limb radical resection of tumor codes. The specialty societies indicated now, as opposed to 10 years ago, most patients will receive a total femoral replacement instead of amputation. The typical Medicare patient population may have more metastatic disease of the distal femur or renal cell carcinoma. Patients are typically in the hospital for a week. The lower limb radical resection procedures have similar intensity to the pelvis iliac wing resection, code 27075, but are not as high as the total pelvis resection or pelvis and acetabulum resections 27077 or 27076. The specialty societies indicated that one 99214 office visit is required for each lower limb radical resection of bone tumor codes. The RUC agreed that the number of office visits were appropriate as the physician will discuss pathology, coordinate care, and assess functional rehabilitation and physical therapy.

27365

The RUC reviewed the pre-service time for code 27365 *Radical resection of tumor; femur or knee* and agreed with the specialty society that pre-time package 4 – Difficult Patient/Difficult Procedure was appropriate, as the physician must conduct an additional extensive review of the pathology studies, coordination with radiation therapy, etc. No additional positioning time is required as typically the patient is in the supine position for this procedure. The RUC then compared code 27365 to key reference service 27134 *Revision of total hip arthroplasty; both components, with or without autograft or allograft* (work RVU = 30.13, intra-service time = 240 minutes) and determined that the physician time required to perform these services is exactly the same and the work required is slightly more intense for 27365. Additionally, the RUC compared 27365 to 27078 and agreed these services are similar, both requiring the same intra-operative time of 240 minutes. However, 27365 is slightly more intense intra-operatively because for this procedure the physician typically must carefully isolate and immobilize the popliteal and femoral arteries. Additionally, 27365 requires the same number of hospital and office visits as 27078. **The RUC recommends the survey median work RVU of 32.00 for 27365.**

27645

The RUC reviewed code 27645 *Radical resection of tumor; tibia* and agreed with the specialty society that pre-time package 4 – Difficult Patient/Difficult Procedure was appropriate, as the

physician must conduct an additional extensive review of the pathology studies, coordination with radiation therapy, etc. No additional positioning time is required as the typically the patient is in the supine position for this procedure. The RUC then compared code 27645 to key reference service 27156 *Osteotomy, iliac, acetabular or innominate bone; with femoral osteotomy and with open reduction of hip* (work RVU = 26.03, intra-service time = 225 minutes) and determined that the physician time, work and intensity is similar for these services. The RUC determined the survey median work RVU of 27.00 and median physician time of 200 minutes appropriately places this procedure in the proper rank order with the other lower limb radical tumor resection services. **The RUC recommends a work RVU of 27.00 for 27645.**

27646

The RUC reviewed 27646 *Radical resection of tumor; fibula* and agreed with the specialty society that pre-time package 4 – Difficult Patient/Difficult Procedure was appropriate, as the physician must conduct an additional extensive review of the pathology studies, coordination with radiation therapy, etc. The RUC determined that an additional 17 minutes of pre-positioning time is required to place the patient in the lateral position after anesthesia is administered. The RUC then compared code 27646 to key reference service 27447 *Arthroplasty, knee, condyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty)* (work RVU = 23.04, intra-service time = 124 minutes) and determined that the physician time, work and intensity is similar for these services. The RUC determined the survey median and 25th percentile work RVU of 23.00 and median physician time of 180 minutes appropriately places this procedure in the proper rank order with the other lower limb radical tumor resection services. **The RUC recommends the survey median work RVU of 23.00 for 27646.**

27647

The RUC reviewed code 27647 *Radical resection of tumor; talus or calcaneus* and agreed with the specialty society that pre-time package 3 – Straightforward Patient/Difficult Procedure was appropriate. The RUC determined that an additional 10 minutes of pre-evaluation time was appropriate for extensive additional review of imaging and pathology studies to correctly mark and plan the procedure and consultation with the reconstructive surgeon. The RUC also determined that an additional 17 minutes of pre-positioning time is required to place the patient in the prone position after anesthesia is administered. The RUC then compared code 27647 to key reference service 27580 *Arthrodesis, knee, any technique* (work RVU = 20.90, intra-service time = 150 minutes) and determined the physician time, work and intensity is similar for these services. The RUC determined the survey median work RVU of 20.10 and median physician time of 144 minutes appropriately places this procedure in the proper rank order with the other lower limb radical tumor resection services. **The RUC recommends the survey median work RVU of 20.10 for 27647.**

28171

The RUC reviewed code 28171 *Radical resection of tumor; tarsal (except talus or calcaneus)* and agreed with the specialty society that pre-time package 3 – Straightforward Patient/Difficult Procedure was appropriate. The RUC determined that an additional 10 minutes of pre-evaluation time was appropriate for extensive additional review of imaging and pathology studies to correctly mark and plan the procedure and consultation with the reconstructive surgeon. The RUC also determined that an additional 17 minutes of pre-positioning time is required to place the patient in the lateral position after anesthesia is administered. The RUC then compared code 28171 to key reference service 27580 *Arthrodesis, knee, any technique* (work RVU = 20.90, intra-service time = 150 minutes) and determined the physician time, work and intensity is slightly lower for 28171. To further support the survey 25th percentile work RVU of 16.25, the

RUC compared 28171 to 28415 *Open treatment of calcaneal fracture, includes internal fixation, when performed* (work RVU = 15.96, intra-service time = 120 minutes), which requires similar physician work and intra-service time. The RUC determined the survey 25th percentile work RVU of 16.25 and median physician time of 120 minutes appropriately places this procedure in the proper rank order with the other lower limb radical tumor resection services and reference service. **The RUC recommends the survey 25th percentile work RVU of 16.25 for 28171.**

28173

The RUC reviewed code 28173 *Radical resection of tumor; metatarsal* and agreed with the specialty society that pre-time package 1b – Straightforward Patient/Straightforward Procedure was appropriate. The RUC determined that an additional 2 minutes of pre-positioning time is required to elevate the patient's leg, stabilize the foot and pad the opposite extremity. The RUC then compared code 28173 to key reference service 28715 *Arthrodesis; triple* (work RVU = 14.40 intra-service time = 130 minutes) and determined the physician time, work and intensity is similar for these services. The RUC determined the survey 25th percentile work RVU of 14.00 and median physician time of 110 minutes appropriately places this procedure in the proper rank order with the other lower limb radical tumor resection services and reference service. **The RUC recommends the survey 25th percentile work RVU of 14.00 for 28173.**

28175

The RUC reviewed code 28175 *Radical resection of tumor; phalanx of toe* and agreed with the specialty society that pre-time package 1b – Straightforward Patient/Straightforward Procedure was appropriate. The RUC determined that an additional 2 minutes of pre-positioning time is required to elevate the patient's leg and stabilize the foot. The RUC then compared code 28175 to key reference service 29891 *Arthroscopy, ankle, surgical, excision of osteochondral defect of talus and/or tibia, including drilling of the defect* (work RVU = 9.47 intra-service time = 60 minutes) and determined the physician time, work and intensity is similar for these services. To further support the survey 25th percentile work RVU of 8.13, the RUC compared 28175 to 24685 *Open treatment of ulnar fracture, proximal end (eg, olecranon or coronoid process[es]), includes internal fixation, when performed* (work RVU = 8.21, intra-service time = 60 minutes), which requires similar physician work and intra-service time. The RUC determined the survey 25th percentile work RVU of 8.13 and median physician time of 60 minutes appropriately places this procedure in the proper rank order with the other lower limb radical tumor resection services. Additionally, the RUC agreed that upper limb radical resection of bone tumor code 26262 is equal to this lower limb resection of bone tumor code 28175. **The RUC recommends the survey 25th percentile work RVU of 8.13 for 28175.**

Practice Expense

The practice expense inputs recommended by the specialty in the facility setting were reviewed and agreed upon. **The RUC recommends the attached standard 090-day direct practice expense inputs.**

Navigation Bronchoscopy (Tab 9)

**Scott Manaker, MD, PhD, American College of Chest Physicians and Alan Plummer, MD
American Thoracic Society**

In October 2008 the CPT Editorial Panel created a new add-on code to describe the pre-planning, real time navigation of the bronchus or placement of fiducial markers.

The RUC reviewed the specialty society recommendation for 316X1 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with computer-assisted, image-guided navigation* and agreed with the physician time and work presented and supported by the survey median (60 minutes intra-service time and work RVU = 2.00). The RUC agreed that the physician work required for planning/mapping, downloading CT information and registering information typically would take 30 minutes and the actual performance of directional bronchoscopy would take an additional 30 minutes. The RUC compared 316X1 to 31637 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; each additional major bronchus stented* (work RVU = 1.58, intra-service time = 30) and determined this supported the physician time and work required to perform 316X1 as 31637 does not include an additional 30 minutes of planning and mapping. **The RUC recommends a work RVU of 2.00 for code 316X1.**

Practice Expense

The RUC recommends the specialty society recommended practice expense inputs for the non-facility setting as attached.

New Technology

The RUC recommends that code 316X1 be placed on the new technology list for future review.

Modifier -51 Exempt

The RUC recommends that code 316X1 be placed on the Modifier-51 Exempt list as this procedure is typically performed with another procedure. The RUC recommended value is based on its Modifier -51 exempt status.

Moderate Sedation

The RUC recommends that 316X1 be added to the Moderate Sedation List.

Laparoscopic Paraesophageal Hernia Repair (Tab 10)

American College of Surgeons and Society of American Gastrointestinal and Endoscopic Surgeons

The Society of American Gastrointestinal and Endoscopic Surgeons (SAGES) requested to defer RUC review of this issue until April 2009 after the CPT Editorial Panel clarifies SAGES October 2008 request to develop two new codes instead of one code to describe this laparoscopic paraesophageal hernia repair. The CPT Editorial Panel will review this issue at its February 2009 meeting.

Rectal Tumor Excision (Tab 11)

Christopher Senkowski, MD, American College of Surgeons and Guy Orangio, MD, American Society of Colon and Rectal Surgeons

CPT code 45170, *Excision of tumor, transanal approach* was identified by the Five-Year Review Identification Workgroup as potentially misvalued through its Site of Service Anomaly screen in September 2007. The Workgroup reviewed all services that include inpatient hospital visits within their global periods, but are performed less than 50% of the time in the inpatient setting, according to recent Medicare utilization data. The RUC originally recommended a two-step action. First, the RUC removed the hospital visits from the service with no impact on the associated work RVU. Second, the RUC recommended that services be surveyed. Code 451X2 was also identified in the High IWPUT screen and discussed by the RUC at its February 2008

meeting. The RUC recommended that the service be referred to CPT because the current descriptor allowed reporting of the code to a bi-modal distribution of patients. In October 2008, the CPT Editorial Panel deleted 45170 (work RVU = 12.48) and replaced it with two new Category I codes to provide greater granularity, 451X1, *Excision of rectal tumor, transanal approach; not including muscularis propria (ie, partial thickness)* and 451X2, *Excision of rectal tumor, transanal approach; including muscularis propria (ie, full thickness)*.

