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.

AMA/Specialty Society RVS Update Committee **Tab 15**
Professional Liability Insurance Workgroup
September 27, 2007

Members Present: Doctors Peter Smith (Chair), Ronald Burd, Mary Foto, OTR, John Gage, David Hitzeman, Stephen Kamenetzky (via phone), Charles Koopmann, Doug Leahy, Charles Mick, Najeeb Mohideen, Gregory Przybylski (via phone)

I. *Proposed Rule* PC/TC Methodology – *Addressed via conference call – July 31, 2007*

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 comment period ended August 31, 2007.

AMA staff analyzed the current Medicare payment for the PLI technical component. The total PLI technical component comprises 15% or $426 million of the total 2.8 billion PLI Medicare payment. When examining the total payment for codes with a technical component (factoring the DRA cap), the total payment equals $7.9 billion or 10.5% of all payments under the Medicare Payment Schedule.

The American College of Radiology (ACR) indicated that they would like the RUC to discuss the PLI Workgroup recommendation further and that the RUC provide final comments to CMS after it has had a full discussion.

The PLI Workgroup discussed the TC PLI at this meeting to accommodate this request. The radiology representatives indicated that they had researched this issue and the feedback indicated that there is no evidence that radiology technologists have separate specific liability insurance. However, specifically medical physicists may have separate professional liability insurance.

The PLI Workgroup reaffirmed its recommendation stated in the August 27, 2007 comment letter to CMS.

The PLI Workgroup understands there are no identifiable separate costs for professional liability for technical professionals. The PLI Workgroup 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.

II. Professional Liability Insurance Premiums

When the PLI Workgroup met via conference call to discuss the above 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."

Stephanie Monroe from CMS clarified that the CMS contractor analyzing the comparison of PIAA premium data and the data collected on six pilot states (Iowa, Colorado, New York, Florida, Pennsylvania and Texas) has currently stated the data is similar. A final report will be available this fall after the GPCI data is completed.

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

III. PLI Crosswalk Requests

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. The October 2006 staff note on this issue and PLI Workgroup report are attached.

Since the last meeting, AAOMS has contacted CMS and has received a response. AAOMS is recommending what the PLI Workgroup and CMS had previously asked them to consider regarding the PLI premium data as outlined in the table below.

CMS Provider Classification	Medicare Specialty	Current PLI Assumptions		Recommendation/ Current Data per AAOMS Letter
19	Oral Surgery	Dentist (DDS) Only – crosswalked to "All Other Physicians"	$22,823	**$6,100** Risk factor of 1.0 (will represent all MDs who do not meet new CMS criteria for Medicare ID 85
85*	Maxillofacial Surgery	MD only or MD/DDS – currently crosswalked to "Plastic Surgery"	$42,569	**$15,948** All oral and maxillofacial surgeons who meet CMS new criteria per OMSNIC data
24	Plastic Surgery	MD	$42,569	$42,569

* *See CMS April 13, 2007 letter to AAOMS for additional criteria for category 85.*

The PLI Workgroup 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.

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.

AMA
AMERICAN
MEDICAL
ASSOCIATION

January 9, 2008

Amy Bassano
Director, Division of Practitioner Services
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-01-14
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Ms. Bassano:

As CMS considers policy issues for proposed rule making related to the 2009 Medicare Physician Payment Schedule, the Professional Liability Insurance (PLI) component of the Resource-Based Relative Value Scale (RBRVS) should be addressed.

The American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC) created a PLI Workgroup in 2003. Since this time the RUC has recommended a number of improvements in the PLI component. CMS has implemented many of these recommendations (eg, alternative utilization data for low volume codes; improved crosswalks). There are three specific outstanding recommendations that we urge you to address, including an additional crosswalk improvement, technical component correction and use of PIAA data.

PLI Crosswalk Improvements

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.

In April 2007, AAOMS received response from CMS regarding specific provider classifications for oral and maxillofacial surgeons. In September 2007, with the correct classifications in place the PLI Workgroup reviewed the PLI crosswalks for oral surgery and maxillofacial surgery.

Currently 19-Oral Surgery is crosswalked to "All Other Physicians" with a PLI assumption of $22,823. A more appropriate PLI premium amount for 19-Oral Surgery would be the current lowest premium amount of $6,100. Please note the actual premiums are lower than $6,100. The RUC has recommended that in the future CMS move to use PLI premium data for all specialties and other health care professionals.

Currently 85-Maxillofacial Surgery is crosswalked to "24-Plastic Surgery" with a PLI assumption of $42,569. The actual average annual PLI premium for 85-Maxillofacial Surgery for minimum coverage is $15,948, as provided in the attached letter.

CMS Provider Classification	Medicare Specialty	Current PLI Assumptions		Recommendation
19	Oral Surgery	Dentist (DDS) Only – crosswalked to "All Other Physicians"	$22,823	**$6,100** Risk factor of 1.0 (will represent all MDs who do not meet new CMS criteria for Medicare ID 85
85*	Maxillofacial Surgery	MD only or MD/DDS – currently crosswalked to "Plastic Surgery"	$42,569	**$15,948** All oral and maxillofacial surgeons who meet CMS new criteria per OMSNIC data
24	Plastic Surgery	MD	$42,569	$42,569

* *See CMS April 13, 2007 letter to AAOMS for additional criteria for category 85.*

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.

Technical Component Methodology

In the July *Proposed Rule*, CMS indicated that "we would like to better understand how, and if, technicians employed by facilities purchase PLI and how their professional liability is insured. In addition, we are soliciting comments on what types of PLI are carried by facilities that perform technical services."

In the *Final Rule* for CY 2008, CMS indicates that the agency will not make any changes to the technical component PLI relative values as no data are available. We are not aware that CMS received any evidence that separate professional liability insurance is typically purchased for technicians. In absence of any submitted evidence, and in receipt of a recommendation from the RUC that these policies are not typical, we are perplexed that CMS did not accept the RUC recommendation to eliminate the PLI relative values for the technical component and redistribute these PLI relative values across all physician services. This recommendation from the RUC received a unanimous vote.

CMS was required to publish resource-based PLI relative values in 2000, however the technical component PLI valuation remains charged based. It has distorted relativity in the PLI component for eight years and it is time that CMS take this component of the RBRVS seriously. Although, it is less than 5% of payment for most services, it is a significant cost for some specialties and it is CMS' responsibility to ensure that the relativity reflects these higher premiums relative to other groups with lower premiums.

