AMA/Specialty RVS Update Committee
Meeting Minutes
February 3 – February 6, 2011

I. Welcome and Call to Order

Doctor Barbara Levy called the meeting to order on Friday, February 4, 2011, at 8:00 am. The following RUC Members were in attendance:

Barbara Levy, MD (Chair)
Bibb Allen, MD
Michael D. Bishop, MD
James Blankenship, MD
R. Dale Blasier, MD
Joel Bradley, MD
Ronald Burd, MD
Scott Collins, MD
John Gage, MD
William Gee, MD
David Hitzeman, DO
Peter Hollmann, MD
Charles F. Koopmann, Jr., MD
Robert Kossmann, MD
Walt Larimore, MD
Brenda Lewis, DO
J. Leonard Lichtenfeld, MD
Scott Manaker, MD, PhD
Bill Moran, Jr., MD
Guy Orangio, MD
Gregory Przybylski, MD
Marc Raphaelson, MD
Sandra Reed, MD
Peter Smith, MD
Susan Spires, MD
James Waldorf, MD
George Williams, MD
Allan Anderson, MD*
Margie Andreae, MD*
Gregory Barkley, MD*
Dennis M. Beck., MD*
Gregory DeMeo, DO*
Jane Dillon, MD*
Verdi DiSesa, MD*
Jeffrey Paul Edelstein, MD*
Emily Hill, PA-C*
Robert Jansen, MD*
Mark Kaufmann, MD*
M. Douglas Leahy, MD*
James Levett, MD*
William J. Mangold, Jr., MD*
Geraldine McGinty, MD*
Terry Mills, MD*
Julia Pillsbury, DO*
Chad Rubin, MD*
Eugene Sherman, MD*
Stanley Stead, MD*
Robert Stomel, DO*
J. Allan Tucker, 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
  - Ryan Howe
  - Elizabeth Truong
  - Ferhat Kassamali
- Doctor Levy welcomed the following Contractor Medical Directors:
  - Charles Haley, MD
- Doctor Levy welcomed Richard Duszak, MD of the CPT Editorial Panel who is observing this meeting.

- Doctor Levy announced the following new RUC Member and Alternate
  - Scott Collins, MD – RUC Member
  - Mark Kaufmann, MD – RUC Alternate Member
- Doctor Levy welcomed the following MedPAC Commissioner:
  - Ronald D. Castellanos, MD
- Doctor Levy welcomed the following observers:
  - Miriam Laugesen, PhD- Assistant Professor of Health Policy and Management at Columbia University. The Robert Wood Johnson Foundation has provided funding to develop a book that reviews the implementation of the RBRVS and Medicare physician payment.
  - Hoon S. Yang, MD – Executive Board member of the Health Insurance Committee, Korean Medical Association.
- Leadership from the AMA and the following specialty societies (AAFP, ACP, ACR and ACS) met to discuss recent media efforts to improve the RUC process.
  - Distinguished between the desire of AAFP and others to infuse "value" into the RBRVS determinations from the RUC's role to articulate typical resources consumed in the provision of physician services.
  - Agreed to continue to look for ways to evolve and improve the RUC process. The AMA commitment to improve the survey process and tools, discussed yesterday at the Research Subcommittee, is an example of such an improvement.
- 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 next RUC meeting will be held on April 27 – May 1, 2011 at the Renaissance Hotel in Chicago, IL.
- The Director thanked those RUC participants who filled out the RUC website survey and announced that those suggestions will go directly into revising the website this summer to ensure the site remains viable and user friendly.

IV. Approval of Minutes of the September 29 – October 2, 2012 RUC Meeting

The RUC approved the October 2010 RUC Meeting Minutes as submitted.

V. CPT Editorial Panel Update

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

- Given that the work of the RUC's Relativity Assessment Workgroup has caused many new Code Change Proposals (CCPs) to come before the Panel, it is critical that specialty RUC participants be heavily involved in their specialty Coding Committee's formation of a CCP.

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 currently hard at work on the Fourth Five-Year Review submission from the RUC and the 2012 Proposed Rule upcoming this year.
- There has been a lot of transition within the Payment Policy area of CMS and there have been a lot of educational efforts with the Agency to catch new staff up to speed.

VII. Contractor Medical Director Update

- Doctor Haley reminded the RUC that CMS has changed its approach to contracting for administrative services for Medicare. Instead of having a single multi-function contractor for each state, they have multiple single-function contractors for each region.
- When the contracting reform process started, 3-4 years ago, there were around 30-35 claims processing contractors. There are now 11, with further revisions expected in the future.
- There are currently 15 jurisdictions and all have been awarded contractors except four. Jurisdictions 6 and 8 have not been awarded, but CMS has received the bids and expects to announce the contractor(s) soon. Jurisdictions 2 and 7 will not be awarded a contractor. Jurisdiction 2 will be combined with jurisdiction 3 and become jurisdiction F and jurisdiction 7 will be combined with jurisdiction 4 and become jurisdiction H.
- All current jurisdictions will be renamed from numbers to letters. In addition to the above combinations, jurisdictions 5 and 6 will be combined to form jurisdiction G, jurisdictions 8 and 15 will be combine to form jurisdiction I and jurisdictions 13 and 14 will be combined to form jurisdiction K.
- Medicare has a new annual wellness visit benefit and further information as to what is included in the visit is available in change request 7079 (Physician Transmittal 2109) on the CMS website. Two G codes were created to describe these wellness visits.
- There is another delay, until mid-summer, in the implementation of the ordering referring provider edits.

VIII. Washington Update

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

- With the 2010 mid-term elections over, Congress is divided: House Republican margin 242-193 (94 new members); Senate Democrat margin 53-47 (13 new members).
    - Some of the promises from the 2010 elections include deficit reduction and killing the Health Reform Bill.
- Recently the House passed a measure repealing the Affordable Care Act (ACA). A similar repeal bill failed in the Senate. A repeal won't be signed into Law, but some sections might be de-funded.

- There are many sections that the AMA wants to keep in the ACA.
    - Coverage expansion to 32 million Americans, health insurance market reforms, administrative simplification, Medicare bonus payments, improved prevention/wellness coverage, closing part D donut hole and comparative effectiveness research.
- There are still areas of concern within the bill
    - Independent Payment Advisory Board, value-based payment modifier, PQRS penalties, hospital ownership restrictions and liability reform.
- The SGR continues to be a problem.
    - Pay scheduled to fall more than 25% in 2012.
    - Permanent repeal costs around $330 billion
- There are a number of regulatory issues surrounding delivery reform.
    - Shared Savings (ACO) Plans – will be operational on 1-1-2012. The AMA wants to ensure all physicians can participate in delivery reforms and maintain a leadership role for physicians in the system.
        - The Department of Justice and Federal Trade Commission are working with CMS to develop anti-trust exemptions for ACOs. The AMA is pressing for protection for practices that integrate around HIT and quality.
    - Health Information Technology
        - Registration for the stimulus bill grants are now open.
        - E prescribing penalties in 2012 will be based on 2011. To avoid penalties, physicians have to report the ePrescribing G-code G8553 at least 10 times between Jan 1, 2011 – June 30, 2011. AMA has vigorously opposed this initiative and will continue with letters and meetings with CMS officials.
- Other quality initiatives from the ACA include the physician compare website and the patient safety initiative
    - The Physician compare website currently has a lot of errors related to enrollment in (PECOS) data. Outcomes data is required in 2013. The AMA is working to improve the enrollment system and ensure that the data is correctly attributed, risk-adjusted and reviewed by physicians.
    - The Patient Safety Initiative is the CMS Administrator Donald Berwick's personal project. He is looking for 40% reduction in HACs and 20% reduction in readmissions by 2013. Funds will be provided to develop and disseminate best practices and bonuses to hospitals that meet targets.
- The ACA also expands the RACs funding and authority to Medicaid.

IX. Relative Value Recommendations for CPT 2012

<u>Lumbar Arthrodesis Codes (Tab 4)</u>
John Wilson, MD (AANS); William Creevy, MD (AAOS); William Sullivan, MD (NASS); John Ratliff, MD (AANS); Alexander Mason, MD (AANS); Charles Mick, MD (NASS)

In April 2010, the Relativity Assessment Workgroup identified codes 22630 *Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar* and 22612 *Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique when performed)* through the Codes Reported Together 75%

Together or More screen. The specialty societies indicated that they would submit a code change proposal to create a new code to describe the physician work when these services are performed together on the same date of service by the same physician. Additionally, a parenthetical would be created to indicate that the separate services (22630 and 22612) not be reported together. In October 2010, the CPT Editorial Panel created two new codes to describe the services when performed together.

2261X ***Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and level; lumbar***
The RUC reviewed the survey results from 104 neurosurgeons, orthopaedic surgeons and spine surgeons for code 2261X and agreed with the specialty societies that the survey 25th percentile work RVU of 27.75 appropriately accounts for the physician work required to perform this service. To justify this value, the RUC compared the surveyed code to the current stand alone services that are being bundled. Codes 22612 *Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique when performed)* (work RVU = 23.53 and intra-time = 150 minutes) and 22630 *Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar* (work RVU = 22.09 and intra-time = 180 minutes) and determined that the survey 25th percentile work RVU accounts for the overlap in physician work for these two services when performed together on the same date. The survey 25th percentile work RVU of 27.75 is approximately 20% lower than the current work RVU of 34.58 for codes 22612 and 22630 when reported together.

For further support, the RUC compared 2261X to services that require similar physician work and time: codes 22857 *Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar* (work RVU = 27.13 and intra-time = 180 minutes), MPC code 44204 *Laparoscopy, surgical; colectomy, partial, with anastomosis* (work RVU = 26. 42 and intra-service time = 180 minutes) and MPC code 44626 *Closure of enterostomy, large or small intestine; with resection and colorectal anastomosis (eg, closure of Hartmann type procedure)* (work RVU = 27.90 and 150 minutes intra-service time). The RUC determined that the survey median intra-service time of 200 minutes appropriately captures the physician time required to perform this service compared to the current codes billed alone and the aforementioned services and should be valued similarly. **The RUC recommends the survey 25th percentile work RVU of 27.75 for CPT code 2261X.**

2261X1 ***Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and level; each additional interspace and segment***
The RUC reviewed the survey results of 56 neurosurgeons, orthopaedic surgeons and spine surgeons for code 2261X1and determined that the survey 25th percentile work RVU of 11.38 overestimated the physician work inherent in the service as it is similar to the sum of work RVUs, 11.65, of the codes being bundled, 22614 *Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment* (work RVU = 6.43 and intra-time = 40 minutes) and 22632 *Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace* (work RVU = 5.22 and

intra-time = 60 minutes). The specialty societies indicated that the work of these two services are completely separate and unlike the base codes there is not a large amount of overlap in physician work. Code 22632 includes an exposed disk space in the spinal canal, preparing end plates and placing a bone graft in the created space, whereas 22614 includes dissecting the muscle beyond the facet processes, exposing the transverse process, drilling down the bone on the outside edge of the facet in order to apply the bone graft and get the external spinal fusion in addition to the internal spinal fusion. However, the median survey intra-service time for code 2261X1 is 70 minutes, which is 30% less than the sum of the intra-service time for the two combined codes, 22614 and 22632, which totals 100 minutes. The specialty societies noted and concurred with the RUC's concerns regarding the disparity between the decrease in intra-service time and the work RVUs suggested by the survey respondents. Therefore, the RUC used magnitude estimation, and compared 2261X1 to similar add-on codes 33884 *Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); each additional proximal extension* (work RVU = 8.20 and intra-service time = 60 minutes) and 61642 *Balloon dilatation of intracranial vasospasm, percutaneous; each additional vessel in different vascular family* (work RVU = 8.66 and intra-service time = 60 minutes) and determined the physician work for 2261X1 is analogous and should be valued similarly. The RUC noted that the sum of the work RVUs for 22614 and 22632 is 11.65 and the survey time is 30% less than the combined intra-service times of 22614 and 22632, 70 versus 100 minutes, respectively. Therefore, 11.65 work RVUs reduced by 30% to account for the reduction in intra-service time, equals 8.16 work RVUs and further supports the magnitude estimation aligning this service with other similar services in the RBRVS**. The RUC recommends a work RVU of 8.16 for CPT code 2261X1.**

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

Practice Expense:
The Practice Expense Subcommittee made no revisions to the direct practice expense inputs recommended by the specialty for these procedures performed in the facility setting.

<u>Bone Marrow Stem Cell Revisions (Tab 5)</u>
James Gajewski, MD (ASH); Samuel Silver, MD (ASH)

In October 2010, the CPT Editorial Panel split CPT code 38230 into two separate codes: 38230 *Bone marrow harvesting for transplantation; autologous* and 3823X1 *Bone marrow harvesting for transplantation; allogeneic*. When code 38230 was developed, and RUC reviewed in 1995, allogeneic transplants were performed the large majority of the time. Currently, the majority of transplants performed are allogeneic using bone marrow/stem cells from a related or unrelated donor. Additionally, CMS approved a change in the global period from 010 to 000, which was requested due to the fact that very few of these harvests require overnight hospitalization and physician follow-up in the days following the procedure.

38230 ***Bone marrow harvesting for transplantation; autologous***
The RUC reviewed and agreed with the specialty survey results from 57 hematologists for CPT code 38230. The RUC agreed with the addition of 12 minutes of pre-service positioning time to account for turning the patient over from supine to the prone position, while under general anesthesia. These additional minutes of positioning time are a RUC standard for complicated patients under general anesthesia for spine procedures. The RUC recommends pre-service time of 45 minutes, intra-service time of 90 minutes and post service time of 30 minutes. The RUC analyzed the survey's estimated physician work and agreed that the data supports the median estimated work RVU of 3.50. To further justify this recommended value, the RUC compared the surveyed code to key reference CPT code 38206 *Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous* (work RVU= 1.50 and intra-time= 35 minutes). The RUC agreed that the surveyed code should be valued greater than the reference code given the large difference in physician intra-time required to perform these procedures, 90 minutes and 35 minutes, respectively. Additionally, survey respondents rated code 38230 higher in every intensity and complexity measure compared to code 38206.

The RUC also compared the surveyed service to reference code 38242 *Bone marrow or blood-derived peripheral stem cell transplantation; allogeneic donor lymphocyte infusions* (work RVU= 1.71 and intra-time= 30 minutes). The specialties noted that code 38230 is a very intense service in the family of codes and should be valued greater than this reference service due to greater total time, 90 minutes and 30 minutes, respectively. Finally, to ensure that the recommended work RVU of 3.50 is appropriate for this service, the RUC noted that the current work value of 38230 is 4.85 which is for a 010 global period and includes one 99213 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU= 0.97). Subtracting the value of the post-operative visit (0.97 work RVUs) leaves 3.88 work RVUs. Given these references, the RUC agreed that the recommended median work value of 3.50 appropriately accounts for the physician work involved in this service. **The RUC recommends a work RVU of 3.50 for CPT code 38230.**

3823X1 ***Bone marrow harvesting for transplantation; allogeneic***
The RUC reviewed and agreed with the specialty survey results from 57 hematologists for CPT code 38230. The RUC agreed with the addition of 12 minutes of pre-service positioning time to account for turning the patient over from supine to the prone position, while under general anesthesia. These additional minutes of positioning time are a RUC standard for complicated patients under general anesthesia in spine procedure. The RUC recommends pre-service time of 55 minutes, intra-service time of 90 minutes and post service time of 30 minutes. The RUC analyzed the survey's estimated physician work and agreed that the data supports the median work RVU of 4.00. To further justify this recommended value, the RUC compared the surveyed code to key reference CPT code 38205 *Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection;* allogenic (work RVU= 1.50 and intra-time= 45 minutes). The RUC agreed that while there is similar physician work involved in code 3823X1 and the reference code, the surveyed code should be valued greater due to longer required intra-service time, 90 minutes and 45 minutes, respectively.

The RUC also compared the surveyed code to reference code 38242 *Bone marrow or blood-derived peripheral stem cell transplantation; allogeneic donor lymphocyte infusions* (work RVU= 1.71 and intra-time= 30 minutes). Again, the RUC noted that while these services have similar physician work the surveyed code is the most intense procedure many of these physician do and should be valued higher due to longer required intra-service time, 90 minutes and 30 minutes, respectively. Finally, the RUC discussed the difference in work RVUs between 38230 and 3823X1. Even though the intra-service time between the two services are similar, the intra-service work for 3823X1 is more intense and stressful because it is necessary to manage the donor while performing a procedure that is not for the donor's benefit. The need to obtain more cells because of the risk of graft rejection, graft versus host disease and ABO mismatching as well as the need to accommodate cell loss at the time of removal and when the cells are processed increases the stress and intensity of the procedure. This was substantiated by the survey respondents who stated that 3823X1 has a higher intensity and complexity in physician work in 8 of the measures compared to 38230. **The RUC recommends a work RVU of 4.00 for CPT code 3823X1.**

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

Practice Expense:
The RUC agreed that there were no direct inputs in the facility nor the non-facility settings as recommended by the specialty.

CPT Editorial Panel:
The RUC had a extensive discussion regarding the appropriate Evaluation and Management billing for CPT code 38240 *Bone marrow or blood-derived peripheral stem cell transplantation; per allogenic donor*. The specialties explained that the physician work involved in the management of infusion, including managing a reaction, is included in the intra-service work of code 38240. The RUC expressed concern that implementing CCI edits to preclude reporting an Evaluation and Management service on the same date of service would limit the ability for physicians to report the separately identifiable visit prior to the procedure on the same date. Given this, the RUC, and the specialty agreed, that this service should be referred back to the CPT Editorial Panel along with the family of services, CPT codes 38241 and 38242, to examine the current descriptors and descriptions of physician work to ensure these services are currently reported correctly and can be properly valued by the RUC.

<u>Percutaneous Laminotomy Disc Procedures (Tab 6)</u>
William Sullivan, MD (NASS)

At the October 2010 Meeting, the CPT Editorial Panel editorially revised 62287 as there was some confusion by providers of the service about whether imaging guidance is included in the procedure. When 62287 was reviewed by the RUC in 1995, the valuation included the performance of percutaneous discectomy utilizing imaging guidance. Therefore, the specialties recommended and the CPT Editorial Panel agreed that the descriptor and subsequent parentheticals be editorially revised to reflect the inclusion of imaging guidance. Provided this history, the RUC agreed with the specialty societies that this revision to the coding language was editorial and recommends that the value for

62287 be maintained. Further, the RUC recommends that a CPT Assistant Article be written by the specialty societies to educate their membership on appropriate coding for this procedure. **The RUC recommends 7.43 work RVUs, the current work RVU, for CPT code 62287.**

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

Electronic Analysis Implanted Pump (Tab 7)
Eduardo Fraifeld, MD (AAPM), Fred Davis, MD (AAPM), Joseph Zuhosky, MD (AAPMR), Marc Leib, MD (ASA) Christopher Merifield, MD (ISIS), Bill Sullivan, MD (NASS), Charlie Mick, MD (NASS), David Carroway, MD (ASIPP), Chris DeWald, MD (NASS)
Facilitation Committee # 3

The Relativity Assessment Workgroup identified codes 62367, 62368, 95990 and 95991 as part of the Codes Reported Together 75% or More screen. In April 2010, the RUC recommended to refer these services to the CPT Editorial Panel to revise and describe those services with three separate codes. In October 2010, the CPT Editorial Panel created two new codes, 6236X2 and 6236X3, to report electronic analysis of programmable implanted pump for intrathecal or epidural drug infusion with reprogramming, with reprogramming and refill requiring and not requiring physician's skill and editorially revised three existing codes, 62367 to report without reprogramming or refill and codes 95990 and 95991, to report refilling and maintenance of implantable pump or reservoir for drug delivery requiring and not requiring physician skill.

62367 ***Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming or refill***
The RUC reviewed the survey results of 34 pain medicine physicians, anesthesiologists and spine physicians for CPT code 62367 and agreed with the specialty societies that the current work RVU of 0.48 appropriately accounts for the physician work required to perform this service. Additionally, the RUC agreed with the specialty society that the pre-service time of 5 minutes, intra-service time of 10 minutes and post-service time of 5 minutes appropriately accounts for the work required to perform this service. The CPT Editorial Panel editorially revised this service to add "without refill" and the specialty societies indicated and the RUC agreed that this does not change the physician work required to perform this procedure. To further support the current work RVU of 0.48, the RUC compared 62367 to MPC codes 95900 *Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study* (work RVU = 0.42) and 92083 *Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degrees, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)* (work RVU = 0.50) and determined that the current value maintains the appropriate relativity among these similar services. **The RUC recommends maintaining the current work RVU of 0.48 for CPT code 62367.**

6236X2 ***Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (not requiring physician's skill)***
The RUC reviewed the survey results for CPT code 6236X2 and recommends that the survey 25th percentile work RVU of 0.67, as it appropriately accounts for the physician work required to perform this service. The RUC recommends pre-service time of 7 minutes, intra-service time of 15 minutes and post-service time of 5 minutes. The RUC determined that the pre-service is slightly higher for 6236X2 compared to 62367 to account for the physician ordering the solution to be injected into the pump/reservoir.

The RUC reviewed two reference services to support the 25th percentile work RVU of 0.67. CPT code 93294 *Interrogation device evaluation(s), up to 90 days (*work RVU= 0.65 and pre-time= 7.5 minutes, intra-time= 15 minutes and post time= 7.5 minutes) and code 99241 *Office consultation for a new or established patient* (work RVU= 0.64 and pre-time= 5 minutes, intra-time= 15 minutes and post time= 5 minutes) were reviewed and the RUC agreed that these services, with similar physician time, ensures the recommended value is relative across physician services. **The RUC recommends a work RVU of 0.67 for CPT code 6236X2.**

62368 ***Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming***
Although CPT code 62368 was not surveyed, the RUC indicated and the specialty society agreed, that CPT code 62368 requires the exact same physician work and time as 6236X2, as the work involved in refilling the pump is done solely by clinical staff. Given that the physician work is identical between the two services, the RUC noted that the current work RVU of 0.75 for 62368 would created a rank order anomaly compared to 6236X2. Therefore, the RUC recommends to directly crosswalk the physician work RVUs, 0.67, and physician time of 7 minutes pre-time, 15 minutes intra-time and 5 minutes immediate post-time. **The RUC recommends a work RVU of 0.67 for CPT code 62368.**

6236X3 ***Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (requiring physician's skill***
The RUC reviewed the survey results for CPT code 6236X3 and recommends crosswalking the physician work to 56605 *Biopsy of vulva or perineum (separate procedure); 1 lesion* (work RVU = 1.10 and total time = 35 minutes) as the 0.43 work difference compared to 6236X2 appropriately accounts for the physician skill required for this procedure (1.10-0.67=0.43). To further justify this value, the RUC referenced many services that have a work RVU of 1.10 and similar physician time that ensures the recommended value is relative across all physician services. These code references include CPT codes, 88360 *Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; manual* (work RVU = 1.10 and total time = 35 minutes) and 99379 *Physician supervision of a nursing facility patient* (work RVU = 1.10 and total time = 35 minutes). The RUC recommends pre-service time of 7 minutes, intra-service time of 20 minutes and post-service time of 10 minutes. **The RUC recommends a work RVU of 1.10 for CPT code 6236X3.**

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

Practice Expense:
The RUC had an extensive discussion concerning the typical patient service and made revisions to the direct practice expense inputs recommended by the specialties. Clinical labor was refined with a comparison to the direct practice expenses of existing chemotherapy services.

Repair of Eye Wound (Tab 8)
Stephen A Kamenetzky, MD (AAO)
Facilitation Committee # 3

In September 2007, the RUC's Relativity Assessment Workgroup (formerly Five-Year Review Identification Workgroup) identified CPT code 65285 *Repair of laceration; cornea and/or sclera, perforating, with reposition or resection of uveal tissue* and 68810 *Probing of nasolacrimal duct, with or without irrigation* as potentially misvalued through the Site-of-Service Anomaly screen. These services were initially priced in the facility setting, i.e. have hospital visits and full discharge management services associated with them, and are now being performed in the outpatient setting more than 50% of the time, according to the Medicare claims data. CMS requested the RUC review these site of service anomalies services. In February 2008, the RUC reviewed these services and accepted the evidence presented by the specialty society that 65285 required inpatient services and an overnight inpatient stay. CMS agreed with the RUC's recommendations for CY 2009. It was also suggested by the specialty that CPT code 65285 not be included on the ASC list and a CPT Assistant article should be written to describe the appropriate use of this code. Following the RUC's recommendation, CMS included code 65285 in Table 15 of the 2011 Proposed Rule and asked the RUC to re-review the physician work of 65285.

The RUC discussed the specialty society's survey results of CPT code 65285 from 30 ophthalmologists. The agreed with the specialty regarding its compelling evidence that the physician work value has changed substantially since the service's original review during the Harvard study. This service had never been RUC surveyed in the past and the RUC agreed with the specialty that this service is the most serious eye trauma service there is, where there is typically a corneal scar or cut and the internal contents of the eye have been extruded. In the past, techniques and procedures limited the success and recovery from such an injury, and the eye was more often extracted. Today, the microsurgery surgery techniques have improved and there is an enhanced knowledge base for caring for these patients. In addition, new high sheer elastics allow the surgeon to re-inflate the eye with a substance similar to jelly that allows the eye to retain its shape and form without leaking while the surgeon attempts to suture the eye. Although the typical patient has not changed (non-Medicare young patient) the intensity of and complexity of the procedure has increased due to enhanced microsurgical technology, improvements in suture and graft materials, and new pharmaceuticals that control post operative complications. In addition, the injuries repaired are more severe and extensive than 20 years ago, as documented in several peer-reviewed articles. The RUC agreed with the compelling evidence presented and the specialty's 25th percentile work relative value survey results, indicating 16.00 work RVUs for code 65285.

The RUC also concluded that, based on discussions with the specialty, the pre-service time package should be changed to package 3 from package 4 as these patients were considered by the RUC to have less co-morbidities and therefore less difficult to treat. In addition, the RUC agreed that the patient today is seen in an outpatient facility which would include a subsequent observation visit (99217) rather than the current discharge day management service (99238).

The RUC unanimously agreed that the typical service is emergent, difficult, and highly intense. In addition, these patients typically have extensive post-operative follow up involving a subsequent observation and six office visits. To ensure the recommended work RVU is relative across the RBRVS, the RUC used magnitude estimation by referencing the following four services in comparison to the work of 65285 to support the work value of this service at 16.00 RVUs.

65710 - *Keratoplasty (corneal transplant); anterior lamellar* (work RVU = 14.45, 90 minutes intra-service time). The RUC considered the service of code 65285 clearly more physician work and emergent than code 65710, with greater total time of 372 minutes compared to 317 minutes. However, both services have similar extensive post operative follow up care.

35266 - *Repair blood vessel with graft other than vein; upper extremity* (work RVU = 15.83, 90 minutes intra-service time). RUC members compared the service of 35266 and agreed that 65285 is more overall work, highly intense, and emergent, than 35266 with total time of 372 minutes compared to 337 minutes for the reference code.

65750 - *Keratoplasty (corneal transplant); penetrating (in aphakia)* (work RVU = 16.90, 90 minutes intra-service time) RUC members compared the service of reference code 65750 to 65285 and agreed that the surveyed code is less overall physician work with similar post operative follow up care and should be valued slightly less than the reference code.

43420 - *Closure of esophagostomy or fistula; cervical approach* (work RVU = 16.78, 90 minutes intra-service time). RUC members compared the service of reference code 43420 to 65285 and agreed that the surveyed code is less overall work than 43420, with total time of 372 minutes compared to 520 minutes for the reference code.

The RUC recommends a relative work value of 16.00 for CPT code 65285.

Radiologic Examination- Spine (Tab 9)
William Creevy, MD (AAOS); Zeke Silva, MD (ACR); Geraldine McGinty, MD (ACR); William Sullivan, MD (NASS); William Donovan, MD (ASNR)

In October 2009, CPT code 72110 was identified through the Five-Year Identification Workgroup (now called the Relativity Assessment Workgroup) Harvard Valued-Utilization over 100,000 Screen. CPT codes, 72100, 72114 and 72120 were added as part of the code family and the specialties submitted an Action Plan to refer codes 72114 and 72120 to the CPT Editorial Panel to clarify the number of views completed for these two spine services.

72100 ***Radiologic examination, spine, lumbosacral; 2 or 3 views***
The RUC reviewed the specialty survey results from 48 radiologists, orthopaedic surgeons and spine surgeons for CPT code 72100. The RUC recommends pre-service time of 1 minute, intra-service time of 3 minutes and post service time of 2 minutes. The RUC analyzed the survey's estimated physician work and agreed that these data support the current work value and survey's 25th percentile of 0.22. To further justify this recommended value, the RUC compared the surveyed code to key reference service CPT code 74020 *Radiologic examination, abdomen; complete, including decubitus and/or erect views* (work RVU= 0.27 and total time= 5 minutes). The RUC agreed that the reference code and the surveyed code are analogous physician services and should be valued similarly. In addition, the RUC compared CPT code 72100 to the MPC code 71020 *Radiologic examination, chest, 2 views, frontal and* lateral (work RVU= 0.22 and total time= 5 minutes). The RUC noted that these services have highly similar physician work and required views and should be valued identically. Finally, the RUC reviewed reference code 88311 *Decalcification procedure* (work RVU= 0.24) and noted that the reference code should be valued slightly higher than the surveyed code due to greater total time of 7 minutes compared to 6 minutes. The RUC agreed that the current physician work value, substantiated by the survey's 25th percentile, is an accurate depiction of the physician work involved. **The RUC recommends a work RVU of 0.22 for CPT code 72100.**

72110 ***Radiologic examination, spine, lumbosacral; minimum of 4 views***
The RUC reviewed and agreed with the specialty survey results from 48 radiologists, orthopaedic surgeons and spine surgeons for CPT code 72110. The RUC recommends pre-service time of 1 minute, intra-service time of 5 minutes and post service time of 2 minutes. The RUC analyzed the survey's estimated physician work and agreed that these data support the current work value of 0.31, which is slightly less than the survey's median estimated value of 0.32. To further justify this recommended value, the RUC compared the surveyed code to key reference CPT code 74022 *Radiologic examination, abdomen; complete acute abdomen series, including supine, erect, and/or decubitus views, single view chest* (work RVU= 0.32 and total time= 5 minutes). The RUC agreed that the reference code and the surveyed code are analogous physician services and should be valued similarly. In addition, the RUC compared CPT code 72110 to the MPC code 71020 *Radiologic examination, chest, 2 views, frontal and* lateral (work RVU= 0.22 and total time= 5 minutes). The RUC agreed that the surveyed code should be valued higher due to greater total time, 8 minutes compared to 5 minutes, and a greater minimum number of views, 4 views compared to 2 views. The RUC agreed that the current physician work value, substantiated by the survey's median work value, is an accurate portrayal of the physician work involved. There is no compelling evidence to increase the value. **The RUC recommends a work RVU of 0.31 for CPT code 72110.**

72114 ***Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views***
The RUC reviewed and agreed with the specialty survey results from 48 radiologists, orthopaedic surgeons and spine surgeons for CPT code 72114. The RUC recommends pre-service time of 1 minute, intra-service time of 5 minutes and post service time of 2 minutes. The RUC analyzed the survey's estimated physician work and agreed that these data do not support the current physician work value of 0.36. The RUC agreed that the specialties' survey median work value of 0.32 accurately values the physician work involved. To further justify this value, the RUC compared the surveyed code to key reference CPT code 74022 *Radiologic examination, abdomen; complete acute abdomen*

series, including supine, erect, and/or decubitus views, single view chest (work RVU= 0.32 and total time= 5 minutes). The RUC agreed that these services have analogous physician work and should be valued similarly. In addition, the RUC compared CPT code 72114 to the reference code 74020 *Radiologic examination, abdomen; complete, including decubitus and/or erect views (*work RVU= 0.27 and total time= 5 minutes). The RUC noted that the reference code and the surveyed code have similar physician work, but the code 72114 should be valued higher than the reference code due to greater total time, 8 minutes and 5 minutes, respectively. Finally, the RUC reviewed reference code 92542 *Positional nystagmus test, minimum of 4 positions, with recording* (work RVU= 0.33) and noted that the reference code should be valued slightly higher than the surveyed code due to greater total time of 9 minutes compared to 8 minutes. The RUC agreed that the current physician work value, substantiated by the survey's median work value, is an accurate portrayal of the physician work involved. **The RUC recommends a work RVU of 0.32 for CPT code 72114.**

72120 ***Radiologic examination, spine, lumbosacral; bending views only, 2 or 3 views***
The RUC reviewed the specialty survey results from 48 radiologists, orthopaedic surgeons and spine surgeons for CPT code 72120. The RUC recommends pre-service time of 1 minute, intra-service time of 3 minutes and post service time of 2 minutes. The RUC analyzed the survey's estimated physician work and agreed that these data support the current work value of 0.22, which is the survey's 25th percentile estimated value. To further justify this value, the RUC compared the surveyed code to key reference CPT code 74020 *Radiologic examination, abdomen; complete, including decubitus and/or erect views (*work RVU= 0.27 and total time= 5 minutes). The RUC agreed that these services have analogous physician work and should be valued similarly. In addition, the RUC compared CPT code 72120 to MPC code 71020 *Radiologic examination, chest, 2 views, frontal and lateral* (work RVU= 0.22 and total time= 5 minutes). RUC noted that the reference code and the surveyed code have similar physician work and code 72120 should be valued identically to code 71020 due to similar total time, 6 minutes and 5 minutes, respectively. Finally, the RUC compared this service in relation to code 72100. The surveyed service is typically performed in the lateral projection, with the patient performing flexion and extension maneuvers. The RUC agreed there is slightly greater work required in the evaluation of the spine itself required in code 72120 than on the 72100 procedure; however, there is more anatomy outside the spine revealed on the 72100 exam, as well as the need to evaluate the spine in two projections. The RUC, and the specialties agreed that these exams are essentially equivalent in terms of physician work. Finally, the RUC reviewed reference code 88311 *Decalcification procedure* (work RVU= 0.24) and noted that the reference code should be valued slightly higher than the surveyed code due to greater total time of 7 minutes compared to 6 minutes. **The RUC recommends a work RVU of 0.22 for CPT code 72120.**

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

Practice Expense:
The RUC discussed at length the direct practice expense inputs for these radiologic examination services under review. The RUC agreed with most of the recommended direct inputs and made minor edits to those within CPT code 72120.

