AMA/Specialty RVS Update Committee
Meeting Minutes
September 29 – October 3, 2010

I. Welcome and Call to Order

Doctor Barbara Levy called the meeting to order on Thursday, September 30, 2010, at 8:00 am. The following RUC Members were in attendance:

Barbara Levy, MD (Chair)
Michael D. Bishop, MD
James Blankenship, MD
R. Dale Blasier, MD
Joel Bradley, MD
Ronald Burd, 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
Geraldine McGinty, MD
Bill Moran, Jr., MD
Guy Orangio, MD
Gregory Przybylski, MD
Marc Raphaelson, MD
Sandra Reed, MD
Daniel Mark Siegel, MD
Lloyd Smith, DPM
Peter Smith, MD
Susan Spires, MD
Arthur Traugott, MD
James Waldorf, MD
George Williams, MD
Allan Anderson, MD*
Gregory Barkley, MD*
Dennis M. Beck., MD*
Bruce Deitchman, MD*
Gregory DeMeo, DO*
Jane Dillon, MD*
Verdi DiSesa, MD*
Jeffrey Paul Edelstein, MD*
Emily Hill, PA-C*
Robert Jansen, MD*
M. Douglas Leahy, MD*
William J. Mangold, Jr., MD*
Daniel McQuillen, MD*
Terry Mills, MD*
Scott D. Oates, MD*
Julia Pillsbury, DO*
Chad Rubin, MD*
Steven Schlossberg, MD*
Stanley Stead, MD*
J. Allan Tucker, MD*
Robert Stomel, DO*

*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
  - Ferhat Kassamali
- Doctor Levy welcomed Jeffrey Cozzens, MD of the CPT Editorial Panel who is observing this meeting.

- Doctor Levy welcomed the following observers:
  - Lori Housman- Principal Analyst in the Medicare Cost Estimate Unit of the Congressional Budget Office.
  - 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.
- Doctor Levy welcomed the following new RUC Advisory Committee specialty societies and advisors:
  - American College of Mohs Surgery (ACMS)
    - Glenn Goldman, MD- Advisor
    - Brent Moody, MD- Alternate Advisor
  - American Society of Interventional Pain Physicians (ASIPP)
    - David Caraway, MD, PhD- Advisor
  - Heart Rhythm Society (HRS)
    - Christopher Jones, MD- Advisor
    - Kevin Wheelan, MD- Alternate Advisor
- Doctor Levy announced the following change to the RUC roster
  - Daniel Mark Siegel, MD will become the RUC Alternate as he is now the AAD President Elect
  - Bruce Deitchman, MD will become the RUC member starting at the February 2011 meeting.
- Doctor Levy congratulated the following RUC Advisors for their appointment to a six year term on the Patient-Centered Outcomes Research Institute (PCORI) Board of Governors
  - Christine Goertz-Choate, DC, PhD- ACA Alternate Advisor to HCPAC
  - Robert Zwolak, MD, SVS Alternate Advisor to RUC
- The RUC reviewed the Administrative Subcommittee's report regarding conflicts of interests for speakers on Tab 44 Urology Procedures and Tab 52 Psychotherapy.
  - The RUC unanimously approved the Subcommittee's report, which is attached to these minutes.
- A facilitation committee met prior to this meeting, to determine if a motion to reconsider the RUC recommendation for CPT code 67028 initially reviewed at the October 2009 meeting is appropriate. This was in response to a motion put forward by the specialty society to reconsider the recommendation for this service. The committee met prior to this meeting via conference call and did not approve the motion to reconsider and the values as approved by the RUC will be submitted to CMS.
- 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 February 3 – 6, 2011 at the Naples Grand Beach Resort in Naples, Florida.

IV. Approval of Minutes of the April 28 – May 1, 2010 RUC Meeting

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

V. CPT Editorial Panel Update

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

- CPT staff worked to get the CPT 2011 electronic files and publication together at the end of August to give payers and physicians additional time to prepare claims systems for the CPT changes.
- The CPT Annual Meeting is occurring October 14 – 16, 2010 at the Millennium Biltmore Hotel in Los Angeles. Among the topics to be discussed is the advisors' role within CPT process and the work of the molecular pathology workgroup.

VI. Centers for Medicare and Medicaid Services Update

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

- Since the last meeting, Doctor Donald Berwick has been appointed as the Administrator for CMS.
- CMS has been busy implementing the healthcare reform legislation in addition to the normal regulatory processes.

VII. Contractor Medical Director Update

There was no Contractor Medical Director Report given at this meeting.

VIII. Washington Update

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

- CMS is still working to implement retroactive provisions from 1/1/2010 to 6/1/2010. These provisions include: one-year extension of work GPCI floor, one-year extension of 5% psychiatric services bonus, bone density scan payment increase and practice expense GPCI changes. CMS has indicated that it needs additional funds ($200 million) to implement these provisions.
- As part of the Pension Relief Act signed into law 6/25/2010 Congress approved a 2.2% conversion factor increase effective 6/10. Also, an increase from 25% to 50% cut in imaging contiguous body parts was implemented effective 7/1/2010.
- For 2011, there are several physician payment provisions that CMS proposed, including: the expiration of the work GPCI floor, PE GPCI floor for 5 frontier states (MT, WY, ND, SD, NV) and the MEI rebasing will increase share of MEI and GPCI attributable to PE and PLI expenses. The AMA has told CMS that it is too early to implement this MEI rebasing and is pushing for CMD to wait for the technical panel to review the modifications prior to finalizing the MEI rebasing.

- There are a number of 2011 Affordable Care Act (ACA) provisions that were addressed in the CMS 2011 proposed rule, including:
    - General surgery and primary care bonus. The primary care bonus is available for physicians who have 60% or more of their allowable charges related to designated visit codes. The general surgery bonus is available for surgeons in health professional shortage areas.
    - Medicare preventive services. CMS created G codes. The AMA commented that CMS should use RUC-valued CPT codes and suggest additional services.
    - Multiple procedure payment reductions. CMS went beyond ACA requirements by expanding the services subject to the reductions to include any advanced imaging and/or ultrasound on the same day and any therapy services on the same day.
- There are a number of quality provisions in the ACA and addressed in the proposed rule including: the PQRI reporting sample will be reduced from 80% to 50% of applicable cases for 2011 and electronic prescribing requirements will be reduced from 50% of all applicable services to 25% of services.
- The ACA has promoted several value-based purchasing and delivery system reforms, including:
    - The Center for Medicare and Medicaid Innovation is mandated by the ACA to pursue new delivery and payment models. They are to look into demos and pilots, including: medical home, telehealth and direct contracting.
    - Shared savings or Accountable Care Organizations has been promoted by MedPAC and is seen as hospitals and physician working together to provide high-quality, effective care.
    - Additional ACA-mandated demos include Independence at home and bundling acute and post-acute care.
- Congress has still not permanently addressed a SGR fix. The 23% cut is coming on December 1 and another 6.3% cut in January 2011. The AMA wants to avoid the chaos of this year, and the looming restructuring following the mid-term elections, by stabilizing payments at least through the end of 2011.

IX. Relative Value Recommendations for CPT 2011

Multi-Layer Compression System (Tab 4)
Gary Seabrook, MD, SVS; Sean Roddy, MD, SVS

In June 2010, the CPT Editorial Panel revised code 29581and created three new codes to describe the application of multi-layer compression to the upper and lower extremities, not just below the knee. Multi-layer compression systems are used to treat edema for a variety of indications, not just venous leg ulcers.

29581
The CPT Editorial Panel determined the revisions to the descriptor for 29581 were editorial when multi-layer compression codes for other body areas were created. Additionally, no changes were made to the vignette and therefore the specialty society explained that resurveying this code was not necessary. The RUC agreed that the changes to 29581 were editorial. The RUC noted that code 29581 was intended predominantly for venous ulcer therapy and includes ulcer related care in addition to compression. **The RUC recommends that the changes to 29581 were editorial and to maintain the work RVU of 0.60 for CPT code 29581.**

Abdominal Paracentesis (Tab 5)
Edward Bentley, MD, ASGE; Nicholas Nickl, MD, ASGE; Jayarani Agrawal, MD, AGA; Zeke Silva, MD, ACR; Sean Tutton, MD, SIR; Bob Vogelzang, MD, SIR; Christopher Senkowski, MD, ACS; Samuel Smith, MD, APSA

In February 2010, the RUC identified CPT codes 49080 *Peritoneocentesis, abdominal paracentesis, or peritoneal lavage (diagnostic or therapeutic); initial* and 49081 *Peritoneocentesis, abdominal paracentesis, or peritoneal lavage (diagnostic or therapeutic); subsequent* through the Harvard Valued-Utilization over 100,000 screen. The specialties noted that the services have evolved since the codes were initially established and need separate codes that distinguish paracentesis performed without imaging guidance and paracentesis performed with imaging guidance. In June 2010, the CPT Editorial Panel created three new CPT codes, 4908X1, 4908X2 and 4908X3, to more accurately describe the current medical practice.

4908X1 ***Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance***
The RUC reviewed the survey results for CPT code 4908X1. The RUC analyzed the survey's estimated physician work and noted that there is no compelling evidence to change the current work value of 1.35 for CPT code 49080, which the surveyed code is replacing. The RUC agreed with the specialty recommended pre-service time of 20 minutes, intra-service time of 20 minutes and post service time of 10 minutes for consistency with the physician time for codes 49080 (pre-service time of 26 minutes, intra-service time of 27 minutes) and 49081 (pre-service time of 25 minutes and intra-service time of 27 minutes). This time also maintains appropriate relativity across the family of services, as the RUC recommends intra-service time of 25 minutes for CPT code 4908X2, which is the same procedure as 4908X1 but with imaging guidance included. To further justify the recommended value, the RUC compared the surveyed code to key reference service CPT code 99233 *Subsequent hospital care* (work RVU= 2.00 and total time= 55 minutes). The RUC agreed that the reference code should be valued higher due to greater intra-service time compared to the surveyed code, 30 minutes and 20 minutes, respectively. The survey respondents indicated, and the RUC agreed, that the reference code requires greater mental effort and judgment compared to CPT code 4908X1. In addition, the RUC compared code 4908X1 to MPC code 11755 *Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds)* (work RVU= 1.31 and total time= 25 minutes). The RUC agreed that these services should be valued similarly, given their analogous total times, 55 minutes and 50 minutes, respectively. **The RUC recommends a work RVU of 1.35 for CPT code 4908X1.**

4908X2 ***Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance***
The RUC reviewed and agreed with the specialty survey results from 75 radiologists, interventional radiologists and gastroenterologists for CPT code 4908X2. The RUC recommends pre-service time of 25 minutes, intra-service time of 25 minutes and post service time of 10 minutes. The RUC analyzed the survey's estimated physician work and agreed that these data support a work value of 2.00, the survey's 25th percentile, which is lower than the current value for this service, CPT code 49080 (work RVU= 1.35) with code 76942 (work RVU= 0.67) for a total RVU of 2.02. To further justify this recommended value, the RUC compared the surveyed code to key reference service CPT code 32422 *Thoracentesis with insertion of tube, includes water seal (eg, for pneumothorax), when performed* (work RVU= 2.19 and total time= 75 minutes). The RUC agreed that the reference code should be valued higher due to greater intra-service time than the surveyed code, 31 minutes and 25 minutes, respectively. In addition, the RUC compared CPT code 4908X2 to the reference MPC code 43235 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing* (work RVU= 2.39 and total time= 63 minutes). The RUC noted that the reference code should be valued greater than the surveyed code due to greater total time, 63 minutes compared to 60 minutes, and greater physician work intensity. Finally, the RUC noted that a work RVU of 2.00 for CPT code 4908X2 maintains the proper rank order with the approved base code 4908X1, accurately accounting for the inclusion of imaging guidance. **The RUC recommends a work RVU of 2.00 for CPT code 4908X2.**

4908X3 ***Peritoneal lavage, including imaging guidance, when performed***
The RUC discussed the compelling evidence provided by the specialty society that incorrect assumptions were made in the previous valuation of this service because of a misleading vignette. During the Harvard review, the vignette used for code 49080 was "Initial abdominal paracentesis" and for code 49081 it was "abdominal paracentesis, subsequent." Peritoneal lavage is distinctly different from paracentesis. Diagnostic peritoneal lavage is performed in the urgent, unstable patient to assess for blood and enteric contents and to determine if exploratory surgery is required. The RUC agreed that compelling evidence had been met to change the value of performing this service.

The RUC reviewed and agreed with the specialty survey results from 35 general surgeons for CPT code 4908X3. The RUC recommends pre-service time of 23 minutes, intra-service time of 20 minutes and post service time of 15 minutes. The RUC analyzed the survey's estimated physician work and agreed that these data support a work value of 2.50, the survey median, for this service. To further justify this value, the RUC compared the surveyed code to key reference CPT code 36556 *Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older* (work RVU= 2.50 and total time= 50 minutes). The RUC agreed that these service should be valued similarly due to their similar total physician time, 58 minutes and 50 minutes respectively. In addition, the RUC compared CPT code 4908X3 to MPC code 52000 *Cystourethroscopy* (work RVU= 2.23 and total time= 42 minutes). The RUC noted that the surveyed code has greater intra-service time and total time compared to the reference code, 58 minutes and 42 minutes, respectively, and should be valued higher. Finally, to ensure the recommended value maintains relativity across the RBRVS, the RUC compared the surveyed code to MPC code 51102 *Aspiration of bladder; with insertion of suprapubic catheter* (work

RVU= 2.70 and total time= 60 minutes). The RUC compared the total times between the two services, 58 minutes for 4908X3 and 60 minutes for 51102, and agreed that the reference code should be valued slightly higher. **The RUC recommends a work RVU of 2.50 for CPT code 4908X3.**

Practice Expense:
The RUC made substantial revisions to the direct practice expense inputs recommended by the specialties for procedures 4908X1-4908X2. Clinical labor was specifically refined after considerable discussion and revisions. An explanation of these changes have been captured in the attached spreadsheet. The RUC approved the modified practice expense recommendations for 4908X1-X2. The RUC approved the direct inputs recommended by the specialty for code 4908X3.

Special Stains (Tab 6)
Jonathan Myles, MD, CAP

In October 2008, CPT codes 88312-88319 were identified through the RUC's Relativity Assessment Workgroup as one of the Top 9 Harvard services with high utilization (performed over 1 million times per year). The RUC recommended a full RUC survey be conducted.

The Practice Expense (PE) Subcommittee did not receive direct practice expense recommendations from the specialty society for these services as the specialty did not believe the services had changed through the CPT process. The PE Subcommittee agreed that the practice expense inputs for these services may have changed since they were first reviewed over 10 years ago. Since the Specialty had not reviewed the practice expense inputs associated with these services based on the changes made by the CPT Editorial Panel, the PE Subcommittee could not make a recommendation to maintain the exiting inputs as suggested by the specialty. **The PE Subcommittee agrees and the RUC recommends that the specialty develop practice expense input recommendations for CPT codes 88312-88319 and present both the work and practice expense input recommendations at the February 2011 RUC Meeting.**

X. CMS Requests

Incision and Drainage of Abscess (Tab 7)
Seth Rubenstein, DPM, APMA; Timothy Tillo, DPM, APMA; Christopher Senkowski, MD ACS; Samuel Smith, MD, APSA

In October 2009, CPT code 10061 was identified by the RUC Relativity Assessment Workgroup through the Harvard Valued – Utilization over 100,000 screen. The RUC recommended a full RUC survey be conducted. CPT code 10060 was identified as part of the this family to be reviewed.

10060 ***Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single***
The American College of Surgeons (ACS) and American Podiatric Medical Association (APMA) indicated that code 10060 was originally surveyed in the Harvard studies by emergency medicine physicians who represented less than 1% of all providers of this service in 1991. The HCPAC, in 2005, reviewed the service with survey responses from

the predominant provider, podiatrists. However, in 2005, CMS chose to maintain the value for the code, which was based on the original flawed Harvard data and was not supported by any similar reference services. The RUC determined there is compelling evidence to review code 10060 because the current value is still based on flawed Harvard data.

The RUC reviewed the survey results from 45 podiatrists and general surgeons. The RUC is recommending the survey median work RVU of 1.50 for CPT code 10060. The RUC noted that the current median value is the same value that the HCPAC had recommended in 2005. The RUC compared the surveyed code to the key reference code *11402 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 1.1 to 2.0 cm* (work RVU = 1.45 and total time = 56 minutes) and determined that the surveyed service requires approximately the same physician time to perform as the key reference service, 57 and 56 minutes, respectively. Additionally, the survey respondents indicated that the surveyed code requires slightly more mental effort, judgment, technical skill, physical effort and psychological stress to perform than the key reference code. Therefore, the RUC agreed that the survey respondents median value of 1.50 appropriately valued this service slightly higher than the similar key reference service. For additional support the RUC compared code 10060 to MPC services 11420 *Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less* (work RVU = 1.03 and total time = 36 minutes) and 11422 *Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm* (work RVU = 1.68 and total time = 56 minutes) and determined that the survey median relative value appropriately places this service in the proper rank order with these similar services. **The RUC recommends a work RVU of 1.50 for CPT code 10060.**

10061 ***Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple***

The RUC reviewed the survey results from 43 podiatrists and general surgeons. Although the survey data for this service suggests a higher value for this service, median survey value of 2.50 work RVUs, the specialties had no compelling evidence to change the current value of the service. The RUC determined that the current work RVU of 2.45 maintains the appropriate value for this service relative to this family and other similar services. To further support maintaining the current value for code 10061, the RUC noted that the key reference code 11423 *Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm* (work RVU = 2.06 and total time = 76 minutes) required slightly less time than the surveyed code, 76 and 83 minutes, respectively, and the surveyed code was more intense and complex. The RUC also compared the surveyed code to similar MPC code 11424 *Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm* (work RVU = 2.48 and total time = 86 minutes), both require the similar total time to perform, 83 and 86 minutes, respectively, and are valued similarly, 2.45 and 2.48, respectively. **The RUC recommends a work RVU of 2.45 for CPT code 10061.**

Dressings/Debridement of Partial-Thickness Burns (Tab 8)
Thomas Weida, MD, AAFP

In October 2009, the RUC Relativity Assessment Workgroup identified CPT codes 16020 and 16025 through the Different Performing Specialty from Survey screen. In 2005, these codes were surveyed and presented by the American Burn Association and the American Society of Plastic Surgeons. According to current Medicare claims data, the dominant providers are family medicine, emergency medicine, internal medicine and general surgery.

16020 ***Dressings and/or debridement of partial-thickness burns, initial or subsequent; small (less than 5% total body surface area)***
The American Academy of Family Physicians (AAFP) conducted a survey and recommended to maintain the current work RVU of 0.80 for CPT code 16020. The RUC agreed that the current value for code 16020, with 15 minutes intra-service time, is supported by the key reference service 11100 *Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion* (work RVU = 0.81 and intra-service time = 12 minutes) which requires similar physician work, time, intensity and complexity to perform. The RUC recommends maintaining the current work RVU of 0.80 for CPT code 16020, as it maintains the appropriate value in relation to this family of services and similar services. Based on these comparisons and that the specialty did not provide compelling evidence to change the current value of the service, the RUC agreed that the survey data supports the current value of this service. **The RUC recommends a work RVU of 0.80 for CPT code 16020.**

16025 ***Dressings and/or debridement of partial-thickness burns, initial or subsequent; medium (eg, whole face or whole extremity, or 5% to 10% total body surface area)***
The American Academy of Family Physicians (AAFP) conducted a survey and recommend to maintain the current work RVU of 1.85 for CPT code 16025. The RUC agreed that the current value for code 16025, with 20 minutes intra-service time, is supported by the key reference service 54150 *Circumcision, using clamp or other device with regional dorsal penile or ring block* (work RVU = 1.90 and intra-service time = 15 minutes) which requires similar physician work, time, intensity and complexity to perform. CPT code 16025 requires 5 more minutes of intra-service time compared to the key reference code, however, the survey respondents indicated and the RUC agreed that the intra-service for 16025 is more intense and complex. The RUC recommends maintaining the current work RVU of 1.85 for CPT code 16025, as it maintains the appropriate value in relation to this family of services and similar services. Based on these comparisons and that the specialty did not provide compelling evidence to change the current value of the service, the RUC agreed that the survey data supports the current value of this service. **The RUC recommends a work RVU of 1.85 for CPT code 16025.**

Arthrocentesis (Tab 9)
William Creevy, MD, AAOS; Tye Ouzounian, MD, AOFAS; Daniel Nagle, MD, ASSH; Seth Rubenstein, DPM, APMA; Timothy Tillo, DPM, APMA; Eileen Moynihan, MD, ACRh

In October 2009, the RUC identified CPT code 20605 as potentially misvalued through the Harvard Valued-Utilization over 100,000 screen. In February 2010, the specialties submitted an action plan to the RUC's Relativity Assessment Workgroup which included the entire Arthrocentesis family of services, CPT codes 20600, 20605 and 20610. The RUC recommended that these services be RUC surveyed.

20600 ***Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, fingers, toes)***
The RUC reviewed the survey results from 76 orthopaedic surgeons, hand surgeons, podiatrists and rheumatologists for CPT code 20600. The RUC noted that although this service is typically reported with an Evaluation and Management service on the same day, 11 minutes of pre-service time is necessary because the physician is discussing possible complications and obtaining consent, prepping the joint for the injection and waiting for the local anesthesia to take effect.

The RUC analyzed the survey's estimated physician work and agreed that these data support maintaining the current work value of 0.66 for this service. To justify this value, the RUC compared the surveyed code to key reference CPT code 20550 *Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")* (work RVU= 0.75 and intra time= 5 minutes). The RUC agreed that these services should be valued similarly given that they have similar physician work and analogous total time, 21 minutes and 20 minutes, respectively. In addition, the RUC compared CPT code 20600 to MPC code 11056 *Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 to 4* lesions (work RVU= 0.61 and total time= 15 minutes). The RUC agreed that the surveyed code should be valued higher due to greater total time than the reference code, 21 minutes and 15 minutes, respectively. **The RUC recommends a work RVU of 0.66 for CPT code 20600.**

20605 Arthrocentesis, ***aspiration and/or injection; intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)***
The RUC reviewed the survey results from 72 orthopaedic surgeons, hand surgeons, podiatrists and rheumatologists for CPT code 20605. The RUC noted that although this service is typically reported with an Evaluation and Management service on the same day, 11 minutes of pre-service time is necessary because the physician is discussing possible complications and obtaining consent, prepping the joint for the injection and waiting for the local anesthesia to take effect.

The RUC analyzed the survey's estimated physician work and agreed that these data support maintaining the current work value of 0.68 for this service. To justify this value, the RUC compared the surveyed code to MPC code 11056 *Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 to 4* lesions (work RVU= 0.61 and total time= 15 minutes). The RUC agreed that the surveyed code should be valued higher due to greater total time than the reference code, 21 minutes and 15 minutes, respectively. Additionally, the RUC compared CPT code 20605 to reference CPT code 20612

Aspiration and/or injection of ganglion cyst(s) any location (work RVU= 0.70 and total time= 20 minutes). The RUC agreed that these two analogous services should be valued closely as they have identical intra-service time, 5 minutes, and similar total time, 21 minutes and 20 minutes, respectively. **The RUC recommends a work RVU of 0.68 for CPT code 20605.**

20610 Arthrocentesis, *aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)*
The RUC reviewed the survey results from 61 orthopaedic surgeons, hand surgeons, podiatrists and rheumatologists for CPT code 20610. The RUC noted that although this service is typically reported with an Evaluation and Management service on the same day, 11 minutes of pre-service time is necessary because the physician is discussing possible complications and obtaining consent, prepping the joint for the injection and waiting for the local anesthesia to take effect.

The RUC analyzed the survey's estimated physician work and agreed that these data support maintaining the current work value of 0.79 for this service. To further justify this value, the RUC compared the surveyed code to MPC code 11056 *Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 to 4* lesions (work RVU= 0.61 and total time= 15 minutes). The RUC agreed that the surveyed code should be valued higher due to greater total time than the reference code, 21 minutes and 15 minutes, respectively. In addition, the RUC compared CPT code 20610 to MPC code 31575 *Laryngoscopy, flexible fiberoptic; diagnostic* (work RVU= 1.10 and intra time= 8 minutes). The RUC noted that the reference code has more total time, 28 minutes, and intra-service time, 8 minutes compared to 5 minutes for the surveyed code. Given this, the RUC agreed that the reference code should be valued higher. **The RUC recommends a work RVU of 0.79 for CPT code 20610.**

The RUC also reviewed a table of other injection codes that includes MPC codes, high volume codes and/or recently RUC-reviewed codes. This review using magnitude estimation comparison of work RVUs further supports the relative ranking and current work RVUs for 20600, 20605, and 20610.

<u>Shoulder Arthroscopy - PE Only (Tab 10)</u>

In February 2010, the following services were identified 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 Workgroup recommended that the RUC consider that 29826 is reported as a stand alone procedure less than 1% of the time per Medicare claims data. CPT code 29826 was placed on the RUC's October 2010 agenda for review of its practice expense inputs, specifically regarding the post operative 090 day global period, as they may be considered duplicative when billed together. The specialty noted that 29826 should not be converted to a ZZZ global period as the service, in the non-Medicare population, is typically performed as a stand alone procedure.

In October 2010, when the RUC attempted to review this issue regarding possible duplication in practice expense inputs, the specialty did not provide a presenter for the meeting. **The RUC agreed that this issue should be postponed to the February 2011 meeting.**

Uroflometry – PE Only (Tab 11)
James Giblin, MD, AUA

In February 2010, CPT codes 51736 *Simple uroflowmetry (UFR) (eg, stop-watch flow rate, mechanical uroflowmeter)* and 51741 *Complex uroflowmetry (eg, calibrated electronic equipment)* were identified by the RUC's Relativity Assessment Workgroup through its Harvard Valued Utilization over 100,000 Screen, and the RUC recommended a review of the physician work required to perform these services. After a review of the physician work in April 2010, the RUC recommended a review of the direct practice expense inputs for 51736 and 51741, due to the apparent change in technology.

In October 2010, the RUC carefully reviewed the specialty recommended reduced typical clinical labor, medial supplies, and equipment for codes 51736 and 51741. The RUC made minor edits and agreed with the modified specialty recommendations. The RUC also noted that the clinical labor time was reduced by over 75% for each of the services. **The RUC recommends the attached direct practice expense inputs for codes 51736 and 51741.**

Spine/Brain Pump, Analyze with Refill and Maintenance – PE Only (Tab 12)
Eddy Fraifeld, MD, AAPM; Joseph Zuhosky, MD, AAPMR; John Wilson, MD, AANS; Frederick Boop, MD, CNS; Marc Leib, MD, ASA; Christopher Merifield, MD, ISIS; William Sullivan, MD, NASS

In April 2010, the following services were identified through the RUC's Relativity Assessment Workgroup' Different Performing Specialty from Survey Screen, High Volume Growth Screen and Codes Reported Together 75% or More Screen.

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*
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*
95990 *Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular);*
95991 *Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular); administered by a physician*

The Relativity Assessment Workgroup referred the above set of codes to the CPT Editorial Panel to delete 62368 and separate into 3 codes. In addition, the Workgroup referred the services to the Practice Expense Subcommittee for review in October 2010 to remove duplication in their direct practice expense inputs. In October 2010, the RUC did not review the direct inputs for this code set as the specialty informed the RUC that a coding proposal has been submitted for discussion at the October 2010 CPT Editorial Panel meeting. In October 2010 the CPT Editorial Panel created two codes and revised three to distinguish and provide specificity to the this group of codes. An additional parenthetical was also added so that codes 95990-95991 are not reported in conjunction with 62367-6236X3. In February 2011 the RUC will review the physician work and practice expense for these Codes 62367 and new codes 6236X2 and 6236X3.

Treatment of Retinal Lesion or Choroid (Tab 13)
Stephen Kamenetzky, MD, AAO; William Mieler, MD ASRS
Facilitation Committee #1

In February 2008, the RUC identified CPT codes 67210 and 67220 as potentially misvalued through the High IWPUT screen. The specialty, at the October 2009 RUC meeting, requested a change in the global period for this service. CMS subsequently rejected this proposal and the specialty surveyed these codes for the October 2010 RUC meeting.

67210 ***Destruction of localized lesion of retina (eg, macular edema, tumors), 1 or more sessions; photocoagulation***
The RUC analyzed the survey results from 39 Ophthalmologists and agreed that the survey respondents overestimated the physician work involved in the service. Therefore, to develop recommendations for these services the RUC compared the surveyed code to the reference CPT code 67221 *Destruction of localized lesion of choroid (eg, choroidal neovascularization); photodynamic therapy (includes intravenous infusion)* (work RVU= 3.45 and intra time of 15 minutes). The RUC noted that these two services have very similar physician work intensity and complexity with identical intra-service times, 15 minutes. Therefore, the RUC determined that these service's values should be identical. However, the RUC noted that CPT code 67221 is a 000 day global service, while CPT code 67210 is a 090 day global service. To determine the value for this service, the RUC agreed to add the typical amount of post operative visits, three 99213 office visits (total work RVU= 2.91), to the base work value of 3.45. Using magnitude estimation, 3.45 + 2.91, the RUC recommends a work value of 6.36 for CPT code 67210.

To ensure the value for this service is relative to similar services, the RUC compared CPT code 67120 to the Key Reference Service code 67228 *Treatment of extensive or progressive retinopathy, 1 or more sessions; (eg, diabetic retinopathy), photocoagulation* (work RVU= 13.82). The RUC noted that when this service was reviewed in February 2007, the value was based off 2.4 treatments. If the work value and times are adjusted to a per single treatment session, the service has a work value of 5.76 and intra-service time of 25 minutes. The RUC agreed with the specialty that compared with the reference code, the surveyed code requires greater physician mental effort, complexity, technical skill and risk due to the fact that this laser treatment is administered in the macular area rather than the more peripheral retinal area treated by 67228. Given this, the RUC agreed that the recommend work value of 6.36 for code 67210 appropriately places this service in the

proper rank order relative to other services performed by Ophthalmologists. Finally, the RUC noted that the recommended value is a significant reduction, 33 percent, from the current value of 9.45 and the recommended IWPUT for this service is 0.199 a significant reduction from the initial IWPUT of 0.336. **The RUC recommends a work RVU of 6.36 for CPT code 67210.**

67220 ***Destruction of localized lesion of choroid (eg, choroidal neovascularization); photocoagulation (eg, laser), 1 or more sessions***
The RUC analyzed the survey results from 46 Ophthalmologists and agreed that the survey respondents overestimated the physician work involved in the service. Therefore, to develop recommendations for these services the RUC reviewed this service in comparison to the other service in the family, code 67210, and agreed that the physician work intensity is the same for both services. Given this, the RUC took the same methodology they used for code 67210 and applied it directly to code 67220, deriving a work value of 6.36 for CPT code 67220. The RUC noted that the recommended value is a significant reduction, 44 percent, from the current value of 14.39 and the recommended IWPUT for this service is 0.183 a significant reduction from the initial IWPUT of 0.389. **The RUC recommends a work RVU of 6.36 for CPT code 67220.**

IMRT with Ultrasound Guidance – PE Only (Tab 14)
Najeeb Mohideen, MD, ASTRO

Duplicative Direct Practice Expense Inputs
In April 2010, the RUC's Relativity Assessment Workgroup identified the following four intensity modulated radiation treatment delivery services for RUC practice expense review through its Codes Reported Together 75% or More Screen and CMS Fastest Growing Screen:

76950 *Ultrasonic guidance for placement of radiation therapy fields*
77418 *Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session*
77014 *Computed tomography guidance for placement of radiation therapy fields*
77421 *Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy*

To assure there is no duplication in practice expense, the Workgroup referred the practice expense components to the RUC for review of potential practice expense input duplication, as the services were reviewed at separate meetings and are frequently reported together.

In October 2010, the RUC examined the direct inputs of the four services together and made minor revisions to eliminate duplicative clinical labor, supplies, and equipment typically used. **In addition, the RUC recommended that the CPT Editorial Panel add the parenthetical after CPT code 77421; (Do not report 77421 more than once per treatment delivery session) to add further clarification to the reporting of this servcie. The RUC recommends the attached direct practice expense inputs for codes 76950, 77014, 77418, and 77421.**

Direct Practice Expense Inputs - Fiducial Screws
In the 2011 proposed Medicare Physician Fee Schedule (MPFS), page 40063, the Centers for Medicare and Medicaid Services (CMS) identified the fiducial screws (CMS Supply Code SD073) as a high-cost supply item and requested the RUC to review this practice expense input with respect to their inclusion as practice expense inputs within CPT codes 77301 *Intensity modulated radiotherapy plan, including dose volume histograms for target and critical structure partial tolerance specifications* and 77011 *Computed tomography guidance for stereotactic localization*.

In October 2010, the RUC's Practice Expense Subcommittee met and discussed the CMS request. After review of the practice expense inputs for CPT code 77011, the RUC's Practice Expense Subcommittee and the RUC agreed that the fiducial screws are not considered typical for this procedure and therefore can be removed from the code's supply list. In addition, fiducial screws should be removed from the list of supplies as a recent CMS transmittal this year (effective as of November 6th 2010) (https://www.cms.gov/transmittals/downloads/R745OTN.pdf) clearly instructs Medicare payers to reimburse fiducial markers with HCPCS code A4648 as a separately billable item when used with CPT codes for the insertion of fiducial markers for IMRT (ie., 77301). **The RUC therefore recommends that fiducial screws (SD073) be removed from the list of practice expense inputs for CPT codes 77011 and 77301.**

IMRT with CT Guidance – PE Only (Tab 15)
Najeeb Mohideen, MD, ASTRO

Duplicative Direct Practice Expense Inputs
In April 2010, the RUC's Relativity Assessment Workgroup identified the following four intensity modulated radiation treatment delivery services for RUC practice expense review through its Codes Reported Together 75% or More Screen and CMS Fastest Growing Screen:

76950 *Ultrasonic guidance for placement of radiation therapy fields*
77418 *Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session*
77014 *Computed tomography guidance for placement of radiation therapy fields*
77421 *Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy*

To assure there is no duplication in practice expense, the Workgroup referred the practice expense components to the RUC for review of potential practice expense input duplication, as the services were reviewed at separate meetings and are frequently reported together.

In October 2010, the RUC examined the direct inputs of the four services together and made minor revisions to eliminate duplicative clinical labor, supplies, and equipment typically used. **In addition, the RUC recommended that the CPT Editorial Panel add the parenthetical after CPT code 77421; (Do not report 77421 more than once per treatment delivery session) to add further clarification to the reporting of this servcie. The RUC recommends the attached direct practice expense inputs for codes 76950, 77014, 77418, and 77421.**

Direct Practice Expense Inputs - Fiducial Screws
In the 2011 proposed Medicare Physician Fee Schedule (MPFS), page 40063, the Centers for Medicare and Medicaid Services (CMS) identified the fiducial screws (CMS Supply Code SD073) as a high-cost supply item and requested the RUC to review this practice expense input with respect to their inclusion as practice expense inputs within CPT codes 77301 *Intensity modulated radiotherapy plan, including dose volume histograms for target and critical structure partial tolerance specifications* and 77011 *Computed tomography guidance for stereotactic localization*.

In October 2010, the RUC's Practice Expense Subcommittee met and discussed the CMS request. After review of the practice expense inputs for CPT code 77011, the RUC's Practice Expense Subcommittee and the RUC agreed that the fiducial screws are not considered typical for this procedure and therefore can be removed from the code's supply list. In addition, fiducial screws should be removed from the list of supplies as a recent CMS transmittal this year (effective as of November 6th 2010) (https://www.cms.gov/transmittals/downloads/R745OTN.pdf) clearly instructs Medicare payers to reimburse fiducial markers with HCPCS code A4648 as a separately billable item when used with CPT codes for the insertion of fiducial markers for IMRT (ie., 77301). **The RUC therefore recommends that fiducial screws (SD073) be removed from the list of practice expense inputs for CPT codes 77011 and 77301.**

IMRT with Stereoscopic X-Ray Guidance – PE only (Tab 16)
Najeeb Mohideen, MD, ASTRO

Duplicative Direct Practice Expense Inputs
In April 2010, the RUC's Relativity Assessment Workgroup identified the following four intensity modulated radiation treatment delivery services for RUC practice expense review through its Codes Reported Together 75% or More Screen and CMS Fastest Growing Screen:

76950 *Ultrasonic guidance for placement of radiation therapy fields*
77418 *Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session*
77014 *Computed tomography guidance for placement of radiation therapy fields*
77421 *Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy*

To assure there is no duplication in practice expense, the Workgroup referred the practice expense components to the RUC for review of potential practice expense input duplication, as the services were reviewed at separate meetings and are frequently reported together.

In October 2010, the RUC examined the direct inputs of the four services together and made minor revisions to eliminate duplicative clinical labor, supplies, and equipment typically used. **In addition, the RUC recommended that the CPT Editorial Panel add the parenthetical after CPT code 77421; (Do not report 77421 more than once per treatment delivery session) to add further clarification to the reporting of this servcie. The RUC recommends the attached direct practice expense inputs for codes 76950, 77014, 77418, and 77421.**

Direct Practice Expense Inputs - Fiducial Screws
In the 2011 proposed Medicare Physician Fee Schedule (MPFS), page 40063, the Centers for Medicare and Medicaid Services (CMS) identified the fiducial screws (CMS Supply Code SD073) as a high-cost supply item and requested the RUC to review this practice expense input with respect to their inclusion as practice expense inputs within CPT codes 77301 *Intensity modulated radiotherapy plan, including dose volume histograms for target and critical structure partial tolerance specifications* and 77011 *Computed tomography guidance for stereotactic localization*.

In October 2010, the RUC's Practice Expense Subcommittee met and discussed the CMS request. After review of the practice expense inputs for CPT code 77011, the RUC's Practice Expense Subcommittee and the RUC agreed that the fiducial screws are not considered typical for this procedure and therefore can be removed from the code's supply list. In addition, fiducial screws should be removed from the list of supplies as a recent CMS transmittal this year (effective as of November 6th 2010) (https://www.cms.gov/transmittals/downloads/R745OTN.pdf) clearly instructs Medicare payers to reimburse fiducial markers with HCPCS code A4648 as a separately billable item when used with CPT codes for the insertion of fiducial markers for IMRT (ie., 77301). **The RUC therefore recommends that fiducial screws (SD073) be removed from the list of practice expense inputs for CPT codes 77011 and 77301.**

Cytopathology (Tab 17)
Jonathan Myles, MD, CAP; Margaret Neal, MD, CAP

In October 2009, CPT code 88104 *Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears with interpretation* was identified through the RUC Relativity Assessment Workgroup as a service based on Harvard times that had utilization over 100,000 and had never been surveyed by the RUC. The RUC recommended a full RUC survey be conducted. CPT codes 88106-88108 were identified as part of the Cytopathology family. Upon subsequent review, the specialty society recommended that CPT code 88107 *Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears and simple filter preparation with interpretation* be deleted as this service is no longer in widespread clinical use.

88104 *Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears with interpretation*
The RUC reviewed the survey results from 88 pathologists who frequently perform this service. The specialty recommended no pre-service or post-service time for this service and intra-time of 24 minutes based on the survey results. The RUC compared the service to key reference CPT code 88112 *Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal* (work RVU=1.18). The specialty society and the RUC noted that the data supplied by the survey respondents over-estimates the work associated with this service as demonstrated in the inappropriate key reference code selected by the survey respondents which has substantial pre-service and post-service time while the surveyed code has no pre-service or post-service time. Although the RUC agreed that the surveyed code overall is a more intense service to perform in comparison to the reference code, the RUC noted that the surveyed code requires 19 less minutes to perform in comparison to the reference code. The RUC agreed that a better reference code to compare the surveyed code to is 88291 *Cytogenetics and molecular cytogenetics, interpretation and report*

(work RVU=0.52). The RUC noted that the surveyed code has more intra-service time as compared to this reference code, 24 minutes and 20 minutes, respectively. Based on these comparisons and that the specialty had no compelling evidence to change the current value of the service, the RUC agreed that the survey data supports maintaining the current value of this service. **The RUC recommends a work RVU of 0.56 for CPT code 88104.**

88106 ***Cytopathology, fluids, washings or brushings, except cervical or vaginal; simple filter method with interpretation***
The RUC reviewed the survey results from 32 pathologists who frequently perform this service. The specialty recommended no pre-service or post-service time for this service and intra-time of 16 minutes based on the survey results. The RUC compared the service to key reference CPT code 88112 *Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal* (work RVU=1.18). The specialty society and the RUC noted that the data supplied by the survey respondents over-estimates the work associated with this service as demonstrated in the inappropriate key reference code selected by the survey respondents which has substantial pre-service and post-service time while the surveyed code has no pre-service or post-service time. The RUC noted that the surveyed code requires 27 less minutes to perform in comparison to the reference code. Further, the RUC noted that the reference code overall is a more intense service to perform in comparison to the surveyed code. The RUC agreed that a better reference code to compare the surveyed code to is 88387 *Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); each tissue preparation (eg, a single lymph node)* (work RVU=0.62). The RUC noted that the surveyed code has less intra-service time as compared to this reference code, 16 minutes and 20 minutes, respectively.

Further, the RUC discussed the relativity between 88104 and 88106 as the specialty is recommending that they be valued the same despite different times associated with both services. The specialty explained that 88106 utilizes a filter method which utilizes a sample that does not contain much blood and little debris while 88104 is a comparable service but because no filter method has been applied the sample reviewed has more blood and debris in it than the sample reviewed in 88106. This variance in sample explains the differences in times for these services despite the same work value. Based on these comparisons and that the specialty had no compelling evidence to change the value of the service, the RUC agreed that the survey data supports maintaining the current value of this service. **The RUC recommends a work RVU of 0.56 for CPT code 88106.**

88108 ***Cytopathology, concentration technique, smears and interpretation (eg, Saccomanno technique)***
The RUC reviewed the survey results from 48 pathologists who frequently perform this service. The specialty recommended no pre-service or post-service time for this service. The specialty recommended no pre-service or post-service time for this service and an intra-time of 19 minutes based on the survey results. The RUC compared the service to key reference CPT code 88112 *Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal* (work RVU=1.18). The specialty society and the RUC noted that the data supplied by the survey respondents over-estimates the work associated with this service as demonstrated in the inappropriate key reference code selected by the survey

respondents which has substantial pre-service and post-service time while the surveyed code has no pre-service or post-service time. The RUC noted that the surveyed code requires 24 less minutes to perform in comparison to the reference code. Further, the RUC noted that the reference code overall is a more intense service to perform in comparison to the surveyed code. The RUC agreed that a better reference code to compare the surveyed code to is 88387 *Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); each tissue preparation (eg, a single lymph node)* (work RVU=0.62). The RUC noted that the surveyed code has less intra-service time as compared to this reference code, 19 minutes and 20 minutes, respectively. Based on these comparisons and that the specialty had no compelling evidence to change the value of the service, the RUC agreed that the survey data supports maintaining the current value of this service. **The RUC recommends a work RVU of 0.56 for CPT code 88108.**

Pathology Consultation During Surgery (Tab 18)
Jonathan Myles, MD, CAP

In October 2009, CPT codes 88331 and 88332 were identified by the RUC Relativity Assessment Workgroup as a service based on Harvard time with utilization over 100,000 and had never been surveyed by the RUC. The RUC recommended a full RUC survey be conducted. CPT code 88329 were identified as part of the 88331-88332 family.

88329 ***Pathology consultation during surgery;***
The RUC reviewed the survey results from 82 pathologists who frequently perform this service. The specialty recommended no pre-service or post-service time for this service and intra-time of 21 minutes based on the survey results. The RUC compared the service to key reference CPT code 88333 *Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), initial site* (work RVU=1.20). The RUC noted that the surveyed code requires less time to perform in comparison to the reference code, 21 minutes and 25 minutes, respectively. Further, the RUC noted that the reference code overall is a more intense service to perform in comparison to the surveyed code requiring more mental effort and judgment and psychological stress. Further, the RUC compared the surveyed code to MPC code 11056 *Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 to 4 lesions* (Work RVU=0.61). The RUC noted that the surveyed code requires more total time to perform than the MPC code, 21 minutes and 15 minutes, respectively. Based on these comparisons and that the specialty had no compelling evidence to change the value of the service, the RUC agreed that the survey data supports the current value of this service. **The RUC recommends a work RVU of 0.67 for CPT code 88329.**

88331 ***Pathology consultation during surgery; first tissue block, with frozen section(s), single specimen***
The RUC reviewed the survey results from 65 pathologists who frequently perform this service. The specialty recommended no pre-service or post-service time for this service and intra-time of 25 minutes based on the survey results. The RUC compared the service to key reference CPT code 88333 *Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), initial site* (work RVU=1.20). The RUC noted that despite the surveyed code requiring more mental effort and judgment technical skill and physical effort to perform, the surveyed code and the reference code have the

same intra-service time, 25 minutes. Based on these comparisons and that the specialty had no compelling evidence to change the value of the service, the RUC agreed that the survey data supports the current value of this service. **The RUC recommends a work RVU of 1.19 for CPT code 88331.**

88332 ***Pathology consultation during surgery; each additional tissue block with frozen section(s)***
The RUC reviewed the survey results from 51 pathologists who frequently perform this service. The specialty recommended no pre-service or post-service time for this service and intra-time of 16 minutes based on the survey results. The RUC compared the service to key reference CPT code 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 requires less time to perform in comparison to the reference code, 16 minutes and 20 minutes, respectively. Further, the RUC noted that the reference code requires more mental effort and judgment to perform in comparison to the surveyed code. In addition, the RUC compared the surveyed code to MPC code 99212 *Office or other outpatient visit for the evaluation and management of an established patient,*(Work RVU=0.48). The RUC noted that the surveyed code has more intra-service time as compared to the MPC code, 16 minutes and 10 minutes. Based on these comparisons and that the specialty had no compelling evidence to change the value of the service, the RUC agreed that the survey data supports the current value of this service. **The RUC recommends a work RVU of 0.59 for CPT code 88332.**

Cardioversion (Tab 19)
Richard Wright, MD, ACC; R. Christopher Jones, MD, ACC

In October 2009, CPT code 92960 *Cardioversion, elective, electrical conversion of arrhythmia; external* was identified through the RUC Relativity Assessment Workgroup as a service based on Harvard time with utilization over 100,000 and had never been surveyed by the RUC. The RUC recommended a full RUC survey be conducted.

The RUC reviewed the survey results from 32 cardiologists and electrophysiologists who frequently perform this service. The specialty recommended 21 minutes of pre-service time, 15 minutes of intra-service time and 15 minutes of post-service time based on survey data and standards. The RUC compared the service to key reference CPT code 99291 *Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes* (work RVU=4.50). The RUC noted that the surveyed code requires less time to perform in comparison to the reference code, 51 minutes and 70 minutes, respectively. Further, the RUC noted that the reference code requires more mental effort and judgment and psychological stress to perform in comparison to the surveyed code. Although the survey respondents selected this service as the key reference service, the RUC found other stronger points of comparison, including 99253 *Inpatient consultation for a new or established patient,* (work RVU=2.27). The RUC noted that the surveyed code and the reference code requires similar physician time to perform, 51 minutes and 55 minutes, respectively. Further, the RUC compared the surveyed code to MPC code 52000 *Cystourethroscopy (separate procedure)* (Work RVU=2.23). The RUC noted that the surveyed code and this reference code have the same intra-service time, 15 minutes. Based on these comparisons and that the specialty had no compelling evidence to change the value of the service, the RUC agreed that the survey data supports maintaining the current value of this service, 2.25 RVUs, which is a

value between the 25th percentile and median of the survey data. **The RUC recommends a work RVU of 2.25 for CPT code 92960.**

Chemotherapy Administration – PE Only (Tab 20)
Eileen Moynihan, MD, ACRh; Samuel Silver, MD, ASH

In April 2010, the following services were identified through the Relativity Assessment Workgroup's Codes Reported 75% or More Together Screen: 96413 *Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug* and 96416 *Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump*.

The Workgroup expressed to the RUC their concerns about potential duplication in resources utilized to perform the service. The specialties acknowledged that there is duplication in the PE pre-service time in the greet patient and change gown activities when multiple services are provided on the same date of service. The specialties explained that the services are done sequentially with separate protocols and contain no physician time duplication, so only practice costs should be addressed. Therefore, the Workgroup recommended a PE review at the October 2010 PE Subcommittee meeting.

In October 2010 the RUC carefully reviewed the typical clinical labor, medial supplies, and equipment recommended by the specialty society for codes 96413 and 96416. The RUC made a few edits and changes and agreed with the modified specialty recommendations. **The RUC recommends the attached direct practice expense inputs for CPT codes 96413 and 96416.**

XI. Fourth Five-Year Review

Drainage of Hematoma/Lesion (Tab 21)
Seth Rubenstein, DPM, AAPM; Timothy Tillo, DPM, AAPM; Christopher Senkowski, MD, ACS; Samuel Smith, MD, APSA

In the 4th Five-Year Review of the RBRVS, CMS identified CPT codes 10140 and 10160 as potentially misvalued through the Harvard-Valued – Utilization over 30,000 screen.

10140 *Incision and drainage of hematoma, seroma or fluid collection*
The RUC reviewed the survey results from 41 general surgeons and podiatrists for CPT code 10140. The RUC analyzed the survey's estimated physician work and agreed that these data support maintaining the current work RVU of 1.58 for this service. To further justify this value, the RUC compared the surveyed code to the key reference service CPT code 11402 *Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 1.1 to 2.0 cm* (work RVU= 1.45 and total time= 56 minutes). The specialty noted that these services require similar physician mental effort and judgment to perform given that both procedures typically involve the same size and depth of skin and subcutaneous tissue. The RUC agreed that the surveyed service should be valued slightly higher than the reference code because of the increased total time 66 minutes compared to 56 minutes for code 11402. The RUC also compared code 10140 to MPC code 11420 *Excision, benign lesion including margins, except skin*

tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less (work RVU= 1.03 and intra time= 10 minutes). The RUC agreed that these are similar physician services, as the surveyed code has greater intra-service time than the reference code, 15 minutes compared to 10 minutes, and total time, 66 minutes compared to 36 minutes. **The RUC recommends a work RVU of 1.58 for CPT code 10140.**

10160 ***Puncture aspiration of abscess, hematoma, bulla, or cyst***
The RUC reviewed the survey results from 41 general surgeons and podiatrists for CPT code 10160. The RUC analyzed the survey's estimated physician work and agreed that these data support maintaining the current work RVU of 1.25 for this service. To further justify this value, the RUC compared the surveyed code to the key reference service CPT code 11402 *Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 1.1 to 2.0 cm* (work RVU = 1.45 and total time= 56 minutes). The specialty noted that these services require similar physician mental effort and judgment to perform given that both procedures typically involve the same size and depth of skin and subcutaneous tissue. The RUC agreed that the surveyed service should be valued lower than the reference code due to lower intra time, 10 minutes compared to 25 minutes, and total time, 51 minutes compared to 56 minutes. The RUC also compared code 10160 to MPC code 11420 *Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less* (work RVU= 1.03 and intra time= 10 minutes). The RUC agreed that these services are similar physician services and the recommended work RVU maintains appropriate rank order, as the surveyed code has greater total time, 51 minutes compared to 36 minutes.
The RUC recommends a work RVU of 1.25 for CPT code 10160.

