

**AMA/Specialty RVS Update Committee
Meeting Minutes
February 4-7, 2010**

I. Welcome and Call to Order

Doctor Barbara Levy called the meeting to order on Friday, February 5, 2010, at 8:00 am.
The following RUC Members were in attendance:

Barbara Levy, MD (Chair)	James Waldorf, MD
Bibb Allen, MD	George Williams, MD
Michael D. Bishop, MD	Allan Anderson, MD*
James Blankenship, MD	Dennis M. Beck., MD*
R. Dale Blasier, MD	Manuel Cerqueira, MD*
Joel Bradley, MD	Bruce Deitchman, MD*
Ronald Burd, MD	Gregory DeMeo, DO*
Thomas Cooper, MD	Jane Dillon, MD*
David Hitzeman, DO	Verdi DiSesa, MD*
Peter Hollmann, MD	Jeffrey Paul Edelstein, MD*
Charles F. Koopmann, Jr., MD	Emily Hill, PA-C*
Robert Kossmann, MD	Allan E. Inglis, Jr., MD*
Walt Larimore, MD	Robert Jansen, MD*
Brenda Lewis, DO	M. Douglas Leahy, MD*
J. Leonard Lichtenfeld, MD	William J. Mangold, Jr., MD*
Lawrence Martinelli, MD	Daniel McQuillen, MD*
Bill Moran, Jr., MD	Scott D. Oates, MD*
Guy Orangio, MD	Terry L. Mills, MD*
Gregory Przybylski, MD	Julia Pillsbury, DO*
Marc Raphaelson, MD	Chad Rubin, MD*
Sandra Reed, MD	Steven Schlossberg, MD*
Daniel Mark Siegel, MD	Stanley Stead, MD*
Lloyd Smith, DPM	Robert Stomel, DO*
Peter Smith, MD	J. Allan Tucker, MD*
Susan Spires, MD	
Arthur Traugott, MD	*Alternate

II. Chair's Report

- Doctor Levy welcomed the CMS staff and representatives attending the meeting, including:
 - Edith Hambrick, MD, CMS Medical Officer
 - Ken Simon, MD, CMS Medical Officer
 - Whitney May
 - Ferhat Kassamali
- Doctor Levy announced that Kevin Hayes of the Medicare Payment Advisory Commission. (MedPAC) was unable to attend due to inclement weather.
- Doctor Levy welcomed the following Contractor Medical Directors:
 - Doctor Charles Haley, MD
 - Richard Whitten, MD

- Doctor Levy welcomed Doctor Qin Jiang as a guest from the China Health Economics Institute.
- Before a presentation, any RUC member with a conflict will state their conflict. That RUC member will not discuss or vote on the issue and it will be reflected in the minutes.
- RUC members or alternates sitting at the table may not present or debate for their specialty. The RUC is an expert panel and individuals are to exercise their independent judgment and are not advocates for their specialty.

III. Director's Report

Sherry Smith made the following announcement:

- The schedule for the fourth Five-Year has not been finalized but after reviewing initial volume of submitted codes, it looks like a separate August meeting will not be necessary. The RUC is still awaiting CMS's list of codes for review. As soon as RUC staff sees the list we will communicate the details to specialty society staff and advisors.

IV. Approval of Minutes of the October 1-4, 2009 RUC Meeting

The RUC approved the October 2009 RUC Meeting Minutes without revision.

V. CPT Editorial Panel Update

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

- There are several CPT Workgroups that will be convening during the upcoming CPT meeting. They are as follows: Skin Substitute, Intraoperative Neurophysiologic Monitoring and Molecular Pathology.
- The CPT Editorial Panel will be holding its next meeting at the Hilton Bonnet Creek in Orlando, FL on February 11-13, 2010. The Panel will be addressing a number of issues related to the potentially misvalued code review process.

VI. Centers for Medicare and Medicaid Services Update

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

- CMS is still awaiting the appointment and confirmation of an Administrator and Deputy Administrator.
- CMS is working to compile the list of codes for the RUC to review in regards to the fourth Five-Year Review and plans to share those codes by late February.

VII. Contractor Medical Director Update

Doctor Charles Haley provided the report of the Contractor Medical Directors:

- All 4 Medicare D MACs have been awarded and are operational. 9 of the 15 A/B MACs are operational, while the other 6 are in dispute. Sometime within the next 12-15 months they are expected to be finalized. For all of the MACs currently in dispute, the legacy contractor is still the point of contact.
- The Contractor Medical Directors developed a short list of codes for the fourth Five-Year Review and submitted to CMS.

VIII. Washington Update

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

- There are currently two key legislative goals for the AMA
 - Passage of meaningful health system reform legislation consistent with AMA policy
 - Permanent repeal of Medicare's sustainable growth rate (SGR) formula
- On January 26, 2010, the AMA sent a letter to Congress outlining key elements of reform, including health coverage for all Americans, repeal the SGR, enact health insurance market reforms, etc.
- At this point achieving health system reform is uncertain because of a lack of votes in Congress. Congress is mulling several options for passage including passing several smaller bills or using the reconciliation process.
- Currently, both the House and Senate bills have issues in which the AMA supports, including, among others, expanding coverage to most uninsured, competition enhanced through exchanges, insurance market reforms, administrative simplifications, and investments in prevention and wellness.
- The AMA also has concerns with the revised Senate bill, including: the creation of an independent Payment Advisory Board, inadequate medical liability reform, the weaker intent standard for anti-kickback statute, and retaining the House bill's Medicaid increase for primary care.
- The AMA continues to focus on eliminating the SGR and consistently opposes another short-term fix.
- In December, Congress passed legislation that provides a 60-day reprieve of the 21% cut to physician payment under Medicare. This reprieve expires March 1.
- Currently, in order to get a permanent repeal of the SGR, there will need to be \$210 billion in offsets and the cost will continue to rise. The House still supports permanent reform, but the Senate is more complex and is considering a 3 or 10 month extension of the current SGR freeze.
- The AMA's message about the SGR remains the same: Congress must honor its commitment to seniors and military families, no more short-term fixes that increase the cuts and grow the cost of reform and health system improvement goals cannot be achieved on the back of a broken Medicare program.

IX. Relative Value Recommendations for CPT 2011

Excision and Debridement (Tab 4)

Charles Mabry, MD, ACS, Christopher Senkowski, MD, ACS, Frank Spinosa, MD, APMA, Timothy Tillo, APMA

CPT Codes 11043 and 11044 were identified by the RUC's Five Year Review Identification Workgroup through the Site of Service Anomaly Screen in September 2007. In addition, 11044 was also identified as being surveyed by one specialty, orthopaedic surgery, and performed by other specialties, general surgery and podiatry. The RUC recommended the entire family of services 11040-11044, 97597 and 97598 be referred to the CPT Editorial Panel as the current descriptor allowed reporting of the code to a bi-modal distribution of patients and also to better define the terms excision and debridement.

11010 Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin and subcutaneous tissues, 11011 Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin, subcutaneous tissue, muscle fascia, and muscle, 11012 Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin, subcutaneous tissue, muscle fascia, muscle, and bone

CPT codes 11010, 11011 and 11012 were revised at the October 2009 CPT Editorial Panel meeting to state, “Debridement including removal of foreign material at the site of an open fracture(s) and/or an open dislocation(s) (eg, excisional debridement):” The intent of this revision was to clarify to payors and providers that these codes describe debridement of a single traumatic wound, despite the number of fractures or dislocations in the same anatomic site. The CPT Editorial Panel and the RUC representative at that meeting were unsure if these changes were editorial and therefore requested further information from the specialty societies who perform these services. The specialty societies who perform these services indicated that the original valuation of this service from a survey conducted in 1996 was based on a single fracture as clearly stated in their vignettes. **Based on this rationale, the RUC agreed with the specialty society that the revisions made to these descriptors were editorial and the current values for these service should be maintained.**

11042 Debridement subcutaneous tissue (includes epidermis and dermis, if performed); first 20 square centimeters or less

CPT Code 11042 was revised by the CPT Editorial Panel from [Debridement; skin, and subcutaneous tissue] to the descriptor shown above. The RUC reviewed the recommended work RVU for this service, 1.12 Work RVUs and noted that it is higher than the current value for this service. The RUC reviewed the compelling evidence provided by the specialty that this service was originally surveyed by podiatry only and while they represent the dominant providers of the service (39%), general surgery (18%) was not represented in the 2005 survey of this service. Additionally, the RUC reviewed the RBRVS history of this codes, including the fact that Harvard surveyed plastic surgeons (who represent a small fraction of the utilization); and that Harvard surveyed the codes with a 10-day global and then CMS (then HCFA) subsequently over several years reduced the work RVUs and changed the global period through the refinement process. The RUC agreed that there was compelling evidence to consider a new work RVU for this service.

The RUC reviewed the survey data for 11042 and made slight modifications to the pre-service time to 11 minutes and agreed that 15 minutes of intra-service time and 10 minutes of post-service time were representative of the service. With this modification, the specialty societies and the RUC agreed that the service times were representative of the service. The specialty societies agreed that the survey median of 1.30 work RVUs was not an appropriate value for this service based on comparisons of time and intensity to the reference code 16020 *Dressings and/or debridement of partial-thickness burns, initial or subsequent; small (less than 5% total body surface area)* (Work RVU=0.80). The specialty societies agreed that an appropriate recommendation would be to reaffirm the existing RUC HCPAC recommendation for this code as valued during the 2005 Five-

Year Review, 1.12 work RVUs. The RUC agreed that this was an appropriate valuation as it maintains relativity between the reference code and the surveyed code as the surveyed code has more intra-service time as compared to the reference code (15 minutes and 10 minutes, respectively). Further, the surveyed code requires more psychological stress, physical effort and mental effort and judgment to perform than the reference code. An additional reference code that the RUC agreed validated this recommended work RVU is MPC code 56605 *Biopsy of vulva or perineum (separate procedure); 1 lesion* (Work RVU=1.10) as this reference code requires a similar amount of work to perform and has the same intra-service time, 15 minutes. **Based on these comparisons, the RUC recommends 1.12 Work RVU for 11042.**

11045X Debridement subcutaneous tissue (includes epidermis and dermis, if performed); each additional 20 square centimeters, or part thereof (List separately in addition to code for primary procedure)

Based on the compelling evidence discussed and accepted by the RUC for code 11042, the RUC agreed that the work RVU for 11045X did not require work neutrality. The specialties estimated that 20% of wounds reported with 11042 will be large enough or extensive enough (ie, trauma) to report one or more units of 11045X. The specialty societies agreed that to appropriately value this service, the relativity of the survey data collected between 11042 and 11045X should be maintained. The survey median work RVU for 11045X was 14% less than the median work RVU for 11042 (1.12 and 1.30, respectively). Therefore, the specialty societies will maintain the percent difference by applying a 14 percent reduction to the median work value of 11045X (0.80 Work RVUs) resulting in a recommendation of 0.69 work RVUs for 11045X. This value is further supported by reference code 36575 *Repair of tunneled or non-tunneled central venous access catheter, without subcutaneous port or pump, central or peripheral insertion site* (Work RVU=0.67) as this service and the surveyed code have similar work RVUs and the same intra-service time, 15 minutes. **Based on this rationale, the RUC recommends 0.69 Work RVUs for 11045X.**

11043 Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 square centimeters or less and 11044 Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 square centimeters or less

The specialty societies requested that a 000 day global period be assigned to these services because a 090 day global survey resulted in disparate results in the length of stay which, according to the specialty societies, can be attributed to the various providers of this service including general surgery, podiatry, plastic surgery and others. The specialty societies agree that the assignment of a 000 day global period will address these issues and allow for more accurate survey results. **The RUC agreed with the rationale as presented by the specialty societies and recommends to CMS representatives that a 000 day global be assigned to 11043 and 11044. CMS representatives accepted this recommendation and the RUC requests that these codes, with a 000 day global period assignment and their respective add-on codes, be surveyed for the April 2010 RUC Meeting.**

Practice Expense

The RUC reviewed and accepted the practice expense inputs for 11042 and 11045X approved by the PE Subcommittee.

Arthrodesis Including Discectomy (Tab 5)

William Creevy, MD, AAOS, Alexander Mason, MD, AANS/CNS, Charles Mick, MD, NASS, William Sullivan, MD, NASS, Edward Vates, MD, AANS/CNS, John Wilson, MD, AANS/CNS

Facilitation Committee # 1

In February 2008, the RUC reviewed 22554 *Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophylectomy and decompression of spinal cord and/or nerve roots; cervical, below C2* as part of its Codes Reported Together Screen. The codes were then referred to the CPT Editorial Panel to create a new coding structure for the family of services. In October 2009, the CPT Editorial Panel approved two new codes, 225X1 and 225X2, to describe fusion and discectomy of the anterior cervical spine.

225X1

The RUC reviewed the survey results for code 225X1 *Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophylectomy and decompression of spinal cord and/or nerve roots; cervical, below C2* and agreed with the specialty society that the pre-service time package 4- FAC Difficult Patient/Difficult Procedure underestimates the amount of time required to perform this service. Patients have spinal cord compression in addition to spinal nerve root compression and thereby require significant education due to the complexity, scope and risks (eg fusion non-union and/or adjacent segment disease) associated with this service. Also, additional pre-service time was added to the positioning time for anterior neck surgery. Thus the RUC agreed to the following pre-service time components: pre-service evaluation = 60 minutes, pre-service positioning = 18 minutes and pre-service scrub, dress, wait = 20 minutes.

The RUC compared the surveyed code to the key reference code 22856 *Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophylectomy for nerve root or spinal cord decompression and microdissection), single interspace, cervical* (Work RVU = 24.05) and noted that the surveyed code has an additional 18 minutes total service time than the reference code, 395 minutes and 377 minutes respectively. The survey respondents also indicated that this service was slightly more intense service to perform in comparison to the reference code. Therefore, to account for the difference in work RVUs for these codes, the RUC agreed that 24.50 Work RVUs, a value slightly below the 25th percentile accurately reflects the work required to perform this service. This service was previously reported with CPT code 22554 (Work RVU = 8.85 after multiple service reduction) and code 63075 (Work RVU = 19.60), resulting in a current work RVU of 28.45. Therefore, the RUC recommendation results in a reduction in total work RVUs. **The RUC recommends 24.50 Work RVUs for 225X1.**

225X2

The RUC reviewed the survey results for code 225X2 *Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophylectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace* and agreed with the specialty society that the survey respondents' median pre-service (5 minutes) and intra-service (45 minutes) times were reflective of the service. The RUC concurred that 5 minutes of pre-service evaluation time was necessary to account for the additional physician work related to assessing and discussing the risks and possible complications which are greater for surgery of multiple levels of the cervical spine.

The RUC compared the surveyed code to the key reference code 22614 *Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment* (Work RVU=6.43). The RUC noted that the intra-service time for the surveyed code is higher than the reference code, 45 minutes and 40 minutes, respectively. Furthermore, the RUC noted that the surveyed code required slightly more mental effort and judgment to perform than the reference code. Given these comparisons, the RUC agreed that the survey's 25th percentile, 6.50 RVUs, is an appropriate value for this service. This service was previously reported with CPT code 22585 *Arthrodesis, anterior interbody technique including minimal discectomy to prepare interspace(other than for decompression); cervical below C2, each additional interspace* (Work RVU = 5.52) and code 63076 *Discectomy, anterior, with decompression of spinal cord and/or nerve roots, including osteophylectomy; cervical, each additional level* (Work RVU = 4.04) for a total work RVU of 9.56. Therefore, the RUC recommendation results in a significant decrease in total work RVUs. **The RUC recommends 6.50 Work RVUs for 225X2.**

Practice Expense

The RUC reviewed these services and direct inputs carefully and agreed that these services have similar facility practice expenses as other complex spine procedures. The RUC agreed that 75 minutes of pre-service time is appropriate rather than the standard 90 day global pre-service time of 60 minutes. These services are performed in the facility setting only.

Work Neutrality

The RUC's recommendation for these codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Nasal Sinus Endoscopy with Balloon Dilation (Tab 6)

Wayne Koch, MD, AAO-HNS, Bradley Marple, MD, AAO-HNS

In October 2009, the CPT Editorial Panel modified introductory language to the nasal/sinus endoscopy section and added three new CPT codes to report balloon dilation when performed alone for a given sinus ostium. The use of balloon dilation alone is now more frequently performed for maxillary, frontal, and sphenoid sinuses.

3129X1

The RUC reviewed specialty survey data from 33 otolaryngologists who had experience with these three new procedures. The RUC reviewed new code 3129X1 *Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine fossa*, which describes the endoscopic treatment of acute and chronic sinusitis by dilation of the maxillary sinus ostium. Upon review of the physician time survey results, the RUC recommended the pre-time evaluation and scrub, dress, wait time be reduced from pre-time package 3 so as not to exceed the survey median time for these pre-service components. All other physician time components, intra-service and post service, were understood to be typical. The specialty survey data indicated in a median work RVU of 5.00, which the specialty and the RUC agreed overstated the total physician work relative to the key reference code 31254 *Nasal/sinus endoscopy, surgical; with ethmoidectomy, partial (anterior)* (000 day global, Work RVU = 4.64) and 31256 *Nasal/sinus endoscopy, surgical, with maxillary antrostomy;* (000 day global, Work RVU = 3.29), which is a similar maxillary endoscopy procedure that is more extensive, including tissue excision.

The RUC also reviewed the physician work of 31233 *Nasal/sinus endoscopy, diagnostic with maxillary sinusoscopy (via inferior meatus or canine fossa puncture* (000 day global, Work RVU = 2.18) and estimated that the physician work for 3129X1 is approximately 25% more total work than 31233, or 2.70 work RVUs [$2.18 \times 125\% = 2.70$]. This recommendation takes into account the increased complexity and additional pre and post work required for 3129X1 which is a facility-based procedure compared with 31233 which is primarily performed in an office setting.