CTA Abdomen and Pelvis (Tab 10)
Zeke Silva, MD (ACR); Geraldine McGinty, MD (ACR)

In April 2010, CPT code 74175 *Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU= 1.90) and 72191 *Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU= 1.81) were identified by the Relativity Assessment Workgroup's Codes Reported Together 75% or More Screen, with both services reported together over 95% of the time together. The American College of Radiology (ACR) submitted an Action Plan that stated they would submit a code change proposal that bundles the work of the two services when reported together. In October 2010, the CPT Editorial Panel created CPT code 7417XX which bundles the work of 74175 and 72191 when reported together on the same date of service.

7417XX *Computed tomographic angiography, abdomen and pelvis; with contrast material(s), including noncontrast images, if performed, and image postprocessing*
The RUC reviewed the specialty survey results from 42 radiologists for CPT code 7417XX. The RUC recommends pre-service time of 5 minutes, intra-service time of 30 minutes, and post service time of 5 minutes. The RUC analyzed the survey's estimated physician work and time. The RUC agreed that these data support the survey's 25th percentile estimated work value of 2.20 work RVUs. The RUC noted that this value, 2.20 work RVUs, is a 69% decrease from the current reporting of these services, 74175 (work RVU= 1.90) + 72191 (work RVU= 1.81)= 3.71 work RVUs. To further justify this recommended value, the RUC compared the surveyed code to key reference service CPT code 75635 *Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU= 2.40, intra-time= 45 minutes). The RUC noted that 75635 includes CTA of 3 body regions (the abdomen, pelvis and lower extremities) while 7417XX only includes 2 of these regions (the abdomen and pelvis). The difference in the number of regions explains the intra-service time differences of 45 minutes for the reference code and 30 minutes for the surveyed code and justifies a higher work RVU for the reference code.

In addition, the RUC compared CPT code 7417XX to the recently RUC reviewed 74178 *Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions* (work RVU= 2.01 and intra-time= 30 minutes). Both 74178 and 7417XX involve the study of the abdomen and pelvis with and without the administration of IV contrast. However, the surveyed code requires the processing, review and reporting of 3-D data, which is captured by the work of 76377 *3D rendering with interpretation and reporting of computed tomography, etc* (work RVU= 0.79). Adding the work RVUs of 74178 and 76377 yields a work RVU of 2.80, which is greater than the survey data supports. Thus, the RUC agreed that a work RVU of 2.20 for 7417XX maintains proper rank order. Finally, the RUC noted that although the 30 minutes of intra-service time is comparable between the surveyed code and base codes 72191 and 74175, the intensity of interpreting 2 body regions and the concordant increase in the number of images and potential pathology warrants a higher work value. Given these comparisons, the RUC agreed that the survey's 25th percentile work RVU of 2.20 maintains appropriate rank order across the family of services and is an accurate depiction of the physician work involved in the service. **The RUC recommends a work RVU of 2.20 for CPT code 7417XX.**

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

Practice Expense:
The RUC reviewed the direct inputs presented, made one edit to the equipment, and accepted the recommendation as presented.

Intraoperative Radiation Treatment Delivery and Management (Tab 11)
David Beyer, MD (ASTRO); Michael Kuettel, MD, PhD (ASTRO); Najeeb Mohideen, MD (ASTRO); Gerald White, MS (ASTRO)
Facilitation Committee # 1

In October 2010, the CPT Editorial Panel created three new codes and revised one code to describe the intraoperative radiation treatment management as the current radiation treatment management code does not describe or include the work required when performed intraoperatively.

The RUC reviewed the survey results of 45 radiation oncologists for CPT code 774X3 *Intraoperative radiation treatment management* and determined that the survey 25th percentile work RVU of 5.75 appropriately accounts for the physician work required to perform this service. The RUC recommended a modification to the pre service time package selection from difficult patient/difficult procedure to pre service package 3 straightforward patient/difficult procedure, ultimately recommending 51 minutes of pre service time. The RUC agreed with the remaining specialty society survey times, intra-service of 90 minutes and post-service time of 30 minutes. The specialty society specifically described the intra-service time required by the radiation oncologist which includes selecting the intra-operative cone most suitable for the field in question, placing the cone in position, ensuring the radiation field covers the area in question, fabricating additional shielding and placing it into the intra-operative wound, adding bolus if necessary, locking cone into position over the wound, checking angles, and moving the whole apparatus, operating table, cone, and patient to align to the radiation machine. Once the apparatus is set the physician leaves the room and delivers radiation to the patient. The RUC agreed that the intra-service time of 90 minutes appropriately accounts for the physician work required. The RUC compared code 774X3 to the reference code 77470 Special *treatment procedure (eg, total body irradiation, hemibody radiation, per oral, endocavitary or intraoperative cone irradiation)* (work RVU = 2.09). The RUC noted that the surveyed code has significantly more intra-service time as compared to the reference code, 90 minutes and 55 minutes, respectively. Further, the RUC noted that the survey respondents indicated that the surveyed code requires more mental effort and judgment, technical skill, physical effort and overall is a more intense service to perform in comparison to the reference code. To further support the survey 25th percentile, the RUC compared the surveyed code to similar services 20555 *Placement of needles or catheters into muscle and/or soft tissue for subsequent interstitial radioelement application (at the time of or subsequent to the procedure)* (work RVU = 6.00 and intra-service time = 70 minutes) and 77787 *Remote afterloading high dose rate radionuclide brachytherapy; over 12 channels* (work RVU = 4.89 and intra-service time = 90 minutes). Based on

magnitude estimation compared to these similar services, the RUC determined the survey 25th percentile work RVU of 5.75 appropriately aligns the surveyed service with other similar services in the RBRVS. **The RUC recommends the survey 25th percentile work RVU of 5.75 for CPT code 774X3.**

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

Practice Expense:
The Practice Expense Subcommittee reviewed the recommended direct inputs from the specialty society in detail and made a slight reduction in the clinical labor time in the facility setting. This procedure is typically performed in the facility only and therefore there are no inputs recommended for the non-facility setting.

Hepatobiliary System Imaging (Tab 12)
Zeke Silva, MD (ACR); Geraldine McGinty, MD (ACR); Gary Dillehay, MD (SNM)

In October 2009, CPT code 78223 *Hepatobiliary ductal system imaging, including gallbladder, with or without pharmacologic intervention, with or without quantitative measurement of gallbladder function* was identified by the RUC's Relativity Assessment Workgroup through the Harvard Valued – Utilization over 100,000 screen. The specialty societies responded by reviewing the family of hepatobiliary codes and developing an action plan to reflect the current practice of reporting hepatobiliary system imaging and hepatobiliary system imaging with pharmacologic intervention. The specialties agreed that hepatobiliary imaging is now provided with a single type of radiopharmaceutical. CPT code 78220 *Liver function study with hepatobiliary agents, with serial image*, which had been previously performed with I-131Rose Bengal, a radiopharmaceutical no longer available, is now done with the same radiopharmaceutical used for gallbladder imaging and all other hepatobiliary imaging. In October 2010, the CPT Editorial Panel agreed that adding the language "gallbladder when present" would help to clarify the appropriate code to report. The current CPT code family did not reflect the major difference in physician and technical work required to perform a study that includes pharmacological intervention. This includes both agents which stimulate gallbladder contraction and those used during assessment for acute cholecystitis (morphine sulfate), which may cause spasm at the Sphincter of Oddi, and can help differentiate between acute and chronic cholecystitis. Additionally, The CPT Editorial panel deleted codes 78223 and 78220, and created two new codes that better describe the services and differences in additional work when a pharmacological intervention is performed. The current CPT code 78223 will now be reported as either of the two new codes 782X1 *Hepatobiliary system imaging, including gallbladder when present;* or 782X2 *Hepatobiliary system imaging, including gallbladder when present; with pharmacologic intervention, including quantitative measurement(s) when performed*. It is expected that utilization will be reasonably split between782X1 (45%) and 782X2 (55%). The RUC agreed that these utilization assumptions be reviewed for accuracy in three years.

782X1 ***Hepatobiliary system imaging, including gallbladder when present;***
The RUC reviewed the survey results from 95 radiologists and nuclear medicine physicians who provide this service. The RUC agreed with the specialty society that the survey respondents overestimated the immediate post service time. The survey median immediate post-service time of 8.5 minutes was considered excessive for planar imaging and therefore the specialty recommended the immediate post-service time to be 5 minutes, which is consistent with other similar nuclear medicine procedure post-service time.

The RUC used magnitude estimation to develop a physician work RVU for 782X1 by comparing the physician work of 782X1 with the survey's key reference service 78707 *Kidney imaging morphology; with vascular flow and function, single study without pharmacological intervention* (work RVU = 0.96), and MPC code CPT 78306 *Bone and/or joint imaging; whole body* (work RVU=0.86) and agreed that these procedures are comparable in intensity and complexity to 782X1. However, the RUC also agreed that 782X1 should be valued lower than 78306 and higher than CPT code 76830 *Ultrasound, transvaginal* (work RVU = 0.69) considering the overall time, intensity, and complexity of the services. The RUC assimilated the physician work effort of 782X1 to CPT code 78580 *Pulmonary perfusion imaging, particulate* (work RVU = 0.74) and agreed that CPT code 782X1 should have an identical work RVU.To maintain rank order within the Medicare physician fee schedule and remain budget neutral, the RUC agreed the appropriate work value for 782X1 is 0.74 RVUs which is below the 25th percentile specialty survey results. **The RUC recommends a work RVU of 0.74 for CPT code 782X1.**

782X2 ***Hepatobiliary system imaging, including gallbladder when present; with pharmacologic intervention, including quantitative measurement(s) when performed***
The RUC reviewed the survey results from 95 radiologists and nuclear radiologists who provide this service. The RUC agreed with the specialty societies that the survey respondents overestimated the immediate post service time. The survey median of 7 minutes was not typical for the service and therefore the specialty recommended the survey's 25th percentile post-service time of 5 minutes. The RUC agreed that this is consistent with similar nuclear medicine procedure post-service time.

The RUC used magnitude estimation to develop a physician work RVU for 782X2 by comparing the reference service code chosen by the survey respondents, CPT 78707 *Kidney imaging morphology; with vascular flow and function, single study without pharmacological intervention* (RVW 0.96) and CPT 78306 *Bone and/or joint imaging; whole body* (Work RVU = 0.86) and recognized that 782X2 has similar work intensity and complexity to 78707, but has higher intensity of medical decision making. Although 7828X2 requires similar intensity and complexity as CPT code 78306, it was agreed that 782X2 should have a higher value because of the longer service time, total time of 26 minutes compared to 18 minutes for the reference code . The RUC also compared 782X2 to CPT 78315 (*Bone and/or joint imaging; 3 phase study* (work RVU = 1.02) and the agreed that 782X2 should be valued lower because 782X2 has much less intensity and complexity compared to the reference code. To maintain rank order across the Medicare physician fee schedule and remain budget neutral, the RUC agreed the appropriate work value for 782X2 is 0.90 RVUs, which is below the 25th percentile specialty survey results. **The RUC recommends a work RVU of 0.90 for CPT code 782X2.**

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

New Technology:
The RUC requested that CPT codes 782X1 and 782X2 be placed on the new technology list to review the volume of this service in three years to ensure that the utilization assumptions were accurate. Therefore, the RUC is adding these codes to the New Technology List solely to review claims data utilization between 782X1and 782X2 to ensure the recommendation is work neutral.

Practice Expense:

The RUC discussed direct practice expense inputs at length for the hepatobiliary services under review. The RUC agreed with all of the recommended direct inputs for CPT codes 782X1 and 782X2.

Pulmonary Imaging (Tab 13)
Zeke Silva, MD (ACR); Geraldine McGinty, MD (ACR); Gary Dillehay, MD (SNM)

As a result of the RUC's Relativity Assessment Workgroup (RAW), CPT 78585 (*Pulmonary perfusion imaging, particulate, with ventilation; rebreathing and washout, with or without single breath)* was identified as a potentially misvalued code through the Harvard Valued – Utilization Over 100,000 screen. Specialty societies presented an action plan to the RAW to include CPT codes 78580-78596 as part of the Pulmonary (Lung) family review, to consolidate 10 codes into 5 at the October 2010 CPT Editorial Panel meeting for CPT 2012.

The CPT Editorial Panel consolidated all codes describing the ventilation part of the studies, as the pulmonary code family was previously comprised of several ventilation codes that were based on a gas versus aerosol method, and also included single view and multiple view ventilation studies, which made choosing the appropriate code difficult. The specialty societies agreed that there is little work or cost difference between a gas and aerosol technique and recommended using the same codes, whether the ventilation portion of the study is done with a gas or with aerosolized particles. There was also some ambiguity about the appropriate code for pulmonary function quantification, since there was currently only one pulmonary quantification code, which is used for measurement of both ventilation and perfusion. The typical patient service usually involved measurement of just perfusion, either regional or global and not both ventilation and perfusion. The specialty societies and the CPT Editorial Panel agreed that this new structure of the pulmonary section simplified the coding of these studies and clearly addresses all the possible nuclear medicine lung studies currently performed. In addition, the new coding structure should result in savings to the Medicare program, while also maintaining relativity within the pulmonary family of codes, relativity with other radiology codes, and maintaining budget neutrality.

785X1 ***Pulmonary ventilation imaging (eg, aerosol or gas)***
The RUC reviewed the joint specialty society survey results from 85 physicians who perform this service. The RUC agreed with the surveyed physician median time of 5 minutes pre-service and 5 minutes of post service. The RUC agreed with the specialty that the survey median 10 minutes intra-service time is not appropriate for ventilation only imaging, therefore recommend the 25th percentile at 5 minutes for intra-service time, which is more typical.

The RUC compared 785X1 to the survey respondents key reference code CPT 78306 *Bone and/or joint imaging; whole body* (work RVU = 0.86, 5 minutes pre-service, 8 minutes intra-service, 5 minutes post service), and agreed that although they are comparable services, the work of 785X1 involves fewer images and less time and work than 78306. The RUC also compared 785X1 to CPT 75571 *Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium* (work RVU = 0.58, 5 minutes pre-service, 10 minutes intra-service, 5 minutes post service) and concurred that procedure's work and physician time are even more alike.

Although below the specialty society's 25th percentile survey results, the specialty indicated and the RUC agreed, that the physician work value of 785X1 should be cross-walked to the existing service of 78593 *Pulmonary ventilation imaging, gaseous, with rebreathing and washout with or without single breath; single projection* (work RVU = 0.49), to maintain rank order and remain budget neutral. **The RUC recommends a work RVU of 0.49 for CPT Code 785X1.**

78580 ***Pulmonary perfusion imaging (eg, particulate)***
The RUC reviewed the joint specialty society survey results from 85 physicians who perform this service. The survey respondents indicated 7 minutes was necessary for providing the pre-service evaluation, however the specialty recommended 5 minutes of pre-service time to be consistent with other nuclear medicine services and reflects the typical patient scenario. The RUC agreed with the specialty recommended physician time of 5 minutes pre-service, 10 minutes intra-service, and 5 minutes of post service.

The RUC reviewed the median and 25th percentile survey results in comparison to the survey respondents key reference code CPT 78306 *Bone and/or joint imaging; whole body* (work RVU = 0.86, 5 minutes pre-service, 8 minutes intra-service, 5 minutes post service), and agreed that although they are comparable services, the work of 78580 involves fewer images and less work intensity and complexity than that of 78306. The specialty and the RUC agreed that the work of 78580 had not fundamentally changed over the years and that maintaining the current work value of 0.74, which is below the survey's 25th percentile survey results, would be appropriate to maintain rank order for this family of services. **The RUC recommends a work RVU of 0.74 for CPT Code 78580.**

785X3 ***Pulmonary ventilation (eg, aerosol or gas) and perfusion imaging***
The RUC reviewed the joint specialty society survey results from 85 physicians who perform this service. The survey respondents indicated 7 minutes was necessary for providing the pre-service evaluation, however the specialty recommended 5 minutes to be consistent with other nuclear medicine services and reflects the typical patient scenario. The RUC agreed with the specialty recommended physician time of 5 minutes pre-service, 12 minutes intra-service, and 10 minutes of post service, as typical for the two studies and multiple sets of images being acquired.

The RUC agreed that two distinct and separate procedures, a pulmonary ventilation and a pulmonary perfusion study, are both performed sequentially at the same session. This multiple study procedure is similar to other nuclear medicine procedures involving multiple studies such as planar myocardial perfusion imaging CPT code 78454 *Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection* (work RVU = 1.34). CPT code 78454 was chosen as the key reference service by the survey respondents and although they indicated CPT code 785X3 was more intense and complex, the survey median work RVU of 1.07, indicated slightly less overall physician work. The RUC agreed that CPT code 78454 is a good comparison to CPT code 785X3, and the RUC agreed that the complexity of reviewing multiple studies, along with reviewing medications and the stress test, supports the higher value RVW of 1.34 for 78454, compared to surveyed code 785X3.

The RUC also compared 785X3 to the current value of the two highest volume CPT crosswalk codes CPT 78585 *Pulmonary perfusion imaging, particulate, with ventilation; rebreathing and washout, with or without single breath* (work RVU = 1.09) and CPT 78588 *Pulmonary perfusion imaging, particulate, with ventilation imaging, aerosol, 1 or multiple projections* (work RVU = 1.09), both of which have an RVW of 1.09, which supports the median survey result. The overall physician work was also assimilated and compared to another multiple procedure nuclear medicine study CPT 78804 *Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, requiring 2 or more days imaging)* (work RVU = 1.07). Considering the work values of these crosswalk and comparison codes, the RUC agreed that the specialty's survey median work RVU of 1.07 appropriately accounts for the physician work required to perform CPT code 785X3. **The RUC recommends a work RVU of 1.07 for CPT Code 785X3.**

785X4 ***Quantitative differential pulmonary perfusion, including imaging when performed***

The RUC reviewed the joint specialty society survey results from 58 physicians who frequently perform this service. The RUC agreed with the specialty recommended physician time of 5 minutes pre-service, 10 minutes intra-service, and 5 minutes of post service, as typical for this service.

The RUC and the specialty agreed that the typical study is not of greater work than the non-quantitative, diagnostic pulmonary imaging studies. In addition, deleted code CPT 78596 *Pulmonary quantitative differential function (ventilation/perfusion) study* (work RVU = 1.27) may not have been appropriately ranked relative to other nuclear medicine procedures. This is higher than any of the single or multiple pulmonary ventilation or perfusion study codes. The RUC agreed that the reference service chosen by the survey respondents, CPT 78306 *Bone and/or joint imaging; whole body* (work RVU = 0.86) has more work intensity and complexity than the new pulmonary perfusion quantitative CPT code 785X4. The RUC also compared CPT 785X4 to 76817 *Ultrasound, pregnant uterus, real time with image documentation, transvaginal* (work RVU = 0.75) and found them analogous in work and total time 23 minutes and 20 minutes, respectively.

The RUC recommends a work RVU of 0.75, which is below the specialty's 25th percentile survey results, to maintain rank order and budget neutrality for this family of services. **The RUC recommends a work RVU of 0.75 for CPT Code 785X4.**

785X5 ***Quantitative differential pulmonary perfusion*** *and ventilation* ***(eg, aerosol or gas)****, including imaging when performed*
The RUC reviewed the joint specialty society survey results from 58 physicians who frequently perform this service. The RUC agreed with the specialty recommended physician time of 5 minutes pre-service, 10 minutes intra-service, and 9 minutes of post service, as typical for this service.

The RUC reviewed the survey median and 25th percentile work relative values of 1.04 and 0.84 respectively, and agreed that the typical quantitative studies are not of greater work than the non-quantitative, diagnostic pulmonary imaging studies. In addition, deleted code CPT 78596 *Pulmonary quantitative differential function (ventilation/perfusion) study* (work RVU = 1.27) may not have been appropriately ranked relative to other nuclear medicine procedures. This is higher than any of the single or multiple pulmonary ventilation or perfusion study codes.

The RUC agreed that the reference service code chosen by the survey respondents CPT 78454 *Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection* (work RVU = 1.34) has more work intensity and complexity than the new multiple quantitative pulmonary perfusion CPT 785X5. The RUC also compared CPT 785X5 to MPC code CPT 78306 *Bone and/or joint imaging; whole body* (work RVU = 0.86 and total time= 18 minutes) and CPT 76700 *Ultrasound, abdominal, real time with image documentation; complete* (work RVU = 0.81 and total time= 17 minutes) and found them comparable in physician work and time.

The RUC recommends a work RVU of 0.85, which is the specialty's 25th percentile survey results, to maintain rank order and budget neutrality for this family of services. **The RUC recommends a work RVU of 0.85 for CPT Code 785X4.**

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

Practice Expense: RUC carefully reviewed the direct practice expense inputs recommended by the specialty societies and approved the clinical labor, supplies and equipment associated with these services.

Molecular Pathology (Tab 14)
Jonathan Myles, MD (CAP)

At the October 2010 CPT Meeting, 28 new codes were approved for the first set of Tier 1 non-infectious disease molecular pathology services. At the February 2011 CPT Meeting, the Tier 2 services will be presented to the CPT Editorial Panel. First, assuming the acceptance of the Tier 2 services by the Panel, the specialty society requests postponement of the review of the initial set to the April 2011 RUC Meeting so that both sets of codes can be reviewed together. The RUC was made aware that there are some

issues pertaining to these services including determining the primary provider of these services as well as which codes will be on the RBRVS or the CLFS. The specialty society has indicated that they will address these issues with CMS and or the CPT Editorial Panel prior to their presentation at the April 2011 RUC Meeting. **The RUC approves the request to present both molecular pathology Tier 1 and 2 services at the April 2011 RUC Meeting.**

Transcranial Magnetic Stimulation (Tab 15)
Jeremy Musher, MD (APA); Patrick Marsh, MD (APA); Shirlene Sampson, MD (APA)
Facilitation Committee # 1

In February 2010, the CPT Editorial Panel converted two Category III codes, 0160T and 0161T, to Category I status to report treatment planning and treatment delivery/management of transcranial magnetic stimulation. In October 2010, the CPT Editorial Panel modified the two existing CPT codes to clarify that 90867 should be used to report the initial TMS treatment including cortical mapping, motor threshold determination and delivery/management and that 90868 should be used to report subsequent delivery and management of TMS session. Further, the CPT Editorial Panel created a third Category I code to report redetermination of motor threshold during a course of transcranial magnetic stimulation therapy.

90867 ***Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management***
The RUC reviewed the survey results from 76 psychiatrists who frequently perform this service. The specialty society convened an expert panel to review the survey data and determined that the surveyed times were inappropriate as they did not reflect the administration of this service. The specialty society recommended that the pre-service time for this service should be derived from pre-service time package 5, which has 7 minutes of evaluation time. The specialty recommended an additional 15 minutes of pre-service time for positioning as precise positioning of the head is critical for this treatment to be successful. The expert panel agreed that 65 minutes of intra-service time, to perform the cortical mapping, motor threshold determination and treatment delivery, and 10 minutes of post-service time was reflective of the service and was derived from the survey data. The RUC agreed that the modified service times presented by the specialty accurately reflected the service provided. The RUC compared the surveyed code to reference code, 95978 *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; first hour* (work RVU=3.50). The RUC noted that although the survey respondents indicated that the surveyed code was a more intense service to perform, the surveyed code and 95978 have similar intra-service times, 65 minutes and 60 minutes, respectively. Based on this comparison, the RUC agreed with the specialty society recommended work RVU of 3.52, the survey median. **The RUC recommends a work RVU of 3.52 for CPT code 90867.**

90868 ***Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session***
The RUC reviewed the survey data for 90868 and agreed with the specialty society that the survey respondents over-estimated the service times and work RVUs associated with this procedure. Therefore, the specialty society recommended that the work RVUs and times for this procedure should be crosswalked to 99212 *Office or other outpatient visit for the evaluation and management of an established patient,* (work RVU=0.48, pre-service= 2 minutes, intra-service= 10 minutes, post service= 4 minutes). The specialty society agrees that these times and work RVUs are appropriate for the procedure being provided. **The RUC agrees with the specialty society and recommends a work RVU of 0.48 for CPT code 90868.**

9086XX ***Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management***
The RUC reviewed the survey results from 67 psychiatrists who frequently perform this service. The specialty society convened an expert panel to review the survey data and determined that the surveyed times were inappropriate as they did not reflect the administration of this service. The specialty society recommended that the pre-service time for this service should be derived from pre-service time package 5, which has 7 minutes of evaluation time. The specialty recommended an additional 10 minutes of pre-service time for positioning as precise positioning of the head is critical for this treatment to be successful. Further, the specialty society's expert panel agreed that the time required to perform the cortical mapping, motor threshold re-determination and treatment delivery was 45 minutes. Therefore, the specialty society recommends 45 minutes for intra-service time. The specialty society agreed that 10 minutes of post-service time was reflective of the service and was derived from the survey data. The RUC agreed that the modified service times presented by the specialty accurately reflected the service provided. The RUC compared the surveyed code to two reference codes, 95978 *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; first hour* (work RVU=3.50) and 99205 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU=3.17). The RUC noted that although the survey respondents indicated that the surveyed code is a more intense service to perform in comparison to the reference code, the surveyed code has less intra-service time as compared to 95978, 45 minutes and 60 minutes, respectively. Further, the RUC noted that the surveyed code and 99205 have the same intra-service time, 45 minutes. Based on these comparisons, the RUC agreed with the specialty society recommended work RVU of 3.20, the survey median. **The RUC recommends a work RVU of 3.20 for CPT code 9086XX.**

New Technology: The specialty society requests and the RUC agrees that these three codes should be added to the new technology list.

Practice Expense: The RUC modified the clinical labor time specifically the assist physician time to reflect the modified intra-service times as stated above. The RUC approved the modified practice expense inputs.

Car Seat/Bed Evaluation (Tab 16)
Steve Krug, MD (AAP); Gil Martin, MD (ASIPP); Stephen Pearlman, MD (AAP)

At the October 2010 Meeting, the CPT Editorial Panel created two codes to report car seat testing which is re-administered to the patient in the private physician's office. These services are performed on an infant who fails the car seat test in the hospital and is currently using the less safe car bed until s/he passes a car seat test administered by the child's physician.

9477X1 ***Car seat/bed testing for airway integrity, neonate, with continual nursing observation and continuous recording of pulse oximetry, heart rate and respiratory rate, with interpretation and report; 60 minutes***
The RUC reviewed the survey data for 9477X1 from 35 pediatricians. The specialty society explained that the survey respondents over-estimated the service times and work RVUs associated with this surveyed code given the fact that this service is typically performed with an evaluation and management service on the same date of service. Therefore, the specialty society is recommending that the surveyed code's work RVU and service times be crosswalked directly from 99212 *Office or other outpatient visit for the evaluation and management of an established patient,* (work RVU=0.48; pre-service time=2 minutes, intra-service time=10 minutes and post-service time=4 minutes). The specialty society agreed that these times and work RVUs accurately reflect the time and intensity required to perform this service. The RUC agreed with the specialty society's recommended time and work RVU for 9477X1. **The RUC recommends a work RVU of 0.48 for CPT code 9477X1.**

9477X2 ***Car seat/bed testing for airway integrity, neonate, with continual nursing observation and continuous recording of pulse oximetry, heart rate and respiratory rate, with interpretation and report; each additional full 30 minutes***
The RUC reviewed the survey data for 9477X2 from 31 pediatricians. The specialty society explained that the survey respondents over-estimated the service times and work RVUs associated with this surveyed code given the fact that this service is always performed with the base code 9477X1 on the same date of service. Therefore, the specialty society is recommending that the surveyed code's work RVU and intra-service time be crosswalked directly from 99211 *Office or other outpatient visit for the evaluation and management of an established patient,* (work RVU=0.17; intra-service time=5 minutes). The specialty society agreed that this service requires no additional pre-service or post-service time beyond the time of the base code, 9477X1. The specialty society also presented another reference code with the same intra-service time and work RVU as the surveyed code to further support the value and time proposed by the specialty, 93000 *Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report* (work RVU=0.17; intra-service time=5 minutes) The specialty society agreed that these times and work RVUs accurately reflect the time and intensity required to perform this service. The RUC agreed with the specialty society's recommended time and work RVU for 9477X2. **The RUC recommends a work RVU of 0.17 for CPT code 9477X2.**

Practice Expense Inputs:
The RUC reviewed the practice expense inputs as submitted by the specialty society and removed the pulse oximetry as it is duplicative with the ECG equipment associated with this service. With this modification, the RUC accepted the practice expense inputs.

CPT Referral:
As this car seat testing is administered in the facility setting when the child is being discharged from the hospital and re-administered in the child's physician office, the RUC was concerned about differential work when the service was performed in either setting. The specialty society explained that facility services would occur when the infant was being discharged from the intensive care setting and the physician services would be performed by the neonatologist caring for the infant. The RUC agreed that an appropriate way to address the concern was to bundle car seat testing services when the child is being discharged from the hospital into the neonatal/infant per diem codes. The RUC also requested a parenthetical excluding simultaneous reporting of pulse oximetry and electrocardiographic monitoring, which is inherent in the car seat evaluation. At the February 2011 Meeting, the CPT Editorial Panel added language to these codes to address the concerns raised by the RUC.

Evoked Potentials and Reflex Studies (Tab 17)
Marianna V. Spanaki, MD, PhD (AAN); Joseph P. Zuhosky, MD (AAPMR); William J. Litchy, MD (AAN)

CPT code pairs 95925/95926 and 95928/95929 were identified the Relativity Assessment Workgroup's Codes Reported Together 75% or More Screen. At the request of the RUC, the specialty societies submitted a coding proposal which was approved by the CPT Editorial Panel to create two bundled codes which will allow providers to report short latency somatosensory evoked potential studies of the upper and lower limbs and central motor evoked potential study of the upper and lower limbs.

95928X *Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs*
The RUC reviewed the survey data from 54 neurologists, neuromuscular and electrodiagnostic physicians, physical medicine and rehabilitation physicians and clinical neurophysiological physicians. The specialty societies explained that the survey respondents accurately represented the physician time required to determine the placement and re-placement of electrodes based on responses, to supervise the patient preparation, stimulation of nerves and/or dermatomes and recording the resulting evoked potentials at several sites. The physician reviews the data from hundreds of trials that are conducted as the test design changes during the course of the study in response to the information obtained. To develop a recommended work RVU, the specialties compared the surveyed code to reference code 95927 *Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in the trunk or head* (work RVU=0.54). The RUC noted that the surveyed code, 95928X, requires more total time to perform than the reference code, 95927, 40 minutes and 31.5 minutes, respectively. Further, the RUC noted that the surveyed code requires more mental effort and judgment, technical skill and physical effort and overall is a more intense service to perform in comparison to the reference code. The RUC also compared the surveyed code to reference code 78802 *Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, single day imaging* (work RVU=0.86). The RUC noted that the surveyed code and the reference code have the same total service time, 40 minutes. Based on these comparisons, the specialty society recommends 0.86 work RVUs, a value

halfway between the 25th percentile and the median survey value. Further, the RUC understands that this recommended value represents a 20% savings in work RVUs as this new code represents the bundling of two existing services, 95925 and 95926. **The RUC recommends a work RVU of 0.86 for CPT code 95928X.**

95929X ***Central motor evoked potential study (transcranial motor stimulation); upper and lower limbs***
The specialty societies request postponement of their presentation of 95929X to the April 2011 RUC Meeting. The specilaty societies conducted a survey of 95929X, but only 31% of the survey respondents indicated that the outpatient vignette was typical. The societies agreed that a new survey needs to be conducted utilizing a new vignette based on an inpatient scenario. **The RUC recommends the postponement of the presentation of 95929X to the April 2011 RUC Meeting.**

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

Practice Expense Inputs:
The practice expense inputs were modified to be reflective of the typical patient service and were approved by the RUC.

X. CMS Requests

Treatment of Ankle Fracture (Tab 18)
William Creevy, MD (AAOS); Tye Ouzounian, MD (AOFAS)

CPT code 27792 was reviewed by the RUC as part of the Internal or External Fixation Services in 2007 utilizing a survey instrument that contained questions regarding site of service. Following the RUC's recommendation, in 2009, CMS identified CPT code 27792 as part of the 4th Five-Year Review through their site of service anomaly screen. In response to this request made by CMS, the RUC re-reviewed the survey data presented by the specialty societies and assessed the previous RUC recommendation for work RVUs.

The specialty societies presented their survey data including physician times and the RUC agreed that these times accurately reflected the service performed by the physician. Importantly, the RUC noted that the work involved in monitoring the typical patient post-operatively on the day of surgery is the same Evaluation and Management work whether the patient's status ends up inpatient or outpatient. Adjustments to the allocation of post-operative visits are used as proxies and do not constitute changes to the physician work relative value of the service which was determined by magnitude estimation and physician specialty survey data during the last RUC review.