Wound Repair (Tab 22)
Brett Coldiron, MD, AAD; Christopher Senkowski, MD, ACS; Samuel Smith, MD, APSA; Jennifer Wiler, MD, ACEP
Facilitation Committee #3

In the 4th Five-Year Review of the RBRVS, CMS identified CPT codes 12031, 12051 and 13101 as potentially misvalued through the Harvard-Valued – Utilization over 30,000 screen. The specialties agreed to add CPT codes 12032-12047, 12053-12057 and 13100 as part of the family of services for RUC review.

Intermediate Wound Repair
The RUC agreed with the compelling evidence submitted by the specialty society that the previous methodology used to establish the work RVUs and physician time for the wound repair codes was flawed. Harvard originally obtained estimates for the family of intermediate wound repair codes from general surgeons, except for CPT code 12052 (data was determined by emergency medicine). Additionally, the Harvard review surveyed for estimated post-service time based on a proposed 030-day global period. The time estimates obtained by survey during the Harvard 1989-1990 study indicated that no estimate was obtained for hospital or office visits for many of these services. Prior to publication of the first Physician Payment Schedule in 1992, CMS abandoned a 030-day global period and determined that this family of 19 codes would have a 010-day global period. Many years later, for the purpose of reviewing practice expense, the time assigned for office visits was inappropriately translated into one 99212 post operative visit for all codes and no facility work was included for any code. The RUC determined that the

original Harvard valuation led to compression within these code families, which the RUC proposes to correct by lowering the relative values for the smallest repair codes and increasing the relative values for the larger repair codes. The overall RUC recommended work relative value revisions for this family of wound repair services result in a small reduction in overall work relative values.

12031 ***Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.5 cm or less***
The RUC reviewed the survey results from 85 general surgeons, dermatologists and emergency medicine physicians for CPT code 12031and determined that the survey 25th percentile work RVU of 2.00 appropriately accounts for the physician work required to perform this service and ensures appropriate relativity among this family of codes. The RUC is recommending a lower value than the current value.

The RUC compared CPT code 12031 to the key reference service CPT code 11602 *Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 1.1 to 2.0 cm* (work RVU= 2.27 and intra-service time = 25 minutes). The RUC agreed that the key reference service required slightly more intra-service time to perform than CPT code 12031, 25 and 20 minutes, respectively. Therefore, the 25th percentile work RVU, appropriately places the surveyed service at a slightly lower work RVU in relation to the key reference service. **The RUC recommends a work RVU of 2.00 for CPT code 12031.**

12032 ***Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.6 cm to 7.5 cm***
The RUC reviewed the survey results from 85 general surgeons, dermatologists and emergency medicine physicians for CPT code 12032 and determined the current work RVU accurately accounts for the physician work required to perform this service and ensures appropriate relativity among this family of codes. The survey 25th percentile work RVU of 2.50 provides further support to maintain the current work RVU. The RUC recommends that the current work RVU be maintained.

The RUC compared code 12032 to the key reference service CPT code 11603 *Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 2.1 to 3.0 cm* (work RVU= 2.82 and intra-service time = 30 minutes). The RUC noted that the key reference service and surveyed service both have the same intra-service time of 30 minutes. However, the RUC agreed with the survey respondents that the key reference service required slightly more mental effort and judgment to perform than CPT code 12032 and that the current work RVU of 2.52 maintains the appropriate relativity for this service compared to the key reference service. **The RUC recommends a work RVU of 2.52 for CPT code 12032.**

12034 ***Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 7.6 cm to 12.5 cm***
The RUC reviewed the survey results from 85 general surgeons, dermatologists and emergency medicine physicians for CPT code 12034 and determined the current work RVU accurately accounts for the physician work required to perform this service and ensures appropriate relativity among this family of codes. The survey 25th percentile work RVU of 3.00 provides further support to maintain the current work RVU. The RUC recommends that the current work RVU be maintained.

The RUC compared code 12034 to reference service CPT code 11603 *Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 2.1 to 3.0 cm* (work RVU= 2.82 and intra-service time = 30 minutes). The RUC noted that the surveyed code requires more intra-service time than the key reference code, 45 and 30 minutes, respectively. Therefore, the RUC agreed that the surveyed service required slightly more physician work, intensity and complexity to perform than the reference service. The specialty society indicated and the RUC agreed that there is no change in the physician work required to perform this service. Compared to the reference service, the current work RVU of 2.97 maintains the appropriate relativity for this service. **The RUC recommends a work RVU of 2.97 for CPT code 12034.**

12035 ***Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 12.6 cm to 20.0 cm***
The RUC reviewed the survey results from 79 general surgeons, dermatologists and emergency medicine physicians for CPT code 12035 and determined that the survey median work RVU of 3.60 appropriately accounts for the work required for this service and maintains appropriate relativity within this family of services.

The RUC compared code 12035 to the key reference service CPT code 11406 *Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4.0 cm* (work RVU= 3.52 and intra-service time = 60 minutes). The specialty society indicated and the RUC agreed that the key reference service required similar intensity and complexity as well as the same physician time (60 minutes) to perform as 12035. **The RUC recommends a work RVU of 3.60 for CPT code 12035.**

12036 ***Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 20.1 cm to 30.0 cm***
The RUC reviewed the survey results from 79 general surgeons, dermatologists and emergency medicine physicians for CPT code 12036 and determined that the survey median work RVU of 4.50 appropriately accounts for the work required for this service and maintains the appropriate relativity within this family of services.

The RUC compared code 12036 to the key reference service CPT code 13121 *Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm* (work RVU = 4.42 and intra-service time = 60 minutes). The RUC agreed that the key reference service required slightly less physician time to perform than code 12036, 60 and 70 minutes, respectively. Since the surveyed service requires slightly more time and physical effort to perform than the reference service, the RUC determined that the survey median work RVU is accurate. **The RUC recommends a work RVU of 4.50 for CPT code 12036.**

12037 ***Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); over 30.0 cm***
The RUC reviewed the survey results from 77 general surgeons, dermatologists and emergency medicine physicians for CPT code 12037 and determined that the survey median work RVU of 5.25 appropriately accounts for the work required for this service and maintains the appropriate relativity among this family of services.

The RUC compared code 12037 to the key reference service CPT code 11606 *Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter over 4.0 cm* (work RVU = 5.02 and intra-service time = 90 minutes). The RUC noted that the surveyed service and the reference service require the same intra-service time of 90 minutes. However, the RUC noted that the total time for the surveyed service was slightly higher that the total time for the reference service, 158 and 153 minutes, respectively. Additionally the RUC agreed with the survey respondents that surveyed code 12037 required more mental effort and judgment and technical skill/physical effort to perform than key reference service 11606. To further support the median value, the RUC compared code 12037 with MPC code 20103 *Exploration of penetrating wound (separate procedure); extremity* (work RVU = 5.34 and total time = 136 minutes) which requires similar physician work to perform. **The RUC recommends a work RVU of 5.25 for CPT code 12037.**

12041 ***Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 2.5 cm or less***

The RUC reviewed the survey results from 88 general surgeons, plastic surgeons, dermatologists and emergency medicine physicians for CPT code 12041 and determined that the survey 25th percentile work RVU of 2.10, appropriately accounts for the physician work required to perform this service and ensured appropriate relativity to this family of codes. The RUC is recommending a lower work relative value than the current work relative value.

The RUC compared code 12041 to the key reference service CPT code 11622 *Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm* (work RVU = 2.41 and intra-service time = 25 minutes). The specialty society indicated and the RUC agreed that the key reference code required slightly more physician time to perform than code 12041, 25 and 21 minutes respectively. The RUC also agreed with the survey respondents that code 12041 is more intense and complex than the reference code for all measures examined. **The RUC recommends a work RVU of 2.10 for CPT code 12041.**

12042 ***Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 2.6 cm to 7.5 cm***

The RUC reviewed the survey results from 88 general surgeons, plastic surgeons, dermatologists and emergency medicine physicians for CPT code 12042 and determined that the current work RVU of 2.79 maintains the appropriate relativity for this service as compared to the reference code. The RUC also indicated that the survey 25th percentile work RVU of 3.00 provides further support to maintain the current work RVU.

The RUC compared code 12042 to key reference service CPT code 11623 *Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm* (work RVU= 3.11 and total time = 93 minutes). The specialty society indicated and the RUC agreed that the key reference service required slightly more total time, 93 and 70 minutes, respectively, and more mental effort and judgment, technical skill/physical effort and psychological stress to perform than code 12042. Therefore, the current value appropriately places this service in the proper rank order relative to the key reference service. **The RUC recommends a work RVU of 2.79 for CPT code 12042.**

12044 ***Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 7.6 cm to 12.5 cm***
The RUC reviewed the survey results from 88 general surgeons, plastic surgeons, dermatologists and emergency medicine physicians for CPT code 12044 and determined that the current work RVU of 3.19 maintains appropriate relativity among this family of services. The RUC also noted that the survey 25th percentile work RVU of 3.20 provides further support to maintain the current work RVU.

The RUC compared code 12044 to key reference service CPT code 11623 *Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm* (work RVU= 3.11 and total time = 93 minutes). Although the total time for the surveyed service is less than the key reference service, 85 and 93 minutes, respectively, the RUC agreed with the survey respondents that the surveyed code 12044 required more mental effort and judgment, technical skill/physical effort and psychological stress to perform than the key reference service. **The RUC recommends a work RVU of 3.19 for CPT code 12044.**

12045 ***Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 12.6 cm to 20.0 cm***
The RUC reviewed the survey results from 83 general surgeons, plastic surgeons, dermatologists and emergency medicine physicians for CPT code 12045 and determined that the survey median work RVU of 3.90 appropriately accounts for the physician work required for this service and maintains the appropriate relativity for this family of services.

The RUC compared code 12045 to the key reference service CPT code 11624 *Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm* (work RVU = 3.62 and intra-service time = 40 minutes). The RUC agreed that the key reference service was less intense and complex and required less physician work to perform than code 12045, 40 and 60 minutes, respectively. Therefore, the survey median work RVU appropriately maintains the rank order of this service compared to the key reference service. **The RUC recommends a work RVU of 3.90 for CPT code 12045.**

12046 ***Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 20.1 cm to 30.0 cm***
The RUC reviewed the survey results from 80 general surgeons, plastic surgeons, dermatologists and emergency medicine physicians for CPT code 12046 and determined that the survey median work RVU of 4.60 appropriately accounts for the work required for this service and maintains the appropriate relativity for this family of services.

The RUC compared code 12046 to the key reference service CPT code 11626 *Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm* (work RVU = 4.61 and intra-service time = 60 minutes). The RUC noted that code 12046 requires 20 minutes more intra-service time (80 minutes) than the key reference code. However, the experienced survey respondents indicated that the same amount of physician work was required to perform code 12046 as the key reference service. The RUC agreed that the survey median work RVU of 4.60 appropriately

accounts for the work required for this service. **The RUC recommends a work RVU of 4.60 for CPT code 12046.**

12047 ***Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; over 30.0 cm***
The RUC reviewed the survey results from 80 general surgeons, plastic surgeons, dermatologists and emergency medicine physicians for CPT code 12046 and determined the survey median work RVU of 5.50 appropriately accounts for the work required for this service and maintains the appropriate relativity among this family of services.

The RUC compared code 12047 to the key reference service CPT code 13132 *Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm* (work RVU = 6.58 and intra-service time = 45 minutes). Although coded 12047 requires 55 more minutes of intra-service time (100 minutes) than the reference code, the RUC agreed with the experienced survey respondents that 12047 was less intense and complex to perform compared to the key reference services. For further support, the RUC compared the surveyed code to MPC code 11606 *Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter over 4.0 cm* (work RVU = 5.02 and intra-service time = 90 minutes), which requires slightly less physician work to perform than 12047 but indicates that the survey median accurately maintains the relativity for this service. **The RUC recommends a work RVU of 5.50 for CPT code 12046.**

12051 ***Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less***
The RUC reviewed the survey results from 84 general surgeons, plastic surgeons, dermatologists, otolaryngologists and emergency medicine physicians for CPT code 12051 and determined that the survey 25th percentile work RVU of 2.33 appropriately accounts for the work required to perform this service and ensures appropriate relativity among this family of codes. The RUC is recommending a lower value than the current value.

The RUC compared code 12051 to the key reference service CPT code 11642 *Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 1.1 to 2.0 cm* (work RVU= 2.62 and intra-service time = 25 minutes). The RUC determined that the key reference service required slightly more physician work to perform than code 12051, 25 and 20 minutes, respectively. For further support the RUC compared the surveyed code to similar service, MPC code 46221 *Hemorrhoidectomy, internal, by rubber band ligation(s)* (work RVU = 2.36 and intra-service time 15 minutes). The RUC determined that both reference codes provide accurate comparisons and supports the survey 25th percentile work RVU is relative among similar services. **The RUC recommends a work RVU of 2.33 for CPT code 12051.**

12052 ***Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm***
The RUC reviewed the survey results from 84 general surgeons, plastic surgeons, dermatologists and emergency medicine physicians for CPT code 12052 and determined that the current work RVU of 2.87 accurately reflects the amount of physician work required to perform this service. The survey 25th percentile work RVU of 2.80 and survey median work RVU of 3.00 provides further support to maintain the current work RVU of 12052.

The RUC compared code 12052 to the key reference service CPT code 11444 *Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 3.1 to 4.0 cm* (work RVU= 3.19 and intra-service time = 40 minutes). The RUC determined that the key reference service required slightly more physician time to perform than code 12052, 40 and 30 minutes, respectively, and the current relative value for code 12052 maintains relativity among these similar services. **The RUC recommends a work RVU of 2.87 for CPT code 12052.**

12053 ***Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 5.1 cm to 7.5 cm***
The RUC reviewed the survey results from 84 general surgeons, plastic surgeons, dermatologists, otolaryngologists and emergency medicine physicians for CPT code 12053 and determined that the current work RVU of 3.17 accurately reflects the amount of physician work required to perform this service. The survey 25th percentile work RVU of 3.20 provides further support to maintain the current work RVU.

The RUC compared code 12053 to the key reference service CPT code 11444 *Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 3.1 to 4.0 cm* (work RVU= 3.19 and intra-service time = 40 minutes). The RUC determined that the key reference service requires comparable physician work and the same intra-service time, 40 minutes, to perform as code 12053. Therefore, the current value maintains relativity among this family of services as well as similar services. **The RUC recommends a work RVU of 3.17 for CPT code 12053.**

12054 ***Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm***
The RUC reviewed the survey results from 84 general surgeons, plastic surgeons, dermatologists, otolaryngologists and emergency medicine physicians for CPT code 12054 and determined that the current work RVU of 3.50 accurately reflects the amount of physician work required to perform this service. The survey 25th percentile work RVU of 3.50 provides further support to maintain the current work RVU.

The RUC compared code 12054 to the key reference service CPT code 11643 *Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 2.1 to 3.0 cm* (work RVU= 3.42 and total time = 93 minutes). The RUC determined that the key reference service requires comparable physician work and time to perform as code 12054 (total time = 96 minutes). Therefore, the current work RVU of 3.50 maintains the appropriate relativity for this service as compared to the reference code and among this family of services. The RUC disagreed with the specialties recommendation for a half day discharge as Medicare data indicates greater than 50% are performed in the office or emergency room setting. **The RUC recommends a work RVU of 3.50 for CPT code 12054.**

12055 ***Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 12.6 cm to 20.0 cm***
The RUC reviewed the survey results from 80 general surgeons, plastic surgeons, dermatologists, otolaryngologists and emergency medicine physicians for CPT code 12055 and determined that the survey median work RVU of 4.65 appropriately accounts for the work required to perform this service and ensures appropriate relativity among this family of codes.

The RUC compared code 12055 to the key reference service CPT code 11626 *Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm* (work RVU= 4.61 and intra-service time = 60 minutes). The RUC determined that the key reference service requires comparable physician work, intensity and complexity to perform as code 12055 (intra-service time = 70 minutes). The RUC agrees that the survey median work RVU of 4.65 maintains the appropriate relativity for this service. **The RUC recommends a work RVU of 4.65 for CPT code 12055.**

12056 ***Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 20.1 cm to 30.0 cm***
The RUC reviewed the survey results from 79 general surgeons, plastic surgeons, dermatologists, otolaryngologists and emergency medicine physicians for CPT code 12056 and determined . The RUC determined that the survey median work RVU of 5.50 appropriately accounts for the work required to perform this service and ensures appropriate relativity among this family of codes.

The RUC compared code 12056 to the key reference service CPT code 11646 *Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter over 4.0 cm* (work RVU= 6.26). The RUC determined that this reference service was not a sufficient comparison as only 26% of respondents chose this code which they rated as less intense and complex but it has a higher value than the median indicated. Therefore, the RUC compared 12056 to MPC code 11606 *Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter over 4.0 cm* (work RVU = 5.02 and total time = 153 minutes) which requires slightly less physician work and total time to perform than 12056 (total time = 177 minutes). The RUC determined that the survey median work RVU of 5.50 maintains the appropriate relativity for this service compared to similar services. **The RUC recommends a work RVU of 5.50 for CPT code 12056.**

12057 ***Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; over 30.0 cm***
The RUC reviewed the survey results from 79 general surgeons, plastic surgeons, dermatologists, otolaryngologists and emergency medicine physicians for CPT code 12057 and determined that the survey median work RVU of 6.28 appropriately accounts for the work required to perform this service and ensures appropriate relativity among this family of codes.

The RUC compared code 12057 to the key reference service CPT code 11646 *Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter over 4.0 cm* (work RVU= 6.26 and intra-time = 65 minutes) and determined that 12057 requires similar physician work to perform. Although code 12057 requires 35 more minutes of intra-service time (100 minutes) than the reference code, the RUC agreed with the experienced survey respondents that 12057 had comparable intensity and complexity

as the key reference service. For further support, the RUC compared 12057 to similar service 17311 *Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; first stage, up to 5 tissue blocks* (work RVU = 6.20 and intra-service time = 110 minutes) and determined code 12057 required comparable physician work and time to perform. Therefore, the RUC determined that the survey median work RVU of 6.28 maintains the appropriate relativity for this service. **The RUC recommends a work RVU of 6.28 for CPT code 12057.**

Complex Wound Repair

13100 ***Repair, complex, trunk; 1.1 cm to 2.5 cm***
The RUC reviewed the survey results from 47 general surgeons, plastic surgeons and dermatologists for CPT code 13100. The RUC agreed that the current work RVU of 3.17 maintains the appropriate relativity for this service as compared to the reference code 11604 *Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 3.1 to 4.0 cm* (work RVU = 3.17 and intra-service time = 40 minutes). The survey 25th percentile work RVU of 3.20 provides further support to maintain the current work RVU. The RUC compared code 13100 to key reference service agreed that the surveyed code requires comparable physician work and time, 35 and 40 minutes, respectively, to perform as compared to this reference code. **The RUC recommends a work RVU of 3.17 for CPT code 13100.**

13101 ***Repair, complex, trunk; 2.6 cm to 7.5 cm***
The RUC reviewed the survey results from 45 general surgeons, plastic surgeons and dermatologists for CPT code 1310 and determined that the current work RVU of 3.96 maintains the appropriate relativity for this service. The survey 25th percentile work RVU of 4.00 provides further support to maintain the current work RVU. The RUC compared code 13101 to key reference service CPT code 13121 *Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm* (work RVU = 4.42 and intra-service time = 60 minutes) and MPC code 11624 *Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm* (work RVU = 3.62 and intra-service time = 40 minutes). The specialty society indicated and the RUC agreed that the surveyed code 13101 (intra-service time = 56 minutes) required less physician work and time than the key reference service and more physician work and time to perform than MPC code 11624. Therefore, the current work relative value maintains the appropriate relativity among these similar services. **The RUC recommends a work RVU of 3.96 for CPT code 13101.**

Skin Grafts (Tab 23)
Martha Matthews, MD, ASPS; Wayne Koch, MD, AAO-HNS

In the 4th Five- Year Review of the RBRVS, CMS identified CPT codes 15120 and 15732 as potentially misvalued through the Site of Service Anomaly screen. The specialties, American Academy of Otolaryngology - Head and Neck Surgery (AAO-HNS) and American Society of Plastic Surgeons (ASPS), agreed to add CPT code 15121 as part of the family of services for RUC review. In addition, CMS identified CPT code 15260 as potentially misvalued through the Harvard-Valued – Utilization over 30,000 screen.

15120 ***Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)***
The RUC reviewed the survey results from 34 plastic surgeons and otolaryngologists for CPT code 15120. The RUC discussed the hospital visits typically provided as Medicare claims data indicate that the service is primarily reported in the outpatient hospital setting. The specialties noted that 81% of the survey respondents indicated that patients at the least stay overnight. The typical patient, who is not a Medicare beneficiary, but rather a trauma victim, will be admitted (50%) or at least stay overnight due to the need for intravenous analgesics, antibiotics and fluids. Given this, the RUC agreed that one hospital visit and one 99238 should be maintained in the post operative visits for this service.

The RUC analyzed the survey's estimated physician work and agreed that these data support the median, a work RVU of 10.15, for this service, which is less than the current value of 11.16. To further justify this value, the RUC compared the surveyed code to key reference service CPT code 15100 *Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children* (work RVU = 9.90, total time = 281 minutes). The RUC agreed that these services have comparable physician work but code 15100 should be valued higher due to the complexity of the procedure which has the increased chance of complications due to the procedure being performed on the face. In addition, the surveyed code requires additional total physician time compared to the reference code, 292 minutes compared to 281 minutes, thus substantiating a higher value. Additionally, the RUC compared code 15120 to the MPC code 15240 *Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; 20 sq cm or less* (work RVU= 10.41). The RUC agreed that these services are similar physician services but the reference code has increased complexity compared to the surveyed code, as it is a full thickness graft, and should be valued slightly higher. **The RUC recommends a work RVU of 10.15 for CPT code 15120.**

15121 ***Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof***
The RUC reviewed the survey results from 30 plastic surgeons and otolaryngologists for CPT code 15121. The RUC analyzed the survey's estimated physician work and agreed that these data support the median, a work RVU of 2.00, for this service, which is less than the current value of 2.67. To further justify this value, the RUC compared the surveyed code to key reference service CPT code 15116 *Epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof* (work RVU= 2.50 and intra time= 35 minutes). The RUC agreed that these services have similar physician total time and intensity, but given the greater intra-service time for the reference code, 35 minutes compared to 30 minutes, 15121 should be valued slight less than 15116. The RUC also compared code 15121 to the MPC code 13113 *Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less* (work RVU= 2.19 total time= 30 minutes). The RUC agreed that these services have similar physician work and intensity. **The RUC recommends a work RVU of 2.00 for CPT code 15121.**

15260 ***Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 sq cm or less***
The RUC reviewed the survey results from 36 dermatologists for CPT code 15260. The RUC analyzed the survey's estimated physician work and agreed that these data support maintaining the current work RVU of 11.64 for this service. To further justify this service, the RUC compared the surveyed code to key reference service CPT code 15240 *Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; 20 sq cm or less* (work RVU= 10.41 and total time= 288 minutes) and agreed that the two services have analogous physician intensity and time and the surveyed service should be valued higher due to greater total time, 300 minutes compared to 273 minutes. The RUC also compared code 15260 to the MPC code 58660 *Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis)* (work RVU= 11.59 and intra time= 90 minutes). The RUC agreed that these services have comparable physician work, with analogous intra-service times, 100 minutes and 90 minutes respectively. **The RUC recommends a work RVU of 11.64 for CPT code 15260.**

15732 ***Muscle, myocutaneous, or fasciocutaneous flap; head and neck (eg, temporalis, masseter muscle, sternocleidomastoid, levator scapulae)***
The RUC reviewed the survey results from 36 plastic surgeons and otolaryngologists for CPT code 15732. Seventy nine percent (79%) of the survey respondents indicated that this service is an inpatient service. The typical patient is unstable and may even require critical care services. The patient is in the hospital for at least three days. This service should not be performed in the outpatient setting and miscoding is the cause for the outpatient settings being the dominant place of service. The RUC and specialties agreed that additional coding education needs to take place and agreed to develop a CPT Assistant article. A separate CPT code may be required. It was noted that Ophthalmologists need to lead the CPT education/proposal efforts.

The RUC analyzed the survey's estimated physician work and agreed that these data support the median, a work RVU of 19.83, for this service, which is slightly less than the current value of 19.90. To further justify this value, the RUC compared the surveyed code to key reference service CPT code 15734 *Muscle, myocutaneous, or fasciocutaneous flap; trunk* (work RVU= 19.86 and total time= 524 minutes). The RUC agreed that the two services have analogous physician work and should be valued similarly. The reference code has slightly more total time than CPT code 15732, 524 minutes compared to 507 minutes, but the surveyed code rated higher in the intensity/complexity measures in almost every category compared to the reference code. Given this, the services should be valued almost identically. The RUC also compared CPT code 15732 to the MPC code 15738 *Muscle, myocutaneous, or fasciocutaneous flap; lower extremity* (work RVU= 19.04 and intra time= 150 minutes). The RUC agreed that these services have very similar physician work and the surveyed code should be valued higher due to greater intensity and more total time, 507 minutes compared to 460 minutes. **The RUC recommends a work RVU of 19.83 for CPT code 15732.**

Re-review after CPT Assistant:
Medicare claims data for CPT code 15732 will be re-reviewed in September 2013 to ensure that the education addressed miscoding.

Island Pedical Flap Graft (Tab 24)
Martha Matthews, MD, ASPS

In the 4th Five-Year Review of the RBRVS, CMS identified CPT code 15740 *Flap; island pedicle* as potentially misvalued through the Site of Service Anomaly screen. This service was previously identified through the RUC's Relativity Assessment Workgroup's Site of Service Anomaly Screen in September 2007. At that time, the specialties all agreed that the CPT code should be referred to the CPT Editorial Panel for further clarification as to when this code should be reported and a CPT Assistant article should be written to educate providers and coders of this service as well. The CPT Editorial Panel approved revised introductory language for this service. The specialties have also made efforts to educate their membership through various publications and seminars. Despite these efforts, the first quarter claims data for 2010 does not show any change in the site of service for this procedure. At this time, the specialties agree and the RUC recommends that this service be referred again to the CPT Editorial Panel to revise the descriptor of this service by using more specific terminology to describe the flap. **The RUC recommends that CPT code 15740 be referred to the CPT Editorial Panel for revision.**

Chemical Cauterization of Granulation Tissue (Tab 25)
Seth Rubenstein, DPM, APMA; Timothy Tillo, DPM, APMA; Christopher Senkowski, MD ACS; Samuel Smith, MD, APSA

In the 4th Five-Year Review of the RBRVS, CMS identified CPT code 17250 as potentially misvalued through the Harvard-Valued – Utilization over 30,000 screen.

17250 ***Chemical cauterization of granulation tissue (proud flesh, sinus or fistula)***
The RUC reviewed the survey results from 39 podiatrists and general surgeons for CPT code 17250. The RUC analyzed the survey's estimated physician work and agreed that these data support the median and current work RVU of 0.50. To further justify this value, the RUC compared the surveyed code to the key reference service CPT code 99212 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU= 0.48 and total time= 16 minutes). The RUC noted that the two services have almost identical total time, 17 minutes and 16 minutes, respectively, and analogous physician work and intensity. **The RUC recommends a work RVU of 0.50 for CPT code 17250.**

Destruction of Skin Lesions (Tab 26)
Brett Coldiron, MD, AAD; Michael Bigby, MD, SID; Scott Collins, MD, ASDS

In the 4th Five-Year Review of the RBRVS, CMS identified CPT codes 17271, 17272 and 17280 as potentially misvalued through the Harvard Valued - Utilization over 30,000 Screen. The specialty identified several other codes in the family to be reviewed concurrently with these services. The specialty submitted recommendations for 17260-17286. The specialty society stated and the RUC agreed that with the exception of one code 17284, the survey data validated the current values of the destruction of skin lesion services.

17260 ***Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 0.5 cm or less***

The RUC reviewed the survey results from 49 dermatologists who frequently perform this service. The specialty recommended pre-service time of 9 minutes, intra-service time of 16 minutes and post service time of 5 minutes based on the survey results and standards. The RUC compared the service to key reference CPT code 11600 *Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 0.5 cm or less* (work RVU=1.63). The RUC noted that the reference code requires more time to perform than the surveyed code, 48 minutes and 46 minutes, respectively. Further, the RUC noted that the reference code requires more mental effort and judgment, technical skill and overall is a more intense service to perform, as compared to the surveyed code. The RUC also compared the surveyed code to MPC code 11400 *Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less* (work RVU=0.90). The RUC noted that the surveyed code requires more total-service time as compared to this reference code, 46 minutes and 36 minutes, respectively. Based on these comparisons and that the specialty did not provide compelling evidence to change the current value of the service, the RUC agreed that the survey data supports the current value of this service. **The RUC recommends a work RVU of 0.96 for CPT code 17260.**

17261 ***Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 0.6 to 1.0 cm***

The RUC reviewed the survey results from 49 dermatologists who frequently perform this service. The specialty recommended pre-service time of 9 minutes, intra-service time of 17 minutes and post service time of 5 minutes based on the survey results and standards. The RUC compared the service to key reference CPT code 11601 *Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 0.6 to 1.0 cm* (work RVU=2.07). The RUC noted that the reference code requires more time to perform than the surveyed code, 63 minutes and 47 minutes, respectively. Further, the RUC noted that the reference code requires more mental effort and judgment, technical skill and overall is a more intense service to perform, as compared to the surveyed code. The RUC also compared the surveyed code to MPC code 11440 *Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5 cm or less* (work RVU=1.05). The RUC noted that the surveyed code requires more total-service time as compared to this reference code, 47 minutes and 36 minutes, respectively. Based on these comparisons and that the specialty did not provide compelling evidence to change the current value of the service, the RUC agreed that the survey data supports the current value of this service. **The RUC recommends a work RVU of 1.22 for CPT code 17261.**

17262 ***Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 1.1 to 2.0 cm***

The RUC reviewed the survey results from 49 dermatologists who frequently perform this service. The specialty recommended pre-service time of 9 minutes, intra-service time of 20 minutes and post service time of 5 minutes based on the survey results and standards. The RUC compared the service to key reference CPT code 11602 *Excision,*

malignant lesion including margins, trunk, arms, or legs; excised diameter 1.1 to 2.0 cm (work RVU=2.27). The RUC noted that the reference code requires more time to perform than the surveyed code, 68 minutes and 50 minutes, respectively. Further, the RUC noted that the reference code requires more mental effort and judgment, technical skill and overall is a more intense service to perform, as compared to the surveyed code. The RUC also compared the surveyed code to MPC code 11620 *Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less* (work RVU=1.64). The RUC noted that the surveyed code requires slightly more total service time in comparison to the reference code, 50 minutes and 48 minutes. Based on these comparisons and that the specialty did not provide compelling evidence to change the current value of the service, the RUC agreed that the survey data supports the current value of this service. **The RUC recommends a work RVU of 1.63 for CPT code 17262.**

17263 ***Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 2.1 to 3.0 cm***

The RUC reviewed the survey results from 49 dermatologists who frequently perform this service. The specialty recommended pre-service time of 9 minutes, intra-service time of 26 minutes and post service time of 5 minutes based on the survey results and standards. The RUC compared the service to key reference CPT code 11603 *Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 2.1 to 3.0 cm* (work RVU=2.82). The RUC noted that the reference code requires more time to perform than the surveyed code, 93 minutes and 56 minutes, respectively. Further, the RUC noted that the reference code requires more mental effort and judgment, technical skill and overall is a more intense service to perform, as compared to the surveyed code. The RUC also compared the surveyed code to MPC code 11423 *Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm* (work RVU=2.06). The RUC noted that the surveyed code requires less total-service time as compared to this reference code, 56 minutes and 76 minutes, respectively. Based on these comparisons and that the specialty did not provide evidence to change the current value of the service, the RUC agreed that the survey data supports the current value of this service. **The RUC recommends a work RVU of 1.84 for CPT code 17263.**

17264 ***Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 3.1 to 4.0 cm***

The RUC reviewed the survey results from 49 dermatologists who frequently perform this service. The specialty recommended pre-service time of 9 minutes, intra-service time of 34 minutes and post service time of 5 minutes based on the survey results and standards. The RUC compared the service to key reference CPT code 11604 *Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 3.1 to 4.0 cm* (work RVU=3.17). The RUC noted that the reference code requires more time to perform than the surveyed code, 103 minutes and 64 minutes, respectively. Further, the RUC noted that the reference code requires more mental effort and judgment, technical skill and overall is a more intense service to perform, as compared to the surveyed code. The RUC also compared the surveyed code to MPC code 11601 *Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 0.6 to 1.0 cm* (work RVU=2.07). The RUC noted that the surveyed code and the reference code require similar total-service times, 64 minutes and 63 minutes, respectively. Based on these

comparisons and that the specialty did not provide compelling evidence to change the current value of the service, the RUC agreed that the survey data supports the current value of this service. **The RUC recommends a work RVU of 1.99 for CPT code 17264.**

17266 ***Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter over 4.0 cm***

The RUC reviewed the survey results from 49 dermatologists who frequently perform this service. The specialty recommended pre-service time of 9 minutes, intra-service time of 37 minutes and post service time of 5 minutes based on the survey results and standards. The RUC compared the service to key reference CPT code 11606 *Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter over 4.0 cm* (work RVU=5.02). The RUC noted that the reference code requires more time to perform than the surveyed code, 153 minutes and 67 minutes, respectively. Further, the RUC noted that the reference code requires more mental effort and judgment, technical skill and overall is a more intense service to perform, as compared to the surveyed code. The RUC also compared the surveyed code to MPC code 11602 *Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 1.1 to 2.0 cm* (work RVU=2.27). The RUC noted that the surveyed code requires more intra-service time as compared to this reference code, 37 minutes and 25 minutes, respectively. Based on these comparisons and that the specialty did not provide compelling evidence to change the current value of the service, the RUC agreed that the survey data supports the current value of this service. **The RUC recommends a work RVU of 2.39 for CPT code 17266.**

17270 ***Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less***

The RUC reviewed the survey results from 42 dermatologists who frequently perform this service. The specialty recommended pre-service time of 9 minutes, intra-service time of 15 minutes and post service time of 5 minutes based on the survey results and standards. The RUC compared the service to key reference CPT code 11600 *Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 1.1 to 2.0 cm* (work RVU=1.63). The RUC noted that the reference code requires more time to perform than the surveyed code, 48 minutes and 45 minutes, respectively. Further, the RUC noted that the reference code requires more mental effort and judgment, technical skill and overall is a more intense service to perform, as compared to the surveyed code. The RUC also compared the surveyed code to MPC code 11400 *Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less* (work RVU=1.05). The RUC noted that the surveyed code requires more intra-service time as compared to this reference code, 15 minutes and 10 minutes, respectively. Based on these comparisons and that the specialty did not provide compelling evidence to change the current value of the service, the RUC agreed that the survey data supports the current value of this service. **The RUC recommends a work RVU of 1.37 for CPT code 17270.**

17271 ***Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm***

The RUC reviewed the survey results from 41 dermatologists who frequently perform this service. The specialty recommended pre-service time of 9 minutes, intra-service time of 19 minutes and post service time of 5 minutes based on the survey results and standards. The RUC compared the service to key reference CPT code 11601 *Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 0.6 to 1.0 cm* (work RVU=2.07). The RUC noted that the reference code requires more time to perform than the surveyed code, 63 minutes and 49 minutes, respectively. Further, the RUC noted that the reference code requires more mental effort and judgment, technical skill and overall is a more intense service to perform, as compared to the surveyed code. The RUC also compared the service to MPC code 11440 *Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5 cm or less* (work RVU=1.05). The RUC noted that this reference code requires less time to perform than the surveyed code, 36 minutes and 49 minutes, respectively. Based on these comparisons and that the specialty did not provide compelling evidence to change the current value of the service, the RUC agreed that the survey data supports the current value of this service. **The RUC recommends a work RVU of 1.54 for CPT code 17271.**

17272 ***Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm***

The RUC reviewed the survey results from 41 dermatologists who frequently perform this service. The specialty recommended pre-service time of 9 minutes, intra-service time of 22 minutes and post service time of 5 minutes based on the survey results and standards. The RUC compared the service to key reference CPT code 11604 *Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 3.1 to 4.0 cm* (work RVU=3.17). The RUC noted that the reference code requires more time to perform than the surveyed code, 103 minutes and 52 minutes, respectively. Further, the RUC noted that the reference code requires more mental effort and judgment, technical skill and overall is a more intense service to perform, as compared to the surveyed code. The RUC also compared the service to MPC code 11423 *Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm* (work RVU=2.06). The RUC noted that the reference code requires more intra-service time to perform than the surveyed code, 30 minutes and 22 minutes, respectively. Based on these comparisons and that the specialty did not provide compelling evidence to change the current value of the service, the RUC agreed that the survey data supports the current value of this service. **The RUC recommends a work RVU of 1.82 for CPT code 17272.**

17273 ***Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; l lesion diameter 2.1 to 3.0 cm***

The RUC reviewed the survey results from 42 dermatologists who frequently perform this service. The specialty recommended pre-service time of 9 minutes, intra-service time of 26 minutes and post service time of 5 minutes based on the survey results and standards. The RUC compared the service to key reference CPT code 11603 *Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 2.1 to 3.0 cm* (work RVU=2.82). The RUC noted that the reference code requires more time to perform than the surveyed code, 93 minutes and 56 minutes, respectively. Further, the RUC noted that the reference code requires more mental effort and judgment, technical skill and overall is a more intense service to perform, as compared to the surveyed code. The RUC also compared the service to MPC code 11423 *Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm* (work RVU=2.06). The RUC noted that the reference code requires more intra-service time to perform than the surveyed code, 30 minutes and 26 minutes, respectively. Based on these comparisons and that the specialty did not provide compelling evidence to change the current value of the service, the RUC agreed that the survey data supports the current value of this service. **The RUC recommends a work RVU of 2.10 for CPT code 17273.**

17274 ***Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 3.1 to 4.0 cm***

The RUC reviewed the survey results from 42 dermatologists who frequently perform this service. The specialty recommended pre-service time of 9 minutes, intra-service time of 32 minutes and post service time of 5 minutes based on the survey results and standards. The RUC compared the service to key reference CPT code 11604 *Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 3.1 to 4.0 cm* (work RVU=3.17). The RUC noted that the reference code requires more time to perform than the surveyed code, 103 minutes and 62 minutes, respectively. Further, the RUC noted that the reference code requires more mental effort and judgment, technical skill and overall is a more intense service to perform, as compared to the surveyed code. The RUC also compared the service to MPC code 11642 *Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 1.1 to 2.0 cm* (work RVU=2.62). The RUC noted that the reference code requires less intra-service time to perform than the surveyed code, 25 minutes and 32 minutes, respectively. Based on these comparisons and that the specialty did not provide compelling evidence to change the current value of the service, the RUC agreed that the survey data supports the current value of this service. **The RUC recommends a work RVU of 2.64 for CPT code 17274.**

17276 ***Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter over 4.0 cm***

The RUC reviewed the survey results from 42 dermatologists who frequently perform this service. The specialty recommended pre-service time of 9 minutes, intra-service time of 40 minutes and post service time of 5 minutes based on the survey results and standards. The RUC compared the service to key reference CPT code 11604 *Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 3.1 to 4.0 cm* (work RVU=3.17). The RUC noted that despite the surveyed code requiring more mental effort and judgment, technical skill and overall is a more intense service to perform in comparison to the reference code, the reference code and the surveyed code have the same intra-service time, 40 minutes. In addition, the RUC also compared the service to MPC code 11643 *Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 2.1 to 3.0 cm* (work RVU=3.42). The RUC noted that the MPC code requires more total service time to perform than the surveyed code, 93 minutes and 70 minutes, respectively. Based on these comparisons and that the specialty did not provide compelling evidence to change the current value of the service, the RUC agreed that the survey data supports the current value of this service. **The RUC recommends a work RVU of 3.25 for CPT code 17276.**

17280 ***Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less***

The RUC reviewed the survey results from 46 dermatologists who frequently perform this service. The specialty recommended pre-service time of 9 minutes, intra-service time of 15 minutes and post service time of 5 minutes based on the survey results and standards. The RUC compared the service to key reference CPT code 11600 *Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 1.1 to 2.0 cm* (work RVU=1.63). The RUC noted that the reference code requires more time to perform than the surveyed code, 48 minutes and 45 minutes, respectively. Further, the RUC noted that the reference code requires more mental effort and judgment, technical skill and overall is a more intense service to perform, as compared to the surveyed code. The RUC also compared the surveyed code to MPC code 11440 *Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5 cm or less* (work RVU=1.05). The RUC noted that the surveyed code requires more total-service time as compared to this reference code, 45 minutes and 36 minutes, respectively. Based on these comparisons and that the specialty did not provide compelling evidence to change the current value of the service, the RUC agreed that the survey data supports the current value of this service. **The RUC recommends a work RVU of 1.22 for CPT code 17280.**

17281 ***Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm***

The RUC reviewed the survey results from 47 dermatologists who frequently perform this service. The specialty recommended pre-service time of 9 minutes, intra-service time of 17 minutes and post service time of 5 minutes based on the survey results and standards. The RUC compared the service to key reference CPT code 11601 *Excision,*

malignant lesion including margins, trunk, arms, or legs; excised diameter 0.6 to 1.0 cm (work RVU=2.07). The RUC noted that the reference code requires more time to perform than the surveyed code, 63 minutes and 47 minutes, respectively. Further, the RUC noted that the reference code requires more mental effort and judgment, technical skill and overall is a more intense service to perform, as compared to the surveyed code. The RUC also compared the surveyed code to MPC code 11640 *Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 0.5 cm or less* (work RVU=1.67). The RUC noted that the surveyed code requires more intra-service time as compared to this reference code, 17 minutes and 10 minutes, respectively. Based on these comparisons and that the specialty did not provide compelling evidence to change the current value of the service, the RUC agreed that the survey data supports the current value of this service. **The RUC recommends a work RVU of 1.77 for CPT code 17281.**

17282 ***Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm***

The RUC reviewed the survey results from 47 dermatologists who frequently perform this service. The specialty recommended pre-service time of 9 minutes, intra-service time of 25 minutes and post service time of 5 minutes based on the survey results and standards. The RUC compared the service to key reference CPT code 11602 *Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 1.1 to 2.0 cm* (work RVU=2.27). The RUC noted that the reference code requires more time to perform than the surveyed code, 68 minutes and 55 minutes, respectively. Further, the RUC noted that the reference code requires more mental effort and judgment, technical skill and overall is a more intense service to perform, as compared to the surveyed code. The RUC also compared the surveyed code to MPC code 11641 *Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 0.6 to 1.0 cm* (work RVU=2.17). The RUC noted that the surveyed code requires less total-service time as compared to this reference code, 55 minutes and 63 minutes, respectively. Based on these comparisons and that the specialty did not provide compelling evidence to change the current value of the service, the RUC agreed that the survey data supports the current value of this service. **The RUC recommends a work RVU of 2.09 for CPT code 17282.**

17283 ***Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 2.1 to 3.0 cm***

The RUC reviewed the survey results from 47 dermatologists who frequently perform this service. The specialty recommended pre-service time of 9 minutes, intra-service time of 30 minutes and post service time of 5 minutes based on the survey results and standards. The RUC compared the service to key reference CPT code 11603 *Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 2.1 to 3.0 cm* (work RVU=2.82). The RUC noted that the reference code requires more time to perform than the surveyed code, 93 minutes and 60 minutes, respectively. Further, the RUC noted that the reference code requires more mental effort and judgment, technical skill and overall is a more intense service to perform, as compared to the surveyed code. The RUC also compared the surveyed code to MPC code 11642 *Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 1.1 to 2.0 cm*

(work RVU=2.62). The RUC noted that the surveyed code requires more intra-service time as compared to this reference code, 30 minutes and 25 minutes, respectively. Based on these comparisons and that the specialty did not provide compelling evidence to change the current value of the service, the RUC agreed that the survey data supports the current value of this service. **The RUC recommends a work RVU of 2.69 for CPT code 17283.**

17284 ***Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 3.1 to 4.0 cm***

The RUC reviewed the survey results from 46 dermatologists who frequently perform this service. The specialty recommended pre-service time of 9 minutes, intra-service time of 36 minutes and post service time of 5 minutes based on the survey results and standards. The RUC compared the service to key reference CPT code 11604 *Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 3.1 to 4.0 cm* (work RVU=3.17). The RUC noted that despite the surveyed code requiring more mental effort and judgment, technical skill and overall is a more intense service to perform in comparison to the reference code, the reference code and the surveyed code have similar intra-service times, 40 minutes and 36 minutes, respectively. The RUC also compared the surveyed code to MPC code 11624 *Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm* (work RVU=3.62). The RUC noted that the surveyed code requires less total-service time as compared to this reference code, 66 minutes and 103 minutes, respectively. Based on these comparisons, the specialty agrees and the RUC recommends that 3.20 work RVUs, the survey median, accurately reflects the physician work required to perform this service. The RUC noted that this recommended value represents a slight decrease from the current work RVU for 17284, 3.26 work RVUs. **The RUC recommends a work RVU of 3.20 for CPT code 17284.**

17286 ***Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 4.0 cm***

The RUC reviewed the survey results from 46 dermatologists who frequently perform this service. The specialty recommended pre-service time of 9 minutes, intra-service time of 48 minutes and post service time of 5 minutes based on the survey results and standards. The RUC compared the service to key reference CPT code 11606 *Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter over 4.0 cm* (work RVU=5.02). The RUC noted that the reference code requires more time to perform than the surveyed code, 153 minutes and 78 minutes, respectively. Further, the RUC noted that the reference code requires more mental effort and judgment, technical skill and overall is a more intense service to perform, as compared to the surveyed code. The RUC also compared the surveyed code to MPC code 11626 *Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm* (work RVU=4.61). The RUC noted that the surveyed code requires less intra-service time as compared to this reference code, 48 minutes and 60 minutes, respectively. Based on these comparisons and that the specialty did not provide compelling evidence to change the current value of the service, the RUC agreed that the survey data supports the current value of this service. **The RUC recommends a work RVU of 4.48 for CPT code 17286.**

Partial Mastectomy (Tab 27)
Eric Whitacre, MD, ASBS; Christopher Senkowski, MD, ACS; Samuel Smith, MD, APSA

In the 4th Five-Year Review of the RBRVS, CMS identified CPT code 19302 *Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy* as potentially misvalued through the Site of Service Anomaly screen.

19302 ***Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy***
The RUC reviewed the survey results from 51 general surgeons, breast surgeons and surgical oncologists for CPT code 19302 and determined that at a minimum the current work relative value of 13.99 for CPT code 19302 appropriately places this service relative to other similar services.

The RUC compared code 19302 to the key reference service CPT code 38745 *Axillary lymphadenectomy; complete* (work RVU= 13.87 and intra-service time = 90 minutes). The survey respondents indicated that the surveyed code was more intense and complex, required more physician time to perform and therefore valued it higher than the reference code. The RUC agreed that surveyed code 19302 is more intense and complex to perform and requires more physician work and time than code 38745, intra-service time 100 and 90 minutes, respectively. The total work to perform the key reference code, a complete axillary lymphadenectomy, is very similar to a partial mastectomy and lymphadenectomy. However, the survey respondents indicated and the RUC agreed that the magnitude difference of 0.12 work RVUs is appropriate. Additionally, although the practice expense visit allocation for the surveyed code includes hospital visits, the RUC determined it is clear that 19302 requires more work to perform. The specialty societies did not indicate that there was compelling evidence that the work has increased for this procedure and therefore recommended to maintain the current value. The RUC agreed that the current work RVU of 13.99 appropriately accounts for the work required to perform this service and ensures appropriate magnitude relativity between these two services. The RUC determined that the current work RVU be maintained. **The RUC recommends a work RVU of 13.99 for CPT code 19302.**

Percutaneous Vertebroplasty/Kyphoplasty (Tab 28)
John Wilson, MD, AANS; William Creevy, MD, AAOS; William Donovan, MD, ASNR; William Sullivan, MD, NASS; Frederick Boop, MD, CNS; Geraldine McGinty, MD, ACR, Robert Vogelzang, MD, SIR

In the 4th Five-Year Review of the RBRVS, CMS identified CPT codes 22521 *Percutaneous vertebroplasty, 1 vertebral body, unilateral or bilateral injection; lumbar* (work RVU= 8.65) and 22523 *Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); thoracic* (work RVU= 9.26) as potentially misvalued through the Site of Service Anomaly screen. The specialties agreed to add CPT codes 22520 *Percutaneous vertebroplasty, 1 vertebral body, unilateral or bilateral injection; thoracic* (work RVU= 9.22), 22522 *Percutaneous vertebroplasty, 1 vertebral body, unilateral or bilateral injection; each additional thoracic or lumbar vertebral body* (work RVU= 4.30), 22524

Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); lumbar (work RVU= 8.86) and 22525 *Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); each additional thoracic or lumbar vertebral body* (work RVU= 4.47) as part of the family of services for RUC review.

The RUC reviewed the letter from the specialty societies and had a thorough discussion in regards to the family of services involved in the Site of Service screen. After reviewing the background information and the specialty society survey results and recommendations compared to other services in the family, it was clear that a half day discharge (99238) should have been captured for all these services in this family.

The RUC noted that in the Third Five-Year Review in 2005, CPT code 22520 was reviewed by the assigned Workgroup and noted that the rationale states, "The RUC also requests that this half day discharge visit should be applied to the reference code 22523 as well." In addition, the RUC looked at the RUC rationale for the last review of CPT code 22521 in April 2000 and noted that the specialty indicated that the patient is typically discharged on the same date. In addition, the reviewers mentioned that the family of services have practice expense inputs in the database consistent with a half day discharge management and should have this work mirrored in the physician work components.

Finally, the RUC reviewers discussed the high IWPUT of this family and agreed with the specialties that they were appropriate. The specialties explained that these services have high intensity due to the difficult anatomic area of the service, the thoracic spinal cord. Also, as is the case with most minimally invasive procedures, there is no ramp up and ramp down of intensity as one would expect in an open procedure. The intensity remains at the maximum throughout the procedure.

