AMA/Specialty RVS Update Committee
Meeting Minutes
October 1-4, 2009

I. Welcome and Call to Order

Doctor Barbara Levy called the meeting to order on Friday, October 2, 2009, at 8:00 am. The following RUC Members were in attendance:

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

II. Chair's Report

Doctor Levy made the following general announcements:

- Doctor Levy welcomed the following new members to the RUC:
  - Robert Kossmann, MD – Renal Physicians Association (RPA)
  - Guy Orangio, MD – American Society of Colon and Rectal Surgeons (ASCRS)
  - Sandra Reed, MD – American College of Obstetricians and Gynecologists (ACOG)
  - George Williams, MD – American Academy of Ophthalmology (AAO)
- Doctor Levy welcomed the following new alternate members to the RUC:
  - Jeffrey Edelstein, MD – American Academy of Ophthalmology (AAO)
  - Robert Jansen, MD – Renal Physicians Association (RPA)
- Doctor Levy welcomed the following new staff to the RUC:

- Zach Hochstetler will have primary responsibilities for the PLI and MPC Workgroups.
- Doctor Levy welcomed the CMS staff and representatives attending the meeting, including:
  - Edith Hambrick, MD, CMS Medical Officer
  - Cassandra Black, Director, Division of Practitioner Services
  - Ken Simon, MD, CMS Medical Officer
  - Pam West, DPT
- Doctor Levy welcomed Kevin Hayes of the Medicare Payment Advisory Commission. (MedPAC).
- Stressed that all RUC members should be focused on RUC business while at the table.
- Before a presentation, any RUC member with a conflict will state their conflict. That RUC member will not discuss or vote on the issue and it will be reflected in the minutes.
- RUC members or alternates sitting at the table may not present or debate for their specialty. The RUC is an expert panel and individuals are to exercise their independent judgment and are not advocates for their specialty.
- Doctor Levy, Sherry Smith, and Susan Clark went to CMS headquarters to discuss RUC related issues including: the Harvard-only valued codes, rejected RUC recommendations from the April 2009 meeting, issues surrounding the *proposed rule*, and collaboration efforts on ongoing Five-Year Review issues.
- The Administrative Subcommittee reviewed the RUC members' Conflict of Interest Forms prior to the meeting and no conflicts were found that would preclude or limit presentations by any presenter.

Thomas Healy, AMA Vice President for Corporate Law, made the following comments in regards to securities law:

- RUC members and staff should refrain from trading in the securities of companies that may be advantaged or disadvantaged by the outcomes of RUC actions.
- Since RUC members have signed conflict of interest policies on the information discussed and voted on at the RUC, the outer boundaries of the insider trading laws in the U.S. could extend to this activity.
- Currently, the RUC disclosure policy does not cover the issue of securities. Everyone needs to take it upon themselves to be familiar with the laws and seek advice when appropriate.

III. Director's Report

Sherry Smith made the following announcements:

- All RUC members should have received the submission for the H1N1 immunization administration proposal prior to the meeting. The specialties have requested that it be presented along with the previously submitted immunization codes set to be discussed later on October 2nd.
- The next scheduled RUC meeting will be:
  - February 4-7, 2010 , Hilton Bonnet Creek, Orlando, FL

IV. Approval of Minutes of the April 23-25, 2009 RUC Meeting

The RUC approved the April 2009 RUC Meeting Minutes.

V. CPT Editorial Panel Update

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

- The CPT Editorial Panel is undergoing a self assessment process to continue to improve their process including creating a strong structure and functions document.
- The CPT Editorial Panel will be holding its next meeting in Dallas, TX October 15-17, 2009.

VI. Centers for Medicare and Medicaid Services Update

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

- CMS is still awaiting the confirmation of an Administrator and Deputy Administrator.
- CMS is developing the 2010 Final Rule and preparing for the initiation of the fourth Five-Year Review.

VII. Contractor Medical Director Update

Doctor Charles Haley was not in attendance and there was no report presented.

VIII. Washington Update

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

- There are currently three health system reform bills being worked on. In the House, the Ways and Means, Energy and Commerce, and the Education and Labor Committees are all working off of a common platform but still have variations. In the Senate, the Health Education Labor Pensions (HELP) Committee have completed their work but it does not include revenue issues relating to Medicare and Medicaid. The Senate Finance Committee finished work early on October 2, 2009. The vote may not be until a week later.
- All three bills have insurance exchanges, subsidies for low income people to get insurance, comparative effectiveness research, and establish value based Medicare payments that encourage efficient use of care, etc.
- Currently, the House bill has stronger physician payment provisions than the Senate bill. The House has invested $228.5 billion to rebase and replace the SGR. There are still likely to be cuts, but not nearly the amount of the current payment system. The Senate Finance Committee proposal is another one year temporary fix with a 0.5% increase in 2010 and a 26% decrease in 2011.
- The House has also invested another $6.4 billion to fund a 5% bonus for primary care physicians. The Senate Finance bill has a 10% bonus, but funds half of it from a 0.5% cut in payments to other physicians.

- The House continues the PQRI bonuses through 2012 and there are no penalties for those not participating. The Senate Finance bill reduced the bonuses and creates penalties for non-participants beginning in 2012.
- Both bills get savings from increasing the reductions on imaging done on contiguous body parts from 25% to 50% and increasing the practice expense equipment utilization assumption from 50% to 75% for advanced diagnostic imaging equipment.
- The Senate will start first and merge the Finance Committee and HELP bills together starting October 13th.
- The AMA has talked with Senate leaders and feels strongly that there will be a long-term physician payment fix once the bill is introduced on the floor for debate.
- Once both bodies have acted, the bills will go to conference and the AMA will in general be arguing that the House provision prevails.
- Without health care reform, there will not be a permanent fix for Medicare physician payment.
- The AMA is continuing to press for additional changes and is working with committee members and staff to get a substantial bill passed with a permanent fix of the SGR.

IX. Relative Value Recommendations for CPT 2011

Percutaneous Cholecystostomy (Tab 4)
Geraldine McGinty, MD, ACR, Ezequiel Silva, MD, ACR, Sean Tutton, MD, SIR, Gerald Niedzwiecki, MD, SIR, Robert Vogelzang, MD, SIR

In October 2008, CPT code 47490 *Percutaneous Cholecystostomy* (2010 Work RVU = 8.13, 090 day global) was requested to be reviewed by CMS following identification by the RUC as potentially misvalued. This service was identified by the RUC's Five-Year Review Identification Workgroup's fastest growing screen and Harvard-valued. In February 2009, the Workgroup recommended the service descriptor be revised by the CPT Editorial Panel to include the imaging guidance by any method to account for the typical procedure, and change the global period to 000, as the number of hospital visits varies widely among physicians who are managing the patient's post-operative care.

The CPT Editorial Panel in May 2009, combined the percutaneous cholecystomy service with radiographic guidance of CPT code 75989 *Radiological guidance (ie, fluoroscopy, ultrasound, or computed tomography), for percutaneous drainage (eg, abscess, specimen collection), with placement of catheter, radiological supervision and interpretation* (2010 Work RVU = 1.19) as they are billed together on the same day approximately 95% of the time. CMS assigned CPT code 47490 a global period of 010, rather than 000.

The American College of Radiology and the Society of Interventional Radiology conducted a survey with nearly 70 respondents. The RUC first reviewed the physician time data collected by the specialty. The RUC agreed that the positioning time for pre-procedure imaging was indeed more than the standard pre-time package for a facility based difficult patient/straightforward procedure with sedation of one minute, and therefore an additional 9 minutes was typical for the task. A total pre-service time of 48 minutes was accepted. In addition, the median and 25th percentile survey results indicated 30 minutes of intra-service physician time was necessary for this service.

The RUC reviewed three other 010 day global services with similar intensities and complexities, inter and post-operatively; 49440 *Insertion of gastrostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report* (Work RVU = 4.18, intra-service time = 38 minutes, one post-operative hospital visit), 49441 *Insertion of duodenostomy or jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report* (Work RVU = 4.77, intra-service time = 45 minutes, one post-operative hospital visit), and 49442 *Insertion of cecostomy or other colonic tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report* (Work RVU = 4.00, intra-service time = 30 minutes, one post-operative hospital visit). The RUC also concurred that interventional radiologists are part of the care team for these critically ill patients, and provide appropriate hospital care. Although the survey results indicated that these physicians typically provided 3 post-operative hospital visits, the RUC agreed that two were typical.

The RUC also reviewed similar services such as the specialty's key reference service 49041 *Drainage of subdiaphragmatic or subphrenic abscess; percutaneous* (Work RVU = 3.99, 000 day global, intra-service time = 60 minutes) and multi-specialty points of comparison code 49320 *Laparoscopy, abdomen, peritoneum, and omentum, diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* (Work RVU = 5.14, 010 day global, intra-service time of 45 minutes, includes one post-operative hospital visit) in considering the appropriate work value.

The RUC agreed that the services provided with CPT code 47490 are very similar to those of CPT code 49442 with an extra hospital visit. The RUC therefore agreed on a relative work value of 4.76 for code 47490 by taking the work value of 49442 of 4.00 and adding the work value an additional hospital 99231 visit of 0.76.

CPT Code	Work Value
49442	4.00
99231	0.76
New value of 47490	**4.76**

The RUC recommends a relative work value of 4.76 for CPT code 47490.

Practice Expense: The RUC concurred that the typical service of code 47490 is performed only in the facility setting and therefore no direct practice expense inputs are recommended at this time.

Practice Liability Insurance Crosswalk: The RUC agreed that the appropriate physician practice liability insurance crosswalk is the base code, 49442, used in the physician work building block methodology.

Work Neutrality

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

Transformaminal Epidural Injections (Tab 5)
Marc Leib, MD, JD, ASA, Richard Rosenquist, MD, ASA, Charles Mick, MD, NASS, Rodney Lee Jones, MD, ISIS, Fred Davis, MD, AAPM, William Sullivan, MD, AAPMR, Sean Tutton, MD, SIR, William Donovan, MD, ASNR
Facilitation Committee #2

CPT codes 64479, 64480, 64483 and 64484 were identified in October 2008 along with other services in its family, paravertebral facet joint codes (currently 64490-64495) through CMS' Fastest Growing Screen. The RUC recommended that these four services along with the other codes in its family be referred to the CPT Editorial Panel to be bundled with the appropriate guidance procedure(s). In June 2009, the CPT Editorial Panel revised codes 64479, 64480, 64483 and 64484 to include guidance (fluoroscopy or CT).

64479 - Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with image guidance (fluoroscopy or CT), cervical or thoracic; single level
The specialty society conducted a survey in which 139 physicians responded. The RUC reviewed the pre-service time package selected for code 64479 (2a-Facility Diff Pat/Straightforward Procedure) and determined to appropriately value this service the pre-service time package should be 1A-FAC Straightforward Patient/Straightforward Procedure (13 minutes evaluation, 1 minute positioning and 6 minutes scrub/dress/wait). The RUC agreed with the specialty societies that 4 minutes additional positioning time is necessary to place the patient in the prone position. Additionally, the specialty societies recommended and the RUC agreed that the immediate post-service time should be reduced from 15 minutes to 10 minutes, to be consistent with the facet family of codes (64490 and 64493) which were reviewed at the April 2009 RUC meeting.

The RUC compared 64479 to the key reference service 62310 *Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic* (work RVU= 1.91) and determined that 64479 was more complex and intense. The RUC also compared this service to similar service 52000 *Cystourethroscopy (separate procedure)* (pre-time 17 minutes, intra-time 15 minutes, and immediate post-time 10 minutes and a work RVU = 2.23) which requires similar physician time and work to perform.

The RUC agreed that a work RVU of 2.29 for 64479 was appropriate compared to the aforementioned reference services and due to the decrease in pre- and post-service times. The value is between the 25% and median survey results. Additionally, the RUC noted that 64479 was appropriately more intense than 64490 *Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level* (April 2009 RUC recommended work RVU = 1.82 and 17 minutes pre-time, 15 minutes intra-time and 10 minutes immediate post-service time). **The RUC recommends a work RVU of 2.29 for code 64479 and 13 minutes pre-evaluation time, 5 minutes pre-positioning time, 6 minutes scrub/dress/wait time, 15 minutes intra-service time and 10 minutes immediate post-service time.**

64480 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with image guidance (fluoroscopy or CT), cervical or thoracic; each additional level

The specialty society conducted a survey in which 115 physicians responded. The RUC reviewed the specialty society recommendation for code 64480 comparing it to base code 64479 and determined that the survey 25th percentile work RVU of 1.20 and 15 minutes intra-service time preserves rank order within this family of services. The RUC compared 64480 to similar ZZZ codes 15136 *Dermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof* (work RVU = 1.50 and 15 minutes intra-service time) and 61517 *Implantation of brain intracavitary chemotherapy agent* (work RVU = 1.38 and 15 minutes intra-service time) to further support the recommended value of 1.20 work RVUs for 64480.

The RUC also compared code 64480 to the April 2009 RUC recommended similar service 64491 *Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level* (RUC recommended work RVU = 1.16 and 15 minutes intra-service time) to further support the recommended work RVU of 1.20 for 64480. **The RUC recommends the survey 25th percentile work RVU of 1.20 for code 64480.**

64483 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with image guidance (fluoroscopy or CT), lumbar or sacral; single level

The specialty society conducted a survey in which 145 physicians responded. The RUC reviewed the pre-service time package selected for code 64483 (2a-Facility Diff Pat/Straightforward Procedure) and determined to appropriately value this service the pre-service time package should be 1A-FAC Straightforward Patient /Straightforward Patient (13 minutes evaluation, 1 minute positioning and 6 minutes scrub/dress/wait). The RUC agreed with the specialty societies that 4 additional minutes of positioning time is necessary to place the patient in the prone position.

The RUC compared 64483 to MPC service 54150 *Circumcision, using clamp or other device with regional dorsal penile or ring block* (work RVU = 1.90 and pre-time 25 minutes, intra-time 15 minutes and post-time 5 minutes) which requires similar physician time and work to perform, supports a work RVU of 1.90 for code 64483.

Additionally, the RUC noted that a work RVU of 1.90 for 64483 was appropriately more intense than 64493 *Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level* (April 2009 RUC recommended work RVU = 1.52 and 17 minutes pre-time, 15 minutes intra-time and 10 minutes immediate post-service time). **The RUC recommends a work RVU of 1.90 for code 64483 and 13 minutes pre-evaluation time, 5 minutes pre-positioning time, 6 minutes scrub/dress/wait time, 15 minutes intra-service time and 10 minutes immediate post-service time.**

64484 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with image guidance (fluoroscopy or CT), lumbar or sacral; each additional level

The RUC reviewed the specialty society recommendation for code 64484 comparing it to base code 64483 and determined that the survey 25th percentile work RVU of 1.00 and 10 minutes intra-service time preserves rank order within this family of services. The RUC compared 64484 to similar ZZZ codes 15331 *Acellular dermal allograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof* (work RVU = 1.00 and 13 minutes intra-service time) and 76802 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first*

trimester (< 14 weeks 0 days), transabdominal approach; each additional gestation (work RVU = 0.83 and 10 minutes intra-service time) to further support the recommended value of 1.00 work RVUs for 64484.

The RUC also compared code 64484 to the April 2009 RUC recommended similar service 64494 *Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT) lumbar or sacral; second level* (RUC recommended work RVU = 1.00 and 15 minutes intra-service time) to further support the recommended work RVU of 1.00 for 64484. **The RUC recommends the survey 25th percentile work RVU of 1.00 for code 64484.**

Practice Expense
The RUC reviewed the clinical labor time and made minor adjustments to reflect the typical patient scenario. In addition, the RUC reviewed the medical supplies and equipment and added a pulse oximeter. The RUC determined to include the fluoroscopic radiographic room until the Practice Expense Subcommittee's Fluoroscopic Workgroup develops final recommendations regarding this issue.

Work Neutrality
The RUC's recommendation for this family of codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor. Approximately 50% of 64479 and 50% of 64483 will be no longer be reported under 77003 now that 64479 and 64483 include image guidance.

Salivary Gland Injection for Sialorrhea (Tab 6)
Kevin Kerber, MD, AANPA, Holly Shill, MD, AANPA, Marianna Spanaki, MD, PhD, MBA, AANPA, Jane Dillon, MD, AAO-HNS, Wayne Koch, MD, AAO-HNS

The CPT Editorial Panel created code 646XX *Chemodenervation of parotid and submandibular salivary glands, bilateral* to describe the use of an botulinum toxin injection in order to treat sialorrhea. The existing codes available for chemodenervation treatment were considered inappropriate to report for the treatment of sialorrhea as they are not specific to the injection of salivary glands or ducts.

The RUC reviewed survey data from over 30 neurologists who perform this service. While reviewing the survey results, the RUC and specialty concurred that the survey respondents overstated the pre-service scrub, dress, wait and positioning time and recommended no time for these activities.
The specialty chose, and the RUC agreed that the standard pre-service package, non-facility procedure without sedation, which includes 7 minutes of pre time. The specialty recommended a pre-service evaluation time of 10 minutes which typically is needed for these patients to find the proper injection point('s), and the RUC concurred. The RUC also agreed with the specialty that the intensity of the five minutes of intra-service time was appropriate considering these patients are quite sick and more difficult to treat than similar botulinum toxin injection services. In addition, the RUC agreed that physician involvement was required post operatively in a follow up office visit and that this service would typically require a level two evaluation and management (99212) in order to assess complications and identify botulinum toxin migration to other muscles in the face.

The RUC agreed with the specialties' rationale for a lower work RVU than the survey median of (2.10 work RVU) after reviewing the following services; 64614 *Chemodenervation of muscle(s); extremity(s) and/or trunk muscle(s) (eg, for dystonia, cerebral palsy, multiple sclerosis)* (Work RVU = 2.20, 010 global, with pre, intra, and post service time components of 15, 20 and 15 respectively), 11420 *Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less* (Work RVU = 1.03, 010 day global, with pre, intra, and post service time components of 5, 10 and 5 respectively, including one post-operative office visit), and 56605 *Biopsy of vulva or perineum (separate procedure); one lesion* (Work value = 1.10, 000 global, with pre, intra, and post service time components of 10, 15 and 10 respectively). The RUC concurred that the physician time, intensity, and complexity of code 646XX was more closely aligned with codes 11420 (total time = 36 minutes) and 56605 (total time = 35 minutes) than with its key reference code 64614 (total time = 50 minutes).

The specialties recommended the survey 25th percentile work RVU of 1.00 to provide for proper rank order among other similar services and across specialty services. The RUC agreed with the specialty recommendation after considering the similar services and rank order amongst services. The value has been updated to the 2010 MFS.

The RUC recommends a relative work value of 1.03 for CPT code 646XX.

Practice Expense: The RUC reviewed the specialty recommended direct practice expense inputs for new code 646XX and made modifications to the clinical labor time, medical supplies, and equipment for the typical patient scenario.

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

E/M Increases
Based on the changes made in the 2010 MFS Final Rule, the E/M values have been increased and appropriately incorporated into the overall value of this code.

In Situ Hybridization (Tab 7)
Jonathan Myles, MD, CAP

CPT created two new codes to describe fluorescent in situ hybridization (FISH), a diagnostic technique used to aid in the detection of certain cancers. Codes 8812X1 and 8812X2 were specifically created to describe quantitative or semi-quantitative in situ hybridization morphometric analyses by manual and computer-assisted methodologies.

8812X1
The RUC reviewed the survey results for code 8812X1 *Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; manual* and agreed with the specialty society that the respondents inappropriately included 10 minutes total in the pre-service and immediate post-service for this XXX-global period service instead of accounting for it all in the intra-service period. Therefore, the RUC determined that 30 minutes intra-service/total time appropriately accounts for the time required to perform this procedure. The RUC compared 8812X1 to key reference service 88365 *In situ hybridization (eg, FISH), each*

probe (work RVU = 1.20 and 40 minutes intra-service time) and agreed with the specialty society that the median work RVU of 1.40 was too high because the survey respondents overestimated the intensity required to perform 8812X1 since it is a quantitative service versus 88365 which is qualitative. The specialty society recommends and the RUC agrees that the survey 25th percentile work RVU of 1.20 appropriate accounts for the physician work required to perform this service. **The RUC recommends a work RVU of 1.20 for code 8812X1.**

8812X2
The RUC reviewed the survey results for code 8812X2 *Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; using computer-assisted technology* and agreed with the specialty society that the respondents inappropriately included 10 minutes total in the pre-service and immediate post-service for this XXX-global period service instead of accounting for it all in the intra-service period. Therefore, the RUC determined that 25 minutes intra-service/total time appropriately accounts for the time required to perform this procedure.

The RUC compared 8812X2 to key reference service 88365 *In situ hybridization (eg, FISH), each probe* (work RVU = 1.20 and 40 minutes intra-service time) and 8812X1, and agreed with the specialty society that the median work RVU of 1.20 was too high. Code 8812X2 requires slightly less work than 8812X1 because the physician is not performing the screening for 8812X2, it is an automated computer-assisted screen. The RUC compared 8812X2 to similar service 15401 *Xenograft, skin (dermal), for temporary wound closure, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof* (work RVU = 1.00 and 20 minutes intra-service time) to further support a work RVU of 1.00 for code 8812X2. **The RUC recommends a work RVU of 1.00 for code 8812X2.**

Practice Expense
The RUC reviewed the direct practice expense inputs and made minor adjustments to the clinical labor, supplies and equipment inputs.

