

**AMA/Specialty RVS Update Committee
Meeting Minutes
September 29 – October 2, 2005**

I. Welcome and Call to Order

Doctor William Rich called the meeting to order on Thursday, September 29, 2005, at 1:15 pm. The following RUC Members were in attendance:

William Rich, MD (Chair)	Brenda Lewis, DO*
Bibb Allen, Jr., MD*	J. Leonard Lichtenfeld, MD
James Anthony, MD*	Charles D. Mabry, MD*
Dennis Beck, MD*	James D. Maloney, MD*
Michael D. Bishop, MD	Scott Manaker, MD
James Blankenship, MD	John E. Mayer, Jr., MD
Dale Blasier, MD*	Charles Mick, MD
James P. Borgstede, MD	Bill Moran, Jr., MD
Ronald Burd, MD*	Bernard Pfeifer, MD
Norman A. Cohen, MD	Gregory Przybylski, MD
Bruce Deitchman, MD*	Sandra Reed, MD*
James Denny, MD*	David Regan, MD
John Derr, Jr., MD	James B. Regan, MD
Thomas A. Felger, MD	Chester W. Schmidt, Jr., MD
Mary Foto, OTR	Daniel Mark Siegel, MD
John O. Gage, MD	Samuel Silver, MD*
William F. Gee, MD*	J. Baldwin Smith, III, MD
Robert S. Gerstle, MD*	Peter Smith, MD*
David F. Hitzeman, DO	Robert J. Stomel, DO*
Peter Hollmann, MD	Susan M. Strate, MD
Charles F. Koopmann, Jr., MD	Trexler Topping, MD
Gregory Kwasny, MD*	Arthur Traugott, MD*
George F. Kwass, MD*	Richard Tuck, MD
M. Douglas Leahy, MD	James C. Waldorf, MD*
Barbara Levy, MD	Richard W. Whitten, MD

*Alternate

II. Chair's Report

Doctor Rich made the following announcements:

- Doctor Rich discussed the following:
 - Financial Disclosure Statements must be submitted to AMA staff prior to presenting. If a form is not signed prior to your presentation, you will not be allowed to present.

- For new codes, the Chairman will inquire if there is any discrepancy between submitted PE inputs and PERC recommendations or PEAC standards. If the society has not accepted PERC recommendations or PEAC conventions, the tab will be immediately referred to a Facilitation Committee before any work relative value and practice expense discussion.
- Doctor Rich welcomed new RUC members:
 - David Regan, MD, American Society of Clinical Oncology
 - James B. Regan, MD, American Urological Association
 - Charles Mick, MD, North American Spine Society
 - Thomas A. Felger, MD, American Academy of Family Physicians
- Doctor Rich welcomed the following Medicare Contractor Medical Director:
 - William J. Mangold, Jr., MD
- Doctor Rich welcomed the Practice Expense Review Committee (PERC) Members attending. The members in attendance for this meeting are:
 - James Anthony, MD
 - Katherine Bradley, PhD, RN
 - Joel Brill, MD
 - Neal Cohen, MD
 - Thomas Felger, MD
 - Gregory Kwasny, MD
 - Peter McCreight, MD
 - Bill Moran, MD
 - Tye Ouzounian, MD
 - James Regan, MD
 - Anthony Senagore, MD
- Doctor Rich announced the members of the Facilitation Committees:
Facilitation Committee #1
 - Bernard Pfeifer, MD (Chair)
 - Michael D. Bishop, MD
 - Keith Brandt, MD
 - Norman A. Cohen, MD
 - Thomas A. Felger, MD
 - Anthony Hamm, DC
 - Charles F. Koopmann, Jr., MD
 - Scott Manaker, MD
 - James B. Regan, MD
 - Chester W. Schmidt, Jr., MD

- Richard W. Whitten, MD

Facilitation Committee #2

- John E. Mayer, MD (Chair)
- Mary Foto, OTR
- John O. Gage, MD
- Robert Kossmann, MD
- Charles Mick, MD
- David Regan, MD
- Daniel Mark Siegel, MD
- J. Baldwin Smith, MD
- Richard H. Tuck, MD
- Trexler Topping, MD
- Arthur Traugott, MD

Facilitation Committee #3

- J. Leonard Lichtenfeld, MD (Chair)
- James Blankenship, MD
- James P. Borgstede, MD
- John Derr, MD
- Emily H. Hill, PA-C
- David Hitzeman, DO
- Barbara Levy, MD
- Terry M. Mills, MD
- Willard Moran, MD
- Gregory Przybylski, MD
- Susan Strate, MD

- The following individuals were observers at the September 2005 meeting:

FirstName	LastName	Society
Deb	Abel	American Academy of Audiology
Gregory	Barkley, MD	American Academy of Neurology
Leon	Benson, MD	American Society for Surgery of the Hand
David	Beyer, MD	American Society for Therapeutic Radiology and Oncology
Michael	Bigby, MD	American Academy of Dermatology
Stephen	Black-Schaffer, MD	College of American Pathologists
Andrea	Boon, MD	American Association of Electrodiagnostic Medicine
Karen	Borman	American College of Surgeons
James	Boxall	American College of Cardiology
Randy	Brooks	American Optometric Association
Michael	Chaglasian, OD	American Optometric Association
Jodi	Chappell	American Academy of Audiology
Leslie	Cohen, MS	American College of Medical Genetics

FirstName	LastName	Society
John	Coleman, MD	American Academy of Otolaryngology - Head and Neck Surgery
Scott	Collins, MD	American Academy of Dermatology
Jeffery	Dann, MD	American Urological Association
Verdi	DiSesa, MD	Society of Thoracic Surgeons
Mary	Essling	American Society of Plastic Surgeons
Mary Ellen	Fletcher	American College of Emergency Physicians
L. Neal	Freeman, MD	American Academy of Ophthalmology
Kim	French	American College of Chest Physicians
Denise	Garris	American College of Cardiology
John	Goodson, MD	American College of Physicians
Robert	Guyton, MD	Society of Thoracic Surgeons
Katie	Hanson	American Association of Electrodiagnostic Medicine
C. Anderson	Hedberg, MD	American College of Physicians
Jenna	Kappel	American Society for Therapeutic Radiology and Oncology
Tripti	Kataria	American Society of Anesthesiologists
Wayne	Koch, MD	American Academy of Otolaryngology - Head and Neck Surgery
Gayle	Lee	American Physical Therapy Association
James	Levett, MD	Society of Thoracic Surgeons
Michael	Levy, MD	American Society for Gastrointestinal Endoscopy
Jennifer	Markkanen	American Academy of Sleep Medicine
Ted	Martin, MD	American College of Cardiology
Nancey	McCann	American Society of Cataract and Refractive Surgery
Marilyn	McMillen	American Academy of Family Physicians
Najeeb	Mohideen, MD	American Society for Therapeutic Radiology and Oncology
Janemarie	Mulvey	College of American Pathologists
Alan	Perlman, MD	American College of Cardiology
Michael	Picard, MD	American College of Cardiology
John	Ridge, MD	American Academy of Otolaryngology - Head and Neck Surgery
Chad	Rubin, MD	American College of Surgeons
Paul	Rudolf, MD	American College of Physicians
James	Scroggs	American College of Obstetricians and Gynecologists
Albert	Strunk, MD	American College of Obstetricians and Gynecologists
Kim	Thomsen, MA	American Dietetic Association
William	Van Decker, MD	American College of Cardiology
Paul E.	Wallner, DO	American Society for Therapeutic Radiology and Oncology
Franklin	West	Society for Vascular Surgery
Joanne	Willer	North American Spine Society
Marc	Williams, MD	American College of Medical Genetics
George	Williams, MD	American Academy of Ophthalmology
W. Patrick	Zeller, MD	American Association of Clinical Endocrinologists

- Doctor Rich thanked John E. Mayer, Jr., MD for all his hard work on the RUC
- Doctor Rich thanked the following Five-Year Review workgroup chairs and presented them with a gift for all their hard work:
 - Barbara Levy, MD
 - Richard H. Tuck, MD
 - Michael D. Bishop, MD
 - Robert M. Zwolak, MD
 - Norman A. Cohen, MD
 - James P. Borgstede, MD
 - J. Baldwin Smith, III, MD
 - Bernard Pfeifer, MD
- Doctor Rich thanked Meghan Gerety, MD for serving as the Chair of the Five-Year Review Workgroup and presented her with a gift.
- Doctor Rich welcomed the CMS Staff attending the meeting, which included:
 - Edith Hambrick, MD, CMS Medical Officer
 - Carolyn Mullen, Deputy Director of the Division of Practitioner Services
 - Ken Simon, MD, CMS Medical Officer
- Doctor Rich welcomed the following Medicare Payment Advisory Commission (MedPAC) staff:
 - Kevin Hayes
 - Dana Kelley
 - Carol Carter
- Doctor Rich reiterated that we are not here representing specialties; we are representing an attempt to have an equitable distribution of fair allocation of the work values in this Five-Year Review.

III. Directors Report

Sherry Smith announced:

- The calendar of meeting dates and locations
- The new subcommittee and workgroup members will take effect immediately following this meeting
- To date there are about a dozen rank order anomalies identified by the Five-Year Review Workgroup that need to be addressed in February, which are dependent on the RUC's final actions at this meeting, including the following codes: 17004, 33506, 33660, 33670, 33770, 33780, 44141, 44144, 44145, 44146 and 44177.

IV. Approval of Minutes for the April 27-May 1, 2005, RUC meeting:

The RUC reviewed the minutes and accepted them as presented.

V. CPT Editorial Panel Update

Doctor Peter Hollmann invited the RUC to the Annual CPT Editorial Meeting in Seattle, Washington, October 20-23, 2005. Discussion will include modifiers, possible sunset of category III codes, robotic surgery, online-consultations and construction of vignettes. Doctor Hollmann also informed the RUC that actions that come from this meeting, such as any code proposals that need to be considered for February, will need to be in the AMA office by November 7, 2005. The codes the RUC will be working on today will all be in the CPT 2007 cycle.

VI. CMS Update

- Doctor Ken Simon briefed the RUC that currently the agency has been engaged in the restorative efforts of Hurricane Katrina as well insuring that displaced evacuees have medical coverage and determining ways to re-establish and retain displaced physicians.
- Doctor Simon announced that September 16, 2005, was the last day for comment on the Outpatient Prospective Payment System and September 30, 2005, is the last day for comment on the Proposed Rule for the Physician Fee Schedule.
- The Final Rule on the Medicare Physician Payment Schedule is to be available on November 1, 2005.
- Currently, the agency is working with many specialty societies to develop performance indicators and measures for the Physician Voluntary Reporting Program (PVRP). PVRP is anticipated to be operational in 2006.
- The agency is waiting to see what possible Congressional actions will be taken regarding concerns to the SGR.

VII. CMD Update

Doctor William Mangold expressed that the Contractor Medical Directors as a group are committed to participate and provide assistance to the RUC to improve the process and procedures of the RUC.

VIII. Washington Update

Sharon McIlrath updated the RUC on the issues surrounding the SGR. Currently, the SGR decrease prediction is -4.4% cut in 2006, partly because a change in the MEI and volume changes. Virtually everyone agrees that payments can not be cut by 26%. It is evident that any SGR fix will be accompanied by some form of pay-for-performance requirement. CMS has sent out sixty to seventy quality indicators, which would be used in a large national demonstration that may be able to be implemented next year. The details on pay-for-performance plans are currently not fully developed. Sixty groups (specialties, AAMC, MGMA, AMGA, etc.) signed framework indicating that pay-for-performance is unacceptable if it is not accompanied by a repeal of the SGR, it must be voluntary, phased in and it must have positive updates for all physicians including those that do not participate. Currently there are two bills proposed, both call for public reporting and both include efficiency measures in addition to quality measures. The Nancy Johnson bill meets most of the AMA pay-for-performance principles and every physician whether or not they participated, would be better off than under current law. The other bill provides no such assurances and is not supported by the provider community.