The example provided in our August letter illustrates the problem. It is intuitive that the PLI costs for an obstetrician performing an amniocentesis is higher than the technician's risk in an MRI of the upper extremity. Yet, CMS PLI relative values are higher for the technician.

The RUC submitted the following recommendation related to technical component PLI valuation in its comments on the Proposed Rule published July 12, 2007. The RUC stated that there are no identifiable separate costs for professional liability for technical professionals. Additionally, the PLI workgroup discussed the TC PLI issues at the September 27-29, 2007, RUC meeting and reaffirmed its recommendation stated in the August 27, 2007 comment letter to CMS.

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.

PLI Premiums

In a letter dated January 11, 2006, CMS has agreed to examine specific malpractice premium data for use in the calculation of the Malpractice Geographic Practice Cost Index (GPCI) available through Doctor Stephen Kamenetzky. Doctor Kamenetzky collaborated with the Physician Insurers Association of America (PIAA) to submit PLI premium data to CMS for six pilot states (Iowa, Colorado, New York, Florida, Pennsylvania and Texas). PIAA submitted the PLI premium data to CMS prior to the October 2006 RUC meeting. At the October 2006 RUC meeting, CMS indicated that they would review the PIAA data and determine if it met the appropriate requirements after the collection efforts for GPCIs were complete and the release of the November 2006 *Final Rule*.

At the September 2007 RUC meeting, the PLI Workgroup 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.

CMS clarified that the contractor analyzing the comparison of PIAA premium data and the data collected on six pilot states has currently stated the data is similar. CMS indicated that a final report will be available in Fall 2007 after the GPCI data is completed.

The RUC requests that CMS share the report prepared by a contractor to compare the PIAA data and the data collected by the CMS contractor on national liability premiums per Medicare specialty.

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 form PIAA or other relevant companies.**

The RUC appreciates the opportunity to offer these comments to CMS. We look forward to the work ahead to further improve the PLI portion of the RBRVS.

Sincerely,

William L. Rich, III, MD, FACS

cc: RUC participants

AMA/Specialty Society RVS Update Committee **Tab 16**
Five Year Review Identification Workgroup
September 27, 2007

Members Present: Barbara Levy, MD (Chair), Michael Bishop, MD, James Blankenship, MD, Katherine Bradley, PhD, RN, Norm Cohen, MD, Thomas Felger, MD, Meghan Gerety, MD, Gregory Kwasny, MD, William J. Mangold, Jr., MD, Geraldine McGinty, MD, Bernard Pfeifer, MD, J. Baldwin Smith, MD, Maurits Weirsema, MD, Robert Zwolak, MD

Doctor Levy initiated the meeting of the Five-Year Review Identification Workgroup by reiterating the charge of the workgroup and recapping the discussions regarding objective criteria in the identification of potentially misvalued services to date.

I. Site of Service Anomalies

The Workgroup discussed the site of service anomalies. The services identified were divided into two categories, those with a full 99238 only (report titled "99238 Only") and those with at least one 99231, 99232, 99233 with or without a 99238 (report titled "99231, 99232, 99233, 99238"). The first category contains 57 services, while the latter contains 96. For each service included on either list, at least one specialty has provided comments on the appropriateness of the hospital visits and provided some recommendation for correcting the anomaly.

The Workgroup first addressed the "99238 Only" list, reviewing each code individually. The workgroup extracted CPT code 15240. The inclusion of the full 99238 was a data entry error as the RUC recommendation explicitly states that only a 0.5 99238 should be included. The workgroup also extracted CPT code 64626 to allow staff time to research and clarify the correct patient visits included in the RUC database.

The Five-Year Review Identification Workgroup recommended the following actions regarding the "99238 Only" Site of Service Anomalies:

Code	Recommended Action
15220	Reduce the 99238 to 0.5. No implication for work RVU from this screen.
15576	Reduce the 99238 to 0.5. No implication for work RVU from this screen.
15770	Reduce the 99238 to 0.5. No implication for work RVU from this screen.
19318	Reduce the 99238 to 0.5. No implication for work RVU from this screen.
20000	Remove the entire 99238. No implication for work RVU from this screen. The primary site of service is the physician's office eliminating the need for discharge management.
20525	Reduce the 99238 to 0.5. No implication for work RVU from this screen.
20694	Reduce the 99238 to 0.5. No implication for work RVU from this screen.
21015	Reduce the 99238 to 0.5 as an interim action. Reassess following recommendations of the CPT Soft Tissue Tumor Workgroup
21557	Reduce the 99238 to 0.5 as an interim action. Reassess following recommendations of the CPT Soft Tissue Tumor Workgroup
22521	Maintain the entire 99238. The RUC recommendation specifically accounts for the appropriateness of the full discharge management services.
23130	Reduce the 99238 to 0.5. No implication for work RVU from this screen.
23405	Reduce the 99238 to 0.5. No implication for work RVU from this screen.
23430	Reduce the 99238 to 0.5. No implication for work RVU from this screen.
23440	Reduce the 99238 to 0.5. No implication for work RVU from this screen.