Given this information, the RUC agreed with the specialties that the current valuation of these services are appropriate and that due to a clerical error the RUC database does not currently reflect the appropriate discharge day management services typically performed for this service and the other recently RUC-reviewed services in the family. **Therefore, the RUC recommends the current work RVUs and a half day discharge, 99238, for CPT codes 22520, 22521, 22523, and 22524.**

CPT Editorial Panel:
The RUC recommends that a parenthetical be added after the Percutaneous Vertebroplasty/Kyphoplasty family of codes precluding reporting these services with the fracture reduction and bone biopsy family of services (CPT codes 20225, 22310-22315, 22325, 22327).

Closed Treatment of Distal Radial Fracture (Tab 29)
Daniel Nagle, MD, ASSH; William Creevy, MD, AAOS

In the 4th Five-Year Review of the RBRVS, CMS identified CPT codes 25600 and 25605 as potentially misvalued through the Harvard Valued - Utilization over 30,000 Screen.

25600 ***Closed treatment of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, includes closed treatment of fracture of ulnar styloid, when performed; without manipulation***

The RUC reviewed the survey results from 48 hand surgeons and orthopaedic surgeons who frequently perform this service. The specialty recommended pre-service time of 7 minutes, intra-time of 15 minutes and post service time of 10 minutes based on the survey results. The RUC reviewed the number of post-operative visits recommended by the specialties and agreed that five 99212 post-operative visits is reflective of the service. The specialties explained that the physician will meet with the patient once a week for the first three weeks following the procedure as the chances of the fracture displacing are highest during this time period. Then, the physician will meet with the patient at six weeks post procedure to remove the cast. Finally, the physician will meet with the patient typically one more time to assess the patient's range of motion. The RUC compared the service to key reference CPT code 26600 *Closed treatment of metacarpal fracture, single; without manipulation, each bone* (work RVU=2.60). The RUC noted that the surveyed code requires more time to perform in comparison to the reference code, 112 minutes and 93 minutes, respectively. Further, the RUC noted that the surveyed code involves more mental effort and judgment and psychological stress to perform in comparison to the reference code. Based on these comparisons and that the specialty did not provide compelling evidence to change the current value of the service, the RUC agreed that the survey data supports the current value of this service. **The RUC recommends a work RVU of 2.78 for CPT code 25600.**

25605 ***Closed treatment of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, includes closed treatment of fracture of ulnar styloid, when performed; with manipulation***

The RUC reviewed the survey results from 48 hand surgeons and orthopaedic surgeons who frequently perform this service. The specialty recommended pre-service time of 20 minutes, intra-time of 30 minutes and post service time of 20 minutes based on the survey results. The RUC reviewed the number of post-operative visits recommended by the specialties and agreed that four 99212 post-operative visits and one 99213 office visit is reflective of the service. The specialties explained that the physician will meet with the patient once a week for the first three weeks following the procedure as the chances of the fracture displacing are highest during this time period. The first of these visits will be the 99213 office visit as this service is performed with manipulation which results in a larger chance of fracture displacing as compared to the fracture being treated in 25600. Then, the physician will meet with the patient at six weeks post procedure to remove the cast. Finally, the physician will meet with the patient typically one more time to assess the patient's range of motion. The RUC compared the service to key reference CPT code 25606 *Percutaneous skeletal fixation of distal radial fracture or epiphyseal separation* (work RVU=8.31). Although the RUC noted that the surveyed code involves more mental effort and judgment and psychological stress to perform in comparison to the reference code, the RUC recognized that the surveyed code requires less time to perform

in comparison to the reference code, 176 minutes and 260 minutes, respectively. Based on these comparisons the specialties recommend that a work RVU of 6.50, the survey's 25th percentile, accurately reflects the work required to perform this service. The RUC recognized that this recommended value represents over a 10 percent decrease in the current value of this service. **The RUC recommends a work RVU of 6.50 for CPT code 25605.**

Orthopaedic Surgery – Thigh/Knee (Tab 30)
William Creevy, MD, AAOS

In the 4th Five-Year Review of the RBRVS, CMS identified CPT codes 27385 *Suture of quadriceps or hamstring muscle rupture; primary* and 27530 *Closed treatment of tibial fracture, proximal (plateau); without manipulation* as potentially misvalued through the Site of Service Anomaly screen.

27385 *Suture of quadriceps or hamstring muscle rupture; primary*
The RUC reviewed the survey responses from 33 orthopaedic surgeons and determined that the current work relative value of 8.11 appropriately accounts for the physician work required to perform this service and maintains relativity to other similar services.

The RUC compared CPT code 27385 to key reference service CPT code 27650 *Repair, primary, open or percutaneous, ruptured Achilles tendon* (work RVU = 9.21) and determined that both services required similar intensity and complexity to perform. The key reference code requires 60 minutes intra-service time and 239 minutes of total time, whereas the surveyed code requires the same intra-service time of 60 minutes but slightly more total time = 266 minutes. Therefore, the RUC determined that survey data supports a slightly higher work RVU for the surveyed code. The RUC determined that there was no compelling evidence that the work required to perform this service has changed and the current work RVU maintains the appropriate relativity among similar services. **The RUC recommends a work RVU of 8.11 for CPT code 27385.**

27530 *Closed treatment of tibial fracture, proximal (plateau); without manipulation*
The RUC reviewed the survey responses from 33 orthopaedic surgeons. The RUC discussed the allocation of the surveyed time and agreed with the specialty society that the time surveyed was incorrectly allocated to pre-service time and agreed with the changes as indicated by the specialty society. The specialty society recommended and the RUC agreed that pre-service package 5 Non-facility procedure without sedation/anesthesia care with the modification of 2 additional minutes positioning time was appropriate as the physician will require extra time to position the patient correctly for tibial fracture treatment. The specialty society recommends and the RUC agrees that 7 minutes pre-evaluation, 2 minutes pre-positioning, 15 minutes intra-service and 10 minutes immediate post-service time appropriately allocated the 34 minutes required to perform this procedure as indicated by the survey respondents. The RUC agreed with the specialty society that the survey respondents may have allocated some of the additional immediate post-service time in the pre-service evaluation section. However, the RUC agreed that the immediate post-service time of 10 minutes, which is 5 minutes more post-time than reference service CPT code 26600 *Closed treatment of metacarpal fracture, single; without manipulation, each bone* (work RVU = 260, total time = 93 minutes), is required to verify the fracture site position has not changed. The RUC determined that 4-99212 visits are appropriate as they include imaging to assure the fracture is healing

appropriately and nothing is changing. The RUC noted this is the same level and number of office visits as are required for the reference service.
The RUC compared code 27530 to similar service CPT code 26600 *Closed treatment of metacarpal fracture, single; without manipulation, each bone* (work RVU = 2.60, total time = 93 minutes) and determined that the surveyed code required slightly more physician work and time to perform, total time = 98 minutes. **The RUC recommends a work RVU of 2.81 for CPT code 27530.**

Orthopaedic Surgery/Podiatry (Tab 31)
William Creevy, MD, AAOS; Tye Ouzounian, MD, AOFAS; Seth Rubenstein, DPM, APMA; Timothy Tillo, DPM, APMA
Facilitation Committee #3

In the 4th Five-Year Review of the RBRVS, CMS identified CPT codes 28002, 28715 and 28820 as potentially misvalued through the Site of Service Anomaly screen. The specialties agreed to add CPT code 28003 as part of the family of services for RUC review. CMS also identified CPT code 28285 as potentially misvalued through the Harvard-Valued - Utilization Over 30,000 screen.

28002 ***Incision and drainage below fascia, with or without tendon sheath involvement, foot; single bursal space***
The RUC reviewed the survey responses from 30 orthopaedic surgeons and podiatrists for CPT code 28002. The RUC is recommending a lower work RVU than the current value. The RUC determined that code 28002 should be decreased to the survey 25th percentile work RVU of 5.34, which is the same as the key reference code, to maintain relativity among these similar services.

The RUC compared 28002 to key reference service CPT code 20103 *Exploration of penetrating wound (separate procedure); extremity* (work RVU = 5.34) and although the total time for the surveyed code is higher than the reference code, 163 and 136 minutes, respectively, the RUC determined that both services required the same intensity and complexity to perform. In August 1995, when the RUC last reviewed this service, only pediatricians were surveyed and the response data included hospital visits, however the RUC did not use this information when developing the work RVU recommendation. The RUC determined that the survey 25th percentile accurately values the work required to perform this service, with no hospital visits required to care for the typical patient. **The RUC recommends a work RVU of 5.34 for CPT code 28002.**

28003 ***Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas***
The specialty society indicated that the predominate provider, podiatry, was not included in the original Harvard valuation. Additionally, the original Harvard valued pre-service and post-service time was incorrectly estimated. The RUC determined that there was compelling evidence that the work for this service may have changed.

The RUC reviewed the survey responses from 30 orthopaedic surgeons and podiatrists for CPT code 28003. The RUC recommends that the current work relative value of 9.06 for 28003 maintains the appropriate relativity among similar services. The RUC noted that 97% of survey respondents indicated that the patient will stay overnight or is admitted to the hospital. The RUC compared 28003 to key reference service CPT code 28046 *Radical resection of tumor (eg, malignant neoplasm), soft tissue of foot or toe; less*

than 3 cm (work RVU = 12.38) and determined that the key reference required almost double the amount of intra-service time, 53 and 90 minutes, respectively. The RUC compared 28003 to similar service CPT code 28289 *Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint* (work RVU = 8.31 and intra-time = 45 minutes) and determined that the intra-service time for 28003 is higher, 53 and 45 minutes, respectively and therefore the physician work for 28003 should be valued higher. The RUC determined that the current work RVU of 9.06 appropriately maintains relativity among these similar services. The RUC also discussed the post-operative visits as indicated by the respondents and determined they are appropriate as the infection is quite extensive on multiple areas of the foot, the patient has many co-morbidities to address and the healing process is slow. **The RUC recommends a work RVU of 9.06 for CPT code 28003.**

28285 ***Correction, hammertoe (eg, interphalangeal fusion, partial or total phalangectomy)***
The RUC determined that there was compelling evidence that the surveyed code is misvalued because the original Harvard study did not include input from podiatrists, the dominant provider and there has been a change in the way this procedure is performed today compared to 15-20 years ago when fusion was not typical in hammertoe correction.

The RUC reviewed the survey responses from 36 orthopaedic surgeons and podiatrists for CPT code 28285. The RUC compared the surveyed code to the reference code 28675 *Open treatment of interphalangeal joint dislocation, includes internal fixation, when performed* (work RVU=5.62) The RUC noted that the surveyed code and the reference code have the same intra-service time, 30 minutes and similar total service time, 190 minutes and 197 minutes, respectively. Further, the RUC noted that both the surveyed code and reference code require similar mental effort and judgment, technical skill and psychological stress to perform. Based on these comparisons, the RUC agreed that the correct work RVU for 28285 is 5.62 work RVUs, crosswalked from 28675. **The RUC recommends a work RVU of 5.62 for CPT code 28285.**

28715 ***Arthrodesis; triple***
The RUC reviewed the survey responses from 30 orthopaedic surgeons and podiatrists for CPT code 28715. Ninety-three percent (93%) of survey respondents indicated that the patient stays overnight or is admitted. The RUC is recommending that the current work RVU of 14.06 maintains the correct relativity among these similar services.

The RUC compared 28715 to reference service CPT code 28415 *Open treatment of calcaneal fracture, includes internal fixation, when performed* (work RVU = 16.19 and total time = 441 minutes) and 24430 *Repair of nonunion or malunion, humerus; without graft (eg, compression technique)* (work RVU = 15.25 and total time = 343 minutes). The RUC determined that the surveyed code requires a total time of 395 minutes and it is less intense and complex to perform than these reference services. The RUC determined that the current work RVU of 14.60, appropriately maintains relativity among these similar services. **The RUC recommends a work RVU of 14.60 for CPT code 28715.**

28820 ***Amputation, toe; metatarsophalangeal joint***
The RUC determined that there was compelling evidence that the surveyed code is misvalued because the original Harvard study did not include input from podiatrists, the dominant provider, and the current value is anomalous to all other amputation codes. The RUC is recommending the survey median of 7.00 work RVUs for CPT code 28820.

The RUC reviewed the survey responses from 85 podiatrists, general surgeons, vascular surgeons and orthopaedic surgeons for CPT code 28820. Eighty-eight (88%) of survey respondents indicated that they typical patient stays overnight or is admitted. The RUC compared 28820 to reference service CPT code 26951 *Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with direct closure* (work RVU = 6.04) and determined both will require the similar intra-operative work, both requiring 30 minutes to perform. However, the patient undergoing 26951 will more likely be a trauma patient that is otherwise healthy. This patient will not typically require hospitalization compared with the typical patient undergoing the surveyed code who will have many co-morbidities that led to the need to perform the toe amputation. The incremental difference in work RVUs conservatively captures the additional complexity and time for the post-operative management required for 28820. For further support, the RUC compared the surveyed service to similar service CPT code 28645 *Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed* (work RVU = 7.44, intra-time = 45 minutes). The RUC determined that the survey median work RVU of 7.00 appropriately reflects the physician work required to perform this service and maintains relativity among similar services. **The RUC recommends a work RVU of 7.00 for CPT code 28820.**

Application of Cast and Strapping (Tab 32)
William Creevy, MD, AAOS; Tye Ouzounian, MD, AOFAS; Seth Rubenstein, DPM, APMA; Timothy Tillo, DPM, APMA; Daniel Nagle, MD, ASSH; Jennifer Wiler, MD, ACEP
Facilitation Committee #3

In the 4th Five-Year Review of the RBRVS, CMS identified CPT codes 29215, 29405 and 29515 as potentially misvalued through the Harvard-Valued – Utilization over 30,000 screen. The specialties agreed to add CPT code 29126 and the specialties agreed to add CPT code 29425 as part of the family of services for RUC review.

29125 ***Application of short arm splint (forearm to hand); static***
The RUC reviewed the survey results from 50 hand surgeons, orthopaedic surgeons and emergency physicians for CPT code 29125. The RUC noted that there is typically an Evaluation and Management services provided on the same day as this service. The specialties' explained that the 7 minutes of pre-service time is justified as the patient is typically moved into a casting room which is separate from the initial consultation. In addition, the patient is draped and the splint materials are collected while the patient's is properly positioned.

The RUC analyzed the survey's estimated physician work and agreed that these data support maintaining the current work RVU of 0.59 for this service. To further justify this value, the RUC compared the surveyed code to key reference service CPT code 29075 *Application, cast; elbow to finger (short arm)* (work RVU= 0.77 and total time= 38 minutes). The RUC agreed that the two services are comparable physician services, requiring similar work related to positioning the wrist and hand in specific position/flexion. However, the specialties noted that 29075 is more complex and will require more intra-service time to apply additional casting material for circumferential coverage, accounting for the slight difference in work RVU. Additionally, the RUC compared 29125 to CPT code 29581 *Application of multi-layer venous wound compression system, below knee* (work RVU= 0.60 and total time= 27 minutes). The

RUC agreed that the two services require similar physician mental effort and judgment to perform and should be valued similarly due to identical total service times, 27 minutes respectively. **The RUC recommends a work RVU of 0.59 for CPT code 29125.**

29126 ***Application of short arm splint (forearm to hand); dynamic***
The RUC reviewed the survey results from 33 hand surgeons and orthopaedic surgeons for CPT code 29126. The RUC noted that there is typically an Evaluation and Management service provided on the same day as this service. The specialties' explained that the 7 minutes of pre-service time is justified as the patient is typically moved into a casting room which is separate from the initial consultation. In addition, the patient is draped and the splint materials are collected while the patient's arm is properly positioned.

The RUC analyzed the survey's estimated physician work and agreed that the median work RVU data overestimates the work value for this service. Given that there is no compelling evidence that the physician work has recently changed, the RUC recommends maintaining the current work RVU of 0.77 for this service. To further justify this value, the RUC compared the surveyed code to key reference service CPT code 29445 *Application of rigid total contact leg* cast (work RVU= 1.78 and total time= 50 minutes). The RUC agreed that the reference code should be valued greater than the surveyed code due to greater total physician time, 50 minutes and 42 minutes, respectively. In addition, the RUC compared code 29126 to reference CPT code 64650 Chemodenervation of eccrine glands; both axillae (work RVU= 0.70 and total time= 35 minutes). The noted that the reference code has less intra-service time compared to the surveyed code, 23 minutes and 30 minutes, respectively, and should be valued lower. **The RUC recommends a work RVU of 0.77 for CPT code 29126.**

29405 ***Application of short leg cast (below knee to toes);***
The RUC reviewed the survey results from 35 orthopaedic surgeons, emergency physicians and podiatrists for CPT code 29405. The RUC analyzed the survey's estimated physician work and agreed that these data support the 25th percentile, a work RVU of 0.80, for this service, which is slightly less than the current value of 0.86. To further justify this value, The RUC compared the surveyed code to key reference service CPT code 29075 *Application, cast; elbow to finger (short arm)* (work RVU= 0.77 and total time= 25 minutes). The RUC agreed that the two services have analogous total time, 27 minutes and 25 minutes, respectively, and should be valued similarly. Additionally, the RUC compared code 29405 to the reviewed short arm splint service, CPT code 29125, and agreed that the service times are similar, but code 29405 should have a higher work RVU due to the increased complexity of a short leg cast compared to the short arm splint, including the extra malleolar padding required, the size of the limb and placement of an extra layered device. **The RUC recommends a work RVU of 0.80 for CPT code 29405.**

29425 ***Application of short leg cast (below knee to toes); walking or ambulatory type***
The RUC reviewed the survey results from 35 orthopaedic surgeons, emergency physicians and podiatrists for CPT code 29425. The RUC analyzed the survey data and agreed that these data overestimates the physician work involved in the service. Comparing the physician work within the family of services, the RUC compared the surveyed code to CPT code 29405 *Application of short leg cast (below knee to toes*) and noted that the survey respondents indicated identical service time components. Given this, the RUC recommends, for CPT code 29425, a direct work RVU crosswalk to code

29405. To further justify this value, the RUC compared code 29425 to the reviewed short arm splint service, code 29125, and agreed that the service times are identical, but 29425 should have a higher work RVU due to the increased complexity of a short leg cast compared to the short arm splint, including the extra malleolar padding required, the size of the limb and placement of an extra layered device. Finally, the RUC compared the surveyed code to key reference service CPT code 29075 *Application, cast; elbow to finger (short arm)* (work RVU= 0.77 and total time= 25 minutes). The RUC agreed that the two services have analogous total time, 27 minutes and 25 minutes, respectively, and should be valued similarly. **The RUC recommends a work RVU of 0.80 for CPT code 29425.**

29515 ***Application of short leg splint (calf to foot)***
The RUC reviewed the survey results from 49 orthopaedic surgeons, emergency physicians and podiatrists for CPT code 29515. The RUC noted that there is typically an Evaluation and Management services provided on the same day as this service. The specialties' explained that the 7 minutes of pre-service time is justified as the patient presents with equinus and must be place in a comfortable position with the leg bent at the knee 90 degrees. In addition, the patient is draped and the splint materials are collected while the patient is properly positioned.

The RUC analyzed the survey's estimated physician work and agreed that these data support maintaining the current work RVU of 0.73 for this service. To further justify this value, the RUC compared the surveyed code to key reference service CPT 29075 *Application, cast; elbow to finger (short arm)* (work RVU= 0.77 and total time= 25 minutes). The RUC agreed that the two services have analogous total time, 27 minutes and 25 minutes, respectively, and should be valued similarly. Additionally, the RUC compared code 29515 to the reviewed short arm splint service, code 29125, and agreed that the service times are similar, but 29425 should have a higher work RVU due to the increased complexity of a short leg cast compared to the short arm splint, including the extra malleolar padding required, the size of the limb and placement of an extra layered device. **The RUC recommends a work RVU of 0.73 for CPT code 29515.**

Orthopaedic Surgery – Arthroscopy (Tab 33)
William Creevy, MD, AAOS; Lous McIntyre, MD, AAOS

In the 4th Five-Year Review of the RBRVS, CMS identified CPT codes 29826, 29880 and 29881 as potentially misvalued through the Harvard Valued - Utilization over 30,000 Screen.

29826 ***Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with or without coracoacromial release***

The RUC reviewed the survey results from 118 orthopaedic surgeons and arthroscopic orthopaedic surgeons who frequently perform this service. The specialty recommended pre-service time of 60 minutes, intra-service time of 60 minutes and post service time of 20 minutes based on the survey results. The RUC compared the service to key reference CPT code 29824 *Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure)* (work RVU=8.98). The RUC noted that the surveyed code requires more total service time to perform than the reference code, 237 minutes and 225 minutes, respectively. Further, the RUC noted that the surveyed code requires more technical skill, physical effort and overall is a more intense procedure to

perform in comparison to the reference code. Based on these comparisons and that the specialty did not provide compelling evidence to change the current value of the service, the RUC agreed that the survey data supports the current value of this service. **The RUC recommends a work RVU of 9.16 for CPT code 29826.**

CPT Referral:

Although the RUC acknowledges that 29826 when performed with other endoscopic services is subject to the Endoscopic Multiple Procedure Reduction, the RUC understands that the specialty will submit a coding proposal to the CPT Editorial Panel, which will outline 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*. 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.

Further, the RUC recommends that 29880 *Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving)* and 29881 *Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving)* be referred to the CPT Editorial Panel so that the descriptor and vignette can be revised to fully capture the work in the administration of these procedures. Specifically, it is typical in performing a meniscectomy that a surgeon will also perform articular shaving and removal of loose bodies. These activities are not included in the current descriptors.

Biopsy of Lung or Mediastinum (Tab 34)
Zeke Silva, MD, ACR; Sean Tutton, MD, SIR; Bob Volgelzang, MD, SIR; Gerald Niedzwiecki, MD, SIR

In the 4th Five-Year Review of the RBRVS, CMS identified CPT code 32405 as potentially misvalued through the Harvard Valued - Utilization over 30,000 Screen.

32405 *Biopsy, lung or mediastinum, percutaneous needle*
The RUC reviewed the survey results from 110 diagnostic and interventional radiologists who frequently perform this service. The specialty recommended pre-service time of 25 minutes, intra-service time of 30 minutes and post service time of 20 minutes based on the survey results. The RUC compared the service to key reference CPT code 32553 *Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-thoracic, single or multiple* (work RVU=3.80). Despite the survey data which suggests that the surveyed code and the reference code require similar mental effort and judgment, technical skill and overall require the same intensity to perform, the RUC noted that the surveyed code requires less total service time to perform than the reference code, 75 minutes and 90 minutes, respectively. The RUC also compared the surveyed code to reference CPT code 60100 *Biopsy thyroid, percutaneous core needle* (work RVU=1.56). The RUC noted that the surveyed code requires more total service time as compared to this reference code, 75 minutes and 50 minutes, respectively. Based on these comparisons and that the specialty did not provide compelling evidence to change the current value of the service, the RUC agreed that the survey data supports the current value of this service. **The RUC recommends a work RVU of 1.93 for CPT code 32405.**

CPT Referral:
The RUC understands that this service is performed more than 90% of the time with CPT code 77012 *Computed tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation* in the Medicare population as identified in the Relativity Assessment Workgroup's 75% or More Reported Together Screen. The work impact of these services is very small and the Workgroup is still determining the best solution to address these types of pairings. However, at this time, the RUC understands that at some point in the future, these services will be referred to the CPT Editorial Panel to create a bundled code. Further, the specialties explained that the survey data supports that moderate sedation is an inherent component of this service. **The RUC recommends that CPT Code 32405 be referred to the CPT Editorial Panel to be included in Appendix G.**

Cardiothoracic Surgery (Tab 35)
Duane Davis, MD, STS; James Levett, MD, STS
Facilitation Committee #2

In the 4th Five-Year Review of the RBRVS, CMS identified CPT code 33411 as potentially misvalued through the Site of Service Anomaly screen. CMS also included a number of services identified by the Society of Thoracic Surgeons (STS), including ventricular assist device (VAD) removal codes, VAD insertion and replacement codes, lung transplant codes, pulmonary artery embolectomy codes, descending thoracic aorta repair codes, congenital cardiac codes and general thoracic surgery code 43415 as part of the 4th Five-Year Review.

33411 ***Replacement, aortic valve; with aortic annulus enlargement, noncoronary cusp***
CMS identified CPT code 33411 as a site of service anomaly stating that it is performed 49% or less in an inpatient setting with at least one inpatient hospital visit. The specialty society provided the 2009 Medicare claims data, which indicates that code 33411 is performed 99.9% in the inpatient hospital setting. This service involves replacing the aortic value in conjunction with enlargement of the aortic annulus, performed in instances where the annulus is too small to accommodate the appropriate size valve for the patient. Surgery requires a median sternotomy and cardiopulmonary bypass. Following surgery, the patient requires intensive care and subsequent inpatient hospitalization. It is not likely that this procedure has ever been performed in the outpatient setting. The specialty society recommended and the RUC agreed that this service should be removed from the CMS site of service anomaly list and maintain its current work RVU. **The RUC recommends a work RVU of 62.07 for CPT code 33411.**

Ventricular Assist Device (VAD) Insertion and Replacement Codes (XXX global)
In the July 22, 1999 Proposed Rule (page 39629), CMS indicated that CPT codes 33975 and 33976 were valued as XXX services for the intra-service work only. CMS proposed that the values be interim until there is more experience with the service. CMS used the median intra-service times from the RUC survey and the work intensity for a cardiac surgical procedure code that does not include any pre- or post-service work, CPT code 33530 *Reoperation, coronary artery bypass procedure or valve procedure, more than 1 month after original operation* (ZZZ, work RVU = 10.13, intra-service time = 70 minutes, IWPUT=0.1154).

In general, the specialty society and RUC agree with the assumptions used by CMS regarding the intra-service intensity used to value these services. However, the RUC agrees with the compelling evidence provided by the specialty society that the existing methodology is flawed as it does not include substantial pre- and post-service work (i.e., pre- and post-service work performed immediately prior to or after the surgery). This time, such as recovery room time, is not separately reported under another CPT code.

The current survey respondents did not include work associated with Evaluation and Management services related to these procedures. The XXX survey instrument used only allowed survey respondents to include pre- and post-service time associated with these services that are not separately reported (eg, pre-surgery review of records or recovery room time).

33975 ***Insertion of ventricular assist device; extracorporeal, single ventricle*** **(XXX global)**
The RUC reviewed the survey responses from 46 cardiothoracic surgeons for VAD insertion CPT code 33975. The specialty recommends 95 minutes of pre-time, 180 minutes of intra-time and 120 minutes of immediate post-time. The pre-service evaluation time is significant to account for the patient typically being completely unknown to the implanting surgeon, thoroughly evaluating the right ventricular function and determining if this is a bridge to transplant or the destination of the device. Additional positioning time is required to account for the physician working around the typical patient having an intra-aortic balloon pump and frequently on a temporary type of cardiopulmonary bypass, the addition of sensing electrodes for the VAD and safely disabling the AICD, a biventricular pacing system.

The RUC reviewed the survey results and compared 33975 to similar services (adjusted for the XXX global period for comparison) CPT codes 33426 *Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring* (XXX work RVU = 25.49, intra-service time = 205 minutes) and 33548 *Surgical ventricular restoration procedure, includes prosthetic patch, when performed (eg, ventricular remodeling, SVR, SAVER, Dor procedures)* (XXX work RVU = 28.16, intra-service time = 217 minutes). The RUC determined that the survey 25th percentile RVU of 25.00 and median intra-service time of 180 minutes appropriately measured the physician time, intensity and complexity of this service relative to similar cardiothoracic surgery procedures. The RUC recommendations result in and IWPUT of 0.1137, similar to the assumption by CMS in the original valuation. **The RUC recommends a work RVU of 25.00 for CPT code 33975.**

33976 ***Insertion of VAD; extracorporeal biventricular*** **(XXX global)**
The RUC reviewed the survey responses from 44 cardiothoracic surgeons for VAD insertion CPT code 33976. The specialty recommends 95 minutes of pre-time, 240 minutes of intra-time and 120 minutes of immediate post-time. The pre-service evaluation time is significant to account for the patient typically being completely unknown to the implanting surgeon, thoroughly evaluating the right ventricular function and determining if this is a bridge to transplant or the destination of the device. Additional positioning time is required to account for the physician working around the typical patient having an intra-aortic balloon pump and frequently on a temporary type of cardiopulmonary bypass, the addition of sensing electrodes for the VAD and safely disabling the AICD, a biventricular pacing system.

The RUC reviewed the survey results and compared 33976 to similar services (adjusted for the XXX global period for comparison) CPT codes 33426 *Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring* (XXX work RVU = 25.49, intra-service time = 205 minutes) and 33548 *Surgical ventricular restoration procedure, includes prosthetic patch, when performed (eg, ventricular remodeling, SVR, SAVER, Dor procedures)* (XXX work RVU = 28.16, intra-service time = 217 minutes). The RUC determined that the survey 25th percentile RVU of 30.75 and median intra-service time of 240 minutes appropriately measured the physician time, intensity and complexity of this service relative to similar cardiothoracic surgery procedures. The RUC also compared 33976 to the code just examined, 33975 *Insertion of ventricular assist device; extracorporeal, single ventricle* (recommended work RVU = 25.00, intra-service time = 180 minutes) and determined that the additional intra-service time and higher work RVU is appropriate as this service includes insertion of VAD for two ventricles, therefore the operation is longer, the patient has more post-operative bleeding and requires more care. Therefore, the RUC determined that the survey 25th percentile is an accurate portrayal of the physician work involved in this procedure. The RUC recommendations result in and IWPUT of 0.1093, similar to the assumption by CMS in the original valuation. **The RUC recommends a work RVU of 30.75 for CPT code 33976.**

33979 ***Insertion of VAD; implantable intracorporeal, single***
The RUC reviewed the survey responses from 40 cardiothoracic surgeons for VAD insertion CPT code 33979. The specialty recommends 95 minutes of pre-time, 280 minutes of intra-time and 120 minutes of immediate post-time. The pre-service evaluation time is significant to account for the patient typically being completely unknown to the implanting surgeon, thoroughly evaluating the right ventricular function and determining if this is a bridge to transplant or the destination of the device. Additional positioning time is required to account for the physician working around the typical patient having an intra-aortic balloon pump and frequently on a temporary type of cardiopulmonary bypass, the addition of sensing electrodes for the VAD and safely disabling the AICD, a biventricular pacing system.

The RUC reviewed the survey results and compared 33979 to similar service (adjusted for the XXX global period for comparison) CPT code 33945 *Heart transplant, with or without recipient cardiectomy* (XXX work RVU = 44.88, intra-service time = 325 minutes). The RUC determined that the survey 25th percentile RVU of 37.50 and median intra-service time of 280 minutes appropriately measured the physician time, intensity and complexity of this service relative to similar cardiothoracic surgery procedures. The RUC recommendations result in and IWPUT of 0.1178, similar to the assumption by CMS in the original valuation. **The RUC recommends a work RVU of 37.50 for CPT code 33979.**

33981 ***Replacement of extracorporeal VAD, single or biventricular, pump(s), single or each pump***
The RUC reviewed the survey responses from 43 cardiothoracic surgeons for VAD replacement CPT code 33981. The specialty recommends 95 minutes of pre-time, 120 minutes of intra-time and 60 minutes of immediate post-time. The pre-service evaluation time is significant to account for the patient typically being completely unknown to the implanting surgeon, thoroughly evaluating the right ventricular function and determining if this is a bridge to transplant or the destination of the device. Additional positioning

time is required to account for the physician working around the typical patient having an intra-aortic balloon pump and frequently on a temporary type of cardiopulmonary bypass, the addition of sensing electrodes for the VAD and safely disabling the AICD, a biventricular pacing system.

The RUC reviewed the survey results and compared 33981 to similar services (adjusted for the XXX global period for comparison) CPT codes 33533 *Coronary artery bypass, using arterial graft(s); single arterial graft* (XXX work RVU = 17.84, intra-service time = 151 minutes) and 33405 *Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve* (XXX work RVU = 23.53, intra-service time = 198 minutes). The RUC determined that the survey 25th percentile RVU of 16.11 and median intra-service time of 120 minutes appropriately measured the physician time, intensity and complexity of this service relative to similar cardiothoracic surgery procedures. The RUC recommendations result in and IWPUT of 0.1077, similar to the assumption by CMS in the original valuation. **The RUC recommends a work RVU of 16.11 for CPT code 33981.**

33982 ***Replacement of VAD pump(s); implantable intracorporeal, single ventricle, without cardiopulmonary bypass***
The RUC reviewed the survey responses from 40 cardiothoracic surgeons for VAD replacement CPT code 33982. The specialty recommends 95 minutes of pre-time, 290 minutes of intra-time and 90 minutes of immediate post-time. The pre-service evaluation time is significant to account for the patient typically being completely unknown to the implanting surgeon, thoroughly evaluating the right ventricular function and determining if this is a bridge to transplant or the destination of the device. Additional positioning time is required to account for the physician working around the typical patient having an intra-aortic balloon pump and frequently on a temporary type of cardiopulmonary bypass, the addition of sensing electrodes for the VAD and safely disabling the AICD, a biventricular pacing system.

The RUC reviewed the survey results and compared 33982 to similar services (adjusted for the XXX global period for comparison) CPT codes 33863 *Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension; with aortic root replacement using composite prosthesis and coronary reconstruction* (XXX work RVU = 37.47, intra-service time = 287 minutes) and 33945 *Heart transplant, with or without recipient cardiectomy* (XXX work RVU = 44.88, intra-service time = 325 minutes). The RUC determined that the survey 25th percentile RVU of 37.86 and median intra-service time of 290 minutes appropriately measured the physician time, intensity and complexity of this service relative to similar cardiothoracic surgery procedures. The RUC recommendations result in and IWPUT of 0.1157, similar to the assumption by CMS in the original valuation. **The RUC recommends a work RVU of 37.86 for CPT code 33982.**

33983 ***Replacement of VAD pump(s); implantable intracorporeal, single ventricle, with cardiopulmonary bypass***
The RUC reviewed the survey responses from 40 cardiothoracic surgeons for VAD replacement CPT code 33983. The specialty recommends 95 minutes of pre-time, 345 minutes of intra-time and 120 minutes of immediate post-time. The pre-service evaluation time is significant to account for the patient typically being completely unknown to the implanting surgeon, thoroughly evaluating the right ventricular function and determining if this is a bridge to transplant or the destination of the device. Additional positioning time is required to account for the physician working around the

typical patient having an intra-aortic balloon pump and frequently on a temporary type of cardiopulmonary bypass, the addition of sensing electrodes for the VAD and safely disabling the AICD, a biventricular pacing system.

The RUC reviewed the survey results and compared 33983 to similar services (adjusted for the XXX global period for comparison) CPT codes 33863 *Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension; with aortic root replacement using composite prosthesis and coronary reconstruction* (XXX work RVU = 37.47, intra-service time = 287 minutes) and 33945 *Heart transplant, with or without recipient cardiectomy* (XXX work RVU = 44.88, intra-service time = 325 minutes). The RUC determined that the survey 25th percentile RVU of 44.54 and median intra-service time of 345 minutes appropriately measured the physician time, intensity and complexity of this service relative to similar cardiothoracic surgery procedures. The RUC recommendations result in and IWPUT of 0.1160, similar to the assumption by CMS in the original valuation. **The RUC recommends a work RVU of 44.54 for CPT code 33983.**

VAD Insertion Codes Budget Neutrality
The RUC noted that the recommended RVU changes for the VAD insertion family of codes (33975, 33976 and 33979) is budget neutral, resulting in a 12% decrease in total RVUs. CPT codes 33981-33983 are currently carrier priced, therefore, are not included in this calculation.

Ventricular Assist Device (VAD) Removal Codes (090-day global)
To be consistent with the insertion and replacement VAD codes, the RUC requests 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*. Upon CMS approval, the specialty society will re-survey and provide recommendations at the February 2011 RUC meeting. **The RUC requests that CMS consider an XXX global period for 33977, 33978 and 33980 and the specialty society will resurvey and present recommendations in February 2011.**

Lung Transplant Codes
The specialty society indicated and the RUC agreed that there is compelling evidence that the patent population has changed for the lung transplant codes. The mean age of patient has increased by 10 years (22% of patients are 65 years-old or more), patients typically require ventilation, patients are typically re-transplants, patients have more underlying diseases such as ventricular fibrosis and critically ill patients are now first to receive transplants. Additionally, the current work RVUs create a rank order anomaly.

32851 ***Lung transplant, single; without cardiopulmonary bypass***
The RUC reviewed survey responses from 52 cardiothoracic surgeons for CPT code 32851. The specialty recommends 140 minutes of pre-time, 240 minutes of intra-time and 90 minutes of immediate post-time. The pre-time is significant to conduct an thorough evaluation of the recipient and provide donor management, make adjustments to protect the airway, position patient in the lateral decubitus position, prepare the patient for cannula to monitor pressure and access arterial blood gases in case of radial arterial line malfunctioning and waiting for donor arrival.

The RUC determined the immediate post-operative time was appropriate to apply dressings, reposition the patient and maximize the patient's cardiopulmonary status. The RUC reviewed the post-operative visits and agreed with the specialty society that the critical care and hospital time indicated by the survey respondents is typical, the discharge day is appropriate to account for the extensive counseling and the level 4 and 5 office visits appropriately account for the post-op surgical care provided.

The RUC agreed with the specialty society that the survey 25th percentile work RVU of 63.00 appropriately accounted for the physician work required to perform this service. The RUC compared 32851 to reference CPT code 33945 *Heart transplant, with or without recipient cardiectomy* (work RVU = 89.50, intra-time = 325 minutes) and MPC code 61697 *Surgery of complex intracranial aneurysm, intracranial approach; carotid circulation* (work RVU = 63.40, intra-time = 300) and determined that code 32851 (survey intra-time = 240 minutes) was more intense to perform in a shorter amount of time than the aforementioned services. The RUC determined that the survey 25th percentile RVU of 63.00 and median intra-service time of 240 minutes appropriately measured the physician time, intensity and complexity of this service relative to similar cardiothoracic surgery procedures. **The RUC recommends a work RVU of 63.00 for CPT code 32851.**

32852 ***Lung transplant, single; with cardiopulmonary bypass***
The RUC reviewed survey responses from 46 cardiothoracic surgeons for CPT code 32852. The specialty recommends 140 minutes of pre-time, 300 minutes of intra-time and 90 minutes of immediate post-time. The pre-time is significant to conduct an thorough evaluation of the recipient and provide donor management, make adjustments to protect the airway, position patient in the lateral decubitus position, prepare the patient for cannula to monitor pressure and access arterial blood gases in case of radial arterial line malfunctioning and waiting for donor arrival.

The determined the immediate post-operative time was appropriate to apply dressings, reposition the patient and maximize the patient's cardiopulmonary status. The RUC reviewed the post-operative visits and agreed with the specialty society that the critical care and hospital time indicated by the survey respondents is typical, the discharge day is appropriate to account for the extensive counseling and the level 4 and 5 office visits appropriately account for the post-op surgical care provided.

The RUC compared 32852 (300 minutes intra-time) to CPT code 33305 *Repair of cardiac wound; with cardiopulmonary bypass* (work RVU = 76.73, intra-time = 296 minutes) and determined that the surveyed code required similar intensity and complexity. The RUC also compared 32852 to key reference service CPT code 33945 *Heart transplant, with or without recipient cardiectomy* (work RVU = 89.50, intra-time = 325 minutes) and MPC code 47130 *Hepatectomy, resection of liver; total right lobectomy* (work RVU = 57.19, intra-time = 240 minutes). The RUC reviewed the survey 25th percentile work RVU = 65.50 and median work RVU = 80.13 for 32852. The RUC determined that the survey RVU difference of 2.50 work RVUs between the without bypass code 32851 (recommended work RVU = 63.00) and the 25th percentile RVU for code 32852 did not capture the work difference for the performance of bypass and the median work RVU difference of 17.13 work RVUs, would overvalue the work required for the performance of cardiopulmonary bypass 32852. Therefore, the RUC calculated

the work RVUs associated with 60 more minutes of intra-service time and additional 99232 and 99233 hospital visits and added them to the without bypass code 32851 to place this service in the proper rank order (work RVU = 74.37). **The RUC recommends a work RVU of 74. 37 for CPT code 32582.**

60 minutes x 0.133 (IWPUT for 32851) = 7.98
99232 = 1.39
99233 = 2.00
Increment = 11.37
63.00 + 11.37 = **74.37**

32853 ***Lung transplant, double (bilateral sequential or en bloc); without cardiopulmonary bypass***
The RUC reviewed survey responses from 48 cardiothoracic surgeons for CPT code 32853. The specialty recommends 130 minutes of pre-time, 375 minutes of intra-time and 90 minutes of immediate post-time. The pre-time is significant to conduct an thorough evaluation of the recipient and provide donor management, make adjustments to protect the airway, position patient in the lateral decubitus position, prepare the patient for cannula to monitor pressure and access arterial blood gases in case of radial arterial line malfunctioning and waiting for donor arrival.

The RUC determined the immediate post-operative time was appropriate to apply dressings, reposition the patient and maximize the patient's cardiopulmonary status. The RUC reviewed the post-operative visits and agreed with the specialty society that the critical care and hospital time indicated by the survey respondents is typical, the discharge day is appropriate to account for the extensive counseling and the level 4 and 5 office visits appropriately account for the post-op surgical care provided.

The RUC agreed with the specialty society that the survey median work RVU of 90.00 appropriately accounted for the physician work required to perform this service. The RUC compared 32853 to key reference service CPT code 33945 *Heart transplant, with or without recipient cardiectomy* (work RVU = 89.50, intra-time = 325 minutes) and determined that code 32853 (survey intra-time = 375 minutes) is more intense, complex and requires more physician work and time to perform. The RUC also agreed that the relativity between the single lung transplant, code 32851, and this double lung transplant, code 32853 was correct. **The RUC recommends a work RVU of 90.00 for CPT code 32853.**

32854 ***Lung transplant, double (bilateral sequential or en bloc); with cardiopulmonary bypass***
The RUC reviewed survey responses from 55 cardiothoracic surgeons for CPT code 32854. The specialty recommends 130 minutes of pre-time, 400 minutes of intra-time and 90 minutes of immediate post-time. The pre-time is significant to conduct an thorough evaluation of the recipient and provide donor management, make adjustments to protect the airway, position patient in the lateral decubitus position, prepare the patient for cannula to monitor pressure and access arterial blood gases in case of radial arterial line malfunctioning and waiting for donor arrival.

The RUC determined the immediate post-operative time was appropriate to apply dressings, reposition the patient and maximize the patient's cardiopulmonary status. The RUC reviewed the post-operative visits and agreed with the specialty society that the critical care and hospital time indicated by the survey respondents is typical, the discharge day is appropriate to account for the extensive counseling and the level 4 and 5 office visits appropriately account for the post-op surgical care provided.

The RUC agreed with the specialty society that the survey median work RVU of 95.00 appropriately accounted for the physician work required to perform this service. The RUC compared 32854 to key reference service CPT code 33945 *Heart transplant, with or without recipient cardiectomy* (work RVU = 89.50, intra-time = 325 minutes) and determined that code 32854 (survey intra-time = 400 minutes) was more intense, complex and required more physician work and time to perform. The RUC also agreed that the relativity between the single lung transplant, code 32852, and this double lung transplant, code 32854 was correct. **The RUC recommends a work RVU of 95.00 for CPT code 32854.**

Lung Transplant Codes

Heart-Lung Transplant Code

33935 ***Heart-lung transplant with recipient cardiectomy-pneumonectomy***
The specialty society indicated and the RUC agreed that there is compelling evidence that the patient population has changed (the average age of patients receiving transplants has increased) and a rank order anomaly existed with the current value of heart transplant alone CPT code 33945 *Heart transplant, with or without recipient cardiectomy* (work RVU = 89.50, intra-time = 325 minutes) compared to the current value of 33935 (2010 work RVU = 62.01)

The RUC reviewed survey responses from 36 cardiothoracic surgeons for CPT code 33935, which is remarkable given that this procedure is performed nationally approximately 35 times per year and was performed on Medicare patients 8 times in 2009. The specialty recommends 160 minutes of pre-time, 380 minutes of intra-time and 90 minutes of immediate post-time. The pre-time is significant to conduct an thorough evaluation of the recipient and provide donor management, prepare the patient for femoral artery cannulation to monitor pressure and access arterial blood gases in case of radial arterial line malfunctioning and waiting for donor arrival (unlike the lung transplant codes, this additional time is more similar to heart transplantation which has a scrub, dress, wait time of 90 minutes).

The RUC determined the immediate post-op time was appropriate to apply dressings, reposition the patient and maximize the patient's cardiopulmonary status. The RUC reviewed the post-operative visits and agreed with the specialty society that the critical care and hospital time indicated by the survey respondents is typical, the discharge day is appropriate to account for the extensive counseling and the level 4 and 5 office visits appropriately account for the post-op surgical care provided monitoring medication interaction, spirometric lung function assessment, cardiac interpretation, overall system assessment and patient education.

The RUC agreed with the specialty society that the survey median work RVU of 100.00 appropriately accounts for the physician work required to perform this service. The RUC compared 33935 to key reference service CPT code 33945 *Heart transplant, with or without recipient cardiectomy* (work RVU = 89.50, intra-time = 325 minutes) and determined that code 33935 (survey intra-time = 380 minutes) was more intense, complex and required more physician work and time to perform. **The RUC recommends a work RVU of 100.00 for CPT code 33935.**

Heart-Lung Transplant Code

Congenital Cardiac Codes

33412 ***Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure)***
The specialty society indicated and the RUC agreed that there is compelling evidence that the patient population has changed, the current valuation is based on an adult cardiac service and typically this procedure is performed on a child.

The RUC reviewed survey responses from 36 cardiothoracic surgeons for CPT code 33412 and compared it to key reference service CPT code 33782 *Aortic root translocation with ventricular septal defect and pulmonary stenosis repair (ie, Nikaidoh procedure); without coronary ostium reimplantation* (work RVU = 60.08 and intra-time = 300 minutes). The specialty recommends 63 minutes of pre-time, 300 minutes of intra-time and 60 minutes of immediate post-time. The specialty society indicated and the RUC agreed that these two services require the same intensity and complexity, physician work and time to perform. Therefore, the specialty society recommends the same physician time for the intra-service, 300 minutes, as well as total time, 866 minutes. The RUC agrees with the specialty society that the survey median work RVU of 60.00 for 33412 appropriately accounts for the work required to perform this service as well as establishes the correct relativity among other similar services. **The RUC recommends a work RVU of 60.00 for CPT code 33412.**

33468 ***Tricuspid valve repositioning and plication for Ebstein anomaly***
The specialty society indicated and the RUC agreed that there is compelling evidence that the technique to perform this procedure has changed as it is now typically performed using the Cone method and the patient population has changed as new techniques have been introduced and widely adopted for the repair of Ebstein's anomaly of the tricuspid valve.

The RUC reviewed survey responses from 58 cardiothoracic surgeons for CPT code 33468 compared to key reference service CPT code 33427 *Valvuloplasty, mitral valve, with cardiopulmonary bypass; radical reconstruction, with or without ring* (work RVU = 44.83 and intra-time = 221 minutes). The specialty society indicated and the RUC agreed that the surveyed service is more intense and complex and requires more physician work and time to perform. The specialty recommends 63 minutes of pre-time, 240 minutes of intra-time and 60 minutes of immediate post-time. The RUC agrees with the specialty society that the survey median work RVU of 50.00 for 33468 appropriately accounts for

the work required to perform this service as well as establishes the correct relativity among other similar services. **The RUC recommends a work RVU of 50.00 for CPT code 33468. The specialty society indicated and the RUC agreed to add a parenthetical to indicated that 33468 should not be reported with atrial septal defect repair code(s).**

33645 ***Direct or patch closure, sinus venosus, with or without anomalous pulmonary venous drainage***
The specialty society indicated and the RUC agreed that there is compelling evidence that the typical patient has changed as many will have anomalous vein drainage to correct as well as have an atrial septal defect. Secondly, the technique for this procedure has changed and is typically performed using the Warden repair method. Lastly, this service is Harvard valued and the current IWPUT is extremely low at 0.0002.

The RUC reviewed survey responses from 55 cardiothoracic surgeons for CPT code 33645 compared to key reference service CPT codes 33641 *Repair atrial septal defect, secundum, with cardiopulmonary bypass, with or without patch* (work RVU = 29.58 and intra-time = 164 minutes) and 33681 *Closure of single ventricular septal defect, with or without patch* (work RVU = 32.34 and intra-time = 150 minutes). The specialty recommends 63 minutes of pre-time, 175 minutes of intra-time and 45 minutes of immediate post-time. The specialty society indicated and the RUC agreed that 33645 (surveyed intra-service time = 175 minutes) requires more intensity and complexity to perform compared to these reference services. The RUC agrees with the specialty society that the survey median work RVU of 33.00 for 33645 appropriately accounts for the work required to perform this service as well as establishes the correct relativity among other similar services. **The RUC recommends a work RVU of 33.00 for CPT code 33645.**

33647 ***Repair of atrial septal defect and ventricular septal defect, with direct or patch closure***
The specialty society indicated and the RUC agreed that there is compelling evidence that the typical patient is even younger, typically 2 month-old and a rank order anomaly exists whereas, the atrial septal defect only CPT code, 33681 *Closure of single ventricular septal defect, with or without patch* (work RVU = 32.34) compared to CPT code 33647 which includes the repair of atrial septal defect **and** ventricular septal defect current (work RVU = 29.53) inappropriately has a lower work RVU.

The specialty society indicated and the RUC agreed that the current survey data represents a more accurate assessment of work, with 58 survey respondents median performance rate of 10 per year. The RUC compared surveyed code 33647 (surveyed intra-service time = 180 minutes) to key reference service CPT code 33681*Closure of single ventricular septal defect, with or without patch;* (work RVU = 32.34 and intra-time = 150 minutes). The specialty society indicated and the RUC agreed that 33647 is more intense and complex and requires more physician work and time to perform. The specialty recommends 63 minutes of pre-time, 180 minutes of intra-time and 53 minutes of immediate post-time.. The RUC agrees with the specialty society that the survey median work RVU of 35.00 for 33467 appropriately accounts for the work required to perform this service as well as establishes the correct relativity among other similar services. **The RUC recommends a work RVU of 35.00 for CPT code 33647.**

33692 ***Complete repair tetralogy of Fallot without pulmonary atresia;***
The specialty society indicated and the RUC agreed that there is compelling evidence that the technique and technology used to perform this service has changed. The specialty society indicated and the RUC agreed that the current survey data represents a more accurate assessment of work, with 56 survey respondents with a median performance rate of 10 per year. The RUC compared surveyed code 33692 to key reference service CPT code 33684 *Closure of single ventricular septal defect, with or without patch; with pulmonary valvotomy or infundibular resection (acyanotic)* (work RVU = 34.37 and intra-time = 200 minutes). The specialty society indicated and the RUC agreed that 33692 is more complex and requires more physician work and time to perform. The specialty recommends 63 minutes of pre-time, 218 minutes of intra-time and 60 minutes of immediate post-time. The RUC agrees with the specialty society that the survey median work RVU of 38.75 for 33692 appropriately accounts for the work required to perform this service as well as establishes the correct relativity among other similar services. **The RUC recommends a median work RVU of 38.75 for CPT code 33692.**

33710 ***Repair sinus of Valsalva fistula, with cardiopulmonary bypass; with repair of ventricular septal defect***
The specialty society indicated and the RUC agreed that there is compelling evidence that the patient population has changed, as the typical patient is even younger. Additionally, a rank order anomaly exists between CPT code 33681 *Closure of single ventricular septal defect; with or without patch* (work RVU = 32.34) and CPT code 33710, whereas 33710 (current work RVU = 30.41) includes closure of a septal defect and repair of sinus fistula.