MedPAC Update:

Kevin Hayes, from the Medicare Payment Advisory Commission, provided the RUC with an update in the Commission's activities. Mr. Hayes spoke about current reports and the Proposed Rule. There will be two reports to Congress, one in March 2006 and the other in June 2006. The goal is constructive recommendations on how to improve Medicare payment policy. The March report will include a recommendation on how the conversion factor for 2007 should change to account for inflation and other factors. The June 2006 report will address a number of issues concerning physician services and the possibility of some mis-pricing of services in the Physician Fee Schedule. The Commission has been concerned about growth in spending in areas such as imaging. The Commission will examine the two main elements of the Fee Schedule, other than the conversion factor, the relative value units and the geographic price cost indices (GPCIs). The Commission will be examining the work of the RUC and its recommendations to CMS, how CMS uses the RUC's recommendations and CMS independent activities. Regarding GPCI's, the Commission will be reviewing payment locality boundaries that have not been revised since 1997, how GPCI's work with services when equipment and supplies constitute a higher than average share of practice expense inputs for services.

IX. Relative Value Recommendations for CPT 2006

Ventricular Restoration (Tab 4)

John Conte, Society of Thoracic Surgeons (STS)/American Association for Thoracic Surgery

Due to advancements in technology that has allowed for standardization of the restoration of the ventricle, CPT created a new code to account for this type of procedure that is technically more complicated and involves different work than is described by current codes.

The presenters stated that the existing code 33542 *Myocardial resection (eg, ventricular aneurysmectomy)* (work RVU = 28.21) involves different work and does not accurately describe this procedure. The presenters stated that patients undergoing ventricular restoration are among the sickest patients with advanced heart failure with the average patient staying in the ICU post-operatively 4-5 days. The presenters stated that in about 80 to 90 percent of these patients, bypass surgery is also performed at the same time and it was explained that the recommended value does not include any of the bypass surgery work. However, since the reference code is included in the current five-year review the RUC assigned an interim value so that the code could be evaluated in comparison to a new value approved by the RUC in September, 2005. The current recommendation for code 33548 is based on the RUC approved STS five-year review alternative methodology.

The presenters explained that the interim relative value of 37.97 resulted in an IWPUR of 0.085, which was felt by the society to be too low in comparison to the recently evaluated five-year review codes. The E/M services assigned to the global period were also distorted by derivation from the Harvard assigned visits of the reference code. The reference code 33542 was refined by the RUC and has a RUC recommended value of 44.20 work relative values. Additionally, intra-service time, length of ICU and regular hospital stay, and duration of mechanical ventilation has been acquired for 33548 from the STS database, which recently added this new procedure to its procedure list. Code 33548 was also surveyed for intensity along with the other adult cardiac codes submitted for refinement. A comparison of the STS data and IWPUR between 33548 and 33542 for the period 2001-2004 is attached. It indicates that 33548 is significantly more intense in intra-service work, more complicated and is associated with significantly more postoperative management physician work (confirming the relationship between the two codes determined by the standard RUC survey) than the reference code.

In recommending a new value for 33548, the specialty considered the following factors:

1. Establishing the new value based on the ratio of refined 33542 and Harvard 33542, adjusting the RUC-approved value of 33548 proportionately. This results in a recommendation of $((44.20/28.21)*36.46) = 57.13$
2. Establishing a new value through the utilization of data from the RUC survey performed for the April 2005 RUC meeting, data from the RUC approved reference code value, data from the STS national database, and intensity data from the survey that was used in the 5 year refinement process. This method led to a recommendation of 49.41. The new value includes an additional 99292 visit compared to the workgroup recommendations for the reference code, consistent with the additional ICU stay and ventilator hours for 33548 and consistent with several of our workgroup approved codes with similar ICU stay and ventilator hours. We maintained the RUC approved 99239 discharge for 33548, and this was consistent with other work group recommendations for similar codes. Otherwise, the number and level of the in-hospital visits are the same as for the reference code.

The presenters recommended the lower value, 49.41, for several reasons:

1. The higher value of 57.13 could only be “built” through increasing peri-operative time and E/M services to levels above even those recommended by our specialty for similar codes.
2. The higher value would create rank order anomalies with other procedures, should the refinement process interim results be finalized. For example, 33548 would have a higher work value than 33545 *Repair of postinfarction ventricular septal defect, with or without myocardial resection*, RUC recommended RVU = 52.49)
3. The value 49.41 is an appropriate relative value compared to the RUC recommended value for 33542 (44.20), and the relationships of intra-service time, IWPUT, and post-operative E/M services are consistent with STS national database data for both procedures.

The RUC agreed with this analysis and felt that the recommended values placed the code in proper rank order with the recently refined RUC recommended values for the adult cardiac codes values.

The RUC recommends a work RVU of 49.41 for code 33548.

Practice Expense

The RUC recommends the standard inputs for 90 day global procedures performed in the facility setting with the exception of using the RN staff type rather than the standard blend.

X. Relative Value Recommendations for CPT 2007

Abdominal Approach Revision of Prosthetic Vaginal Graft (Tab 5)
Robert Harris, MD – American College of Obstetricians and Gynecologists

As a result of an aging population, the incidence of complex pelvic surgery has increased. With this, surgical techniques have expanded and improved to include the use of prosthetic materials for vaginal reconstruction. As in any specialty, complications may occur with prosthetic materials thereby requiring revision or removal. Therefore, the CPT Editorial Panel created a new CPT code to address potential surgical problems associated with the use of new materials and new techniques and to accurately describe the work associated with a revision of a prosthetic vaginal graft performed with the open abdominal approach.

The RUC was presented with survey data from the American College of Surgeons and the American Urogynecologic Society. It was noted that although there were only 19 survey respondents, that this procedure is not very common and very few providers perform it. The specialty society stated that they felt the pre-service time was over-estimated and the post-service time was underestimated by the survey respondents when comparing this code to the reference code 57280 *Colpopexy, abdominal approach* (Work RVU=15.02). Therefore, the specialty society recommended and the RUC accepted that the pre-service time associated with this service should be decreased by 20 minutes and the pre-service time components should be as follows: 45 minutes pre-service evaluation time, 10 minutes pre-service positioning time and 10 minutes pre-service scrub/dress/wait time. In addition, the specialty society recommended and the RUC accepted that the post-service time be increased by 10 minutes to accurately reflect the work performed to result in 40 minutes of immediate post-service. The RUC assessed these new time increments and intensity/complexity measures of the surveyed code in comparison to the times and intensities/complexities of the reference code. The RUC noted that the physician times (405 total minutes for the surveyed code and 411 minutes for the reference code) and the complexity/intensity measures for these two codes are very similar. Therefore, the RUC agrees with the specialty society that the work RVU for this code should be the median surveyed value of 15.02 work RVUs. **The RUC recommends 15.02 work RVUs for 572XX1.**

Practice Expense

The RUC recommends the standard inputs for 90 day global procedures performed only in the facility setting.

Ultrasound Transplanted Kidney with Doppler (Tab 6)
Bibb Allen, Jr., MD – American College of Radiology (ACR)
Jonathan Berlin, MD - American College of Radiology (ACR)
Gary Seabrook, MD - Society for Vascular Surgery (SVS)

The CPT Editorial Panel deleted one code and created another to accurately reflect current medical practice and the physician work involved. The procedure of ultrasound of a transplanted kidney has changed since the with or without Doppler terminology was created. Ultrasound of a transplanted kidney without Doppler is an uncommon study today, however when performed it can be accurately reported by existing limited retroperitoneum code 76775 *Ultrasound, retroperitoneal (eg, renal, aorta, nodes), B-scan and/or real time with image documentation; limited* (2005 Work RVU = 0.58). Code 76778 *Ultrasound, transplanted kidney, B-scan and/or real time with image documentation, with or without duplex Doppler study* (2005 Work RVU = 0.74) was deleted by the Editorial Panel and the new code describes the performance of a complete ultrasound of the transplanted kidney which includes both real time imaging and duplex Doppler evaluation. The CPT Editorial Panel believed that by developing this new code would appropriately describe how ultrasound of the transplanted kidney is now typically performed and bring the coding for this procedure in line with other codes in CPT by deleting the “with and without” phrase.

The RUC reviewed the specialty society’s survey results carefully and believed that the physician work for new code 7677X *Ultrasound, transplanted kidney, real time and duplex Doppler with image documentation* was similar to existing codes 76778 *Ultrasound, transplanted kidney, B-scan and/or real time with image documentation, with or without duplex Doppler study* (2005 Work RVU = 0.74), and 78707 *Kidney imaging with vascular flow and function; single study without pharmacological intervention* (2005 Work RVU = 0.96). The RUC understood that the new code did not reflect new technology and therefore was subject to CMS’s work neutrality rules, in addition, the specialty believed that the service of deleted code 76778 would be reported by 76775 2-5% of the time and 7677X 95-98% of the time.

The RUC also believed that there was some increment of additional physician work for the Doppler study and the more direct supervision of the technician for this procedure. The RUC also reviewed the combination of the physician work of add on code 93325 *Doppler echocardiography color flow velocity mapping* (2005 Work RVU = 0.07) and code 76775. After considering the work of the above mentioned codes, the specialty survey results, and work neutrality, **the RUC recommends a relative work value of 0.76 for new code 7677X.**

Practice Expense

The RUC reviewed the specialty society's practice expense recommendation for new code 7677X, and compared the direct practice inputs to code 76778. The specialty society and the RUC made minor changes to the clinical labor and medical supplies typically used in the procedure and recommends the attached inputs.

Stereotactic Radiation Treatment Delivery (Tab 7)
American Society of Therapeutic Radiation Oncology

The CPT Editorial Panel created two new codes for stereotactic-based radiation treatment for cranial lesions delivered in a single fraction as a complete course of treatment. The Panel combined two CMS G-codes; G0173 *Stereotactic radiosurgery, complete course of therapy in one session* and G0243 *Multi-source photon stereotactic radiosurgery, delivery, including collimator changes and custom plugging, complete course of treatment, all lesions*, into their own single CPT codes. The treatment is delivered by either a linear accelerator (sometimes called linac radiosurgery) or a multisource cobalt-60 unit (sometimes referred to as the Gamma knife). These new codes were required to define the technical component of single fraction cranial SRS (i.e. stereotactic radiosurgery) complete course of treatment in one session for the two SRS technical modalities which are utilized. There is no physician work associated with these two new codes.

The RUC, the Practice Expense Review Committee, and the specialty society carefully reviewed the direct practice expense inputs for new codes 7741X1 *Radiation treatment delivery, stereotactic radiosurgery (SRS) (complete course of treatment of cerebral lesion(s) consisting of one session); multi-source Cobalt 60 based* and 7741X2 *Radiation treatment delivery, stereotactic radiosurgery (SRS) (complete course of treatment of cerebral lesion(s) consisting of one session); linear accelerator based*, both agreed that the initial specialty recommendation included more clinical labor time than typically would occur for these procedures. The discussion of the workgroup is listed below and the full revised practice expense inputs are attached.