451X1

The specialty society presented the survey data from 92 general and colorectal surgeons. The RUC reviewed the intra-service physician time and noted that the median time of 45 minutes was appropriate. The specialty indicated that this service would typically be provided on an outpatient basis. The RUC agreed with the specialty society that the pre-service time package should be package #3, straightforward patient/difficult procedure, as this time most accurately reflects the work performed. However, the RUC did not agree with the specialty that 20 minutes of positioning time was correct. Survey respondents indicated that 15 minutes were necessary. Therefore, the RUC adjusted the pre-service positioning time from the 3 minutes within package #3 to 15 minutes, rather than the 20 minutes recommended by the specialty. The RUC then reviewed the survey RVU and agreed with the specialty society that the survey 25th percentile work recommendation of 8.00 was appropriate. The RUC considered the surveyed code in comparison to the key reference service, 45190, *Destruction of rectal tumor (eg, electrodesiccation, electrosurgery, laser ablation, laser resection, cryosurgery) transanal approach* (work RVU = 10.29). The RUC noted that despite similar intensity and complexity measurements between the surveyed code and the key reference code, the reference code requires 15 additional minutes of intra-service time (60 minutes and 45 minutes, respectively). Based on this comparison, the RUC agreed that the survey 25th percentile work RVU of 8.00 was appropriate. **The RUC recommends the survey 25th percentile RVU of 8.00 for 451X1.**

451X2

The specialty society presented the survey data from 92 general and colorectal surgeons. The RUC reviewed the intra-service physician time and noted that the median time of 75 minutes was appropriate. The RUC agreed with the specialty society that the pre-service time package should be package #4, difficult patient/difficult procedure, as this time most accurately reflects the work performed. However, the RUC did not agree with the specialty that 20 minutes of positioning time was correct. Survey respondents indicated that 15 were necessary. Therefore, the RUC adjusted the pre-service positioning time from the 3 minutes within package #4 to 15 minutes, rather than the 20 minutes recommended by the specialty. The RUC then reviewed the survey RVU and agreed with the specialty society that the survey median work RVU of 12.00 was appropriate. The RUC considered the surveyed code in comparison to the key reference service, 45190, *Destruction of rectal tumor (eg, electrodesiccation, electrosurgery, laser ablation, laser resection, cryosurgery) transanal approach* (work RVU = 10.29). The RUC noted that the key reference service requires 15 fewer minutes of intra-service time (60 minutes and 75 minutes, respectively). Code 451X2 also includes a full 99238 discharge day management procedure as well as a 99231 hospital visit within its global period, whereas the reference code does not. The RUC agreed that 451X2 would typically require an inpatient stay. Lastly, the RUC noted that survey respondents indicated 451X2 requires greater mental effort and judgment as well as greater technical skill and physical effort than the reference code. In light of these differences, the RUC agreed that the median work RVU of 12.00 was appropriate. **The RUC recommends the survey median work RVU of 12.00 for 451X2.**

Practice Expense

The RUC recommended the standard 90 day global practice expense inputs.

Temporary Prostatic Urethral Stent Insertion (Tab 12)
James G. Giblin, MD, American Urological Association

At its October 2008 meeting, the CPT Editorial Panel created 5385X, *Insertion of a temporary prostatic urethral stent, including urethral measurement*, a Category I code to describe the work previously reported in Category III code, 0084T, *Insertion of a temporary prostatic urethral stent*, to accurately describe the measurement and insertion of a temporary prostatic stent as a stand alone procedure used as treatment for complications that follow microwave therapy (code 53850, *Transurethral destruction of prostate tissue; by microwave thermotherapy*). Approximately 10% of patients who have microwave therapy may potentially require this procedure or placement of a foley catheter, which is the only present treatment.

The RUC reviewed the survey data from 30 urologists presented by the specialty society. The RUC reviewed the survey physician times and agreed that the median survey intra-service time of 15 minutes is appropriate. The RUC also agreed with the specialty society that pre-service time package 5, non-facility procedure without sedation or anesthesia, is appropriate. The RUC also agreed with the specialty society expert panel that the survey 25th percentile work RVU of 1.64 is appropriate. The RUC compared 5385X to key reference service 53620, *Dilation of urethral stricture by passage of filiform and follower, male; initial* (work RVU = 1.62), which reflects similarities to the time. The RUC concluded that the two services are similar and recommended the survey 25th percentile work RVU of 1.64. **The RUC recommends the survey 25th percentile work RVU of 1.64 for 5385X.**

Modifier 51

The RUC recommends that 5385X not be placed on the modifier -51 exempt list because the procedure is performed within the global period of 53850, *Transurethral destruction of prostate tissue; by microwave thermotherapy*, but never performed with 53850.

Practice Expense

The RUC reviewed the direct practice expense inputs for 5385X and approved the attached inputs.

New Technology

The RUC recommends that 5385X be placed on the New Technology list.

Spinal Neurostimulator Electrode (Tab 13)

The Five-Year Review Identification Workgroup identified code 63660 *Revision or removal of spinal neurostimulator electrode percutaneous array(s) or place/paddle(s)* on its site-of-service anomaly screen, indicating that this service is no longer provided predominantly in the inpatient setting. The RUC recommended that this code be reassigned to a 010-day global period and be resurveyed. However, the multi-specialty expert panel determined that the current descriptor was too broad to be able to define the work. The specialty society requested that the CPT Editorial Panel create separate codes to describe the distinct work involved in the revision and in the removal of a percutaneous electrode when compared to the revision or the removal of a “plate/paddle” electrode array. In October 2008, the CPT Editorial Panel deleted code 63660 and created four new codes to appropriately describe these services.

In November 2008, the specialty societies requested that CMS reconsider the global period assigned to codes 6366X1 and 6366X3 since percutaneous procedures are usually classified as minor

procedures. In December 2008 CMS agreed to assign a 010-day global period to codes 6366X1 and 6366X3. The specialty society will present recommendations at the April 2009 RUC meeting.

Multi-Leaf Collimator IMRT Device Use (Tab 14)

Najeeb Mohideen, MD American Society for Therapeutic Radiology and Oncology

In October 2008 the CPT Editorial Panel created a new code to describe the design and construction of multi-leaf collimator (MLC) intensity modulated radiation therapy (IMRT) device use. Previously, patients treated with IMRT were reported under code 77334 *Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)* (work RVU = 1.24). However, the technical component expense portion was incorrectly captured in the practice expense of code 77418 *Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session*, not under code 77334.

The RUC reviewed 7733X *Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction*. The specialty societies indicated that 7733X captures the appropriate physician work and practice expense, specifically the medical physics and medical dosimetry time and equipment that was not in code 77418. The specialty societies indicated that the physician work starts at the time following treatment plan 77301 *Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications* (work RVU = 7.99). Multiple fluence patterns are generated and the physician must review the plan and make the proper adjustments to the MLC device prior to treatment to protect normal surrounding tissue (i.e., bladder, anterior rectal wall, etc). The physician selects a range set of segments for each device, fine tunes and deletes small segments to eliminate any treatment inefficiency and adjusts the dose profile again for every beam (typically 9 beams). The specialty society indicated and the RUC agreed that the physician work required to adjust each beam is approximately 13 minutes per beam (total intra-service time = 115 minutes). The specialty society indicated that each fluence map is different for every beam so each requires approximately the same amount of time, in other words, each additional beam would not require less time nor would the physician become more efficient.

The specialty society indicated and the RUC agreed that the survey 25th percentile work RVU of 4.29 appropriately accounted for the work required to perform this service. The RUC compared 7733X to reference service 77295 *Therapeutic radiology simulation-aided field setting; 3-dimensional* (work RVU = 4.56 and 98 minutes intra-service time) and determined that although the reference code requires less physician time, it is slightly more intense and complex to perform than 7733X. Additionally, the RUC compared 7733X to the physician work that is currently reported as 77334 *Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)* (work RVU = 1.24, intra-service time = 35 minutes), which is reported per field. The IWPUT for CPT 77334 (0.035) when compared to the survey physician time for 7733X (115 minutes) supports the survey 25th percentile RVU recommended by the specialty society (0.035 x 115 = 4.03). **The RUC recommends the survey 25th percentile work RVU of 4.29 for code 7733X.**

Practice Expense

The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

PLI

The RUC recommends the PLI for 7733X be crosswalked to 77295 *Therapeutic radiology simulation-aided field setting; 3-dimensional* and a 0.00 PLI for the technical component only.

Coronary Computed Tomographic Angiography (Tab 15)

Reviewed by Facilitation Committee #3

James Maloney, MD, American College of Cardiology, and Geraldine McGinty, MD, American College of Radiology

In October 2008 the CPT Editorial Panel deleted eight Category III codes and created four new codes to describe the evolution of performing cardiac and coronary computed tomography for specific clinical scenarios.

7557X1 Computed tomography, heart without contrast material, with quantitative evaluation of coronary calcium

The RUC reviewed the specialty societies' recommended data and agreed that the physician time (5 minutes pre-, 10 minutes intra- and 5 minutes post-service time) recommended by the specialties accurately reflected the service. However, the RUC did not agree that the survey values were reflective of the work performed, noting that even the survey 25th percentile work RVU of 0.70 was too high. The RUC compared 7557X1 to code 75962 *Transluminal balloon angioplasty, peripheral artery, radiological supervision and interpretation* (work RVU = 0.54 and 12 minutes total physician time) and determined that 7557X1 required slightly more work. The RUC also compared 7557X1 to similar services 95903 *Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study* (work RVU = 0.60 and 8 minutes pre-, 10 minutes intra- and 10 minutes post-service time) and 11000 *Debridement of extensive eczematous or infected skin; up to 10% of body surface* (work RVU=0.60 and 5 minutes pre-, 10 minutes intra- and 5 minutes post-service time). The RUC determined that a work RVU of 0.58 for 7557X1 appropriately accounts for the work required to perform this service. Additionally, CPT codes 75962, 95903 and 11000 have similar work RVUs and physician time compared to surveyed code 7557X1. **The RUC recommends a work RVU of 0.58 for CPT code 7557X1.**

7557X2 Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3D image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed)

The specialty society provided a very detailed description of the work included in 7557X2, which includes evaluation of cardiac structure, morphology, venous structures, 3D reconstruction, contrast and administration of a beta-blocker. The RUC agreed with the specialty society that the survey median work RVU of 2.25 is too high, while the survey 25th percentile work RVU of 1.25 does not account for the extent of the work performed. The RUC reviewed several comparable reference services: 72196, *Magnetic resonance (eg, proton) imaging, pelvis; with contrast material(s)* (work RVU = 1.72, pre-service = 15, intra-service = 20, post-service = 10); 71551, *Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); with contrast material(s)* (work RVU = 1.73, pre-service = 10, intra-service = 25, post-service = 10); 70498, *Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU = 1.75, pre-service = 7, intra-service = 20, post-service = 10); and 70496, *Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU = 1.75, pre-service = 8, intra-service = 20, post-service = 10). The RUC agreed that these services are appropriate references and a work RVU of 1.75, which is half way between the survey 25th percentile and median, maintains rank order within this family of services. **The RUC recommends a work RVU of 1.75 for 7557X2.**

7557X3 Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3D image postprocessing, assessment of LV cardiac function, RV structure and function and evaluation of venous structures, if performed)

The RUC reviewed the pre-service time for 7557X3 and agreed with the societies' recommended additional pre-service time compared to the other services within this family, as the physician has several pre-operative tests to review and as the service is typically performed on a child, the physician must answer many questions posed by the patient and the patient's family. The RUC agreed that the service time, 15 minutes of pre-service time, 30 minutes of intra-service time and 15 minutes of post-service time, accurately reflect the service. After reviewing the physician time, the RUC compared the surveyed code to the reference code, 75564 *Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with flow/velocity quantification and stress* (Work RVU=3.35). As the surveyed code has significantly less total service time as compared to the reference code (60 and 85 minutes, respectively) and the surveyed code is performed on a child rather than an adult as in the reference code, the RUC agreed that a work RVU of 2.55, the surveyed 25th percentile, accurately reflects the work associated with 7557X3. **The RUC recommends a work RVU of 2.55 for 7557X3.**

7557X4 Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)

The RUC reviewed the specialty society physician time and work RVU data recommended data for code 7557X4, 10 minutes pre-service, 30 minutes intra-service and 10 minutes post-service time. The specialty society recommended a lower pre- and post-service time than the surveyed time by reducing 5 minutes from both the pre- and post-service time because the respondents indicated higher times than are typical when compared to similar services. The RUC determined that 30 minutes of intra-service time, as indicated by the survey respondents, was appropriate to account for the time required to perform this service (issue multiple beta blockers, contrast media two times, calculate fractions, calculate cardiac output, etc). The RUC then compared 7557X4 to code 75557 *Cardiac magnetic resonance imaging for morphology and function without contrast material* (work RVU = 2.35, 10 minutes pre-time, 40 minutes intra-time and 10 minutes post-time) plus 96375 *Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug* (work RVU = 0.10) (2.35 + 0.10 = 2.45) to support a work RVU of 2.40 for code 7557X4, which is less than the survey 25th percentile. **The RUC recommends a work RVU of 2.40 and 10 minutes pre-, 30 minutes intra- and 10 minutes immediate post-service time for code 7557X4.**

Practice Expense

The RUC reviewed the practice expense inputs for all four services within the family and confirmed the clinical labor time proposed by the Practice Expense Subcommittee. The RUC discussed the equipment and recommends that the uninterruptible power supply be deleted as it is an indirect expense. The tilt table was also deleted from equipment. The RUC reviewed the appropriate time that the CT scanner will be in use and recommends the following time (activities = lines 78 and 79):

7557X1, 16 slice CT = 15 minutes
7557X2, 64 slice CT = 26 minutes
7557X3, 64 slice CT = 37 minutes

7557X4, 64 slice CT = 43 minutes

The computer workstation and all software are equal to (line 88 - reconstruct images at selected intervals...)