The RUC reviewed survey responses from 57 cardiothoracic surgeons for CPT code 33710 compared to key reference service CPT code 33405 *Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve* (work RVU = 41.32 and intra-time = 198 minutes). The specialty society indicated and the RUC agreed that code 33710 requires slightly more intensity and complexity, physician work and time to perform than the reference code 33405. The specialty recommends 63 minutes of pre-time, 200 minutes of intra-time and 60 minutes of immediate post-time. The RUC agrees with the specialty society that the survey median work RVU of 43.00 for 33710 appropriately accounts for the work required to perform this service as well as establishes the correct relativity among other similar services. **The RUC recommends a work RVU of 43.00 for CPT code 33710.**

Congenital Cardiac Codes

General Thoracic Code

43415 ***Suture of esophageal wound or injury; transthoracic or transabdominal approach***
The specialty society indicated and the RUC agreed that there is compelling evidence that the specialty originally surveyed, general surgery, no longer predominantly provides this service. Cardiothoracic surgery performs this service 58% of the time on Medicare patients. Additionally, the patient population has changed and new technology is available. The utilization of endoscopically deployed stents as a conservative treatment for smaller and earlier leaks has changed the clinical profile of the patients presenting for surgical repair. Therefore, surgical repair is now necessary in patients with larger esophageal perforations, not amenable to stenting.

The RUC reviewed the survey responses from 56 cardiothoracic and general surgeons for CPT code 43415. The specialty recommends 80 minutes of pre-time, 180 minutes of intra-time and 60 minutes of immediate post-time. The RUC determined the pre-service time is significant to account for the physician positioning the patient supine for the induction of anesthesia and re-positioning the patient postero-lateral.

The RUC reviewed the survey results compared to key reference service CPT codes 32815 *Open closure of major bronchial fistula* (work RVU = 50.03 and intra-service time = 155 minutes) and 33512 *Coronary artery bypass, vein only; 3 coronary venous grafts* (work RVU = 43.98 and intra-service time = 213 minutes). The RUC determined that the survey 25th percentile RVU of 44.88 and median intra-service time of 180 minutes appropriately measured the physician time, intensity and complexity of this service relative to similar procedures. **The RUC recommends a work RVU of 44.88 for CPT code 43415.**

Adult Cardiac Codes

33030 ***Pericardiectomy, subtotal or complete; without cardiopulmonary bypass***
The specialty society indicated and the RUC agreed that there is compelling evidence that the technique for this procedure has changed; the patient population has changed, as indicated in peer reviewed literature (most patients are post-radiation treatment); and a rank order anomaly exists (this service currently has a negative IWPUT) in relation to other recently valued related codes.

The RUC reviewed survey responses from 54 cardiothoracic surgeons for CPT code 33030 compared to key reference service CPT code 35820 *Exploration for postoperative hemorrhage, thrombosis or infection; chest* (work RVU = 36.89 and intra-time = 136 minutes). The specialty society indicated and the RUC agreed that code 33030 requires more intensity, complexity, physician work and time to perform than the reference code. The specialty recommends 63 minutes of pre-time, 180 minutes of intra-time and 45 minutes of immediate post-time. The RUC agrees with the specialty society that the survey median work RVU of 39.50 for 33030 appropriately accounts for the work required to perform this service as well as establishes the correct relativity among other similar services. **The RUC recommends a work RVU of 39.50 for CPT code 33030.**

33031 ***Pericardiectomy, subtotal or complete; with cardiopulmonary bypass***
The specialty society indicated and the RUC agreed that there is compelling evidence that the technique for this procedure has changed; the patient population has changed, as indicated in peer reviewed literature; the original methodology is flawed: Harvard Phase 3 valuation regarding intra-service assumptions; and a rank order anomaly in relation to other recently valued related codes.

The RUC reviewed survey responses from 54 cardiothoracic surgeons for CPT code 33031 compared to key reference service CPT code 33430 *Replacement, mitral valve, with cardiopulmonary bypass* (work RVU = 50.93 and intra-time = 223 minutes) and determined that 33031 requires less physician work and time to perform. The RUC also compared 33031 to similar service CPT code 33464 *Valvuloplasty, tricuspid valve; with ring insertion* (work RVU = 44.62) which has the same intra-service time of 205 minutes as indicated by the survey respondents. The RUC determined that the 25th percentile

work RVU of 45.00 for code 33031 appropriately accounts for the work required to perform this service as well as establishes the correct relativity among other similar services. **The RUC recommends a work RVU of 45.00 for CPT code 33031.**

33315 ***Cardiotomy, exploratory (includes removal of foreign body, atrial or ventricular thrombus); with cardiopulmonary bypass***
The specialty society indicated and the RUC agreed that there is compelling evidence that the typical patient has changed. The specialty society indicated that although almost all lead extraction is being performed by a percutaneous method, the open method is still used in patients with complications such as frayed wires, large vegetations or are combined with tricuspid valve procedures due to its injury by the leads. Additionally, this code has never been RUC surveyed.

The RUC reviewed survey responses from 77 cardiothoracic surgeons for CPT code 33315 compared to key reference service CPT code 33465 *Replacement, tricuspid valve, with cardiopulmonary bypass* (work RVU = 50.72 and intra-time = 211 minutes) and determined that 33315 requires significantly less physician work and time to perform. Therefore, the RUC compared the surveyed code to similar service 33533 *Coronary artery bypass, using arterial graft(s); single arterial graft* (work RVU = 33.75 and intra-time of 151 minutes). The RUC determined that the surveyed code 33315 (intra-service time = 180 minutes) required slightly more physician work and time to perform than reference code 33533. The RUC determined that the 25th percentile work RVU of 35.00 for code 33315 appropriately accounts for the work required to perform this service as well as establishes the correct relativity among other similar services. **The RUC recommends a work RVU of 35.00 for CPT code 33315.**

33120 ***Excision of intracardiac tumor, resection with cardiopulmonary bypass***
The specialty society indicated and the RUC agreed that there is compelling evidence that the technique for this procedure has changed, whereas the complexity of this procedure has increased now that the large part of the arterial septum is involved. Additionally, a rank order anomaly exists in relation to recently valued vascular and cardiothoracic codes.

The RUC reviewed survey responses from 76 cardiothoracic surgeons for CPT code 33120 compared to key reference service CPT code 33426 *Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring* (work RVU = 43.28 and intra-time = 205 minutes) and determined that 33120 requires approximately the same physician work and time to perform. The key reference service has the same intra-service time of 205 minutes, as indicated by the survey respondents. The RUC determined that the 25th percentile work RVU of 42.88 for code 33120 appropriately accounts for the work required to perform this service as well as establishes the correct relativity among other similar services. **The RUC recommends a work RVU of 42.88 for CPT code 33120.**

33875 ***Descending thoracic aorta graft, with or without bypass***
The specialty society indicated and the RUC agreed that there is compelling evidence that the patient population has changed due to the evolution of treatment alternatives which as subsequently changed the work required to perform this procedure as indicated by peer review literature.

The RUC reviewed survey responses from 52 cardiothoracic surgeons for CPT code 33875 and compared the service to the reference CPT code 33863 *Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension; with aortic root replacement using composite prosthesis and coronary reconstruction* (work RVU = 58.79 and intra-time = 287 minutes) and determined that reference service requires slightly more physician work and time to perform than the surveyed code (intra-service time = 240 minutes). The RUC determined that the 25th percentile work RVU of 56.83 for code 33875 appropriately accounts for the work required to perform this service as well as establishes the correct relativity among other similar services. **The RUC recommends a work RVU of 56.83 for CPT code 33875.**

Adult Cardiac Codes

Pulmonary Artery Embolectomy and Endarterectomy
These services are different than the above as they are emergent procedures.

33910 ***Pulmonary artery embolectomy; with cardiopulmonary bypass***
The specialty society indicated and the RUC agreed that there is compelling evidence that there is a change in the patient population due to a change in embolectomy management and a change in technique by removing embolus from smaller branches which necessitates accessing both pulmonary arteries.

The RUC reviewed survey responses from 34 cardiothoracic surgeons for CPT code 33910 compared to key reference service CPT code 33511 *Coronary artery bypass, vein only; 2 coronary venous grafts* (work RVU = 38.45 and intra-time = 186 minutes). The specialty society indicated and the RUC agreed that code 33910 requires more intensity, complexity, physician work and time to perform than the reference code. For additional support, the RUC also compared 33910 to similar service CPT code 33545 *Repair of postinfarction ventricular septal defect, with or without myocardial resection* (work RVU = 57.06 and intra-time =236 minutes). The specialty recommends 63 minutes of pre-time, 190 minutes of intra-time and 45 minutes of immediate post-time. **The RUC recommends a work RVU of 52.33 for CPT code 33910.**

33916 ***Pulmonary endarterectomy, with or without embolectomy, with cardiopulmonary bypass***
The specialty society indicated and the RUC agreed that there is compelling evidence that there is a change in technique as this procedure now employs deep hypothermia and circulatory arrest as a standard. Secondly, the patient population has changed because the technique has changed and this technique is performed on patients with end-stage pulmonary function. Additionally the original Harvard assumptions were incorrect.

The RUC reviewed survey responses from cardiothoracic surgeons for CPT code 33916 (total time = 1,259 minutes) compared to key reference service CPT code 33945 *Heart transplant, with or without recipient cardiectomy* (work RVU = 89.50, total time = 1,716 minutes). The specialty society indicated and the RUC agreed that code 33916 requires slightly less physician work and time to perform than the reference code. For further support the RUC compared the surveyed code to similar service 43113 *Total or near total esophagectomy, with thoracotomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es*) (work RVU = 80.06, intra-service time = 391 minutes) which requires similar physician work and time to perform. The specialty recommends 63 minutes of pre-time, 360 minutes of

intra-time and 45 minutes of immediate post-time. The RUC determined that the median work RVU of 78.00 for code 33916 appropriately accounts for the work required to perform this service as well as establishes the correct relativity among other similar services. **The RUC recommends a work RVU of 78.00 for CPT code 33916.**

Vascular Surgery (Tab 36)
David Han, MD, SVS; Sean Roddy, MD, SVS; Gary Seabrook, MD, SVS; Mathew Sideman, MD, SVS; Robert Zwolak, MD, SVS; Christopher Senkowski, MD, ACS
Facilitation Committee #1

In the 4th Five-Year Review of the RBRVS, CMS identified CPT code 36819 as potentially misvalued through the Site of Service Anomaly screen. The Society for Vascular Surgery submitted additional CPT codes 35188, 35612, 35800, 35840, 35860, 37140, 37145, 37160, 37180, and 38181 to be included in the 4th Five Year Review.

35188 ***Repair, acquired or traumatic arteriovenous fistula; head and neck***
The RUC agreed that there is compelling evidence to change the work value for CPT code 35188 as currently vascular surgery is one of the predominant providers of this service and had not participated in the original Harvard studies. In addition, errors occurred in extrapolation of visits during the Harvard study, and rank order anomalies in comparison to vascular procedures of equivalent magnitude.

The RUC reviewed the survey results from vascular and general surgeons who perform this service and agreed that the survey results reflected the typical patient scenario. The RUC compared the service to key reference CPT code 35011 *Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm and associated occlusive disease, axillary-brachial artery, by arm incision* (work RVU=18.58) and agreed they were similar services in the sense that they are both vascular operations on similar sized vessels in the upper body. The RUC also compared the surveyed code to multi-specialty points of comparison codes 19318 *Reduction mammaplasty* (work RVU=16.03) and 44140 *Colectomy, partial; with anastomosis* (work RVU=22.59), which are similarly intensive surgical procedures requiring technical skill to successfully complete the operation. The differences between 35188, 19318, and 44140 lie in the post operative work which is quite different yet in proper rank order. The RUC agreed that the specialty's recommended value, and survey median work value of 18.50 for 35188, which allows for proper rank order amongst these services. **The RUC recommends a work RVU of 18.50 for CPT code 35188.**

35612 ***Bypass graft, with other than vein; subclavian-subclavian***
The RUC agreed that there is compelling evidence to change the work value for CPT code 35612 as currently vascular surgery is one of the predominant providers of this service and had not participated in the original Harvard studies. In addition, errors occurred in extrapolation of visits during the Harvard study, and rank order anomalies in comparison to vascular procedures of equivalent magnitude.

The RUC reviewed the survey results from vascular and general surgeons who perform this service and agreed that the survey results reflected the typical patient scenario. The RUC assimilated this service to key reference CPT code 35661 *Bypass graft, with other than vein; femoral-femoral* (work RVU= 20.35) and noted that the key reference service bypasses the femoral arteries in the lower extremities, whereas 35612 bypasses the subclavian arteries in the upper extremities. The femoral vessels are more accessible

surgically than the subclavian arteries, which are in proximity to the brachial plexuses that are at risk for injury and nerve dysfunction from retraction and manipulation. The subclavian arteries contain more elastic tissue and less muscular tissue making them technically more difficult to operate on compared to the femoral arteries. Therefore, the RUC agreed the work value of 35612 should be higher than 35661. The RUC also compared the surveyed code to multi-specialty points of comparison codes 22595 *Arthrodesis, posterior technique, atlas-axis (C1-C2)* (work RVU=20.46) and 62165 *Neuroendoscopy, intracranial; with excision of pituitary tumor, transnasal or trans-sphenoidal approach* (work RVU=23.23), which have similar work intensities to perform (IWPUTs 0.0744 for 22595, 0.0762 for 62165, and 0.071 for 35612). The key differences in the MPC codes and the surveyed code are in the post operative visit patterns that are unique to each service. The RUC agreed that the work of 22595 and 62165 were similar to 35612 and were comfortable with the rank order achieved with specialty recommended survey median work RVU of 22.00. **The RUC recommends a work RVU of 22.00 for CPT code 35612.**

35800 ***Exploration for postoperative hemorrhage, thrombosis or infection; neck*****:** The RUC agreed that there is compelling evidence to change the work value for CPT code 35800 as currently vascular surgery is one of the predominant providers of this service and had not participated in the original Harvard studies. In addition, errors occurred in extrapolation of visits during the Harvard study, and rank order anomalies in comparison to vascular procedures of equivalent magnitude.

The RUC reviewed the survey results from over 30 vascular and general surgeons who perform this service. The specialty recommended pre-service time totaling 38minutes, with an intra-service time of 60 minutes based on the survey median results. The RUC agreed that the pre-service and intra-service specialty survey time data was appropriate for the service provided. The RUC referenced the following comparable services to reach proper work relativity for this service: 35701 *Exploration (not followed by surgical repair), with or without lysis of artery; carotid artery* (work RVU = 9.19, 60 minutes intra-service time), 35201 *Repair blood vessel, direct; neck* (work RVU = 16.93, 93 minutes of intra-service time, *Harvard valued*), and 44950 *Appendectomy* (work RVU = 10.60, 60 minutes intra-service time) in comparison to the intra-service work. The RUC concurred that the work value for 35800 should be less than the work of 35201 yet greater than 44950. The RUC also discussed the post-operative visits and agreed the typical hospital stay is one less day than the survey respondents had indicated. The RUC noted that these services are typically (almost exclusively) billed with a 78 modifier which accounts for the intra-operative percentage of the service only. The RUC agreed with the intensity, physician work, and proper rank order amongst the comparison codes achieved when code 35800 is valued between the survey 25th percentile (12.00 RVUs) and median work value (15.00 RVUs), at 13.89 work RVUs. **The RUC recommends a work RVU of 13.89 for CPT code 35800.**

35840 ***Exploration for postoperative hemorrhage, thrombosis or infection; abdomen*****:** The RUC agreed that there is compelling evidence to change the work value for CPT code 35840 as currently vascular surgery is one of the predominant providers of this service and had not participated in the original Harvard studies. In addition, errors occurred in extrapolation of visits during the Harvard study, and rank order anomalies in comparison to vascular procedures of equivalent magnitude.

The RUC reviewed the survey results from over 30 vascular and general surgeons who perform this service. The specialty recommended pre-service time totaling 38 minutes, with an intra-service time of 120 minutes based on the survey median results. The RUC agreed that the pre-service and intra-service specialty survey time data was appropriate for the service provided. The RUC referenced the following comparable services to reach the proper work relativity value for this service, 49002 *Reopening of recent laparotomy* (work RVU = 17.63, 75 minutes intra-service time), and 37617 *Ligation, major artery (e.g.post-traumatic, rupture); abdomen* (work RVU = 23.70, 120 minutes intra-service time), in comparison to the intra-service work. Although the RUC agreed that 35840 should be valued similarly to 37617 the RUC also agreed the overall work for 35840 is less than the overall work of 37617. The RUC also discussed the post-operative visits and agreed the typical hospital stay is one less day than the survey respondents had indicated. The RUC noted that these services are typically (almost exclusively) billed with a 78 modifier which accounts for the intra-operative percentage of the service only. The RUC agreed with the intensity, physician work, and proper rank order amongst the comparison codes achieved when code 35840 is valued between the survey 25th percentile (19.25 RVUs) and median work value (22.30 RVUs), at 21.19 work RVUs. **The RUC recommends a work RVU of 21.19 for CPT code 35840.**

35860 ***Exploration for postoperative hemorrhage, thrombosis or infection; abdomen*****:** The RUC agreed that there is compelling evidence to change the work value for CPT code 35860 as currently vascular surgery is one of the predominant providers of this service and had not participated in the original Harvard studies. In addition, errors occurred in extrapolation of visits during the Harvard study, and rank order anomalies in comparison to vascular procedures of equivalent magnitude.

The RUC reviewed the survey results from over 30 vascular and general surgeons who perform this service. The specialty recommended pre-service time totaling 38 minutes, with an intra-service time of 75 minutes based on the survey median results. The RUC agreed that the pre-service and intra-service specialty survey time data was appropriate for the service provided. The RUC referenced the following comparable services to reach the proper work relativity value for this service 34203 *Embolectomy or thrombectomy, popliteal-tibioperoneal artery, by leg incision* (work RVU = 17.86, 108 minutes intra-service time) and 44602 *Suture of small intestine for perforation* (work RVU = 24.72, 90 minutes intra-service time) in comparison to the intra-service work. The RUC concurred that the work value for 35860 should be slightly less than 34203. The RUC also discussed the post-operative visits and agreed the typical hospital stay is one less day than the survey respondents had indicated. The RUC noted that these services are typically (almost exclusively) billed with a 78 modifier which accounts for the intra-operative percentage of the service only. The RUC agreed with the intensity, physician work, and proper rank order amongst the comparison codes achieved when code 35860 is valued between the survey 25th percentile (15.25 RVUs) and median work value (18.00 RVUs), at 16.89 work RVUs. **The RUC recommends a work RVU of 16.89 for CPT code 35860.**

36819 ***Arteriovenous anastomosis, open; by upper arm basilic vein transposition*** The RUC reviewed the survey results from over 30 vascular and general surgeons who perform this service. The RUC analyzed the survey's estimated physician work and agreed that these data support maintaining the current work RVU of 14.47 for this service. The survey results also indicated that 53% of the survey respondents stated the patient is kept overnight and 13% were admitted to the hospital. In addition, the typical

patient is a 38 year old diabetic and not necessarily a Medicare patient. The RUC agreed that this service would be categorized as one being typically performed in an inpatient hospital setting. To further justify this value, the RUC compared the service to key reference CPT code 36818 *Arteriovenous anastomosis, open; by upper arm cephalic vein transposition* (work RVU=11.89). The RUC noted that the surveyed code overall is a more intense service to perform in comparison to the reference code and requires an additional 40 minutes to perform in comparison to the reference code. The extra time is due to the additional work associated work on the basilic vein, which is located deeper within the arm, than the cephalic vein, and the avoidance of skin nerves. The RUC also compared the surveyed code to multi-specialty points of comparison codes 30410 *Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip* (work RVU=14.00) and 33249 *Insertion or repositioning of electrode lead(s) for single or dual chamber pacing cardioverter-defibrillator and insertion of pulse generator* (work RVU=15.17). The specialty and the RUC agreed that there was no compelling evidence for a higher work value for CPT code 36819 and that its current value should be maintained. **The RUC recommends a work RVU of 14.47 for CPT code 36819.**

37140 Venous anastomosis, open; portocaval
The RUC agreed that there is compelling evidence to change the work value for CPT code 37140 as currently vascular surgery is one of the predominant providers of this service and had not participated in the original Harvard studies. In addition, errors occurred in extrapolation of visits during the Harvard study, and rank order anomalies in comparison to vascular procedures of equivalent magnitude.

The RUC reviewed the survey results from vascular and general surgeons who perform this service and agreed that the survey results reflected the typical patient scenario. The RUC compared the service to key reference CPT code 35082 *Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta* (work RVU= 42.09). The RUC noted that key reference code and 37140 are emergency surgical treatments for patients with active hemorrhage and life threatening conditions, requiring a vascular graft with two vascular anastomoses. Both codes have 10 day hospital stays, however according to the survey results, although 37140 involves more intra-service time, its intensity is lower. The RUC also compared the surveyed code to multi-specialty points of comparison code 35631 *Bypass graft, with other than vein; aortoceliac, aortomesenteric, aortorenal* (work RVU=36.03) for its intensity and complexity and found similarities in the clinical and technical features of 37140. The RUC determined that the survey median work RVU of 40.00 for CPT code 37140 places this service in the proper rank order . and justifies the recommended median work RVU of 40.00. **The RUC recommends a work RVU of 40.00 for CPT code 37140.**

37145 Venous anastomosis, open; renoportal
The RUC agreed that there is compelling evidence to change the work value for CPT code 37145 as currently vascular surgery is one of the predominant providers of this service and had not participated in the original Harvard studies. In addition, errors occurred in extrapolation of visits during the Harvard study, and rank order anomalies in comparison to vascular procedures of equivalent magnitude.

The RUC reviewed the survey results from vascular and general surgeons who perform this service and agreed that the survey results reflected the typical patient scenario. The RUC also compared this service to key reference CPT code 35082 *Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta* (work RVU= 42.09). The RUC noted that key reference code and 37145 are emergency surgical treatments for patients with active hemorrhage and life threatening conditions, requiring a vascular graft with two vascular anastomoses. Both codes have 10 day hospital stays, however according to the survey results, although 37145 involves more intra-service time, its intensity is lower. The RUC also compared the surveyed code to multi-specialty points of comparison codes 35631 *Bypass graft, with other than vein; aortoceliac, aortomesenteric, aortorenal* (work RVU=36.03) and determined that surveyed code requires slightly more physician work to perform. The RUC determined that the survey median work RVU of 37.00 for code 37145, places this service in the proper rank order. **The RUC recommends a work RVU of 37.00 for CPT code 37145.**

37160 Venous anastomosis, open; caval-mesenteric

The RUC agreed that there is compelling evidence to change the work value for CPT code 37160 as the introduction of new technology has changed the physician work associated with this service. The routine use of transvenous intrahepatic portosystemic shunts (TIPS) in the less complex patients has resulted in more complex patients being treated with the open portal decompression procedures. Further, vascular surgery currently is one of the predominant providers of CPT code 37160 and did not participated in the original Harvard studies

The RUC reviewed the survey results from vascular and general surgeons who perform this service and agreed with the specialties recommendations for 63 minutes of pre-service time, 220 minutes of intra-service time and 60 minutes of post-service time. The RUC compared the service to key reference CPT code 35082 *Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta* (work RVU = 42.09). The RUC noted that the surveyed code and the key reference code are both emergency surgical treatments for patients with active hemorrhage and a life threatening condition needing an emergency operation requiring a vascular graft with two vascular anastomoses. However, the RUC noted that the reference code requires more total service time to perform in comparison to the surveyed code, 830 minutes and 785 minutes, respectively. Further, the RUC noted that the reference code requires significantly more mental effort and judgment to perform in comparison to the surveyed code. The RUC also compared the surveyed code to multi-specialty points of comparison codes 35631 *Bypass graft, with other than vein; aortoceliac, aortomesenteric, aortorenal* (work RVU=36.03). The RUC noted that the surveyed code has more total service time in comparison to this MPC Code, 822 minutes and 648 minutes, respectively. Based on these comparisons, the RUC agreed with the specialty's median survey work RVU of 38.00 for 37160 was appropriate. **The RUC recommends a work RVU of 38.00 or CPT code 37160.**

37180 Venous anastomosis, open; splenorenal, proximal
The RUC agreed that there is compelling evidence to change the work value for CPT code 37180 as the introduction of new technology has changed the physician work associated with this service. The routine use of transvenous intrahepatic portosystemic shunts (TIPS) in the less complex patients has resulted in more complex patients being treated with the open portal decompression procedures. Further, vascular surgery currently is one of the predominant providers of CPT code 37180 and did not participated in the original Harvard studies

The RUC reviewed the survey results from vascular and general surgeons who perform this service and agreed with the specialties recommendations for 63 minutes of pre-service time, 240 minutes of intra-service time and 60 minutes of post-service time. The RUC compared the service to key reference CPT code 35082 *Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta* (work RVU = 42.09). The RUC noted that the surveyed code and the key reference code are both emergency surgical treatments for patients with active hemorrhage and a life threatening condition needing an emergency operation requiring a vascular graft with two vascular anastomoses. However, the RUC noted that the reference code requires more total service time to perform in comparison to the surveyed code, 830 minutes and 805 minutes, respectively. Further, the RUC noted that the reference code requires more mental effort and judgment to perform in comparison to the surveyed code. The RUC also compared the surveyed code to multi-specialty points of comparison codes 35631 *Bypass graft, with other than vein; aortoceliac, aortomesenteric, aortorenal* (work RVU=36.03). The RUC noted that the surveyed code has slightly more intra-service time in comparison to this MPC Code, 240 minutes and 225 minutes, respectively. Based on these comparisons, the RUC agreed with the specialty's median survey work RVU of 36.50 for 37180 was appropriate. **The RUC recommends a work RVU of 36.50 or CPT code 37180.**

37181 Venous anastomosis, open; splenorenal, distal (selective decompression of esophagogastric varices, any technique)
The RUC agreed that there is compelling evidence to change the work value for CPT code 37181 as the introduction of new technology has changed the physician work associated with this service. The routine use of transvenous intrahepatic portosystemic shunts (TIPS) in the less complex patients has resulted in more complex patients being treated with the open portal decompression procedures. Further, vascular surgery currently is one of the predominant providers of CPT code 37181 and did not participated in the original Harvard studies

The RUC reviewed the survey results from vascular and general surgeons who perform this service and agreed with the specialties recommendations for 63 minutes of pre-service time, 270 minutes of intra-service time and 60 minutes of post-service time. The RUC compared the service to key reference CPT code 35082 *Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta* (work RVU = 42.09). The RUC noted that the surveyed code and the key reference code are both emergency surgical treatments for patients with active hemorrhage and a life threatening condition needing an emergency operation requiring a vascular graft with two vascular anastomoses. However, the RUC noted that the reference code requires more total service time to perform in comparison to the surveyed code, 830 minutes and 785 minutes, respectively. Further, the RUC noted that the reference code requires more mental effort and judgment

to perform in comparison to the surveyed code. The RUC also compared the surveyed code to multi-specialty points of comparison codes 35631 *Bypass graft, with other than vein; aortoceliac, aortomesenteric, aortorenal* (work RVU=36.03). The RUC noted that the surveyed code has significantly more total service time in comparison to this MPC Code, 758 minutes and 648 minutes, respectively. Based on these comparisons, the RUC agreed with the specialty's median survey work RVU of 40.00 for 37181 was appropriate. **The RUC recommends a work RVU of 40.00 or CPT code 37181.**

Vascular Injection Procedures (Tab 37)
David Han, MD, SVS; Sean Roddy, MD, SVS; Gary Seabrook, MD, SVS; Mathew Sideman, MD, SVS; Robert Zwolak, MD, SVS; Christopher Senkowski, MD, ACS; Sean Tutton, MD, SIR; Zeke Silva, MD, ACR

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 specialties requested that CPT code 36470 be added to the 4th Five Year Review.

36470 ***Injection of sclerosing solution; single vein***
The RUC reviewed the survey results from over 50 vascular surgeons, general surgeons, radiologists, and interventional radiologists who perform this service. Pre-service time of 10 minutes for this service is recommended, which includes skin markings of the injection site. The specialty recommended an intra-service time of 15 minutes, and immediate post time of 5 minutes for dressings, and review of home care instructions based on the survey median results.

The RUC analyzed the survey's estimated physician work and agreed that the data support maintaining the current work RVU of 1.10 for this service, and there was no compelling evidence to change the work value. The RUC compared this service to key reference CPT code 11401 *Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.6 to 1.0 cm* (work RVU=1.28). The RUC concurred that the surveyed code is similar in comparison to the reference code in physician time, intensity, and complexity. The RUC also agreed the surveyed code's physician work, time, and intensity was analogous to multi-specialty points of comparison codes 11420 *Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less* (work RVU=1.05) and 11421 *Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm* (work RVU=1.53). The RUC agreed that in order to maintain rank order amongst services, the work value should be maintained. **The RUC recommends a work RVU of 1.10 for CPT code 36470.**

36471 ***Injection of sclerosing solution; multiple veins, same leg***
The RUC reviewed the survey results from over 50 vascular surgeons, general surgeons, radiologists, and interventional radiologists who perform this service. Pre-service time of 15 minutes for this service is recommended, which includes skin markings of several injection sites. The specialty recommended an intra-service time of 15 minutes, and immediate post time of 5 minutes for multiple dressings and review of home care instructions based on the median survey results.

The RUC analyzed the survey's estimated physician work and agreed that the data supported maintaining the current work RVU of 1.65 for this service, and there was no compelling evidence to change the work value. The RUC compared this service to key reference CPT code 11404 *Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 3.1 to 4.0 cm* (work RVU= 2.11). The RUC noted that the surveyed code is similar in comparison to the reference code in physician time, intensity, and complexity. The RUC also concurred with the specialty that the physician work for the surveyed code is analogous to multi-specialty points of comparison codes 11423 *Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm* (work RVU=2.06) and 11421 *Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm* (work RVU=1.53). The RUC agreed that in order to maintain rank order amongst services, the work value should be maintained. **The RUC recommends a work RVU of 1.65 for CPT code 36471.**

The specialty 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. In addition, the specialty had difficulties surveying CPT codes 36200, 36246, and 36247 as the global period assignment of XXX appears inappropriate for these surgical services. The specialty recommended codes 36200, 36246, and 36247 be surveyed for February 2011 RUC review and that the RUC recommend a change in the global period for these codes to an 000 from an XXX day global period. The specialty stated that codes 36010, 36215, 36216, and 37620 will be sent to CPT for revision based on the new and revised coding structure of the lower extremity revascularization services, and to better describe the services when these codes are reported together on the same date by the same physician. The RUC agreed with these specialty recommendations. **The RUC requests that CMS consider an 000 global period for 36200, 36246, and 36247 and the specialty society will resurvey and present recommendations to the RUC in February 2011. The RUC recommends CPT codes 36010, 36215, 36216, and 37620 be referred the CPT Editorial Panel for revision.**

<u>Withdrawal of Arterial Blood (Tab 38)</u>
Burt Lesnick, MD, ACCP; Kathrin Nicolacakis, MD, ATS

In the 4th Five-Year Review of the RBRVS, CMS identified CPT code 36600 as potentially misvalued through the Harvard-Valued – Utilization over 30,000 screen.

36600 ***Arterial puncture, withdrawal of blood for diagnosis***
The RUC reviewed the survey results from 38 chest and thoracic physicians for CPT code 36600. The RUC analyzed the survey's estimated physician work and agreed that these data support maintaining the current work RVU of 0.32 for this service. To further justify this value, the RUC compared the surveyed code to the key reference service CPT code 36400 *Venipuncture, younger than age 3 years, necessitating physician's skill, not to be used for routine venipuncture; femoral or jugular vein* (work RVU= 0.38 and total time= 20 minutes). The RUC noted that these two services have analogous physician work and total-service time and should be valued similarly. **The RUC recommends a work RVU of 0.32 for CPT code 36600.**

Interruption of Inferior Vena Cava (Tab 39)
Sean Tutton, MD, SIR; Zeke Silva, MD, ACR; Gary Seabrook, MD, SVS; Richard Wright, MD, ACC; Clifford Kavinsky, MD, SCAI

In the 4th Five-Year Review of the RBRVS, CMS identified CPT code 37620 *Interruption, partial or complete, of inferior vena cava by suture, ligation, plication, clip, extravascular, intravascular (umbrella device)* as potentially misvalued through the Harvard-Valued - Utilization Over 30,000 screen.

At the September 29-October 1, 2010 RUC meeting the specialty societies indicated that CPT code 37620 has been identified by the Relativity Assessment Workgroup as part of the Codes Reported Together 75% or More Screen. In April 2010, the RUC recommended to refer codes 37620 and 36010 to the CPT Editorial Panel. The specialty societies indicated that they will submit a code change proposal, no later than the February 2011 CPT Editorial Panel meeting, to better describe the service when these codes are reported together on the same date by the same physician.

Endoscopic Cholangiopancreatography (Tab 40)
Nicholas Nickl, MD, ASGE; Edward Bentley, MD, ASGE; Jayarani Agrawal, MD, AGA

In the 4th Five-Year Review of the RBRVS, CMS identified CPT code 43262 as potentially misvalued through the Harvard Valued - Utilization over 30,000 Screen.

43262 ***Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy***

The RUC reviewed the survey results from 55 gastroenterologists who frequently perform this service. The specialty recommended several modifications to pre-service time package 4 (FAC Difficult Patient/Difficult Procedure) for this service. This package was selected because the patients who receive this service have a proven pathology based on some earlier imaging study. Since the original valuation of this service, more complex diagnostic and therapeutic ERCP modalities have been developed which have enabled the endoscopic treatment of older and sicker patients who previously required open procedures, resulting in more complex patients with more intense disease undergoing ERCP procedures. The specialties agreed and the RUC recommends 15 minutes of pre-service evaluation time, 5 minutes positioning time and 5 minutes scrub, dress and wait time. The RUC agreed with the specialties' recommendations for pre-service time.

The specialty recommended intra-time of 45 minutes and 20 minutes of post service based on the survey results. The RUC compared the service to key reference CPT code 43269 *Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of foreign body and/or change of tube or stent* (work RVU=8.20). Although the RUC noted that the surveyed code overall is a more intense service to perform in comparison to the reference code, the RUC noted that the surveyed code requires 51 less minutes to perform in comparison to the reference code. The RUC also compared the surveyed code to CPT code 43260 *Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* (work RVU=5.95). The specialty noted that although the total service times for this reference service and the surveyed code are similar 86 minutes and 90 minutes, respectively, 43262 is inherently more complex than

43260, which is the base code for this family. Further, the current value of the service maintains proper rank order within the family. Based on these comparisons and that the specialty did not provide compelling evidence to change the current value of the service, the RUC agreed that the survey data supports the current value of this service. **The RUC recommends a work RVU of 7.38 for CPT code 43262.**

Sigmoidoscopy (Tab 41)
Nicholas Nickl, MD, ASGE; Edward Bentley, MD, ASGE; Jayarani Agrawal, MD, AGA

In the 4th Five-Year Review of the RBRVS, CMS identified CPT code 45331 as potentially misvalued through the Harvard Valued - Utilization over 30,000 Screen.

45331 ***Sigmoidoscopy, flexible; with biopsy, single or multiple***
The RUC reviewed the survey results from 40 gastroenterologists who frequently perform this service. The specialty recommended pre-service time of 15 minutes, intra-time of 15 minutes based on the 75th percentile of the survey results and post service time of 10 minutes. The RUC agreed with this recommendation after the societies explained that this recommended intra-service time maintains rank order with the surveyed code's base CPT code 45330 *Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* (work RVU=0.96) which has intra-service time of 17 minutes. The RUC compared the service to key reference CPT code 45330. The RUC acknowledged that the surveyed code requires greater mental effort and judgment, technical skill and overall is a more intense service to perform in comparison to the reference code. Further, the RUC noted that the surveyed code requires 8 more minutes to perform in comparison to the reference code. In addition, the current value of the service maintains proper rank order between these two services. The specialty explained that despite the change in patient severity and complexity over the past two decades, as this service is often performed on a patient who cannot tolerate a colonoscopy or who is at high risk for a colonoscopy and an older population is undergoing this procedure as documented in the Medicare claims, they recommend that the current value of this service be maintained. Based on this explanation, the comparisons to base code 45330 and the lack of compelling evidence to the RUC to change the current value of the service, the RUC agreed that the survey data supports the current value of this service. **The RUC recommends a work RVU of 1.15 for CPT code 45331.**

Needle Biopsy of Liver (Tab 42)
Zeke Silva, MD, ACR; Sean Tutton, MD, SIR; Bob Vogelzang, MD, SIR

In the 4th Five-Year Review of the RBRVS, CMS identified CPT code 47000 as potentially misvalued through the Harvard Valued - Utilization over 30,000 Screen.

47000 Biopsy of liver, needle; percutaneous
The RUC reviewed the survey results from 102 interventional and diagnostic radiologists who frequently perform this service. The specialty recommended pre-service time of 25 minutes, intra-service time of 20 minutes and post service time of 15 minutes based on the survey results. The RUC agreed that these times accurately reflect the service performed. The RUC compared the service to key reference code 19102 *Biopsy of breast; percutaneous, needle core, using imaging guidance* (work RVU=2.00). The RUC noted that the surveyed code requires less intra-service time as compared to the reference

code, 20 minutes and 30 minutes, respectively. However, the RUC noted that both the reference code and the surveyed code require similar intensities to perform. The specialties explained that a biopsy of a liver is a more challenging procedure to perform in comparison to a biopsy of a breast given the differences in anatomical locations and potential risks to the patient. However, CPT code 19102 includes imaging guidance where CPT code 47000 does not include guidance. Therefore, the specialties agree that current value maintains appropriate relativity between these services. The specialties also compared the surveyed code to MPC code 43235 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* (work RVU=2.39) and noted that this MPC code has more total service time in comparison to the surveyed code, 63 minutes and 55 minutes respectively. Based on these comparisons and that the specialties did not provide compelling evidence to change the current value of the service, the RUC agreed that the survey data supports the current value of this service**. The RUC recommend a work RVU of 1.90 for CPT Code 47000**.

Referral to CPT Editorial Panel:
The specialties explained that the survey data supports that moderate sedation is an inherent component of this service. **The RUC recommends that CPT Code 47000 be referred to the CPT Editorial Panel to be included in Appendix G.**

Referral to the Practice Expense Subcommittee
The RUC recommends that the practice expense inputs for this service be reviewed and revised to reflect the inclusion of moderate sedation. The specialties will present these recommendations at the February 2011 RUC Meeting.

Laparoscopic Cholecystectomy (Tab 43)
Christopher Senkowski, MD, ACS; Michael Edye, MD, SAGES

In the 4th Five-Year Review of the RBRVS, CMS identified CPT code 47563 as potentially misvalued through the Harvard Valued - Utilization over 30,000 Screen and Site of Service Anomaly Screen.

47563 ***Laparoscopy, surgical; cholecystectomy with cholangiography***
The RUC reviewed the survey results from 60 general surgeons and gastrointestinal endoscopic surgeons who frequently perform this service. The specialties addressed several questions posed by the RUC including the change in the patient population. The specialties explained that more than half of the survey respondents indicated a change in the patient population. The specialties attributed this to more obese patients with more comorbidities. Further, advances in technology have led to a change in the medical management of these patients which leaves the more complex patients undergoing surgery. In addition, these advances in medical management have led to a decrease in Medicare utilization for this service over the past 5 years 2004-2008. The specialty societies also addressed the site of service anomaly issue with this service. The specialty societies explained that although the Medicare utilization data demonstrates that this service is performed 49.70% of the time in the outpatient setting, the survey data supports a majority of the patients having this procedure are admitted over night (46%) or are admitted as an inpatient (25%). Therefore, the specialty agrees and the RUC recommends that this service should be valued as a service performed predominately in the facility setting.

The specialties recommended and the RUC agreed to several modifications to pre-service time package 4 (FAC Difficult Patient/Difficult Procedure) for this service. The specialties recommended pre-service time of 65 minutes, intra-service time of 90 minutes and post service time of 25 minutes based on the survey results. Further, because patients will be kept at least overnight in the facility, the RUC agreed that a full day discharge, 99238 should be included in the performance of the service. The RUC compared the service to key reference CPT code 47562 *Laparoscopy, surgical; cholecystectomy* (work RVU=11.76). The RUC noted that the intra-service time for the surveyed code was higher than the reference code, 90 minutes and 80 minutes, respectively. Further, the RUC noted 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. Further, the current value of the service maintains proper rank order within the family. Based on these comparisons and that the specialties had no compelling evidence to offer the RUC to change the current value of the service, the RUC agreed that the survey data supports the current value of this service. **The RUC recommends a work RVU of 12.11 for CPT code 47563.**

47564 ***Laparoscopy, surgical; cholecystectomy with exploration of common duct***
The RUC reviewed the survey results from 50 general surgeons and gastrointestinal endoscopic surgeons who frequently perform this service. The specialties addressed several questions posed by the RUC including the change in the patient population. The specialties explained that 64% of the survey respondents indicated a change in the patient population. The specialties attributed this to more obese patients with more comorbidities. Further, advances in technology have led to a change in the medical management of these patients. This change in medical management results in patients undergoing this procedure, as indicated in the vignette, that have failed ERCP, have known gallstones and are very sick.

In addition, the specialties explained that when this service was first valued it was the policy at the time to crosswalk the values of the laparoscopic procedures to the comparable open procedures. No survey was ever conducted for this code. Upon further review, it was determined that this method to value the laparoscopic procedures was not an accurate measure of the work required to perform these services. Therefore, the specialties offer both the change in patient population and the fact that the current value for this service was based on a flawed methodology (crosswalking and no survey) as compelling evidence to change the value of this service. The RUC accepted these arguments as compelling evidence to change the current value of CPT code 47564.

The specialties recommended and the RUC agreed to several modifications to pre-service time package 4 (FAC Difficult Patient/Difficult Procedure) for this service. The specialties recommended pre-service time of 65 minutes, intra-service time of 120 minutes and post service time of 30 minutes based on the survey results. The RUC compared the service to key reference CPT code 47610 *Cholecystectomy with exploration of common duct*; (work RVU=20.92). The RUC noted that despite the fact 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, the total time for the surveyed code is less than the total time for the reference code, 415 minutes and 512 minutes, respectively. Based on these comparisons, the RUC agreed that the survey data supports a work RVU of 20.00, the 25th survey percentile for this service. **The RUC recommends a work RVU of 20.00 for CPT code 47564.**

Urologic Procedures (Tab 44)
James Giblin, MD, AUA; Richard Gilbert, MD, AUA; Thomas Cooper, MD, AUA
Facilitation Committee #2

In the 4th Five-Year Review of the RBRVS, CMS identified CPT codes 51705, 52005 and 52310 as potentially misvalued through the Harvard-Valued – Utilization over 30,000 screen. The specialty society agreed to add CPT codes 51710, 52007 and 52315 as part of the family of services for RUC review. In addition, CMS identified CPT codes 52630, 52649, 53440 and 57288 as potentially misvalued through the Site of Service Anomaly screen. The specialty agreed to add CPT codes 52640 and 57287 as part of the family of services for RUC review.

The specialty indicated a request was sent to CMS to have the global service period for CPT codes 51705 and 51701 changed from a 010 day global to 000 day global period. In the standards of care for this procedure, there are no hospital time and no follow up visits. The physician does not see the patient again until 1-3 months to change the tubes depending on how often the patient forms calculi. The RUC also noted that while the two services were surveyed as 010 day globals, the respondents inadvertently included a hospital visit, 99231, and overvalued the physician work. The RUC did not use the survey results to value the codes.

51705 ***Change of cystostomy tube; simple***
The RUC reviewed the survey results from 74 urologists for CPT code 51705. The RUC analyzed the survey data agreed that these data overestimates the physician work involved in the service. The RUC compared the surveyed code to the reference CPT code *Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance* (work RVU= 0.90, total time= 32 minutes). The RUC noted that the two services have identical total time and analogous physician mental effort and judgment. Given this, the RUC recommends, for CPT code 51705, a direct work RVU crosswalk to code 43760. **The RUC recommends a work RVU of 0.90 for CPT code 51705 and requests that CMS change the global period to 000.**

51710 ***Change of cystostomy tube; complicated***
The RUC reviewed the survey results from 54 urologists for CPT code 51710. The RUC analyzed the survey data and agreed that these data overestimates the physician work involved in the service. Comparing the physician work within the family of services, the RUC compared the surveyed code to CPT code 51705 *Change of cystostomy tube; simple* and noted that code 51710 has 50% more physician intra-service time, 15 minutes and 10 minutes, respectively, than the simple code 51705. In order to maintain the appropriate relativity within the family of services, the RUC recommends a work RVU of 1.35 for the surveyed service. To further justify this value, the RUC compared the surveyed code to the reference CPT code 36580 *Replacement, complete, of a non-tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access* (work RVU= 1.31 and total time= 50 minutes). The RUC members agreed that these two services have analogous physician work and intensity and the reference code should be valued similarly. In addition, the RUC compared code 51710 to reference CPT code 32561 *Instillation(s), via chest tube/catheter, agent for fibrinolysis (eg, fibrinolytic agent for break up of multiloculated effusion); initial day* (work RVU= 1.39, total time= 45 minutes). The RUC noted that the two services have similar physician

mental effort and judgment and the reference code should be valued slightly higher due to greater total time, 45 minutes compared to 47 minutes. **The RUC recommends a work RVU of 1.35 for CPT code 51710 and requests that CMS change the global period to 000..**

52005 ***Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;***
The RUC reviewed the survey results from 49 urologists for CPT code 52005. The RUC analyzed the survey's estimated physician work and agreed that these data support maintaining the current work RVU of 2.37 for this service. To further justify this value, the RUC compared the surveyed code to the MPC code 52000 *Cystourethroscopy* (work RVU= 2.23, total time= 42 minutes). The RUC agreed that these services have comparable physician work, but noted that the surveyed code should be valued higher due to greater intra-service time, 30 minutes compared to 15 minutes. In addition, the RUC compared code 52005 to MPC code 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed* (work RVU= 2.78, intra time= 30 minutes). The RUC noted that the services have identical intra-service times, 30 minutes. However, the reference is a more complex procedure and should be valued higher. **The RUC recommends a work RVU of 2.37 for CPT code 52005.**

52007 ***Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with brush biopsy of ureter and/or renal pelvis***
The RUC reviewed the survey results from 36 urologists for CPT code 52007. The RUC analyzed the survey's estimated physician work and agreed that these data support maintaining the current work RVU of 3.02 for this service. To further justify this value, the RUC compared the surveyed code to the key reference service CPT code 52341 *Cystourethroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)* (work RVU= 5.35, intra time= 45 minutes). The RUC agreed that though these services are comparable in their physician work, the reference code should be valued much higher due to greater total time, 135 minutes compared to 81.5 minutes. In addition, the RUC compared code 52007 to MPC code 43239 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with biopsy, single or multiple* (work RVU= 2.87 and total time= 84.5 minutes). The RUC noted that these services have very similar total time, 84.5 minutes and 81.5 minutes, respectively, and physician work and should be valued similarly. **The RUC recommends a work RVU of 3.02 for CPT code 52007.**
52310 ***Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); simple***
The RUC reviewed the survey results from 32 urologists for CPT code 52310. The RUC analyzed the survey's estimated physician work and agreed that these data support maintaining the current work RVU of 2.81 for this service. To further justify this value, the RUC compared the surveyed code to the key reference service CPT 52204 *Cystourethroscopy, with biopsy(s)* (work RVU= 2.59 and total time= 54 minutes). The RUC agreed that the services have similar physician work and intensity, with the surveyed code valued higher due to greater total time, 62 minutes compared to 54 minutes. In addition, the RUC compared code 52315 to MPC code 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell*

washing, when performed (work RVU= 2.78 and total time= 55 minutes). The RUC noted that these services have identical intra-service time of 30 minutes, with comparable physician work. **The RUC recommends a work RVU of 2.81 for CPT code 52310.**

52315 ***Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); complicated***
The RUC reviewed the survey results from 40 urologists for CPT code 52315. The RUC analyzed the survey's estimated physician work and agreed that these data support maintaining the current work RVU of 5.20 for this service. To further justify this value, the RUC compared the surveyed code to the key reference service CPT code 52341 *Cystourethroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)* (work RVU= 5.35, intra time= 45 minutes). Although the survey respondents indicated in the intensity/complexity measures that the surveyed code is a more intense procedure than the reference code, the RUC noted that the reference code has greater total time, 135 minutes compared to 94 minutes for CPT 52315. In addition, the RUC compared code 52315 to MPC code 52276 *Cystourethroscopy with direct vision internal urethrotomy* (work RVU= 4.99 and total time= 95 minutes). The RUC noted that the reference code should be valued slightly less than the surveyed code due to less intra-service time, 35 minutes compared to 45 minutes. **The RUC recommends a work RVU of 5.20 for CPT code 52315.**

52630 ***Transurethral resection; residual or regrowth of obstructive prostate tissue including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)***
The RUC reviewed the survey results from 40 urologists for CPT code 52630. Ninety seven percent (97%) of the survey respondents indicated that patients at the least stay overnight. Given this, the RUC agreed that one hospital visit occurs the evening of the procedure and one 99238 should be allocated for the discharge work on the following day.