Code	Recommended Action
25210	Reduce the 99238 to 0.5. No implication for work RVU from this screen.
25260	Reduce the 99238 to 0.5. No implication for work RVU from this screen.
25280	Reduce the 99238 to 0.5. No implication for work RVU from this screen.
26356	Reduce the 99238 to 0.5. No implication for work RVU from this screen.
27324	Reduce the 99238 to 0.5 as an interim action. Reassess following recommendations of the CPT Editorial Panel
27619	Reduce the 99238 to 0.5 as an interim action. Reassess following recommendations of the CPT Editorial Panel
27685	Reduce the 99238 to 0.5. No implication for work RVU from this screen.
27687	Reduce the 99238 to 0.5. No implication for work RVU from this screen.
27818	Reduce the 99238 to 0.5. No implication for work RVU from this screen.
28111	Reduce the 99238 to 0.5. No implication for work RVU from this screen.
28118	Reduce the 99238 to 0.5. No implication for work RVU from this screen.
28124	Remove the entire 99238. No implication for work RVU from this screen. The primary site of service is the physician's office eliminating the need for discharge management.
28298	Reduce the 99238 to 0.5. No implication for work RVU from this screen.
28300	Reduce the 99238 to 0.5. No implication for work RVU from this screen.
28310	Reduce the 99238 to 0.5. No implication for work RVU from this screen.
28740	Reduce the 99238 to 0.5. No implication for work RVU from this screen.
30465	Reduce the 99238 to 0.5. No implication for work RVU from this screen.
31571	Reduce the 99238 to 0.5. No implication for work RVU from this screen.
36870	Reduce the 99238 to 0.5. No implication for work RVU from this screen.
37609	Reduce the 99238 to 0.5. No implication for work RVU from this screen.
37785	Reduce the 99238 to 0.5. No implication for work RVU from this screen.
46200	Reduce the 99238 to 0.5. No implication for work RVU from this screen.
48102	Reduce the 99238 to 0.5. No implication for work RVU from this screen.
51040	Reduce the 99238 to 0.5. No implication for work RVU from this screen.
54520	Reduce the 99238 to 0.5. No implication for work RVU from this screen.
55873	Maintain the entire 99238. The RUC recommendation specifically accounts for the appropriateness of the full discharge management services.
56515	Reduce the 99238 to 0.5. No implication for work RVU from this screen.
58660	Reduce the 99238 to 0.5. No implication for work RVU from this screen.
58661	Reduce the 99238 to 0.5. No implication for work RVU from this screen.
61793	Reduce the 99238 to 0.5. No implication for work RVU from this screen.
62281	Remove the entire 99238. No implication for work RVU from this screen. The primary site of service is the physician's office eliminating the need for discharge management.
62287	Reduce the 99238 to 0.5. No implication for work RVU from this screen.
64640	Remove the entire 99238. No implication for work RVU from this screen. The primary site of service is the physician's office eliminating the need for discharge management.
65105	Reduce the 99238 to 0.5. No implication for work RVU from this screen.
66982	Reduce the 99238 to 0.5. No implication for work RVU from this screen.
67039	Reduce the 99238 to 0.5. No implication for work RVU from this screen.
67040	Reduce the 99238 to 0.5. No implication for work RVU from this screen.
67107	Reduce the 99238 to 0.5. No implication for work RVU from this screen.
67108	Reduce the 99238 to 0.5. No implication for work RVU from this screen.
67110	Remove the entire 99238. No implication for work RVU from this screen. The

Code	Recommended Action
	primary site of service is the physician's office eliminating the need for discharge management.
69801	Remove the entire 99238. No implication for work RVU from this screen. The primary site of service is the physician's office eliminating the need for discharge management.

Following discussion of the "99238 Only" list, the Workgroup deferred discussion of the "99231, 99232, 99233, and 99238" list. At the recommendation of the Chair, a smaller group, comprised of Doctors Levy, Cohen, Mangold, and Zwolak met separately to discuss these services. Their recommendations were reported to the entire Workgroup and approved.

This exercise by the Workgroup is not meant to imply that these codes, which were all valued by either Harvard or RUC using magnitude estimation, are correctly valued. The Workgroup has agreed with the specialty societies with respect to the allocation of discharge management. Since the work was determined by magnitude estimation and not by building block methodology for the codes reviewed, the members of the workgroup were comfortable, after extensive discussion, in maintaining the current work values despite the change in time and discharge management. It was noted that much of this discrepancy in the database occurred as a result of arbitrary allocation of total times in the Harvard data into specific CPT codes for our RUC database. Many of these codes are likely to 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 mis-valued codes.

The recommendations of the Workgroup regarding the "99231, 99232, 99233, and 99238" Site of Service Anomalies are included in the table below. The actions represent a two-step process providing a primary or ultimate recommendation to correct the discrepancy between E/M visits and utilization data as well as an immediate action to address the anomaly in the interim. **The Five-Year Review Identification Workgroup recommends:**

Code	Primary Action	Interim Action
11043	Refer to CPT for potential coding changes	Remove hospital visits, reduce 99238
11044	Refer to CPT for potential coding changes	Remove hospital visits, reduce 99238
14001	Recommend to CMS to make this a 000 day global; and survey	Remove hospital visits, remove entire 99238
14021	Recommend to CMS to make this a 000 day global; and survey	Remove hospital visits, remove entire 99238
14041	Recommend to CMS to make this a 000 day global; and survey	Remove hospital visits, remove entire 99238
14061	Recommend to CMS to make this a 000 day global; and survey	Remove hospital visits, remove entire 99238
14300	Recommend to CMS to make this a 000 day global; and survey	Remove hospital visits, remove entire 99238
15120	Retain current hospital visits, based on ASPS specialty society rationale	

Code	Primary Action	Interim Action
15400	Reconsider in one year to evaluate recent claims data and consider possible change to global period	Maintain current hospital visits
15574	Recommend to CMS to make this a 000 day global; and resurvey	Remove hospital visits, reduce 99238
15732	Reconsider in one year to evaluate recent claims data and consider possible change to global period	Maintain current hospital visits
15740	Recommend to CMS to make this a 000 day global; and survey	Remove hospital visits, reduce 99238
19020	Remove hospital visits, reduce 99238, retain work rvu	
19357	Refer to CPT to consider coding changes because of difference in delayed and immediate breast reconstruction; survey	Remove hospital visits, reduce 99238
20005	Refer to CPT to consider description change to clarify target - dominant specialty followed closely by podiatry does not make sense b/c deep abscess is unlikely to be done in office; survey	Request CPT assistant to publish an article on correct coding.
20900	Recommend to CMS to make this a 000 day global; and survey	Refer to CPT to consider addition to the -51 modifier exempt list
21025	Resurvey	Remove hospital visits, reduce 99238
21935	Survey following CPT workgroup recommendations	Remove hospital visits, reduce 99238
22900	Survey following CPT workgroup recommendations	Remove hospital visits, reduce 99238
23076	Survey following CPT workgroup recommendations	Remove hospital visits, reduce 99238
23120	Survey	Remove hospital visits, reduce 99238
23410	Survey	Remove hospital visits, reduce 99238
23412	Survey	Remove hospital visits, reduce 99238
23415	Survey	Remove hospital visits, reduce 99238
23420	Resurvey	Remove hospital visits, reduce 99238
25116	Survey	Remove hospital visits, reduce 99238
25310	Survey	Remove hospital visits, reduce 99238
26080	Survey	Remove hospital visits, reduce 99238
27048	Survey following CPT workgroup recommendations	Remove hospital visits, reduce 99238
27062	Survey	Remove hospital visits, reduce 99238

