AMA/Specialty RVS Update Committee
Meeting Minutes
October 2-4, 2008

I. Welcome and Call to Order

Doctor William Rich called the meeting to order on Thursday, October 2, 2008, at 9:00 am. The following RUC Members were in attendance:

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

*Alternate

II. Chair's Report

Doctor Rich made the following general announcements:

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

- Presenters are expected to announce any conflicts or potential conflicts, including travel reimbursement paid by an entity other than the specialty society, at the onset of their presentation.
- Before a presentation, any RUC member with a conflict must state their conflict and the Chair will rule on recusal.
- RUC members or alternates sitting at the table may not present or advocate on behalf of their specialty.
- All RUC Advisors are required to sign the attestation statement and submit it with their recommendations to be incorporated into the agenda book.

- Doctor Rich welcomed the CMS staff and representatives attending the meeting, including:
    - Edith Hambrick, MD, CMS Medical Officer
    - Whitney May, Deputy Director, Division of Practitioner Services
    - Ken Simon, MD, CMS Medical Officer
    - Pam West, PT, DPT, MPH, Health Insurance Specialist

- Doctor Rich welcomed the following Medicare Contractor Medical Director:
    - Charles Haley, MD

- Doctor Rich welcomed the following Medicare Payment Advisory Commission (MedPAC) staff
    - Kevin Hayes, PhD

- Doctor Rich welcomed the following Government Accountability Office (GAO) staff
    - Kelly Barar
    - Iola D'Souza
- Doctor Rich announced the members of the Facilitation Committees:

Facilitation Committee 1	Facilitation Committee 2	Facilitation Committee 3
Gregory Kwasny, MD (Chairman)	Bibb Allen, MD (Chairman)	Susan Spires, MD (Chairman)
James Anthony, MD	Joel Bradley, Jr., MD	John Gage, MD
Michael Bishop, MD	Ron Burd, MD	David Hitzeman, DO
James Blankenship, MD	Thomas Cooper, MD	Charles Koopmann, MD
Dale Blasier, MD	Emily Hill, PA-C	Lawrence Martinelli, MD
Katherine Bradley, PhD	Peter Hollmann, MD	Bill Moran, MD
Norman Cohen, MD	Leonard Lichtenfeld, MD	Jonathan Myles, MD
Thomas Felger, MD	Charles Mick, MD	Daniel Mark Siegel, MD
Barbara Levy, MD	Gregory Przybylski, MD	Lloyd Smith, DPM
William Mangold, MD	Peter Smith, MD	Arthur Traugott, MD
Maurits Wiersema, MD	Samuel Smith, MD	James Waldorf, MD
Robert Zwolak, MD		

- Doctor Rich welcomed the following individuals as observers at the April 2008 meeting:
  - Debra Abel – American Academy of Audiology
  - Margie Andreae – American Academy of Pediatrics
  - Rasa Balaisyte – American Society of Neuroradiology
  - Michael Beebe – American Academy of Audiology
  - David Beyer - American Society for Therapeutic Radiology and Oncology
  - Michael Bigby – American Academy of Dermatology
  - Bruce Blehart, - American Academy of Sleep Medicine
  - Darryl Bronson, DC – American Academy of Dermatology
  - Leo Bronson - American Chiropractic Association
  - Benjamin Byrd, MD – American College of Cardiology
  - Nicholas Cekosh – American Academy of Sleep Medicine
  - Scott Collins – American Academy of Dermatology
  - William Creevy, MD – American Academy of Orthopaedic Surgeons
  - Michele Daugherity – American Osteopathic Association
  - Alan Desmond – American Speech-Language-Hearing Association
  - Maurine Dennis – American College of Radiology
  - Thomas Eichler - American Society for Therapeutic Radiology and Oncology
  - Charles Fitzpatrick, OD – American Optometric Association
  - Taylor Frawley – American Academy of Sleep Medicine
  - Jennifer Frazier - American Society for Therapeutic Radiology and Oncology
  - Mark Friedberg, MD – American College of Physicians
  - James Gajewski, MD – American Society of Hematology
  - Jerome Garden – American Academy of Dermatology
  - Emily Gardner – American College of Cardiology
  - Denise Garris – American College of Cardiology
  - Roy Geronemus, MD – American Academy of Dermatology
  - Richard Gilbert, MD – American Urological Association
  - Janice Gregory – American Urological Association
  - Nancy Heath – Society for Vascular Surgery
  - John Heiner - American Academy of Orthopaedic Surgeons
  - Elizabeth Hoy – American College of Surgeons
  - Jenny Jackson - American Society of Plastic Surgeons
  - Robert Jones – Heart Rhythm Society
  - Kirk Kanter, MD – Society of Thoracic Surgeons
  - Lisa Kaplan, JD - American Society for Physical Medicine and Rehabilitation
  - Ronald Kaufman, MD – American Urological Association

- Rebecca Kelly – American College of Cardiology
- Cathy Kerr – American Society of Echocardiography
- Sheela Kerstetter, MD – American Academy of Dermatology
- Kendall Kodey – American College of Cardiology
- Carrie Kovar – American College of Cardiology
- Katie Kuechenmeister - American Academy of Neurology
- Venay Malhotra, MD – American College of Cardiology
- Martha Matthews – American Society of Plastic Surgeons
- John Mayer, MD – Society of Thoracic Surgeons
- Faith McNicholas – American Academy of Dermatology
- Stephen McNutt - American Society for Therapeutic Radiology and Oncology
- Erika Miller – American College of Physicians
- Lisa Miller-Jones – American College of Surgeons
- Dian Millman – American College of Cardiology
- Frank Nichols, MD – Society of Thoracic Surgeons
- Gerald Neidzwiecki, MD – Society of Interventional Radiology
- Bernard Patashnik, MD – American Speech-Language-Hearing Association
- Paul Pessis – American Academy of Audiology
- Sandra Peters – American Academy of Dermatology
- Wayne Powell – American College of Cardiology
- Debbie Ramsburg – Society of Interventional Radiology
- John Ratliff, MD – American Association of Neurological Surgeons
- Paul Rudolf, MD, JD – American Geriatrics Society
- Margarita Shephard – American College of Obstetricians and Gynecologists
- Matthew Sideman, MD – Society for Vascular Surgery
- Ezequiel Silva, MD – Society of Interventional Radiology
- Shovana Sloan – American Gastroenterological Association
- Stan Stead, MD – American Society of Anesthesiologists
- Claire Tibiletti, MD – International Spine Intervention Society
- Stuart Trembath – American Speech-Language-Hearing Association
- Peter Weber, MD – American Academy of Otolaryngology – Head and Neck Surgery
- Joanne Willer – American Academy of Orthopaedic Surgery
- Donavan William – American Society of Neuroradiology
- Kadyn Williams – American Academy of Audiology

- Doctor Rich and the entire RUC thanked Doctor Norm Cohen for years of service and noted that this is the last meeting for which he will serve on the RUC.

III. Director's Report

Sherry Smith made the following announcements:

- Future RUC meeting locations have been confirmed as follows:
  - Jan 29 – Feb 1, 2009, RUC Meeting, Pointe Hilton at Squaw Peak, Phoenix, AZ
  - April 23-26, 2009, RUC Meeting, Swissotel, Chicago, IL
  - October 1-4, 2009, RUC Meeting, Hyatt Regency, Chicago, IL
  - February 4-7, 2010 RUC Meeting, Hilton Bonnet Creek, Orlando, FL

IV. Approval of Minutes for the April 24-27, 2008 RUC Meeting

The RUC approved the minutes without revision.

V. CPT Editorial Panel Update

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

- As chair of the CPT Assistant Editorial Board, Doctor Hollmann reported that the publication plans to publish (the specialty societies will be drafting these articles) several articles in the coming year based on the recommendations of the Five-Year Review Identification Workgroup. CPT Assistant will also generally address issues of concern that have been raised by the Workgroup, including component coding and bundling services.
- The CPT Editorial Panel will be holding its next meeting in Chicago October 23-25, 2008. The meeting is also the annual meeting of the CPT and HCPAC and will include many educational sessions of interest to panel members. The sessions include presentations on the Medicare Medical Home Demonstration project and the RUC Five-Year Review Identification Process. All RUC participants are encouraged to attend.
- Lastly, Doctor Hollmann reported that there are several issues coming to the February Panel meeting referred by the Five-Year Review Identification Workgroup. The Panel agrees that the referral of these services on a rolling basis will create a more even distribution of work over the course of a CPT cycle.

VI. Centers for Medicare and Medicaid Services Update

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

- The Agency is in the final stages of developing the 2009 Medicare Physician Payment Schedule Final Rule.

- The Agency has been reviewing the many changes due to the MIPPA legislation. Several components of MIPPA will be implemented in 2009.
- Doctor Simon reported that the Agency is considering the addition of office visits to services performed predominantly in the outpatient setting, where the patient stays overnight, but is discharged shy of 24 hours (23-hour stay). The CMS leadership has not made any determination on the issue but is looking forward to reviewing the RUC recommendation.
- Lastly, in the NPRM CMS commented that it is in the process of reconfiguring payment locations for GPCIs. The Agency is looking at alternative payment location determinations and requesting input from physicians. Physicians may submit comments directly to: cms_mpfs@cms.hhs.gov.

VII. Carrier Medical Director Update

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

- Because of the changes in the way that Medicare contracts with carriers, physicians may receive medical records requests from several different contractors. CMS now employs several single function contractors as opposed to one multi-function contractor. Physicians may receive notices from any one of the following four kinds of contractors:
    - Administrative Contractor – these are the claims-paying contractors.
    - Comprehensive Error Rate Testing (CERT) contractor – these contractors oversee the Administrative Contractors to ensure accuracy of payment.
    - Payment Safeguards Contractor (formerly called the fraud unit) – these contractors investigate physician fraud.
    - Recovery Audit Contractor – these are post-payment contractors.
- Doctor Haley reported that MAC awards have been presented within six additional regions. Two more have been awarded, but they are currently under protest. The GAO will make a determination on the protest in the near future. Six more jurisdictions are yet to be awarded.
- CMS has decided to charge the Administrative Contractors with the review and payment of hospital inpatient claims (validating DRGs). These are pilot contracts that will last until March 2009 and, at that time, the Agency will determine if the continuation of this process.

VIII. Washington Update

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

- Ms. McIlrath reported that the economic bailout plan has passed in the House and is expected to be enacted. While the bill contains many provisions, one of interest to the medical community is the provision for mental health payment parity.
- Though not certain, the large cost of the bailout may have an impact on the willingness of Congress to make major changes to the issue of physician payment reform.
- In the case of election of either presidential candidate, the rising cost of health care will be a major issue.
- The Senate Finance Committee has indicated that it would like to bring forward legislation to reform physician payment as early as May of 2009.
- The House Ways and Means Committee has also begun considering the issue and held a session on physician payment in September of 2008.
- Any revision to physician payment will likely have much broader reform efforts than repeal of the sustainable growth rate formula. The plans are likely to include some or all of the following:
    - Payment bundling
    - Pay for performance
    - Gainsharing
    - Multiple spending targets (possibly based on specialty)
    - Health Information Technology reform
    - Comparative effectiveness research
    - Value based purchasing.
    - Repealing the SGR would require payment of a $3 billion deficit caused by the short term fixes over the past several years. Any plan to reform payment will likely include direct scoring of the SGR; that is, wiping the deficit clean. It has been done in a few instances in the past by Congress. Because of the mounting cost of fixing the SGR, direct scoring is an attractive alternative. The approach would result in a payment cut of roughly 1-2%, which is much more appealing than the looming 20% cuts estimated for 2010.
    - A bill will also likely include some form of cost containment. The AMA is certain that medicine must be willing to make some concessions with this element of reform.
        - The AMA Council on Medical Services is looking into each of the suggested payment reform mechanisms and will be making recommendations for programs to support during the upcoming House of Delegates meeting.
    - Ms. McIlrath also discussed several provisions of MIPPA:
        - She noted that in the two weeks when payment cuts appeared absolutely imminent, physicians generated ten times the number of calls to Congress than they did in all of 2006. Patients also generated a high volume of calls. Both efforts had a palpable impact on the passage of MIPPA.
        - MIPPA extended the PQRI program through 2010 and increased the bonus payment from 1.5% to 2%.

- MIPPA also calls for the operation of confidential resource utilization reports by January 2009. The AMA has concerns about this program noting that there is inadequate lead time to develop and comment on the measures used. CMS noted that this is a pilot project focusing on four acute and four chronic conditions only. The reports will also use different kinds of comparison groups – including comparisons at the local level, specialty level, and regional level. Participation will be voluntary. CMS does not yet have the structure to move into public reporting of the data, but the general trend is moving in that direction quickly. AMA intends to take a leading role in the development of the criteria of the comparative resource utilization reporting.
- CMS has also announced new coverage determination for surgeries performed on the wrong patient or body part in an effort to better track medical errors. There will be difficulties in determining the difference between real errors and changes in the surgical plan. AMA has made these concerns known to the Agency.

IX. Relative Value Recommendations for CPT 2010

Tunneled Pleural Catheter Removal (Tab 5)
Francis Nichols, MD, Society of Thoracic Surgeons (STS); John Mayer, MD, STS; Sean Tutton, MD, Society of Interventional Radiology (SIR); Robert Vogelzang, MD, SIR; Geralidine McGinty, MD, American College of Radiology (ACR)

When the insertion of indwelling tunneled pleural catheter with cuff was initially developed, the majority of patients received this new procedure for symptomatic malignant pleural effusions as an end-of-life treatment. With increased usage of this catheter in malignant pleural effusions, it has become evident that the catheter can be removed in up to 70% of patients after successful resolution of the pleural effusion. Therefore the CPT Editorial Panel created a code to describe the removal of an indwelling pleural catheter with cuff to reflect this new practice pattern.

The RUC reviewed the specialty societies data from 80 radiologists and thoracic surgeons for 3255X *Removal of indwelling tunneled pleural catheter with cuff.* The RUC compared this surveyed procedure to its reference code 36589 *Removal of tunneled central venous catheter, without subcutaneous port or pump* (Work RVU=2.27). Although the total service times of the surveyed code and the reference code are similar, 82 minutes and 79 minutes, respectively, the surveyed code is clearly a more intense procedure to perform. The specialty society explained and the RUC agreed that the surveyed code was a far more intense procedure to perform than the reference code for several reasons including: 1.) the surveyed procedure has 2-3 wound sites whereas the reference procedure has 1

wound site, 2.) the surveyed procedure has a greater risk of pneumothorax as the catheter is going directly into the chest and 3.) due to the patient's cancer, the assessment of the patient is more extensive requiring a more extensive physical exam and a more extensive discussion with the patient and their family in comparison to the reference code. This difference between the surveyed code and the reference code is reflected in the survey data in the intensity complexity measures where it is demonstrated that the surveyed procedure has a greater level of intensity in all service time periods. Therefore the RUC agrees with the specialty societies that the median work RVU of 2.50 for 3255X is appropriate as it maintains proper rank order with the reference code 36589. **The RUC recommends 2.50 RVUs for 3255X.**

PLI Crosswalk:
The RUC established a new PLI crosswalk for 3255X, its reference code 36589, as they determined this service would be more appropriate as it is closer in work RVUs to the proposed work for the surveyed code.

Practice Expense:
With the exception of a few minor changes to the pre-service time clinical labor inputs, the RUC agreed with the practice expense inputs recommended by the specialty societies.

<u>Nikaidoh Procedure (Tab 6)</u>
Kirk Kanter, MD and John Mayer, MD Society of Thoracic Surgeons

The CPT Editorial Panel created two codes to describe a new repair technique applied to children suffering from transposition of the great arteries with ventricular septal defect and pulmonary stenosis.

337X1
The RUC reviewed the specialty society data from 40 thoracic surgeons for 337X1 *Aortic root translocation with ventricular septal defect and pulmonary stenosis repair (ie, Nikaidoh procedure); without coronary ostium reimplantation reconstruction.* The RUC noted that the reference code, 33413 *Replacement, aortic valve; by translocation of autologous pulmonary valve with allograft replacement of pulmonary valve (Ross procedure)* (Work RVU=59.74), selected by the survey respondents was very similar to the surveyed code. The reference code and the surveyed code have very similar intra-service times, 297 minutes and 300 minutes, respectively. The intensities for the surveyed code were slightly higher than the reference code, which the specialty society explained was due to the typical patient being a 14 month old child as opposed to the reference code which is performed on an adult. The RUC agreed that due to the very similar intra-service times and slightly higher intensities as compared to the reference code, 337X1 is appropriately valued at 60.00 RVUs, the survey median. **The RUC recommends 60.00 RVUs for 337X1.**

337X2
The RUC reviewed the specialty society data from 40 thoracic surgeons for 337X2 *Aortic root translocation with ventricular septal defect and pulmonary stenosis repair (ie, Nikaidoh procedure); with reimplantation of 1 or both coronary ostia.* The RUC noted that the reference code, 33413 Replacement, aortic valve; by translocation of autologous pulmonary valve with allograft replacement of pulmonary valve (Ross procedure) (Work RVU=59.74), selected by the survey respondents was more difficult to perform than the surveyed code. The reference code has significantly less intra-service time than the surveyed code, 297 minutes and 360 minutes, respectively. The intensities for the surveyed code were higher than the reference code, which the specialty society explained was due to the typical patient being a 12 month old child as opposed to the reference code which is performed on an adult. In addition, the surveyed code requires additional suture lines and physicians have to control has more bleeding as compared to the reference code. The RUC agreed that due to the very higher intra-service times and higher intensities as compared to the reference code, 337X2 is appropriately valued at 65.00 RVUs. **The RUC recommends 65.00 RVUs for 337X2.**

PLI Crosswalk
The RUC agreed with the specialty society that 33413 is an appropriate PLI crosswalk for 337X1 as they are similarly valued and performed by the same specialty. However, the RUC established a new PLI crosswalk for 337X2, 33980 *Removal of ventricular assist device, implantable intracorporeal, single ventricle* (Work RVU=64.86) as they determined this service would be more appropriate as it is closer in work RVUs to the proposed work for the surveyed code.

Practice Expense:
The RUC recommends the standard 090 day global practice expense packages for these services as they are only performed in the facility setting.

<u>Laparoscopic Revision of Prosthetic Vaginal Graft (Tab 7)</u>
George Hill, MD, American College of Obstetricians and Gynecologists

The CPT Editorial Panel created a new code to describe the work associated with performing the excision, revision or removal of prosthetic vaginal material via the laparoscopic approach as this work is currently not captured accurately in CPT.

The RUC reviewed the survey data for 574XX *Revision (including removal) of prosthetic vaginal graft; laparoscopic approach.* The RUC discovered that the specialty society removed the post-operative visit times associated with 99232 Hospital Visit and a 99213 Office Visit from the survey data in their recommendation. The RUC agreed that the work RVUs associated with these visits should be removed from the survey median RVW, 16.46 RVUs. Removing this

associated work results in a work RVU of 14.15. The RUC believed this value to be appropriate as it maintains rank order in comparison to several reference codes including: 57296 *Revision (including removal) of prosthetic vaginal graft; open abdominal approach* (RVU=16.46) which has a total service time of 429 minutes in comparison to the surveyed code which has a recommended total service time of 360 minutes and 51990 *Laparoscopy, surgical; urethral suspension for stress incontinence* (Work RVU=13.26) which has a total service time of 324 minutes in comparison to the surveyed code which has a recommended total service time of 360 minutes. **The RUC recommends 14.15 RVUs for 574XX.**

The RUC also addressed the specialty society recommended frequency information. The specialty society recommended that this service will be performed nationally 200 times per year and 100 times a year to Medicare patients. The RUC noted that the coding proposal stated different statistics regarding this frequency data. The specialty society stated that this was an error on the coding proposal and that the frequency data supplied on the summary of recommendation form is correct.