The RUC analyzed the survey's estimated physician work and agreed with the specialty that the respondents overestimated the physician work involved in the surveyed code. Given that there is no compelling evidence to indicate there has been a recent change in physician work, the RUC recommends maintaining the current work RVU of 7.73 for this service. The RUC compared the surveyed code to the key reference service CPT code 52601 *Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)* (work RVU= 15.26 and total time= 355 minutes). The RUC agreed with the specialty that these service do not have comparable physician work as the reference code has greater total time and almost twice the work RVUs of the current valuation. In addition, the RUC compared code 52630 to the reference CPT code 49572 *Repair epigastric hernia (eg, preperitoneal fat); incarcerated or strangulated* (work RVU= 7.87 and intra-service time= 60 minutes. The RUC agreed that the reference code should be valued higher than the surveyed code due to greater total-service time, 312 minutes compared to 298 minutes. **The RUC recommends a work RVU of 7.73 for CPT code 52630.**

52640 ***Transurethral resection; of postoperative bladder neck contracture***
The RUC reviewed the survey results from 40 urologists for CPT code 52630. The RUC analyzed the survey's estimated physician work and agreed with the specialty that the respondents overestimated the physician work involved in the surveyed code. Given that there is no compelling evidence to indicate there has been a recent change in physician work, the RUC recommends maintaining the current work RVU of 4.79 for this service. The RUC compared the surveyed code to the key reference service CPT code 52601 *Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)* (work RVU= 15.26 and total time= 355 minutes). The RUC agreed with the specialty that these service do not have comparable physician work as the reference code has greater total time and well over twice the work RVUs of the current valuation. In addition, the RUC compared the surveyed code to the reference CPT code 64721 *Neuroplasty and/or transposition; median nerve at carpal tunnel* (work RVU= 4.97 and total time= 171 minutes). The RUC agreed that with similar total times, 184 minutes and 171 minutes, the services should be valued similarly. **The RUC recommends a work RVU of 4.79 for CPT code 52640.**

52649 ***Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)***
The RUC reviewed the survey results for CPT code 52649. Sixty seven percent (67%) of the survey respondents indicated the typical patient is at least kept overnight. The typical patient is kept overnight as there is post operative follow up that occurs the next day including checking the catheter and irrigation, checking lab values and discussing post operative care of the catheter at home. Given this, the RUC agreed that one 99238 should be maintained in the post operative visits for this service.

The RUC analyzed the survey's estimated physician work and agreed that these data support the 25th percentile, a work RVU of 15.20, for this service, which is lower than the current value of 17.29. To further justify this value, the RUC compared the surveyed code to the key reference service CPT code 52601 *Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)* (work RVU= 15.26 and total time= 355 minutes). Despite the reference code having more total time than CPT code 52649, 355 minutes compared to 298 minutes, the RUC noted that the survey respondents indicated that the surveyed code requires more technical skill and physical effort to perform. Therefore the RUC agreed that these services should be valued similarly. Additionally, the RUC compared code 52649 to the MPC code 33249 *Insertion or repositioning of electrode lead(s) for single or dual chamber pacing cardioverter-defibrillator and insertion of pulse generator (*work RVU= 15.17 and intra time= 120). The RUC agreed with the specialty that the services have similar physician work, with identical intra-service times, 120 minutes. **The RUC recommends a work RVU of 15.20 for CPT code 52649.**

53440 ***Sling operation for correction of male urinary incontinence (eg, fascia or synthetic)***
The RUC reviewed the survey results from 30 urologists for CPT code 53440. Sixty two percent (62%) of the survey respondents indicated the typical patient is at least kept overnight. The typical patient is kept overnight as there is post operative follow up that occurs the next day. Given this, the RUC agreed that one 99238 should be maintained in the post operative visits for this service.

The RUC analyzed the survey's estimated physician work and agreed that these data support the median, a work RVU of 14.00, for this service, which is lower than the current value of 15.54. To further justify this value, the RUC compared the surveyed code the reference CPT code 27416 *Osteochondral autograft(s), knee, open (eg, mosaicplasty) (includes harvesting of autograft[s])* (work RVU= 14.16 and intra time= 90 minutes). The RUC agreed that the two services have identical intra service work, 90 minutes, and analogous total service time. Additionally, the RUC compared code 53440 to the reference CPT code 38745 *Axillary lymphadenectomy; complete* (work RVU= 13.87 and intra time= 90 minutes) and agreed that the surveyed code should be valued slightly higher than the reference code due to greater total time, 270.5 minutes and 267 minutes, respectively. **The RUC recommends a work RVU of 14.00 for CPT code 53440.**

57287 ***Removal or revision of sling for stress incontinence (eg, fascia or synthetic)***
The RUC reviewed the survey results from 45 urologists and gynecologists for CPT code 57287. The RUC analyzed the survey's estimated physician work and agreed that these data support maintaining the current work RVU of 11.15 for this service. To further justify this value, the RUC compared the surveyed code to the key reference service CPT code 57240 *Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele* (work RVU= 11.50 and intra time= 60 minutes). The RUC noted that the reference code has greater total time than the surveyed code, 307 minutes compared to 239 minutes. Additionally, the RUC compared code 57287 to the MPC code CPT 47562 *Laparoscopy, surgical; cholecystectomy* (work RVU= 11.76 and total time= 246 minutes). The RUC noted that the reference code has slightly more total time compared to the surveyed code, 246 minutes compared to 239 minutes, and agreed that the services should be valued accordingly. **The RUC recommends a work RVU of 11.15 for CPT code 57287.**

57288 ***Sling operation for stress incontinence (eg, fascia or synthetic)***
The RUC reviewed the survey results from 38 urologists and gynecologists for CPT code 57288. Sixty three (63%) of the survey respondents indicated the typical patient is discharged the same day. The RUC agreed with the specialty that this service is typically performed in the outpatient hospital setting and agreed that a half day discharge (99238) should be applied in the post operative visits for this service.

The RUC analyzed the survey's estimated physician work and agreed that these data support maintaining the current work RVU of 12.13 for this service. To further justify this value, the RUC compared the surveyed code to the key reference service CPT code 57240 *Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele* (work RVU= 11.50 and intra time= 60 minutes). Although the reference code has greater total time than the surveyed code, 307 minutes compared to 246 minutes, the survey respondents indicated that CPT 57288 is a more complex and intense procedure compared to CPT 57240. Additionally, the RUC compared code 57288 to the MPC code

CPT 47562 *Laparoscopy, surgical; cholecystectomy* (work RVU= 11.76 and total time= 246 minutes). The RUC noted that although these two services have identical total time, 246 minutes, the surveyed code requires greater intensity to perform compared to the reference code. Finally, the RUC compared the surveyed code to reference CPT code 52648 *Laser vaporization of prostate, including control of postoperative bleeding, complete* (work RVU= 12.15 and intra time= 60 minutes. Given that these services have identical intra-service times, 60 minutes, and similar total physician times, 249 minutes and 246 minutes, respectively, the services should be valued similarly. **The RUC recommends a work RVU of 12.13 for CPT code 57288.**

Removal of Thyroid/Parathyroid (Tab 45)
Wayne Koch, MD, AAO-HNS; Christopher Senkowski, MD, ACS; Samuel Smith, MD, APSA

In the 4th Five-Year Review of the RBRVS, CMS identified CPT codes 60220, 60240 and 60500 as potentially misvalued through the Site of Service Anomaly Screen.

60220 ***Total thyroid lobectomy, unilateral; with or without isthmusectomy***
The RUC reviewed the survey results from 35 otolaryngologists and general surgeons for CPT code 60220. Eighty two percent (82%) of the survey respondents indicated that patients at the least stay overnight. The typical patient requires close monitoring on the day of the procedure and is admitted for continued monitoring overnight for airway patency and for potential development of cervical hematoma. Given this, the RUC agreed that one hospital visit occurs the day of the procedure and one 99238 should be allocated for the discharge work on the following day.

The RUC analyzed the survey's estimated physician work and agreed that these data support maintaining the current work RVU of 12.37 for CPT code 60220. To further justify this value, the RUC compared the surveyed code to key reference service CPT code 38700 *Suprahyoid lymphadenectomy* (work RVU= 12.81 and total time= 300 minutes). The RUC agreed that these services are similar in both total time, 296 minutes for code 60220 compared to 300 minutes for code 38700, and physician intensity and complexity. Given this comparison, the surveyed code should be valued slightly less than the reference code to maintain appropriate relativity. Additionally, the RUC compared code 60220 to MPC code 47562 *Laparoscopy, surgical; cholecystectomy* (work RVU= 11.76 and total time= 246). The RUC agreed that the surveyed code should be valued higher than the reference code due to greater total time, 300 minutes and 246, respectively. **The RUC recommends a work RVU of 12.37 for CPT code 60220.**

60240 ***Thyroidectomy, total or complete***
The RUC reviewed the survey results from 35 otolaryngologists and general surgeons for CPT code 60240. One hundred percent (100%) of the survey respondents indicated that patients stay overnight. The typical patient requires close monitoring on the day of the procedure and is admitted for continued monitoring overnight for airway patency and for potential development of cervical hematoma. Given this, the RUC agreed that one hospital visit occurs the day of the procedure and one 99238 should be allocated for the discharge work on the following day.

The RUC analyzed the survey's estimated physician work and agreed that these data support maintaining the current work RVU of 16.22 for CPT code 60240. To further justify this value, the RUC compared the surveyed code to the reference CPT code 60271 *Thyroidectomy, including substernal thyroid; cervical approach* (work RVU= 17.62 and total time= 377 minutes). The RUC agreed that in order to maintain appropriate relativity, the reference code should be valued greater than the surveyed code due to greater total physician time, 377 minutes and 356 minutes, respectively. Additionally, the RUC compared code 60240 to the MPC code 19318 *Reduction mammaplasty* (work RVU= 16.03 and total time= 321 minutes). The RUC agreed that although these service have comparable physician mental effort and judgment required to perform the service, in order to maintain appropriate relativity, the reference code should be valued lower than the surveyed code due to less total physician time, 321 minutes and 356, respectively. **The RUC recommends a work RVU of 16.22 for CPT code 60240.**

60500 ***Parathyroidectomy or exploration of parathyroid(s);***
The RUC reviewed the survey results from 35 otolaryngologists and general surgeons for CPT code 60500. Eighty two percent (82%) of the survey respondents indicated that patients at the least stay overnight. The typical patient requires close monitoring on the day of the procedure and is admitted for continued monitoring overnight for airway patency and for potential development of cervical hematoma as well as monitoring of serum calcium. Given this, the RUC agreed that one hospital visit occurs the day of the procedure and one 99238 should be allocated for the discharge work on the following day.

The RUC analyzed the survey's estimated physician work and agreed that these data support maintaining the current work RVU of 16.78 for CPT code 60500. To further justify this value, the RUC compared the surveyed code to the key reference service CPT code 42415 *Excision of parotid tumor or parotid gland; lateral lobe, with dissection and preservation of facial nerve* (work RVU= 18.12 and intra time= 150 minutes). The RUC agreed that the reference code should be valued higher because it is has greater physician intra-service time, 150 minutes compared to 120 minutes for CPT 42415. Additionally, the RUC compared the surveyed code to the reference CPT code 60271 *Thyroidectomy, including substernal thyroid; cervical approach* (work RVU= 17.62 and total time= 377 minutes). The RUC agreed that the reference code should be valued greater than the surveyed code due to greater total physician time, 377 minutes and 342 minutes, respectively. **The RUC recommends a work RVU of 16.78 for CPT code 60500.**

Injection of Anesthetic Agent (Tab 48)
Kevin Kerber, MD, AAN; Marc Leib, MD, ASA; Christopher Merifield, MD, ISIS; William Sullivan, MD; NASS; Joseph Zuhosky, MD, AAPM&R; Eduardo Fraifeld, MD, AAPM

In the 4th Five-Year Review of the RBRVS, CMS identified CPT code 64405 as potentially misvalued through the Harvard-Valued – Utilization over 30,000 screen.

64405 ***Injection, anesthetic agent; greater occipital nerve***
The RUC reviewed the survey results from 97 neurologists, anesthesiologists and spine surgeons for CPT code 64405. The RUC analyzed the survey's estimated physician work and agreed that these data support the median, a work RVU of 1.00, a value lower than the current value of 1.32 for this service. To further justify this value, the RUC compared the surveyed code to the key reference service CPT code 20526 *Injection, therapeutic*

(eg, local anesthetic, corticosteroid), carpal tunnel (work RVU= 0.94 and intra time= 5 minutes). The RUC agreed that the two services have comparable physician work and noted that the survey respondents indicated the surveyed code is a more intense procedure compared to the reference code and should be valued higher. In addition, the RUC compared code 64405 to MPC code CPT 31575 *Laryngoscopy, flexible fiberoptic; diagnostic* (work RVU= 1.10 and total time= 28 minutes). The RUC agreed that the reference code, while similar to the surveyed code, should be valued higher due to greater total time, 28 minutes and 22 minutes respectively. **The RUC recommends a work RVU of 1.00 for CPT code 64405.**

Biopsy of Eyelid (Tab 49)
Greg Kwasny, MD, AAO

Five-Year Review of the RBRVS, CMS identified CPT code 67810 *Biopsy of eyelid* as potentially misvalued through the Harvard-Valued – Utilization Over 30,000 screen. **The RUC reviewed code 67810 and agreed with the specialty society that this service should be referred to the CPT Editorial Panel to expand the descriptor to include the "eyelid margin" as that is the intent of the code, as well as to clarify the vignette to also include the eyelid margin. The RUC will review this service following review by the CPT Editorial Panel.**

Debridement of Mastoid Cavity (Tab 50)
Wayne Koch, MD, AAO-HNS

In the 4th Five-Year Review of the RBRVS, CMS identified CPT code 69220 *Debridement, mastoidectomy cavity, simple (eg, routine cleaning)*as potentially misvalued through the Harvard-Valued – Utilization Over 30,000 screen.

The RUC reviewed the survey results for CPT code 69220 and determined that the current work RVU of 0.83 maintains the appropriate relativity for this service compared to similar services.

The RUC compared code 69220 to key reference service CPT code 69100 *Biopsy external ear* (work RVU= 0.81 and intra-service time = 12 minutes). The specialty society indicated and the RUC agreed that the key reference service required slightly more intra-service time than 69220, 12 minutes and 10 minutes, respectively. However, surveyed code 69220 is more intense requiring more mental effort and judgment, technical skill/physical effort and psychological stress to perform than code 69100. The RUC determined that the current work RVU of 0.83 maintains the appropriate relativity for this service.

The RUC noted that this service is typically billed with an Evaluation and Management (E/M) service 58% of the time. Therefore, the RUC determined that pre-service time package 5 (Non-facility procedure without sedation/anesthesia care) with modification to subtract 2 minutes from the pre-evaluation time appropriately removed any duplicative time already captured in the E/M service. Additionally, the RUC agreed with the specialty society to add 1 minute to the positioning time to position the patient relative to the microscope and to be consistent with the amount of time indicated by the survey respondents was accurate for this procedure. **The RUC recommends a work RVU of 0.83 for CPT code 69220.**

Gastric Emptying Study (Tab 51)
Kevin Donohoe, MD, SNM; Kenneth McKusick, MD, SNM; Zeke Silva, MD, ACR

In the 4th Five-Year Review of the RBRVS, CMS identified CPT code 78264 *Gastric emptying study* as potentially misvalued through the Harvard-Valued – Utilization Over 30,000 screen.

78264 ***Gastric emptying study***
The specialty society provided compelling evidence there has been a change in technology as the protocol to perform CPT code 78264 has been standardized, the procedure is different than it was 20 years ago and the Harvard methodology was flawed as it used extrapolation to determine physician time and the work RVU. The performance and interpretation of radionuclide solid phase gastric emptying was standardized in 2009. The new guideline standardized the radiolabled meal, the preparation of the patient, the acquisition and processing of the imaging data and the interpretation criteria. The preparation of the patient requires a standard patient questionnaire, assessment of the patient's glucose level, assessment of patient's current medications to avoid an adverse reaction and determining womens' menstrual cycle. The standardized procedure now requires that the interpreting physician be certain that there was or was not >90% gastric emptying of the radiolabeled meal by four hours. Additionally, the interpretation is more complex requiring both greater knowledge of the clinical conditions leading to the procedures as well as the limitations and causes of errors in the results. The RUC determined that there is compelling evidence that the physician work and time required to perform this service has changed.

The RUC review the survey results from 168 radiologists and nuclear medicine physicians for code 78264 and determined that the median work RVU of 0.95 appropriately maintains the relativity among similar services. The RUC compared 78264 to key reference service CPT code 78707 *Kidney imaging morphology; with vascular flow and function, single study without pharmacological intervention* (work RVU = 0.96 and total time = 22 minutes) and determined that this service is a code comparison because the total physician time is the same, 22 minutes. For further support, the RUC compared this service to CPT code 78453 *Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)* (work RVU = 1.00 and total time = 20 minutes) and determined that the total physician time is similar to the surveyed service,.22 and 20 minutes, respectively, and that the survey median work RVU of 0.95 is appropriate in relation to this service. **The RUC recommends a work RVU of 0.95 for CPT code 78264.**

Psychotherapy (Tab 52)
Naakesh Dewan, MD, APA; Chester Schmidt, MD, APA; Sherry Barron-Seabrook, MD, AACAP; Mary Moller, DNP, ARNP, ANA; Eileen Carlson, RN, JD, ANA; James Georgoulakis, PhD, APA; Doris Tomer, LCSW, NASW
Facilitation Committee #1

In the 4th Five-Year Review of the RBRVS, CMS received comment letters from the providers of psychotherapy, CPT codes 90801-90880 as potentially misvalued. CMS forwarded these services to the RUC to be included in the fourth Five-Year Review process. CPT code 90849 was withdrawn by the original commenter as the specialties

indicated that very few of their members provide this service. This specialty recommendation was supported by the Medicare utilization data for this service which was very low in 2008, 343 claims. In April 2010 and May 2010, the Research Subcommittee met to review vignettes and reference service lists. The Subcommittee recommended that 90801 and 90802 be removed from the list of codes to be reviewed and be referred to the CPT Editorial Panel so that modifications could be made to the descriptors to reflect the different work performed by the physician and non-physician providers. In June 2010, the Pre-Facilitation Committee met with the sponsoring specialty societies. The Pre-Facilitation Committee agreed with the Research Subcommittee's recommendations to refer 90801 and 90802 to the CPT Editorial Panel. The Pre-Facilitation Committee recommended that all of the psychotherapy codes with Evaluation and Management components (90805, 90807, 90809, 90811, 90813, 90815, 90817, 90819, 90822, 90824, 90827, 90829, and 90862) be referred to the CPT Editorial Panel to potentially create a new coding structure based on the varying levels of evaluation and management within each code. The remainder of the CPT codes identified were surveyed for the October 2010 RUC Meeting.

At the October 2010 RUC Meeting, the specialties presented compelling evidence arguments to change the current value of the remaining psychotherapy services. The specialties indicated that the patient population receiving these services has dramatically changed since the codes were previously reviewed. Currently, according to a National Comorbidity Survey, 56% of patients receiving psychotherapy have comorbid conditions, meaning having more than one mental or physical disorder, including substance abuse. Due to the prevalence of co-morbid patients, the work of the provider has changed as most research treatment protocols were originally designed for patients with single disorders. Further, the specialties indicated that the site of service for patients receiving many of these services has changed. Patients, who were once treated n the hospital setting, are now more frequently being treated in the office setting at the number of psychiatric beds has dropped by more than 60% between 1970 and 2000. The RUC accepted these compelling evidence arguments to change the current value of these services.

The specialties requested that the remaining psychotherapy codes be referred to the CPT Editorial Panel along with the other psychotherapy codes for revision to address the differences in work performed by the physician and the non-physician providers. The RUC understands that a CPT Workgroup has been created to address all of these concerns with the psychotherapy codes and that a coding proposal will be issued from this Workgroup upon completion of their work to the CPT Editorial Panel for review. **The RUC recommends the psychotherapy codes be referred to the CPT Editorial Panel for revision.**

<u>Nasopharyngoscopy (Tab 53)</u>
Wayne Koch, MD, AAO-HNS

In the 4th Five-Year Review of the RBRVS, CMS identified CPT code 92511 as potentially misvalued through the Harvard-Valued – Utilization over 30,000 screen.

92511 ***Nasopharyngoscopy with endoscope (separate procedure)***
The RUC reviewed the survey results 30 otolaryngologists for CPT code 92511. The RUC noted that there is typically an Evaluation and Management services provided on the same day as this service. The specialties' explained that pre-service time of 11

minutes is justified because the physician is performing evaluation services, including explaining the procedure, obtaining consent and verifying equipment/supplies are available, which are not captured in the Evaluation Management service. In addition, the patient is positioned relative to the equipment and topical anesthesia spray is applied to each nostril.

The RUC analyzed the survey data and agreed that these data overestimates the physician work involved in the service. Comparing the physician work to a similar physician service, the RUC compared the surveyed code to CPT code 69210 *Removal impacted cerumen (separate procedure), 1 or both ears* (work RVU= 0.61 and total time= 19 minutes), which has similar total time, 19 minutes and 21 minutes respectively, and analogous physician work. Given this, the RUC recommends, for CPT code 92511, a direct work RVU crosswalk to code 69210. To further justify this value, the RUC compared the surveyed code to the key reference service CPT code 31231 *Nasal endoscopy, diagnostic, unilateral or bilateral* (work RVU= 1.10 and total time= 30 minutes). The RUC noted that the reference code should be valued higher than the surveyed service due to greater total time, as the intensity is the same. Finally, the RUC compared the surveyed service to CPT code 11056 *Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 to 4 lesions* (work RVU= 0.61 and total time= 15 minutes). The RUC noted that the services have similar time intra-service times, 8 minutes for CPT 11056 and 5 minutes for CPT 92511, with the reference code having greater intensity and complexity. **The RUC recommends a work RVU of 0.61 for CPT code 92511.**

Cardiopulmonary Resuscitation (Tab 54)
Jennifer Wiler, MD, ACEP

In the 4th Five-Year Review of the RBRVS, CMS identified CPT 92950 as potentially misvalued through the Harvard-Valued – Utilization over 30,000 screen.

Anomalous relationship between the code being valued and other codes
The RUC discussed the compelling evidence that this family of services is undervalued due to the following RUC-approved compelling evidence argument: An anomalous relationship between previously RUC-reviewed service and a change in physician work since the last valuation.
Although the Critical Care Evaluation and Management services were reviewed during the third Five-Year Review in 2005 and the work RVUs were increased, the cardiopulmonary resuscitation (CPR) services were not reviewed at that time, or subsequently. Given the increase to these highly comparable codes, the RUC agreed the CPR services have met compelling evidence for an anomalous relationship between comparable codes.

Change in physician work
The specialty indicated that the physician work involved in CPR has changed due to sicker patients and more complex algorithms. According to peer-reviewed literature, patients who arrive at the hospital for CPR services are more complex due to an increase in outpatient resuscitation efforts, which has caused a 90% decrease in patients who are dead upon arrival. Thus, the patients who continue to need resuscitation services are only the most complex patients. Additionally, physician work has become more complex due to new recommended algorithms including, cardio-cerberal resuscitation and strictly limiting excessive positive pressure ventilation to prevent brain injury, that were not

typically used when the service was last valued by the Harvard studies. Finally, the RUC noted that 63% of RUC survey respondents for this service indicated that the physician work has changed in the last five years and that the patients are more complex.

92950 ***Cardiopulmonary resuscitation (eg, in cardiac arrest)***
The RUC reviewed the survey results from 41 emergency medicine physicians for CPT 92950. The RUC analyzed the survey's estimated physician work and agreed that these data support the median work RVU of 4.50 for this service. To further justify this value, the RUC compared the surveyed code to the key reference service CPT code 99291 *Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes* (work RVU= 4.50 and total time= 70 minutes). The RUC agreed that these services have analogous physician work and noted that the survey respondents rated the intensity and complexity of the services very similarly. The RUC also compared CPT 92950 to reference code 99285 *Emergency department visit for the evaluation and management of a patient* (work RVU= 3.80 and total time= 63 minutes). The RUC agreed that the surveyed code is a more intense procedure with greater total time, 78 minutes compared to 63 minutes than the reference code and should be valued higher. **The RUC recommends a work RVU of 4.50 for CPT code 92950.**

Doppler Echocardiography Exam – Heart (Tab 55)
Richard Wright, MD, ACC; Diane Wallis, MD, ACC

In the 4th Five-Year Review of the RBRVS, CMS identified CPT code 93321 *Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); follow-up or limited study* as potentially misvalued through the Harvard-Valued – Utilization Over 30,000 screen.

The specialty society indicated and the RUC agreed that there was no compelling evidence that the physician work has changed for this service. The RUC reviewed the survey data for 93321 and determined that 10 minutes of intra-service time as indicated by the survey respondents for this follow-up or limited study is appropriate compared to the complete exam CPT code 93320 *Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete* (work RVU = 0.38 and intra-service time = 15 minutes). For further support to maintain the current work RVU, the RUC compared 93321 to similar service, CPT code 93010 *Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only* (work RVU = 0.17). The RUC determined that the current work RVU of 0.15 maintains the appropriate relativity for this service. **The RUC recommends a work RVU of 0.15 for CPT code 93321.**

Positive Airway Pressure, CPAP (Tab 56)
Burt Lesnick, MD, ACCP; Kathrin Nicolacakis, MD, ATS; Marianna Spanaki, MD, AAN

In the 4th Five-Year Review of the RBRVS, CMS identified CPT code 94660 as potentially misvalued as submitted by a Contractor Medical Director.

94660 ***Continuous positive airway pressure ventilation (CPAP), initiation and management***
The RUC reviewed the survey results from 40 chest physicians and neurologists who frequently perform this service. The specialty recommended 10 minutes of pre-service time as supported by their survey data and that Evaluation and Management services are not billed with this CPT code. The specialty recommended intra-time of 20 minutes based on the survey results. The RUC compared the service to key reference CPT code 99214 *Office or other outpatient visit for the evaluation and management of an established patient,* (work RVU=1.50). The RUC noted that the surveyed code has less intra-service time as compared to the reference code, 20 minutes and 25 minutes, respectively. Further, the RUC noted that the surveyed code requires less technical skill, physical effort and psychological stress to perform in comparison to the reference code. The RUC also compared this service to MPC code 77300 *Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician* (work RVU=0.62). The RUC noted that the surveyed code requires more intra-service time as compared to the reference code, 20 minutes and 15 minutes respectively. Based on these comparisons and that the specialty did not provide compelling evidence to change the current value of the service, the RUC agreed that the survey data supports the current value of this service. **The RUC recommends a work RVU of 0.76 for CPT code 94660.**

Observation Care (Tab 57)
Larry Martinelli, MD, ACP; Thomas Wedia, MD, AAFP; Alan Lazaroff, MD, AGS; Jennifer Wiler, MD, ACEP
Facilitation Committee #2

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 (ACEP) 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.

The specialty society indicated and the RUC agreed that there is compelling evidence demonstrating that the patient population has changed for the initial observation care codes and observation care codes. Literature, such as the NHAMCS (national hospital ambulatory medical care survey), has indicated that the age of patients has increased up to age 75 or older and the number of medications a patient is on has increased 20%. The RUC also agreed that a rank order anomaly exists within this family of codes as the observation codes have an analogous relationship to the hospital admission codes (99221-99223). In October 2009, the RUC considered three new CPT codes for subsequent observation and recommended a direct crosswalk to the corresponding level of subsequent hosptial care codes (99231-99233) for the work RVU. The RUC determined that that similarly, the initial observation codes should be valued equivalent to the corresponding initial hospital care codes (99221-99223) since the levels of history, exam and medical decision making correspond in each instance.

99218 ***Initial Observation Care***
The RUC reviewed the survey results from 65 internal medicine physicians, family practice physicians, geriatricians and emergency medicine physicians. The RUC compared CPT code 99218 to key reference service CPT code 99221 *Initial hospital care visit* (work RVU = 1.92, pre-time = 10 minutes, intra-time = 30 minutes and immediate post-time = 10 minutes). The survey respondents indicated and the RUC agreed that these services required similar intensity and complexity, physician time and work to perform. The specialty society recommends that the physician work and time is the same for 99218 and 99221 and should be directly crosswalked. The RUC determined that pre-time = 10 minutes, intra-time = 30 minutes and immediate post-time = 10 minutes and determined that the median work RVU of 1.92 appropriately places this service in the proper rank order. **The RUC recommends a work RVU of 1.92 for CPT code 99218.**

99219 ***Initial Observation Care***
The RUC reviewed the survey results from 54 internal medicine physicians, family practice physicians, geriatricians and emergency medicine physicians. The RUC compared CPT code 99219 to key reference service CPT code 99222 *Initial hospital care visit* (work RVU = 2.61, pre-time = 15 minutes, intra-time = 40 minutes and immediate post-time = 20 minutes). The survey respondents indicated and the RUC agreed that these services required similar intensity and complexity, physician time and work to perform. The RUC determined that pre-time = 10 minutes, intra-time = 40 minutes and immediate post-time = 14.5 minutes and the median work RVU of 2.60 appropriately places this service in the proper rank order. **The RUC recommends a work RVU of 2.60 for CPT code 99219.**

99220 ***Initial Observation Care***
The RUC reviewed the survey results from 53 internal medicine physicians, family practice physicians, geriatricians and emergency medicine physicians. The RUC compared CPT code 99220 to key reference service CPT code 99285 *Emergency department visit* (work RVU = 3.80, pre-time = 8 minutes, intra-time = 40 minutes and immediate post-time = 15 minutes). The survey respondents indicated and the RUC agreed that 99220 is slightly less intense and complex to perform than the key reference service, however, it requires more physician time. The RUC also compared 99220 to the similar service CPT code 99223 *Initial hospital care visit* (work RVU = 3.86, pre-time = 15 minutes, intra-time = 55 minutes and immediate post-time = 20 minutes) and determined that the surveyed code 99220 requires slightly less time to perform and therefore should be valued less than CPT code 99223. The RUC determined that pre-time = 15 minutes, intra-time = 45 minutes and immediate post-time = 15 minutes and the median work RVU of 3.56 places this service in the proper rank order as compared to the rest of this family of codes . **The RUC recommends a work RVU of 3.56 for CPT code 99220.**

The RUC requested that the code descriptors clarify the typical times, the same as the initial hospital care codes. **The CPT Executive Committee accepted the descriptor change and the typical times of 30, 50 and 70 minutes are included in the descriptors for codes 99218-99220.**

99234, 99235 and 99236 ***Observation or Inpatient Hospital Care***
The RUC reviewed the survey results for CPT codes 99234, 99235 and 99236 and agree with the specialty society that the survey results are flawed as the time estimates are grossly inaccurate compared to the current times and among similar services**. The RUC recommends that CPT codes 99234-99236 maintain the current work RVUs as interim and the specialty society work with the Research Subcommittee to develop a survey to appropriately capture the work and time required to perform these services.**

Nursing Facility Discharge Day (Tab 58)
Thomas Wedia, MD, AAFP; Alan Lazaroff, MD, AGS; Dennis Stone, MD, AMDA; Charles Crecelius, MD, AMDA

CMS received a comment letter from the American Medical Directors Association requesting that CPT codes 99315 and 99316 be reviewed in the 4th Five Year Review.

The specialties presented compelling evidence arguments to the RUC. Although the current RUC rationale for the valuation of CPT codes 99315 and 99316 indicates that there is more work associated with a hospital discharge than with a nursing facility discharge, the specialties indicated that this relationship has changed since 1998 when these services were evaluated. The specialties explained that currently the vast majority of discharges are patients who are hospitalized, admitted to a SNF and then discharged. This is a very different scenario from when these services were reviewed where the typical patient was a long stay nursing facility patient. Currently, over 80% of nursing facility patients are short term patients who have been admitted to a nursing facility for sub-acute care after a hospital admission. The RUC agreed with the specialty's compelling evidence arguments to change the current values of these services

99315 ***Nursing facility discharge day management; 30 minutes or less***
The RUC reviewed the survey results from 56 medical directors, family physicians and geriatricians who frequently perform this service. The specialty recommended 10 minutes of pre-service time as supported by their survey data. The RUC agreed with the specialties' recommendations for pre-service time.

The specialty recommended intra-service time of 20 minutes based on the survey results. The RUC compared the service to key reference CPT code 99238 *Hospital discharge day management; 30 minutes or less* (work RVU=1.28). The RUC noted that the reference code requires the same intra-service time as the surveyed code, 20 minutes. Further, the RUC noted that the reference code and the surveyed code require similar mental effort and judgment, technical skill and overall requires the same intensity to perform the service. Based on these comparisons, the RUC agreed that the survey data supports a work RVU of 1.28, the 25th percentile of the survey data. **The RUC recommends a work RVU of 1.28 for CPT code 99315.**

99316 ***Nursing facility discharge day management; more than 30 minutes***
The RUC reviewed the survey results from 52 medical directors, family physicians and geriatricians who frequently perform this service. The specialty recommended 14 minutes of pre-service time as supported by their survey data. The RUC agreed with the specialties' recommendations for pre-service time.

The specialty recommended intra-service time of 25 minutes based on the survey results. The RUC compared the service to key reference CPT code 99238 *Hospital discharge day management; more than 30 minutes* (work RVU=1.90). The RUC noted that the reference code requires similar total service time as the surveyed code, 55 minutes and 54 minutes, respectively. Further, the RUC noted that the reference code and the surveyed code require similar mental effort and judgment, technical skill and overall requires similar intensity to perform the service. Based on these comparisons, the RUC agreed that the survey data supports a work RVU of 1.90, the 25th percentile of the survey data. **The RUC recommends a work RVU of 1.90 for CPT code 99316.**

Preventive Medicine (Tab 59)
Steve Krug, MD, AAP; Margie Andreae, MD, AAP; Richard Tuck, MD, AAP; Lawrence Martinelli, MD, ACP; Alan Lazaroff, MD, AGS
Facilitation Committee #3

In the 4th Five-Year Review of the RBRVS, several specialty societies requested review of CPT codes 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396 and 99397 as potentially misvalued.

The RUC discussed the compelling evidence that this family of services is undervalued due to the following RUC-approved compelling evidence arguments.

Anomalous relationship between the code being valued and other codes
When the Evaluation and Management services were reviewed during the third Five-Year Review in 2005 and the work RVUs were increased, the preventive medicine services were not reviewed at that time, or subsequently. Given the increase to these highly comparable codes, the RUC agreed the preventive medicine services have met compelling evidence for an anomalous relationship between comparable codes.

Change in physician work
Pediatric preventive medicine services
The specialties indicated that the physician work involved in pediatric preventive medicine services has changed in the last two years. In 2008, the third edition of the American Academy of Pediatrics' Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents was published. This evidence-based guideline exact more robust and interactive services than were in place when the services were previously valued. For instance, assessing oral health between 6 and 12 months of age, calculating and plot body mass index (BMI) according to age and gender and reviewing standardized autism screenings are now part of the standards of care for these services and were not considered in the codes' current valuation. Finally, the RUC noted that between 88% and 95% of RUC survey respondents for these services indicated that the physician work has changed in the last five years.

Adult preventive medicine services
The specialties indicated that the physician work involved in the adult preventive medicine services has also changed in the last five years. Additional screenings have become standards of care including osteoporosis, prostate and colonoscopy screenings. The physician work has also increased due to controversial and often conflicting recommendations for preventive care cause confusion for physician and for patients including PSA, mammography, vaccinations and estrogen replacement therapy. Finally, the RUC noted that between 83% and 93% of RUC survey respondents for these services indicated that the physician work has changed in the last five years.

99381 ***Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age younger than 1 year)***
The RUC reviewed the survey results from 45 pediatricians for CPT code 99381. The RUC analyzed the survey's estimated physician work and agreed that these data support the 25th percentile, a work RVU of 1.50, for this service. To further justify this value, the RUC compared the surveyed code to the key reference service CPT code 99204 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU= 2.43 and intra time= 30 minutes) The RUC noted that the surveyed code has 10 less minutes of intra-service time, 20 minutes compared to 30 minutes, and should be valued less due to the less complicated medical decision making compared to the reference code. Additionally, the RUC compared code 99381 to the MPC code 99203 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU= 1.42 and total time= 29 minutes), which has almost identical total times, 30 minutes and 29 minutes, respectively, and requires similar mental effort and judgment to perform. **The RUC recommends a work RVU of 1.50 for CPT code 99381.**

99382 ***Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; early childhood (age 1 through 4 years)***
The RUC reviewed the survey results from 43 pediatricians for CPT code 99382. The RUC analyzed the survey's estimated physician work and agreed that these data support the 25th percentile, a work RVU of 1.60, for this service. To further justify this value, the RUC compared the surveyed code to key reference service CPT code 99204 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU= 2.43 and total time= 45 minutes). The RUC noted that the surveyed code has 10 less minutes of intra-service time compared to the reference code, 20 minutes and 30 minutes respectively, and should be valued less due to fewer complicated medical decision making elements. Additionally, the RUC compared code 99382 to reference CPT code 99203 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU= 1.42 and total time= 29 minutes), which has slightly less total time, 29 minutes compared to 32 minutes, and should be valued lower than the surveyed code due to less complicated medical decision making and mental effort to perform. **The RUC recommends a work RVU of 1.60 for CPT code 99382.**

99383 ***Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; late childhood (age 5 through 11 years)***
The RUC reviewed the survey results from 43 pediatricians for CPT code 99383. The RUC analyzed the survey's estimated physician work and agreed that these data support the 25th percentile, a work RVU of 1.70, for this service. To further justify this value, the RUC compared the surveyed code to key reference service CPT code 99215 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU= 2.11 and total time= 55 minutes). The RUC noted that the surveyed code has less intra-service time than the reference service, 20 minutes compared to 35 minutes, and should valued less due to fewer complicated medical decision making elements. **The RUC recommends a work RVU of 1.70 for CPT code 99383.**

99384 ***Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; adolescent (age 12 through 17 years)***
The RUC reviewed the survey results from 41 pediatricians for CPT code 99384. The RUC analyzed the survey's estimated physician work and agreed that these data support the 25th percentile, a work RVU of 2.00, for this service. To further justify this value, the RUC compared the surveyed code to key reference service CPT code 99204 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU= 2.43 and total time= 45 minutes). The RUC noted that the surveyed code has less total time than the reference code, 40 minutes compared to 45 minutes, and should be valued less because the service requires less mental effort and judgment than code 99204. **The RUC recommends a work RVU of 2.00 for CPT code 99384.**

99385 ***Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 18-39 years***
The RUC reviewed the survey results from 30 physicians for CPT code 99385. The RUC analyzed the survey data and agreed that these data overestimates the physician work involved in the service. The RUC compared the surveyed code to reference CPT code 99221 *Initial hospital care, per day, for the evaluation and management of a patient* (work RVU= 1.92 and total time= 50 minutes). The RUC noted that the two service have identical time components and complexity of decision making. Given this, the RUC recommends, for CPT code 99385, a direct work RVU crosswalk to code 99221. To further justify this value, the RUC compared code 99385 to reference CPT code 99239 *Hospital discharge day management; more than 30 minutes* (work RVU= 1.90 and total time= 55 minutes), which has greater total time compared to the surveyed code, 55 minutes and 50 minutes respectively, and should be valued less because the surveyed code has more complex medical decision making elements. RVUs. **The RUC recommends a work RVU of 1.92 for CPT code 99385.**

99386 ***Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 40-64 years***
The RUC reviewed the survey results from 67 physicians for CPT code 99386. The RUC analyzed the survey data and agreed that these data overestimates the physician work involved in the service. The RUC compared the surveyed code to reference CPT code 99349 *Home visit for the evaluation and management of an established patient* (work RVU= 2.33 and intra time= 40 minutes). The RUC noted that the two services have identical physician intra-service times, 40 minutes, and should be valued identical. Given this, the RUC recommends, for CPT code 99386, a direct work RVU crosswalk to code 99349. To further justify this value, the RUC compared code 99386 to reference CPT code 74261 *Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material* (work RVU= 2.28 and intra time= 40 minutes), which has comparable physician work, but has less pre-service and post-service time and should be valued lower than the surveyed code. **The RUC recommends a work RVU of 2.33 for CPT code 99386.**

99387 ***Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 65 years and older***
The RUC reviewed the survey results from 48 physicians for CPT code 99387. The RUC analyzed the survey's estimated physician work and agreed that these data support the median, a work RVU of 2.50, for this service. To further justify this value, the RUC compared the surveyed code to the key reference service CPT code 99204 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU= 2.43 and total time= 45 minutes). The RUC agreed that the services have comparable physician work and noted that the surveyed code has more total time compared to the reference code, 65 minutes and 45 minutes respectively, and should be valued higher than code 99204. Additionally, the RUC compared code 99387 to reference CPT code 99336 *Domiciliary or rest home visit for the evaluation and management of an established patient* (work RVU= 2.46 and intra time= 40 minutes), which has identical total time, 65 minutes, and comparable physician work. **The RUC recommends a work RVU of 2.50 for CPT code 99387.**

99391 ***Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; infant (age younger than 1 year)***
The RUC reviewed the survey results from 43 pediatricians for CPT code 99391. The RUC analyzed the survey's estimated physician work and agreed that these data support the 25th percentile, a work RVU of 1.37, for this service. To further justify this value, the RUC compared the surveyed code to the key reference service CPT code 99214 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU= 1.50 and total time= 40 minutes). The RUC noted that the surveyed code has less total time than the reference code, 26 minutes compared to 40 minutes, and requires less mental effort and judgment to perform. Additionally, the RUC compared code 99391 to reference CPT code 99203 *Office or other outpatient visit for the evaluation and*

management of a new patient (work RVU= 1.42 and total time= 29 minutes), which has comparable physician work and slightly more total time compared to the surveyed code, 29 minutes and 26 minutes respectively, and should be valued accordingly. **The RUC recommends a work RVU of 1.37 for CPT code 99391.**

99392 ***Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; early childhood (age 1 through 4 years)***

The RUC reviewed the survey results from 42 pediatricians for CPT code 99392. The RUC analyzed the survey's estimated physician work and agreed that these data support the 25th percentile, a work RVU of 1.50, for this service. To further justify this value, the RUC compared the surveyed code to the key reference service CPT code 99214 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU= 1.50 and total time= 40 minutes). Although the RUC noted that the surveyed code has less intra-service time, 20 minutes compared to 25 minutes it was also noted that the reference code requires similar mental effort and judgment, physical effort and intensity to perform as compared to the surveyed code. Additionally, the RUC compared code 99392 to reference CPT code 99203 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU= 1.42 and total time= 29 minutes), which has analogous physician work and time, 29 minutes and 30 minutes, respectively. **The RUC recommends a work RVU of 1.50 for CPT code 99392.**

99393 ***Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; late childhood (age 5 through 11 years)***

The RUC reviewed the survey results from 42 pediatricians for CPT code 99393. The RUC analyzed the survey's estimated physician work and agreed that these data support the 25th percentile, a work RVU of 1.50, for this service. To further justify this value, the RUC compared the surveyed code to the key reference service CPT code 99214 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU= 1.50 and total time= 40 minutes). Although the RUC noted that the surveyed code has less intra-service time, 20 minutes compared to 25 minutes, it was also noted that the reference code requires similar technical skill, physical effort and intensity to perform as compared to the surveyed code. Additionally, the RUC compared code 99393 to reference CPT code 99203 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU= 1.42 and total time= 29 minutes), which has analogous physician work and time, 29 minutes and 29.5 minutes, respectively. **The RUC recommends a work RVU of 1.50 for CPT code 99393.**

99394 ***Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; adolescent (age 12 through 17 years)***

The RUC reviewed the survey results from 42 pediatricians for CPT code 99394. The RUC analyzed the survey's estimated physician work and agreed that these data support the 25th percentile, a work RVU of 1.70, for this service. To further justify this value, the

RUC compared the surveyed code to the key reference service CPT code 99215 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU= 2.11 and total time= 55 minutes). The RUC noted that the surveyed code has less total time compared the reference code, 35 minutes and 55 minutes, respectively and should be valued less. **The RUC recommends a work RVU of 1.70 for CPT code 99394.**

99395 ***Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 18-39 years***
The RUC reviewed the survey results from 55 physicians for CPT code 99395. The RUC analyzed the survey's estimated physician work and agreed that these data support the median, a work RVU of 1.75, for this service. To further justify this value, the RUC compared the surveyed code to the reference CPT code 99318 *Evaluation and management of a patient involving an annual nursing facility assessment* (work RVU= 1.71 and total 47 minutes). The RUC noted that the surveyed code has slightly less total time, 45 minutes compared to 47 minutes, but contains more intra time, 30 minutes compared to 27 minutes, and requires more mental effort and judgment to perform the service compared to the reference code. Additionally, the RUC compared code 99395 to reference CPT code 99335 *Domiciliary or rest home visit for the evaluation and management of an established patient* (work RVU= 1.72 and total time= 44 minutes), which has almost identical total time compared to code 99395, 44 minutes and 45 minutes respectively, and should be valued similarly. **The RUC recommends a work RVU of 1.75 for CPT code 99395.**

99396 ***Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 40-64 years***
The RUC reviewed the survey results from 52 physicians for CPT code 99396. The RUC analyzed the survey data and agreed that these data overestimates the physician work involved in the service. The RUC compared the surveyed code to the reference CPT code 73706 *Computed tomographic angiography, lower extremity, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU= 1.90 and intra time= 30 minutes). The RUC noted that the two services have identical intra-service times and analogous physician work. Given this, the RUC recommends, for CPT code 99396, a direct work RVU crosswalk to code 73706. To further justify this value, the RUC compared code 99396 to the reference CPT code 71275 *Computed tomographic angiography, chest (noncoronary), with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU= 1.92 and intra time= 30 minutes), which has slightly more total time than the surveyed code, 49.5 minutes compared to 46 minutes, and should be valued slightly higher than code 99396. **The RUC recommends a work RVU of 1.90 for CPT code 99396.**

99397 ***Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 65 years and older***
The RUC reviewed the survey results from 31 physicians for CPT code 99397. The RUC analyzed the survey's estimated physician work and agreed that these data support the

median, a work RVU of 2.00, for this service. To further justify this value, the RUC compared the surveyed code to the key reference service CPT code 99214 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU= 1.50 and total time= 40 minutes). The RUC noted that the surveyed code has more intra-service time, 30 minutes compared to 25 minutes, and requires more mental effort and judgment to perform the medical decision making compared to the reference code. Additionally, the RUC compared code 99397 to the reference CPT code 99233 *Subsequent hospital care, per day, for the evaluation and management of a patient* (work RVU= 2.00 and total time= 55 minutes), which requires more total time compared to the surveyed code, 55 minutes and 45 minutes respectively, but has identical intra-service time, 30 minutes, and similar decision making elements. **The RUC recommends a work RVU of 2.00 for CPT code 99397.**

Newborn Services (Tab 60)
Steve Krug, MD, AAP; Margie Andreae, MD, AAP; Richard Tuck, MD, AAP
Facilitation Committee #3

In the 4th Five-Year Review of the RBRVS, the American Academy of Pediatrics (AAP) submitted CPT codes 99460, 99462 and 99463 as potentially misvalued.

Anomalous relationship between the code being valued and other codes
The RUC discussed the compelling evidence that this family of services is undervalued due to the following RUC-approved compelling evidence arguments: An anomalous relationship between previously RUC-reviewed services and a change in physician work since the last valuation. Although the Evaluation and Management services were reviewed during the third Five-Year Review in 2005 and the work RVUs were increased, the newborn care services were not reviewed at that time, or subsequently. Given the increase to these highly comparable codes, the RUC agreed the newborn care services have met compelling evidence for an anomalous relationship between comparable codes.

Change in physician work
The specialties indicated that the physician work involved in pediatric preventative medicine services has changed in the last two years. In 2008, the third edition of the American Academy of Pediatrics' Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents was published. This evidence-based guideline is more robust and interactive services than the guidelines that were in place when the services were previously valued. For instance, reviewing expanded newborn metabolic screening tests, conducting risk assessment for jaundice and counseling mother to request pertussis vaccine from a care provider are now part of the standards of care for these services and were not considered in the codes' current valuation. Finally, the RUC noted that between 78% and 85% of RUC survey respondents for these services indicated that the physician work has changed in the last five years.

99460 ***Initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant***
The RUC reviewed the survey results from 40 pediatricians for CPT code 99460 and agreed with the specialty that the survey data was not reflective of the service. The RUC compared the surveyed code to the key reference service CPT code 99221 *Initial hospital care, per day, for the evaluation and management of a patient* (work RVU= 1.92 and total time= 50 minutes). The specialty explained to the RUC that when code 99460 was originally reviewed by the RUC, the rationale stated that, "The in-hospital or birthing

room services were considered to be somewhat more work than a level 1 hospital admission, code 99221." Therefore, the RUC agreed that the service times and RVU for the surveyed code should be directly crosswalked to CPT code 99221 so that this relationship between the two analogous services can be maintained. **The RUC recommends a work RVU of 1.92 for CPT code 99460.**

99462 ***Subsequent hospital care, per day, for evaluation and management of normal newborn***

The RUC reviewed the survey results from 40 pediatricians for CPT code 99462. The RUC analyzed the survey's estimated physician work and agreed that these data support the 25th percentile, a work RVU of 0.84, for this service. To further justify this value, the RUC compared the surveyed code to the reference CPT code 76700 *Ultrasound, abdominal, real time with image documentation; complete* (work RVU= 0.81 and intra time= 10 minutes). The RUC agreed that these services have comparable physician work and that the surveyed code should be valued slightly higher than this reference code due to greater total time, 20 minutes compared to 17 minutes, respectively. Additionally, the RUC compared code 99462 to the reference CPT code 77056 *Mammography; bilateral* (work RVU= 0.87 and intra time= 10 minutes). The RUC agreed that these services have comparable physician work and that the reference code should be valued slightly higher than this reference code due to greater total time, 23 minutes compare to 20 minutes, respectively. **The RUC recommends a work RVU of 0.84 for CPT code 99462.**

99463 ***Initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant admitted and discharged on the same date***

The RUC reviewed the survey results from 40 pediatricians for CPT code 99463. The RUC analyzed the survey's estimated physician work and agreed that these data support the median, a work RVU of 2.13, for this service. However, the RUC agreed with the specialty that the survey median time components were not reflective of the service. The RUC compared the surveyed code to the reference CPT code 99215 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU= 2.11 and total time= 55 minutes). The RUC agreed that these two services have vey similar physician work and intensity. In addition, the RUC compared code 99463 to reference CPT code 99222 *Initial hospital care, per day, for the evaluation and management of a patient* (work RVU= 2.61 and total time= 75 minutes), which should be valued higher than the surveyed code due to greater total-service time, 75 minutes and 55 minutes, respectively. Finally, the RUC considered that code 99463 has more physician work than the family's base code CPT code 99460 because discharge management is inherent in the procedure. Given the analogous physician work between CPT codes 99463 and 99215 and taking magnitude estimation within the family into account, the RUC recommends the following physician service times for code 99463, a direct physician time crosswalk to code 99215: pre-service time of 5 minutes, intra time of 35 minutes and immediate post-service time of 15 minutes. **The RUC recommends a work RVU of 2.13 for CPT code 99463.**

XII. CMS Requests: Site of Service Anomaly Additional Review

Excision of Bone - Mandible (Tab 61)
James Startzell, MD, AAOMS

October 2010 RUC Re-Review

In response to the CMS request to re-review Code 21025 *Excision of bone (eg, for osteomyelitis or bone abscess); mandible*, the RUC asked the specialty to provide additional rationale regarding the appropriateness of the current work RVU of 10.03. The specialties enclosed letter explains the mathematical problems and confusion surrounding the CMS proposed "reverse building block" method. The RUC discussed the CMS proposed value of 8.09 and agreed that a value this low would lead to rank order anomalies with other services. The relativity of this service should be maintained and again determined that the service is more work than 29891 *Arthroscopy, ankle, surgical, excision of osteochondral defect of talus and/or tibia, including drilling of the defect* (Work RVU = 9.67) and slightly less work than 25394 Osteoplasty, carpal bone, shortening (Work RVU = 10.85). A list of other comparable services is listed below in the original RUC recommendations.

