AMA/Specialty RVS Update Committee
Meeting Minutes
September 28-29, 2007

I. Welcome and Call to Order

Doctor William Rich called the meeting to order on Friday, September 28, 2007, at 9:00 am. The following RUC Members were in attendance:

William Rich, MD (Chair)
Bibb Allen, Jr., MD
Michael D. Bishop, MD
James Blankenship, MD
Ronald Burd, MD
Norman A. Cohen, MD
John Derr, Jr., MD
Thomas A. Felger, MD
John Gage, MD
Meghan Gerety, MD
David F. Hitzeman, DO
Peter Hollmann, MD
Charles F. Koopmann, Jr., MD
Gregory Kwasny, MD
Barbara Levy, MD
J. Leonard Lichtenfeld, MD
Bill Moran, Jr., MD
Bernard Pfeifer, MD
Gregory Przybylski, MD
James B. Regan, MD
Daniel Mark Siegel, MD
J. Baldwin Smith, III, MD
Lloyd Smith, DPM
Peter Smith, MD
Samuel Smith, MD
Susan Strate, MD
Arthur Traugott, MD
Richard Tuck, MD
Maurits Wiersema, MD
Allan Anderson, MD*
Dennis M. Beck, MD*
Manuel D. Cerqueira, MD*
Thomas P. Cooper, MD*
Bruce Deitchman, MD*
James Denneny, MD*
Verdi DiSesa, MD*
James Gajewski, MD*
Robert S. Gerstle, MD*
Emily Hill, PA-C*
Allan Inglis, Jr., MD*
Walt Larimore, MD*
M. Douglas Leahy, MD*
Brenda Lewis, DO*
William J. Mangold, Jr., MD*
Marc Raphaelson, MD*
Sandra B. Reed, MD*
Chad Rubin, MD*
Susan Spires, MD*
Holly Stanley, MD*
J. Allan Tucker, MD*
James Waldorf, MD*
George Williams, MD*
John A. Wilson, MD*

*Alternate

II. Chair's Report

Doctor Rich made the following general announcements:

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

- Presenters are expected to announce any conflicts or potential conflicts, including travel reimbursement paid by an entity other than the specialty society, at the onset of their presentation.
- Before a presentation, any RUC member with a conflict must state their conflict and the Chair will rule on recusal.
- RUC members or alternates sitting at the table may not present or advocate on behalf of their specialty.
- 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 standardized PE conventions, the tab will be immediately referred to a Facilitation Committee before any work relative value or practice expense discussion.
- The Summary of Recommendation form has been edited and includes a number of new questions, including modifier 51 status, PLI crosswalk and others. The RUC should provide feedback if sections of the summary are incorrect.
- All RUC Advisors presenting survey data are required to sign the attestation statement at the bottom of the Summary of Recommendation form.

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

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

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

- Doctor Rich announced the members of the Facilitation Committees

Facilitation Committee #1	Facilitation Committee #3
John A. Wilson, MD (Chair)	Scott Manaker, MD, PhD (Chair)
Bibb Allen, MD	James Blankenship, MD
Ronald Burd, MD	Michael Chaglasian, MD
Thomas A. Felger, MD	John Derr, MD
Emily H. Hill, PA-C	John Gage, MD
David F. Hitzeman, MD	Meghan Gerety, MD

Charles F. Koopmann, MD
Barbara Levy, MD
Daniel M. Siegel, MD
Peter Smith, MD
Richard H. Tuck, MD
Robert M. Zwolak, MD
J. Leonard Lichtenfeld, MD
William J. Mangold, MD
Gregory Przybylski, MD
James Regan, MD
Arthur Traugott, MD
Maurits J. Wiersema, MD

Facilitation Committee #2
Gregory Kwasny, MD (Chair)
Michael Bishop, MD
Norman A. Cohen, MD
Peter Hollmann, MD
Bill Moran, MD
Eileen Moynihan, MD
Bernard Pfeifer, MD
J. Baldwin Smith, MD
Lloyd Smith, DPM
Samuel Smith, MD
Susan M. Strate, MD

- Doctor Rich welcomed the following individuals as observers at the April 2006 meeting:
  - Edward Bentley – American Society for Gastrointestinal Endoscopy
  - Kenneth Bloom, MD – American Academy of Dermatology
  - Phil Bongiorno – American Academy of Audiology
  - Darryl Bronson – American Academy of Dermatology
  - Tiffany Brooks – American Society for Therapeutic Radiology and Oncology
  - George Constantino – National Government Services
  - Maurine Dennis – American College of Radiology
  - Alan Desmond – American Academy of Audiology
  - Yolanda Doss – American Osteopathic Association
  - Mary Eiken – American Academy of Physician Assistants
  - Marjorie Eskay-Auerback – North American Spine Society
  - Robert Fine – American Academy of Orthopaedic Surgeons
  - Emily Gardner – American College of Nuclear Physicians
  - John Goodson – American College of Physicians
  - Richard Hamburger – Renal Physicians Association
  - Robert Jasak – American Academy of Orthopaedic Surgeons
  - Ronald McLawhon, MD – College of American Pathologists
  - Faith McNicholas – American Academy of Dermatology
  - Jennifer Mercurio – American Geriatrics Society
  - Samuel Michelson – American Academy of Otolaryngology – Head and Neck Surgery
  - Ericka Miller – American College of Physicians
  - Lisa Miller-Jones – American College of Surgeons

- Irvin Muszynski – American Psychiatric Association
- Alan Pearlman – American College of Surgeons
- Julia Pillsbury – American Academy of Pediatrics
- Judy Rosenbloom – American College of Surgeons
- Steven Schlossberg – American Urological Association
- James Scroggs – American College of Obstetricians and Gynecologists
- James Starzell – American Association of Oral and Maxillofacial Surgeons
- Ted Thurn – American Academy of Sleep Medicine
- J. Allan Tucker, MD – College of American Pathologists
- Joanne Willer – American Academy of Orthopaedic Surgeons
- Kavin William – American Osteopathic Association
- Kadyn Williams – American Audiology Association

III. Director's Report

Sherry Smith made the following announcement:

- AMA staff has distributed a meeting evaluation form to assess the quality of the RUC meeting. Ms. Smith asks all attendees to complete the form at the conclusion of the meeting and to leave it at the registration desk.
- Future RUC meeting locations have been confirmed as follows:
  - January 31-February 3, 2008, Rancho Las Palmas Resort, Rancho Mirage, CA
  - April 23-27, 2008, RUC Meeting, Renaissance Hotel, Chicago, IL
  - October 2-5, 2008, RUC Meeting, Renaissance Hotel, Chicago, IL

IV. Approval of Minutes for the April 26-29, 2007 RUC meeting

The RUC approved the minutes and accepted them without revision.

V. CPT Editorial Panel Update

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

- The 2008 CPT book is currently in production and will be available in October.
- All approved changes from the February 2007 Panel meeting are included in the 2008 book; however, changes from the June 2007 Panel meeting are to be included in the 2009 book.
- The annual meeting of the CPT Editorial Panel will take place in October in Philadelphia, PA. During the meeting meetings, the following issues will be discussed, among others:

  - Industry relations and CPT
  - Advanced Medical Home coding
  - Consultation coding
- The 2008 CPT/RBRVS Annual Symposium will be held November 14-16, 2007 in Chicago, IL.
- November 7, 2007 is the deadline for proposals to be considered at the February 2008 Panel meeting, which is the last meeting for 2009 code changes.

VI. Centers for Medicare and Medicaid Services Update

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

- The 2008 Medicare Physician Payment Schedule and final rule is scheduled to be released on November 1, 2007.
- The Agency published the Ambulatory Surgical Center payment rule in August. The rule establishes a new payment classification system. More than 3,000 services all approved to be paid under the Medicare ASC system.
- The Agency has been actively engaged with the American College of Physicians and the American Academy of Family Physicians addressing the Advanced Medical Home demonstration project. Based on the Tax Relief and Healthcare Act of 2007, CMS has initiated a $500 million demonstration project on the medical home. Highlights of the project include
  - Monthly capitated payment rates
  - Approximately 500 participants
  - A duration of three years
  - Physician payment above the normal E/M payments.
- The Agency has met with members of Lewin group and AMA regarding the Physician Practice Expense Survey. CMS supports the ongoing effort and understands that the data will now be available by March 2009 for the 2010 rulemaking process.

VII. Carrier Medical Director Update

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

- Doctor Haley continued his explanation of the new Medicare Administrative Contracting (MAC) program established under Section 911 of the Medicare prescription Drug, Improvement, and Modernization Act of 2003 (MMA) to be completed by October 2011. Doctor Haley noted that a number of contracts have been awarded since the last meeting

of the RUC and provided a presentation highlighting the changes. The presentation is attached to these minutes.

VIII. Washington Update

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

- The AMA Advocacy Group has been active as the House Medicare committees began drafting a bill addressing both children's health and Medicare in June. The AMA also began legislative efforts unusually early to stop the schedule 10% reduction to the conversion factor. These efforts also resulted in new alliances including the American Association of Retired People. Following the campaign, the House passed the Children's Health and Medicare Protection Act (CHAMP), which contained $47 billion for SCHIP and $100 billion to fix the SGR, paid for primarily by reducing current subsidies to Medicare Advantage Plans. The House bill contains provisions including:
    - $20 billion over five years and $67 billion over 10 years toward fixing the SGR formula. This is more than Congress has ever spent on the issue.
    - Two years of small but positive updates of 0.5% as well as extensions of the work GPCI floors and the scarcity area bonus
    - Reduction of Medicare's 50% cost sharing requirement for outpatient mental health services to 20%.
    - Stabilization of beneficiary premiums and co-pay since cuts in Medicare Advantage and other providers would have offset the improvements in payment to physicians
    - Division of the SGR into six service-specific targets.
    - Creation of an expert panel recommended by MedPAC to identify misvalued services.
    - Examination of services with substantial changes in length of stay, site of service, volume, PE, or other factors and gave Secretary of HHS authority to reduce payments for services with growth rates that exceeded the average for all physicians services by 10%.
- The Senate has excluded physician payment policy changes from their version of the SCHIP bill. As a result, the bills may not be reconciled and another last-minute fix may become necessary.
- Congress passed a bill that regulates prescription pads in an attempt to make them tamper-resistant. The requirements were part of a cost savings plan which is predicted to save about $210 million over five years. It would apply only to handwritten prescriptions and go into effect on October 1. Physicians commented that implementation would be onerous and the AMA succeeded in delaying implementation by six months.

- AMA has made progress toward ending insurance discrimination to mental health patients as a mental health parity bill is currently moving through the House.
- A lawsuit between Consumer Checkbook and the government has resulted in an order to release Medicare claims data in an effort to rate physicians on the quality and cost of the care they provide. The judge ruled that the benefits of making the information public outweigh the benefits of keeping physician information private. The government has filed a motion to delay this order. Whether or not the issue is resolved in the present case, there is increased pressure to make this information public.
    - Senators Judd Greg and Hillary Clinton have introduced legislation to create quality reporting organizations that would produce reports on provider performance that would eventually be made public.
    - CMS has also launched a "federal transparency initiative" that also would eventually make performance measurement results for individual physicians available on the web. A notice in the Federal Register on September 12 announced that HHS is setting up a system of records to accomplish this goal. However, it also notes that this information will be "disclosed only as long as it is consistent with the privacy act," which implies that the government would have to secure consent of the individual physicians before disclosing the information.