Code	Primary Action	Interim Action
27250	Recommend to CMS to make this a 000 day global; and survey	Remove hospital visits, remove entire 99238
27615	Survey following CPT workgroup recommendations	Remove hospital visits, reduce 99238
27640	Recommend to CMS to make this a 000 day global; and survey	Maintain current hospital visits
27650	Survey	Remove hospital visits, reduce 99238
27654	Survey	Remove hospital visits, reduce 99238
27690	Survey	Remove hospital visits, reduce 99238
27691	Survey	Remove hospital visits, reduce 99238
28120	Recommend to CMS to make this a 000 day global; and survey	Remove hospital visits, reduce 99238
28122	Recommend to CMS to make this a 000 day global; and survey	Remove hospital visits, reduce 99238
28296	Survey	Remove hospital visits, reduce 99238
28725	Survey	Maintain current hospital visits
28730	Resurvey	Remove hospital visits, reduce 99238
28825	Survey	Maintain current hospital visits
29888	Survey	Remove hospital visits, reduce 99238
31611	Request follow-up from AAO-HNS. How often is this done with 31360 or 31356	Remove hospital visits, reduce 99238
36820	Resurvey	Remove hospital visits, reduce 99238
36821	Survey	Remove hospital visits, reduce 99238
36825	Survey	Remove hospital visits, reduce 99238
36834	Refer to CPT for clarification of "plastic repair"; and survey	Remove hospital visits, reduce 99238
37760	Refer to CPT for clarification - consider creation of code for minor perforator ligation; and survey	Remove hospital visits, reduce 99238
38542	Survey	Remove hospital visits, reduce 99238
42145	Resurvey	Remove hospital visits, reduce 99238
42415	Survey	Remove hospital visits, reduce 99238
42420	Survey	Remove hospital visits, reduce 99238
42440	Survey	Remove hospital visits, reduce 99238
45170	Resurvey	Remove hospital visits, reduce 99238
49421	Recommend to CMS to make this a 010 day global; and survey	Remove hospital visits, reduce 99238
49507	Resurvey	Maintain current hospital visits
49521	Resurvey	Remove hospital visits, reduce 99238

Code	Primary Action	Interim Action
49587	Resurvey	Remove hospital visits, reduce 99238
51010	Recommend to CMS to make this a 000 day global; and resurvey	Remove hospital visits, remove entire 99238
	51010 has been renumbered to 51102 for CPT 2008.	
52344	Resurvey	Discuss with specialty society the cause for discrepancy in global periods
52400	Resurvey	Remove hospital visits, reduce 99238
52500	Resurvey	Remove hospital visits, reduce 99238
52640	Survey	Remove hospital visits, reduce 99238
53445	Survey	Remove hospital visits, reduce 99238
54405	Survey	Remove hospital visits, reduce 99238
54410	Resurvey	Remove hospital visits, reduce 99238
54530	Survey	Remove hospital visits, reduce 99238
56620	Survey	Remove hospital visits, reduce 99238
57155	Recommend to CMS to make this a 010 day global; and resurvey	Remove hospital visits, reduce 99238
57287	Resurvey	Remove hospital visits, reduce 99238
60220	Resurvey	Remove hospital visits, reduce 99238
60225	Survey	Maintain current hospital visits
61885	Resurvey	Remove hospital visits, reduce 99238
62263	Resurvey	Remove hospital visits, reduce 99238
62350	Recommend to CMS to make this a 010 day global; and resurvey	Remove hospital visits, reduce 99238
62355	Recommend to CMS to make this a 000 day global; and resurvey	Remove hospital visits, reduce 99238
62362	Recommend to CMS to make this a 010 day global; and resurvey	Remove hospital visits, reduce 99238
62365	Recommend to CMS to make this a 010 day global; and resurvey	Remove hospital visits, reduce 99238
63650	Recommend to CMS to make this a 010 day global; and survey	Remove hospital visits, reduce 99238
63660	Recommend to CMS to make this a 010 day global; and survey	Remove hospital visits, reduce 99238
63685	Recommend to CMS to make this a 010 day global; and survey	Remove hospital visits, reduce 99238
63688	Recommend to CMS to make this a 010 day global; and survey	Remove hospital visits, reduce 99238
64416	Recommend to CMS to make this a 000 day global; and resurvey	Remove hospital visits, reduce 99238

Code	Primary Action	Interim Action
64573	Resurvey	Remove hospital visits, reduce 99238
64581	Resurvey	Remove hospital visits, reduce 99238
64708	Survey	Remove hospital visits, reduce 99238
64712	Survey	Remove hospital visits, reduce 99238
64831	Survey	Remove hospital visits, reduce 99238
65285	Survey	Remove hospital visits, reduce 99238
67038	Deleted from CPT no action needed	
68810	Resurvey	Remove hospital visits, remove entire 99238
69930	Resurvey	Remove hospital visits, remove entire 99238; Increasing frequency reporting with intraoperative neurological monitoring - discuss when presenting the code
77427	Request clarification from specialty before taking action	

Although some specialties have recommended that office visits be increased for these services, the workgroup does not feel that it would be appropriate to do so, until the services are surveyed. Prior to notifying CMS of its request to change the global period of services identified, specialty societies will be contacted and given the opportunity to add services within the family of codes to the RUC's comments to CMS.

II. Services Performed on the Same Day by the Same Provider

The Workgroup requested a review of services that are provided by the same physician on the same date of service at least 90% of the time. Only codes with a utilization of 1,000 and greater were included. The utilization data to conduct this query was provided by CMS from the 2005 five percent sample file. Staff reviewed these data with the 2007 physician payment schedule, modifier 51 exempt list and global period to provide a more accurate list of services that should be further evaluated. Those paired services that have been deleted from CPT or are accurately combined ZZZ codes were removed.

The Workgroup agreed 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 Five-Year Review Identification Workgroup recommended that all services included on the report be referred to CPT for possible coding changes. Further, the Workgroup recommends that a joint workgroup between CPT and RUC be formed to discuss the complex coding issues involved, with input from specialty societies. The Workgroup recommends that this new workgroup be empanelled before the February RUC and CPT meetings so that a meeting of the workgroup may be convened prior to that time and its deliberations and recommendations may be reviewed at the February meetings. The Workgroup envisions this workgroup to meet in between meetings, involve the input from any and all interested specialty societies, and make its recommendations as soon as possible. It was noted that in no circumstance could the process be completed prior to CPT 2010.

III. Services with High/Low IWPUT

The Workgroup briefly discussed the list of services that were identified with both exceptionally high and low IWPUT. Discussion and review of services with high IWPUT was deferred until the next meeting of the Workgroup during the February RUC meeting. **The Five-Year Review Identification Workgroup recommends 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.**

IV. Services with High Volume Growth

The review of services with high volume growth was deferred until the next meeting of the Workgroup during the February RUC meeting.

V. Private Payor Claims Data

Doctor Levy reported to the Workgroup that several AMA staff and Doctor Peter Hollmann have approached the Blue Cross and Blue Shield Association (BCBSA) regarding the solicitation of claims data for use by the Workgroup. Staff will follow-up with BCBSA staff and continue to pursue procurement of these data.