7557X1 = 12 minutes

7557X2 = 21 minutes

7557X3 = 23 minutes

7557X4 = 29 minutes

New Technology

The RUC recommends that these services be added to the New Technology List.

PLI Codes

The RUC recommends the PLI for the technical component of each service be 0.00. The RUC recommends following PLI crosswalks:

7557X1 should be crosswalked to 78472

7557X2 should be crosswalked to 70498

7557X3 should be crosswalked to 75558

7557X4 should be crosswalked to 75557

Myocardial Perfusion Imaging (Tab 16)

Reviewed by Facilitation Committee #3

James Maloney, MD, American College of Cardiology, and Geraldine McGinty, MD, American College of Radiology Gary Dillehey, MD and Kenneth McKusick, MD, Society of Nuclear Medicine/American College of Nuclear Physicians

The RUC identified 78465, 78478, and 78480 as potentially misvalued through its Codes Frequently Reported Together screening mechanism, as combinations of these codes are reported together more than 95% of the time. To address its concerns, the RUC recommended that the services be referred to CPT to create bundled services that accurately describe the work that is typically performed. The CPT Editorial Panel, at its October 2008 meeting, deleted the existing family of myocardial perfusion imaging services (which included 78460, 78461, 78464, 78465, 78478, and 78480) and created four new Category I CPT codes to describe the work. These new codes are 784X1, *Myocardial perfusion imaging; tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)*, 784X2, *Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection*, 784X3, *Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)*, and 784X4, *Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection*

784X2

The RUC discussed CPT code 784X2, which is the most complex code within this family and accounts for the greatest utilization. The specialty society provided a detailed description of the work included within the service. The RUC discussed the survey results and noted that there was an exceptionally high median survey performance rate among the 83 respondents, which adds significant support to the survey data. As such, the RUC agreed that the median survey physician times of 10 minutes pre-service, 20 minutes intra-service, and 10 minutes immediate post-service time accurately reflect the time required to perform this service. However, the RUC agreed that the median survey work RVU of 1.87 was too high and did not accurately reflect the work being performed in the surveyed code. The RUC agreed that the key reference service, 78492, *Myocardial imaging, positron emission tomography (PET), perfusion; multiple studies at rest and/or stress*, was inappropriate because of the wide difference in intra-service time between the survey code and reference code (20 minutes and 55 minutes, respectively). The RUC agreed a better reference code for 784X2 is MPC code 70496, *Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU = 1.75, pre-service = 8, intra-service = 20, post-service = 10). The RUC and the specialty society presenters agreed that the two services are comparable in intensity and work. However, the RUC did note that the surveyed code contains two additional minutes of pre-service time, which is related to the physician management of the injection. **With a direct crosswalk from reference code 70496, the RUC recommends a work RVU of 1.75 for CPT code 784X2.**

784X1

The RUC reviewed the specialty society's survey results and work RVUs recommended by the specialty society for 784X1. The RUC discussed the survey results and noted that there was an exceptionally high median survey performance rate among the 83 respondents, which adds significant support to the survey responses. The RUC agreed that that survey physician times of 10 minutes pre-service, 15 minutes intra-service, and 10 minutes immediate post-service time accurately reflect the time required to perform this service. However, the RUC agreed that the median work RVU of 1.50 was too high and did not accurately reflect the work being performed in the surveyed code. In order to maintain relativity with 784X2, the RUC derived the recommended RVU for 784X1 by calculating the relationship between the median survey RVUs of X1 and X2 and maintaining this relationship between the recommended RVU for 784X1 and 784X2. The survey work RVU relationship between 784X1 : 784X2 is (1.50 : 1.87) resulting in a relationship between the recommended RVU for 784X1 : 784X2 (1.40 : 1.75).

$$\begin{array}{l} 784X1 = \quad \frac{1.50}{1.87} \quad \frac{1.40}{1.75} \\ 784X2 = \end{array}$$

The RUC agreed that this computed work RVU, 1.40 RVUs, maintains the relativity of the original survey data and is an appropriate measure of the work for 784X1. The RUC also compared 784X1 to 45308, *Proctosigmoidoscopy, rigid; with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery* (work RVU = 1.40, intra-service time = 15 minutes) and agreed that it supports the RUC's recommendation of 1.40 work RVUs for 784X1. **The RUC recommends a work RVU of 1.40 for CPT code 784X1, which maintains the relativity between the 784X1 and 784X2 and is the appropriate value for the service.**

784X3

The RUC reviewed the survey results for 784X3 agreed with the specialty society that the survey median physician times were too high, and did not reflect the time required to perform this service. The RUC agreed that the surveyed 25th percentile physician time (pre-service = 5, intra-service = 10, post-service = 5) and 25th percentile work RVU of 1.00 accurately reflects the work and time required to perform this service. In addition, the RUC compared 784X3 to 78315, *Bone*

and/or joint imaging; 3 phase study (work RVU = 1.02, pre-service = 5, intra-service = 8, post-service = 5) and noted the similarity in the physician time and work. **Therefore, the RUC recommends the 25th percentile time and work RVU of 1.00 for CPT code 784X3.**

784X4

The RUC reviewed the survey results for 784X4 and agreed with the specialty society that the survey median physician times were too high, and did not accurately reflect the time required to perform this service. The RUC agreed that the surveyed 25th percentile times (pre-service = 5, intra-service = 15, post-service = 5) and that the 25th percentile work RVU of 1.34 accurately reflect the work and time required to perform this service. In addition, the RUC compared 784X3 to 73721, *Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material* (work RVU = 1.35, pre-service = 0, intra-service = 20, post-service = 0). The RUC agreed that 73721 was a good alternative reference code because the physician work for both codes is similar and the total physician times are the same, though the intra-service work of 73721 is slightly more intense. Based on the survey results and similarity to the reference code, the RUC agrees that the 25th percentile work RVU is appropriate. **Therefore, the RUC recommends the 25th percentile time and work RVU of 1.34 for CPT code 784X4.**

PLI

The RUC recommends that the PLI RVUS be cross-walked from the original base-codes: 784X1 = 78464, 784X2 = 78465, 784X3 = 78460, and 784X3 = 78461. The RUC also recommends that the PLI RVU for the technical component of each service be 0.00, and the PLI RVU be applied only to the physician component.

Practice Expense

The RUC reviewed the practice expense inputs approved by the PE Subcommittee and accepted them.

Peripheral Electrical Bioimpedance (Tab 17)

In October 2008 the CPT Editorial Panel revised code 93701 *Bioimpedance derived physiologic cardiovascular analysis* to fully describe all types of bioimpedance procedures presently in use. In 2001, the RUC recommended 0.00 physician work RVUs for 93701, as the physician work of reviewing this computer generated report is included as part of an associated E/M service. The RUC agreed the change was editorial. **The RUC reaffirmed their previous recommendation and recommends 0.00 work RVUs for 93701.**

Nerve Conduction Tests (Tab 18)

Reviewed by Facilitation Committee #2

Gregory Barkley, MD, American Academy of Neurology (AAN); Andrea Boon, MD, American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM); Neil Busis, MD, AAN; Lee Mills, MD American Academy of Family Physicians; John A. Seibel, MD, MACE, American Association of Clinical Endocrinologists; Benn Smith, MD, AANEM

The CPT Editorial Panel created one new Category I CPT code to describe a new nerve conduction test performed with newer technologies that differ from traditional technologies. The Editorial Panel created, 9590X1, *Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study; each limb, includes F-wave study when performed,*

with interpretation and report at its October 2008 Meeting. The Editorial Panel specified that this codes may be reported only once per limb studied.

The specialty societies presented survey data from 75 physicians; however, the median service performance rate of all surveyees was zero. Following RUC policy, the specialties provided additional data from their original survey, including the compilation of responses from physicians with a service performance rate of at least one and the compilation of responses from physicians with a service performance rate of zero, which the RUC compared with the aggregate data in the Summary of Recommendation form. The specialties also provided a complete description of the work that is included in the procedure to support the contention that there is physician work involved since it was noted that 21 of the survey respondents compared the new code to a reference code with no physician work. Based on this description and the overall survey results, the RUC agreed that although the median survey work RVUs and some of the surveyed physician times are inflated, physician work is appropriate. The RUC reviewed the times recommended by the specialties and noted that there is no pre-service or post-service physician time and that the physician work is only performed during the intra-service period. Specifically, the RUC decided that the physician work described by the specialties within the pre-service time is included within the evaluation and management service that is typically reported on the same day and that the physician work described by the specialties within the post-service time is inappropriate and is included within the five minutes of intra-service time. The RUC compared 9590X1 to 76977, *Ultrasound bone density measurement and interpretation, peripheral site(s), any method* (work RVU = 0.05, intra-service = 5 minutes), which is identical in physician time and work. The RUC agreed that 76977 serves as a direct comparison code and the appropriate work RVU for 9590X1 is 0.05, based on this magnitude estimation. The Committee also noted that 0.05 is the survey 25th percentile work RVU. The RUC also commented that this service is Modifier 51 exempt and assumed it may often be reported more than once, supporting pre- and post-service times of 0 minutes. **Therefore, the RUC recommends a work RVU of 0.05, no pre- or post-service time and five minutes of intra-service time for 9590X1.**

Practice Expense

The RUC reviewed the practice expense inputs and revised the clinical staff time to reflect that multiple units of services are typically reported.

PLI

The RUC recommends a PLI crosswalk to the key reference service, 76977-26 (the professional component only).

New Technology

The RUC recommends that 9590X1 is placed on the New Technology list.

X. CMS Requests

Foot Bone Resection Partial (Tab 19)

Reviewed by Facilitation Committee #1

William Creevy, MD, American Academy Orthopaedic Surgeons, Tye Ouzounian, MD, American Orthopaedic Foot and Ankle Society, Frank Spinoso, DPM Robb Mothershed, DPM and Timothy Tillo, DPM, American Podiatric Medical Association

CPT codes 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 Five-Year Review Identification Workgroup as potentially misvalued through its Site of Service Anomaly screen in September 2007. The Workgroup reviewed all services that include inpatient hospital visits within their global periods, but are performed less than 50% of the time in the inpatient setting, according to recent Medicare utilization data. The RUC originally recommended a two-step action. First, the RUC removed the hospital visits from the service with no impact on the associated work RVU. Second, the RUC recommended that services be surveyed. At the April 2008 RUC Meeting, the specialty societies presented data that indicated that although these procedures are reported as outpatient procedures more than 50% of the time, patients typically spend at least one night in the hospital. The RUC deferred action on these issues until an adequate survey instrument was developed. The RUC approved a revised survey instrument in October 2008 and these procedures were surveyed for review at the February 2009 RUC Meeting.