IX. Relative Value Recommendations for CPT 2008

Computer Navigation (Tab 4)
Dale Blasier, MD, American Academy of Orthopaedic Surgery (AAOS)

The CPT Editorial Panel created three new Category I CPT codes in February 2007 to replace three existing Category III CPT codes used to describe computer assisted navigation for musculoskeletal surgical procedures. The Panel was under the assumption that adequate evidence on the improved results with this technology had been published on these series of codes to warrant the conversion of these codes to Category I status. The Panel also concluded that an add-on code was necessary to describe this extra effort since the use of this technology requires additional physician work, complexity and time beyond that normally involved in a musculoskeletal procedure. In April 2007, the RUC made an RVU recommendation for the first service in the series, 20985, and recommended carrier pricing for 20986 and 20987 until the specialty could bring more conclusive survey data to the RUC for appropriate valuation.

The RUC considered the specialty society survey results and recommendations for CPT code 20986, *Computer assisted surgical navigational procedure for musculoskeletal procedures; image-less; with image-guidance based on intra-operatively obtained images (eg fluoroscopy, ultrasound)* and 20987, *Computer*

assisted surgical navigational procedure for musculoskeletal procedures; image-less; with image-guidance based on pre-operative images (eg, CT, MRI). Because of the low response rate (n = 25) and the service performance rate (median = 0), the RUC concluded that the survey results were unreliable and could not make an appropriate recommendation of physician work based on these data. Due to the discussions at the meeting, it became apparent to the RUC that these services are not performed and that the Panel did not have appropriate evidence to support the conversion of these codes from Category III codes to Category I codes. Therefore, the RUC and the specialty society agree that the service does not require a Category I CPT code and may be better described as a Category III code.

The RUC recommends that CPT code 20986 and 20987 be valued as carrier priced for CPT 2008. The RUC recommends that the CPT Editorial Panel rescind Category I status and reinstate Category III status for 20986 and 20987.

Practice Expense
There were no practice expense inputs in either the facility setting or non-facility setting for these add-on codes.

Femoral Head Fracture Treatment (Tab 5)
Dale Blasier, MD, American Academy of Orthopaedic Surgery (AAOS) and William Creevey, MD, Orthopaedic Trauma Association (OTA)

The CPT Editorial Panel created three new Category I CPT codes to describe services performed by orthopedists that are distinctly different from the treatment of other proximal femoral fractures, involving the femoral neck, intertrochanteric or subtrochanteric regions. Whereas these other fractures do not involve the femoral head (i.e. the cartilage covered "ball" of the hip joint's "ball joint articulation") fractures of the femoral head are both intraarticular and intracapsular by definition. These injuries may involve any part of the femoral head. Displaced fractures, especially those involving the superior head, place the hip joint at grave risk for developing osteoarthritis (degeneration of the joint) as the weight bearing portion is affected directly. New codes are necessary to reflect the management of these patients and the varied injury patterns that have been described. An open treatment code is required as the procedure is distinctly different from the treatment of other proximal femoral fractures as fractures of the head usually require a hip arthrotomy with a surgical dislocation of the hip to affect a repair and place internal fixation.

27267
The specialty society presenters provided a detailed explanation to the RUC regarding service 27267, *Closed treatment of femoral fracture, proximal end, head; without manipulation.* Following the discussion, the RUC focused its attention on the number and level of the post-operative hospital and office visits.

The specialty society modified its recommendation to include two 99231 inpatient hospital visits, 1 99238 discharge management service, and 4 99212 office visits, bringing it in line with other femoral fracture codes. The RUC also discussed the allocation of the surveyed time and agreed with the specialty society that time as surveyed was incorrectly allocated to pre-service time and agreed with the changes the society made. The society referred to CPT code, 26600, *Closed treatment of metacarpal fracture, single; without manipulation, each bone*, (work RVU = 2.48, intra-service time = 15 minutes), in determination of the allocation of time between pre-, intra-, and post-service times. Following these changes, the society made a work RVU recommendation based on a building block methodology. In order to derive the IWPUT of 0.031, the RUC looked to the lowest level anesthesia service based on the PIPPA data (0.031), which is the same IWPUT as a generic evaluation and management service. Further, 26600, has an IWPUT of 0.024 and 27230, the society's original key reference service, has an IWPUT of 0.034, placing an imputed IWPUT of 0.031 appropriately among the similar services.

Pre-Service Time = 9 minutes x 0.0224 =	0.20
Intra-Service Time = 15 minutes x 0.031 =	0.47
Immediate Post Service Time = 5 minutes x 0.0224 =	0.11
2 x 99231 =	1.52
1 x 99238 =	1.28
4 x 99212 =	1.80
Total =	5.38

The resulting work RVU is 5.38. **The RUC recommends 5.38 work RVUs for 27267.**

27268

The specialty society presenters provided further explanation to the RUC regarding service 27268, *Closed treatment of femoral fracture, proximal end, head; with manipulation*. The RUC agreed with the presenters that the surveyed time differed from the actual time, after a more in-depth explanation of work typically involved in pre- and post-service time, the specialty society revised its recommendations of time to a pre-service evaluation of 7 minutes, pre-service positioning time of 2 minutes mirroring. These values mirror those of 27267 as the pre-service work is identical. 23268 is typically performed in the OR and the committee recommended pre-service scrub dress wait time of 10 minutes, intra-service time of 30 minutes, and immediate post-service time of 5 minutes. The RUC also discussed the appropriate hospital and office visits. The specialty society revised the recommended office and hospital visits to be in line with 27267 and the other services in the families of femoral fracture codes. The specialty society recommends and the RUC agrees that two 99231 in-patient hospital visits, one 99238 hospital discharge management service, and four 99212 office visits are appropriate. Following these changes, the

RUC was comfortable with the society's revised work RVU recommendation of the 25th percentile survey value of 7.00 work RVUs.

The RUC recommends 7.00 work RVUs for 27268.

The specialty society recommended and the RUC agreed that 27347, *Excision of lesion of meniscus or capsule (eg, cyst, ganglion), knee* (work RVU = 6.58) be used as an appropriate PLI crosswalk.

27269

The RUC reviewed CPT code 27269 *Open treatment of femoral fracture, proximal end, head, includes internal fixation, when performed.* The RUC reviewed the specialty society recommended times and made several modifications as listed below:

	Old Times (minutes) and Visits	New Times (minutes) and Visits
Pre-service Evaluation Time	40	25
Pre-service Positioning Time	20	20
Pre-service Scrub, Dress, Wait Time	15	15
Intra-Service Time	125	125
Immediate Post- Service Time	30	30
99231	2	2
99232	1	1
99233	1	0
99238	1	1
99212	2	3
99213	3	1

The RUC agreed that these new times and visits were more typical of the service being provided. The RUC reviewed the key reference code 27236 *Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement* (Work RVU=17.43) to the surveyed code. It noted that the surveyed code has more intra-service time associated with it than the reference code, 125 minutes and 90 minutes, respectively. Further, the RUC noted that the surveyed code requires more mental effort, judgment and technical skill to perform than the reference code. Lastly, the RUC noted that the IWPUT for this service given the revised times, visits and recommended RVU is 0.086. The RUC agreed that this is inline with the other services in the family and demonstrates a gradual and appropriate increase in intensity of services within the family. Therefore, the RUC recommends the 25th percentile of the survey data, 18.75 RVUs for 27269 as this value properly places this code in comparison to the reference code. **The RUC recommends 18.75 work RVUs for 27269.**

G-, J-, G-J, C-Tube Procedures (Tab 6)

Joel Brill, MD, Geraldine McGinty, MD, Klaus Mergener, MD, PhD, Nick Nickl, MD, Sean Tutton, MD, and Robert L. Vogelzang, MD American College of Radiology (ACR), American Gastroenterological Association (AGA), American Society for Gastrointestinal Endoscopy (ASGE), Society of Interventional Radiology (SIR)

The CPT Editorial Panel created nine new codes and revised one current code to describe the array of percutaneous gastrostomy, jejunostomy, gastro-jejunostomy or cecostomy tube procedures and services including initial placement, conversion, replacement and removal, as well as mechanical removal of obstructive material and injection of contrast for radiological evaluation of a tube.

At the April 2007 RUC meeting the RUC reviewed 49440 – 49465 and 43760. The RUC recognized that the survey response rates were low, ranging from 15-20 respondents for 49440-49465. The RUC noted that these procedures are frequently performed and the small number of respondents did not adequately represent these services as performed. The RUC recommended interim work RVUs until the September 2007 meeting, after the specialty societies resurveyed and were able to present representative recommendations. Additionally, code 43760 had a sufficient response rate of 40 respondents however, the recommended value is linked to 49450 and the specialty society determined that it should be resurveyed as well.

The RUC reviewed the specialty society recommendations for 49440-49465 and 43760 at the September 2007 RUC meeting. The RUC recommendations are as follows:

49440 *Insertion of gastrostomy tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report*

The RUC reviewed code 49440 and determined that the pre-service times should be equal to code 43246 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube* (physician pre-evaluation time = 35 minutes, pre-positioning time = 8 minutes and pre-scrub, dress, and wait time = 5 minutes). Therefore, the RUC determined the evaluation time should be 35 minutes and the pre-service positioning time should be reduced to 8 minutes and the pre-service scrub, dress, wait time should be reduced to 5; for a total pre-service time of 48 minutes. The RUC then determined that the intra-service time should be reduced by 7 minutes to total 38 minutes, which is equal to reference code 43246 (intra-service time = 38 minutes). The RUC recommends the specialty society surveyed immediate post-service time of 20 minutes.

In order to determine the appropriate work RVU for code 49440 the RUC used code 43205 *Esophagoscopy, rigid or flexible; with band ligation of esophageal varices* (work RVU=3.78, 000 day global) a similar service as a base. The RUC then added 0.76 RVU to account for the one 99231 hospital visit included in 49440 (3.78+0.76=4.54). The RUC then reduced the work RVU by 0.36, accounting for the 7 minute reduction in intra-service work intensity (0.052 IWPUT x 7 minutes = 0.36).

The RUC had a discussion on what type of post-operative visit would occur. Since the typical patient would be a patient who had a stroke, the post-operative visit would typically be a 99231 hospital visit. The specialty society indicated and the RUC agreed that code 49041 *Drainage of subdiaphragmatic or subphrenic abscess; percutaneous* (work RVU=3.99) and 43246 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube* (work RVU=4.32) would also serve as supporting reference codes for 49440-49442.

The RUC recommends a work RVU of 4.18 for code 49440 (4.54-0.36=4.18).