Work Neutrality
The RUC's recommendation for this family of codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor. Approximately 47% of the utilization for 88368 will now be reported under code 8812X1 and 69% of the utilization for 88367 will now be reported under code 8812X2, since the new codes account for approximately 4 probes, whereas 88367 and 88368 describe each probe.

<u>Immunization Administration (Tab 8)</u>
Steve Krug, MD, AAP, Margie Andreae, MD, AAP

The CPT Editorial Panel revised the reporting of immunization administration in the pediatric population in order to better align the service with the evolving best practice model of delivering combination vaccines. This revision in the reporting of immunization administration will then permit a more accurate reflection of the physician work involved, reducing barriers to the spread of technology and allowing positive change in the practice of medicine. The CPT nomenclature needs to be kept up-to-date with the reporting of services associated with vaccine delivery, which has changed due to the

licensure of additional combination vaccines as well as those with more components. The two new immunization administration codes will more accurately reflect the service as currently delivered.

The specialty society presented compelling evidence that the physician time has changed in performing these services by providing rationale for an increasing frequency of counseling necessary to convince parents to 1) immunize their children at all; and 2) to persuade them of the safety and efficacy of component vaccines. Increased attention to vaccine safety on the Internet and in other media has driven anxiety and have necessitated additional physician involvement and discussion with parents. The RUC agreed that this increased physician work should be recognized.

The specialty society presented that the typical patient receives two vaccinations in one visit. However, based upon the age of the patient and specific vaccines available, some visits require only 9046X1, some visits require one or more units of 9046X1 and one or more units of 9046X2. It was noted that higher multiples of reporting of these codes would occur at infrequent visits (primarily 2 month, 6 months, and 4 years of age) and any payor concern regarding coding and valuation with these outlier visits may be addressed with a limit on the number of 9046X2 units allowed.

9046X1 Immunization Administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care profession; first vaccine/toxoid component

The RUC recommends that the survey intra-service time of 7 minutes should be reflected as the total time. Pre-service time, as described in the original SOR, is described in the preventive medicine services and the post-service descriptions reflect activities performed by clinical staff. The RUC agreed that the valuation for this service falls between the range of a 99211 (Work RVU=0.17) and the survey median of 0.25, and determined that considering that more than one unit is often coded, a value of 0.20 would be appropriate. 99401 *Preventive Counseling, 15 minutes* (work RVU = 0.48) is a reasonable comparison. Using the ratio of time of 7 minutes/15 minutes, a value of 0.20 is reasonable. In addition, the committee considered that they typical patient may receive two units of this service 0.40 total with 14 minutes of counseling, which is comparable to a 99212 (work RVU = 0.48 and 16 minutes of total time). **The RUC recommends a work value of 0.20 and physician intra-service time of 7 minutes for 9046X1.**

9046X2 – Immunization Administration through 18 years of age via any route of administration, with counseling by physician or other qualified health profession; each additional vaccine/toxoid component (List separately in addition to code for primary procedure)

The RUC understands that additional counseling is required to describe the additional vaccines and to address concern related to media reports of component vaccines. The survey indicated that this additional counseling requires 5 minutes of physician time. The RUC determined that the survey's 25th percentile work RVU of 0.16 is appropriate and reflects a proper rank order relationship with 99401 *Preventive Counseling* as described above and also in relationship to other counseling services, such as 99407 *Smoking Cessation (5/15 or 1/3 of 0.50).* **The RUC recommends a work value of 0.16 and a physician intra-service time of 5 minutes for 9046X2.**

Practice Expense – The RUC recommends the direct expense inputs of18 minutes clinical staff time, supplies and equipment for 9046X1 and no direct inputs for 9046X2 The individual inputs are described in the attached handout.

PLI Crosswalk – The new codes could be crosswalked to the existing immunization and administration codes, 90471 and 90472.

Subsequent Observation Services (Tab 9)
Scott Manaker, MD, ACP, Christopher Senkowski, MD, ACS, Charles Mabry, MD, ACS

Shifts in practice and payment policy have made it increasingly common for patients to remain in a hospital for several days under observation or outpatient status, instead of being "admitted." The RUC has had several discussions pertaining to valuing the 23+ hour codes and has resorted to using work proxies in order to capture the work being performed in these services. As currently, in CPT, there are only codes to report the initial day of observation service and discharge from observation. CPT advice for "subsequent" observation services has directed that code 99499 *Unlisted evaluation and management service* be reported for subsequent days. In response to the increase in the number of observation services that extend beyond the initial observation, a CPT coding proposal was prepared to request subsequent care observation codes to allow providers to report these services. At the June 2009 CPT meeting, three new codes were approved to report subsequent observation services in a facility setting.

992X1 Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: Problem focused interval history; Problem focused examination; Medical decision making that is straightforward or of low complexity Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Physicians typically spend XX minutes at the bedside and on the patient's hospital floor or unit.

The RUC reviewed the survey data as presented from the American College of Physicians and the American College of Surgeons for 992X1. The specialty societies presented modifications to the pre-service time package selected 1A (total pre-service time-20 minutes) to reflect their survey data of 5 minutes of evaluation time as the remainder of the pre-service time associated with this package was not reflective of the service provided. Further, the specialty societies recommend the 25th percentile for the intra-service time, 20 minutes, and 5 minutes of post-service time as they agreed that the intra-service time and the post-service times for the new codes should be the same as the reference code 99231 *Subsequent hospital care, per day, for the evaluation and management of a patient,* (Work RVU=0.76). After reviewing the service times as recommended by the specialty societies, the RUC compared the reference code to the surveyed code and determined that both services require similar intensity and complexity to perform. Given that the recommended times for 992X1 are the same as the reference code and that the intensity and complexity of performing 992X1 is the same as the reference code, the specialty societies recommended that 992X1 should have the same work RVU as 99231, 0.76 work RVUs, which is also the survey 25th percentile. **The RUC recommends 0.76 work RVUs for 992X1.**

992X2 Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend XX minutes at the bedside and on the patient's hospital floor or unit.

The RUC reviewed the survey data as presented from the American College of Physicians and the American College of Surgeons for 992X2. The specialty societies presented modifications to the pre-service time package selected 2A (total pre-service time-25 minutes) to 10 minutes of evaluation time as the remainder of the pre-service time associated with this package was not reflective of the service provided. Further, the specialty societies recommend the survey median for the intra-service time, 20 minutes, and 10 minutes of post-service time as they agreed that the intra-service time and the post-service times for the new codes should be the same as the reference code 99232 *Subsequent hospital care, per day, for the evaluation and management of a patient,* (Work RVU=1.39). After reviewing the service times as recommended by the specialty societies, the RUC compared 992X2 to the reference code and determined that both services require similar intensity and complexity to perform. Given that the recommended times for 992X2 are the same as the reference code and that the intensity and complexity of performing 992X2 is the same as the reference code, the specialty societies recommended that 992X2 should have the same work RVU as 99232, 1.39 work RVUs, which is just below the survey median (1.40 Work RVUs). **The RUC recommends 1.39 work RVUs for 992X2.**

992X3 Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend XX minutes at the bedside and on the patient's hospital floor or unit.

The RUC reviewed the survey data as presented from the American College of Physicians and the American College of Surgeons for 992X3. The specialty societies presented modifications to the pre-service time package selected 2A (total pre-service time-25 minutes) to reflect their survey data of 10 minutes of evaluation time as the remainder of the pre-service time associated with this package was not reflective of the service provided. Further, the specialty societies recommend the intra-service time, 30 minutes, and 15 minutes of post-service time as they agreed that the intra-service time and the post-service time for the new codes should be the same as the reference code 99233 *Subsequent hospital care, per day, for the evaluation and management of a patient,* (Work RVU=2.00). After reviewing the service times as recommended by the specialty societies, the RUC compared 992X3 to the reference code and determined that both services require similar intensity and complexity to perform. Given that the recommended times for 992X3 are the same as the reference code and that the intensity and complexity of performing 992X3 is the same as the reference code, the specialty societies recommended that 992X3 should have the same RVUs as 99233, 2.00 work RVUs, which is the survey median. **The RUC recommends 2.00 work RVUs for 992X3.**

Practice Expense Inputs: Similar to the other facility-only evaluation and management services, including the subsequent hospital care, the RUC recommends no practice expense inputs for these services.

CPT Follow-up: The RUC recommends that the language, "Physicians typically spend XX minutes at the bedside and on the patient's hospital floor or unit" in the descriptors of 992X1-992X3 match the times as stated in the descriptors of the subsequent hospital visit services 99231-99233.

X. CMS Requests

<u>Insertion of Breast Prosthesis (Tab 10)</u>
Martha Matthews, MD, ASPS

CPT code 19340 *Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction* was identified by CMS for RUC review as requested by the American Society of Plastic Surgeons (ASPS). In 2006, ASPS notified CMS that although 19340 had a ZZZ global period assigned to it, the code as noted in the CPT Book did not have a "+" denotation. ASPS claimed that the lack of the "+" denotation had the potential to cause confusion among Medicare and other payers and requested, after surveying their membership, that 19340 should be a stand alone code. ASPS requested that the code be assigned a 090 global and be reviewed by the RUC. CMS granted this request for a change in global period and subsequent RUC review. ASPS presented compelling evidence to the RUC that because this code obtained its value with a different global period that incorrect assumptions were made in the previous valuation of the service.

The RUC discussed several issues pertaining to the specialty society's recommendations including the pre-service time package selected. The RUC was not compelled by the specialty society's indication that the typical patient as described was a difficult patient. The RUC agreed that Pre-Service Time Package 3: Straightforward Patient/Difficult Procedure was more reflective of the service. However, the RUC agreed that an additional 5 minutes of positioning time was appropriate as the patient is checked multiple times for symmetry by being placed in a seated position. In summary, the pre-service time should be: 33 minutes – Evaluation time, 8 minutes – Positioning time, and 15 minutes – Scrub, Dress and Wait time. The RUC discussed concerns about time/work overlap when this service is performed with other codes. The RUC agreed that when this service is reported with another service, it will be subject to Modifier -51, which adequately adjusts for any pre-service time/work and post-service time/work overlap. Further, the RUC members discussed their concerns with the intra-service work being duplicative with the work performed by the general surgeon. The specialty addressed this concern by stating that the incision that the physician performs to insert the breast prosthesis is separate from the incision made to perform the mastectomy. The plastic surgeon assesses the muscle coverage and the adequacy and viability of the skin flaps as created by the general surgeon and then must create a submuscular pocket to insert the breast prosthesis which is in a separate site from the location of the mastectomy.

After discussing these issues, the RUC discussed the work RVU associated with this service. The RUC agreed that the intensity of the intra-service work has not changed and

used the following building block to evaluate the service. The RUC agreed that this was an appropriate method as CMS had requested that the pre-service and post-service work be added.

33 minutes	Evaluation	0.0224	0.74
8 minutes	Positioning	0.0224	0.18
15 minutes	SDW	0.0081	0.12
120 minutes	Intra	0.05265 (existing intensity of the current service)	6.32
30 minutes	Post	0.0224	0.67
1 visit	99231	0.76	0.76
1 visit	99238	1.28	1.28
1 visit	99214	1.50	1.50
2 visits	99213	0.97	1.94
1 visit	99212	0.48	0.48
		Work RVU	**13.99**
		Total Service Time	**366 minutes**

The RUC agreed that this was an appropriate value when they compared this service to MPC code 30410 *Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip* (Work RVU=14.00) as both services have 120 minutes of intra-service time and similar total service times, 366 minutes and 362 minutes, respectively. **The RUC recommends 13.99 Work RVUs for 19340.**

Practice Expense: To reflect the recommended post-operative visits, the existing practice expense inputs associated with this service have been modified and are attached.

<u>**Tissue Grafts (Tab 11)**</u>
William Creevy, MD, AAOS, Charles Mick, MD, NASS, John Wilson, MD, AANS, Jane Dillon, MD, AAO-HNS, Fredrick Boop, MD, CNS

In October 2008, 20926 *Tissue grafts, other (eg, paratenon, fat, dermis)* was identified by the RUC's Five-Year Identification Workgroup as one of the fastest growing services. The RUC agreed that this service may be misvalued and recommended the specialty conduct a RUC survey.

The specialty society informed the RUC that they will be presenting this service at the CPT Editorial Panel's October 2009 meeting. Currently, 20926 is most frequently being reported with two inappropriate services, 27447 *Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)* and 27130 *Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft*. The specialty indicated that 20926 is not intended to be used with these other services unless an autologous tissue graft from a separate incisional site is necessary. Therefore, the RUC agreed with the specialty to refer 20926 to the CPT Editorial Panel to add a cross-reference to indicate that another code be reported instead.

The RUC recommends that 20926 be referred to the CPT Editorial Panel for clarification.

<u>Tenodesis (Tab 12)</u>
William Creevy, MD, AAOS

In September 2007, 23430 *Tenodesis of long tendon of biceps* was identified by the RUC's Five-Year Identification Workgroup through the CMS Fastest Growing Screen. Since this code has never been surveyed through the RUC process and was flagged by a number of key criteria for potential misvaluation, the RUC recommended that the specialty society present this code to the RUC.

The RUC reviewed the survey results of more than 50 Orthopedic surgeons and agreed that the survey supports at least the current valuation for this service. The specialty society selected pre-service time package number 3, straightforward patient/difficult procedure, adding 9 minutes to the positioning time for beach chair positioning. The RUC agreed that this type of position necessitates an additional 9 minutes. In addition, the RUC recommended that this service have the following post operative visits: 0.5- 99238, 2- 99213, and 2- 99212. These number of visits are substantiated through the following: the key reference code 29828 *Arthroscopy, shoulder, surgical; biceps Tenodesis* (work RVU = 13.16), which is a similar service and has the same number of post operative visits; and the survey respondents who identified analogous post operative visits. The RUC also concurred with the median survey results that 23430 should have 60 minutes pre-service time, 60 minutes intra-service time, and 20 minutes immediate post-service time, for a total of 237 minutes (including post operative visits). These times are appropriate in comparison to 29828 which has a higher relative value of 13.16 and 70 minutes pre-service time, 75 minutes intra-service time, and 20 minutes immediate post-service time, for a total of 262 minutes (including post operative visits). Both the RUC and the specialty society agreed that, while the survey indicated a 25th percentile (11.00 RVU), which is higher than the current work relative value, there was no compelling evidence to validate a change in the work.

The RUC recommends a physician work RVU of 10.17 for 23430.

Practice Expense:
The RUC recommends that the direct practice expense inputs be adjusted to account for the change in post operative visits.

E/M Increases:
Based on the changes made in the 2010 MFS Final Rule, the E/M values have been increased and appropriately incorporated into the overall value of this code.

<u>Arthroscopy (Tab 13)</u>
William Creevy, MD AAOS

CMS received comments from physicians stating that they are currently performing arthroscopy service code 29870 *Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)* in the non-facility setting. CMS therefore requested that the RUC revisit the non-facility direct practice expense inputs for arthroscopy code 29870 at its October 2009 meeting.

The specialty society's direct practice expense input recommendations for code 29870 were extensively discussed by the RUC. The direct inputs were modified to reflect the

typical labor, medical supplies and equipment for the typical patient. Specifically; the clinical labor time was reduced by 12 minutes in the service period to reflect the RUCs standard clinical labor activity times, a video system and diagnostic arthroscope with computer were eliminated, and a medium instrument pack (which includes the arthroscope) and arthroscopic video equipment were added.

The RUC recommends the attached non-facility practice expense inputs for CPT Code 29870.

Laparoscopic Radical Prostatectomy (Tab 14)
James Giblin, MD, AUA, Richard Gilbert, MD, AUA

Code 55866 *Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing* was initially identified in September 2007 though CMS' Fastest Growing Screen as well as the new technology screen. Initially the specialty society planned to develop a coding proposal to separate code 55866 into two codes to distinguish between robotic and non-robotic laparoscopic prostatectomy. The CPT Editorial Panel determined that the code should be surveyed to describe the typical modality and not be separated into two codes. In April 2009, the RUC thoroughly discussed this issue and recommended that the code be surveyed to describe the typical method and presented at the October 2009 RUC meeting.

The specialty society indicated that for a number of years, code 55866 has been reported by physicians that typically use robotics to perform this service. The specialty society indicated that it is rare for a physician to perform a laparoscopic prostatectomy without robotics.

The RUC reviewed the survey results from 129 urologists for code 55866 and determined that pre-service time package 3-Facility Straightforward Patient/Difficult Procedure plus an additional 17 minutes for positioning is appropriate. The patient must be positioned in the lithotomy maximal Trendelenberg position and have all pressure points padded. The RUC determined that the reduction in the current intra-service time of 310 minutes to the recently surveyed intra-service time to 210 minutes appropriately accounts for the time required to perform this procedure. Although, the time has decreased, this service is very intense because the physician must manipulate the large robotic equipment from across the operating room. The RUC agreed with the specialty society recommended post-operative visits (1-99232, 1-99238, 2-99213 and 2-99214). The two 99214 visits are necessary as the physician is following up immediately with the patient to manage the catheter, perform imaging to determine leaks, talk to the patient and/or family regarding pathology results, discuss possible incontinence on the first post-operative visit, discussing penile rehabilitation and erectile dysfunction and associated medication that was not previously offered as part of post-op care.

The RUC determined that the survey 25th percentile work RVU of 32.06 appropriately accounts for the mental effort/judgment, technical skill/physical effort and intensity and complexity required for the physician to perform this service. The RUC compared 55866 to similar laparoscopic codes 43645 *Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption* (work RVU = 31.53 and 200 minutes intra-service time) and 44207 *Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis)* (work RVU =

31.92 and 195 intra-service time) to further support a work RVU of 32.06. **The RUC recommend the survey 25th percentile work RVU of 32.06 for 55866.**

CPT Change
The RUC determined that this service is typically performed using robotics, therefore the RUC requests that the CPT Editorial Panel add a parenthetical or appropriate editorial language change to the descriptor to indicate that this service includes robotic assistance when performed. The CPT Editorial Panel revised the code descriptor to include the recommended language, "includes robotic assistance when performed."

Practice Expense
The RUC recommends the 090-day global standard direct practice expense inputs for code 55866.

New Technology
The RUC agreed that this procedure is not performed the same as it was when established in 2003 and recommends that 55866 be placed on the new technology list.

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

E/M Increases
Based on the changes made in the 2010 MFS Final Rule, the E/M values have been increased and appropriately incorporated into the overall value of this code.

Obstetrical Care (Tab 15)
George Hill, MD, ACOG, Gregory DeMeo, DO, ACOG, Thomas Weida, MD, AAFP
Facilitation Committee #3

CMS requested review of the CPT codes that define obstetrical care (59400-59622) 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, most likely due to errors in the physician time. The RUC confirmed the recommendation and CMS agreed, requesting that the services be surveyed for review at the October 2009 RUC meeting.

The RUC reviewed the work RVU history of these codes and determined that for two of the obstetrical care base codes, 59400 and 59510, the existing work RVUs were based on a building block established by CMS. The specialty societies reviewed the building block as outlined in the *Final Rule* published on December 2, 1993 and were unable to replicate it. Further, the building block did not account for any discharge day management for the patient. As all of these codes were valued based on building blocks between each other, the RUC was compelled to believe that incorrect assumptions were used to develop the current work RVUs associated with these procedures, with the exception of CPT codes 59412 *External cephalic version, with or without tocolysis* and 59414 *Delivery of placenta (separate procedure).* Although these two codes have a MMM global period, they are typically performed as separate procedures. The RUC agreed that there was no compelling evidence to increase the RVU associated with these procedures and recommended that the

work and service time survey values for these services supports their existing value. The RUC agreed to maintain the existing value of these services and recommends the surveyed times and service descriptions be used in the RUC database. **The RUC recommendsto maintain the RVUs for 59412 at 1.71 RVUs and 59414 at 1.61 RVUs.**

The RUC reviewed the survey data from more than 70 obstetricians and family physicians for 59400 and 59510. In addition, the RUC reviewed the survey data from over 50 obstetricians for 59610 and 59618. After reviewing the survey data, the RUC learned that the specialties had broken the procedure into four parts: antepartum, management of labor, delivery and postpartum care. Each part was evaluated by the survey respondent separately. The survey data would be used as support for the time and intensity of the service provided. The RUC agreed with the specialty societies that a building block approach would be the best method to evaluate these services given the complexity of valuing services provided over 9 full months of care.