28120

The RUC first considered the compelling evidence presented by the specialty societies to review the work of 28120. The specialty societies indicated that during the Harvard studies, the wrong specialty was surveyed. The original surveys included on orthopaedic surgeons; however, podiatrists are the primary providers. Further, there is a rank order anomaly between 28120 and 28122. Currently, 28122 requires less physician time, but has a higher work RVU. **The RUC agreed that compelling evidence exists to review the work RVU of 28120.**

The specialty society presented the results of a survey of 52 orthopaedic surgeons and podiatrists. 65% of the survey respondents indicated that patients spend at least one night in the hospital and are seen post-operatively by the physician on the same day of surgery following the procedure. The RUC agreed that the inclusion of one 99231 hospital visit was appropriate. The RUC also agreed with the two 99213 and three 99212 post-operative office visits as indicated by the surveyees. The RUC understands that the first two visits include a splint/bandage change. The physician continues to see the patient once per week until the wound heals and physical therapy begins. The RUC reviewed the physician time and noted that the pre-service positioning time should be reduced to 10 minutes to more accurately reflect the service. Lastly, the RUC discussed the proposed work RVU and agreed with the survey 25th percentile work RVU of 8.08. The RUC compared this service to several other codes to support the work RVU including, 15100, *Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)* (work RVU = 9.74, pre-service = 65, intra-service = 60, post-service = 20) and 29891, *Arthroscopy, ankle, surgical, excision of osteochondral defect of talus and/or tibia, including drilling of the defect* (work RVU = 9.47, pre-service = 50, intra-service = 60, post-service = 25). The RUC compared 28120 to 49505, *Repair initial inguinal hernia, age 5 years or older; reducible* (work RVU = 7.88) and noted that the codes are similar, but that 28120 requires greater intensity and complexity. The RUC also agreed that the work RVU of 8.08 corrects an existing rank order anomaly with 28122, which has a work RVU of 7.56. **Therefore, the RUC recommends the survey 25th percentile work RVU of 8.08 for CPT code 28120.**

28122

The RUC first considered the compelling evidence presented by the specialty societies to review the work of 28122. The specialty societies indicated that during the Harvard studies, the wrong specialty was surveyed. The original surveys included on orthopaedic surgeons; however, podiatrists are the primary providers. Further, there is a rank order anomaly between 28120 and 28122. Currently, 28120 requires greater physician time, but has a lower work RVU. **The RUC agreed that compelling evidence exists to review the work RVU of 28122.**

The specialty society presented the results of a survey of 52 orthopaedic surgeons and podiatrists. 67% of the survey respondents indicated that patients spend at least one night in the hospital and are seen post-operatively by the physician on the same day of surgery following the procedure. The RUC agreed that the inclusion of one 99231 hospital visit is appropriate. The RUC also agreed with the two 99213 and two 99212 post-operative office visits as indicated by the surveyees. The RUC reviewed the physician time and noted that the pre-service positioning time should be reduced to 10 minutes to more accurately reflect the service. Lastly, the RUC discussed the proposed work RVU and agreed that there is no compelling evidence to change the work RVU from its current value, which is 7.56. The RUC compared this service to several other codes to support the work RVU including, 33207, *Insertion or replacement of permanent pacemaker with transvenous electrode(s); ventricular* (work RVU = 8.00, pre-service = 47.5, intra-service = 60, post-service = 30) and 49505, *Repair initial inguinal hernia, age 5 years or older; reducible* (work RVU = 7.88, pre-service = 50, intra-service = 70, post-service = 20). The RUC also agreed that maintaining the current work RVU of 7.56 is appropriate in relation to its recommendation for 28120. **Therefore, the RUC recommends the maintaining the current work RVU of 7.56 for 28120.**

Practice Expense

The RUC recommends that the non-facility practice expense inputs be modified to reflect changes to the post-operative office visits and that the physician-assist time be modified to reflect changes to the intra-service time.

Foot Arthrodesis (Tab 20)

Reviewed by Facilitation Committee #1

William Creevy, MD, American Academy Orthopaedic Surgeons, Tye Ouzounian, MD, American Orthopaedic Foot and Ankle Society, Frank Spinosa, DPM Robb Mothershed, DPM and Timothy Tillo, DPM, American Podiatric Medical Association

CPT codes 28725, *Arthrodesis; subtalar* and 28122, *Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse*; were identified by the Five-Year Review Identification Workgroup as potentially misvalued through its Site of Service Anomaly screen in September 2007. The Workgroup reviewed all services that include inpatient hospital visits within their global periods, but are performed less than 50% of the time in the inpatient setting, according to recent Medicare utilization data. The RUC originally recommended a two-step action. First, the RUC removed the hospital visits from the service with no impact on the associated work RVU. Second, the RUC recommended that services be surveyed. At the April 2008 RUC Meeting, the specialty societies presented data that indicate that although these procedures are reported as outpatient procedures more than 50% of the time, patients typically spend at least one night in the hospital. The RUC deferred action on these issues until an adequate survey instrument was developed. The RUC approved a revised survey instrument in October 2008 and these procedures were surveyed for review at the February 2009 RUC Meeting.

28725

The RUC reviewed the specialty's evidence in order to recommend increases in the current work RVU for 28725. The specialty noted that the procedure has never been reviewed by the RUC and that podiatrists, who perform 31% of the procedures were not included in the original Harvard survey. The RUC did not agree that compelling evidence existed to justify an increase in work RVU, but did agree that there was evidence to support a recommendation by the specialty to maintain the current work RVU. The specialty society presented the results of a survey of 71 orthopaedic surgeons and podiatrists. The survey data showed that 74% of patients stay overnight following the surgery. The specialty also indicated that the typical patient is seen on

the same day following the procedure as well as the next day. Because these patients typically have several morbidities, including diabetes, they require close observation of their medical status as well as wound inspection and monitoring of lower extremity neurovascular status. Therefore, the RUC agreed that one 99231 hospital visit as well as a full 99238 discharge day management service are appropriate. The RUC reviewed the survey data and agreed with the survey median physician times of 70 pre-service, 90 intra-service, and 20 immediate post-service. The RUC was convinced, following a review of the survey data, that the survey physician time and visit data accurately the work included in the procedure. Based on its review of the survey data, the RUC agreed that the current work RVU of 11.97 was the appropriate valuation of the work involved in the service. The RUC noted that the current work RVU is below the survey 25th percentile work RVU. The RUC also reviewed several reference codes to support a work RVU of 11.97 for 28725. Codes 28261, *Capsulotomy, midfoot; with tendon lengthening*, (work RVU = 12.91, pre-service = 60, intra-service = 103, post-service = 30) and 25608, *Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments*, (10.86, pre-service = 65, intra-service = 90, post-service = 30). **The RUC recommends maintaining the current work RVU of 11.97 and accepting the median survey physician time and post-operative visits for CPT code 28725.**

28730

The RUC reviewed the specialty's evidence in order to recommend increases in the current work RVU for 28730. The specialty noted that the procedure has never been reviewed by the RUC and that podiatrists, who perform 33% of the procedures were not included in the original Harvard survey. The RUC did not agree that compelling evidence existed to justify an increase in work RVU, but did agree that there was evidence to support a recommendation by the specialty to maintain the current work RVU. The specialty society presented the results of a survey of 71 orthopaedic surgeons and podiatrists. The survey data showed that 74% of patients stay overnight following the surgery. The specialty also indicated that the typical patient is seen on the same day following the procedure as well as the next day. Because these patients typically have several morbidities, including diabetes, they require close observation of their medical status as well as wound inspection and monitoring of lower extremity neurovascular status. Therefore, the RUC agreed that one 99231 hospital visit as well as a full 99238 discharge day management service are appropriate. The RUC survey data and agreed with the survey median physician times of 70 pre-service, 100 intra-service, and 20 immediate post-service. The RUC was convinced, following a review of the survey data, that the survey physician time and visit data accurately the work included in the procedure. Based on its review of the survey data, the RUC agreed that the current work RVU of 12.21 was the appropriate valuation of the work involved in the service. The RUC also noted that the current work RVU is below the survey 25th percentile work RVU. The RUC also reviewed several reference codes to support a work RVU of 12.21 for 28730. 28309, *Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; multiple (eg, Swanson type cavus foot procedure)* (work RVU = 13.96, pre-service = 60, intra-service = 110, post-service = 30) and 29862, *Arthroscopy, hip, surgical; with debridement/shaving of articular cartilage (chondroplasty), abrasion arthroplasty, and/or resection of labrum* (work RVU = 10.97, pre-service = 75, intra-service = 100, post-service = 30). The RUC noted that while the procedures are similar in intensity and complexity, 28730 required less intra-service time than 28309, which accounts for the smaller work RVU. The RUC also commented that 28730 is similar to 29862, which both require 100 minutes of intra-service time, but requires slightly more complexity, which supports the higher work RVU of 28730. **The RUC recommends maintaining the current work RVU of 12.21 and accepting the median survey physician time and post-operative visits for CPT code 28730.**

Practice Expense

The RUC recommends that the non-facility practice expense inputs be modified to reflect changes to the post-operative office visits and that the physician-assist time be modified to reflect changes to the intra-service time.

Interventional Radiology Procedures – PE Only (Tab 21)
American College of Radiology
Society of Interventional Radiology

In June 2008, CMS requested the RUC to make direct practice expense recommendations in the non-facility setting for the following CPT Codes:

- 36481 *Percutaneous portal vein catheterization by any method*
- 37183 *Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanalization/dilatation, stent placement and all associated*
- 47382 *Ablation, one or more liver tumor(s), percutaneous, radiofrequency*
- 50200 *Renal biopsy; percutaneous, by trocar or needle*

At the October 2008 RUC meeting all of the CMS requested interventional radiology procedures were reviewed for practice expense and recommendations were made to place all of the procedures on CPT's appendix G to indicate that Moderate Sedation is inherent to these procedures. At that time, the RUC tabled code 36481 after determining that the medical supplies and equipment time included in the recommendation overlapped other services, such as imaging services, that are typically billed at the same time. The RUC also determined the specialty society recommendation lacked RUC standards for practice expense and that other similar services recently reviewed by the RUC may require revised recommendations. Codes 75885 *Percutaneous transhepatic portography with hemodynamic evaluation, radiological supervision and interpretation* and 75887 *Percutaneous transhepatic portography without hemodynamic evaluation, radiological supervision and interpretation* were identified as services to be reviewed concurrently with 36481 at the February 2009 RUC meeting.

At the February 2009 RUC meeting the RUC reviewed the practice expense input recommendations for codes 36481, 75885, and 75887 in tandem as to prevent any overlap or double counting of clinical staff, medical supplies, and/or equipment. The RUC made a minor change to a medical supply and agreed with the remainder of the specialty society's recommendations. **The RUC recommends the attached non-facility direct practice expense inputs for CPT codes 36481, 75885, and 75887.**

Arteriovenous Procedure (Tab 22)

Gary Seabrook MD FACS, Matthew Sideman MD FACS, David Han MD FACS, Robert Zwolak MD FACS, and Michael Sutherland MD FACS, Society for Vascular Surgery and Christopher Senkowski, MD, FACS American College of Surgeons

CPT code 36825, *Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); autogenous graft*, was identified by the Five-Year Review Identification Workgroup as potentially misvalued through its Site of Service Anomaly screen in September 2007. The Workgroup reviewed all services that include inpatient hospital visits within their global periods, but are performed less than 50% of the time in the inpatient setting, according to recent Medicare utilization data. The RUC originally recommended a two-step action. First, The RUC removed the hospital visits from the service with no impact on the

associated work RVU, which CMS agreed with. Second, the RUC recommended that services be surveyed. At the April 2008 RUC Meeting, the specialty societies presented data that indicate that although these procedures are reported as outpatient procedures more than 50% of the time, patients typically spend at least one night in the hospital. The RUC deferred action on these issues until an adequate survey instrument was developed. The RUC approved a revised survey instrument in October 2008 and these procedures were surveyed for review at the February 2009 RUC Meeting.

The RUC first reviewed 36825 to determine if there was compelling evidence to justify a review of the work RVU for a potential increase in value. The specialty society indicated that the service had never been reviewed by the RUC and was originally valued during the Harvard studies. Additionally, the specialty commented that the work involved in the procedure has changed due to a change in the typical patient since its inception. The procedure, which is used to create access for hemodialysis patients, is used less frequently now and on much more complicated patients, than it was in the past. Because of the “fistula first” initiative, patients are typically not undergoing this procedure unless they have failed a direct anastomosis. Since this is a secondary procedure, the patients that undergo a 36825 are typically older, sicker, and have no available hemodialysis access in their arms. Therefore, the physician work has changed. **The RUC agreed that compelling evidence to review this procedure exists.**

The specialty society presented the data from a survey of 31 general and vascular surgeons. The RUC first reviewed the physician time and post-operative evaluation and management visits. According to the survey, 74% of patients are kept overnight and more than 80% of those patients are seen on the evening of the day of the procedure and again the following day before being discharged. Because of this survey data, the RUC agreed that 36825 includes a full 99238 discharge day management visit as well as one 99231 hospital visit. The RUC also agreed with the survey post-service office visits, which include one 99212 and two 99213 visits. The RUC also agreed with the survey median intra-service time of 120 minutes, the survey median immediate post-service time of 30 minutes, and pre-service time package #4, difficult patient/difficult procedure, with an additional seven minutes of positioning time. Lastly, the RUC reviewed the recommended work RVU and disagreed with the specialty society expert panel recommendation. The RUC considered the survey data in comparison to the MPC reference code selected by the specialty, 36819, *Arteriovenous anastomosis, open; by upper arm basilic vein transposition*, (work RVU = 14.39). The RUC agreed that the survey median work RVU of 18.00 was too high, but that the survey 25th percentile work RVU was appropriate. The RUC reviewed 36819 and noted that the reference service and the surveyed code contain identical intra-service times of 120 minutes. The specialty noted that there are two differences between 36825 and 36819 that warrant a higher RVU for 36825: (1) 36825 requires a vein that is harvested from a remote location. As a result, it requires two anastomoses, one where the vein is sewn to the inflow artery and a second where it is attached to the outflow vein. (2) The surveyed code includes an additional 99213 office visit. As a result, the RUC agreed that the survey 25th percentile work RVU of 15.00 is appropriate in comparison to 36819 for 36825. **The RUC recommends the specialty’s survey 25th percentile work RVU of 15.00 for CPT code 36825.**

Practice Expense

The RUC recommends that the non-facility practice expense inputs be modified to reflect changes to the post-operative office visits and that the physician-assist time be modified to reflect changes to the intra-service time.