Code 43205	3.78
99231	+0.76
	4.54
0.052 IWPUT x 7 minutes	-0.36
Work RVU	**4.18**

49441 *Insertion of duodenostomy or jejunostomy tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report*

The RUC reviewed the pre-service time for code 49441 and determined that the pre-service times should be equal to code 43246 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube tube* (physician pre-evaluation time = 35 minutes, pre-positioning time = 8 minutes and pre-scrub, dress, and wait time = 5 minutes) and recommended physician time for code 49440 (physician pre-evaluation time = 35 minutes, pre-positioning time = 8 minutes and pre-scrub, dress, and wait time = 5 minutes). Therefore, the RUC recommends that the pre-service evaluation time should be the specialty society survey median of 35 minutes, the pre-service positioning time should be reduced to 8 minutes and the pre-service scrub, dress, wait time should be reduced to 5 minutes; totaling 48 minutes. The specialty society recommended and the RUC agreed that the survey 25th percentile intra-service time of 45 minutes appropriately accounted for the time required to perform this service. The RUC recommends the specialty society surveyed immediate post-service time of 20 minutes.

The specialty society and the RUC examined the physician work involved and determined that the 25th percentile work RVU (4.46) with adjustment to the post-operative visits, would appropriately account for the physician work required to perform code 49441. The specialty society determined and the RUC agreed that the 99212 office visit (0.45) should be removed and a 99231 hospital visit (0.76) should be added to code 49441 (4.46-0.45+0.76=4.77).

The RUC had a discussion on what type of post-operative visit would occur. Since the typical patient would be a patient who had a stroke, the post-operative visit would typically be a 99231 hospital visit. The specialty society indicated and the RUC agreed that code 49041 *Drainage of subdiaphragmatic or subphrenic abscess; percutaneous* (work RVU=3.99) and 43246 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube* (work RVU=4.32) would also serve as supporting reference codes for 49440-49442.

The RUC recommends a work RVU of 4.77 for code 49441.

49442 *Insertion of cecostomy or other colonic tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report*

The RUC reviewed the pre-service time for code 49442 and determined that the pre-service times should be equal to code 43246 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy* (physician pre-evaluation time = 35 minutes, pre-positioning time = 8 minutes and pre-scrub, dress, and wait time = 5 minutes) and recommended physician time for code 49440 (physician pre-evaluation time = 35 minutes, pre-positioning time = 8 minutes and pre-scrub, dress, and wait time = 5 minutes). Therefore, the RUC recommends that the pre-service evaluation time should be reduced to 35 minutes, the pre-service positioning time should be reduced to 8 minutes and the pre-service scrub, dress, wait time should be reduced to 5 minutes; totaling 48 minutes. The specialty society recommended and the RUC agreed that the survey 25th percentile intra-service time of 30 minutes appropriately accounted for the time required to perform this service. The RUC recommends the specialty society surveyed immediate post-service time of 20 minutes.

The specialty society and the RUC examined the physician work involved and determined that the 25th percentile work RVU (4.00) appropriately accounts for the physician work required to perform code 49442. The specialty society determined and the RUC agreed that the 99212 office visit should be removed and a 99231 hospital visit should be added to code 49442.

The RUC had a discussion on what type of post-operative visit would occur. Since the typical patient would be a patient who had a stroke, the post-operative visit would typically be a 99231 hospital visit. The specialty society indicated and the RUC agreed that code 49041 *Drainage of subdiaphragmatic or subphrenic abscess; percutaneous* (work RVU=3.99) and 43246 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube* (work RVU=4.32) would also serve as supporting reference codes for 49440-49442.

The RUC recommends the survey 25th percentile work RVU of 4.00 for code 49442.

49446 *Conversion of gastrostomy tube to gastro-jejunostomy tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report*

The specialty society believed that respondents may have slightly overestimated the pre-service time. The RUC reviewed specialty society surveyed pre-service physician time for code 49446 and determined that the pre-service evaluation time should be the specialty society surveyed 25 minutes, the pre-service positioning time should be reduced to 5 minutes and the pre-service scrub, dress, wait time should be reduced to 8 minutes; totaling 38 minutes. The specialty society recommended and the RUC agreed that the survey median intra-service time of 40 minutes appropriately accounted for the time required to perform this service. The RUC recommends the specialty society surveyed immediate post-service time of 15 minutes.

The specialty society indicated and the RUC agreed that codes 49041 *Drainage of subdiaphragmatic or subphrenic abscess; percutaneous* (work RVU=3.99) and 43245 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with dilation of gastric outlet for obstruction (eg, balloon, guide wire, bougie)* (work RVU= 3.18) would also serve as a supporting reference codes for code 49446.

The specialty society and the RUC examined the physician work involved and determined that the 25th percentile work RVU of 3.31 placed code 49446 in the proper rank order. **The RUC recommends the 25th percentile work RVU of 3.31 for code 49446.**

49450 *Replacement gastrostomy or cecostomy (or other colonic) tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report*

The RUC reviewed the specialty society surveyed pre-service time for code 49450 and determined that the pre-service evaluation time should be reduced to

20 minutes, the pre-service positioning time should be 5 minutes and the pre-service scrub, dress, wait time should be reduced to 5 minutes; totaling 30 minutes. The specialty society recommended and the RUC agreed that the survey 25th percentile intra-service time of 10 minutes appropriately accounted for the time required to perform this service. The RUC recommends the surveyed post-service time of 10 minutes.

The specialty society and the RUC examined the physician work involved in order to perform code 49450. The RUC compared code 49450 to the survey reference service code 49423 *Exchange of previously placed abscess or cyst drainage catheter under radiological guidance (separate procedure)* (work RVU=1.46) and determined that the 25th percentile work RVU of 1.50 minus the reduction of pre-service time appropriately valued this procedure at 1.36. Additionally, the RUC determined that code 36580 *Replacement, complete, of a non-tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access* (work RVU=1.31, physician times = 20 minutes pre-service time, 15 minutes intra-service time and 10 minutes immediate post-service time) is another appropriate reference service.

The RUC recommends a work RVU of 1.36 for code 49450.

49451 *Replacement duodenostomy or jejunostomy tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report*

The RUC reviewed the specialty society surveyed pre-service time for code 49451 and determined that the pre-service evaluation time should be reduced to 20 minutes, the pre-service positioning time should be 5 minutes and the pre-service scrub, dress, wait time should be reduced to 5 minutes; totaling 30 minutes. The specialty society recommended and the RUC agreed that the specialty society survey 25th percentile intra-service time of 15 minutes appropriately accounted for the time required to perform this service. The RUC recommends the specialty society surveyed immediate post-service time of 10 minutes.

The specialty society and the RUC examined the physician work involved in order to perform code 49451. The RUC determined that the 25th percentile work RVU of 1.98 minus the reduction of pre-service time appropriately valued this procedure at 1.84. Additionally, the RUC compared code 49451 to codes 57456 *Colposcopy of the cervix including upper/adjacent vagina; with endocervical curettage* (work RVU = 1.85) and 57410 *Pelvic examination under anesthesia* (work RVU=1.75, physician times = 30 minutes pre-service time, 15 minutes intra-service time and 25 minutes immediate post-service time). The RUC determined that code 49451 was comparable to reference codes 57456 and 57410 and a work RVU of 1.84 appropriately captures the physician work and time involved to perform this procedure.

The RUC recommends a work RVU of 1.84 for code 49451.

49452 *Replacement gastro-jejunostomy tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report*

The RUC reviewed the specialty society surveyed pre-service time for code 49452 and determined that the pre-service evaluation time should be reduced to 20 minutes, the pre-service positioning time should be 5 minutes and the pre-service scrub, dress, wait time should be reduced to 5 minutes; totaling 30 minutes. The specialty society recommended and the RUC agreed that the specialty society survey 25th percentile intra-service time of 20 minutes appropriately accounted for the time required to perform this service. The RUC recommends the specialty society surveyed immediate post-service time of 10 minutes.

The specialty society and the RUC examined the physician work involved in order to perform code 49452. The RUC determined that the 25th percentile work RVU of 3.00 minus the reduction in pre-service time appropriately values this procedure at 2.86. Addtionally, the RUC compared code 49452 to codes 46615 *Anoscopy; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique* (work RVU=2.68, physician times = 25 minutes pre-service time, 20 minutes intra-service time and 13 minutes of immediate post-service time) and 57460 *Colposcopy of the cervix including upper/adjacent vagina; with loop electrode biopsy(s) of the cervix* (work RVU = 2.83, physician times = 15 minutes pre-service time, 25 minutes intra-service time and 10 minutes of immediate post-service time). The RUC determined that code 49452 was comparable to reference codes 46615 and 57460 and a work RVU of 2.86 appropriately captures the physician work and time involved to perform this procedure.

The RUC recommends a work RVU of 2.86 for code 49452.

49460 *Mechanical removal of obstructive material from gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy or cecostomy (or other colonic) tube, any method, under fluoroscopic guidance including contrast injection(s) if performed, image documentation and report*

The RUC reviewed the specialty society surveyed pre-service time for code 49460 and determined that the pre-service evaluation time should be reduced to 20 minutes, the pre-service positioning time should be 5 minutes and the pre-service scrub, dress, wait time should be reduced to 5 minutes; totaling 30 minutes. The specialty society recommended and the RUC agreed that the survey 25th percentile intra-service time of 15 minutes appropriately accounted for the time required to perform this service. The RUC recommends the specialty society surveyed immediate post-service time of 10 minutes.

The specialty society and the RUC examined the physician work involved in order to perform code 49460. The RUC determined that the 25th percentile work RVU of 1.10 minus the reduction in pre-service time appropriately values this procedure at 0.96. Additionally, the RUC compared code 49460 to codes 36596 *Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen* (work RVU=0.75, physician times = 23 minutes pre-service time, 9 minutes intra-service time and 5 minutes immediate post-service time) and 75902 *Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen, radiologic supervision and interpretation* (work RVU=0.39, physician times = 5 minutes pre-service time, 10 minutes intra-service time and 5 minutes immediate post-service time). Therefore, by adding the two work RVUs together (0.75+0.39=1.14) the reference RVU would be 1.14. The RUC also compared code 49460 to code 45307 *Proctosigmoidoscopy, rigid; with removal of foreign body* (work RVU=0.94, physician times = 25 minutes pre-service time, 15 minutes intra-service time and 10 minutes immediate post-service time). The RUC determined that code 49460 was comparable to reference code 45307 and a work RVU of 0.96 appropriately captures the physician work and time involved to perform this procedure.

The RUC recommends a work RVU of 0.96 for code 49460.

49465 *Contrast injection(s) for radiological evaluation of existing gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy, or cecostomy (or other colonic) tube, from a percutaneous approach including image documentation and report*

The specialty society believed that respondents may have slightly overestimated the pre-service time. The RUC reviewed the pre-service time for code 49465 and agreed with the specialty society recommendation to reduce the pre-service evaluation time to 5 minutes, reduce the pre-service positioning time to 5 minutes and reduce the pre-service scrub, dress, wait time to 5 minutes; totaling 15 minutes. The RUC determined that the survey median intra-service time of 10 minutes for 49465 was appropriate. The RUC recommends the specialty society surveyed immediate post-service time of 10 minutes.