The RUC reaffirms its recommendation of 10.03 for CPT Code 21025.

February 2008 RUC Recommendations

CPT Code 21025 was identified by the RUC's Five Year Identification Workgroup's in an effort to address site of service anomalies. The specialty's original survey data from August 1995 indicated the service was performed in the facility setting whereas recent Medicare Utilization data indicated the service was typically performed in the non-facility setting. The RUC had requested the specialty to resurvey this service.

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

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

The RUC agreed that reducing the specialty recommended work relative value by the difference in the pre-service time (11.07 - .56 = 10.51) was appropriate. The RUC also agreed that given the Medicare Utilization data for 2006 indicated that the service was

provided over 50% of the time in the physician's office, an additional reduction in work RVUs with respect to eliminating the specialty recommended one-half discharge day management was necessary (10.51 - .64 = 9.87) to arrive at its final recommended value of 9.87 *(now 10.03 in 2010)*.

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

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

The RUC compared the physician work of code 21025 to code 29891 and agreed that more time pre-operatively and intra-operatively is necessary for code 21025 for patient airway protection and infection control. The RUC considered the overall physician work for code 21025 to be greater than code 29891. Based on this agreement and the other reference points and adjustments made to the work relative value to reflect the service's typical site of service, the RUC agreed that a work value of 9.87 *(now 10.03 in 2010)* would provide for accurate rank order relativity of this service among procedures with similar work.

Shoulder Ligament Release (Tab 62)
William Creevy, MD, AAOS

October 2010 RUC Re-Review

In response to the CMS request to re-review CPT code 23415 *Coracoacromial ligament release, with or without acromioplasty*, the RUC asked the specialty to provide additional rationale regarding the appropriateness of the current work RVU of 9.23. The specialty's enclosed letter and table of comparison codes emphasize the need to use relativity in reviewing physician work. The specialty also explained that the Harvard study measured post-operative time and did not articulate visits. The visits were extrapolated later for practice expense purposes. The February 2008 survey median was 9.35 and included an estimated 70 minutes of pre-time; 60 minutes intra-time; 20 minutes post-time, ½ day discharge, and 4 office visits and is similar in work to CPT code 24539 *Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); debridement, soft tissue and/or bone, open with tendon repair or reattachment* (work RVU = 8.98, pre-time = 50 minutes, intra-time = 60, post-time=20, ½ day discharge and 4 office visits). CPT code

24575 *Open treatment of humeral epicondylar fracture, medial or lateral, includes internal fixation, when performed* (work RVU = 9.71, pre-time = 75 minutes, intra-time = 60, post-time = 30, 1 discharge day and 4 office visits).

The RUC reaffirms its recommendation of 9.23 for CPT Code 23415.

February 2008 RUC Recommendations

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

<u>Forearm Excision (Tab 63)</u>
William Creevy, MD, AAOS; Daniel Nagle, MD, ASSH; Martha Matthews, MD, ASPS

October 2010 RUC Re-Review

In response to the CMS request to re-review CPT code 25116 *Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); extensors, with or without transposition of dorsal retinaculum*, the RUC asked the specialty to provide additional rationale regarding the appropriateness of the current work RVU of 7.56. The specialties enclosed letter and table of comparison codes emphasize the need to use relativity in reviewing physician work. The specialty also explained that the Harvard study measured post-operative time and did not articulate visits. The visits were extrapolated later for practice expense purposes. The RUC notes that the specialty survey actually supported a higher work RVU (median = 9.89), however compelling evidence was not presented in April 2008. The survey times for 25116 are 65 minutes of pre-time, 60 minutes intra-time, 20 minutes post-time, ½ day discharge day management and 4 office visits. CPT code 25116 is similar in work to 24076 *Excision, tumor, soft tissue of upper arm or elbow area,*

subfascial (eg, intramuscular); less than 5 cm (work RVU = 7.41, pre-time = 68 minutes; intra-time = 60 minutes, post-time=20 minutes, ½ day discharge day and 3 office visits) and 46261 *Hemorrhoidectomy, internal and external, 2 or more columns/groups; with fissurectomy* (work RVU = 7.76, pre-time = 60 minutes; intra-time = 70 minutes; post-time = 30 minutes, ½ day discharge and 3 office visits).

The RUC also reviewed a table of codes that includes MPC codes, high volume codes and/or recently RUC-reviewed codes that have the same intra-time, similar total time, and/or similar IWPUT. This review using magnitude estimation comparison of work RVUs further supports the current work RVU for 25116.

RUC Review	CPT	LONG DESCRIPTOR	GLOB	RVW	IWPUT	TOT Time
2001 MPC	**57155**	Insertion of uterine tandems and/or vaginal ovoids for clinical brachytherapy	090	**6.87**	**0.059**	**181**
2009	**26480**	Transfer or transplant of tendon, carpometacarpal area or dorsum of hand; without free graft, each tendon	090	**6.90**	**0.041**	**222**
2005	**27619**	Excision, tumor, soft tissue of leg or ankle area, subfascial (eg, intramuscular); less than 5 cm	090	**6.91**	**0.042**	**225**
2006	**25109**	Excision of tendon, forearm and/or wrist, flexor or extensor, each	090	**6.94**	**0.063**	**191**
2000	**38520**	Biopsy or excision of lymph node(s); open, deep cervical node(s) with excision scalene fat pad	090	**7.03**	**0.054**	**193**
2008	**25073**	Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); 3 cm or greater	090	**7.13**	**0.042**	**221**
2005	**24076**	Excision, tumor, soft tissue of upper arm or elbow area, subfascial (eg, intramuscular); less than 5 cm	090	**7.41**	**0.043**	**229**
2008	**25116**	Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); extensors, with or without transposition of dorsal retinaculum	090	**7.56**	**0.031**	**249**
2000	**46261**	Hemorrhoidectomy, internal and external, 2 or more columns/groups; with fissurectomy	090	**7.76**	**0.038**	**241**
2000	**46288**	Closure of anal fistula with rectal advancement flap	090	**7.81**	**0.042**	**236**
2005	**57295**	Revision (including removal) of prosthetic vaginal graft; vaginal approach	090	**7.82**	**0.064**	**202**
2001	**24332**	Tenolysis, triceps	090	**7.91**	**0.051**	**230**
2007	**26665**	Open treatment of CMC fracture dislocation, thumb (Bennett fracture), incl. internal fix, when performed	090	**7.94**	**0.047**	**237**
2005 MPC	**49505**	Repair initial inguinal hernia, age 5 years or older; reducible	090	**7.96**	**0.065**	**198**
2001	**25652**	Open treatment of ulnar styloid fracture	090	**8.06**	**0.056**	**225**
2008	**25310**	Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single; each tendon	090	**8.08**	**0.056**	**235**
2006	**25606**	Percutaneous skeletal fixation of distal radial fracture or epiphyseal separation	090	**8.31**	**0.042**	**260**
2007	**24685**	Open treatment of ulnar fracture, proximal end (eg, olecranon or coronoid process[es]), includes internal fixation, when performed	090	**8.37**	**0.047**	**252**
2008 MPC	**14040**	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less	090	**8.60**	**0.050**	**223**

The RUC reaffirms its recommendation of 7.56 for CPT Code 25116.

April 2008 RUC Recommendations

CPT code 25116, *Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); extensors, with or without transposition of dorsal retinaculum,* was identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicates that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated for physician work. At the February 2008 RUC meeting, the RUC established a series of procedural rules to guide the reevaluation of Site of Service Anomalies. Included in these procedural guidelines is the necessity of compelling evidence for any specialty society recommendation to increase work RVU for a Site of Service Anomaly.

At the April 2008 RUC meeting, the specialty society agreed that there was no compelling evidence to recommend a higher work RVU than is currently assigned to 25116. However, the specialty society noted that current data for 25116 is based on a Harvard survey for intra-service time only and the post-op visits in the database were predicted by CMS using an algorithm rather than a survey. While the specialty society agreed that there was no compelling evidence to increase the value of the service, they also agreed that there was no evidence that the service is misvalued. The specialty society conducted a survey of 55 orthopaedic surgeons to validate physician work, physician time components, and post-operative office visits. The survey resulted in a median pre-service evaluation time of 40 minutes, pre-service positioning time of 10 minutes, pre-service scrub, dress and wait time of 15 minutes, intra-service time of 60 minutes, and immediate post-service time of 20 minutes. The survey respondents also indicated that the outpatient procedure includes one-half 99238 discharge management service, one 99212 office visit, and three 99213 office visits within its 090 day global period. Further, the survey resulted in a median work RVU of 9.89 and 25th percentile work RVU of 9.08. Sixty-nine percent of survey respondents indicated the key reference service 25115, *Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); flexors*, (work RVU = 9.89, intra-service time = 90 minutes). The key reference service requires greater intra-service time and, therefore, the RUC agreed that it should be valued slightly higher than the surveyed code. Further supporting the current work RVU for 25116, the calculated intra-service work per unit of time (IWPUT) with the surveyed times and post-operative visits is 0.031, which is lower than the key reference service IWPUT of 0.050. The RUC concluded that the incremental difference in IWPUT between the survey code and reference code and the difference between the current work RVU of 25116 and 25115 are appropriate to maintain proper rank order between the services.

Submandibular Gland Excision (Tab 64)
Wayne Koch, MD, AAO-HNS; Christopher Senkowski, MD, ACS

October 2010 RUC Re-Review

In response to the CMS request to re-review CPT code 42440 *Excision of submandibular (submaxillary) gland,* the RUC asked the specialties to provide additional rationale regarding the appropriateness of the current work RVU of 7.13. The specialties' enclosed letter and table of comparison codes emphasize the need to use relativity in reviewing physician work. The specialties also explained that the Harvard study measured post-operative time and did not articulate visits. The visits were extrapolated later for practice expense purposes. The RUC notes that the specialty survey actually supported a higher work RVU (median = 12.00), however compelling evidence was not presented in February 2008. The survey times for 42440 are 55 minutes of pre-time, 60 minutes intra-time, 20 minutes post-time, ½ day discharge day management and 2 office visits. CPT code 42440 is similar in work to 38520 *Biopsy or excision of lymph node(s); open, deep cervical node(s) with excision scalene fat pad* (work RVU = 7.03, pre-time = 45 minutes; intra-time = 60 minutes, post-time=30 minutes, ½ day discharge day and 2 office visits) and 63650 *Percutaneous implantation of neurostimulator electrode array, epidural* (work RVU = 7.20, pre-time = 48 minutes; intra-time = 60 minutes; post-time = 20 minutes, ½ day discharge and 1 office visit).

The RUC reaffirms its recommendation of 7.13 for CPT Code 42440.

February 2008 RUC Recommendations

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

The specialty society presenters agreed that the site of service for this code has shifted from predominantly inpatient to outpatient. Based on a survey of 25 surgeons, the presenters recommended the following median survey times, pre-service evaluation = 30, pre-service positioning = 10, pre-service scrub, dress, and wait = 15, intra-service = 60, immediate post-service = 20. The specialty society presenter and the RUC agreed that the median survey physician time was appropriate. The specialty society recommended two post-service office visits, one 99212, one 99213, and one-half 99238 discharge day management visits. The specialty society presenter clarified the increase in intensity of office visits, noting that rather than an overnight stay in the hospital, the typical patient is discharged the same day with tubes in their neck and a more intense office visits is needed to remove the tube and check the other dressings. There is also a slightly less intense service for general follow-up care with the patient regarding this service. The specialty society did not agree with the survey median of 12.00 or the 25th percentile of 10.00, but rather recommended maintaining the current RVU of 7.05 (7.13 in 2010).

Further, this recommendation was further supported when the RUC considered another reference service, 38520, *Biopsy or excision of lymph node(s); open, deep cervical node(s) with excision scalene fat pad*, (work RVU = 6.95, intra-service time = 60 minutes), which was reviewed by the RUC in the second Five-Year Review. This service contains the same number and level of office visits as the surveyed code. The RUC also compared the intra-service work intensity between the two codes and noted that the IWPUT of the survey code was 0.0596 and for 38520, the IWPUT was nearly identical at 0.0560. The RUC agreed and noted that while the hospital visits were removed, the intensity of the office visits increased significantly and the pre- and post-service times increased slightly. In consideration of the similarity to the reference service, 38520, and the RUC agreed that 7.05 (7.13 in 2010) is an appropriate valuation.

Urological Procedures (Tab 65)
Thomas Cooper, MD, AUA

October 2010 RUC Re-Review

In response to the CMS request to re-review several urological services (CPT codes 52341, 52342, 52343, 52344, 52345, 52346, 52400, 52500, 53445, 54410, and 54530), the RUC asked the specialty to provide additional rationale regarding the appropriateness of the current work RVUs for each code. Two additional codes, 52640 and 57287 were also identified and addressed as part of the 4th Five-Year Review process (see October 2010 submission to CMS).

52341, 52342, 52343, 52344, 52345, and 52346
The six rarely performed cystourethroscopy codes (52341, 52342, 52343, 52344, 52345, and 52346) are all outpatient procedures with a 000 day global and no hospital discharge or visit work is included within the physician time for these services. The complexity of the services increase as the code numbers progress, however, the CMS proposed methodology does not recognize the clinical distinction of these services and creates rank order anomalies. The RUC reviewed the previous recommendations, which followed CMS basic premise and deducted any hospital visit work from the original valuation. The RUC review the relativity for the entire family of services and recommends that the 2010 values be maintained.

The RUC recommends a work RVU of 5.35 for 52341, 5.85 for 52342, 6.55 for 52343, 7.05 for 52344, 7.55 for 52345, and 8.58 for 52346.

52400
The RUC previously modified the post-operative work to concede that the service is reflected as an outpatient service in the Medicare population. However, the actual typical patient for this services is a pediatric patient and inpatient status may be typical for this patient population. The number of Medicare claims for this codes has decided as the specialty has educated their membership in the
specific intent of this code. The 2010 work RVU of 8.69 for this service is dramatically lower than the 25% (13.75) and median (16.00) of the 2008 survey and the RUC, therefore, could not support any further decrease in the valuation of this service.

The RUC recommends a work RVU of 8.69 for CPT Code 52400.

52500
Despite a survey that supported the original valuation of 52500, the RUC deducted the hospital visit work from the valuation. The CMS "reverse building block" method results in a higher work RVU for this service, but neither the specialty or the RUC recommend that this method be used as a substitute for the RUC recommendation of 8.14.

The RUC recommends a work RVU of 8.14 for 52500

53445
The Medicare claims data indicate that 41% of these services are performed in the inpatient setting. The specialty argues that the typical patient spends at least one night in the hospital. The RUC has requested that the specialty survey to address whether an overnight stay is typical.

The RUC recommends an interim work RVU of 15.39 and a survey addressing whether the service requires an overnight stay.

54410
The Medicare claims data indicate that nearly 30% of these services are performed in the inpatient setting. The specialty argues that the typical patient spends at least one night in the hospital. The RUC has requested that the specialty survey to address whether an overnight stay is typical.

The RUC recommends an interim work RVU of 15.18 and a survey addressing whether the service requires an overnight stay.

54530
The specialty noted that this service should be typically reported for testicular tumors, which are rare in the Medicare population. The original survey supported an inpatient service and a value at least equivalent to the 2008 valuation. Nevertheless, the specialty and RUC did value the service as an outpatient service. The RUC supports its previous recommendation based on a comparison to other reference services. The RUC compared this service to codes 37650 *Ligation of femoral vein* (work RVU = 8.41, intra-service time =
60 minutes) and 53505 *Urethrorrhaphy, suture of urethral wound or injury; penile* (work RVU = 8.16, intra-service time = 59 minutes) to further support the recommendation of 8.46 for code 54530.

The RUC recommends a work RVU of 8.46 for 54530.

February 2008 and April 2008 RUC Recommendations

52341
In April 2008, the RUC received notification that the specialty society determined that there was not sufficient evidence to support an increase in RVUs for code 52341 *Cystourethroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)* (2008 work RVU = 6.11). The specialty society recommended and the RUC agreed that since this service is typically performed in an outpatient setting, the physician work value of a 99231 *Subsequent hospital care visit* (work RVU = 0.76) should be removed. The RUC deleted the value of a 99231 visit from the current value for code 52341 (6.11-0.76 = 5.35) resulting in a work RVU of 5.35.

52342
In April 2008, the RUC received notification that the specialty society determined that there was not sufficient evidence to support an increase in RVUs for code 52342 *Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)* (2008 work RVU = 6.61). The specialty society recommended and the RUC agreed that since this service is typically performed in an outpatient setting, the physician work value of a 99231 *Subsequent hospital care visit* (work RVU = 0.76) should be removed. The RUC deleted the value of a 99231 visit from the current value for code 52342 (6.61-0.76 = 5.85) resulting in a work RVU of 5.85.

52343
In April 2008, the RUC received notification that the specialty society determined that there was not sufficient evidence to support an increase in RVUs for code 52343 *Cystourethroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)* (2008 work RVU = 7.31). The specialty society recommended and the RUC agreed that since this service is typically performed in an outpatient setting, the physician work value of a 99231 *Subsequent hospital care visit* (work RVU = 0.76) should be removed. The RUC deleted the value of a 99231 visit from the current value for code 52343 (7.31-0.76 = 6.55) resulting in a work RVU of 6.55.

52344
In April 2008, the RUC received notification that the specialty society determined that there was not sufficient evidence to support an increase in RVUs for code 52344 *Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)* (2008 work RVU = 7.81). The specialty society recommended and the RUC agreed that since this service is typically performed in an outpatient setting, the physician work value of a 99231 *Subsequent hospital care visit* (work RVU = 0.76) should be removed. The RUC deleted the value of a 99231 visit from the current value for code 52344 (7.81-0.76 = 7.05) resulting in a work RVU of 7.05.

52345
In April 2008, the RUC received notification that the specialty society determined that there was not sufficient evidence to support an increase in RVUs for code 52345 *Cystourethroscopy with ureteroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)* (2008 work RVU = 8.31). The specialty society recommended and the RUC agreed that since this service is typically performed in an outpatient setting, the physician work value of a 99231 *Subsequent hospital care visit* (work RVU = 0.76) should be removed. The RUC deleted the value of a 99231 visit from the current value for code 52345 (8.31-0.76 = 7.55) resulting in a work RVU of 7.55.

52346
In April 2008, the RUC received notification that the specialty society determined that there was not sufficient evidence to support an increase in RVUs for code 52346 *Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)* (2008 work RVU = 9.34). The specialty society recommended and the RUC agreed that since this service is typically performed

in an outpatient setting, the physician work value of a 99231 *Subsequent hospital care visit* (work RVU = 0.76) should be removed. The RUC deleted the value of a 99231 visit from the current value for code 52346 (9.34-0.76 = 8.58) resulting in a work RVU of 8.58.

52400

In April 2008, the RUC received notification that the specialty society determined that there was not sufficient evidence to support an increase in RVUs for code 52400 *Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds* (2008 work RVU = 10.06). The specialty society recommended and the RUC agreed that since this service is typically performed in an outpatient setting, the physician work value of a 99231 *Subsequent hospital care visit* (work RVU = 0.76) should be removed and the physician work for half of a 99238 *Hospital discharge day management* (work RVU = 1.28) should be removed as well. The RUC deleted the value of a 99231 visit and deleted the value for half a discharge day management from the current value for code 52400 (10.06-0.76-0.64 = 8.66) resulting in a work RVU of 8.66 (8.69 in 2010).

52500

In April 2008, the RUC received notification that the specialty society determined that there was not sufficient evidence to support an increase in RVUs for code 52500 *Transurethral resection of bladder neck (separate procedure)* (2008 work RVU = 9.39). The specialty society recommended and the RUC agreed that since this service is typically performed in an outpatient setting, the physician work value of a 99231 *Subsequent hospital care visit* (work RVU = 0.76) should be removed and the 99238 *Hospital discharge day management* (work RVU = 1.28) should be reduced to a half discharge day. The RUC deleted the value of a 99231 visit and deleted the value for half a discharge day management from the current value for code 52500 (9.39-0.76-0.64 = 7.99) resulting in a work RVU of 7.99 (8.14 in 2010).

53445

In February 2008, the RUC discussed code 53445 *Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff* and determined that it should be removed from the site-of-service screen and that the current work RVU of 15.21 be maintained. The specialty society indicated that although the Medicare data indicates this service is predominately performed in the outpatient setting (54% outpatient hospital and 45% inpatient hospital), survey respondents indicated this service is typically performed in the facility setting. The specialty society indicated that these patients typically have had a radical prostatectomy and are admitted for 24 hours in order to administer intravenous antibiotics and manage urethral catheters post-operatively. The RUC recommends maintaining the existing work RVU for 53445, however recommends using the new survey data for physician time and post-operative visits. The RUC recommends 1-99232, 1-99233, 1-99238, 1-99212, and 3-99213 post-operative visits. The RUC recommends removing this service from the site-of-service screen and recommends maintaining the work RVU of 15.21 for code 53445 (15.35 in 2010).

54410

In February 2008, the RUC reviewed specialty society survey results for code 54410 *Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session* and determined that after removing the appropriate post-operative visits the surveyed 25th percentile work RVU of 15.00 was appropriate. The RUC recommends 1-99238, 1-99212 and 3-99213 post-operative visits for this service.

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

Additionally, the RUC determined that the survey pre-service evaluation time was slightly high compared to the pre-service evaluation time for reference service 54411 *Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue (pre-service evaluation = 50 minutes)* and other similar procedures. The RUC recommends pre-service evaluation time of 40 minutes, pre-service positioning time of 10 minutes and pre-service scrub, dress, wait time of 15 minutes. The RUC recommends the 25th percentile work RVU of 15.00 (15.18 in 2010) for code 54410.

54530

In February 2008, the RUC reviewed and agreed with the specialty society survey recommendation for code 54530 *Orchiectomy, radical, for tumor; inguinal approach.* The survey median RVU was 10.38. However, since this service is predominantly performed in the hospital outpatient setting, the specialty society recommended and the RUC agreed to start with the survey median value of 10.38 and delete one 99323 visit, reduce the discharge day to a half-day and remove the associated RVUs with these post-operative visit deletions, (10.38 – 1.39 – 0.64 = 8.35). The RUC recommends the surveyed physician times and a half day-99238, 2-99212 and 1-99213 post-operative visits.

Additionally, the RUC compared this service to codes 37650 *Ligation of femoral vein* (work RVU = 8.41, intra-service time = 60 minutes) and 53505 *Urethrorrhaphy, suture of urethral wound or injury; penile* (work RVU = 8.16, intra-service time = 59 minutes) to further support the recommendation of 8.35 (8.46 in 2010) for code 54530.

Epidural Lysis (Tab 66)
Eddy Fraifeld, MD, AAPM; Joseph Zuhosky, MD, AAPMR; John Wilson, MD, AANS; Frederick Boop, MD, CNS; Marc Leib, MD, ASA; Christopher Merifield, MD, ISIS; William Sullivan, MD, NASS

October 2010 RUC Re-Review

In response to the CMS request to re-review CPT code 62263 *Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days*, the RUC asked the specialty to provide additional rationale regarding the appropriateness of the current work RVU of 6.54. The enclosed letter from the specialty examines the flaw in the CMS methodology, explaining that using a building block from the ground up (or a zero-based building block methodology) results in a different work RVU. The original RUC recommendation that 62263 be valued higher than the base code 62264, is still appropriate and should factor in the work of the follow up office visits.

The RUC recommends a work RVU of 6.54 for CPT code 62263.

February 2008 Initial RUC Review

CPT code 62263 was identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated.

The specialty societies presented data from 19 pain medicine physicians, neurosurgeons, anesthesiologists and spine surgeons. The RUC compared the survey code to the reference code, 62264 *Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day* (Work RVU=4.42). The RUC reviewed the survey data presented by the specialty societies and determined that the surveyed code in comparison to the reference code had considerably longer total service time, 194 minutes and 109 minutes respectively. Further, the RUC noted that the surveyed code required greater mental effort, physical effort and judgment in comparison to the reference code. In addition, the RUC noted that the survey data supported that this service is now more frequently being performed in the ASC or outpatient setting as the 2-99231 hospital visits have been removed and the full discharge day management service has been reduced to half a discharge day management service. The RUC determined that after an analysis of the survey intensity measures as compared with the reference code and of the calculated IWPUT of 62263 using the specialties recommended values and times (Current IWPUT=0.046, New IWPUT=0.0451), the current work RVU for this service is correct. Therefore, given the comparison to the reference code and the survey data, the RUC determined that the current work RVU for this service was appropriate.

Intrathecal Epidural Catheters and Pumps (Tab 67)
Eddy Fraifeld, MD, AAPM; Joseph Zuhosky, MD, AAPMR; John Wilson, MD, AANS; Frederick Boop, MD, CNS; Marc Leib, MD, ASA; Christopher Merifield, MD, ISIS; William Sullivan, MD, NASS

October 2010 RUC Re-Review

In response to the CMS request to re-review CPT codes 62350, 62355, 62360, 62361, 62362, and 62365, the RUC asked the specialty to provide additional rationale regarding the appropriateness of the current work RVUs for this family of codes. The enclosed letter from the specialty examines the flaw in the CMS methodology, explaining that the use of a building block from the ground up (or a zero-based building block methodology) results in different work RVUs. The RUC reviewed the original rationale and several cross-specialty comparisons identified in the initial review. The 2010 work RVUs for this family continued to be supported by these reference service comparisons.

The RUC recommends the 2010 work RVUs for 6.05 for 62350, 4.35 for 62355, 4.33 for 62360, 5.65 for 62361, 6.10 for 62362, and 4.65 for 62365.

February and April 2008 Initial RUC Review

CPT codes describing intrathecal/epidural catheters/pumps (62350*,* 62355, 62360, 62361, 62362 and 62365) were identified by the RUC's Five-Year Review Identification Workgroup as site of service anomalies utilizing information from the current physician time data and the Medicare claims data. The physician time data for these codes currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that these services are typically performed in an outpatient setting. CMS agreed with the RUC that these services should be evaluated for physician work. CMS further agreed that each of these codes be assigned a 010 global, rather than the 090 day global currently assigned to these services.

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

At the February 2008 RUC meeting, the specialty societies presented survey data from 58 pain medicine physicians, neurosurgeons, anesthesiologists and spine surgeons. The RUC compared the surveyed code to the reference code, 64561 *Percutaneous implantation of neurostimulator electrodes; sacral nerve (transforaminal placement)* (Work RVU=7.07) and determined that the surveyed code in comparison to the reference code had less total service time, 170 minutes and 204 minutes respectively. In addition, the RUC noted that the survey data supported that this service is now more frequently being performed in the outpatient setting. The respondents indicated that the two 99233 and one 99231 hospital visits, which were previously included in the service's global period, are not included and the full discharge day management service has been reduced to a one-half discharge day management service. Therefore, given the comparison to the reference code, the RUC determined that the median work RVU, 6.00 (6.05 in 2010) was appropriate

62355 ***Removal of previously implanted intrathecal or epidural catheter***

At the February 2008 RUC meeting, the specialty societies presented data from 58 pain medicine physicians, neurosurgeons, anesthesiologists and spine surgeons. The RUC compared the survey code to the reference code, 36589 *Removal of tunneled central venous catheter, without subcutaneous port or pump* (Work RVU=2.27). The RUC reviewed the survey data presented by the specialty societies and determined that the surveyed code in comparison to the reference code had considerably longer total service time, 140 minutes and 79 minutes respectively. Further, the RUC noted that the surveyed code required greater mental effort, physical effort and judgment in comparison to the reference code. In addition, the RUC noted that the survey data supported that this service is now more frequently being performed in the outpatient setting. The respondents indicated that the two 99233 and one 99231 hospital visits, which were previously included in the service's global period, are not included and the full discharge day management service has been reduced to a one-half discharge day management service. However, the specialty societies determined that the survey median was not an appropriate value for the service as it would cause rank order anomalies with codes in the family. Therefore, the specialty societies recommend 4.30 work RVUs, or approximately half-way between the median and the 75th percentile of the survey data as this value maintains rank order within the family. This value is further supported by another reference code, 44391 *Colonoscopy through stoma; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)* (work RVU=4.31) as this code and the surveyed code have similar work and total service times, 141 minutes and 140 minutes, respectively. Therefore, given the comparison to the reference codes, the RUC determined that 4.30 (4.35 in 2010) work RVUs was appropriate and maintained rank order within the family of codes.

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

At the April 2008 RUC meeting, the specialty society presented compelling evidence to the RUC in order to consider recommendations to increase the work RVU for 62360. The compelling evidence consists of the change from a 090 global period to a 010 day global considering that the service with the original times and work RVU results in a negative IWPUT. The RUC agreed that compelling evidence to consider a change in the work RVU existed because backing out the work associated with the EM services could result in a negative work valuation. Additionally, the specialty noted that incorrect assumptions were made during the original valuation of work by the RUC in 1995, which created a rank order anomaly within the family.

The RUC approved the compelling evidence to consider a change to the work RVU for 62360.

The specialty society reviewed the results of a survey of 30 neurosurgeons for 62360. The specialty society adjusted the survey pre-service time to package 2B (difficult patient/straightforward procedure) because they agreed the survey respondents may have overstated the pre-service time. The median intra-service time based on the survey was 60 minutes. The survey median work RVU was 5.00, which the specialty society agreed was too high. The specialty society instead recommended the 25th percentile work RVU of 4.28. The RUC found the key reference service 61888, *Revision or removal of cranial*

neurostimulator pulse generator or receiver (work RVU = 5.20, intra-service time = 34 minutes) to be similar but commented that it has never been RUC reviewed. The RUC compared the service to another reference service, 36585, *Replacement, complete, of a peripherally inserted central venous access device, with subcutaneous port, through same venous access*, (work RVU = 4.81, intra-service time = 60 minutes) and determined the 25th percentile RVU placed this code in proper rank order.

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

At the February 2008 RUC meeting, the specialty societies presented data from 37 physicians from pain medicine physicians, neurosurgeons, anesthesiologists and spine surgeons. The RUC compared the survey code to the reference code, 61888 *Revision or removal of cranial neurostimulator pulse generator or receiver* (Work RVU=5.20). The RUC reviewed the survey data presented by the specialty societies and determined that the surveyed code in comparison to the reference code had similar total service time, 170 minutes and 171 minutes respectively. However, the RUC noted that the surveyed code required greater mental effort, physical effort and judgment in comparison to the reference code. In addition, the RUC noted that the survey data supported that this service is now more frequently being performed in the outpatient setting. The respondents indicated that the two 99233 and one 99231 hospital visits, which were previously included in the service's global period, are not included and the full discharge day management service has been reduced to a one-half discharge day management service. However, the specialty societies determined that the survey median was not an appropriate value for the service as it would cause rank order anomalies with codes in the family. Therefore, the specialty societies recommend 5.60 work RVUs, a value between the median and the 75th percentile of the survey data as this value appropriately maintains rank order within the family. This value is further supported by another reference code, 53853 *Transurethral destruction of prostate tissue; by water-induced thermotherapy* (work RVU=5.54) as this code and the surveyed code have similar work and intra-service times, 60 minutes. Therefore, given the comparison to the reference codes, the RUC determined that 5.60 (5.65 in 2010) work RVUs was appropriate and maintained rank order within the family of codes.

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

At the February 2008 RUC meeting, the specialty societies presented data from 37 pain medicine physicians, neurosurgeons, anesthesiologists and spine surgeons. The RUC compared the survey code to the reference code, 61888 *Revision or removal of cranial neurostimulator pulse generator or receiver* (Work RVU=5.20). The RUC reviewed the survey data presented by the specialty societies and determined that the surveyed code in comparison to the reference code had similar total service time, 170 minutes and 171 minutes respectively. However, the RUC noted that the surveyed code required greater mental effort, physical effort and judgment in comparison to the reference code. In addition, the RUC noted that the survey data supported that this service is now more frequently being performed in the outpatient setting. The respondents indicated that the two 99233 and one 99231 hospital visits, which were previously included in the service's global period, are not included and the full discharge day management service has been reduced to a one-half discharge day management service. However, the specialty societies determined that the survey median was not an appropriate value for the service

as it would cause rank order anomalies with codes in the family. Therefore, the specialty societies recommend 6.05 work RVUs, a value between the median and the 75th percentile of the survey data as this value appropriately maintains rank order within the family. This value is further supported by another reference code, 49570 *Repair epigastric hernia (eg, preperitoneal fat); reducible (separate procedure)* (work RVU=5.97) as this code and the surveyed code have similar work and intra-service times, 60 minutes. Therefore, given the comparison to the reference codes, the RUC determined that 6.10 work RVUs was appropriate and maintained rank order within the family of codes.

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

At the April 2008 RUC meeting, the specialty societies requested to re-survey this service as they believe the vignette associated with this service may have caused inaccurate survey data as it referred to the removal and replacement of the reservoir or pump. At the April meeting, the specialty society reviewed the results of a survey of 30 neurosurgeons with the revised clinical vignette. The specialty society noted that this service had originally been brought up in a previous Five-Year Review because of a negative intra-service work per unit of time (IWPUT), but that it was removed because there were not enough survey responses. Based on the results of this survey, the specialty society recommended decreasing the pre-service time from 72 minutes to 48 minutes. This includes the time associated with pre-service time package 2B with an additional 9 minutes for positioning the patient. The additional positioning time is needed to move the patient from the supine position to a lateral position. This also required placing a pad between the patient's knees, placing the upper arm on a board away from the surgical area, and inserting a foley catheter. The median intra-service time is 45 minutes. The presenters noted that this time is appropriate. The typical patient for this service is taken to the operating room because of an infection, commonly MRSA, and requires the removal of a pump or reservoir. However, the typical service is removal of a pump, rather than reservoir. While the catheter is sometimes removed at the same time, it is separately reportable. However, it is often left in the patient or externalized in order to deliver antibiotics to fight the infection. The pump that requires removal is most commonly held within a cloth sac within the patient. As such, the cloth becomes attached to the fascia with scar tissue and is difficult to remove. The removal must be performed without damaging the catheter. The survey median work RVU was 4.60, which the RUC agreed was appropriate for this service. The RUC also compared the service to reference service, 61888, *Revision or removal of cranial neurostimulator pulse generator or receiver*, (work RVU = 5.20; intra-time = 34 minutes).

<u>Neurostimulators (Tab 68)</u>
Eddy Fraifeld, MD, AAPM; Joseph Zuhosky, MD, AAPMR; John Wilson, MD, AANS; Frederick Boop, MD, CNS; Marc Leib, MD, ASA; Christopher Merifield, MD, ISIS; William Sullivan, MD, NASS

October 2010 RUC Re-Review

In response to the CMS request to re-review CPT Codes 63650 *Percutaneous implantation of neurostimulator electrode array, epidural* and 63685 *Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling,* the RUC asked the specialty to provide additional rationale regarding the

appropriateness of the current work RVUs. The enclosed letter from the specialty examines the flaw in the CMS methodology, explaining that the use of a building block from the ground up (or a zero-based building block methodology) results in different work RVUs. The RUC reviewed the original rationale and several cross-specialty comparisons identified in the initial review. The 2010 work RVUs for this family continued to be supported by these reference service comparisons.

The RUC reaffirms its recommendation of 7.20 for CPT Code 63650 and 63685 for CPT Code 6.05.

February 2008 RUC Recommendation

63650 *Percutaneous implantation of neurostimulator electrode array, epidural*

The specialty societies presented data from 45 pain medicine physicians, neurosurgeons, anesthesiologists, spine surgeons and physical medicine and rehabilitation physicians. The RUC compared the surveyed code to the reference code, 64561 *Percutaneous implantation of neurostimulator electrodes; sacral nerve (transforaminal placement)* (Work RVU=7.07). The RUC reviewed the survey data presented by the specialty societies and determined that the surveyed code in comparison to the reference code had similar intra-service time, 60 minutes and 70 minutes respectively. However, the surveyed code requires slightly more mental effort and judgment, technical skill and physical effort and overall is a more intense service to perform in comparison to the reference code due to the positioning and needle placement into the thoracic or cervical spine which has significant risk of spinal cord injury. In addition, the RUC noted that the survey data supported that this service is now more frequently being performed in the outpatient setting as the 2.5-99231 hospital visits have been removed and the full discharge day management service has been reduced to a one-half discharge day management service. Therefore, given the comparison to the reference code intensity analysis and IWPUT comparisons, the RUC determined that the median work RVU, 7.15 (7.20 for 2010) was appropriate.

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

The specialty societies presented data from 36 pain medicine physicians, neurosurgeons, anesthesiologists, spine surgeons and physical medicine and rehabilitation physicians. The RUC compared the surveyed code to the reference code, 61888 *Revision or removal of cranial neurostimulator pulse generator or receiver* (Work RVU=5.20). The RUC reviewed the survey data presented by the specialty societies and determined that the surveyed code in comparison to the reference code had significantly more intra-service time, 60 minutes and 34 minutes respectively. In addition, the surveyed code requires more mental effort and judgment, technical skill and physical effort and overall is a more intense service to perform in comparison to the reference code. In addition, the RUC noted that the survey data supported that this service is now more frequently being performed in the outpatient setting as the 2.5-99231 hospital visits have been removed and the full discharge day management service has been reduced to a one-half discharge day management service. Therefore, given the comparison to the reference code, the RUC determined that the median work RVU, 6.00 (6.05 for 2010) was appropriate.

Neuroplasty (Tab 69)
Eddy Fraifeld, MD, AAPM; Joseph Zuhosky, MD, AAPMR; John Wilson, MD, AANS; Frederick Boop, MD, CNS; Marc Leib, MD, ASA; Christopher Merifield, MD, ISIS; William Sullivan, MD, NASS

October 2010 RUC Re-Review
In response to the CMS request to re-review CPT code 64708, *Neuroplasty, major peripheral nerve, arm or leg; other than specified*, and 64712, *Neuroplasty, major peripheral nerve, arm or leg; sciatic nerve*, the RUC asked the specialty to provide additional rationale regarding the appropriateness of the current work RVU of 6.36. The enclosed letter from the specialty articulates that despite a survey that indicated much higher work relativity, the specialty recommended the current valuation as their was no compelling evidence to increase the value. The specialty agreed that the reference services used by the RUC to validate the current value were appropriate: 19298, *Placement of radiotherapy afterloading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, includes imaging guidance*, (work RVU = 6.00, intra-service time = 60 minutes) and 30520, *Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft* (work RVU = 6.85, intra-service time = 60 minutes). The specialty also explained that the Harvard study measured post-operative time and did not articulate visits. The RUC agreed that the previous valuation was appropriate.

The RUC also reviewed a table of codes that includes MPC codes, high volume codes and/or recently RUC-reviewed codes that have the same intra-time, similar total time, and/or similar IWPUT. This review using magnitude estimation comparison of work RVUs further supports the current work RVU for 64708.

RUC Review	CPT	LONG DESCRIPTOR	GLOB	RVW	IWPUT	TOT Time
2009	**21013**	Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal, intramuscular); less than 2 cm	090	**5.42**	**0.043**	**174**
2009	**28045**	Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); less than 1.5 cm	090	**5.45**	**0/041**	**169**
2009	**24071**	Excision, tumor, soft tissue of upper arm or elbow area, subcutaneous; 3 cm or greater	090	**5.70**	**0.045**	**183**
2008	**27062**	Excision; trochanteric bursa or calcification	090	**5.75**	**0.050**	**185**
2001	**25651**	Percutaneous skeletal fixation of ulnar styloid fracture	090	**5.82**	**0.040**	**190**
2005	**20680**	Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)	090	**5.96**	**0.056**	**181**
2005	**15170**	Acellular dermal replacement, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children	090	**5.99**	**0.013**	**220**
2004 MPC	**19298**	Placement of radiotherapy afterloading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, includes imaging guidance	000	**6.00**	**0.059**	**169**
2009	**64708**	Neuroplasty, major peripheral nerve, arm or leg; other than specified	090	**6.36**	**0.031**	**220**
2001 MPC	**57155**	Insertion of uterine tandems and/or vaginal ovoids for clinical brachytherapy	090	**6.87**	**0.059**	**181**

RUC Review	CPT	LONG DESCRIPTOR	GLOB	RVW	IWPUT	TOT Time
2009	**26480**	Transfer or transplant of tendon, carpometacarpal area or dorsum of hand; without free graft, each tendon	090	**6.90**	**0.041**	**222**
2009	**27619**	Excision, tumor, soft tissue of leg or ankle area, subfascial (eg, intramuscular); less than 5 cm	090	**6.91**	**0.042**	**225**
2005 MPC	**30520**	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft	090	**7.01**	**0.041**	**210.5**
2000	**38520**	Biopsy or excision of lymph node(s); open, deep cervical node(s) with excision scalene fat pad	090	**7.03**	**0.054**	**193**
2009	**24076**	Excision, tumor, soft tissue of upper arm or elbow area, subfascial (eg, intramuscular); less than 5 cm	090	**7.41**	**0.043**	**229**
2000	**46261**	Hemorrhoidectomy, internal and external, 2 or more columns/groups; with fissurectomy	090	**7.76**	**0.038**	**241**
2000	**46288**	Closure of anal fistula with rectal advancement flap	090	**7.81**	**0.042**	**236**
2001	**24332**	Tenolysis, triceps	090	**7.91**	**0.051**	**230**
2007	**26665**	Open treatment of CMC fracture dislocation, thumb (Bennett fracture), incl. internal fix, when performed	090	**7.94**	**0.047**	**237**
2005 MPC	**49505**	Repair initial inguinal hernia, age 5 years or older; reducible	090	**7.96**	**0.065**	**198**
2008	**25310**	Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single; each tendon	090	**8.08**	**0.056**	**235**
2008 MPC	**14040**	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less	090	**8.60**	**0.050**	**223**
2007	**64910**	Nerve repair; with synthetic conduit or vein allograft (eg, nerve tube), each nerve	090	**11.39**	**0.067**	**264**

The RUC reaffirms its recommendation of 6.36 for CPT Code 42440.

April 2008 RUC Recommendations

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

At the April 2008 RUC meeting, the specialty society commented that the current physician time and work RVU data for 64708 is based on a Harvard survey of 7 orthopaedic surgeons. Podiatrists, plastic surgeons, and hand surgeons were not included in the Harvard study. Additionally, Harvard only surveyed intra-service time (from orthopaedic surgeons and the post-operative visits were predicted by CMS using an algorithm rather than a survey. One of the RUC's compelling evidence standards is that "a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according

to utilization data." Current Medicare utilization data indicate that orthopaedic surgery is the primary provider for 64708 (33%), but not the only provider. For the current RUC survey, orthopaedic surgeons and plastic surgeons and their subspecialties were surveyed. Because there is not compelling evidence to review the work RVU with consideration for an increase, the specialty society provided data to support that the service is appropriately valued with its current work RVU of 6.22.

The specialty society provided the results of a survey of 82 orthopaedic, hand, plastic, and foot and ankle surgeons to the RUC. Based on the survey results, the presenters recommended pre-service evaluation time of 35 minutes, pre-service positioning time of 10 minutes, and pre-service scrub, dress and wait time of 10 minutes. The median intra-service time is 60 minutes. The specialty society agreed that the primary site of service is the outpatient setting and that this service would not typically require an overnight stay. The specialty society then recommended and the RUC agreed with one-half 99238 discharge day management service, three 99212, and one 99213 office visits within the 090 day global period of 67408. The survey also resulted in a median work RVU of 10.00 and a 25th percentile work RVU of 8.50. The survey respondents selected 64910, *Nerve repair; with synthetic conduit or vein allograft (eg, nerve tube), each nerve* (work RVU = 11.21, intra-service time = 90 minutes) as a key reference service. The RUC noted that the intra-service time for 64910 was too high for the RUC to use as a comparison and instead considered several other reference services including, 19298, *Placement of radiotherapy afterloading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, includes imaging guidance*, (work RVU = 6.00, intra-service time = 60 minutes) and 30520, *Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft* (work RVU = 6.85, intra-service time = 60 minutes). Therefore, the RUC agreed that the current value of 6.22 (6.36 in 2010) is not overvalued and is an appropriate work RVU for the service.

Neurorrhaphy (Tab 70)
William Creevy, MD, AAOS; Daniel Nagle, MD, ASSH; Martha Matthews, MD, ASPS

October 2010 RUC Re-Review

In response to the CMS request to re-review CPT code 64831 *Suture of digital nerve, hand or foot; one nerve*,, the RUC asked the specialties to provide additional rationale regarding the appropriateness of the current work RVU of 9.16. The specialties' enclosed letter and table of comparison codes emphasize the need to use relativity in reviewing physician work. The specialties also explained that the Harvard study measured post-operative time and did not articulate visits. The visits were extrapolated later for practice expense purposes. The RUC notes that the specialty survey actually supported a higher work RVU (median = 10.50), however compelling evidence was not presented in February 2008. The survey times for 64831 are 65 minutes of pre-time, 60 minutes intra-time, 15 minutes post-time, ½ day discharge day management and 4 office visits. CPT code 64831 is similar in work to 37761 *Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed, 1 leg* (work RVU = 9.13, pre-time = 68 minutes; intra-time = 60 minutes, post-time=25 minutes, ½ day discharge day and 3 office visits) and 14060 *Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less* (work RVU = 9.23, pre-time = 30 minutes; intra-time = 60 minutes; post-time = 15 minutes and 4 office visits).

The RUC also reviewed a table of codes that includes MPC codes, high volume codes and/or recently RUC-reviewed codes that have the same intra-time, similar total time, and/or similar IWPUT. This review using magnitude estimation comparison of work RVUs further supports the current work RVU for 64831.

The RUC reaffirms its recommendation of 9.16 for CPT Code 64831.

February 2008 RUC Recommendations
CPT code 64831 *Suture of digital nerve, hand or foot; one nerve*, was identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated.

The specialty society presenters agreed that the site of service for this code has shifted from predominantly inpatient to outpatient. The presenters did not agree that the current work RVU is misvalued, but did agree that the current time and post-service hospital and office visits were no longer accurate and appropriate adjustments to the work RVU are necessary. Based on the specialty society survey, the RUC agreed that the survey median time was appropriate. The recommended physician times are pre-service evaluation = 40, pre-service scrub, dress and wait = 15, pre-service positioning = 10, intra-service = 60, and immediate post-service = 15. Further, the specialty recommended and the RUC agreed that the changes in office and hospital visits based on the survey be adjusted to the work RVU, using a building block method. The survey data showed that four office visits including two 99212 and two 99213 were associated with this service. The specialty also recommended one-half 99238 discharge day management visit. To find an appropriate value, the specialty society reduced the current work RVU, to account for the removal of one-half 99238 (0.64 work RVUs), one 99231 (0.76 work RVUs), and one-half 99213 (0.46 work RVUs). This accounted for a total reduction in work RVU of 1.86. The specialty then added the work associated with two 99212 (0.90 work RVUs). The resulting value is 9.27, which the RUC agreed was too high, considering the survey results. The RUC agreed that the surveyed 25th percentile RVU of 9.00 was more appropriate. The RUC referred to the key reference service, 64910, Nerve repair; with synthetic conduit or vein allograft (eg, nerve tube), each nerve, (work RVU = 11.21). The key reference service has slightly less pre-service time (50 minutes and 65 minutes, respectively), but considerably more intra-service time (90 minutes and 60 minutes, respectively). However, survey respondents indicated that the intensity and complexity of the services are very similar. The RUC further validated the 25th percentile RVU by calculating the IWPUT for both the surveyed code (0.06738) and the key reference service (0.06674) and found that they were very similar. The RUC recommends the survey 25th percentile work RVU of 9.00 (9.16 in 2010).

Repair of Eye Wound (Tab 71)
Stephen Kamenetzky, MD, AAO

October 2010 RUC Re-Review
In response to the CMS request to re-review CPT code 65285 *Repair of laceration; cornea and/or sclera, perforating, with reposition or resection of uveal tissue,* the RUC asked the specialty to provide additional rationale regarding the appropriateness of the current work RVU of 14.71. The specialty explained that the typical patient is a young trauma patient that is hospitalized. The RUC suggested that a CPT clarification to ensure that the code is reported appropriately (ie, not to reported to repair a surgical wound) and that the specialty re-survey the clarified descriptor.

The CPT Editorial Panel will clarify 65285 and the specialty will survey the service for the February 2011 RUC Meeting.

February 2008 RUC Recommendation
The RUC had indicated that compelling evidence was necessary if the specialty believed the site of service should remain the same for a particular service, despite recent Medicare claims data. The specialty presented a recent journal article that described the service, its complexity, and necessity of being performed in the facility setting. The specialty explained that many of the services in the Medicare data are coding errors and that the service should be removed from the ambulatory service center listing because it requires an overnight hospital stay. The RUC agreed that the procedure is typically provided within the facility inpatient setting.

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

XIII. Practice Expense Subcommittee Report (Tab 72)

Doctor Joel Brill, MD provided the RUC's Practice Expense Subcommittee Report. Doctor Brill reported that the Subcommittee had developed three Workgroups at its previous meeting in April. A non-facility clinical labor time out workgroup, a migration of radiologic images from film to digital workgroup, and a direct input expense for moderate sedation workgroup. Each Workgroup met over the summer and provided recommendations or action plans to be carried out over the next year.

Doctor Brill explained that the Subcommittee agreed with the time out clinical labor time workgroup that clinical labor time outs were not typically performed in the non-facility setting. The Subcommittee also agreed that the initial research on the migration of imaging from film to digital should be coordinated through the dominant providers of radiologic imaging and recommendations are expected to be presented to the Subcommittee next year. In addition, the Subcommittee had robust discussions regarding the direct input expenses of moderate sedation in the non-facility setting. This discussion resulted in an agreement that the workgroup would develop a new proposed package of equipment and supplies for moderate sedation in the non-facility setting and present it to the Subcommittee at its next meeting.