In the previous RUC recommendation for this service, the specialty societies, utilizing magnitude estimation, compared this service to 28299 *Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy* (Work RVU=11.57). The RUC noted that the intra-service time of 27792 is significantly less than the intra-service time of the reference code, 60 minutes and 90 minutes, respectively. The RUC also noted that the care for this type of fracture is slightly more complex than 27784 *Open treatment of proximal fibula or shaft fracture, includes internal fixation, when*

performed (RUC Recommended Value=9.67). In 2008, with the lower amount of intra-service time of the surveyed code in comparison to the reference code and maintaining the proper rank order between the surveyed code and 27784, the RUC agreed that the median of the survey, 10.50 RVUs appropriately places this code in comparison to the reference codes. However, despite the compelling evidence provided, CMS applied work neutrality to the group of fracture codes, resulting in 9.55 Work RVUs, a 9% reduction in the work compared with the RUC recommendation. This value was then increased in 2010 to 9.71 work RVUs based on the redistribution of RVUs from the CMS coverage determination to no longer recognize the consultation services. Therefore, based on this history and magnitude estimation comparison to the reference codes, the specialty societies agree and the RUC recommends that the current value of this service be maintained. **The RUC recommends 9.71 work RVUs for CPT code 27792.**

Removal of Foot Bone (Tab 19)
William Creevy, MD (AAOS); Tye Ouzounian, MD (AOFAS); Seth Rubenstein, DPM (APMA); Timothy Tillo, DPM (APMA)

In September 2007, the RUC's Relativity Assessment Workgroup identified CPT codes 28120 and 28122 as potentially misvalued through the Site-of-Service Anomaly screen. In 2008, the American Academy of Orthopaedic Surgery, the American Orthopaedic Foot and Ankle Society and the American Podiatric Medical Association conducted a RUC survey for these services. The RUC deferred review of these services until the RUC survey instrument could be modified to capture information about typical site of service. In 2009, the specialties presented code 28120 and 28122 using data from a modified RUC survey instrument that included a question regarding site-of-service and visits on the day of the procedure. Following the RUC's recommendation, CMS included code 28120 and 28122 as part of the 4th Five-Year Review and in Table 16 of the 2011 Proposed Rule to re-review these services. In response to this request by CMS, the RUC re-reviewed the survey data presented by the specialty societies and assessed the previous RUC recommendation for work RVUs.

The specialty societies presented their survey data including physician times and the RUC agreed that these times accurately reflected the service performed by the physician. Importantly, the RUC noted that the work involved in monitoring the typical patient post-operatively on the day of surgery is the same Evaluation and Management work whether the patient's status ends up inpatient or outpatient. Adjustments to the allocation of post-operative visits are used as proxies and do not constitute changes to the physician work relative value of the service which was determined by magnitude estimation and physician specialty survey data during the last RUC review.

28120
In the previous RUC recommendation for this service, the specialty societies utilizing magnitude estimation, compared this service to two reference codes, 15100 *Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)* (work RVU = 9.89) and 49505 *Repair initial inguinal hernia, age 5 years or older; reducible* (work RVU = 7.96). The RUC noted that the surveyed code has less total service time in comparison to 15100, 260 minutes and 281 minutes, respectively. Further, the RUC noted that the surveyed code has more total service time in comparison to 49505, 260 minutes and 198 minutes, respectively. In 2009, based on magnitude estimation, the RUC agreed that the survey's 25th percentile, 8.08 RVUs. CMS accepted the RUC recommended value for this service for 2010.

Further, for 2010, this value was increased to 8.27 work RVUs based on the redistribution of RVUs from the CMS coverage determination to no longer recognize the consultation services. Therefore based on this history and magnitude estimation comparisons to the reference codes, the specialty societies agree and the RUC recommends that the current value of this service be maintained. **The RUC recommends 8.27 Work RVUs for CPT code 28120.**

28122
In the previous RUC recommendation for this service, the RUC discussed the proposed work RVU and agreed that there was no compelling evidence to change the work RVU from its current value. To justify the current value of this service, the specialty societies utilizing magnitude estimation, compared this service to two reference codes, 33207, *Insertion or replacement of permanent pacemaker with transvenous electrode(s); ventricular* (work RVU = 8.05) and 49505 *Repair initial inguinal hernia, age 5 years or older; reducible* (work RVU = 7.96). The RUC noted that the surveyed code has less intra-service time in comparison to 33207, 45 minutes and 60 minutes, respectively. Further, the RUC noted that the surveyed code has less intra-service time in comparison to 49505, 45 minutes and 70 minutes, respectively. Based on these comparisons, the RUC recommended that the current value of 28122, 7.56 work RVUs should be maintained. CMS accepted the RUC recommended value for this service for 2010. Further, for 2010, this value was increased to 7.72 work RVUs based on the redistribution of RVUs from the CMS coverage determination to no longer recognize the consultation services. Therefore based on this history and magnitude estimation comparisons to the reference codes, the specialty societies agree and the RUC recommends that the current value of this service be maintained. **The RUC recommends 7.72 Work RVUs for CPT code 28122.**

Foot Arthrodesis (Tab 20)
William Creevy, MD (AAOS); Tye Ouzounian, MD (AOFAS); Seth Rubenstein, DPM (APMA); Timothy Tillo, DPM (APMA)

In September 2007, the RUC's Relativity Assessment Workgroup identified CPT codes 28725 and 28730 as potentially misvalued through the Site-of-Service Anomaly screen. In 2008, the American Academy of Orthopaedic Surgery, the American Orthopaedic Foot and Ankle Society and the American Podiatric Medical Association conducted a RUC survey for these services. The RUC deferred review of these services until the RUC survey instrument could be modified to capture information about typical site of service. In 2009, the specialties presented code 28725 and 28730 using data from a modified RUC survey instrument that included a question regarding site-of-service and visits on the day of the procedure. Following the RUC's recommendation, CMS included code 28120 and 28122 in Table 16 of the 2011 Proposed Rule to re-review these services. In response to this request by CMS, the RUC re-reviewed the survey data presented by the specialty societies and assessed the previous RUC recommendation for work RVUs.

The specialty societies presented their survey data including physician times and the RUC agreed that these times accurately reflected the service performed by the physician. Importantly, the RUC noted that the work involved in monitoring the typical patient post-operatively on the day of surgery is the same Evaluation and Management work whether the patient's status ends up inpatient or outpatient. Adjustments to the allocation of post-

operative visits are used as proxies and do not constitute changes to the physician work relative value of the service which was determined by magnitude estimation and physician specialty survey data during the last RUC review.

28725
In the previous RUC recommendation for this service, based on its review of the survey data, the RUC agreed that the current work RVU was the appropriate valuation of the work involved in the service. The RUC noted that the current work RVU is below the survey 25th percentile work RVU. The RUC utilizing magnitude estimation, also reviewed several reference codes to support the 2009 work RVU of 11.97 for 28725 including CPT code 28261, *Capsulotomy, midfoot; with tendon lengthening*, (work RVU = 13.11) and 47562, *Laparoscopy, surgical; cholecystectomy*, (work RVU=11.76). The RUC noted that the surveyed code requires less intra-service time as compared to 28261, 90 minutes and 103 minutes, respectively. Further, the RUC noted that the surveyed code requires more intra-service time as compared to 47562, 90 minutes and 80 minutes, respectively. In 2009, the RUC recommended maintaining the current work RVU of 11.97 for CPT code 28725. CMS accepted the RUC recommended value for this service for 2010. Further, for 2010, this value was increased to 12.18 work RVUs based on the redistribution of RVUs from the CMS coverage determination to no longer recognize the consultation services. Therefore, based on this history and magnitude estimation comparisons to the reference codes, the specialty societies agree and the RUC recommends that the current value of this service be maintained. **The RUC recommends 12.18 RVUs for CPT code 28725.**

28730
In the previous RUC recommendation for this service, based on its review of the survey data, the RUC agreed that the current work RVU was the appropriate valuation of the work involved in the service. The RUC also noted that the current work RVU is below the survey 25th percentile work RVU. The RUC also reviewed several reference codes to support the 2009 work RVU of 12.21 for 28730 including CPT codes 28309, *Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; multiple (eg, Swanson type cavus foot procedure)* (work RVU = 14.16) and 29862, *Arthroscopy, hip, surgical; with debridement/shaving of articular cartilage (chondroplasty), abrasion arthroplasty, and/or resection of labrum* (work RVU = 11.17). The RUC noted that while the procedures are similar in intensity and complexity, 28730 required less total-service time than 28309, 317 minutes and 350 minutes, respectively. The RUC also commented that the surveyed code has more total-service time that 29862, 317 minutes and 297 minutes, respectively. In 2009, the RUC recommended maintaining the current work RVU of 12.21 for CPT code 28730, a value less than the 25th percentile of the survey data. CMS accepted the RUC recommended value for this service for 2010. Further, for 2010, this value was increased to 12.42 work RVUs based on the redistribution of RVUs from the CMS coverage determination to no longer recognize the consultation services. Therefore, based on this history and magnitude estimation comparisons to the reference codes, the specialty societies agree and the RUC recommends that the current value of this service be maintained. **The RUC recommends 12.42 RVUs for CPT code 28730.**

Partial Amputation of Toe (Tab 21)
Seth Rubenstein, DPM (APMA); Timothy Tillo, DPM (APMA); Gary Seabrook, MD, (SVS); Robert Zwolak, MD, FACS (SVS); Christopher Senkowski, MD FACS (ACS); Charles Mabry, MD FACS (ACS); William Creevy, MD (AAOS); Tye Ouzounian, MD (AOFAS)

CPT code 28825, *Amputation, toe; interphalangeal joint*, was identified by the RUC's Five-Year Review Identification Workgroup in 2007 as potentially misvalued through the Site-of-Service Anomaly screen.. CMS agreed with the RUC that this service should be evaluated. The involved specialties argued that the typical patient requiring 28825 would be variable (co-morbidities) and bi-modal (inpatient vs outpatient), and that the correct global period to account for this variability would be 0-day.. Based on the 2009 Medicare utilization data, the service is performed approximately 41% in the inpatient hospital setting, about 51% in the outpatient hospital and ambulatory surgery center settings, and about 7% in the physician office. The service is performed by a wide variety of specialties including podiatry, orthopaedic surgery, vascular surgery, and general surgery, further supporting a bi-modal distribution. The typical patient is bi-modal and requires amputation because of either diabetes or gangrene resulting from peripheral vascular disease. The specialties, based on their own survey data which indicated a bi-modal distribution and the Medicare utilization data, recommended that the service be resurveyed with a 000 day global period to more accurately include the work given the bi-modal distribution. The RUC agreed and further noted that a change in CPT descriptor will not resolve the issue, but a change in global period would. The RUC recommended that CMS change the global period for 28825 to 000 day global period and the specialty societies to resurvey for the April 2008 RUC meeting. CMS responded that the 090 day global will be maintained. **Based on the aforementioned arguments, the RUC reiterates its requests that the global period for 28825 be changed to a 000 day global. If CMS agrees with this recommendation, the RUC would review the code again with the new global period.**

In 2008, the American Academy of Orthopaedic Surgery, the American College of Surgeons, the American Podiatric Medical Association, and Society for Vascular Surgery conducted a RUC survey for these services. The specialties presented code 28825 using data from a modified RUC survey instrument that included a question regarding site-of-service and visits on the day of the procedure. CMS accepted the RUC's recommendation for this service. Following the RUC's recommendation, CMS included code 28825 as part of the 4th Five-Year Review. In response to this request by CMS, the RUC re-reviewed the survey data presented by the specialty societies and assessed the previous RUC recommendation for work RVUs.

The specialty society commented that as the physician work for this service has not changed since its last review, the current value, 6.01 RVUs should be maintained. The specialty society presented two reference services that are similar procedures and that have the same intra-time and require similar total work: 28288, *Ostectomy, partial, exostectomy or condylectomy, metatarsal head, each metatarsal head* (work RVU = 6.02, intra-service time = 30 minutes) and 26951, *Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with direct closure* (work RVU = 6.04, intra-service time = 30 minutes). The RUC agrees with the specialties that the current value for 28825, 6.01 RVUs is appropriate and relative to

these other two similar services. Therefore, based on the magnitude estimation comparisons to the reference codes, the specialty societies agree and the RUC recommends that the current value of this service be maintained.

Additionally, the RUC further analyzed the site-of-service data and post-operative visit data. Code 28825 is not typically same day surgery. Diabetic patients requiring 28825 are sick with multiple co-morbidities. Amputation of an appendage is a last resort for patients who have failed medical management of their disease. Patients require close monitoring of the wound and co-morbid disease(s) on the day of the procedure and are kept in the hospital for continued monitoring at least overnight. The surgeon would: Review interval chart notes. Discuss ongoing care with floor nurses. Evaluate vital signs and intake/output. Examine patient, check wounds and drain, and change dressings. Assess circulation, sensation, and motor function of the operated extremity, along with anticoagulation therapy. Continue prophylaxis for DVT and antibiotic therapy. Assess pain scores and adequacy of analgesia. Review nursing/other staff patient chart notes. Coordinate care as necessary with endocrinology, infectious disease, and possibly the PCP. Answer patient and family questions. Answer nursing/other staff questions. Then, the next day or several days later, after reviewing the patient's chart and examining the patient, the surgeon will determine if it is safe to discharge the patient. Some patients will be discharged on the second day and others will remain additional days in the hospital (either admitted to inpatient status or maintained under outpatient or observation care status). This was substantiated by the survey data which shows that the typical patient receives this procedure in the hospital (84%), stays at least overnight in the hospital following surgery (63%) and receives an Evaluation and Management service on the same date (53%). Given this data, the RUC enacted its policy to allocate the appropriate proxy for the post-operative visits. Importantly, the RUC noted that whether the hospital admission criteria program designates this service outpatient or inpatient, the physician work at the bed of a patient in a hospital surgical ward to review the patient chart, take down dressings, examine the patient, write subsequent orders, and talk to the floor staff and the family is the same. Adjustments to the allocation of post-operative visits are used as proxies and do not constitute changes to the physician work relative value of the service which was determined by magnitude estimation and physician specialty survey data during the last RUC review. **The RUC recommends a work RVU of 6.01 for CPT code 28825.**

Shoulder Arthroscopy (Tab 22)
William Creevy, MD (AAOS)

In February 2010, the following services were identified in the 4th Five-Year Review through CMS' screen for Harvard valued services with utilization over 30,000 and Codes Reported 75% or More Together Screen as being frequently billed together:

29824 *Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure)*(Work RVU = 8.98, 090 day global)
29826 *Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with or without coracoacromial release* (Work RVU = 8.98, 090 day global)
29827 *Arthroscopy, shoulder, surgical; with rotator cuff repair* (Work RVU = 15.59, 090 day global)
29828 *Arthroscopy, shoulder, surgical; biceps tenodesis* (Work RVU = 13.16, 090 day global)

The RUC reviewed the physician work for CPT Code 29826 in October 2010 and review of practice expense for this service was deferred to the February 2011 meeting. The RUC acknowledged that 29826 when performed with other endoscopic services is subject to the Endoscopic Multiple Procedure Reduction. CPT Code 29826 is reported as a stand alone procedure less than 8% of time in the Medicare population. However, in younger populations it is often a procedure provided independent of other surgeries. The RUC understood that the specialty submitted a coding proposal to the CPT Editorial Panel for consideration at the February 2011 meeting, which outlined the bundling of 29826 when performed with 29824 *Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure),* or 29827 *Arthroscopy, shoulder, surgical; with rotator cuff repair* or 29828 *Arthroscopy, shoulder, surgical; biceps Tenodesis*. The RUC deferred the review of the practice expense inputs until these codes are revised by the CPT Editorial Panel and will therefore be placed on the April 2011 RUC agenda.

Biopsy of Lung or Mediastinum (Tab 23)
Zeke Silva, MD (ACR); Geraldine McGinty, MD (ACR)

In the 4th Five-Year Review of the RBRVS, CMS identified CPT code 32405 *Biopsy, lung or mediastinum, percutaneous needle* as potentially misvalued through the Harvard Valued - Utilization over 30,000 Screen. The RUC carefully reviewed the work relative value of this service in October 2010 and recommended its value be maintained. In addition, at that time, the specialties explained that the survey data supported the fact that moderate sedation is an inherent component of this service. The RUC recommended that CPT Code 32405 be referred to the CPT Editorial Panel to be included in Appendix G. The inclusion of 32405 in CPT's Appendix G necessitates the inclusion of the direct practice expense inputs associated with moderate sedation, and therefore the RUC scheduled a review of the inputs at its February 2011 meeting.

In February 2011, the RUC carefully reviewed the specialty recommended typical clinical labor, medial supplies, and equipment for CPT code 32405, and agreed upon the presented direct practice expense inputs associated with the performance of moderate sedation. **The RUC recommends the attached direct practice expense inputs for code 32405.**

Ventricular Assist Device (VAD) Removal (Tab 24)
James Levett, MD (STS)

In the 4th Five-Year Review of the RBRVS, the Society of Thoracic Surgeons (STS) identified services including ventricular assist device (VAD) removal codes, VAD insertion and replacement codes, lung transplant codes, pulmonary artery embolectomy codes, descending thoracic aorta repair codes and congenital cardiac codes. In October 2010, the RUC reviewed the VAD insertion and replacement codes, which have an XXX global period. To be consistent with the insertion and replacement VAD codes, the RUC requested that CMS consider an XXX global period for CPT codes 33977 *Removal of ventricular assist device; extracorporeal, single ventricle*, 33978 *Removal of ventricular assist device*; *extracorporeal, biventricular* and 33980 *Removal of ventricular assist device, implantable intracorporeal, single ventricle*. CMS approved this global change request and the specialty society re-surveyed the VAD removal codes with an XXX global period and provided recommendations at the February 2011 RUC meeting.

The RUC agreed with the specialty society that there is compelling evidence that the patient population has changed because the complexity of patients has increased as many have been on cardiopulmonary bypass. Additionally, although the RUC is recommending slight increases for 33977 and 33978, the previous 090 global work RVU of this code did not include any post-operative hospital visits and therefore was valued incorrectly.

33977 Removal of ventricular assist device; extracorporeal, single ventricle
The RUC reviewed the survey results of 44 cardiothoracic surgeons and determined that he survey 25th percentile work RVU of 20.86 appropriately accounts for the work required to perform this procedure and places it in the proper rank order with other VAD procedures. Additionally, the pre-service time of 95 minutes, intra-service time of 180 minutes and immediate post-service time of 60 minutes appropriately accounts for the physician work required to this service compared to the VAD insertion and replacement services. The RUC compared 33977 to the key reference service (adjusted for the XXX global period for comparison) 33548 *Surgical ventricular restoration procedure, includes prosthetic patch, when performed (eg, ventricular remodeling, SVR, SAVER, Dor procedures)* (XXX work = 30.26, intra-service time = 217) and MPC code 33405 *Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve* (XXX work RVU = 23.53, intra-service time = 180 minutes) and agreed with the survey respondents that the physician work and time for 33977 is less as the reference codes include cardiopulmonary bypass and 33977 does not. Therefore, **the RUC recommends a work RVU of 20.86 for CPT code 33977.**

33978 Removal of ventricular assist device; extracorporeal, biventricular
The RUC reviewed the survey results of 44 cardiothoracic surgeons and determined that he survey 25th percentile work RVU of 25.00 appropriately accounts for the work required to perform this procedure and places it in the proper rank order with other VAD procedures. Additionally, the pre-service time of 95 minutes, intra-service time of 200 minutes and immediate post-service time of 60 minutes appropriately accounts for the physician work required to this service compared to the VAD insertion and replacement services. The RUC compared 33978 to the key reference service (adjusted for the XXX global period for comparison) 33548 *Surgical ventricular restoration procedure, includes prosthetic patch, when performed (eg, ventricular remodeling, SVR, SAVER, Dor procedures)* (XXX work = 30.26, intra-service time = 217) and MPC code 33426 *Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring* (XXX work RVU = 25.49, intra-service time = 205 minutes) and agreed with the survey respondents that the physician work and time for 33978 is less as the reference codes include cardiopulmonary bypass and 33978 does not. Therefore, **the RUC recommends a work RVU of 25.00 for CPT code 33978.**

33980 Removal of ventricular assist device, implantable intracorporeal, single ventricle
The RUC reviewed the survey results of 44 cardiothoracic surgeons and determined that he survey median work RVU of 40.00 appropriately accounts for the work required to perform this procedure and places it in the proper rank order with other VAD procedures. Additionally, the pre-service time of 95 minutes, intra-service time of 300 minutes and immediate post-service time of 90 minutes appropriately accounts for the physician work required to this service compared to the VAD insertion and replacement services. The RUC determined that the median survey work RVU was appropriate for code 33980

because the physician time and work for the intracorporeal removal, 300 minutes intra-service time, is significantly more than for the extracorporeal removal codes 33977, 180 minutes intra-service time, and 33978, 200 minutes intra-service time.

The RUC also compared 33980 to the key reference service (adjusted for the XXX global period for comparison) 43123 *Partial esophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)* (XXX work = 49.95, intra-service time = 442) and agreed with the survey respondents that 33980 was more intense, but required less physician time. The RUC also compared 33780 to MPC code 47130 *Hepatectomy, resection of liver; total right lobectomy* (XXX work RVU = 34.80, intra-service time = 240 minutes) and determined that 33780 requires more physician work and time to perform. Therefore, **the RUC recommends a work RVU of 40.00 for CPT code 33980.**

Additional Information:
Please note that the October 2010 summary of recommendation forms which include survey responses based on a 090-day global period are attached as requested by CMS.

Vascular Injection Procedures (Tab 25)
Gary Seabrook, MD, (SVS); Robert Zwolak, MD, FACS (SVS); Sean Tutton, MD (SIR); Jerry Niedzwieck, MD (SIR); Clifford Kavinsky, MD (ACC); Richard Wright, MD (ACC); Ezequiel Silva, MD (ACR); Geraldine McGinty, MD (ACR); Christopher Senkowski, MD (ACS); Charles Mabry, MD (ACS)
Facilitation Committee # 2

In the 4th Five-Year Review of the RBRVS, CMS identified CPT codes 36010, 36200, 36215, 36216, 36246, 36247, and 36471 as potentially misvalued through the Harvard Valued with Utilization Greater than 30,000 Screen. The specialty societies requested that CPT code 36470 be added to the 4th Five-Year Review.

During its October 2010 meeting, the RUC reviewed the physician work for CPT Codes 36470 *Injection of sclerosing solution; single vein* and 36471 *Injection of sclerosing solution; multiple veins, same leg*, as a subset of the large family of lower extremity revascularization services that describe complete therapy procedures for the revascularization of the lower extremities. The specialty societies explained that with the new CPT 2011 codes involving lower extremity revascularization becoming effective in January 2011, they anticipate utilization shifts for the remainder of the codes under this review of the vascular injection procedures. The specialty societies had difficulties surveying CPT codes 36200, 36246, and 36247 as the global period assignment of XXX appeared inappropriate for these surgical services. Therefore, the RUC recommended, and CMS agreed to change the global period for these services from an XXX -day global to a 000 global period, and survey for February 2011. The RUC also recommended CPT codes 36010, 36215, 36216, and 37620 be referred to the CPT Editorial Panel for revision based on the new and revised coding structure of the lower extremity revascularization services and better describe the services when these codes are reported together on the same date by the same physician.

The component non-selective code 36200 *Introduction of catheter, aorta*, and selective catheterization codes 36246 *Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family* and 36247 *Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family* describe those scenarios where a diagnostic study is performed without intervention or where angiography and intervention are performed outside of the lower extremities or carotid circulation.

The RUC's review of the vascular injection codes and catheterization codes was based on magnitude estimation as the amount of work and intensity is progressively greater as one moves from a short non-selective catheterization 36140 *Introduction of needle or intracatheter; extremity artery* (work RVU = 2.01), progressing to a deeper more invasive aortic catheterization (36200), progressing to a selective catheterization of the origin of a vessel 36245 *Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family* (work RVU = 4.67), its first named branch after a bifurcation (36246), and finally deep into a vascular bed in its second or third named branch often requiring a telescoping construct of base catheter, microcatheter, and microwire (36247).

36200 *Introduction of catheter, aorta*
The RUC reviewed the survey results from over 80 vascular surgeons, general surgeons, cardiologists, radiologists, interventional radiologists, and interventional cardiologists who perform this service and agreed with the specialty societies that the work has not changed for this service and the current work RVU of 3.02 should be maintained.

The specialties reported that only fourteen percent of the respondents indicated that there has been a change in work over the past five years. In addition, the specialties agreed that the time to perform 36200 has not changed in the past 5 years and there is no significant data to suggest a change in work. However, the intensity and complexity of this service certainly has increased similar to almost every other procedure and service in the physician fee schedule, as physicians are now treating more complex patients who may be older and have more co-morbidities.

The RUC compared the physician work of 36200 to recently RUC reviewed key reference service 93503 *Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes* (work RVU = 2.91). Code 93503 is typically performed on an ICU patient for cardiac and hemodynamic monitoring whereas code 36200 is typically performed on a vascular patient with associated co-morbidities, cardiac risks, and/or disease. The RUC agreed that the intra-service work portion of the key reference code and surveyed code are similar in that they both involve Seldinger technique, manipulation, and placement of a catheter. RUC members agreed that the inherent differences of working in the arterial vs. venous system, the length of the aorta, and presence of atherosclerosis and its complications, would account for the additional intra-service time required in 36200, 30 versus 15 minutes, respectively. The RUC noted the survey respondents indicated that code 36200 requires more intensity and complexity to perform than code 93503. The RUC determined that the lower pre- and post-time and physician work for 93503 are due to the fact that 93503 is modifier 51 exempt and the RUC reduced the physician time to be certain of no overlapping time with other work typically performed. Additionally, moderate sedation is not inherent to 93503 and thus requires less pre-time and pre-work than the surveyed service.

To further support maintaining the current work RVU of 3.02, the RUC compared the physician work of 36200 to CPT Code 51102 *Aspiration of bladder; with insertion of suprapubic catheter* (work RVU = 2.70) and 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)* (work RVU = 3.69). The RUC determined that MPC code 51102 requires similar physician work in that a Seldinger technique would be employed with needle, wire, and catheter placement. However, code 51102 does not include moderate sedation and therefore 51102 would have less pre-work. The RUC compared 36200 to MPC code 45378 and noted they have identical intra-service time and moderate sedation is inherent to both procedures and therefore should be valued similarly. Considering the specialties survey results and key reference service and cross specialty comparisons, the RUC agreed with the specialty that the physician work value for CPT code 36200 should be maintained at 3.02, which is supported by the survey's 25th percentile work RVU of 3.00. **The RUC recommends maintaining the current work RVU of 3.02 for CPT code 36200.**

36246 ***Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family***
The RUC considered compelling evidence to increase the work value of this service. The RUC reviewed the survey results from 75 vascular surgeons, general surgeons, cardiologists, radiologists, interventional radiologists, and interventional cardiologists who perform this service and determined that the physician work for this service has not changed and the current work RVU of 5.27 should be maintained

The RUC agreed that the survey respondents did not indicate any change in physician work for code 36246 due to the creation of the new lower extremity revascularization codes. The RUC compared the physician work of 36246 to its key reference service 32550 *Insertion of indwelling tunneled pleural catheter with cuff* (work RVU = 4.17) which is inherently less complex and intense than 36246 with 15 minutes less intra time. Both codes include moderate sedation as inherent. The survey's comparative intensity measures were much greater than the reference code supporting a higher RVW for 36246 compared with 32550.

To justify the current value of this service, the specialty societies utilizing magnitude estimation, compared this service to MPC codes 45385 *Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique* (work RVU = 5.30) and 43260 *Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* (work RVU = 5.95) which are RUC reviewed 000-day global services. In comparison, the RUC agreed that the typical vascular patient undergoing second order angiography for the surveyed code is just as complex as the 45385 and 43260. Code 36246 requires multiple catheter exchanges and manipulations, carries the risk of radiation exposure to the operator throughout the procedure, and carries significant risk of life-threatening complications to the patient. Moderate sedation is inherent to all three codes. The RUC concurred that the current physician work value of 5.27 and intra service time for 36246 are in rank order with these similarly valued services. In addition, the RUC concurred that the current physician work value is supported by the specialty's median survey value of 5.50. **The RUC recommends a work RVU of 5.27 for CPT code 36246.**

36247 ***Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family***
The RUC considered compelling evidence to increase the work value of this service based primarily on the fact that a very large percentage of patients in whom this code would have been used previously are now be reported with the new family of lower extremity intervention codes. The remaining cohort of patients for whom this code will be used are exemplified by the typical patient vignette, a clinical situation in which more physician work is required . Procedures now reported with 36247, as exemplified by the vignette, would be catheterization of the mesenteric vessels and renal vessels which are inherently more complex. The caliber of the vessels is smaller than the iliac and superficial femoral artery and the end-organs are much more susceptible to the complication of thrombo-embolic injury. Catheterization of second and third order branches of the mesentery have a definite higher failure rate than the lesser catheterizations reflecting the incrementally more difficult nature of this work.

The RUC agreed with the specialty's compelling evidence that the physician work of 36247 had increased. The RUC agreed that the when 36247 had been originally valued through the Harvard studies, the predominate provider was radiology, whereas now it is vascular surgery and cardiology. The RUC also agreed that there had been a change in the physician work for 36247 due to: patient population changes, the change in the global period change from XXX to 000, moderate sedation is now inherent, and the procedures that remain in 36247 after the creation of the lower extremity revascularization codes, are inherently more complex. In addition, the caliber of the vessels are smaller than the iliac and superficial femoral artery femoral artery and the end organs are much more susceptible to the complication of thrombo-embolic injury. The RUC accepted these arguments as compelling evidence to change the current value of code 36247.

The RUC reviewed the survey results from 74 vascular surgeons, general surgeons, cardiologists, radiologists, interventional radiologists, and interventional cardiologists who perform this service and determined that the survey median work RVU of 7.00 appropriately accounts for the work required to perform this service.

The RUC compared the physician work of 36247 to its key reference service 32550 *Insertion of indwelling tunneled pleural catheter with cuff* (work RVU = 4.17) which is inherently less complex, and less intense than 36247 with 30 minutes less intra time. Both codes include moderate sedation as inherent. The survey's comparative intensity measures were much greater than the reference code supporting a higher RVW for 36246 compared with 32550.

The RUC also compared code 36147 *Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); initial access with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report (includes access of shunt, injection[s] of contrast, and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava)* (work RVU = 3.72) as a recently RUC reviewed bundled service that incorporates placement of a short catheter into the AV access (inherently less difficult) followed by imaging of the graft and central veins. A portion of the additional 25 minutes of intra-service time is in part due to the bundled imaging of the graft and the central veins. If this is reported separately with 75791, the

work RVU = 1.71, with the surgical component value (derived) is equal to 2.01 as supported by RUC rationale for 36147. The surgical work of introducing the catheter into the AV graft is in rank order with other catheter placement procedures.

The specialty society explained to the RUC that 36247 was previously reported with a blend of services and 90% of that blend of services shifted to the new lower extremity revascularization (LER) services. The patients and services of that 90% shift represent less complex catheterization services and less intense patients. The RUC accepted this argument after reviewing the top diagnosis codes for 36247 prior to the creation of the new LER codes and compared it to the newly established vignette for the 36247 and recognized that the patients described by the top diagnosis codes was significantly less intense than the patient described in the newly created vignette. Based on this premise, the RUC reviewed the survey data for this service and compared it to several reference codes including; MPC codes 58560 *Hysteroscopy, surgical; with division or resection of intrauterine septum (any method)* (work RVU = 6.99) and 31600 *Tracheostomy, planned (separate procedure* (work RVU = 7.17), code 34812 *Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral* (work RVU = 6.74), and code 43272 *Endoscopic retrograde cholangiopancreatography (ERCP); with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique* (work RVU = 7.38). MPC code 58560 is a low Medicare volume 000-day global code, but has the same intra time of 60 minutes and almost identical work RVU, however, moderate sedation is inherent for code 36247, but not for 58560. Code 31600 requires 20 minutes less intra time, however would require more overall time, reflected in the higher work RVU. The additional pre-time for general anesthesia for 31600 and post-time are offset by the difference in intra-time, making the similarity in work RVU appropriate in terms of total physician work. CPT code 43272 was considered a comparable service to 36247, although the intensity of 43272 was considered a higher than 36247.

The RUC also compared 36247 to similar service, code 34812 *Open femoral artery cut-down for delivery of endovascular prosthetic device* (work RVU = 6.74), performed frequently by vascular surgeons, requires 15 minutes less intra-service time than the surveyed code and therefore has a lower work RVU. The concurred that survey median physician work value and intra service time for 36247 maintains the proper rank order with these comparable services. **The RUC recommends a work RVU of 7.00 for CPT code 36247.**

Referral to CPT Editorial Panel:
The specialties explained that the survey data supports that moderate sedation is an inherent component of these services. **The RUC recommends that CPT Codes 36200, 36425, 36426, and 36247 be referred to the CPT Editorial Panel to be included in Appendix G.**

Practice Expense
The RUC recommends the revised practice expense direct inputs, in order to account for the inherency of moderate sedation in CPT Codes 36200, 36245, 36426, and 36247.

Open Arteriovenous Anastomosis (Tab 26)
Gary Seabrook, MD, (SVS); Robert Zwolak, MD, FACS (SVS); Christopher Senkowski, MD (ACS); Charles Mabry, MD (ACS)

In September 2007, the RUC's Relativity Assessment Workgroup identified CPT codes 36821 and 36825 as potentially misvalued through the Site-of-Service Anomaly screen. In 2008, the American College of Surgeons (ACS) and Society for Vascular Surgery (SVS) conducted a RUC survey for these services. The specialty societies indicated and the RUC agreed that code 36821 is not an inpatient service. In February 2009, the specialties presented code 36825 using a modified RUC survey instrument that included a question regarding site-of-service and visits on the day of the procedure. Following the RUC's recommendation, CMS included code 36821 as part of the 4th Five-Year Review and code 36825 in Table 16 of the 2011 Proposed Rule to re-review these services.

36821 ***Arteriovenous anastomosis, open; direct, any site (eg, Cimino type) (separate procedure)***
The RUC reviewed the previous rationale and physician work survey data for CPT code 36821. The RUC noted that, in 2008, the RUC recommended the median survey work RVU, with strong support from reference services, specialty survey data and a three-fold compelling evidence argument: 1) flawed Harvard valuation; 2) physician work for this service changed; and 3) fistula performance is now a Quality Performance Indicator. At this time, the RUC finds no additional compelling evidence to further change the current physician work value of this service.