59400 Routine Obstetrical care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps, and post-partum care

The RUC reviewed the methodology that CMS utilized to value 59400. In the Final Rule published in December 1993, CMS, then HCFA, increased the work for 59400 from 19.70 to 21.50 by adding the following component RVUs:

8.85 RVUs for prenatal care (1- 99214 initial pre-natal visit and 12-99213 subsequent visits),

1.10 RVUs for an admission history and physical (some blend of hospital visits 99221 was 1.07 in 1994),

6.65 RVUs for the management of labor (no discussion regarding rationale for this value),

3.20 RVUs for the intra-service work of a vaginal delivery (no discussion regarding rationale for this value),

1.11 RVUs for in-hospital post-partum care (some blend of hospital visits - not specified 99232 was 0.89 in 1994, 99231 was 0.52 in 1994) and

0.59 RVUs for out-of-hospital post-partum care (some proxy to an office visit - not specified 99213 was 0.56 in 2004).

The RUC agreed with the methodology that CMS utilized to value this service and determined that a similar methodology should be utilized to value all of the obstetric services. The RUC reviewed a value for this code based on a review of multiple evaluation and management codes and a crosswalk from the intra-service intensity of the survey’s key reference code 58260 *Vaginal hysterectomy, for uterus 250 g or less;* (Work RVU=14.02) to the intra-service work of the surveyed code as the RUC agreed that the intra-service intensity for the reference code and the surveyed code were the same.

Antepartum:

Number of Visits	Visit	Time	Work RVU
1	99204	45	2.43
2	99214	80 (40x2)	3.00 (1.50 x2)
8	99213	184 (8x23)	7.76 (8x0.97)
2	99212	32 (2x16)	0.96 (2x0.48)
	Totals	341	14.15

Management of Labor:

Number of Visits	Visit	Time	Work RVU
0.70 (a proxy for the amount of face-to-face time of this service)	99222	52.5 (75x0.70)	1.80
1	99356	60	1.71
3	99357	90 (3x30)	5.13(1.71x3)
	Totals	202.5	8.64

Delivery Management

Intensity	Time	Work RVU
0.0224	10	0.224
0.0081	5	0.0405
0.104 (Intensity of the reference code)	45	4.68
0.0224	35	0.784
Totals	95	5.73

Post Operative Visits

Number of Visits	Visit	Time	Work RVU
1	99232	40	1.39
1	99238	38	1.28
1	99214	40	1.50
	Totals	118	4.17

RVU Calculation for 59400

	Time	Work RVU
Antepartum	341	14.15
Management of Labor	202.5	8.64
Delivery	95	5.73
Post-Partum	118	4.17
Totals	757	32.69

The RUC recommends 32.69 Work RVUs and a total service time of 757 minutes for 59400.

59409 and 59410

To value the other codes identified in this family, 59409 *Vaginal delivery only (with or without episiotomy and/or forceps);* and 59410 *Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care,* the RUC used a similar building block approach by utilizing the building blocks established in 59400. For 59409, the RUC utilized the management of labor and delivery building blocks in deriving a work RVU of 14.37 with 298 minutes. For 59410, the RUC utilized the management of labor, delivery and post-partum building blocks in deriving a work RVU of 18.54 with 416 minutes. The building blocks utilized for these codes are detailed on the attached spreadsheet. **The RUC recommends 14.37 RVUs with 298 minutes of total service time for 59409 and 18.54 RVUs with 416 minutes for 59410.**

59425

For 59425 *Antepartum care only; 4-6 visits,* the specialty society explained that the typical patient according to their survey data would be seen 5 times. Four of these visits, the society explained would be at a 99213 level. However, the initial visit would be a 99204 to be consistent with the other codes in this family. The building block utilized for this code is detailed on the attached spreadsheet. **The RUC recommends 6.31 RVU and 137 minutes for 59425.**

59426

For 59426 *Antepartum care only; 7 or more visits*, the specialty society explained that the typical patient according to their survey data would be seen 10 times. Nine of these visits, the society explained would be at a 99213 level. However, the initial visit would be a 99204 to be consistent with the other codes in this family. The building block utilized for this code is detailed on the attached spreadsheet. **The RUC recommends 11.16 RVU and 252 minutes for 59426.**

59430

For 59430, *Postpartum care only (separate procedure),* the specialty society explained that any physician who performs this service but does not deliver the baby would expect to see the patient twice and recommended the best reflection of these visits would be 1-99213 and 1-99214. The building block utilized for this code is detailed on the attached spreadsheet. **The RUC recommends 2.47 RVUs and 63 minutes total service time for 59430.**

59510 Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
The RUC approved a value for this code based on a building block of multiple evaluation and management codes and a crosswalk from the intra-service intensity of the survey's reference code 58260 *Vaginal hysterectomy, for uterus 250 g or less;* (Work RVU=14.02) to the intra-service work of the surveyed code as it was agreed upon that the intra-service intensity for the reference code and the surveyed code were the same. The building block is as follows:

Antepartum:

Number of Visits	Visit	Time	Work RVU
1	99204	45	2.43
2	99214	80 (40x2)	3.00 (1.50x2)
8	99213	184 (8x23)	7.76 (8x0.97)
2	99212	32 (2x16)	0.96 (2x0.48)
	Totals	341	14.15

Management of Labor: The RUC noted that the management of labor total time was supported by the survey data collected by the specialties. The RUC acknowledged that the survey median was 167.5 minutes and 75th percentile was 247 minutes for this service and the time established using the building block methodology was appropriately between those values.

Number of Visits	Visit	Time	Work RVU
0.70 (a proxy for the amount of face-to-face time of this service)	99222	52.5 (75x0.70)	1.80
1	99356	60	1.71
4	99357	120 (4x30)	6.84(1.71x4)
	Totals	232.5	10.35

Intensity	Time	Work RVU
0.0224	10	0.224
0.0081	10	0.0810
0.104 (Intensity of the reference code)	45	4.68
0.0224	35	0.784
Totals	100	5.77

Post Operative Visits

Number of Visits	Visit	Time	Work RVU
1	99232	40	1.39
1	99231	20	0.76
1	99238	38	1.28
1	99213	23	0.97
1	99214	40	1.50
	Totals	161	5.90

RVU Calculation for 59510

	Time	Work RVU
Antepartum	341	14.15
Management of Labor	232.5	10.35
Delivery	100	5.77
Post-Partum	161	5.90
Totals	835	36.17

The RUC recommends 36.17 Work RVUs and a total service time of 835 minutes for 59510.

59514 and 59515

To value the other codes identified in this family, 59514 *Cesarean delivery only;* and 59515 *Cesarean delivery only; including postpartum care*, the RUC used a similar building block approach by utilizing the building blocks established in 59510. For 59514, the RUC utilized the management of labor and delivery building blocks in deriving a work RVU of 16.13 with 333 minutes. For 59515, the RUC utilized the management of labor, delivery and post-partum building blocks in deriving a work RVU of 22.00 with 494 minutes. The building blocks utilized for these codes are detailed on the attached spreadsheet. **The RUC recommends 16.13 RVUs with 333 minutes of total service time for 59514 and 22.00 RVUs with 494 minutes for 59515.**

59610 Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery

The RUC approved a value for this code based on a building block of multiple evaluation and management codes and a crosswalk from the intra-service intensity of the survey's reference code 58260 *Vaginal hysterectomy, for uterus 250 g or less;* (Work RVU=14.02) to the intra-service work of the surveyed code as it was agreed upon that the intra-service intensity for the reference code and the surveyed code were the same. The building block is as follows:

Antepartum:

Number of Visits	Visit	Time	Work RVU
1	99204	45	2.43
2	99214	80 (40x2)	3.00 (1.50x2)
8	99213	184 (8x23)	7.76 (8x0.97)
2	99212	32 (2x16)	0.96 (2x0.48)
	Totals	341	14.15

Management of Labor: The RUC selected to utilize 99357 *Prolonged physician service in the inpatient setting, requiring unit/floor time beyond the usual service; each additional 30 minutes* (Work RVU=8.55) in the building block as the RUC agreed that this proxy better accounted for the increased intensity of performing a VBAC. Further, the RUC noted that the management of labor total time was supported by the survey data collected by the specialties. The RUC acknowledged that the survey median was 169.5 minutes and 75th percentile was 253 minutes for this service and the time established using the building block methodology was appropriately between those values.

Number of Visits	Visit	Time	Work RVU
0.70 (a proxy for the amount of face-to-face time of this service)	99222	52.5 (75x0.70)	1.80
5	99357	150 (5x30)	8.55 (1.71x5)
	Totals	202.5	10.35

Delivery of Care

Intensity	Time	Work RVU
0.0224	10	0.224
0.0081	5	0.0405
0.104 (Intensity of the reference code)	45	4.68
0.0224	35	0.784
Totals	95	5.72

Post Operative Visits

Number of Visits	Visit	Time	Work RVU
1	99232	40	1.39
1	99238	38	1.28
1	99214	40	1.50
	Totals	118	4.17

RVU Calculation for 59610

	Time	Work RVU
Antepartum	341	14.15
Management of Labor	202.5	10.35
Delivery	95	5.73
Post-Partum	118	4.17
Totals	757	34.40

The RUC recommends 34.40 Work RVUs and a total service time of 757 minutes for 59610.

59612 and 59614

To value the other codes identified in this family, 59612 *Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps);* and 59614 *Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care* the RUC used a similar building block approach by utilizing the building blocks established in 59610. For 59612, the RUC utilized the management of labor and delivery building blocks in deriving a work RVU of 16.09 with 298 minutes. For 59614, the RUC utilized the management of labor, delivery and post-partum building blocks in deriving a work RVU of 20.26 with 416 minutes. The building blocks utilized for these codes are detailed on the attached spreadsheet. **The RUC recommends 16.09 RVUs with 298 minutes of total service time for 59612 and 20.26 RVUs with 416 minutes for 59614**

59618 Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery

The RUC approved a value for this code based on a building block of multiple evaluation and management codes and a crosswalk from the intra-service intensity of the survey's reference code 58260 *Vaginal hysterectomy, for uterus 250 g or less;* (Work RVU=14.02) to the intra-service work of the surveyed code as it was agreed upon that the intra-service intensity for the reference code and the surveyed code were the same. The building block is as follows:

Antepartum:

Number of Visits	Visit	Time	Work RVU
1	99204	45	2.43
2	99214	80 (40x2)	3.00 (1.50x2)
8	99213	184 (8x23)	7.76 (8x0.97)
2	99212	32 (2x16)	0.96 (2x0.48)
	Totals	341	14.15

Management of Labor: The RUC selected to utilize 99357 *Prolonged physician service in the inpatient setting, requiring unit/floor time beyond the usual service; each additional 30 minutes* (Work RVU=8.55) in the building block as the RUC agreed that this proxy better accounted for the increased intensity of performing a VBAC. Further, the RUC noted that the management of labor total time was supported by the survey data collected by the specialties. The RUC acknowledged that the survey median was 169.5 minutes and 75th percentile was 257 minutes for this service and the time established using the building block methodology was appropriately between those values.

Number of Visits	Visit	Time	Work RVU
0.70 (a proxy for the amount of face-to-face time of this service)	99222	52.5 (75x0.70)	1.80
5	99357	150 (5x30)	8.55 (1.71x5)
	Totals	202.5	10.35

Delivery of Care: The RUC agreed with the specialty society that an additional 5 minutes of intra-service time as compared to 59400, 59510 and 59610, was appropriate for this service as the patient is always experiencing a repeat cesarean delivery.

Intensity	Time	Work RVU
0.0224	10	0.224
0.0081	10	0.081
0.104 (Intensity of the reference code)	50	5.20
0.0224	35	0.784
Totals	105	6.29

Post Operative Visits

Number of Visits	Visit	Time	Work RVU
1	99232	40	1.39
1	99231	20	0.76
1	99238	38	1.28
1	99213	23	0.97
1	99214	40	1.50
	Totals	161	5.90

RVU Calculation for 59618

	Time	Work RVU
Antepartum	341	14.15
Management of Labor	202.5	10.35
Delivery	105	6.29
Post-Partum	161	5.90
Totals	810	36.69

The RUC recommends 36.69 Work RVUs and a total service time of 810 minutes for 59618.

59620 and 59622
To value the other codes identified in this family, 59620 *Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery;* and 59622 *Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care* the RUC utilized the building blocks established in 59618. For 59620, the RUC utilized the management of labor and delivery building blocks in deriving a work RVU of 16.66 with 308 minutes. For 59622, the RUC utilized the management of labor, delivery and post-partum building blocks in deriving a work RVU of 22.53 with 469 minutes. The building blocks utilized for these codes are detailed on the attached spreadsheet. **The RUC recommends 16.66 RVUs with 308 minutes of total service time for 59620 and 22.53 RVUs with 469 minutes for 59622.**

The RUC agreed that the work RVU recommendations for these services were appropriate as they utilized a combination of RUC approved methodologies including survey data and building block analysis. The RUC noted that the average intensity level of monitoring time for the labor period computes to a level of intensity similar to the PIPPA intensity Level 2 (Presenting problems are of low severity; medical decision making and treatment of low complexity) during the review of the anesthesia monitoring time. Further, the RUC recommended work RVUs and physician time to resolve the high IWPUT issue as this was the reason why these codes were identified by the Five-Year Review Identification Workgroup.

Professional Liability Insurance (PLI) Crosswalks: The RUC recommends the existing PLI Crosswalk for these services.

Practice Expense: The RUC recommends that the practice expense inputs for these services be modified to reflect the number and level of post-operative visits recommended in the associate building blocks.

CPT Referral: As the RUC has valued inpatient post-delivery follow-up, including discharge services as part of delivery management, the RUC requests that the current definition of post-partum care be revised to accurately reflect the RUC's recommendations.

E/M Adjustment: In the *Final Rule* published in the *Federal Register* on November 25, 2009, CMS announced that they will no longer recognize office or inpatient consultation services and will redistribute the savings to the new and established office visits, initial hospital and initial nursing facility visits. These RUC recommendations reflect the work RVU increases to these identified evaluation and management services.

Injection of Anesthetic Agent (Tab 16)
Marc Leib, MD, JD, ASA, Richard Rosenquist, MD, ASA, Fred Davis, MD, AAPM

Codes 64415, 64445 and 64447 were identified through CMS' Fastest Growing Screen. The specialty society noted that the increase in utilization may be due to inappropriate reporting of these injection codes (typically performed in the hospital setting) instead of reporting muscle injection codes. **The RUC recommends that the specialty develop a CPT Assistant article to clarify correct coding and review these services again in two years (September 2012).**

64415
The RUC reviewed the survey results for code 64415 *Injection, anesthetic agent; brachial plexus, single* and agreed with the specialty society recommended pre-time package 1A-Facility straightforward patient/procedure (no sedation/anesthesia) with a one minute reduction to the scrub/dress/wait time. The RUC also determined that the survey median 15 minutes intra-service and 10 minutes immediate post-service appropriately reflect the time required to perform this service. The RUC compared 64415 to key reference service 64416 *Injection, anesthetic agent; brachial plexus, continuous infusion by catheter (including catheter placement)* (work RVU = 1.81 and 20 minutes intra-service time) and determined that the survey recommended times and current work RVU of 1.48 appropriately place code 64415 in the proper rank order. **The RUC recommends to maintain the current work RVU of 1.48 for code 64415.**

64445
The RUC reviewed the survey results for code 64445 *Injection, anesthetic agent; sciatic nerve, single* and agreed with the specialty society recommended pre-time package 1A-Facility straightforward patient/procedure (no sedation/anesthesia) with four additional minutes positioning the patient into the prone position and a one minute reduction to the scrub/dress/wait time. The RUC also determined that the survey median 15 minutes intra-service and 10 minutes immediate post-service appropriately reflect the time required to perform this service. The RUC compared 64445 to key reference service 64446 *Injection, anesthetic agent; sciatic nerve, continuous infusion by catheter (including catheter placement)* (work RVU = 1.81 and 20 minutes intra-service time) and determined that the survey recommended times and current work RVU of 1.48 appropriately place code 64445 in the proper rank order. **The RUC recommends to maintain the current work RVU of 1.48 for code 64445.**

64447
The RUC reviewed the survey results for code 64417 *Injection, anesthetic agent; femoral nerve, single* and agreed with the specialty society recommended pre-time package 1A-Facility straightforward patient/procedure (no sedation/anesthesia) with a one minute reduction to the scrub/dress/wait time. The RUC also determined that the survey median 15 minutes intra-service and 10 minutes immediate post-service appropriately reflect the time required to perform this service. The RUC compared 64447 to key reference service 64448 *Injection, anesthetic agent; femoral nerve, continuous infusion by catheter (including catheter placement)* (work RVU = 1.63 and 20 minutes intra-service time) and determined that the survey recommended times and current work RVU of 1.50 appropriately place code 64447 in the proper rank order. **The RUC recommends to maintain the current work RVU of 1.50 for code 64447.**

Practice Expense
The RUC reviewed the direct practice expense inputs and recommends the inputs as presented by the specialty society.

<u>Incision for Implantation of Neurostimulator Electrodes (Tab 17)</u>
James G. Giblin, MD, AUA

CPT code 64581 *Incision for implantation of neurostimulator electrodes; sacral nerve (transforaminal placement)* was identified in September 2007 by the Site of Service Anomaly Screen. The Five-Year Review Identification Workgroup reviewed all services that include inpatient hospital visits within their global periods, but are performed less than 50% of the time in the facility setting, according to recent Medicare utilization data. These services were identified in the latter group.

The specialty society recommended and the RUC agreed that removing the post-operative physician time components of the hospital visit (99232), half discharge day (99238) and the associated work RVUs with these visits would appropriately value this typically out-patient service (Work RVU for 64581 = 14.23 - 1.39 - 0.64 = 12.20). **The RUC recommends a work RVU of 12.20 for code 64581.**

<u>Practice Expense</u>
The RUC recommends adjusting the direct practice expense inputs based on this site of service change to the post-operative visits.

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

E/M Increases
Based on the changes made in the 2010 MFS Final Rule, the E/M values have been increased and appropriately incorporated into the overall value of this code.

<u>Iridotomy and Iridectomy (Tab 18)</u>
Stephen Kamenetzky, MD, AAO

The RUC identified 66761, *Iridotomy/iridectomy by laser surgery (eg, for glaucoma) (1 or more sessions),* through the RUC's Five-Year Identification Workgroup's High

IWPUT screen. The RUC agreed that the service may be misvalued and recommended a RUC survey be conducted.

The specialty society updated the RUC that this code is being referred to the CPT Editorial Panel to be discussed at their February 2010 meeting and if approved will be presented at the April 2010 RUC meeting. Previously, the RUC recommended that this code be valued as a single surgical session with a 10-day global period. In order to comply with this recommendation, the specialty society is going back to the CPT Editorial Panel to change the code descriptor to a "single session."

The RUC agreed with the specialty society's request to present 66761 at the February 2010 CPT Meeting.

<u>Intravitreal Injection (Tab 19)</u>
Stephen Kamenetzky, MD, AAO
Facilitation Committee #1

In February 2008, 67028 *Intravitreal injection of a pharmacologic agent (separate procedure)* was identified by the RUC's Five-Year Identification Workgroup through the High Volume CMS Fastest Growing Screens. This Harvard-valued code has seen recent rapid growth in Medicare utilization. The Five–Year Identification work group accepted the specialty's explanation for the increase in utilization as being consistent with the development of new and more effective treatment options for age-related macular degeneration, but requested that the code be surveyed to establish a RUC-reviewed work value.

The RUC agreed with the specialty society that the specialty-conducted survey was flawed, as the respondents chose what the RUC believed was an inappropriate reference code with a 090 day global. The RUC agreed with the specialty society's choice of pre-service package 6, procedure with sedation/anesthesia care, removing 11 minutes because an evaluation and management code is typically reported in addition to the procedure. Thus, the RUC agreed that the physician time required to perform this service is 12 minutes pre-service, 5 minutes intra-service, and 5 minutes immediate post-service. The RUC compared 67028 to 67515 *Injection of medication or other substance into Tenon's capsule* (work RVU = 1.40, pre-service time = 11, intra-service time = 5, post-service time = 5) and determined that the work relative value for 67028 should be somewhat higher because the procedure has slightly more pre-service time and greater intensity and complexity than 67515. The RUC also compared the service to 67500 *Retrobulbar injection; medication (separate procedure, does not include supply of medication)* (work RVU = 1.44, pre-service time = 15, intra-service time = 5, post-service time =5). The RUC came to a consensus that these two services are similar in both physician time and intensity and the relative value for 67028 should be directly crosswalked to 67500.

The RUC recommends a physician work RVU of 1.44 for 67028.

Practice Expense
The RUC reviewed the direct practice expense inputs for 67028 and adjusted the clinical labor and medical supplies from the specialty's recommendations to reflect the typical patient service. In addition, the RUC understands that the specialty and CMS will continue to discuss the reimbursement for the injectable drugs.

Practice Liability Insurance Crosswalk
67500 is an appropriate PLI crosswalk to 67028.

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

Labyrinthotomy (Tab 20)
Jane Dillon, MD, AAO-HNS

CPT code 69801 Labyrinthotomy, with or without cryosurgery including other nonexcisional destructive procedures or perfusion of vestibuloactive drugs (single or multiple perfusions); transcanal was identified by the CMS Fastest Growing and the Site of Service Anomaly Screens.