The RUC reviewed similarly valued services across specialties to validate its recommendation, these 000 day global codes were; 51102 *Aspiration of bladder; with insertion of suprapubic catheter* (work RVU = 2.70, MPC code, 20 minutes intra-service time), 49452 *Replacement of gastro-jejunoscopy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report* (work RVU = 2.86, 20 minutes intra-service time), and 36555 *Insertion of non-tunneled centrally inserted central venous catheter; younger than 5 years of age* (work RVU = 2.68, 20 minutes of intra-service time). The work RVU recommendation of is below the 25th percentile specialty survey results and places the work of 3129X1 correctly between 31233 (Work RVU = 2.18) and 31256 (Work RVU = 3.29). **The RUC recommends a relative work value of 2.70 for CPT Code 3129X1.**

3129X2

The RUC reviewed the survey data from 35 otolaryngologists who were familiar with 3129X2 *Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (eg, balloon dilation)*, that describes the endoscopic treatment of acute and chronic sinusitis by dilation of the frontal sinus ostium. Upon review of the physician time survey results the RUC recommended the pre-time evaluation and scrub, dress, wait time be reduced from pre-time package 3 so as not to exceed the survey median time for these pre-service components. All other physician time components, intra-service and post service, were understood to be typical. The specialty survey data indicated in a median work RVU of 7.00, which the specialty and the RUC agreed overstated the total physician work relative to the key reference code 31255 *Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior)* (000 day global, Work RVU = 6.95).

To place the total work of 3129X2 relative to other sinus surgical procedures, the RUC determined that the total work of 3129X2 would be similar to the total work effort of 31256 *Nasal/sinus endoscopy, surgical, with maxillary antrostomy* (work RVU = 3.29, 45 minutes/Harvard). Although the intra-time for 31256 is greater than 3129X2, the expertise required and complexity is greater for 3129X2 (ie, passing the guide wire through the labyrinth of the frontal recess, between lamina (bone over orbit) and cribriform, near the anterior ethmoidal artery).

The RUC reviewed similarly valued services across specialties to validate its recommendation, these 000 day global codes were; 31625 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites* (work RVU = 3.36, 30 minutes intra-service time), 50386 *Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation* (work RVU = 3.30, 30 minutes intra-service time), and 52000 *Cystourethroscopy (separate procedure)* (work RVU = 2.23, 15 minutes of intra-service time).

The RUC considered that the recommendation for 3129X2 should be greater than the recommendations for 3129X1 (RVW=2.70) and 3129X3 (RVW=2.64); and is approximately three times more work than 31231 *Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)* (work RVU = 1.10, 10 minutes intra-service time). The work value of 3.29 for 3129X2 provides proper rank order for physician work and intensity within this group of services and across specialties. Therefore, a work RVU of 3.29 is recommended for 3129X2. This value is below the 25th percentile surveyed work RVU of 5.10 and appropriately places 3129X2 relative to the other sinus balloon endoscopy procedures, the identical value of 31256. **The RUC recommends a relative work value of 3.29 for CPT Code 3129X2.**

3129X3

The RUC reviewed the survey data from 32 otolaryngologists who were familiar with 3129X3 *Nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium (eg, balloon dilation)*, which describes the endoscopic treatment of acute and chronic sinusitis by dilation of the sphenoid. Upon review of the physician time survey results the RUC recommended the pre-time evaluation and scrub, dress, wait time be reduced from pre-time package 3 so as not to exceed the survey median time for these pre-service components. All other physician time components, intra-service and post service, were understood to be typical. The specialty survey data indicated in a median work RVU of 6.05, which the specialty and the RUC agreed overstates the total physician work relative to the key reference code 31255 *Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior)* (000 day global, Work RVU = 6.95). The RUC agreed that the total physician work for 3129X3 should be crosswalked to 31235 *Nasal/sinus endoscopy, diagnostic with sphenoid sinusoscopy (via puncture of sphenoidal face or cannulation of ostium)*, (000 global, Work RVU = 2.64) which requires similar time and intensity to perform. The RUC agreed that CPT code 3129X3 should have the same work value as 31235, as it appropriately places 3129X3 slightly less than 3129X1, and less than 31287 *Nasal/sinus endoscopy, surgical, with sphenoidotomy*, (000 day global, Work RVU = 3.91). The work value of 2.64 for 3129X3 would provide proper rank order for physician work and intensity within this group of services and across specialties.

The RUC reviewed similarly valued services across specialties to validate its recommendation, these 000 day global codes were; 43220 *Esophagoscopy, rigid or flexible; with balloon dilation (less than 30 mm diameter)* (work RVU = 2.10, 22 minutes intra-service time), 52281 *Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female* (work RVU = 2.80, 33 minutes intra-service time/Harvard), and 52000 *Cystourethroscopy (separate procedure)* (work RVU = 2.23, 15 minutes of intra-service time).

Practice Expense: The RUC reviewed the direct practice expense inputs for CPT codes 3129X1, 3129X2, and 3129X3 and made minor adjustments to reflect the typical patient service in the facility and non-facility settings.

New Technology: The RUC considers CPT codes 3129X1, 3129X2, and 3129X be placed on the RUC's new technology listing.

Bronchoscopy with Balloon Occlusion (Tab 7)

Burt Lesnick, MD, ACCP, Scott Manaker, MD, PhD, ACCP, Alan Plummer, MD, ATS

In October 2009, the CPT Editorial Panel created a new CPT code to describe a bronchoscopic technique that is performed as part of a last resort effort to resolve persistent bronchopleural fistulas.

The RUC reviewed the specialty survey results from 32 pulmonologists who were familiar with new procedure 316X1 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, with assessment of air leak with administration of occlusive substance (eg, fibrin glue), if performed*, and agreed the physician time components reflected their typical service time. The RUC compared the surveyed code to key reference code 31629 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)* (000 day global, work RVU = 4.09) and determined they were similar in intensity, complexity, and overall physician time. The specialty indicated that code 31629 is one of the most intense procedures performed by pulmonologists and that 316X1 is typically performed in the intensive care unit. In addition, 78% of the respondents agreed with the typical patient vignette. The RUC agreed the specialty survey results, median work RVU, and the recommended physician time components are reflective of the service.

The RUC also reviewed code 31628 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe* (000 day global, work RVU = 3.80, intra-service time = 40 minutes) in relation to new procedure 316X1 and agreed that the survey code is a more intense procedure to perform. The RUC agreed that upon review of reference services the median value of 4.00 accurately reflects the physician work value of new code 316X1, and is rank ordered within this family of codes. **The RUC recommends a relative work value of 4.00 for CPT Code 316X1.**

Practice Expense: The RUC reviewed the direct practice expense inputs recommendation for the facility and non-facility settings and made minor edits to reflect the typical patient scenario.

New Technology: The RUC considers CPT code 316X1 be placed on the RUC's new technology listing.

Cardiac Hybrid Procedures (Tab 8)

**James Levett, MD, STS, Alex Little, MD, STS, John Mayer, MD, STS
Facilitation Committee # 2**

In November 2009, the CPT Editorial Panel created three new codes to represent new operations that use a hybrid approach to treating neonates and infants for congenital cardiac diseases. All three procedures are generally performed on a patient but at different stages during the patient's development.

3362X Application of right and left pulmonary artery bands (eg, hybrid approach stage 1)

New procedure 3362X is typically performed in conjunction with 3362X1 *Transthoracic insertion of catheter for stent placement with catheter removal and closure (eg, hybrid approach stage 1)* and with a cardiologist, who will separately bill for stent insertion (37207 *Transcatheter placement of an intravascular stent(s) (non-coronary vessel), open; initial vessel* (Work RVU = 8.27)). This procedure is also performed as a stand alone procedure or in a staged manner with 3362X1. When this procedure is performed with 3362X1, the multiple procedure reduction would apply for the surgeon, who would bill 3362X and 3362X1.

The RUC reviewed specialty survey data from 20 physicians who were familiar with this new stage 1 procedure. The RUC understood that this procedure is rarely performed, estimated to be 100 times yearly for the non-Medicare population, and the typical patient is a newborn. The RUC was therefore comfortable with the number of survey respondents.

The RUC reviewed the specialty survey results and recommended physician time components, and agreed they accurately reflected the time required to perform the service. The RUC compared the surveyed code to its reference service code 33690 *Banding of pulmonary artery* (Work RVU = 20.36, 120 minutes of intra-service time) which had the same intra-service time. The RUC noted that the survey respondents indicated the intensity and complexity of this new procedure was greater than code the new code's key reference service. The RUC also reviewed the similarities with multi-specialty points of comparison codes 33533 *Coronary artery bypass, using arterial graft(s); single arterial graft* (Work RVU = 33.75, 151 minutes of intra-service time) and 33681 *Closure of single ventricular septal defect, with or without patch;* (Work RVU = 32.34, 150 minutes of intra-service time) in relation to new code 3362X. The RUC agreed that while these services have greater intra-service time, the intensity and complexity, along with similarities in total time, of the surveyed code is greater and should be valued similarly.

Based on comparisons to the reference codes with regard to the specialty survey data and physician work and time comparisons, the survey median of 30.00 work RVUs is appropriate and maintains rank order amongst similar services. **The RUC recommends a relative work value of 30.00 for CPT code 3362X.**

3362X1 Transthoracic insertion of catheter for stent placement with catheter removal and closure (eg, hybrid approach stage 1)

The RUC discussed the physician work of new code 3362X1 *Transthoracic insertion of catheter for stent placement with catheter removal and closure (eg, hybrid approach stage 1)* in relation to code 3362X *Application of right and left pulmonary artery bands (eg, hybrid approach stage 1)* as it is a staged procedure. RUC members concurred that four level one hospital visits should be removed from the specialty recommended physician time and work of code 3362X1, as well as the discharge day management since these activities were considered duplicative with the work post operatively of 3362X. After the subtraction of this work, the RUC agreed that the work value of 3362X1 would be 16.18.

The RUC also discussed and agreed that the pre-service evaluation time of 40 minutes was justified for this procedure given the complexity and incremental work involved. In addition, the specialty had adjusted this pre time from over 90 minutes in order to fit into

the standard pre-time package. The RUC reviewed several services in relation to the work value of 16.18 for 3362X1. Two specific services were identified as having similar intensity, complexity, and physician time. These codes are: 33320 Suture repair of aorta or great vessels; without shunt or cardiopulmonary bypass (work RVU = 18.54) and 32100 *Thoracotomy, major; with exploration and biopsy* (work RVU = 16.16, 100 minutes intra service time, IWPUT = 0.0658), 50040 *Nephrostomy, nephrotomy with drainage* (work RVU = 16.68, 90 minutes intra-service time). **The RUC recommends a relative work value for CPT code 3362X1 of 16.18.**

3362X2 Reconstruction of complex cardiac anomaly (eg, single ventricle or hypoplastic left heart) with palliation of single ventricle with aortic outflow obstruction and aortic arch hypoplasia, creation of cavopulmonary anastomosis, and removal of right and left pulmonary bands (eg, hybrid approach stage 2, Norwood, bidirectional Glenn, pulmonary artery debanding)

The RUC reviewed specialty survey data from 20 physicians who were familiar with this new stage 2 procedure. Most survey respondents indicated the intensity and complexity of this new procedure are quite similar to code 33783 *Aortic root translocation with ventricular septal defect and pulmonary stenosis repair (ie, Nikaidoh procedure); with reimplantation of 1 or both coronary ostia* (Work RVU = 65.08, 360 minutes of intra-service time), which was selected as the new code's key reference service. The RUC also reviewed the similarities with multi-specialty points of comparison codes 61697 *Surgery of complex intracranial aneurysm, intracranial approach; carotid circulation* (Work RVU = 63.22, 300 minutes of intra-service time) and 33863 *Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension; with aortic root replacement using composite prosthesis and coronary reconstruction* (Work RVU = 58.71, 287 minutes of intra-service time) in relation to new code 3362X2. **The RUC recommends a relative work value for CPT code 3362X2 of 64.00.**

Practice Expense: The RUC reviewed and agreed with the specialty recommended 090 day global standard direct practice expense inputs for these three new procedures performed only in the facility setting.

New Technology: The RUC considers CPT codes 3362X, 3362X1, and 3362X2 be placed on the RUC's new technology listing.

Ascending Aorta Repair (Tab 9)

James Levett, MD, STS, Alex Little, MD, STS, John Mayer, MD, STS

In October 2009, the CPT Editorial Panel deleted CPT code 33861 *Ascending aorta graft, with cardiopulmonary bypass, includes with or without valve suspension, when performed, includes coronary reconstruction, when performed; with coronary reconstruction* as the code is not commonly performed and contains overlap of physician work with the other procedures in the family. Editorial revisions were also made to CPT codes 33863 and 33864 for clarification only.

The RUC reviewed code 33861 and its family as part of the specialty societies' request to determine whether or not the new coding structure for reporting coronary reconstruction with ascending aorta repairs created by the deletion of 33861 necessitates budget neutrality adjustments. The specialties explained that the ascending aorta repair family of codes, 33860 *Ascending aorta graft, with cardiopulmonary bypass, includes with or*

without valve suspension, when performed, (Work RVU = 59.46) and 33863 *Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension; with aortic root replacement using composite prosthesis valved conduit and coronary reconstruction (eg, Bentall)* (Work RVU = 58.79) were reviewed in August 2005 at the 3rd Five-Year Review and were revalued based on the Society of Thoracic Surgeons (STS) adult cardiac database. CPT code 33861 was not reviewed at the meeting due to a lack of data because the service has low Medicare utilization (255 instances billed in 2008). Entering the 3rd Five-Year Review, 33860 was valued at 37.94 RVUs and was increased to 59.33 RVUs after the RUC's review. However, 33861 was valued at 41.94 RVUs and not reviewed by the RUC. **Given that 33861 is the same service as the base code, 33860, with the additional work of the coronary reconstruction, the RUC agreed that this represented a rank order anomaly and should the RUC have valued the physician work of 33861 it would have been valued similar to the base code. The RUC also concurred that this family of codes should not need a budget neutrality reassessment.**

Gastric Intubation (Tab 10)

Edward Bentley, MD, AGA, Nicholas Nickl, ASGE, Jennifer Wiler, MD, ACEP

In October 2009, the CPT Editorial Panel deleted 11 low volume CPT codes and created 5 new codes to clarify, update, and simplify the gastric intubation services involving enteric tubes being passed to collect specimens of gastric or duodenal fluid for analysis.

4375X1 Gastric intubation and aspiration(s), therapeutic (eg, gastrointestinal hemorrhage), including lavage if performed

Code 4375X1 was modified and renumbered from deleted code 91105 *Gastric intubation, and aspiration or lavage for treatment (eg, for ingested poisons)* (Work RVU = 0.37, 000 global) by the CPT Editorial Panel. Survey data from 39 emergency medicine physicians who have had experience performing this service were collected. The specialty survey results indicated that this service was undervalued as the survey median work relative value was 1.30 and total physician time was 24 minutes as compared to its current total service time of 16 minutes. The RUC and the specialty society acknowledged that the procedure will typically be reported with an E/M service and believed some reduction in the pre-service time and physician work value, from the survey results, was appropriate. The RUC agreed with the specialty society's that the typical patient is now one who has a gastrointestinal hemorrhage rather than one who ingested poisons. The RUC also agreed that there was compelling evidence that the service had been reviewed by Harvard at a time when emergency medicine was not a recognized Medicare specialty. The RUC reviewed the survey's key reference service CPT code 31575 *Laryngoscopy; flexible fiberoptic; diagnostic* (Work RVU = 1.10, Total physician time = 25 minutes, 000 global), and 29075 *Application, cast; elbow to finger (short arm)* (Work RVU = 0.77, Total physician time = 25 minutes, 000 global) in relation to new code 4375X1. The RUC concluded that the pre-service evaluation physician time (3 minutes) should be extracted from the surveyed time and that the intra-service time of 10 minutes and immediate post time of 5 minutes adequately reflected the time it required to perform the service. Total time consisting of pre-service time of 6 minutes, 10 minutes intra-service, and 5 minutes immediate post service, was accepted. The RUC agreed that the value of 4375X1 is very similar to new service 4375X2 *Gastric intubation and aspiration, diagnostic; single specimen (eg, acid analysis)* (RUC recommended Work RVU of 0.45) and was similar to a code renumbered from code 89130 *Gastric intubation and aspiration, diagnostic, each specimen, for chemical*

analyses or cytopathology (work RVU = 0.45) as therapeutic gastric intubation should be valued no lower. Lastly, the RUC compared the work of 4375X1 to CPT code 99212 *established office visit code* (work RVU = 0.48) and agreed that the work, time, and intensities were similar. **The RUC recommends a relative work value of 0.45 for CPT code 4375X1.**

4375X2 Gastric intubation and aspiration, diagnostic; single specimen (eg, acid analysis)

New code 4375X2 was modified and renumbered from deleted code 89130 *Gastric intubation and aspiration, diagnostic, each specimen, for chemical analyses or cytopathology*; (Work RVU = 0.45, XXX global). The specialty society's survey response rate was low as the performance of these services is estimated to be 470 in the Medicare population. Given the small number of physicians who perform this service and the wide variation in survey response, the median service performance rate was zero, the specialty societies and RUC agreed that there was no compelling reason to change the work relative value of 4375X2 from the virtually identical service 89130. The physician work for this service involves patient evaluation and the supervision of the specimen collection and its assessment. The RUC reviewed the physician work of existing code 89130 and the work of CPT code 99212 *established office visit code* (work RVU = 0.48) in relation to this service, and agreed that the relative work value should remain at 0.45. **The RUC recommends a relative work value of 0.45 for CPT code 4375X2.**

4375X3 Gastric intubation and aspiration, diagnostic; collection of multiple fractional specimens with gastric stimulation, single or double lumen tube (gastric secretory study) (eg, histamine, insulin, pentagastrin, calcium, secretin)

The specialty survey response rate was low as the performance of these services is estimated to be 40 in the Medicare population. The RUC also agreed that 13 minutes of pre-service time was excessive and recommends 7 minutes to account for the physician time to ensure that the appropriate intravenous medication was being used for gastric stimulation. The RUC agreed that the appropriate physician time components should be 7 minutes pre-service, 25 minutes intra-service, and 5 minutes immediate post service. The RUC agreed that the survey's key reference service, CPT code 91038 *Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)* (Work RVU = 1.10, Total physician time = 41 minutes, 000 global), requires more total time and intensity compared to the surveyed service. The RUC agreed that the physician work value was quite similar to that the code it replaces, 89140 *Gastric intubation, aspiration, and fractional collections (eg, gastric secretory study); 2 hours including gastric stimulation (eg, histalog, pentagastrin)* (Work RVU = 0.94, 30 minutes total physician time, XXX global). **The RUC recommends a relative work value of 0.94 for CPT code 4375X3.**

4375X4 Duodenal intubation and aspiration, diagnostic; single specimen (eg, bile study for crystals or afferent loop culture)

New code 4375X3 represents and is currently reported as a combination of two services: 89100 *Duodenal intubation and aspiration; single specimen (eg, simple bile study or afferent loop culture) plus appropriate test procedure* (Work RVU = 0.60, 20 minutes total physician time, XXX global) and 76000 *Fluoroscopy (separate procedure), up to 1 hour physician time, other than 71023 or 71034 (eg, cardiac fluoroscopy)* (work RVU = 0.17, 5 minutes total physician time). The sum of these work values is 0.77. Given the

small number of physicians who perform this service, the small response rate, and the wide variation in the responses, the specialty and the RUC could not identify a compelling reason for the work RVU of new code 4375X4 to change in comparison to the existing code (89100 + 76000), the sum of which is 0.77. The RUC recognized that the use of fluoroscopy was an inherent component of this service and that a new paragraph in CPT should be made to assist users of CPT. The RUC also noted that code 43752 *Naso- or oro-gastric tube placement, requiring physician's skill and fluoroscopic guidance (includes fluoroscopy, image documentation and report)* (Work RVU = 0.81, 30 minutes total physician time, 000 global) is an appropriate comparator to the physician work and intensity of code 4375X4. **The RUC recommends maintaining a work relative value of 0.77 for CPT code 4375X4.**

4375X5 Duodenal intubation and aspiration, diagnostic; collection of multiple fractional specimens with pancreatic or gallbladder stimulation, single or double lumen tube

New code 4375X5 represents and is currently reported as a combination of two services: 89105 *Duodenal intubation and aspiration; collection of multiple fractional specimens with pancreatic or gallbladder stimulation, single or double lumen tube* (Work RVU = 0.50, 17 minutes of physician time, XXX global), and code 76000 *Fluoroscopy (separate procedure), up to 1 hour physician time, other than 71023 or 71034 (eg, cardiac fluoroscopy)* (Work RVU = 0.17, 5 minute of physician time, as fluoroscopy is used to position the tube. The sum of these two distinct services is 0.67 work RVUs, which represents an anomaly when compared to existing code 89100 (work RVU = 0.60), now captured within code 4375X4, which is placement of a duodenal tube and aspiration of a single specimen. For this reason, the RUC agreed there was compelling evidence to change the current valuation, and provide proper rank order among this CPT family. The RUC also recognized that the use of fluoroscopy was an inherent component of this service and that a new parenthetical in the CPT introductory language should be made to assist users of this service.