The RUC and the specialty society representatives reviewed each clinical labor activity line by line and made appropriate changes to reflect the typical patient encounter. In total the clinical labor time for 7741X1 was reduced from the specialty recommendation of 368 minutes to 266 minutes, and for 7741X2 was reduced from the specialty recommendation of 278 minutes to 191 minutes. Below are the details of the reductions in clinical labor time that were made to reflect the typical practice and current PERC standards. These reductions were unanimously agreed upon by the RUC and specialty society:

Pre-Service Clinical Labor Time:

The committee reviewed the pre-service activities and reduced the time to the standards and to the typical time reducing the total pre-service time from 13 minutes to 9 minutes. These reductions occurred in coordinating the pre-service activities and providing pre-service education/obtain consent.

Intra-Service Clinical Labor Time:

The committee spent significant time understanding the details of the clinical labor activities involved in the two services and reduced the intra-service time from 355 to 254 minutes for 7741X1 and from 305 to 179 for 7741X2.

Reductions in time in the pre-service of the service period reflected a change to the PERC standards, and reductions in the intra- and post-service time of the service period reflected the typical patient.

Two clinical labor staff members are needed during the intra service period, an RT and a Medical Physicist. The activities of each staff member were broken out by the specialty society so that the committee understood each increment of time being spent during the treatment plan and treatment time periods. With the clinical labor detailed, the committee understood the treatment and the typical time spent performing the procedure. The typical time spent by the RT after a line by line analysis was reduced by 41 minutes to 71 minutes, and the Medical Physicist time was reduced by 38 minutes. The specialty society agreed with these reductions as they again thought through the steps of the treatment plan and delivery procedure. In addition, the committee agreed that the staff monitoring the patient after the procedure needed only 20 minutes rather than 30 minutes as they would be multi-tasking.

Post-Service Clinical Labor Time:

The RUC agreed that a phone call in the post service time period was needed and agreed to 3 minutes for this activity.

Medical Supplies and Equipment:

The RUC reviewed the medical supplies carefully for both new codes and agreed with the specialty recommended medical supplies. No changes to medical supplies were needed and are recommended to the RUC.

Equipment

The RUC reviewed and discussed the necessity and the cost of the very expensive equipment used for this procedure. The specialty society assured the RUC that the new and CMS listed equipment were required for the service.

The RUC identified these two codes as a new technology codes. Codes 7741X1 and 7741X2 need to be re-reviewed by the RUC based on new information which the specialty society will present how this information affects the original RUC recommendation once wide-spread use of the new technology occurs.

Continuous Bronchodilator Therapy (Tab 8)
American College of Chest Physicians (ACCP)
American Thoracic Society (ATS)

The CPT Editorial Panel believed that Continuous Bronchodilator Therapy (CBT) is a unique new procedure, which involves specialized equipment and intense monitoring and assessment by non-physician health care professionals. This new service differs from current CPT code 94640 *Pressurized or nonpressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes (eg, with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPB) device)* (XXX Global, Work RVU 2005 = 0.00) has a duration of approximately 10 minutes, whereas the continuous monitoring and or observation of patients receiving CBT is required. In addition, higher doses of medication and a large volume nebulizer are required for CBT.

The RUC reviewed the non-facility practice expense inputs carefully focusing on the typical patient encounter. The RUC understood that an evaluation and management service is typically billed on the same day as the CBT and that the service would not be performed in the facility setting. The RUC believed, and the specialty agreed, that the clinical labor time initially presented to the RUC was too high for the typical patient encounter. The RUC reduced specific clinical labor activity line items to recommend a total clinical labor time of 29 minutes for code 9464X1 *Continuous inhalation of aerosol medication for acute airway obstruction; first hour (For services of less than 1 hour, use 94640)* and 22 minutes for add on code 9464X2 *Continuous inhalation of aerosol medication for acute airway obstruction; first hour: each additional hour (List separately in addition to code for primary procedure)*. A detailed spreadsheet shows a detailed allocation of the clinical labor time in the non-facility setting and no direct practice expense inputs in the facility setting.

Genetic Counseling (Tab 9)
American College of Medical Genetics (ACMG)

The CPT Editorial Panel created a new medical genetics and counseling code to be used by non-physician practitioners to adequately describe the clinical labor activities performed. Currently the procedure is performed but is frequently not billed for independently. The service could not be adequately described using existing evaluation and management codes. The CPT Editorial Panel created code 96XX1 *Medical genetics and genetic counseling services, each 30 minutes face-to-face with patient/family* so that it would not be codable with initial encounter E/M codes.

The RUC reviewed in detail the direct practice expense recommendations for medical genetic counseling in the non-facility setting with the understanding that there would be no inputs in the facility setting. The RUC understood that the typical patient had cancer, and the RUC and the specialty society agreed on a reduction, from what the specialty originally recommended, in the pre and post service clinical labor time typically needed to perform the service. **To reflect the typical patient and to eliminate double counting in staff activities, the RUC recommends a total of 55 minutes to perform this service with 30 minutes of intra service face to face time. 25 minutes of the total time includes pre-service time and post-service on going patient management and follow-up.**

XI. Practice Expense Review Committee Report (Tab 10)

The Practice Expense Review Committee (PERC) met on September 29, 2005 to critically review practice expense (PE) recommendations for all new and revised codes on the RUC agenda. PERC members; Bill Moran, MD (Chair), James Anthony, MD, Joel V. Brill, MD, Neal H. Cohen, MD, Thomas A. Felger, MD, Gregory Kwasny, MD, Peter McCreight, MD, Tye Ouzounian, MD, and James B. Regan, MD, thoroughly reviewed each of the specialty society's practice expense recommendations, and after considerable discussion, and additional facilitation for some new codes, specialty society representatives and PERC members reached consensus on the direct practice expense inputs for each code.

XII. Five-Year Review Recommendations (Tab 11)

RUC Health Care Professionals Advisory Committee (HCPAC) Review Board

Mary Foto, OTR, updated the RUC regarding the Five-Year Review codes reviewed by the HCPAC. CMS requested that six podiatric codes be reviewed at the 2005 Five-Year Review. CMS selected codes 10060, 11040, 11041, 11042, 11730 and 29580 to be reviewed because these procedures have never been reviewed by the HCPAC (that is, Harvard RVUs are still being used, or there is no information).

The HCPAC agreed with the American Podiatric Medical Association (APMA) that there was compelling evidence due to a flawed methodology used in the previous Harvard valuation for all six podiatric codes. The HCPAC recommended increasing the work RVU for three codes, maintaining the work RVU for one code and decreasing the work RVU for two codes.

Ms. Foto also informed the RUC that per CMS' request, the HCPAC gathered PLI premium data. **The HCPAC believed that the yearly average PLI premium data per profession is accurate and will submit the data to CMS.**

The full report of the RUC HCPAC Review Board Report was accepted for filing and is attached to these minutes.

Workgroup 1 – Dermatology/Plastic Surgery

Doctor Barbara Levy presented Workgroup One's report and consent calendars to the RUC and explained that the workgroup reviewed approximately 57 codes from dermatology/plastic surgery. There were no extractions from the consent calendar for this workgroup. **The RUC unanimously approved the dermatology/plastic surgery workgroup report and its relative value recommendations. The final RUC recommendations are attached to these minutes.**

Workgroup 2 – Orthopaedic Surgery

Doctor Tuck presented Workgroup Two's report and consent calendars to the RUC and explained that the workgroup reviewed 108 codes. There were several extractions from the workgroup's report including:

27130 Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft (2005 Work RVU= 20.09)

27236 Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement (2005 Work RVU = 15.58)

27447 Arthroplasty, knee, condyle and plateau;medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty) (2005 Work RVU= 21.45)

27647 Radical resection of tumor, bone; talus or calcaneus (2005 Work RVU = 12.22)

The four codes were extracted by the specialty which asked for a facilitation meeting. The RUC provided a facilitation committee meeting. The facilitation committee agreed with the workgroup that for codes 27130, 27236 and 27447, given the lack of survey data and uncertainty on how to adjust the existing value based on Harvard times and visits and lack of compelling evidence, the values for these codes should be maintained. However, the

facilitation committee recommended that the new physician time data should be utilized for these codes. **The RUC agreed with the facilitation committee and recommends utilizing the NSQIP physician times and maintaining the values of the following codes: 20.09 work RVUs for 27130, 15.58 work RVUs for 27236, 21.45 work RVUs for 27447 and 12.22 work RVUs for 27647.**

The facilitation committee also reviewed CPT code 27647 and after lengthy discussion recommends to refer code 27647 to CPT based on Medicare data and confusion about the meaning of the “radical resection.” Medicare data indicates that podiatry is the typical provider of this service and an examination of the podiatry survey data resulted in a median RVU of 12.78 with significantly lower intra-service time; therefore there was not sufficient evidence to increase the value to the requested RVU of 20.00. The facilitation committee was concerned that the APMA data was based on a mini-survey that did not include an anchor code and a full RUC survey. In addition, the RUC was not convinced that the size of the typical tumor has changed for this procedure and the meaning of “radical” could mean have different meanings to different specialties. **The RUC agreed with the facilitation committee’s recommendation to refer code 27647 to CPT for clarification of deep excision and possibly creating new codes to differentiate based on the size and depth of the tumor.**

23200 *Radical resection of bone tumor; clavicle* (2005 Work RVU = 12.06)

23210 *Radical resection of bone tumor; scapula* (2005 Work RVU = 12.47)

23220 *Radical resection of bone tumor, proximal humerus;* (2005 Work RVU = 14.54)

24077 *Radical resection of tumor (eg, malignant neoplasm), soft tissue of upper arm or elbow area* (2005 Work RVU = 11.74)

24150 *Radical resection of tumor, shaft or distal humerus;* (2005 Work RVU = 13.25)

24152 *Radical resection of tumor, radial head or neck;* (2005 Work RVU = 10.04)

25077 *Radical resection of tumor (eg, malignant neoplasm), soft tissue of forearm and/or wrist area*(2005 Work RVU = 9.75)

25170 *Radical resection of tumor, radius or ulna* (2005 Work RVU = 11.07)

27049 *Radical resection of tumor, soft tissue of pelvis and hip area (eg, malignant neoplasm)* (2005 Work RVU = 13.64)

27076 *Radical resection of tumor or infection; ilium, including acetabulum, both public rami, or ischium and acetabulum (2005 Work RVU = 22.09)*

27078 *Radical resection of tumor or infection; ischial tuberosity and greater trochanter of femur (2005 Work RVU = 13.42)*

27329 *Radical resection of tumor (eg, malignant neoplasm), soft tissue of thigh or knee area (2005 Work RVU = 14.12)*

27365 *Radical resection of tumor, bone, femur or knee (2005 Work RVU = 16.25)*

27615 *Radical resection of tumor (eg, malignant neoplasm), soft tissue of leg or ankle area (2005 Work RVU = 12.54)*

27645 *Radical resection of tumor, bone; tibia (2005 Work RVU = 14.15)*

27646 *Radical resection of tumor, bone; fibula (2005 Work RVU = 12.64)*

At the presentation to the RUC, a RUC member extracted the previous 16 codes and recommended they be sent to CPT for clarification of the term “radical resection” and “deep excision.” and thereby possibly creating new codes that differentiate a tumor based on its size and depth: **The RUC agreed with this recommendation and recommends referring the preceding codes to CPT for further clarification.**

After addressing the above issues, the RUC approved the Orthopaedic Surgery Workgroup report and relative value recommendation without revision. The final RUC recommendations are attached to these minutes.