The specialty society requested that this code be referred to the CPT Editorial Panel to be discussed at their February 2010 Meeting. The specialty society proposes a revision of the descriptor and the vignette to clarify the actual procedure being performed – a single perfusion of the drug. As such, the specialty society also requests that the global assigned to this service would be a 000 day global period. **The RUC agreed with this request to refer the issue to the CPT Editorial Panel and recommends that the specialty develop a CPT Assistant article to explain the correct reporting of this service as it is currently stated in CPT.**

CT Thorax (21)
Geraldine McGinty, MD, ACR, Ezequiel Silva, MD, ACR

In October 2008, CPT Code 71250 *Computed tomography, thorax; without contrast material* (Work RVU = 1.16) was identified by the RUC's Five-Year Identification Workgroup as one of the fastest growing services and had never been surveyed by the RUC. The RUC recommended a full RUC survey be conducted.

The RUC reviewed survey data from nearly 60 physicians who frequently perform this service. The specialty recommended a pre-service time of 5 minutes based on the survey results and the RUC concurred. The RUC also agreed that the surveyed intra-service of 15 minutes and immediate post service time of 5 minutes were typical for the physician work required for the service. The total time of 25 minutes is comparable to the 22 minutes of total time assumed by CMS.

The RUC compared 71250 to key reference service 71260 *Computed tomography, thorax; with contrast material(s)* (Work RVU = 1.24, with pre, intra, and post service times of 3, 15, and 5 minutes respectively), and noted that the survey respondents indicated that in general a CT of the thorax without contrast is a slightly less intense service than one with contrast, as reflected in slightly lower values for the intensity and complexity measures. The RUC also compared 71250 to the specialty's multi-specialty points of comparison codes 78306 *Bone and/or joint imaging; whole body* (Work RVU = 0.86, with pre, intra, and post service times of 5, 8, and 5 minutes respectively) and 74160 *Computed tomography, abdomen; with contrast material(s)* (Work RVU = 1.27, with pre, intra, and post service times of 3, 15, and 5 minutes respectively).

The RUC agreed that there is significant evidence to support the current valuation, given changes in technology and the patient population.. The RUC and the specialty sited the following as evidence to maintain the work relative value of 1.16 for CT of the thorax:

- Modern CT technology produces an increased amount of data to be reviewed and interpreted. Because of the improved spatial resolution and multi-planar reformation of the data, a higher level of diagnostic specificity and accuracy is expected, and the number of possible protocols to be considered in the pre-service period by the interpreting physician has increased. Many patients require prone and supine imaging with both inspiration and expiration for the evaluation of interstitial lung disease. Further, 2D reconstructions (previously separately billable using code 76375 *Coronal, sagittal, multiplanar, oblique, 3-dimensional and/or holographic reconstruction of computed tomography, magnetic resonance imaging, or other tomographic modality* in 2005 with 0.16 work RVUs) were bundled into the base code in 2006 and are now being considered an inherent part of the service.

- Using multi-detector row CT scanners, modern high resolution CT protocols are able to generate contiguous 1.25 mm images through the entirety of the lungs which are also used to create coronal 2D reconstructions to more accurately assess distribution of disease. As such, these examinations now generate more than 300 images for interpretation.

- The expectation of the referring physician is now much higher in terms of defining the various subtypes of interstitial lung disease and also in evaluating whether a lung nodule merits follow up or more aggressive intervention. The incidence of smoking-related lung disease continues to increase in the Medicare population, as does the ability to characterize these diseases with the advent of high resolution multi-detector CT. Current estimates are that pulmonary emphysema and the smoking related interstitial lung diseases – centrilobular emphysema, respiratory bronchiolitis interstitial lung disease (RBILD), desquamative interstitial pneumonia (DIP), and Langerhan's cell histiocytosis (LCH) – are among the top ten causes of morbidity and mortality in the Medicare population and both morbidity and mortality from these illnesses are expected to increase by 2020.

- Because of refinements in technique and the ability to examine the entire lung, specific diagnoses of potentially reversible diseases such as RBILD and DIP can now be made and differentiated from irreversible diseases such as LCH and pulmonary fibrosis (usual interstitial pneumonia) without open lung biopsy or the need to institute potentially harmful empiric therapy without a definitive diagnosis. The extent and distribution of pulmonary centrilobular and bullous emphysema is now well characterized and critically important in both medical and surgical treatment planning.

While CT technology is changing rapidly, the adoption of newer techniques is not yet universal. The reasons for the increase in utilization of non-enhanced CT procedures are likely multi-factorial but concerns over the use of intravenous contrast and its potential nephrotoxicity in at-risk patients is felt to contribute at least in part to this increase.

Advances in CT technology have provided new indications for non-enhanced CT leading to volume growth. The most common indication for non-enhanced CT of the thorax is

evaluation and follow-up of pulmonary nodules. The ability to detect small non-calcified pulmonary nodules has increased dramatically in recent years with high-resolution exam protocols. And while any of these nodules could represent small malignancies, most of the nodules are benign. The protocol for following likely benign pulmonary nodules developed by the Fleischner Society stated that pulmonary nodules should be followed with serial CT examinations for two years to assure benignity. Recent literature has prompted a re-evaluation of these guidelines by the Fleischner Society with the end result being a statement that will drastically reduce the number of follow-up examinations in low-risk patients with nodules less than 8 mm in size. These recommendations are supported by pulmonary medicine and thoracic surgery societies as well, and it is expected that the volume of these service will likely decrease in the future as these practice guidelines are established in the community.

From the survey results, comparison of similar services, rank order maintenance, and considerations regarding the rationale for the volume growth in the service, the RUC agreed that the physician work relative value should be maintained at its current value of 1.16 work RVUs, which was lower than the survey's 25% percentile of 1.20. The RUC acknowledges the growth in CT scans in the Medicare population. However, there is no evidence that this growth has led to a reduction in physician resources, as confirmed by the recent survey time data.

The RUC recommends maintaining the relative work value for CPT code 71250 of 1.16.

Practice Expense

The Practice Expense Subcommittee reviewed all direct costs for CT in 2003 and did not believe that the direct inputs had changed in the past six years.

<u>CT Spine (22)</u>

Geraldine McGinty, MD, ACR, Ezequiel Silva, MD, ACR, William Donovan, MD, MPH, ASNR, Robert Barr, MD, ASNR

In October 2008, CPT Codes 72125 *Computed tomography, cervical spine; without contrast material* (2009 Work RVU = 1.16), 72128 *Computed tomography, thoracic spine; without contrast material* (2009 Work RVU = 1.16), and 72131 *Computed tomography, lumbar spine; without contrast material* (2009 Work RVU = 1.16) were identified through the RUC's Five-Year Identification Workgroup as some of the fastest growing services and had never been surveyed by the RUC. The RUC recommended a full RUC survey be conducted for each.

72125

The RUC reviewed survey data from over a hundred physicians who frequently perform this service. The specialty recommended a pre-service time of 5 minutes based on the survey results and the RUC concurred. The RUC also agreed that the surveyed intra-service of 15 minutes and immediate post service time of 5 minutes were typical for the physician work required for the service. The total time of 25 minutes is higher than the 22 minutes of total time assumed by CMS.

The RUC compared 72125 to key reference service 70498, *Computed tomographic angiography, neck, with contrast material(s), including non-contrast images, if performed, and image post-processing* (Work RVU = 1.75 and pre, intra, and post

service times of 7, 20 and 10 minutes respectively) and agreed that the physician work for 72125 is less intense and takes less time. The RUC also compared 72125 to multi-specialty points of comparison codes 78306 *Bone and/or joint imaging; whole body* (Work RVU = 0.86, with pre, intra, and post service times of 5, 8, and 5 respectively) and 74160 *Computed tomography, abdomen; with contrast material(s)* (Work RVU = 1.27, with pre, intra, and post service times of 3, 15, and 5 respectively).

The RUC recommends maintaining the relative work value for CPT code 72125 of 1.16.

72128
The RUC reviewed survey data from over a hundred physicians who frequently perform this service. The specialty recommended a pre-service time of 5 minutes based on the survey results and the RUC concurred. The RUC also agreed that the surveyed intra-service of 15 minutes and immediate post service time of 5 minutes were typical for the physician work required for the service. The total time of 25 minutes is higher than the 22 minutes of total time assumed by CMS.

The RUC compared 72128 to key reference service 71260, *Computed tomography, thorax; with contrast material(s)* (Work RVU = 1.24 and pre, intra, and post service times of 3, 15, and 5 minutes respectively), and agreed the services were similar in physician work and time.

The RUC also compared 72128 to multi-specialty points of comparison codes 78306 *Bone and/or joint imaging; whole body* (Work RVU = 0.86, with pre, intra, and post service times of 5, 8, and 5 respectively) and 74160 *Computed tomography, abdomen; with contrast material(s)* (Work RVU = 1.27, with pre, intra, and post service times of 3, 15, and 5 respectively), and agreed the physician work value for 72128 should be between the two, though more closely aligned with 74160. Based on the specialty's strong survey results and evidence that the service, technology, and patient population had changed, however the RUC and the specialty agreed that the survey supported its current value and to maintain relativity amongst services the current work value of 1.16 should be maintained.

The RUC recommends maintaining the relative work value for CPT code 72128 of 1.16.

72131
The RUC reviewed survey data from over a hundred and ten physicians who frequently perform this service. The specialty recommended a pre-service time of 5 minutes based on the survey results and the RUC concurred. The RUC also agreed that the surveyed intra-service of 15 minutes and immediate post service time of 5 minutes were typical for the physician work required for the service. The total time of 25 minutes is higher than the 22 minutes of total time assumed by CMS.

The RUC compared 72131 to key reference service 70498, *Computed tomographic angiography, neck, with contrast material(s), including non-contrast images, if performed, and image post-processing* (Work RVU = 1.75 and pre, intra, and post service times of 7, 20 and 10 minutes respectively) and agreed that the physician work for 72125 is less intense and takes less time. The RUC also compared 72131 to multi-specialty points of comparison codes 78306 *Bone and/or joint imaging; whole body*

(Work RVU = 0.86, with pre, intra, and post service times of 5, 8, and 5 respectively) and 74160 *Computed tomography, abdomen; with contrast material(s)* (Work RVU = 1.27, with pre, intra, and post service times of 3, 15, and 5 respectively). Based on the specialty's strong survey results and evidence that the service, technology, and patient population had changed, however the RUC and the specialty agreed that the survey supported its current value and to maintain relativity amongst services the current work value of 1.16 should be maintained.

The RUC recommends maintaining the relative work value for CPT code 72131 of 1.16.

In addition, RUC agreed with the specialty that these CT services had changed and that there is significant evidence to support the current valuations, given changes in technology and the patient population. The RUC and specialty sited the following as evidence to maintain the work relative values of all three CT of the spine services:

- Modern CT technology produces an increased amount of data to be reviewed and interpreted. Because of the improved spatial resolution and multiplanar reformation of the data, a higher level of diagnostic specificity and accuracy is expected.

- The technique and technology have changed significantly; CT scanners have gone through several generations of upgrades that have revolutionized its practice. These exams now routinely include hundreds of axial images, compared to an average of 15-25 previously. Multiplanar 2D reformats are now routinely performed (previously separately billable using code 76375 *Coronal, sagittal, multiplanar, oblique, 3-dimensional and/or holographic reconstruction of computed tomography, magnetic resonance imaging, or other tomographic modality* in 2005 with 0.16 work RVUs) and were bundled into the base code in 2006 and are now being considered an inherent part of the service.

- The patient population has changed, now with the majority representing emergency department and urgent-care patients, as opposed to outpatients being worked up for chronic pain 15 years ago, and the occasional emergency department patient. Therefore, the site of service has changed along with the patient population.

- The specialty surveys reflect an increase in physician time for these exams and it is evident that technology has changed the physician work; the increased availability and rapidity of CT scanning has led to its routine use in emergent situations. This (along with the factors mentioned above) has made physician work more time-critical and warrant the corresponding increase in time and maintenance of the work RVUs for these services.

The increased utilization of CT spine services stems mainly from changing practice patterns related to improved CT technology. There is increasing literature and anecdotal evidence supporting the use of CT in the setting of acute trauma, and with newer scanners the scan time and radiation dose are now comparable to or in many cases lower than that of a complete radiographic series. Because a proportion of potentially significant fractures are missed on plain radiographs, CT has become the first test in virtually all patients with significant risk of spine injury. Spine CT is also increasingly relied upon

for complex preoperative planning and for post-surgical evaluation, including cases of suspected non-union, pseudarthrosis, infection, or other complications.

The advent of 64-slice CT scanners also likely plays a role in this evolution. 64-slice CT scanners were first introduced into clinical practice in 2004, the "base year" of the survey period. It is interesting to note that the rate of growth in utilization for both spine CT codes has decreased each successive year from 2005-2007, suggesting that adaptation to this newer technology and/or newer practice model is fairly advanced. The dramatic increase in the number of images generated by newer scanners argues against any reduction in physician work associated with recent technological improvements.

From the survey results, comparison of similar services, rank order maintenance, and considerations regarding the rationale for the volume growth in the service, the RUC agreed that the physician work relative values for all three of these CT spine services should be maintained their current values of 1.16 work RVUs which was lower than the surveys' 25% percentile of 1.20. The RUC acknowledges the growth in spine CT scans in the Medicare population. However, there is no evidence that this growth has led to a reduction in physician resources, as confirmed by the recent survey time data.

Practice Expense
The Practice Expense Subcommittee reviewed all direct costs for CT in 2003 and did not believe that the direct inputs had changed in the past six years.

CT Upper Extremity (23)
Geraldine McGinty, MD, ACR, Ezequiel Silva, MD, ACR

In October 2008, CPT code 73200 *Computed tomography, upper extremity; without contrast material* (Work RVU = 1.09) was identified through the RUC's Five-Year Identification Workgroup as one of the fastest growing services and had never been surveyed by the RUC. The RUC recommended a full RUC survey be conducted.

The RUC reviewed the survey results from over 40 radiologists who frequently perform this service. The specialty recommended a pre-service time of 5 minutes based on the survey results, and the RUC concurred. The RUC also agreed that the surveyed intra-service of 15 minutes and immediate post service time of 5 minutes were typical for the physician work required for the service. The total time of 25 minutes is higher than the 21 minutes of total time assumed by CMS.

The RUC compared 73200 to key reference service 73721, *Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material* (Work RVU = 1.35 and pre, intra, and post service times of 0, 20 and 0 minutes respectively), and agreed the two services are similar in intensity and complexity. In addition, the extremity CT requires urgency of medical decision making and carries a great risk of significant complications and malpractice suits with a poor outcome. The RUC also compared 73200 to multi-specialty points of comparison codes 78306 *Bone and/or joint imaging; whole body* (Work RVU = 0.86, with pre, intra, and post service times of 5, 8, and 5 respectively) and 74160 *Computed tomography, abdomen; with contrast material(s)* (Work RVU = 1.27, with pre, intra, and post service times of 3, 15, and 5 respectively), and agreed the physician work value for 72128 should be between the two.

In addition, RUC agreed with the specialty that these CT services had changed and that there is significant evidence to support the current valuations, given changes in technology and the patient population. The RUC and specialty sited the following as evidence to maintain the work relative values of all three CT of the spine services:

- Modern CT technology produces an increased amount of data to be reviewed and interpreted. Because of the improved spatial resolution and multiplanar reformation of the data, a higher level of diagnostic specificity and accuracy is expected.

- The technique and technology have changed significantly; CT scanners have gone through several generations of upgrades that have revolutionized its practice. The number of possible protocols to be considered in the pre-service period by the interpreting physician has increased with many patients requiring modifications to standard imaging protocols because of the variability of acute injuries and that 2D reconstructions are now routinely performed (previously separately billable using code 76375 *Coronal, sagittal, multiplanar, oblique, 3-dimensional and/or holographic reconstruction of computed tomography, magnetic resonance imaging, or other tomographic modality* in 2005 with 0.16 work RVUs) and were bundled into the base code in 2006 and are now being considered an inherent part of the service.

- Using multi-detector row CT scanners, modern high resolution CT protocols are able to generate contiguous images through the affected extremity with the added ability to create coronal and sagittal 2D reconstructions. These reconstructions enable the interpreting physician to more accurately evaluate fractures and permit more thorough surgical planning for those that require open reduction and internal fixation. As such, these examinations may now generate hundreds of axial images as well as several sets of reconstructed images for interpretation.

While CT technology is changing rapidly, the adoption of newer techniques is not yet universal. The reasons for the increase in utilization of non-enhanced CT procedures are likely multi-factorial but concerns over the use of intravenous contrast and its potential nephrotoxicity in at-risk patients is felt to contribute at least in part to this increase.

From the survey results, comparison of similar services, rank order maintenance, and considerations regarding the rationale for the volume growth in the service, the RUC agreed that the physician work relative value should be maintained its current value of 1.09 work RVUs which was lower than the survey's 25% percentile of 1.10. The RUC acknowledges the growth in CT scans in the Medicare population. However, there is no evidence that this growth has led to reduced physician resources, as confirmed by the recent survey time data.

The RUC recommends maintaining the relative work value for CPT code 73200 of 1.09.

Practice Expense
The Practice Expense Subcommittee reviewed all direct costs for CT in 2003 and did not believe that the direct inputs had changed in the past six years.

Radiologic Examination (Tab 24)
Geraldine McGinty, MD, ACR, William Creevy, MD, AAOS, Tye Ouzounian, MD, AOFAS, Frank Spinosa, DPM, APMA

Three radiologic examination codes 73510 *Radiologic examination, hip, unilateral; complete, minimum of 2 views* (Work RVU = 0.21), 73610 *Radiologic examination, ankle; complete, minimum of 3 views* (Work RVU = 0.17), and 73630 *Radiologic examination, foot; complete, minimum of 3 views* (Work RVU = 0.17) were identified by the RUC's Five-Year Review Identification Workgroup through its CMS screen for Harvard-valued codes with utilization greater than 1 million.

The Five-Year Review Workgroup agreed that these services required a review, but that a complete survey may not be the appropriate mechanism. The specialty had noted that it would be very difficult to differentiate the relatively low work values, and the Workgroup recommended that the specialty work with the Research Subcommittee to develop an appropriate survey or other method to validate valuation for these services with small RVUs (e.g., 0.17).

In October 2009, the RUC's Research Subcommittee reviewed the recommendation made by the specialty societies to crosswalk the physician times and values for these identified codes to codes frequently performed by the specialty societies. The specialty societies explained that when determining an appropriate crosswalk, they tried to find RUC reviewed codes that were similar in service and time, performed on similar anatomical site, required similar number of views and required similar positioning of patients. The Research Subcommittee and the RUC agreed that the methodology employed by the specialty was appropriate for these services, however this methodology should not be applied to other codes without RUC approval. Since these codes were not surveyed, vignettes were not developed. At the RUC's request the specialty societies provided vignettes and descriptions of work for these services. The RUC accepted the new vignettes and descriptions of physician work.

The RUC recommends to maintain the work relative values for codes 73510, 73610 and 73630 and a direct physician time crosswalk from codes 73564, 73110, and 73130 respectively. This crosswalk is outlined below.

Code	RUC Recommended Work RVU	Cross-walk	Physician Time Cross-walk
73510	**0.21**	73564 (Radiologic examination, knee; complete, 4 or more views), (Work RVU = 0.22) (RUC reviewed August 1995) 73510 is cross-walked to 73564 since these services are both performed on large joints. 73564 has been RUC surveyed and has .01 higher RVU reflective of its increased number of views. This difference is similar to the.01 difference between 73560 *Radiologic examination,*	5 minutes intra service time with total time = 5 minutes

		knee; 1 or 2 views (work RVU= 0.17 RVU) and 73562 *Radiologic examination, knee; 3 views* (work RVU = 0.18).	
73610	**0.17**	Cross-walk to code 73110 (X-ray exam of wrist; complete, min of 3 views), (Work RVU = 0.17) (RUC reviewed August 1995)	1 minute pre-service, 3 minutes intra-service, and 1 minute immediate post, with total time = 5 minutes
73630	**0.17**	Cross-walk to code 73130 (X-ray exam of hand; min of 3 views), (Work RVU = 0.17) (RUC reviewed August 1995)	1 minute pre-service, 3 minutes intra-service, and 1 minute immediate post, with total time = 5 minutes

CT Lower Extremity (Tab 25)
Geraldine McGinty, MD, ACR, Ezequiel Silva, MD, ACR

In October 2008, CPT code 73700 *Computed tomography, lower extremity; without contrast material* (Work RVU = 1.09) was identified through the RUC's Five-Year Identification Workgroup as one of the fastest growing services and had never been surveyed by the RUC. The RUC recommended a full RUC survey be conducted.

The RUC reviewed the survey results from over 40 radiologists who frequently perform this service. The specialty recommended a pre-service time of 5 minutes based on the survey results and the RUC concurred. The RUC also agreed that the surveyed intra-service of 15 minutes and immediate post service time of 5 minutes were typical for the physician work required for the service. The total time of 25 minutes is higher than the 21 minutes of total time assumed by CMS.