The RUC compared code 49465 to the key reference code stated at from the interim meeting 36598 *Contrast injection(s) for radiologic evaluation of existing central venous access device, including fluoroscopy, image documentation and report* (work RVU=0.74, physician times = 15/10/10). The RUC determined that reference code 36598 requires more mental effort, technical skill and psychological stress than code 49465. The RUC also reviewed the following to develop a work RVU:

1.36	49450 recommendation
-0.90	43760 recommendation

0.46 is too low of an RVU for 49465

The RUC determined that a work RVU of 0.46 for code 49465 would be too low and the median work RVU of 0.76 or reference service code 36598 (work RVU=0.74) would be too high, as both values would not place code 49465 in the proper rank order. Therefore the RUC recommends the April 2007 interim work RVU of 0.62 for code 49465. Additionally, the RUC compared code 49465 to code 36575 *Repair of tunneled or non-tunneled central venous access catheter, without subcutaneous port or pump, central or peripheral insertion site* (work RVU=0.67, physician times = 15 minutes of pre-service time, 15 minutes of intra-service time and 9 minutes immediate post-service time). The RUC determined that code 49465 was comparable to reference code 36575 and a work RVU of 0.62 appropriately captures the physician work and time involved to perform this procedure.

The RUC recommends a work RVU of 0.62 for code 49465.

43760 *Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance*

At the April 2007 meeting the RUC reviewed the survey results for 43760 and agreed with the specialty society that the surveyed pre-service time did not reflect that this service is typically performed in the outpatient emergency room setting. The RUC decreased the pre-service physician time to reflect the typical site of service. The RUC determined that the surveyed median of 1.15 RVUs should be reduced to reflect the lack of fluoroscopic guidance and image documentation, but also that the service be relative to other cross specialty services.

Code	Pre-Eval	Pre-Pos	Pre-SDW	Intra	Post	Visits	Work RVU	Reference Code	PLI Crosswalk
49440	35	8	5	38	20	1 - 99231	4.18	43246 and 49041	43246
49441	35	8	5	45	20	1 - 99231	4.77	43246 and 49041	43246
49442	35	8	5	30	20	1 - 99231	4.00 (25^{th} %)	43246 and 49041	43246
49446	25	5	8	40	15	N/A	3.31 (25^{th} %)	49041	49041
49450	20	5	5	10	10	N/A	1.36	36580	36580
49451	20	5	5	15	10	N/A	1.84	57410	57410
49452	20	5	5	20	10	N/A	2.86	46615	46615
49460	20	5	5	15	10	N/A	0.96	36596 and 75902	36596

49465	5	5	5	10	10	N/A	0.62	36598	36598
43760	10	5	2	10	5	N/A	0.90	99213	99213

The RUC reviewed the following codes and believed the overall physician work was similar in intensity and complexity and physician time.

99282 *Emergency department visit for the evaluation and management of a patient* (Work RVU = 0.88)
99213 *Office or other outpatient visit for the evaluation and management of an established patient* (Work RVU = 0.92)

The RUC determined that a reduction of 0.25 work RVUs from the survey median of 1.15 reflects the lack of fluoroscopic guidance and documentation and places the service in the correct rank order with other services on the physician payment schedule (1.15-0.25=0.90). In addition, the specialty survey 25th percentile results was comparable to 0.90, with a work RVU of 0.95.

The RUC recommends a work RVU of 0.90, the same as the April 2007 interim value, for code 43760.

Conscious Sedation
At the April 2007 meeting, the RUC determined that conscious sedation was only inherent in codes 49440, 49441, 49442 and 49446 but <u>not</u> for any other code in this family. The RUC recommends no conscious sedation components in the practice expense for codes 49450, 49451, 49452, 49460, 49465 and 43760.

Practice Expense
The specialty society recommends the practice expense inputs approved by the PERC at the April 2007 meeting, with revisions to the assist physician time and post-operative visits. The practice expense recommendations are attached.

X. Relative Value Recommendations for CPT 2009

<u>Tongue Base Tissue Volume Reduction (Tab 7)</u>
Peter Weber, MD and Samuel Mickelson, MD, American Academy of Otolaryngology – Head and Neck Surgery (AAO-HNS)

With the increasing recognition of sleep disordered breathing due to retro-lingual airway narrowing, tongue base tissue volume reduction has become a commonly used method for surgical management as it is designed to create a larger oropharyngeal airway and help prevent obstruction at this site during sleep. To address this more commonly used method of surgical management, the CPT Editorial Panel replaced a Category III codes with a Category I code to describe tongue base tissue volume reduction.

The RUC reviewed 41XXX *Submucosal ablation of the tongue base, radiofrequency, one or more sites, per session.* The specialty presented data from 35 otolaryngologists. A recommendation slightly more than the 25 percentile of the survey data was not accepted by the RUC. The RUC garnered further information about the procedure including that 80 percent of these procedures are performed in a facility setting and 20 percent are performed in the non-facility setting. The service is performed under local anesthesia. Further, the RUC learned that typically there are no more than 6 sites ablated and it takes 6-10 minutes per site. The RUC reviewed the times and visits associated with this procedure and determined that the 2 office visits were appropriate in a the 010 day global period as there is a need to check for artery swelling.

The committee agreed with the specialty society that the surveyed code has the same intra-service intensity as compared to the reference code, 30520 *Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft* (Work RVU=6.85, IWPUT = 0.041). Therefore, the committee used a building block approach to evaluate the surveyed code. The committee used the specialty society recommended times and associated work RVUs as well as the reference service's IWPUT to compute a recommended value as described below:

Time	Intensity	Work RVU
25 minutes of Pre-Service Evaluation and Positioning Time	0.0224	0.56
15 minutes of Pre-Service Scrub, Dress & Wait Time	0.0081	0.12
30 minutes of Intra-Service Time	0.041	1.24
20 minutes of Post-Service Time	0.0224	0.45
0.5 – 99238	1.28	0.64
1.0 – 99212	0.45	0.45
1.0 – 99213	0.92	0.92
Total RVUs		4.38

The RUC agrees that 4.38 work RVUs is an appropriate value for this procedure as compared to other reference codes which have similar times and intensities including 62264 *Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day* (Work RVU=4.42) which has a pre-service time of 40 minutes, intra service times of 30 minutes and a post-service time of 20

minutes and 43887 *Gastric restrictive procedure, open; removal of subcutaneous port component only* (Work RVU=4.24) which has a pre-service time of 45 minutes, an intra-service time of 30 minutes and a post-service time of 20 minutes. An additional reference is 51102 *Aspiration of bladder; with insertion of suprapubic catheter* (Work RVU=4.27) which has a pre-service time of 33 minutes, an intra-service time of 30 minutes and a post-service time of 20 minutes. Because of all of these reference services as well as further support from the building block methodology employed by the RUC, the RUC believes that 41XXX is appropriately valued at 4.38 Work RVUs. **The RUC recommends 4.38 Work RVU for 41XXX**.

Practice Expense:
The RUC reviewed the proposed practice expense inputs for 411XX and modified them to reflect the appropriate number and level of office visits and include several pieces of supplies including an endoscope for the first office visit and equipment necessary to perform the procedure.

Tongue Suspension (Tab 8)
Peter Weber, MD and Samuel Mickelson, MD, American Academy of Otolaryngology – Head and Neck Surgery (AAO-HNS)

With the increasing recognition of sleep disordered breathing/obstructive sleep apnea syndrome due to retro-lingual airway narrowing, tongue base suspension has become a commonly used method for surgical management. Tongue base suspension is designed to create a larger retrolingual airway and help prevent airway obstruction at this site during sleep.

The RUC reviewed 415XX *Tongue base suspension, permanent suture technique.* The specialty presented data for 54 otolaryngologists. The RUC determined that the survey 25th percentile as recommended by the specialty overstated the amount of work associated with this procedure.

The committee agreed with the specialty society that the surveyed code has the same intra-service intensity as compared to the reference code, 21685 *Hyoid myotomy and suspension (*Work RVU=14.89, IWPUT = 0.047). Therefore, the committee used a building block approach to evaluate the surveyed code. The committee used the specialty society recommended times and associated work RVUs as well as the reference service's IWPUT to compute a recommended value as described below:

Time	Intensity	Work RVU
30 minutes of Pre-Service Evaluation and Positioning Time	0.0224	0.67
15 minutes of Pre-Service	0.0081	0.12

Scrub, Dress & Wait Time		
60 minutes of Intra-Service Time	0.047	2.82
30 minutes of Post-Service Time	0.0224	0.67
0.5 – 99238	1.28	0.64
2.0 – 99212	0.45	0.90
1.0 – 99213	0.92	0.92
Total RVUs		6.75

The RUC agrees that 6.75 work RVUs is an appropriate value for this procedure as compared to other reference codes which have similar times and intensities including 30520 *Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft* (Work RVU=6.85) which has a pre-service time of 38.5 minutes, an intra-service time of 60 minutes and a post-service time of 15 minutes and 49325 *Laparoscopy, surgical; with revision of previously placed intraperitoneal cannula or catheter, with removal of intraluminal obstructive material if performed* (Work RVU=6.77) which has a pre-servie time of 40 minutes, an intra-servie time of 60 minutes and a post-servie time of 20 minutes. Because of these reference services as well as further support from the building block methodology employed by the RUC, the RUC believes that 415XXX is appropriately valued at 6.75 Work RVUs. **The RUC recommends 6.75 Work RVU for 415XXX**.

Practice Expense:
The RUC reviewed the proposed practice expense inputs for 415XX and modified them to reflect the appropriate number and level of office visits and include several pieces of equipment necessary to perform the procedure.

<u>Laparoscopic Abdominal Wall Hernia Repair (Tab 9)</u>
Michael Edye, MD, Christopher Senkowski, MD, and Guy Orangio, MD, American College of Surgeons (ACS), American Society of Colon and Rectal Surgeons (ASCRS), and Society of American Gastrointestinal Endoscopic Surgeons (SAGES)

In June 2007, the CPT Editorial Panel created six new CPT codes to describe the specific levels of work associated with abdominal hernia repairs that are being performed frequently with laparoscopic techniques. This new type of surgery is different from the open repair of abdominal wall hernia that involves placement of mesh prosthesis on the surface of the muscle layers through the incision, whereas these new procedure codes describe the laparoscopic placement of the mesh behind the fascia and muscle layers, where it is affixed to the abdominal wall muscles. All of these laparoscopic repairs are performed within the peritoneal cavity, in open procedures only enough abdominal wall for suture or mess positioning would typically be exposed and in many circumstances entry into the

peritoneal cavity would be avoided or limited. In these procedures, the laparoscope must be free to see the edges of the hernia defect and for trocar / instrument placement, therefore complete freedom of the intra-abdominal portion of the abdominal wall from adherent bowel and omentum is necessary for safe mesh placement.