Parotid Tumor Excision (Tab 23)

**Jane Dillon, MD, American Academy of Otolaryngology – Head and Neck Surgery and
Christopher Senkowski, MD, FACS American College of Surgeons**

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 Five-Year Review Identification Workgroup as potentially misvalued through its Site of Service Anomaly screen in September 2007. The Workgroup reviewed all services that include inpatient hospital visits within their global periods, but are performed less than 50% of the time in the inpatient setting, according to recent Medicare utilization data. The RUC originally recommended a two-step action. First, the RUC removed the hospital visits from the service with no impact on the associated work RVU, which CMS agreed with. Second, the RUC recommended that services be surveyed. At the April 2008 RUC Meeting, the specialty societies presented data that indicate that although these procedures are reported as outpatient procedures more than 50% of the time, patients typically spend at least one night in the hospital. The RUC deferred action on these issues until an adequate survey instrument was developed. The RUC approved a revised survey instrument in October 2008 and these procedures were surveyed for review at the February 2009 RUC Meeting.

42415

The specialty society agreed that there was not compelling evidence to support a review of the physician work in order to recommend a higher work RVU than is currently assigned to 42415. However, the specialty presented data from a survey of 76 otolaryngologists and general surgeons as well as consensus recommendations from an expert panel of otolaryngologists and general surgeons to validate physician time and post-operative visits. The survey results and expert panel consensus show that patients are typically kept overnight in the hospital following this procedure. The survey results indicated that 97% of respondents perform the procedure in the hospital. Of those 97% respondents, 91% stated that the patient stays overnight. The specialty society panel indicated pre-service time package four applied – facility, difficult patient, difficult procedure. The specialty societies indicated that an additional 9 minutes of positioning time is necessary to assist the patient with the shoulder roll, rotating and stabilizing the head. Further, the survey and panel, based on the survey median, recommended an intra-service time of 150 minutes and immediate post-service time of 20 minutes. Lastly, the specialty presented data that one 99238 discharge day management service, and one 99212 and two 99213 office visits are included. The RUC agreed with the specialty society survey results regarding physician time and post-operative visits. The RUC also compared 42415 to the key reference service, 60271, *Thyroidectomy, including substernal thyroid; cervical approach*, (work RVU = 17.54, intra-time = 150), which supports the current work RVU of 17.99. The RUC also noted that the survey 25th percentile work RVU was 18.00. **The RUC recommends the new physician times as well as hospital and office visits, but recommends maintaining the current work RVU of 17.99 for CPT code 42415.**

42420

The specialty society agreed that there was no compelling evidence to support a review of the physician work in order to recommend a higher work RVU than is currently assigned to 42420. However, the specialty presented data from a survey of 76 otolaryngologists and general surgeons as well as consensus recommendations from an expert panel of otolaryngologists and general surgeons to validate physician time and post-operative visits. The survey results and expert panel consensus show that patients are typically kept overnight in the hospital following this procedure. The survey results indicated that 100% of respondents perform the procedure in the hospital. Of those respondents, 98% stated that the patient stays overnight, and 62% stated that the patient

stays longer than one day. The consensus panel indicated that the typical length of stay for this procedure is 3 days monitoring for airway patency, hematoma formation, facial nerve function, and control of pain and nausea is necessary. The specialty society survey and panel indicated pre-service time package four applied – facility, difficult patient, difficult procedure. The specialty societies indicated that an additional 9 minutes of positioning time is necessary to assist the patient with the shoulder roll, rotating and stabilizing the head. Further, the survey and panel, based on the survey median, recommended an intra-service time of 180 minutes and immediate post-service time of 20 minutes. Lastly, the specialty presented data that one 99231 hospital visit, one 99232 hospital visit, one 99238 discharge day management service, and one 99212 and two 99213 office visits are included. The RUC agreed with the specialty society survey results regarding physician time and post-operative visits. The RUC compared the 42420 to MPC code 35141, *Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, common femoral artery (profunda femoris, superficial femoral)*, (work RVU = 20.83, intra-time = 150 minutes) and code 34471, *Thrombectomy, direct or with catheter; subclavian vein, by neck incision* (work RVU = 21.00 intra-service = 180) and agreed that the two services support the current work RVU of 20.87. The RUC also noted that the survey respondents indicated a median work RVU of 25.00 work RVUs and a 25th percentile of 23.36, comparing the work of 42420 to 38724, *Cervical lymphadenectomy (modified radical neck dissection)* (work RVU = 23.72). **The RUC recommends the new physician times as well as hospital and office visits, but recommends maintaining the current work RVU of 20.87 for CPT code 42420.**

Practice Expense

The RUC recommends that the non-facility practice expense inputs be modified to reflect changes to the post-operative office visits and that the physician-assist time be modified to reflect changes to the intra-service time.

Hernia Repair (Tab 24)

Christopher Senkowski, MD, FACS and Charles Mabry, MD, FACS, American College of Surgeons

CPT codes 49507, *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 Five-Year Review Identification Workgroup as potentially misvalued through its Site of Service Anomaly screen in September 2007. The Workgroup reviewed all services that include inpatient hospital visits within their global periods, but are performed less than 50% of the time in the inpatient setting, according to recent Medicare utilization data. The RUC originally recommended a two-step action. First, the RUC removed the hospital visits from the service with no impact on the associated work RVU, which CMS agreed with. Second, the RUC recommended that services be surveyed. At the April 2008 RUC Meeting, the specialty societies presented data that indicate that although these procedures are reported as outpatient procedures more than 50% of the time, patients typically spend at least one night in the hospital. The RUC deferred action on these issues until an adequate survey instrument was developed. The RUC approved a revised survey instrument in October 2008 and these procedures were surveyed for review at the February 2009 RUC Meeting.

49507

The specialty society agreed that there was no compelling evidence to support a review of the physician work in order to recommend a higher work RVU than is currently assigned to 49507.

To support the current work RVU, the specialty presented data from a survey of 84 general surgeons and consensus recommendations from an expert panel of general surgeons to validate physician time and post-operative visits. The survey results and expert panel consensus show that patients are typically kept overnight in the hospital following this procedure. The survey results indicated that 98% of respondents perform the procedure in the hospital. Of those 98%, 83% stay overnight, and of those 83%, 73% (or 59% of all patients) are seen for an evaluation and management visit on the same day. The surveyees and the specialty expert panel noted and the RUC agreed that typically patients require close monitoring the day of and the day after the procedure for problems such as ileus, intestinal ischemia, and urinary retention. There is also a significant amount of pain management. A patient will not be discharged until there is a return of bowel function, the patient is taking adequate nutrition, and there is adequate pain control with oral analgesics. The specialty society panel indicated pre-service time package four applied – facility, difficult patient, difficult procedure. Further, the survey and panel recommended an intra-service time of 70 minutes and immediate post-service time of 30 minutes. Lastly, the specialty presented data that one 99231 hospital visit, one 99238 discharge day management service, and one 99212 and one 99213 office visits are typical. The RUC agreed with the specialty society survey results regarding physician time and post-operative visits. The RUC compared 49507 to the key reference service 49505, *Repair initial inguinal hernia, age 5 years or older; reducible* (work RVU = 7.88 intra-time = 70 minutes). The RUC also compared 49507 to 54512, *Excision of extraparenchymal lesion of testis* (work RVU = 9.22, pre-time = 50 minutes, intra-time = 70 minutes, post-service = 30) and noted that there is more pre-service time in the surveyed code (63 versus 50 minutes) accounting for the slight difference in work RVU. The RUC noted that the reference service contains less pre-service and immediate post-service and is less intense than the surveyed code. The RUC also noted that the 25th percentile survey work RVU was 9.91 and the median work RVU was 11.00. **The RUC recommends the new survey times as well as hospital and office visits, but recommends maintaining the current work RVU of 9.97 for CPT code 49507.**

49521

The specialty society agreed that there was no compelling evidence to support a review of the physician work in order to recommend a higher work RVU than is currently assigned to 49521. To support the current work RVU, the specialty presented data from a survey of 84 general surgeons and consensus recommendations from an expert panel of general surgeons to validate physician time and post-operative visits. The survey results and expert panel consensus show that patients are typically kept overnight in the hospital following this procedure. The survey results indicated that 99% of respondents perform the procedure in the hospital. Of those 99%, 82% stay overnight, and of those 82%, 68% (or 55% of all patients) are seen for an evaluation and management visit on the same day. The surveyees and the specialty expert panel noted and the RUC agreed that typically patients require close monitoring the day of and the day after the procedure for problems such as ileus, intestinal ischemia, and urinary retention. There is also a significant amount of pain management. A patient will not be discharged until there is a return of bowel function, the patient is taking adequate nutrition, and there is adequate pain control with oral analgesics. The specialty society panel indicated pre-service time package four applied – facility, difficult patient, difficult procedure. Further, the survey and panel recommended an intra-service time of 90 minutes and immediate post-service time of 30 minutes. During the immediate post-service work, the physician protects the wound with a hand while the patient comes out of anesthesia so that an unrestrained cough does not disrupt the repair. Lastly, the specialty presented data that one 99231 hospital visit, one 99238 discharge day management service, and one 99212 and one 99213 office visits are typical. The RUC agreed with the specialty society survey results regarding physician time and post-operative visits. The RUC compared 49521 to the key reference service, 49520, *Repair recurrent inguinal hernia, any age;*

reducible, (work RVU = 9.91, intra-service time = 60 minutes). The RUC noted that the reference service requires 30 minutes less intra-service time and involves less intensity and complexity than the survey code. The RUC also compared 49521 to 49652, *Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed)*; *reducible* (work RVU = 12.80, pre-time = 75, intra-time = 90, immediate post-time = 30) and noted that the two codes are similar and have identical intra- and immediate post-service time, but that the reference code has slightly more pre-service time accounting for the difference in work RVU. The RUC also noted that the survey respondents indicated a median work RVU of 14.00 and a 25th percentile work RVU of 11.00. **The RUC recommends the new survey times as well as hospital and office visits, but recommends maintaining the current work RVU of 12.36 for CPT code 49521.**

49587

The specialty society agreed that there was no compelling evidence to support a review of the physician work in order to recommend a higher work RVU than is currently assigned to 49587. To support the current work RVU, the specialty presented data from a survey of 84 general surgeons and consensus recommendations from an expert panel of general surgeons to validate physician time and post-operative visits. The survey results and expert panel consensus show that patients are typically kept overnight in the hospital following this procedure. The survey results indicated that 100% of respondents perform the procedure in the hospital. Of those, 71% stay overnight, and of those 71%, 77% (or 55% of all patients) are seen for an evaluation and management visit on the same day. The surveyees and the specialty expert panel noted and the RUC agreed that typically patients require close monitoring the day of and the day after the procedure for problems such as ileus, intestinal ischemia, and urinary retention. There is also a significant amount of pain management. A patient will not be discharged until there is a return of bowel function, the patient is taking adequate nutrition, and there is adequate pain control with oral analgesics. The specialty society panel indicated pre-service time package four applied – facility, difficult patient, difficult procedure. Further, the survey and panel recommended an intra-service time of 60 minutes and immediate post-service time of 30 minutes. Lastly, the specialty presented data that one 99231 hospital visit, one 99238 discharge day management service, and one 99212 and one 99213 office visits are typical. The RUC agreed with the specialty society survey results regarding physician time and post-operative visits. The RUC compared 49587 to the key reference service, 49585, *Repair umbilical hernia, age 5 years or older; reducible*, (work RVU = 6.51, intra-service time = 45 minutes). The RUC noted that the reference service requires 15 fewer minutes and requires less intensity and complexity than the surveyed code. The RUC also compared 49587 to 49572, *Repair epigastric hernia (eg, preperitoneal fat); incarcerated or strangulated* (work RVU = 7.79, pre-time = 45 intra-time = 60, immediate post-time = 30). The RUC agreed that the two codes are similar, but that the difference in intra-service accounts for the slight difference in work RVUs. The RUC also noted that the survey respondents indicated a median work RVU of 11.50 work RVUs. **The RUC recommends the new survey times as well as hospital and office visits, but recommends maintaining the current work RVU of 7.96 for CPT code 49587.**

Practice Expense

The RUC recommends that the non-facility practice expense inputs be modified to reflect changes to the post-operative office visits.