The RUC reviewed the survey data from 32 vascular surgeons for CPT code 36821. The RUC agreed with the previous recommended pre-service time package 2B, difficult patient/straightforward procedure. At that time the specialty recommended and the RUC agreed that the positioning and scrub, dress and wait times should be slightly higher than the package to account for the additional time required to position and prepare for the procedure, due to the intricate vein mapping required to ensure the patient has adequate length and caliber donor vein conduit. The RUC agreed that the procedure requires 10 minutes of pre-service positioning time and 10 minutes of pre-service scrub dress and wait time. To justify the current value of this service, the specialty societies utilizing magnitude estimation compared code 36821 to the key reference service 36819 *Arteriovenous anastomosis, open; by upper arm basilic vein transposition* (Work RVU=14.47, intra-service time = 120 minutes). The survey respondents noted that the intensities and complexities of the key reference service and the surveyed code are nearly identical. The RUC agreed that the difference in intra-service times between the two services appropriately accounts for the work RVU difference between these two services. For further support the RUC compared code 36821 to MPC reference code 60220 *Total thyroid lobectomy, unilateral; with or without isthmusectomy* (work RVU = 12.37) and determined that the physician work is very similar and the intra-service time required to perform these services is the same, 90 minutes.

In 2008, the RUC determined that the median survey work RVU of 12.00, was justified by magnitude estimation in comparison to these reference services. CMS accepted the RUC recommended value for this service. Further, for 2010, this value was increased to 12.11 work RVUs based on the redistribution of RVUs from the CMS coverage

determination to no longer recognize the consultation services. Therefore, based on this history and magnitude estimation comparisons to the reference codes, the specialty societies agree and the RUC recommends that the current value of this service be maintained.

The RUC further analyzed the site-of-service data and post-operative visit data. The specialty societies and the RUC have always agreed that code 36821 is an outpatient procedure with same-day discharge. Although the RUC agreed with the specialty societies that significant discharge work is required, the RUC's formal policy for same-day discharge coding (0.5 x 99238) should be implemented. This proxy for work in the global period does not change the physician work relative value of the service which was determined by magnitude estimation and physician specialty survey data during the last RUC review. **The RUC recommends a work RVU of 12.11 for CPT code 36821.**

36825 ***Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); autogenous graft***

The RUC reviewed the previous rationale and physician work survey data for CPT code 36825. The RUC reviewed the survey results from 31 vascular and general surgeons and noted that in 2009, the RUC previously recommended the survey 25th percentile work RVU, with strong support from reference services, specialty survey data, and a two-fold compelling evidence argument: 1) flawed Harvard valuation and 2) physician work for this service changed. At this time, the RUC finds no additional compelling evidence to further change the current physician work value of this service.

The RUC considered the survey data in comparison to the MPC reference code selected by the specialty, 36819, *Arteriovenous anastomosis, open; by upper arm basilic vein transposition*, (work RVU = 14.47). The RUC agreed that the survey median work RVU of 18.00 was too high, but that the survey 25th percentile work RVU was appropriate. The RUC reviewed 36819 and noted that the reference service and the surveyed code contain identical intra-service times of 120 minutes. The specialty noted that there are two differences between 36825 and 36819 that warrant a higher RVU for 36825: 1) Code 36825 requires a vein that is harvested from a remote location. As a result, it requires two anastomoses, one where the vein is sewn to the inflow artery and a second where it is attached to the outflow vein. 2) Code 36825 includes an additional 99213 office visit. As a result, the RUC agreed that the survey 25th percentile work RVU of 15.00 for 36825 was appropriate in comparison to 36819. Further, for 2010, this value was increased to 15.13 work RVUs based on the redistribution of RVUs from the CMS coverage determination to no longer recognize the consultation services. Therefore, based on this history and magnitude estimation comparisons to the reference codes, the specialty societies agree and the RUC recommends that the current value of this service be maintained.

The RUC further analyzed the site-of-service data and post-operative visit data. According to the survey, the typical patient undergoes this procedure in the hospital (100%), is admitted or stays at least overnight in the hospital following surgery (74%) and received an Evaluation and Management service on the same date (61%). Given this data, the RUC enacted its policy to allocate the appropriate proxy for post-operative visits. Importantly, the RUC noted that the work involved in monitoring the typical patient post-operatively on the day of surgery is the same Evaluation and Management work whether the patient's status ends up inpatient or outpatient. Adjustments to the

allocation of post-operative visits are used as proxies and do not constitute changes to the physician work relative value of the service which was determined by magnitude estimation and physician specialty survey data during the last RUC review. **The RUC recommends a work RVU of 15.13 for CPT code 36825.**

Excise Parotid Gland-Lesion (Tab 27)
Christopher Senkowski, MD (ACS); Charles Mabry, MD (ACS); Wayne Koch, MD, (AAO-HNS)

In September 2007, the RUC's Relativity Assessment Workgroup (formerly Five-Year Review Identification Workgroup) identified CPT codes 42415 and 42420 as potentially misvalued through the Site-of-Service Anomaly screen. In October 2008, the American Academy of Otolaryngology - Head and Neck Surgery (AAO-HNS) and the American College of Surgeons (ACS) conducted a RUC survey, but RUC action was deferred on these services until an adequate survey instrument was developed to capture information about typical site of service and post-operative visits. In February 2009, the specialties presented these services using a modified RUC survey instrument that included a question regarding site-of-service and typical visits on the day of the procedure. CMS accepted the RUC's recommendation for these services. Following the RUC's recommendation, CMS included codes 42415 and 42420 in Table 16 of the 2011 Proposed Rule and asked the RUC to re-review these services.

42415 ***Excision of parotid tumor or parotid gland; lateral lobe, with dissection and preservation of facial nerve***
In 2009, the RUC determined that the current work RVU of 17.99 was justified by magnitude estimation in comparison to several reference services. CMS accepted the RUC recommended value for 42415. Further, for 2010, this value was increased to 18.12 work RVUs based on the redistribution of RVUs from the CMS coverage determination to no longer recognize the consultation services. The RUC reviewed the previous rationale and physician work survey data for CPT code 42415. The RUC noted that the RUC recommended the 2009 work RVU of 17.99 was further validated by the 25th percentile survey data, 18.00 work RVUs. The RUC also compared 42415 to the key reference service, 60271, *Thyroidectomy, including substernal thyroid; cervical approach*, (work RVU = 17.62, intra-time = 150 minutes). The RUC noted that both procedures require the same intra-time (150 minutes), and have analogous physician work and should be valued closely. The RUC agreed that the surveyed code was accurately valued during the February 2009 meeting, with strong support from the reference service and specialty survey data, and finds no compelling evidence to change the current physician work value of this service. The RUC also reviewed a table provided by the specialties that compares the survey code to many other RUC reviewed codes as further support that the current value for 42415 is appropriate Therefore, based on this history and magnitude estimation comparisons to reference codes, the specialty societies agree and the RUC recommended that the current value of this service be maintained.

Additionally, the RUC further analyzed the site-of-service data and post-operative visit data. Code 42415 is not typically same day surgery. Patients require close monitoring for airway patency, formation of hematoma, and facial nerve function and would be kept at least one night in the hospital. This was substantiated by the survey data which shows that the typical patient receives this procedure in the hospital (97%), stays at least overnight in the hospital following surgery (91%) and receives an Evaluation and Management service on the same date (53%). Given this data, the RUC enacted its policy

to allocate the appropriate proxy for the post-operative visits. Importantly, the RUC noted that whether the hospital admission criteria program designates this service outpatient or inpatient, the physician work at the bed of a patient in a hospital surgical ward to review the patient chart, take down dressings, examine the patient, write subsequent orders, and talk to the floor staff and the family is the same. Adjustments to the allocation of post-operative visits are used as proxies and do not constitute changes to the physician work relative value of the service which was determined by magnitude estimation and physician specialty survey data during the last RUC review. **The RUC recommends a work RVU of 18.12 for CPT code 42415.**

42420 ***Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve***

In 2009, the RUC determined that the current work RVU of 20.87, was justified by magnitude estimation in comparison to several reference services. CMS accepted the RUC recommended value for 42420. Further, for 2010, this value was increased to 21.00 work RVUs based on the redistribution of RVUs from the CMS coverage determination to no longer recognize the consultation services. The RUC reviewed the previous rationale and physician work survey data for CPT code 42420. The RUC noted that the RUC recommended the 2009 work RVU of 20.87 which was lower than the 25th percentile survey data, 23.36 work RVUs. The RUC agreed with the specialty society survey results regarding physician time and post-operative visits. The RUC compared code 42420 to MPC code 35141, *Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, common femoral artery (profunda femoris, superficial femoral),* (work RVU = 20.91, intra-time = 150 minutes). The RUC noted that the two services have comparable physician work, with similar total time, 427 minutes and 432 minutes, respectively and should be valued closely. The RUC also reviewed code 34471, *Thrombectomy, direct or with catheter; subclavian vein, by neck incision* (work RVU = 21.11 intra-service = 180) and noted that both procedures had the same intra-service time, 180 minutes, and the reference code supports the current work RVU. The RUC agreed that the surveyed code was accurately valued during the February 2009 meeting, with strong support from reference services and specialty survey data, and finds no compelling evidence to change the current physician work value of this service. . The RUC also reviewed a table provided by the specialties that compares the survey code to many other RUC reviewed codes as further support that the current value for 42420 is appropriate Therefore, based on this history and magnitude estimation comparisons to reference codes, the specialty societies agree and the RUC recommended that the current value of this service be maintained.

Additionally, the RUC further analyzed the site-of-service data and post -operative visit data. Code 42420 is not typically same day surgery. Patients require close monitoring for airway patency, hematoma formation, facial nerve function, and intervention for any noted deficits, drain function, and control of pain and nausea. This was substantiated by the survey data which shows that the typical patient receives this procedure in the hospital (100%), stays at least overnight in the hospital following surgery (97%) and receives an Evaluation and Management service on the same date (64%). Given this data, the RUC enacted its policy to allocate the appropriate proxy for the post-operative visits. Importantly, the RUC noted that patient facility status is not tied to physician work in the programs that assign patient facility status. Levels of physician work are accounted for by the level(s) of Evaluation and Management code(s) reported, not based on the facility resources utilized by a patient and facility payment system. Adjustments to the allocation

of post operative visits are used as proxies and do not constitute changes to the physician work relative value of the service which was determined by magnitude estimation and physician specialty survey data during the last RUC review. **The RUC recommends a work RVU of 21.00 for CPT code 42420.**

Needle Biopsy of Liver (Tab 28)
Zeke Silva, MD (ACR); Geraldine McGinty, MD (ACR)

In the 4th Five-Year Review of the RBRVS, CMS identified CPT code 47000 *Biopsy of liver, needle; percutaneous* as potentially misvalued through the Harvard Valued - Utilization over 30,000 Screen. The RUC carefully reviewed the work relative value of the service in October 2010 and recommended its value be maintained. In addition, at that time, the specialties explained that the survey data supported the fact that moderate sedation is an inherent component of this service. The RUC recommended that CPT Code 47000 be referred to the CPT Editorial Panel to be included in Appendix G. The inclusion of 47000 in CPT's Appendix G necessitates the inclusion of the direct practice expense inputs associated with moderate sedation, and therefore the RUC scheduled a review of the inputs at its February 2011 meeting.

In February 2011, the RUC carefully reviewed the specialty recommended typical clinical labor, medial supplies, and equipment for code 47000, and agreed upon the presented direct practice expense inputs to perform moderate sedation. **The RUC recommends the attached direct practice expense inputs for code 47000.**

Hernia Repair (Tab 29)
Christopher Senkowski, MD (ACS); Charles Mabry, MD (ACS); Michael Edye, MD, (SAGES)

In September 2007, the RUC's Relativity Assessment Workgroup (formerly Five-Year Review Identification Workgroup) identified CPT codes 49507, 49521 and 49587 as potentially misvalued through the Site-of-Service Anomaly screen. In October 2008, the American College of Surgeons (ACS) conducted a RUC survey, but RUC action was deferred on these services until an adequate survey instrument was developed to capture information about typical site of service and post-operative visits. In February 2009, the specialties presented these services using a modified RUC survey instrument that included a question regarding site-of-service and visits on the day of the procedure. CMS accepted the RUC's recommendation for these services. Following the RUC's recommendation, CMS included codes 49507, 49521 and 49587 in Table 16 of the 2011 Proposed Rule and asked the RUC to re-review these services.

49507 ***Repair initial inguinal hernia, age 5 years or over; incarcerated or strangulated***
The RUC reviewed the previous rationale and physician work survey data for CPT code 49507. In 2009, the RUC noted that the RUC recommended the 2009 work RVU of 9.97, which was slightly higher than the 25th percentile survey data. The RUC compared 49507 to the key reference service 49505, *Repair initial inguinal hernia, age 5 years or older; reducible* (work RVU = 7.96 intra-time = 70 minutes). The RUC noted that the while the two services have comparable physician work, the surveyed code should be valued higher due to greater total time, 260 minutes compared to 198 minutes. The RUC also compared 49507 to 54512, *Excision of extraparenchymal lesion of testis* (work RVU = 9.33 and intra-time = 70 minutes) and noted that the surveyed code has greater total time compared to the reference code, 260 minutes and 216 minutes, respectively and should be valued

higher. In 2010, the value for 49507 was increased to 10.15 work RVUs based on the redistribution of RVUs from the CMS coverage determination to no longer recognize the consultation services. The RUC also reviewed a table provided by the specialties that compares the survey code to many other RUC reviewed codes as further support that the current value for 49507 is appropriate. The RUC agreed that the surveyed code was accurately valued during the February 2009 meeting, with strong support from reference services and specialty survey data, and finds no compelling evidence to change the current physician work value of this service.

Additionally, the RUC further analyzed the site-of-service data and post-operative visit data for the surveyed service. Code 49507 is not typically same day surgery. The typical patient requires close monitoring for problems such as ileus, intestinal ischemia and urinary retention. Additionally, there will be significant pain post-operatively requiring management before discharge. The specialty noted, and the RUC agreed, that the shift in patient facility status for this service has nothing to do with healthier patients that require less physician work and everything to do with the recent OPPS changes related to facility reimbursement. This was substantiated by the survey data which shows that the typical patient receives this procedure in the hospital (98%), stays at least overnight in the hospital following surgery (83%) and receives an Evaluation and Management service on the same date (59%). Given this data, the RUC enacted its policy to allocate the appropriate proxy for the post-operative visits. Importantly, the RUC noted that the work involved in monitoring the typical patient post-operatively on the day of surgery is the same Evaluation and Management work whether the patient's facility status ends up inpatient or outpatient. Adjustments to the allocation of post-operative visits are used as proxies and do not constitute changes to the physician work relative value of the service which was determined by magnitude estimation and physician specialty survey data during the last RUC review. **The RUC recommends a work RVU of 10.15 for CPT code 49507.**

49521 ***Repair recurrent inguinal hernia, any age; incarcerated or strangulated***
The RUC reviewed the previous rationale and physician work survey data for CPT code 49521. In 2009, the RUC noted that the RUC recommended the 2009 work RVU for 12.36, which fell between the survey's 25th percentile and median work value estimates. The RUC compared 49521 to the key reference service, 49520, *Repair recurrent inguinal hernia, any age; reducible*, (work RVU = 9.99, intra-service time = 60 minutes). The RUC noted that the reference code contains 30 minutes less intra-service time and requires less intensity and complexity that the surveyed code. The RUC also compared 49521 to 49652, *Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible* (work RVU = 12.88, pre-time = 75, intra-time = 90, immediate post-time = 30) and noted that the two codes are similar and have identical intra- and immediate post-service time, but that the reference code has slightly more pre-service time accounting for the difference in work RVU. In 2010, the value for 49521 was increased to 12.44 work RVUs based on the redistribution of RVUs from the CMS coverage determination to no longer recognize the consultation services. The RUC also reviewed a table provided by the specialties that compares the survey code to many other RUC reviewed codes as further support that the current value for 49521 is appropriate. The RUC agreed that the surveyed code was accurately valued during the February 2009 meeting, with strong support from reference services and specialty survey data, and finds no compelling evidence to change the current physician work value of this service.

Additionally, the RUC further analyzed the site-of-service data and post-operative visit data. Code 49521 is not typically same day surgery. The typical patient requires close monitoring for problems such as ileus, intestinal ischemia and urinary retention. Additionally, there will be significant pain post-operatively requiring management before discharge. The specialty noted, and the RUC agreed, that the shift in patient facility status for this service has nothing to do with healthier patients that require less physician work and everything to do with the recent OPPS changes related to facility reimbursement. This was substantiated by the survey data which shows that the typical patient receives this procedure in the hospital (99%), stays at least overnight in the hospital following surgery (82%) and receives an Evaluation and Management service on the same date (55%). Given this data, the RUC enacted its policy to allocate the appropriate proxy for the post-operative visits. Importantly, the RUC noted that the work involved in monitoring the typical patient post-operatively on the day of surgery is the same Evaluation and Management work whether the patient's facility status ends up inpatient or outpatient. Adjustments to the allocation of post operative visits are used as proxies and do not constitute changes to the physician work relative value of the service which was determined by magnitude estimation and physician specialty survey data during the last RUC review. **The RUC recommends a work RVU of 12.44 for CPT code 49521.**

49587 ***Repair umbilical hernia, age 5 years or over; incarcerated or strangulated***
The RUC reviewed the previous rationale and physician work survey data for CPT code 49587. In 2009, the RUC noted that the RUC recommended the 2009 work RVU for 7.96, which was slightly below the survey's 25th percentile physician work value estimates. The RUC compared 49587 to the key reference service, 49585, *Repair umbilical hernia, age 5 years or older; reducible*, (work RVU = 6.59, intra- time = 45 minutes). The RUC noted that the reference service requires less intra-service time compared to the surveyed codes, 45 minutes and 60 minutes, respectively. Also, the reference code requires less intensity and complexity compared to the surveyed code and should be valued less. The RUC also compared 49587 to 49572, *Repair epigastric hernia (eg, preperitoneal fat); incarcerated or strangulated* (work RVU = 7.87, total time= 312 minutes). The RUC noted that while the reference code has greater total time, the surveyed code has greater intensity and complexity in the physician work and should be valued slightly higher. In 2010, the value for 48587 was increased to 8.04 work RVUs based on the redistribution of RVUs from the CMS coverage determination to no longer recognize the consultation services. The RUC also reviewed a table provided by the specialties that compares the survey code to many other RUC reviewed codes as further support that the current value for 49587 is appropriate. The RUC agreed that the surveyed code was accurately valued during the February 2009 meeting, with strong support from reference services and specialty survey data, and finds no compelling evidence to change the current physician work value of this service.

Additionally, the RUC further analyzed the site-of-service data and post-operative visit data. Code 49587 is not typically same day surgery. The typical patient requires close monitoring for problems such as ileus, intestinal ischemia, and urinary retention. Additionally, there will be significant pain post-operatively requiring management before discharge. The specialty noted, and the RUC agreed, that the shift in patient facility status for this service has nothing to do with healthier patients that require less physician work, but is due to the recent OPPS changes related to facility reimbursement. This was substantiated by the survey data which shows that the typical patient receives this procedure in the hospital (100%), stays at least overnight in the hospital following surgery (71%) and receives an Evaluation and Management service on the same date

(55%). Given this data, the RUC enacted its policy to allocate the appropriate proxy for the post-operative visits. Importantly, the RUC noted that the work involved in monitoring the typical patient post-operatively on the day of surgery is the same Evaluation and Management work whether the patient's facility status ends up inpatient or outpatient. Adjustments to the allocation of post operative visits are used as proxies and do not constitute changes to the physician work relative value of the service which was determined by magnitude estimation and physician specialty survey data during the last RUC review. **The RUC recommends a work RVU of 8.04 for CPT code 49587.**

Laparoscopic Hernia Repair (Tab 30)
Christopher Senkowski, MD (ACS); Charles Mabry, MD (ACS); Michael Edye, MD, (SAGES)

In June 2007, the CPT Editorial Panel created six new CPT codes to describe the specific levels of work associated with abdominal hernia repairs that are being performed frequently with laparoscopic techniques. This new type of surgery is different from the open repair of abdominal wall hernia that involves placement of mesh prosthesis on the surface of the muscle layers through the incision, whereas these new procedure codes describe the laparoscopic placement of the mesh behind the fascia and muscle layers, where it is affixed to the abdominal wall muscles. CMS accepted the RUC's recommendation for these services. In 2010, CMS submitted to the RUC four of the laparoscopic hernia repair codes, 49652, 49653, 49654 and 49655, as part of their request for services to be reviewed under the Fourth Five-Review that met the criteria for the Site-of-Service Anomaly screen.

49652 ***Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible***
The RUC reviewed the previous rationale and physician work survey data for CPT code 49652. The RUC noted that in 2007, the RUC recommended the survey's 25th percentile, 12.80 work RVUs which was a 12% reduction from the 2007 work value. The RUC compared 49652 to its key reference code 49560 *Repair initial incisional or ventral hernia; reducible* (work RVU = 11.92, intra-time= 90 minutes) and noted the surveyed code has more intra-service time, 100 minutes compared to 90 minutes. The RUC also understood that the mesh implantation requires additional work (valued at 4.88 RVUs), however in relation to code 49654 the value would have to be lower than the sum of its parts (11.92 RVUs from code 49560 plus 4.88 equals 16.80). The RUC therefore believed that the specialty society's 25th percentile survey results of 12.80 work RVUs reflected the true value for code 49652. In 2010, this value was increased to 12.88 work RVUs based on the redistribution of RVUs from the CMS coverage determination to no longer recognize the consultation services. The RUC also reviewed a table provided by the specialties that compares the survey code to many other RUC reviewed codes as further support that the current value for 49652 is appropriate. The RUC agreed that the surveyed code was accurately valued during the September 2007 meeting, with appropriate relativity across the family and strong support from reference services and specialty survey data, and finds no compelling evidence to change the current physician work value of this service.

Code 49652 is not typically same day surgery. Although, these laparoscopic procedures result in significantly lower incidence of incisional pain and morbidity related to the incision (compared with an open repair), these patients do have considerable postoperative pain from the fixation of the sensitive peritoneal surface and are typically

provided postoperative narcotics. Patients are also susceptible to post-operative ileus, and patients typically require hospital care. The RUC also noted that this procedure is considered a site-of-service anomaly based on one year of Medicare claims data (2009), indicating 35% inpatient. Given that this service was published in CPT just two years ago, Medicare claims data is still new and may not reflect accurate Medicare utilization for this procedure. Some providers may still be using the unlisted procedure code or an open procedure code with a modifier and report.

The specialties noted, and the RUC agreed, that the typical patients undergoing code 49652 require continued post-operative management by the surgeon on the day of the procedure and on subsequent days until the patient is discharged. This was substantiated by the survey data which shows that the typical patient receives this procedure in the hospital (100%), stays at least overnight in the hospital following surgery (84%) and receives an Evaluation and Management service on the same date (84%). Given this data, the RUC enacted its policy to allocate the appropriate proxy for the post-operative visits. Importantly, the RUC noted that the work involved in monitoring the typical patient post-operatively on the day of surgery is the same Evaluation and Management work whether the patient's facility status ends up inpatient or outpatient. Adjustments to the allocation of post-operative visits are used as proxies and do not constitute changes to the physician work relative value of the service which was determined by magnitude estimation and physician specialty survey data during the last RUC review. **The RUC recommends a work RVU of 12.88 for CPT code 49652.**

49653 ***Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated***
The RUC reviewed the previous rationale and physician work survey data for CPT code 49653. The RUC noted that in 2007, the RUC recommended the survey's 25th percentile, 16.10 work RVUs which was a 11% reduction from the 2007 work value. The RUC compared 49653 to key reference service 49566 *Repair recurrent incisional or ventral hernia; incarcerated or strangulated* (work RVU = 15.53) and determined that both require the same physician intra-service time of 120 minutes. However, the surveyed code is more intense and complex, therefore the 25th percentile survey work of 16.10 appropriately places this service in the proper rank order. In 2010, the value for 49653 was increased to 16.21 work RVUs based on the redistribution of RVUs from the CMS coverage determination to no longer recognize the consultation services. The RUC also reviewed a table provided by the specialties that compares the survey code to many other RUC reviewed codes as further support that the current value for 49653 is appropriate. The RUC agreed that the surveyed code was accurately valued during the September 2007 meeting, with appropriate relativity across the family and strong support from reference services and specialty survey data, and finds no compelling evidence to change the current physician work value of this service.

Code 49653 is not typically same day surgery. Although, these laparoscopic procedures result in significantly lower incidence of incisional pain and morbidity related to the incision (compared with an open repair), these patients do have considerable postoperative pain from the fixation of the sensitive peritoneal surface and are typically provided postoperative narcotics. Patients are also susceptible to post-operative ileus, and patients typically require hospital care. The RUC also noted that this procedure is considered a site-of-service anomaly based on one year of Medicare claims data (2009), indicating 39% inpatient. Given that this service was published in CPT just two years

ago, Medicare claims data is still new and may not reflect accurate Medicare utilization for this procedure. Some providers may still be using the unlisted procedure code or an open procedure code with a modifier and report.

The specialties noted, and the RUC agreed, that the typical patients undergoing code 49653 require continued post-operative management by the surgeon on the day of the procedure and on subsequent days until the patient is discharged. The typical patient will stay in the hospital for three calendar days and two nights. This was substantiated by the survey data which shows that the typical patient receives this procedure in the hospital (100%), stays at least overnight in the hospital following surgery (91%) and receives an Evaluation and Management service on the same date (91%). Given this data, the RUC enacted its policy to allocate the appropriate proxy for the post-operative visits. Importantly, the RUC noted that the work involved in monitoring the typical patient post-operatively on the day of surgery is the same Evaluation and Management work whether the patient's facility status ends up inpatient or outpatient. Adjustments to the allocation of post operative visits are used as proxies and do not constitute changes to the physician work relative value of the service which was determined by magnitude estimation and physician specialty survey data during the last RUC review. **The RUC recommends a work RVU of 16.21 for CPT code 49653.**

49654 ***Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible***
The RUC reviewed the previous rationale and physician work survey data for CPT code 49654. The RUC noted that in 2007, the RUC recommended the survey's 25th percentile, 14.95 work RVUs which was a 7% reduction from the current work value. The RUC compared 49654 to key reference service *44180 Laparoscopy, surgical, enterolysis (freeing of intestinal adhesion) (separate procedure)* (work RVU = 15.27) and determined that both services require similar physician time, intra-service of 120 minutes, and physician work to complete. Therefore, the RUC recommended the survey 25th percentile work RVU, 14.95 work RVUs. In 2010, this value was increased to 15.03 work RVUs based on the redistribution of RVUs from the CMS coverage determination to no longer recognize the consultation services. The RUC also reviewed a table provided by the specialties that compares the survey code to many other RUC reviewed codes as further support that the current value for 49654 is appropriate. The RUC agreed that the surveyed code was accurately valued during the September 2007 meeting, with appropriate relativity across the family and strong support from reference services and specialty survey data, and finds no compelling evidence to change the current physician work value of this service.

Code 49654 is not typically same day surgery. Although, these laparoscopic procedures result in significantly lower incidence of incisional pain and morbidity related to the incision (compared with an open repair), these patients do have considerable postoperative pain from the fixation of the sensitive peritoneal surface and are typically provided postoperative narcotics. Patients are also susceptible to postoperative ileus, and patients typically require hospital care. The RUC also noted that this procedure is considered a site-of-service anomaly based on one year of Medicare claims data (2009), indicating 37% inpatient. Given that this service was published in CPT just two years ago, Medicare claims data is still new and may not reflect accurate Medicare utilization for this procedure. Some providers may still be using the unlisted procedure code or an open procedure code with a modifier and report.

The specialties noted, and the RUC agreed, that the typical patients undergoing code 49654 require continued post-operative management by the surgeon on the day of the procedure and on subsequent days until the patient is discharged. The typical patient will stay in the hospital for three calendar days and two nights. This was substantiated by the survey data which shows that the typical patient receives this procedure in the hospital (100%), stays at least overnight in the hospital following surgery (90%) and receives an Evaluation and Management service on the same date (90%). Given this data, the RUC enacted its policy to allocate the appropriate proxy for the post-operative visits. Importantly, the RUC noted that the work involved in monitoring the typical patient post-operatively on the day of surgery is the same Evaluation and Management work whether the patient's facility status ends up inpatient or outpatient. Adjustments to the allocation of post operative visits are used as proxies and do not constitute changes to the physician work relative value of the service which was determined by magnitude estimation and physician specialty survey data during the last RUC review. **The RUC recommends a work RVU of 15.03 for CPT code 49654.**

49655 ***Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated***

The RUC reviewed the previous rationale and physician work survey data for CPT code 49655. The RUC noted that in 2007, the RUC recommended a direct crosswalk to CPT code 43280 *Laparoscopy, surgical, esophagogastric fundoplasty (eg, Nissen, Toupet procedures)* (work RVU=18.10), which fell between the survey's 25th percentile and median estimated physician work values. This represented a 10% reduction from the 2007 work value. In 2010, the value for 49655 was increased to 18.11 work RVUs based on the redistribution of RVUs from the CMS coverage determination to no longer recognize the consultation services. The RUC also reviewed a table provided by the specialties that compares the survey code to many other RUC reviewed codes as further support that the current value for 49655 is appropriate. The RUC agreed that the surveyed code was accurately valued during the September 2007 meeting, with appropriate relativity across the family and strong support from reference services and specialty survey data, and finds no compelling evidence to change the current physician work value of this service.

Code 49655 is not typically same day surgery. Although, these laparoscopic procedures result in significantly lower incidence of incisional pain and morbidity related to the incision (compared with an open repair), these patients do have considerable post-operative pain from the fixation of the sensitive peritoneal surface and are typically provided postoperative narcotics. Patients are also susceptible to post-operative ileus, and patients typically require hospital care. The RUC also noted that this procedure is considered a site-of-service anomaly based on one year of Medicare claims data (2009), indicating 45% inpatient. Given that this service was published in CPT just two years ago, Medicare claims data is still new and may not reflect accurate Medicare utilization for this procedure. Some providers may still be using the unlisted procedure code or an open procedure code with a modifier and report. Additionally, the RUC agreed with the specialty that almost 3% of the Medicare claims were from non-surgical specialties that could not perform the procedure.

The specialties noted, and the RUC agreed, that the typical patients undergoing code 49655 require continued post-operative management by the surgeon on the day of the procedure and on subsequent days until the patient is discharged. The typical patient will stay in the hospital for three calendar days and two nights. This was substantiated by the

survey data which shows that the typical patient receives this procedure in the hospital (100%), stays at least overnight in the hospital following surgery (95%), requires multiple days in the hospital (87%), and receives an Evaluation and Management service on the same day of the procedure (95%). Given this data, the RUC enacted its policy to allocate the appropriate proxy for the post-operative visits. Importantly, the RUC noted that the work involved in monitoring the typical patient post-operatively on the day of surgery is the same Evaluation and Management work whether the patient's facility status ends up inpatient or outpatient. Adjustments to the allocation of post-operative visits are used as proxies and do not constitute changes to the physician work relative value of the service which was determined by magnitude estimation and physician specialty survey data during the last RUC review. **The RUC recommends a work RVU of 18.11 for CPT code 49655.**

New Technology:
These services were placed on the Relativity Assessment Workgroup's New Technology List and will be re-reviewed by the RUC after Medicare utilization is more robust.

Urological Procedures (Tab 31)
James Giblin, MD (AUA)

In September 2007, the RUC's Relativity Assessment Workgroup (formerly Five-Year Review Identification Workgroup) identified CPT codes 53445 and 54410 as potentially misvalued through the Site-of-Service Anomaly screen. In February 2008, the American Urological Association (AUA) conducted a RUC survey and presented data that showed that the typical setting for this procedure was an inpatient hospital. CMS accepted the RUC's recommendation for these services. Following the RUC's recommendation, CMS included codes 53445 and 54410 in Table 15 of the 2011 Proposed Rule and asked the RUC to re-review these services. Prior to this meeting, the RUC approved a mini-survey instrument to be utilized by the specialty society that included questions regarding site-of-service and whether or not an Evaluation and Management service is performed on the same date of service as these questions were not on the original survey conducted by the specialty society in 2008.

53445 ***Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff***
The RUC reviewed the previous rationale and physician work survey data for CPT code 53445. The RUC noted that during the last review in 2008, the RUC removed the code from the Site-of-Service Anomaly Screen and recommended to maintain the 2008 physician work RVU of 15.21 for this service. As part of its re-review of code 53445, the RUC reviewed the specialty's mini-survey data to get an accurate portrayal of the typical site-of-service for this code. The specialty society indicated that the typical patient has had a radical prostatectomy and are kept in the hospital overnight in order to administer intravenous antibiotics and manage urethral catheters post-operatively. This was substantiated by the mini-survey data which shows that the typical patient receives the procedure in the hospital (98%), stays at least overnight in the hospital following surgery (82%) and receives an Evaluation and Management service on the same date (64%).

The RUC, and the specialty agreed, that the typical patient stays in the hospital one night and agreed that the post-operative hospital visits should be reduced to one. Given this data, the RUC enacted its policy to allocate the appropriate proxy for the post-operative visits. To arrive at a physician work value, the RUC reviewed the previous survey data

and agreed that the survey's 25th percentile of 13.00 work RVUs is the appropriate value for this service. To validate this recommended work RVU, the RUC reviewed CPT code 63030 *Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, including open and endoscopically-assisted approaches; 1 interspace, lumbar* (work RVU= 13.18 and intra time= 90 minutes). The RUC agreed that since this service has similar total time to code 53445, 342 minutes and 343 minutes respectively, the services should be valued similarly. Additionally, the RUC reviewed CPT code 27556 *Open treatment of knee dislocation, includes internal fixation, when performed; without primary ligamentous repair or augmentation/reconstruction* (work RVU= 13.00 and intra time= 90 minutes) and agreed that the surveyed code should be valued similarly to this service given the analogous total time 369 minutes and 343 minutes respectively.
The RUC noted that all post-operative visits for services reviewed by the RUC are used as proxies to account for the appropriate physician work involved in the global service of the code. The RUC work RVU was originally valued based off the specialty's 25th percentile survey data. The physician work, whether the typical patient is considered inpatient or outpatient, for this service is the same. **The RUC recommends a work RVU of 13.00 for CPT code 53445**

54410 ***Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session***
The RUC reviewed the previous rationale and physician work survey data for CPT code 54410. The RUC noted that the RUC recommended the 25th percentile specialty survey data of 15.00 work RVU during the last review. The RUC compared 54410 to reference service 54411 *Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue* (work RVU = 18.35 and intra-time= 180 minutes) and determined that 54411 is a more intense procedure and has greater intra-service time compared to the surveyed code, 180 minutes and 120 minutes, respectively. Therefore, the 25th percentile work RVU appropriately places this service in the proper rank order. In 2010, the value for code 54410 was increased to 15.18 work RVUs based on the redistribution of RVUs from the CMS coverage determination to no longer recognize the consultation services. The RUC agreed that the surveyed code was accurately valued, with strong support from reference services and specialty survey data, during the February 2008 meeting and finds no compelling evidence to change the current physician work value of this service.