The RUC compared 73700 to key reference service 73721, *Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material* (Work RVU = 1.35 and pre, intra, and post service times of 0, 20 and 0 minutes respectively), and agreed the two services are similar in intensity and complexity. In addition, the extremity CT requires urgency of medical decision making and carries a great risk of significant complications and malpractice suits with a poor outcome. The RUC also compared 73700 to multi-specialty points of comparison codes 78306 *Bone and/or joint imaging; whole body* (Work RVU = 0.86, with pre, intra, and post service times of 5, 8, and 5 respectively) and 74160 *Computed tomography, abdomen; with contrast material(s)* (Work RVU = 1.27, with pre, intra, and post service times of 3, 15, and 5 respectively), and agreed the physician work value for 72128 should be between the two.

In addition, RUC agreed with the specialty that these CT services had changed and that there is significant evidence to support the current valuations, given changes in technology and the patient population. The RUC and specialty sited the following as evidence to maintain the work relative values of all three CT of the spine services:

- Modern CT technology produces an increased amount of data to be reviewed and interpreted. Because of the improved spatial resolution and multiplanar reformation of the data, a higher level of diagnostic specificity and accuracy is expected.

- The technique and technology have changed significantly; CT scanners have gone through several generations of upgrades that have revolutionized its practice. The number of possible protocols to be considered in the pre-service period by the interpreting physician has increased with many patients requiring modifications to standard imaging protocols because of the variability of acute injuries and that 2D reconstructions are now routinely performed (previously separately billable using code 76375 *Coronal, sagittal, multiplanar, oblique, 3-dimensional and/or holographic reconstruction of computed tomography, magnetic resonance imaging, or other tomographic modality* in 2005 with 0.16 work RVUs) and were bundled into the base code in 2006 and are now being considered an inherent part of the service.

- Using multi-detector row CT scanners, modern high resolution CT protocols are able to generate contiguous images through the affected extremity with the added ability to create coronal and sagittal 2D reconstructions. These reconstructions enable the interpreting physician to more accurately evaluate fractures and permit more thorough surgical planning for those that require open reduction and internal fixation. As such, these examinations may now generate hundreds of axial images as well as several sets of reconstructed images for interpretation.

While CT technology is changing rapidly, the adoption of newer techniques is not yet universal. The reasons for the increase in utilization of non-enhanced CT procedures are likely multi-factorial but concerns over the use of intravenous contrast and its potential nephrotoxicity in at-risk patients is felt to contribute at least in part to this increase.

From the survey results, comparison of similar services, rank order maintenance, and considerations regarding the rationale for the volume growth in the service, the RUC agreed that the physician work relative value should be maintained its current value of 1.09 work RVUs which was lower than the survey's 25% percentile of 1.10. The RUC acknowledges the growth in CT scans in the Medicare population. However, there is no evidence that this growth has led to a reduction in physician resources, as confirmed by the recent survey time data.

The RUC recommends maintaining the relative work value for CPT code 73700 of 1.09.

Practice Expense
The Practice Expense Subcommittee reviewed all direct costs for CT in 2003 and did not believe that the direct inputs had changed in the past six years.

<u>Lower Extremity Ultrasound (Tab 26)</u>
Geraldine McGinty, MD, ACR, Frank Spinosa, DPM, APMA

Code 76880 *Ultrasound, extremity, nonvascular, real time with image documentation* was identified through CMS' Fastest Growing Screen. At the October 2008 RUC Meeting, the RUC approved the recommendation of the American Podiatric Medical Association (APMA) to survey 76880. APMA indicated a level 1 interest to survey the code. However, the APMA later notified the RUC that it rescinded its level of interest to survey 76880, as it is not the dominant specialty. Specifically, the APMA noted that the physician work component of 76880 is more commonly performed by Diagnostic Radiology. According to the 2007 Medicare utilization data. Podiatry is the dominant provider of this service in the non-facility setting.

The American College of Radiology indicated its willingness to take interest in the service. The specialty society indicated that the availability of handheld ultrasound equipment has enabled podiatry and other specialties to perform this and other similar procedures within their offices, which is driving the increase in utilization. The Five-Year Review Identification Workgroup noted that value of 76880 includes the ultrasound room, which is priced significantly higher than the handheld device. The Workgroup agreed that this is an issue that may need to be addressed through either CPT changes and/or significant changes in the practice expense and possibly physician work.

Some Workgroup members stated that there may be other services that were valued using larger, more expensive, and more sophisticated equipment where there is now smaller and more affordable equipment to perform a similar procedure. In February 2009, the RUC recommended the creation of a joint CPT and RUC workgroup to research this issue to identify similar services and develop recommendations to appropriately describe and/or address the valuation of these services.

The joint CPT and RUC workgroup understood the issue presented by the identification of 76880 in the high volume growth screen and recommended that the Five-Year Review Workgroup and RUC review this code to determine if it is appropriately valued. However, the charge to expand this issue to all services utilizing ultrasound and/or technologies that have "small box" models available is unclear. The Workgroup determined the RUC should review the work and practice expense inputs for 76880at the October 2009 meeting.

In October 2009, the specialty society indicated that current existing codes describe a complete ultrasound, therefore they would propose the creation of a code to report ultrasound of a limited portion of an extremity. **The specialty society requested and the RUC agreed to refer this code to CPT to specifically describe the targeted soft tissue or other specific anatomic region examination.** A RUC member noted that this would be a different level of service from a complete evaluation and current codes exist to report when you are inserting needles for ultrasound, therefore CPT should be aware of this when reviewing the coding proposal for this issue.

<u>Radiation Treatment Management (Tab 27)</u>
Najeeb Mohideen, MD, ASTRO, Michael Kuettel, MD, PhD, ASTRO, David Beyer, MD, ASTRO, Thomas Eichler, MD, ASTRO
Facilitation Committee #2

Radiation treatment management code 77427 *Radiation treatment management, 5 treatments* (Work RVU = 3.70) was identified by the RUC's Five-Year Review Identification Workgroup through its site of service anomaly screen in 2007 as this XXX global code includes physician time components that include hospital, discharge day, and post-operative office visit time.

The specialty society and CMS indicated that code 77427 has an "implied" 090 day global period associated with it. In the CMS 2005 MFS *Proposed Rule*, CMS proposed to change the global period for the weekly treatment management code from XXX to 090. However, CMS did not finalize the proposal as a 090 day global. If CMS changed the global period from XXX to 090, the carriers' claims processing systems would have rejected all claims submitted within 90 days of the first date of service for code 77427. CMS retained the global period of XXX for CPT code 77427 and stated that there was an implied 090 day global following the end of treatment.

To resolve the issue, the specialty worked with the RUC's Research Subcommittee and the CPT Editorial Panel to finalize the survey tool with one vignette. To address the post-operative visit issue, the specialty modified their XXX survey instrument with questions pertaining to post-treatment services per week. These modifications include: 1.) Addition of a question - How many fractions are typically used for treating the disease described in the vignette and 2.) Addition of a table discerning how the office visits (99211-99215) are provided following the final fraction of treatment over the 90 days with introductory text detailing the definitions of the office visits as well as explaining how to complete the table (similar to question 2B on the 090 day RUC survey). Additionally, the specialty produced a cover letter specifically clarifying that the survey respondents be made explicitly aware of the office visit data request and only refer to encounters that take place after completion of the last radiotherapy fraction session.

At the October 2009 RUC meeting, the specialty provided a detailed description of an entire week of service. The RUC reviewed the specialty survey results of over a hundred physicians and agreed that the surveyed physician time of 7 minutes pre-service, 70 minutes intra-service, 10 minutes immediate post service, and its fractional post operative office visits (1x99214, 2x99213 averaged over 6 weeks treatment) were typical for this service. In relation to this service, the RUC reviewed several other services including:

- 95953 *Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG, electroencephalographic (EEG) recording and interpretation, each 24 hours* (Work RVU = 3.30, XXX Global)
- 77263 *Therapeutic radiology treatment planning;complex* (Work RVU = 3.14, XXX Global)
- 90962 *End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face physician visit per month* (Work RVU = 3.15, XXX Global)
- 77315 *Teletherapy, isodose plan (whether hand or computer calculated); complex (mantle or inverted Y, tangential ports, the use of wedges, compensators, complex blocking, rotational beam, or special beam considerations)* (Work RVU = 1.56, XXX Global).

The RUC agreed that the work of 77427 was similar to that of 77315 plus weekly and after treatment planning evaluation and management visits which typically occur over 6 weeks of treatment within the post operative 090 day global period (This service is

treated by CMS as a 090 day global service although it is listed as an XXX global). There are six weeks of treatment management that are typically performed and the levels of evaluation and management that occur at this time and post-operatively become higher as the treatment's effects are more apparent to the patient and the physician. (The E/M would typically be 2 weeks x 99213, followed by 4 weeks x 99214, 1 - 99214 in the post op period followed by 2 – 99213). RUC agreed that the physician work of CPT code 77427 should be valued based on the following building block:

Activity	**Work RVU**
Complex Planning-77315	1.56
E/M Average weekly visit	1.32 (6 weeks = 2x99213, 4x99214)
E/M Visits after treatment planning	0.57 (1x99214, 2x99213 averaged over 6 weeks treatment)
Total Work RVU Recommended	**3.45**

Practice Expense:
The RUC concurred that this was a site of service anomaly issue and that the practice expense should not have been fully refined. The RUC allocated the recommended post service office visits data (blend verses current 99211) to the practice expense inputs and maintained the other inputs (none in the service period). It was noted that the weekly visits during radiation are typically performed at the facility. The specialty society indicated that they will ask CMS for future practice expense refinement.

CPT Note Required:
The RUC concurred that the society should work with the CPT Editorial Panel to add a note to the CPT descriptor requiring that a "with physician evaluation" be included, similar to the end stage renal disease monthly management codes.

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

E/M Increases
Based on the changes made in the 2010 MFS Final Rule, the E/M values have been increased and appropriately incorporated into the overall value for this code.

<u>High Dose Rate Brachytherapy (Tab 28)</u>
Najeeb Mohideen, MD, ASTRO

Four high dose rate brachytherapy codes identified through CMS' fastest growing and high volume growth screens and the physician work was subsequently revised by the CPT Editorial Panel for CPT 2009 and combined into three new codes. The RUC made recommendations for physician work and practice expense for these newly revised services in April 2008. CMS accepted the RUC's recommendations however received several comments concerning the extent of practice expense inputs. In the Notice of Proposed Rule making, CMS requested the RUC revisit the practice direct inputs for all three services.

The direct practice expense inputs for these services were reviewed carefully by the RUC. The RUC adjusted the recommended clinical labor staff type from a registered

nurse to a clinical staff blend and changed the time for some activities. The medical supplies and equipment were also thoroughly discussed and edited for the typical patient scenario.

In addition, the RUC discussed the specialty society's concern over the reimbursement methodology of the Iridium-192 source used in these procedures. The RUC understood that the useful life of 73.8 days for the source does not fit the description of equipment in CMS' methodology. In addition, the source may be reimbursed by Medicare eitherthrough a separately billable HCPCs code, as a disposable medical supply, or designated as a piece of equipment with an annual cost and specific useful life. While the RUC did not identify which reimbursement methodology would be appropriate, they did however recommend and support further discussion between the specialty and CMS regarding a resolution to this practice expense input's reimbursement.

The RUC recommends the attached direct practice expense inputs for CPT codes 77785, 77786, and 77787.

The RUC also recommends and supports further discussion between the specialty and CMS regarding a resolution to practice expense input source Iridium-192's reimbursement typically used in CPT codes 77785, 77786, and 77787.

<u>Pathology Services (Tab 29)</u>
Jonathan Myles, MD, CAP

The Five-Year Review Workgroup reviewed the specialties comments on both families of services (tissue exams and special stains). In February 2009, the College of American Pathologists (CAP) commented that the Harvard studies used many vignettes per code and there were 191 pathologists surveyed. Conducting a standard RUC survey for these services may not produce data that is any more precise than the original Harvard services and may not be feasible. However, the Workgroup agreed that a survey to validate physician time and valuation is necessary, even if it is not the standard RUC survey. The Workgroup recommended that the specialty work with the Research Subcommittee to develop an appropriate survey for the entire family of pathology tissue exam codes. Further, the Workgroup recommended that a survey be developed and implemented, and the recommendations be presented to the RUC no later than the February 2010 meeting, with October 2009 strongly preferred.

The specialty society recommended to the RUC that the work values and times derived from the Harvard Studies for these services are still valid. The specialty society commented that the technology to perform these services has not changed since they were reviewed in the Harvard Studies. Further, the specialty society expressed concern about conducting a survey given the inability to develop a vignette as these services are reported for multiple diagnoses. The RUC had a robust discussion about this recommendation and raised several points of discussion. Several RUC members agreed that a survey would be very challenging for the specialty society to perform given the inability to develop a vignette and that the specialty society would be unable to get a similar response rate to the Harvard Studies (191 Pathologists participated in the Harvard Studies to value these services). Other RUC members expressed concern that the specialty society was able to conduct a survey for 88314, which was also Harvard reviewed, but unable to conduct surveys for other stain codes. Further, there were concerns about setting precedent that the values and times associated with the Harvard Studies are accurate for some of the codes but

not for other codes. Given this discussion, the RUC ultimately agreed with the Five-Year Review Identification Workgroup's consensus that a survey of these codes was needed to validate the physician time and valuation. **The RUC recommends that all of the identified codes in this family be surveyed using the standard RUC survey instrument, or present an alternative methodology to the Research Subcommittee for review, or present a code change proposal to the CPT Editorial Panel for their review. Further, the RUC agreed that the presentation of the recommendations for 88314 *Special stains; histochemical staining with frozen section(s), including interpretation and report*, should be presented to the RUC with the other codes in this family.**

Hemodialysis-Dialysis Services (Tab 30)
Richard Hamburger, MD, RPA, Robert Jansen, MD, RPA, Eileen Brewer, MD, RPA

CPT code 90935 *Hemodialysis procedure with single physician evaluation* was requested to be reviewed by CMS following identification by the RUC as potentially misvalued. This service was identified by the Five-Year Review Identification Workgroup as having Harvard-developed values and a service with utilization of greater than 1,000,000. During the Workgroup's review, the Workgroup agreed that the entire family of hemodialysis – dialysis codes should be reviewed so as to maintain rank order. Therefore, the Workgroup agreed that surveying the entire family of codes would be appropriate. The RUC confirmed the recommendation and CMS agreed, requesting that the services be surveyed for review at the October 2009 RUC meeting.

The specialty society presented compelling evidence to the RUC to review these services indicating that the valuation for these services includes the payment for subsequent hospital visits and follow-up impatient consultations, per CMS. In 2005, CMS, as part of the third Five-Year Review, incorporated the full increases for the evaluation and management codes into the surgical global packages; however, these increases were not incorporated into the values for the inpatient dialysis family of services. As such, the RUC agreed that a rank order anomaly exists between the inpatient evaluation and management service and the inpatient dialysis services.

90935
The RUC reviewed the survey data from over 50 renal physicians for CPT code 90935 *Hemodialysis procedure with single physician evaluation*. Although the specialty society agrees that the surveyed total service time of 45 minutes is representative of the time required to perform this service, the survey respondents when allocating time for the pre-, intra- and post-service periods incorrectly included the evaluation and management work in the pre-service time period instead of in the intra-service time period. In order to correctly include this work and time in the correct service period, the specialty society's expert panel made adjustments to the surveyed service times. The specialty society is recommending 10 minutes of pre-service evaluation time, 25 minutes of intra-service time and 10 minutes of post-service time. The RUC agreed with the specialty society's recommended modifications to the service times. Further, the RUC compared this service to 99232 *Subsequent hospital care, per day,* (Work RVU=1.39) and noted that the surveyed code has 5 additional minutes of intra-service time in comparison to the reference code. Therefore, to appropriately value this code in comparison to the reference code, the RUC agreed with the specialty society's recommendation of the surveyed 25th percentile, 1.48 RVUs. **The RUC recommends 1.48 Work RVUs for 90935.**

90937
The RUC reviewed the survey data from over 40 renal physicians for CPT code 90937 *Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription*. Although the specialty society agrees that the surveyed total service time of 60 minutes is representative of the time required to perform this service, the survey respondents when allocating time for the pre-, intra- and post-service periods incorrectly included the evaluation and management work in the pre-service time period instead of in the intra-service time period. In order to correctly include this work and time in the correct service period, the specialty society's expert panel made adjustments to the surveyed service times. The specialty society is recommending 10 minutes of pre-service evaluation time, 40 minutes of intra-service time and 10 minutes of post-service time. The RUC agreed with the specialty society's recommended modifications to the service times. Further, the RUC compared this service to 99233 *Subsequent hospital care, per day,* (Work RVU=2.00) and noted that the surveyed code has 5 additional minutes of intra-service time in comparison to the reference code. Therefore, to appropriately value this code in comparison to the reference code, the RUC agreed with the specialty society's recommendation of the surveyed 25th percentile, 2.11 RVUs. **The RUC recommends 2.11 Work RVUs for 90937.**

90945
The RUC reviewed the survey data from over 50 renal physicians for CPT code 90945 *Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies), with single physician evaluation*. Although the specialty society agrees that the surveyed total service time of 47 minutes is representative of the time required to perform this service, the survey respondents when allocating time for the pre-, intra- and post-service periods incorrectly included the evaluation and management work in the pre-service time period instead of in the intra-service time period. In order to correctly include this work and time in the correct service period, the specialty society's expert panel made adjustments to the surveyed service times. The specialty society is recommending 10 minutes of pre-service evaluation time, 27 minutes of intra-service time and 10 minutes of post-service time. The RUC agreed with the specialty society's recommended modifications to the service times. Further, the RUC compared this service to 99232 *Subsequent hospital care, per day,* (Work RVU=1.39) and noted that the surveyed code has 7 additional minutes of intra-service time in comparison to the reference code. The RUC noted that the 25th percentile, 1.71 RVUs would create a rank order with the other codes in this family. Therefore, the RUC reviewed other services with similar times including 99309 *Subsequent nursing facility care, per day,* (Work RVU=1.55) which has 10 minutes of pre-service time 25 minutes of intra-service time and 10 minutes of post-service time. After reviewing the reference services and in an effort to preserve rank order in the family, the RUC agreed with the specialty society's recommendation of 1.56 RVUs, a value slightly below the 25th percentile. **The RUC recommends 1.56 RVUs for 90945.**

90947
The RUC reviewed the survey data for CPT code 90935 *Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies) requiring repeated physician evaluations, with or without substantial revision of dialysis prescription*. Although the specialty society agrees that the surveyed total service time of 70 minutes is representative of the time required to perform this service, the survey respondents when allocating time for the pre-, intra- and

post-service periods incorrectly included the evaluation and management work in the pre-service time period instead of in the intra-service time period. In order to correctly include this work and time in the correct service period, the specialty society's expert panel made adjustments to the surveyed service times. The specialty society is recommending 10 minutes of pre-service evaluation time, 50 minutes of intra-service time and 10 minutes of post-service time. The RUC agreed with the specialty society's recommended modifications to the service times. Further, the RUC compared this service to 99233 *Subsequent hospital care, per day,* (Work RVU=2.00) and noted that the surveyed code has 20 additional minutes of intra-service time in comparison to the reference code. Therefore, to appropriately value this service, the RUC agreed with the specialty society's recommendation of the surveyed 25th percentile, 2.52 RVUs. **The RUC recommends 2.52 Work RVUs for 90947.**

Professional Liability Insurance (PLI) Crosswalk: The RUC recommends that these services maintain their existing PLI RVUs.

Practice Expense: The RUC recommends no direct practice expense inputs for codes 90935, 90937, 90945 and 90947.

<u>Ophthalmic Diagnostic Imaging (Tab 31)</u>
Stephen Kamenetzky, MD, AAO

In October 2008, 92135, *Scanning computerized ophthalmic diagnostic imaging, posterior segment, (eg, scanning laser) with interpretation and report, unilateral,* was identified by the RUC's Five-Year Identification Workgroup as one of the fastest growing services. The RUC agreed that this service may be misvalued and recommended the specialty conduct a RUC survey.

The specialty society updated the RUC that this code is being referred to the CPT Editorial Panel to be discussed at their October 2009 meeting and if approved will be presented at the April 2010 RUC meeting, due to scheduling conflicts with the society's advisor. Since 92135 is primarily used for diagnosing glaucoma, the specialty society has requested that descriptor language be inserted to indicate its usage for glaucoma and a new code be created for retina usage.

The RUC agreed with the specialty's request to present 92135 at the October 2009 CPT Meeting.

<u>Ocular Photography (Tab 32)</u>
Stephen Kamenetzky, MD, AAO, Michael Chaglasian, OD, AOA
Facilitation Committee #1

In October 2008, 92285 *External ocular photography with interpretation and report for documentation of medical progress (eg, close-up photography, slit lamp photography, goniophotography, stereo-photography)* was identified by the RUC's Five-Year Identification Workgroup through the CMS Fastest Growing Screen. Since this code has never been surveyed through the RUC process and has seen recent rapid growth in Medicare utilization, the RUC agreed that this service may be misvalued and recommended that the specialty society present this code to the RUC.