Workgroup 3 – Gynecology/Urology/Pain Medicine/Neurosurgery

Doctor Michael Bishop presented Workgroup Three’s report and stated that the workgroup diligently reviewed 73 codes of which 43 were withdrawn. There were several extractions from the workgroup’s report including:

50590 – Lithotripsy, extracorporeal shock wave

The Workgroup recommended and the specialty society agrees with the recommended work value of 9.08 work RVUs for this procedure. However, the specialty society disagrees with the Workgroup’s recommendation for intra-service time. The workgroup felt that the 25th percentile/Median of the survey data, 45 minutes, was appropriate. The specialty society felt that 80 minutes, more accurately reflected the amount of intra-service time associated

with this procedure. Thus, the American Urological Association (AUA) extracted this code for discussion. The AUA explained that this procedure reflects a new technology being utilized and therefore included within the Five-Year Review. This new technology is patient/user friendly and very precise. Also, this technology is far less powerful and requires more time to use appropriately. They described their survey data as being bi-modal and those surveyees that had the older technology had less time and those surveyees with the new technology had more time. However, the new technology will rapidly become more dispersed in the future and it was mentioned that the PEAC reviewed this service in 2003 and based its recommendations on the new technology. It was suggested by a RUC member, taking into consideration the specialty society's comments as well as the survey data that the 75th percentile would be a more appropriate intra-service time. It was also noted that the 99231 visit was to be removed from this service as this procedure is primarily performed in the outpatient setting. **The RUC accepts 9.08 work RVUs and 60 minutes of intra-service time for 50590.**

52000 – Cystourethroscopy

52204 – Cystourethroscopy, with biopsy

55700 – Biopsy, prostate; needle or punch, single or multiple, any approach

These codes were extracted by a RUC member because there was some concern as to the compelling evidence to increase the value of these codes as the survey results indicated that there had not been a change in work in the last five years. The specialty society explained that they agree that there has not been a change in the work of these codes for the last five years, however, the only data that exists with these codes is from the original Harvard studies. Therefore, the data associated with these codes was established almost 10 years ago. The data collected by the specialty society for the Five-Year Review was thought to be more representative of the services currently performed. **The RUC accepts the Workgroup's recommendation of 2.23 work RVUs associated with 52000, 2.59 work RVU for 52204 and 2.58 work RVUs for 55700.**

61697 – Surgery of complex intracranial aneurysm, intracranial approach; carotid stenting

61700 – Surgery of simple intracranial aneurysm; intracranial approach; carotid circulation

61702 – Surgery of simple intracranial aneurysm; intracranial approach; vertebrobasilar circulation

These three codes were extracted for the same reason. In each of these codes, the specialty society recommended critical care visits (99291) be added to the post service. The Workgroup felt that this recommendation was not appropriate and that a high level hospital visit (99233) more accurately

reflected the post service associated with this service. The number of visits was maintained for all three codes by the Workgroup.

The specialty society felt that after reviewing their survey data that if the survey respondent did not select a critical care visit (99291) that they recommended 2 high level hospital visits (2-99233). Therefore, the specialty society would recommend changing the workgroup recommended visits to reflect their survey data by adding in the additional high level hospital visits and add the work RVU associated with these visits to the work RVU for the service. The specialty society recommends:

CPT Code	Workgroup Recommended Number of 99233 Visits	Specialty Society Recommended Number of 99233 visits	Work RVU Adjustment	Specialty Society Work RVU Recommendation
61697	1	2	1.51	58.82
61700	2	4	3.02	49.03
61702	1	2	1.51	55.79

This motion failed as there was some concern expressed by several RUC members regarding the payment policy aspects of billing 2-99233 visits on the same day. It was discussed that although billing 2 hospital visits on the same day is prohibited by CPT coding convention, it is not prohibited on the RUC survey instrument. There was a suggestion made that the RUC survey instrument should instruct the respondents to bill the prolonged care service codes to reflect additional time spent with a non-critically ill patient. This issue was referred to the Research Subcommittee.

Due to this discussion, a RUC member made a further recommendation and was supported by the specialty society that instead of equating a 99291 code with 2-99233 codes that perhaps it would be more accurate, after hearing a description of the post-op services provided, to equate the original specialty society's recommendation of a 99211 code with a 99233 and a 99356 Prolonged care in the inpatient setting. The recommendation would be the following:

CPT Code	Workgroup Recommended Number of 99233 Visits	RUC Member Recommended Number of Additional 99356	Work RVU Adjustment	Specialty Society Work RVU Recommendation
61697	1	1	1.71	59.02
61700	2	2	3.42	49.43
61702	1	1	1.71	55.99

The motion failed. As part of the parliamentary procedure, if a specialty society recommendation fails, the original workgroup recommendations must be voted upon. **The following Workgroup recommendations were accepted by the RUC:**

CPT Code	Workgroup Recommended Number of 99233 Visits	Workgroup Work RVU Recommendation
61697	1	57.31
61700	2	46.01
61702	1	54.28

61537 – Craniotomy with elevation of bone flap; for lobectomy, temporal lobe without electrocorticography during surgery

61538 – Craniotomy with elevation of bone flap; for lobectomy, temporal lobe with electrocorticography during surgery

The specialty society has requested to extract these codes from the consent calendar. These codes were withdrawn without prejudice by the specialty society during the Workgroup review of these codes. The specialty society felt they did not adequately present their compelling evidence during the August Workgroup Meetings and would like to extract these codes as they now have the compelling evidence to support a review of these codes. The RUC accepted the motion to allow these codes to be extracted from the Workgroup’s consent calendar to be further reviewed by the workgroup and subsequently approved by the RUC.

The workgroup began by addressing the compelling evidence for these codes. The specialty societies stated that the reason why these codes were brought forward was because there is an anomalous relationship between these codes being valued and other codes within the craniotomy family. The specialty society felt that 61538 involved the most amount of physician work within this family and this is not reflected in its current evaluation. In addition, because 61538 was the key reference code when 61537 was reviewed by the RUC, there also exists a rank order anomaly for 61537 as well. The workgroup agreed with the specialty society that there was an anomalous relationship and thereby compelling evidence.

The workgroup reviewed the service times for 61537. The workgroup felt that the pre-service time needed to be adjusted to reflect the services being performed and to be consistent with other neurological surgery codes reviewed by the workgroup. The workgroup recommended and the societies agreed with the following times for pre-service – 60 minutes of pre-service evaluation time, 20 minutes of positioning time and 20 minutes of scrub, dress

and wait time. The workgroup accepted the specialty societies' recommended intra-service time and post-service time, 265 minutes and 45 minutes respectively, as they felt this time adequately reflects the services being performed. The workgroup reviewed the specialty societies' recommended post-operative visits and amended them to four-99231 visits, one-99232 visits and two-99213 office visits as they felt this more accurately reflected the post-operative care of the typical patient. The workgroup reviewed the recommended RVW for this procedure and agreed with the specialty society that 35.00 RVU, the 25th percentile, represents the amount of physician work associated with this code and produces an IWPUT of 0.098 which the workgroup and the specialty societies felt was appropriate. The workgroup recommends the 35.00 work RVUs for 61537. **The RUC recommends the workgroup recommendation of 35.00 work RVUs for 61537.**

The workgroup reviewed the service times for 61538. The workgroup felt that the pre-service time needed to be adjusted to reflect the services being performed and to be consistent with other neurological surgery codes reviewed by the workgroup. The workgroup recommended and the societies agreed with the following times for pre-service – 60 minutes of pre-service evaluation time, 20 minutes of positioning time and 20 minutes of scrub, dress and wait time. The workgroup accepted the specialty societies' recommended intra-service time and post-service time, 330 minutes and 45 minutes respectively, as they felt this time adequately reflects the services being performed. The workgroup maintained the specialty societies' recommended post-operative visits as the workgroup felt this accurately reflected the post-operative care of the typical patient. The workgroup reviewed the recommended RVW for this procedure and agreed with the specialty society that 38.00 RVU, the 25th percentile, represents the amount of physician work associated with this code and produces an IWPUT of 0.087 which the workgroup and the specialty societies felt that this value places this code in rank order within its family. The workgroup recommends the 38.00 work RVUs for 61538. **The RUC recommends the workgroup recommendation of 38.00 work RVUs for 61538.**

After addressing the above issues, the RUC approved the Gynecology/Urology/Pain Medicine/Neurosurgery Workgroup report and relative value recommendations without revision. Th RUC adopted the full report and consent calendar. The final RUC recommendations are attached to these minutes.

Workgroup 4 – Radiology/Pathology/Other Misc. Services

Doctor Zwolak presented Workgroup Four's report and consent calendars to the RUC and explained that the workgroup reviewed 80 codes. Of these 80 codes; 68 remained on the consent calendar, 8 were extracted and 4 had no consensus.

Ventilation Management - 94657

CPT code 94657 was extracted by a RUC member for discussion. The RUC first discussed workgroup extracted code 94657 and agreed with the workgroup that the code should be reviewed with its base code 94656 *Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; first day* (2005 Work RVU = 1.22). The specialty stated that the typical patient was more complex, however the RUC believed there was still a substantial portion of typical patient scenarios that are less complex and require less physician work. The RUC reviewed the specialty's survey results and rationale, and believed there is a bimodal patient distribution of procedure. **The RUC referred the specialty to the CPT Editorial Panel to have the code split into two distinct patient population specific codes.**

Spinal Fluid Tap - 62270

This code was extracted by the specialty society for discussion. The RUC heard from specialty society representatives that 1) the code was not appropriately valued by Harvard, and 2) at least in the pediatric population, there has been an increased level of complexity in the typical patient. The current RVW for code 62270 Spinal puncture, lumbar, diagnostic is 1.13. The specialty believed that the patient population had changed whereas the procedure is now more frequently performed on older children than in the past, apparently a more difficult cohort. The RUC noted that the Medicare utilization indicates the specialties that brought the code forward are infrequent providers of the service, but pediatrics provide a substantial number of these services outside the Medicare population. Medicare data indicates diagnostic radiology as the specialty most frequently billing this service but the American College of Radiology (ACR) although initially indicating a level 1 interest in the code changed to a level 2 interest. The ACR did later provide a comment letter supporting pediatrics' recommendation for an increase in the relative value.

Specialty society representatives and RUC members discussed the survey results and the level of physician work, in relation to similar procedures and similar work RVUs to establish the correct level of physician work for this spinal procedure. The RUC did believe that there had been an increase in the level of physician work for this service however, the RUC had difficulty accepting the median and the 25th percentile of the specialty society's survey results. The RUC believed that the level of physician work for code 62270 should not exceed the work of code 62284 *Injection procedure for*

myelography and/or computed tomography, spinal (other than C1-C2 and posterior fossa) (000 day global, work RVU 2005 = 1.54). In addition, the RUC and specialty society believed that the physician work was closer to, but not equivalent to, code 27096 *Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid* (000 day global, work RVU 2005 = 1.40; 10-25-5 minutes). **The RUC recommends a relative work value of 1.35 for code 62270** since the intra-time of 62272 is 5-minutes less than the reference. With this recommendation, the specialty agreed that a rank order anomaly would not be generated with code 62272 Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter) (000 day global, 2005 work RVU = 1.35)

The physician time components were also discussed in light of the fact that an evaluation and management code is typically billed with 62270. The RUC recommends that the pre-service time be reduced from 25 minutes to 10 minutes. The RUC recommends the intra-service time of 20 minutes and immediate post time of 10 minutes from the specialty's survey results.