As part of its re-review of code 54410, the RUC reviewed the specialty's mini-survey data to get an accurate portrayal of the typical site-of-service for this code. The specialty society indicated that the typical patient undergoes 30 minutes of immediate post-service care, at which point the physician rounds on them late in the day and the decision is made that the patient needs to stay in a monitored hospital setting overnight. This was substantiated by the mini-survey data which shows that the typical patient receives the procedure in the hospital (96%), stays at least overnight in the hospital following surgery (80%) and receives an Evaluation and Management service on the same date (64%). Given this data, the RUC enacted its policy to allocate the appropriate proxy for the post-operative visits.

The RUC noted that all post-operative visits for services reviewed by the RUC are used as proxies to account for the appropriate physician work involved in the global service of the code. The RUC work RVU was originally valued based off the specialty's 25th percentile survey data. The physician work, whether the typical patient is considered inpatient or outpatient, for this service is the same. **The RUC recommends a work RVU of 15.18 for CPT code 54410.**

Stereotactic Body Radiation Delivery (Tab 32)
David Beyer, MD (ASTRO); Michael Kuettel, MD, PhD (ASTRO); Najeeb Mohideen, MD (ASTRO); Gerald White, MS (ASTRO)

In September 2010, CPT codes 77373 *Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions* and 77435 *Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions* were identified by the RUC's Relativity Assessment Workgroup as services listed on the RUC's New Technology list in need of RUC review. Therefore, in February 2011 the RUC reviewed CPT code 77435 for physician work and its direct practice expense inputs, and 77373 only for its direct practice expense inputs, as it does not involve the work of a physician.

CPT codes 77373 and 77435 were initially reviewed by the RUC in April 2006 as new services. At that time, the RUC valued the physician work for CPT code 77435 at the specialty's survey median of 13.00 RVUs, which was accepted by CMS for CY 2007. In February 2011, the RUC agreed that the specialty survey results from 65 radiation oncologists was slightly overstated in the pre-service and post-service time periods by 10 minutes each. The RUC agreed then that the typical patient service involves 20 minutes pre-service evaluation and 20 minutes immediate post-service, rather than 30 minutes each, and 210 minutes of intra-service time. The RUC reviewed the physician work of the specialty's key reference service CPT code 77432 *Stereotactic radiation treatment management of cranial lesion(s) (complete course of treatment consisting of 1 session)* (work RVU = 7.92) in relation to code 77435, and agreed that 77435 involves more time as the physician is directing a large quantity of radiation at a respiratory continuously moving 3-4 centimeter tumor(s) and delivering an average of 4 high dose treatments with very high precision, which is understood to be a higher intensity service than directing radiation to a stationary cranial lesion. The dose per fraction (generated by the radiation delivery machine) is higher than the traditional dose per fraction that is typical for a 6 to 7 week conventional course of treatment. Therefore, the risk of toxicity is severe. In addition, the physician confirms the patient is placed into a body mold, to prevent movement, and the radiation delivery apparatus is moved around the patient prior to the radiation delivery in order to assure that there is no patient or other device interference (this activity is quite different than the separately billable service of 77290 *Therapeutic radiology simulation-aided field setting; complex* (work RVU = 1.56) and 77435 is not typically billed with 77290).

The RUC also reviewed the physician work of CPT code 77301 *Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications* (work RVU = 7.99, XXX, total time = 196 minutes), and understood that the work of 77435 in comparison to 77301 required more time to perform, 250 minutes and 196 minutes, respectively and required more overall physician work.

The RUC discussed the specialty society's survey results for CPT code 77435 and did not agree with the median survey results. The RUC agreed with the survey time results which suggested that the typical service time had decreased since the RUC's last evaluation due to efficiencies in this now mature technology. Using magnitude estimation, the committee agreed that the percentage change in the intra-service time from the first specialty survey to the current survey (230 minutes to 210 minutes, a 8.7% decrease) should be applied to the current physician work value of 13.00, resulting in a work value of 11.87. **The RUC recommends a work relative value of 11.87 for CPT code 77435. The RUC also recommends that CPT codes 77373 and 77435 be removed from the new technology list as the service is now mature.**

Practice Expense: The RUC carefully reviewed the practice expense recommendations for CPT code 77373 and 77435 and agreed the practice expense inputs for CPT codes 77373 and 77435 had not changed since the codes were created. However, the RUC agreed the specialty will provide current invoices from 5-6 different vendors for the equipment used in this procedure.

Special Stains (Tab 33)
Jonathan Myles, MD (CAP)

The special stains services were identified by the RUC's Relativity Assessment 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, present an alternative methodology to the Research Subcommittee for review, or present a code change proposal to the CPT Editorial Panel for their review. The College of American Pathologists (CAP) submitted a CPT coding proposal to revise the current descriptors of the special stains services to clarify the appropriate use of these codes. CAP conducted a standard RUC survey for each of the special stains services. The survey data demonstrates that the current work associated with these services is accurate and furthermore supports the specialty society's recommendation that there is no compelling evidence to change the current work of these services. However, as 88318 is being deleted and the utilization is shifting to another code, 88313, which has a lower work RVU, and the RUC understands that these recommendations will represent a work savings.

88312 ***Special stain including interpretation and report; Group I for microorganisms (eg, acid fast, methenamine silver)***
The RUC reviewed the survey data for 88312. The specialty society recommended and the RUC agreed that the surveyed time accurately reflects the service being performed. The RUC reviewed the surveyed code in comparison to 88334 *Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site* (Work RVU=0.73). The RUC noted that although the surveyed code has slightly more intra-service time as compared to the reference code, 24 minutes and 20 minutes, respectively, the reference code is a more intense service to perform as the survey respondents indicated in all of the intensity/complexity measures. Although the survey median for this service was 0.73 work RVUs, the specialty society recommended and the RUC agreed that there was no compelling evidence to change the current value for this service, 0.54 work RVUs. **Therefore, the RUC recommends a work RVU of 0.54 for CPT code 88312.**

88313 ***Special stain including interpretation and report; Group II, all other, (eg, iron, trichrome), except stain for microorganisms, stains for enzyme constituents, or immunocytochemistry and immunohistochemistry***
The RUC reviewed the survey data for 88313. The specialty society recommended and the RUC agreed that the surveyed time accurately reflects the service being performed. The RUC reviewed the surveyed code in comparison to 89060 *Crystal identification by light microscopy with or without polarizing lens analysis, tissue or any body fluid (except urine)* (Work RVU=0.37). The RUC noted that the surveyed code has slightly more intra-service time as compared to the reference code, 13 minutes and 10 minutes, respectively. Further, the surveyed code is a more intense service to perform as the survey respondents indicated in all of the intensity/complexity measures. The RUC also compared the surveyed code to another reference code 77083 *Radiographic absorptiometry (eg, photodensitometry, radiogrammetry), 1 or more sites* (Work RVU=0.20). The RUC noted that the surveyed code has more intra-service time in comparison to this reference code, 13 minutes and 10 minutes, respectively. Although the survey median for this service was 0.56 work RVUs, the specialty society recommended and the RUC agreed that there was no compelling evidence to change the current value for this service, 0.24 work RVUs. **Therefore, the RUC recommends a work RVU of 0.24 for CPT code 88313.**

88314 ***Special stain including interpretation and report; histochemical stain on frozen tissue block***
The RUC reviewed the survey data for 88314. The specialty society recommended and the RUC agreed that the surveyed time accurately reflects the service being performed. The RUC reviewed the surveyed code in comparison to 88334 *Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site* (Work RVU=0.73). The RUC noted that the surveyed code has less intra-service time as compared to the reference code, 13 minutes and 20 minutes, respectively. Further, the reference code requires more mental effort and judgment, technical skill and overall is a more intense service to perform in comparison to the surveyed code as indicated by the survey respondents. The surveyed 25th percentile for this service was 0.45 Work RVUs, which is the current work RVU. Based on these magnitude estimation comparisons and the specialty society recommendation that there was no compelling evidence to change the current value for this service, the RUC recommends maintaining the current value of this service. **The RUC recommends a work RVU of 0.45 for CPT code 88314.**

88319 Special stain including interpretation and report; Group III, for enzyme constituents
The RUC reviewed the survey data for 88319. The specialty society recommended and the RUC agreed that the surveyed time accurately reflects the service being performed. The RUC reviewed the surveyed code in comparison to 88334 *Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site* (Work RVU=0.73). The RUC noted that the surveyed code has slightly less intra-service time as compared to the reference code, 18 minutes and 20 minutes, respectively. Further, the reference code requires more mental effort and judgment, psychological stress and overall is a more intense service to perform in comparison to the surveyed code as indicated by the survey respondents. Although the survey median for this service was 0.75 work RVUs, the specialty society recommended and the RUC agreed that there was no compelling evidence to change the current value for this service, 0.53 work RVUs. **Therefore, the RUC recommends a work RVU of 0.53 for CPT code 88319.**

Practice Expense Inputs:
After the specialty society made several modifications, the RUC approved the clinical labor, supplies and equipment associated with special stains services.

Osteopathic Manipulative Treatment (Tab 34)
Joseph R. Schlecht, MD (AOA); Judith A. O'Connell, MD (AOA)
Facilitation Committee # 2

In the 4th Five-Year Review of the RBRVS, CMS identified codes 98925, 98928 and 98929 through the Harvard-Valued – Utilization over 30,000 screen. Additionally, the American Osteopathic Association (AOA) identified codes 98926 and 98927 to be reviewed as part of this family since these were also identified to be reviewed by the Relativity Assessment Workgroup through the Harvard-Valued – Utilization over 100,000. The AOA originally planned on requesting as global period change for these codes, however determined that it was unnecessary.

The RUC accepted the compelling evidence that these services were based on flawed methodology when established by Harvard. The original Hsiao study only provided one reference service, the original code values were derived form a combination of Harvard surveyed codes with crosswalks performed by Contractor Medical Directors (CMDs) and errors were made when the work values were crosswalked from the Harvard surveyed codes to the CMD valued codes.

The RUC had a robust discussion regarding Evaluation and Management codes being reported separately on the same day. The specialty society clearly indicated that the Evaluation and Management and the OMT procedure performed are separately identifiable procedures. The separate pre-service time for the OMT procedures include the physician explaining the regions to address and positioning. The separate post-service time for these procedures includes discussion of potential adverse effects, post procedure instructions and separate documentation. The specialty society reiterated that the descriptions of service for the OMT services do not describe work associated with an Evaluation and Management service.

98925 ***Osteopathic manipulative treatment (OMT); 1-2 body regions involved***
The RUC reviewed the survey results of 295 osteopathic physicians and compared the survey 25th percentile, 0.50 work RVU, to key reference service 99212 *Office visit, established patient* (work RVU = 0.48, 2 minutes pre, 10 minutes intra, and 4 minutes post-service time). The RUC agreed with the survey respondents that this service requires greater intensity and complexity for all the surveyed measures: mental effort and judgment, technical and physical effort, and psychological stress than 99212. The RUC noted that the intra-service time of 10 minutes and the total physician time of 16 minutes is identical to key reference service 99212. Therefore based on these comparisons, the survey 25th percentile work RVU of 0.50 reflects the accurate amount of physician work required to perform this service based on magnitude estimation.

The RUC specifically discussed the pre and post physician work associated with 98925 and determined that 3 minutes pre- and 3 minutes post-time were separate from the separately reportable Evaluation and Management service reported on the same day as the surveyed code . The pre-service and post-service time for the surveyed service requires explaining the regions to address, positioning, discussion of potential adverse

effects, post procedure instructions and separate documentation. To further support 3 minutes of immediate post-service time, the RUC referenced code 20552 *Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)* (work RVU = 0.66 and 3.5 minutes of post-service time) which is also typically performed with an Evaluation and Management visit on the same date of service. **The RUC recommends the survey 25th percentile work RVU of 0.50 for code 98925.**

98926 ***Osteopathic manipulative treatment (OMT); 3-4 body regions involved***
The RUC reviewed the survey results of 253 osteopathic physicians and determined that the survey 25th percentile work RVU of 0.75 provides the appropriate increment (0.25 work RVUs) and magnitude estimation between this family of services to account for the 5 additional minutes of intra-service time required for the additional body regions involved.

To further support the survey 25th percentile work RVU of 0.75 the RUC compared 98926 to similar services 43756 *Injection(s); single tendon origin/insertion* (work RVU = 0.77 and 15 minutes intra-service time) and 49424 *Contrast injection for assessment of abscess or cyst via previously placed drainage catheter or tube* (work RVU = 0.76 and 15 minutes intra-service time) and determined that these service require similar physician work and time.

The RUC agreed that the intra-service time of 15 minutes appropriately accounts for the time required to perform this service and places this service in the proper rank order among this family and similar services. The RUC specifically discussed the pre and post physician work and determined that 3 minutes pre-service and 3 minutes post-service time were separate from the Evaluation and Management service reported on the same day as the surveyed code. The pre-service and post-service time for the surveyed code requires explaining the regions to address, positioning, discussion of potential adverse effects, post procedure instructions and separate documentation. To further support 3 minutes of immediate post-service time, the RUC referenced code 20552 *Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)* (work RVU = 0.66 and 3.5 minutes of post-service time) which is also typically performed with an Evaluation and Management visit on the same date of service. **The RUC recommends the survey 25th percentile work RVU of 0.75 for code 98926.**

98927 ***Osteopathic manipulative treatment (OMT); 5-6 body regions involved***
The RUC reviewed the survey results of 233 osteopathic physicians and determined that a work RVU of 1.00 provides the appropriate increment (0.25 work RVUs) and magnitude estimation between this family of services to account for the 5 additional minutes of intra-service time required for the additional body regions involved. Additionally, the recommended work RVU of 1.00 is supported by the survey 25th percentile work RVU of 0.97.

To further support a work RVU of 1.00 the RUC compared 98927 to key reference service 99213 *Office visit, established patient* (work RVU = 0.97 and 15 minutes intra-service time) and MPC code 45330 *Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* (work RVU = 0.96 and 17 minutes intra-service time). The RUC agreed with the survey respondents that 98927 requires greater intensity and complexity for all the surveyed measures:

mental effort and judgment, technical and physical effort, and psychological stress than 99213. Therefore, the slightly higher 25th percentile work RVU of 1.00 provides the appropriate magnitude estimation.

The RUC agreed that the intra-service time of 20 minutes appropriately accounts for the time required to perform this service and places this service in the proper rank order among this family and similar services. The RUC specifically discussed the pre-service and post-service physician work and determined that 3 minutes pre-service time and 3 minutes post-service time were separate from the Evaluation and Management service reported on the same day as the surveyed code and requires explaining the regions to address and positioning, discussion of potential adverse effects, post procedure instructions and separate documentation. To further support 3 minutes of immediate post-service time, the RUC referenced code 20552 *Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)* (work RVU = 0.66 and 3.5 minutes of post-service time) which is also typically performed with an Evaluation and Management service. **The RUC recommends a work RVU of 1.00 for code 98927.**

98928 ***Osteopathic manipulative treatment (OMT); 7-8 body regions involved***
The RUC reviewed the survey results of 222 osteopathic physicians and determined that a work RVU of 1.25 provides the appropriate increment (0.25 work RVUs) and magnitude estimation between this family of services to account for the 5 additional minutes of intra-service time required for the additional body regions involved. Additionally, the recommended work RVU of 1.25 is supported by the survey 25th percentile work RVU of 1.29.

To further support a work RVU of 1.25 the RUC compared 98928 to key reference service 99214 *Office visit, established patient* (work RVU = 1.50 and 25 minutes intra-service time), MPC code 99238 *Hospital discharge day management; 30 minutes or less* (work RVU = 1.28) and similar service *45330 Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* (work RVU = 0.96 and 17 minutes intra-service time) and determined that these services require similar physician work and time.

The RUC agreed that the intra-service time of 25 minutes appropriately accounts for the time required to perform this service and places this service in the proper rank order among this family and similar services. The RUC specifically discussed the pre-service and post-service physician work and determined that 3 minutes pre and 3 minutes post-time were separate from the Evaluation and Management service reported on the same day as the surveyed code and requires explaining the regions to address and positioning, discussion of potential adverse effects, post procedure instructions and separate documentation. To further support 3 minutes of immediate post-service time, the RUC referenced code 20552 *Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)* (work RVU = 0.66 and 3.5 minutes of post-service time) which is also typically performed with an Evaluation and Management service. **The RUC recommends a work RVU of 1.25 for code 98928.**

98929 ***Osteopathic manipulative treatment (OMT); 9-10 body regions involved***
The RUC reviewed the survey results of 222 osteopathic physicians and determined that the survey 25th percentile work RVU of 1.50 provides the appropriate increment (0.25 work RVUs) and magnitude estimation between this family of services to account for the 5 additional minutes of intra-service time required for the additional body regions involved.

To further support the survey 25th percentile work RVU of 1.50 the RUC compared 98929 to key reference service 99214 *Office visit, established patient* (work RVU = 1.50 and 25 minutes intra-service time) and MPC codes 99238 *Hospital discharge day management; 30 minutes or less* (work RVU = 1.28) and 99232 *Subsequent hospital care, per day, for the evaluation and management the a patient* (work RVU = 1.39) and determined that these service all require similar physician work and time.

The RUC agreed that the intra-service time of 30 minutes appropriately accounts for the time required to perform this service and places this service in the proper rank order among this family and similar services. The RUC specifically discussed the pre-service and post-service physician work and determined that 3 minutes pre and 3 minutes post-time were separate from the Evaluation and Management service reported on the same day as the surveyed code and requires explaining the regions to address and positioning, discussion of potential adverse effects, post procedure instructions and separate documentation. To further support 3 minutes of immediate post-service time, the RUC referenced code 20552 *Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)* (work RVU = 0.66 and 3.5 minutes of post-service time) which is also typically performed with an Evaluation and Management service. **The RUC recommends the survey 25th percentile work RVU of 1.50 for code 98929.**

RUC Recommendation Summary

CPT Code	Rec wRVU	Eval	Posit	SDW	Intra	Immed Post
98925	0.50	2	1	0	10	3
98926	0.75	2	1	0	15	3
98927	1.00	2	1	0	20	3
98928	1.25	2	1	0	25	3
98929	1.50	2	1	0	30	3

Practice Expense:
The RUC recommends to remove the duplicate direct practice expense inputs for CPT codes 98925-98929: medical supplies SB022 gloves non-sterile, SB026 gown patient and SB037 pillow case, as these supplies are included in the Evaluation and Management service.

Observation Care (Tab 35)
Larry Martinelli, MD (ACP); Thomas Weida, MD (AADP); Alan Lazaroff, MD (AGS); Jennifer Wiler (ACEP)

In the 4th Five-Year Review of the RBRVS, CMS identified CPT codes 99218-99220 as potentially misvalued through the Harvard-Valued – Utilization Over 30,000 screen. The American College of Physicians (ACP) also submitted public comment identifying 99218-99220 to be reviewed in the 4th Five-Year Review. The American College of Emergency Physicians (ACEP) identified 99234-99236 as part of the family of services for RUC review as the valuation for 99234-99236 are based on 99218-99220.

In October 2010, the RUC reviewed and provided recommendations to CMS for codes 99218-99220. However, when the RUC reviewed the survey results for CPT codes 99234, 99235 and 99236, they agreed with the specialty societies that the survey results were flawed, as the time estimates were grossly inaccurate compared to the current times and among similar services. The RUC recommended that CPT codes 99234-99236 maintain the current work RVUs as interim and the specialty societies work with the Research Subcommittee to develop a survey to appropriately capture the work and time required to perform these services. The specialty societies utilized a RUC approved, modified survey instrument to resurvey 99234-99236.

In February 2011, the specialty societies indicated and the RUC agreed that there is compelling evidence demonstrating that the observation or inpatient care services (including admission and discharge services on the same date) were previously valued based on surveys by the specialties of Pediatrics and Emergency Medicine but now these services are primarily provided by Internal Medicine and Family Physicians. In 1997, the RUC previously established that codes 99234-99236 are equivalent to the value of the corresponding initial observation care codes (99218-99220) plus the value of a hospital discharge day service (99238). Since the RUC recommended new work RVUs for the corresponding initial observation codes in October 2010, the RUC determined that the observation or inpatient care services should be similarly reviewed.

99234 ***Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date***
In February 2011, the RUC reviewed the survey results from 50 internal medicine, family, geriatric and emergency physicians. The specialty societies indicated and the RUC agreed that survey results appeared flawed again. The specialty societies determined that the inability to accurately survey the physician time and work required to perform this service was due to the fact that observation same day admit/discharge services are typically performed by hospitalists (primarily internists) or emergency physicians who work in shifts. Therefore, the physician performing the admission is typically not the same physician who performs the discharge and the survey respondents were not including the physician time and work for both parts of the service.

The specialty societies indicated and the RUC agreed to use a similar methodology as was established to value these services in 1997, by taking the corresponding initial observation care code, 99218 *Initial observation care, per day, for the evaluation and management of a patient which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the*

problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to "observation status" are of low severity. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit. (RUC recommended work RVU = 1.92, pre-time = 10 minutes, intra-time = 30 minutes and post-time = 10 minutes) plus half the value of a hospital discharge day service, 99238 (work RVU = 1.28, pre-time = 8 minutes, intra-time = 20 minutes and post-time = 10 minutes) which appropriately accounts for the physician work and time required to perform this service. Therefore, for CPT code 99234, the RUC recommends maintaining the work RVU of 2.56 as using the aforementioned methodology produces the same result. The RUC also agreed with the specialty societies that to appropriately capture the physician time requires the same methodology, taking the time associated with a 99218 and half the time associated with a 99238. For additional support to the value of 2.56, the RUC noted that key reference service 99221 *Initial hospital care evaluation and management* (work RVU = 1.92) and MPC codes 99204 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 2.43) 99222 *Initial hospital care evaluation and management* (work RVU = 2.61) are similar services and maintain the relativity between these services. **The RUC recommends maintaining the current work RVU of 2.56 for CPT code 99234.**

CPT Code	Pre-Eval	Intra	Immed Post	work RVU
99218	10	30	10	1.92
+ ½ 99238	4	10	5	0.64
99234	**14**	**40**	**15**	**2.56**

99235 ***Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date***
The RUC reviewed the survey results from 33 internal medicine, family, geriatric and emergency physicians. The specialty societies indicated and the RUC agreed that survey results appeared flawed again. The specialty societies determined that the inability to accurately survey the physician time and work required to perform this service was due to the fact that observation same day admit/discharge services are typically performed by hospitalists (primarily internists) or emergency physicians who work in shifts. Therefore, the physician performing the admission is typically not the same physician who performs the discharge and the survey respondents were not including the physician time and work for both parts of the service.

The specialty societies indicated and the RUC agreed to use a similar methodology as was established to value these services in 1997, by taking the corresponding initial observation care code, 99219 *Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to "observation status" are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit.* (RUC recommended work RVU = 2.60, pre-time = 10 minutes, intra-time = 40 minutes and post-time = 14.5 minutes) plus half the value of a

hospital discharge day service, 99238 (work RVU = 1.28, pre-time = 8 minutes, intra-time = 20 minutes and post-time = 10 minutes) which appropriately accounts for the physician work and time required to perform this service. Therefore, for CPT code 99235, the RUC recommends a work RVU of 3.24. The RUC also agreed with the specialty societies that to appropriately capture the physician time requires the same methodology, the time associated with a 99219 and half the time associated with a 99238. For additional support to the value of 3.24, the RUC noted that key reference service 99222 *Initial hospital care evaluation and management* (work RVU = 2.61) and MPC codes 99205 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 3.17) and 99223 *Initial hospital care evaluation and management* (work RVU = 3.86) are similar services and maintain the relativity between these services. **The RUC recommends a work RVU of 3.24 for CPT code 99235.**

CPT Code	Pre-Eval	Intra	Immed Post	work RVU
99219	10	40	14.50	2.60
+ ½ 99238	4	10	5	0.64
99235	**14**	**50**	**19.50**	**3.24**

99236 ***Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date***
The RUC reviewed the survey results from 33 internal medicine, family, geriatric and emergency physicians. The specialty societies indicated and the RUC agreed that survey results appeared flawed again. The specialty societies determined that the inability to accurately survey the physician time and work required to perform this service was due to the fact that observation same day admit/discharge services are typically performed by hospitalists (primarily internists) or emergency physicians who work in shifts. Therefore, the physician performing the admission is typically not the same physician who performs the discharge and the survey respondents were not including the physician time and work for both parts of the service.

The specialty societies indicated and the RUC agreed to use a similar methodology as was established to value these services in 1997, by taking the corresponding initial observation care code, 99220 *Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to "observation status" are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit.* (RUC recommended work RVU = 3.56, pre-time = 15 minutes, intra-time = 45 minutes and post-time = 15 minutes) plus half the value of a hospital discharge day service, 99238 (work RVU = 1.28, pre-time = 8 minutes, intra-time = 20 minutes and post-time = 10 minutes) appropriately accounts for the physician work and time required to perform this service. Therefore, for CPT code 99236, the RUC recommends a work RVU of 4.20. The RUC also agreed with the specialty societies that to appropriately capture the physician time requires the same methodology, the time associated with a 99220 and half the time associated with a 99238. For additional support to the value of 4.20, the RUC noted that key reference service 99223 *Initial hospital care evaluation and*

management (work RVU = 3.86) and MPC codes 99255 *Inpatient consultation for a new or established patient* (work RVU = 4.00) and 99285 *Emergency department visit for the evaluation and management of a patient* (work RVU = 3.80) are similar services and maintain the relativity between these services. **The RUC recommends a work RVU of 4.20 for CPT code 99236.**

CPT Code	Pre-Eval	Intra	Immed Post	work RVU
99220	15	45	15	3.56
+ ½ 99238	4	10	5	0.64
99236	**19**	**55**	**20**	**4.20**

Diagnostic Cardiac Catheterization (Tab 36)

In the 2010 Final Rule, CMS requested that the RUC reexamine the diagnostic cardiac catheterization family of services as quickly as possible and put forward an alternative approach to valuing these services that would produce relative values that are resource-based and do not rely predominantly on the current component service values in a circular rationale. A RUC Workgroup was formed to work with the specialty society on analyzing the budget neutrality information relating to the history of the services' valuation to determine if there are resulting efficiencies in the 2011 bundled services.

The Workgroup requested the following from the specially society:

1. **The Workgroup requests that the specialty society provide the Workgroup the valuation history for all of the new bundled cardiac catheterization services utilizing the above format. Further, the Workgroup requests that the specialty society provide the Workgroup the historical service times for the bundled cardiac catheterization services.**
2. **The Workgroup requests that the specialty societies provide information supporting this shift in patient population to the Workgroup to further validate the RUC recommended values for these services.**
3. **The Workgroup requests that the specialty societies review pre, post and intraservice work for each of the bundled codes, to help determine what duplication might be present when services are bundled.**
4. **The Workgroup requests that the specialty societies provide alternative reference codes to support the RUC recommended values for each of the bundled diagnostic cardiac catheterization services.**

The specialty society will meet with the Workgroup to present their response to these requests via conference calls between the February and April RUC Meetings. At the April RUC Meeting, the RUC will receive a report from the Workgroup with its recommendations.

XI. Practice Expense Subcommittee Report (Tab 37)

Doctor Moran reported that the Practice Expense Subcommittee reviewed direct practice expense inputs and made recommendations for over 40 CPT codes.

The Subcommittee also discussed the work of its two workgroups; the Migration of Radiologic Images from Film to Digital Workgroup and the Direct Input Expense for Moderate Sedation Workgroup. The Subcommittee received a update from the American College of Radiology (ACR) regarding their recent efforts in developing the direct inputs of digital imagery and the Subcommittee looks forward to additional information from the society.

The Direct Input Expense for Moderate Sedation Workgroup reported they had reviewed the existing direct inputs for moderate sedation in the non-facility setting and recommended three additional equipment items. The Subcommittee agreed with the additional items and asked that within the RUC's next comment letter to CMS that the cost of emergency only equipment (such as a crash cart), be considered as direct costs if they are not currently covered in CMS' practice expense methodology under as indirect costs.

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

XII. Administrative Subcommittee (Tab 38)

Administrative Subcommittee

1. **Development of Standard Spreadsheet for RUC Recommendations**
   Dale Blasier, MD, informed the RUC that in October 2010, a RUC member requested that the RUC develop a standard spreadsheet to summarize survey results when a specialty society is presenting two or more codes. **The Subcommittee determined that specialty societies are required to provide a summary spreadsheet for all code recommendations. RUC staff will develop a standard summary spreadsheet and distribute with the survey packet.** The summary spreadsheet is attached to these minutes in the full Administrative Subcommittee report.

2. **Review of Appeals Process**
   Doctor Blasier indicated that the RUC Chair requested that the Administrative Subcommittee review the RUC Rules and Procedures Appeals Process for Reconsideration of RUC Recommendations. During the appeal of a code from the April 2009 RUC meeting, the American Academy of Ophthalmology (AAO) questioned the clarity of Section II A.

   The Administrative Subcommittee reviewed the appeals process for reconsideration of RUC recommendations and revised as indicated below:

II. **Appeals Process for Reconsideration of RUC Recommendations**

A. Requests for reconsideration at a RUC meeting will follow the standard *Sturgis, Standard Code of Parliamentary Procedures*.

B. If a specialty requests an appeal of a RUC recommendation made at the previous RUC meeting, the Chair will appoint an Ad Hoc Facilitation Committee as in Section I.F.3., with the exception of I.F.3.d. If time permits, the RUC will hold the relevant portion of the final recommendation of the RUC while the reconsideration process continues.

C. All appeals of RUC decisions shall be in writing, subsequent to the previous meeting and prior to the next meeting.

D. The Ad Hoc Facilitation Committee shall meet in person or by telephone conference within two weeks, when possible, of receipt of a written request for an appeal.

E. The Ad Hoc Facilitation Committee shall invite appellants to meet with the Ad Hoc Facilitation Committee in person or by telephone to discuss the rationale for RUC decisions or to provide written comments.

F. The Ad Hoc Facilitation Committee will notify anyone individuals or specialty societies who previously provided written comments commented on an issue under appeal and elicit further comments.

G. The Ad Hoc Facilitation Committee shall vote to recommend to the RUC whether the RUC should reconsider its previous recommendation and, if so, shall develop a new recommendation for consideration by the RUC. If the Ad Hoc Committee determines not to reconsider a RUC recommendation, no further RUC action is taken.

H. The Ad Hoc Facilitation Committee shall provide its recommendation for reconsideration to the AMA for distribution to the RUC at least two weeks prior to the next meeting of the RUC and shall communicate to all relevant parties in a timely manner. A recommendation not to reconsider can be submitted any time prior to the RUC meeting.

I. An appeal request of a RUC recommendation submitted less than two weeks prior to an upcoming RUC meeting will be deferred to the subsequent RUC meeting to permit at least two weeks notice to all parties.

J. In the event the RUC reconsiders an action by this appeal process, the RUC decision will be final.

K. Approval of reconsideration of a vote RUC recommendation, which required a two-thirds majority shall itself require a two-thirds approval.

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

XIII. Multi-Specialty Points of Comparison Workgroup (Tab 39)

Doctor Burd reviewed the work of the MPC Workgroup as it begins a systematic review/restructuring of the MPC list. The Workgroup is developing methods and criteria that will lead to the establishment of a list of services that are cross specialty and reflect relativity across services. The Workgroup is seeking to run queries to find relationships between specialties and services that were not apparent before and to then applies these relationships into a cross-specialty MPC list.

The RUC discussed the value of the current MPC list now that most of the CPT codes in the RBRVS have RUC valuation. The Chair made it clear that the MPC Workgroup is currently looking at the MPC list in terms of adding services that are cross-specialty (performed by multiple specialties many times) rather than looking at codes that are just deemed appropriately valued by the RUC. There was agreement that an MPC list made up of cross-specialty services is more useful for valuation than the current methodology.

The members will be meeting on conference calls prior to the April 2011 meeting and continue to refine the criteria and services to be included in this cross-specialty list.

The RUC filed the Multi-Specialty Points of Comparison Workgroup report which is attached to these minutes.

XIV. Research Subcommittee (Tab 40)

Doctor Brenda Lewis presented the Subcommittee report to the RUC.

1. **Specialty Society Request: Molecular Pathology (88XX1-88XX28)**
   College of American Pathologists

   The Research Subcommittee reviewed and approved the request for the College of American Pathologists to present both Tier 1 and 2 services at the April 2011 RUC Meeting. The Subcommittee also recommended the attached description of service be utilized within the instrument used to survey these codes.

2. **Identification of Extant Databases**
   The Subcommittee also continued its identification of extant databases. Five additional extant databases were identified by specialty societies. Doctor Lewis noted that if the specialty societies who identified these databases would like to use these databases in accordance with RUC policy, they would have to make a formal presentation to the Research Subcommittee to determine if they meet the RUC's Inclusionary/Exclusionary Criteria for Extant Databases.