Practice Expense:
The RUC recommends the standard 090 day global practice expense packages for these services as they are only performed in the facility setting.

New Technology:
Because this service represents new technology that has not been widely used, the RUC recommends that 574XX be added to the new technology list as well as 57425 *Laparoscopy, surgical, colpopexy (suspension of vaginal apex*), as 57425 is a mirror service to 574XX..

Prolonged Services (Tab 8)
Scott Manaker, MD, PhD, American College of Physicians, American Geriatrics Society

The RUC considered code descriptor modification to CPT codes 99358 and 99359 , which describe non face-to-face prolonged services. The RUC agreed with the specialty societies that the June 2008 revisions made by the CPT Editorial Panel to these codes reflect an editorial change in the description of the services and do not represent a change in the physician work involved in furnishing them. These codes are used to describe non face-to-face time that is provided beyond that listed in the CPT book as the typical time for an E/M service code. CPT 99358 is used to describe the first hour of such service and CPT 99359 is used to describe each additional 30 minutes. The CPT Editorial Panel change specifies that the non-face-to-face time need not be provided on the same date as the initial E/M service, but must be provided on a single date (i.e. not added up over many days). The work itself is not changed, merely the date on which it is provided. A change in global period would typically require a RUC survey, however, in tis case a change from a ZZZ code to an XXX code without any pre- or post- time does not appear to necessitate a survey. Without a change

in time or a change in work, these are the same services described in the current codes. In summary, the RUC agreed that this change be considered editorial and does not require a survey. However, the RUC does suggest that the vignette for these services be changed to reflect the current service:

An 85-year-old new patient with multiple complicated medical problems has moved to the area to live closer to her daughter. She is brought to the primary care office by her daughter and has been seen and examined by the physician. The physician indicated that past medical records would be obtained from the patient's prior physicians' and that he will communicate further with the daughter upon review of them.

X. CMS Requests

Skin Tissue Rearrangement (Tab 9)
Brett Coldiron, MD, American Academy of Dermatology, Jane Dillon, MD, American Academy of Otolaryngology – Head and Neck Surgery, Christopher Senkowski, MD, American College of Surgeons, Scott Oates, MD, American Society of Plastic Surgeons

CPT codes 14001, 14021, 14041, 14061 and 14300 were identified by the Five-Year Review Identification Workgroup as potentially misvalued through its Site of Service Anomaly screen in September 2007. The Workgroup reviewed all services that include inpatient hospital visits within their global periods, but are performed less than 50% of the time in the inpatient setting, according to recent Medicare utilization data. These services were identified in the latter group. The specialty society added the following codes within the family to the review, 14000, 14020, 14040, and 14060. The RUC recommended a two-step action. First, the hospital visits were removed from the service with no impact on the associated work RVU, which CMS agreed with. Second, the RUC recommended that the global period change from 090 to 000 day and that the services then be re-surveyed. CMS did not agree with the recommendation to change the global period.

14000, ***Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less***
Consistent with the RUC recommendations for site of service anomalies in February and April 2008, the specialty societies recommended that all inpatient hospital visits be removed from the global periods of each service and the work RVU be reduced to account for their removal. The RUC agreed with the specialty societies' recommendation to remove one-half 99238 discharge day management service from the global period and the 0.64 work RVUs associated with it, as this is a service typically performed in the office. The RUC also noted that the times associated with the visits should be removed and the practice expense inputs adjusted accordingly. The resulting work RVU is 6.19.

Existing work RVU	6.83
minus ½ 99238	0.64
Recommendation	6.19

The RUC recommends removal of one-half 99238 discharge day management service, resulting in a work RVU of 6.19 for 14000.

14001, ***Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm***

Consistent with the RUC recommendations for site of service anomalies in February and April 2008, the specialty societies recommended that all inpatient hospital visits be removed from the global periods of each service and the work RVU be reduced to account for their removal. The RUC agreed with the specialty societies' recommendation to remove one-half 99238 discharge day management service from the global period and the 0.64 work RVUs associated with it as well as the one-half 99231 hospital visit and the 0.38 work RVUs associated with it, as this is a service typically performed in the outpatient hospital. The RUC also noted that the times associated with the visits should be removed and the practice expense inputs adjusted accordingly. The resulting work RVU is 8.58.

Existing work RVU	9.60
minus ½ 99231	0.38
minus ½ 99238	0.64
Recommendation	8.58

The RUC recommends removal of one-half 99238 discharge day management service and one-half 99231 post-operative hospital visit resulting in a work RVU of 8.58 for 14001.

14020, ***Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm or less***

Consistent with the RUC recommendations for site of service anomalies in February and April 2008, the specialty societies recommended that all inpatient hospital visits be removed from the global periods of each service and the work RVU be reduced to account for their removal. The RUC agreed with the specialty societies' recommendation to remove one-half 99238 discharge day management service from the global period and the 0.64 work RVUs associated with it, as this is a service typically performed in the office. The RUC also noted that the times associated with the visits should be removed and the practice expense inputs adjusted accordingly. The resulting work RVU is 7.02.

Existing work RVU	7.66
minus ½ 99238	0.64
Recommendation	7.02

The RUC recommends removal of one-half 99238 discharge day management service resulting in a work RVU of 7.02 for 14020.

14021, ***Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10.1 sq cm to 30.0 sq cm***

Consistent with the RUC recommendations for site of service anomalies in February and April 2008, the specialty societies recommended that all inpatient hospital visits be removed from the global periods of each service and the work RVU be reduced to account for their removal. The RUC agreed with the specialty societies' recommendation to remove one-half 99238 discharge day management service from the global period and the 0.64 work RVUs associated with it as well as the one-half 99231 hospital visit and the 0.38 work RVUs associated with it, as this is a service typically performed in the office. The RUC also noted that the times associated with the visits should be removed and the practice expense inputs adjusted accordingly. The resulting work RVU is 9.52.

Existing work RVU	11.18
minus ½ 99231	0.38
minus 1 99238	1.28
Recommendation	9.52

The RUC recommends removal of one-half 99238 discharge day management service and one-half 99231 post-operative hospital visit resulting in a work RVU of 10.16 for 14021.

14040, ***Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less***

The RUC commented that 14040 is typically performed in the office and was valued appropriately in the Third Five-Year review without any hospital visits. **The RUC recommends removal of 14040 from the site of service anomaly screen and no change in work RVU.**

14041, ***Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm***

Consistent with the RUC recommendations for site of service anomalies in February and April 2008, the specialty societies recommended that all inpatient hospital visits be removed from the global periods of each service and the work RVU be reduced to account for their removal. The RUC agreed with the specialty societies' recommendation to remove one 99238 discharge day management service from the global period and the 1.28 work RVUs associated with it as well as the one 99231 hospital visit and the 0.76 work RVUs associated with it, as this is a service typically performed in the office. The RUC also noted that the times associated with the visits should be removed and the practice expense inputs adjusted accordingly. The resulting work RVU is 10.63.

Existing work RVU	12.67
minus 1 99231	0.76
minus 1 99238	1.28
Recommendation	10.63

The RUC recommends removal of one 99238 discharge day management service and one 99231 post-operative hospital visit resulting in a work RVU of 10.63 for 14041.

14060, ***Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less***
The RUC commented that 14060 is typically performed in the office and was valued appropriately in the Third Five-Year review without any hospital visits. **The RUC recommends removal of 14060 from the site of service anomaly screen and no change in the existing work RVU of 8.44.**

14061, ***Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10.1 sq cm to 30.0 sq cm***
Consistent with the RUC recommendations for site of service anomalies in February and April 2008, the specialty societies recommended that all inpatient hospital visits be removed from the global periods of each service and the work RVU be reduced to account for their removal. The RUC agreed with the specialty societies' recommendation to remove one 99238 discharge day management service from the global period and the 1.28 work RVUs associated with it as well as the one and one-half 99231 hospital visits and the 1.14 work RVUs associated with it, as this is a service typically performed in the office. The RUC also noted that the times associated with the visits should be removed and the practice expense inputs adjusted accordingly. The resulting work RVU is 11.25.

Existing work RVU	13.67
minus 1.5 99231	1.14
minus 1 99238	1.28
Recommendation	11.25

The RUC recommends removal of one 99238 discharge day management service and one and one-half 99231 post-operative hospital visit resulting in a work RVU of 11.25 for 14061.

14300, ***Adjacent tissue transfer or rearrangement, more than 30 sq cm, unusual or complicated, any area***
The specialty society commented that the descriptor does not accurately describe the work that may be involved in this service. Specifically, the work that is involved in performing the procedure in one area of the body may vary greatly from the work that is involved in performing the procedure in other areas of the body. The specialty society recommended and the RUC agreed that the code be referred to the CPT Editorial Panel for revision. **The RUC recommended that**

14300 be referred to the CPT Editorial Panel for revision of the code descriptor.

Skin Pedical Flaps (Tab10)
Christopher Senkowski, MD, American College of Surgeons, Scott Oates, MD, American Society of Plastic Surgeons

CPT code 15574, *Formation of direct or tubed pedicle, with or without transfer; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet*, and CPT code 15576, *Formation of direct or tubed pedicle, with or without transfer; eyelids, nose, ears, lips, or intraoral*, were identified by the Five-Year Review Identification Workgroup as potentially misvalued through its Site of Service Anomaly screen in September 2007. The Workgroup reviewed all services that include in-patient hospital visits within their global periods, but are performed less than 50% of the time in the in-patient setting, according to recent Medicare utilization data. The Workgroup divided its analysis into two groups, services that contained only in-patient discharge day management service (a full 99238) and services that include additional in-patient visits. 15576 was identified in the former and was not recommended to be surveyed because of that anomaly. Rather, the RUC recommended and CMS agreed to reduce the full 99238 discharge day management service to one-half, with no impact on the work RVU. 15574 was recommended to be surveyed because the inclusion of the additional in-patient hospital visits within its global period. At that time, the RUC also recommended that the global period of 15574 and the other services within its family be changed from 090 to 000 days. CMS did not agree with the RUC regarding the change in global period, but did agree with the RUC's recommendation that 15570, *Formation of direct or tubed pedicle, with or without transfer; trunk*, 15572, *Formation of direct or tubed pedicle, with or without transfer; scalp, arms, or legs*, 15574, and 15576 be re-surveyed.

At the February 2008 RUC meeting, the RUC established a series of procedural rules to guide the reevaluation of Site of Service Anomalies, which the RUC continues to use. 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.

15570
The specialty society agreed that there was not compelling evidence to support a review of the physician work in order to recommend a higher work RVU than is currently assigned to 15570. However, the specialty presented data from a survey of 25 plastic and general surgeons and consensus recommendations from an expert panel of plastic and general surgeons and otolaryngologists to validate physician time and post-operative visits. The survey results and expert panel consensus show that patients are typically kept overnight in the hospital following this procedure. The rise of 23-hour observation stays in the out-patient hospital

and ambulatory surgical setting as well as the fact that roughly one-third of the procedures are performed in the in-patient setting account for this overnight stay. The specialty society survey and panel indicated pre-service time package four applied – facility, difficult patient, difficult procedure. Additionally, the specialty recommended 10 minutes of positioning time to account for positioning the patient in the supine and slightly lateral position. The resulting pre-service time is 73 minutes. Further, the survey and panel recommended an intra-service time of 100 minutes and immediate post-service time of 30 minutes. The intra-service reflects a five minute reduction in time as compared to the current time and the immediate post-service is unchanged. Lastly, the specialty presented data that one 99231 hospital visit, one 99238 discharge day management service, and one 99212, two 99213 and one 99214 office visits are included. This differs from the current data which indicate that two 99231 visits and no 99214 visits are provided. The RUC agreed with the specialty society. The RUC also noted that the survey respondents indicated a median work RVU of 13.00 work RVUs.

The RUC recommends the new physician times as well as hospital and office visits, but recommends maintaining the current work RVU of 10.00 for 15570.

15572

The specialty society agreed that there was not compelling evidence to support a review of the physician work in order to recommend a higher work RVU than is currently assigned to 15572. However, the specialty presented data from a survey of 25 plastic and general surgeons and consensus recommendations from an expert panel of plastic and general surgeons and otolaryngologists to validate physician time and post-operative visits. The specialty society survey and panel indicated pre-service time package four applied – facility, difficult patient, difficult procedure. Additionally, the specialty recommended 10 minutes of positioning time to account for positioning the patient in the supine and slightly lateral position. The resulting pre-service time is 73 minutes. Further, the survey and panel recommended an intra-service time of 90 minutes and immediate post-service time of 30 minutes, which is the same as the current intra-service and immediate post-service times. Lastly, the specialty presented data that one-half 99238 discharge day management service, and one 99212 and three 99213 office visits are performed. This differs from the current data which indicate that a full 99238, one 99231 visits and two 99213 visits are provided. The RUC agreed with the specialty society. The RUC also noted that the survey respondents indicated a median work RVU of 12.00 work RVUs.

The RUC recommends the new physician times and office visits, but recommends maintaining the current work RVU of 9.94 for 15572.

15574

The specialty society agreed that there was not compelling evidence to support a review of the physician work in order to recommend a higher work RVU than is

currently assigned to 15574. However, the specialty presented data from a survey of 25 plastic and general surgeons and consensus recommendations from an expert panel of plastic and general surgeons and otolaryngologists to validate physician time and post-operative visits. The specialty society survey and panel indicated pre-service time package four applied – facility, difficult patient, difficult procedure. Additionally, the specialty recommended 7 minutes of positioning time to account for positioning the patient in the various positions pending the area of the body the procedure is performed on. The resulting pre-service time is 70 minutes. Further, the survey and panel recommended an intra-service time of 110 minutes and immediate post-service time of 30 minutes, which reflect a 10 minute reduction in intra-service time. Lastly, the specialty recommended adjusting post-operative office visits to include one 99212 and three 99213 visits as well as one-half 99238 discharge day management service. The RUC agreed with the specialty society. The RUC also noted that the survey respondents indicated a median work RVU of 14.00 work RVUs.

The RUC recommends the new physician times and office visits, but recommends maintaining the current work RVU of 10.52 for 15574.

15576

The specialty society agreed that there was not compelling evidence to support a review of the physician work in order to recommend a higher work RVU than is currently assigned to 15576. However, the specialty presented data from a survey of 25 plastic and general surgeons and consensus recommendations from an expert panel of plastic and general surgeons and otolaryngologists to validate physician time and post-operative visits. The specialty society survey and panel indicated pre-service time package four applied – facility, difficult patient, difficult procedure. Additionally, the specialty recommended 7 minutes of positioning time to account for positioning the patient in the various positions pending the area of the body the procedure is performed on. The resulting pre-service time is 70 minutes. Further, the survey and panel recommended an intra-service time of 90 minutes and immediate post-service time of 30 minutes, which is the same as the current intra-service and immediate post-service times. Lastly, the specialty recommended adjusting post-operative office visits to include one 99212 and two 99213 visits as well as one-half 99238 discharge day management service, which is identical to what is currently included. The RUC agreed with the specialty society. The RUC also noted that the survey respondents indicated a median work RVU of 13.50 work RVUs.

The RUC recommends the new physician times and office visits, but recommends maintaining the current work RVU of 9.24 for 15576.

Destruction of Skin Lesions (Tab 11)
Jerome Garden, MD, Roy Geronemus, MD, Scott Collins, MD American Academy of Dermatology

CPT codes 17106, *Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm*, 17107, *Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm*, and 17108, *Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm*, were requested to be reviewed by CMS following identification by the RUC as potentially misvalued. These services were identified by the RUC's Five-Year Review Identification Workgroup through the High intra-service work per unit of time (IWPUT) screen. During the Workgroup's review, the Workgroup agreed that the current work relative values result in an excessively high IWPUT and the amount of physician time was either too low or the work RVU was too high. In addition, the services may have changed since the first Five-Year Review, when the RUC reviewed them. Therefore, the Workgroup agreed that resurveying these services would be appropriate. The RUC confirmed the recommendation and CMS agreed, requesting that the services be surveyed for review at the October 2008 RUC meeting.

17106
The RUC reviewed the survey data from 28 dermatologists presented by the specialty society and received additional clarification from the specialty society regarding this service. The RUC did not agree that the survey or the specialty society presentation provided an accurate account of the intensity involved in performing the service on the typical patient. The RUC did not agree with the specialty that the pre-service time warranted additional time beyond that of the 7 minutes for the standard non-facility procedure and recommends a pre-service time of 7 minutes. The RUC also discussed the post-operative visits in the society's summary of recommendations and agreed that one 99212 and one 99213 were appropriate. Lastly, the RUC agreed with the survey median intra-service time of 30 minutes, rather than the specialty society-recommended 20 minutes. The RUC considered imputing physician work through an IWPUT calculation using the intensity of other services commonly performed by dermatologists. However, the specialty clarified that the procedure is typically not performed in the non-Medicare population and that derivation of a value through means of IWPUT calculation of other dermatology codes would be inappropriate. It was noted that this service requires the highest level of intensity for a dermatologist. The RUC then looked to other services to develop a work value recommendation through magnitude estimation with appropriate reference codes.

The RUC identified 21031, *Excision of torus mandibularis* (wRVU = 3.26, intra-time = 30 minutes) as a primary reference code. The RUC noted that 21031 had one 99211 and one 99212 office visits. To develop an appropriate reference, the RUC added the value of the difference between the 99211 and 99213 office visits which is 0.75 work RVUs. (0.92 – 0.17 = 0.75) Lastly, the RUC noted that

21031 requires significantly more pre-service time, 25 minutes rather than 7 minutes. By reducing the value by that difference of 18 minutes, 0.4032 RVUs are reduced. 18 minutes x 0.0224 = 0.4032 RVUs. The resulting value is 3.61. 3.26 + 0.75 – 0.4032 = 3.61 work RVUs.