VI. Codes Indicated for Re-Review

Staff performed an exhaustive search of the RUC database, mining 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 Workgroup considered recommending that the services be reviewed in the next Five-Year Review or that they be added to the New Technology review cycle. The Workgroup agreed that the services should be reviewed prior to the upcoming five-year review. **The Five-Year Review Identification Workgroup recommends that the RUC contact CMS and request permission to review the RVU recommendations for 55866, 57288, and 67225 in consideration for 2009 Medicare Physician Payment Schedule.**

VII. Contractor Medical Director Input

Doctor Richard Whitten, contractor medical director (CMD) from Noridian and former AMA representive to the RUC, has provided the following offer to the RUC:

> *Through their liaison participants in the RUC process, the CMDs have offered to begin a process of improved communication with the RUC and specialty societies by identifying codes that they have concerns may be misvalued to be forwarded to this committee, with evidence, and to welcome further ongoing discussions with the RUC not only at the times of the Five-Year Reviews, but also continuously.*
>
> *It is hoped such a process may address MedPAC and congressional concerns while preserving the primacy of our RUC processes.*

The Workgroup is open to this suggestion and supports it in principle. A general concern and suggestion is that the CMD comments be articulated utilizing the standards such as the RUC's Guidelines for Compelling Evidence. The Workgroup would request that the

CMD representative to the RUC review these comments in advance of sending them to the Workgroup. Only high quality pre-screened comments should be provided to avoid submissions such as those received by CMS in the First Five-Year Review. The Workgroup will invite Doctor Charles Haley to a future meeting to discuss this concept.

AMA
AMERICAN
MEDICAL
ASSOCIATION

October 4, 2007

Ms. Amy Bassano
Director of the Division of Practitioner Services
Center for Medicare Management
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Subject: Remaining RUC Recommendations for CPT 2008

Dear Ms. Bassano:

The American Medical Association/Specialty Society RVS Update Committee (RUC) met on September 27-29, 2007 to consider recommendations related new/revised codes for *CPT 2008*. We understand that CMS in currently in the process of preparing the *Final Rule* on the 2008 Medicare Physician Payment Schedule. We urge CMS to consider these recommendations in the publication of this *Final Rule*, expected to be published in the *Federal Register* on November 1, 2007.

Attached are documents including work relative value recommendations, direct practice inputs, utilization estimates, and suggested PLI relative value crosswalks for the following issues:

- Computer Navigation (20986-20987)
- Femoral Head Fracture (27267-27269)
- G-, J-, G-J, C-Tube Procedures (49440-49465 and 43760)

Also attached are several documents including anesthesia base units recommendations, direct practice expense inputs, utilization estimates and suggested PLI anesthesia base unit crosswalks for several CMS requests received by AMA Staff including:

- Anesthesia Services (00142)
- Chemotherapy Administration (96405, 96406, 96440, 96445, 96450 and 96542)
- Hypothermia (99185-99186)
- Dual Energy X-Ray Absorptiometry

A table for all of the RUC recommendations for CPT 2008 including all of the above recommendations has been included in this submission. Further, a revised time spreadsheet that incorporates all the changes for CPT 2008 including the recommendations from the Five Year Review Identification Workgroup has been included as well. In addition to these recommendations, the RUC would also like to make additional recommendations at this time to be considered in the publication of the *Final Rule*. These recommendations include issues pertaining to professional liability insurance and a request for a re-review of several existing services.

Professional Liability Insurance Recommendations

Professional Liability Insurance (PLI) RVUs (TC/PC) Issue
The RUC originally commented on the PLI technical component/professional component (TC/PC) issue on August 27, 2007, in its comment letter on the Proposed Rule to CMS. However, The American College of Radiology (ACR) indicated that they would like the RUC to discuss its recommendation further and that the RUC provide final comments to CMS after it has had a full discussion.

The PLI Workgroup discussed the TC PLI issue at the September 2007 RUC meeting to accommodate this request. The radiology representatives indicated that they had researched this issue and the feedback indicated that there is no evidence that radiology technologists have separate specific liability insurance.

The RUC reaffirms its recommendation stated in the August 27, 2007 comment letter to CMS.

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.

PLI TC/PC History
In order to review this TC/PC methodology discussion a brief history is outlined below.

Federal Register / Vol. 69, No. 219 / Monday, November 15, 2004, page 66275
Comment: The American College of Radiology (ACR) commented that there is an imbalance between the distribution of malpractice RVUs to the professional component and technical component of a service. The ACR requested that we work with ACR staff to identify alternative methodologies for the more appropriate valuation of technical component services.

CMS Response:
Physician work RVUs are used to adjust for risk of service. Because technical component services do not have physician work RVUs, they are still valued using charge-based RVUs instead of the resource-based malpractice RVU methodology. We look forward working with the ACR and the other interested specialty organizations to examine alternative methodologies that would allow technical component services to also reflect resource-based malpractice RVUs.

October 2006 RUC Recommendation:
CMS should appropriately reallocate PLI RVUs within the physician fee schedule by

accepting the RUC interim recommendation to establish the technical component PLI RVU to be equivalent to the professional component PLI RVU for each CPT code. A long-term strategy should then be explored to allow technical component PLI RVUs to reflect resource-based professional liability costs.

38142 Federal Register / Vol. 72, No. 133 / Thursday, July 12, 2007 / Proposed Rules, Page 38142 -38143
CMS Comment:
In response to our review of the MP RVUs of services, the RUC's PLI Workgroup brought to our attention the fact that there are approximately 600 services that have a technical component MP RVU that is greater than the professional component MP RVU. The RUC has asked CMS to change the technical component MP RVU values, stating that, as physicians have to pay the larger PLI premiums, there should be higher RVUs associated with the professional portions of these services.

In the RUC's comments to CMS, the RUC made two alternative suggestions:
1. CMS should ''flip'' the MP RVUs associated with each of the component parts, so the technical component MP RVUs are assigned the value of the professional component RVUs, and the professional component are assigned the MP RVUs of the technical component MP RVUs; or 2. CMS should make the RVUs of the technical component MP RVUs equal to component. We are not accepting the first suggestion. The professional portion of the MP RVUs have undergone review and are derived from actual data, and are an integral part of our resource based methodology. We do not believe, in the absence of evidence, that our data or conclusions for the professional MP RVUs are inaccurate. It would not be consistent with our resource-based fee schedule methodology to make changes in the professional RVUs that are not supported by actual data. Because no data have been offered to demonstrate that the malpractice costs for the technical portion of these services are the same as for the professional portion of these services, we also do not believe it would be appropriate to accept the second suggestion at this time. To ensure that any changes we make to any MP RVUs are resource-based, we need more information from the affected community. Specifically, we would like to better understand how, and if, technicians employed by facilities purchase PLI or how their professional liability is insured. In addition, we are soliciting comments on what types of PLI are carried by facilities that perform technical services.