Doctor Brill also informed the RUC that the Subcommittee's previous recommendation for deletion of the fluoroscopy radiographic room from four services was re-reviewed at the request of the North American Spine Society. The Subcommittee agreed with the society that codes 62310, 62311, 62318 should be extracted from that recommendation. Doctor Brill also reported a new Subcommittee policy that a rationale for the specialties choice of a reference code should be provided on the practice expense summary of recommendation form when submitted. This rationale would be available with the summary of recommendations for RUC and Subcommittee members to review and comment prior to the meeting.

Lastly, Doctor Brill reported that the Subcommittee reviewed the practice expense input recommendations for eleven RUC agenda tabs and provided recommendations to the RUC for their review.

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

XIV. Relativity Assessment Workgroup Report (Tab 73)

I. New Technology/New Services List

Walter Larimore, MD, informed the RUC that this meeting was the first meeting in which the RUC re-examined codes placed on the new technology/new services list. The Workgroup reviewed 32 services identified to discuss whether there has been a diffusion of technology for these services which may warrant re-evaluation. The Workgroup reviewed the specialty society responses on each of these codes and compared the 2007-2009 Medicare utilization data to the original submission estimate. **The Workgroup recommended 21 codes be removed from the list as these services do not need to be re-evaluated, 5 codes be deferred until Sept 2011 with the rest of the family of codes that are on the new technology list, 4 codes remain on the list and review in three years and 2 codes be reviewed at the February 2011 meeting (See attached report for specific CPT codes).**

II. 4th Five-Year Review Issues

Doctor Larimore indicated that the Workgroup reviewed the following 4th Five-Year Review issues and agreed with the specialty society requests below:

- 21365 & 21470 – withdrawn by original commenter (ASPS)
- 36010, 36215, 36216, 37260 – refer to CPT (SIR, ACR, ACC, SVS)
- 90801, 90802, 90805, 90807, 90809, 90811, 90813, 90815, 90817, 90819, 90822, 90824, 90827, 90829, 90862 – Refer to CPT by original commenter (APA)
- 90849 – withdrawn by original commenter (APA/APA-HCPAC)
- 90875, 90876 & 90880 - withdrawn by original commenter (APA-HCPAC)
- 98925-98929 (OMT) – change from refer to CPT to survey (AOA)
- 99026 & 99027 – refer to CPT (On-Call Workgroup)
- 99288 – withdrawn by original commenter (AAP)

III. CMS Requests

MPC Codes – Table 9 of NPRM

Doctor Larimore indicated that in the July 13, 2010, Medicare Physician Payment Schedule *Proposed Rule*, CMS indicated that they believe the entire MPC list should be assessed to ensure that services are paid appropriately under the PFS. 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.

Doctor Larimore stated that the MPC Workgroup currently intends to review all criteria for placing a code on the MPC list, review the current MPC list and determine what additional codes may be appropriate to place on the MPC list. The Workgroup agreed that the list is important and requires maintenance to be relevant. **The Relativity Assessment Workgroup recommended that it will review the MPC services identified by CMS after the MPC Workgroup completes its review of the MPC criteria and list.**

Low Value/Billed in Multiple Units – Table 10 of NPRM

Doctor Larimore indicated that the second CMS request was regarding low value services commonly billed in multiple units. 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 has requested that the RUC review 12 services that have high multiple services, one that is commonly perform in multiples of 5 or more per day, with work RVUS of less than or equal to 0.50 RVUs.

The Workgroup reviewed these 12 services and determined for 6 codes do not meet the CMS criteria as these services were not commonly billed 5 times or more per day (over 50% of the time) and recommended that they be removed from the list. **The Workgroup requests that the specialty societies that perform the remaining low value/billed in multiple unit codes identified, provide an action plan in Feb 2011 on how to address these services (Codes 95004, 95010, 95015, 95024, 95027, 95144).**

Low Value/High Volume Codes – Table 11 of NPRM

Doctor Larimore stated that the third CMS request involved low value/high volume codes. 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 has requested that the RUC review 24 services that have low work RVUs (less than or equal to 0.25) and high utilization.

The Workgroup questioned the criteria CMS used to identify these services as it appeared some codes may be missing from the screen criteria indicated, for example 99211. **Therefore, the Workgroup recommended that 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) be identified. The Workgroup will review the codes identified by this criteria and determine the next steps in Feb 2011.**

Site of Service Anomalies – Tables 15 of NPRM
Lastly, the Workgroup pre-facilitated agenda tabs 61-71, which the RUC will be reviewing in detail at this meeting regarding site of service concerns identified by CMS. The Workgroup hopes the discussion and input they provided helped the RUC in this review.

Sherry Smith provided an editorial note that Table 16 of the NPRM, Site of Service Anomaly codes, included codes reviewed during the CPT 2010 cycle where specialties did provide evidence through survey questions that an overnight stay was required. With CMS' concurrence, those issues will be reviewed in February 2011, after release of the Final Rule, to address any remaining CMS issues.

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

XV. HCPAC Review Board Report (Tab 74)

Lloyd Smith, DPM, informed the RUC that the HCPAC reviewed and developed recommendations for three new multi-layer compression system codes and two existing excision of nail codes as part of the 4th Five-Year Review. Dr. Smith also indicated that two psychophysiological codes and one hypnotherapy code originally identified by the American Psychological Association for review in the 4th Five-Year Review was subsequently withdrawn. The rationale for these recommendations are detailed in the HCPAC report attached to these minutes.

Dr. Smith noted that the HCPAC discussed that bonus payments for e-prescribing are now available and CMS has a report on its website that reviews these bonus payments.

The RUC filed the HCPAC Review Board report which is attached to these minutes.

XVI. Multi-Specialty Points of Comparison Workgroup Report (Tab 75)

Ronald Burd, MD reviewed the MPC Workgroup's August 3 conference call. The Workgroup, leading up to the February 2010 RUC meeting will be reviewing the current MPC list ensuring that, at a minimum, the absolute criteria are met for the current services. In addition, the members will review the list of absolute and suggested criteria to determine if any changes are necessary to strengthen the validity of the MPC list. Finally, in an effort to identify services that are not currently on the MPC list, but may be helpful in establishing true relativity across the RBRVS, the Workgroup will obtain and evaluate a list of all codes reviewed by the RUC since 2000 where multiple specialties performed the service (example, at least two specialties with utilization over 20%).

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

XVII. Research Subcommittee Report (Tab 76)

Brenda Lewis, MD reviewed the three Research Subcommittee conference call reports. On May 26, 2010 the Subcommittee reviewed several reference service lists and vignettes for the October 2010 meeting. **The following tabs' reference service lists were approved with little or no modifications: Observation Codes, Ventricular Assist Device, Withdrawal of Arterial Blood, Adult Preventive Medicine Codes, Nerve Block Injection - Greater Occipital Nerve, Gastric Emptying Study and Positive Airway Pressure.**

The Research Subcommittee also made specific recommendations for other services, including:

Direct Advanced Life Support
The Research Subcommittee approves the vignette as proposed by the specialty society and recommends that the specialty society submit a coding proposal to revise the current CPT descriptor to reflect a pediatric patient.

Pediatric Preventative Medicine Codes
The Research Subcommittee recommends that the existing vignettes for these services, with the aforementioned proposed modifications, be utilized in the surveying process.

On Call Services
The Research Subcommittee did not accept the vignettes or reference service list as presented by the American Academy of Neurology. A workgroup has been established and will work to define what physician work is involved in this service.

Psychiatric Diagnostic and Therapeutic Procedures
Therefore, the Research Subcommittee recommends that the specialty societies should submit a coding proposal to split both 90801 and 90802 into 2 codes to accurately represent the typical patient and work of each service. In addition, the Research Subcommittee reviewed the proposed vignette for 90804 and agreed that is does not describe the typical patient. **Therefore, the Research Subcommittee recommends that the specialties utilize the vignette for 90804 as approved by the Subcommittee at the April 2010 RUC Meeting in their surveying process.**

On June 28, 2010, the Research Subcommittee reviewed specialty society survey instrument changes for two tabs: Ultrasound of Extremity and Special Stains. **The members accepted the instruments with modifications and suggestions to the specialty societies, which can be viewed in the attached report**. Also, the Society of Nuclear Medicine asked the Subcommittee members to review a Power Point presentation based on the standard RUC survey presentation listed on the RUC participant website. **The Subcommittee accepted the presentation with minor modifications.**

On August 10, 2010, the Research Subcommittee held a conference all to discuss the use of the median for the October 2010 Meeting and the CMS request to include additional data points for this meeting. At the April 2010 RUC Meeting, **The Research Subcommittee recommended that the 5th percentile, 95th percentile and the geometric mean be included on the Summary of recommendation forms and also would like to provide to CMS other central tendency points including: arithmetic mean and mode (including bimodal distribution, if applicable).**

Doctor Lewis explained that the RUC policy for using median was developed in a meeting on November 12, 1991 between AMA Staff and four outside consultants and approved by the Research Subcommittee at the February 1992 RUC Meeting. Although, per the request of CMS, these additional statistical data points will be made available during the RUC's deliberations for all codes identified in the 2010 Five Year Review at the October 2010 RUC Meeting, **the Research Subcommittee recommends to the RUC, that these additional points of statistical data will not impact the RUC Process in developing recommendations to CMS. Further, the Research Subcommittee recommends that language be added to the cover letter submitted with the 2010 Five Year Review Recommendations, which are included in the report attached to these minutes.**

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

XVIII. Professional Liability Insurance Workgroup Report (Tab 77)

Sandra Reed, MD reviewed the PLI Workgroup's August 2 conference call. On the call, the workgroup members discussed the current ambiguity surrounding the methodology that CMS uses to gap fill utilization for new/revised codes. Following the meeting, AMA staff clarified from CMS that CMS is using the RUC recommended crosswalk to review and develop PLI RVUs. CMS takes specialty utilization mix, not work RVU, as the primary factor when determining an appropriate PLI crosswalk. In light of this clarification, AMA staff made necessary adjustments to the 2011 New/Revised PLI Crosswalk submission originally sent to CMS in May 2010. The revised submission is attached to this report.

The RUC formally passed the following PLI Workgroup's motion as presented by Doctor Reed to adopt the following changes to the Instructions for Specialty Societies Developing Work Value Recommendations and the PLI Crosswalk section of the SOR

Specialty Society Instruction Document Changes:

Professional Liability Insurance Information

The primary determining factor CMS uses to establish PLI crosswalks is specialty utilization mix. To establish the PLI crosswalk, specialty societies must determine whether the surveyed code is: 1) an existing CPT code and is retaining the same specialty mix or 2) a new/revised or existing CPT code with a specialty mix that will change. To determine an existing CPT code's specialty mix consult the Medicare claims data found in the RUC database.

Existing CPT Codes and retaining the same specialty mix
If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the current CPT code number as the PLI crosswalk.

New/Revised or Existing CPT Codes with specialty mix that will change
New and revised CPT codes are temporarily assigned a professional liability insurance (PLI) relative value based on CMS staff analysis of an appropriate crosswalk. If the surveyed code is a new/revised or an existing code in which the specialty utilization mix will change as a result of the CPT revision, select another crosswalk based on a similar specialty mix.

~~New and revised CPT codes are temporarily assigned a professional liability insurance (PLI) relative value based on CMS staff analysis of an appropriate crosswalk. The crosswalk should represent a code with a similar work RVU or other appropriate measure and be performed by the same specialty. The RUC has agreed that specialty input into this crosswalk is important and is providing that opportunity by including a section on the Summary of Recommendation Form to specifically collect this information. Please complete this section of the Summary form with your specialty RVS committee.~~

~~Surgical risk factors are applied to services in the surgery section of CPT, codes 10000-69999, and the non-surgical risk factor is applied to all other codes. A few exceptions are made to this general principal. In the November 2, 1999, November 1, 2000, November 15, 2004 and November 21, 2005, *Final Rules*, CMS acknowledged that certain codes in the "non-surgical" section of CPT may indeed be invasive and, therefore, be valued based on the surgical risk factor. CMS changed the risk factor to surgical for the cardiology catheterization, angioplasty and electrophysiology codes (92973-92975, 92980-92998, 93501-93536, 93600-93613, 93618-93641, 93580-93581, and 93650-93652). In the case of OB/GYN services, the higher obstetric premiums and risk factors were used for services that were obstetrical services, while the lower gynecology risk factor was used for all other services.~~

Summary of Recommendation (SOR) Changes:

Professional Liability Insurance Information (PLI)

~~Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (i.e. similar work RVU and specialty) []~~
If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number [ ]

~~If no, please select another crosswalk and provide a brief rationale.~~
If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix [ ]

~~Indicate what risk factor the new/revised code should be assigned to determine PLI relative value [ ]~~

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

XIX. Other Issues

- The Research Subcommittee will look into ways to make the specialty society survey data collection more transparent. With increased scrutiny from outside sources, the RUC should ensure that the data collection process is as open as possible.
- The Research Subcommittee will establish minimum requirements for a data comparison spreadsheet due by the specialty societies to the RUC prior to each meeting for all tabs with more than one code.
- The Relativity Assessment Workgroup will discuss the issue of whether or not Harvard valuation should be accepted as a criterion for compelling evidence to increase a work value for a service under review by the RUC.
- The RUC reviewed the American College of Surgeons (ACS) letter sent to Doctor Levy on September 18, 2010. The RUC formally adopts the following motion for 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 99317) for discharge on a day <u>subsequent</u> to the day of a procedure.**
- The Relativity Assessment Workgroup will discuss with input from AMA statisticians the validity of the ACS proposal to have the RUC consider modifying the criteria for the site-of-service screen going forward to require three complete years of consecutive data showing 45% or less inpatient before requiring review of a code under that screen. The Workgroup will focus on whether or not 45% is the correct bench mark for determining this screen.

The meeting adjourned on Saturday, October 2, 2010 at 4:00 pm.

AMA/Specialty Society RVS Update Committee **TAB 72**
Practice Expense Subcommittee Report
Wednesday, October 29, 2010

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

Time Out Clinical Labor Time Workgroup
Doctor Gee provided the report of the Time Out Clinical Labor Time Workgroup. The Workgroup was formed by the Subcommittee at its April 2010 meeting when it recognized that for the endovascular revascularization codes the specialties had recommended non-facility clinical labor time for a "Time Out", to confirm orders, patient identity and mandatory time out prior to the procedure initiation. The Subcommittee agreed that this may evolve into a larger issue and therefore it created a Workgroup to resolve the issue. The Workgroup met via conference call over the summer and concluded:

- That clinical labor time outs were not typically performed in the non-facility setting
- That there is an absence of specific state or federal regulations that mandate time outs be performed in the non-facility setting.
- If the specialty society can establish documentation that "Time Out" typically occurs in the non-facility setting and that there are state and/or federal regulation mandates for the performance of a "Time Out", then the practice expense subcommittee should consider developing an appropriate time.
- In absence of these items, the Workgroup recommends that the Practice Expense Subcommittee not assign clinical labor staff time for "Time Out" in the non-facility setting.

Subcommittee members unanimously agreed with the Workgroup's findings and conclusions.

Migration of Radiologic Images from Film to Digital Workgroup
Subcommittee members have discussed the necessity to capture the migration taking place from radiologic film imaging inputs to the appropriate digital images and data storage inputs. This Workgroup was formed to research and discuss the method and inputs to capture the technology change. The Workgroup met via conference call on July 27, 2010 and agreed that the dominate providers of radiologic imaging should take the lead in providing the Subcommittee with initial research on the migration of imagery from film to digital, and therefore asked the American College of Radiology to research the issue and provide feedback.

Doctor Geraldine McGinty provided the Subcommittee with an update. The American College of Radiology along with Specialty Society representation has begun the groundwork for development of a set of practice expense inputs that reflect the digital imaging environment. As this project progresses they plan to garner input from all other interested specialties and hope to bring recommendations to the Practice Expense Subcommittee next year.

Direct Input Expense for Moderate Sedation Workgroup
This Workgroup was initially formed to address a request from the GI societies to define the practice expenses required to provide moderate sedation in the non-facility setting for 24 endoscopic services (Appendix G of CPT). The request was based on the increasing number of states that have imposed safety regulations for services performed in offices and other non-facility settings. The endoscopy procedures within the original request are currently priced in the non-facility setting (except for 43219) and on Appendix G of CPT and the standard moderate sedation package has been applied within the direct practice expense inputs.

Doctor Katherine Bradley presented the Workgroup's report. The Workgroup had 2 conference calls to consider the issue and how best to address it. The discussion was initially focused on a review of the number of GI procedures reported in the non-facility setting. The Workgroup identified that less than 5% of the GI endoscopy procedure claims were reported in the non-facility setting. A review of the Medicare data also indicated that the top ten services performed with moderate sedation are not typically performed

in the physician's office nationwide. In addition the Workgroup noted that the PE Subcommittee has not previously used state regulatory requirements as a reason to define practice expenses for procedures that are rarely performed in the non-facility setting and whether it was appropriate to recommend national policy based on safety recommendations from a few states. Finally the Workgroup questioned whether there was any evidence to indicate if the use moderate sedation in the non-facility setting was patient or provider initiated. As a result, the Workgroup did not forward any proposed practice expenses for these codes, but recommended discussion by the Subcommittee before determining next steps.

Based on the information provided by the Workgroup, the Subcommittee discussion centered on how to determine what would be considered as standards to determine practice expense direct inputs. Members noted that historically the RUC has provided, and continues to provide practice expense recommendations to CMS when they request it, regardless of the place of service. While the committee recognized that there are increasing state regulations regarding non-facility services, the committee reiterated that, in general, state regulatory actions should not be the standard upon which to define practice expenses. The standards used for practice expense should be the driven by professional society standards and/or national healthcare accreditation groups (ie: JCAHO, AAAASF, AAAHC). Nonetheless, since many procedures are migrating to the non-facility setting, the committee agreed that the practice expenses associated with moderate sedation in the non-facility setting should be revisited. Although at the present time, the administration of moderate sedation is not typical, it does occur in practice and should be properly defined.

In follow-up to the discussion by the PE Subcommittee, the Workgroup will develop a new proposed package of equipment and supplies for moderate sedation in the non-facility setting and present it to the Subcommittee at its next meeting. As part of the recommendations, the Workgroup will attempt to clarify what equipment and supplies are required specifically for the moderate sedation and those that are currently required for the specific clinical service to prevent duplicate practice expenses and, if so, how to define the specific additional practices expenses required for moderate sedation.

Radiographic - Fluoroscopy Workgroup Discussion
The April 2010 Practice Expense Subcommittee made recommendations to delete the Fluoroscopy Room equipment item from CPT codes (50590, 62310, 62311, 62318). Codes 62310, 62311, 62318 were extracted at the full RUC pending further review. Information from the North American Spine Society was reviewed and agreed to that the equipment item should not be extracted. The Subcommittee agreed to extract the three codes from the previous recommendation.

Reference Code for Direct Practice Expense Inputs
In order to create more consistency in the way physician work and practice expense is reviewed, the Subcommittee suggested that when providing comparison practice expense direct inputs along side of the specialty's recommended direct inputs, that the selection of this reference code should be explained. Subcommittee members agreed that a rationale for the specialties choice of a reference code should be provided on the practice expense summary of recommendation form when submitted. This rationale would be available with the summary of recommendations for RUC and Subcommittee members to review and comment prior to the meeting. AMA staff will add a space to the practice expense summary of recommendation form to accommodate this change.

New and Revised Direct Practice Expense Input Recommendations **TAB**
Relative Value Recommendations for *CPT 2012*:

Multi-Layer Compression System (29581, 2958X2 – 2958X4) 4/74
The Subcommittee made no revisions to the direct practice expense inputs recommended by the specialty for these procedures.

Abdominal Paracentesis (4908X1-4908X3)* 5

The Subcommittee made substantial revisions to the direct practice expense inputs recommended by the specialties for procedures 4908X1-4908X2. Clinical labor was specifically refined after considerable discussion and revisions. An explanation of these changes have been captured in the spreadsheet. The Subcommittee made no revisions to the direct inputs recommended by the specialty for code 4908X3.

Special Stains (88312-88314, 88319)* 6
The Subcommittee did not receive direct practice expense recommendations from the specialty society for these services as the specialty did not believe the services had changed through the CPT process. The Subcommittee agreed that the services may have changed since the practice expense inputs were first reviewed at least nine years ago. Since the specialty had not performed an internal review and the services had not been recently reviewed the Subcommittee, the Subcommittee could not make a recommendation to maintain the exiting inputs as suggested by the specialty, ask the specialty to return with a recommendation after the society's internal review.

CMS Requests – Separate from 4th Five Year Review

Shoulder Arthroscopy - PE Only (29826)* 10
The Subcommittee reviewed the issue related to the duplication in practice expense inputs for this code and others frequently billed with it. Specialty society did not provide a presenter for the meeting and the Subcommittee agreed that the discussion of this issue should be postponed.

Uroflometry – PE Only (51736 & 51741)* 11
The Subcommittee made minor revisions to the direct practice expense inputs recommended by the specialty for these procedures.

Spine/Brain Pump, Analyze with Refill and Maintenance – PE Only 12
(62367, 62368, 95990 & 95991)* The Subcommittee was informed by the specialty that these services have been referred to the CPT Editorial Panel for revision and therefore took no action.

IMRT – PE Only (76950 & 77418)*, (77011, 77014 & 77301), (77418 & 77421)* 14/15/16
The Subcommittee made minor revisions to the direct practice expense inputs recommended by the specialty for these procedures. The Subcommittee also agreed to the removal of the practice expense supply, fiducial screws from codes 77011 and 77301.

Chemotherapy Administration – PE Only (96413, 96416)* 20
The Subcommittee made minor revisions to the direct practice expense inputs recommended by the specialty for these procedures.

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

AMA/Specialty Society RVS Update Committee **Tab 73**
Relativity Assessment Workgroup
September 29, 2010

Members: Doctors Walt Larimore *(Chair)*, Michael Bishop, Dale Blasier, John Gage, Stephen Levine, Brenda Lewis, William Mangold, Larry Martinelli, Geraldine McGinty, Marc Raphaelson, George Williams and Ken Brin, MD (Chair of the Joint CPT/RUC Workgroup).

I. New Technology/New Services List

The Workgroup reviewed 32 services identified on the New Technology/New Services list to discuss whether there has been a diffusion of technology for these services which may warrant re-evaluation. The Workgroup reviewed the specialty society responses on each of these codes and compared the 2007-2009 Medicare utilization data to the original submission estimate. **The Workgroup recommends the following:**

CPT Code	Recommendation
22526, 22527, 22857, 22862, 22865, 32998, 43647, 43648, 43881, 43882, 70554, 70555, 77371, 77372, 88384, 88385, 88386, 96020, 96904, 99363, 99364	Remove from list. These services do not need to be re-evaluated.
33254, 33255, 33256, 33265, 33266	Defer for review until Sept 2011 with the rest of this family of codes that are on the new technology list.
58541-58544	Review in 3 years (Sept 2013). Specifically review site of service and length of stay.
77373	Practice expense review (Feb 2011).
77435	Survey (work) and PE review (Feb 2011).

II. 4th Five-Year Review Issues

The Workgroup reviewed the following 4th Five-Year Review issues, agreed with the specialty society requests and recommend the following:

- 21365 & 21470 – withdrawn by original commenter (ASPS)
- 36010, 36215, 36216, 37620 – refer to CPT (SIR, ACR, ACC, SVS)
- 90801, 90802, 90805, 90807, 90809, 90811, 90813, 90815, 90817, 90819, 90822, 90824, 90827, 90829, 90862 – Refer to CPT by original commenter (APA)
- 90849 – withdrawn by original commenter (APA/APA-HCPAC)
- 90875, 90876 & 90880 - withdrawn by original commenter (APA-HCPAC)
- 98925-98929 (OMT) – change from refer to CPT to survey (AOA)
- 99026 & 99027 – refer to CPT (On-Call Workgroup)
- 99288 – withdrawn by original commenter (AAP)

III. CMS Requests

MPC Codes – Table 9 of NPRM

In the July 13, 2010, Medicare Physician Payment Schedule *Proposed Rule*, CMS indicated that they believe the entire MPC list should be assessed to ensure that services are paid appropriately under the PFS. 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 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 currently intends to review all criteria for placing a code on the MPC list, review the current MPC list and determine what additional codes may be appropriate to place on the MPC list. The Workgroup agrees that the list is important and requires maintenance to be relevant. **The Relativity Assessment Workgroup recommends that it will review the MPC services identified by CMS after the MPC Workgroup completes its review of the MPC criteria and list.**

Low Value/Billed in Multiple Units – Table 10 of NPRM

In the July 13, 2010 Medicare Physician Payment Schedule *Proposed Rule*, 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 has requested that the RUC review 12 services that have high multiple services, one that is commonly perform in multiples of 5 or more per day, with work RVUS of less than or equal to 0.50 RVUs.

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 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.

CPT Code	Short descriptor	RUC Assumed Units	CMS Mean # of Units	5 Units	6+ Units
11101	Biopsy, skin add-on	2	1.5	1%	1%
17003	Destruct premalg les, 2–14	4	4.4	8%	31%
76000	Fluoroscope examination	N/A	1.1	0%	0%
76000	-26		1.0	0%	0%
76000	TC		1.5	0%	0%
*88300	Surgical path, gross	1	1.1	0%	0%
88300	-26		1.0	0%	0%
88300	TC		1.1	0%	0%
95148	Antigen therapy services	N/A	2.5	7%	9%
**95904	Sense nerve conduction test		4.1	4%	27%
95904	-26		3.7	6%	20%
95904	TC		4.1	3%	29%

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

Low Value/High Volume Codes – Table 11 of NPRM
In the July 13, 2010 Medicare Physician Payment Schedule *Proposed Rule*, 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 has requested that the RUC review 24 services that have low work RVUs (less than or equal to 0.25) and high utilization.

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 recommends to identify 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). The Workgroup will review the codes identified by this criteria and determine the next steps in Feb 2011.**

Site of Service Anomalies – Tables 15 of NPRM
CMS requested that the RUC "re-review" the RUC recommendations for 29 existing CPT codes, originally identified as site-of-service anomalies. These CPT codes were included in Table 15 of the Proposed Rule for the 2011 Medicare Physician Payment Schedule.

The RUC will discuss 29 codes (Table 15) in detail at this meeting (agenda tabs 61-71). The Workgroup identified concerns for each of these services and discussed what the specialty society should address at the full RUC. The specialty societies reiterated the validity of the RUC methodology used to develop the recent RUC recommendations and provided additional references and rationale that will be presented to the full RUC at this meeting.

IV. Other Issues

The following items were provided as informational materials:

- CPT Editorial Panel Referrals
- CPT Assistant Referrals
- Full status report of the Relativity Assessment Workgroup

Members Present
Members: Arthur Traugott, MD (Chair), Lloyd Smith, DPM (Co-Chair), Emily Hill, PA-C (Alt. Co-Chair), Michael Chaglasian, OD, Robert Fifer, PhD, CCC-A, Mary Foto, OTR, James Georgoulakis, PhD, Stephen Levine, PT, DPT, MSHA, William Mangold, MD, Eileen Carlson JD, RN, Doris Tomer, LCSW, Jane White, PhD, RD, FADA, Marc Raphaelson, MD

I. CMS Update

Edith Hambrick, MD provided the CMS Update. She indicated that two Proposed Rules have recently been released, HOPPS and the Physician Payment Rule. The Final Rule for Physician Payment is expected to be released November 1, 2010. All comments for the Final Rule will be due 60 days after its release.

II. CMS Request: Relative Value Recommendations for CPT 2011

Multi-Layer Compression System (2958X2-X4)
American Physical Therapy Association

2958X2

The HCPAC reviewed CPT code 2958X2 *Application of multi-layer compression system; thigh and leg, including ankle and foot, when performed*. Due to the low survey response rate, the HCPAC agreed with the specialty society that the survey data was not reflective of the service. The specialty society, using an expert panel, developed reflective service times for the surveyed code and developed a recommended work RVU of 0.35 by crosswalking 2958X2 to reference code 97124 *Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)* (Work RVU=0.35). The HCPAC noted that the reference code has 3 additional minutes of pre-service time. The specialty society explained that this additional 3 minutes was appropriate because the reference code is a time based code with the assumption that it would be billed multiple times in the same session whereas the surveyed code would be billed once per session. The specialty society indicated that because these services require the same total service time (18 minutes) and intensity to perform they should be valued the same. The HCPAC agreed with the specialty society recommendations. **The HCPAC recommends a work RVU of 0.35 and total time of 18 minutes for 2958X2.**

2958X3

The HCPAC reviewed CPT code 2958X3 *Application of multi-layer compression system upper arm and forearm*. Due to the low survey response rate, the HCPAC agreed with the specialty society that the survey data was not reflective of the service. The specialty society, using an expert panel, developed reflective service times for the surveyed code and developed a recommended work RVU of 0.25 by crosswalking 2958X3 to reference code 97762 *Checkout for orthotic/prosthetic use, established patient, each 15 minutes* (Work RVU=0.25). The HCPAC noted that the reference code has 2 additional minutes of pre-service time. The specialty society explained that this additional 2 minutes was appropriate because the reference code is a time based code with the assumption that it would be billed multiple times in the same session whereas the surveyed code would be billed once per session. The specialty society indicated that because the surveyed code and the reference code require the similar total service time (16 minutes and 18

minutes, respectively) and intensity to perform they should be valued the same. Further this recommended value maintains rank order within this family of codes. The HCPAC agreed with the specialty society recommendations. **The HCPAC recommends a work RVU of 0.25 and total time of 16 minutes for 2958X3.**

2958X4

The HCPAC reviewed CPT code 2958X4 *Application of multi-layer compression system; upper arm, forearm, hand and fingers*. Due to the low survey response rate, the HCPAC agreed with the specialty society that the survey data was not reflective of the service. The specialty society, using an expert panel, developed reflective service times for the surveyed code and developed a recommended work RVU of 0.35 by crosswalking 2958X4 to reference code 97124 *Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)* (Work RVU=0.35). The HCPAC noted that the reference code has 3 additional minutes of pre-service time. The specialty society explained that this additional 3 minutes was appropriate because the reference code is a time based code with the assumption that it would be billed multiple times in the same session whereas the surveyed code would be billed once per session. The specialty society indicated that because these services require the same total service time (18 minutes) and intensity to perform they should be valued the same. Further this recommended value maintains rank order within this family of codes. The HCPAC agreed with the specialty society recommendations. **The HCPAC recommends a work RVU of 0.35 and total time of 18 minutes for 2958X4.**

PLI Crosswalks:

The specialty society proposed and the HCPAC recommends that the PLI crosswalk for 2958X2 and 2958X4 is 97124 *Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)*. The specialty society proposed and the HCPAC recommends that the PLI crosswalk for 2958X3 is 97762 *Checkout for orthotic/prosthetic use, established patient, each 15 minutes*.

New Technology/Service List:

As these services represent new technology, the HCPAC recommends that these services be added to the New Technology/Service List for future review.

CPT Referral:

The specialty society proposed and the HCPAC recommends that these services be referred back to the CPT Editorial Panel for the inclusion of parenthetical stating that these services should not be reported with the following services 97140 *Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes,* 36475 *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated* and 36478 *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated* as these services already allow for the use of compression wrapping.

Practice Expense:

The practice expense inputs as presented by the specialty society was accepted by the HCPAC.

III. Five-Year Review Relative Value Recommendation

Excision of Nail (11732 & 11765)

11732
The HCPAC reviewed the survey data for 11732 *Avulsion of nail plate, partial or complete, simple; each additional nail plate (List separately in addition to code for primary procedure*). The HCPAC noted that the survey respondents indicated and the specialty society is recommending 2 minutes of pre-service time and 3 minutes of post-service time. As this service has a ZZZ global period, the HCPAC questioned if this time was duplicative to the pre-service and post-service time associated with the base code 11730 *Avulsion of nail plate, partial or complete, simple; single*. The specialty society explained that this pre-service time was not duplicative and specific to the surveyed code as typically this service is performed on the opposite foot which would require additional prepping, draping, anesthetizing, and post-operative care. The HCPAC agreed with the specialty society that the service times as recommended with reflective of the service. The HCPAC compared the surveyed code to reference code 99212 *Office Visit* (Work RVU=0.48). The HCPAC noted that the surveyed code and the reference code have the same intra-service time, 10 minutes and require similar intensity to perform. Further, the HCPAC compared the surveyed code to MPC code 92250 *Fundus photography with interpretation and report* (Work RVU=0.44). The HCPAC agreed that this was an appropriate reference as this MPC code has 1 less minute of intra-service time as compared to the surveyed code. **Based on the comparisons to these reference codes, the HCPAC recommends 0.48 Work RVUs and total time of 15 minutes for 11732.**

11765
The HCPAC reviewed the compelling evidence as presented by the specialty society for 11765 *Wedge excision of skin of nail fold (eg, for ingrown toenail)*. The specialty society indicated that the original survey as conducted by Harvard did not include podiatry. The HCPAC accepted this compelling evidence argument. The HCPAC reviewed the survey times for 11765 and questioned the amount of pre-service time recommended by the specialty as compared to the pre-service time associated with reference codes, 11422 *Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm* (Pre- time-10 minutes, Work RVU=1.68) and 11421 *Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm* (Pre-time- 10 minutes, Work RVU=1.47). The specialties explained that these reference codes include time for prepping the surgical area and administering the anesthetic within the intra-service time period. These activities, after the creation of the pre-service time packages, were included within the pre-service time period. The HCPAC accepted this rationale for the discrepancy between the pre-service time period of the reference codes and the surveyed code. The HCPAC compared the surveyed code to reference code *11422 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm* (Work RVU=1.68). The HCPAC noted that the reference code requires more intra-service time to perform as compared to the surveyed code, 25 minutes and 15 minutes, respectively. Further, the HCPAC noted that the reference code requires more mental effort and judgment, and higher psychological stress to perform as compared to the surveyed code. **Based on these comparisons, the HCPAC agrees with the specialty society's recommendation and recommends 1.48 work RVUs and total time of 59 minutes for 11765.**

Psychophysiological Therapy (90875, 90876)

The American Psychological Association submitted codes 90875 *Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); approximately 20-30 minutes* and 90876 *Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); approximately 45-50 minutes* for review in the 4th Five-Year Review. However, APA was unable to obtain a valid survey response rate and request that these codes be withdrawn from the 4th Five-Year Review. The HCPAC recommends codes 90875 and 90876 be withdrawn by APA without prejudice.

Hypnotherapy (90880)

The American Psychological Association submitted code 90880 *Hypnotherapy* for review in the 4th Five-Year Review. However, APA was unable to obtain a valid survey response rate and request that this code be withdrawn from the 4th Five-Year Review. The HCPAC recommends code 90880 be withdrawn by APA without prejudice.

AMA/Specialty Society RVS Update Committee **Tab 75**
Multi-Specialty Points of Comparison Workgroup
August 3, 2010, Conference Call

Members Present: Doctors Ron Burd, (Chair), Susan Spires, (Vice Chair), Mary Foto, OTR, Peter Hollmann, J. Leonard Lichtenfeld, Eileen Moynihan, Bill Moran, Guy Orangio, Arthur Traugott

Guests Present: Doctors Bruce Deitchman, Barbara Levy

Introduction/ Review of Current Criteria
Doctor Burd reviewed CMS's call for the review of the MPC services in the 2011 NPRM. CMS states in the Proposed Rule, "While we believe that the entire MPC list should be assessed to ensure that services are paid appropriately under the PFS, we have prioritized the review of the MPC list, ranking the codes by allowed service units and charges based on CT 2009 claims data." The Workgroup reviewed the current absolute and suggested criteria for codes being considered for the MPC list. The following list of criteria was carefully crafted by a RUC subcommittee with the help of specialty societies to develop the MPC list as a tool to assist the RUC in maintaining relativity across the RBRVS.

Absolute Criteria:

- The codes should have current work RVUs that the specialty(s) accept as valid and that have been implemented by CMS.
- The specialty(s) that perform a significant percentage of the service should have the right to review the appropriateness of the inclusion of the service on the MPC.
- Any code included in the MPC list should have gone through the RUC survey process and have RUC approved time.

Suggested Criteria (not Absolute Requirements):

- Codes submitted should represent a range of low to high work RVUs within the specialty services.
- The submitted codes should include the range of global periods for services provided by the specialty.
- Codes should be reflective of the entire spectrum of services provided by a specialty society.
- Codes that are frequently performed should be reflected on the MPC.
- To the maximum extent possible, the MPC list should include codes that are performed by multiple specialties.
- Codes on the MPC should be understood and familiar to most physicians.
- Codes with utilization of less than 1,000 should not be included on the MPC without justification by a specialty society.

Re-Review of Current MPC List

The Workgroup agreed that for the MPC list to be effective, all the services currently on the list need to meet, at a minimum, the absolute criteria. The assumption by the specialty societies, RUC and CMS has been that these services do meet the absolute criteria. The Workgroup discussed the initial steps for a re-review of the MPC services.

1. The MPC Workgroup will review the list of absolute and suggested criteria to determine if any changes are necessary to strengthen the validity of the MPC list.
2. The Workgroup will review the current 316 services on the MPC list and validate that they meet the absolute criteria.
3. In an effort to identify services that are not currently on the MPC list, but may be helpful in establishing true relativity across the RBRVS, the Workgroup will obtain and evaluate a list of all codes reviewed by the RUC since 2000 where multiple specialties performed the service (example, at least two specialties with utilization over 20%).

Next Steps

AMA staff will circulate the data set with all services reviewed by the RUC in the last ten years where multiple specialties performed the service, as described in bullet point 3. Due to an extremely busy schedule for the September RUC meeting, the Workgroup is not currently scheduled to meet. It may be possible to schedule an early morning meeting, if necessary. AMA staff will poll the members.

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE **Tab 76**
Research Subcommittee Conference Call
May 26, 2010

Members: Brenda Lewis, DO (Chair), Bibb Allen, MD, J. Leonard Lichtenfeld, MD, Marc Raphaelson, MD, Sherry Barron-Seabrook, MD, Daniel Mark Siegel, MD, Lloyd Smith, DPM, Peter Smith, MD

I. Specialty Society Requests for Review of Vignettes and Reference Service Lists

Ventricular Assist Device (33975, 33976, 33979, 33981, 33982, 33983) (RSL only)
Society of Thoracic Surgery

The Research Subcommittee discussed the proposed reference service list from the specialty society. The Subcommittee was comfortable with the proposed list, when the specialty society confirmed that the codes on the list were valued utilizing the building block methodology. Further, the Subcommittee recommended that the specialty societies remove 44950 *Appendectomy* from their list and add 33970 *Insertion of intra-aortic balloon assist device through the femoral artery, open approach*. **The Research Subcommittee approved the proposed reference service list with the aforementioned modifications.**

Withdrawal of Arterial Blood (36600)
American College of Chest Physicians/American Thoracic Society

The Research Subcommittee discussed the proposed reference service list and vignette from the specialty society. **The Research Subcommittee approved the reference service list and vignette as proposed by the specialty society.**

Nerve Block Injection - Greater Occipital Nerve (64405)
American Academy of Neurology
American Academy of Pain Medicine
American Society of Anesthesiologists
International Spine Intervention Society
North American Spine Society

The Research Subcommittee discussed the proposed reference service list and vignette from the specialty societies. The Subcommittee agreed with the specialty societies that the proposed vignette could be made more generic and applicable to all specialties surveying this code. The Research Subcommittee recommends the following modification to the proposed vignette:

> A 54 year old woman has had daily aching and throbbing ~~left sided neck~~ pain ~~with radiation to the lateral scalp~~ consistent with occipital neuralgia. Neurologic exam is normal, but there is tenderness over the left occipital notch, where palpation triggers pain in the distribution of the greater occipital nerve. For both diagnostic and therapeutic purposes, a local injection of anesthetic and steroid is planned to evaluate and treat the patients symptoms.

The Research Subcommittee approved the reference service list and the modified vignette as proposed by the specialty societies.

Gastric Emptying Study (78264)
American College of Radiology
Society of Nuclear Medicine

The Research Subcommittee discussed the proposed reference service list and vignette from the specialty societies. The Research Subcommittee agreed that the specialties needed to add some codes to their reference service list to bridge the work RVU gap between 71020 *Radiologic examination, chest, 2 views, frontal and lateral;* (Work RVU=0.22) and 70450 *Computed tomography, head or brain; without contrast material* (Work RVU=0.85). **The Research Subcommittee approved the reference service list with recommended modifications and the vignette as proposed by the specialty societies.**

Psychiatric Diagnostic and Therapeutic Procedures (90801-90862 & 90870-90880)
American Academy of Child and Adolescent Psychiatry
American Nurses Association
American Psychiatric Association
American Psychological Association
National Association of Social Workers

The Research Subcommittee reviewed the proposed vignettes as submitted by the specialty societies. The Research Subcommittee questioned the specialty societies about the typical patient and the work being performed in 90801 *Psychiatric diagnostic interview examination* and 90802 *Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication*. In the current descriptions of work, medical evaluation and physical examination are part of the work of these two codes. If the service can be typically provided by other health care professionals and does not require a medical evaluation or physical evaluation then separate codes may be appropriate. **Therefore, the Research Subcommittee recommends that the specialty societies should submit a coding proposal to split both 90801 and 90802 into 2 codes to accurately represent the typical patient and work that each service.**

The Research Subcommittee reviewed the proposed vignette for 90804 *Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient;* and agreed that is does not describe the typical patient. **Therefore, the Research Subcommittee recommends that the specialties utilize the vignette for 90804 as approved by the Subcommittee at the April 2010 RUC Meeting in their surveying process.**

The Research Subcommittee approved the reference service lists and the remaining vignettes as proposed by the specialty societies. The specialties were reminded that this issue will also be discussed by a pre-facilitation committee via conference call on Tuesday, June 1, 2010 at 7 pm Central.

Positive Airway Pressure (94660)
American Academy of Neurology
American College of Chest Physicians/American Thoracic Society

The Research Subcommittee discussed the proposed reference service list and vignette from the specialty societies. **The Research Subcommittee approved the reference service list and vignette as proposed by the specialty societies.**

On Call Services (99026-99027)
American Academy of Neurology

The Research Subcommittee discussed the proposed vignettes and reference service list from the specialty society. The Research Subcommittee expressed concern that the proposed vignettes did not accurately reflect the typical patients for these services, as they are provided by various specialties. Further, the Research Subcommittee expressed concern that this service, during the Level of Interest Process, only had one specialty indicate a Level One Interest to develop primary RUC recommendations. The Research Subcommittee notes that if these services are not reviewed by a comprehensive group of specialties they could be difficult to value. **The Research Subcommittee did not accept the vignettes or reference service list as presented by the American Academy of Neurology.**

Observation Codes (99218-99220 & 99234-99236)
American Academy of Family Physicians
American College of Emergency Physicians
American Geriatrics Society
Society of Interventional Radiology

The Research Subcommittee discussed the proposed reference service list and vignettes from the specialty societies. **The Research Subcommittee approved the reference service list and vignettes as proposed by the specialty societies.**

Direct Advanced Life Support (99288) (Vignette Only)
American Academy of Pediatrics

The Research Subcommittee discussed the proposed vignette from the specialty society. The Research Subcommittee agreed that the vignette is representative of the service as it describes a pediatric patient. However, the Research Subcommittee agrees that the CPT descriptor should be modified to reflect that the typical patient is a pediatric patient. **The Research Subcommittee approves the vignette as proposed by the specialty society and recommends that the specialty society submit a coding proposal to revise the current CPT descriptor to reflect a pediatric patient.**

Pediatric Preventative Medicine Codes (99381-99384 & 99391-99394) (Vignettes Only)
American Academy of Pediatrics
American College of Physicians

The Research Subcommittee discussed the proposed vignettes from the specialty societies. The Research Subcommittee agreed that the proposed vignettes contained description of physician work and could potentially bias the survey respondent. The Research Subcommittee reviewed the existing vignettes for these services and agreed that they were more representative of the typical patient but could be modified further by removing any exam specific language. **The Research Subcommittee recommends that the existing vignettes for these services, with the aforementioned proposed modifications, be utilized in the surveying process.**

Adult Preventative Medicine Codes (99385-99387 & 99395-99397)
American Academy of Family Physicians
American College of Emergency Physicians
American College of Physicians
American Geriatrics Society

The Research Subcommittee discussed the proposed reference service list and vignettes from the specialty societies. **The Research Subcommittee approved the reference service list and vignettes as proposed by the specialty societies.**

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE **Tab 76**
Research Subcommittee Conference Call
June 28, 2010

Members Present: Brenda Lewis, DO (Chair), Bibb Allen, MD, John Gage, MD, Sherry Barron-Seabrook, MD, Daniel Mark Siegel, MD

I. Specialty Society Requests for Review of Survey Instruments

Ultrasound of Extremity (7688X2)
American Podiatric Medical Association

At the April 2010 RUC Meeting 7688X2 *Ultrasound, extremity, nonvascular, real-time with image documentation; limited anatomic specific* was discussed. The RUC reviewed the direct practice expense inputs for 7688X1 and 7688X2 and edited the typical equipment used for each service. The RUC understands that 76882 is performed with mobile ultrasound, however the RUC was not able to come to a consensus regarding an invoice for the typical mobile ultrasound unit typically purchased by podiatry. The RUC recommends that AMA staff assist in facilitating this discussion between radiology, podiatry, and CMS. APMA discussed this recommendation with CMS representatives who agreed that they would accept practice expense data about this mobile ultrasound unit from a survey that was vetted through the RUC process, i.e. the Research Subcommittee. APMA submitted a proposed survey instrument. The Research Subcommittee reviewed it and made the following recommendations to the specialty society: 1.) Question 1 and 2 under Section 2 entitled Unit should be removed, 2.) Section 4 should be renamed to Model Number, 3.) Question 2 under section 4 currently titled State should be deleted.

The specialty indicated that they may want to include question 2 under Section 2 as verification of the specific model survey respondents report. The Subcommittee did not object to the specialty obtaining the price information for their data collection, however, this data will not replace the need for CMS to receive invoices to be used to price the ultrasound equipment. Further, the Subcommittee recommends that the specialty society review the Proposed Rule released on Friday, June 25, 2010 to learn the new requirements that CMS requires for submitting an invoice. Also, the Subcommittee stated that the specialty society could request Doctor Moran, Chair of the Practice Expense Subcommittee, to review the final survey instrument if the specialty society desires. **With these modifications and suggestions, the Research Subcommittee accepts the survey instrument as proposed by the specialty society.**

Special Stains (88312-88319)
College of American Pathology

At the October 2010 RUC Meeting, the RUC will be reviewing recommendations for Special Stains CPT Codes 88312 – 88319. AMA Staff received the following request from the College of American Pathologists to modify the pathology survey instrument to survey these services: At the June 2010 CPT meeting, the special stains codes 88312-88319 went through the revision process. These codes are part of the Harvard, High Volume screen like the 88300-88309 codes. Because these codes have only intra-service work, CAP recommends that the pre-service and post-service descriptions be removed and the following intra-service description be included on the pathology survey instrument for these services:

INTRA-SERVICE PERIOD
<u>The intra-service work may include (among other activities):</u>

- Perform microscopic evaluation of prepared material including control slide(s)
-Compare the preparation to current and/or prior specimens and reports
- Incorporate the special stain results, edit and sign-out the report

The Research Subcommittee recommends the specialty society's proposed modifications to the Pathology Survey Instrument for surveying the Special Stain Services.

II. Specialty Society Request for Presentation Review

Gastric Emptying Study (78264)
Society of Nuclear Medicine

In an effort to educate its members on the RUC survey process, the Society of Nuclear Medicine has developed a RUC Survey Power Point Presentation based on the standard RUC Survey Power Point Presentation that is posted to the RUC participant Website and requests approval of this presentation to post to their specialty society website with a voice-over presenter. The Research Subcommittee reviewed the specialty society's power point presentation and recommend that slides 32-43 should be removed as these slides were code specific and had the potential to influence survey respondents. Further, the Research Subcommittee recommends that the power point presentation be branded with the specialty society's logo and that the AMA logo and template be removed. The Research Subcommittee instructed the specialty society that if they would like to revise their presentation further, that the Subcommittee would be happy to review at their next conference call meeting which will be the week of November 8, 2010. The Research Subcommittee informed the specialty society that once the voice over presentation has been finalized, the Subcommittee would like to hear it before it is posted the specialty society website. **With these modifications and instructions, the Research Subcommittee accepts the power point presentation as proposed by the specialty society.**

Research Subcommittee Report **Tab 76**
August 10, 2010
RUC Policy of the Use of Median

The Research Subcommittee, after reviewing the *Final Rule* published on November 25, 2009, noted that CMS has requested to add data points to the Summary of Recommendation Form for the services included in the 2010 Five Year Review including: 5th percentile, 95th percentile and the geometric mean. The geometric mean, in mathematics, is a type of mean or average, which indicates the central tendency or typical value of a set of numbers. It is similar to the arithmetic mean, which is what most people think of with the word "average", except that the numbers are multiplied and then the *n*th root (where n is the count of numbers in the set) of the resulting product is taken. The geometric mean, like the arithmetic mean, takes into account all points of data for determining a point of central tendency, whereas the median excludes outliers when determining a point of central tendency. For this reason, the median is a more accurate measure of central tendency for survey sample sizes of 30 participants as compared to the mean.

The Research Subcommittee questioned CMS what was the rationale behind this decision. CMS representative, Edith Hambrick, MD, stated that these data points will provide CMS more information about the distribution of data from the survey respondents and will provide another measure of central tendency. At the April 2010 RUC Meeting, **The Research Subcommittee recommended that the 5th percentile, 95th percentile and the geometric mean be included on the Summary of recommendation forms and also would like to provide to CMS other central tendency points including: arithmetic mean and mode (including bimodal distribution, if applicable).**

The RUC has specific policy regarding the use of the median. This policy was developed in a meeting on November 12, 1991 between AMA Staff and four outside consultants (Allen Dobson, PhD – Vice President, Lewin/ICF; Monica Noether, PhD, Vice President, Abt Associates; Stephen Jencks, MD – HCFA and Daniel Dunn, PhD, Research Economist, Department of Health Policy Management, Harvard School of Public Health. At this meeting, it was recommended that:

> *In cooperation with AMA staff, specialty society staff will tabulate results and develop numerical and graphical summaries of results, focusing on rank order, specific values assigned, comparisons to key services (i.e. the Harvard standard versus a related family member) and the range of disagreement. A goal with be to move to uniformity of presentation formats across specialties.*
>
> *Use median results. Develop appropriate numerical or graphical summaries of variability for small groups. (Standard statistical measures of variability for small groups will not be valid.)*

This policy was presented to the Research Subcommittee and approved by the RUC at its February 1992 meeting. Although, per the request of CMS, these additional statistical data points will be made available during the RUC's deliberations for all codes identified in the 2010 Five Year Review at the October 2010 RUC Meeting, **the Research Subcommittee recommends to the RUC, that these additional points of statistical data will not impact the RUC Process in developing recommendations to CMS. Further, the Research Subcommittee recommends that the following language be added to the cover letter submitted with the 2010 Five Year Review Recommendations:**

In the November 25, 2009 *Final Rule,* CMS states, "For purposes of the Fourth Five-Year Review of work RVUs and in order to gain a better understanding of the distribution of data from surveys and other data sources submitted in support of work RVU refinements, we will require that the minimum/maximum values, the 5th, 25th, 50th (Median), 75th and 95th percentile be reported. In addition we will require reporting of the geometric mean. This is similar to the information currently reported for the specialty surveys, with some additional percentiles and the geometric mean being included. However, if the AMA RUC recommendation does not include the information discussed above we may reject the recommendation."