The value reflects an IWPUT of 0.062, which the RUC agreed was appropriate. The RUC also discussed several other reference codes including 25001, *Incision, flexor tendon sheath, wrist (eg, flexor carpi radialis)* (wRVU = 3.68, intra-time = 30 minutes) and 11624, *Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm*, (wRVU = 3.57, intra-time = 40 minutes). **The RUC recommends a work RVU of 3.61, pre-service time of 7 minutes, intra-service time of 30 minutes, one 99212 visit and one 99213 visit for code 17106.**

17107

The RUC applied a building block approach to recommend values for the remainder of the codes in this family. For 17107, the RUC discussed the post-service office visits and agreed with the survey respondents concluding that the service requires two 99212 and one 99213 office visits. Additionally, the RUC agreed with the survey median intra-service time of 40 minutes. The RUC did not agree with the specialty society recommendation that the pre-service time warranted additional time beyond that of the 7 minutes for the standard non-facility procedure and recommends a pre-service time of 7 minutes. By applying the same IWPUT derived above, the RUC arrived at a work RVU recommendation of 4.68. (40 minutes of intra-service time x 0.062 = 2.48. 7 minutes pre + 10 minutes immediate post x 0.0224 = 0.38. 99212 x 2 = 0.90. 99213 x 1 = 0.92. 2.48 + 0.38 + 0.90 + 0.92 = 4.68) In support of this recommendation, the RUC also discussed several reference services, including 33282, *Implantation of patient-activated cardiac event recorder* (wRVU = 4.70, intra-time = 40 min) and 46255, *Hemorrhoidectomy, internal and external, simple*; (w RVU = 4.88, intra-time = 45 minutes). **The RUC recommends a work RVU of 4.68 and pre-service time of 7 minutes, intra-service time of 40 minutes, two 99212 visits, and one 99213 visit for code 17107.**

17108

The RUC reviewed code 17108 and discussed the post-service office visits and agreed with the survey respondents concluding that the service requires three 99212 and one 99213 office visits. Additionally, the RUC agreed with the survey median intra-service time of 60 minutes. The RUC did not agree with the specialty society recommendation that the pre-service time warranted additional time beyond that of the 7 minutes for the standard non-facility procedure and recommends a pre-service time of 7 minutes. The RUC applied the same IWPUT value of 0.062 to 17108, noting that the same IWPUT as the other codes in the family was appropriate because, while the lesions are typically not located near the mouth or eye, they are much larger, deeper, and more vascularized requiring work of similar intensity. The resulting computation was a work RVU of 6.37.

(60 minutes of intra-service time x 0.062 = 3.72. 7 minutes pre + 10 minutes immediate post x 0.0224 = 0.38. 99212 x 3 = 1.35. 99213 x 1 = 0.92. 3.72 + 0.38 + 1.35 + 0.92 = 6.37) The RUC then discussed a reference service in support of this recommendation, including 27347, *Excision of lesion of meniscus or capsule (eg, cyst, ganglion), knee* (wRVU = 6.58, intra-time = 60 min). **The RUC recommends a work RVU of 6.37, pre-service time of 7 minutes, intra-service time of 60 minutes, three 99212 visits, and one 99213 visit for code 17108.**

New Technology
Because the procedures reflect a new and novel approach to the use of existing technology, the RUC recommended that 17106, 17107, and 17108 be added to the New Technology List.

Practice Expense
The practice expense direct inputs related to intra-service time and visits will be adjusted to the new recommended times and visits.

Treat Thigh Fracture (Tab 12)
William Creevy, MD, American Academy of Orthopaedic Surgeons

In April 2008, CPT Code 27245 *Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with intramedullary implant, with or without interlocking screws and/or cerclage* was identified by the RUC's Five Year Review Identification Workgroup as a service having a high intra-service work per unit of time (2008 Work RVU = 21.09; IWPUT = 0.133). The Workgroup agreed that similar service, CPT code 27244 *Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with plate/screw type implant, with or without cerclage,*(2008 Work RVU = 17.63) should be surveyed as it was directly related to 27245. The Workgroup had also agreed in April 2008 that the two codes should be valued the same as they describe a similar procedure utilizing different devices.

In October 2008, the RUC reviewed the survey results provided by the specialty for codes 27244 and 27245 and agreed that these survey data demonstrate that the services require the same work. From the specialty's survey results, both services have identical pre-service and post-service physician work time and there is a five minute difference in intra-service physician work (75 minutes and 80 minutes respectively). The survey median work RVU for both codes was 18.50 RVUs, however the specialty society agreed that both codes should be valued at 18.00 RVUs, the 25th percentile survey results for code 27245, as this value best reflects the work of the service.

The RUC reviewed the survey's key reference code 27236 *Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement*

(Work RVU = 17.43, 090 Day Global) in relation to these two codes which indicated that the technical skill, physical effort and psychological stress required to perform these services were higher for both 27244 and 27245. The RUC agreed that CPT code 27245 is currently overvalued and should be reduced to be equivalent to 27244. **The RUC recommends relative work values of 18.00 for CPT Codes 27244 and 27245.**

Practice Expense
The direct practice expense inputs are recommended to be modified for changes in post-operative offices visits.

Interventional Radiology Procedures (Tab 13)
American College of Radiology and Society of Interventional Radiology

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

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

The RUC initiated a level of interest process in June 2008 and in September 2008 received practice expense recommendation from a specialty society for review at the October 2008 RUC meeting.

36481
The RUC reviewed the direct practice expense inputs recommendation for code 36481 from the specialty society and determined that the medical supplies and equipment time included in the recommendation overlapped other services, such as imaging services, that are typically billed at the same time. The RUC also determined the specialty society recommendation lacked RUC standards for practice expense and that other similar services recently reviewed by the RUC may require revised recommendations. Based on these issues the RUC could not make an informed recommendation at this time. **The RUC recommends that the specialty society develop a revised direct practice expense input recommendation for code 36481 and all codes typically billed with code 36481 (to be determined) for presentation at the next RUC meeting . The RUC also recommends this service be placed on CPT's appendix G to indicate that Moderate Sedation is inherent to the procedure.**

37183

The RUC reviewed the specialty society direct practice expense inputs recommendation for code 37183 and made several edits in clinical staff types and time to be more reflective of the service. The RUC also agreed that this service is typically performed with moderate sedation. **The RUC recommends the attached direct practice expense inputs for code 37183 and recommends that this service be placed on CPT's appendix G to indicate that Moderate Sedation is inherent to the procedure.**

47382

The RUC reviewed the specialty society direct practice expense inputs recommendation for code 37183 and made several edits in clinical staff types for the typical patient scenario. The RUC also agreed that this service is typically performed with moderate sedation. **The RUC recommends the attached direct practice expense inputs for code 47382 and recommends that this service be placed on the CPT's appendix G to indicate that Moderate Sedation is inherent to the procedure.**

50200

The RUC reviewed the specialty society direct practice expense inputs recommendation for code 50200 and made edits in clinical staff types and time to reflect the typical patient encounter. The RUC also agreed that this service is typically performed with moderate sedation. **The RUC recommends the attached direct practice expense inputs for code 50200 and recommends that this service be placed on the CPT's appendix G to indicate that Moderate Sedation is inherent to the procedure.**

Change Biliary Drainage Catheter (Tab 14)

Sean Tutton, MD, Society of Interventional Radiology (SIR), Robert Vogelzang, MD, SIR, Gerald Niedzwiecki, MD, SIR , Geraldine McGinty, MD, American College of Radiology

In April 2008, the Five-Year Review Identification Workgroup identified CPT code 47525 *Change of percutaneous biliary drainage catheter* in its high IWPUT screening process. Additionally, the RUC recommended and CMS agreed that code 47525 be changed from a 010-day global period to a 000-day global period. The RUC requested that the specialty society survey code 47525.

The RUC reviewed code 47525 and determined when utilizing magnitude estimation that this procedure is a more difficult procedure compared to other tube change procedures. Patients are typically terminally ill and are in a fragile state. The RUC compared code 47525 to its key reference service code 49423 *Exchange of previously placed abscess or cyst drainage catheter under radiological guidance (separate procedure)* (work RVU = 1.46) and 50387 *Removal and replacement of externally accessible transnephric ureteral stent (eg,*

external/internal stent) requiring fluoroscopic guidance, including radiological supervision and interpretation (work RVU = 2.00).

The RUC reviewed the physician time required to provide this service and determined that the specialty society recommended pre-service package 1B – Straightforward patient procedure (with sedation/anesthesia) (19 minutes evaluation, 1 minute positioning and 5 minutes scrub, dress wait), 20 minutes intra-service time and 10 minutes immediate post-service time are appropriate. The RUC determined that a half discharge day was not required.

The RUC determined that the proper rank order for this service is between the two reference services 49423 and 50387. The RUC determined that code 47525 was approximately 20% more complex and intense than code 50387, excluding the fluoroscopy. Therefore, the RUC used reference code 50387 as a base, subtracted the work RVUs associated with the fluoroscopy and then increased the RVU by 20% to account for the higher complexity of this service (2.00 – 0.72 = 1.28 x 1.20 = 1.54).

2.00 (50387)
\- 0.72 (fluoroscopy)
1.28
x 1.20 (increased by 20%)
1.54 work RVUs

At a value of 1.54 work RVUs, code 47525 has an intra-service work per unit of time of 0.0413, which the RUC noted is appropriate for this short intra-service procedure. The RUC compared this intra-service intensity to similar services 45303 *Proctosigmoidoscopy, rigid; with dilation (eg, balloon, guide wire, bougie)* (work RVU = 1.50, intra-service time =15 minutes and immediate post-service time = 10) and 45990 *Anorectal exam, surgical, requiring anesthesia (general, spinal, or epidural), diagnostic* (work RVU = 1.80, intra-service time = 20 minutes and immediate post-service time = 25) to support this 20% increase. The recommended work RVU of 1.54 is substantially lower than the current 2008 value of 5.55. **The RUC recommends a work RVU of 1.54 for code 47525 with a global period of 000.**

The RUC recommends that code 47525 be placed on the conscious sedation list, as it is inherent in this procedure. The conscious sedation standard package will be added to the direct practice expense inputs. The practice expense inputs should also be adjusted to remove the cost of the visits and to update the assist the physician time to be consistent with the new intra-service time.

Cystourethroscopy (Tab 15)
American Urological Association

In April 2008, the RUC's Five Year Identification Workgroup identified codes 52214 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands* and 52224 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy* through the high volume growth screen. The RUC recommended the elimination of the duplication between the electrocautery and the laser techniques as supplies and equipment for both modalities are currently included in the direct practice expense inputs. In October 2008, the RUC and the specialty society agreed with the elimination of the electrocautery supplies and equipment. **The RUC recommends the following revised direct practice expense inputs for codes 52214 and 52224.**

Cryoablation of Prostate (Tab 16)
American Urological Association

In June 2008, CMS requested the RUC to review direct practice expense recommendations for the non-facility setting for CPT Code 55873 *Cryosurgical ablation of the prostate (includes ultrasonic guidance for interstitial cryosurgical probe placement).* The RUC initiated a level of interest process in June 2008 and in September 2008 received practice expense recommendation from Urology for review at the October 2008 RUC meeting.

The American Urological Association Quality Improvement and Patient Safety Committee maintained that procedure CPT Code 55873 may be performed in the office setting assuming that a Class C surgical facility designation for anesthesia has been achieved. The RUC reviewed the direct practice expense recommendation in the non-facility setting as presented by the specialty and realized the service was initially reviewed as a new code by the RUC in February 2001. RUC members believed that the intra-service physician time had most likely declined (from 200 minutes) as the service is now more often performed. The RUC agreed with the specialty that the service should be surveyed for physician work for presentation with revised direct practice expense input information at the next RUC meeting. **The RUC recommends that code 55873 be surveyed for physician work for presentation with revised direct practice expense inputs for the RUC's January 29 – February 1, 2009 meeting.**

Audiology Services (Tab 17)

Robert Fifer, PhD, American Speech-Language-Hearing Association (ASHA) Jane Dillon, MD, American Academy of Otolaryngology – Head and Neck Surgery (AAO-HNS), Paul Pessis, AuD, ASHA, Peter Weber, MD (AAO-HNS)

The American Speech-Language-Hearing Association (ASHA) met with CMS on September 8, 2006, and requested that CMS agree to consider establishing physician work relative values for services provided by audiologists. ASHA specifically requested that the professional work effort for audiologists providing these services be reflected in the work relative values rather than in the practice expense relative values. CMS responded to ASHA on November 14, 2006, and indicated that they agree to consider this possibility further. CMS advised the RUC and HCPAC that if the committee recommends the use of work values for the audiology services, CMS will consider their recommendation. CMS also indicated that the practice expense relative values would need to be adjusted as appropriate to avoid double counting of the audiologists' work effort.

In April 2007, the RUC reviewed and made work RVU recommendations for nine audiology services, which were implemented in January 2008. ASHA and the American Academy of Otolaryngology – Head and Neck Surgery (AAO-HNS) surveyed over 100 physicians and audiologists. At this meeting, October 2008, the RUC reviewed the remaining six audiology services.

92620 ***Evaluation of central auditory function, with report; initial 60 minutes***
The RUC reviewed the specialty societies' survey results for CPT code 92620. The median survey data reflected an intra-service time in excess of 60 minute time definition of this code. The specialty societies indicated and the RUC agreed that median survey time of 85 minutes may have been the time estimate for the total service and, therefore, the median RVW may have been overstated. The specialty societies recommended and the RUC agreed that 60 minutes of intra-service time as indicated in the descriptor and close to the survey 25th percentile (56 minutes) is appropriate. The RUC also determined that the recommended pre-service time of 7 minutes for reviewing the patient history and audiometric results and immediate post-service time of 10 minutes to generate a report was appropriate. The specialty society recommended and the RUC agreed that the 25th percentile work RVU of 1.50 is an appropriate estimate of the work required to perform this service.

The RUC also compared 92620 to two additional codes to support this recommendation: 95972 *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, first hour* (work RVU = 1.50, 3

minutes pre-service, 60 minutes intra-service and 5 minutes post-service); and 95928 *Central motor evoked potential study (transcranial motor stimulation); upper limbs* (work RVU = 1.50, 15 minutes pre-service, 60 minutes intra-service and 15 minutes post service).

The RUC recommends the survey 25th percentile work RVU of 1.50 for code 92620.

92621 ***Evaluation of central auditory function, with report; each additional 15 minutes***

The RUC reviewed add-on service 92621 with the understanding that the work required to perform 92621 is approximately one-fourth that of its 60 minute base code, 92620, for which the RUC recommends a work RVU of 1.50. Although the intra-service time is one-fourth of CPT 92620, because there are no pre- and post-time, the specialty societies recommended a slightly lower work RVU of 0.35. The RUC also reviewed the following reference codes to support a work RVU of 0.35 for this service: 92568 *Acoustic reflex testing; threshold* (work RVU = 0.29, 1 minute pre-service, 8 minutes intra-service and 1 minute post-service time); 97036 *Application of a modality to one or more areas; Hubbard tank, each 15 minutes* (work RVU = 0.28, 0 minutes pre-service, 15 minutes intra-service, 0 minutes post-service time); and 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, 0 minutes pre-service, 15 minutes intra-service, 0 minutes post-service time). **The RUC recommends a work RVU of 0.35 for code 92621.**

92625 ***Assessment of tinnitus (includes pitch, loudness matching, and masking)***

The RUC reviewed the specialty societies' survey results for code 92625 and compared code it to 92604 *Diagnostic analysis of cochlear implant, age 7 years or older; subsequent reprogramming* (work RVU = 1.25, 5 minutes pre-service, 50 minutes intra-service and 10 minutes post-service time) and determined that the intensity and complexity required for 92625 is slightly lower than that required for 92604. The RUC also compared 92625 to codes: 92557 *Comprehensive audiometry threshold evaluation and speech recognition* (work RVU = 0.60, 3 minutes pre-service, 20 minutes intra-service and 5 minutes post-service times); and 88361 *Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; using computer-assisted technology* (work RVU = 1.18, 0 minutes pre-service time, 40 minutes intra-service time and 0 minutes post-service time).

The RUC determined that the survey median work RVU of 1.15 appropriately reflects the work required to perform this service. **The RUC recommends 7 minutes pre-service, 40 minutes intra-service, and 10 minutes post-service time and the survey median work RVU of 1.15 for code 92625.**

92626 ***Evaluation of auditory rehabilitation status; first hour***

The RUC reviewed code 92626 and determined that this service requires slightly less intensity and complexity than code 92620 (recommended work RVU of 1.50). The specialty societies recommended and the RUC agreed that a work RVU of 1.40 for 92626 was appropriate. The intensity for 92626 with an RVU of 1.40 and 7 minutes pre-service, 60 minutes intra-service, and 10 minutes post-service times was calculated at 0.01699 which is slightly less than the IWPUT for 92620 (0.01865). The RUC also compared 92626 to codes 92602 *Diagnostic analysis of cochlear implant, patient younger than 7 years of age; subsequent reprogramming* (work RVU = 1.30, 5 minutes pre-service, 50 minutes intra-service and 10 minutes post-service time); and 38211 *Transplant preparation of hematopoietic progenitor cells; tumor cell depletion* (work RVU = 1.42, 5 minutes pre-service, 60 minutes intra-service and 10 minutes post-service time) in relation to the physician work time and intensity. **The RUC recommends a work RVU of 1.40 for code 92626.**

92627 ***Evaluation of auditory rehabilitation status; each additional 15 minutes***
The RUC reviewed the specialty societies' survey results for this add-on service 92627. The specialty societies recommended that the work required to perform 92627 is approximately one-fourth that of its 60 minute base code, 92626, therefore the RUC recommends a work RVU of 1.40. The intensity for this service is higher than the intensity for 92626 due to testing beyond the first hour and the need to maintain the patient's attention to obtain accurate test measurements of residual hearing function. Additionally, although the intra-service time is one-fourth of CPT 92620, because there are no pre- and post-time, the specialty societies recommended a slightly lower work RVU of 0.33.

The RUC also reviewed the following reference codes to support a work RVU of 0.33 for this service: 92568 *Acoustic reflex testing; threshold* (work RVU = 0.29, 1 minute pre-service, 8 minutes intra-service and 1 minute post-service time); 97036 *Application of a modality to one or more areas; Hubbard tank, each 15 minutes* (work RVU = 0.28, 0 minutes pre-service, 15 minutes intra-service, 0 minutes post-service time); and 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, 0 minutes pre-service, 15 minutes intra-service, 0 minutes post-service time). **The RUC recommends a work RVU of 0.33 for code 92627.**

92640 ***Diagnostic analysis with programming of auditory brainstem implant, per hour***
The RUC reviewed the specialty societies' survey results for CPT code 92640. The median survey data reflected an intra-service time in excess of 60 minute time definition of this code. The specialty societies indicated and the RUC agreed that median survey time of 95 minutes may have been the time estimate for the total service and, therefore, the median work RVU may have been overstated. The specialty societies recommended and the RUC agreed that 60 minutes of intra-service time as indicated in the descriptor is appropriate. The RUC also

determined that the recommended pre-service time of 4 minutes for describing the various components of programming the brainstem implant and immediate post-service time of 5 minutes was appropriate. The specialty society recommended the survey 25th percentile work RVU of 1.76, which is appropriate because the 60 minutes of intra-service time falls between the survey 25th percentile and median times (43.75 minutes and 95 minutes). The RUC agreed that the 25th percentile work RVU of 1.76 is an appropriate estimate of the work required to perform this service.

The RUC also compared 92620 to two additional codes to support this recommendation: 96125 *Standardized cognitive performance testing (eg, Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report* (work RVU = 1.70, 0 minutes pre-service, 60 minutes intra-service and 0 minutes post-service time); and 96116 *Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report* (work RVU = 1.86, 7 minutes pre-service, 60 minutes intra-service and 0 minutes post-service time).

The RUC recommends the survey 25th percentile work RVU of 1.76 for code 92640.

Practice Expense
The RUC recommends removing the associated audiologists' time from the direct practice expense inputs, as all physician and audiologist work is captured in the work RVU.