Laparoscopic repair procedures such as these are typically reserved for larger hernias, general anesthesia is always required, and a larger mesh is nearly always implanted. Although, these laparoscopic procedures result in significantly lower incidence of incisional pain and morbidity related to the incision, these patients do have considerable postoperative pain from the fixation of the sensitive peritoneal surface and are typically provided postoperative narcotics. Patients are also susceptible to postoperative ileus, and patients typically require inpatient hospital care and postoperative follow up visits with their physician.

The RUC reviewed the specialty society's survey results for these six new laparoscopic surgical repair of a hernia using mesh insertion and understood that the utilization for these types procedures would not change with this coding change. Therefore, the RUC believes that there will be no budget neutrality impact for these recommendations.

The RUC also understood that laparoscopic repairs such as these cannot be considered as simply laparoscopic equivalents for open repairs since these are performed within the peritoneal cavity and extensive adhesiolysis is typically a major part of each procedure. However RUC also believed the specialty survey median physician work values for 496XX0 – 496XX4 were greater than the typical patient scenario should warrant. The RUC therefore believed that these codes should be valued at the specialty society's 25th percentile survey results for physician work, and to insure proper rank order in work values and intra-service work intensities, the RUC reviewed all the codes as a family.

496XX0 F1 *Laparoscopy, surgical repair ventral, umbilical, Spigelian or epigastric hernia (includes mesh insertion, when performed); reducible* The RUC reviewed code 496X0 and believed that in relation to its key reference code 49560 *Repair initial incisional or ventral hernia; reducible* (work RVU = 11.84, 90 minutes intra-service time) the surveyed code has more post operative discharge day management time associated. The RUC also understood that the mesh implantation requires additional work (valued at 4.88 RVUs), however in relation to code 496XX2 the value would have to be lower than the sum of its parts (11.84 RVUs from code 49560 plus 4.88 equals 16.72). The RUC therefore believed that the specialty society's 25th percentile survey results of 12.80 reflected the true value for new code 496XX0. **The RUC recommends a work RVU of 12.80 for code 496XX0.**

496XX1 F2 *Laparoscopy, surgical repair ventral, umbilical, Spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or*

strangulated The RUC reviewed the physician work of code 496XX5 as an anchor for this new code and the entire family of laparoscopic surgical abdominal wall hernia repair codes. The RUC reviewed the relativity amongst the family of codes and believed in maintaining rank order at the 25th percentile survey results while understanding the similarities in physician work between codes 496XX1 and 496XX5. The RUC also reviewed code key reference code 49566 *Repair recurrent incisional or ventral heria; incarcerated or strangulated* (work RVU = 15.45) in relation to 496XX1 and understood that with the mesh insertion the new code should be valued below code 15.45. In order to maintain the rank order between 496XX1, 496XX5, and 49566 related to the intra-service work per unit of time, the committee agreed and **recommends a work RVU of 14.95 for code 496XX1.**

496XX2 F3 *Laparoscopy, surgical repair incisional hernia (includes mesh insertion, when performed); reducible*
The RUC believed in maintaining rank order in intensity and physician work throughout the family and therefore believed the 25th percentile specialty work RVU survey results were appropriate. The committee understood that the median physician work time (120 minutes) was also appropriate considering the key reference code 44180 *Laparoscopy, surgical, enterolysis (freeing of intestinal adhesion) (separate procedure)* (work RVU = 15.19, 120 intra-service time) and mesh insertion. **The RUC recommends a relative work RVU of 16.10 for code 496XX2.**

496XX3 F4 *Laparoscopy, surgical repair incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated*
The RUC reviewed code 496XX3 in relation to the anchor code, 496XX5, and understood that the recurrent procedure was more work and more intense than this code. However, the surveyed physician work and time is greater than 496XX4. The RUC believed the relative work value was between the 25th percentile survey results (17.20) and the median (20.00). The RUC agreed that code 43280 *Laparoscopy, surgical, esophagogastric fundoplasty (eg, Nissen, Toupet procedures)* (work RVU = 18.00, 150 minutes of intra-service time) had similar overall physician work and required the same intra-service time. **The RUC recommends a work relative value of 18.00 for code 496XX3.**

496XX4 F5 *Laparoscopy, surgical repair recurrent incisional hernia (includes mesh insertion, when performed); reducible*
Within this new family of procedure codes, the RUC believed codes that are "reducible", are slightly less intense than the "incarcerated or strangulated" codes. In relation to the specialty surveyed key reference service code 49565 *Repair recurrent incisional or ventral hernia; reducible* (work RVU = 12.29, 100 minutes intra-service time), the RUC believed the recommended value of 17.25 for 496XX4 was generous and that it was greater than the sum of its parts (key reference code for the repair plus the implantation of the mesh (code 49568 – work RVU 4.88 = 17.17). The RUC and specialty believed that to maintain physician work intensity

rank order, the value should be lower. The committee also reviewed code 58545 *Laparoscopy, surgical, myomectomy, excision; 1 to 4 intramural myomas with total weight of 250 g or less and/or removal of surface myomas* (work RVU = 15.45, 120 minutes of Intra-service time) in relation to the specialty's 25th percentile survey results. The RUC agreed that the 25th percentile specialty survey results provided for the proper rank order with the family of codes and the proper work value. **The RUC recommends a relative work value of 15.00 work RVUs for code 496XX4.**

496XX5 F6- *Laparoscopy, surgical repair recurrent incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated* The RUC discussed new service 496XX5 in relation to its key reference service 49566 Repair recurrent incisional or ventral hernia; incarcerated or strangulated (Work RVU = 15.45) with the understanding that they are similar services, however the laparoscopic approach involves more work, time, and intensity than the open approach. Laparoscopic repair procedures such as these are typically reserved for larger hernias, general anesthesia is always required, and a larger mesh is nearly always implanted. These procedures are performed within the peritoneal cavity and extensive adhesiolysis is typically a major part of each procedure.

The committee also discussed the physician time components carefully and believed for the survey data reflected the typical patient scenario. The survey results supported a higher value than the key reference service and the committee linked the physician work intensity to MPC code 44140 *Colectomy, partial; with* anastomosis (Work RVU = 22.46, 150 minutes of intra-service time, IWPUT = 0.72). The committee believed code 496XX5 could serve as an anchor for the rest of this new family of codes. **The RUC recommends 22.00 work RVUs for code 496XX5**

Practice Expense
The practice expense for these facility only codes was reviewed and modified slightly to reflect the 090 day standard facility standard direct practice expense inputs.

Echocardiography (Tab 10)

Thomas Ryan, MD, Michael Picard, MD, and Benjamin Byrd, III, MD, American College of Cardiology (ACC)

Background
For the 2005 Five Year Review, CMS originally requested review of CPT Code 93325 *Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)* (work RVU = 0.07, ZZZ global) as it had not been reviewed by the RUC. The American College of Cardiology (ACC) surveyed the code and recommended an increased work RVU to the RUC. During that meeting, the RUC reviewed the specialty's survey results and

rationale and noted that code 93307 *Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete* (work RVU = 0.92, XXX global period) was almost always billed with 93325. The RUC recommended code 93325 be referred to the CPT Editorial Panel for consideration for bundling with 93307.

During the October 2006 RUC meeting, the RUC was informed that CPT code 93325, had not yet been reviewed by the CPT Editorial Panel following the most recent Five-Year Review. The specialty society had indicated to CPT that it did not intend to submit a CPT code proposal. Although the RUC indicated an interest in bundling the service with other cardiology services, ACC argued that bundling is inappropriate due to the service's varied utilization pattern with a wide variety of other services. Since ACC did not develop a bundled coding proposal and the CPT Panel Executive Committee did not discuss it, the RUC would need to examine the code again.

The specialty presented their 2005 survey data results for 93325 at the February 2007 RUC meeting. The RUC also reviewed data from the 2005 Medicare Utilization files for 93325 and other services in this family of codes. The RUC discussed the inherent nature of providing the services described in 93325, 93307, and 93320 *Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete* on the same day by the same physician, as illustrated in the following table:

Same Day Occurrences for 93325 with Codes Billed Together at Least 90% of the Time

Produced from the 2005 5% Sample File

CPT Code 1	CPT Code 2	Code 1 Services	Same Day Billed Occurrences	% of Time Code 1 Billed with Code 2
93325	93320	138,398	136,433	98.58%
93325-TC	93320-TC	23,039	22,645	98.29%
93325-26	93320-26	211,640	206,755	97.69%
93325	93307	13,8398	130,949	94.62%
93325-TC	93307-TC	23,039	22,298	96.78%
93325-26	93307-26	211,640	197,093	93.13%

The RUC discussed its policy for other services that are inherent in the provision of physician services. For example, when conscious sedation is inherent to procedures it is included within the valuation of the procedure and not reported separately. Likewise, the CPT Editorial Panel has moved to an approach of including radiological guidance within a new CPT code if it is inherent to the procedure. The RUC understood that the American College of Cardiology is

taking a long-term, broad review of their services and welcomed this approach. However, the data for 93320, 93325, and 93307 is clear and the RUC recommended a coding proposal be prepared by the specialty society to immediately address this as one service versus three distinct services.

In June 2007, the CPT Editorial Panel edited four codes and created a new code that reflects the work of CPT codes 93307, 93320 and 93325 when performed together. The panel created new code 933XX *Echocardiography, transthoracic real-time with image documentation (2D), including M-mode recording if prerformed, with spectral Doppler echocardiography, and with color flow Dopper echocardiographty* which combined the following three codes into one service:

- 93307 *Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete* (work RVU = 0.92)
- 93320 *Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete* (work RVU = 0.38)
- 93325 *Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)* (work RVU = 0.07)

This CPT code revision was in response to changes in clinical practice that have generally made the performance of spectral and color flow Doppler an integral part of a complete transthoracic echocardiogram. The introduction of the new code serves to maintain 93307 (two dimensional echocardiography) and to preempt coding confusion for the instance when imaging without color flow or velocity information is requested. In addition, the CPT Editorial Panel made necessary editorial changes in the introductory language of Echocardiography to accommodate the new code.

RUC Review and Recommendation
In September 2007, the RUC reviewed the specialty society's survey results of the physician work for new code 933XX from a random sample of 597 physicians. The specialty received a response rate of 16.4% (nearly 100 respondents) that indicated the physician work was believed to approximate the sum of its inherent procedure codes (93307+93320+93325). The median survey results indicated a work RVU of 1.44 which is slightly more than the sum of its parts (0.92+0.38+0.07 = 1.37). The specialty society indicated that the majority of echocardiography laboratories have shifted from image recording on videotape to digital image recording. While the physician is now able to review recorded images and associated flow velocity waveforms in a shorter period of time due to the use of digital technology, the interpreting physician actually reviews more data (and provides more complex analyzes) in a shorter period of time. The specialty society's RUC Advisory Committee believed that the intensity of the

physician work had increased, and compared the work to several other codes as reference points, including:

- 76485 *Myocardial perfusion imaging; tomographic (SPECT), multiple studies (including attenuation correction when performed), at rest and/or stress (exercise and/or pharmacologic) and redistribution and/or rest injection, with or without quantification* (Work RVU = 1.46, 2005 Five Year Review Code)
- 78708 *Cardiac blood pool imaging, gated equilibrium, SPECT, at rest, wall motion study plus ejection fraction, with or without quantitative processing* (Work RVU = 1.19, RUC Multi-specialty Points of Comparison Listed)
- 93975 *Echocardiography, transthoracic, real-time with image documentation (2D), with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report* (Work RVU = 1.48, 2000 Five Year Review Code)
- 70551 *Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material* (Work RVU = 1.48)

The specialty society's RUC Advisory Committee understood that although the intensity of the service had increased with imaging technological advances, the overall physician work may have decreased. This same committee reviewed the distribution of the survey results and noted that survey median physician time (31.50 minutes) is less than the building block time of 43 minutes and that there was a tight spread between the 25th and 75th percentiles (1.30 – 1.76). The specialty acknowledged that although the survey respondents indicated the physician work was slightly more (1.44) than the sum of its parts (1.37), the total physician time was lower by 11.5 minutes. The specialty therefore acknowledged that there are economies of scale when these services are provided together and recommended the 25th percentile survey results (Work RVU = 1.30) would provide the proper valuation of this new code.