Cardiac Magnetic Resonance Imaging – 75552-75556

The cardiac magnetic resonance imaging family (75552-75556) was extracted by interested specialties. The American College of Cardiology and the American College of Radiology believed that the current CPT coding structure for Cardiac MRI (CPT codes 75552 - 75556) did not accurately reflect current practice and as a result is confusing to members of both societies as well as payers for the services. **The RUC agreed with the specialty's recommendation to send this Cardiac MRI family of codes to the CPT Editorial Panel for a revision in their CPT descriptor terminology.**

Electroencephalogram (EEG); including recording awake and asleep - 95819

Code 95819 was extracted by the American Academy of Neurology and was discussed by the full RUC. Specialty representatives maintained that since the technology had changed from an analog to a digital system, there had been an increase in the amount of physician work for the typical patient.

The RUC reviewed the specialty's survey results showing a requested change in the RVU for this service, and did not believe an increase, as suggested by the specialty, was warranted at this time. **The RUC recommends to maintain the current value of 1.08 RVUs. The RUC agreed with the physician time survey data and recommends all of the physician time elements.**

Pathology Consultations 88309 & 88321-88325

Code 88309 was extracted by the workgroup because of a math error when calculating its recommended RVU. The workgroup and the RUC discussed the error and its relationship with the 25th percentile survey results. The workgroup and the RUC agreed that the physician work had changed and that compelling evidence was established. The Workgroup amended its recommendation to the specialty's 25th percentile surveyed RVU of 2.80 and the RUC accepted the workgroup's recommendation. **The RUC recommends a work RVU of 2.80 for code 88309.**

The Workgroup recommended no consensus on code 88321, 88323 and 88325. The specialty society representatives first clarified to the RUC how the physician work had changed recently by describing the typical patient scenario for each of the three other extracted pathology consultations (88321, 88323, 88325). The RUC accepted the compelling evidence to consider a change in physician work. The change in work is due to the increased number and type of slides undergoing review in the typical case, and in particular, the number of immunohistochemical slides that must undergo review. The RUC also believed that the clinical practice of these pathology consultations have changed based on recent literature. The specialty society's survey results supported the specialty's contention that the physician work had increased.

The specialty's survey results indicated pathology consultations now take longer to perform, and require more work. After further clarification and discussion, the RUC and the specialty society agreed that the level of physician work equals the specialty's 25th percentile survey results. **The RUC therefore recommends the following relative value units and physician time components for codes 88321, 88233, and 88325, which represent the 25th percentile specialty society's survey results:**

Code	Current RVU	Recommended RVU	Current Intra-Service Time	Recommended Intra-Service Time
88321	1.30	1.63	41 minutes-Hrvd	50 minutes
88323	1.35	1.83	42 minutes-Hrvd	56 minutes
88325	2.22	2.50	69 minutes-Hrvd	80 minutes

Doppler Color Flow Add-On – 93325

The RUC reviewed the specialty's survey results and rationale and believed that code 93307 Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete (work RVU = 0.92) was typically billed with 93325. The RUC could not recommend a change in the value of the code without CPT review of the code. **The RUC recommends code 93325 be referred to the CPT Editorial Panel for consideration for inclusion of the work of 93325 in the work of 93307.**

Workgroup 5 – Evaluation and Management Services

Workgroup Members: Doctors Norman Cohen, John Derr, David Hitzeman, George Kwass, Gregory Pzybylski, and Maurits Wiersema

Workgroup Recommendations

99201	0.45	99241	0.64
99202	0.88	99242	1.34
99203	1.34	99243	1.97
99204	2.03	99244	3.02
99205	3.00	99245	3.77
99211	0.17	99251	1.00
99212	0.45	99252	1.50
99213	0.80	99252	2.27
99214	1.30	99253	3.29
99215	2.00	99255	4.00
99221	1.88	99281	0.33
99222	2.56	99282	0.55
99223	3.78	99283	1.24
99231	0.76	99284	1.95
99232	1.30	99285	3.06
99233	2.00	99291	4.29
99238	1.28	99292	2.15
99239	1.90		

Individuals Presenting for Specialty Society:

James Anthony, MD	American Academy of Neurology
Katherine Bradley, PhD, RN	American Nurses Association
Dennis Beck, MD	American College of Emergency Physicians
Doug Leahy, MD	American College of Physicians
Meghan Gerety, MD	American Geriatrics Society
Larry Martinelli, MD	Infectious Disease Society
Lee Mills, MD	American Academy of Family Physicians
Alan Plummer, MD	American College of Chest Physicians
Joseph Schlect, MD	American Osteopathic Association

The RUC member representing the American College of Surgeons extracted all of the Workgroup recommendations for consideration by the full RUC.

A coalition of medical specialty societies initially extracted the following 19 E/M codes for additional review by the RUC:

99204, 99205, 99213, 99214, 99215, 99231, 99232, 99233, 99244, 99245, 99254, 99255, 99281, 99282, 99283, 99284, 99285, 99291, and 99292.

Introductory Remarks and Discussion

Prior to discussion of each individual E/M code, the RUC considered the compelling evidence standard approved by the Workgroup for these codes. Doctor Cohen explained that the Workgroup concluded that compelling evidence standard applicable to these codes was that “Evidence that incorrect assumptions were made in the previous valuation of the service, as documented.” This is consistent with the previous RUC recommendation and communications to HCFA following the 1st Five-Year Review. At this time, HCFA also indicated that that the agency would be willing to review new information to support the original RUC recommendations. The Workgroup utilized this compelling evidence to open the codes for discussion, while reviewing each individual codes on its own merit. The Workgroup did not find that the compelling evidence standards were met for either the Emergency Department services or the Critical Care codes. However, the Workgroup did recommend increases for critical care codes 99291 and 99292 to avoid rank order anomalies that would be otherwise be created with the new E/M increases.

The RUC approved the following motion:

The RUC agrees that the compelling evidence standards have been met for all E/M codes (except critical care and emergency medicine) under consideration. The application of the following compelling evidence standard allows discussion of each individual code on its own merit:

Evidence that incorrect assumptions were made in the previous valuation of the service, as documented.

The RUC also discussed the survey data collected by the surgical specialty societies. Doctor Cohen explained that the Workgroup considered the surgeons submission as a comment and obtained the specialty specific survey data on the day of the Workgroup meeting as information only. Doctor Rich clarified that any RUC member may share information on a particular issue, but requested that any documentation provided should be shared with all RUC members. Any materials to be distributed to RUC members should be provided to AMA staff in a timely fashion and should be distributed by AMA staff.

Doctor Cohen also provided clarification that IWPUT was not utilized to establish the relative value recommendations for E/M codes. This analysis

was only used to review the Workgroup's recommendations within and between families of E/M services to ensure relativity.

Doctor Leahy began his presentation by extending thanks to the Workgroup, his surgical colleagues, and AMA staff. He stated that as a group, the coalition of medical specialty societies wished to stress their support of the RUC process. He indicated that they wished to make the RUC stronger and did not wish to do any harm to the process. He acknowledged that there are other view points and indicated that they understood that the process must consider these viewpoints. Doctor Leahy then indicated that the coalition of medical specialties wished to extract 19 of the 35 Workgroup recommendations as they to argue that further increases were warranted. Doctor Leahy emphasized that the medical groups would continue to present evidence that the E/M services had increased in physician work over the past ten years. He shared data with the RUC to emphasize their arguments that:

- Chronic care management has become a larger portion of E/M services;
- Number of diagnosis per patient have increased;
- Number of medications have increased; and
- The length of hospital stay has decreased, leading to sicker patients in the outpatient setting.

The E/M codes were then discussed in the order requested by the medical specialty societies. The discussion will be listed here in CPT code order, with the date and time of the discussion noted.

Office Visits, New

The RUC reviewed the new office visits on Saturday, 5:30 - 6:30 pm. The medical specialties accepted the Workgroup recommendations for 99201, 99202, 99203, and 99205 (had dropped their earlier extraction of 99205).

99201

The RUC approved the Workgroup recommendation of 0.45 for 99201.

99202

The RUC approved the Workgroup recommendation of 0.88 for 99202.

99203

The RUC approved the Workgroup recommendation of 1.34 for 99203.

99204

The Workgroup had recommended 2.03 for this service. The medical specialties extracted this recommendation and requested consideration of a value of 2.50 based on their survey data. The motion to accept the value of 2.50 failed. A subsequent vote to accept the Workgroup recommendation of 2.03 also failed. A RUC member made a motion to consider 2.30, with a reference service of 99343 (work RVU, 2.27). This motion passed.

The RUC approved a recommendation of 2.30 for 99204.

99205

The RUC approved the Workgroup recommendation of 3.00 for 99205.

Office Visits, Established Patient

The established office visits were discussed on 7:30 pm - 10:00 pm on Saturday and 10:30 am - 11:00 am on Sunday.

99211

The specialty and the E/M Workgroup did not recommend a change in the work relative value for this code. **The RUC recommends a work relative value of 0.17 for 99211.**

99212

The specialty and the E/M Workgroup did not recommend a change in the work relative value for this code. **The RUC recommends a work relative value of 0.45 for 99212.**

99213

The Workgroup recommendation for 99213 was 0.80. The medical specialty societies extracted this code for further discussion and requested that the RUC consider a work relative value of 1.20 for this service. The specialties provided a number of reference services to consider with total time of 25-30 minutes, including 70544 (1.20) and 31231 (1.10). Other RUC members indicated that there were other services with similar time, with lower values, including 99347 (0.76) and 76005 (0.60). A motion to approve the specialty recommendation of 1.20 failed. A subsequent motion to approve the Workgroup recommendation of 0.80 also failed. A review of the ballots

indicate that 2/3 of the RUC agree that the work relative value should be at or above the Workgroup recommendation of 0.80.

A RUC member made a motion to value 99213 at 1.00. The specialty argued that 1.00 was appropriate relative to other services, such as echocardiography, colostomy, and simple skin biopsy. Other RUC members expressed concern that the intensity of 99213 would not be higher than 99203 and that although IWPUR was not being used to determine the value of these codes, a comparison across families and within families was appropriate. It was noted a large 100% increase in the IWPUR between 99212 (RUC approved at 0.45, IWPUR = 0.27) and 99213 (specialty recommendation of 1.00, IWPUR = 0.52) is also not appropriate. The motion to recommend 1.00 for 99213 failed (13 in favor, 13 opposed).

The RUC postponed discussion of 99213 to allow further review, discussion, and reflection prior to the February 2006 RUC meeting.

99214

99214 was not discussed during the course of the meeting. The RUC action to postpone discussion on 99213 and 99215 also incorporated 99214. **The RUC postponed discussion of 99214 until the February 2006 meeting.**

99215

The Workgroup recommendation for 99215 was 2.00. The medical specialty societies extracted this code for further discussion and requested that the RUC consider a work relative value of 2.35 for this service. The specialty argued that this service should be valued slightly higher than 99204, approved at 2.30. RUC members expressed concern that this request would reflect a higher intensity for a follow-up visit as compared to a new office visit. A motion to approve 2.35 failed (15 in favor, 11 opposed).

The RUC then voted on the Workgroup recommendation of 2.00. This motion also failed. However, more than 2/3 of RUC members agreed that the work value for 99215 should be at or above 2.00.

A motion was made by a RUC member to value 99215 at 2.30. This motion also failed (12 in favor, 14 opposed).

A motion was made by a RUC member to value 99215 at 2.17. This motion also failed (9 in favor, 16 opposed).

A motion was made again to approve the Workgroup recommendation of 2.00. Individuals voiced objection again right before the vote and indicated

that they would propose a recommendation of 2.15 next. The motion for 2.00 subsequently failed (13 in favor, 13 opposed).

A final motion was made to value 99215 at 2.15, the 25% of the survey data where the endocrinology data is removed. This motion also failed (15 in favor, 11 opposed).