The RUC compared the physician work of 4375X5 to representative services performed by a physician. The RUC agreed that the work of the key reference service, 91022 *Duodenal motility (manometric) study* (work RVU = 1.44), was not an appropriate comparison in terms of the physician work due to the differences in analyzing the data from the tube studies. The specialty and the RUC agreed that the pre-time recommendations of 24 minutes were not representative, and recommended a pre-time of 7 minutes, consistent with the recommended pre-time for code 4375X3. The RUC reviewed the work of code 43752, *Naso- or oro-gastric tube placement, requiring physician's skill and fluoroscopic guidance (includes fluoroscopy, image documentation and report)*, (work RVU = 0.81, 5/20/5, 000 global), and understood that the physician work and intensity of code 4375X5 was higher. The RUC noted that there was additional physician work in code 4375X5 compared to 4375X4, as the physician personally administered the intravenous agent, monitored the patient's response to the agent, performed the initial aspirations of duodenal secretions for the first 15 minutes, and was responsible for maintaining the proper position of the tube for the duration of the study. The RUC noted that while code 43752 describes placement of a naso- or oro-gastric tube requiring physician skill, code 4375X5 required placement beyond the stomach and included sampling of duodenal gastric contents, evaluation of the procedure findings, and generation of management recommendations to the referring physician which would not be captured by any other procedure or E/M service on the date

of service. With this understanding, the RUC agreed that the work value of 4375X5 involves the work of 4375X4 (0.77) and the difference in work between 4375X3 and 4375X2 ($0.94 - 0.45 = 0.49$). The summation of all this physician work equals 1.26 work RVUs. **The RUC recommends a relative work value of 1.26 for CPT code 4375X5.**

Practice Expense: The RUC reviewed the direct practice expense inputs for this family of codes and recognized that there would be no direct inputs associated with code 4375X1, as it is performed in the facility setting. The RUC also made adjustments to the typical medical supplies and equipment for 4375X2 – 5 for the typical patient encounter.

Fiducial Marker Placement (Tab 11)
Christopher Senkowski, MD, ACS

In November 2010, the CPT Editorial Panel created two new codes and revised one code to provide further clarity and a broader applicability of the placement of fiducial markers for radiation therapy guidance technology to more common primary abdominal procedures. The American College of Surgeons attempted to survey 180 surgeons that may be familiar with the new and revised procedures and received a very low response rate. **The specialty requested, and the RUC agreed to, an extension until the April 2010 RUC meeting so that they may continue to identify surgeons who are familiar with these procedures.**

Vaginal Radiation Afterloading Apparatus for Clinical Brachytherapy (Tab 12)
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Facilitation Committee # 2

In September 2007, the RUC identified CPT Code 57155 *Insertion of uterine tandems and/or vaginal ovoids for clinical brachytherapy* (090 day global, Work RVU = 6.78) through its Site of Service Anomaly Screen and recommended to CMS that the service be changed to a 010 day global service and that its physician discharge day management time be halved. The specialty believed that the typical patient may have changed requiring modification to the descriptor, and the service was referred to the CPT Editorial Panel. In October 2009 the CPT Editorial Panel added a new code to report the insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy and revised 57155 to indicate insertion of a single tandem rather than tandems. CMS changed the global period of 57155 from a 090 day to a 000 day global service for 2011.

57155 Insertion of uterine tandems and/or vaginal ovoids for clinical brachytherapy
The RUC reviewed the specialty society's survey results and questioned the specialty in order to obtain a clear understanding of the intra-service and post-operative work time, intensities, and complexities of this revised service. The RUC reviewed the survey data physician time from data 69 radiation oncologists, obstetricians and gynecologists, and agreed that most of the time components reflected the typical current practice. The specialty recognized the need for an additional four minutes of pre-service positioning time with standard pre-time package 2B – facility difficult patient/straightforward procedure with sedation/anesthesia, for a total pre-service time of 43 minutes. The RUC also agreed with the specialty that the respondents underestimated the immediate post service time, and that 30 minutes is typical rather than 20 and corresponds with the 75th percentile of the survey results.

The RUC reviewed the survey's key reference service 55920 *Placement of needles or catheters into pelvic organs and/or genitalia (except prostate) for subsequent interstitial radioelement application* (work RVU = 8.31, 000 day global, 90 minutes intra-service time) as a comparable service and noted that less than 40% of the respondents chose this code. The RUC reviewed additional services with similar physician work and time, including: 50382 *Removal (via snare/capture) and replacement of internally dwelling ureteral stent via percutaneous approach, including radiological supervision and interpretation* (000 global, Work RVU = 5.50, 60 minutes intra-service), 52001 *Cystourethroscopy with irrigation and evacuation of multiple obstructing clots* (000 global, Work RVU = 5.44, 60 minutes intra-service). Based on the 25th percentile survey results (5.80 RVUs) and the above RUC reviewed comparison services, the committee agreed that a value of 5.40 work relative value units would appropriately rank order 57155 within the radiation oncology family of services and across specialties.

The RUC agreed that the reduction in the work value from 6.87 to 5.40, with 60 minutes of intra-service time and intensity is appropriate given the new RUC survey data, and other reference services. **The RUC recommends a relative work value of 5.40 for CPT code 57155.**

571XX Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy

The RUC reviewed the survey results from 60 physicians familiar with this service and agreed that most of the time components reflected the typical current practice. The specialty recognized the need for an additional four minutes of pre-service positioning time with standard pre-time package 2A – difficult patient/straightforward procedure no sedation/anesthesia care) for at total pre-service time of 29 minutes. The RUC also agreed with the specialty that the respondents underestimated the immediate post service time, and that 20 minutes rather than 15, is typical and corresponds with the 75th percentile of the survey results.

The RUC reviewed the survey's key reference service 19296 *Placement of radiotherapy afterloading expandable catheter (single or multichannel) into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy* (work RVU = 3.63, 000 day global, 30 minutes intra-service time) as a comparable service and agreed that it was a more difficult and time consuming service than the surveyed code. The RUC reviewed additional services with similar physician work and time, including; MPC code 45378 *Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)* (000 day global, Work RVU = 3.69, 30 minutes intra-service) and 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)* (000 day global, Work RVU= 2.78, 30 minutes of intra-service time). It was agreed that the survey respondents overestimated the physician work of 571XX and the 25th percentile survey results (2.69 work RVUs) were more appropriate for the time, intensity, and complexity the physician would endure. In comparison services, the RUC agreed that a value of 2.69 work relative value units would appropriately rank order 571XX. **The RUC recommends the specialty's 25th percentile survey work relative value of 2.69 for new code 571XX.**

Practice Expense: The RUC reviewed the specialty recommended direct practice expense inputs for the non-facility and facility settings and eliminated clinical labor time that was duplicative with evaluation and management services and the medical supplies and equipment was edited for the typical patient service.

Moderate Sedation: The RUC recommends that CPT code 57155 be placed on CPT's Appendix G as moderate sedation is inherent in this procedure.

Work Neutrality: The RUC's recommendation for these codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Stereotactic Computer-Assisted Volumetric-Navigational Procedures (Tab 13)
Alexander Mason, MD, AANS/CNS, Edward Vates, MD, AANS/CNS, John Wilson MD, AANS/CNS

In October 2008, 61795 *Stereotactic computer-assisted volumetric (navigational) procedure, intracranial, extracranial, or spinal* (Work RVU = 4.03) was identified for potential misvaluation through the CMS Fastest Growing Screen. The RUC and the specialty societies determined that the work and technology related to intracranial, extracranial and spinal procedures may be different. Thus, the specialty societies submitted a code change proposal to the CPT Editorial Panel and 61795 was deleted and three new codes were created to separately report cranial intradural, cranial extradural and spinal.

6179X1

The RUC reviewed the survey results for code 6179X1 *Stereotactic computer assisted (navigational) procedure; cranial, intradural* and agreed with the specialty societies that the survey respondents overstated the pre-service time and physician work. The specialty explained that this add-on procedure is difficult to separate the pre-service evaluation time between the surveyed code and the primary procedure. The RUC, as is typical for many neurosurgical procedures, recommends 15 minutes of pre-service evaluation due to the high intensity and complexity of this procedure.

In addition, the RUC reviewed the median survey time of 4.50 RVUs and agreed with the specialties that it is not reflective of the service. The RUC compared the surveyed code to the key reference code 20985 *Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less* (Work RVU = 2.50, ZZZ global period) and noted that the surveyed code has an additional 5 minutes of pre-service time and 10 additional minutes of intra-service time. It was also noted that the survey respondents scored 6179X1 higher in every intensity and complexity measure compared to the key reference code.

Finally, to maintain appropriate relatively amongst similar services, the RUC compared 6179X1 to MPC code 60512 *Parathyroid autotransplantation* (Work RVU = 4.44, intra-service time = 45 minutes). The RUC agreed with the specialty that this reference code has more intra-service time and is a more complex procedure. Based on these comparisons to CPT codes 20985 and 60512, 3.75 Work RVUs, slightly higher than the 25th percentile, accurately reflects the work required to perform this service. **The RUC recommends 3.75 Work RVUs for 6179X1.**

6179X2

The RUC reviewed the survey results for code 6179X2 *Stereotactic computer assisted (navigational) procedure; cranial, extradural* and agreed with the specialty societies that the survey respondents overstated the pre-service time and median physician work. The RUC, as is typical for many neurosurgical procedures, recommends 15 minutes of pre-service time due to the high intensity and complexity of this procedure.

In addition, the RUC reviewed the median survey time of 3.50 RVUs and agreed with the specialties that it is not reflective of the service. The RUC compared the surveyed code to the key reference code 20985 *Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less* (Work RVU = 2.50) and noted that the surveyed code has an additional 5 minutes of pre-service time and 5 additional minutes of intra-service time. It was also noted that the survey respondents scored the surveyed code higher in many of the intensity and complexity measures compared to the reference code.

Finally, to maintain appropriate relatively amongst similar services, the RUC compared 6179X2 to MPC code 22525 *Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); each additional thoracic or lumbar vertebral body* (Work RVU = 4.47, intra-service time = 40 minutes). The RUC agreed with the specialty that this reference code has more intra-service time and is a more complex procedure. The RUC also noted that this service has 25 minutes intra-service time compared to 30 minutes for the other codes in the family (6179X1 and 6179X3) and recommends a value lower than these services. Based on the above comparisons, 3.18 Work RVUs, in between the 25th percentile and median survey physician work estimates, accurately reflects the work required to perform this service. **The RUC recommends 3.18 Work RVUs for 6179X2.**

6179X3

The RUC reviewed the survey results for code 6179X3 *Stereotactic computer assisted (navigational) procedure; Spinal* and agreed with the specialty societies that the survey respondents overstated the pre-service time and median physician work. The RUC recommends 15 minutes of pre-service time due to the intensity and complexity of this procedure.

In addition, the RUC reviewed the median survey time of 5.00 RVUs agreed with the specialties that it is not reflective of the service. The RUC compared the surveyed code to the key reference code 20985 *Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less* (Work RVU = 2.50) and noted that the surveyed code has an additional 5 minutes of pre-service time and 10 additional minutes of intra-service time. It was also noted that the survey respondents scored the surveyed code higher in many of the intensity and complexity measures compared to the reference code.

Finally, to maintain appropriate relatively amongst similar services, the RUC compared 6179X1 to MPC code 60512 *Parathyroid autotransplantation* (Work RVU = 4.44, intra-service time = 45 minutes). The RUC agreed with the specialty that this reference code has more intra-service time and is a more complex procedure. Based on these comparisons to CPT codes 20985 and 60512, 3.75 Work RVUs, a value slightly higher than the 25th percentile, accurately reflects the work required to perform this service. **The RUC recommends 3.75 Work RVUs for 6179X3.**

Practice Expense

The RUC agreed that there would be no direct practice expense inputs for these services as they are add-on services performed in a facility setting.

Work Neutrality

The RUC's recommendation for these codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Vagus Nerve Stimulator (Tab 14)

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Facilitation Committee # 3

In September 2007, CPT code 61885 was identified by the RUC through its Site of Service Anomaly Screen. After reviewing the vagal nerve stimulator family of services, the specialty societies agreed that the family lacked clarity and the CPT Editorial Panel, in October 2009, created three new codes to accurately describe revision of a vagal nerve stimulator lead, the placement of the pulse generator and replacement or revision of the vagus nerve electrode.

61885

The RUC reviewed the survey results for code 61885 *Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array* and agreed that the survey data accurately reflects the specialties' selected pre-service time package (3- FAC Straightforward Patient/Difficult Procedure), intra time of 45 minutes and immediate post time of 20 minutes. However, the RUC agreed that the survey respondents overstated the physician work with a median of 7.00 RVUs.

The RUC compared the surveyed code to the key reference code 63685 *Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling* (Work RVU = 6.05 and intra time = 60 minutes) and found that the typical intra-service work between the two services is highly comparable even though the survey median intra-service time of is fifteen minutes lower than the intra-service time for the reference code. The specialty described that the difference is explained because the surveyed code has a higher percentage of neurosurgeons performing the service more efficiently than 63685, which is performed by a wide variety of specialties. Additionally, 61885 has a greater intensity of work because of the anatomic region, which has the potential for damage to the proximal electrodes during the procedure, and has greater total physician time of 181 minutes compared to 170 minutes.

The RUC also compared the surveyed code to other relative services. First the RUC compared 61885 to 49585 *Repair umbilical hernia, age 5 years or older; reducible* (Work RVU = 6.59, intra time = 45 minutes). This code has similar intra-service work and similar post operative physician work. Additionally, code 43888 *Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only* (Work RVU = 6.44, intra time = 45 minutes) was compared to the surveyed service and the RUC agreed that this reference service, with an RVU of 6.44, properly approximates the intensity and complexity of 61885 and demonstrates appropriate relative work value amongst all physician services. **Therefore, based on the above comparisons, the RUC recommends 6.44 Work RVUs for 61885.**

6457X0

The RUC reviewed the survey results for code 6457X0 *Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator* and agreed that the survey data accurately reflects the specialties' selected pre-service time package (3- FAC Straightforward Patient/Difficult Procedure), intra time of 90 minutes and immediate post time of 30 minutes. However, the RUC agreed that the survey respondents overstated the physician work with a median of 12.00 RVUs.

The RUC compared the surveyed code to the key reference code 62223 *Creation of shunt; ventriculo-peritoneal, -pleural, other terminus* (Work RVU = 14.05, total time = 357 minutes). The committee agreed with the specialty that the reference service requires more total physician time and physician work compared to 6457X0. The RUC also reviewed the following codes in comparison to 645X0: 63655 *Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural* (Work RVU = 11.56 and total time = 273 minutes), 26260 *Radical resection of tumor, proximal or middle phalanx of finger* (Work RVU = 11.16 and total time = 256 minutes) and 58660 *Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis)* (Work RVU = 11.59, total time = 209.5 minutes). The RUC came to a consensus that these services accurately portray similar physician intra-service work with analogous work intensity and complexity. A work RVU of 11.19, slightly lower than the median survey RVU, demonstrates appropriate relative value amongst all physician services. This service was previously reported with CPT code 61885 (2010 Work RVU = 7.57) and code 64573 (2010 Work RVU = 4.13 after multiple service reduction), resulting in a current work RVU of 11.70. Therefore, the RUC recommendation results in a reduction in total work RVUs. **The RUC recommends 11.19 Work RVUs for 6457X0.**

6457X1

The RUC reviewed the survey results for code 6457X1 *Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator* and agreed that the survey data accurately reflects the physician time components involved in the procedure (pre-service time = 58 minutes, intra-service time = 120 minutes, immediate post service time = 30 minutes). The specialties selected pre-service time package 4- Difficult Patient/Difficult Procedure, subtracting 5 minutes from the scrub, dress and wait time because the survey respondents indicated a median pre-service time of 15 minutes for that component.

The RUC compared the surveyed code to the key reference code 63047 *Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda quine and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar* (Work RVU = 15.37 and total time = 362 minutes). The RUC found that while the reference code has 50 more minutes of total time, 6457X1 has 120 minutes intra-service time compared to 90 minutes for 63047. The median survey work RVU of 15.00 was chosen as it accurately aligns itself in relation to similar physician services. **The RUC recommends 15.00 Work RVUs for 6457X1.**

6457X2

The RUC reviewed the survey results for code 6457X2 *Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator* and agreed that the survey data accurately reflects the physician time components involved in the procedure

(pre-service time = 58 minutes, intra-service time = 90 minutes, immediate post service time = 30 minutes). The specialties selected pre-service time package 4- Difficult Patient/Difficult Procedure, subtracting 5 minutes from the scrub, dress and wait time because the survey respondents indicated a median pre-service time of 15 minutes for that component.