The RUC reviewed the survey data from almost 90 ophthalmologist and optometrists and agreed that the median work RVUs and physician times were excessive, due to the respondents choosing an inappropriate key reference service, 92250 *Fundus photography with interpretation and* report (work RVU = 0.44). It was noted by the specialty societies that when an ophthalmologist performs the service a technician takes the photograph, but optometrists typically produce their own photographs. The RUC agreed that since ophthalmology is the dominant specialty according to the Medicare utilization data (71%), this service's physician work should be valued accordingly. In light of this, the RUC agreed with the specialty society to revise the physician time to 5 minutes intra-service time to reflect interpretation and report only. The RUC compared 99285 to the code 76977 *Ultrasound bone density measurement and interpretation, peripheral site(s), any method*, (work RVU = 0.05, intra-service time = 5). The RUC came to a consensus that these services are similar in both physician time and intensity and their relative values should be directly crosswalked.

The RUC recommends a physician work RVU of 0.05 for 92285.

Practice Expense
The RUC reviewed the specialty recommended direct practice expense inputs for CPT code 92285 and made minor modifications to reflect the typical patient service. These recommendations are attached.

Practice Liability Insurance Crosswalk
The RUC recommends 92285 be crosswalked to 76977 for its PLI relative value.

CPT Note
The RUC compared 92285 to 96904 *Whole body integumentary photography, for monitoring of high risk patients with dysplastic nevus syndrome or a history of dysplastic nevi, or patients with a personal or familial history of melanoma*, (work RVU = 0.00). It was noted that this code is similar in physician work and complexity and has 0.00 physician work. However, the specialties noted that 92285 includes "interpretation and report" in the descriptor. Thus, the RUC recommended that the specialty societies consider a CPT proposal for 92285 to remove the language stating "with interpretation and report." Doing so will result in the service having only practice expense RVUs assigned.

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

Assessment of Aphasia (Tab 33)
Dee Adams Nikjeh, PhD, CCC-SLP, ASHA, Marianna V. Spanaki, MD, PhD, AAN, Kevin A. Kerber, MD, AANPA

On July 15 2008, H.R. 6331 Medicare Improvements for Patients and Providers Act of 2008 was signed into law. Section 143 of HR 6331 specifies that speech-language pathologists may independently report services they provide to Medicare patients. Starting in July 2009, speech-language pathologists are able to bill Medicare independently as private practitioners.

On October 9, 2008, the American Speech-Language-Hearing Association (ASHA) sent a request to CMS that in light of the recent legislation, speech-language pathology services should be based on professional work values and not through the practice expense component. CMS requested that the RUC review the speech-language pathology codes for professional work as requested by ASHA. ASHA indicated that it will survey the 13 speech-language pathology codes over the course of the CPT 2010 and CPT 2011 cycles.

At the October 2009 meeting, the RUC reviewed the work and practice expense for code 96105 *Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour.*

96105

The RUC reviewed the survey data from 49 speech-language pathologists and 8 neurologists for code 96105. The RUC compared 96105 to key reference service 96116 Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report (work RVU = 1.86 and 60 minutes intra-service time) and determined that both services required similar work, mental effort/judgment, technical skill/physical effort, psychological stress and time to perform. The RUC determined that the survey times of 15 minutes pre-time, 60 minutes intra-time and 15 minutes post-time should be reduced to reflect that multiple units of this code will be reported. The specialty society indicated that two units of this service is typically reported. The RUC recommends 4 minutes pre-time, 60 minutes intra-time and 5 minutes immediate post-service time. When multiple units are reported, there will be no duplication of pre- and post-service work, as this has already been factored into the valuation. The RUC determined that the survey median work RVU of 1.75 appropriately accounts for the time and work required to perform this service. The RUC recommends the survey median work RVU of 1.75 for code 96105.

Practice Expense

The specialty society recommended direct practice expense inputs were approved by the RUC. The only modification was the addition of a denture cup as a medical supply.

Rhythm EKG (Tab 34)

Jennifer Wiler, MD, ACEP

CPT code 93042 *Rhythm ECG, 1-3 leads; interpretation and report only* was requested to be reviewed by CMS following identification by the RUC as potentially misvalued. This service was identified by the RUC's Five-Year Review Identification Workgroup as having Harvard-developed values and a service with Medicare utilization of greater than 1,000,000. The RUC also recommended that associated codes 93040 and 93041 be reviewed as part of this family in order to avoid any rank order anomalies.

93042

The American College of Cardiology and American College of Emergency Physicians surveyed code 93042 *Rhythm ECG, 1-3 leads; interpretation and report only* (Harvard Valued, work RVU = 0.16 and 3 minutes total physician time). The RUC reviewed the survey results and the specialty societies' recommendations. The specialty societies

indicated that the survey median physician time was slightly overestimated by the respondents and recommended the 25th percentile. The RUC agreed with the specialty society reduction to a total of 2 minutes of pre-evaluation time, 3 minutes of intra-service time and 2 minutes post-service time.

The RUC compared 93042 to key reference code 93010 *Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only* (work RVU = 0.17 and 4 minutes intra-service time). The specialty societies indicated that the survey median work RVU result for 93042 was the same as the reference service at 0.17 work RVUs. However, the specialty society indicated and the RUC agreed that the typical patient had not substantively changed in many years and that there was no compelling evidence to request an increase in work RVUs for this service. The specialty societies recommended and the RUC agreed that the survey 25th percentile work RVU of 0.15 appropriately accounts for the physician work required to perform this service and maintains rank order with 93010 (4 minutes intra-time versus 3 minutes intra-time for 93042). **The RUC recommends the survey 25th percentile work RVU of 0.15 for 93042.**

93040
The specialty societies indicated and the RUC agreed, that the physician work for 93040 is identical to 93042, therefore the physician time and work should be the same. **The RUC recommends physician pre-time of 2 minutes, intra-time of 3 minutes and immediate post-service time of 2 minutes for code 93040. The RUC recommends a work RVU of 0.15 for code 93040.**

93041
Code 93041 has zero physician work. **The specialty societies recommended and the RUC agreed that the practice expense inputs have not changed for code 93041.**

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

<u>**EEG Monitoring (Tab 35)**</u>
Marianna Spanaki, MD, PhD, MBA, AANPA, Susan Herman, MD, ACNS

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

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

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

service time and 18 minutes of post-service time as indicated by the survey respondents was inflated. The specialty societies recommend that 10 minutes of both pre-service and post-service time would be more representative of this service. The RUC compared the surveyed code to the reference code, 95813 *Electroencephalogram (EEG) extended monitoring; greater than 1 hour* (Work RVU=1.73) and noted that the reference code has an additional 7 minutes of total service time as compared to the surveyed code. The RUC also noted that the reference code and surveyed code had similar intensity and complexity measurements. Given the comparison to the reference code, the specialty societies recommend maintaining the current value of this service, 1.51 work RVUs, a value below the 25th percentile. This recommended work RVU is an appropriate reflection of the work performed by the physician and maintains rank order within its family of services. The RUC agreed with the specialty societies' recommendation. **The RUC recommends 1.51 work RVUs for 95950.**

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

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

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

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

computerized portable 16 or more channel EEG, electroencephalographic (EEG) recording and interpretation, each 24 hours. The RUC accepted this compelling evidence to increase the value of this service.

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

Practice Expense: The specialty societies will be bringing forward practice expense recommendations for these services at the February 2010 Meeting

Work Neutrality: The RUC understands that the recommendations for this family overall are work neutral.

XI. Practice Expense Subcommittee Report (Tab 36)

Doctor Moran described the two workgroups the subcommittee members were involved in over the summer, the Review Charts and Fluoroscopy Workgroups. Doctor Moran discussed the work and actions of each workgroup and the RUC unanimously approved the following recommendations made by the subcommittee:

Review Charts Workgroup Recommendation
The "Review Charts" line 20 on the Practice Expense Spreadsheet will be eliminated and this activity will be placed on line 21 along with "Greet Patient and Provide Gowning". The Workgroup recommends Line 21 be reworded as "Greet Patient, Provide Gowning, Ensure Appropriate Medical Records are Available". The standard for these activities represented in Line 21 would remain at 3 minutes.

There was no recommendation made changing previous Review Charts recommendations by the Subcommittee, as the Review Charts activity was retained within line 21. The RUC however, tentatively agreed to a motion that any Review Charts Time be eliminated from all previous recommendations, pending future research by AMA staff regarding its scope and implications. The RUC expressed concern that if line 20 was eliminated the Review Charts time for any future and past recommendations would become zero. AMA staff stated that the Review Charts activity has always had an assumed standard of zero minutes until justified and agreed to be typical. In addition, the recommendation does not eliminate the activity it simply moves it to the line below. **AMA staff will research the motion and report back to the RUC.**

Fluoroscopy Workgroup
Doctor Moran explained that the workgroup's charge is to discuss the typicality of various fluoroscopic imaging equipment within 111 services identified as containing a high cost fluoroscopy room and decide what next steps were appropriate. The 111 codes were segregated into three main groups. The first group identifies all services that the subcommittee recommends a Radiographic Fluoroscopic Room (EF024) remain in the code's direct PE inputs (28 codes). The second group identifies services where the subcommittee recommends a deletion of the fluoroscopic PE inputs (3 codes). The workgroup used the Medicare non-facility utilization percentages (dominant specialty) and their medical expertise to populate the first and second groups. The third group consists of those codes in which the subcommittee could not make a definitive recommendation without specialty society assistance (80 codes).

Fluoroscopy Workgroup Recommendation
Specialties are to review each of the three groups of codes and provide the Practice Expense Subcommittee with their feedback in February 2010, as to whether they agree or disagree with the workgroup's recommendation and provide a rationale. In addition, for Group Three, the involved specialties will provide clarification of the service and describe the typical radiographic equipment used in the non-facility setting for each identified CPT code.

Doctor Moran also explained that the subcommittee reviewed carefully all relevant RUC agenda items (32 issues) and provided recommendations to the RUC.

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

XII. Research Subcommittee Report (Tab 37)

Doctor Lewis delivered the Research Subcommittee report to the RUC detailing the five items reviewed: 1.) A specialty society request from the American Academy of Orthopaedic Surgeons, American College of Radiology, American Orthopaedic Foot and Ankle Society and American Podiatric Medical Association pertaining to the radiologic examination codes; 2.) A specialty society request from the American Academy of Dermatology and the College of American Pathologists pertaining to the pathology tissue exam codes; 3.) 2010 Five-Year Review: review of alternative methodologies by the Research Subcommittee; 4.) Incorporation of the Subsequent observation codes into the RUC survey instrument and summary of recommendation form and 5.) Research Subcommittee's July 9, 2009 Conference Call report.

The Research Subcommittee reviewed the recommendations pertaining to radiologic examination codes, to crosswalk times and values for these identified codes to other codes performed by the specialty societies. The specialty societies explained that when determining an appropriate crosswalk, they tried to find RUC reviewed codes that were similar in service and time, performed on similar anatomical sites, required similar number of views and required similar patient positions. The Research Subcommittee agreed that the methodology employed by the specialty was appropriate for these services. **The Research Subcommittee recommends the cross-walking methodology as proposed by the specialty society is appropriate for 73510, 76310 and 73630. The**

Research Subcommittee also recommends that the specialty societies develop vignettes and descriptions of service for these codes to be included in their presentation to the RUC.

The specialty societies recommended to the Research Subcommittee that the RVUs and times that were derived from the Harvard Studies for the pathology tissue exam codes are still valid. Several Subcommittee members agreed that a survey would be very challenging for the specialty societies to perform given the inability to develop a vignette and that the specialty societies would be unable to get a similar response rate to the Harvard Studies (191 Pathologists participated in the Harvard Studies to value these services). Other Subcommittee members expressed concern that the specialty societies were able to conduct surveys for some of their stain codes and unable to conduct surveys for other stain codes. Further, there were concerns about setting precedent that the values and times associated with the Harvard Studies are accurate for some of the stain codes but not for other stain codes. This discussion resulted in a vote of 5/4 in favor of the specialty societies recommended methodology. **The Research Subcommittee recommends the methodology as proposed by pathology and dermatology.**

The RUC had a robust discussion about this recommendation and agreed with all of the points made by the Research Subcommittee. Given this discussion, the RUC ultimately agreed with the Five-Year Review Identification Workgroup's consensus that a survey of these codes was needed to validate the physician time and valuation. **The RUC recommends that all of the identified codes in this family be surveyed using the standard RUC survey instrument, or present an alternative methodology to the Research Subcommittee for review, or present a code change proposal to the CPT Editorial Panel for their review. Further, the RUC agreed that the presentation of the recommendations for 88314 *Special stains; histochemical staining with frozen section(s), including interpretation and report*, can be presented to the RUC with the other codes in this family.**

Doctor Lewis reminded the RUC that per the RUC-approved, Five-Year Review Timeline, specialty societies will be able to propose alternative methodologies of valuing these codes to the Research Subcommittee at the February and April 2010 RUC Meetings.

Doctor Lewis informed the RUC that at the June 2009 CPT Editorial Panel Meeting, three codes were approved to describe subsequent observation care. These codes are under review at the October 2009 RUC Meeting under Tab 09. The introduction of these codes into the Fee Schedule in 2011 will allow for a more accurate measure of work for these 23+ Hour Stay Services. The Research Subcommittee briefly discussed how these codes should be incorporated into the RUC Survey Instruments and Summary of Recommendation Forms that will be used in the CPT 2012 Cycle and recommended that this agenda item be added to the February 2010 Research Subcommittee agenda.

Doctor Lewis announced that the minutes from the Research Subcommittee's July 9, 2009 Conference Call Report is attached to these minutes.

The RUC approved the Research Subcommittee report and the July 9, 2009 conference call report and they are attached to these minutes.

XIII. PLI Workgroup Report (Tab 38)

Doctor Sandra Reed provided the report of the PLI Workgroup to the RUC. The Chair gave a brief update about the Workgroup's recent work to gather more data on CMS' proposed decision to separate surgery classifications into minor and major. AMA staff will work with the Workgroup and specialties to gather further data and communicate to the 13 specialties that have PLI payment splits which codes may be affected. The Workgroup will review the information and continue the discussion at the February 2010 RUC Meeting.

Doctor Reed also reviewed the American Association of Oral & Maxillofacial Surgeons' (AAOMS) request to reevaluate the RUC dominant specialty recommendations for codes: 21047, 21100, and 21195. **The Workgroup recommended that the following RUC recommended dominant specialties should be 21195- Maxillofacial Surgery, 21047- Maxillofacial Surgery, and 21100- Maxillofacial Surgery.**

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

XIV. Administrative Subcommittee Report (Tab 39)

Conflict of Interest
Dale Blasier, MD presented the Administrative Subcommittee report and recommendations. The Subcommittee first discussed consideration for RUC members and alternates to submit a financial disclosure form for each RUC meeting.

Doctor Blasier stated that RUC members and alternates annually indicate that they are in compliance with the RUC conflict of interest policy. Doctor Blasier indicated that the Administrative Subcommittee determined it would be beneficial for RUC members and alternates to confirm that they have no conflicts with agenda issues prior to each meeting and AMA staff will keep a record of compliance in an electronic database. **The RUC agreed and recommended that prior to each meeting, after the RUC agenda has been published, RUC members and alternates electronically (via e-mail) update a signed statement of compliance with the RUC conflict of interest policy.**

Doctor Blasier indicated that the Administrative Subcommittee had a robust discussion regarding adding a question on the survey instrument requesting if survey respondents have a financial interest for the code in which they are completing a survey. The Administrative Subcommittee questioned what the RUC would do with this data. The Subcommittee determined that it would be up to the specialty societies to review the responses and assess whether those survey respondents with financial interests skewed the results in any way.

A few RUC members indicated that they are somewhat concerned about creating disincentives for respondents to complete the survey, but in this time of transparency financial interests should be identified.

- **The RUC recommended to add a question to the beginning of the survey instrument requesting if survey respondents have a direct financial interest in the code which they are surveying.**

- **The RUC recommended that the survey question mirror current direct financial interest policy defined by the RUC for presenters.**

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

- **A financial ownership interest of *5%* or more: (Yes/No)**
- **A financial ownership interest which contributes materially (cumulative lifetime income of at least $10,000) to your income: (Yes/No)**
- **Ability to exercise stock options now or in the future: (Yes/No)**
- **A position as proprietor, director, managing partner, or key employee: (Yes/No)**
- **Serve as a consultant, expert witness, speaker or writer, where payment contributes materially (cumulative lifetime income of at least $10,000) to your income: (Yes/No)**

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

If you have answered yes to the above question, you do not have to complete this survey. However, please submit the first two pages of this survey.

Doctor Blasier also noted that the Administrative Subcommittee reviewed informational items regarding awareness of solicitation for consulting opportunities, the Physician Consortium for Performance Improvement (PCPI) COI policy and the JAMA article on professional medical associations and their relationships with industry.

RUC Voting Procedures

Doctor Blasier indicated that in public comments and statements, various questions have been raised regarding the RUC's voting processes, specifically the confidential vote for relative value recommendations. As specified by the RUC's Structure and Functions, the RUC conducts meetings according to Sturgis, Standard Code of Parliamentary Procedures. According to Sturgis, the method of voting is determined by the Chair, which historically has been ballot voting. Additionally, the RUC uses a confidential ballot process to allow RUC representatives to execute independent judgment in their deliberations consistent with membership on the RUC. The Subcommittee recognized that an open ballot process would be inefficient and exposes individual RUC members to outside lobbying. The confidential ballot allows a RUC member to act as an expert panel member. The RUC agreed that the current voting process is appropriate. **The RUC reaffirmed utilizing the current voting process, which is consistent with Sturgis' rules and procedure.**

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

XV. MPC Workgroup Report (Tab 40)

Doctor Burd provided the MPC Workgroup report to the RUC. The Workgroup recommended that two new codes be added to the MPC list. *99475 Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age* and 94621 *Pulmonary stress testing; complex (including measurements of CO2 production, O2 uptake, and electrocardiographic recordings)* as both met the criteria for inclusion.

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

XVI. Five Year Identification Workgroup Report (Tab 41)

Walt Larimore, MD, provided the Five-Year Review Identification Workgroup report to the RUC. Doctor Larimore indicated that the Workgroup reviewed the current progress of the RUC's identification of misvalued services and discussed potential future screens.

The status of CMS requests and RUC Five-Year Review Identification Workgroup codes is as follows:

Total Number of Codes Identified	**547**
Codes Completed	**346**
Work and PE Maintained	101
Work Increased	12
Work Decreased	108
Direct Practice Expense Reviewed	101
Deleted from CPT	24
Codes Under Review	**201**
Referred to CPT	89
RUC to Review Oct 09/Feb 10	84
Re-Review in Sept 2011	28

Potential Future Screens:

Codes originally surveyed by one specialty, but now performed by another specialty
Doctor Larimore indicated that a RUC member suggested this potential screen and AMA staff reviewed codes that had originally been surveyed by one specialty, but according to 2008 utilization data are now dominantly being performed by other specialties. The top two dominant specialties performing this service were examined and services with Medicare utilization less than 1,000 and zero work RVUs were deleted. The Workgroup reviewed the list of codes originally surveyed by one specialty, but now performed by another specialty and recommended that specialty societies submit an action plan for the codes identified. **The RUC agreed and recommends that specialty societies submit an action plan for the codes identified by this screen as indicated in the attached table.**

<u>*Harvard Codes – Performed Over 100,000 times per year (2007 Medicare Claims Data)*</u>
Doctor Larimore indicated that CMS requested that the RUC pay specific attention to Harvard valued codes that have a high utilization. The RUC has identified 9 Harvard valued services with high utilization (performed over 1 million times per year). The RUC also incorporated an additional 9 Harvard valued codes within the family of the 9 services identified. These 18 services will be reviewed in October 2009.

The RUC indicated it will continue to review Harvard-only valued codes with significant utilization. **The RUC recommends to expand the review of Harvard codes to those with utilization over 100,000 (58 codes) and requests action plans from the specialty societies. The specialties will also identify the codes included in the family for inclusion in the review. The Five-Year Review Identification Workgroup will review this information in February 2010 and will develop a work plan for review.**

Multiple Services Performed on the Same Date
Doctor Larimore indicated that the Workgroup reviewed the July 2009 U.S. Government Accountability Office (GAO) Report, *Medicare Physician Payments: Fees could better reflect efficiencies achieved when services are provider together,* in which the GAO recommends that CMS ensure that physician fees reflect efficiencies occurring when services are commonly furnished together. The GAO's review suggests expanding the multiple procedure payment reduction (MPPR) policy to non-surgical and non-imaging services when provided together. The GAO suggests that Congress consider exempting any resulting savings from federal budget neutrality so savings accrue to Medicare.

Additionally, in the Proposed Rule for 2010, CMS stated that the agency is actively engaged in continuing to analyze codes furnished together more than 75 percent of the time, excluding E/M codes.