Several RUC members expressed concern that many of the above motions for values were made without the same level of rationale and justification as the original Workgroup recommendation of 2.00.

The RUC postponed discussion of 99215 to allow further review, discussion, and reflection prior to the February 2006 RUC meeting.

Initial Hospital Visits

The initial hospital visit codes were discussed on Sunday, 7:00 am - 7:30 am. The medical specialty society did not extract any of these services for discussion. Doctor Gage extracted all three codes as a RUC member.

This was the first family of codes to be discussed on Sunday morning and a RUC member mentioned that due to the lack of time to sufficiently discuss each issue, the RUC should consider labeling the recommendations interim if a quick resolution could not be made on each individual code.

A motion to approve the Workgroup recommendation for all codes 99221 - 99223 failed (13 in favor, 13 opposed). A decision was then made to review the family on a code-by-code basis.

99221

A motion to approve the Workgroup recommendation of 1.88 was approved. **The RUC recommends a work relative value of 1.88 for 99221.**

99222

A motion to approve the Workgroup recommendation of 2.56 initially failed and then was approved as an interim recommendation. **The RUC recommends a work relative value of 2.56 for 99222 as an interim recommendation.**

99223

A motion to approve the Workgroup recommendation of 3.78 initially failed and then was approved as an interim recommendation. **The RUC recommends a work relative value of 3.78 for 99223 as an interim recommendation.**

Subsequent Hospital Visits

The subsequent hospital visits were discussed on Sunday, 8:15 am - 8:45 am.

The medical specialties indicated that they were extracted all three codes in this family.

99231

The medical specialty societies requested that their median survey value of 1.00 be considered for 99231. This motion failed. The Workgroup recommendation of 0.76, based on a comparison to CPT code 99347, was considered by the RUC and the motion to approve this recommendation was approved. It was noted that in the first Five-Year Review, the RUC recommended that 99213 should reflect a higher work value than 99231 and the Workgroup's recommendations are consistent with these earlier actions.

The Workgroup recommendation of 0.76 for 99231 was approved by the RUC.

99232

The Workgroup recommendation for this service was 1.30. The medical specialty requested that the RUC consider a work relative value of 1.60. A motion to consider 1.60 failed (12 in favor, and 14 opposed). A motion to consider the Workgroup recommendation of 1.30 also failed. A RUC member then made a motion that the RUC consider the 25th percentile of 1.50 for 99232. This recommendation also failed (14 in favor and 12 opposed). It was noted that the RUC recommended 1.30 for 99232 in the first Five-Year Review. The RUC considered another motion to approve 1.30 as an interim recommendation. This motion was approved.

The Workgroup recommendation of 1.30 for 99232 was approved by the RUC as an interim recommendation.

99233

The Workgroup recommendation for this service was 2.00. The medical specialty requested that the RUC consider a work relative value of 2.50 and compared the service to 36010 (work RVU = 2.43; 26 minutes total time). A motion to consider the 2.50 failed. A motion to consider the Workgroup recommendation also failed. A motion to consider 2.00 as an interim recommendation was approved.

The Workgroup recommendation of 2.00 for 99233 was approved by the RUC as an interim recommendation.

A RUC member stated that the RUC should have a conversation in February regarding the potential need for CPT to consider if three levels of E/M is appropriate for hospital services.

Hospital Discharge

The hospital discharge codes were discussed on Sunday, 7:30 am - 7:45 am.

The medical specialties did not extract these services. Doctor Charles Mabry indicated that he had not intended to extract these two codes.

99238

The Workgroup recommendation of 1.28 for 99238 was approved by the RUC.

99239

The Workgroup recommendation of 1.90 for 99239 was approved by the RUC.

Outpatient Consultations

The RUC initially voted on the entire family of outpatient consultation codes as one vote (Saturday, 8am). The vote was 16 in favor, and 10 opposed. As the vote was one shy of a 2/3 majority, a detailed discussion of each code ensued during the course of the meeting at the following days/times:

Saturday, 8 am - noon;
Saturday, 4:30 - 5:30 pm; and
Saturday, 6:30 - 7:30 pm

99241

Doctors Gage and Mabry extracted this code for discussion and argued that the work had not changed for this code. In addition, they expressed concern that such a large percentage of survey respondents were from endocrinology. **The RUC approved the Workgroup recommendation of 0.64 for this 99241.**

99242

Doctors Gage and Mabry extracted this code for discussion and argued that the work had not changed for this code. In addition, they expressed concern that such a large percentage of survey respondents were from endocrinology. **The RUC approved the Workgroup recommendation of 1.34 for this 99242.**

99243

Doctors Gage and Mabry extracted this code for discussion and argued that the work had not changed for this code. In addition, they expressed concern that such a large percentage of survey respondents were from endocrinology. A vote to approve this individual code at the Workgroup recommendation of 1.97 failed. A motion was then made that this code should be valued the same as CPT code 99386 at a work RVU of 1.88. This motion also failed. Later, the recommendation of 1.88 was reconsidered and approved. **The RUC approved a recommendation of 1.88 for 99243.**

99244

The medical specialties agreed with the Workgroup recommendation of 3.02. However, they did not agree with the Workgroup recommendation to increase the median survey time of 45 minutes to the 75% of 60 minutes. Initially, the specialty withdrew its objections. However, after extensive discussion, the RUC agreed with the medical specialties that the survey median of time 45 minutes should be utilized. A vote to approve the Workgroup recommendation of 3.02 initially failed and then was approved later with the adjustment of time and a comparison to the approved value of 3.00 for 99205. **The RUC approved the Workgroup recommendation of 3.02 for this 99244.**

99245

The medical specialties agreed with the Workgroup recommendation of 3.77. However, they did not agree with the Workgroup recommendation to increase the median survey time of 60 minutes to the 75% of 75 minutes. Initially, the specialty withdrew its objections. However, after extensive discussion, the RUC agreed with the medical specialties that the survey median of time 60 minutes should be utilized. A vote to approve the Workgroup

recommendation of 3.77 initially failed and then was approved later with the adjustment of time. **The RUC approved the Workgroup recommendation of 3.77 for this 99245.**

The detailed recommendations for all of the E/M services are attached to these minutes.

Inpatient Consultations

The inpatient consultations were discussed on Sunday from 7:45 am - 8:15 am.

Doctor Mabry indicated that he was not extracting 99251 and 99252. The medical specialties indicated that they only planned to extract 99555.

99251

The RUC approved the Workgroup recommendation of 1.00 for 99251.

99252

The RUC approved the Workgroup recommendation of 1.50 for 99252.

99253

The RUC approved the Workgroup recommendation of 2.27 for 99253

99254

A RUC member recommended that the median survey time of 50 minutes be utilized, rather than the 75th percentile time of 65 minutes, as recommended by the Workgroup. The specialty and the full RUC agreed with this recommendation.

The RUC approved the Workgroup recommendation of 3.29 for 99254.

99255

A RUC member recommended that the median survey time of 60 minutes be utilized, rather than the 75th percentile time of 75 minutes, as recommended by the Workgroup. The specialty and the full RUC agreed with this recommendation.

The specialty requested that the RUC consider a work relative value of 4.25 for 99255 and compared the work for this service to 99236 (work RVU = 4.26, total time of 110 minutes). A motion to recommend 4.25 for 99255

failed. A subsequent motion to approve the Workgroup recommendation of 4.00 was approved.

The RUC approved the Workgroup recommendation of 4.00 for 99255.

Critical Care

The critical care services were considered on Sunday, 8:45 am - 9:00 am.

The E/M Workgroup recommended that there was no compelling evidence that the critical care services were under-valued. However, due to the Workgroup's actions on other E/M families, adjustments were required in the critical care services to avoid rank order anomalies. The Workgroup recommended 4.29 for 99291 and 2.15 for 99292. The medical specialties extracted 99291 and 99292 and requested that the survey medians of 5.10 for 99291 and 2.66 for 99292 be approved.

The presenters argued that there has been a change in the patient population for these services and technology has also contributed to an increase in work. The specialty also indicated that they were concerned that codes 99223 (3.78), 99245 (3.77), and 99255 (4.00) were now valued close to the critical care services and 99291 should reflect a significant increase in work.

The specialty did not object to the method used to initially value these codes in the first Five-Year Review. Therefore, the Workgroup only considered these codes to prevent rank order anomalies. It is unclear from specialty society statements if they do believe that this building block method (four 99213 + ventilation mgt 99656 + chest x-ray) is inappropriate.

A motion to consider the specialty request of 5.10 for 99291 and 2.66 for 99292 was not approved. A motion to consider the Workgroup recommendation of 4.29 for 99291 and 2.15 for 99292 also failed. A motion to consider the Workgroup recommendations as interim was approved.

The RUC approved the Workgroup recommendation of 4.29 for 99291 and 2.15 for 99292.

Emergency Department Services

The Emergency Department services were reviewed on Sunday, 9:00 am - 10:00 am. The medical specialties extracted all five of these codes for further review.

The presenter first articulated that the compelling evidence to consider the emergency department services was based on a rank order issue. When these

services were first reviewed in the first Five-Year Review, the RUC recommended the following linkages:

99281 = 99201; 99282 = 99202; 99283 = 99203; 99284 = more than 99204; 99285 = more than 99205. The presenter recommended the same linkages for 99281 and 99282, but recommended that 99283 = 99243; 99284 = 99244; and 99285 = 99255. The presenter indicated that these values associated with these linkages would be consistent with the values between the 25th percentile and survey medians.

99281

The RUC agreed with the previous relationship established between 99281 and 99201. A motion to approve 0.45 for 99281 was approved.

The RUC approved a recommendation of 0.45 for 99281.

99282

The RUC agreed with the previous relationship established between 99282 and 99202. A motion to approve 0.88 for 99282 was approved.

The RUC approved a recommendation of 0.88 for 99282.

99283

The RUC considered a motion to approve the specialty society recommendation that 99283 be valued the same as 99243 (1.88). The motion was not approved. The RUC then considered a motion to use the existing RUC crosswalk of 99283 to 99203 (1.34). A motion to value 99283 at 1.34 was approved.

The RUC approved a recommendation of 1.34 for 99283.

99284

The RUC considered a motion to approve the specialty society recommendation that 99284 be valued the same as 99244 (3.02). This motion was not approved. The RUC then considered a motion to value 99284 at the survey 25th percentile of 2.56 (which is greater than 99204 = 2.30). A motion to value 99284 at 2.56 was approved.

The RUC approved a recommendation of 2.56 for 99284.

99285

The RUC considered a motion to approve the specialty society recommendation that 99285 be valued the same as 99255 (4.00). This motion was not approved. The RUC then considered a motion to value 99285 at the survey 25th percentile of 3.80 (which is greater than 99205 = 3.00). A motion to value 99284 at 3.80 was approved.

The RUC approved a recommendation of 3.80 for 99285.

Concluding Remarks on Evaluation and Management

Doctor Rich announced that a few RUC members would be selected to join the original E/M Workgroup to resolve the three postponed codes and the six codes with interim values prior to the February 2006 RUC meeting. The following individuals are to participate in the E/M Workgroup: Doctors Norman Cohen (Chair), John Derr, William Gee, David Hitzeman, George Kwass, Douglas Leahy, Charles Mabry, Greg Pzybylski, J. Baldwin Smith, and Maurits Wiersema.

Workgroup 6 – Cardiothoracic Surgery

Doctor James Borgstede presented Workgroup Six's report and stated that the Workgroup reviewed 81 cardiothoracic surgery codes which can be further separated into three categories, congenital codes, adult cardiac codes and general thoracic codes. All 81 codes were extracted by the American College of Chest Physicians (ACCP) for discussion. The three reasons in which all codes from Workgroup Six were extracted were issues surrounding sufficient compelling evidence, appropriateness of the evaluation of work and time and appropriate valuation of the post-operative services, such as critical care.