We appreciate the RUC's recommendation and are interested in addressing their concerns. Ideally, we would like to develop a resource-based methodology for the technical portion of the MP RVUs. However, at this time we do not have data that would support such a change. Therefore, we are soliciting comments on how we could obtain the necessary data to create resource-based RVUs for these services.

RUC Comment Letter August 27, 2007
Two suggestions regarding corrections to the TC/PC PLI RVU allocation issue appeared in the July 12, 2007 *Proposed Rule,* page 38142. The American College of Radiology (ACR) had initially identified the TC methodology calculation issue in December 1999.

Subsequently, ACR recommended that CMS should "flip" the PLI RVUs associated with each of the component parts. The RUC did not recommend a "flip" of the technical and professional components, but had recommended the equalization as a stopgap measure.

The RUC PLI Workgroup then convened via conference call on July 31, 2007, to further discuss a response to the above CMS question on how to obtain the necessary data to create resource-based RVUs for TC services. The Workgroup determined that liability cost for clinical staff, compared to professional liability cost for the physician service, is inseparable from general practice setting liability insurance cost. Therefore, since there are not separately identifiable PLI premiums paid for the professional technical staff, TC PLI costs should already be included in both the professional component PLI RVU for office-based services and in the facility payment for services performed in hospitals and other facilities. This is consistent with how PLI is handled in the rest of the Physician Payment Schedule, where clinical staff are not included in the PLI resource-based calculation, and where there is no distinction between facility and non-facility PLI.

CMS asks what types of insurance policies are carried by facilities that perform only technical services. General business insurance to insure customers (patients), employees, office, equipment, etc, is considered a component of practice expense and should not be confused with professional liability insurance, or as CMS terms it "malpractice insurance."

A compelling example of inequity created with TC PLI is that CMS currently states that the liability for a MRI technologist to perform an MRI of an upper extremity joint is higher than an Obstetrician performing an amniocentesis. The total PLI RVUs for the MRI in the example below should be about one-forth of the amniocentesis code (0.31/4 =0.08) to represent the relative difference in PLI premiums between the dominant specialties. Therefore, the example below solidifies that using only the professional component is the appropriate approach.

Code	Descriptor	Physician Work RVU	Physician Intra-Service	PLI RVU	Clinical Staff Time	National Avg PLI Premium per CMS
59000	*Amniocentesis; diagnostic*	1.30	20 minutes	0.31	70 minutes – RN	Obstetrician $69,514
73221	*MRI, joint upper extremity*	1.35	20 minutes	0.45 PC=0.06 TC=0.39	71 minutes – MRI Tech	Radiologist $16,913

PLI Crosswalks

The American Association of Oral and Maxillofacial Surgeons (AAOMS) submitted a letter to the RUC, dated July 25, 2007, requesting that the PLI Workgroup review and use more appropriate data for the PLI premium crosswalk for oral surgery and maxillofacial surgery.

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.

CMS Provider Classification	Medicare Specialty	Current PLI Assumptions		Recommendation/ Current Data per AAOMS Letter
19	Oral Surgery	Dentist (DDS) Only – crosswalked to "All Other Physicians"	$22,823	**$6,100** Risk factor of 1.0 (will represent all MDs who do not meet new CMS criteria for Medicare ID 85
85*	Maxillofacial Surgery	MD only or MD/DDS – currently crosswalked to "Plastic Surgery"	$42,569	**$15,948** All oral and maxillofacial surgeons who meet CMS new criteria per OMSNIC data
24	Plastic Surgery	MD	$42,569	$42,569

Requested Re-Review of Existing Services

In 2006, the RUC established the Five-Year Review Identification Workgroup to identify potentially misvalued services using objective mechanisms for reevaluation during the upcoming Five-Year Review. The Workgroup was created following numerous comments from the Medicare Payment Advisory Commission urging medicine to be more diligent in the identification of both potentially over- and under- valued services within the payment schedule for review during the five-year reviews. To that end, the workgroup has identified several objective criteria that may indicate potential misvaluation of services. Chief among these criteria are services with anomalous sites of service when compared to their utilization data. Specifically, these are services that are performed less than 50% of the time in the inpatient setting, yet include inpatient hospital E/M services within their global period. Following discussion of the implication of such anomalies within the RBRVS, the RUC determined that these services would be best reviewed prior to the next Five-Year Review. With affirmative feedback from CMS representatives, the RUC has moved forward on identification and recommendation for action on these site of service anomalies.

The RUC identified two distinct categories of site of service anomalies, those with a full 99238 visit only and those with a 99231, 99232, 99233, and 99238 visit. After requesting feedback from specialty societies for potential justification for such anomalies, the RUC reviewed the services and made a recommendation for action to correct the anomalies. In reviewing services with a full 99238 visit only, the RUC found that a majority of services

have never been reviewed by the RUC and the allocation of office and hospital visits was arbitrarily assigned. As such, the RUC recommends that the full 99238 visit be reduced to 0.5-99238 visit or 0-99238 visit (where appropriate based on dominant site of service), consistent with RUC conventions for the majority of these services. Any impact this may have on time should not be mitigated and total time should subsequently be reduced. However, the RUC does not consider this to have any implication on the work RVU. Following the correction of the time and visit data, the codes will be returned to the pool of all services screened for potential misvaluation through other criteria. Several services, in this screening, were identified as currently under review by the CPT Editorial Panel and will be surveyed following referral from CPT. Additionally, two services were found by the RUC to appropriately contain a full 99238 visit.

The RUC also assessed the services with a 99231, 99232, 99233, and 99238 visit. Following this review, the RUC identified more complex discrepancies that require a greater amount of attention to correct as most of these services are potentially misvalued. For nearly all services, the RUC recommends that the service be surveyed or resurveyed as the site of service may have shifted or may never have been accurately described during the original valuation. In the interim, until the services can be surveyed, the RUC recommends that the inpatient hospital visits (99231, 99232 and/or 99233) be removed and the 99238 visit be reduced or removed from the service's global period. The RUC also recommends that many of the services have their global periods changed. The RUC identified many services that have bi-modal typical patients. Where corrections in CPT coding are not appropriate, the RUC has asked that CMS change the global period so that services for typical patients that do not require an inpatient stay will be correctly reported and services performed for typical patients that do require an inpatient stay may include appropriate E/M coding. Following any change to the global period, the RUC asks that the service be resurveyed. For those services where there is a clear need for greater granularity in code descriptor, the RUC has referred them to the CPT Editorial Panel for review.