Doctor Larimore noted that the RUC has already identified and is reviewing services provided on the same day by the same provider 95% of the time. **The RUC recommends to continue review of services provided on the same day by the same provider at a lower threshold. The RUC recommends it analyze code pairs provided on the same day by the same provider more than 75% of the time, excluding E/M, ZZZ and modifier -51 exempt codes. The 2008 Medicare claims data are now available and have been presented to AMA staff. AMA RUC staff will analyze the data and convene conference calls with the Joint CPT/RUC Workgroup to identify next steps before the February 2010 RUC meeting.**

Review of Action Plans
Doctor Larimore indicated that the Workgroup reviewed action plans for 38571 and agreed with the specialty society that no action is necessary at this time since this service is being reported appropriately. Additionally, when code 38571 is reported with 55866, it is subject to the multiple procedure reduction. **The RUC recommended removing 38571 from this screen.**

The RUC reviewed CT without contrast material codes at this October 2009 RUC meeting and the specialty society indicated that they will address whether these other codes need to be addressed to avoid rank order anomalies with the presented codes upon completion of the RUC review. **The RUC has validated the work values from the identified codes at the October 2009 meeting. Therefore, the remaining family of codes does not require additional review.** However, code 73706 is a very different

service involving different technology and may have been erroneously included with these CT lower extremity codes. **The RUC recommends removing 73706 from this review.**

Items not yet submitted to CPT
a. Referrals to the CPT Editorial Panel
Doctor Larimore indicated that the Workgroup reviewed the list of codes which were previously referred to the CPT Editorial Panel, but were still outstanding. The RUC agreed with the Workgroup's recommendations and below is a summary of actions to address codes previously referred to the CPT Editorial Panel.

26080	Specialty Society to develop CPT Assistant article to describe the correct coding of 26080, 26070, 24000 and 23107, and the various scenarios of removal of a foreign body and incision and drainage of an infection without exploration of the joint. Workgroup recommends to review this service again after 2 years of claims data. (September 2012)
27370	Specialty Society to create CPT Assistant Article to address misuse reporting of arthrography codes.
33213	Specialty society indicated will submit coding proposal for review at the February 2010 CPT Editorial Panel meeting. If no coding proposal is received, the Workgroup recommends that this issue be referred to the Feb 2010 CPT Editorial Panel meeting for revision by a workgroup.
35471	Remove from referral to CPT Editorial Panel list. Code was inappropriately included with another code family referred to CPT.
35472	Remove from referral to CPT Editorial Panel list. Code was inappropriately included with another code family referred to CPT.
35475	Remove from referral to CPT Editorial Panel list. Code was inappropriately included with another code family referred to CPT.
35476	Remove from referral to CPT Editorial Panel list. Code was inappropriately included with another code family referred to CPT.
36248	Specialty society indicated will submit coding proposal for review at the February 2010 CPT Editorial Panel meeting.
49420	Specialty society indicated will submit coding proposal for review at the February 2010 CPT Editorial Panel meeting.
49421	Specialty society indicated will submit coding proposal for review at the February 2010 CPT Editorial Panel meeting.
63056	Specialty society indicated will submit coding proposal for review at the February 2010 CPT Editorial Panel meeting.
64712	Specialty society indicated will submit coding proposal for review at the February 2010 CPT Editorial Panel meeting.
67210	Code identified by high IWPUT screen. Specialty society requested to survey this service.
67220	Code identified by high IWPUT screen. Specialty society requested to survey this service.

67228	Remove from screen. Code was recently reviewed by the RUC (Feb 2007) and CMS indicated that the 90-day global period is appropriate.
73580	Specialty Society to create CPT Assistant Article to address misuse reporting of arthrography codes.
93922	Specialty society indicated will submit coding proposal for review at the February 2010 CPT Editorial Panel meeting.
93923	Specialty society indicated will submit coding proposal for review at the February 2010 CPT Editorial Panel meeting.
93924	Specialty society indicated will submit coding proposal for review at the February 2010 CPT Editorial Panel meeting.

b. Referrals to CPT Assistant
Doctor Larimore noted that one remaining code referred to CPT Assistant will be addressed following the October 2009 meeting. The American Academy of Neurology submitted an article to address code 95956 and the CPT Assistant Editorial Board requested that specific comments be addressed. The specialty society indicated that they plan to submit clarification after the October 2009 RUC meeting in which EEG Monitoring codes (95950, 95953 & 95956) are being reviewed.

Other Issues
Doctor Larimore noted that the following materials were provided as informational items:

a. New Technology/New Services List and Timeline – Claims data for 33 codes are scheduled to be reviewed by the Five-Year Review Identification Workgroup in September 2010
b. 2010 Five-Year Review Timetable
c. Full status report of the Five-Year Review Identification Workgroup

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

XVII. HCPAC Review Board Report (Tab 42)

Emily Hill, PA-C, provided the HCPAC report to the RUC and indicated that surveys for Speech-Language Pathology Services (92605, 92606, 92607, 92608, 92609) were flawed based on survey respondents using a timed reference code that did not appropriately compare the services being reviewed and the alternate methodology presented by the American Speech-Language-Hearing Association (ASHA) was not an appropriate methodology to arrive at relative valuations for these services. Therefore, the HCPAC tabled review of these five services until the February 2010 HCPAC Meeting after ASHA either resurveys their members or reconvenes an expert panel using the same survey results and offers an alternate methodology for developing RVUs.

Ms. Hill also reported that ASHA submitted a letter to the HCPAC indicating that they will form an Audiology Coding and Valuation Advisory Committee (ACVAC) composed of representatives of Audiology organizations that have an active Audiology coding and valuation interest to ensure that views of other audiology organizations are fully considered. ACVAC members will include, ASHA, AAA, Academy of Doctors of Audiology, Academy of Rehabilitative Audiology, Association of VA Audiologists,

Directors of Speech and Hearing Programs in State Health and Welfare Agencies, Educational Audiology Association and the Military Audiology Association. The HCPAC filed the aforementioned letter.

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

XVIII. Other Issues

H1N1 Immunization Administration

George Hill MD, ACOG, Margie Andrae MD, ACP, Steve Krug MD, AAP, Tom Weida MD, AAFP

At the request of the Department of Health and Human Services, the CPT Editorial Panel created a new code 90470 *H1N1 immunization administration (intramuscular, intranasal), including counseling when performed* to assist the public health effort to immediately vaccinate for H1N1. The Centers for Medicare and Medicaid Services (CMS) asked the RUC to immediately review the new service and provide recommendations on the estimated physician work and direct practice expense inputs anticipated to be required to provide the immunization. The American Academy of Family Physicians, American Academy Pediatrics, American College of Obstetricians and Gynecologists, and American College of Physicians provided information for the RUC to review on October 3.

The RUC reviewed newly described immunization services for children at the October meeting and was persuaded that physician efforts related to counseling for immunization have increased. The RUC agreed that increased attention to vaccine safety on the Internet and other media has driven anxiety and has necessitated additional physician involvement and discussion with parents. The RUC recommends that the same level of physician work, for many adults and children, will also be necessary as the H1N1 vaccine becomes available. The RUC agreed that immunization administration for H1N1 should be valued higher than the routine immunization administration code 90471 (0.17) as high risk individuals must first be identified and patients are more likely to have questions about this vaccine and the H1N1 epidemic. **The RUC recommends a physician work value of 0.20 and intra-service time of 7 minutes for 90470 *H1N1 immunization administration.***

Practice Expense: The RUC recommends that the practice expense inputs for H1N1 be equivalent to the pediatric immunization codes reviewed at the October 2009 meeting and 90471 with two primary exceptions. First, an additional two minutes of staff time should be added to capture the additional work of identifying and contacting patients as the vaccine is provided by the State. In addition, these patients may come for this service only, and therefore, the standard greet patient time of 3 minutes should also be added. The total clinical staff time should be 23 minutes.

Other:

- Doctor Daniel Mark Siegel explained to the RUC that some private payers are misusing RUC vignettes and rationales from the RUC Data Manager to deny cognitive services the same day as minor procedures are being done. AMA staff will work with specialties to insert clarifying language on the proper use of the data.

- Doctor Barbara Levy reiterated that the RUC should continue to maintain its place as an expert panel and continue to have open communication among all specialty societies. Furthermore, moving forward each RUC member will be given an assignment before each meeting so that an analysis can be completed and reviewed by the specialty society staff and advisors before their presentation.

The meeting adjourned on Saturday October 3, 2009 at 4:00 p.m.

AMA/Specialty Society RVS Update Committee
Practice Expense Subcommittee Report
Thursday, October 1, 2009 Tab 36

Members: *Doctors Bill Moran (Chair), Joel Brill (Vice Chair), Joel Bradley, Ron Burd, Thomas Cooper, Peter Hollmann, William Mangold, Terry Mills, Guy Orangio, Tye Ouzounian, John Seibel, Anthony Senagore, Susan Spires, Janet Selway DNSc, CRNP.*

The Practice Expense Subcommittee began with a closed session where members reviewed: their roles as a committee members, the ways in which codes end up on our agenda, and several suggestions for retaining existing practice expense knowledge and providing new members assistance in their reviews.
There were several suggestions on how best to assist the members in reviewing codes, these included:

- Case studies that showed what the specialty recommended, what the subcommittee discussed and why in order to establish the final recommendation
- Compile minutes for all the meetings and provide a summary booklet which provides the standards and procedures
- One page check point lists that members may use in their review
- Web conference on how to approach and review recommendations
- New practice expense subcommittee member orientation

Doctor Moran and staff will discuss and review these options and report back to the group.

The Subcommittee opened its session with a discussion of its two workgroup reports from the summer, the Review Charts and Fluoroscopy Workgroups. The minutes and recommendations of both workgroups were unanimously approved. The Practice Expense Subcommittee recommends:

Review Charts Workgroup – see the full workgroup report in Tab 36 of the agenda book
Workgroup members believed there are instances where the clinical staff team would need access to the patient's medical history, however previous RUC recommendations have indicated that this is infrequent and therefore setting a standard for these activities was not necessary. In addition, Workgroup members believed that the "Review Charts" line item could easily be mistakenly populated with physician work "Review Charts" time. To avoid confusion and to reduce any duplication of work between the clinical labor staff and the physician, the Workgroup recommends:

The "Review Charts" line 20 on the Practice Expense spreadsheet be eliminated and this activity be placed on line 21 along with "Greet Patient and Provide Gowning". The Workgroup recommends Line 21 be reworded as "Greet Patient, Provide Gowning, Ensure Appropriate Medical Records are Available". The standard for this Line 21 would remain at 3 minutes.

There was no recommendation made as to changing previous recommendations at the subcommittee. At the full RUC it was agreed that any Review Charts Time be eliminated from previous recommendations, however this action was postponed for future research by AMA staff and discussion by the Subcommittee at the next meeting.

Fluoroscopy Workgroup – referring to the fluoroscopy spreadsheet in Tab 36 in the agenda book.
Specialties review each of the three groups of codes and provide the Practice Expense Subcommittee with their feedback as to whether they agree or disagree with the

workgroup's recommendation and why (a rationale). In addition, for group three, the involved specialties provide clarification of the service and describe the typical radiographic equipment used in the non-facility setting for each CPT code.

There was a lengthy Fluoroscopy Workgroup discussion involving the proper method to assign fluoroscopy equipment once specialties provide the group feedback. Specialties involved will be provided notification of expected clarification of the service they provide and the typical fluoroscopy equipment utilized in the non-facility setting so that the responses will be compiled for further discussion and recommendation development at the next Subcommittee meeting.

The following RUC agenda items were reviewed carefully and the recommendations by the Subcommittee follow:
Tab 4 Percutaneous Cholecystostomy (47490) – Recommendation is: no direct inputs are recommended
Tab 5 Transforaminal Epidural Injections (64479, 64480, 64483 & 64484) – the clinical labor time was robustly discussed and edited slightly to reflect the typical patient scenario. In addition, medical supplies and equipment were reviewed and a pulse oximeter was added and the fluoroscopic radiographic room is recommended until conclusion and decisions are made from the practice expense subcommittee's fluoroscopic workgroup.
Tab 6 Salivary Gland Injection for Sialorrhea (646XX) – the clinical labor time was extensively discussed and adjusted from the specialty recommendation, in addition the medical supplies and equipment were edited for the typical patient with subtractions and additions.
Tab 7 In Situ Hybridization (8812X1 & 8812X2) – extensive discussion and revision of the clinical labor ensued and the supplies and equipment were edited as well. The specialty will follow up with medical supplies and equipment invoices and other information.
Tab 8 Immunization Administration (9046X1 & 9046X2) – the clinical labor times were revised downward by 3 minutes from the specialty recommendation.
Tab 9 Subsequent Observation Services – Recommendation is for no direct inputs in either site of service for these services
Tab 10 Insertion of Breast Prosthesis (19340) – Recommendation is for facility only 90 day standard inputs for the facility setting and no direct inputs in the non-facility setting.
Tab 11 Tissue Grafts (20926) – Specialty requests code be referred to the CPT Editorial Panel
Tab 12 Tenodesis (23430)– Service was identified through CMS' fastest growing and site of service anomalies screens and only physician work was presented. The subcommittee saw no need to revisit the practice expense inputs for this service as it is only performed in the facility setting.
Tab 13 Arthroscopy (29870) – The direct inputs in the non-facility setting were extensively discussed and the clinical labor was adjusted to reflect the standard inputs and medical supplies and equipment were edited for the typical patient. In addition, a medium instrument pack was added and video system and diagnostic arthroscope and computer were eliminated.
Tab 14 Laparoscopic Radical Prostatectomy - Recommendation is for facility only 90 day standard direct inputs.
Tab 15 Obstetrical Care – These services were identified through CMS' high IWPUT screen and only physician work was presented. The direct practice expense inputs were adjusted to reflect the building block methodology and RUC approved prenatal and post-delivery visits.
Tab 16 Injection of Anesthetic Agent - Nerve (64415, 64445 & 64447) –The specialty recommendation was reviewed and accepted as presented.
Tab 17 Urological Procedures - These services were identified through CMS' site of service anomaly screen and only physician work was presented. The subcommittee saw no need to revisit the practice expense inputs for these services at this time.

Tab 18 Iridotomy and Iridectomy - Specialty requests code be referred to the CPT Editorial Panel
Tab 19 Intravitreal Injection (67028) – The clinical labor and supplies were adjusted slightly to account for the typical patient service. The specialty and CMS also plan continued collaboration on reimbursement for the injected drug.
Tab 20 Labryinthotomy - Specialty requests code be referred to the CPT Editorial Panel
Tab 21 CT Thorax - These services were identified through CMS' fastest growing screen and only physician work was presented. The subcommittee saw no need to revisit the practice expense inputs for these services at this time, as the direct inputs are straightforward and most likely had not changed.
Tab 22 CT Spine - These services were identified through CMS' fastest growing screen and only physician work was presented. The subcommittee saw no need to revisit the practice expense inputs for these services at this time, as the direct inputs are straightforward and most likely had not changed..
Tab 23 CT Upper Extremity - These services were identified through CMS' fastest growing screen and only physician work was presented. The subcommittee saw no need to revisit the practice expense inputs for these services at this time, as the direct inputs are straightforward and most likely had not changed.
Tab 24 Radiologic Examination - Physician work related issue only
Tab 25 CT Lower Extremity - These services were identified through CMS' fastest growing screen and only physician work was presented. The subcommittee saw no need to revisit the practice expense inputs for these services at this time, as the direct inputs are straightforward and most likely had not changed.
Tab 26 Lower Extremity Ultrasound - Specialty requests code be referred to the CPT Editorial Panel.
Tab 27 Radiation Treatment Management (77427) – The specialty society recommended direct inputs were accepted as presented.
Tab 28 High Dose Rate Brachytherapy (77785, 77786 & 77787) – These services were reviewed carefully and the recommended inputs edited to lower times and the staff type changed for some activities from an RN to a blend. The medical supplies and equipment were thoroughly discussed and edited for the typical patient scenario. In addition, the committee had a discussion concerning the useful life of the source. The useful life of 73.8 days does not fit the description of equipment in CMS' methodology. The specialty requests that the RUC write a letter to CMS weighing in on the issue of the useful life of the source.
Tab 29 Pathology Services - These services were identified through CMS' top 9 Harvard screen and only physician work was presented. The subcommittee recommended that the direct inputs should be revisited at its next meeting.
Tab 30 Hemodialysis-Dialysis Services – These services were identified through CMS' top 9 Harvard screen and only physician work was presented. The subcommittee saw no need to revisit the practice expense inputs for these services at this time.
Tab 31 Ophthalmic Diagnostic Imaging – Specialty requests code be referred to the CPT Editorial Panel
Tab 32 Ocular Photography (92285) – The direct practice expense inputs were edited slightly for the typical patient scenario.
Tab 33 Assessment of Aphasia (96105) – The specialty society's recommended inputs were accepted as presented. The only modification was an addition of a denture cup in the medical supplies.
Tab 34 Rhythm EKG (93040, 93041 & 93042) – The specialty societies' recommended inputs were accepted as presented.

Tab 35 EEG Monitoring - These services were identified through CMS' fastest growing screen and only physician work was presented. The subcommittee recommends that the practice expense inputs be reviewed at its next meeting.

AMA/Specialty Society RVS Update Committee
Research Subcommittee Report
Thursday, October 1, 2009 Tab 37

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

I. Specialty Society Requests:

CMS indicated in the July 2008 NPRM that the Agency requests the RUC to review Harvard-valued codes. At its October 2008 meeting, the RUC recommended an initial review of the nine Harvard-valued codes with utilization greater than 1,000,000. The RUC also approved a process to initiate the review. The nine services (73510, 73610, 73630, 88304, 88305, 88312, 88313, 90935, 93042) were distributed to all specialties with a request for interested specialties to submit other codes that may need to be reviewed with these codes (ie, those within the same family), projected timeline for review, and any other special concerns. The Five Year Review Workgroup considered the responses and made the following recommendations:

Radiologic Examination (73510, 76310 and 73630) - *American Academy of Orthopaedic Surgeons, American College of Radiology, American Orthopaedic Foot and Ankle Society, American Podiatric Medical Association*

The Five Year Review Workgroup agreed these services require a review, but that a complete survey may not be the appropriate mechanism. The specialty noted that it would be very difficult to differentiate the relatively low work values. The Workgroup recommends that the specialty work with the Research Subcommittee to develop an appropriate survey or other method to validate valuation for these services with small RVUs (e.g., 0.17). Further, the Workgroup recommends that a survey method be developed and implemented, and the recommendations be presented to the RUC no later than the February 2010 meeting.

The Research Subcommittee reviewed the recommendation made by the specialty societies to crosswalk times and values for these identified codes to other codes performed by the specialty societies. The specialty societies explained that when determining an appropriate crosswalk, they tried to find RUC reviewed codes that were similar in service and time, performed on similar anatomical site, required similar number of views and required similar patient positions. The Research Subcommittee agreed that the methodology employed by the specialty was appropriate for these services. **The Research Subcommittee recommends the cross-walking methodology as proposed by the specialty society is appropriate for 73510, 76310 and 73630. The Research Subcommittee also recommends to the specialty societies to develop vignettes and descriptions of service for these codes to be included in their presentation to the RUC.**

Pathology Tissue Exam Codes (88304 and 88305) - *American Academy of Dermatology, College of American Pathologists*

The Five Year Review Workgroup reviewed the specialties comments on both families of services (tissue exams and special stains). CAP commented that the Harvard studies used many vignettes per code and there were more than 180 pathologists surveyed. Conducting a standard RUC survey for these services may not produce data that is any more precise than the original

Harvard services and may not be feasible. However, the Workgroup agreed that a survey to validate physician time and valuation is necessary, even if it is not the standard RUC survey. The Workgroup recommends that the specialty work with the Research Subcommittee to develop an appropriate survey for he entire family of pathology tissue exam codes. Further, the Workgroup recommends that a survey be developed and implemented, and the recommendations be presented to the RUC no later than the February 2010 meeting, with October 2009 strongly preferred.

The specialty societies recommended to the Research Subcommittee that the RVU values and times that were derived from the Harvard Studies for these services are still valid. The specialty societies commented that the services and the technology to perform the services have not changed since they were reviewed in the Harvard Studies. Further, the specialty societies expressed concern about conducting a survey given the inability to develop a vignette as these services are reported for multiple diagnoses. The Research Subcommittee had a robust discussion about this recommendation and raised several points of discussion. Several Subcommittee members agreed that a survey would be very challenging for the specialty societies to perform given the inability to develop a vignette and that the specialty societies would be unable to get a similar response rate to the Harvard Studies (191 Pathologists participated in the Harvard Studies to value these services). Other Subcommittee members expressed concern that the specialty societies were able to conduct surveys for some of their stain codes and unable to conduct surveys for other stain codes. Further, there were concerns about setting precedent that the values and times associated with the Harvard Studies are accurate for some of the stain codes but not for other stain codes. This discussion resulted in a vote of 5/4 in favor of the specialty societies recommended methodology. **The Research Subcommittee recommends the methodology as proposed by pathology and dermatology.**

The RUC discussed the recommendations from the Research Subcommittee and ultimately agreed with the Five-Year Review Identification Workgroup's consensus that a survey of these codes was needed to validate the physician time and valuation. **The RUC recommends that all of the identified codes in this family be surveyed using the standard RUC survey instrument, or present an alternative methodology to the Research Subcommittee for review, or present a code change proposal to the CPT Editorial Panel for their review. Further, the RUC agreed that the presentation of the recommendations for 88314 *Special stains; histochemical staining with frozen section(s), including interpretation and report*, can be presented to the RUC with the other codes in this family.**

II. 2010 Five Year Review: Review of Alternative Methodologies

This informational agenda item is to remind the Research Subcommittee that the services identified to be part of the 2010 Five-Year Review will be published in the 2010 *Final Rule*. Per the RUC-approved, Five-Year Review Timeline, specialty societies will be able to propose alternative methodologies of valuing these codes to the Research Subcommittee at the February and April 2010 RUC Meetings. It should be noted that all previously approved alternative methodologies can be utilized by specialty societies during any Five-Year Review process. All of the RUC-approved alternative methodologies can be found in the Structure and Functions binder.