<u>Microvolt T-Wave Assessment (Tab 18)</u>
American College of Cardiology

CMS requested that code CPT Code 93025 *Microvolt T-wave alternans for assessment of ventricular arrhythmias* be reviewed by the RUC for proposed changes to the direct practice expense inputs. In CMS' Notice of Proposed Rule Making dated Monday, July 7, 2008 page 38512, CMS proposes to change the clinical staff type from blend of clinical labor staff to a registered nurse, and to assign the entire service period time of 53 minutes. In addition, CMS proposed to replace the cardiac monitoring equipment with treadmill equipment with a Microvolt T-wave testing treadmill. The RUC and the specialty society agreed with CMS's proposed direct practice expense inputs changes. **The RUC recommends the attached direct practice expense inputs for CPT code 93025.**

Stress Echo with ECG Monitoring (Tab 19)
James Maloney, MD and Benjamin Byrd, MD, American College of Cardiology

CPT code 93351 *Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with physician supervision* (RUC recommended work RVU = 1.75) was recently surveyed and reviewed by the RUC in April 2008. The RUC recognized that the new survey data and recommended total physician time for 93351 (35 minutes) is lower than the current 2008 total physician time for 93350 (40 minutes), and therefore, noted the potential anomalies in the physician work and/or physician time data for 93350. The RUC recommended that 93350 be surveyed and reviewed at the October 2008 RUC meeting for physician work and physician time.

The RUC reviewed the specialty society recommendations for code 93350 *Echocardiography, transthoracic, real-time with image documentation (2D), with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report*. The specialty society recommended slightly reduced pre- and post-services from the expert panel responses. The RUC agreed with 3 minutes pre-service, 20 minutes intra-service and 5 minutes immediate post-service time as indicated by the specialty society. The RUC compared code 93350 to key reference service 78465 *Myocardial perfusion imaging; tomographic (SPECT), multiple studies (including attenuation correction when performed), at rest and/or stress (exercise and/or pharmacologic) and redistribution and/or rest injection, with or without quantification* (work RVU = 1.46) and agreed that these services are very similar. Although the results indicated that 93350 is more complex than the key reference service, the expert panel recommended identical intra-service time. The RUC determined that an intra-service time of 20 minutes is appropriate to review these images. The specialty society recommended and the RUC agreed that the survey 25th percentile work RVU of 1.46, which is slightly lower than the currently work RVU of 1.48, appropriately estimates the physician work required to perform this service. **The RUC recommends a work RVU of 1.46 for 93350.**

XI. Practice Expense Subcommittee (Tab 20)

Doctor Moran reported that AMA staff director Sherry Smith provided a PowerPoint presentation update on the AMA/Specialty Society Physician Practice Information Survey. This presentation provided members with an update to the

survey progress and AMA staff urges specialties to please continue to communicate the importance of the survey through October and November.

The Practice Expense Subcommittee reviewed several direct practice expense recommendations for new, revised, and existing CPT codes referred to the group by CMS. These recommendations were either postponed for further clarification, or revised by the RUC and approved. These recommendations are attached to the Practice Expense Subcommittee minutes.

The Subcommittee also had a general discussion concerning CMS' 2009 proposal to establish a process to update prices of high cost disposable medical supplies. It is assumed that the cost of new high priced supplies would decrease over time due to competition in the marketplace. For 2009 CMS is proposing to create a process to update prices for high cost supplies. CMS had asked for comments on alternatives that could be used to update pricing information in absence of information provided by the specialties societies and organizations. CMS received numerous supply pricing data from specialties that was also supplied to AMA staff for this meeting. These data were collated and provided to the RUC and CMS staff.

The Subcommittee expressed its concern about the validity of the data CMS may receive when only requiring the submission of one invoice. In addition, members were concerned that the submissions may not match the CMS described supply or may be different due to a change in practice patterns. The Subcommittee reiterated that any change practice expense inputs due to in practice patterns would need to be reviewed carefully and may impact physician work.

Doctor Moran lastly stressed that the Practice Expense Subcommittee's work is time consuming and its members respectfully request more time to conduct its business at the next RUC meeting.

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

XII. Research Subcommittee (Tab 21)

Doctor Siegel delivered the Research Subcommittee report. The Research Subcommittee and the RUC made the following recommendations:

The RUC recommends that an Ad Hoc Pre-Service Time Workgroup be created to further refine the pre-service time packages. The Workgroup will also address the issue of retroactive application of pre-service time packages and discuss new pre-service time standards proposed by specialty societies including the proposal from the North American Spine Society. Doctor Rich has appointed

the following members to the Workgroup:

Thomas Felger, MD
John Gage, MD
Emily Hill, PA-C
Gregory Kwasny, MD
Brenda Lewis, MD
Greg Przybylski, MD
Peter Smith, MD
Sam Smith, MD
Maurits Wiersema, MD

The American College of Surgeons (ACS) recommended several revisions to the Research Subcommittee report pertaining to this Pre-Service Time Workgroup issue including the addition of more surgeons to the workgroup. The RUC rejected these revisions and recommended that the report pertaining to this issue be maintained.

The Research Subcommittee expressed several concerns and comments regarding the proposed MMM survey instrument from the American College of Obstetricians and Gynecologists (ACOG). **The Research Subcommittee will meet via conference call to review the revised survey instruments and summary of recommendation forms as provided by the specialty.**

The Research Subcommittee, after reviewing the survey instrument for radiation treatment management proposed by the specialty society, expressed concern regarding the current work values because the new vignettes proposed by the specialty society appear to represent patients of different acuity than those surveyed in 2002. Because of these new vignettes, the Research Subcommittee believed that ASTRO should conduct a full RUC survey for this code using the new vignettes. **The RUC recommends that a modified survey instrument, as described in the Research Subcommittee Report, be utilized by the society to survey this code or if the specialty society requests, the service be sent to the CPT Editorial Panel to more clearly define the different intensity levels of this service.**

Specialty determined, after the RUC Meeting, that they will submit a coding proposal to the CPT Editorial Panel in March 2009 for the June 2009 Meeting.

To address the 23 hour stay issue**, the RUC recommends adding the following questions to the survey instrument:**

Question 2b: Post-Operative Work – Please respond to the following questions based on your *typical* experience for each survey code. *Typical* for purpose of this survey means more than 50% of the time.

What is "Typical"?		New/Revised Code
		(Check only one row)
Do you *typically* (>50%) perform this procedure in a hospital, ASC or	Typically performed in a hospital	

in your office?	Typically performed in a ASC	
	Typically performed in my office	

(Check only one row)

If you *typically* perform this procedure in a hospital, is your patient discharged the same day, kept overnight but less than 24 hours, or admitted to the hospital?	Same-day discharge	
	Overnight, but stays less than 24 hrs	
	Admitted, stays more than 24 hrs	
	N/A – typically in ASC or office	

(Check only one row)

If your patient is *typically* kept overnight in a hospital, will you perform an E&M service later on the same day?	Yes	
	No	

Further, the RUC recommends adding the following survey statistics to the Summary of Recommendation Form:

Percent of survey respondents who stated they perform the procedure:
in the hospital____ in the ASC____ in the office_____

Percent of survey respondents who stated they typically perform this procedure in the hospital stated the patient is discharged the same day____ kept overnight (less than 24 hours)_____admitted (more than 24 hours)____

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day____

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

XIII. MPC Workgroup (Tab 22)

Doctor Felger presented the report of the MPC Workgroup including the recommendation to add 94010, *Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation*, to the Multi-Specialty Points of Comparison (MPC) list brought forward by the American College of Chest Physicians and American Thoracic Society. The Workgroup noted that the service meets all criteria for inclusion as an MPC Type A code. **The RUC approved the MPC Workgroup recommendation that 94010 be added to the MPC.**

Doctor Felger also discussed the recommendation to establish a suggested minimum frequency threshold for services on the MPC. The RUC agreed that in some instances,

the available Medicare utilization data do not reflect the commonness of the service. Specialties, therefore, will have the opportunity to express this to the RUC before a code is removed. The RUC agreed that services that are not commonly performed should not appear on the MPC. The RUC noted that two existing "Suggested Criteria" for addition of MPC codes provide support for this recommendation, (1) Codes that are frequently performed should be reflected on the MPC and (2) Codes on the MPC should be understood and familiar to most physicians. Several members of the RUC noted that this request adds a burden to the societies and the RUC agreed that the rationale for maintaining a code on the list may be as simple as a single sentence stating that the procedure is not commonly performed in the Medicare population. **The RUC approved the recommendation to add to the "Suggested Criteria" for inclusion on the MPC: Codes with a utilization of less than 1,000 should not be included on the MPC without justification by a specialty society. The vote was not unanimous.**

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

XIV. Administrative Subcommittee (Tab 23)

Financial Disclosure Review Workgroup
Doctor Blankenship informed the RUC that the Financial Disclosure Review Workgroup reviewed the disclosures for Roy Geronemus, MD (AAD), Peter Weber, MD (AAO-HNS) and Scott Manaker, MD (ACP). The Workgroup determined that these three presenters do not have significant conflicts related to the issues on the October 2008 RUC agenda and may present at the October 2008 RUC meeting.

I. Financial Disclosures

A. Process for Review of Financial Disclosures (Guidelines)
Doctor Blankenship indicated that the Administrative Subcommittee determined it needed a set of guidelines outlining the review of financial disclosures process. The Administrative Subcommittee determined that a subcommittee of the Administrative Subcommittee, consisting of five individuals, should review all financial disclosures prior to each meeting. One individual would remain the Financial Disclosure Review Workgroup each year to maintain an institutional memory of previous decisions and to maintain consistency of the decision process of this Workgroup. Any individual RUC member that may have a conflict will not be assigned to this Workgroup. **The RUC determined that the Chair of the Administrative Subcommittee will appoint the permanent Financial Disclosure Review Workgroup individual each year and the four rotating Workgroup members.**

The Guidelines attached to these minutes outline the processes for reviewing financial disclosure forms and addressing any instances of false disclosures or failure to disclose financial interests discovered after a RUC meeting. Regarding failure to disclose financial interests, the RUC indicated that the course of action will be dependent upon the level of conflict and the underlying motivation regarding the lack of

disclosure. If the conflict is not substantive, a letter may simply be sent to the individual and specialty society as a reminder about the RUC conflict of interest policy. More substantive conflicts may require reconsideration of the relative value recommendations by the RUC. A willful, misleading disclosure may lead to discussion regarding the ability of the presenter/society to present in the future. Any review of future RUC participation would be conducted in a face-to-face meeting of the full RUC with the presenter and specialty society in question in attendance to provide clarification.

B. Financial Disclosure Statement

Doctor Blankenship indicated that the Administrative Subcommittee reviewed the current Financial Disclosure statement and recommended revisions of the statement as indicated below. Revisions included reordering the format of the form so that it reads in a logical sequence, clarifies that the presenter report his/her relationship to this specific code/code set they are presenting, separates financial interests in the last year and cumulative lifetime. A RUC member suggested simplifying the form to request that the presenter identify whether the interest is either less than or greater than $10,000 and that the form request that if **disclosure relates to stock the presenter should list the number of shares owned, options or warrants.**

AMA/Specialty Society RVS Update Committee (RUC)
Financial Disclosure Statement

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

"Family member" means spouse, domestic partner, parent, child, brother or sister. Disclosure of family member's interest applies to the extent known by the representative.

For purposes of this Disclosure, "direct financial interest" means:

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

Include only interests that relate to the specific issue that you are presenting at this RUC meeting.

Specific Disclosure	**Explain relationship between the**	**Identify interest for**	**Identify cumulative**	**If disclosure relates to stock, please list**

(see above list)	**service(s) that you are presenting and your disclosure**	**the past 12 months (circle one)**	**lifetime interest (circle one)**	**number of shares owned, options or warrants**
		< $10,000 > $10,000	< $10,000 > $10,000	
		< $10,000 > $10,000	< $10,000 > $10,000	
		< $10,000 > $10,000	< $10,000 > $10,000	

_____

Agenda Tab/Issue

_____

Signature Date

_____

Print Name Specialty Society

II. Paper Reduction/Process Efficiency

Doctor Blankenship indicated that all RUC participants were queried to provide suggestions on how the RUC may reduce paper as well as improve aspects of the RUC process. The majority of commenters continue to emphasize that the RUC use electronic communications where possible. Doctor Blankenship indicated that AMA staff already distributing information via broadcast e-mails to all RUC participants and will continue to do so.

The Administrative Subcommittee discussed additional paper reduction and process efficiency recommendations to address improvements regarding agenda materials, handouts, survey instruments and summary of recommendation (SOR) forms.

- Handouts
  - The Administrative Subcommittee determined that AMA staff will provide instructions to specialty society staff to consistently name and date submissions and revised forms.
  - The Administrative Subcommittee indicated that submitting all revised documents to the AMA with track changes would not prove beneficial.

- Surveys and SORs
  - The Administrative Subcommittee reviewed RUC participant comments regarding changes to the intensity and complexity measures of the survey instrument and summary of recommendation form. The Administrative Subcommittee suggested that any proposed revisions be formally requested for review by the Research Subcommittee.
  - The Administrative Subcommittee discussed having a centralized online location for conducting surveys, the Administrative Subcommittee determined this was not feasible due to the high expense, logistics and security.
  - The Subcommittee discussed limiting word counts for the physician work descriptions on the SORs. The Subcommittee determined that limiting all specialty societies descriptions on the SORs were not appropriate, but that AMA staff should specifically address specialty societies with excessive descriptions.

  The Administrative Subcommittee recommends that the following be added to the Instructions document for specialty societies submitting recommendations to the RUC: Please note that some information submitted on your summary of recommendation form may be used in the public domain. Please be concise with your pre-, intra- and post-service work descriptions.

- PE Submissions
  The Administrative Subcommittee discussed eliminating the Word document provided for practice expense direct inputs. The Administrative Subcommittee determined that the information provided on this document was important to identify and describe the actual the clinical labor activities performed.

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

XV. PLI Workgroup (Tab 24)

Doctor Peter Smith informed the RUC that the PLI Workgroup reviewed comment letter for the NPRM regarding following the two PLI issues: 1) The RUC recommended that CMS reduces the PLI technical component to zero; and 2) The RUC reiterated its recommendation that CMS use the updated PLI crosswalk and use the PLI premium data provide by AAOMS: $6,100 for Oral Surgery and $15,948 for Maxillofacial Surgery. CMS indicated that is would take this issues under consideration of the current rule-making process.

Doctor Smith indicated that the remainder of the PLI Workgroup discussion surrounded PLI methodology and review of prior PLI Workgroup recommendations to CMS.

Several specific several concerns the PLI Workgroup voiced to the CMS representatives were:

- The current PLI methodology includes calculations that are based on a previous charge-based pool of PLI RVUs which results in inappropriate risk factor determination for the "all physicians" category.
- CMS should utilize the PLI premium data provided by the non-physician health care professionals of the HCPAC, the new Physician Practice Information Survey as it appears that their current contractor is not collecting premium data for these professionals; and
- CMS new contractor is collecting premium data for only 20 physician specialties and those specialties with the highest premiums (neurosurgery, obstetrics/gynecology and cardiothoracic surgery) are not included in the data collection.

Doctor Smith reported that the PLI Workgroup concluded that we need to interact more with CMS on these issues if the RUC is going to be effective on influencing policy regarding PLI. Doctor Smith indicated that he and the two former PLI Workgroup Chairpersons will meet with CMS to establish additional mechanisms of communication to improve the PLI methodology, recognizing this body may be the only people representing physicians outside of the agency.

The RUC discussed whether a different forum or possible legislative approach should be examined in order to voice the RUC's recommendations. CMS representative, Ken Simon, indicated that he would take this issue back to the agency and ensure that the chairperson of the PLI Workgroup be engaged with CMS leadership. AMA staff advised that it may be best to address these PLI methodology issues through regulation, via face-to-face meeting with CMS and cautions taking action via legislation, as CMS are looking for a savings not a redistribution of monies.

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

XVI. HCPAC Review Board (Tab 25)

Lloyd Smith, DPM, informed the RUC that the HCPAC had a robust discussion regarding a request from the American Academy of Audiology (AAA) to have a seat to represent audiologists. Currently, the American Speech-Language-Hearing Association (ASHA) represents both audiologists and speech language pathologists as the exiting umbrella organization on the HCPAC. ASHA has historically represented audiologists on the HCPAC. **The HCPAC recommends that AMA continue the current seat arrangement with ASHA as the umbrella organization and that AAA and ASHA continue to work together on both the HCPAC and RUC recommendations.**

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

XVII. Five-Year Review Identification Workgroup (Tab 26)

Doctor Barb Levy presented the report of the Five-Year Review Identification Workgroup to the RUC. Doctor Levy presented each of the 79 recommendations the Workgroup made for services identified by CMS in its list of the 114 fastest growing procedures.

The RUC approved all recommendations of the Workgroup with the following exceptions:

> **All serviced that were recommended to be surveyed will be brought forward at the January 2009 RUC meeting and all specialties will have the opportunity to make comments to the Workgroup on the need for a survey before the code is scheduled to be surveyed.**
>
> **Several services were extracted for further discussion at the request of the specialty society. Following the extraction and discussion, the RUC agreed that any action for 22214, 22843 and 22849 be deferred until AMA staff provide a complete history of the review of the services during the first Five-Year Review at the January 2009 meeting.**

Doctor Levy then presented a summary of the Workgroup's review of the 35 services within the CMS Fastest Growing list that the Workgroup has already identified through a previous screening mechanism. **The RUC approved all recommendations of the Workgroup.**

Harvard-Reviewed Codes

CMS indicated in the July 2008 NPRM that it will request the RUC to review the remaining 2,856 Harvard-valued codes. The RUC, in its comments to the NPRM, informed CMS that reviewing all 2,856 Harvard-valued codes would require an inordinate amount of time and financial resources, possibly spanning a decade. In the NPRM, CMS states that the focus of the RUC review should give priority to high volume and low intensity services. As such, Doctor Levy reported that the Workgroup analyzed the list with a threshold for high volume of 10,000 per year. The resulting list was 296 services, which accounts for more than $4.5 billion or 86% of the slightly more than $5.2 billion in allowable charges for all Harvard-valued services that CMS cites in the NPRM. Further, Doctor Levy reported that while a list of 296 codes appears, at its face, to be manageable, the list does not account for the additional codes that would be reviewed within the families of those 296. The RUC agreed that though the task will be laborious, it should still take place. The RUC agreed that the initial review of Harvard-valued services should begin with a small number of services with the highest frequency. The RUC agreed that services with utilization of 1,000,000 or more should be surveyed in the initial review.

In order to initiate the review, the RUC approved the recommendation of the Workgroup proposing the following:

1. **Inform CMS that the RUC will limit its current review to the top 9 services, which have a volume of one million or more (as well as their respective families).**
2. **Inform CMS that the RUC will ask specialty societies for the families of codes as well as comment**
3. **The Workgroup will plan a schedule for review at their February 2009 meeting.**

Practice Expense RVUs

CMS, also through the NPRM, made a presumption that increases in the practice expense (PE) RVUs were due to changes in the direct PE inputs. RUC staff performed a detailed analysis and found an 82% concurrence between codes where PE RVUs increased and specialties that submitted supplemental surveys to CMS on indirect practice expense.

Therefore, the increase in PE RVUs is most likely due to CMS acceptance of indirect practice expense supplemental surveys. However, the RUC agreed that increase in PE RVU is not an adequate screening criterion for potential misvaluation. The Practice Expense Subcommittee should continue to work with CMS to identify a process of ongoing review of PE inputs.