As a result of this discussion, the RUC recommends that 18 codes be referred to the CPT Editorial Panel for clarification. Several of these codes are already under consideration by the CPT Editorial Panel through the Soft Tissue Tumor Workgroup. Attached is a letter to Tracy Gordy, MD, Chair of the CPT Editorial Panel, detailing the list of codes the RUC is referring to the Panel as well as a rationale for this referral. Further, the RUC requests that 93 codes be re-reviewed by CMS so that accurate data can be collected from the specialty societies. As part of this re-review, the RUC requests that the global period for 31 codes be assessed for appropriateness. A detailed list of these recommendations is as follows:

CPT Codes Referred to the CPT Editorial Panel for Clarification:

CPT Code	RUC Recommended Action	Rationale for Referral To CPT
11044	Refer to CPT for potential coding changes	Descriptor enables a bi-modal typical patient. Additional granularity in descriptor will provide greater clarity and more accurate valuation based on only one typical patient.
19357	Refer to CPT to consider coding changes because of difference in delayed and immediate breast reconstruction; survey	Differences in delayed and immediate breast reconstruction are likely to affect typical patient being an inpatient or outpatient. Descriptor enables a bi-modal typical patient. Additional granularity in descriptor will provide greater clarity and more accurate valuation based on only one typical patient.
20005	Refer to CPT to consider description change to clarify target - dominant specialty followed closely by podiatry does not make sense b/c deep abscess is unlikely to be done in office; survey	Descriptor enables a bi-modal typical patient. Additional granularity in descriptor will provide greater clarity and more accurate valuation based on only one typical patient.
21015	Refer to CPT for potential coding changes	Already under review by CPT as part of the Soft Tissue Tumor Workgroup
21557	Refer to CPT for potential coding changes	Already under review by CPT as part of the Soft Tissue Tumor Workgroup
21935	Refer to CPT for potential coding changes	Already under review by CPT as part of the Soft Tissue Tumor Workgroup
22900	Refer to CPT for potential coding changes	Already under review by CPT as part of the Soft Tissue Tumor Workgroup
23076	Refer to CPT for potential coding changes	Already under review by CPT as part of the Soft Tissue Tumor Workgroup
27048	Refer to CPT for potential coding changes	Already under review by CPT as part of the Soft Tissue Tumor Workgroup
27615	Refer to CPT for potential coding changes	Already under review by CPT as part of the Soft Tissue Tumor Workgroup
27619	Refer to CPT for potential coding changes	Already under review by CPT as part of the Soft Tissue Tumor Workgroup

CPT Code	RUC Recommended Action	Rationale for Referral To CPT
36834	Refer to CPT for clarification of "plastic repair"; and survey	The RUC was unable to determine the meaning of "plastic repair" and requests clarification from CPT prior to making any determination
37760	Refer to CPT for clarification - consider creation of code for minor perforator ligation; and survey	Descriptor enables a bi-modal typical patient. Additional granularity in descriptor will provide greater clarity and more accurate valuation based on only one typical patient.
57155	Refer to CPT, review global, and resurvey	The typical patient may have changed requiring modification to the descriptor
64416	Refer to CPT, review global, and resurvey	The RUC has recommended for this code a change in global period to 000 for accuracy and consistency of valuation; however, a change in the CPT descriptor is necessary as the existing descriptor implies a global period different from recommended global period. Change in the descriptors and the globals for this entire family of codes is necessary for uniformity and accuracy.
64446	Refer to CPT, review global, and resurvey	The RUC has recommended for this code a change in global period to 000 for accuracy and consistency of valuation; however, a change in the CPT descriptor is necessary as the existing descriptor implies a global period different from recommended global period. Change in the descriptors and the globals for this entire family of codes is necessary for uniformity and accuracy.
64448	Refer to CPT, review global, and resurvey	The RUC has recommended for this code a change in global period to 000 for accuracy and consistency of valuation; however, a change in the CPT descriptor is necessary as the existing descriptor implies a global period different from recommended global period. Change in the descriptors and the globals for this entire family of codes is necessary for uniformity and accuracy

64449	Refer to CPT, review global, and resurvey	The RUC has recommended for this code a change in global period to 000 for accuracy and consistency of valuation; however, a change in the CPT descriptor is necessary as the existing descriptor implies a global period different from recommended global period. Change in the descriptors and the globals for this entire family of codes is necessary for uniformity and accuracy.

Requested CPT Codes to be Re-reviewed Including Requested CMS Global Review:

CPT Code	Requested Global Review	Current Global	Requested Global
11043	No		
14000	Yes	090	000
14001	Yes	090	000
14020	Yes	090	000
14021	Yes	090	000
14040	Yes	090	000
14041	Yes	090	000
14060	Yes	090	000
14061	Yes	090	000
14300	Yes	090	000
15570	Yes	090	000
15572	Yes	090	000
15574	Yes	090	000
15576	Yes	090	000
15740	Yes	090	000
20900	Yes	090	000
20902	Yes	090	000
21025	No		
23120	No		
23410	No		
23412	No		
23415	No		
23420	No		
25116	No		
25310	No		
26080	No		
27062	No		

CPT Code	Requested Global Review	Current Global	Requested Global
27250	Yes	090	000
27640	Yes	090	000
27641	Yes	090	000
27650	No		
27654	No		
27690	No		
27691	No		
28120	Yes	090	000
28122	Yes	090	000
28296	No		
28725	No		
28730	No		
28825	No		
29888	No		
36820	No		
36821	No		
36825	No		
38542	No		
42145	No		
42415	No		
42420	No		
42440	No		
45170	No		
49421	Yes	090	010
49507	No		
49521	No		
49587	No		
51010 (51102 for CPT 2008)	Yes	010	000
52344	No		
52400	No		
52500	No		
52640	No		
53445	No		
54405	No		
54410	No		

CPT Code	Requested Global Review	Current Global	Requested Global
54530	No		
56620	No		
57287	No		
60220	No		
60225	No		
61885	No		
62263	No		
62350	Yes	090	010
62355	Yes	090	000
62360	Yes	090	010
62361	Yes	090	010
62362	Yes	090	010
62365	Yes	090	010
63650	Yes	090	010
63660	Yes	090	010
63685	Yes	090	010
63688	Yes	090	010
64573	No		
64581	No		
64708	No		
64712	No		
64831	No		
65285	No		
68810	No		
69930	No		