Cryoablation of Prostate (Tab 25)

James Giblin, MD, Richard Gilbert, MD, and Mark Chelsky, MD, American Urological Association

In June 2008, CMS requested the RUC to review non-facility setting direct practice expense recommendations for CPT Code 55873 *Cryosurgical ablation of the prostate (includes ultrasonic guidance for interstitial cryosurgical probe placement)*. The American Urological Association's Quality Improvement and Patient Safety Committee maintained that 55873 may be performed in the office setting assuming that a Class C surgical facility designation for anesthesia has been achieved. The RUC reviewed the direct practice expense recommendation in the non-facility setting as presented by the specialty and realized the service was initially reviewed as a new code by the RUC in February 2001. RUC members believed that the intra-service physician time since the RUC's initial review had declined (from 200 minutes) as the service is now more often performed. The RUC agreed with the specialty that the service should be surveyed for physician work for presentation with revised direct practice expense input information at the RUC's January 29 – February 1, 2009 meeting.

At the RUC's January 29 – February 1, 2009 meeting the specialty society provided a clear description of the service being provided. The survey respondents had chosen CPT code 55875 *Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy* (Work RVU = 13.31) as its key reference service. RUC members had expressed their concern regarding the high intra-service work per unit of time (IWPUT) and the change in intra-service time from the previous survey performed eight years prior. The specialty explained that the performance of the procedure has changed and the intensity had increased. The monitoring of multiple body data points for temperature change simultaneously, the placement of multiple probes, and the reduction of time of obtaining and maintaining a -40F ice ball formation, has increased the intensity and reduced the intra-service time. In addition, it was explained that the risk of patient injury during the entire procedure is quite high.

The RUC agreed that the work value for code 55873 is similar to the specialty's key reference service 55875. However, the RUC did not agree with the specialty's recommended value of 15.50. The RUC reviewed its previous recommendation from February 2001 which was established through a building block methodology with an intra-service work per unit of time (IWPUT) of 0.071. RUC members understood that from the recent survey the intra-service time is lower (100 rather than 200 minutes) and a higher intensity and complexity has been recognized than when the code was first surveyed. Due to a more complex and intense monitoring of the organs and ablated area, RUC members concurred that the intensity of 55873 is between the specialty survey's key reference service code 55873 (IWPUT = 0.0948) and its originally determined intensity of 0.071 established from CPT code 55845 *Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes* (Work RVU = 30.52). The RUC agreed the IWPUT to be approximately 0.083 which is precisely between the IWPUT of 55845 and 55873. Using the specialty's surveyed physician time components and an IWPUT of 0.083 the RUC constructed a building block methodology that resulted in a work relative value of **13.45** for CPT code 55873.

The RUC agreed that an anchor code and a building block approach would also be useful at establishing the correct value. The RUC considered several similar services with a range of complexities including code 50593 *Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy* (Work RVU = 9.08, IWPUT = 0.064). Code 50593 has 90 minutes of intra-service time, however the ultrasound guidance needed to place the needles is coded separately, and the insertion of a superpubic catheter is required for cryoablation of the prostate. Adding up these components was agreed be appropriate in establishing the physician work value for code 55873.

The RUC agreed that although the physician work for code 55873 is similar to code 50593, it is more intense and concurred the intensity of 0.083 needed to be maintained.

The RUC then took 90 minutes of intra-service work time out of code 50593 at an IWPUT of 0.064 ($0.064 \times 90 = 5.76$) and replaced with 90 minutes of work at an IWPUT of 0.083 ($0.083 \times 90 = 7.47$) to arrive at a beginning value of 10.79. ($7.47 - 5.76 = 1.71$ RVUs + $9.08 = 10.79$). The insertion of a suprapubic catheter and the ultrasound guidance are then added to arrive at a value similar to 13.45 as shown below.

This building block utilizes the work the following three codes:

50593 *Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy* (Work RVU = $9.08 + 1.71$ (intensity RVU difference) = 10.79.

51102 *Aspiration of bladder; with insertion of suprapubic catheter* (Work RVU = $2.70 \times 50\%$ (multiple procedure reduction) = 1.35)

76965 *Ultrasonic guidance for interstitial radioelement application* (Work RVU = 1.34)

10.79

+1.35

+1.34

13.48

The RUC's building block and IWPUT methodologies led them approximately to the same physician work value of 13.45 RVUs. The RUC also reviewed and compared the work of codes 49565 *Repair recurrent incisional or ventral hernia; reducible* (Work RVU = 12.29, 100 minutes intra-service time), 58550 *Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less*; (Work RVU = 14.97, 100 minutes intra-service time), and 29806 *Arthroscopy, shoulder, surgical; capsulorrhaphy* (Work RVU = 14.95, 100 minutes intra-service time). After developing a building block methodology, reviewing similar procedures with 100 minutes of intra-service time and intensity ranges, **the RUC recommends a relative work value of 13.45 for CPT code 55873**. This value preserves the rank order between 55873 and its key reference code 55875.

Practice Expense: The RUC reviewed the direct practice expense inputs as recommended by the specialty and made some minor edits to the clinical labor and medical supplies to reflect the typical patient service.

Hysterectomy – PE Only (Tab 26)
American College of Obstetricians and Gynecologists

At the request from the Centers for Medicare and Medicaid Services, the RUC reviewed a list of direct practice expense input changes specific to the following CPT codes:

58555 *Hysteroscopy, diagnostic (separate procedure)*

58558 *Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C*

58562 *Hysteroscopy, surgical; with removal of impacted foreign body*

58563 *Hysteroscopy, surgical; with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation)*

The specialty society noticed that some practice expense items for the typical service, needed to be included. The RUC reviewed these practice expense additions carefully and agreed with the specialty's recommendations. They agreed that a pack for cleaning surgical instruments, already included in the practice expense items for these services, is necessary in addition to the pack for cleaning and disinfecting the endoscope because the hysteroscopy services need a speculum, a tenaculum, and other sterile equipment to access the uterus, in addition to the endoscopy instruments. The cystoscopy pack is required for installation of the distention fluid and is in addition to the exam pack that is now recommended. **The RUC recommends the following additions and deletions to the direct practice expense inputs:**

1. **58555-** *Hysteroscopy, diagnostic (separate procedure)*
 - a. SA058- Pack, Urology cystology visit
 - b. SA042-Pack, Cleaning and disinfecting, endoscope
 - c. SB001-Cap, Surgical
 - d. SB027-Gown, Staff, impervious
 - e. SB034-Mask Surgical, with face shield
 - f. SB039-Shoe Cover, Surgical
 - g. SJ036- Monsel's Soln
 - h. SC053- Syringe, 20 ml
 - i. **Remove Items:** (SB024-Gloves- sterile, SJ041-Povidone Soln Betadine, SC062 Toomey syringe)

2. **58558-** *Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C*
 - a. SA058- Pack, Urology cystology visit
 - b. SA042-Pack, Cleaning and disinfecting, endoscope
 - c. SB001-Cap, Surgical
 - d. SB027-Gown, Staff, impervious
 - e. SB034-Mask Surgical, with face shield
 - f. SB039-Shoe Cover, Surgical
 - g. SJ036- Monsel's Soln
 - h. SC053- Syringe, 20 ml
 - i. **Remove Items:** (SB024 Gloves-sterile, SJ041-Providone Soln Betadine, SC062 Toomey syringe)

3. **58562-** *Hysteroscopy, surgical; with removal of impacted foreign body*
 - a. SA058- Pack, Urology cystology visit
 - b. SA042-Pack, Cleaning and disinfecting, endoscope
 - c. SB001-Cap, Surgical

- d. SB027-Gown, Staff, impervious
 - e. SB034-Mask Surgical, with face shield
 - f. SB039-Shoe Cover, Surgical
 - g. SJ036- Monsel's Soln
 - h. SC053- Syringe, 20 ml
 - i. **Remove Items:** (SB024 Gloves-sterile, SJ041-Providone Soln Betadine, SC062 Toomey syringe)
4. **58563- Hysteroscopy, surgical; with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation)**
- a. SA058- Pack, Urology cystology visit
 - b. SA042-Pack, Cleaning and disinfecting, endoscope
 - c. **Remove Items:** (SM018 Glutaraldehyde 3.4% Cidex, Maxicide, Wavicide, SH048-Lidocaine 2% jelly, topical (Xylocaine), SH069- Sodium chloride 0.9% irrigation (500-1000ml), SD129 Tubing, irrigation(Cysto), SD118 (-1) vaginal specula)

Obstetric Procedures (Tab 27)

American Academy of Family Physicians, American College of Obstetricians and Gynecologists

The Five Year Review Identification Workgroup identified the following codes as potentially misvalued through the High IWPUR Screen and the RUC recommended that they be surveyed: 59400, 59409, 59410, 59412, 59414, 59425, 59426, 59430, 59510, 59515, 59610, 59612, 59614, 59618, 59620, and 59622. The RUC referred development of an MMM survey instrument to the Research Subcommittee with input from the specialty society at its October 2008 meeting. The Research Subcommittee has worked with the specialty since that time to develop a survey method to review these codes. The survey and process will be finalized by the April 2009 RUC meeting so data can be collected and presented at the October 2009 RUC meeting.

Cranial Neurostimulators (Tab 28)

American Association of Neurological Surgeons/Congress of Neurological Surgeons

CPT codes 61885 *Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array*, and 64753 *Incision for implantation of neurostimulator electrodes; cranial nerve* were identified by the Five-Year Review Identification Workgroup as potentially misvalued through its Site of Service Anomaly screen in September 2007. The Workgroup reviewed all services that include inpatient hospital visits within their global periods, but are performed less than 50% of the time in the inpatient setting, according to recent Medicare utilization data. The RUC originally recommended a two-step action. First, the RUC removed the hospital visits from the service with no impact on the associated work RVU, which CMS agreed with. Second, the RUC recommended that services be surveyed. At the April 2008 RUC Meeting, the specialty societies presented data that indicate that although these procedures are reported as outpatient procedures more than 50% of the time, patients typically spend at least one night in the hospital. The RUC deferred action on these issues until an adequate survey instrument was developed. The RUC approved a revised survey instrument in October 2008.

The specialty societies presented information to the RUC that as a result of recent developments in the use of vagal nerve stimulators, there are some concerns about the use of 61885 and 64753 with respect to these procedures. The specialty societies are bringing forth a CPT coding proposal to revise 61885 and 64753 to better describe revision of a vagal nerve stimulator lead and the placement of the pulse generator and replacement or revision of the vagus nerve electrode. The specialties requested that the RUC review of CPT codes 61885 and 64753 be postponed until a revision of the descriptors for these codes has been reviewed by the CPT Editorial Panel.

The RUC agreed with the specialty societies and recommended referral of 61885 and 64753 to the CPT Editorial Panel.

End-Stage Renal Disease – PE and Physician Time Only (Tab 29)

Renal Physicians Association

In February 2008, the RUC reviewed physician work and practice expense recommendations for the adult and pediatric end stage renal dialysis services. These recommendations were submitted to CMS in May 2008 for implementation beginning January 2009. However, in the 2009 Final Rule, CMS requested the RUC to again review its practice expense recommendations to make certain that they accurately reflect the typical direct resources required for these services. In addition, CMS requested the RUC to review the physician time for CPT codes 90960 and 90961.