The RUC reviewed the specialty recommendation for new code 933XX and believed that the specialty survey results provided an accurate depiction of the typical patient. The RUC reviewed the new bundled code in relation to code 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.* (Work RVU = 1.34, 20 minutes of intra-service time). The RUC believed that the rationale provided by the specialty was consistent with efficiency gains associated with performing these services together and their proposed physician work value of 1.30 is appropriate in relation to other services among and across specialties.

The RUC recommends a physician work relative value of 1.30 for code 933XX.

Practice Expense
The RUC reviewed the direct practice expense which was an additive approach from existing inputs (93307+93320+93325) which were reviewed and recommended by the RUC in March 2002. The RUC, understanding that the issue originated from the most recent Five Year Review, believed that than addition of these existing clinical labor, medical supplies, and equipment, provided an accurate set of direct inputs. The RUC did, however, believe that a reduction in the clinical staff time was appropriate due efficiencies in performing these services together. The RUC recommends a total clinical labor time of 82 minutes rather than the sum of its parts totaling 91 minutes, and no change to the medical supplies and equipment (other than a reduction in equipment time). The specialty society contended that the Echocardiography is now digitally recorded and a revision of the equipment for these services should be made. The RUC suggested this discussion should more appropriately be discussed either through formal request from CMS or as part of a Five Year Review of practice expense. An Excel spreadsheet is attached with these recommendations for the facility and non facility settings.

XI. CMS Requests

Anesthesia Services (Tab 11)
Tripti Kataria, MD, MPH, American Society of Anesthesiologists (ASA)

As part of the RUC's submission to CMS regarding the Anesthesia Workgroup's Recommendations from the April 2007 RUC meeting, the RUC also identified three anesthesia services that may be misvalued based on their analysis and recommended that CMS allow review of the base units at an upcoming RUC meeting:

00142 *Anesthesia for procedures on eye; lens surgery*
00210 *Anesthesia for intracranial procedures; not otherwise specified*
00562 *Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator*

AMA RUC Staff was informed that CMS agreed with this recommendation and these codes were placed on the agenda for the September 2007 RUC Meeting. As part of this recommendation, the RUC received a request from the American Society of Anesthesiologists (ASA) to refer 00210 and 00562 to the CPT Editorial Panel to revise the existing descriptors to provide better clarity. The RUC supports this request. **The RUC recommends that 00210 and 00562 be referred to the CPT Editorial Panel for revision.**

00142
The RUC reviewed the specialty society survey results for 00142 and compared it to key reference service 00147 *Anesthesia for procedures on eye; iridectomy* (Base Units = 4). The survey respondents indicated that code 00142 required the same mental judgment, technical skill and physical effort and psychological stress to perform as the key reference service 00147. The intensity/complexity measures broken into pre-, intra-, and post-anesthesia time frames are also comparable to the key reference service 00147. Additionally, the specialty society survey median and 25th percentile indicated a base unit of 4.

The RUC recommends the survey median base unit of 4 for code 00142.

XII. Direct Practice Expense Input Recommendation – CMS Requests:

Chemotherapy Administration (Tab 12)
American Academy of Dermatology, American Society of Clinical Oncology, American Society of Hematology

Chemotherapy Administration (96405 – 96542) were requested by CMS for review by the RUC, because their original CPEP direct practice expense inputs had never been reviewed. A level of interest for these codes was sent to specialties in June 2007

The RUC reviewed the specialty society's direct practice expense inputs for codes provided by the American Society of Clinical Oncology (96445, 96450, 96542) and made modifications to the clinical labor, medical supplies, and equipment. **The RUC recommends the attached direct practice expense inputs for codes 96445, 96450, and 96542.**

The RUC also reviewed recommendations submitted by the American Academy of Dermatology (96405-6), however the RUC could not evaluate the specific inputs without a more detailed spreadsheet of clinical activities. The RUC asked the society to provide detailed inputs for its next meeting.

The RUC did not receive a recommendation for code 96440 and deferred to the pulmonary and thoracic societies for comments/recommendations to be considered at the following RUC Practice Expense Subcommittee meeting.

Hypothermia (Tab 13)
No Interest

CPT codes 99185 *Hypothermia; regional* and 99186 *Hypothermia; total body* were requested by CMS for review by the RUC, because their original CPEP direct practice expense inputs had never been reviewed. A level of interest for the

two codes was sent to specialties in June 2007, however no specialty society expressed interest in developing a recommendation. The RUC based on this lack of specialty society interest and very low Medicare utilization refers these procedures to the CPT Editorial Panel for deletion. **The RUC recommends that codes 99185 and 99186 be referred to the CPT Editorial Panel for deletion.**

Dual Energy X-Ray Absorptiometry (Tab 14)
American Association of Clinical Endocrinologists

In September 2007 the RUC acknowledged that a mistake had been made in the specialty society's previous recommendation from earlier this year. Whereas the equipment item ER024 densitometry unit, whole body, DXA (pencil beam) was listed, and equipment item ER019 densitometry unit, fan bam, DXA (w- computer hardware and software) (fan beam axial DXA system –CMS valued at $85,000) should have been listed. The RUC agreed with this change and thanked the society for going through the RUC process for this change. **The RUC recommends the equipment item ER024 currently listed as a direct practice expense input for *Dual-energy X-ray (77080)* be changed to ER019.**

This change is reflected in the attached Excel spreadsheet.

XIII. PLI Workgroup

Proposed Rule PC/TC Methodology
Peter Smith, MD, provided the PLI Workgroup report to the RUC. Doctor Smith indicated that the PLI Workgroup convened a conference call on July 31, 2007, to provide comment on the PLI technical component issue raised in the July 12, 2007 Proposed Rule. The PLI Workgroup reviewed the RUC's longstanding concern that the PLI technical component is overvalued.

The RUC reaffirmed the PLI Workgroup's its recommendation stated in the August 27, 2007 comment letter to CMS, as follows:

> **The RUC understands there are no identifiable separate costs for professional liability for technical professionals. The RUC recommends that CMS reduce the PLI technical component to zero. The PLI RVUs should then be recalculated to ensure that these PLI RVUs are redistributed across all physician services. This would be accomplished by modifying the budget neutrality adjustment applied as the last step in the methodology of assigning PLI RVUs. The total pool of available PLI RVUs would not change as a result of our proposal.**

Professional Liability Insurance Premiums

Doctor Smith informed the RUC that when the PLI Workgroup met via conference call to discuss the technical component issue it also asked CMS if it was possible to share any preliminary report it may have on the data comparison between PIAA data and the data collected by the CMS contractor on national liability premiums per Medicare specialty.

We received the following response from CMS:

"We asked our contractor to take a look at the PLI data you provided to us and compare it to the data they collected from the states for use in calculating the malpractice GPCIs. Their comparison did not show any great difference in the two sets of data. They did not provide a written report on this work."

The RUC determined that CMS should use the most efficient and accurate premium liability data on an annual basis. **The RUC requests that CMS annually update PLI RVUs based on insurance data from PIAA or other relevant companies.**

PLI Crosswalk Requests

Doctor Smith indicated that in October 2006, the American Association of Oral and Maxillofacial Surgeons (AAOMS) initially requested that the PLI Workgroup review the PLI premium crosswalk for oral surgery. However, after lengthy discussion AAOMS withdrew their crosswalk changes request until they received further clarification from the CMS Enrollment Division regarding specific provider classifications.

Since the last meeting, AAOMS contacted CMS and has received a response. AAOMS recommended what the PLI Workgroup and CMS had previously asked them to consider regarding PLI premium data.

The RUC recommends that CMS use the PLI premium data provided by the American Association of Oral and Maxillofacial Surgeons: $6,100 for CMS provider classification 19-Oral Surgery and $15,948 for CMS provider classification 85-Maxillofacial Surgery.

Additionally, at the PLI Workgroup Meeting Doctor Przybylski questioned how the "all physicians" PLI premium assumption ($22,823) is calculated. CMS and AMA staff indicated they will work together to locate this calculation as stated in a previous Bearing Report.

XIV. Five-Year Identification Workgroup

Barbara Levy, MD, provided the report of the Five-Year Review Identification Workgroup to the RUC. Doctor Levy noted that the Workgroup assessed codes according to several criteria.

Site of service anomalies.
The RUC considered the Workgroup's recommendations to correct anomalies to those on the "99238 Only" list. The RUC reiterated that these codes, which were all valued by either Harvard or RUC using magnitude estimation, may or may not be correctly valued, rather the RUC is only considering the allocation of discharge management. Many of these codes may require RUC survey as the process of identifying potentially misvalued codes progresses. These codes, as well as all other codes, will continue to be screened by other methods developed by the RUC to identify potentially misvalued codes. The RUC's actions on these codes has no implication on work RVUs from this screen. **The RUC approved the Workgroup's recommendations for changes to the "99238 Only" Site of Service Anomalies.**

Doctor Levy next described the Workgroup's efforts to recommend action for the "99231, 99232, 99233 and 99238" list of services. Many of the recommendations include changes to the global periods of services where there were clearly bi-modal typical patient distributions. The actions represent a two-step process providing a primary or ultimate recommendation to correct the discrepancy between E/M visits and utilization data (usually a survey) as well as an immediate action to address the anomaly in the interim (usually removal of visits with no immediate implication of work value). The RUC noted that many of the Workgroup's recommendations were limited within families by minimum utilization limitations of the screens. As such, the RUC agreed that for families where some services were not included, specialties will be asked to include the entire family of services in the impending surveys. Although some specialties have indicated that there should be increases in some office visits, the Workgroup did not agree that was appropriate until these services have been surveyed. **The RUC approved the Workgroup's recommendations for changes to the "99231, 99232, 99233, and 99238" Site of Service Anomalies.**

Same Date of Service by Same Provider.
The Workgroup reviewed services that are provided by the same physician on the same date of service at least 90% of the time and recommended that the services should be referred to the CPT Editorial Panel for consideration of coding changes. Independent of whether the changes result in any change in valuation of the physician work associated with the services, the services will be better served by more efficient and accurate coding. **The RUC approved the Workgroup's recommendation to create a joint workgroup between CPT and RUC.**

Services with High/Low IWPUT
Doctor Levy briefly discussed the list of services that were identified with both exceptionally high and low IWPUT noting that high IWPUT discussion was tabled for the next meeting. **The RUC approved the Workgroup recommendation that the services with low IWPUTs be referred to all**

specialty societies with an invitation to recommend these services to CMS for review in the next Five-Year Review.