The RUC discussed compelling evidence in lengthy detail and ultimately felt that the issue of compelling evidence for the congenital codes was met due to the existence of rank order anomalies. The RUC accepted that the patient population for the adult cardiac and general thoracic codes had changed in the last five years. The RUC considered evaluating the compelling evidence on a code by code basis for the adult cardiac and general thoracic codes, but instead determined that since the RUC already approved the STS building block methodology, the RUC would not examine the compelling evidence for each code. Rather the RUC accepted the previous RUC approval of the STS methodology as compelling evidence for each code.

The RUC extensively discussed the appropriateness of the evaluation of work and time by the workgroup. ACCP questioned the use of means instead of medians and length of stay differentiation between the STS database and the RUC database for the adult cardiac and general thoracic codes. The RUC considered the two intensity measures, the magnitude estimation of intensity

survey and the RASCH analysis of intensity, using the STS database. The RUC agreed that the blended measure of intensity was a fair representation of the intensity of the intra-service period.

The RUC accepted that Workgroup Six thoroughly reviewed all data elements for each code on a code by code basis. The Workgroup spent a great deal of time examining the work performed by the operating surgeon and agreed that a critical care visit should be used in the STS building block methodology. The assignment of the level of critical care services was recommended for each code based on the STS expert panel's knowledge and experience in caring for these patients, within the framework of duration of mechanical ventilation and the length of ICU stay provided by appropriate data in the STS database. The RUC accepted the valuation of the critical care visits by the Workgroup.

After addressing the above issues, the RUC approved the Cardiothoracic Surgery Workgroup report and relative value recommendations without revision, which included accepting the workgroup's majority recommendation for the 'no consensus' codes. The final RUC recommendations are attached to these minutes.

Workgroup 7 – General Surgery/Colorectal Surgery/Vascular Surgery

Doctor J. Baldwin Smith presented Workgroup Seven's report and stated that the workgroup diligently reviewed 106 codes of which 16 were withdrawn. Doctor Smith gave a brief introduction of the alternative methodologies employed by the specialty societies in their recommendations to the workgroup including the National Surgical Quality Improvement Project (NSQIP) data and the mini-survey data.

The NSQIP was started by the VA for quality improvement purposes but now includes a large volume of surgical procedures from non-VA hospitals as well. The NSQIP database contains intra-service times and length of stay data. The ACS proposed a building block methodology that would use a consensus panel to assign pre service times, immediate post service times as well as IWPUT estimates. The intra-service times would be the median times from the NSQIP database. The NSQIP database length of stay will be used by the expert panel to develop number and level of hospital visits. The expert panel will also develop number and level of office visits based on comparisons to codes requiring similar physician work.

Overall, where the NSQIP time and length of stay data was available, the Workgroup felt that for these few procedures, the physicians responding to the survey underestimated their intra-service time and therefore the Workgroup felt that the NSQIP data more accurately reflected the intra-service times for

these procedures. For the remaining procedures, the workgroup reviewed the survey data and typically agreed with the survey median intra-service times and work with some notable exceptions where the workgroup disagreed with these inputs as they felt did not reflect the service. In addition, the workgroup, when reviewing these procedures, recommended standardized inputs for pre-service elements including 30 minutes of evaluation, 15 minutes of positioning and 15 minutes of scrub, dress and wait to most procedures unless otherwise specified.

There were several extractions from the workgroup's report including:

35081 Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta

35102 Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta involving iliac vessels (common, hypogastric, external)

35556 Bypass graft, with vein; femoral-popliteal

35566 Bypass graft, with vein; femoral-anterior tibial, posterior tibial, peroneal artery or other distal vessels

35583 In-situ vein bypass; femoral popliteal

35585 In-situ vein bypass; femoral-anterior tibial, posterior tibial or peroneal artery

For codes 35102, 35556, 35566, 35583 and 35585 the workgroup reviewed the NSQIP data and the survey data in regard to the intra-service times. The workgroup agreed that the survey data demonstrated physicians underestimating their time and thus the NSQIP time was more accurate. Therefore to derive the recommended work RVU, the RUC determined the difference in time between the NSQIP and the survey data and multiplied this difference by a recommended IWP/UT. The workgroup then added this resultant work to the median surveyed RVU. In addition, for all of the above codes, further adjustments in the resultant work were made based on modifications to the pre-service times. This methodology was criticized by the full RUC as a "mix and match" methodology utilizing various components of alternative methodologies to create one recommendation. Due to this utilized methodology, there were some RUC members who questioned the validity of the Workgroup's recommendations. In addition, there were varying opinions about whether the pre-service time and resultant work should have been removed from the total work RVU from all of the aforementioned codes. Therefore, the specialty society requested that the original specialty society recommendation, with slight modifications in work to account for modified pre-service times, be accepted as this methodology was solely based on NSQIP data. The specialty society recommended the following:

CPT Codes	Specialty Society Recommendations
35081	34.40 RVUs
35102	39.65 RVUs
35556	27.25 RVUs
35566	32.00 RVUs
35583	28.25 RVUs
35585	32.00 RVUs

The specialty society recommendation was divided by the RUC. For 35081, The RUC reviewed the recommended RVU and the survey median work RVU and the survey median intra-service time. A motion was made to accept the specialty society's recommendation for 35081. This motion failed. The RUC then considered the workgroup's recommendation of the surveyed median value and intra-service times and felt that that the surveyed median work and intra-service time is appropriate, as compared to the reference code, 35646 Bypass graft, with other than vein; aortobifemoral (Work RVU=30.95) properly places this procedure amongst the family. **Therefore, the RUC recommends 31.00 work RVUs for 35081.**

For 35102, the RUC reviewed the specialty society recommendation. A motion was made to accept the specialty society's recommendation for 35102. This motion failed. The RUC then considered the workgroup recommendation of 36.28 work RVUs and the NSQIP intra-service times for 35102 as part of parliamentary procedure. Discussion of this motion led to the discovery of further support for the workgroup's recommendation in the form of an additional reference code 35531 Bypass graft, with vein; aortoceliac or aortomesentric (Work RVU = 36.15) which had similar intensities, work and service times to the surveyed code. **Therefore the RUC recommends 36.28 work RVU for 35102.**

For 35556, the RUC reviewed the intensity, mental effort, technological skill associated with this procedure and agreed with the specialty society recommendation that the 75th percentile of the survey data, 27.25 accurately reflects the work associated with this code. **The RUC recommends 27.25 work RVUs for 35556.**

For 35566, the RUC reviewed the intensity, mental effort, technological skill associated with this procedure and agreed with the specialty society recommendation that the 75th percentile of the survey data, 32.00 accurately reflects the work associated with this code. **The RUC recommends 32.00 work RVUs for 35566.**

For 35583, the RUC reviewed the intensity, mental effort, and technological skill associated with this procedure and ascertained the specialty society's recommendation of the 75th percentile of the survey data, 28.25. A motion

was made to accept the specialty society's recommendation of 28.25. This motion failed. The Workgroup suggested an alternative recommendation of the median survey data, 26.00 work RVUs. The RUC reviewed the intensity, mental effort and technological skill associated with this procedure and felt that the median value of the survey data, 26.00 accurately reflects the work associated with this code. **The RUC recommends 26.00 work RVUs for 35583.**

For 35585, the RUC reviewed the intensity, mental effort, technological skill associated with this procedure and agreed with the specialty society recommendation that the 75th percentile of the survey data, 32.00 accurately reflects the work associated with this code. **The RUC recommends 32.00 work RVUs for 35585.**

It was noted that all of the aforementioned codes, would be utilizing the NSQIP times for intra-service and post-op visits.

An issue was raised by Doctor Simon of CMS questioning the ability of workgroup members and specialty societies to utilize data from several sources to establish their recommendations for the Five-Year Review. It was clarified that the Society of Thoracic Surgery did not utilize data from several sources that they used their database used for their alternative methodology. For Workgroup Seven, there were 12 codes where NSQIP time will be used in the RUC database and for those 12 codes the workgroup was convinced that the NSQIP data was more accurate than the survey data due to the large sample size that the NSQIP data provided.

It was then noted that there were three additional codes that utilized this "mix and match" methodology. Although the RUC agreed that these values appropriately placed these codes in rank order, the RUC requested additional rationale to further support these values. These codes and rationales are as follows:

44120 Enterectomy, resection of small intestine; single resection and anastomosis

44130 Enteroenterostomy, anastomosis of intestine, with or without cutaneous enterostomy

47600 Cholecystectomy;

The RUC agreed that there was compelling evidence that the current relative value is inappropriate due to a change in the patient population. The RUC reviewed each input and made a number of changes to standardize the pre-service times and accepted the NSQIP intra-service time and post-operative visits. The RUC reviewed the service times and post-operative visits for the reference service code for this procedure, 43631 Gastrectomy, partial, distal; with gastroduodenostomy (Work RVU=22.56). The RUC noted that the

reference code has 150 minutes of intra-service time while the surveyed code has 134 minutes of intra-service time. In addition, the RUC noted that the only difference between the post-operative visits between these two codes is that the reference code has 2-99232 and 5-99231 hospital visits while, the surveyed code has 2-99233, 2-99232 and 4-99231. To account for these differences, and to maintain rank order between the surveyed and reference code the RUC recommends a value of 20.11 work RVUs for 44120, which is a value precisely between the median and 75th percentile survey values. **The RUC recommends 20.11 work RVUs for 44120.**

The RUC agreed that there was compelling evidence that the current relative value is inappropriate due to a change in the patient population. The RUC reviewed each input and made a number of changes to standardize the pre-service times and accepted the NSQIP intra-service time and post-operative visits. The RUC reviewed the service times and the post-operative visits for the reference service code for this procedure, 43631 Gastrectomy, partial, distal; with gastroduodenostomy (Work RVU=22.56). The RUC noted that the reference code has 150 minutes of intra-service time while the surveyed code has 131 minutes of intra-service time. In addition, the RUC noted that the only difference between the post-operative visits between these two codes is that the reference code has 2-99232 and 5-99231 hospital visits while, the surveyed code has 1-99233, 1-99232 and 5-99231. To account for these differences, and to maintain rank order between the surveyed and reference code the RUC recommends the 20.87 work RVUs, which is slightly below the 75th percentile. In addition, this value keeps proper rank order between 44120 *Enterectomy, resection of small intestine; single resection and anastomosis* (RUC recommended work RVU 20.11) and 44130, as 44130 is deemed to be more intense than 44120 based on survey intensity. **The RUC recommends 20.87 work RVUs for 44130.**

The RUC agreed that there was compelling evidence that the current relative value is inappropriate due to a change in the patient population. The workgroup reviewed each input and made a number of changes to standardize the pre-service times and accepted the NSQIP intra-service time and post-operative visits. The RUC reviewed the service times and the post-operative visits for the reference code for this procedure, 47605 Cholecystectomy; with cholangiography (Work RVU=14.67). The RUC noted that the reference code has 90 minutes of intra-service time while the surveyed code has 115 minutes of intra-service time. In addition, the RUC noted that the only difference between the post-operative visits between these two codes is that the surveyed code has one additional 99231 hospital visit in comparison to the reference code. To account for these differences, and to maintain rank order between the surveyed and reference code the RUC recommends a value of 15.88 work RVUs for 47600, which is a value slightly above the 75th percentile. **The RUC recommends 15.88 work RVUs for 47600.**

47562 Laparoscopy, surgical; cholecystectomy

A RUC member extracted 47562 because of several concerns. The first concern is that with the amount of work RVUs being recommended by the Workgroup, 12.00 work RVUs, for this code, an anomalous relationship would be created amongst the spectrum of intensity of laparoscopic codes. The RUC member stated that this value may not be appropriate as it is his perception that surgeons have become much more comfortable performing laparoscopic surgeries over the last 15 years. The second concern raised was regarding the amount of intra-service time recommended by the workgroup, 80 minutes. The RUC member stated that in his experience, 60 minutes was a more accurate intra-service time. The third concern raised whether the issue of familiarity with new technology that occurs over time would be applicable as this technology becomes more dispersed over time the intensity of this procedure would presumably decrease. The fourth concern was the allocation of a full discharge day management to this service considering that more than 50% of these procedures are performed in an outpatient hospital or ASC setting. A more appropriate allocation for this procedure would have been a half a discharge day management service.