III. Incorporation of the Subsequent Observation Codes into the RUC Survey Instrument and Summary of Recommendation Form

At the June 2009 CPT Editorial Panel Meeting, three codes were approved to describe subsequent observation care. These codes are under review at the October 2009 RUC Meeting under Tab 09. Per the RUC Process, the RUC recommendations for these codes would be submitted to the

Centers for Medicare and Medicaid Services (CMS) in May 2010. These codes would be published in the 2011 Final Rule for use beginning January 1, 2011. These codes are of importance to the RUC process because they address the 23+ hour stay policy issue that the RUC has been discussing. The current RUC policy for a 23+ hour stay code is:

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

However, the introduction of these codes into the Fee Schedule in 2011 will allow for a more accurate measure of work for these 23+ Hour Stay Services. The Research Subcommittee briefly discussed how these codes should be incorporated into the RUC Survey Instruments and Summary of Recommendation Forms that will be used in the CPT 2012 Cycle and recommended that this agenda item be added to the February 2010 Research Subcommittee agenda.

II. Other Issues

The minutes from the Research Subcommittee's July 9, 2009 Conference Call Report have been included in the RUC agenda book on page 844-845 for review by the Research Subcommittee and the RUC.

AMA/Specialty Society RVS Update Committee
Administrative Subcommittee Report
October 1, 2009 Tab 38

Members: Doctors Dale Blasier (Chair), David Hitzeman (Vice Chair), Michael Bishop, James Blankenship, Emily Hill, PA-C, Robert Kossmann, Walt Larimore, Scott Manaker, Larry Martinelli, Sandra Reed, Arthur Traugott, James Waldorf and George Williams

II. Consideration for RUC members and alternates to submit a Financial Disclosure form for each RUC agenda meeting

The Administrative Subcommittee indicated that RUC members and alternates annually indicate that they are in compliance with the RUC conflict of interest policy. Currently RUC members are responsible for notifying the RUC of any potential conflicts throughout the year and prior to any deliberation or vote on an issue. The Administrative Subcommittee discussed consideration of RUC members and alternates to indicate any financial interests for each RUC meeting. The Administrative Subcommittee determined that it would be beneficial for RUC members and alternates to confirm that they have no conflicts with agenda issues prior to each meeting and AMA staff will keep record of compliance in an electronic database. **The Administrative Subcommittee recommends prior to each meeting, after the RUC agenda has been published, RUC members and alternates electronically (via e-mail) update a signed statement of compliance with the RUC conflict of interest policy.**

III. Conflict of Interest

Direct Financial Interest Question on the RUC Survey Instrument

The Administrative Subcommittee had a robust discussion regarding adding a question on the survey instrument requesting (yes/no) if survey respondents have a financial interest for the code in which they are completing a survey. The Administrative Subcommittee questioned what would the RUC do with this data. The Subcommittee determined that it would be up to the specialty societies to review the responses and assess whether those with financial interests skewed the results in any way.

- **The Administrative Subcommittee recommends to add a question to the beginning of the survey instrument requesting if survey respondents have a direct financial interest in the code which they are surveying.**

- **The Administrative Subcommittee recommends that the survey question mirror current direct financial interest policy defined by the RUC for presenters.**

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

  - **A financial ownership interest of *5%* or more: (Yes/No)**
  - **A financial ownership interest which contributes materially (cumulative lifetime income of at least $10,000) to your income: (Yes/No)**
  - **Ability to exercise stock options now or in the future: (Yes/No)**
  - **A position as proprietor, director, managing partner, or key employee: (Yes/No)**

- **Serve as a consultant, expert witness, speaker or writer, where payment contributes materially (cumulative lifetime income of at least $10,000) to your income: (Yes/No)**

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

If you have answered yes to the above question, you do not have to complete this survey. However, please submit the face sheet of this survey.

The Administrative Subcommittee reviewed informational items regarding awareness of solicitation for consulting opportunities, the Physician Consortium for Performance Improvement (PCPI) COI policy and the JAMA article on professional medical associations and their relationships with industry.

IV. RUC Voting Procedures

In public comments and statements, various questions have been raised regarding the RUC's voting processes, specifically the confidential vote for relative value recommendations. As specified by the RUC's Structure and Functions, the RUC conducts meetings according to Sturgis, Standard Code of Parliamentary Procedures. According to Sturgis, the method of voting is determined by the Chair, which historically has been ballot voting. Additionally, the RUC uses a confidential ballot process to allow RUC representatives to execute independent judgment in their deliberations consistent with membership on the RUC. The Subcommittee recognized that an open ballot process would be inefficient and exposes individual RUC members to outside lobbying. The confidential ballot allows a RUC member to act as an expert panel member. **The Administrative Subcommittee reaffirmed the RUC utilizing the current voting process, consistent with Sturgis.**

AMA/Specialty Society RVS Update Committee
Professional Liability Insurance Workgroup
October 1, 2009 Tab 39

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

I. PLI Workgroup 8-19-09 Conference Call Report

The Chair asked the workgroup to review the report from the August 19, 2009 workgroup conference call and provide any comments. There were no comments.

II. CMS Proposed "Minor Surgery" vs. "Major Surgery" Classifications

The workgroup discussed the issue of CMS's proposed decision to separate surgery classifications into minor and major. Surgery is defined as all codes in the 10000-69999 range in CPT. Major surgery is classified as CPT codes with a 090 day global period, while minor surgery will be all codes with a 000 or 010 day global period. There was consensus that the 090 day global flag does not accurately identify all the that are considered "major." The workgroup discussed whether or not to send to the specialty societies all the codes in their specialty code set and reply with any surgery codes that should be reclassified. The workgroup also discussed the importance of hearing from the liability insurance vendors about how they classify surgery procedures. Since it is the insurance providers that are setting these classifications, the collection of specialty comments on the codes may not be useful at this time. To date, the AMA staff have contracted the following carriers:

- ISMIE: Surgery classifications are determined by whether the physician is located in the hospital setting (major) or the office setting (minor).
- Norcal: Awaiting response
- The Doctor's Company: Awaiting response

AMA staff will continue to reach out to insurance companies to determine the breadth of surgery classification definitions. The workgroup will review the information and further the discussion at the February RUC Meeting. Additionally, staff will review the 13 specialties (Cardiology, Dermatology, Emergency Medicine, Endocrinology, Family Medicine, Gastroenterology, General Practice, Geriatric Medicine, Nephrology, Neurology, Obstetrics Gynecology, Ophthalmology, and Otolaryngology) that have major and minor distinctions in their PLI premiums per CMS to determine if the classifications are even applicable (i.e. do these specialties have any 090 services in the CPT surgery section).

III. Review of Dominant Specialties for CPT Codes 21047, 21100, 21195

The workgroup reviewed the recent American Association of Oral & Maxillofacial Surgeons (AAOMS) request to reevaluate the RUC dominant specialty recommendations for codes: 21047, 21100, and 21195. The workgroups recommendations are as follows:

- CPT Code 21195- RUC recommended dominant specialty should be Maxillofacial Surgery and NOT Otolaryngology.
- CPT Code 21047- RUC recommended dominant specialty should be Maxillofacial Surgery and NOT Otolaryngology.
- CPT Code 21100- RUC Recommended dominant specialty should remain Maxillofacial Surgery.

IV. Further Business

No further business was brought forth.

AMA/Specialty Society RVS Update Committee
Five-Year Review Identification Workgroup
October 1, 2009 Tab 40

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

I. Five-Year Review Identification Workgroup Overview

a. Progress Report

The Workgroup reviewed the current progress of the Five-Year Review Identification Workgroup and made one editorial change to the bundled CPT services section, removing "to reduce duplicative work."

CMS Requests and RUC Five-Year Review Identification Workgroup Code Status:

Total Number of Codes Identified	**547**
Codes Completed	**346**
Work and PE Maintained	101
Work Increased	12
Work Decreased	108
Direct Practice Expense Reviewed	101
Deleted from CPT	24
Codes Under Review	**201**
Referred to CPT	89
RUC to Review Oct 09/Feb 10	84
Re-Review in Sept 2011	28

b. Potential Future Screens

Codes originally surveyed by one specialty, but now performed by another specialty

A RUC member suggested this potential screen and AMA staff reviewed codes that had originally been surveyed by one specialty, but according to 2008 utilization data are now dominantly being performed by other specialties. The top two dominant specialties performing this service were examined and services with Medicare utilization less than 1,000 and zero work RVUs were deleted. **The Workgroup reviewed the list of codes originally surveyed by one specialty, but now performed by another specialty and recommends the following action per code as indicated in the attached table.**

Harvard Codes – Performed Over 100,000 times per year (2007 Medicare Claims Data)

CMS requested that the RUC pay specific attention to Harvard valued codes that have a high utilization. The RUC identified 9 Harvard valued services with high utilization (performed over 1 million times per year). The RUC also incorporated an additional 9 Harvard valued codes within the family of the 9 services identified. These 18 services will be reviewed in October 2009.

The RUC indicated it will continue to review Harvard-only valued codes with significant utilization. **The Five-Year Review Identification Workgroup recommends to expand the review of Harvard codes to those with utilization over 100,000 (56 codes) and requests**

action plans from the specialty societies. The specialties will also identify the codes included in the family for inclusion in the review. The Five-Year Review Identification Workgroup will review this information in February 2010 and will develop a work plan for review.

II. Multiple Services Performed on the Same Date

The U.S. Government Accountability Office (GAO) July 2009 Report

In the July 2009 U.S. Government Accountability Office (GAO) Report, *Medicare Physician Payments: Fees could better reflect efficiencies achieved when services are provider together,* the GAO recommends that CMS ensure that physician fees reflect efficiencies occurring when services are commonly furnished together. The GAO's review suggests expanding the multiple procedure payment reduction (MPPR) policy to non-surgical and non-imaging services when provided together. The GAO suggests that Congress consider exempting any resulting savings from federal budget neutrality so savings accrue to Medicare.

Additionally, in the Proposed Rule for 2010, page 33554, CMS states that the agency is actively engaged in continuing to analyze codes furnished together more than 75 percent of the time, excluding E/M codes. "We will analyze both physician work and PE inputs. If duplications are found, we will consider whether an MPPR or bundling of services is most appropriate. Any proposed changes will be made through rulemaking and be subject to public comment at a later date."

The RUC has already identified and are reviewing services provided on the same day by the same provider 95% of the time. **The Workgroup recommends to continue review of service provided on the same day by the same provider at a lower threshold. The Workgroup recommends the RUC analyze code pairs provided on the same day by the same provider more than 75% of the time, excluding E/M, ZZZ and modifier -51 exempt codes. The 2008 Medicare claims data are now available and have been presented to AMA staff. AMA RUC staff will analyze the data and convene conference calls with the Five-Year Review Identification Workgroup to identify next steps before the February 2010 RUC meeting.**

III. Review Action Plans

a. Laparoscopic Pelvic Lymphadenectomy - 38571
The American Urological Association recommends no action at this time since other specialties perform this service and it is being reported appropriately. Additionally, when code 38571 is reported with 55866, it is subject to the multiple procedure reduction. **The Workgroup recommends removing 38571 from this screen.**

The RUC is reviewed CT without contrast material codes at this October 2009 RUC meeting and the specialty society indicated that they will address whether these other codes need to be addressed to avoid rank order anomalies with the presented codes upon completion of the RUC review. **The RUC has validated the work values from the identified codes at the Oct 2009 meeting. Therefore, the remaining family of codes does not require additional review.** However, code 73706 is a very different services involving different technology and may have been erroneously included with these CT lower extremity codes. **The Workgroup recommends removing 73706 from this review.**

IV. Items not yet submitted to CPT to be discussed

a. Referrals to the CPT Editorial Panel

The Workgroup reviewed the list of codes which were previously referred to the CPT Editorial Panel, but were still outstanding. Below is a summary of actions for codes previously referred to the CPT Editorial Panel.

26080	Specialty Society to develop CPT Assistant article to describe the correct coding of 26080, 26070, 24000 and 23107, and the various scenarios of removal of a foreign body and incision and drainage of an infection without exploration of the joint. Workgroup recommends to review this service again after 2 years of claims data. (September 2012)
27370	Specialty Society to create CPT Assistant Article to address misuse reporting of arthrography codes.
33213	Specialty society indicated will submit coding proposal for review at the February 2010 CPT Editorial Panel meeting. If no coding proposal is received, the Workgroup recommends that this issue be referred to the Feb 2010 CPT Editorial Panel meeting for revision by a workgroup.
35471	Remove from referral to CPT Editorial Panel list. Code was inappropriately included with another code family referred to CPT.
35472	Remove from referral to CPT Editorial Panel list. Code was inappropriately included with another code family referred to CPT.
35475	Remove from referral to CPT Editorial Panel list. Code was inappropriately included with another code family referred to CPT.
35476	Remove from referral to CPT Editorial Panel list. Code was inappropriately included with another code family referred to CPT.
36248	Specialty society indicated will submit coding proposal for review at the February 2010 CPT Editorial Panel meeting.
49420	Specialty society indicated will submit coding proposal for review at the February 2010 CPT Editorial Panel meeting.
49421	Specialty society indicated will submit coding proposal for review at the February 2010 CPT Editorial Panel meeting.
63056	Specialty society indicated will submit coding proposal for review at the February 2010 CPT Editorial Panel meeting.
64712	Specialty society indicated will submit coding proposal for review at the February 2010 CPT Editorial Panel meeting.
67210	Code identified by high IWPUT screen. Specialty society requested to survey this service.
67220	Code identified by high IWPUT screen. Specialty society requested to survey this service.
67228	Remove from screen. Code was recently reviewed by the RUC (Feb 2007) and CMS indicated that the 90-day global period is appropriate.
73580	Specialty Society to create CPT Assistant Article to address misuse reporting of arthrography codes.
93922	Specialty society indicated will submit coding proposal for review at the February 2010 CPT Editorial Panel meeting.
93923	Specialty society indicated will submit coding proposal for review at the February 2010 CPT Editorial Panel meeting.
93924	Specialty society indicated will submit coding proposal for review at the February 2010 CPT Editorial Panel meeting.

b. Referrals to CPT Assistant

One remaining code referred to CPT Assistant will be addressed following the Oct 2009 meeting. The American Academy of Neurology submitted an article to address code 95956 and the CPT Assistant Editorial Board requested that specific comments be addressed. The specialty society indicated that they plan to submit clarification after the October 2009 RUC meeting in which EEG Monitoring codes (95950, 95953 & 95956) are being reviewed.

V . Other Issues

The following materials were provided as informational items:

d. New Technology/New Services List and Timeline – Claims data for 33 codes are scheduled to be reviewed by the Five-Year Review Identification Workgroup in September 2010
e. 2010 Five-Year Review Timetable
f. Full status report of the Five-Year Review Identification Workgroup

AMA/Specialty Society RVS Update Committee
MPC Workgroup
October 1, 2009 Tab 41

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

I. Specialty Society Requests to Update the MPC

- AAP Requests 99475

  The workgroup heard from Doctor Joel Bradley (AAP) about CPT code 99475 *Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2-5 years of age*.
  This code meets the 4 absolute criteria for inclusion on the MPC list.
  - This code is accepted as valid by the specialty and implemented by CMS.
  - Pediatrics is thought to be the dominant specialty for this code.
  - The code was reviewed by the RUC in January, 2009.
  - The code's utilization is over 1,000 in the 2008 Medicare utilization data.

  The workgroup recommends that 99475 be added to the MPC list.
- AACP and ATS Requests 94621

  The workgroup heard from Doctors Scott Manaker (AACP) and Alan Plummer (ACP) about CPT code 94621 *Pulmonary stress testing; complex (including measurements of CO2 production, O2 uptake, and electrocardiographic recordings)*.
  This code meets the 4 absolute criteria for inclusion on the MPC list.
  - This code is accepted as valid by the specialty and implemented by CMS.
  - The dominant specialty is Cardiology. They have reviewed the appropriateness for the inclusion of this code on the MPC and agree that it should be included.
  - The code was reviewed by the RUC in May 1998.
  - The code's Medicare utilization in 2007 was 10,399.

  The workgroup recommends that 94621 be added to the MPC list.

II. Further Business

There was no further business.

AMA/Specialty Society RVS Update Committee
RUC HCPAC Review Board Meeting
October 01, 2009 Tab 42

Arthur Traugott, MD, Chair
Lloyd Smith, DPM, Co-Chair
Emily H. Hill, PA-C, Alternate Co-Chair
Michael Chaglasian, OD
Mirean Coleman, LCSW
Robert Fifer, PhD, CCC-A
Mary Foto, OTR
Christine Goertz-Choate, DC, PhD
James Georgoulakis, PhD
Stephen Levine, PT, DPT, MSHA
William J. Mangold, Jr., MD
Janet Selway, RN
Marc Raphaelson, MD

I. CMS Update

Doctor Edith Hambrick provided an update on activities at CMS. There were not many items directly related to HCPAC members in the Medicare Proposed Rule released this summer. Currently CMS staff is working on the Final Rule and will be published around November 1, 2009.

II. CMS Request: Relative Value Recommendations for CPT 2011:
Speech-Language Pathology Services (92605, 92606, 92607, 92608, 92609)

The American Speech-Language-Hearing Association (ASHA) submitted recommendations to the HCPAC for review. ASHA indicated that the surveys were flawed based on survey respondents using a timed reference code that did not appropriately compare the services being reviewed. The HCPAC identified concerns with the recommendations submitted, specifically the alternate methodology presented by ASHA was not an appropriate methodology to arrive at relative valuations for these services. The HCPAC determined to pre-facilitate this issue and requested that ASHA submit new recommendations and rationale at the February 2010 meeting.

The HCPAC heard from ASHA representatives regarding the intricacies of the procedures in review. Following this presentation the committee reviewed the comments submitted by various RUC and HCPAC members. The HCPAC recognized that since these speech language pathology services are converting from practice expense only inputs to work, the survey respondents had limited reference services to identify with and, without further education of the members, will likely necessitate an alternate methodology formulated by ASHA.

It was discussed that there are two options for moving forward with this code set. 1). ASHA can resurvey their members and present their summary of recommendations to the HCPAC at the February 2010 meeting. Additionally, ASHA may also choose to provide survey education to their members at one of their meetings with the condition that an AMA staff member and a member of the Research Subcommittee must be in attendance as a proctor. 2). ASHA can reconvene an expert panel using the same survey results and offer an alternate methodology for developing RVUs.

III. Audiology/Speech Language Pathology HCPAC Seat- Informational Item Only

The American Speech-Language-Hearing Association (ASHA) submitted a letter to the HCPAC indicating that they will form an audiology Coding and Valuation Advisory Committee (ACVAC) composed of representatives of Audiology organizations that have an active Audiology coding and valuation interest to ensure that views of other audiology organizations are fully considered. ACVAC members will include, ASHA, AAA, Academy of Doctors of Audiology, Academy of Rehabilitative Audiology, Association of VA Audiologists, Directors of Speech and Hearing Programs in State Health and Welfare Agencies, Educational Audiology Association and the Military Audiology Association. The HCPAC filed the aforementioned letter.

October 6, 2009

Cassandra Black
Director of Division of Practitioner Services
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD, 21244-1850

Subject: Remaining RUC Recommendations for 2010 Medicare Physician Payment Schedule

Dear Ms. Black:

The American Medical Association/Specialty Society RVS Update Committee (RUC) met on October1-3, 2009 to consider recommendations related to several Centers for Medicare and Medicaid services (CMS) requests. CMS requested that four of the issues on the October RUC meeting agenda be submitted to CMS immediately after the RUC Meeting. These issues include:

- H1N1 Immunization Administration (90470) – CMS requested an expedited RUC review of this issue as the vaccine will be made available to the public this month. The RUC has received numerous requests for the relative value information since the meeting this past weekend. **The RUC requests that CMS immediately make the RUC recommendations and the Medicare relative values for the H1N1 Immunization Administration public.**

- Insertion of Breast Prosthesis (19340) – CMS requested RUC review of this service as the global period assigned to this service has changed from a ZZZ to a 090 day global period.

- Arthroscopy (29870) – CMS requested that practice expense inputs for the non-facility setting be developed for this service

- High Dose Brachytherapy (77785, 77786 & 77787) – CMS requested that the practice expense inputs for these service be reviewed to address questions concerning supply costs and useful life of the renewable sources.

We appreciate your consideration of these RUC recommendations. If you have any questions regarding the attached materials, please contact Sherry Smith at (312) 464-5604.

Sincerely,

Barbara Levy, MD

cc: Gaysha Brooks
Rick Ensor
Edith Hambrick, MD
Whitney May
Ken Simon, MD
Pam West, DPT
RUC Participants