Progress of the Joint Workgroup on Bundled Services

Doctor Levy reported that Doctor Kenneth Brin, Chair of the Joint CPT/RUC Workgroup on Bundled Services, participated by conference call to discuss the progress of the recommendations by the RUC and CPT for Type A codes to be bundled. Doctor Brin reported that a coding change proposal was submitted by SNM, ACR, ACC, and ASNC and will be considered during the October Panel meeting. The remaining Type A services will be brought to the Panel within the CPT 2010 cycle. Type B coding change proposals are expected to be submitted for review at the February 2009 CPT Meeting.

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

XVIII. Other Issues

No other issues were presented.

The meeting adjourned on Saturday October 4, 2008 at 5:00 p.m.

Physician Practice Information Survey

RUC Meeting – October 2, 2008

AMA

TOGETHER WE ARE STRONGER




Survey Launched in 1st Qtr 2008

- **Dmr**kynetec mailed survey packets in three waves from late January through late March.
- All sample for each specialty (1,000 per specialty) was released by late March.
- More than 50,000 physicians received the survey packet.
- 100 interviewers began calling the first wave on January 31. All physicians should have received at least six phone calls to date. Some physicians have received as many as 15 calls.




Expectations

- 1,000 new completes by April 30.
- 3,000 completed surveys by August 31
- 4,000 completed surveys by October 31
- 100 useable completes per specialty (5,000 overall) by December 31, 2008
- PE/Hour computations to be delivered to CMS by March 31, 2009.




Responses - September 26

- Nearly 5,000 physicians have participated
- 611 useable completes from 2007 Gallup effort.
- 3,030 Dmrkynetec New Completes
- Total of 3,641 Completed Surveys
- Project is 62% Complete

Specialties with 100 + Completes

- Allergy and Immunology
- Anesthesiology
- Colon and Rectal Surgery
- Family Medicine
- Hand Surgery
- Internal Medicine
- Optometry
- Oral Surgery (Dentist only)
- Pediatrics
- Physical Therapy
- Podiatry




Specialties not likely to meet 100 completes (completes to date)

Note: Precision may be met with less than 100

- General Practice
- Geriatrics
- Interventional Radiology
- Nuclear Medicine
- Osteopathic Manipulative Therapy
- Reproductive Medicine
- Sleep Medicine
- Spine Surgery




Strategies to move other specialties to 100+ completes

- Additional sample mailed in September for 15 specialties
- E-mails/membership information – share with survey firm if policy allows
- Urge maximum communication throughout October and November




Communication

- The AMA has organized e-mail announcements from Professional Association of Health Care Office Management (PAHCOM), Medical Group Management Association (MGMA), Practice Management Center (PMC)
- AMA organized uniform announcement used by each of these groups and the participating specialty societies




Communication

- January 21 edition of *Advocacy Update*
- January 22 edition of *Federation News*
- January 28-31, 5 day run in *Morning Rounds*
- January 28 - AMA Website - Headline Story
- March/April *AMA Voice* Article
- March 20 *eVoice*
- April 1 *Federation Newsletter*




Communication

- Specialty societies have been cooperative: websites, e-mails, newsletters, membership lists, etc.
- Need to ramp up communication again. We encourage broadcast e-mails and have distributed a new message to send out.
- Dmrkynetec has made more than 350,000 phone calls, 100,000 faxes, and thousands of e-mails (bi-weekly to available e-mails)
- AMA financed distribution of 40,000 postcards in June.




4th Quarter 2008

- We will continue to share progress reports on a weekly basis.
- Survey data collection will be completed by December 31.
- Survey firm is re-contacting physicians to provide missing responses and other clarification to maximum useable completes – more than 700 cleaned to date.

AMA/Specialty Society RVS Update Committee **Tab 21**
Research Subcommittee Report
October 2, 2008

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

I. Pre-Service Time Packages

The RUC developed pre-service time packages to be used in specialty society's recommendations to the RUC. These standards of time were reviewed by the Pre-Service Time Workgroup and the Research Subcommittee and finally approved by the RUC. At the April 2008 meeting there was a request for a standard time to be developed for prone position as well as any other exceptions to the supine positioning based on medical knowledge. The American College of Surgeons (ACS) has recommended that an ad hoc workgroup be created to further refine the pre-service time packages. The Workgroup will also address the issue of retroactive application of pre-service time packages and discuss new pre-service time standards proposed by specialty societies including the proposal from the North American Spine Society. **The Research Subcommittee recommends that an Ad Hoc Pre-Service Time Workgroup be created.** Doctor Rich has appointed the following members to the Workgroup:

Thomas Felger, MD
John Gage, MD
Emily Hill, PA-C
Gregory Kwasny, MD
Brenda Lewis, MD
Greg Przybylski, MD
Peter Smith, MD
Sam Smith, MD
Maurits Wiersema, MD

II. Specialty Society Requests

American College of Obstetricians and Gynecologists (ACOG) – Development of a MMM Global Survey Instrument

The Five Year Review Identification Workgroup identified the following codes to be reviewed by the RUC through the High IWPUT Screen: 59400, 59409, 59410, 59412, 59414, 59425, 59426, 59430, 59510, 59515, 59610, 59612, 59614, 59618, 59620, 59622**.** The RUC referred development of an MMM survey instrument to the Research Subcommittee with input from the specialty society at its October 2008 meeting and that these services then be surveyed and reviewed by the RUC. The Research Subcommittee reviewed and offered several comments on the survey instrument proposed by the specialty societies. The Research Subcommittee expressed several concerns and comments regarding the proposed survey instruments including:

1.) The Reference Service List includes procedures not typically performed by OB/GYNs,
2.) The Management of Labor Survey, the Delivery Survey and the Post-Partum Care Survey should be combined into one survey instrument to ensure that there is no overlap in time or work for services provided,
3.) Modifications should be made to the pre-service time portion of the Summary of Recommendation Form as these services do not align with the current pre-service time standards,
4.) The specialty societies should carefully consider if there is more than one typical patient in the management delivery service and

5.) The Antepartum Survey Instrument should be modified to include question regarding performance rate, number of visits provided and final recommended RVU, definition of physician work, and instructions for completing the table.

The Research Subcommittee will meet via conference call to review the revised survey instruments and summary of recommendation forms as provided by the specialty.

American Society for Therapeutic Radiation Oncology (ASTRO) – Development of a Survey Instrument for Radiation Treatment Management

CPT code 77427 was originally identified in the site of service anomaly screen and deferred for discussion to the April 2008 meeting to provide the specialty an opportunity to clarify the reasons for the anomaly. The specialty society clarified that current CMS policy precludes separate payments for evaluation and management services, including those provided during the 90 day period following the last treatment of this multi-treatment service. Therefore, the service, while officially an XXX global period is treated in the RBRVS much like a 90 day global. The Workgroup recognizes the inconsistency of the site of service and recommended conducting a mini-survey to address post radiation follow up care. The Research Subcommittee, after reviewing the proposal by the specialty society, expressed concern regarding the current work values because the new vignettes proposed by the specialty society appear to represent patients of different acuity than those surveyed in 2002. Because of these new vignettes, the Research Subcommittee believed that ASTRO should conduct a full RUC survey for this code using the new vignettes.

In addition, to address the post-operative visit issue, the Research Subcommittee recommends that the XXX survey instrument be modified with questions pertaining to post-treatment services per week. These modifications include: 1.) Addition of a question - How many fractions are typically used for treating the disease described in the vignette and 2.) Addition of a table discerning how the office visits (99211-99215) are provided following the final fraction of treatment over the 90 days with introductory text detailing the definitions of the office visits as well as explaining how to complete the table. Additionally, the specialty should produce a cover letter specifically clarifying that the survey respondents be made explicitly aware that the office visit data being requested only refer to encounters that take place after completion of the last radiotherapy fraction session.

The specialty society, after hearing the discussion from the Subcommittee expressed concern that the coding structure of 77427 does not adequately reflect the practice of this service and that perhaps the code needs to return to the CPT Editorial Panel to address the perceived different levels of intensity of providing this service. **The Research Subcommittee recommends that a modified survey instrument, as described, be utilized by the society to survey this code or if the specialty society requests, the service be sent to the CPT Editorial Panel to more clearly define the different intensity levels of this service.**

Specialty determined, after the RUC Meeting, that they will submit a coding proposal to the CPT Editorial Panel in March 2009 for the June 2009 Meeting.

III. Development of RUC Policy to Address 23 Hour Stay Services

During the review of the potentially misvalued services identified through the site of service anomaly screening mechanism, the RUC uncovered several services that are reported in the Medicare database as typically outpatient services, but where the patient is kept overnight and, on

occasion, several nights. The RUC referred to these issues as 23-hour stay services. Rather than apply a methodology to review the services during at the April 2008 meeting, the RUC referred the issue to the Research Subcommittee to develop modifications to the existing survey instrument and summary of recommendation form regarding whether new or revised services are typically performed in the outpatient or inpatient setting and further what services are performed during that time. The Research Subcommittee reviewed and modified a proposal from the ACS which modifies the existing RUC Survey Instrument and Summary of Recommendation Form. **The Research Subcommittee recommends adding the following questions to the survey instrument:**

Question 2b: Post-Operative Work – Please respond to the following questions based on your *typical* experience for each survey code. *Typical* for purpose of this survey means more than 50% of the time.

What is "Typical"?		New/Revised Code
		(Check only one row)
Do you *typically* (>50%) perform this procedure in a hospital, ASC or in your office?	Typically performed in a hospital	
	Typically performed in a ASC	
	Typically performed in my office	
		(Check only one row)
If you *typically* perform this procedure in a hospital, is your patient discharged the same day, kept overnight but less than 24 hours, or admitted to the hospital?	Same-day discharge	
	Overnight, but stays less than 24 hrs	
	Admitted, stays more than 24 hrs	
	N/A – typically in ASC or office	
		(Check only one row)
If your patient is *typically* kept overnight in a hospital, will you perform an E&M service later on the same day?	Yes	
	No	

Further, the Research Subcommittee recommends adding the following survey statistics to the Summary of Recommendation Form:

Percent of survey respondents who stated they perform the procedure:
in the hospital____ in the ASC____ in the office_____

Percent of survey respondents who stated they typically perform this procedure in the hospital stated the patient is discharged the same day____ kept overnight (less than 24 hours)_____admitted (more than 24 hours)____

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day____

AMA/Specialty Society RVS Update Committee **Tab 22**
Multi-Specialty Points of Comparison Workgroup
Thursday, October 2, 2008

Members Present: Thomas Felger, MD (Chair), Bibb Allen, Jr, MD, Joel Bradley, MD, Thomas Cooper, MD, Peter Hollmann, MD, William Moran, MD, David Regan, MD, Susan Spires, MD, Arthur Traugott, MD, and James Waldorf, MD

Request for Addition of 94010
The MPC Workgroup reviewed the recommendation of the American College of Chest Physicians and American Thoracic Society to add 94010, *Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation*, to the Multi-Specialty Points of Comparison (MPC) list. The Workgroup noted that the service meets all criteria for inclusion as an MPC Type A code. The service was reviewed by the RUC during the third Five Year Review, it is performed by several specialties (pulmonary disease, internal medicine, family medicine, and allergy and immunology), and it is widely understood by many physicians. **The RUC approved the MPC Workgroup recommendation that 94010 be added to the MPC.**

Request to Establish Frequency Threshold
The Workgroup discussed the request of the American Academy of Family Physicians to establish a minimum frequency threshold for services on the MPC. The Workgroup agreed that in some instances, particularly where the typical patient is not a Medicare patient, the available Medicare utilization data do not reflect the commonness of the service. However, the Workgroup felt that services that are not commonly performed should not appear on the MPC and that codes with a frequency of less than 1,000 should not be included without rationale of the recommending specialty society. The Workgroup noted that two existing "Suggested Criteria" for addition of MPC codes provide support for this concept. Those suggested criteria are: (1) Codes that are frequently performed should be reflected on the MPC and (2) Codes on the MPC should be understood and familiar to most physicians. The Workgroup concurred that the most efficient and the appropriate way to facilitate a minimum frequency without disenfranchising any specialty by allowing exceptions to the rule is to expand the "Suggested Criteria" for inclusion on the MPC list. **The RUC approved the recommendation to add to the "Suggested Criteria" for inclusion on the MPC: Codes with a utilization of less than 1,000 should not be included on the MPC without justification by a specialty society. The vote was not unanimous.**

On the approval of the above recommendation by the RUC, the Workgroup agrees that the suggested criteria should be applied to current MPC codes. **The RUC approved the Workgroup recommendation that specialties be solicited to provide rationales for inclusion of existing MPC services with a Medicare utilization of less than 1,000 before their code(s) are deleted from the MPC. If no response is received by the January 2009 RUC meeting, the codes will be deleted.**

Request to Limit Services with Identical RVU
The Workgroup discussed the request of the American Academy of Family Physicians to remove codes from the MPC that have identical work RVUs. The Workgroup agreed that codes that

share identical RVUs are not problematic and, in fact, provide a very useful comparison across specialties. The Workgroup did not accept the specialty's request.

Members: Doctors James Blankenship (Chair), Michael Bishop, Dale Blasier, Joel Bradley, Ronald Burd, John Gage, Charles Koopmann, Robert Kossman, Barbara Levy, Doug Leahy, Lawrence Martinelli, Lloyd Smith and Arthur Traugott.

I. Financial Disclosures

A. Define Process for Review of Financial Disclosures (Guidelines)
The Administrative Subcommittee met via conference call August 12, 2008, to discuss the processes to review specialty society advisors' and presenters' financial disclosure statements. The Administrative Subcommittee developed guidelines for reviewing financial disclosures on the August conference call and reviewed the guidelines at this meeting. Please refer to page 678-679 of agenda book for recommended guidelines. The Administrative made a minor revision to indicate that the individuals comprising the Financial Disclosure Review Workgroup will rotate each meeting, with the exception of one permanent individual per year. The Administrative Subcommittee determined it was important that one individual of the Review Workgroup continue to serve on the Workgroup to maintain an institutional memory of previous decisions and to maintain consistency of the decision process of this Workgroup. Any individual RUC member that may have a conflict will not be assigned to this Workgroup. **The Chair of the Administrative Subcommittee will appoint the permanent Financial Disclosure Review Workgroup individual each year.**

B. Penalty for False Disclosure or Failure to Disclose Financial Interest discovered after a RUC meeting
The Administrative Subcommittee discussed mechanisms to address the discovery of false disclosures or failure to disclose financial interests, following the presentation at the RUC meeting. If the lack of disclosure is discovered during the same meeting as the presentation then the RUC may reconsider the issue. If however, the discovery occurs following a RUC meeting, the Administrative Subcommittee recommends the following process of review to determine the course of action:

1. The Financial Disclosure Review Workgroup reviews any discovered false disclosures or failures to disclose financial interests and determines the extent to which these may have affected the RUC's evaluation of the code. The Workgroup develops a recommendation for action.
2. The Administrative Subcommittee reviews the Workgroup's recommendation and modifies it as needed.
3. The RUC reviews the Administrative Subcommittee's recommendation.
4. If the RUC recommendation has already been submitted to CMS, the RUC Chair will notify CMS and outline recommended course of action.

The course of action will be dependent upon the level of conflict and the underlying motivation regarding the lack of disclosure. If the conflict is not substantive, a letter may simply sent to the individual and specialty society as a reminder about the RUC conflict of interest policy. More substantive conflicts may require reconsideration of the relative value recommendations by the RUC. A willful, misleading disclosure may lead to discussion regarding the ability of the presenter/society to present in the future. Any review of future RUC participation would be

conducted in a face-to-face meeting of the full RUC with the presenter and specialty society in question in attendance to provide clarification.

C. Review Financial Disclosure Statement

The Administrative Subcommittee reviewed the current Financial Disclosure statement and recommends revision of the statement as indicated below.

AMA/Specialty Society RVS Update Committee (RUC)
Financial Disclosure Statement

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

"Family member" means spouse, domestic partner, parent, child, brother or sister. Disclosure of family member's interest applies to the extent known by the representative.

For purposes of this Disclosure, "direct financial interest" means:

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

Include only interests that relate to the specific issue that you are presenting at this RUC meeting.

Specific Disclosure (see above list)	**Explain relationship between the service(s) that you are presenting and your disclosure**	**Identify interest for the past 12 months (circle one)**	**Identify cumulative lifetime interest (circle one)**	**If disclosure relates to stock, please list number of shares owned, options or warrants**
		< $10,000 > $10,000	< $10,000 > $10,000	
		< $10,000 > $10,000	< $10,000 > $10,000	
		< $10,000 > $10,000	< $10,000 > $10,000	

_____
Agenda Tab/Issue

_____ _____
Signature Date

_____ _____

Print Name Specialty Society

Paper Reduction/Process Efficiency
In June 2008, all RUC participants were queried to provide suggestions on how the RUC may reduce paper as well as improve aspects of the RUC process.

The majority of commenters continue to emphasize that the RUC use electronic communications where possible. Currently, the AMA RBRVS Web site does operate a public section and a private RUC participant section. The RUC participant section provides relevant meeting materials, such as an agenda, survey instruments, instructions for developing RUC recommendations, etc. Additionally, AMA staff is continuing to distribute information via broadcast e-mails to all RUC participants.

The Administrative Subcommittee discussed additional paper reduction and process efficiency recommendations to address improvements regarding agenda materials, handouts, survey instruments and summary of recommendation (SOR) forms.

Handouts
The Administrative Subcommittee determined that AMA staff will provide instructions to specialty society staff to consistently name and date submissions and revised forms. The Administrative Subcommittee indicated that submitting all revised documents to the AMA with track changes would not prove beneficial.

Surveys and SORs
The Administrative Subcommittee reviewed RUC participant comments regarding changes to the intensity and complexity measures of the survey instrument and summary of recommendation form. The Administrative Subcommittee suggested that any proposed revisions be formally requested for review by the Research Subcommittee.

The Subcommittee discussed limiting word counts for the physician work descriptions on the SORs. The Subcommittee determined that limiting all specialty societies descriptions on the SORs were not appropriate, but that AMA staff should specifically address specialty societies with excessive descriptions. **The Administrative Subcommittee recommends that the following be added to the Instructions document for specialty societies submitting recommendations to the RUC: Please note that some information submitted on your summary of recommendation form may be used in the public domain. Please be concise with your pre-, intra- and post-service work descriptions.**

PE Submissions
The Administrative Subcommittee discussed eliminating the Word document provided for practice expense direct inputs. The Administrative Subcommittee determined that the information provided on this document was important to identify and describe the actual the clinical labor activities performed.

AMA/Specialty Society RVS Update Committee (RUC)

Guidelines and Processes for Reviewing Financial Disclosures

- Specialty Societies must submit financial disclosure statements for Advisors/Presenters due with the summary of recommendation (SOR) submissions prior to each meeting.
- AMA staff will screen all financial disclosure statements that are submitted.
- The Financial Disclosure Review Workgroup will review all disclosures via conference call. The conference call will be held as soon as possible (less than a week) after the SOR/financial disclosure due date.
- The Financial Disclosure Review Workgroup will come to consensus regarding whether any restrictions should be placed on the Advisor/Presenter's presentation to the RUC, as follows:
    1. No restriction. Advisor/Presenter may present to the full RUC.
    2. Advisor/Presenter may provide a brief (less than 5 minutes) description of how the procedure is performed. The presenter must then leave the RUC table, but may answer questions from the floor limited to the procedure itself.
    3. Advisor/Presenter may not present at the RUC table or attend the RUC meeting.
- If necessary, AMA staff will contact specific Advisors/Presenters to obtain more information as requested by the Financial Disclosure Review Workgroup.
- After the conference call, AMA Staff will contact the Advisor/Presenter and Specialty Society in writing regarding the Financial Disclosure Review Workgroup determinations.
- If an Advisor/Presenter is prohibited from presenting to the RUC, the Specialty Society may immediately submit a financial disclosure form of an alternate. The Financial Disclosure Workgroup will review the alternate's financial disclosure form immediately via conference call.