The RUC compared the surveyed code to the key reference code 63047 *Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda quine and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar* (Work RVU = 15.37 and total time = 362 minutes). The RUC noted that while both services have 90 minutes of intra-service time, 63047 has significantly more total time due to a greater number of post operative visits, 362 minutes compared to 282 minutes for 6457X2. Given this gap in time and intensity, the median survey Work RVU of 13.00 was chosen as it accurately aligns itself in relation to similar physician services. **The RUC recommends 13.00 Work RVUs for 6457X2.**

Practice Expense

The RUC reviewed the direct practice expense inputs and agreed that the 90 day global standard would apply and is recommended for these facility based services.

New Technology

The RUC recommends CPT codes 645X1 and 645X2 be placed on the RUC's new technology listing.

Amniotic Membrane Placement (Tab 15)

David Glasser, MD, AAO

In October 2009, the CPT Editorial Panel created two codes, 657XX1 and 657XX2, to accurately describe the placement of amniotic membrane for ocular surface wound repair and healing. CMS assigned these codes 090 day global periods and the services were surveyed through the RUC process. Following the survey, the specialty society requested that CMS classify codes as 010 day globals to more accurately describe the physician work and post operative visits described in these services. CMS accepted this request and the recommended values of the two codes are valued accordingly.

657XX1

The RUC reviewed the survey results for code 657XX1 *Placement of amniotic membrane on the ocular surface for wound healing; self-retaining* and agreed with the specialty that the survey respondents greatly overestimated the physician work and time components involved in the procedure. This was due to the services incorrectly being surveyed as a 090 day global service. The specialty society chose pre-service time package 5- Procedure without Sedation/Anesthesia Care and removed 7 minutes from the pre-service evaluation, while adding 5 minutes to the pre-service time for positioning and preparation apart from the E/M visit billed on the same day. This results in a pre-service time of 5 minutes for this procedure. The RUC also agreed that the appropriate intra-service time of 5 minutes, immediate post service of 5 minutes and 1 level two office visit (99212) accurately reflects the physician time involved in the service.

The RUC compared the surveyed code to 67820 *Correction of trichiasis; epilation, by forceps only* (Work RVU = 0.71, intra-service = 5 minutes, 000 day global) and 65205 *Removal of foreign body, external eye; conjunctival superficial* (Work RVU = 0.71, intra-

service = 5 minutes, 000 day global). Both these services require similar physician intensity and skill and mental effort to perform, but 657XX1 has 16 additional minutes of total time due to a level two office visit included in the 010 day global period. Additionally, the RUC noted that adding the work RVUs of 65205 (0.71) and the work RVUs of one 99212 office visit (0.48) comes out to 1.19 total work RVUs. The RUC agreed on a work RVU of 1.19, which accurately reflects relativity amongst the family of services.

The RUC also compared the surveyed code to 67505 *Retrolbulbar injection; alcohol* (Work RVU = 1.27, total time = 35 minutes) and 68840 *Probing of lacrimal canaliculi, with or without irrigation* (Work RVU = 1.30, total time = 39 minutes). Both these procedures have slightly more total time and intensity compared to the surveyed code and maintain appropriate relativity amongst physician services. **The RUC recommends 1.19 Work RVUs for 657XX1.**

657XX2

The RUC reviewed the survey results for code 657XX2 *Placement of amniotic membrane on the ocular surface for wound healing; single layer, sutured* and agreed with the specialty that the respondents greatly overestimated the physician work and time components involved in the procedure. This was due to the services incorrectly being surveyed as a 090 day global service. The specialty society chose pre-service time package 1b- Straightforward Patient Procedure (with Sedation/anesthesia) and subtracted 2 minutes from the evaluation time. The following physician service times are recommended: pre-service time = 23 minutes, intra-service time = 16 minutes and immediate post service time = 10 minutes. The RUC agreed with these times as there is no E/M visit billed on the same date of service.

To determine the appropriate amount of intra-service time for this service, the RUC reviewed two reference services. 65420 *Excision or transposition of pterygium; without graft* (Work RVU = 4.36, intra-time = 31 minutes) and 65426 *Excision or transposition of pterygium; with graft* (Work RVU = 6.05, intra-service = 47.5 minutes) were reviewed and it was determined that the additional work associated with the placement of the graft in 65426 was 16.5 minutes. The RUC agreed with the specialty that the physician work involved in suturing the single layer on the ocular surface in 657XX2 and the placing of a graft in the reference service should be 16.5 minutes, as both procedures have similar skill, intensity and physical effort. Having agreed to the intra-service time, the RUC subtracted the work RVUs of the two services to calculate the intensity for this work at 1.69 RVUs. The RUC then added the RVUs for the post operative visits as follows: 0.64 for the half day discharge (99238), 0.97 for the level three office visit (99213) and 0.48 for the level two office visit (99212), for a total of 3.78 work RVUs. Finally, the RUC allowed a small increment for the 33 minutes of same day pre-service and post service time inherent in the procedure, bringing the total to 3.92 work RVUs.

The RUC compared the surveyed code to 65885 *Trabeculoplasty by laser surgery, 1 or more sessions (defined treatment series)* (Work RVU = 3.99 and intra-service time = 15 minutes). The RUC agreed that while the surveyed code has more total time than 65885, 107 minutes and 88 minutes respectively, the intensity and complexity of the reference service is greater and should be valued slightly above 657XX2. **The RUC recommends 3.92 Work RVUs for 657XX2.**

Practice Expense

The RUC reviewed these services and direct inputs carefully and made one edit to the equipment for 65XX1 and agreed with all other inputs recommended by the specialty.

New Technology

The RUC recommends CPT codes 657XX1 and 657XX2 be placed on the RUC's new technology listing.

CT Abdomen/CT Pelvis (Tab 16)

Geraldine McGinty, MD, ACR, Ezequiel Silva, MD, ACR

Facilitation Committee # 3

CPT codes 74150, 74160, and 74170 were identified by the RUC's Five-Year Review Identification Workgroup as potentially misvalued through its Codes Frequently Reported Together screening mechanism, as combinations of these codes and codes that describe CT of the pelvis 72192, 72193 and 72194 are reported together more than 95% of the time. To address its concerns, the RUC recommended that the services be referred to the CPT Editorial Panel to create new bundled services of the CT of abdomen and pelvis.

7417X1 Computed tomography, abdomen and pelvis; without contrast material

The RUC reviewed the survey data for this service and agreed that the physician time (Pre-5 minutes, Intra-22 minutes, Post-5 minutes) is representative of the overall service. However, the RUC found that the respondents overstated the physician work required to perform this combined service. The RUC determined that an appropriate value for this service could be developed by comparing this service to 74182 *Magnetic resonance (eg, proton) imaging, abdomen; with contrast material(s)* (Work RVU=1.73) which has a similar intra-service time, 20 minutes. The RUC also considered that any application of a multiple procedure reduction would not have resulted in a work value of less than 1.74 work RVUs. (The full value of 74150 *Computed tomography, abdomen; without contrast material* (Work RVU=1.19) plus half the value of 72192 *Computed tomography, pelvis; without contrast material* (1/2 Work RVU=0.55) equals 1.74 work RVUs). The RUC understands that the current combination of 74150 and 72192 results in a total work RVU of 2.28 and 1.74 work RVUs reflects a significant reduction. However, in comparing the value to other services across the RBRVS, including new patient evaluation and management services the RUC determined that 1.74 Work RVUs was appropriate. **The RUC recommends 1.74 Work RVUs for 741X1.**

7417X2 Computed tomography, abdomen and pelvis; with contrast material

The RUC reviewed the survey data for this service and agreed that the pre-service time and post-service time were over-estimated. The RUC reduced the pre-service time and post-service time to 5 minutes each. The specialty society and RUC agreed that the intra-service physician time of 25 minutes is representative of the service. The RUC agreed that the best way to value 7417X2 was to determine an appropriate add-on for "with contrast". The RUC reviewed the incremental difference between 74150 *Computed tomography, abdomen; without contrast material* (Work RVU=1.19) and 74160 *Computed tomography, abdomen; with contrast material(s)* (Work RVU=1.27) (1.27-1.19=0.08 RVUs). The RUC applied this increment to 7417X1 (Proposed Work RVU=1.74) to develop a work RVU for this service. The resulting work RVU is 1.82 Work RVUs. This proposed value for the surveyed code is further supported by 72198 *Magnetic resonance angiography, pelvis, with or without contrast material(s)* (Work RVU=1.80) which has a similar total service time of 38 minutes as compared to 40 minutes for 7417X2. The RUC understands that the current

combination of 74160 and 72193 results in a total work RVU of 2.43 and 1.82 Work RVUs reflects a significant reduction. However, in comparing the value to other services across the RBRVS, including new patient evaluation and management services, the RUC determined that 1.82 Work RVUs was appropriate. **The RUC recommends 1.82 Work RVUs for 741X2.**

7417X3 Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by with contrast material(s) and further sections in one or both body regions

The RUC reviewed the survey data for this service and agreed that the pre-service time and post-service time were over-estimated. The RUC reduced the pre-service time and post-service time to 5 minutes each. The specialty society and RUC agreed that the intra-service time of 30 minutes is representative of the service. The RUC agreed that the best way to value 7417X3 was to determine an appropriate increment between 7417X2 and 7417X3. The RUC reviewed the incremental difference between 72194 *Computed tomography, pelvis; without contrast material, followed by contrast material(s) and further sections* (Work RVU=1.22) and 74170 *Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections* (Work RVU=1.40), 0.18 RVUs and recognized that this difference best approximated the work variance between 7417X2 and 7417X3. Therefore, when applying this increment of work to the proposed value for 7417X2, 1.82 Work RVUs, it results in 2.00 Work RVUs. The RUC also considered that any application of a multiple procedure reduction would not have resulted in a work value of less than 2.01 work RVUs. (The full value of 74170 *Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections* (Work RVU=1.40) plus half the value of 72194 *Computed tomography, pelvis; without contrast material, followed by contrast material(s) and further sections* (1/2 Work RVU=0.61) equals 2.01 work RVUs). Therefore, the RUC agreed that 2.01 work RVUs accurately reflects the work required to perform this service. This value is further validated by comparing it to MPC code 99233 *Subsequent hospital care, per day, for the evaluation and management of a patient* (Work RVU=2.00) which has the same intra-service time as the surveyed code, 30 minutes. The RUC understands that the current combination of 74170 and 72194 results in a total work relative value of 2.62 and that 2.01 RVUs reflects a significant reduction. However, in comparing the value to other services across the RBRVS, including evaluation and management services, the RUC determined that 2.01 work RVUs was appropriate. **The RUC recommends 2.01 Work RVUs for 7417X3.**

Practice Expense

The RUC reviewed and approved the practice expense inputs as modified and approved by the PE Subcommittee.

Archival Retrieval for Mutational Analysis (Tab 17)

Jonathan Myles, CAP

Facilitation Committee # 2

In October 2009, the CPT Editorial Panel created a new CPT code 883XX to account for pathologists' identification and selection of the appropriate tumor tissue in KRAS assays.

883XX

The RUC reviewed the survey results for code 883XX *Examination and selection of retrieved archival (ie, previously diagnosed) tissue(s) for molecular analysis (eg, KRAS mutational analysis)* and agreed with the specialty society's recommendation to bundle the surveyed pre and post-service time into the intra-service time to be consistent with other Pathology codes that have recently been reviewed. The RUC agreed to a total time of 17 minutes.

The RUC compared the surveyed code to the reference code 88334 *Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site* (Work RVU = 0.73 and intra time = 20 minutes). Given that the survey respondents overwhelmingly ranked the reference code's intensity and complexity measures higher than 883XX and 88334 has 3 more intra-service minutes, the RUC agreed that the surveyed code should be significantly lower than 88334.

To find appropriate relativity, the RUC compared the service to three analogous services. First, the RUC reviewed 86320 *Immunoelectrophoresis; serum* (Work RVU = 0.37 and total time = 17 minutes) and agreed that this service compared similarly to 883XX in its intensity, complexity and total time. Second, 86325 *Immunoelectrophoresis; other fluids (eg, urine, cerebrospinal fluid) with concentration* (Work RVU = 0.37, 14 minutes total time) was compared to the survey code and the RUC agreed that while this code has 3 less total minutes, it has a higher intensity and should thus be valued similarly. Finally, the RUC compared 85576 *Platelet, aggregation (in vitro), each agent* (Work RVU = 0.37, 19 minutes total time) with the surveyed code and came to a consensus that this physician work valuation is also highly comparable to the service in review. **The RUC recommends 0.37 Work RVUs for 883XX.**

Practice Expense

The RUC reviewed the practice expense inputs and approved 10 minutes of total clinical time for this service. Additionally, medical supplies and equipment were edited and agreed upon for the typical patient scenario.

Work Neutrality

The RUC's recommendation for these codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Diagnostic Cardiac Catheterization (Tab 18)

Joseph Babb, MD, FSCAI, Clifford Kavinsky, MD, SCAI, Gregory Thomas, MD, MPH, ACC

The RUC identified the cardiac catheterization services as potentially misvalued through its Codes Frequently Reported Together screen as combination 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 the CPT Editorial Panel for development of coding change proposals to condense code pairs into a single code and create new coding structures. The specialty submitted a code proposal for the June 2009 CPT meeting, however, the Panel postponed review until October 2009 to provide the Panel with additional time to review. The CPT Editorial Panel at its October 2009 Meeting approved

the addition of 20 codes, introductory language and deletion of 19 codes to accurately report diagnostic cardiac catheterization and injection services where imaging supervision and intraprocedural injection(s) have been bundled into the cardiac catheterization services.

Due to a low survey respondent rate, the specialty society requested to re-survey the diagnostic cardiac catheterization services and present their recommendations at the April 2010 RUC Meeting. **The RUC recommends that the presentation of the diagnostic cardiac catheterization codes be deferred to the April 2010 RUC Meeting.**

Sleep Testing (Tab 19)

Marianna Spanaki, MD, PhD, AAN

The CPT Editorial Panel created new codes to report unattended sleep studies that would be conducted while the patient was at home or in a hospital without attendance by a technologist. The specialty societies sponsoring the Sleep Testing issue have requested to return to the CPT Editorial Panel with a CPT Coding Proposal including a more comprehensive revision to this section of services to describe polysomnography on pediatric and non-pediatric patients. **The RUC recommends that this issue be referred to the CPT Editorial Panel for revision.**

X. CMS Requests

Breast Reconstruction (Tab 20)

Keith Brandt, MD, ASPS, Melissa Crosby, MD, ASPS, Martha Matthews, MD, ASPS, Michael Miller, MD, ASPS
Facilitation Committee # 1

In September 2007, the RUC's Five-Year Review Identification Workgroup identified 19357 through the Site of Service Anomaly screen. The RUC recommended that this service be referred to the CPT Editorial Panel as this service has bi-modal distribution and it may need to be separated into two codes to describe interval and immediate reconstruction. At the October 2009 CPT Editorial Panel meeting, the specialty decided to retain a single code as the same physician work is required whether the service is performed as immediate or delayed.

19357

The RUC reviewed the survey results for code 19357 *Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion* and agreed with the survey respondents that the surveyed physician time components were reflective of the service. The specialty chose pre-service time package 3- Straightforward Patient/Difficult Procedure. The specialty indicated, and the RUC concurred, that the pre service times of 33 minutes for evaluation, 3 minutes for positioning and 15 minutes for scrub, dress and wait time were justified as the typical patient scenario involves the plastic surgeon seeing and marking the patient directly and discussing with the general surgeon about positioning. Additionally, the RUC discussed the appropriateness of the number of post operative visits associated with this procedure. The specialty explained that four 99212 office visits and five 99213 office visits were appropriate because of the complexity of the service due to the high risk of infection. Also, the patient is returning to the office

multiple times to receive tissue expansion fills. The RUC reviewed this information and compared it to the survey results and agreed that one 99231, one 99238, four 99212, five 99213 and one 99214 office visits are typically reflected in this service.

The RUC compared the surveyed code to the key reference code 19318 *Reduction mammoplasty* (Work RVU = 16.00 and total time of 321 minutes). While the reference service has 150 minutes of intra-service time compared to 110 minutes for the surveyed service, 19318 has more intense physician work due to the large amount of wound closures involved in the service. Thus it was agreed that 19357 has physician work that is more intense, with significantly more total time due to more post operative visits and should be valued higher than the reference service code. Given this information, the RUC agreed that the survey's 25th percentile of 18.50 RVUs accurately demonstrates appropriate relativity amongst all physician services. **The RUC recommends 18.50 Work RVUs for 19357.**

Work Neutrality

The RUC's recommendation for these codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Stab Phlebectomy of Varicose Veins (Tab 21)

Scott Collins, MD, ASDS, Geraldine McGinty, MD, ACR, Michael Bigby, MD, SID, Ezequiel Silva, MD, ACR

The Society for Vascular Surgery, the American Academy of Dermatology, the American College of Surgeons, and the American College of Radiology, and CMS all agreed that CPT Codes 37765 *Stab phlebectomy of varicose veins, one extremity; 10-20 stab incisions* and 37766 *Stab phlebectomy of varicose veins, one extremity; more than 20 incisions* should have non-facility direct practice expense inputs as 68–71% of these procedures are now performed in a physicians' office. The CMS requested RUC review of the direct practice expense inputs for these two codes.

The RUC reviewed the specialty societies recommended direct practice expense inputs revised the clinical labor, medical supplies, and equipment necessary for these services. **The RUC recommends the attached direct practice expense inputs for CPT codes 37765 and 37766.**

Pathology Services (Tab 22)

Darryl Bronson, MD, AAD, Bruce Deitchman, MD, AAD

The pathology services were identified by the RUC's Five-Year Review Identification Workgroup through its CMS screen for Harvard-valued codes with utilization greater than 1 million. At the October 2009 RUC Meeting, the RUC recommended that all of the identified codes in this family be surveyed using the standard RUC survey instrument, or present an alternative methodology to the Research Subcommittee for review, or present a code change proposal to the CPT Editorial Panel for their review. Further, the RUC agreed that the presentation of the recommendations for 88314 *Special stains; histochemical staining with frozen section(s), including interpretation and report*, should be presented to the RUC with the other codes in this family.