After a brief discussion of RUC members as well as specialty society representatives, a motion was made to accept the Workgroup's recommendation of 12.00 work RVUs as part of parliamentary procedure. This motion failed. The RUC felt that there was no compelling evidence that the current relative value is inappropriate due to evidence that incorrect assumptions were made in the previous valuation of the service. The RUC reviewed the surveyed times for this procedure and felt that the NSQIP time of 80 minutes most accurately reflected the intra-service time for this procedure. However, because this procedure is primarily performed in the outpatient setting, the RUC recommends a half day discharge management service, 99238. As a full discharge day management was recommended by the society, removing the work associated with a half a discharge day management from the specialty society's recommended value is approximately the existing value associated with this code. **Therefore, the RUC recommends to maintain the value currently associated with 47562, 11.07 work RVUs.**

47760 Anastomosis of extrahepatic biliary ducts and gastrointestinal tract

For 47760, the Workgroup had achieved consensus on its recommendation for this procedure of 34.75 work RVUs. Therefore, the workgroup would like to change the Action Key for this code from Action Key 7 *No Consensus* to Action Key Item 4 *Suggest a New Value* for acceptance of the workgroup recommended value.

After addressing the above issues, the RUC approved the General Surgery/Colorectal Surgery/Vascular Surgery Workgroup report and relative value recommendations without revision. The final RUC recommendations are attached to these minutes.

Workgroup 8 – Otolaryngology/Ophthalmology

Doctor Bernard Pfeifer presented Workgroup Eight's report and stated that the workgroup reviewed 60 otolaryngology and ophthalmology codes. Doctor Pfeifer indicated that there was one correction to the consent calendar: CPT code 41145 specialty society work RVU should read as 34.00, in which the workgroup recommended to adopt the specialty society's recommended increase in the work RVU.

CPT code 69210 *Removal impacted cerumen (separate procedure), one or both ears* was extracted for discussion. A RUC member extracted CPT code 69210 to validate that there is data present to raise the work RVU. The RUC did not agree with the specialty society that the patient population has changed to a more complex population for code 69210. The RUC also noted that the survey was completed by a specialty society, AAO-HNS, who perform this procedure less than 50 percent of the time. This issue was problematic for the RUC. **The RUC recommends to maintain the current value of this service (work RVU=0.61), which the RUC felt was justified by the survey in which 94% of respondents indicated that the work in performing this service has not changed in the past five years.**

CPT code 66984 *Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)* was extracted for discussion. A RUC member extracted code 66984 on the basis that the IWPOT of 0.211 was high. The RUC member stated that the amount of intra-service time has gone down dramatically and the technique and complications associated with the procedure seem to have gone down. The RUC member was concerned with the significant reduction in time without a commensurate reduction in work and therefore wanted the full RUC to review code 66984.

The workgroup chair and specialty society indicated that the workgroup was aware of the high IWPOT, however accepted it because this code is a high

intensity procedure from start to finish. **The RUC accepted the workgroup work RVU recommendation of 9.78 for CPT code 66984.**

After the RUC resolved issues surrounding the extracted codes, the full report and consent calendar were adopted. The final RUC recommendations are attached to these minutes.

XIII. Other

Doctor Rich reiterated that all the information discussed at this Five-Year Review is confidential. Doctor Rich discussed new business issues. These issues include:

Research Subcommittee

- Review the survey instrument and summary of recommendation form (Feb 2006)
- Review specific guidelines for new and revised codes on how we evaluate the validity of new data sources (April 2006)
- Review the use of multiple E/M codes performed on the same day in the global period (Feb 2006)
- Define the use of mini-surveys with low volume codes (April 2006)

Administrative Subcommittee

- Review and clarify the conflict of interest statement policy (Feb 2006)

The meeting adjourned on Sunday, October 2, 2005 at noon.

**AMA/Specialty Society RVS Update Committee
RUC HCPAC Review Board Meeting
September 29, 2005**

Members Present:

Richard Whitten, MD, Chair
Mary Foto, OTR, Co-Chair
Katherine Bradley, PhD, RN
Jonathan Cooperman, PT
Robert Fifer, PhD
James Georgoulakis, PhD
Anthony Hamm, DC

Emily H. Hill, PA-C
Bernard Pfeifer, MD
Christopher Quinn, OD
Lloyd Smith, DPM
Doris Tomer, LCSW
Arthur Traugott, MD
Jane White, PhD, RD, FADA

I. CMS Update

Edith Hambrick, MD, provided a CMS update and indicated that the comment period for the Hospital Outpatient Prospective Payment System closed on September 16, 2005 and that the comment period for the Medicare Physician Fee Schedule would close on September 30, 2005. Doctor Hambrick also informed the HCPAC that Congress is discussing legislation regarding a pay-for-performance system, therefore CMS is investigating this methodology of physician payment. Doctor Hambrick informed the HCPAC that the Medicare drug program under the MMA is scheduled to go into effect on January 1, 2006.

II. Timed Codes

The HCPAC requested clarification from CMS for reporting 15-minute timed codes. AMA staff indicated that in the *CPT Assistant* December 2003 issue, CPT has indicated how one could appropriately code timed codes. For example, if a healthcare professional is performing a procedure for 25 minutes he/she could report the 15-minute timed code twice. If a healthcare professional is performing a procedure for 17 minutes, then he/she should report the 15-minute timed code once. Coding should not be determined just based on the number of minutes spent per body part but rather is limited by the total aggregate time. Doctor Hambrick indicated that she will investigate what CMS's policy is on this issue.

III. PLI Discussion

CMS indicated in the 2004 November 15 *Final Rule* that the agency was interested in RUC input on the appropriateness of the PLI crosswalk assumptions. The risk factors are currently set at the all physician risk factor for the professions indicated below. The RUC requested the PLI risk factor be set to 1.00 (\$6,100) for the following eight health professionals and that CMS investigate other data as \$6,100 most likely over estimates the PLI premium for these professions. The RUC also invited these professions to present evidence that their annual PLI premiums are greater than \$6,100. These professions include:

- Clinical Psychologist
- Licensed Clinical Social Worker

- Occupational Therapist
- Psychologist
- Optician
- Optometry
- Chiropractic
- Physical Therapist

At the April 2005 meeting, the HCPAC professions indicated that they would make their best effort to gather information on the collection of PLI premium data and submit it to the HCPAC. The professions indicated above, except opticians/optometry submitted PLI premium data to the HCPAC. Subsequently, at this meeting the dieticians also shared their PLI premium data. **The HCPAC believed that the yearly average PLI premium data per profession is accurate and will submit the data to CMS.**

Specialty Society	Average Yearly Premium	Yearly Premium Range
American Chiropractic Association	\$1,870 (in 2005)	\$4,000 - \$6,000 (New York averages \$4,000 and Florida \$6,000)
American Occupational Therapy Association		\$250 - \$1,000 (in 2004/2005)
American Psychological Association	\$1,500	
American Physical Therapy Association	\$1,100 (2005) \$1,500 (projected for 2006)	
American Speech-Language-Hearing Association	\$700 (Typical private practice with hearing aid dispensing capabilities)	\$62 (Individual) \$167 (Group)
National Association of Social Workers	\$500	
American Optometric Association	AOA does not have current premium PLI data. AOA does not agree with CMS' crosswalk to the non-surgical risk factor of 1.00.	
American Dietetic Association		\$118-\$144 (hospital facility) \$900 (small practice)

IV. HCPAC Five-Year Review Recommendations

CMS requested that the RUC HCPAC Review Board review six podiatric codes. CMS selected codes 10060 *Drainage of skin abscess*, 11040 *Debride skin, partial*, 11041 *Debride skin, full*, 11042 *Debride skin/tissue*, 11730 *Removal of nail plate* and 29580 *Application of paste boot* to be reviewed because these procedures have never been reviewed by the RUC HCPAC (that is, Harvard RVUs are still being used, or there is no information). The HCPAC agreed with the American Podiatric Medical Association (APMA) that there was compelling evidence due to a flawed methodology used in the previous Harvard valuation and that these codes have never been reviewed by the HCPAC.

The HCPAC agreed with the specialty society and recommends to (1) adopt the recommended increase in the work RVU for code 10060. Although the current work RVU = 1.17, the HCPAC recommends the median work RVU of 1.50 for code 10060 *Drainage of skin abscess*. The HCPAC recommends the modified physician time of 7 minutes for pre-evaluation, 2 minutes pre-positioning, 8 minutes pre-scrub, dress and wait time, 15 minutes intra-service, 10 minutes immediate post-service and one 99212 office visit.

The HCPAC did not agree with the specialty society and (4) suggested a new work RVU for code 11040. Although the current work RVU=0.50, the HCPAC recommends the 25th percentile work RVU of 0.55 for code 11040 *Debride skin, partial*. The HCPAC recommends the survey physician time of 5 minutes for pre-evaluation, 1 minute pre-positioning, 1 minute pre-scrub, dress and wait time, 10 minutes intra-service and 7 minutes immediate post-service time.

The HCPAC agreed with the specialty society and recommends to (3) adopt the recommended decrease in the work RVU for code 11041. Although the current work RVU=0.82, the HCPAC recommends the median work RVU of 0.80 for code 11041 *Debride skin, full*. The HCPAC recommends the modified physician time of 7 minutes for pre-evaluation, 1 minute pre-positioning, 1 minute pre-scrub, dress and wait time, 12 minutes intra-service, and 7 minutes immediate post-service time.

The HCPAC did not agree with the specialty society and recommends to (2) maintain the current work RVU of 1.12 for code 11042 *Debride skin/tissue*. The HCPAC recommends the modified physician time of 9 minutes for pre-evaluation, 1 minute pre-positioning, 1 minute pre-scrub, dress and wait time, 15 minutes intra-service and 10 minutes immediate post-service time.

The HCPAC agreed with the specialty society and recommends to (3) adopt the recommended decrease in the work RVU for code 11730. Although the current work RVU=1.13, the HCPAC recommends the median work RVU of 1.10 for code 11730 *Removal of nail plate*. The HCPAC recommends the survey physician time of 5 minutes for pre-evaluation, 2 minutes pre-positioning, 8 minutes pre-scrub, dress and wait time, 12 minutes intra-service and 10 minutes immediate post-service time.

The HCPAC agreed with the specialty society and recommends to (1) adopt the recommended increase in the work RVU for code 29850. Although the current work RVU=0.57, the HCPAC recommends the median work RVU of 0.60 for code 29850 *Application of paste boot*. The HCPAC recommends the modified physician time of 5 minutes for pre-evaluation, 2 minutes pre-positioning, 1 minute pre-scrub, dress and wait time, 12 minutes intra-service, and 7 minutes immediate post-service time.