3. **Evaluation of NSQIP and STS Database to the RUC Extant Data Criteria**
   The Subcommittee evaluated two extant databases to determine if they meet the RUC's extant data criteria.
   1. NSQIP: **Based on lack of data, the Research Subcommittee recommends that the NSQIP database currently does not meet the RUC's inclusionary/ exclusionary criteria for extant databases.**

2. STS Database: **The Subcommittee recommended that the STS Database met the RUC's Inclusionary/Exclusionary Criteria to be used in accordance with current RUC policy. Further, the Research Subcommittee recommends that the specialty society at the next Research Subcommittee meeting present a proposal for when this information should be presented with the specialty societies' recommendations.**

4. RUC Survey Process – Informational Item

AMA Market Research is currently developing an online survey tool for specialties to use when conducting RUC surveys. The Research Subcommittee will be reviewing the online survey content prior to the April 2011 meeting. The specialty societies will be education on the survey process at the September 2011 RUC meeting, with full implementation expected to be complete in time for the January 2012 RUC meeting.

5. IWPUT Presentation -

American Academy of Ophthalmology

The American Academy of Ophthalmology gave a presentation to the Research Subcommittee regarding their concerns about the use of IWPUT in the RUC process. **The Research Subcommittee reaffirms the current RUC policy pertaining to IWPUT:**

IWPUT should be used only as a measure of relativity between codes or in families of codes. IWPUT is a complimentary measure and should not be used as the sole basis for ranking or the assignment of value to a service. IWPUT may be used to validate survey data.

6. 23+ Hour E/M – Proxy Discussion

The Research Subcommittee reviewed a letter from several surgical specialties questioning the appropriate proxy to be used for when a separate evaluation and management visit is performed later on the same day of surgery.

As the Research Subcommittee agreed that the introduction of the subsequent observation codes into the Fee Schedule in 2011 allow for a more accurate measure of work for these 23+ hour stay services, the Research Subcommittee recommends that the appropriate proxy for a separate evaluation and management visit performed later on the same day of surgery is the subsequent observation codes, 99224-99226.

Further, the Research Subcommittee discussed the appropriate proxies for discharge management. At the October 2010, RUC Meeting, the RUC approved the following policy pertaining to discharge service code assignments**, 0.5 x 99238 (or 0.5 x 99217) for <u>same-day</u> discharge and 1.0 x 99238 (or 1.0 x 99217) for discharge on a day <u>subsequent</u> to the day of a procedure. The Research Subcommittee recommends that the 99217 service be added to the survey instrument and summary of recommendation form.**

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

XV. Relativity Assessment Workgroup (Tab 41)

1. Low Value/Billed in Multiple Units Screen

Walter Larimore, MD indicated that Workgroup reviewed the 12 services CMS identified that have high multiple services, that are typically performed in multiples of 5 or more per day, and have work RVUS of less than or equal to 0.50 RVUs. The Workgroup determined for 6 codes, the RUC assumed number of units when valuing these services are the same or similar to the CMS mean number of units. Additionally, these 6 services (11101, 17003, 76000, 88300, 95148 and 95904) were not commonly billed 5 times or more per day (over 50% of the time), therefore, did not meet the CMS criteria screen as indicated.

The Workgroup determined that the 6 remaining services commonly billed 5 times or more per day (over 50% of the time) be examined. The RUC requested that the specialty societies that perform the low value/billed in multiple unit codes identified, provide an action plan in Feb 2011 to the Workgroup on how to address these services (codes 95004, 95010, 95015, 95024, 95027, 95144). **The Workgroup reviewed the action plans from the specialty societies and recommends the following:**

CPT Code	Recommendation
95004	Reaffirmed RUC recommendation. The RUC recommended comparison code 99212 (0.48) divided by the number of RUC assumed units, 40, or the CMS mean number of units, 50, both result in a work RVU of 0.01. Additionally, the RUC appropriately divided the physician time by the typical number of units.
95010	Resurvey, as physician times are not representative of the number of units typically performed and Refer to CPT Assistant to publish an article to ensure proper coding
95015	Resurvey, as physician times are not representative of the number of units typically performed and Refer to CPT Assistant to publish an article to ensure proper coding
95024	Review practice expense in April 2011. Reaffirmed RUC recommendation for work. The RUC recommendation established an RVU of 0.12 for a battery of 12 tests resulting in 0.01 work RVU (identical to 95004 and 95027). The specialty indicated and the Workgroup agreed that it is reasonable to suggest that if the RUC assumed typical number of tests were 17 at the time of valuation, an RVU of 0.17 would similarly been established for the battery of tests still resulting in a work RVU of 0.01. Additionally, the RUC appropriately divided the physician time by the typical number of units.
95027	Reaffirmed RUC recommendation. The RUC recommended comparison code 99212 (0.48) divided by the number of RUC assumed units, 45, or the CMS mean number of units, 40, both result in a work RVU of 0.01. Additionally, the RUC appropriately divided the physician time by the typical number of units.
95144	Reaffirmed RUC recommendation. The Workgroup determined that the RUC assumed number of units, 6, and CMS mean number of units, 6.8, would not result in a different work RVU than the recent RUC recommended work RVU of 0.06. Additionally, the physician time of 3 minutes is appropriate as this is antigen therapy service is different than the battery of allergy tests reviewed above.

2. **Low Value/High Volume Screen**
   Doctor Larimore indicated that CMS requested the RUC review 24 services that have low work RVUs (less than or equal to 0.25) and high utilization. In October 2010, the Workgroup questioned the criteria CMS used to identify these services as it appeared some codes may be missing from the screen criteria indicated. The Workgroup recommended identification of codes with a work RVU 0.50 or below and Medicare utilization of 1 million or more (excluding codes with a 0.00 work RVU). Based on these criteria, 61 codes were identified, 16 of which have already been identified by another Relativity Assessment screen. Additionally, 6 of the 24 codes identified by CMS did not meet the over 1 million utilization criteria (codes 72040, 73310, 73130, 73620, 92543 and 93701).

   The Workgroup reviewed the list of codes and recommends to remove the codes already identified by another relativity assessment screen and reaffirm the RUC recommendations for all RUC reviewed codes. The Workgroup determined that the remaining five "CMS/Other" source codes should be resurveyed (codes 72170, 73030, 72040, 73620 and 93971). Two codes, G0101 and G0283, were identified by the Workgroup expanded criteria of codes with a work RVU of 0.50 or below and Medicare utilization of 1 million or more. **Since CMS did not identify these codes, the Workgroup recommends submitting a letter to CMS requesting their preference regarding a RUC review of these services. Additionally, as part of this screen CMS identified code 93701 which has a work RVU of 0.00. The Workgroup recommends that 93701 be removed from this screen as it has zero work RVUs.**

   A Workgroup member noted that any "CMS/Other" source codes would not have been flagged in the Harvard only screens, **therefore the Workgroup recommends that a list of all "CMS/Other" codes be developed and reviewed at the April 2011 meeting.**

3. **Site-of-Service Re-review Criteria**
   The Workgroup discussed the inpatient threshold percentage for re-reviewing codes regarding site-of-service and recommends maintaining the current 50% or less inpatient threshold. The Workgroup agreed and recommends that <u>three</u> consecutive years of data indicating 50% or less inpatient each year, is appropriate in order to eliminate any annual fluctuations in the claims data.

4. **MPC List Discussion**
   Doctor Larimore indicated that the Workgroup reviewed the CMS identified MPC List of codes to review at the October 2010 meeting and noted that 6 of the 33 codes have been identified by another screen and have been re-reviewed by the RUC in the last two years, leaving 27 newly identified codes. In the *Final Rule for 2011,* CMS indicated that one of the rationale for review of MPC services was that the code was not reviewed by the RUC in the last 6 years. The Workgroup noted that 17 of the 27 services have been reviewed by the RUC in the last 6 years. **The Workgroup reaffirmed the RUC recommendation for the 17 MPC codes that were reviewed by the RUC in the last 6 years. For the remaining 10 MPC codes identified, the Workgroup requests that the specialty societies submit an action plan or survey for April 2011 (codes 11056, 11721, 31231, 43239, 45380, 45385, 73721, 77003, 92980 and 94060).**

5. **Review Compelling Evidence Standards**
   Doctor Larimore stated that the Workgroup reviewed the compelling Evidence Standards since CMS is no longer accepting rank order anomalies as the sole compelling evidence to review/revise a code. **The Workgroup recommends reaffirming the rank order anomaly compelling evidence standard.** However, CMS does not accept rank order anomaly as the sole basis for compelling evidence. **The Workgroup recommends adding the following parenthetical to the compelling evidence standards: (CMS does not accept rank order anomaly as the sole basis for compelling evidence).** The Workgroup noted that the Harvard Valued screen started with a utilization of 1 million or more, then was expanded to 100,000 or more and most recently 30,000 or more. **The Workgroup recommends that staff develop a list of how many Harvard Value codes remain and will discuss this list at the April 2011 meeting. The Workgroup also recommends that staff analyze all the Harvard Valued codes with utilization over 30,000 that have been reviewed by the RUC and compare to the original Harvard valuation to assess the results of this review.**

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

XVI. Health Care Professional Advisory Committee (Tab 42)

1. **CMS Overview: Multiple Procedure Payment Reduction (MPPR) "Always Therapy" Policy**
   Emily Hill, PA-C, indicated the HCPAC met to discuss issues in the *Final Rule*. Many HCPAC societies voiced concern regarding the "Always Therapy" policy reducing the practice expense payment for therapy services performed by the same practitioner on the same date of service by 25 percent. The HCPAC members are concerned about the inconsistencies in addressing these services. Previously, CMS referred issues to the HCPAC for re-review of work and practice expense instead of applying an arbitrary reduction, when there was a concern regarding a potential overall in services. The HCPAC indicated that it welcomes any CMS referred re-review and prefers to vet any issues through the HCPAC Review Board process.

2. **CMS Acceptance of HCPAC Recommendations**
   Ms. Hill noted that the HCPAC is also concerned not only with the rate HCPAC recommendations that are rejected but also with the magnitude difference between the HCPAC recommended values and CMS final values. The HCPAC was also concerned that the CMS rationale for rejecting proposed HCPAC values lacked sufficient support and explanation. The HCPAC noted that they submit recommendations based on valid survey data with support from similar reference codes. The HCPAC outlined its specific concerns for the 2011 interim final values in its December 20, 2010 comment letter to CMS.

3. Other Issues

- Ms. Hill indicated that a call for individuals who wish to run for the HCPAC Co-Chair and Alternate Co-Chair will be sent following this meeting. Elections will occur at the April 2011 meeting for the term September 2011-May 2013.

- The HCPAC discussed that due to the low number of codes many HCPAC specialties provide, it is difficult to develop reference service lists when most or all the codes typically performed are being surveyed. **The HCPAC will discuss methods to develop appropriate reference service lists at the April 2011 meeting.**

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

XVII. Other Issues

- A RUC member recommended that a workgroup be developed to review codes where a global period change would be appropriate (i.e. 010 to 000 day global). The Workgroup will be formed during the CPT 2013 cycle.

The meeting adjourned on Saturday, February 5, 2011 at 6:00 pm.

AMA/Specialty Society RVS Update Committee **TAB 37**
Practice Expense Subcommittee Report
Thursday, February 03, 2011

Members present: *Doctors Bill Moran (Chair), Joel Brill (Vice Chair), Joel Bradley, Ron Burd,, Bill Gee, Peter Hollmann, Howard Lando, Bill Mangold, Lee Mills, Guy Orangio Chad Rubin, Robert Stomel, Susan Spires, and Eileen Carlson, JD, PhD, RN.*

Relative Value Recommendations for CPT 2012 New and Revised Services:

Lumbar Arthrodesis Codes (2261X & 2261X1) 4
The Subcommittee made no revisions to the direct practice expense inputs recommended by the specialty for these procedures performed in the facility setting.

Bone Marrow Stem Cell Revisions (38208, 38209, 38230, 3823X1 &38240) 5
The Subcommittee agreed that there were no direct inputs in the facility nor the non-facility settings as recommended by the specialty.

Electronic Analysis Implanted Pump (62367, 6236X2 & 6236X3) 7
The Subcommittee had an extensive discussion concerning the typical patient service and made revisions to the direct practice expense inputs recommended by the specialties. Clinical labor was refined after considerable discussion and comparison to the direct practice expenses of existing chemotherapy services.

Spine Codes Revision (72100, 72110, 72114 & 72120) 9
The Subcommittee discussed at length the radiologic examination services under review. The Subcommittee agreed with a most of the recommended direct inputs and made minor edits to those within CPT code 72120.

CTA Abdomen and Pelvis (7417XX) 10
The Subcommittee reviewed the direct inputs presented, made one edit to the equipment, and accepted the recommendation as presented.

Intraoperative Radiation Treatment Delivery and Management 11
(774X1-774X3 & 77470)
The Subcommittee reviewed the recommended direct inputs from the specialty in detail and made a slight reduction in the clinical labor time in the facility setting. This procedure is typically performed in the facility only and therefore there were no inputs recommended in the non-facility setting.

Hepatobiliary System Imaging (782X1 & 782X2) 12
The Subcommittee carefully reviewed the direct practice expense inputs recommended by the specialty and agreed with the recommendation in the non-facility setting. It was also recommended and agreed there were no direct inputs in the facility setting for this service.

Pulmonary Imaging (785X1-785X5) 13
The Subcommittee reviewed the direct practice expense inputs recommended and made a few minor changes to the clinical labor to reflect the typical patient service.

Transcranial Magenetic Stimulation (90867, 90868 & 9086XX) 15
The Subcommittee reviewed the direct practice expense inputs recommended by the specialty and agreed upon with one minor change to the equipment inputs.

Car Seat/Bed Evaluation (9477X1-9477X2) 16
The Subcommittee reviewed the direct practice expense inputs recommended by the specialty and agreed upon the recommendations.

Evoked Potentials and Reflex Studies (9592X1-9592X2) 17
The Subcommittee had an extensive discussion concerning the typical patient service and made extensive revisions to the direct practice expense inputs recommended by the specialties. Clinical labor was refined after considerable discussion and a comparison to the direct practice expenses to codes 95925, 95928, and 95929.

CMS Requests
Shoulder Arthroscopy – PE Only (29826) 22
The Specialty requested deferral of the review of these services until April after the February CPT meeting. The Subcommittee agreed with this request.

Biopsy Lung or Mediastinum – (32405) 23
The Subcommittee reviewed the direct practice expense inputs recommended by the specialty and agreed upon the recommendation without edit.

Needle Biopsy of Liver –(47000) 28
The Subcommittee reviewed the direct practice expense inputs recommended by the specialty and agreed upon the recommendation without edit.

Stereotactic Body Radiation Delivery (77373 & 77435) 32
The facilitation committee agreed with the practice expense inputs as reviewed by the Practice Expense Subcommittee and agreed that the specialty will provide invoices from 5-6 different vendors for the equipment used in this procedure.

Special Stains (88312-88314 & 88319) 33
The Subcommittee had an extensive discussion concerning the typical patient service and made extensive revisions to the direct practice expense inputs recommended by the specialties. Clinical labor was refined after considerable discussion.

Migration of Radiologic Images from Film to Digital Workgroup 37
The American College of Radiology provided the Subcommittee with an update of their work on developing direct inputs of digital imagery. As the dominate user of PACS technology ACR representative Doctor Zeke Silva reported that the ACR had been evaluating the migration of film acquisition to PACS. Doctor Silva reported that the internal ACR workgroup has been attempting to address the following questions:

- For what modalities and specialties is PACS typical?
- What is a "typical" PACS system?
- How long to store images and at what resolution?
- Different requirements for different modalities
- How to translate costs to a code level

As ACR continues to gather pertinent information, Zeke Silva outlined for the Subcommittee what ACR envisions as the next steps which include the following:

- Validate PACS costs assumptions across vendor spectrum
- Assemble "typical" environment across specialties and procedures
- Specialty societies to survey their members on what is typical
- Ask vendors to quote per exam costs using assumptions validated by CMS
- Populate the database with these inputs
- Budget neutrality concerns

In conclusion, Doctor Silva reported that this work will be ongoing and ACR will keep the Subcommittee appraised of its progress.

Direct Input Expense for Moderate Sedation Workgroup Report 37
Doctor Spires reported that the Workgroup met twice since the Subcommittee's last meeting in October and explained that a level of interest was sent out to all specialties for their participation and input. Several societies

participated in the Workgroup and in the development of a package of additional supplies and equipment necessary for safe and effective moderate sedation in the non-facility setting. These additional inputs were reviewed carefully by the Workgroup members and a subset of them were agreed upon as typically used. These additional inputs are listed below:

A2 - Equipment recommended as necessary for each patient
Table, for equipment
Pulse Oxymetry monitor recording software (prolonged monitoring)
Blood pressure monitor

The Practice Expense Subcommittee accepted the Workgroup's recommendations. In addition, the Subcommittee requests that within the RUC's next comment letter to CMS that the cost of those emergency only equipment, drugs, and supply items listed as groups B and C on the specialty recommendation be considered as direct costs if they are not currently covered in CMS' practice expense methodology under as indirect costs.

The Practice Expense Subcommittee was adjourned at 5:41 pm.

Questions from the PPI Survey:
Direct Expense Question
Provide your share (dollar amount) of the specialty or department level's share (dollar amount) of practice's total (dollar amount) for] 2006 expenses for depreciation, maintenance contracts, leases/rental of medical equipment used in diagnosis or treatment of patients. Include the 2006 tax-deductible portion of the purchase price or replacement value of medical equipment, if not leased. Do not include expenses for office equipment and furniture. Also, do not include the total purchase price or the total replacement value of medical equipment. Report only the portion that was tax-deductible in 2006.

Indirect Expense Question
Provide share (dollar amount) of the specialty or department level's share (dollar amount) of the practice's total (dollar amount) for] 2006 office expenses, including office (non-medical) equipment and office (non-medical) supplies, as well as rent, mortgage interest, maintenance, refrigeration, storage, security, janitorial, depreciation on medical buildings used in your practice, utilities, or other office computer systems (including information management systems/electronic medical record systems) and telephone.

AMA/Specialty Society RVS Update Committee
Moderate Sedation Practice Expense Recommendation

Direct Input Expense for Moderate Sedation Recommendation
In February 2010, The American Gastroenterological Association (AGA), the American Society for Gastrointestinal Endoscopy (ASGE), and the American College of Gastroenterology (ACG) recommended that the RUC revisit the supplies and equipment needed to perform medical procedures involving moderate sedation safely and effectively in the non-facility setting. The RUC formed a moderate sedation practice expense workgroup which carefully reviewed and reaffirmed the existing supplies and equipment, and provided a recommendation for three additional equipment items; a table for equipment, a pulse oxymetry monitor recording software (prolonged monitoring), and a blood pressure monitor. Below is the complete RUC standard package of moderate sedation practice expense inputs which includes these additional equipment items.

Clinical Labor:
RN - 2 minutes to initiate sedation
RN - 100% of the physician intra-service work time
RN - 15 minutes of follow every hour for post-service patient monitoring

Medical Supplies:
Standard Moderate Sedation Package: The contents of this package are:

	Code	Unit	Qty	Unit price
pack, conscious sedation	**SA044**	**pack**		**17.311**
angiocatheter 14g-24g		item	1	1.505
bandage, strip 0.75in x 3in		item	1	0.043
catheter, suction		item	1	0.620
dressing, 4in x 4.75in (Tegaderm)		item	1	1.771
electrode, ECG (single)		item	3	0.090
electrode, ground		item	1	0.445
gas, oxygen		liter	200	0.003
gauze, sterile 4in x 4in		item	4	0.159
gloves, sterile		pair	1	0.840
gown, surgical, sterile		item	1	4.671
iv infusion set		item	1	1.112
kit, iv starter		kit	1	1.368
oxygen mask (1) and tubing (7ft)		item	1	0.963
pulse oximeter sensor probe wrap		item	1	0.617
stop cock, 3-way		item	1	1.175
swab-pad, alcohol		item	2	0.013
syringe 1ml		item	1	0.140
syringe-needle 3ml 22-26g		item	2	0.160
tape, surgical paper 1in (Micropore)		inch	12	0.002
tourniquet, non-latex 1in x 18in		item	1	0.226

Equipment:
EF027* table, instrument, mobile
EQ011 ECG, 3-channel (with SpO2, NIBP, temp, resp)
EQ032 IV infusion pump
EQ212* pulse oxymetry recording software (prolonged monitoring)
EQ269* blood pressure monitor, ambulatory, w-battery charger

* indicates additional equipment specifically added in this recommendation

The AMA CPT Editorial panel currently has a list of CPT codes where moderate sedation is inherent. This list of services is attached to this recommendation so that you may assure that their direct practice expense inputs include these items.

0200T	33214	36583	43226	43453	45321	50021	93318	93651
0201T	33216	36585	43227	43456	45327	50200	93451	93652
0250T	33217	36590	43228	43458	45332	50382	93452	94011
0251T	33218	36870	43231	44360	45333	50384	93453	94012
19298	33220	37183	43232	44361	45334	50385	93454	94013
20982	33222	37184	43234	44363	45335	50386	93455	
22520	33223	37185	43235	44364	45337	50387	93456	
22521	33233	37186	43236	44365	45338	50592	93457	
22526	33234	37187	43237	44366	45339	50593	93458	
22527	33235	37188	43238	44369	45340	57155	93459	
31615	33240	37203	43239	44370	45341	58823	93460	
31620	33241	37210	43240	44372	45342	66720	93461	
31622	33244	37215	43241	44373	45345	69300	93462	
31623	33249	37216	43242	44376	45355	77371	93463	
31624	35471	37220	43243	44377	45378	77600	93464	
31625	35472	37221	43244	44378	45379	77605	93505	
31626	35475	37222	43245	44379	45380	77610	93530	
31627	35476	37223	43246	44380	45381	77615	93561	
31628	36147	37224	43247	44382	45382	92953	93562	
31629	36148	37225	43248	44383	45383	92960	93563	
31634	36200	37226	43249	44385	45384	92961	93564	
31635	36245	37227	43250	44386	45385	92973	93565	
31645	36426	37228	43251	44388	45386	92974	93566	
31646	36427	37229	43255	44389	45387	92975	93568	
31656	36481	37230	43256	44390	45391	92978	93571	
31725	36555	37231	43257	44391	45392	92979	93572	
32201	36557	37232	43258	44392	47000	92980	93609	
32405	36558	37233	43259	44393	47011	92981	93613	
32550	36560	37234	43260	44394	47382	92982	93615	
32551	36561	37235	43261	44397	47525	92984	93616	
32553	36563	43200	43262	44500	48511	92986	93618	
33010	36565	43201	43263	44901	49021	92987	93619	
33011	36566	43202	43264	45303	49041	92995	93620	
33206	36568	43204	43265	45305	49061	92996	93621	
33207	36570	43205	43267	45307	49411	93312	93622	
33208	36571	43215	43268	45308	49418	93313	93624	
33210	36576	43216	43269	45309	49440	93314	93640	
33211	36578	43217	43271	45315	49441	93315	93641	
33212	36581	43219	43272	45317	49442	93316	93642	
33213	36582	43220	43273	45320	49446	93317	93650	

AMA/Specialty Society RVS Update Committee **Tab 38**
Administrative Subcommittee
February 3, 2011

Members: *Doctors Dale Blasier (Chair), Michael Bishop, James Blankenship, Emily Hill, PA-C, Robert Kossmann, Walt Larimore, Scott Manaker, Sandra Reed, James Waldorf, George Williams*

I. Development of Standard Spreadsheet for RUC Recommendations

In October 2010, a RUC member requested that the RUC develop a standard spreadsheet to summarize survey results when a specialty society is presenting two or more codes. **The Subcommittee determined that specialty societies are required to provide a summary spreadsheet for all code recommendations. RUC staff will develop a standard summary spreadsheet and distribute with the survey packet. The standard summary spreadsheet will include the following:**

- Rows
  - Current Code Data (if applicable)
  - Survey Data
  - Key Reference Code Data
  - Specialty Society Recommended Data
- Columns
  - Source (RUC, Harvard, Survey, Recommendation)
  - CPT Code
  - CPT Descriptor
  - Global Period
  - IWPUT (optional)
  - Percent of respondents who chose key reference code (for survey data row only)
  - Work RVU (Minimum, 25th, Median, 75th, Maximum)
  - Pre-Service Time (Eval, Positioning, SDW)
  - Intra-Service Time (Minimum, 25th, Median, 75th, Maximum)
  - Immediate Post-Service Time
  - Total Time
  - Visits (hide columns if recommendation is zero)

See attached spreadsheet

II. Review of Appeals Process

The RUC Chair requested that the Administrative Subcommittee review the RUC Rules and Procedures Appeals Process for Reconsideration of RUC Recommendations. During the appeal of a code from the April 2009 RUC meeting, the American Academy of Ophthalmology (AAO) questioned the clarity of Section II A.

AAO stated that this section indicates requests of an appeal of a recommendation made "at ***the previous*** meeting". The specialty believes the section is silent on requests for appeal of decisions made at a different meeting. The specialty also believes this section does not contain language indicating that an appeal request must be filed before the first meeting after the recommendation was given or it will be considered not timely.

The Administrative Subcommittee reviewed the appeals process for reconsideration of RUC recommendations and revised as indicated below:

II. **Appeals Process for Reconsideration of RUC Recommendations**

A. Requests for reconsideration at a RUC meeting will follow the standard *Sturgis, Standard Code of Parliamentary Procedures*.

~~A.~~B. If a specialty requests an appeal of a RUC recommendation made at the previous RUC meeting, the Chair will appoint an Ad Hoc ~~Facilitation~~ Committee as in Section I.F.~~1~~3., with the exception of I.F.3.d. If time permits, the RUC will hold the relevant portion of the final recommendation of the RUC while the reconsideration process continues.

C. All appeals of RUC decisions shall be in writing, subsequent to the previous meeting and prior to the next meeting.

~~B.~~D. The Ad Hoc ~~Facilitation~~ Committee shall meet in person or by telephone conference within two weeks, when possible, of receipt of a written request for an appeal.

~~C.All appeals of RUC decisions shall be in writing.~~

~~D.~~E. The Ad Hoc ~~Facilitation~~ Committee shall invite appellants to meet with the Ad Hoc ~~Facilitation~~ Committee in person or by telephone to discuss the rationale for RUC decisions or to provide written comments.

~~E.~~F. The Ad Hoc ~~Facilitation~~ Committee will notify ~~anyone~~ individuals or specialty societies who previously provided written comments ~~commented~~ on an issue under appeal and elicit further comments.

~~F.~~G. The Ad Hoc ~~Facilitation~~ Committee shall vote to recommend to the RUC whether the RUC should reconsider its previous recommendation and, if so, shall develop a new recommendation for consideration by the RUC. If the Ad Hoc Committee determines not to reconsider a RUC recommendation, no further RUC action is taken.

~~G.~~H. The Ad Hoc ~~Facilitation~~ Committee shall provide its recommendation for reconsideration to the AMA for distribution to the RUC at least two weeks prior to the next meeting of the RUC and shall communicate to all relevant parties in a timely manner. A recommendation not to reconsider can be submitted any time prior to the RUC meeting.

~~H.~~I. An appeal request of a RUC recommendation submitted less than two weeks prior to an upcoming RUC meeting will be deferred to the subsequent RUC meeting to permit at least two weeks notice to all parties.

~~I.~~J. In the event the RUC reconsiders an action by this appeal process, the RUC decision will be final.

~~J.~~K. Approval of reconsideration of a ~~vote~~ RUC recommendation, which required a two-thirds majority shall itself require a two-thirds approval.

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SS Rec Summary

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3						RVW					Total	PRE			INTRA					imm	Facility - inpt							Office					Prolonged			
4	source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	post	91	92	33	32	31	38	39	15	14	13	12	11	54	55	56	57
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AMA/Specialty Society RVS Update Committee
Multi-Specialty Points of Comparison Workgroup
February 3, 2011 **TAB 39**

Members Present: Doctors Ron Burd, (Chair), Susan Spires, (Vice Chair), Scott Collins, Peter Hollmann, J. Leonard Lichtenfeld, Eileen Moynihan, Bill Moran, Guy Orangio, William Mangold

Doctor Burd reviewed the primary direction of the MPC Workgroup's review of the MPC list. The MPC Workgroup will conduct a systematic review/restructuring of the MPC list. The Workgroup is developing methods and criteria that will lead to the establishment of a list of services that are cross specialty and reflect relativity across services.

I. Review of January 12, 2011 conference call minutes

The Workgroup reviewed the minutes from the January 12, 2011 conference call and approved the minutes as reviewed. Doctor Burd announced that AMA staff has discussed the RUC's request to CMS to delay the individual review of the 33 MPC services indicated in the Proposed and Final 2011 Rules to allow the MPC Workgroup to complete a systematic review of the MPC list and criteria. Please refer to the Relativity Assessment Workgroup Report for further details regarding the planned review of these services.

II. Review the absolute and suggested criteria for inclusion on the MPC list

The Workgroup discussed the absolute and suggested criteria for inclusion on the MPC list. The Workgroup members reiterated the importance of reviewing these criteria to make certain that services that are included on the MPC list pass through a rigorous screening process to ensure only appropriate, cross-specialty services are included. However, the Workgroup agreed that it is premature to revise the current criteria. The cross-specialty data set should first be refined. As services are defined as cross-specialty, the Workgroup will review the criteria for inclusion on the MPC list and make necessary refinements.

III. Workgroup member review of services on the Multi-Specialty Analysis spreadsheet

The Workgroup reviewed the Multi-Specialty Analysis spreadsheet. The Workgroup members identified a number of issues moving forward to help narrow the list down from the current 345 services. There was consensus among the members that a system of "classes" or "tiers" is important to distinguish those services that are clearly cross-specialty codes compared to those services that do not provide as strong a link between specialties. The Workgroup is reviewing the spreadsheet to develop criteria to then apply to the MPC. The Workgroup did not finalize a set of criteria for each level, but will discuss this issue on future conference calls.

The Workgroup agreed that additional sets of data should be developed in order to further the review of the MPC list. First, a list of specialties should be created and grouped into "like" families. Once these families are developed, services with these specialty utilization mixes can easily be identified. Additionally, services that meet the required criteria within these families could be used as the basis for establishing links between specialties in different families. For example, a code that has Obstetrics/Gynecology and Gynecology/Oncology performing the service would allow a linkage between these specialties and Hematology/Oncology. Also, a code that has utilization from both procedural and non-procedural specialties will provide critical linkages. Finally, a data set will be created that looks not just at the percentage of specialty utilization for a service, but at the absolute times each specialty reports a service. For example,

some high volume codes may have a specialty reporting the services over 10,000 times but it may represent under 10 percent of the total utilization. This is still a considerable utilization amount and could provide additional useful linkages across specialties and families of codes. The Workgroup will also identify specialties not well represented on the MPC list and work with these specialties to rectify that as possible.

The MPC Workgroup will continue the systematic review of the MPC list on conference calls leading up to the April 2011 RUC meeting.

AMA/Specialty Society RVS Update Committee
Research Subcommittee
February 3, 2011

Members Present
Members: Brenda Lewis, DO (Chair), Greg Przybylski, MD (Vice Chair), Bibb Allen, MD, Jane Dillon, MD, John Gage, MD, J. Leonard Lichtenfeld, MD, Marc Raphaelson, MD, Sherry Barron-Seabrook, MD Daniel Mark Siegel, MD, Peter Smith, MD

I. Specialty Society Request:

Molecular Pathology (88XX1-88XX28)
College of American Pathologists

At the October 2010 CPT Meeting, 28 new codes were approved for the first set of Tier 1 non-infectious disease molecular pathology services. At the February 2011 CPT Meeting, the Tier 2 services will be presented to the CPT Editorial Panel. First, assuming the acceptance of the Tier 2 services by the Panel, the specialty society requests postponement of the review of the initial set to the April 2011 RUC Meeting so that both sets of codes can be reviewed together. The Subcommittee was made aware that there are some issues pertaining to these services including determining the primary provider of these services as well as which codes will be on the RBRVS or the CLFS. The specialty society has indicated that they will address these issues with CMS and or the CPT Editorial Panel prior to their presentation at the April 2011 RUC Meeting. **The Research Subcommittee approves the request to present both Tier 1 and 2 services at the April 2011 RUC Meeting.**

The specialty society requests that their modified survey instrument be approved by the Research Subcommittee to establish physician work RVU recommendations for these services. **The Research Subcommittee recommends the following description of service be utilized within the instrument used to survey these codes:**

No Pre-Service Description

Intra-Service Description
- Interpretation of any electrophoretic gels, charts, graphs, PCR products, or other information generated during the test procedure which is used in the formulation of a clinically meaningful result
- Review of any reference literature during the procedure interpretation and preparation of the report
- Review of standardized normative data used in the evaluation of the specific test
- Dictation, editing and finalization of the report
- Communication of the report to the appropriate health care professional

No Post-Service Description

II. Identification of Extant Databases – *Informational Item Only*

In September 2007, the Extant Data Workgroup identified six extant databases including: the STS Database, the ACS National Surgical Quality Improvement Program (NSQIP), ASPS Tracking Operation and Outcomes for Plastic Surgeons (TOPS), the National Ambulatory Medical Care Survey (NAMCS) and Medicare's Better Quality Information to Improve Care for Medicare

Beneficiaries (BQI). At the April 2010 RUC Meeting, the Research Subcommittee recommended that at the February 2011 RUC Meeting, the results of a solicitation to the specialty societies to identify any additional extant databases be presented. Five additional extant databases were identified including: 1.) The Renal Physicians of America identified the United States Renal Data System 2.) Vascular Registry® (VR), 3.) Vascular Quality Initiative (VQI), 4.) Registry of Patient Registries (RoPR) and 5.) Mastery of Breast Surgery Program.

The Research Subcommittee agreed that if the specialty societies who identified these databases would like to use these databases in accordance with RUC policy, they would have to make a formal presentation to the Research Subcommittee to determine if they meet the RUC's Inclusionary/Exclusionary Criteria for Extant Databases. Further, in the future, if a specialty society identifies or creates a database, they are invited to bring it forward for review by the Research Subcommittee at any time.

