

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

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

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, MD
Maurits Wiersema, MD
Robert Zwolak, MD

Facilitation Committee 2

Bibb Allen, MD
(Chairman)
Joel Bradley, Jr., MD
Ron Burd, MD
Thomas Cooper, MD
Emily Hill, PA-C
Peter Hollmann, MD
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

- 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 Daugherty – 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
 - Donovan William – American Society of Neuroradiology
 - Kady 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; Geraldine 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.

Nikaidoh Procedure (Tab 6)

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.

Laparoscopic Revision of Prosthetic Vaginal Graft (Tab 7)

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 this 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
<u>minus 1 99238</u>	<u>1.28</u>
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
<u>minus 1 99238</u>	<u>1.28</u>
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
<u>minus 1 99238</u>	<u>1.28</u>
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. $18 \text{ minutes} \times 0.0224 = 0.4032 \text{ RVUs}$. The resulting value is 3.61. $3.26 + 0.75 - 0.4032 = 3.61 \text{ work RVUs}$.

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. ($40 \text{ minutes of intra-service time} \times 0.062 = 2.48$. $7 \text{ minutes pre} + 10 \text{ minutes immediate post} \times 0.0224 = 0.38$. $99212 \times 2 = 0.90$. $99213 \times 1 = 0.92$. $2.48 + 0.38 + 0.90 + 0.92 = 4.68$) 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 recanalization/dilatation, stent placement and all associated*
- 47382 *Ablation, one or more liver tumor(s), percutaneous, radiofrequency*
- 50200 *Renal biopsy; percutaneous, by trocar or needle*

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 ($2.00 - 0.72 = 1.28 \times 1.20 = 1.54$).

$$\begin{array}{r} 2.00 \text{ (50387)} \\ - 0.72 \text{ (fluoroscopy)} \\ \hline 1.28 \\ \times 1.20 \text{ (increased by 20\%)} \\ \hline \mathbf{1.54 \text{ work RVUs}} \end{array}$$

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.

Microvolt T-Wave Assessment (Tab 18) **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 <i>typically</i> (>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 <i>typically</i> 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 <i>typically</i> 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
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(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 reduce 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.