The specialty society informed the RUC that they have submitted proposed vignettes and modified survey instruments to the Research Subcommittee, which were approved at the February 2010 RUC Meeting. They will be using these vignettes and survey instruments to survey the pathology consultation codes (88300-88307) for the April 2010 RUC Meeting. The specialty societies have requested that the special stain codes (88312-88314) be referred to the CPT Editorial Panel for review at their June 2010 Meeting. **The RUC recommends that 88300-88307 be reviewed by the RUC at the April 2010 RUC Meeting and that 88312-88314 be referred to the CPT Editorial Panel for revision.**

Gastroenterological Tests (Tab 23)

Edward Bentley, MD, AGA, Nicholas Nickl, MD, ASGE

The American Gastroenterological Association and the American Society for Gastrointestinal Endoscopy identified several missing medical supplies and equipment items that are typically being utilized in the delivery of two gastroenterological tests. The CMS requested that the direct practice expense inputs for these two tests be reviewed by the RUC. The non-facility medical supplies and equipment for CPT codes 91038 *Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)* and 91065 *Breath hydrogen test (eg, for detection of lactase deficiency, fructose intolerance, bacterial overgrowth, or oro-cecal gastrointestinal transit)* were presented to the RUC as a correction.

The RUC reviewed the specialty societies recommended direct practice expense inputs and revised the medical supplies and equipment necessary for these services. **The RUC recommends the attached direct practice expense inputs for CPT codes 91038 and 91065.**

Electrogastrography (Tab 24)

Edward Bentley, MD, AGA, Nicholas Nickl, MD, ASGE

The American Gastroenterological Association, the American College of Gastroenterology, and the American Society for Gastrointestinal Endoscopy identified the lack of technical component inputs and appropriate practice expense reimbursement for CPT codes 91132 *Electrogastrography, diagnostic, transcutaneous*; 91133 *Electrogastrography, diagnostic, transcutaneous; with provocative testing*. CMS agreed that this issue needed resolution and requested the RUC review revised direct practice inputs for these codes.

The RUC reviewed the specialty societies recommended direct practice expense inputs carefully and made edits to the clinical labor time, medical supplies and equipment necessary for these services. **The RUC recommends the attached direct practice expense inputs for CPT codes 91132 and 91133.**

Intracardiac Catheter Ablation (Tab 25)

Robert Jones, MD, ACC, Gregory Thomas, MD, ACC

CPT code 93652 was identified through the RUC's Five Year Identification workgroup's CMS fastest growing screen. Although the service continues to be infrequently performed, its utilization grew in the Medicare population from 1000 in 2002 to 2000 in 2007. The American College of Cardiology, in collaboration with the Heart Rhythm Society,

distributed the survey to electrophysiologists who are likely to perform the procedure. The 41 respondents of the survey recommended a median work RVU of 22.00, higher than the 17.65 currently assigned to the service.

The RUC reviewed the specialty survey data in relation to its key reference service, CPT code 93651 *Intracardiac catheter ablation of arrhythmogenic focus; for treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathways, accessory atrioventricular connections or other atrial foci, singly or in combination* (work RVU = 16.23, 120 pre-service, 285 intra-service, 60 immediate post time, 000 day global) and found the physician time components reflected the typical service. The society chose pre-service package 4 – facility based difficult patient/difficult procedure (63 minutes total), and made no modifications. The RUC agreed with the pre-service time package and reviewed two other services in their comparison of physician work; 49002 *Reopening of recent laparotomy* (work RVU = 17.63, 090 day global) and 34203 *Embolectomy or thrombectomy, with or without catheter; popliteal-tibio-peroneal artery, by leg incision* (work RVU = 17.86, 090 day global). The RUC noted that there was 15 additional intra-service minutes reported by the survey respondents for 93652 than for its key reference service.

The comparisons with the key reference code showed that survey respondents believed the survey code to be more intense and complex. The RUC discussed the change in the service since it was initially valued by the RUC in 1993. The typical patient of 1993 would have had more stable heart disease and would have required a treatment that included only 10 or so ablations whereas today's typical patient is likely to have a internal cardioverter defibrillator (ICD), more serious and unstable heart disease and requires a treatment that includes up to 60 ablations. The procedure is commonly performed today with the assistance of improved mapping software which has become common practice since 1993. The mapping software allows more difficult patients to receive this procedure but increases the average time for the procedure.. The RUC concluded that the median survey value was too high and the work relative value for CPT code 93652 of 17.65 was still appropriate after review of these other services.

The RUC recommends a work relative value for CPT code 93652 of 17.65.

EEG Monitoring (Tab 26)

Marianna Spanaki, MD, PhD, AAN

The RUC identified 95950, 95953 and 95956 as potentially misvalued services based on the recommendation of the Five-Year Review Identification Workgroup. These codes were referred to the Workgroup for review via the CMS Fastest Growing Screen. The RUC recommended that these services be surveyed for October 2009.

95950 Monitoring for identification and lateralization of cerebral seizure focus, electroencephalographic (eg, 8 channel EEG) recording and interpretation, each 24 hours

The specialty societies indicated that this code would eventually be deleted as the technology required to perform this service is no longer being manufactured. However, for the providers who still have this technology, this service needs to be appropriately valued for work and physician time. The RUC reviewed the survey data as presented by the specialty societies. The specialty societies indicated that the 15 minutes of pre-service time and 18 minutes of post-service time as indicated by the survey respondents was inflated. The specialty societies recommend that 10 minutes of both pre-service and

post-service time would be more representative of this service. The RUC compared the surveyed code to the reference code, 95813 *Electroencephalogram (EEG) extended monitoring; greater than 1 hour* (Work RVU=1.73) and noted that the reference code has an additional 7 minutes of total service time as compared to the surveyed code. The RUC also noted that the reference code and surveyed code had similar intensity and complexity measurements. Given the comparison to the reference code, the specialty societies recommend maintaining the current value of this service, 1.51 work RVUs, a value below the 25th percentile. This recommended work RVU is an appropriate reflection of the work performed by the physician and maintains rank order within its family of services. The RUC agreed with the specialty societies' recommendation. **The RUC recommends 1.51 work RVUs for 95950.**

95953 Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG, electroencephalographic (EEG) recording and interpretation, each 24 hours

The RUC reviewed the survey data as presented by the specialty societies. The specialty societies indicated that the 15 minutes of pre-service time as indicated by the survey respondents was inflated. The specialty societies recommend that 10 minutes of pre-service time would be more representative of this service. The RUC noted that this service was last reviewed in August 2005 and acknowledged that the surveyed intra-service time had changed from 60 minutes to 45 minutes. The RUC questioned the specialty society about this decrease in intra-service time. The specialty societies explained that the providers of this service in the past four years have become more familiar with the software used in this service and therefore the service takes less time to perform. The RUC compared the surveyed code to the reference code, 95810 *Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist* (Work RVU=3.52) and noted that the reference code has an additional 15 minutes of total service time as compared to the surveyed code. Given the comparison to the reference code and the time data from the August 2005 survey, the specialty societies recommend a decrease in the existing work RVU to 3.08 work RVUs, the 25th percentile of the current survey. This recommended work RVU is an appropriate reflection of the work performed by the physician, the shorter intra-service time and maintains rank order within its family of services. The RUC agreed with the specialty societies' recommendation. **The RUC recommends 3.08 work RVUs for 95953.**

95956 Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, electroencephalographic (EEG) recording and interpretation, each 24 hours

The specialty society presented compelling evidence to the RUC explaining the rationale for the recommended increase in work RVU for this service. The specialty societies explained that the technology has changed in providing this service from paper recordings to digital recordings which results in more data for the physician to analyze and interpret. Further, the specialty societies explained that a rank order anomaly exists within this family of codes. CPT code 95956 is the most complex of the three codes in this family to perform as it does require a minimum of 16 channels but the typical patient requires 20-32 channels. Even though it is the most complex of the three codes, it is currently valued below 95953 *Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG, electroencephalographic (EEG) recording and interpretation, each 24 hours*. The RUC accepted this compelling evidence to increase the value of this service.

The RUC reviewed the survey data as presented by the specialty societies. The specialty societies indicated that the 25 minutes of pre-service time as indicated by the survey respondents was inflated. The specialty societies recommend that 15 minutes of pre-service would be more representative of this service. The RUC understands that this is typically a specialist that has not seen the patient. The RUC compared the surveyed code to the reference code, 95810 *Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist* (Work RVU=3.52) and noted that the surveyed code has an additional 10 minutes of total service time as compared to the reference code. The RUC also noted that the surveyed code had significantly greater intensity and complexity measurements as compared to the reference code. Given the comparisons to the reference code, the specialty societies recommend 3.61 work RVUs, the 25th percentile. This recommended work RVU is an appropriate reflection of the work performed by the physician and maintains rank order within its family of services. The RUC agreed with the specialty societies' recommendation. **The RUC recommends 3.61 work RVUs for 95956.**

Practice Expense: During the RUC's February 2010 meeting the direct practice expense inputs were reviewed. The clinical labor time was scrutinized resulting in several reductions in the recommended clinical staff time. Edits to the equipment and supplies were also made to accurately reflect the typical patient service scenario. **The RUC recommends the attached direct practice expense inputs for CPT codes 95950, 95953, and 95956.**

Work Neutrality: The RUC understands that the recommendations for this family of codes is budget neutral.

XI. Practice Expense Subcommittee Report (Tab 27)

Doctor Moran discussed the actions of the practice expense subcommittee involving the Review Charts and Fluoroscopy Workgroups. RUC unanimously approved the following recommendations made by the subcommittee:

Review Charts Line Item

At its last meeting the RUC agreed with the deletion of the "Review Charts" line on the standard practice expense spreadsheet and this activity be combined with "Greet Patient and Provide Gowning" to form the new line "Greet Patient, Provide Gowning, Ensure Appropriate Medical Records are Available". The standard for this Line 21 would remain at 3 minutes. The RUC intended this action to be implemented for all codes reviewed from February 2010 and beyond. The RUC at that time recommended that this elimination should also be pursued retroactively, however was suggested that AMA staff research the feasibility of conducting such a large automatic adjustment. AMA staff researched the retroactive elimination of all "Review Charts" time and believed, rank order anomalies and distortions in the physician fee schedule would result. The RUC concluded that there is no objective way to retroactively remove "Review Charts" time from the previously approved RUC recommendations and implementation of this action would require the subcommittee to review clinical staff time for all CPT codes. **The RUC recommends no retroactive omission of Review Charts clinical labor time.**

Radiographic - Fluoroscopy Workgroup Discussion

The RUC reviewed the typical use of imaging equipment for 111 CPT codes that currently incorporate the use of a radiographic fluoroscopic room, in the non-facility setting. The 111 codes were grouped into three groups, the first group consisting of 28 codes was agreed upon and recommended **that the specialties involved in two services (36598 and 49424) may return to the Practice Expense Subcommittee and present a joint recommendation that would include data supporting the typical use of the Angiography Room (EL012) in the Non-Facility setting. Until such data is presented and acted upon, all services in the first group of codes are recommended to have their Radiographic Fluoroscopic room (EL014) retained.**

For the three services contained in group two the RUC **recommends that the Radiographic Fluoroscopic room (EL014) be deleted from codes contained in group two (64420, 64421, and 64620), as the general and majority specialty feedback indicated deletion and fluoroscopic guidance may be separately reportable when needed. It is also recommended that a CPT Assistant article be written for further clarification as to when and when not to report fluoroscopy services.**

The RUC recommended those **specialties who perform services in group three, in the Non-Facility setting, who haven't responded, submit the type of imaging equipment used typically in the non-facility setting, to AMA staff by February 26, 2010.** A workgroup conference call would follow to provide recommendations and feedback to the practice expense subcommittee.

Rank Order Anomaly in Direct Practice Expense Inputs – 51726

A rank order anomaly was identified in the practice expense RVUs for codes 51726 – 51729. American Urological Association prepared several adjustments to the clinical staff time. The subcommittee agreed with all the changes suggested.

Gastrointestinal Endoscopy Non-Facility Change Request

The three main gastroenterology and gastrointestinal endoscopy societies brought forward a request to add several equipment and medical supply items to 24 codes, as a change in the standard of practice due to recent regulation. Doctor Moran stated that although it was recognized that these additional items may be appropriately added, RUC questioned how other services utilizing these supplies and equipment would be revised to remain appropriately valued, and delayed any action as there is no established mechanism to review each service for a similar changes practice expense.

Equipment Time

The Subcommittee discussed the need for specific time elements for each equipment item on the practice expense spreadsheet for our recommendations. In the past this information was populated typically by CMS staff. The subcommittee agreed that the method that CMS determined the specific time elements needs to be outlined and consistently applied to all the codes reviewed at this meeting. AMA staff will work with CMS for this information and report back to the subcommittee at the next meeting.

Doctor Moran also explained that the subcommittee reviewed carefully all relevant RUC agenda items (19 issues) and provided recommendations to the RUC for over twelve hours on Wednesday, February 4, 2010.

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

XII. HCPAC Review Board Report (Tab 28)

Lloyd Smith, DPM informed the RUC that the HCPAC reviewed the specialty society recommendations for several speech-language pathology services and one Audiology service. The HCPAC referred three of these services to the CPT Editorial Panel for clarification and developed work recommendations for the remaining codes. The HCPAC reviewed and developed work recommendations for two debridement services, as well. The rationale for these recommendations are detailed in the HCPAC report attached to these minutes. The practice expense inputs for these issue, with the exception of the codes referred to the CPT Editorial Panel, will be reviewed by the HCPAC Review Board at their April 2010 Meeting.

XIII. Research Subcommittee Report (Tab 29)

Doctor Lewis briefed the RUC on the four items discussed by the Research Subcommittee including: 1) 2010 Five-Year Review of Alternative Methodologies, 2) RUC Survey Instrument and Summary of Recommendation Form Modifications, 3) Specialty Society Requests and 4) Clarification on the Final Rule by CMS.

Doctor Lewis reminded the Subcommittee that the April 2010 RUC Meeting is the last opportunity for specialties to bring forward an alternative methodology for services in the 2010 Five-Year Review to be reviewed by the Research Subcommittee.

Doctor Lewis informed the RUC that to incorporate the subsequent observation codes into the survey process, pending their acceptance by CMS in November 2010, **The Research Subcommittee recommends the following modifications to the ZZZ, 010 and 090 Global RUC Survey Instruments be made for the February 2011 RUC Meeting:**

Subsequent Observation Care*

	Day of Surgery	Day 1	Day 2	Day 3	Day 4	Days 5-10	Days 11-30	Days 31-60	Days 61-90
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Subsequent Observation Care*

99231	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
99232	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
99233	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Subsequent Observation Care ^{3,5}

992X1	20	15	Problem focused	Low or straightforward
992X2	40	25	Expanded	Moderate
992X3	55	35	Detailed	High

⁵ All levels of subsequent observation care include reviewing the medical record and reviewing the results of diagnostic studies and changes in the patient's status (i.e., changes in history, physical condition, and response to management) since the last assessment by the physician.

Further the Research Subcommittee recommends the following modifications to the Summary of Recommendation Form be made for the February 2011 RUC Meeting:

1.) Addition of a row in the Survey Data Table and Specialty Society Recommended Data Table and modification to a note-

Sub Obs Care:	_____	992X1 ___ 992X2 _____ 992X3 _____
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**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 992X1 (20); 992X2 (40); 992X3 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

2.) Under the relationship of code being reviewed to key reference service(s) section a row should be added

Time Estimates	CPT Code	Key Reference CPT Code
Median Subsequent Observation Care Time	_____	_____

Doctor Lewis explained that although CMS finalized its proposal to eliminate the office consultation services (99241-99245) and the inpatient consultation services (99251-99255), the Research Subcommittee agrees that these services not be deleted as they can only assist the survey respondent to accurately complete the RUC survey. **The Research Subcommittee recommends that the current language be maintained in the 000, 010 and 090 Global Survey Instruments.**

Doctor Lewis informed the RUC that the Research Subcommittee reviewed and made minor modifications to the vignette proposed by the specialty society for Sleep Medicine. **With these modifications, the Research Subcommittee recommends the vignettes as proposed by the specialty societies.** The reference service list proposed for Sleep Medicine was reviewed and **the Research Subcommittee recommends that there are several evaluation and management services, nerve conduction studies and other services that the specialties perform that could be added to this reference service list.** The proposed modifications to the pathology survey instruments were reviewed and **the Research Subcommittee recommends the following description of intra-service time for 88300:**

Intra-Service Time:

The intra-service work may include (among other activities):

- Reviewing the clinical history including prior study reports
- Performing or directly supervising the specimen preparation
- Examine the specimen

- Compare the specimen to prior specimens and reports
- Prepare, edit and sign-out the report
- Discuss observations with other professionals

Further, the Research Subcommittee recommends the following description of intra-service time for 88302-88307:

Intra-Service Time:

The intra-service work may include (among other activities):

- Reviewing the clinical history including prior study reports
- Performing or directly supervising the specimen preparation
- Perform gross and microscopic evaluation of prepared material
- Compare the specimen to prior specimens and reports
- Prepare, edit and sign-out the report
- Discuss observations with other professionals

The proposed vignettes for Pathology Services were reviewed and **the Research Subcommittee recommends the vignettes as proposed by the specialty society.**

Doctor Lewis informed the RUC that the Research Subcommittee questioned why CMS requested in the *Final Rule* to add data points to the Summary of Recommendation Form for the 2010 Five-Year Review. CMS representative, Edith Hambrick, MD, stated that these data points will provide CMS more information about the distribution of data from the survey respondents and will provide another measure of central tendency. Doctor Lewis informed the RUC that the Research Subcommittee will review Five-Year Review Survey Instruments and Summary of Recommendation Forms at the April 2010 RUC Meeting.