III. Evaluation of NSQIP and STS Database to the RUC Extant Data Criteria

At the February 2010 RUC Meeting, a RUC 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. The RUC, through the Extant Data Workgroup, reviewed how extant data should be used in the RUC process, due to a query posed by CMS in the *Proposed Rule* published in June 21, 2006. The Workgroup developed an Inclusionary and Exclusionary Criteria List for Extant Database Use which was reviewed by all specialty societies and approved by the RUC in February 2008.

Further the Workgroup discussed how extant data would be optimally incorporated into the RUC process. The Workgroup recommended and the RUC approved that: 1.)Extant data could be incorporated into the RUC process as supplementary data to the RUC survey in the new and revised process when that extant database meets all approved Inclusionary/Exclusionary Criteria for Extant Database Use and 2.) Extant data could be incorporated into the RUC process as primary data in various collected components within the Five Year Review Process when that extant database meets all approved Inclusionary/Exclusionary Criteria for Extant Database Use, as in the approved alternative methodologies used in previous Five Year Reviews.

This historical background demonstrates that the RUC does have a mechanism to use extant data in its new and revised process to validate time data presented to the RUC. Further, in order to be proactive, the Research Subcommittee recommends that at the February 2011 RUC Meeting, the NSQIP and STS Databases be evaluated to determine if they meet the RUC's extant data criteria which is listed on page 2180 of the February 2011 RUC Agenda Book**.**

NSQIP

The American College of Surgeons stated that as they did not anticipate the use of NSQIP data in the near future for several reasons, they were currently unable to provide the NSQIP database or database summary reports for RUC evaluation regarding the RUC's extant data criteria. **Based on lack of data, the Research Subcommittee recommends that the NSQIP database currently does not meet the RUC's inclusionary/ exclusionary criteria for extant databases.**

STS Database

The Society of Thoracic Surgeons made a presentation to the Research Subcommittee explaining that they agreed that their database met the RUC's Inclusionary/ Exclusionary Criteria for Extant Databases. **After lengthy discussion the Subcommittee recommended that the STS Database met the RUC's Inclusionary/Exclusionary Criteria to be used in accordance with current RUC policy. Further, the Research Subcommittee recommends that the specialty society at**

the next Research Subcommittee meeting present a proposal for when this information should be presented with the specialty societies' recommendations.

IV. RUC Survey Process – Informational Item

AMA Staff has received many requests over the years to enhance the RUC survey process. To address, these requests, RUC staff has requested assistance from AMA Market Research Staff, Sara Thran and Joanna Wicher to:

- Conduct a review of the RUC survey instrument to determine if any modifications could be made to 1.) streamline the survey and 2.) make the survey more comprehensible for survey respondents.

The RUC Survey Instrument has been reviewed several times over the tenure of the RUC to determine its efficiency and effectiveness for accurately developing physician work RVUs for new, revised and existing services. In December 2010, AMA RUC Staff asked AMA Survey Methodologists to review the survey instrument to determine if any modifications are warranted. They will be providing several editorial modifications to the survey instrument in late-February to the Research Subcommittee for review.

- Create a mechanism to have a centralized website for specialties to conduct online RUC surveys.

With the assistance of the AMA Market Research Staff, AMA RUC staff has spoken with a vendor with whom the AMA currently has a contract to determine the feasibility of implementing such a website. The vendor has indicated that this project is possible and could be offered to the specialty societies at no cost. AMA RUC Staff informed the Subcommittee on the estimated timeline of this project:

Late February 2011	The editorially revised survey instrument will be programmed into the survey software for a conference call/webinar. At that time, the Research Subcommittee will be able to provide input directly to the vendor and AMA RUC staff regarding the website.
Mid March 2011	The specialty societies would be given a demonstration of the centralized website for comment
June 2011	One specialty will pilot test the website for presentation at the September 2011 RUC Meeting
September 2011	Education session at the September 2011 RUC Meeting to specialty societies on use of the website
November 1, 2011	Full implementation of the website is scheduled to be complete in time for the January 2012 RUC Meeting.

V. IWPUT Presentation

American Academy of Opthalmology

The American Academy of Ophthalmology gave a presentation to the Research Subcommittee regarding their concerns about the use of IWPUT in the RUC process. The specialty society made three requests including 1.) The RUC should consider suspending the use of IWPUT pending further analysis, 2.) The RUC should consider having an outside methodologist review IWPUT if it elects to continue the use of this model and 2.) addition of a question on the RUC survey instrument stating:

What percentage of the work RVU above do you attribute to the intra-service (skin-to-skin) work of the procedure for both the surveyed code and the reference code?

The Research Subcommittee considered and did not approve these three requests made by the specialty society. **The Research Subcommittee reaffirms the current RUC policy pertaining to IWPUT:**

IWPUT should be used only as a measure of relativity between codes or in families of codes. IWPUT is a complimentary measure and should not be used as the sole basis for ranking or the assignment of value to a service. IWPUT may be used to validate survey data.

VI. 23+ Hour E/M – Proxy Discussion

The Research Subcommittee reviewed a letter from several surgical specialties questioning the appropriate proxy to be used for when a separate evaluation and management visit is performed later on the same day of surgery.

As the Research Subcommittee agreed that the introduction of the subsequent observation codes into the Fee Schedule in 2011 allow for a more accurate measure of work for these 23+ hour stay services, the Research Subcommittee recommends that the appropriate proxy for a separate evaluation and management visit performed later on the same day of surgery is the subsequent observation codes, 99224-99226.

Further, the Research Subcommittee discussed the appropriate proxies for discharge management. At the October 2010, RUC Meeting, the RUC approved the following policy pertaining to discharge service code assignments**, 0.5 x 99238 (or 0.5 x 99217) for <u>same-day</u> discharge and 1.0 x 99238 (or 1.0 x 99217) for discharge on a day <u>subsequent</u> to the day of a procedure. The Research Subcommittee recommends that the 99217 service be added to the survey instrument and summary of recommendation form.**

In addition the RUC reaffirms its comments to CMS regarding their valuation of the subsequent observation services. First and foremost, the RUC disagrees with the notion stated by CMS that the acuity level of the typical patient receiving outpatient observation services would generally be lower than the inpatient level. The RUC carefully considered the typical patient as described by the specialties and agreed they were comparable to those described in the subsequent hospital care codes. Second, the RUC agrees that whether the patient is in observation status or admitted to the hospital, the work provided by the physician is the same. This notion is supported by the survey data collected by the specialty societies and forwarded to CMS. Finally, the RUC disagrees with how the agency has attempted to value these services. Removing the pre-and post-service time of each code implies there is not such time or physician work involved and it implies that subsequent observation care only involves face-to-face time with the patient. The RUC contends that these codes involve physician work both before and after the patient encounter, just as almost all evaluation and management service do. Based on these arguments, the RUC respectfully requested CMS to accept the RUC recommended values for these services, 0.76 RVUs for 99224, 1.39 RVUs for 99225 and 2.00 RVUs for 99226.

The detailed comments addressing this issue can be found in the RUC comment letter which was sent to CMS on December 20, 2010, in response to the *Final Rule* published in November 2011.

AMA/Specialty Society RVS Update Committee **Tab 41**
Relativity Assessment Workgroup
February 3, 2011

Members: Doctors Walt Larimore *(Chair)*, Robert Zwolak *(Vice Chair)*, Bibb Allen, Michael Bishop, Dale Blasier, John Gage, Stephen Levine, Brenda Lewis, Larry Martinelli, Marc Raphaelson, and George Williams.

I. Low Value/Billed in Multiple Units Screen Review action plan 95004, 95010, 95015, 95024, 95027 and 95144

In the Medicare Physician Payment Schedule *Proposed Rule* and *Final Rule* for 2011 (Table 10), CMS indicated that they believe services with low work RVUs that are commonly billed with multiple units in a single encounter are an additional appropriate category for identifying potentially misvalued codes. CMS requested that the RUC review 12 services that have high multiple services, that are typically performed in multiples of 5 or more per day, and have work RVUS of less than or equal to 0.50 RVUs.

In October 2010, the Workgroup reviewed these 12 services and determined for 6 codes, the RUC assumed number of units when valuing these services are the same or similar to the CMS mean number of units. Additionally, these 6 services (11101, 17003, 76000, 88300, 95148 and 95904) were not commonly billed 5 times or more per day (over 50% of the time), therefore, did not meet the CMS criteria screen as indicated.

The Workgroup determined that the 6 remaining services commonly billed 5 times or more per day (over 50% of the time) be examined. The RUC requested that the specialty societies that perform the low value/billed in multiple unit codes identified, provide an action plan in Feb 2011 to the Workgroup on how to address these services (codes 95004, 95010, 95015, 95024, 95027, 95144). The Workgroup reviewed the action plans from the specialty societies and recommends the following:

CPT Code	Recommendation
95004	Reaffirmed RUC recommendation. The RUC recommended comparison code 99212 (0.48) divided by the number of RUC assumed units, 40, or the CMS mean number of units, 50, both result in a work RVU of 0.01. Additionally, the RUC appropriately divided the physician time by the typical number of units.
95010	Resurvey, as physician times are not representative of the number of units typically performed and Refer to CPT Assistant to publish an article to ensure proper coding
95015	Resurvey, as physician times are not representative of the number of units typically performed and Refer to CPT Assistant to publish an article to ensure proper coding
95024	Review practice expense in April 2011. Reaffirmed RUC recommendation for work. The RUC recommendation established an RVU of 0.12 for a battery of 12 tests resulting in 0.01 work RVU (identical to 95004 and 95027). The specialty indicated and the Workgroup agreed that it is reasonable to suggest that if the RUC assumed typical number of tests were 17 at the time of valuation, an RVU of 0.17 would similarly been established for the battery of tests still resulting in a work RVU of 0.01. Additionally, the RUC appropriately divided the physician time by the typical number of units.
95027	Reaffirmed RUC recommendation. The RUC recommended comparison code 99212 (0.48) divided by the number of RUC assumed units, 45, or the CMS mean number of units, 40, both result in a work RVU of 0.01. Additionally, the RUC appropriately divided the physician time by the typical number of units.

95144	Reaffirmed RUC recommendation. The Workgroup determined that the RUC assumed number of units, 6, and CMS mean number of units, 6.8, would not result in a different work RVU than the recent RUC recommended work RVU of 0.06. Additionally, the physician time of 3 minutes is appropriate as this is antigen therapy service is different than the battery of allergy tests reviewed above.

II. Low Value/High Volume Screen

In the Medicare Physician Payment Schedule *Proposed Rule* and *Final Rule for 2011 (Table 11)*, CMS indicated that they believe services with low work RVUs but are high volume based on claims data are another category for identifying potentially misvalued codes. CMS requested that the RUC review 24 services that have low work RVUs (less than or equal to 0.25) and high utilization.

In October 2010, the Workgroup questioned the criteria CMS used to identify these services as it appeared some codes may be missing from the screen criteria indicated. The Workgroup recommended identification of codes with a work RVU 0.50 or below and Medicare utilization of 1 million or more (excluding codes with a 0.00 work RVU). Based on these criteria, 61 codes were identified, 16 of which have already been identified by another Relativity Assessment screen. Additionally, 6 of the 24 codes identified by CMS did not meet the over 1 million utilization criteria (codes 72040, 73310, 73130, 73620, 92543 and 93701).

The Workgroup reviewed the list of codes and recommends to remove the codes already identified by another relativity assessment screen and reaffirm the RUC recommendations for all RUC reviewed codes. The Workgroup determined that the remaining five "CMS/Other" source codes should be resurveyed (codes 72170, 73030, 72040, 73620 and 93971). Two codes, G0101 and G0283, were identified by the Workgroup expanded criteria of codes with a work RVU of 0.50 or below and Medicare utilization of 1 million or more. **Since CMS did not identify these codes, the Workgroup recommends submitting a letter to CMS requesting their preference regarding a RUC review of these services. Additionally, as part of this screen CMS identified code 93701 which has a work RVU of 0.00. The Workgroup recommends that 93701 be removed from this screen as it has zero work RVUs.**

A Workgroup member noted that any "CMS/Other" source codes would not have been flagged in the Harvard only screens, **therefore the Workgroup recommends that a list of all "CMS/Other" codes be developed and reviewed at the April 2011 meeting.**

III. Site-of-Service Re-review Criteria

In the recent CMS request of re-review of codes regarding site-of-service, the American College of Surgeons requested that the RUC consider modifying the criteria for the site-of-service screen going forward to require <u>three</u> complete years of consecutive data showing <u>45% or less</u> inpatient before requiring review of a code under that screen.

AMA staff discussed the 45% or less threshold as well as the years of data collected with AMA economists who indicated there is no statistical basis to set the threshold at 45%. However, reasons to set a threshold slightly lower than 50% or collect three years of data would reduce 1) Errors in claims and 2) Eliminate cases where a code would fall below 50% just by chance.

The Workgroup discussed the inpatient threshold percentage and recommends maintaining the current 50% or less inpatient threshold. The Workgroup agreed and recommends that <u>three</u> consecutive years of data indicating 50% or less inpatient each year, is appropriate in order to eliminate any annual fluctuations in the claims data.

IV. MPC List Discussion

In the Medicare Physician Payment Schedule *Proposed Rule* and *Final Rule for 2011 (Table 9)*, CMS indicated that they believe the entire MPC list should be assessed to ensure that services are paid appropriately under the Physician Payment Schedule. CMS prioritized the review of the MPC list to 33 codes, ranking the codes by allowed service units and charges based on CY 2009 claims data.

The RAW reviewed this list at the October 2010 meeting and noted that 6 of the 33 codes have been identified by another screen and have been re-reviewed by the RUC in the last two years, leaving 27 newly identified codes. The Workgroup had a robust discussion regarding the MPC list and codes identified by this CMS screen. The assumption by the specialty societies, RUC and CMS has been that the MPC list services are appropriately valued, well established and understood physician services. The MPC Workgroup is currently reviewing all criteria for placing a code on the MPC list and reconstructing the MPC list.

The RUC agrees that the MPC list is important and requires maintenance to be relevant. However, the RUC requested in its comment letter to CMS on the 2011 Final Rule, that CMS allow the RUC to postpone review of the MPC codes identified until after the MPC Workgroup completes review and revision of the MPC criteria and list. The AMA received conflicting responses on whether the RUC should review these codes prior to the revision of the MPC List. The RUC Chair will meet with CMS leadership following this meeting to determine CMS' intention.

The Workgroup determined that as a proactive measure it should further examine the 33 MPC codes identified at this time. In the *Final Rule for 2011,* CMS indicated that one of the rationale for review of MPC services was that the code was not reviewed by the RUC in the last 6 years. The Workgroup noted that 17 of the 27 services have been reviewed by the RUC in the last 6 years. **The Workgroup reaffirmed the RUC recommendation for the 17 MPC codes that were reviewed by the RUC in the last 6 years. For the remaining 10 MPC codes identified, the Workgroup requests that the specialty societies submit an action plan or survey for April 2011 (codes 11056, 11721, 31231, 43239, 45380, 45385, 73721, 77003, 92980 and 94060).**

V. Review Compelling Evidence Standards

At the October 2010 RUC meeting a RUC member requested that the RUC review and possibly revise the RUC Compelling Evidence Standards since CMS is no longer accepting rank order anomalies as the sole compelling evidence to review/revise a code as well as whether a Harvard Valued code is acceptable criteria for review.

The Workgroup recommends reaffirming the rank order anomaly compelling evidence standard. However, CMS does not accept rank order anomaly as the sole basis for compelling evidence. **The Workgroup recommends adding the following parenthetical to the compelling evidence standards: (CMS does not accept rank order anomaly as the sole basis for compelling evidence).** The Workgroup noted that the Harvard Valued screen started with a utilization of 1 million or more, then was expanded to 100,000 or more and most recently 30,000 or more. **The Workgroup recommends that staff develop a list of how many Harvard Value codes remain and will discuss this list at the April 2011 meeting. The Workgroup also recommends that staff analyze all the Harvard Valued codes with utilization over 30,000 that have been reviewed by the RUC and compare to the original Harvard valuation to assess the results of this review.**

IV. Other Issues

The following items were provided as informational materials: CPT Editorial Panel Referrals, CPT Assistant Referrals and full status report of the Relativity Assessment Workgroup.

Low Value/High Volume Codes (Work RVU ≤ 0.50 with Utilization Over 1 million)

CPT Code	Decriptor	RUC Mtg Date	Global	2011 Work RVU	Pre Time	Intra Time	Post Time	Source	2009 Medicare Utilization	Screen	Recommendation
11101	Biopsy skin add-on	Aug-95	ZZZ	0.41	0	10	0	RUC	1,120,739		Reaffirm
11719	Trim nail(s)	Apr97 (HCPAC)	000	0.17	2	2	5	RUC	1,472,007		Reaffirm
11720	Debride nail 1-5	Apr96 (HCPAC)	000	0.32	5	8	5	RUC	2,140,683		Reaffirm
17003	Destruct premalg les 2-14	Aug-05	ZZZ	0.07	0	2	0	RUC	15,004,060		Reaffirm
71010	Chest x-ray	Aug-05	XXX	0.18	1	3	1	RUC	18,889,676		Reaffirm
71020	Chest x-ray	Aug-05	XXX	0.22	1	3	1	RUC	13,740,080		Reaffirm
72100	X-ray exam of lower spine	Feb-11	XXX	0.22	0	6	0	CMS/Other	1,824,948	Harvard Valued - Utilization over 100,000	Remove from Screen
72170	**X-ray exam of pelvis**	**Aug-95**	**XXX**	**0.17**	**0**	**5**	**0**	**CMS/Other**	**1,683,045**		**Survey**
73030	**X-ray exam of shoulder**	**Aug-95**	**XXX**	**0.18**	**0**	**5**	**0**	**CMS/Other**	**2,137,263**		**Survey**
73510	X-ray exam of hip	Apr-10	XXX	0.21	0	5	0	RUC	2,424,907	Top 9 Harvard	Remove from Screen
73560	X-ray exam of knee 1 or 2	May-98	XXX	0.17	0	3	0	RUC	2,137,514		Reaffirm
73562	X-ray exam of knee 3	May-98	XXX	0.18	0	4	0	RUC	1,747,709		Reaffirm
73564	X-ray exam knee 4 or more	May-98	XXX	0.22	0	5	0	RUC	1,025,955		Reaffirm
73610	X-ray exam of ankle	Oct-09	XXX	0.17	1	3	1	RUC	1,121,102	Top 9 Harvard	Remove from Screen
73630	X-ray exam of foot	Oct-09	XXX	0.17	1	3	1	RUC	2,066,436	Top 9 Harvard	Remove from Screen
74000	X-ray exam of abdomen	Aug-05	XXX	0.18	1	3	1	RUC	1,886,517		Reaffirm
77052	Comp screen mammogram add-on	Sep-03	ZZZ	0.06	0	1	0	RUC	4,688,454		Reaffirm
77080	Dxa bone density axial	Aug-05	XXX	0.31	1	4	1	RUC	2,593,314		Reaffirm
88304	Tissue exam by pathologist	Apr-10	XXX	0.22	0	15	0	RUC	1,105,302	4th Five-Year Review	Remove from Screen
88313	Special stains group 2	Feb-11	XXX	0.24	0	11	0	Harvard	1,273,054	Top 9 Harvard	Remove from Screen
90471	Immunization admin	Feb-08	XXX	0.17	0	7	0	RUC	1,000,147	CMS Request PE Review/ CMS Fastest Growing	Remove from Screen
90970	Esrd home pt serv p day 20+	Feb-08	XXX	0.14	0	2.5	0	RUC	1,237,354		Reaffirm
92083	Visual field examination(s)	Aug-05	XXX	0.50	3	10	0	RUC	2,580,775		Reaffirm
92225	Special eye exam initial	Aug-95	XXX	0.38	9	20	11	RUC	1,143,435		Reaffirm
92226	Special eye exam subsequent	Aug-05	XXX	0.33	5	10	5	RUC	2,704,783		Reaffirm
92250	Eye exam with photos	Aug-05	XXX	0.44	0	9	5	RUC	2,175,839		Reaffirm
92567	Tympanometry	Apr-09	XXX	0.20	1	4	1	RUC	1,015,010	Codes Reported Together 95% or More	Remove from Screen
93000	Electrocardiogram complete	Aug-95	XXX	0.17	0	5	2	RUC	11,544,414		Reaffirm
93010	Electrocardiogram report	Aug-05	XXX	0.17	0	4	1	RUC	19,334,268		Reaffirm
93016	Cardiovascular stress test	Apr-10	XXX	0.45	10	38	10	RUC	1,124,995	Codes Reported Together 75% or More	Remove from Screen
93018	Cardiovascular stress test	Apr-10	XXX	0.30	2	5	5	RUC	1,285,579	Codes Reported Together 75% or More	Remove from Screen

Low Value/High Volume Codes (Work RVU ≤ 0.50 with Utilization Over 1 million)

Reaffirm

CPT Code	Decriptor	RUC Mtg Date	Global	2011 Work RVU	Pre Time	Intra Time	Post Time	Source	2009 Medicare Utilization	Screen	Recommendation
93293	Pm phone r-strip device eval	Apr-08	XXX	0.32	5	10	5	RUC	1,149,761		Reaffirm
93971	**Extremity study**	**Aug-95**	**XXX**	**0.45**	**0**	**16**	**0**	**CMS/Other**	**1,419,577**		**Survey**
94010	Breathing capacity test	Aug-05	XXX	0.17	0	5	2	RUC	1,256,953		Reaffirm
94060	Evaluation of wheezing	Aug-05	XXX	0.31	5	10	5	RUC	1,231,072		Reaffirm
95004	Percut allergy skin tests	Feb-11	XXX	0.01	0.125	0.125	0.125	RUC	7,281,377	Low Value/Billed in Multiple Units	Remove from Screen
95024	Id allergy test drug/bug	Feb-11	XXX	0.01	0	0.416	0.833	RUC	1,586,553	Low Value/Billed in Multiple Units	Remove from Screen
95165	Antigen therapy services	Feb-06	XXX	0.06	0	3	0	RUC	5,412,909		Reaffirm
95900	Motor nerve conduction test	Aug-05	XXX	0.42	4	6	4	RUC	1,371,085		Reaffirm
95904	Sense nerve conduction test	Apr-10	XXX	0.34	4	5	3	RUC	3,595,537	Codes Reported Together 75% or More	Remove from Screen
96365	Ther/proph/diag iv inf init	Oct-04	XXX	0.21	2	5	2	RUC	1,423,549		Reaffirm
96367	Tx/proph/dg addl seq iv inf	Oct-04	ZZZ	0.19	1	5	0	RUC	2,153,424		Reaffirm
96372	Ther/proph/diag inj sc/im	Oct-04	XXX	0.17	2	3	2	RUC	8,933,442		Reaffirm
96375	Tx/pro/dx inj new drug addon	Oct-04	ZZZ	0.10	1	3	0	RUC	2,029,330		Reaffirm
96413	Chemo iv infusion 1 hr	Oct-10	XXX	0.28	4	7	2	RUC	2,354,203	Codes Reported Together 75% or More	Remove from Screen
96415	Chemo iv infusion addl hr	Oct-04	ZZZ	0.19	0	5	0	RUC	1,508,975		Reaffirm
97032	Electrical stimulation	May94 (HCPAC)	XXX	0.25	1	11	2	RUC	2,642,285		Reaffirm
97035	Ultrasound therapy	May94 (HCPAC)	XXX	0.21	1	12	2	RUC	4,491,827		Reaffirm
97110	Therapeutic exercises	Apr-10	XXX	0.45	1	15	2	RUC	40,440,714	Codes Reported Together 75% or More	Remove from Screen
97112	Neuromuscular reeducation	May94 (HCPAC)	XXX	0.45	1	15	2	RUC	6,303,631		Reaffirm
97113	Aquatic therapy/exercises	May94 (HCPAC)	XXX	0.44	1	15	2	RUC	1,555,571		Reaffirm
97116	Gait training therapy	Apr-10	XXX	0.40	1	12	2	RUC	1,406,465	Codes Reported Together 75% or More	Remove from Screen
97124	Massage therapy	May94 (HCPAC)	XXX	0.35	1	15	2	RUC	1,050,891		Reaffirm
97140	Manual therapy	May98(HCPAC)	XXX	0.43	2	14	2	RUC	16,259,478		Reaffirm
97530	Therapeutic activities	May94 (HCPAC)	XXX	0.44	1	15	2	RUC	6,858,915		Reaffirm
98940	Chiropractic manipulation	Apr96 (HCPAC)	000	0.45	2	7	3	RUC	6,533,294		Reaffirm
99211	Office/outpatient visit est	Feb-06	XXX	0.18	0	5	2	RUC	8,696,065		Reaffirm
99212	Office/outpatient visit est	Feb-06	XXX	0.48	2	10	4	RUC	19,660,131		Reaffirm
G0101	CA screen;pelvic/breast exam		XXX	0.45	0	0	0	CMS/Other	1,094,967		Letter to CMS - questioning RUC review
G0179	MD recertification HHA PT	Feb-10	XXX	0.45	0	0	0		1,443,130	CMS Fastest Growing	Remove from Screen
G0283	Elec stim other than wound		XXX	0.18	0	0	0	CMS/Other	6,153,297		Letter to CMS - questioning RUC review

Codes Identified by CMS Screen, Did not meet criteria as Utilization < 1 million											
CPT Code	**Decriptor**	**RUC Mtg Date**	**Global**	**2011 Work RVU**	**Pre Time**	**Intra Time**	**Post Time**	**Source**	**2009 Medicare Utilization**	**Screen**	**Recommendation**
72040	**X-ray exam of neck, spine**	**Aug-95**	**XXX**	**0.22**		**6**		**CMS/Other**	**572,449**		**Survey**
73110	X-ray exam of wrist	Aug-05	XXX	0.17	1	3	1	RUC	857,179		Reaffirm
73130	X-ray exam of hand	Aug-05	XXX	0.17	1	3	1	RUC	890,262		Reaffirm
73620	**X-ray exam of foot**	**Aug-95**	**XXX**	**0.16**		**5**		**CMS/Other**	**865,846**		**Survey**
92543	Caloric vestibular test	Apr-09	XXX	0.10		10		CMS/Other	469,356	Codes Reported Together	Remove from Screen
93701	Bioimpedance, cv analysis	Feb-09	XXX	0.00					416,300		Remove from Screen

Table 9 - Codes on the MPC List Referred for RUC Review

CPT Code	Short descriptor	RUC Review	Global	Work RVU	Pre-Eval	Pre-S/D/W	Pre-Position	Intra-Service	Post-Svc	Visits	IWPUT	2009 Medicare Utilization	Notes
11056	Trim skin lesions, 2 to 4	Apr-97	000	0.61	2			8	5		0.0567	1,687,654	Action plan or survey for April 2011
11100	Biopsy, skin lesion	Aug-05	000	0.81	5			12	5		0.0488	2,579,687	
11721	Debride nail, 6 or mor	Apr-96	000	0.54	5			8	5		0.0395	7,539,975	Action plan or survey for April 2011
17000	Destruct premalg lesion	Aug-05	010	0.65	4			3	2	99212=1	0.0119	4,730,673	
20610	Drain/inject, joint/burs	Oct-10	000	0.79	5	1	5	5	5		0.10062	5,847,320	Oct 2010, Harvard Over 100,000 screen
31231	Nasal endoscopy, dx	June-93	000	1.10	10			10	10		0.0652	361,190	Action plan or survey for April 2011
31575	Diagnostic laryngoscopy	Sep-05	000	1.10	5	5	5	8	5		0.0904	557,616	
43235	Uppr gi endoscopy, diagnosis	Aug-05	000	2.39	18	5	5	20	15		0.0749	408,630	
43239	Upper GI endoscopy, biopsy	Aug-00	000	2.87	27			34	23.5		0.0511	1,419,531	Action plan or survey for April 2011
45380	Colonoscopy and biopsy	Aug-00	000	4.43	45			51.5	22		0.0569	799,816	Action plan or survey for April 2011
45385	Lesion removal colonoscopy	Jun-93	000	5.3	16			43	15		0.1071	641,691	Action plan or survey for April 2011
52000	Cystoscopy	Aug-05	000	2.23	10	5	2	15	10		0.1131	920,676	
66821	After cataract laser surgery	Aug-05	090	3.42	15			11	10	99213=2	0.0836	566,092	
66984	Cataract surg w/iol, 1 stage	Aug-05	090	10.52	10	10	5	30	10	99212=2 99213=2 99238=0.5	0.2113	1,674,939	April 2008 RUC rec to review in Sept 2011, High IWPUT screen
71020	Chest x-ray	Aug-05	XXX	0.22	1			3	1		0.0584	13,740,080	
71275	Ct angiography, chest	Feb-01	XXX	1.92	9.5			30	10		0.0494	593,556	Feb 2009 RUC rec to review in Sept 2011, CMS Fastest Growing screen
73721	Mri jnt of lwr extre w/o dye	Apr-01	XXX	1.35				20			0.0675	610,825	Action plan or survey for April 2011
74160	Ct abdomen w/dye	Aug-05	XXX	1.27	3			15	5		0.0727	2,219,593	Feb 2008 RUC rec to maintain code reviewed only new codes, Codes Reported Together screen
76700	Us exam, abdom, complete	Aug-05	XXX	0.81	3			10	4		0.0653	1,039,419	
77003	Fluoroguide for spine inject	May-99	XXX	0.60	10			20	5		0.0132	2,185,916	Action plan or survey for April 2011
77290	Set radiation therapy field	Aug-05	XXX	1.56				70			0.0223	339,258	
77300	Radiation therapy dose plan	Aug-05	XXX	0.62				15			0.0413	1,638,636	
77334	Radiation treatment aid(s)	Aug-05	XXX	1.24				35			0.0354	1,476,951	
78815	Pet image w/ct, skull-thigh	Apr-07	XXX	0.00	15			35	15		-0.0192	487,518	
92083	Visual field examination(s)	Aug-05	XXX	0.5	3			10			0.0433	2,580,775	
92250	Eye exam with photos	Aug-05	XXX	0.44				9	5		0.0364	2,175,839	
92980	Insert intracoronary stent	May-94	000	14.82	45			120	60		0.1039	320,072	Action plan or survey for April 2011
93010	Electrocardiogram report	Aug-05	XXX	0.17				4	1		0.0369	19,334,268	
94060	Evaluation of wheezing	Aug-95	XXX	0.31	5			10	5		0.0086	1,231,072	Action plan or survey for April 2011
95165	Antigen therapy services	Feb-06	XXX	0.06				3			0.0200	5,412,909	
95810	Polysomnography, 4 or more	Apr-10	XXX	2.5	15			36.5	15		0.0501	311,495	CMS Fastest Growing
95900	Motor nerve conduction test	Aug-05	XXX	0.42	4			6	4		0.0401	1,371,085	
97110	Therapeutic exercises	Apr-10	XXX	0.45	1			15	2		0.0255	40,440,714	Apr 2010, RUC rec was to maintain, Codes Reported Together 75% or More screen

AMA/Specialty Society RVS Update Committee **Tab 42**
Health Care Professionals Advisory Committee Review Board
February 4, 2011

Members Present
Emily Hill, PA-C (*Alt. Co-Chair*), Eileen Carlson JD, RN, Michael Chaglasian, OD, Robert Fifer, PhD, CCC-A, Terry Moon, 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 the CMS Update. Doctor Hambrick indicated all are welcome to contact and meet with the Agency regarding items for the 2011 Proposed Rule. She noted that the Agency is currently working on a number of initiatives to work within the current resources available. The Agency appreciates all the work the HCPAC has contributed thus far and looks forward to working together in the future.

II. CMS Overview: Multiple Procedure Payment Reduction (MPPR)"Always Therapy" Policy

Many HCPAC societies voiced concern regarding the "Always Therapy" policy reducing the practice expense payment for therapy services performed by the same practitioner on the same date of service by 25 percent. The HCPAC members are concerned about the inconsistencies in addressing these services. Previously, CMS referred issues to the HCPAC for re-review of work and practice expense instead of applying an arbitrary reduction, when there was a concern regarding a potential overall in services. The HCPAC indicated that it welcomes any CMS referred re-review and prefers to vet any issues through the HCPAC Review Board process.

III. CMS Acceptance of HCPAC Recommendations

The HCPAC noted that it is concerned not only with the rate HCPAC recommendations that are rejected but also with the magnitude difference between the HCPAC recommended values and CMS final values. The HCPAC was also concerned that the CMS rationale for rejecting proposed HCPAC values lacked sufficient support and explanation. The HCPAC noted that they submit recommendations based on valid survey data with support from similar reference codes. The HCPAC outlined its specific concerns for the 2011 interim final values in its December 20, 2010 comment letter to CMS.

IV. Other Issues

AMA Staff announced that a call for individuals who wish to run for the HCPAC Co-Chair and Alternate Co-Chair will be sent following this meeting. Elections will occur at the April 2011 meeting for the term September 2011-May 2013.

AMA Staff announced if any specialties require information regarding educating their survey respondents, they may contact Susan Clark who along with a Research Subcommittee member will proctor any HCPAC educational sessions.

The HCPAC discussed that due to the low number of codes many HCPAC specialties provide, it is difficult to develop reference service lists when most or all the codes typically performed are being surveyed. **The HCPAC will discuss methods to develop appropriate reference service lists at the April 2011 meeting.**

AMA
AMERICAN
MEDICAL
ASSOCIATION

February 28, 2011

Jonathan Blum
Deputy Administrator and Director
Center for Medicare
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Subject: RUC Recommendations

Dear Mr. Blum:

The American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC) submits the enclosed recommendations for work and direct practice expense inputs to the Centers for Medicare and Medicaid Services (CMS). The RUC is a committee of physician volunteers utilizing their first amendment right to petition CMS to consider a number of improvements to the Resource-Based Relative Value Scale (RBRVS). These recommendations are a component of the RUC's consideration of services that were identified as potentially misvalued. The RUC is fully committed to this ongoing effort to improve relativity in the work, practice expense, and professional liability insurance values.