As of the date of the February 2009 RUC agenda book publication AMA RUC staff had not received comments from the Renal Physicians Association (RPA). RUC members discussed the issue and agreed that RPA staff and advisors were unprepared to provide a cohesive recommendation to the RUC at that time and asked that the issue be deferred to the April 2009 RUC meeting. **The RUC recommends that this issue be deferred to its next meeting in April 2009.**

Speech-Language Pathology – (Tab 30)

Jane Dillon, MD, American Academy of Otolaryngology – Head and Neck Surgery, Robert Fifer, PhD and Dee Adams Nikjeh, PhD, American Speech-Language and Hearing Association

On July 15 2008, H.R. 6331 Medicare Improvements for Patients and Providers Act of 2008 was signed into law. Section 143 of HR 6331 specifies that speech language pathologists may independently report services they provide to Medicare patients. Starting in July 2009, speech language pathologists will be able to bill Medicare independently as private practitioners.

On October 9, 2008, the American Speech-Language-Hearing Association (ASHA) sent a request to CMS that in light of the recent legislation, that speech language pathologists services be based on professional work values and not through the practice expense component. CMS requested that the RUC review the speech language codes for professional work as requested by ASHA. ASHA indicated that it will survey the 13 speech language pathology codes over the course of the CPT 2010 and CPT 2011 cycles.

At the February 2009 meeting, the RUC reviewed codes 92597 *Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech* and 92610 *Evaluation of oral and pharyngeal swallowing function*.

92597

The RUC reviewed the survey data from 31 speech pathologists and 5 otolaryngologists for code 92597. The survey data between both specialties was comparable. The specialty societies confirmed that this service is not included in the 090-day global period of performing a laryngectomy 31360 *Laryngectomy; total, without radical neck dissection* or 31365 *Laryngectomy; total, with radical neck dissection* which does not involve placing a fistula or dilating a stoma. However, the specialty societies recommended and the RUC agreed that the survey respondents slightly overestimated the time required to perform this service. Therefore, the RUC recommends pre-service package 5-Non-facility procedure without sedation/anesthesia care (7 minutes evaluation), a reduction of the intra-service time by 15 minutes to 40 minutes, and the immediate post-service time by 2 minutes to 13 minutes. The RUC also compared 92597 to code 97001 *Physical therapy evaluation* (work RVU = 1.20, 4 minutes pre-, 30 minutes intra- and 8 minutes immediate post-service time) and determined that 92597 required slightly more work and time to perform than 97001. The RUC determined that the decrease in physician time and survey median work RVU of 1.48 appropriately reflects the work required to perform this service. **The RUC recommends a work RVU of 1.48 for code 92597.**

92610

The RUC reviewed the survey data from 125 speech pathologists and 5 otolaryngologists for code 92610. The specialty society recommended and the RUC agreed that the survey respondents slightly overestimated the time required to perform this service. Therefore, the RUC recommends pre-service package 5-Procedure without sedation/anesthesia care (7 minutes evaluation), a reduction in the intra-service time by 10 minutes to 35 minutes, and a reduction the immediate post-service time by 5 minutes to 10 minutes. The RUC also compared 92610 to codes 97001 *Physical therapy evaluation* (work RVU = 1.20, 4 minutes pre-, 30 minutes intra- and 8 minutes immediate post-service time) and 92557 *Comprehensive audiometry threshold evaluation and speech recognition* (work RVU = 0.60 and 3minute pre-time, 20 minutes intra-time and 5 minutes immediate post service time). The RUC determined that 92610 required slightly more work and time to perform than 97001 and required approximately double that of the time and work required for 92557. The RUC determined that the decrease in physician time and surveyed 25th percentile work RVU of 1.30 appropriately reflects the work required to perform this service. **The RUC recommends a work RVU of 1.30 for code 92610.**

Practice Expense

The RUC recommends removing the associated speech language pathologists' time from the direct practice expense inputs, as all physician and speech pathologist work is captured in the work RVU. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

PLI

The RUC recommends that code 92610 be crosswalked to 92557.

Cardiology Services - PE Only (Tab 31)
American College of Cardiology

In September 2007, the RUC had reviewed its recommendations for physician work and practice expense for then new code 93306 *Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography*. Code 93306 is a

bundled code comprised of codes 93307 *Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete*, 93320 *Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete* and 93325 *Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)*. At that time, the RUC made its practice expense recommendations based on the sum of the codes' parts. The RUC made minor edits to the recommended clinical labor and medical supplies, and the equipment was recommended to remain the same. These recommendations were then forwarded to CMS in 2008 for implementation in 2009. In the 2009 Final Rule, CMS stated that prior to accepting the RUC's recommendation for code 93306, they would like the RUC to review the practice expense inputs of 93307, 93320, and 93325 to ensure that they are consistent with the recommended direct inputs for 93306. In the interim, they would continue to use the established practice expense RVUs for these services. In February 2009, the RUC reviewed the practice expense inputs for codes 93307, 93320, and 93325 in comparison with 93306. The RUC understood that the sum of the practice expense inputs of codes 93307, 93320, and 93325 should be greater than the inputs for code 93306 because of economies of scale. The RUC agreed with the specialty's recommendations for clinical labor, medical supplies, and equipment. **The RUC recommends the attached practice expense direct inputs for codes 93307, 93320, and 93325.**

The CMS had also asked the RUC review the practice expense inputs of cardiac catheterization procedures (93510 – 93556) at its February 2009 meeting. As follow-up to a letter sent by the American College of Cardiology (ACC) in the summer of 2008. The ACC addressed the recent changes in the practice expense methodology that caused a substantial reduction in payment for cardiac catheterization services performed in the physician office setting. The ACC agrees with the practice expense input recommendations submitted by the RUC and accepted by CMS in 2007. **The RUC recommends no changes in the practice expense inputs for CPT codes 93017, 93510, 93543, 93545, 93555 and 93556.** The ACC noted that the society is developing a code proposal to re-write cardiac catheterization codes as bundled procedures for initial discussion at the June 2009 CPT Meeting.

Measure Blood Oxygen Level – PE Only (Tab 32)

American College of Chest Physicians, American Thoracic Society

In October 2008 the RUC's Five Year Identification Workgroup reviewed 94762 *Noninvasive ear or pulse oximetry for oxygen saturation; by continuous overnight monitoring (separate procedure)* as part of the CMS Fastest Growing Procedures screen and noted that it consists of practice expense only, with independent testing facilities predominantly performing this procedure. The Workgroup recommended that this code and the other codes in the family (94760 *Noninvasive ear or pulse oximetry for oxygen saturation; single determination* and 94761 *Noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations (eg, during exercise)*) be referred to the RUC's Practice Expense Subcommittee for review of the direct practice expense inputs.

In January 2009 the RUC carefully reviewed the typical clinical labor, medial supplies, and equipment recommended by the specialty society for codes 94760, 94761, and 94762. The RUC made few edits and changes and agreed with the modified specialty recommendations. **The RUC recommends the attached direct practice expense inputs for codes 94760, 94761, and 94762.**

Moderate Sedation Practice Expense Inputs – PE Only (Tab 33)

American College of Radiology, American Society of Neuroradiology, North American Spine Society, Society of Interventional Radiology

In 2005, CPT began identifying services in which moderate sedation is inherent and listed them in a separate addendum. The CMS reviewed its direct practice expense inputs database in 2008 and found 12 CPT codes that had moderate sedation practice expense inputs but were not listed in CPT's moderate sedation addendum. All 12 codes had been reviewed for practice expense direct inputs by the RUC prior to CPT 2005. CMS removed the moderate sedation inputs of all 12 codes for its 2009 physician fee schedule calculations and asked specialty societies to bring any of the codes forward to the RUC to reestablish the inputs. In February 2009, specialty societies contended that moderate sedation was inherent to two of these codes. The RUC discussed and agreed that moderate sedation was inherent in codes 22520 *Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; thoracic*, and 22521 *Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; lumbar*. **The RUC recommends that the moderate sedation practice expense inputs be added back to codes 22520 and 22521. In addition, the RUC recommends codes 22520 and 22521 be placed on CPT's Appendix G, summary of CPT codes that include moderate (conscious) sedation.**

XI. Practice Expense Subcommittee (Tab 34)

Doctor Moran reported that Sherry Smith provided a PowerPoint presentation update on the AMA/Specialty Society Physician Practice Information Survey. Ms. Smith informed the RUC that the survey has concluded and that staff was waiting for the results to analyze. It is anticipated that a report on the results will be presented at the April RUC meeting.

The Practice Expense Subcommittee reviewed an array of direct practice expense recommendations for new, revised, and existing CPT codes referred to the group by CMS. The RUC approved the recommendations and will forward to CMS.

The Practice Expense Subcommittee expressed concern regarding requests to review services non-facility practice expense inputs that require general anesthesia.

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

XII. Research Subcommittee and Ad Hoc Pre-Time Workgroup (Tab 35)

Doctor Daniel Siegel delivered the Research Subcommittee Report to the RUC detailing the two items reviewed: 1.) A request from the American College of Obstetricians and Gynecologists (ACOG) and American Academy of Family Physicians (AAFP) to review a MMM global survey instrument and 2.) A referral from the Ad Hoc Pre-Service Time Workgroup to review their recommendations pertaining to a request made by North American Spine Society (NASS) to review a cover letter and survey instrument for developing pre-service time standards.

The Research Subcommittee reviewed the MMM global survey instrument. **The RUC agreed with the Research Subcommittee recommended modifications to the cover letter and survey instrument including:**

- **Cover Letter –**
 - **In the first paragraph, the term “payment” should be replaced with the term “valuation” and**
 - **The sentence, “These 2 areas will be the most critical to evaluate, since they most likely require the most work and a significant amount of risk.” should be deleted.**
- **Survey Instrument –**
 - **Question 2 – the first sentence should read, “This question refers only to services provided by the physician prior to the hospital admission for the onset of labor.” Further, weeks 43 and 44 should be removed from the grid**
 - **Background for Question 3 – the second sentence should read, “It will also include any time spent with the patient and her family during her labor, interpretation of the fetal monitor strip and placement of monitors if indicated.” Further, the third sentence should be bolded and read, “This is not limited to face to face time with the patient, but may also include time on the floor or unit providing non-face to face patient care, not including office time” In addition, the second paragraph should be deleted.**
 - **Question 3 – the question should read, “Please identify how much time is spent providing care to the patient during each encounter of management of typical labor. Further, the critical care time column should be removed and the non-critical care column should read, Minutes.**
 - **Question 4 – the question should read, “Which of the reference services on the attached list is most similar to the delivery portion of the maternity service described on the cover of this questionnaire, with respect to the intra-service work.**
 - **Question 6b – the third sentence, “For critical care service exceeding 74 minutes, use 99291 and the appropriate number of 99292 services.” should be deleted. Further, the hospital visits (critical care) section should be deleted and prolonged services (99356 and 99357) should be added**
 - **Question 7 – the immediate post-service section should be deleted**

The Research Subcommittee reviewed the reference service list proposed by the societies and **With the addition of five services primarily performed by family physicians and the modifications listed in the report, the Research Subcommittee recommends and the RUC approves the proposed reference service list.**

The Research Subcommittee reviewed the cover letter and survey instrument proposed by NASS to develop pre-service time standards for spine surgery. **With a modification to the survey instrument as listed in the report, the Research Subcommittee recommends and the RUC approves the cover letter and survey instrument proposed by NASS.**

Ad Hoc Pre-Time Workgroup

Doctor Brenda Lewis delivered the Ad Hoc Pre-Service Time Workgroup Report to the RUC detailing the two items discussed: 1.) Pre-service time workgroup background and 2.) Ad Hoc Pre-Service Time Workgroup’s Mission.

Doctor Lewis reviewed with the current Pre-Service Time Workgroup the charges as directed by the RUC. The Workgroup will be tasked to further refine the pre-service time packages. The Workgroup will also address the issue of retroactive application of pre-service time packages.

Doctor Lewis reviewed the mission of the Ad Hoc Pre-Service Time Workgroup as detailed in the report. The Workgroup addressed one of the concerns raised by ACS was that the current pre-service time packages do not address a straightforward patient undergoing a straightforward procedure under general anesthetic. **To address the concern raised by the ACS, the Workgroup recommends and the RUC agrees to add the following language to the note section of the pre-service time document:**

Additional time may be justified for a straightforward patient undergoing a straightforward procedure (Package 1B), if the procedure is performed under general anesthesia and the surveys support additional pre-service time.