Codes Indicated for Re-Review
Lastly, Dr. Levy reported that staff searched the RUC database for services indicated by the RUC to be re-reviewed at a later date. Three codes were found that have not yet been addressed by the RUC. **The RUC approved the Workgroup recommendation that the services should be reviewed prior to the next Five-Year Review.**

During the meeting, a participant asked if they could share the RUC's work on this report. Staff responded that it was subject to all the usual RUC rules and protocols, but could certainly be shared internally within an organization.

XV. HCPAC Review Board

Lloyd Smith, DPM, provided the HCPAC report to the RUC.

Structure and Functions
Doctor Smith indicated that the HCPAC had the AMA General Counsel review a change of the HCPAC Structure and Functions. In April 2007, the HCPAC determined by a two-thirds vote, that the following be added to the HCPAC Structure and Functions document under the Processes section: "Any person who is identified as a presenter, who is also a member of the HCPAC, is prohibited from voting on the specific code issue presented."

The AMA General Counsel reviewed and agreed with all the changes made by the HCPAC.

HCPAC Process Improvement
Doctor Smith indicated that the majority of the HCPAC meeting focused on how it can improve the overall review process of new and revised codes and improve the acceptance rates of HCPAC recommendations by CMS. The following options were discussed:

1. The HCPAC should provide adequate reference codes in the rationale, both codes performed by non-physicians as well as physicians.
2. Stronger MD involvement on the HCPAC. MD's sitting on the HCPAC should offer constructive criticism as much as possible.
3. Consider time constraints. The HCPAC Chair and Co-Chair should work with AMA staff to ensure enough time is available to review all new and revised codes.
4. Assignment of specific codes to a HCPAC member, as the RUC assigns.
5. Assignment of Facilitation Committees.

6. Educate the HCPAC on each organization on the HCPAC. Organizations are to provide an educational summary to AMA staff, Susan Clark, who will distribute.
7. Review nuances associated with each HCPAC recommendation rejected by CMS.
    a. Why rejected – rationale, RVU, etc
    b. What was the time allotted at the HCPAC meeting in which the rejected code was discussed
    c. AMA Staff will gather this information so that the HCPAC can review the relevant issues at its next meting.

Other Issues
Doctor Smith also indicated that as a point of information the HCPAC discussed the 5% increase in overall payment for psychology codes requested by the American Psychological Association (APA) in the CHAMP Act.

XVI. MPC Workgroup

Thomas Felger, MD, provided the report of the Multi-Specialty Points of Comparison Workgroup. **The RUC approved the addition of 21 codes to the MPC.** Dr. Felger also reported that the Workgroup recommends that all "B" and "C" codes be removed from the MPC. The RUC commented that the removal of these services will improve the integrity of the MPC and should happen immediately rather than at any future time. **The RUC approved the immediate removal of all "B" and "C" codes from the MPC list.**

XVII. Practice Expense Subcommittee

The newly formed Practice Expense Subcommittee, now encompassing both the expertise and work of both the Practice Expense Review Committee and the Practice Expense Subcommittee, discussed the following issues;

Specialty Society Practice Information Survey
Sherry Smith provided an update, via a detailed slideshow presentation, of the AMA/Specialty Society Practice Information Survey efforts. AMA staff and Subcommittee members acknowledged that the survey is a large multifaceted survey that is complex to administer. AMA staff indicated that the response rate to the survey, even after several adjustments and different strategies, has remained lower than initially anticipated. AMA staff is committed to continuing the survey effort and has discussed with CMS new time frames for delivery of the data. In mid October, AMA staff will make decisions regarding a new contract with an external survey firm, and re-launch the survey in January 2008. The full presentation is attached to these minutes.

Practice Expense Recommendations on new, revised, and existing CPT codes
The PE Subcommittee spent considerable time reviewing practice expense recommendations and made recommendations to the RUC on 7 new or revised CPT issues and 3 existing code issues. These recommendations were forwarded to the RUC for approval.

Consideration of indirect practice expense items as direct expenses,
Representatives from the American Academy of Pediatrics discussed the current costs associated with the administration of vaccines in the typical Pediatrics' physician practice. It was explained that additional practice expense items, that have traditionally been assigned to the indirect costs, are now needed to be categorized as direct practice expense items. It was discussed that when the equipment cost and vaccine insurance is allocated to the specific service, the per service cost may be miniscule. The Subcommittee sought direction from the RUC as to whether such specialty society edits to the direct practice expense inputs should be considered by the PE Subcommittee as they are identified, or should they wait for the Five Year Review of practice expense. The Subcommittee will discuss this issue at its next meeting and provide a formal recommendation to the RUC at that time. The Subcommittee has also asked the specialty to list out specific recommendations for the RUC to consider at a later date.

Specialty Mix for New and Revised codes
The importance of recommending an accurate specialty mix was highlighted by Doctor Charles Mick, MD with an explanation of their society's recommendations for three total disc arthroplasty codes presented at the February 2006 RUC meeting. The specialty mix recommendation resulted in a rank order anomaly for the total RVUs once implemented by CMS. This error was corrected which resulted in a proposed increase in the practice expense for one of the three codes by 33% for 2008. After discussion at the RUC, the RUC recommends:

1. **The RUC should consider formalizing the recommendation of specialty mix to CMS.**
2. **The RUC should track acceptance, rejection, or modification of specialty mix by CMS.**
3. **The RUC should request CMS to review and report on the specialty mix utilized for new codes during the past year to determine if this is a global problem.**
4. **The RUC should request that CMS publish in the final rule the specialty mix chosen for new codes.**
5. **The RUC should request that if CMS disagrees with the RUC recommended specialty allocation that CMS utilize a more accurate estimate than the "all physician" PE modifier. For example, CMS might consider the usage of an "all surgeon" or "multi-specialty blend" practice expense modifier until actual charge data became available.**

XVIII. Administrative Subcommittee

James Blankenship, MD, informed the RUC that the Administrative Subcommittee essentially discussed two topics: the potential primary care seat and aspects of confidentiality and conflicts of interest.

I. Conflict of Interest Policy/Confidentiality Review
Doctor Blankenship indicated that at the April 2007 RUC meeting several RUC members proposed that the Administrative Subcommittee review several different elements of confidentiality and conflict of interest. There are four different types of statements/forms regarding RUC confidentiality, conflict of interest and financial disclosures.

1. There is a confidentiality statement in front of the RUC books, which is not signed and may not be read by many participants. One question was should the RUC require this statement to be signed.
2. There is a conflict of interest policy
3. There is a statement of compliance with the conflict of interest policy which must be signed by RUC and HCPAC members and alternates on an annual basis
4. There is a financial disclosure form, which presenters and advisors are required to sign and verbally disclose prior to each presentation.

A. Confidentiality
Doctor Blankenship indicated that a confidentiality statement is currently in front of the RUC agenda books. One issue the Administrative Subcommittee determined is that this statement should be clear on is that this confidentiality statement not only applies to RUC members, alternates and advisors, but also to any consultants and staff members. After discussion, the **Administrative Subcommittee determined that any individual who attends the RUC meeting shall sign a RUC Confidentiality Notice to be developed and reviewed at the February 2008 RUC meeting.**

B. Conflict of Interest Policy – RUC Members and Alternates
Doctor Blankenship indicated that various RUC members had requested that the RUC review its current conflict of interest forms/requirements for RUC members and alternates and possibly expand on what should be disclosed. AMA staff met with AMA Office of General Counsel (OGC) to review the current RUC conflict of interest policy. The AMA OGC determined that the current policy is still relevant. However, a more detailed policy is not discouraged if the RUC determines to create one.

The Administrative Subcommittee reviewed three conflict of interest policies: the current RUC, CPT Editorial Panel and AMA council and committee policies. After discussion, the Administrative Subcommittee determined that the current conflict of interest policy for RUC Members and Alternates is appropriate. **The**

Administrative Subcommittee reaffirms the current conflict of interest policy for RUC Members and Alternates.

C. Financial Disclosures for Advisors/Presenters

Doctor Blankenship indicated that the Administrative Subcommittee determined that specific financial disclosures for Advisors and presenters are necessary. For example, a Subcommittee member suggested a disclosure form similar to the FDA. However, due to limited time the Administrative Subcommittee was not able to develop such disclosure forms at this meeting.

The Administrative Subcommittee will revise the financial disclosure form for Advisors and presenters for discussion at the February 2008 Administrative Subcommittee.

The Administrative Subcommittee decided to convene by conference call before the next RUC meeting to expedite the development of policies and draft financial disclosure forms.

D. Review of Conflicts of Interest and Financial Disclosures

Doctor Blankenship indicated that the Administrative Subcommittee discussed if a conflict of interest or financial disclosure form is identified, then what happens. The Administrative Subcommittee determined that the RUC Chair and AMA Staff will review all conflicts of interest and financial disclosure statements. The current language in the Structure and Functions document indicates that "Any individual who is presenting or discussing relative value recommendations before the RUC shall disclose his or her potential interest prior to any presentations." However, the Administrative Subcommittee determined that the Structure and Functions document lacked language to specify what recourse the Chair may take if a significant conflict is disclosed. **At the February 2008 RUC meeting, the Administrative Subcommittee will develop language to specify what recourse the Chair may take if a significant conflict is discovered or disclosed. The Administrative Subcommittee will determine a mechanism on how to handle when a RUC member identifies a presenter as having a significant conflict.**

E. Instructions Document

Doctor Blankenship indicated that the current standard is that presenters are to suppose to file their financial disclosure forms when the specialty society submits its summary of recommendation forms. However, there are occurrences of non-compliance for this request.

In order to ensure that AMA Staff and the RUC Chair have enough time to review potential conflicts, all financial disclosures should be submitted by the specific due date in the *Instructions for Specialties Developing Recommendations* document. The Administrative Subcommittee determined the *Instructions for Specialties Developing Recommendations* document should be specific and elaborate the following:

If a financial disclosure form is not received from a presenter by the summary of recommendation forms submission due date, the presenter will not be allowed to present at the RUC meeting.

I. Primary Care Seat

Doctor Blankenship indicated that at the April 2007 meeting, the RUC determined that it would further consider the addition of a rotating primary care seat. The charge was to have AMA staff develop appropriate language, which the Administrative Subcommittee would review at the September meeting. In the interim, a coalition of six primary care specialty societies presented a letter (as well as three letters from three additional specialty societies after the production of the agenda book supporting this primary care coalition letter) for consideration. The coalition letter offered amendments to ensure that 1) The primary care seat would be limited to a licensed MD/DO physician and 2) The primary care seat would require a physician with special expertise in chronic disease management and prevention.