Financial Disclosure Review Workgroup

- A workgroup of the Administrative Subcommittee consisting of five individuals will review all financial interests disclosed.
- The five individuals on this workgroup will be assigned by the Administrative Subcommittee Chair. Any individual RUC member that may have a conflict will not be assigned to this Workgroup.
- The individuals comprising the Review Workgroup will rotate each meeting, with the exception of one permanent member per year.

Appeals Process

- If a Specialty Society requests an appeal of a Financial Disclosure Review Workgroup decision, the full Administrative Subcommittee will meet via telephone conference prior to the RUC meeting.

- All appeals of the Financial Review Workgroup shall be in writing and received by AMA staff within 1 week after the Specialty Society received notification of the Financial Disclosure Review Workgroup decision.
- The Administrative Subcommittee shall invite appellants to meet via telephone to discuss the rationale of the Financial Disclosure Review Workgroup decision and the reason for the appeal.
- The Administrative Subcommittee will come to consensus regarding whether to reverse the Financial Disclosure Review Workgroup decision.
- The Administrative Subcommittee decision will be final.

Pre-Facilitation and Facilitation Committee Guidelines

- Advisors/Presenters with restricted presentation privileges:
    - Will wear a bright color badge
    - Will be announced by the Committee chair at the beginning of each meeting
    - Will not sit at the table
    - At pre-facilitation meetings may speak freely, as the pre-facilitation committee does not make relative value recommendations
    - At facilitation meetings may only discuss technical aspects of the procedure, as the committee does make formal relative value recommendations

Discovery of False Disclosures/Failure to Disclose prior to the RUC Meeting

- If an Advisor/Presenter's financial interest is not disclosed or discovered until the RUC meeting, that individual must immediately leave the RUC meeting.
- The remaining presenters will continue with the presentation.

Discovery of False Disclosures/Failure to Disclose after the RUC Meeting

- The Financial Disclosure Review Workgroup reviews any discovered false disclosures or failures to disclose financial interests and determines the extent to which these may have affected the RUC's evaluation of the code. The Workgroup develops a recommendation for action.
- The Administrative Subcommittee reviews the Workgroup's recommendation and modifies it as needed.
- The RUC reviews the Administrative Subcommittee's recommendation.
- If the RUC recommendation has already been submitted to CMS, the RUC Chair will notify CMS and outline recommended course of action.

AMA/Specialty Society RVS Update Committee **Tab 24**
Professional Liability Insurance Workgroup
October 2, 2008

Members: *Doctors Peter Smith (Chair), Ronald Burd, John Gage, David Hitzeman, Charles Koopmann, Doug Leahy, Charles Mick, Najeeb Mohideen, Gregory Przybylski and Daniel Mark Siegel.*

CMS staff responsible for PLI methodology issues within the agency joined the meeting via conference call.

I. NPRM 2008 Proposed Rule: Comment Letter PLI Section (Informational Item)

Technical Component/Professional Component
The PLI Workgroup reviewed the recent August 27, 2008 RUC comment letter to CMS on the NPRM 2009 *Proposed Rule*. The PLI Workgroup reiterated to CMS that it understands that there are no identifiable separate costs for professional liability for technicians. The PLI Workgroup recommended that CMS reduce the PLI technical component to zero. Additionally that the PLI RVUs be recalculated to ensure that these PLI RVUS are redistributed across all physician services.

CMS indicated that their current contractor for the 2010 malpractice RVU update will research this issue and address it in the 2009 NPRM. The workgroup expressed frustration that this issue was initially raised by the RUC in 2004 and it appears that it may not be addressed until 2010.

Crosswalks (Maxillofacial/Oral Surgery)
The PLI Workgroup also reviewed the recent RUC comment letter in which the RUC reiterated its recommendation that CMS use the updated PLI crosswalk and use the PLI premium data provide by AAOMS: $6,100 for Oral Surgery and $15,948 for Maxillofacial Surgery.

CMS indicated that they will review this issue and address as soon as allowed by the rulemaking process, again most likely in the 2009 NPRM.

II. PLI Methodology

The PLI Workgroup voiced several concerns to the CMS representatives, including:

- The current PLI methodology includes calculations that are based on a previous charge-based pool of PLI RVUs which results in inappropriate risk factor determination for the "all physician" category.
- CMS should utilize the PLI premium data provided by the non-physician health care professionals of the HCPAC, the new Physician Practice Information Survey as it appears that their current contractor is not collecting premium data for these professionals; and
- CMS new contractor is collecting premium data for only 20 physician specialties and those specialties with the highest premiums (neurosurgery, obstetrics/gynecology and cardiothoracic surgery) are not included in the data collection.

AMA staff compiled previous PLI related RUC recommendations and will be forwarded to CMS. CMS indicated that they will review these issues, as well as provide them to their current PLI RVU update contractor. CMS and the RUC indicated that they look forward to establishing additional mechanisms of communication to improve the PLI methodology.

AMA/Specialty Society RVS Update Committee **Tab 25**
RUC HCPAC Review Board Meeting
October 2, 2008

Members Present:
Arthur Traugott, MD, Chair
Lloyd Smith, DPM, Co-Chair
Katherine Bradley, PhD, RN
Michael Chaglasian, OD
Robert Fifer, PhD
James Georgoulakis, PhD, JD
Christine Goertz Choate, DC, PhD
Emily H. Hill, PA-C
William J. Mangold, Jr., MD
Doris Tomer, LCSW
Erik van Doorne, PT, DPT
Jane White, PhD, RD, FADA
Maurits Wiersema, MD

I. CMS Update
Edith Hambrick, MD, provided a CMS update and informed the HCPAC that CMS is currently in the rule making process and the HCPAC could expect to see the *Final Rule* by November 1, 2008. Doctor Hambrick noted that the HCPAC proposed regulation to address MIPPA provisions will be included, which may address issues related to health care professionals.

II. CMS Request: Practice Expense Recommendation for *CPT 2010*:
The American Speech-Language Hearing Association (ASHA) requests that the HCPAC postpone review of speech device evaluation code 92597, until a future meeting in 2009. ASHA fully realizes the HCPAC needs to review CPT code 92597. However, due to the new legislation which allows speech language pathologists to bill Medicare directly for their services starting in 2009 and the need to reassess the SLP services for the professional work component, ASHA is requesting postponement. ASHA has submitted this request to CMS.

III. HCPAC Composition – Speech Language Pathologists
On July 15 2008, H.R. 6331 Medicare Improvements for Patients and Providers Act of 2008 was signed into law. Section 143 of HR 6331 specifies that speech language pathologists may independently report services they provide to Medicare patients.

The American Academy of Audiology (AAA) requested that AAA represent audiologists and the American Speech-Language-Hearing Association (ASHA) represent the speech language pathologists on the HCPAC. ASHA sent a letter to the HCPAC stating that they believe that ASHA serves as an umbrella organization for both speech pathology and audiology. ASHA requested that they continue its representation on the RUC HCPAC.

The HCPAC reviewed the HCPAC Structure and Functions document and letters from AAA and ASHA. The HCPAC had a robust discussion where AAA and ASHA both addressed their concerns regarding the allocation of seats for audiology. AAA and ASHA informed the HCPAC that 70% of audiologists are members of both organizations and both organizations have similar position papers defining audiologist's scope of practice. AAA indicated that they represent 10,673 members and ASHA indicated that they represent 12,976 audiology members.

A HCPAC member also noted that the HCPAC, as the RUC, is a not a representative body, but an expert panel to review and provide relative value recommendations to CMS. The HCPAC determined that speech language pathologists and audiologists should be represented on the HCPAC under the existing umbrella organization, ASHA, and encourage AAA and ASHA to continue to work together on both the HCPAC and RUC recommendations. The HCPAC reaffirmed the current HCPAC Structure and Functions that audiologists are fairly and meaningfully represented on the HCPAC by an umbrella organization.

AMA/Specialty Society RVS Update Committee **Tab 26**
Five-Year Review Identification Workgroup
October 3, 2008

Members Present: Barbara Levy, MD (Chair), James Anthony, MD, Michael Bishop, MD, James Blankenship, MD, Dale Blasier, MD, Katherine Bradley, PhD, RN, Norm Cohen, MD, Thomas Felger, MD, Gregory Kwasny, MD, William J. Mangold, Jr., MD, Lawrence Martinelli, MD, Geraldine McGinty, MD, Maurits Weirsema, MD, Robert Zwolak, MD

Doctor Levy welcomed the Workgroup, thanked them for their work and reiterated that the mandate of this Workgroup is to identify potentially misvalued services for possible review by the RUC.

June 19, 2008 CMS Request for Review of 114 Services

Review of Specialty Society Action Plans
In the NPRM regarding the 2009 Physician Payment Schedule published on July 1, CMS provided a list of the 114 fastest growing procedures. CMS was supportive of the RUC's role in the identification of and review potentially misvalued services. CMS compiled this list based on codes that grew at least 10% per year over the course of three previous years be reviewed. This generated a list of 114 services, for which approximately a third have already been identified by the RUC. Seventy-nine additional high volume growth codes were identified under this method. To begin the review of these services, AMA staff requested specialties to provide action plans that will detail the reason for the growth, if any, and a timeline for the review of the procedure or any other special concerns related to the valuation of these services or other services within their respective coding families.

The Five-Year Review Identification Workgroup discussed each code individually and made several different recommendations – to survey, refer to CPT, draft CPT Assistant article, request more data, review in 2 years, or remove from this screen. For those services that may need to be surveyed, the Workgroup recommends that they not be immediately referred for survey, but, because of the number of codes, be prioritized by this Workgroup in February 2009, with surveys to potentially begin thereafter. RUC staff will be performing the prioritization by utilization and forwarding the list to all specialties for review and comment prior to the February 2009 meeting. Specialties are asked to confirm that the correct family of services is included with the potentially misvalued service discussed below. **The RUC approved the following actions recommended by the Workgroup.**

Code	Recommendation to the RUC
10022	The specialty indicated that imaging should always be reported with this service. In its recommendations, the specialty indicated that utilization of more invasive procedures has decreased commensurate with the increase in 10022. However, those services were not listed in the specialty's action plan. Because of the potential of creating bundled services rather than surveying the code as is, the Workgroup requests additional data regarding the imaging procedures that are inherent and the relevant codes that have experienced a decrease in utilization due to the increase in utilization of this service. The Workgroup requests that the specialty return in February 2009 with this additional data.
13121	The Workgroup noted that 13121 is performed in conjunction with a excision of lesion service more than 70% of the time. The Workgroup agrees that the creation of a bundled service is most appropriate and requests that the specialty come back to the workgroup with data regarding the services that are most commonly performed with this family (13120, 13121 and 13122) to recommend the development of a bundled code.
19295	The Workgroup accepted the specialty society's rationale for the growth in volume and agreed with the recommendation to remove this service from the volume growth screen. The only actual resource cost in this service is the clip; there is no physician work.
20551	The Workgroup agreed with the specialty society's request for additional data from CMS. Specifically, the data requested is the number of units of 20551 and 20550 billed on the same day by the same provider as well as the number and level of evaluation and management services reported at the same time as the 20551 and 20550.
20926	The Workgroup agreed with the specialty society's request for additional data from CMS. Specifically, the data requested are the other services billed on the same day by the same surgeon.
22214	The Workgroup noted that this service has never been reviewed by the RUC. In combination with the growth in volume, the Workgroup agreed that the service was potentially misvalued and may need to be surveyed along with 22210, 22212, and 22216 of the same family. **The RUC delayed action on this service while staff researches why the RUC database indicates RUC time, but with no available survey data. The RUC requests that the Five-Year Review Identification Workgroup review this service again with all available data from the previous RUC recommendation.**
22533	The Workgroup accepted the specialty society's rationale for the growth in volume and agreed with the recommendation to draft a CPT Assistant article. The article should include the other services in the family, 22532 and 22534.

22843	The Workgroup noted that this service has never been reviewed by the RUC. In combination with the growth in volume, the Workgroup agreed that the service was potentially misvalued and may need to be surveyed with 22840, 22841, 22842, 22844, 22845, 22846, 22847, 22848, and 22851. **The RUC delayed action on this service while staff researches the previous RUC recommendation. The RUC requests that the Five-Year Review Identification Workgroup review this service again with all available data from the previous RUC recommendation.**
22849	The Workgroup noted that this service has never been reviewed by the RUC. In combination with the growth in volume, the Workgroup agreed that the service was potentially misvalued and may need to be surveyed. **The RUC delayed action on this service while staff researches the source of data within the RUC database. The RUC requests that the Five-Year Review Identification Workgroup review this service again with all available data from the previous RUC actions.**
22851	The Workgroup reviewed the service and noted that it may be appropriate to develop a bundled service or may need to re-survey the service because of the growth in the add-on code. The Workgroup agreed that this service was potentially misvalued and asks that either the service be revised at CPT to bundle with the base code or may need to be resurveyed. The Workgroup also supported the request to obtain data on the number of times it is reported per operative session.
23430	The Workgroup noted that this service has never been reviewed by the RUC. In combination with the growth in volume, the Workgroup agreed that the service was potentially misvalued and may need to be surveyed.
23472	The Workgroup accepted the specialty society's rationale for the growth in volume and agreed with the recommendation to remove this service from the volume growth screen. This service was recently reviewed by the RUC.
26480	The Workgroup noted that this service has never been reviewed by the RUC. In combination with the growth in volume, the Workgroup agreed that the service was potentially misvalued and may need to be surveyed.
29822	The Workgroup noted that the specialty society's explanation that the open procedure has decreased is correct. The relevant open codes have decreased over the same period. However, the service is Harvard-valued. The Workgroup agreed that the service is potentially misvalued and may need to be surveyed. Lastly, the Workgroup commented that this procedure may also be done on the same day with other procedures, which should be taken into account at the time of re-evaluation.
29827	The Workgroup agreed with the specialty society's explanation that the laparoscopy procedure has increased in volume and the open procedure has decreased, offsetting the overall growth. The Workgroup recommends that this service be removed from the screen. This service was also recently reviewed by the RUC.

31579	The Workgroup accepted the specialty society's rationale for the growth in volume and agreed with the recommendation to remove this service from the volume growth screen. The specialty noted that while the typical patient is not a Medicare patient, the service is still commonly performed in the Medicare population and the number of patients requiring this procedure has increased.
32663	The Workgroup noted that this procedure was recently reviewed during the Third Five-Year Review. The specialty society provided a very detailed analysis of the total number of lobectomies performed showing that while 32663 has increased, utilization has merely shifted and total number of lobectomies is static. The Workgroup accepted the specialty society's rationale for the growth in volume and agreed with the recommendation to remove this service from the volume growth screen.
33213	The Workgroup found that this service was billed 76% of the time with the removal code, despite the fact that 33213 describes an insertion or replacement. The Workgroup agrees that this is inappropriate and recommends that the service be referred to CPT for revision of the descriptor and/or instructions.
35470	The Workgroup agreed that this service is currently structured as component coding and, consistent with previous recommendations, should be referred to CPT to create bundled services.
35474	The Workgroup agreed that this service is currently structured as component coding and, consistent with previous recommendations, should be referred to CPT to create bundled services.
36248	The Workgroup agreed that this service is currently structured as component coding and, consistent with previous recommendations, should be referred to CPT to create bundled services.
36516	The Workgroup noted that this was a new service in 2002 and has relatively low volume. The Workgroup agreed with the specialty society and recommends development of a CPT Assistant article to clarify coding.
38571	The specialty society indicated that several new codes are being developed to describe the robotic procedure. The Workgroup noted that 38571 may also need to be surveyed at that same time and should not be used as the base code or reference code for the new codes.
43236	The Workgroup agreed with the specialty society and recommends development of a CPT Assistant article. Further, the Workgroup noted that utilization should be reviewed again in three years to assess the effectiveness of the article.
43242	The Workgroup agreed with the specialty society and recommends development of a CPT Assistant article. Further, the Workgroup noted that utilization should be reviewed again in three years to assess the effectiveness of the article.

43259	The Workgroup agreed with the specialty society and recommends development of a CPT Assistant article. Further, the Workgroup noted that utilization should be reviewed again in three years to assess the effectiveness of the article.
44205	The Workgroup agreed with the specialty society's rationale for the increase in volume that open procedures have decreased commensurate with the increase in the laparoscopic procedure. The comparison reveals that overall colectomies have decreased. The Workgroup agreed with the specialty's recommendation to remove this service from the screen.
44207	The Workgroup agreed with the specialty society's rationale for the increase in volume that open procedures have decreased commensurate with the increase in the laparoscopic procedure. The comparison reveals that overall colectomies have decreased. The Workgroup agreed with the specialty's recommendation to remove this service from the screen.
44970	The Workgroup agreed with the specialty society's rationale for the increase in volume that open procedures have decreased commensurate with the increase in the laparoscopic procedure. The comparison reveals that overall appendectomies have decreased. The Workgroup agreed with the specialty's recommendation to remove this service from the screen.
45381	The Workgroup agreed with the specialty society's rationale for volume growth and recommended that a CPT Assistant article be drafted to discuss the gastroenterology services. Further, the Workgroup noted that utilization should be reviewed again in three years to assess the effectiveness of the article.
47490	The Workgroup noted that this was a relatively low volume procedure, but that it is still Harvard-valued. In combination with the recent growth in volume, the Workgroup agreed that the procedure is potentially misvalued and recommends that the procedure may need to be surveyed.
50542	The Workgroup agreed with the specialty society that this was a new code in 2003 and the growth in volume is not excessive for a newer code. The Workgroup recommended removing it from the screen.
50548	The Workgroup agreed with the specialty society's rationale that the increase in utilization of 50548 is offset by a reduction in the open procedure. The Workgroup recommended removing this service from the screen. This service was recently reviewed by the RUC.
50605	The Workgroup agreed that this service should be referred to CPT for revision of the descriptor. Urologists are not typically the primary physician and are not performing the opening or closing, and descriptor of physician work should reflect this.
61793	This service has been deleted from CPT.