A second issue raised by ACS was a concern that the pre-services packages that currently exist may not allow for specialties to support additional time when complex procedures require review of pathology reports and extensive imaging that is imperative to the operation. **The Workgroup recommends and the RUC agrees with addition of the following language which currently accompanies the pre-service time package instructions:**

“The Workgroup allows additional time if justified by the specialty society. The Workgroup believed additional increments of 15 minutes for TEE, Invasive monitoring , complex positioning, or extensive data review (reports or imaging studies as examples) may be appropriate for some procedures.”

Furthermore, the Workgroup determined that until there is more data from RUC recommendations utilizing the pre-service time packages, making RUC policy to address the retroactive application of the new pre-service time packages to the entire RBRVS issue would be premature. The Workgroup recommends that it will address this issue after the fourth Five-Year Review when a few years of data have been collected and can be statistically reviewed by the Workgroup. **However, in the interim, the Workgroup recommends and the RUC agrees that services that have utilized the pre-service time packages be flagged in the RUC database.**

The RUC approved the Research Subcommittee and Ad Hoc Pre-Time Workgroup reports and they are attached to these minutes.

XIII. PLI Workgroup (Tab 36)

Peter Smith, MD, reported on the meeting with CMS and the two former PLI Workgroup Chairman. Doctor Smith indicated that the following issues were discussed with CMS at this meeting:

- The PLI technical component methodology and the current lack of existence of separate liability insurance for technical staff;
- The collection of premium data by the contractor, especially the concern to include all top high risk specialties; (neurosurgery, obstetrics/gynecology and cardiothoracic surgery) as well as health care professionals data;
- Previously recommended Maxillofacial crosswalks;
- Utilizing the RUC low volume (< 100) dominant specialty recommendations; and
- Utilizing current premium data (PIAA submitted data).

Doctor Smith indicated that his impression was that significant progress was made with the RUC’s recommendations to CMS. CMS indicated basic agreement with the issues. The agency

has charged their contractor to specifically look for PLI evidence for technical staff as well as collect publicly available premium data for all specialties. The Agency indicated that they may address the maxillofacial crosswalk in the next *Proposed Rule*. Additionally, the Agency requested that the RUC resubmit their dominant specialty recommendations for low volume codes for consideration in proposed rulemaking.

As a result of the meeting with CMS, AMA staff identified 1,839 codes with frequency less than 100, based on 2007 Medicare utilization data. These codes were sent out to all specialty societies for comment to indicate who is the dominant specialty performing these services. These data were compiled and adjudicated with the previous 2006 recommendations, current utilization data and specialty society recommendations. The RUC reviewed all 1,839 assignments and by consensus recommends a dominant specialty assignment for each code.

Doctor Smith indicated that codes 99185 and 99186 were deleted from the screen as they have 0.00 work RVUs. However, the PLI workgroup did note that these codes incorrectly have PLI RVUs. The RUC recommends that the PLI RVUs for codes 99185 and 99186 should be 0.00.

The RUC dominant specialty recommendations for low volume codes are attached to this report and will be forwarded to CMS following this meeting.

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

XIV. HCPAC Review Board (Tab 37)

Lloyd Smith, DPM, informed the RUC that the HCPAC did not review CPT code 76880 *Ultrasound, extremity, nonvascular, real time with image documentation*. The Five-Year Review Identification Workgroup as part of its CMS-initiated 114 Fastest Growing Procedures screen identified this code. The American Podiatric Medical Association (APMA) rescinded its level of interest, as it stated that podiatrists are not the dominant specialty performing this service. The Workgroup identified that this services is predominantly provided by podiatry in the office setting, but is performed by diagnostic radiologists primarily in the facility setting. The HCPAC understands that the RUC Five-Year Review Identification Workgroup has recommended a joint CPT/RUC Workgroup review this and other services that utilize significantly less expensive technology than originally valued (eg, ultrasound room v. handheld ultrasound).

CMS Request: Relative Value Recommendations for CPT 2010:

Dr. Smith also informed the RUC that the HCPAC reviewed two speech-language pathology services codes.

On July 15 2008, H.R. 6331 Medicare Improvements for Patients and Providers Act of 2008 was signed into law. Section 143 of HR 6331 specifies that speech language pathologists may independently report services they provide to Medicare patients. Starting in July 2009, speech language pathologists will be able to bill Medicare as private practitioners.

On October 9, 2008, the American Speech-Language-Hearing Association (ASHA) sent a request to CMS that in light of the recent legislation the services of speech language pathologists be based on professional work values and not through the practice expense component. CMS requested that the RUC review the speech language codes for professional work as requested by ASHA. ASHA indicated that it will survey the 13 speech language pathology codes over the course of the next couple of meetings.

92611

The HCPAC reviewed the American Speech-Language-Hearing Association (ASHA) recommendation for 92611 *Motion fluoroscopic evaluation of swallowing function by cine or video recording*. The HCPAC recognized that since this speech language pathology service is converting from practice expense only inputs to work, that survey respondents had limited reference services to identify with. The HCPAC reviewed the pre-service time and determined that 7 minutes of pre-service time appropriately accounted for the time required to review the patients medical records, review the patient's history, prepare the barium liquids, prepare items of different consistencies and dress in the appropriate radiation deterrent gowns. The HCPAC reviewed the intra-service time and determined that 30 minutes appropriately accounted for the time to feed patients the numerous substances while watching the video fluoroscopy and make determinations on the subsequent liquid consistencies to utilize and patient postures employ. The HCPAC reviewed the immediate post-service time and recommended reducing the survey respondents and specialty society recommended time from 15 minutes to 10 minutes. The HCPAC determined that 10 minutes appropriately accounts for time required discussing findings with the patient/family, writing a report and communicating necessary information with the referring physician.

The HCPAC compared 92611 to 97001 *Physical therapy evaluation* (work RVU = 1.20, 4 minutes pre-service, 30 minutes intra-service, and 8 minute post-service time) and 92602 *Diagnostic analysis of cochlear implant, patient younger than 7 years of age; subsequent reprogramming* (work RVU = 1.30, 5 minutes pre-service, 50 minutes intra-service, and 10 minutes immediate post-service time). The HCPAC determined that 92611 is more intense than 97001 and 92602 as more management and following strategy determination is required.

The HCPAC also compared 92611 to code 99203 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 1.34, pre-service time = 4 minutes, intra-service time = 20 minutes and immediate post-service time = 5 minutes), and determined that the survey 25th percentile work RVU of 1.34 is exactly the same as 99203 and appropriately accounts for the work required to perform this service. **The HCPAC recommends a work RVU of 1.34, 7 minutes per-service time, 30 minutes intra-service time, and 10 minutes immediate post-service time for code 92611.**

Practice Expense

The HCPAC recommends removing the previous speech language pathologist's time from the practice expense inputs as well as replacing outdated recording output VHS tape with a DVD for the non-facility setting for code 92611.

92526

The HCPAC reviewed code 92526 *Treatment of swallowing dysfunction and/or oral function for feeding*. After a robust discussion of the intra-service work and episodes of therapy, the HCPAC recommends postponing recommending a work value for this service until additional frequency data is gathered and the RUC has reviewed the evaluation code, 92527 *Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech*, associated with this treatment code.

Other Issues:

Dr. Smith also indicated that the first term for the HCPAC Co-Chair and Alternate Co-Chair will conclude May 31, 2009. AMA Staff will be requesting nominations following this meeting and voting for these seats will occur at the April 2009 HCPAC meeting. Dr. Smith indicated that he and Emily Hill are eligible to serve a second 2-year term.

The RUC approved the HCPAC Review Board report and it is attached to these minutes.

XV. Five-Year Review Identification Workgroup (Tab 38)

Barbara Levy, MD provided the report of the Five-Year Review Identification Workgroup to the RUC. Doctor Levy presented the Workgroup's recommendations regarding the 32 codes originally recommended to be surveyed based on the Workgroup's review of each service in October 2008. In order to provide a complete and timely response to CMS, the Workgroup recommended and the RUC agreed that for any service where a survey is recommended, the survey be conducted and recommendations presented to the RUC at the October 2009 RUC meeting. However, the RUC would welcome surveys by April 2009 and would understand if some specialties (e.g., radiology) choose to split their codes between April 2009, October 2009, and February 2010. **The RUC recommends that for all recommendations to survey, except where otherwise stated, that the survey be conducted and RVU recommendations be presented in October 2009, allowing for April 2009 presentations if desired and requiring that all issues be presented no later than February 2010.**

The RUC also noted that a request to survey does not imply that an increase in utilization automatically translates to misvaluation. Rather, many of these codes have never been validated by the RUC and have now been presented to the RUC via multiple screens. **The RUC approved all recommendations of the Workgroup regarding the 32 Codes that May Need to Be Surveyed.**

Doctor Levy next discussed the recommendations of the Workgroup regarding a group of services that required more complete historical data. These services were deferred to this meeting to allow staff time to collect the requested data. **The RUC approved the recommendations of the Workgroup regarding Services Requiring Historical Data.**

Doctor Levy next discussed several services that were deferred to allow specialties to acquire additional data and present it to the Workgroup. **The RUC approved the recommendations of the Workgroup regarding these services.**

The Workgroup reviewed a request regarding the RUC's recommendation for the specialty societies to develop a coding change proposal to create a Category I CPT code to describe the work performed in G0181. Several specialties informed the RUC that such an action would be unnecessary as a Category I CPT code describing the work of G0181 already exists, 99375. **As such, the RUC rescinds its original recommendation and instead recommends that G0181 be removed from this screen.**

The RUC approved the recommendations of the Workgroup regarding Codes that Require Additional Information from Specialty.

Doctor Levy presented an overview of the Workgroup's discussion regarding "small-box" technologies emanating from discussion of APMA's rescission of a level of interest in surveying 76880. The APMA noted that the physician work component of 76880 is more commonly performed by Diagnostic Radiology. According to the 2007 Medicare utilization data, the physician work component of 76880 (which is a PC/TC split) is reported 32 percent of the time by Podiatry and 44 percent by Diagnostic Radiology. However, Podiatry is the dominant provider of the technical component of the code, providing slightly more than 50 percent of the

technical component. The ACR indicated an interest in the service. The ACR noted that the availability of handheld ultrasound equipment has enabled podiatry and other specialties to perform this and other similar procedures within their offices, which is driving the increase in utilization. The Workgroup noted that value of 76880 includes the ultrasound room, which is priced significantly higher than the handheld device. The Workgroup agreed that this is an issue that may need to be addressed through either CPT changes and/or significant changes in the practice expense and possibly work. **The RUC recommends the creation of a joint CPT and RUC workgroup to research this issue to identify similar services and develop recommendations to appropriately describe and/or address the valuation of these services.**

Doctor Levy reported that the Workgroup has established a timeline for review of the nine Harvard-valued codes with utilization greater than 1,000,000 and their respective families. **The RUC approved the recommendations of the Workgroup regarding a timeline for review of these services.**

Doctor Levy updated the RUC on several services that the Workgroup and RUC had asked CMS to investigate. CMS indicated an understanding of this recommendation and assured the Workgroup that the Agency will be investigating each of these issues. **The RUC approved the recommendation of the Workgroup that the evaluations of 76790, 94450, 94014, 94015, 94016, G0237, and G0238 are complete upon the referral of the RUC's articulated concerns to CMS.**

Doctor Levy discussed a preliminary timeline for initiation and facilitation of the fourth Five-Year Review. The Workgroup discussed the timeline and will recommend a timeline, general procedures, and specific issues for review to the RUC for consideration at the April 2009 RUC meeting.

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

XVI. Other Issues

23-Hour Stay Issue

The RUC entertained a discussion of the 23+-hour stay issue. That is, where patients stay overnight following a procedure, but are not admitted as inpatients. The RUC confronted several examples where physicians indicate an evaluation and management procedure on the evening of the procedure (99231) and another visit on the morning after the procedure in conjunction with discharge management. According to RUC convention, the physician work would otherwise not include a 99231 or a full 99238 discharge day management procedure in a service that was predominately performed in the outpatient setting. The RUC agreed that if physicians are performing this work, it should be reflected within the valuation of the service despite RUC convention. In order to capture the work, the RUC considered several options for a work proxy to reflect this 23+-hour observation stay. These options for a work proxy included other E/M services, such as 99217 or 99218, or adjusting the valuation or fractioning of hospital visits to account for this work. **The RUC did not reach a consensus and referred the issue for further discussion to the Research Subcommittee.**

The meeting adjourned on Saturday January 31, 2009 at 5:30 p.m.