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

XIV. PLI Workgroup Report (Tab 30)

Doctor Sandra Reed, explained that the PLI Workgroup looked at two specific issues. The first issue the Workgroup discussed dealt with the major vs. minor PLI premium split that CMS discussed in the 2010 NPRM. CMS chose not to finalize the proposal that would have defined the “major” surgery classification as CPT codes within the range 10000-69999 with a global 090 day and “minor” surgery all those same codes with a 000 or 010 global. For those 8 specialties that had premium splits, CMS applied the major PLI premium to these specialty’s services resulting in significant increases in PLI payments. **The Workgroup has asked CMS to look at this flawed rational and look back at the contractor information to ensure that the typical premium specialty data are used.**

The second topic the Workgroup discussed was the PLI crosswalk analysis. All 2009 and 2010 CPT codes were analyzed to determine if CMS used the RUC recommended PLI crosswalk information for all new and revised codes. For the majority of the codes, CMS did not use the crosswalk information provided by the RUC, resulting in wide variances

in PLI RVUs. **The Workgroup agreed to reaffirm to CMS that all PLI crosswalks for new and revised codes should be established by the corresponding RUC Summary of Recommendation form.**

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

XV. Five Year Identification Workgroup Report (Tab 31)

Action Plans

Doctor Walt Larimore explained that the Five-Year Identification Workgroup received action plans presented by specialty societies which addressed 50 code groups and contained 161 codes flagged by the following screens: Harvard Utilization over 100,000, services surveyed by one specialty and now performed by another specialty and a few remaining high service codes. The Workgroup made recommendations for these services and their families in the Workgroup's Report attached to these minutes.

Codes Performed Together 75% or More Screen

Doctor Larimore reviewed the Five-Year Identification Workgroup's discussion regarding the Codes Performed Together 75% or More Screen and its work with the CPT/RUC Workgroup. All codes performed by the same physician on the same date of service to a beneficiary was provided by CMS and based on 2008 utilization data. Doctor Kenneth Brin, Joint Workgroup chairman, had explained to the Workgroup that the 151 relevant code pairs were grouped into similar "groups" and then were prioritized based on allowed charges. Given this analysis, the Joint Workgroup recommended to the Five-Year Review Identification Workgroup that the highest priority "groups" be sent out to the specialty societies and have action plans delivered to the Joint CPT/RUC Workgroup for consideration for the April 2010 RUC meeting. The Joint CPT/RUC Workgroup outlined 4 next steps regarding the screening process and are included in the Five-Year Workgroup Report attached to these minutes.

In addition, Doctor Larimore explained that this analysis compares favorably with the July 2009 GAO Report. The Workgroup highlighted that the Joint RUC/CPT Workgroup review is a more comprehensive analysis. Many of the GAO code pairs have already been addressed by the RUC or reflect services with low Medicare volume.

Items not yet submitted to CPT

Doctor Larimore outlined to the RUC five (33213, 74175, 63056, G0179, G0180) outstanding CPT Editorial Panel and CPT Assistant codes from various screens. The Workgroup's recommendations for these services are included in the Five-Year Workgroup Report attached to these minutes.

The RUC approved the Five-Year Review Identification Workgroup's report, with no changes, and it is attached to these minutes.

XVI. Administrative Subcommittee (Tab 32)

Doctor Dale Blasier presented the discussion of the Administrative Subcommittee from their January conference call to the RUC. At the October 2009 RUC meeting, the Administrative Subcommittee approved the addition of a series of financial disclosure questions at the beginning of the standard RUC survey. If a respondent had an relevant financial interest, as written in the statement, he or she would fill out the first three pages

only. In response to this policy, the gastroenterology societies, in December, requested that the RUC look at this policy and determine what truly constitutes a conflict of interest. Furthermore, these societies believed the policy overly restricts potential respondents from completing a survey. In response, AMA staff consulted legal advice and made the following changes to the questions.

1. The following was added to clarify the definition of an organization:
 - a. Organization means any entity that makes or distributes the product that is utilized in performing the service, and not the physician group or facility in which you work or perform the service. ~~with an interest in the service(s) you are evaluating for this survey, other than the physician group in which you work.~~
2. The following was added to address what constitutes a material financial interest:
 - a. Materially means ~~any~~ \$10,000 or more in income (excluding any reimbursement for expenses) for the past twenty-four ~~twelve months or cumulative lifetime income of at least \$10,000.~~

The RUC discussed and approved that the definition of materially should be \$10,000 or more, as that was the intent of the Subcommittee at the time of approval. The RUC also discussed further refinements to the report. Under the Administrative Subcommittee’s response to the gastroenterology specialty societies item 2 should read “training in the use of a particular device or the performance of a procedure.” In addition, the RUC discussed whether or no to add extra language that separates medical legal work with physicians. This language might make the issue clearer for potential survey respondents. Most physicians think of medical legal relative to other physicians as opposed to a product. **The RUC agreed to revise the last bulleted question “(excluding professional liability testimony)” to read as follows:**

- a. Serve as a consultant, researcher, expert witness (excluding professional liability testimony), speaker or writer for an organization, where payment contributes materially to your income.

A motion was made to reconsider the previous RUC action stating that if a potential survey respondent has a conflict of interest he or she should not fill out the survey. Some of the RUC members felt that surveyees with a conflict should be able to complete a survey and that data should be compared to the respondents from surveyees without conflicts. Other members disagreed and commented that the Administrative Subcommittee has already spent a considerable amount of time discussing this point and the original language represents the Subcommittee’s intentions. **The RUC voted on the motion to reconsider and it did not pass.**

Furthermore, RUC members discussed the above statement and approved two editorial changes that state: If you have answered yes to any of the above questions, you do not have to complete this survey. However, please submit the first three pages of this survey.

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

XVII. Other Issues

Other:

- The RUC discussed the potential issue of consultants who attend RUC meeting in an advisory role for one entity but have or still do represent other entities that may have material before the RUC. RUC members debated whether or not these individuals need to be identified and whether or not RUC books and materials should be limited. Doctor Levy referred this issue to the Administrative Subcommittee for review at the April 2010 meeting. Specifically the Subcommittee will look at whether or not registered guests should be required to list all clientele before admittance to a meeting is allowed. Furthermore, it was requested that the Administrative Subcommittee review the process that is used to ensure a potential guest adheres to the RUC confidentiality provisions.
- The RUC also requested that the Administrative Subcommittee look at whether or not the RUC advisor and member financial disclosure statement should include a time table for the accumulation of \$10,000 or more in income from related interests in order to stay consistent with the RUC survey. The Administrative Subcommittee will review the changes to the financial disclosure questions and determine if these changes should be made to all RUC and RUC advisory policies and disclosures.
- A member discussed the need for the RUC to beginning looking for an external validation of time data. Doctor Levy referred this issue to the Research Subcommittee for consideration and to discuss reorganizing the Extant Database Workgroup.

The meeting adjourned on Saturday, February 6, 2010 at 3:15pm.

**AMA/Specialty Society RVS Update Committee
Practice Expense Subcommittee Report
Thursday, February 4, 2010
8:00 am – 5:00 pm**

Tab 27

Members present: *Doctors Bill Moran (Chair), Joel Brill (Vice Chair), Joel Bradley, Ron Burd, Manuel Cerqueira, Neal Cohen, Thomas Cooper, Peter Hollmann, Guy Orangio, Tye Ouzounian, John Seibel, Anthony Senagore, Susan Spires, and Eileen Carlson, JD, RN.*

Review Charts Research Update

At the October 2009 meeting, the Practice Expense Subcommittee and the RUC agreed with the deletion of the “Review Charts” line on the standard Practice Expense spreadsheet. The subcommittee intended this action to be implemented for all codes reviewed from February 2010 and beyond. The full RUC agreed with the elimination of the “Review Charts” line item. However, the RUC recommended that this elimination should also be pursued retroactively. It was suggested that AMA staff research the feasibility of conducting such an automatic adjustment and report back to the next Practice Expense Subcommittee meeting. AMA staff reported that it was evident from the review that the “Review Charts” activity has been viewed differently by each specialty over time, and had been listed by specialties 17 different ways and has been listed in the intra-service and/or in the pre-service time periods in both the non-facility and facility settings.

It was evident to AMA staff that the effect of eliminating all “Review Charts” time may be inappropriate. If this specific activity were deleted retroactively, rank order anomalies and distortions in the physician fee schedule most certainly would result. The Practice Expense Subcommittee concluded that there is no objective way to retroactively remove “Review Charts” from the previously approved RUC recommendations. Implementation of this action would require the Practice Expense Subcommittee to review all CPT codes. **The Practice Expense Subcommittee recommends no retroactive omission of Review Charts clinical labor time.** *At the full RUC, this action was voted on and approved separately.*

Radiographic - Fluoroscopy Workgroup Discussion

AMA staff compiled independent feedback from 13 different specialties in a spreadsheet format (attached) for the workgroup’s review. Practice expense members reviewed the specialty feedback for first and second groups of codes. Members agreed that all codes in group one should retain the present inputs with a radiographic fluoroscopy room. For codes 36598 *Contrast injection(s) for radiologic evaluation of existing central venous access device, including fluoroscopy, image documentation and report* and 49424 *Contrast injection for assessment of abscess or cyst via previously placed drainage catheter or tube (separate procedure)* the specialty feedback indicated that a Radiographic Fluoroscopic room (EL014) was typically insufficient for these procedures and that an Angiography Room (EL012) was typically used. **The Subcommittee agreed and recommend that the specialties involved in these services (36598 and 49424) may return to the Practice Expense Subcommittee and present a joint recommendation that would include data supporting the typical use of the Angiography Room (EL012) in the Non-Facility setting. Until such data is presented and acted upon, all services in the first group of codes are recommended to have their Radiographic Fluoroscopic room (EL014) retained.**

For the three services contained in group two where previously the RUC had recommended that the Radiographic Fluoroscopic room be deleted from their direct practice expense inputs, after review of specialty feedback, the workgroup agreed the room be deleted. The Subcommittee

members agreed that previous recommendations regarding services where fluoroscopy is may be separately reported, the RUC had reviewed these services side by side to prevent duplication in direct practice expense inputs (see PEAC Radiology Standard Package document attached). **The Subcommittee recommends that the Radiographic Fluoroscopic room (EL014) be deleted from codes contained in group two (64420, 64421, and 64620), as the general and majority specialty feedback indicated deletion and fluoroscopic guidance may be separately reportable when needed. It is also recommended that a CPT Assistant article be written for further clarification as to when and when not to report fluoroscopy services.**

The subcommittee had a lengthy discussion regarding the services in group three. They discussed codes that appeared to have utilization that was inconsistent with what subcommittee members felt was consistent with common sense. The subcommittee also reviewed inputs received from the specialty societies. After a review of submitted documentation the subcommittee did not feel that there was sufficient information upon which to make an educated recommendation. For example, for some codes specialties not performing the procedure had responded with inputs and in other codes, specialties commonly performing the procedure (according to utilization data) had not provided the requested inputs.

The Subcommittee reviewed the specialty feedback for many codes in group three and after much discussion agreed that there was too much inconsistency in the specialty feedback to make an educated definitive decision on each code. The Subcommittee agreed that the entire group should be reviewed by specialties who have non-facility utilization and provide AMA staff with their typical non-facility imaging equipment used for these services. Specialties will be requested to respond to AMA staff by February 26, 2010 so that workgroup can meet the first week in March.

The Subcommittee recommends that specialties who perform services in group three, in the Non-Facility setting, who haven't responded, submit the type of imaging equipment used typically in the non-facility setting, to AMA staff by February 26, 2010.

Rank Order Anomaly in Direct Practice Expense Inputs – 51726

A rank order anomaly was identified in the practice expense RVUs for codes 51726 – 51729. American Urological Association prepared several adjustments to the clinical staff time. The subcommittee agreed with all the changes suggested.

Gastrointestinal Endoscopy Non-Facility Change Request

The three main gastroenterology and gastrointestinal endoscopy societies brought forward a request to add 11 equipment items and 20 medical supplies to 24 codes, as a change in the standard of practice due to recent regulation. The question of funding for a crash cart by CMS was raised and the request for equipment to meet sedation requirements was recognized, but needed to be procedure related. In addition, the subcommittee questioned how other services utilizing these supplies and equipment would be revised to remain appropriately valued. The subcommittee reviewed the request carefully and delayed action because as there is no mechanism established to review each service for a similar change practice expense.

Equipment Time

The Subcommittee discussed the need for specific time elements for each equipment item on the practice expense spreadsheet for our recommendations. In the past this information was populated typically by CMS staff. The subcommittee agreed that the method that CMS determined the specific time elements needs to be outlined and consistently applied to all the codes reviewed at this meeting. AMA staff will work with CMS for this information and report back to the subcommittee at the next meeting.

New and Revised Direct Practice Expense Input Recommendations

Excision and Debridement (11010-11012, 11042, 11045X, 11043, 11046X, 11044, 11047X)

The Subcommittee reviewed these services and direct inputs carefully and agreed on a minor reduction in the clinical labor time and a number of changes to the medical supplies for each.

Arthrodesis Including Discectomy (2255X & 2255X2)

The Subcommittee reviewed these services and direct inputs carefully and agreed that these services have similar facility practice expenses as other complex spine procedures. The subcommittee agreed on 75 minutes of pre-service time is appropriate rather than the standard 90 day global pre-service time of 60 minutes. These services are performed in the facility setting only.

Nasal/Sinus Endoscopy with Balloon Dilation (31256, 31267, 31276, 31287, 31288, 3129X1, 3129X2 & 3129X3) The Subcommittee reviewed these services and direct inputs carefully and agreed with the clinical labor time submitted and deleted one unnecessary medical supply.

Bronchoscopy with Balloon Occlusion (316X1)

The Subcommittee made reductions to the clinical labor time for this service and no edits to medical supplies and equipment. An additional catheter was added subsequent to the meeting as it was accidentally left out.

Cardiac Hybrid Procedures (3362X, 3362X1 & 3362X2)

The Subcommittee reviewed these services and direct inputs carefully and agreed that the 90 day global standard would apply and is recommended.

Gastric Intubation (4375X1, 4375X2, 4375X3, 4375X4 & 4375X5)

The Subcommittee reviewed these services and direct inputs carefully and agreed that almost all of the work for X2-X5 is performed by the clinical labor staff. Edits were made to the medical supplies and equipment for the typical patient scenario.

Vaginal Radiation Afterloading Apparatus for Clinical Brachytherapy (571XX & 57155)

The Subcommittee reviewed these services and direct inputs carefully and made several reductions in the clinical labor staff time for both codes. In addition, the Subcommittee agreed to deletions of some medical supplies.

Stereotactic Computer-Assisted Volumetric Navigational Procedures (6179X1-6179X3)

The Subcommittee agreed that there would be no direct practice expense inputs for these services.

Vagus Nerve Stimulator (61885, 6457X, 6457X1, 6457X2)

The Subcommittee reviewed these services and direct inputs carefully and agreed that the 90 day global standard would apply and is recommended.

Amniotic Membrane Placement (657XX1 & 647XX2)

The Subcommittee reviewed these services and direct inputs carefully and made one edit to the equipment for 65XX1 and agreed with all other inputs recommended by the specialty.

CT Abdomen/CT Pelvis (7417X1-7417X3)

The Subcommittee reviewed these services and direct inputs carefully and agreed to reductions to the clinical labor staff time from what was submitted and no changes to the medical supplies and equipment.

Archival Retrieval for Mutational Analysis (883XX)

The Subcommittee reviewed these services and direct inputs carefully. However, the subcommittee suggested that the labor time may be administrative and captured in the indirect expense. The subcommittee believe if clinical labor does exist for these codes, they would recommend a total time of 10 to 15 minutes whereas the specialty believed the service required approximately 50 minutes. The specialty and the subcommittee could not agree on the direct practice expense inputs for 883XX.

Diagnostic Cardiac Catheterization (93XX1-93XX20)

The Subcommittee reviewed these services and direct inputs carefully and made significant changes to the clinical labor and medical supplies as there were several duplicative lines in the specialty recommendation.

Stab Phlebectomy of Varicose Veins (37765 & 37766)

The Subcommittee reviewed these services and direct inputs carefully and made reductions to the clinical labor and supplies.

Gastroenterological Tests (91038 & 91065)

The Subcommittee reviewed these services and direct inputs carefully and reduced and modified the medical supplies as recommended to agree with the typical patient scenario.

Electrogastrography (91132 & 91133)

The Subcommittee reviewed these services and direct inputs carefully and made significant reductions to the clinical labor and supplies for each code. The Subcommittee agreed these changes were necessary and the specialty agreed.

EEG Monitoring (95950, 95953 & 95956)

The Subcommittee reviewed these services and direct inputs carefully and made several reductions in the recommended clinical staff time as well made a few edits to the equipment and supplies needed.

Speech-Language Pathology Services (92506, 92507, 92508, 92605, 92606, 92607, 92608 & 92609)

The review of these services was postponed until April 2010.

Audiology Testing (92587)

The review of these services was postponed until April 2010.

Excision and Debridement (97597 & 97598)

The Subcommittee reviewed these services and direct inputs carefully and made few modifications to the recommended direct inputs.

The Practice Expense Subcommittee was adjourned at 7:15 pm.

**AMA/Specialty Society RVS Update Committee
RUC HCPAC Review Board Meeting Report
Thursday, February 4, 2010**

Tab 28

Members Present

Arthur Traugott, MD (Chair)
Lloyd Smith, DPM (Co-Chair)
Emily Hill, PA-C (Alt. Co-Chair)
Eileen Carlson, JD, RN
Michael Chaglasian, OD
Robert Fifer, PhD, CCC-A
Mary Foto, OTR

James Georgoulakis, PhD
Anthony Hamm, DC
Stephen Levine, PT, DPT, MSHA
William Mangold, MD
Doris Tomer, LCSW
Jane White, PhD, RD, FADA
Marc Raphaelson, MD

I. CMS Update

Edith Hambrick, MD, provided a CMS update and informed the HCPAC that CMS is currently awaiting appointment of the new CMS Administrator and that there is a new Director of the Division of Practitioner Services, Doctor Carol Bazell. Doctor Hambrick also suggested that the organizations represented on the HCPAC may bring issues to CMS' attention at this time for the proposed rulemaking process.

II. CMS Request: Relative Value Recommendations for *CPT 2011*:

Speech-Language Pathology Services

92506 Evaluation of speech, language, voice, communication, and/or auditory processing

The specialty society after reviewing the survey data for this service agreed that more than one service is being represented under this code and requests the service be referred back to the CPT Editorial Panel for further clarification. **The HCPAC recommends that 92506 be referred back to the CPT Editorial Panel to clearly describe the services being performed.**

92507 Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual

The specialty society reviewed the survey data and agreed that the pre-service time and post-service time for this service were over-estimated by the survey respondents. Therefore, the specialty society reduced the pre-service time to 5 minutes and post-service time to 5 minutes as this time was agreed to be more representative of the service. The HCPAC compared the surveyed code to the reference code, 92526 *Treatment of swallowing dysfunction and/or oral function for feeding* (work RVU=1.34) and noted that the intra-service time for the surveyed code and the reference code are very similar, 50 minutes and 45 minutes, respectively. Further, the HCPAC noted that the surveyed code and the reference code require similar amounts of technical skill, mental effort and judgment to perform. Therefore, based on these comparisons to the reference code, the HCPAC agreed with the specialty recommendation of 1.30 RVUs, the survey median. **The HCPAC recommends 1.30 RVUs for 92507.** After reviewing the recommended RVU, the specialty society changed their professional liability insurance (PLI) crosswalk to this reference code, 92526.