The RUC had multiple conversations regarding this request made by CMS, which included participation from AMA economists to better understand these additional statisical data points, specifically geometric mean. The RUC noted that the geometric mean is often used for a set of numbers whose values are meant to be multiplied together or are exponential in nature, such as data on adjustments of salary or interest rates of a financial investment. As this is not the case for survey respondents estimates of time, intensity and work RVUs, the RUC was perplexed why this statisical data point was being requested. Further the arithmetic and geometric means of a dataset can dramatically shift based on the presence of low or high data points while the median of a dataset is far more consistent despite the presence of outliers. For this reason, the RUC agrees that the median is a more accurate measure of central tendency as compared to the geometric or arithmetic mean.

The RUC also conducted a historical review of the use of median policy in the RUC process. This policy was developed in a meeting on November 12, 1991 between AMA Staff and four outside consultants (Allen Dobson, PhD – Vice President, Lewin/ICF; Monica Noether, PhD, Vice President, Abt Associates; Stephen Jencks, MD – HCFA and Daniel Dunn, PhD, Research Economist, Department of Health Policy Management, Harvard School of Public Health. At this meeting, it was recommended that:

> *In cooperation with AMA staff, specialty society staff will tabulate results and develop numerical and graphical summaries of results, focusing on rank order, specific values assigned, comparisons to key services (i.e. the Harvard standard versus a related family member) and the range of disagreement. A goal with be to move to uniformity of presentation formats across specialties.*
>
> *Use median results. Develop appropriate numerical or graphical summaries of variability for small groups. (Standard statistical measures of variability for small groups will not be valid.)*

This policy was presented to the Research Subcommittee and approved by the RUC at its February 1992 meeting.

After these discussions and historical review, **the RUC developed policy at the October 2010 meeting that these additional points of statistical data will not impact the RUC Process in developing recommendations to CMS.** Since 1992, the RUC has been using the same statistical data points to develop recommendations to CMS. To alter this process by using other inappropriate statistical measurements would create a different metric of review and disrupt many of the current values within the RBRVS which have been evaluated through the RUC process and are based on magnitude estimation. **Although the additional information has been provided for the Fourth Five-Year Review Recommendations at the request of CMS, the RUC requests that CMS not utilize these additional statistical data points in their development of work RVUs.**

AMA/Specialty Society RVS Update Committee **Tab 77**
Professional Liability Insurance Workgroup
August 2, 2010 Conference Call

Members Present: Doctors Sandra Reed (Chair), Charles Koopmann (Vice Chair), David Hitzeman, William Gee, Stephen Kamenetzky, Robert Kossmann, Scott Manaker, Margaret Neal, Peter Smith, James Waldorf

New/Revised gap fill utilization
The Workgroup discussed the current ambiguity surrounding the methodology that CMS uses to gap fill utilization for new/revised codes. Beginning in 2005, the RUC asked specialties to provide an appropriate crosswalk from an existing code with a similar work RVU and specialty mix to be used to assign a temporary PLI RVU to the new code. The RUC assumed that CMS was utilizing this information until recent analysis indicated that the resulting PLI RVUs for many new codes bore no relationship to the recommended crosswalks.

The RUC believed that CMS was using an analytic crosswalk based on utilization for new/revised codes PLI crosswalks. There were two primary reasons for this assumption. First, in the final contractor report for the 2010 Five-Year Review of PLI RVUs the contractor mentions, when discussing the process for updating new or revised CPT codes, "CMS provided an analytical crosswalk for the revised CPT codes which allow mapping of specialties, RVUs, and MTUS for these procedures." Second, CMS also uses the term "analytic crosswalk" in the 2011 NPRM to describe the list they will publish in the Final Rule for determining their malpractice RVUs.

AMA staff has clarified from CMS, however, that CMS is using the RUC recommended crosswalk to review and develop PLI RVUs. CMS takes specialty utilization mix, not work RVUs, as the primary factor when determining an appropriate PLI crosswalk. When an existing code is surveyed, the PLI crosswalk will always be itself unless the specialty indicates that the specialty utilization mix is changing. In these situations, a new crosswalk will need to be determined. For new/revised codes or existing codes in which the utilization specialty mix will change, CMS compares the RUC recommended crosswalk to the new code and accounts for risk of service by adjusting for differences in the work RVUs between the two codes. Here is an example:

Code	Work RVU	PLI RVU
RUC Crosswalk	9.80	0.50
New Code	10.00	**0.51***

***New Code PLI RVU is determined by:**

1). Finding the percent difference between the two work RVUs
10.00 – 9.80 = 0.20
0.20/9.80 = 2.04%
Percent difference = 2.04%

2). Adding the percent difference to the PLI RVU of the RUC Crosswalk
0.50 x 2.04% = .0102
0.50 + .0102 = 0.51
New Code PLI RVUs = 0.51

2011 New/Revised PLI Crosswalk Submission to CMS

In light of the CMS methodology clarification, AMA staff revised the 2011 New/Revised PLI Crosswalk submission originally sent to CMS in May 2010. The spreadsheet crosswalks all existing codes in which the specialty mix is not changing to the existing CPT code and makes some adjustments to new or substantively revised CPT codes to account for the specialty utilization mix. The revised submission is attached to this report.

Changes to SOR and Specialty Instructions

To improve the PLI crosswalk collection process, the PLI Workgroup recommends that the following changes to the Instructions for Specialty Societies Developing Work Value Recommendations and the PLI Crosswalk section of the SOR be adopted by the RUC.

Specialty Society Instruction Document Changes:

Professional Liability Insurance Information

The primary determining factor CMS uses to establish PLI crosswalks is specialty utilization mix. To establish the PLI crosswalk, specialty societies must determine whether the surveyed code is: 1) an existing CPT code and is retaining the same specialty mix or 2) a new/revised or existing CPT code with a specialty mix that will change. To determine an existing CPT code's specialty mix consult the Medicare claims data found in the RUC database.

Existing CPT Codes and retaining the same specialty mix

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the current CPT code number as the PLI crosswalk.

New/Revised or Existing CPT Codes with specialty mix that will change
New and revised CPT codes are temporarily assigned a professional liability insurance (PLI) relative value based on CMS staff analysis of an appropriate crosswalk. If the surveyed code is a new/revised or an existing code in which the specialty utilization mix will change as a result of the CPT revision, select another crosswalk based on a similar specialty mix.

~~New and revised CPT codes are temporarily assigned a professional liability insurance (PLI) relative value based on CMS staff analysis of an appropriate crosswalk. The crosswalk should represent a code with a similar work RVU or other appropriate measure and be performed by the same specialty. The RUC has agreed that specialty input into this crosswalk is important and is providing that opportunity by including a section on the Summary of Recommendation Form to specifically collect this information. Please complete this section of the Summary form with your specialty RVS committee.~~

~~Surgical risk factors are applied to services in the surgery section of CPT, codes 10000-69999, and the non-surgical risk factor is applied to all other codes. A few exceptions are made to this general principal. In the November 2, 1999, November 1, 2000, November 15, 2004 and November 21, 2005, *Final Rules*, CMS acknowledged that certain codes in the "non-surgical" section of CPT may indeed be invasive and, therefore, be valued based on the surgical risk factor. CMS changed the risk factor to surgical for the cardiology catheterization, angioplasty and electrophysiology codes (92973-92975, 92980-92998, 93501-93536, 93600-93613, 93618-93641, 93580-93581, and 93650-93652). In the case of OB/GYN services, the higher obstetric premiums and risk factors were used for services that were obstetrical services, while the lower gynecology risk factor was used for all other services.~~

Summary of Recommendation (SOR) Changes:

Professional Liability Insurance Information (PLI)

~~Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (i.e. similar work RVU and specialty) []~~
If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number [ ]

~~If no, please select another crosswalk and provide a brief rationale.~~
If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix [ ]

~~Indicate what risk factor the new/revised code should be assigned to determine PLI relative value [ ]~~

Use of PPI and/or HCPAC submitted premium data for non-MD/DO professionals without contractor collected data

The Workgroup discussed the need to have CMS accept actual premium data for non-MD/DO professional specialties rather than their current methodology of crosswalking them to the lowest specialty risk factor (Allergy Immunology). In 2009, the RUC submitted premium data obtained from the PPI survey showing that these specialties' average PLI premiums are much less than all other specialties. **The Workgroup agreed that the comment letter should again include a request that CMS use actual premium cost data for non-physician specialties.**

Surgical Premium Methodology

CMS continues to base PLI premiums for eight specialties on the major premium level, causing an inappropriate shift in dollars from higher risk services to lower risk services. In March 2010, the PLI Workgroup submitted a letter to CMS outlining the effects of this crosswalk methodology. **The Workgroup agreed that the comment letter should again include a request for CMS to review the contractor report information along with the average specialty case mix to determine an accurate average premium level for these specialties.**

AMA/Specialty Society RVS Update Committee
Financial Disclosure Review Workgroup
August 2010 – via e-mail

Members Present: Doctors David Hitzeman (Chair), Dale Blasier, Michael Bishop, Emily Hill, PA-C, and George Williams.

The Financial Disclosure Review Workgroup reviewed the submission of two financial disclosure forms submitted for the September 29-October 3, 2010 RUC meeting.

Tab 44 Urology Procedures
Doctor Robert L. Harris, American Urogynecologic Society, initially submitted a financial disclosure. However, ACOG subsequently withdrew Doctor Harris as a presenter so no further action is required.

Tab 52 Psychotherapy
Mary Moller, DNP, American Psychiatric Nurses Association, disclosed the following financial interest "Astra Zeneca Pharmaceuticals – speaker's bureau for Seroquel in 2008 and 2009, ended the contract 12/31/2009, greater than $10,000." The Review Workgroup determined that there was no conflict for Ms. Moller to present this tab because the codes to be presented are psychotherapy without medication management.

American College of Surgeons

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e-mail: postmaster@facs.org ACS Web site: www.facs.org

September 18, 2010

Barbara Levy, MD
Chair, AMA/Relative Value Update Committee
American Medical Association
515 N. State St.
Chicago, IL 60610

RE: Agenda Items for Other Business

Dear Dr. Levy,

On behalf of the American College of Surgeons, I would like to add two issues for discussion under "other business" for the upcoming RUC meeting in October 2010. The first issue relates to assignment of discharge management work for procedure codes that have a 10-day or 90-day global period. The second issue relates to the use of 50% as typical for the site-of-service screen.

Discharge Service Code Assignment

"Outpatient" in the Medicare database can refer to patients who are discharged on the same-day or discharged on a day other than the day of a procedure or service. This is important with respect to assignment of a discharge management code for codes that have a 10-day or 90-day global period.

Historically, the RUC has used 0.5 x 99238 as a proxy for same-day outpatient discharge. The rationale for this reduction was that there would be overlap of work during the period after skin-to-skin and before the patient leaves the hospital or ASC on the same day. Alternatively, if a patient is admitted to a hospital overnight or longer (whether inpatient or observation), because they cannot be safely discharged home on the same day, then the discharge work on a subsequent day would include all discharge work (ie, no overlap with immediate post-service work).

The CPT manual discussion for hospital discharge services and observation care discharge services include: final examination of the patient, discussion of the hospital stay, instructions for continuing care, and preparation of discharge records. Independent of the status assigned (ie, observation or inpatient), the elements of discharge are the same and do not include overlapping work from the previous day. Further, the RUC and CMS have agreed that 99238 (hospital discharge) and 99217 (observation discharge) represent the same physician work (work RVU = 1.28).

We request the RUC formally adopt 0.5 x 99238 (or 0.5 x 99217) for same-day discharge and 1.0 x 99238 (or 1.0 x 99217) for discharge on a day subsequent to the day of a procedure.

Fifty Percent Rule for Site-of-Service Screen

In October 2006, the RUC 5-Year-Review Identification Workgroup identified the "site-of-service" screen as an objective measure to identify potentially misvalued codes. The screen was implemented immediately and required review of any code that included hospital inpatient visits and where Medicare data indicated less than 50% inpatient status. Since that time, there have been discussions at the RUC and between CMS and other stakeholders regarding: 1) the Medicare database; 2) the typical patient (Medicare versus non-Medicare); and 3) assignment of status (inpatient versus outpatient).

Discussions over the four years since implementation of the site-of-service screen have uncovered a number of issues. Most importantly, that the "admitting status" assignment is important to everyone:

- *Patients* may be burdened with significant expenses related to observation status, including additional co-payments, payment for self-administered medication, and denial for follow-up skilled nursing facility care.
- *Facilities* may be burdened with reduced payments or fines for assigning inpatient status to patients that the InterQual program deems unacceptable – sometimes days after the patient has left the facility.
- *Providers* may be burdened with justifying work performed in a hospital for post-surgical patients.

We have also learned that overall site-of-service distribution (inpatient, outpatient, office) can vary from year to year due to: changes in CPT codes; changes in technology; changes in treatment protocols; and/or changes in patient over-all health (eg, co-morbidity). With this in mind, we believe the absolute percentage for "typical" for the site-of-service screen should be reduced to 45% or less inpatient status. We also believe a code should be consistently below this percentage for at least three full years of data before requiring review and action. As justification, we note that at this current RUC meeting, several codes have been surveyed that were identified through the site-of-service screen using "preliminary" 2009 data, only to find that final data for 2009 shows greater than 50% inpatient status.

We request the RUC consider modifying the criteria for the site-of-service screen going forward to require three complete years of consecutive data showing 45% or less inpatient before requiring review of a code under that screen.

Thank you for your consideration of this request to place these two issues under "other business" at the upcoming RUC meeting.

Sincerely,

Christopher Senkowski, MD, FACS
RUC Advisor, American College of Surgeons

4th Five Year Review RUC Recommendations Physician Time File

CPT Code	Pre-Service Evaluation	Pre-Service Positioning	Pre-Service Scrub Dress & Wait	Intra-Service	Immediate Post Service	_99291	_99292	_99231	_99232	_99233	_99238	_99239	_99212	_99213	_99214	_99215	Total Time
10140	17	3	5	15	10								1				66
10160	7	3	5	10	10								1				51
11732		1	1	10	3												15
11765	17	1	5	15	5								1				59
12031	7	1	5	20	7								1				56
12032	8	1	5	30	8								1				68
12034	8	1	5	45	10								1				85
12035	11	3	5	60	10						0.5		1				124
12036	13	3	5	75	12						0.5		1				143
12037	13	3	5	90	12						0.5		1				158
12041	8	1	5	21	8								1				59
12042	8	1	5	30	9								1				69
12044	8	1	5	45	10								1				85
12045	10	3	5	60	11						0.5		1	1			147
12046	13	3	5	80	13						0.5		1	1			172
12047	13	3	5	100	15						0.5		1	1			194
12051	8	1	5	20	8								1				58
12052	8	1	5	30	10								1				70
12053	8	1	5	40	10								1				80
12054	12	3	5	50	10								1				96
12055	13	3	5	70	13						0.5		1	1			162
12056	13	3	5	85	13						0.5		1	1			177
12057	13	3	5	100	15						0.5		1	1			194
13100	17	1	5	35	16								1				90
13101	17	1	5	56	18								1				113
15120	40	12	20	75	25			1			1		1	2			292
15121				30													30
15260	17	1	10	100	30									5			273
15732	40	12	20	150	30			1	1	1	1		1	2	1		507
17250	5	2		5	5												17
17260	7		2	16	5								1				46
17261	7		2	17	5								1				47
17262	7		2	20	5								1				50
17263	7		2	26	5								1				56
17264	7		2	34	5								1				64
17266	7		2	37	5								1				67
17270	7		2	15	5								1				45
17271	7		2	19	5								1				49
17272	7		2	22	5								1				52
17273	7		2	26	5								1				56
17274	7		2	32	5								1				62
17276	7		2	40	5								1				70

4th Five Year Review RUC Recommendations Physician Time File

CPT Code	Pre-Service Evaluation	Pre-Service Positioning	Pre-Service Scrub Dress & Wait	Intra-Service	Immediate Post Service	_99291	_99292	_99231	_99232	_99233	_99238	_99239	_99212	_99213	_99214	_99215	Total Time
17280	7		2	15	5								1				45
17281	7		2	17	5								1				47
17282	7		2	25	5								1				55
17283	7		2	30	5								1				60
17284	7		2	36	5								1				66
17286	7		2	48	5								1				78
19302	40	3	15	100	20						0.5		1	1	1		276
22520	30	15	15	45	30						0.5			1			177
22521	30			75	30						0.5			1			196
22523	30	15	15	58	20						0.5			1			199
22524	30	15	15	55	20						0.5			1			196
25600	7			15	10								5				112
25605	14	1	5	30	20						0.5		4	1			176
27385	33	9	15	60	20			1			1		3	1			266
27530	7	2		15	10								4				98
28002	30	3	15	30	20						0.5			2			163
28003	33	3	15	53	20			1	1		1		2	3			323
28285	30	3	15	30	15						0.5		2	2			190
28715	40	3	15	125	30			1			1		2	4			395
28820	33	10	15	30	20			1			1		2	2			244
29125	7			15	5												27
29126	7			30	5												42
29405	7			15	5												27
29425	7			15	5												27
29515	7			15	5												27
29826	33	12	15	60	20						0.5		2	2			237
32405	19	1	5	30	20												75
32851	80	30	30	240	90	3	1	1	3	3		1			1	1	1165
32852	80	30	30	300	90	3	1	1	4	4		1			1	1	1320
32853	80	20	30	375	90	3	1	1	4	5		1			1	1	1440
32854	80	20	30	400	90	3	1	1	6	6		1			1	1	1600
33030	40	3	20	180	45	2	0	1	2	2	1			1	1		739
33031	40	3	20	205	48	2	0	1	2	3		1		1	1		839
33120	40	3	20	205	60	1	0	1	2	2	1				1		686
33315	40	3	20	180	60	1	0	1	1	2	1				1		621
33411	60	15	20	283	40	2		1	4	4	1			1	1		1059
33412	40	3	20	300	60	2	0	1	1	3	1				1		866
33468	40	3	20	240	60	2	0	1	1	3	1				1		806
33645	40	3	20	175	45	1	0	1	1	1	1				1		546
33647	40	3	20	180	53	1	0	1	1	2	1				1		614
33692	40	3	20	218	60	1	0	3	2	1	1				1		684
33710	40	3	20	200	60	2	0	1	1	1	1				1		656

4th Five Year Review RUC Recommendations Physician Time File

CPT Code	Pre-Service Evaluation	Pre-Service Positioning	Pre-Service Scrub Dress & Wait	Intra-Service	Immediate Post Service	_99291	_99292	_99231	_99232	_99233	_99238	_99239	_99212	_99213	_99214	_99215	Total Time
33875	50	30	20	240	60	3	0	1	2	3		1		1	1		976
33910	40	3	20	190	60	3	0	1	2	3	1			1	1		889
33916	40	3	20	360	60	3	1	2	3	5	1			1	1		1259
33935	80	20	60	380	90	3	1	1	8	6		1		1	1	1	1713
33975	60	15	20	180	120												395
33976	60	15	20	240	120												455
33979	60	15	20	280	120												495
33981	60	15	20	120	60												275
33982	60	15	20	290	90												475
33983	60	15	20	345	120												560
35188	40	3	20	150	30			1	1		1		1	1			380
35612	40	5	20	180	40			1	2		1		1	2			485
35800	30	3	5	60	30			1	1	1	1		2	1			336
35840	30	3	5	60	30			1	2	2	1		2	1			431
35860	30	3	5	60	30			1	2	1	1		2	1			376
36470	10			15	5								1				46
36471	16			30	10								1				72
36600	5			10	5												20
36819	40	5	20	130	25			1			1		1	1			317
37140	40	3	20	240	60	2	0	3	3	1	1			3			845
37145	40	3	20	233	60	2	0	3	2	1	1			3			798
37160	40	3	20	220	60	2	0	3	2	1	1			3			785
37180	40	3	20	240	60	2	0	3	2	1	1			3			805
37181	40	3	20	270	60	1	0	2	3	1	1			3			785
43262	15	5	5	45	20												90
43415	40	20	20	180	60	3	0	1	2	1	1		1	1	2		842
45331	13	1	1	15	10												40
47000	19	1	5	20	15												55
47563	40	10	15	90	25						1		1	1			257
47564	40	10	15	120	30			1	2		1		1	2			415
51705	7	5		10	10												32
51710	7	10		15	15												47
52005	19	5	5	30	20												79
52007	19	5	5	32.5	20												81.5
52310	7	5		40	20												72
52315	19	5	5	45	20												94
52630	33	5	15	60	25			1			1		2	1			251
52640	33	5	15	30	20						0.5		1	2			184
52649	33	5	15	120	25						1		1	2			298
53440	33	7	15	90	22						1		1	2			267
57287	33	7	15	60	20						0.5		1	3			239
57288	33	7	15	60	27						0.5		1	3			246

4th Five Year Review RUC Recommendations Physician Time File

CPT Code	Pre-Service Evaluation	Pre-Service Positioning	Pre-Service Scrub Dress & Wait	Intra-Service	Immediate Post Service	_99291	_99292	_99231	_99232	_99233	_99238	_99239	_99212	_99213	_99214	_99215	Total Time
60220	40	12	20	90	30			1			1			2			296
60240	40	12	20	150	30			1			1			2			356
60500	40	12	20	120	30			1			1		1	2			342
62284	13	5	6	15	10												49
63655	33	15	15	90	20						1		1	2			273
64405	7			5	10												22
69220	5	1		10	2												18
78264	5			12	5												22
92511	6		5	5	5												21
92950	2	1		45	30												78
93321				10													10
94660	10			20	10												40
99218	10			30	10												50
99219	10			40	14.5												64.5
99220	15			45	15												75
99234	10			60	15												85
99235	10			75	15												100
99236				110													110
99315	10			20	10												40
99316	14			25	15												54
99381	5			20	5												30
99382	7			20	5												32
99383	6			20	5												31
99384	8			25	7												40
99385	10			30	10												50
99386	10			40	10												60
99387	10			40	15												65
99391	4			17	5												26
99392	5			20	5												30
99393	4.5			20	5												29.5
99394	5			25	5												35
99395	5			30	10												45
99396	5			30	11												46
99397	5			30	10												45
99460	10			30	10												50
99462	5			10	5												20
99463	5			35	15												55

Summary of Direct Practice Expense Changes
RUC Recommendations for 2010 Five Year Review

Previous Recommendation											Current Recommendation										Change in Practice Expense Components							
CPT Code	Clinical Labor Assist Time	Intra-Service Time	99238	99239	99211	99212	99213	99214	99215		Clinical Labor Assist	Intra-Service Time	99238	99239	99211	99212	99213	99214	99215		Intra Service Change in Clinical Labor Time	99238	99239	99211	99212	99213	99214	99215
10140	12	16				1					11	15				1					-1							
10160	7	11				1					6	10				1					-1							
11732	13	20									7	10									-6							
11765	16	24				1					10	15				1					-6							
12031	18	24				1					15	20				1					-3							
12032	38	38				1					30	30				1					-8							
12034	35	52				1					30	45				1					-5							
12035	68	68				1					60	60	0.5			1					-8	0.5						
12036	84	84				1					75	75	0.5			1					-9	0.5						
12037	102	102				1					90	90	0.5			1					-12	0.5						
12041	18	27				1					14	21				1					-4							
12042	27	40				1					20	30				1					-7							
12044	37	56				1					30	45				1					-7							
12045	75	75				1					60	60	0.5			1	1				-15	0.5				1		
12046	90	90				1					80	80	0.5			1	1				-10	0.5				1		
12047	111	111				1					100	100	0.5			1	1				-11	0.5				1		
12051	16	24				1					13	20				1					-3							
12052	17	28				2					18	30				1					1				-1			
12053	33	49				1					27	40				1					-6							
12054	44	66				1					33	50				1					-11							
12055	59	89				1					46	70	0.5			1	1				-13	0.5				1		
12056	71	106				1					57	85	0.5			1	1				-14	0.5				1		
12057	87	131				1					66	100	0.5			1	1				-21	0.5				1		
13100	22	33				1					23	35				1					1							
13101	35	53				1					37	56				1					2							
15120	102	102	1				4				75	75	1			1	2				-27				1	-2		
15121	64	64									30	30									-34							
15260	92	92					5				100	100					5				8							
15732	150	150	1				4				150	150	1			1	2	1			0				1	-2	1	
17250	4	6									3	5									-1							
17260	8	13				1					10	16				1					2							
17261	10	16				1					11	17				1					1							
17262	11	15				1					15	20				1					4							
17263	15	25				1					15	26				1					0							
17264	20	33				1					21	34				1					1							
17266	22	37				1					22	37				1					0							
17270	9	15				1					9	15				1					0							
17271	11	18				1					12	19				1					1							
17272	12	22				1					12	22				1					0							
17273	13	25				1					14	26				1					1							
17274	20	32				1					20	32				1					0							
17276	23	40				1					23	40				1					0							
17280	8	13				1					9	15				1					1							

Summary of Direct Practice Expense Changes
RUC Recommendations for 2010 Five Year Review

Previous Recommendation											Current Recommendation									Change in Practice Expense Components							
CPT Code	Clinical Labor Assist Time	Intra-Service Time	99238	99239	99211	99212	99213	99214	99215		Clinical Labor Assist	Intra-Service Time	99238	99239	99211	99212	99213	99214	99215	Intra Service Change in Clinical Labor Time	99238	99239	99211	99212	99213	99214	99215
17281	12	14				1					15	17				1				3							
17282	15	25				1					15	25				1				0							
17283	20	34				1					18	30				1				-2							
17284	26	43				1					22	36				1				-4							
17286	28	48				1					28	48				1				0							
19302	NA	109	1			3.5					NA	100	0.5			1	1	1		NA	-0.5			-2.5	1	1	
22520	45	45	1				1				45	45	0.5				1			0	-0.5						
22521	75	75	1				1				75	75	0.5				1			0	-0.5						
22523	58	58	1				1				58	58	0.5				1			0	-0.5						
22524	55	55	1				1				55	55	0.5				1			0	-0.5						
25600	25	25				3					15	15				5				-10				2			
25605	35	35					4.5				30	30	0.5			4	1			-5	0.5			4	-3.5		
27385	NA	66	1			3.5					NA	60	1			3	1			NA				-0.5	1		
27530	33	33	1			4					15	15				4				-18	-1						
28002	60	60	1				3				30	30	0.5				2			-30	-0.5				-1		
28003	52	52	1			3.5					53	53	1			2	3			1				-1.5	3		
28285	31	31				3.5					30	30	0.5			2	2			-1	0.5			-1.5	2		
28715	NA	130	1				4				NA	125	1			2	4			NA				2			
28820	42	42	1			3.5					30	30	1			2	2			-12				-1.5	2		
29125	15	21									11	15								-4							
29126	15	25									18	30								3							
29405	15	27									8	15								-7							
29425	20	28									11	15								-9							
29515	15	22									10	15								-5							
29826	NA	95				3.5					NA	60	0.5			2	2			NA	0.5			-1.5	2		
32405	NA	35									NA	30								NA							
32851	NA	360					2	3	3		NA	240		1				1	1	NA		1			-2	-2	-2
32852	NA	390					3	3	4		NA	300		1				1	1	NA		1			-3	-2	-3
32853	NA	480					2	3	3		NA	375		1				1	1	NA		1			-2	-2	-2
32854	NA	480					2	4	4		NA	400		1				1	1	NA		1			-2	-3	-3
33030	NA	179	1					2			NA	180	1				1	1		NA					1	-1	
33031	NA	186	1					1			NA	205		1			1	1		NA	-1	1			1		
33120	NA	191	1					2			NA	205	1					1		NA						-1	
33315	NA	163	1					2			NA	180	1					1		NA						-1	
33411	NA	283									NA	283								NA							
33412	NA	300		1	1	1	1	1			NA	300	1					1		NA	1	-1	-1	-1	-1		
33468	NA	228	1					2			NA	240	1					1		NA						-1	
33645	NA	185	1					2			NA	175	1					1		NA						-1	
33647	NA	240						2			NA	180	1					1		NA	1					-1	
33692	NA	390						2			NA	218	1					1		NA	1					-1	
33710	NA	240					1	1			NA	200	1					1		NA	1				-1		
33875	NA	300	1				2				NA	240		1			1	1		NA	-1	1			-1	1	
33910	NA	186	1					2			NA	190	1				1	1		NA					1	-1	

Summary of Direct Practice Expense Changes
RUC Recommendations for 2010 Five Year Review

Previous Recommendation											Current Recommendation									Change in Practice Expense Components							
CPT Code	Clinical Labor Assist Time	Intra-Service Time	99238	99239	99211	99212	99213	99214	99215		Clinical Labor Assist	Intra-Service Time	99238	99239	99211	99212	99213	99214	99215	Intra Service Change in Clinical Labor Time	99238	99239	99211	99212	99213	99214	99215
33916	NA	230	1					2			NA	360	1				1	1			NA					1	-1	
33935	NA	360							3		NA	380		1			1	1	1		NA		1			1	1	-2
33975	NA	330									NA	180									NA							
33976	NA	360									NA	240									NA							
33979	NA	410									NA	280									NA							
33981	NA	NA										120									NA							
33982	NA	NA										290									NA							
33983	NA	NA										345									NA							
35188	NA	140	1			3.5					NA	150	1			1	1				NA				-2.5	1		
35612	NA	167	1			3.5					NA	180	1			1	2				NA				-2.5	2		
35800	NA	66	1			2.5					NA	60	1			2	1				NA				-0.5	1		
35840	NA	103	1			3					NA	60	1			2	1				NA				-1	1		
35860	NA	71	1			2.5					NA	60	1			2	1				NA				-0.5	1		
36470	15	13			0.5						17	15				1				2			-0.5	1			
36471	28	24				1.5					35	30				1				7				-0.5			
36600	NA	8									NA	10								NA							
36819	NA	120	1			1	1				NA	130	1			1	1			NA							
37140	NA	200	1			3.5					NA	240	1				3			NA				-3.5	3		
37145	NA	181	1			3.5					NA	233	1				3			NA				-3.5	3		
37160	NA	205	1			3.5					NA	220	1				3			NA				-3.5	3		
37180	NA	212	1			3.5					NA	240	1				3			NA				-3.5	3		
37181	NA	226	1			3.5					NA	270	1				3			NA				-3.5	3		
43262	NA	75									NA	45								NA							
43415	NA	150	1			1	2	1			NA	180	1			1	1	2		NA					-1	1	
45331	18	18									15	15								-3							
47000	10	26									8	20								-2							
47563	NA	143	1			2.5					NA	90	1			1	1			NA				-1.5	1		
47564	NA	112	1			1					NA	120	1			1	2			NA					2		
51705	4	11				0.5					4	10								0				-0.5			
51710	12	26				0.5					7	15								-5				-0.5			
52005	20	31									19	30								-1							
52007	22	45									16	32.5								-6							
52310	10	24									17	40								7							
52315	29	43									30	45								1							
52630	NA	49	1				1.5				NA	60	1			2	1			NA				2	-0.5		
52640	25	30				2					25	30	0.5			1	2			0	0.5			-1	2		
52649	NA	180	1			1	2				NA	120	1			1	2			NA							
53440	NA	100	1				4				NA	90	1			1	2			NA				1	-2		
57287	NA	60				1	3				NA	60	0.5			1	3			NA	0.5						
57288	NA	60	1			1	2				NA	60	0.5			1	3			NA	-0.5				1		
60220	NA	90	1			1	1				NA	90	1				2			NA				-1	1		
60240	NA	159	1		1	1					NA	159	1				2			NA			-1	-1	2		
60500	NA	138	1			3					NA	120	1			1	2			NA				-2	2		

Summary of Direct Practice Expense Changes
RUC Recommendations for 2010 Five Year Review

Previous Recommendation											Current Recommendation										Change in Practice Expense Components							
CPT Code	Clinical Labor Assist Time	Intra-Service Time	99238	99239	99211	99212	99213	99214	99215		Clinical Labor Assist	Intra-Service Time	99238	99239	99211	99212	99213	99214	99215		Intra Service Change in Clinical Labor Time	99238	99239	99211	99212	99213	99214	99215
62284	16	25									10	15									-6							
63655	NA	90	1			1	2				NA	90	1			1	2				NA							
64405	6	12									3	5									-3							
69220	11	11									10	10									-1							
78264	NA	20									NA	12									NA							
92511	20	20									5	5									-15							
92950	25	51									22	45									-3							
93321	NA	15									NA	10									NA							
94660	NA	43									NA	20									NA							
99218	NA	40									NA	30									NA							
99219	NA	67									NA	40									NA							
99220	NA	90									NA	45									NA							
99234	NA	60									NA	60									NA							
99235	NA	75									NA	75									NA							
99236	NA	110									NA	110									NA							
99315	NA	15									NA	20									NA							
99316	NA	30									NA	25									NA							
99381	6	20									6	20									0							
99382	6	25									5	20									-1							
99383	6	30									4	20									-2							
99384	6	30									5	25									-1							
99385	6	30									6	30									0							
99386	6	40									6	40									0							
99387	6	45									5	40									-1							
99391	5	20									4	17									-1							
99392	5	20									5	20									0							
99393	5	20									5	20									0							
99394	5	25									5	25									0							
99395	5	25									6	30									1							
99396	5	30									5	30									0							
99397	5	35									4	30									-1							
99460	NA	25									NA	30									NA							
99462	NA	15									NA	10									NA							
99463	NA	20									NA	35									NA							

Physician Time for CPT 2012 - October 2010							
CPT Code	Pre-Service Evaluation	Pre-Service Positioning	Pre-Service Scrub, Dress, and Wait	Intra-Service	Immediate Post Service	99212	99213
10060	8	3	5	15	10	1	
10061	8	3	5	25	10	2	
16020	7			15	5		
16025	10	3	5	20	5		
20600	5	1	5	5	5		
20605	5	1	5	5	5		
20610	5	1	5	5	5		
67210	10	5	2	15	5		3
67220	15	5	3.5	15	10		3
88104				24			
88106				16			
88108				19			
88329				21			
88331				25			
88332				16			
92960	15	1	5	15	15		
2958X2	4			12	2		
2958X3	4			10	2		
2958X4	4			12	2		
4908X1	13	1	6	20	10		
4908X2	15	5	5	25	10		
4908X3	15.00	3.00	5.00	20	15		

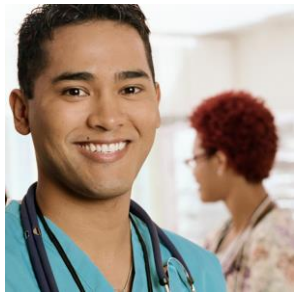
RUC Chair Report

September 30, 2010

Chicago, IL

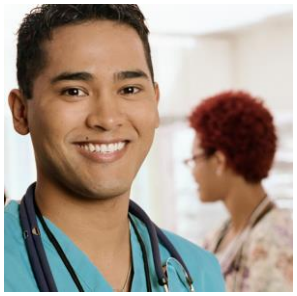
AMA

TOGETHER WE ARE STRONGER



CMS Representatives

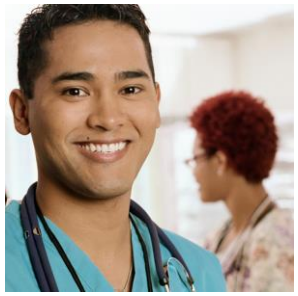
- Edith Hambrick, MD – CMS Medical Officer
- Ken Simon, MD – CMS Medical Officer
- Ryan Howe
- Ferhat Kassamali



CPT Editorial Panel

- Jeffrey Cozzens, MD



Observers

- David Chan, MD, MSc
  - Thesis-writing PhD candidate in economics at the Massachusetts Institute of Technology.
- Lori Housman
  - Principal Analyst in the Medicare Cost Estimate Unit of the Congressional Budget Office.
- 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.

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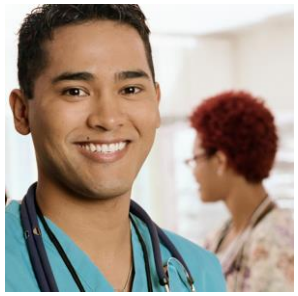
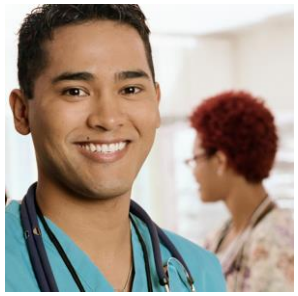


Welcome: New RUC Advisory Committee Specialty Societies

- American College of Mohs Surgery (ACMS)
  - Glenn Goldman, MD – Advisor
  - Brent Moody, MD – Alternate Advisor
- American Society of Interventional Pain Physicians (ASIPP)
  - David Caraway, MD, PhD – Advisor
- Heart Rhythm Society (HRS)
  - Christopher Jones, MD – Advisor
  - Kevin Wheelan, MD – Alternate Advisor

AMA

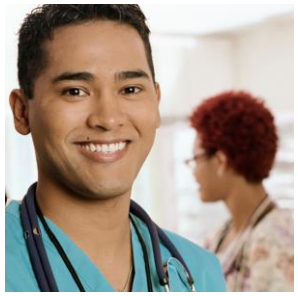


RUC Members - AAD

- Daniel Mark Siegel, MD
  - Last meeting as RUC member
  - Will continue as RUC Alternate
  - AAD President Elect (2011) and President (2012)
- Bruce Deitchman, MD
  - Moving from RUC Alt to RUC member Feb 2011

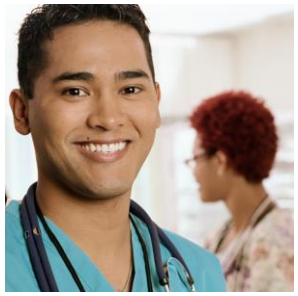


Congratulations!

- Christine Goertz-Choate, DC, PhD, American Chiropractic Association Alternate Advisor to the HCPAC and
- Robert M. Zwolak, Society for Vascular Surgery Alternate Advisor to the RUC and former RUC member
- They have each been appointed to a six year term on the Patient-Centered Outcomes Research Institute (PCORI) Board of Governors.

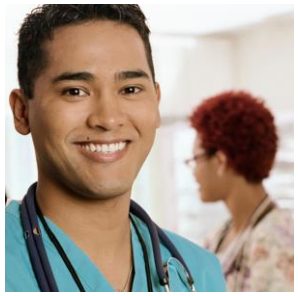


Financial Disclosure Review Workgroup Report

- Review the Workgroup's report
  - Tabs 44 Urology Procedures and 52 Psychotherapy
  - Vote

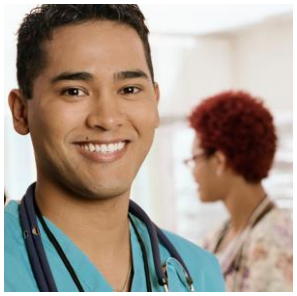


Research Subcommittee Reports
Tab 76

- May 26, 2010 Report – review of specialty society reference service lists and vignettes
- June 28, 2010 Report – review of survey instrument and instructional PowerPoint (Pathology)
- August 10, 2010 Report – RUC Policy on the Use of Median

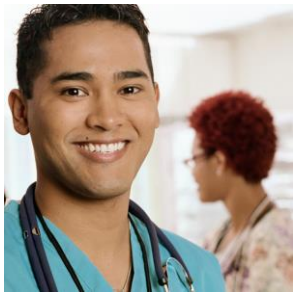


Reconsideration of 67028

- Brief RUC regarding reconsideration of 67028 (October 2009 RUC Review for CPT 2011)

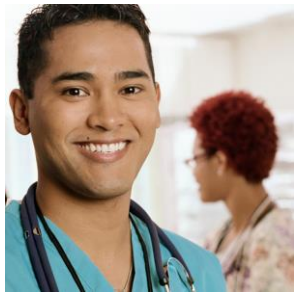


Confidentiality

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

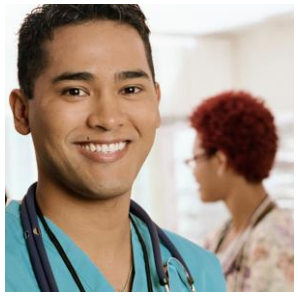


Procedural Issues

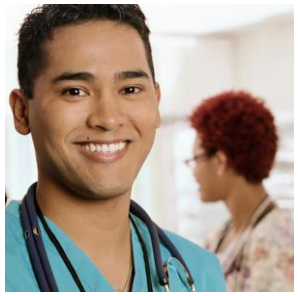
RUC Members:

- 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

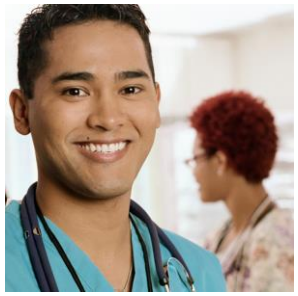
- Individuals exercise their independent judgment and are not advocates for their specialty



Always keep your RUC hat on

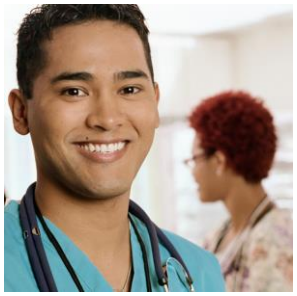
I am famous for my power red. Now we all have red RUC hats as reminders for us to use our collective power and wisdom to be fair, impartial and equitable as we do our work here.

Source: Logo from American Heart Association



"Always do right. This will gratify some people and astonish the rest."

--Mark Twain



- Test Clickers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Washington Update
September 30, 2010

Sharon McIlrath
Asst. Director, Federal Affairs

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Accountable Care Act Regulatory Aftermath

New Commissions

- Patient Centered Outcomes Research Institute
  - Two members of the RUC family won 6-year terms
  - AMA nominee Robert Zwolak, MD
  - Christine Goertz, DC
  - Chair is Eugene Washington, MD, UCLA Vice Chancellor
- National Health Care Workforce Commission
  - Expect appointments today

Tight Timelines

- Provisions Retroactive to 1-1-2010
  - 1-yr extension of work GPCI floor
  - 1-yr extension of 5% psychiatric services bonus
  - Bone density scan payment increase
  - Practice expense GPCI Changes
    - In 2010 and 2011, recognize only half of wage and rent differences; hold losers harmless.
    - CMS to conduct study and make budget neutral changes in 2012.
- Implemented for claims filed after 6-1-10
- Funds needed to adjust earlier claim
- AMA has registered concern with Congress and Administration; looking for anecdotes

Mid-Year 2010 Changes

- 2.2% CF increase
  - Part of Pension Relief Act not ACA
  - Signed into law 6-25-10/effective 6-10
- 50% cut in contiguous body part imaging
  - Effective 7-1-10

Health Insurance Reforms Effective 9-23-10

- Patient Protections
  - Prohibit: lifetime $ limits, recissions, prior auth for emergency care, including out-of-network care and pre-existing condition limits for kids
  - IFR issued 6-28; AMA wants plans to pay billed charge for out-of-network emergencies
- Coverage of Preventive Services
  - Requires coverage and no co-pays for mammograms, colonoscopies, cancer screenings, bp/cholesterol, weight and smoking counseling
  - IFR 7-19; AMA says require CPT codes and conventions so plans can't bundle preventive services into other codes.
- Appeals/External Review phased in from 9-23-10
  - IFR 7-23; AMA concerned that appeal based on insurer's definition of medical necessity.
- Also commented to CMS &/or NAIC on medical loss ratios, grandfathering and exchanges.
- See http://www.ama-assn.org/ama/pub/health-system-reform/resources/ama-comments-on-aca-regulations.shtml

2011 Physician Payment Provisions

- **GPCI Changes**
- Work GPCI floor expires
- PE GPCI floor for 5 frontier states (MT, WY, ND, SD, NV)
- ACA PE GPCI changes accelerated and supplemented by:
  - Increasing share of MEI & GPCI attributable to PE and PLI.
  - Disaggregating MEI & GPCI practice expense components
  - Regular 3-year GPCI changes (phased in over two years)
  - Combined impact is to decrease portion of the GPCI that varies by location from 42% to 29%. Most changes are less than 1% but some urban areas cut by up to 6% in 2011 alone
  - No additional modifications in 2012; however due to phase in of the regular three-year update, there will be some additional redistribution in 2012.
- Technical panel will look at whether the MEI reflects a modern medical practice.
- AMA had pushed for technical panel; thinks modifications in MEI and PE GPCIs should be delayed until panel issues findings.
- IOM is doing a study of the current payment localities and GPCIs.

ACA provisions in 2011 PFS NPRM

- General surgery and primary care bonus
  - 60% of primary care physicians allowable charges must be for designated visit codes.
  - Surgery must be performed in health professional shortage area.
  - AMA argued that CMS's definitions are too restrictive.
- Medicare preventive services
  - CMS created G codes; AMA says use RUC-Valued CPT codes and suggests additional services
- Multiple Procedure Payment Reductions
  - CMS went beyond ACA requirement; expanded services subject to the reductions to include any advanced imaging and/or ultrasound on same day and any therapy services on the same day.
  - AMA argues that there is little or no overlap when different modalities involved; address any problems through RUC.

Quality Provisions Of ACA

PQRI

- As AMA had advocated, PQRI reporting sample will be reduced from 80% to 50% of applicable cases for 2011.
- ACA requirements for more timely PQRI reports and informal appeals process have not been met.

ERx

- E-Rx reporting requirement will be reduced from 50% of all applicable services to 25 services.
- ACA requires penalties for non-ERx users in 2012-2014. AMA strongly opposing CMS proposal to base 2012 penalties on use of ER-x in first six months of 2011.

Value-Based Purchasing and Delivery System Reforms

- Center For Medicare and Medicaid Innovation—2011
- Shared Savings Plans–2012
- Value-Based Modifier—2015-2017

Center for Medicare and Medicaid Innovation

- Geisinger's Rick Gilfillan named acting director.
- ACA appropriated $10 billion over 10 years.
- Mandate to pursue new delivery & payment models.
- Act specifies some specific demos and pilots, including:
  - Medical home
  - Direct contracting
  - Geriatric assessment plans
  - Telehealth
  - Medication management
  - Community-based health teams
  - Comprehensive Payments to Health Care Innovation Zones

Shared Savings AKA ACOs

- Accountable Care Organization concept promoted by MedPAC
- Seen as hospitals and physicians working together to provide high-quality, efficient care.
- Modeled after the Physician Group Practice Demonstration where 10 large groups shared in any savings over a 2% threshold providing they met specified quality goals.
- ACA does not require that ACO include a hospital; must have primary care network with 5000 Medicare patients.
- Law also permits partial capitation and other payment arrangements.
- Proposed rule expected by the end of 2010.

Research and Demonstrations

- New ACA-mandated demos include Independence at home and bundling acute and post-acute care.
- Ongoing demos include bundling hospital and physician fee for orthopedic and cardiac procedures, previously mentioned PGP demo.
- CMS also has projects to improve risk adjusters and episode groupers in the works.

AMA: Steering through the Morass

- Regional seminars with consultants and physicians who have designed and/or participated in payment and delivery reforms.
- Multiple conversations with top officials at HHS, White House, DOJ and FTC.
- Participation in multitude of “listening sessions” where government has sought input on ACOs, episode groupers, data issues, geographic equity and legal impediments to reform.
- Goal is to ensure that physicians are not forced into large hospital-dominated networks in order to remain in business. Hope CMI will provide technological and financial aid that would help small practices get into the game.
- Believe that rules should allow practices to take transitional steps to better care coordination and make it possible for physicians to join together for this purpose without the threat of a visit from the FTC or the OIG.

Elephant in the Room: SGR

- Physicians are foundation of any successful delivery system.
- But Congress continues to avoid fixing the SGR.
- 23% cut coming on December 1; another 6.3% in January.
- Won't be addressed until lame duck Congress
- Not enough time then to address permanent reforms.
- Want to avoid the chaos of this year by stabilizing payments at least through the end of 2011.
- Even this will be an uphill battle; will remind physicians that they need to remember this year's experience when making par/non-par decision in Nov/Dec. Kits with calculators and patient letters.
- Bring permanent reform back to the forefront next year. Need physicians to flesh out the framework for reform agreed to by nearly all specialties in 2008.


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Value-Based Payment Modifier

- Viewed as way to redistribute money to regions with low Medicare spending.
- Widely-regarded as unworkable.
- Requires CMS to apply budget neutral value payment modifier that combines cost and quality measures.
- Begins in 2015 for specific physicians or groups of physicians; applicable to all by 2017.
- Expected to rely on physician feedback reports, which currently are being provided on a confidential basis to a relatively few physicians.
- Rely on episode groupers and have significant methodological issues.
- May never be feasible for all physicians; provision could be revised.
- .

The RUC Relativity Assessment Workgroup

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Why Change the Name from “Five Year Review Identification Workgroup”?

- Acronym doesn’t make sense (5YRIDWG?)
- Too long to pronounce frequently
- The review is now ongoing, not every 5 years
- Some thought it sounded like a prison term
- Doesn’t describe the work adequately (members felt that they weren’t valued appropriately)

New name—Relativity Assessment Workgroup

- Easy to remember—“RAW”, “RUC-RAW”, or “RAW/RUC”
- Relativity: It really might be rocket science!
- Assessment: Adequately describes what is done by the workgroup

The “Old” 5 Year Review Identification Workgroup

The New RAW?




Screens to Date

- Site of Service Anomalies
- High Volume Growth
- CMS Fastest Growing Procedures
- High IWPUT (intra-service work per unit of time)
- Services Surveyed by One Specialty and Now Performed by a Different Specialty
- Harvard Valued Codes
- Codes Inherently Performed Together
- New Technology Services




Summary of Recommendations to Date

- To date, the RAW Workgroup has identified 853 codes for review.
- Codes Completed – 622
  - Work and PE Maintained – 177
  - Work Increased – 34
  - Work Decreased – 221
  - Direct Practice Expense Reviewed – 114
  - Deleted from CPT – 76