<u>February 2011 RUC Recommendations</u>

The enclosed recommendations result from the RUC's review of physicians' services from the February 3-5, 2011 meeting and include:

- *Fourth Five-Year Review of the RBRVS* – The RUC submitted a comprehensive set of recommendations in October 2010 and requested that 29 codes be deferred until the February meeting. The RUC has now completed the review of these codes. With the exception of issues deferred to the CPT Editorial Panel, the RUC has concluded the review of codes identified for the Fourth Five-Year Review.

- *Harvard Valued, Utilization greater than 100,000* – The RUC submits recommendations for five high volume services (vascular injections and special stains) that were previously reviewed under the Harvard research in the 1980s.

- *New Technology* – The RUC initiated its review of codes previously identified as new technology at the October 2010 meeting and requested a re-survey of stereotactic radiosurgery. The RUC submits revisions to the work and/or direct practice expense costs for these two services.

- *Site of Service Anomalies* – The RUC has completed its re-review of physician services identified as "site-of-service anomalies" and submits recommendations for 20 services. The Medicare claims data for these services reflect that the patient is in the outpatient hospital setting, while nearly all of these 20 services typically require an overnight stay (23+ hours). To the physician and the patient, the experience is the same, the patient is in a hospital bed and visits and discharge planning services are performed. The hospitals, under increased pressure due to CMS recovery audit contractors, are using a black box software package to determine admission status. The RUC strongly recommends that CMS consider evidence from the specialties and the RUC that visits and discharge management are typical and should be included as work proxies in the surgical global period.

  As stated in our December 20, 2010 comment letter to the CMS Final Rule for the 2011 Medicare Physician Payment Schedule, the RUC urges CMS to reconsider its decision to value subsequent observation visits lower than subsequent hospital visits. We are hopeful that the refinement panel will restore equity between these services. The subsequent observation visits (99224 – 99226) and the observation discharge (99217) represent the appropriate proxy for these 23+ hour services. In 2006 rulemaking regarding Evaluation and Management (E/M), CMS developed policy that E/M services in surgical global periods were equivalent in work to stand alone E/M services. Therefore, we ask that you reconsider any policy that would remove pre- and post-service work from observation visits performed by physicians within a procedure's global period.

  The RUC originated the review of services where the site-of-service had migrated from the inpatient setting to the outpatient setting. However, the RUC had assumed that this would represent services that are truly outpatient. Some of the codes identified recently were still 47% to 48% inpatient in one year and then 50% or 51% in the next. Coding or data errors could misclassify a code as an outpatient service. The RUC recommends that moving forward, we consider three consecutive years of data indicating 50% or fewer inpatients each year before indentifying a site of service anomaly. This would avoid misclassification due to annual fluctuations in the claims data.

- *Moderate Sedation* – At the request of the specialty societies representing gastroenterology, a workgroup was formed to consider whether the existing practice expense inputs related to moderate sedation are appropriate. The RUC suggests the addition of additional monitoring equipment as discussed in the enclosed recommendations.

Cost estimates for medical supplies and equipment not listed on the "CMS Labor, Supply, an Equipment List for the Year 2011" are based on provided source(s) as noted, such as manufacturer's catalogue prices and may not reflect the wholesale prices, quantity, or cash discounts, prices for used equipment or any other factors that may alter the cost estimates. The RUC shares this information with CMS without making specific recommendations on the pricing for supplies and equipment. For example, the RUC identified 77373 *Stereotactic body radiation therapy* as a new technology when initially reviewed in 2005. This technology has now matured and the RUC recommends revisions in the work and practice expense. The RUC requested that the specialty share with CMS invoices for all vendors of the SRS system to reflect updated pricing information.

Update on Progress of the Relativity Assessment Workgroup

The RUC has reviewed nearly 800 physicians services identified under one or more objective screens as potentially misvalued. The implementation of these RUC recommendations to improve the relativity within the RBRVS began in 2009, continued in 2010, with significant impact in 2011. The cumulative impact of the three years of effort is $1.5 billion in redistribution. The practice and professional liability redistribution occurs within the relative values, while the work value redistribution was implemented with minor increases to the Medicare conversion factor in 2009 and 2010 and a 0.4% increase in 2011.

The significance of the RUC's work should not be underestimated. This work would not be possible without the contributions of the volunteer physicians on the RUC and the medical specialty societies. Many specialty societies have shepherded through coding changes, surveys, and relative value recommendations that ultimately result in payment reductions for their members. The individuals in this process have done so as organized medicine understands that ensuring the relativity within the RBRVS is important. This volunteer effort should be recognized by CMS and other policymakers, not only in descriptions within rulemaking, but also in methods of implementation and expectations regarding ongoing review. For example, the RUC has called on CMS to transition the practice expense data implementation into services that were newly bundled. Additionally, specialties that are undergoing significant redistribution and changes in coding should be afforded the opportunity to address these modifications in a deliberate manner. Finally, we urge CMS to refrain from arbitrary adjustments through multiple procedure reductions or other policies. A process that allows for a comparison of today's practice to the original valuation history, with input of the individuals that perform the service, is imperative to maintaining a fair resource-based system.

In rulemaking for the 2011 Medicare Physician Payment Schedule, CMS identified additional screens to identify mis-valued services. The RUC has developed objective screens over the past five years and welcomes any ideas related to these or other screens. At the most recent RUC meetings, the Relativity Assessment Workgroup has reviewed the services identified in the CMS screens. Our recommendations on each of these screens are attached to this letter. The RUC's review of these services is ongoing. The screens include:

- *Codes with Low Work RVUs/Billed with Multiple Units* – CMS identified 12 services that are billed in multiples of 5 or more per day, with work RVUs of less than or equal to 0.50. In subsequent review of claims data provided to the RUC, it was determined that most of these 12 services are actually performed in multiples of less than 5 per day. Nevertheless, the RUC has now reviewed each of these codes to ensure that the typical number of units per Medicare claims data is consistent with the number of units assumed by the RUC during original valuation. The RUC has requested re-survey, practice expense review, or CPT referral for four of the 12 codes. These recommendations will follow by May 2011. The RUC is interested in obtaining claims data regarding number of units performed and the AMA is working to incorporate this data into the RUC database. A retrospective review to ensure that correct assumptions were made in original valuation is reasonable and warranted.

- *Low Value/High Volume Codes* – CMS requested that the RUC review 24 services that have low work RVUs (less than or equal to 0.25) and high utilization (over 1 million). It is not clear that the assignment of a low work relative value has any relationship to misvaluation. However, the RUC expanded the query to ensure that all codes with a work value of 0.50 and over 1 million were discussed. The RUC reviewed this list in February and determined that any low value code reviewed by the RUC should not be reconsidered as the valuation, combined with a review of the time data, is unlikely to be modified. However, the RUC has requested that specialties survey codes that have not yet been reviewed by the RUC. These services are noted as crosswalked by CMS (CMS/Other source). In reviewing the more comprehensive query the RUC identified CPT code 93971 *Extremity study*; G0101 *CA screen, pelvic/breast exam*; and G0283 *Elect. Stim other than wound*. The RUC requests that CMS indicate whether a review of G0101 and G0283 is desired by the agency. The RUC has previously reviewed G codes, but only at the request of CMS. A detailed list of the RUC recommendations and status update is included in the enclosed materials.

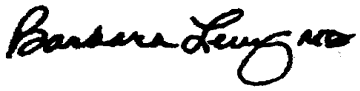
  The RUC review of this screen resulted in a request of complete list of all codes that were valued by neither the RUC or the Harvard study (ie, CMS/Other source). The RUC has reviewed all Harvard codes with utilization greater than 30,000.

Before any identification to review additional Harvard codes with lower volume thresholds, the CMS/Other codes with high volume should be addressed. The RUC will review the list of these codes to determine next steps at the April 2011 meeting.

- *Multi-Specialty Points of Comparison (MPC) List* – In the rulemaking for the 2011 Medicare Physician Payment Schedule, CMS requested review of 33 services, ranked by utilization and charges, included on the RUC's MPC list. In our comments to the rulemaking, we informed CMS that the RUC is engaged in a systematic review and restructuring of the MPC list. The RUC requested that CMS allow this review to continue without the requirement to resurvey key codes during the process. At the February meeting, the RUC reviewed the list of 33 codes and determined that 6 codes were identified by another screen and have either been very recently reviewed or are undergoing a review. An additional 17 codes have been reviewed by the RUC in the past six years. In the *Final Rule* for 2011, CMS indicated that the agency had screened for codes that had not been reviewed in the past six years. The RUC agrees that a review of stable codes describing matured technology would not likely result in a different valuation. The RUC, therefore, requests that CMS remove these codes from the screen. The remaining 10 codes have been referred to specialty societies to either survey for April 2011 presentation or develop an action plan to survey for September 2011. Action plans were needed for several services as the code can't be reviewed in isolation from a larger family of services. A list of the RUC's recommendations and status for these 33 codes is included in the enclosed materials.

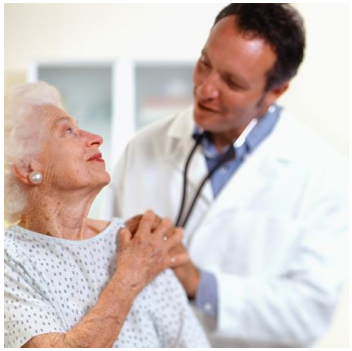
Thank you for your careful consideration of the RUC's recommendations. We look forward to continued opportunities to offer recommendations to improve the RBRVS.

Sincerely,



Barbara S. Levy, MD

cc: Carol Bazell, MD
Edith Hambrick, MD
Marc Hartstein
Ryan Howe
Ken Simon, MD
Elizabeth Truong
RUC Participants



RUC Chair Report

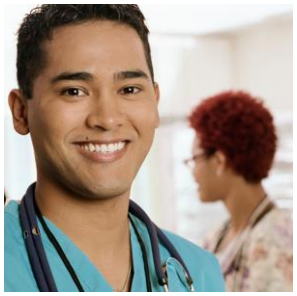
February 4, 2011

Naples, FL

AMA

TOGETHER WE ARE STRONGER

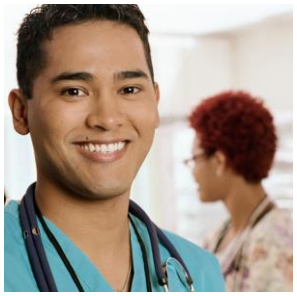


New RUC Members

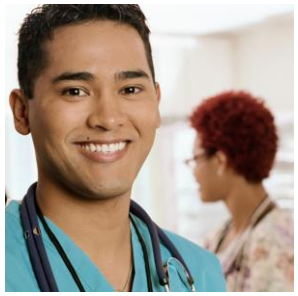
American Academy of Dermatology

- **Scott Collins, MD – RUC Member**
- **Mark Kaufmann, MD – RUC Alternate**



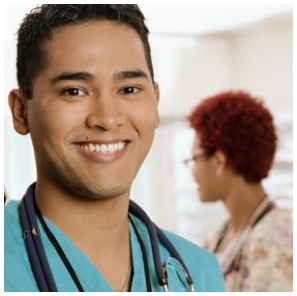
CPT Editorial Panel Member

- Richard Duszak, MD



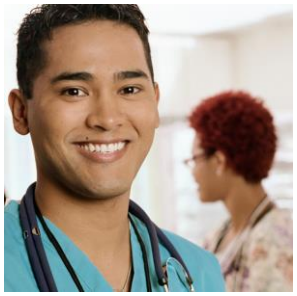
CMS Representatives

- **Edith Hambrick, MD – CMS Medical Officer**
- **Ken Simon, MD – CMS Medical Officer**
- **Ryan Howe**
- **Elizabeth Truong**
- **Ferhat Kassamali – L& M Policy Research**



CMD

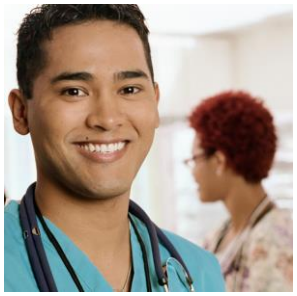
- **Charles Haley, MD**



MedPAC Commissioner

- Ronald D. Castellanos, MD

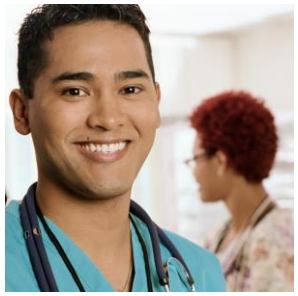


Columbia University Professor

- **Miriam Laugesen, PhD**
  - Assistant Professor of Health Policy and Management at Columbia University's Mailman School of Public Health.
  - The Robert Wood Johnson Foundation has provided funding to develop a book that reviews the implementation of the RBRVS and Medicare physician payment.

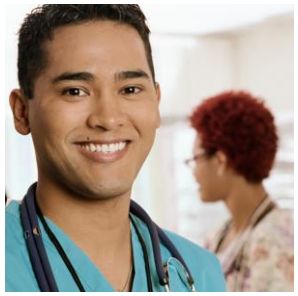


Korean Medical Association

- Hoon S. Yang, MD
  - Korean CPT
  - Executive Board member of Health Insurance Committee of KMA

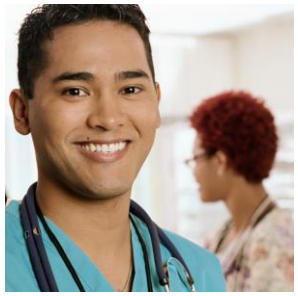


CPT Meeting - October 2011

- Request for RUC Representative to attend
  - October 13-15, 2011
  - Chicago Marriott Downtown

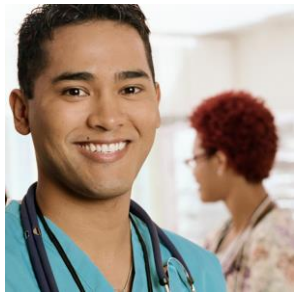


Confidentiality

- All RUC attendees/participants are obligated to adhere to the RUC confidentiality policy. (All signed an agreement at the registration desk)

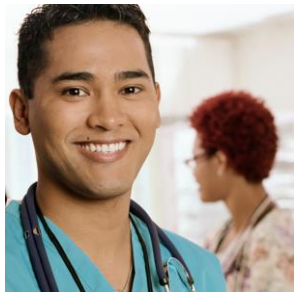


Procedural Issues

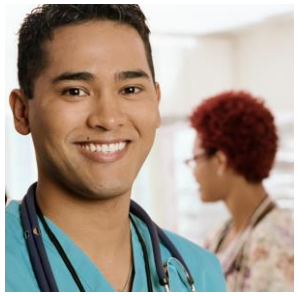
RUC Members:

- 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 society



The RUC is an Expert Panel

- Individuals exercise their independent judgment and are not advocates for their specialty



October 29 AMA Meeting on RUC

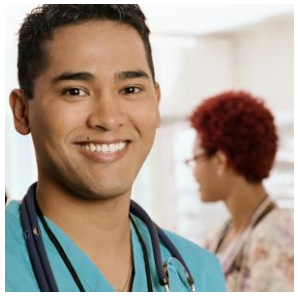
Leadership from the AMA and the following specialty societies met to discuss recent media and efforts to improve RUC process:

AAFP

ACP

ACR

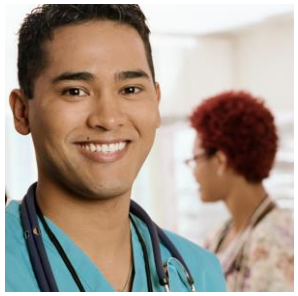
ACS



October 29 AMA Meeting on RUC

Distinguished desire of AAFP and others to infuse "value" into the RBRVS determinations from the RUC's role to articulate typical resources consumed in the provision of physician services.

Agreed to continue to look for ways to evolve and improve the RUC process. The AMA commitment to improve the survey process and tools, discussed yesterday at the Research Subcommittee, is an example of such an improvement.



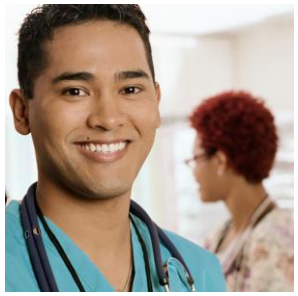
Always keep your RUC hat on

February 4, 2011

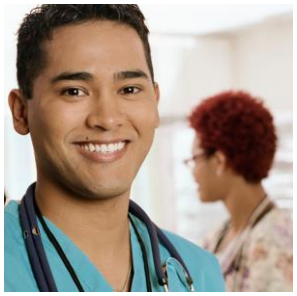
National wear Red to fight heart disease in women

I am famous for my power red. Now we all have red RUC hats as reminders for us to use our collective power and wisdom to be fair, impartial and equitable as we do our work here.

Source: Logo from American Heart Association



Jackson Paul Hochstetler
Dec 22, 2010 - 7lbs 11oz - 21in



- Test Clickers


AMA
AMERICAN
MEDICAL
ASSOCIATION

Washington Update 2-4-11

Sharon McIlrath
American Medical Association

Legislative Environment

- Divided Congress
  - House Republican margin 242-193 (94 new)
  - Senate Democratic margin 53-47 (13 new)
  - President's Veto Pen
- Promises from 2010 Elections
  - Deficit Reduction
  - Kill Health Reform Bill

Repeal, Replace, Reduce?

- House Passed Measure Repealing ACA
  - Directs Committees to develop alternative
  - Includes amendment calling for permanent replacement of SGR
- Repeal Bill Failed in Senate
- More to Follow
- But Repeal Won't Be Signed into Law
- Some Sections Might Be De-funded
- Court Cases have Created Ambiguity

ACA Considerations for Physicians

- Must Evaluate Likely End-Game Results
- Consider Collateral Damage
- Need Bipartisan Effort to Fix SGR
- Using ACA Savings for SGR Will Create Foes
- AMA Will Focus on Priority Concerns

Things to Keep

- Coverage Expansion to 32 million
- Health Insurance Market Reforms
- Administrative Simplification
- Medicare Bonus Payments
- Improved Prevention/Wellness Coverage
- Closing Part D Donut Hole
- Comparative Effectiveness Research

Problematic Proposals

- Dropping the Individual Mandate
  - Undermines market reforms
- De-funding CER
  - Weakens evidence base for medical decisions
- Eliminating/de-funding Innovation Center
  - Removes resources to test new payment models

Things to Change or Chuck

- Independent Payment Advisory Board
- Value-based Payment Modifier
- PQRI (now PQRS) Penalties
- Form 1099 Reporting
- Hospital Ownership Restrictions
- Liability Reform

SGR: Perpetual Problem

- Pay Scheduled to Fall More Than 25% in 2012
- Permanent Repeal Costs Around $330 Billion
- SGR Task Force of States and Specialties
  - Agreed to seek 1-year fix in 2011
  - Discussed 3 to 5 year period of stability
  - To test new payment and delivery methods
  - Followed by long term reform
  - Meeting this month to decide “what’s next”
- MedPAC will be looking at options & pay-fors

Private Contracting

- Opposition to Loosening Current Rules
- May Be Declining A Little Due to:
  - SGR Debacle,
  - Ballooning Deficit
  - Concern over Medicare Sustainability
- Another AMA Task Force Designed Proposal
  - Permits balance billing on case by case basis
  - Doing Patient Focus Groups and Public Polling
  - Have Made it and SGR and Medical Liability top issues at National Advocacy Conference

Regulatory Issues
Delivery Reform

- **Shared Savings (ACO) Plans**
  - Operational 1-1-12
  - Opportunities for input
  - Issues: attribution, players, privacy, risk/incentive structure
  - Timeline for proposed regulation
  - AMA message: ensure any physician can participate in delivery reforms; maintain leadership role for physicians.

Delivery Reform Regulations

- **Anti-trust**
  - DOJ and FTC coordinating with CMS in development of anti-trust exemption for ACOs
  - AMA pressing for protection for practices that integrate around HIT and quality
  - Also need relief from anti-kickback and Stark
- **CMMI**
  - Could help finance infrastructure to allow small physician practices to participate in reform.

Delivery Reform Regulations

- **Health Information Technology**
  - Registration for stimulus bill grants now open.
    - See www.ama-assn.org/go/hit.
  - E-Rx penalties in 2012 to be based on 2011
    - 10 times in first six months
    - 2013 based on all 12 months of 2011
    - AMA vigorously opposed
    - Continue to press for change—letters & meetings with Berwick and Sebelius.

Delivery Reform Regulations

- **Quality Initiatives**
  - Physician Compare
    - Required by ACA
    - the old physician directory with successful PQRS participants
    - lots of errors, often related to enrollment (PECOS) data
    - outcome data required in 2013
  - AMA is working with CMS to:
    - improve the enrollment system
    - and ensure that data is correctly attributed, risk-adjusted & reviewed by physician
  - Patient Safety Initiative
    - Berwick's personal project to be announced soon
    - Looking for 40% reduction in HACs and 20% reduction in readmissions by 2013; emphasis on care transitions
    - Will provide funds to develop and disseminate best practice information and bonuses to hospitals that meet targets

Other Regulations

- **Insurance Market Reforms**
  - benefits package, appeals, medical loss ratio, rate review
- **Fraud and Abuse**
  - ACA expanded funding & authority
    - extends RACs to Medicaid
    - new enrollment, screening & suspension rules
  - AMA communicating to HHS, DOJ, CPI
    - Medicaid must follow Medicare RAC rules
    - Got physicians in the lowest risk tier.
    - Will fight heightened screening/$500 fee for physician suppliers.

Other Regulations

- Signature on Lab Test Requisitions
  - At behest of AMA & others delayed 3 months
  - Still pressing for redaction
- Referring/Ordering Physician on Claims
  - Won't reject claims until PECOS improved
- Home Health Documentation
  - Face to face physician visit required 90 days before to 30 days after home care begins.
  - Delayed 3 months

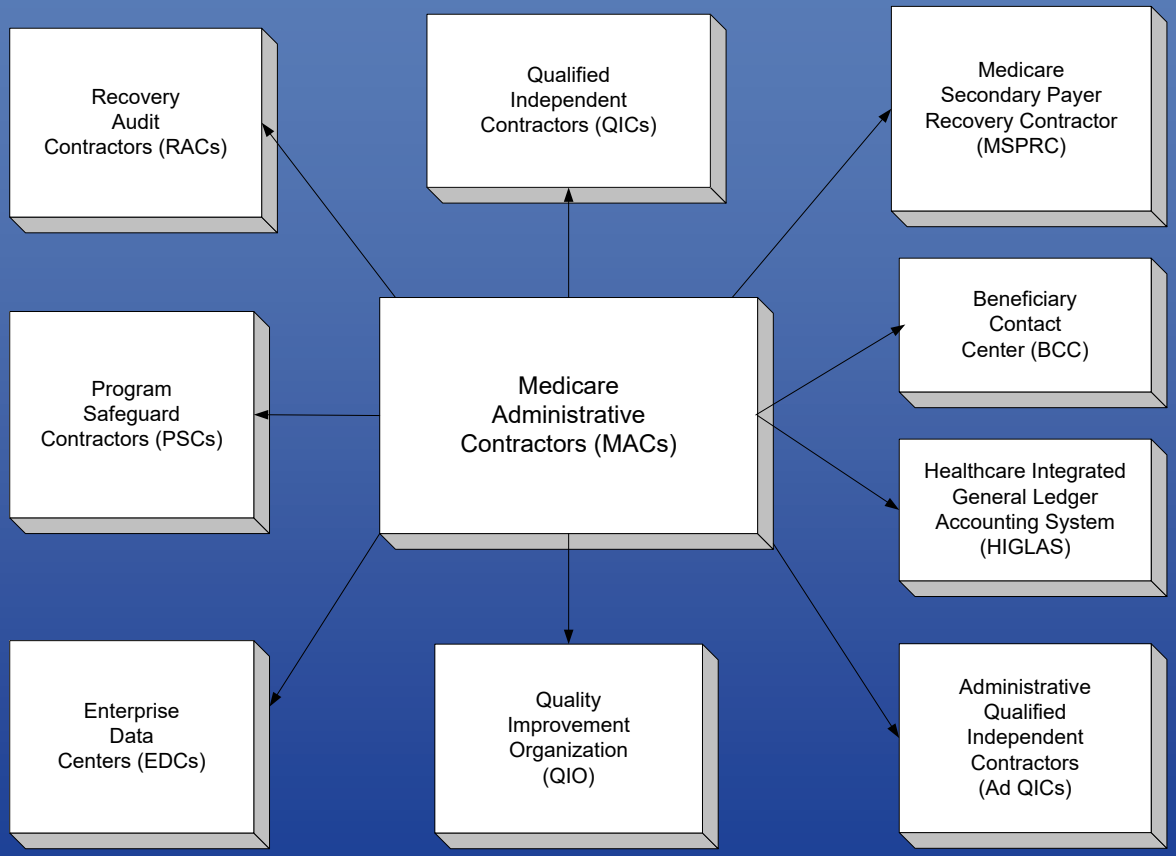
Help From On High?

- **Presidential Executive Order**
  - Issued January 18/tells agencies to:
    - Improve projected costs and benefits of regulations
    - Create process for better balance in future
    - Retrospective review of existing regulations
      - Identify “outmoded, ineffective, insufficient or excessively burdensome rules”
      - “Modify, streamline, expand or repeal them
    - AMA developing a priority list; sought input from specialties

Contracting Reform

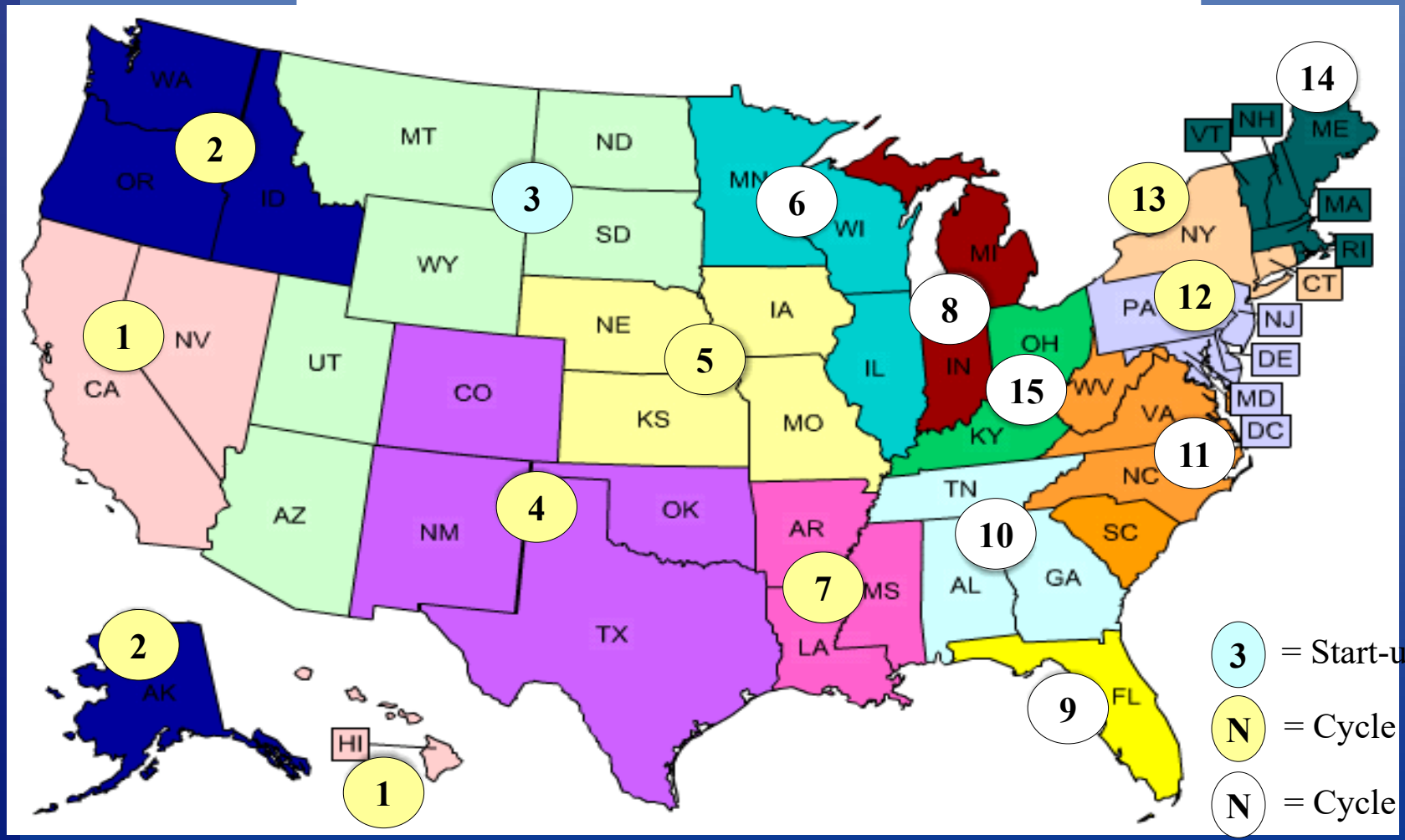
- Started in early 1990's with the development of specialty contractors for DME and Home Health Claims.
- HIPAA legislation created "Payment Safeguard Contractors" for fraud investigation.
- Accelerated with MMA (2003).
- CMS is moving away from single multifunction contractor to many single function contractors.

Medicare Functional Environment



Medicare Contracting Reform

Old A/B MAC Jurisdictions



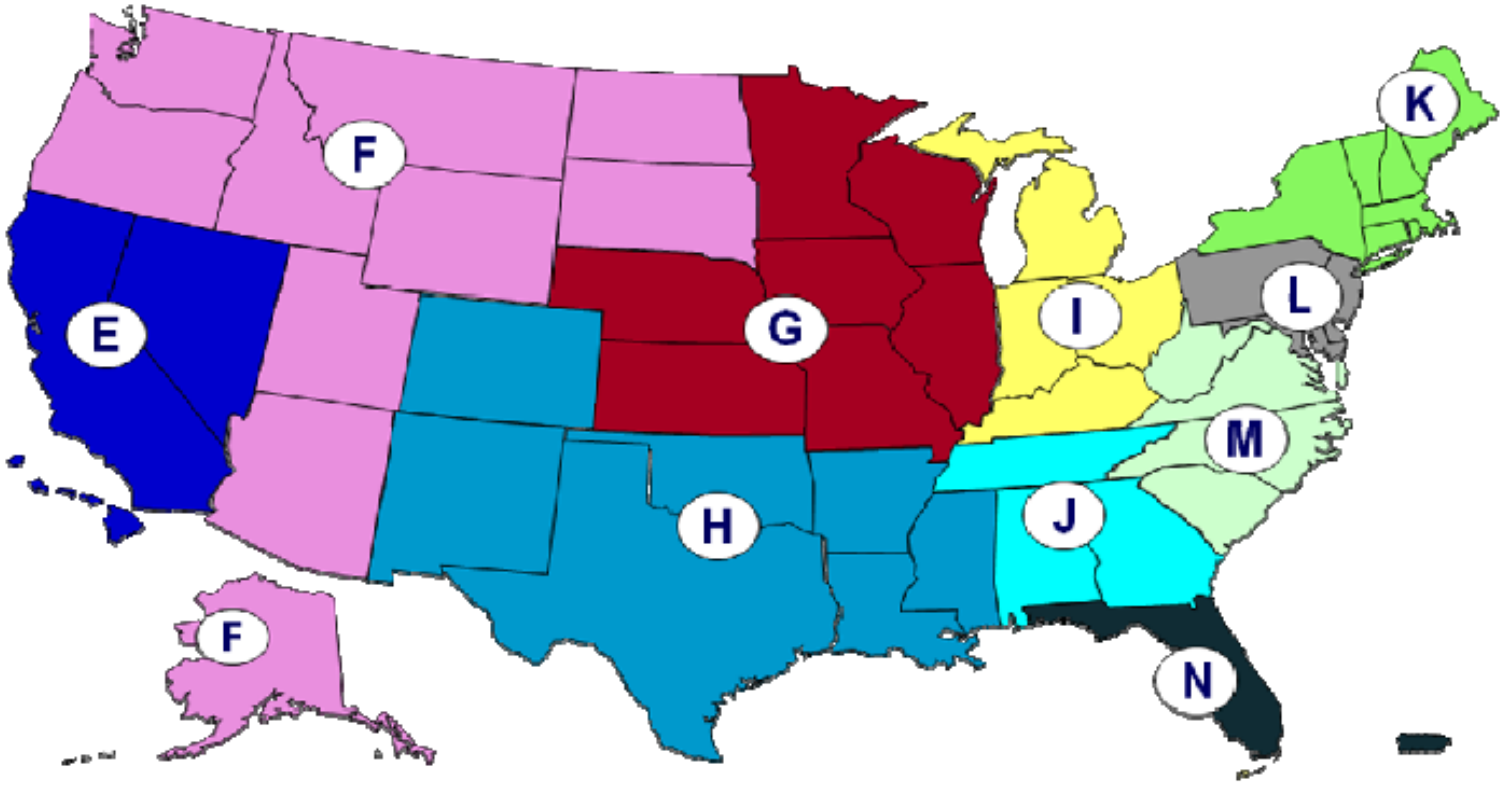
Medicare Contracting Reform

- **Operational:**
  - J1 - Palmetto
  - J3 - Noridian
  - J4 - TrailBlazer
  - J5 - WPS
  - J9 - FCSO
  - J10 - Cahaba
  - J12 - Highmark
  - J13 - NGS
  - J14 – NHIC

- **In Progress:**
  - **J11 – Palmetto**
  - **J15 - CIGNA**

- **Bid/Re-Bid**
  - J6 award pending
  - J8 award pending
  - J2 + J3 = JF
  - J7 + J4 = JH

Consolidated A/B MAC Jurisdictions



Changes for 2011

- New “Annual Wellness Visit” (CR 7079).
- Co-Pay and Deductibles waived for certain preventive services (CR 7012).
- Ordering/Referring provider edits delayed until mid-year (or later) (CR 6417 - revised).

- ICD10 by 2013.