61795	The Workgroup noted that this is a relatively high volume procedure that has never been surveyed by the RUC. The Workgroup agreed that the service is potentially misvalued and should be surveyed in the future.
63056	The Workgroup noted that this is a relatively high volume procedure that has never been surveyed by the RUC. The Workgroup agreed that the service is potentially misvalued and may need to be surveyed in the future. Further, the Workgroup agrees with the specialty society that a CPT Assistant article and a CCI edit be created in the interim. The survey should also include the family of codes indicated by the specialty, 63055 and 63057.
63655	The Workgroup noted that while this is a low volume procedure, it has never been surveyed by the RUC and in combination with the growth in volume, the Workgroup agreed that the service is potentially misvalued and may need to be surveyed in the future. This service is also migrating to the outpatient setting.
64415	The Workgroup noted that this is a volume procedure that has never been surveyed by the RUC. The Workgroup agreed that the service is potentially misvalued and may need to be surveyed in the future. The family of injection codes should be addressed with this code.
64445	The Workgroup noted that this is a volume procedure that has never been surveyed by the RUC. The Workgroup agreed that the service is potentially misvalued and may need to be surveyed in the future.
64447	The Workgroup commented that the vignette for this service indicated that it is performed in conjunction with another procedure, but there are 25 minutes of pre-time. As such, the Workgroup agreed that the service is potentially misvalued and may need to be resurveyed.
64483	The specialty society commented that imaging guidance is absolutely necessary in this procedure. However, the procedure is only reported with an imaging service little more than 50% of the time. The Workgroup agreed that lesser injection codes may be incorrectly reported using this coded. The Workgroup recommended that this service along with the other codes in its family (64470, 64472, 64475, 64476, 64479, 64480, 64483, 64484) be referred to CPT to be bundled with the appropriate guidance procedure(s).
64484	The specialty society commented that imaging guidance is absolutely necessary in this procedure. However, the procedure is only reported with an imaging service little more than 50% of the time. The Workgroup agreed that lesser injection codes may be incorrectly reported using this coded. The Workgroup recommended that this service along with the other codes in its family (64470, 64472, 64475, 64476, 64479, 64480, 64483, 64484) be referred to CPT to be bundled with the appropriate guidance procedure(s).

64561	The Workgroup agreed that had the New Technology list been in existence at the time this procedure was developed, it would have been included. As such, the Workgroup would like to continue to monitor this procedure and review the change in volume in two years. Further, the Workgroup will review the utilization of 64581 and 64590 indicated by the specialty.
65780	The Workgroup agreed with the specialty society recommendation to draft a CPT Assistant article to clarify correct reporting.
69100	The Workgroup noted that this is a high volume procedure that has never been surveyed by the RUC. The Workgroup agreed that the service is potentially misvalued and should be surveyed in the future. The service may need to be surveyed with 69105 as indicated in the action plan. When the specialty reviews this, the Workgroup asks that it provide data regarding evaluation and management on the same date.
69801	The Workgroup noted that this service has migrated to being predominantly performed in the office-setting. In tandem with the growth in volume, the Workgroup agreed that it is potentially misvalued and may need to be surveyed.
71250	The Workgroup noted that this is a high volume procedure that has never been surveyed by the RUC and that there is some question as to what procedures are performed by the same provider on the same date of service. The Workgroup agreed that the service is potentially misvalued and may need to be surveyed in the future.
71275	The Workgroup noted that this is a high volume procedure that has never been surveyed by the RUC and that there is some question as to what procedures are performed by the same provider on the same date of service. The Workgroup agreed that the service is potentially misvalued and may need to be surveyed in the future.
72125	The Workgroup noted that this is a high volume procedure has been surveyed by the RUC, but that there is some question as to what procedures are performed by the same provider on the same date of service. The Workgroup agreed that the service is potentially misvalued and may need to be surveyed in the future.
72128	The Workgroup noted that this is a high volume procedure that has never been surveyed by the RUC and that there is some question as to what procedures are performed by the same provider on the same date of service. The Workgroup agreed that the service is potentially misvalued and may need to be surveyed in the future.
72192	The Workgroup noted that this service is already under consideration to be bundled as part of the recommendations of the Joint Workgroup on Bundled Services. The Workgroup will defer any action on this service until the coding change proposal has been considered by CPT.
73200	The Workgroup noted that this is a high volume procedure that has never been surveyed by the RUC and that there is some question as to what procedures are performed by the same provider on the same date of service. The Workgroup agreed that the service is potentially misvalued and may need to be surveyed in the future.

73218	The Workgroup noted that this is a high volume procedure that has never been surveyed by the RUC and that there is some question as to what procedures are performed by the same provider on the same date of service. The Workgroup agreed that the service is potentially misvalued and may need to be surveyed in the future.
73700	The Workgroup noted that this is a high volume procedure that has never been surveyed by the RUC and that there is some question as to what procedures are performed by the same provider on the same date of service. The Workgroup agreed that the service is potentially misvalued and may need to be surveyed in the future.
74175	The Workgroup noted that this service is structured as a component code and agreed that that structure may not be appropriate. Further, the typical patient may have changed from the patient that is described in the vignette. The Workgroup agreed that this service is potentially misvalued, but requested that first be reviewed by the CPT to consider the appropriateness of component coding and other services it may be typically performed with.
76536	The Workgroup noted that this is a high volume procedure that has never been surveyed by the RUC. The Workgroup agreed that the service is potentially misvalued and may need to be surveyed in the future.
76880	The Workgroup accepted the specialty society's recommendation to survey this service.
77301	The Workgroup agreed with the specialty society recommendation to draft a CPT Assistant article to clarify correct reporting. Additionally, the Workgroup will review the change in volume again in 3 years to assess the effectiveness of the article.
77418	The Workgroup agreed with the specialty society recommendation to draft a CPT Assistant article to clarify correct reporting. Additionally, the Workgroup will review the change in volume again in 3 years to assess the effectiveness of the article.
77781	This service has been deleted from CPT
92135	The Workgroup commented that this service has increased in volume dramatically over the past 10 years, since it was reviewed by the RUC. The Workgroup agreed that it is potentially misvalued and recommends that it may need to be resurveyed.
92136	The Workgroup noted that this is a high volume procedure that has never been surveyed by the RUC. The Workgroup agreed that the service is potentially misvalued and may need to be surveyed in the future.
92285	The Workgroup noted that this is a high volume procedure that has never been surveyed by the RUC. The Workgroup agreed that the service is potentially misvalued and may need to be surveyed in the future.
92587	The Workgroup noted that this is a high volume procedure that has never been surveyed by the RUC. The Workgroup agreed that the service is potentially misvalued and may need to be surveyed in the future.

92986	The Workgroup accepted the specialty society recommendation to remove from the list. This was a low volume code and has not changed significantly in the last 20 years.
93308	The specialty society has developed guideline to reduce the inappropriate use of this code. Remove from this list.
93613	The Workgroup agreed that the increase in volume is appropriate and recommends that the service be removed from this screen. Advances in technology have allowed application of ablation for many previously untreatable and complex arrhythmias, such as atrial fibrillation and ventricular tachycardia. This requires use of 3-dimensional mapping to optimize the outcome. The increase in utilization is a reflection of an appropriate increase in the rate of use of this technology.
93652	The Workgroup commented that the service was last reviewed by the RUC in 1993. Further, the typical patient may be changing as indicated by the specialty. Lastly, the service contains seemingly excessive pre-service time, compared to more currently reviewed services. The Workgroup agreed that this service is potentially misvalued and that it and the others in the family – 93650 and 93651 may need to be surveyed.
93743	This service has been deleted from CPT
93922	The Workgroup noted that the existing data does not include any description of physician work as it was previously crosswalked to other services. The Workgroup agreed that it is potentially misvalued and recommends that it, and the other services in the family (93923, 93924, 93925, 93926, 93930, and 93931) may need to be surveyed. The Workgroup recommended a review a PE inputs for staff time as well.
93976	The Workgroup noted that this is a high volume procedure that has never been surveyed by the RUC. The Workgroup agreed that the service is potentially misvalued and may need to be surveyed in the future.
93990	The Workgroup accepted the recommendation of the specialty society to remove the code from the list because is has been reviewed by the RUC and the specialty's rationale is appropriate.
94762	The Workgroup noted that service is PE only, with IDTFs predominantly performing this procedure. The Workgroup recommends that this and the other codes in the family (94760 and 94761) be referred to the Practice Expense Subcommittee for review of the direct PE inputs.
95956	The Workgroup noted that this is a high volume procedure that has never been surveyed by the RUC. The Workgroup agreed that the service is potentially misvalued and should be surveyed in the future along with the other services in the family – 95950, 95951, 95953, 95954, 95955, 95957, 95958, 95961, 95962, 95965, 95966, and 95967. The specialty also recommended a CPT Assistant article and the Workgroup agreed.

96920	The Workgroup noted that this service was new in 2002 and that volume should be reviewed again two years along with the other code in the family, 96921 and 96922.
G0179	The Workgroup agreed with the specialty society that the utilization of this service should actually be higher. Further, the Workgroup agreed that this service would be more appropriately reported with a CPT Category I code. The Workgroup accepted the specialty society's recommendation to remove this service from this screen and recommends that the specialty submit a coding change proposal to develop a CPT code for this service as well as G0180 and G0181.
G0181	The Workgroup agreed with the specialty society that the utilization of this service should actually be higher. Further, the Workgroup agreed that this service would be more appropriately reported with a CPT Category I code. The Workgroup accepted the specialty society's recommendation to remove this service from this screen and recommends that the specialty submit a coding change proposal to develop a CPT code for this service.
G0268	The Workgroup noted that this service is indistinguishable from the CPT code 69210. The G code has never been reviewed by the RUC and CMS currently crosswalks the valuation to 69210. The Workgroup requests that CMS clarify the need for this service and, in the alternative, that they delete the G code. CMS provided the following information, which was originally given in response to a request for clarification to AAO-HNS: CMS has responded to the Academy's plea to correct the NCCI bundling of 69210 and audiometric testing by developing a new HCPCS II G code. "G0268 Removal of impacted cerumen (one or both ears) by physicians on same date of service as audiologic function testing." The RVUs for physician work, practice expense and malpractice will remain the same as CPT code 69210, removal impacted cerumen (separate procedure), one or both ears. It should be noted that this code should be billed only in those situations where a physician's expertise is needed to remove impacted cerumen on the same day as audiologic function testing performed by his employed audiologist. The two must share the same UPIN number. G0268 code cannot be billed by independent audiologists. Routine removal of cerumen, as defined by CMS, is the use of softening drops, cotton swabs and/or cerumen spoon) and is not paid separately. It is considered incidental to the office visit and cannot be reimbursed on the same day as the E&M service

Review of Specialty Society Actions on Previously Reviewed Services
Thirty-five of the services identified by CMS were already identified through one of the various screens for potential misvaluation. A separate list of those services has been compiled and specialty societies, with the assistance of staff, have provided updates regarding the progress of the actions recommended by the RUC. The Five-Year Review Identification Workgroup reviewed the updates on each of the 35 services from the specialty societies and submits the following information and recommendations to the RUC for these services. **The RUC approved the following actions based on the Workgroup's recommendations:**

Code	Recommendation and/or Update to the RUC
14021	14021 is scheduled to be presented at the October 2008 RUC Meeting.
14300	The service was referred to CPT
15740	A coding change proposal regarding 15740 has been submitted and will be included in the October 2008 AMA CPT meeting agenda.
27245	27245 is scheduled to be presented at the October 2008 RUC Meeting
27370	**The Workgroup agreed that due to the utilization of this service and fact that it has never been reviewed by the RUC, that it is potentially misvalued and may need to be surveyed.**
37765	The Workgroup reviewed its previous recommendation and agreed that its decision to continue to monitor the service was appropriate in light of the fact that 37765 and 37766 were new codes in 2004. It reiterated that the growth in utilization was most likely because the codes were new. The Workgroup will review the services again in two years to determine the appropriateness of the utilization.
51772	The specialty society reported that it will submit coding change proposals to the CPT Editorial Panel to delete the 51772 as well as condense codes to include the Urethral Pressure Profile. The specialty indicated that the changes will be submitted in time for discussion at the February 2009 CPT Editorial Panel Meeting.
55866	The specialty society reported that it will submit coding change proposals to the CPT Editorial Panel to request new CPT codes. Code 55866 Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing will remain. Additional CPT coding change proposals will be submitted for the following: 5586X *Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing; with total pelvic lymphadenectomy* and 5586X *Laparoscopy, robotic assisted surgical prostatectomy, retropubic radical, including nerve sparing*, and 5586X, *with total pelvic lymphadenectomy*, in time for discussion at the February 2009 CPT Editorial Panel Meeting.
63650	The RUC reviewed the potentially misvalued service at its February 2008 meeting and submitted recommendations to CMS in May 2008.
63660	The specialty societies submitted a coding change proposal for the October 2008 CPT Editorial Meeting to split the work previously described in 63660 into four separate codes.
63685	The RUC reviewed the potentially misvalued service at its February 2008 meeting and submitted recommendations to CMS in May 2008.

64448	The Workgroup noted that 64448 was revised at the Feb 2008 CPT Panel meeting and presented at the April 2008 RUC meeting. Recommendation was to change the global from 10 to zero with 1.63 work RVUs. Descriptor was revised to read: *Injection, anesthetic agent; femoral nerve, continuous infusion by catheter (including catheter placement).* The language regarding daily management was deleted per the Workgroup's recommendation.
64555	The specialty society indicated that two articles have appeared in their Health Policy Brief (May 2008 and August 2008) advising members of the proper coding of the percutaneous tibial nerve stimulation procedure using the 64999 unlisted nervous system code instead of the 64555. The specialty is also drafting a CPT Assistant Article with similar clarification.
64622 64626 64627	CPT Executive Committee addressed on May 1 and added parenthetical to instruct use of unlisted code for pulsed radiofrequency.
66982	The Workgroup previously recommended that 66984 and 66982 were not potentially misvalued because of pharmocologically induced Floppy Iris Syndrome. The impact of this new condition and its results on utilization of 66982 will be monitored and the Workgroup will review the service again in two years to assess changes in utilization.
67028	**The Workgroup agreed that due to the utilization of this service and fact that it has never been reviewed by the RUC, that it is potentially misvalued and may need to be surveyed.**
70496	The Workgroup agreed with its previous recommendation to review utilization of this service at a later date as the technology is currently shifting from 16 to 64 slice scanners. The Workgroup established a time-certain date for re-review in two years.
70498	The Workgroup agreed with its previous recommendation to review utilization of this service at a later date as the technology is currently shifting from 16 to 64 slice scanners. The Workgroup established a time-certain date for re-review in two years.
72191	The Workgroup agreed with its previous recommendation to review utilization of this service at a later date as the technology is currently shifting from 16 to 64 slice scanners. The Workgroup established a time-certain date for re-review in two years.
72194	The specialty society is in the process of developing a coding change proposal for CPT 2010.
73580	**The Workgroup agreed that due to the utilization of this service and fact that it has never been reviewed by the RUC, that it is potentially misvalued and may need to be surveyed.**
75635	The Workgroup agreed with its previous recommendation to review utilization of this service at a later date as the technology is currently shifting from 16 to 64 slice scanners. The Workgroup established a time-certain date for re-review in two years.

76513	CPT Executive Committee addressed on May 1 and added parenthetical to instruct not to report 76513 where 0187T is appropriate. The specialty society is currently engaged in an effort to develop a CPT Assistant article to clarify this.
77781 77782	Deleted in CPT 2009
90471	The RUC submitted its recommendations for changes to the PE for this code in its May 2008 recommendations to CMS. In its 2009 RBRVS proposed rule, CMS noted that it does not agree with the RUC-recommended clinical staff times related to "quality" activities. The AAP, AAFP, ACP, and RUC proposed rule comment letters will included clarification of the rationale for why CMS should include the RUC recommendations in the 2009 PE RVUs.
94681	The Workgroup commended the specialty society for the depth of the analysis they performed and the quality of their review of the growth in utilization. The Workgroup recommends that the RUC express its concern over the appropriateness of reporting of this procedure to CMS. The Workgroup will look at the change in utilization of this service again in two years.
95922	The Workgroup noted that a CPT Assistant article has been submitted to clarify coding of 95922.
96567	At the April 2008 meeting of the RUC, the specialty society presented the requested additional Practice Expense data. At that time the RUC agreed that the service was not potentially misvalued and no further action was required.
96921	The Workgroup agreed that this service as well as 96920 and 96922 should be assessed again in two years to review the change in utilization.
G0237 G0238	The change in site of service is a result of administrative regulations made by CMS and is not potentially misvalued based on this screen. The Workgroup requests that CMS review the current status of the impact on the SGR and make necessary changes to ensure funding. Further, the Workgroup recommends that the specialty society develop coding change proposals to add these codes as a Category I CPT Codes.
G0249	The Workgroup noted that the specialty society plans to include G0249 in its expanded review of anticoagulation management services in scheduled for April 2009.

CMS Request for Review of Services – Other Objective Criteria

Harvard Valued Codes

CMS indicated in the July 2008 NPRM that it will request the RUC to review the remaining 2,856 Harvard-valued codes. The RUC, in its comments to the NPRM, informed CMS that reviewing all 2,856 Harvard-valued codes would require an inordinate amount of time and financial resources, possibly spanning a decade.

In the NPRM, CMS states that the focus of the RUC review should give priority to high volume and low intensity services. As such, the RUC analyzed the list with a threshold for high volume of 10,000 per year. The resulting list was 296 services, which accounts for more than $4.5 billion or 86% of the slightly more than $5.2 billion in allowable charges for all Harvard-valued services that CMS cites in the NPRM.

The Workgroup discussed the list in light of the amount of work that it will place on the specialty societies. The Workgroup noted that while a list of 296 codes appears, at its face, to be manageable, the list does not account for the additional codes that would be reviewed within the families of those 296. The Workgroup agreed that though the task will be laborious, it should still take place.

In order to initiate the review, the RUC approved the recommendation of the Workgroup proposing the following:

1. **Inform CMS that the RUC will limit its current review to the top 9 services, which have a volume of one million or more (as well as their respective families).**
2. **Inform CMS that the RUC will ask specialty societies for the families of codes as well as comment**
3. **The Workgroup will plan a schedule for review at their February 2009 meeting.**

Practice Expense RVUs

CMS, also through the NPRM, made a presumption that increases in the practice expense (PE) RVUs were due to changes in the direct PE inputs. RUC staff performed a detailed analysis and found an 82% concurrence between codes where PE RVUs increased and specialties that submitted supplemental surveys to CMS on indirect practice expense.

Therefore, the increase in PE RVUs is most likely due to CMS acceptance of indirect practice expense supplemental surveys. However, the Workgroup agree that increase in PE RVU is not an adequate screening criterion for potential misvaluation. The Practice Expense Subcommittee should continue to work with CMS to identify a process of ongoing review of PE inputs.

Other Objective Criteria for Potential Misvaluation

MPC Additions – to Qualify as A Codes

The Workgroup discussed the proposal that a criterion for reviewing a code in the rolling Five-Year Review include desire to add a code to the MPC.

Workgroup members expressed concern that doing so would create the potential for abuse by allowing an avenue for specialties to request that codes be reviewed outside of the regular CMS comment process. The desire to add a code to the MPC is not a criterion for potential misvaluation and should not be treated as such. Further, the Workgroup noted that the issue may be moot pending the outcome of its plans to review the Harvard-valued codes over time.

Joint CPT/RUC Workgroup on Bundled Services

Doctor Brin, Chair of the Joint CPT/RUC Workgroup on Bundled Services, participated by conference call to discuss the progress of the recommendations by the RUC and CPT for Type A codes to be bundled. Doctor Brin reported that a coding change proposal was submitted by SNM,

ACR, ACC, and ASNC and will be considered during the October Panel meeting. The Panel also received letters from American College of Cardiology (ACC) and American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) and American Speech-Language-Hearing Association (ASHA) regarding their respective bundling issues. Based on a recommendation of the Joint Workgroup, Doctors Rich and Thorwarth forwarded letters to those specialties reaffirming and clarifying the request to bundle the services.

ASHA and AAO-HNS indicated that their initial response in opposition to the change was based on a misunderstanding and that with clarification from the Workgroup, they are now developing a coding change proposal that makes clinical sense in their situation. They are working towards the November 8, 2008 deadline for the February 2009 CPT Meeting.