92508 Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals

The specialty society reviewed the survey data and agreed that the service times and work RVU recommendations from the survey data are not representative of the service because the survey respondents were estimating the time and work of the total service. Therefore, the specialty societies agreed that the pre-service time and post-service time for this service were over-estimated by the survey respondents. Accordingly, the specialty society reduced the pre-service time to 2 minutes and post-service time to 3 minutes as this time was agreed to be more representative of the service and consistent with other group codes performed by the HCPAC professionals. The HCPAC questioned the specialty society about the typical number of participants in a group. The specialty society explained that typically there are 3 participants in a group. Given this information, the specialty society explained that when developing the recommendation, they divided the intra-service time and work associated with 92507 by the three participants to develop recommendations for the group code as this code will be billed three times. This action resulted in 17 minutes of intra-service time and 0.43 work RVUs. This work RVU for the surveyed code is further supported by an additional reference code 97530 *Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes* (Work RVU=0.44) as both services have similar intra-service times (17 minutes and 15 minutes, respectively) and total service times (22 minutes and 18 minutes, respectively). Given these comparisons to reference codes, **the HCPAC recommends 0.43 Work RVUs for 92508.** After reviewing the recommended RVU, the specialty society changed their PLI crosswalk to 92557 *Comprehensive audiometry threshold evaluation and speech recognition* (Work RVU=0.60).

92605 Evaluation for prescription of non-speech-generating augmentative and alternative communication device

The specialty society after reviewing the survey data for this service agreed that this code would be better captured as a “per hour” code and requests the service be referred back to the CPT Editorial Panel for modification. **The HCPAC recommends that 92605 be referred back to the CPT Editorial Panel to modify the descriptor to make it more reflective of the service performed.**

92606 Therapeutic service(s) for the use of non-speech-generating device, including programming and modification

The specialty society reviewed the survey data and agreed that the pre-service time for this service was over-estimated by the survey respondents as it includes administrative activities. Therefore, the specialty society reduced the pre-service time to 7 minutes as this time was agreed to be more representative of the service. The HCPAC compared the surveyed code to the reference code, 92526 *Treatment of swallowing dysfunction and/or oral function for feeding* (work RVU=1.34) and noted that the intra-service time for the surveyed code is greater than the key reference code, 60 minutes and 45 minutes, respectively. Further, the HCPAC noted that the surveyed code is a more intense service to perform as compared to the key reference code. In addition, the HCPAC compared the surveyed code to an additional reference code, 92626 *Evaluation of auditory rehabilitation status; first hour* (Work RVU=1.40). The HCPAC noted that the times and work RVU for both this reference service and the surveyed code are exactly the same. Therefore, based on these comparisons to both of these reference codes, the HCPAC agreed with the specialty recommendation of 1.40 RVUs, the survey median. **The HCPAC recommends 1.40 RVUs for 92606.**

92607 Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour

The specialty society reviewed the survey data and agreed that the pre-service time and post-service time for this service were over-estimated by the survey respondents. Therefore, the specialty society reduced the pre-service time to 10 minutes and post-service time to 20 minutes as this time was agreed to be more representative of the service. The HCPAC compared the surveyed code to the reference code 96116 *Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report* (Work RVU=1.86) and noted that although the surveyed code required more technical skill, mental effort and judgment to perform, the intra-service time for the surveyed code and the reference code are very similar, 60 minutes and 67 minutes, respectively. Therefore, based on these comparisons to the reference code, the HCPAC agreed with the specialty recommendation of 1.85 RVUs, the survey 25th percentile. **The HCPAC recommends 1.85 Work RVUs for 92607.**

92608 Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure)

The specialty society reviewed the survey data and agreed that the post-service time for this service was over-estimated by the survey respondents. Therefore, the specialty society reduced the post-service time to 0 minutes as this time was agreed to be more representative of the service. In addition, the specialty society agreed that the survey respondents over-estimated the recommended work RVU. Therefore, to develop a work RVU recommendation for this service, the specialty society reviewed other ZZZ global codes that their members perform and identified 92608 *Evaluation of central auditory function, with report; each additional 15 minutes* (Work RVU=0.35, total service time=15 minutes). The specialty society agreed that this reference service is exactly half of the surveyed code in time and in work and recommend 0.70 work RVU for the surveyed code. **The HCPAC recommends 0.70 Work RVUs for 92608.** After reviewing the recommended RVU, the specialty society changed their PLI crosswalk to 92557 *Comprehensive audiometry threshold evaluation and speech recognition* (Work RVU=0.60).

92609 Therapeutic services for the use of speech-generating device, including programming and modification

The specialty society reviewed the survey data and agreed that the pre-service time for this service was over-estimated by the survey respondents and reflect administrative activities. Therefore, the specialty society reduced the pre-service time to 10 minutes as this time was agreed to be more representative of the service. The HCPAC compared the surveyed code to the reference code, 92526 *Treatment of swallowing dysfunction and/or oral function for feeding* (work RVU=1.34) and noted that the intra-service time for the surveyed code is greater than the key reference code, 60 minutes and 45 minutes, respectively. Further, the HCPAC noted that the surveyed code is a more intense service to perform as compared to the key reference code. In addition, the HCPAC compared the surveyed code to an additional reference code, 92626 *Evaluation of auditory rehabilitation status; first hour* (Work RVU=1.40). The HCPAC noted that the total service times for both this reference service and the surveyed code are similar, 77 minutes and 80 minutes, respectively. Therefore, based on these comparisons to both of these reference codes, the HCPAC agreed with the specialty recommendation of 1.50 RVUs, the survey median. **The HCPAC recommends 1.50 RVUs for 92609.**

Audiology Testing

92587 Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products)

The specialty society after reviewing the survey data for this service agreed that more than one service is being represented under this code and requests the service be referred back to the CPT Editorial Panel for further clarification. **The HCPAC recommends that 92587 be referred back to the CPT Editorial Panel to clearly describe the services being performed.**

Debridement

The codes on the HCPAC agenda were only surveyed by APTA and APMA. Other societies representing general surgery, family medicine, orthopaedic surgery, dermatology and plastic surgery either expressed no interest in developing primary recommendations or expressed an interest in commenting on the primary recommendations from another society. The HCPAC understands that all specialties/professions that report these services were provided the opportunity to participate.

97597 Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, when performed, per session, total wound(s) surface area; first 20 square centimeters or less

The HCPAC reviewed the global period assigned to this service and questioned if it was appropriate given that this service is currently reported with 11040 *Debridement; skin, partial thickness*, which has a 000 Day global period. **Therefore, the HCPAC recommended and the CMS agreed to assign this service a 000 day global period.** The HCPAC reviewed the survey times recommended by the specialty and agreed they were representative of the service. The HCPAC discussed the proposed valuation for this service and understood that it was a value between the existing values for 11040 (Work RVU=0.50) and 97597 (Work RVU=0.58). **The HCPAC recommends 0.54 Work RVU for 97597.**

97598 Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, when performed, per session, total wound(s) surface area; each additional 20 square centimeters, or part thereof (List separately in addition to code for primary procedure)

The HCPAC reviewed the service time associated with this service and agreed that the intra-service time of this service should be the same as the intra-service time of the 97597 and reduced the intra-service time to 14 minutes. The HCPAC compared the reference code 11001 *Debridement of extensive eczematous or infected skin; each additional 10% of the body surface, or part thereof (List separately in addition to code for primary procedure)* (Work RVU=0.30). The RUC noted that the surveyed code has more intra-service time as compared to the reference code, 15 minutes and 10 minutes, respectively. Further, the HCPAC noted that the surveyed code required more technical skill, mental effort and judgment to perform than the reference code. Therefore to retain relativity with this surveyed code the HCPAC recommends 0.40 Work RVUs, the survey 25th percentile. **The RUC recommends 0.40 Work RVUs for 97598.**

Practice Expense: The recommended practice expense inputs will be reviewed by the Practice Expense Subcommittee and subsequently reviewed for approval by the HCPAC at the April 2010 HCPAC Meeting

Budget Neutrality: AMA staff will work with the specialty societies to obtain data on 11040 and 11041 with regard to what percent of these codes will now be reported with 97598 (add-on). **The HCPAC recommends that these codes be re-reviewed after claims data is available to ensure that frequency estimates were accurate.**

**AMA/Specialty Society RVS Update Committee
Research Subcommittee Report
Thursday, February 4, 2010**

Tab 29

Members Present

Members: Brenda Lewis, DO (Chair), Greg Przybylski, MD (Vice Chair), Bibb Allen, MD, Charles Koopmann, Jr, MD, J. Leonard Lichtenfeld, MD, Marc Raphaelson, MD, Chad Rubin, MD, Sherry Barron-Seabrook, MD, Daniel Mark Siegel, MD, Lloyd Smith, DPM, Peter Smith, MD

I. 2010 Five Year Review: Review of Alternative Methodologies

Doctor Lewis reminded the Subcommittee that the April 2010 RUC Meeting is the last opportunity for specialties to bring forward an alternative methodology for services in the 2010 Five-Year Review to be reviewed by the Research Subcommittee.

II. RUC Survey Instrument and Summary of Recommendation Form Modifications

Incorporation of the Subsequent Observation Codes

At the June 2009 CPT Editorial Panel Meeting, three codes were approved to describe subsequent observation care. These codes were reviewed at the October 2009 RUC Meeting. Per the RUC Process, the RUC recommendations for these codes would be submitted to the Centers for Medicare and Medicaid Services (CMS) in May 2010. These codes would be published in the 2011 Final Rule for use beginning January 1, 2011. These codes are of importance to the RUC process because they address the 23+ hour stay policy issue that the RUC has been discussing. The current RUC policy for a 23+ hour stay code is:

If a procedure or service is typically performed in the hospital and the patient is kept overnight and/or admitted, the RUC should evaluate it as an inpatient service or procedure using the hospital visits as a work proxy regardless of any status change made by the hospital.

However, the introduction of these codes into the Fee Schedule in 2011 will allow for a more accurate measure of work for these 23+ Hour Stay Services. **The Research Subcommittee recommends the following modifications to the ZZZ, 010 and 090 Global RUC Survey Instruments on pages 8 and 9 be made for the February 2011 RUC Meeting:**

Subsequent Observation Care*

Day of Surgery	Day 1	Day 2	Day 3	Day 4	Days 5-10	Days 11-30	Days 31-60	Days 61-90
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Subsequent Observation Care*

99231	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
99232	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
99233	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Subsequent Observation Care ^{3,5}

992X1	20	15	Problem focused	Low or straightforward
992X2	40	25	Expanded	Moderate
992X3	55	35	Detailed	High

⁵ All levels of subsequent observation care include reviewing the medical record and reviewing the results of diagnostic studies and changes in the patient's status (i.e., changes in history, physical condition, and response to management) since the last assessment by the physician.

The Research Subcommittee expressed concern about influencing the survey respondent if these visit codes were not treated in the exact manner as other visit codes on the survey instrument, hence, the survey will be modified as described above.

Further the Research Subcommittee recommends the following modifications to the Summary of Recommendation Form:

1.) Addition of a row in the Survey Data Table and Specialty Society Recommended Data Table and modification to a note-

Sub Obs Care:	_____	992X1 _____	992X2 _____	992X3 _____
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**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 992X1 (20); 992X2 (40); 992X3 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

2.) Under the relationship of code being reviewed to key reference service(s) section a row should be added

Time Estimates	CPT Code	Key Reference CPT Code
Median Subsequent Observation Care Time	_____	_____

Removal of Reference to Consultation Codes

In the *Final Rule* published on November 25, 2009, CMS finalized its proposal to eliminate the office consultation services (99241-99245) and the inpatient consultation services (99251-99255). The Research Subcommittee discussed this policy change to determine how it could effect the 000, 010 and 090 Global Survey Instruments. The Research Subcommittee identified the Background for Questions 2 and 3: Surgery Section, under the description of the pre-service period reads:

The following services are **not included**:

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

The Research Subcommittee agrees that although CMS will not recognize the consultation services, these services have not been deleted and can only assist the survey respondent to accurately complete the RUC survey. **The Research Subcommittee recommends that the current language be maintained in the 000, 010 and 090 Global Survey Instruments.**

III. Specialty Society Requests

Sleep Testing (958X1, 958X2, 95803, 95805, 95806, 95807, 95808, 95810 & 95811)

The specialty societies sponsoring the Sleep Testing issue have requested to return to the CPT Editorial Panel with a more comprehensive revision to this section of services. However, in preparation to survey the sleep testing services for the April 2010 RUC Meeting, the specialty societies requested a review of proposed vignettes and reference service lists. The specialty society indicated that new vignettes were created for the existing codes for two reasons: several of the existing codes do not currently have vignettes and the existing codes that do have vignettes are outdated as the patient population and technology for these services have changed. The Research Subcommittee recommends that for CPT codes 95806 *Sleep study, unattended, simultaneous recording of, heart rate, oxygen saturation, respiratory airflow, and respiratory effort (eg, thoracoabdominal movement)* and 95807 *Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, attended by a technologist*, the specific test performed is added to the vignette to make it consistent with the vignette proposed for 95803 *Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)*. **With this modification, the Research Subcommittee recommends the vignettes as proposed by the specialty societies.**

The Research Subcommittee reviewed the reference service list as proposed by specialty societies. The specialty societies informed the RUC that this would be the reference service list they would use for the codes they are proposing to the CPT Editorial Panel at the February 2010 CPT Meeting. The Research Subcommittee had concerns that there were several gaps in work RVUs on the list including between, 0.17-0.31 work RVUs, 0.50-1.0 Work RVUs, 1.0 and 1.4 Work RVUs and 1.42 and 2.43 Work RVUs. **The Research Subcommittee recommends that there are several evaluation and management services, nerve conduction studies and other services that the specialties perform that could be added to this reference service list.** At the request of the specialty societies, the Research Subcommittee will review the modified reference service list via e-mail before the next RUC meeting.

Pathology Services (88300, 88302, 88304, 88305, 88307, 88312, 88313 & 88314)

At the October 2009 RUC Meeting, the RUC recommended that all of the identified codes in this family be surveyed using the standard RUC survey instrument, or present an alternative methodology to the Research Subcommittee for review, or present a code change proposal to the CPT Editorial Panel for their review. At this time, the specialty societies requested the Research Subcommittee to review two proposed descriptions of service to be included in their survey instruments and to review proposed vignettes for the 88300 code family. They will be recommending to the full RUC that the special stain family of codes (88312-88319) be referred back to the CPT Editorial Panel for review.

The Research Subcommittee agreed with the specialty society that there be no pre-service time description and no post-service time description, as these activities will be included in the intra-service description. This recommendation is consistent with recent pathology services that have been reviewed by the RUC, where the time allocated for these services have been incorporated into the intra-service time.

The Research Subcommittee reviewed the proposed description of service for both 88300 and 88302-88307 and agreed that they were both too detailed and could potentially bias the survey respondent. **Accordingly, the Research Subcommittee recommends the following description of intra-service time for 88300:**

Intra-Service Time:

The intra-service work may include (among other activities):

- Reviewing the clinical history including prior study reports
- Performing or directly supervising the specimen preparation
- Examine the specimen
- Compare the specimen to prior specimens and reports
- Prepare, edit and sign-out the report
- Discuss observations with other professionals

Further, the Research Subcommittee recommends the following description of intra-service time for 88302-88307:

Intra-Service Time:

The intra-service work may include (among other activities):

- Reviewing the clinical history including prior study reports
- Performing or directly supervising the specimen preparation
- Perform gross and microscopic evaluation of prepared material
- Compare the specimen to prior specimens and reports
- Prepare, edit and sign-out the report
- Discuss observations with other professionals

**Underlined content represents edits from the specialty society

The Research Subcommittee reviewed the vignettes as proposed by the specialty society. The specialty societies developed only one vignette for each of these codes and given the code descriptors for these services which include many types of specimens, the Subcommittee questioned the rationale behind this decision. The specialty society stated that the patients described in the vignettes represent the most typical diagnosis for each of these codes. **Given this rationale, the Research Subcommittee recommends the vignettes as proposed by the specialty society.**

IV. Other Issues

The Research Subcommittee, after reviewing the *Final Rule*, noted that CMS has requested to add data points to the Summary of Recommendation Form for the services included in the 2010 Five Year Review including: 5th percentile, 95th percentile and the geometric mean. The Research Subcommittee questioned CMS what was the rationale behind this decision. CMS representative, Edith Hambrick, MD, stated that these data points will provide CMS more information about the distribution of data from the survey respondents and will provide another measure of central tendency. The Research Subcommittee will review Five-Year Review Survey Instruments and Summary of Recommendation Forms at the April 2010 RUC Meeting.