Primary Care Definition

Doctor Blankenship reviewed the primary care definition recommendation from the Administrative Subcommittee:

The Administrative Subcommittee reviewed the proposed Primary Care definition as proposed at the April 2007 meeting, which included "qualified health care professional." Upon further discussion and in support of amendment proposed by Primary Care, the Administrative Subcommittee determined that the Rotating Seat Policies and Election Rules should mirror the AMA definition of Primary Care verbatim and only include licensed MD/DO physicians as outlined below:

AMA Definition of Primary Care:

> *Primary Care consists of the provision of a broad range of personal medical care (preventive, diagnostic, palliative, therapeutic, curative, counseling and rehabilitative) in a manner that is accessible, comprehensive and coordinated by a licensed MD/DO physician over time. Care may be provided to an age-specific or gender-specific group of patients, as long as the care of the individual patient meets the above criteria.*

Candidate Eligibility

Doctor Blankenship reviewed the candidate eligibility recommendation from the Administrative Subcommittee:

The Administrative Subcommittee reviewed the candidate eligibility for the Primary Care Seat. At the April 2007 RUC meeting the following eligibility criterion was determined: The Primary Care rotating seat candidate must be in

active clinical practice, with at least 50% of their professional time in direct patient care. A coalition of primary care specialties suggested that the Administrative Subcommittee add candidate eligibility criteria that the physician has expertise in chronic disease management and preventive care. The Administrative Subcommittee determined that such specification is appropriate to add to the Primary Care seat candidate eligibility. The Administrative Subcommittee recommends the following candidate eligibility in the Rotating Seat Policies and Election Rules as follows:

> *The Primary Care rotating seat candidate must be in active clinical practice, with at least 50% of their professional time in direct patient care. The Primary Care rotating seat candidate must be a physician with significant experience and expertise in broad-based chronic disease management, comprehensive treatment plan development and management, and preventive care.*

Item I. Primary Care Seat was not voted on by the full RUC.

The RUC Chair directed the RUC to first vote on the addition of the rotating primary care seat, by voting on the language which would be included in the RUC Structure and Functions document.

II. Structure and Functions

A. Primary Care Seat

Doctor Blankenship informed the RUC of the changes to the RUC Structure and Functions document to vote on for the addition of the Primary Care seat:

A. RVS Update Committee

(2) Composition – The RUC shall have a total of 27 voting seats. The RUC shall be composed of physician representatives from the twenty-~~three~~ permanent medical specialties as indicated on Appendix B as attached hereto and made a part hereof. The AMA and the American Osteopathic Association (AOA) shall also each have one voting representative to the RUC. The AMA and the AOA shall also each have one alternate representative to the RUC to participate and vote at the RUC only in the absence of the respective AMA and AOA representative. The Chair shall also have one seat and shall be appointed by the AMA. A member of the CPT Editorial Panel as selected by the AMA shall be a non-voting representatives to RUC. The RUC shall include ~~three~~ four rotating seats whose membership shall rotate every two years. Each term will conclude with the provision of final recommendations to CMS for the following year's CPT codes. The four rotating seats will be reserved as follows:

- One seat will be reserved for a primary care

representative.
- Two seats will be reserved for an internal medicine subspecialty.
- ~~The other~~ The remaining seat will be open to any other specialty society not a member of the RUC. The "other" rotating seat on the RUC should not be open to internal medicine subspecialties or primary care representatives.

The Structure and Function modifications did not achieve a two-thirds majority vote by the RUC. The RUC did not approve the addition of a rotating primary care seat on the RUC.

A request was made to note the vote, which was 13 in favor, 12 opposed, and one abstention.

B. Practice Expense Review Committee

Doctor Blankenship indicated that currently, the PERC reviews direct practice expenses (clinical staff, medical supplies, and medical equipment) for individual services and the Practice Expense Subcommittee examines the many broad and methodological issues relating to the development of practice expense relative values. The RUC Chair indicated that since the direct practice expense review for over 6,500 codes has been accomplished, these committees should be combined to make up one Practice Expense Subcommittee.

The Administrative Subcommittee recommends making all appropriate changes in the RUC Structure and Functions document to replace "Practice Expense Review Committee (PERC)" with Practice Expense Subcommittee. The recommended changes are indicated in the full Administrative Subcommittee report attached to these minutes.

XIX. Research Subcommittee

Doctor Siegel delivered the Research Subcommittee report. He discussed several additions to the survey instrument pertaining to the addition of site of service for moderate sedation. **The Research Subcommittee and the RUC recommend that the survey instrument be modified to read:**

Moderate sedation is a service provided by the operating physician or under the direct supervision of the physician performing the procedure to allow for sedation of the patient with or without analgesia through administration of medications via the intravenous, intramuscular, inhalational, oral, rectal or intranasal routes. For purposes of the following question, sedation and analgesia delivered separately by an anesthesiologist or other anesthesia

provider not performing the primary procedure is not considered moderate sedation.

Do you or does someone under your direct supervision typically administer moderate sedation for these procedures when performed in the Hospital/ASC setting or in the Office setting?

	Hospital/ASC Setting		Office Setting	
	Yes	**No**	**Yes**	**No**
New/Revised Code				
Reference Code				

The Research Subcommittee and the RUC recommend that the Summary of Recommendation form be modified to read:

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated it is typical in the Hospital/ASC setting?
Is moderate sedation inherent in your reference code (Hospital/ASC setting)?
Is moderate sedation inherent to this procedure in the Office setting?
Percent of survey respondents who stated it is typical in the Office setting? Is moderate sedation inherent in your reference code (Office setting)?

Doctor Siegel also discussed situations in which the specialty society is confident before surveying that moderate sedation is not inherent in the surveyed code. **The Research Subcommittee and the RUC recommend that in such situations, the specialty society may remove the moderate sedation questions from the RUC survey instrument. To reflect this action, the Research Subcommittee and the RUC recommend that the summary of recommendation form include a section where the RUC Advisor will attest that moderate sedation is not inherent in this service when performed in the facility or non-facility settings and therefore the moderate sedation questions were removed from their survey instrument**.

Doctor Siegel continued by discussing an issue that was referred to the Research Subcommittee to develop policy on how to address RUC surveys with a "low" median service performance rate. The Research Subcommittee discussed several options to address this situation. After a lengthy discussion, *the Research Subcommittee recommends that where the survey data for a new/revised code reflects a median performance rate of zero, the code will be referred back to CPT with the rationale that there are not enough providers with direct expertise in performing the procedure to evaluate the service.*

The RUC discussed this recommendation made by the Research Subcommittee and expressed concern that this recommendation would prohibit some procedures from being valued at the RUC. Therefore, the RUC does not support this

recommendation made by the Research Subcommittee. **The RUC recommends that this issue be referred back to the Research Subcommittee for further consideration.**

Doctor Siegel reviewed two specialty society requests. The first was a request made by the Renal Physicians Association (RPA) to review their proposed survey instrument for the End Stage Renal Disease Codes scheduled to be reviewed by the CPT Editorial Panel at its October 2007 Meeting. The Research Subcommittee made several modifications to the survey instrument and proposed several recommendations to modify the summary of recommendation (SOR) form that will summarize their survey results. This modified SOR will be distributed to the Research Subcommittee for its approval prior to the survey period for the February 2008 RUC meeting. The second request was an update from the American College of Physicians (ACP) regarding the proposed care management code as established in the 2006 Tax Relief and Health Care Act's Medicare medical home demonstration project. CMS has announced that they plan to have the descriptors for these codes ready for review at the February 2008 RUC Meeting, the procedures will be evaluated for work at the April 2008 Meeting and the codes will be implemented in January 2009.

Doctor Siegel ended his report with a discussion of the RUC's recommended modification to the CMS pre-service time definition to make it consistent with the pre-service definition utilized for the practice expense methodology. **The RUC reaffirmed its recommendation that the physician pre-service period begin when the decision for surgery is made, similar to the CMS definition for clinical staff time.** CMS informed the RUC that this recommendation is currently under consideration for the *Final Rule*.

The August 27, 2007 Research Subcommittee Conference regarding the ESRD issue call minutes were approved by the RUC and attached to the RUC meeting minutes.

XX. Extant Data Workgroup

Doctor Hitzeman delivered the Extant Data Workgroup report. At its meeting the workgroup assessed all of the proposed inclusionary/exclusionary criteria for extant databases for use in the RUC process and created the following list:

- Databases must collect time data for the procedures, at a minimum the skin-to-skin or intra-service time and length of stay. An additional time element may include ICU, LOS, and other specialty specific time factors (i.e. phone calls, ventilator hours)
- Databases must have data integrity/reliability
    - Must collect data prospectively,
    - Should have the ability to identify and assess outliers – multiple procedures resulting in greater LOS; diseases with high mortality

rate (LOS=0) or extended recovery (LOS>90); age variance (bi-modal)
    - Should have the ability to have transparency of data to compare to other databases including the RUC database
    - Should have the ability to audit the database
    - Should have the ability to track the data/changes over time
    - Should have the ability to collect data on all cases done by participants or for large volume procedures or E/M encounters, should have sampling criteria that are statistically valid to eliminate sampling bias
    - Should have current data, preferably from the last three to five years, although older sets can be used for comparison purposes
- Must have the ability to unequivocally map the procedure to a CPT code and isolate the procedure from associated physician work that is otherwise billable in the same setting
- Databases must list their limitation – include what is provided and not provided with respect to the RUC database
- Databases must be representative
    - The data should be geographically representative eg, regionally and nationally for the specialty,
    - The data should have various levels of patient severity
    - The data should have adequate practice site representation and sample size – practice sites and rural and urban representation
    - The data should be from various practice types – representative of the academic, non-academic and other types of practices for the specialty
    - The data should be collected from the majority specialties (including subspecialties) that perform the procedure or encounter
    - The data should be collected from either hospital/institution or individual physician.

The Workgroup and the RUC recommend that this inclusionary/ exclusionary list be sent to the specialty societies for their review and comments. These comments will be reviewed at the next workgroup meeting. Additionally, the Workgroup and the RUC recommend that the specialty societies be solicited again to identify any extant databases with which they are familiar.

Doctor Hitzeman stated that the Workgroup at its next meeting will 1.) Approve the inclusionary/exclusionary criteria for extant databases for use in the RUC Process, 2.) Discuss the statistical components of the data points collected, eg mean and median, 3.) Identify and approve the possible uses of extant data in the RUC Process.

XXI. Other Issues

Doctor Rich indicated that he would like to see the RUC begin to assess the linkage between work valuation and efficiency measures. He asked the RUC members to begin thinking about possible future involvement.

Doctor Cooper asked the RUC to consider the elimination of global periods to better describe the actual work provided by physicians. He requested that staff provide a report on the history of global periods for potential referral to the Research Subcommittee in September 2008.

Doctor Traugott indicated that the AMA had received a request to develop a RUC mission statement. Doctor Rich referred the development of a mission statement to the Administrative Subcommittee for it February 2008 meeting.

The meeting adjourned on Saturday, September 29, 2007 at 3:00 p.m.