ACC is also attempting to accelerate their process and hopes to have their coding change proposal prepared in time for submission to the June 2009 CPT Meeting, with an update to the RUC in February 2009.

Other Issues

MedPAC Comment Letter on 2009 NPRM
Doctor Levy noted that a copy of MedPAC's comment letter to CMS regarding the NPRM was included in the meeting materials and encouraged Workgroup members to read it as it contains several passages of note regarding the identification of potentially misvalued services.

Items of Discussion for February 2009
Doctor Levy thanked the Workgroup for the tremendous amount of work they accomplished. Before adjourning, Doctor Levy provided a preliminary agenda for the Workgroup's next meeting in February 2009. She noted that the group will be discussing the prioritization of the review of services identified for survey during this meeting and the development of a specific work plan and timeline for review of the Harvard-valued services.

Moderate Sedation Workgroup
Minutes of Conference Call
August 13, 2008

The RUC/CPT Moderate Sedation Workgroup met on August 13, 2008 at 3:00pm Central via conference call. The following workgroup members and observers participated in the call: Doctors Stanley Stead (Chair), Edward Bentley, Michael Bishop, Charles Haley, Rodney Lee Jones, Charles Koopmann, Steve Krug, Brenda Lewis, Andrea McGuire, Charles Mick, Tim Shahbazian, Ken Simon, and Katherine Bradley, PhD. Observers of the call included: Doctors Joel Brill, Edith Hambrick, Peter Hollmann, Daniel Pambianco, Anthony Spina; and Jim Menas and Whitney May.

Doctor Stead opened the meeting with a brief background and review of the issue. RUC submitted work relative value and direct practice expense recommendations for moderate sedation services in May 2005. Rather than publish the RUC recommendations, CMS chose to carrier price these services. The RUC repeatedly has commented that CMS should reconsider this decision. CMS indicated that the agency would first review claims data to understand the utilization of these services. CMS has reviewed 2006 and 2007 claims data and has expressed concern that specialties other than those that originally participated in the survey of the new moderate sedation codes were the dominant providers. CMS has specifically questioned the appropriateness of claims submitted by anesthesiologists.

Doctor Stead contacted Ken Simon, MD at CMS last week and obtained data from CMS' 2007 5% file for all of the Moderate Sedation codes (99143-99150) and the corresponding CPT code pairing. He explained to the workgroup that the data shows the most commonly reported CPT codes with provision of moderate sedation on the same date. There is no specialty indication in these claims data. However, reviewing the type of service, Doctor Stead reviewed that the anesthesiology claims were rather physicians who perform pain management services. These data include 22,219 moderate sedation claims, and of that 22,219, 11,665 are moderate sedation associated with pain codes (52.5%). Nearly all moderate sedation claims are to be used by the physician providing the service and the sedation. Therefore, it seems unlikely that these are anesthesiologists providing anesthesia services for another physician

Total 2007 claims for moderate sedation codes and comparison to total claims for 2006 are as follows:

CPT Code	Total 2006 Claims	Total 2007 Claims
99143	54	94
99144	45,589	158,391
99145	10,403	34,464
99148	15	54
99149	1,473	3,165
99150	264	972

The CMS data indicates some miscoding (0.1% of the Moderate Sedation codes are for CPT codes that have Moderate Sedation included in their valuation – endoscopy and others in Appendix G). There appears to be similar problems with the use of moderate sedation with E&M codes, unless the E/M services happened to be listed first on the claim (as appears to have occurred with 77003). It was agreed that the workgroup has insufficient information to draw

concrete conclusions and that a complete Medicare 5% file for the Moderate Sedation codes needed to be analyzed for geographic region, IDC-9 code, specialty designation, and site of service.

Doctor Krug and members expressed significant concern regarding the pediatric moderate sedation codes being carrier priced. When CMS doesn't publish values it is perceived as a coverage issue and payers typically deny reimbursement. Moderate sedation may be provided to pediatrics patients and the fact that these services are carrier priced presents a significant problem for pediatricians and emergency medicine physicians. It was noted that CMS' review of the Medicare reporting of these services would not be fruitful in the pediatrics population, only in adults. The workgroup acknowledged this particular data issue and agreed to split the issue into pediatrics and adult patient reporting of Moderate Sedation. Doctor Simon stated that he would discuss this issue with CMS leadership, review carrier denials to see if there is a common scenario for pediatrics, and report back to the workgroup. He recommended that any recommendation regarding the pediatrics population be submitted during the NPRM comment period.

The workgroup also agreed that it may be helpful to share any current specialty developed clinical indications or guidelines for moderate sedation with CMS. Pain medicine may also wish to work together to develop guidelines for use of moderate sedation with interventional pain management. Doctor Simon agreed that this would be of use and benefit in changing the status of these codes from carrier priced. The Workgroup will collate these position statements and provide the information to CMS.

The workgroup had unanimous agreement to the following:

- Pediatric moderate sedation is distinct from adult moderate sedation. The RUC and pediatrics should comment to CMS again urging them to publish RVUs.

- RUC and CPT participants will provide current specialty specific moderate sedation guidelines to Todd Klemp by Wednesday, August 20. These guidelines will be collated and shared with CMS.

- AMA staff and the Chair will obtain, compile, and analyze additional information from CMS for the moderate sedation codes. These analyses will focus on reporting activity by geographic region, specialty, site of service, and ICD-9-CM code. A summary of this analysis will be provided to the group prior to the next conference call.

AMA staff will set up the next conference call for the workgroup after Wednesday, August 20th.

Moderate Sedation Workgroup
Minutes of Conference Call
September 19, 2008

The RUC/CPT Moderate Sedation Workgroup met on September 19, 2008 at 2:00pm Central via conference call. The following workgroup members and observers participated in the call: Doctors Stanley Stead (Chair), Edward Bentley, Rodney Lee Jones, Charles Koopmann, Steve Krug, Brenda Lewis, Andrea McGuire, Charles Mick, Tim Shahbazian, Ken Simon. Observers of the call included: Doctors Joel Brill and Edith Hambrick.

Doctor Stead opened the meeting with a brief review of the minutes from the Workgroup's first conference call held on August 13, 2008, and the minutes were approved without revision.

Workgroup members reviewed Doctor Stead's summary analysis of CMS' 5% file on the moderate sedation codes. The Workgroup reviewed spreadsheets that identified utilization by code, specialty, and place of service. The bulk of the utilization is being provided in the facility setting (70%) and the majority of the claims are related to pain management services provided by Anesthesiologists (24.6%) and Interventional Pain Management (24.7%). In general, the analysis of this 5% file did not reveal any new information about patient care or practice patterns. In addition, the workgroup did not have access to what other codes were being billed with these pain codes, and perhaps that data would be useful to CMS.

The members agreed that unless there is some flaw in the CPT nomenclature encouraging inappropriate coding, there is little CPT or the RUC could do to alleviate CMS' concerns regarding the use of the codes, and that it may be best for CMS to work directly with the specialties to develop further moderate sedation guidelines.

As recommended during the workgroup's first conference call, the group stressed the need for CMS to publish the relative values for the pediatrics moderate sedation codes (99143 and 99148). Codes that are Carrier Priced by Medicare are often viewed by insurance carriers as being not covered and this has caused significant problems for pediatricians. In addition, Doctor Shahbazian also acknowledged that physicians providing moderate sedation to the adult population also have difficulty being reimbursed for these services, and the Workgroup agreed that the adult population should also be addressed. It was suggested that a national coverage decision may be explored through collaboration between the specialties and CMS.

Workgroup members agreed that it is very important for CMS to publish the relative values for the adult and pediatric moderate sedation services in Addendum B of the Federal Register to insure insurance carrier coverage. From this conference call the Moderate Sedation Workgroup recommends:

- August 2008 Comment Letter from RUC requested that CMS publish all relative values for the moderate sedation CPT codes in Addendum B of the Federal Register, with particular importance to publish the pediatric codes immediately
- AMA staff will again forward CMS the collated specialty society sedation guidelines document and 5% sample analyses.
- These recommendations, analyses, and minutes are to be forwarded to the RUC Chair and Moderate Sedation Workgroup be discontinued.

Presidential Health Care Reform Proposals

William L. Rich III, MD, FACS

AAO Medical Director of Health Policy

October 2, 2008

- No financial conflicts.

Givens

- All pre-election health care reform plans are meaningless
- Only reflect philosophy, not reality
- First meaningful document is when reform ideas are placed into a proposed law after the election

The “Plans”

Uninsured

- **Obama**
- Expand existing public programs and create new pubic program for small businesses and individuals
- Mandate for children
- Employers must offer insurance or pay into pool to finance the new public program

- **McCain**
- Remove tax deductibility of health insurance and provide tax credits for individuals and families
- No mandate

Employer mandates

- **Obama**
- Employers must offer meaningful insurance or contribute a percentage of payroll into the public plan.
- Small business exempted

- **McCain**
- No employer mandate

Premium subsidies

- **Obama**
- Income related subsidies to enable individuals and families buy into the new “FEHB” like plan with portable coverage

- **McCain**
- $2500 individual tax credit; $5000 family credit for purchase of insurance
- Income related subsidies in addition to tax credit

Employer premium subsidies

- **Obama**
- Tax credit for small business of up to 50% of premium if insurance supplied.

- **McCain**
- None

Insurance pools

- **Obama**
- National Health Insurance Exchange
- Participating insurers must provide a guaranteed issue
- Coverage = that of new public plan

- **McCain**
- Guaranteed Access Plan for those denied coverage; premiums limited and financial assistance available.

Private insurance reforms

- **Obama**
- **$50 billion for health IT**
- **Encourage generic drugs and drug re-importation**
- **Allow direct public negotiation of drug prices**
- **Malpractice reform while preserving patient rights**

- **McCain**
- **Encourage competition, use of alternate providers and retail outlets**
- **Allow re-importation of drugs**
- **Empower consumers**
- **Malpractice reform**

Quality

- **Obama**
- **Independent comparative effectiveness institute**
- **Pay for performance**
- **Address health disparities**
- **Public reporting of quality**

- **McCain**
- **Bundled MD payments**
- **Pay for preventive benefits and care coordination**
- **Public reporting of outcomes, costs and prices**
- **Encourage TM**

Cost/Financing

- **Obama**
- **$50-65 billion/yr in costs paid for with “savings” and increase taxes on those with > $250K of yearly income**

- **McCain**
- **Not specified**

The Reality

- We can't pay for those covered now so payment reform must precede expansion of coverage.
- The history of Hr 3162 and MIPPA reflect the political philosophy of the parties and hint at possible reforms in a Democratic Congress

Philosophy

- D
- Medicare-a ***benefit***
- Extend health care to populations at risk
- Expand benefits
- Public sources more efficient
- CMS should negotiate drug costs
- Favors regulations

- R
- Medicare should be a ***defined contribution***
- Restrict growth of public programs
- Limit benefit growth
- Private competition
- No direct drug negotiations
- Favors “competition”

D's

- Increase aid to low income beneficiaries(50% with incomes less than $20,000; 28% without Medigap coverage)
- Waiver of cost sharing and deductibles for colorectal screening and other preventive services
- Protect rural physicians with extension of support due to expire 1/1/08-done
- Support PQRI and public reporting-done
- **Support for FFS, cuts to Medicare Advantage**

D”s and MIPPA

- Physician payment fix for 18 months-0.5% for six months in ’08 and 1.1% increase for ’09
- 2% bonus for PQRI in ’09 with no cap
- 2% bonus for “e” rx. In ’09 and ’10
- Removal of “deemed” status of private Medicare plans
- Increase asset limits to qualify for Part D
- Expansion of preventive services
- Reduces co-pays for mental health

D's

- Establishes report on comparative effectiveness
- Allows CMS to pay for drugs in head to head clinical trials

R's

- President vetoed MIPPA
- Supported Medicare private plans despite excessive premium payment of 117% of Medicare FFS
- Supported deemed status of Medicare Advantage FFS plans.

Possible payment reform methodologies

- Bundled payments
- Efficiency measure -Grouper software
- Global periods for office based care
- Multiple conversion factors HR 3162

Summary

- Incremental payment reforms will precede more comprehensive reform
- Enhanced primary care payments
- Support for medical home/chronic care
- More public reporting of participation in quality programs-delayed

- More bundled payments for services shared by hospitals and physicians
- More research and implementation of efficiency measures
- Public program “creep”
- More comparative effectiveness

- Further scrutiny of relations with industry(“Sunshine Act”
- Support for physician pharmacologic education by academic outreach programs
- Long term pressure on testing/imaging by payment reform, bundling of services(global periods for office based care of chronic diseases) and use of remote imaging

Chairman's Report
RUC

Oct 2-5, 2008

Chicago, IL

AMA
TOGETHER WE ARE STRONGER




Procedural Issues

Advisors:

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




Procedural Issues

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




Procedural Issues

RUC Members:

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




Procedural Issues

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




Summary of Recommendation Form

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




RUC Meeting

- **Cell phones!!!**




CMS Representatives

- Edith Hambrick, MD – CMS Medical Officer
- Whitney May – Deputy Director, Division of Practitioner Services
- Ken Simon, MD – CMS Medical Officer
- Pam West, DPT, MPH – Health Insurance Specialist




Medicare Contractor Medical Directors

- Charles Haley, MD




MedPAC Staff

- Kevin Hayes




U.S. Government Accountability Office (GAO)

- Kelly Barar
- Iola D'Souza




Facilitation Committee #1

Destruction of Skin Lesion Pre-Facilitation – Tab 11
Friday, October 3, Noon – 1pm
Audiology Services Pre-Facilitation – Tab 17
Friday, October 3, 5:00 - 6:30pm

- Gregory Kwasny, MD (Chairman)
- James Anthony, MD
- Michael Bishop, MD
- James Blankenship, MD
- Dale Blasier, MD
- Katherine Bradley, PhD
- Norman Cohen, MD
- Thomas Felger, MD
- Barbara Levy, MD
- William Mangold, Jr, MD
- Maurits Wiersema, MD
- Robert Zwolak, MD

Facilitation Committee #2

Resection of Soft Tissue and Bone Tumors

Pre-Facilitation Friday, October 3, 7:00 am – Noon

- Bibb Allen, MD (Chairman)
- Joel Bradley, Jr., MD
- Ron Burd, MD
- Thomas Cooper, MD
- Emily Hill, PA-C
- Peter Hollmann, MD
- J. Leonard Lichtenfeld, MD
- Charles Mick, MD
- Gregory Przybylski, MD
- Peter Smith, MD
- Samuel Smith, MD




Facilitation Committee #3

- Susan Spires, MD (Chairman)
- John Gage, MD
- David Hitzeman, DO
- Charles Koopmann, MD
- Lawrence Martinelli, MD
- Bill Moran, MD
- Jonathan Myles, MD
- Daniel Mark Siegel, MD
- Lloyd Smith, DPM
- Arthur Traugott, MD
- James Waldorf, MD




RUC Observers

- Debra Abel – American Academy of Audiology
- Margie Andreae – American Academy of Pediatrics
- Rasa Balaisyte – American Society of Neuroradiology
- Jerome Barrett – American Academy of Sleep Medicine
- Michael Beebe – American Academy of Audiology
- David Beyer - American Society for Therapeutic Radiology and Oncology
- Michael Bigby – American Academy of Dermatology




RUC Observers

- Bruce Blehart, - American Academy of Sleep Medicine
- Darryl Bronson, DC – American Academy of Dermatology
- Leo Bronson - American Chiropractic Association
- Benjamin Byrd, MD – American College of Cardiology
- Nicholas Cekosh – American Academy of Sleep Medicine
- Scott Collins – American Academy of Dermatology
- William Creevy, MD – American Academy of Orthopaedic Surgeons
- Michele Daugherity – American Osteopathic Association




RUC Observers

- Alan Desmond – American Speech-Language-Hearing Association
- Maurine Dennis – American College of Radiology
- Thomas Eichler - American Society for Therapeutic Radiology and Oncology
- Charles Fitzpatrick, OD – American Optometric Association
- Taylor Frawley – American Academy of Sleep Medicine
- Jennifer Frazier - American Society for Therapeutic Radiology and Oncology
- Mark Friedberg, MD – American College of Physicians




RUC Observers

- James Gajewski, MD – American Society of Hematology
- Jerome Garden – American Academy of Dermatology
- Emily Gardner – American College of Cardiology
- Denise Garris – American College of Cardiology
- Roy Geronemus, MD – American Academy of Dermatology
- Richard Gilbert, MD – American Urological Association
- Janice Gregory – American Urological Association
- Nancy Heath – Society for Vascular Surgery




RUC Observers

- John Heiner - American Academy of Orthopaedic Surgeons
- Elizabeth Hoy – American College of Surgeons
- Jenny Jackson - American Society of Plastic Surgeons
- Robert Jones – Heart Rhythm Society
- Kirk Kanter, MD – Society of Thoracic Surgeons
- Lisa Kaplan, JD - American Society for Physical Medicine and Rehabilitation
- Ronald Kaufman, MD – American Urological Association
- Rebecca Kelly – American College of Cardiology




RUC Observers

- Cathy Kerr – American Society of Echocardiography
- Sheela Kerstetter, MD – American Academy of Dermatology
- Kendall Kodey – American College of Cardiology
- Carrie Kovar – American College of Cardiology
- Katie Kuechenmeister - American Academy of Neurology
- Venay Malhotra, MD – American College of Cardiology
- Martha Matthews – American Society of Plastic Surgeons




RUC Observers

- John Mayer, MD – Society of Thoracic Surgeons
- Faith McNicholas – American Academy of Dermatology
- Stephen McNutt - American Society for Therapeutic Radiology and Oncology
- Erika Miller – American College of Physicians
- Lisa Miller-Jones – American College of Surgeons
- Dian Millman – American College of Cardiology
- Frank Nichols, MD – Society of Thoracic Surgeons
- Gerald Neidzwiecki, MD – Society of Interventional Radiology




RUC Observers

- Bernard Patashnik, MD – American Speech-Language-Hearing Association
- Paul Pessis – American Academy of Audiology
- Sandra Peters – American Academy of Dermatology
- Wayne Powell – American College of Cardiology
- Debbie Ramsburg – Society of Interventional Radiology
- John Ratliff, MD – American Association of Neurological Surgeons
- Paul Rudolf, MD, JD – American Geriatrics Society




RUC Observers

- Margarita Shephard – American College of Obstetricians and Gynecologists
- Matthew Sideman, MD – Society for Vascular Surgery
- Ezequiel Silva, MD – Society of Interventional Radiology
- Shovana Sloan – American Gastroenterological Association
- Stan Stead, MD – American Society of Anesthesiologists
- Claire Tibiletti, MD – International Spine Intervention Society




RUC Observers

- Stuart Trembath – American Speech-Language-Hearing Association
- Peter Weber, MD – American Academy of Otolaryngology – Head and Neck Surgery
- Joanne Willer – American Academy of Orthopaedic Surgery
- Donavan William – American Society of Neuroradiology
- Kadyn Williams – American Academy of Audiology




Welcome New RUC Members

- Joel Bradley, MD – American Academy of Pediatrics
- Dale Blasier, MD – American Academy of Orthopaedic Surgeons
- Thomas Cooper, MD – American Urological Association
- Larry Martinelli, MD – Infectious Diseases Society of America
- James Waldorf, MD – American Society of Plastic Surgeons