**AMA/Specialty Society RVS Update Committee
Professional Liability Insurance Workgroup Report
February 4, 2010**

Tab 30

Members Present: Doctors Sandra Reed (Chair), Charles Koopmann (Vice Chair), Michael Chaglasian, OD David Hitzeman Robert Kossmann, Margaret Neal, Gregory Przybylski, Peter Smith, James Waldorf

I. 2010 Final Surgery Classification Analysis

The Workgroup reviewed the implications of the Final Rule in which CMS chose not to finalize its proposal to establish a major/minor split, defining the “major” surgery classification as CPT codes within the range 10000-69999 with a global 090 day and “minor” surgery all those same codes with a 000 or 010 global. In reverting back to the surgical and non-surgical only, CMS chose the proposed major surgery premiums for all specialties affected by this proposal, without consideration of the services typically provided by the individual specialties. The Workgroup discussed why CMS did not finalize the PLI premiums for these codes based upon the typical scenario for these specialties. CMS responded that they received the PLI information from their carrier and decided to finalize the higher premium rates. In addition, the Workgroup discussed the value of knowing how PLI carriers determine the threshold for charging a “minor” surgical premium vs. a “major” surgical premium. **The Workgroup agreed that CMS’s rationale is flawed and requests that CMS review the contractor information to ensure that the typical premium specialty data are used.**

Increase in PLI RVUs (2009 vs. 2010)		
Specialty	Average % Increase	Number of codes
Cardiology	117%	61
Dermatology	76%	150
Emergency	17%	70
Family Medicine	19%	26
Gastroenterology	41%	112
Nephrology	67%	4
Neurology	148%	6
Otolaryngology	15%	458

Increase in Surgical PLI Premiums (2009 vs. 2010)			
Specialty	2009 Surgical Premium	2010 Surgical Premium	% Increase
Cardiology	\$15,579	\$65,918	323%
Dermatology	\$11,428	\$42,705	274%
Emergency	\$27,990	\$53,247	90%
Family Medicine	\$26,206	\$41,490	58%
Gastroenterology	\$21,469	\$44,356	107%
Nephrology	\$12,057	\$45,560	278%
Neurology	\$16,849	\$111,899	564%
Otolaryngology	\$23,284	\$38,818	67%

II. RUC Recommended PLI Crosswalk Analysis – 2009 and 2010 CPT

The Workgroup became aware of several PLI crosswalk anomalies resulting from gap fill utilization assumptions for new CPT codes for the CPT 2009 and 2010 cycle. According to the analysis, most of the RUC recommended PLI crosswalks for these new and revised codes were not utilized. CMS mentioned that they are currently looking into the situation and could not provide any comments at the meeting. The Workgroup also asked CMS how they determine the PLI crosswalk for new and revised codes. Currently, CMS uses three criteria: crosswalk to a code with similar utilization, similar RVUs, or specialty type. CMS may also default crosswalk to the average risk factor for all physicians. The Workgroup made it clear to CMS that this work has already been done on the Summary of Recommendation forms using these exact criteria. Additionally, members were perplexed that if CMS is using similar crosswalk assumptions to the RUC, why are there such wide PLI RVU variances. **The Workgroup agreed to reaffirm to CMS that all PLI crosswalks for new and revised codes should be established by the corresponding RUC Summary of Recommendation form.**

**AMA/Specialty Society RVS Update Committee
Five-Year Review Identification Workgroup Report
February 04, 2010**

Tab 31

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

I. Review Action Plans

The Five-Year Review Identification Workgroup received action plans presented by specialty societies to address the following screens: Harvard only with utilization over 100,000, services surveyed by one specialty and now performed by another specialty,* and a few remaining high growth services.** **The Workgroup recommends the following actions related to each code.**

CPT Code	CPT Family Identified by Specialty	Specialty that developed Action Plan	Workgroup Recommendation
10061	10060	APMA	RUC Survey
11900	11901, 11950	AAD	RUC Survey
12001-12002		ACEP, AAFP	RUC Survey
12032	12031, 12034, 12035, 12036, 12037, 12041, 12042, 12044, 12045, 12046, 12047, 12051, 12052, 12053, 12054, 12055, 12056, 12057	AAD	The RUC should send out an LOI for the entire family. The interested specialties should amend the action plan and present at to the Five-Year ID Workgroup at the April 2010 RUC meeting to consider all codes in the family.
15175*	15170, 15171, 15176	APMA, ASPS	Referral to CPT Editorial Panel
15320*	15321	APMA, ASPS	Referral to CPT Editorial Panel
15335*	15330, 15331, 15336	AAO-HNS, APMA, ASPS	Referral to CPT Editorial Panel
15365*	15360, 15361, 15366	APMA, ASPS	Referral to CPT Editorial Panel
15420*	15421	APMA, ASPS, AAD	Referral to CPT Editorial Panel
15823		AAO/ASOPRS, ASPS	RUC Survey
16020-16025*	16030	ACEP(16020), ASPS, AAFP	A workgroup of stakeholder societies (add Burn Surgeons and General Surgery) should amend the action plan and present at the Five-Year ID Workgroup at the April 2010 RUC meeting to consider all codes in the family.
17261	17271, 17281	AAD	Specialty to present method to Research Subcommittee at April 2010 RUC meeting.
17282	17262, 17272	AAD	Specialty to present method to Research Subcommittee at April 2010 RUC meeting.
20605	20600, 20605, 20610	AAOS, ACRh, APMA	Specialty to present method to Research Subcommittee at April 2010 RUC

CPT Code	CPT Family Identified by Specialty	Specialty that developed Action Plan	Workgroup Recommendation
			meeting. Reevaluate prior RUC survey data.
20926**		AAOS, AAO-HNS, AANS	Review claims data after 2 years at September 2012 RUC meeting.
22851**		NASS, AANS	Review claims data after 2 years at September 2012 RUC meeting.
27096*		ACR, ASA, AAPM, AAMP&R, NASS	Specialty societies need to amend action plan to consider the reporting of multiple codes on same date and other fluoroscopy cost issues and present at the Five-Year ID Workgroup at the April 2010 RUC.
29540	29550, 29590, 29520, 29530	APMA	RUC Survey
30901		AAO-HNS, ACEP	RUC Survey CPT 30901 only.
36000		ACC	Distribute LOI to develop a workgroup to submit a amended action plan to the Five-Year ID Workgroup at the April 2010 RUC meeting. The LOI should indicate that the Workgroup considered a recommendation to delete or revise the CPT code, but would first like input from all relevant specialties.
36245	36246, 36247	ACC, ACR, AUR, SIR, SVS	These codes are related to a coding issue to be discussed at the February 2010 CPT Editorial Panel Meeting. It is anticipated that volume will decrease substantially. Review claims after 2 years (September 2012 RUC meeting).
36410	36400, 36405, 36406, 36415, 36416, 36420, 36425	AAFP, ACP	RUC survey
49080	49081	ACR, AGA, ASGE, AUR, SIR	Anticipated submission to June CPT Editorial Panel meeting.
51741	51736	AUA	RUC survey
52281		AUA	RUC survey
52332		AUA	RUC survey
62290*		ASA, AAPM, AAMP&R, NASS	Referral back to specialty societies to revise action plan and present at the Five-Year ID Workgroup at the April 2010 RUC meeting.
62367-62368*		ASA, AAPM	Referral back to specialty societies to amend action plan to address inclusion of codes in the 75% or more reported together screen for presentation at the April 2010 RUC meeting.

CPT Code	CPT Family Identified by Specialty	Specialty that developed Action Plan	Workgroup Recommendation
64450		ASA, AAPM, APMA	Table action plan and address at February 2011 RUC meeting when the 2009 5% claims data are available to identify which diagnoses are typical so a survey vignette can be developed.
70470		ACR, ASNR, AUR	Referral back to specialty society to revise action plan for presentation at the Five-Year ID Workgroup at the April 2010 RUC meeting.
72110	72114, 72120	ACR, ASNR, AUR	Referral back to specialty society to revise action plan for the entire family to present at the Five-Year ID Workgroup at the April 2010 RUC meeting.
72275*		ASA, AAPM, AAMP&R, NASS	Referral to CPT Assistant.
73080		ACR, AUR, AAOS	Present physician work and time via crosswalks at April 2010 RUC meeting.
73542*		ASA, AAPM, AAMP&R, NASS, ACR	This code will be sent to CPT Editorial Panel to add parentheticals. Specialty societies will present revised action plans and incorporate the relevance of CPT 27096 to the Five-Year Identification Workgroup at the April 2010 RUC meeting.
77079*		ACR, AAFP, ACP	Referral to CPT Editorial Panel for deletion.
77083*		ACR, ACP	Referral to CPT Editorial Panel for deletion
78223	78220	ACR, SNM	Referral to CPT Editorial Panel.
78585	78580, 78584, 78586, 78587, 78588, 78591, 78593, 78594, 78596	ACR, SNM	Referral to CPT Editorial Panel.
79101*		ACR, SNM	Referral to CPT for a CPT Assistant article and specialty will work with CMS to create coding edits.
88104	88106, 88107, 88108, 88112	ASC, CAP	RUC survey
88331-88332	88329, 88333, 88334	AAD, CAP	RUC survey
90870		APA	RUC survey
92081		AAO, AOA	RUC survey
92082		AAO, AOA	RUC survey
92504		AAO-HNS	RUC survey
92960		ACC	RUC survey
93224, 93227, 93237		ACC	Referral to CPT Editorial Panel

CPT Code	CPT Family Identified by Specialty	Specialty that developed Action Plan	Workgroup Recommendation
95860	95861, 95863, 95864, 95865, 95866, 95867, 95868 95869, 95870	AANEM, ACNS, AAN, AAMP&R	RUC survey
95971	95970, 95972, 95973	AUA	Send out LOI to have specialty societies present a revised action plan at the Five-Year Identification Workgroup at the April 2010 RUC meeting.
98926-98927	98925, 98928, 98929	AOA	Specialty to present method to Research Subcommittee at April 2010 RUC meeting to review proposed valuation method.

II. Codes Performed Together 75% or more (same day/same physician)- Update from Workgroup

Doctor Kenneth Brin joined the Workgroup via conference call to share the finding of the Joint CPT/RUC Workgroup for the codes performed together 75% or more together screen. All codes performed by the same physician on the same date of service to a beneficiary was provided by CMS and based on 2008 utilization data. Doctor Brin explained that the 151 relevant code pairs were grouped into similar “groups” and then were prioritized based on allowed charges. Given this analysis, the Joint Workgroup recommended to the Five-Year Review Identification Workgroup that the highest priority “groups” be sent out to the specialty societies and have action plans delivered to the Joint CPT/RUC Workgroup for consideration for the April 2010 RUC meeting.

In addition, the Joint Workgroup addressed this analysis compared to the July 2009 GAO Report. The GAO code pairs were identified in the spreadsheet provided to the RUC on the RUC CD. The members highlighted that the Joint RUC/CPT Workgroup review is a more comprehensive analysis. Many of the GAO code pairs have already been addressed by the RUC or reflect services with low Medicare volume.

The Five-Year Review Workgroup accepted the Joint Workgroup’s report and recommendations as written.

1. The simplified spreadsheet be provided to the specialty societies with a cover letter requesting a response to the code pairs identified therein.
2. The specialty societies be asked to provide an action plan for:
 - a. The first 20 “groups” on the spreadsheet by the end of the CPT 2012 cycle. These first 20 groups comprise 75 of the 151 code pairs identified and 82% of the sum of the lower of the two codes reported together.
 - b. If a specialty society has more than two code groups identified in the first 20 groups, they may chose to address only the top two groups in the CPT 2012 cycle and would be asked to address the others in the 2013 CPT cycle.
3. Action plans may include:
 - a. When the “group” includes only one pair of codes, agreement to submit a CCP proposing a new code for services described by the two codes when reported together;

- b. When the “group” includes more than one pair of codes, agreement to submit a CCP proposing a new set of codes for services described by a the full set of codes reported together in that group;
 - c. An explanation why the specialty society feels that there is no duplication in work or practice expense when the two codes are reported together (in which case the Joint Workgroup will review the explanation and recommend either acceptance or rejection of the explanation to the Five-Year Review Identification Workgroup); or
 - d. In the case of codes already subject to a multiple procedure reduction rule, an explanation why the specialty society feels that this is the appropriate reduction (again, to be reviewed by the Joint Workgroup with a recommendation passed to the Five-Year Review Identification Workgroup).
4. Timelines proposed are:
- a. A letter to the specialty societies and the spreadsheet would be finalized and distributed to the specialty societies by February 15, 2010, with requests for response by March 31, 2010.
 - b. A draft of the letter is attached.

III. Items Not Yet Submitted to CPT to be Discussed

a. Referrals to the CPT Editorial Panel

33213-

CPT 33213 was originally identified by the CMS Fastest Growing screen and when initially reviewed by the RUC, a referral to CPT was made as it was assumed that removal should not be reported on the same date as insertion/replacement. The ACC did not submit a code proposal. The Workgroup re-reviewed and now understands that the insertion/replacement was valued with the understanding that removal is coded separately. **However, this code pair is included in the top 20 code groups reported more than 75% of the time together and will be addressed via this screen.**

74175-

The ACR submitted a letter regarding CPT 74175, which was identified by the CMS Fastest Growing screen. The society explained that the increase in utilization is due to the increasing substitution of non-invasive CT angiography for more invasive catheter based angiography. **The Workgroup recommends that this service be referred to the CPT Editorial Panel at the June 2010 meeting for consideration of bundling this service with pelvis, etc.**

b. Referrals to CPT Assistant

63056-

The CPT Assistant article for this code was published in the October 2009 (vol. 19, issue 10) edition.

G0179- Originally Identified as high volume growth

The ACP and ACFP submitted an action plan for G0179 requesting that the code retain its status as a Level II (HCPCS) code. The RUC, in October 2008, requested that this code be converted to a CPT Category I code. CMS has expressed no further interest in converting this code to a CPT code. **The Workgroup recommends that G0179 be removed from the screen.**

G0180- Originally Identified as high volume growth

The ACP and ACFP submitted an action plan for G0180 requesting that the code retain its status as a Level II (HCPCS) code. The RUC, in October 2008, requested that this code be converted to a CPT Category I code. CMS has expressed no further interest in converting this code to a CPT code. **The Workgroup recommends that G0180 be removed from the screen.**

IV. Other Issues

The following materials were provided as informational items:

- a. Full status report of the Five-Year Review Identification Process
- b. 2010 Five-Year Review Timetable
- c. CPT Referral
- d. CPT Assistant Referral

**AMA/Specialty Society RVS Update Committee (RUC)
Administrative Subcommittee Report
January 27, 2010 Conference Call**

Tab 32

Participating Members: Doctors Dale Blasier (Chair), David Hitzeman (Vice Chair), Michael Bishop, James Blankenship, Robert Kossmann, Walt Larimore, Larry Martinelli, Sandra Reed, Arthur Traugott, James Waldorf and George Williams

At the October 1-4, 2009 RUC meeting, the RUC considered a recommendation by the Administrative Subcommittee to add a new section to the standardized RUC Survey to determine if the respondent has a direct financial interest in a product utilized in the provision of the physician service under review. The Subcommittee suggested that the same financial disclosure standards that are applied to the advisors and presenters also be applied to the survey respondents. It was recommended that specialties consider these conflicts in reviewing data and formulating their recommendations to the RUC. The Subcommittee further requested that specialties share their experiences related to skewed data or impacted response rates with the Administrative Subcommittee so that further policy may be developed.

The RUC accepted the Administrative Subcommittee's recommendation to add the new financial disclosure section to the survey. However, the RUC did not agree with the suggested use of this information. Instead, the RUC developed policy that once a conflict was disclosed, the data could be potentially biased and therefore should not be considered in developing physician time and relative value recommendations. The RUC approved an amendment to the Subcommittee report to move the financial disclosure section to the beginning of the survey instrument and instruct the survey respondent, "If you have answered yes to any of the above questions, you do not have to complete this survey. However, please submit the first three pages of this survey." The first three pages of the survey include the cover sheet (code, description, etc), the respondent's demographic information, and the financial disclosure section.

AMA staff implemented the recommendations of the RUC with the distribution of the November 2009 surveys that were utilized for relative value development for the February 2010 RUC meeting. On December 22, 2009, the gastroenterology specialty societies requested via a letter (included in Tab 32 of RUC agenda book and CD) that the issue be discussed further to "determine what truly constitutes a conflict." These specialty societies viewed the new section in the survey instrument to be overly restrictive. The letter also asked a series of questions related to the RUC's intent related to conflict of interest. The Chairman of the Administrative Subcommittee, Doctor Dale Blasier, suggested that a conference call be convened before the February 4-7, 2010 RUC meeting to review the letter and potentially offer revisions to the financial disclosure section of the survey.

In preparation for the conference call, AMA staff worked with AMA legal staff to offer the following revisions to the financial disclosure section of the survey to respond to the specific concerns and questions posed by the gastroenterology specialty societies. The Administrative Subcommittee discussed and approved these revisions.

The Administrative Subcommittee recommends that RUC Survey Instrument financial disclosure section be amended as follows:

Financial Disclosure:

Please answer the following questions by checking yes or no.

Do you or a family member* have a direct financial interest in this procedure, other than providing these services in the course of patient care? For purposes of this Survey “direct financial interest” means:

- A financial ownership interest in an organization** of 5% or more: Yes / No
- A financial ownership interest in an organization** which contributes materially*** to your income: Yes / No
- Ability to exercise stock options in an organization** now or in the future: Yes/No
- A position as proprietor, director, managing partner, or key employee in an organization**: Yes / No
- Serve as a consultant, researcher, expert witness (excluding professional liability testimony), speaker or writer for an organization**, where payment contributes materially*** to your income: Yes/No

*Family member means spouse, domestic partner, parent, child, brother or sister. Disclosure of family member’s interest applies to the extent known by the survey respondent.

** Organization means any entity that makes or distributes the product that is utilized in performing the service, and not the physician group or facility in which you work or perform the service. ~~with an interest in the service(s) you are evaluating for this survey, other than the physician group in which you work.~~

***Materially means any \$10,000 or more in income (excluding any reimbursement for expenses) for the past twenty-four ~~twelve months or cumulative lifetime income of at least \$10,000.~~

If you have answered yes to any of the above questions, you do not have to complete this survey. ~~However, please submit the first three pages of this survey.~~

The Subcommittee also addressed the individual questions on page two of the letter sent by gastroenterology specialty societies (see Tab 32), as follows:

1. The financial disclosure section is clear that the disclosure relate to the individual and/or their immediate family member. It does not related to the physician’s department or facility. To provide clarification, the definition of organization was revised, as described above. In addition, the term “researcher” was added to clarify that if an individual directly receives more than \$10,000 from a vendor in the previous twenty-four months related to his/her research, that would be considered a conflict.

2. The Administrative Subcommittee agreed that reimbursement of physician expenses related to the training of a procedure that uses a particular device would not constitute a conflict and does not believe that anything in the current financial disclosure section requires such disclosure. The clarification to definition *** above will remove ambiguity in this regard.
3. The specialty societies question the source of the RUC's decision to define materially as "cumulative lifetime income of at least \$10,000." AMA staff explained that this definition was developed by the RUC, based on members' experience with their own specialty society conflict of interest policies.

Finally, the Administrative Subcommittee is aware that the American College of Cardiology (ACC) has requested reconsideration (letter dated January 24, 2010 in handout documents – Tab 2 October RUC Minutes) of the RUC's decision to exclude survey responses from those individuals that have provided a financial disclosure. The ACC states "the current RUC policy, which prohibits anyone who as a potential conflict of interest from completing a survey seems to be an inappropriate standard to establish." ACC argues that it has and will impede survey responses. The RUC will consider this reconsideration request, along with any other letters of request received prior to the meeting, as a full committee. At that time, the Administrative Subcommittee may articulate the rationale for their original recommendation to collect and study information from the specialties prior to proceeding with any further policy development.

Note: A motion was made to reconsider the previous RUC action. The motion was not adopted.