In addition to identifying site of service anomalies, the Five-Year Review Identification Workgroup performed an exhaustive search of the RUC database, mining 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 Workgroup considered recommending that the services be reviewed in the next Five-Year Review or that they be added to the New Technology review cycle. The Workgroup agreed that the services should be reviewed prior to the upcoming Five-Year Review. **The Five-Year Review Identification Workgroup and the RUC request permission to review the RVU recommendations for 55866, 57288, and 67225 in consideration for 2009 Medicare Physician Payment Schedule.**

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

Sincerely,

William L. Rich, III, MD, FACS

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

Attachments

AMA/Specialty Society RVS Update Committee **Tab 17**
RUC HCPAC Review Board Meeting
September 27, 2007

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

I. CMS Update

Edith Hambrick, MD, provided a CMS update and informed the HCPAC that the Proposed Rule comment period is closed and CMS is currently in the rule making process. Doctor Hambrick announced that Kerry Weems is the new Acting Administrator for CMS, Herb Kuhn is the Deputy Director and Whitney May is the Deputy Director of the Division of Practitioner Services.

II. HCPAC Structure and Functions

The HCPAC reviewed the HCPAC Structure and Functions document at the February 2007 meeting. When the Non-Physician Team Conference codes were presented, the issue of HCPAC members recusing themselves from voting on a code they have presented arose. 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."

AMA staff provided the above changes to AMA General Counsel to review and they agreed with all the changes made by the HCPAC.

III. HCPAC Process Improvement

The HCPAC discussed 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.

IV. Other Issues

Lloyd Smith, DPM, HCPAC Co-Chair, informed the HCPAC that the American Psychological Association (APA) had persued language in the House CHAMP Act that would result in an 5% increase in overall payment for psychology codes and requires CMS to review the valuation by the next Five-Year Review. The Senate Finance Committee is currently reviewing this provision.

Primary Care Seat
The HCPAC discussed the issue of the primary care seat which will be voted upon by the full RUC at this meeting. The HCPAC indicated that they prefer the definition of primary care to include the addition of "qualified health care professional" as proposed at the April 2007 RUC meeting.

AMA/Specialty Society RVS Update Committee **Tab 18**
Multi-Specialty Points of Comparison Workgroup
September 27, 2007

Members Present: Thomas Felger, MD (Chair), Bibb Allen, Jr, MD, John Derr, Jr, MD, Peter Hollmann, MD, William Moran, MD, David Regan, MD, James Regan, MD, Samuel Smith, MD, Susan Strate, MD, and Richard Tuck, MD

I. Specialty Society Requests to Update the MPC

- **American Academy of Pediatrics (AAP) –** The AAP requested that four "A" criteria codes be added to the MPC List: 62270, 99293, 99295 and 99298. **The MPC Workgroup recommended that these four codes be added to the MPC list and that Radiology, as that the dominant provider of 62270, be contacted to make sure they are in support of this addition.**

- **American Academy of Oral and Maxillofacial Surgeons –** The AAOMS requested that 17 "A" criteria codes be added to the MPC List: 21025, 21030, 21031, 21040**,** 21046, 21047, 21048, 21125, 21141, 21145, 21146, 21147, 40840, 40842, 40843, 40844, 41100. **The MPC Workgroup recommended that these 17 codes be added to the MPC List.**

- **American Academy of Family Physicians –** The AAFP submitted a letter requesting the removal of "C" criteria codes from the MPC List. The MPC Workgroup had a lengthy discussion about the three criteria categories. This discussion included the definitions of the criteria categories:

    - "A" Codes meet all absolute criteria including that the code has gone through the RUC survey process and has RUC approved time

    - "B" Codes do not have RUC time data available, however, the code is performed by several specialties and is well understood by many physicians

    - "C" Codes do not have RUC time data available, however, the specialty society would like the code to be included as a reference point.

  The MPC Workgroup agreed, that in light of the 2010 Five Year Review, action must be taken to ensure the validity of the MPC List. **The MPC Workgroup recommends that all 34 Category "B" and "C" codes be removed from the MPC List following the September 2007 RUC Meeting.**

II. Other Business

The MPC Workgroup at its next meeting will discuss the implications of low volume codes and the wide range of IWPUTs of MPC codes and MPC codes that have been modified through the Five-Year Review Identification Workgroup's recommendations.

Approved by the RUC on September 29, 2007.

AMA/Specialty Society RVS Update Committee **Tab 19**
Practice Expense Subcommittee
Thursday, September 27, 2007

Doctors Bill Moran, MD (Chair), Bibb Allen, MD, Joel Brill, MD, Katherine Bradley, MD, Manuel Cequeira, MD, Thomas Felger, MD, Neal Cohen, MD, David Hitzeman, MD, Peter Hollmann, MD, William Mangold, Jr., MD, Gregory Kwasny, MD, Tye Ouzounian, MD, James Regan, MD, John Seibel, MD, and Anthony Senegore, MD, participated in the discussions.

Doctor Moran began the meeting by welcoming both all of the members to the newly formed Practice Expense Subcommittee that now encompasses both the expertise and work of both the Practice Expense Review Committee and the Practice Expense Subcommittee.

Update on AMA/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. AMA staff expects to receive revised new proposals from Gallup and other survey firms including firms that have conducted supplemental surveys. In mid October, AMA staff is to make decisions regarding the a new contract with an external survey firm, and re-launch the survey (retaining already collected data) in late 2007. The survey will continue through 2008 for data delivery to CMS no later than March 31, 2009. The full presentation is attached to these minutes.

New and Revised CPT Codes - Direct Practice Expense Input Recommendations

- Tab 4. *Computer Navigation (20986-20987)* - The Subcommittee accepted the specialty society recommendation of no practice expense inputs in the non-facility nor the facility setting for these add-on codes.
- Tab 5 *Femoral Head Fracture Treatment (27267-27269)* – The Subcommittee recognized that these codes were emergent procedures performed in the facility setting and the specialty society agree reductions in the pre-service and post service clinical labor time as well as to the supplies and equipment.
- Tab 7 *Tongue Base Tissue Volume Reduction (411XX)* – The Subcommittee and specialty made several modifications to the original recommendation regarding clinical labor, medical supplies, and equipment. The specialty society will supply AMA staff with an invoice regarding the cost of one of the medical supplies.
- Tab 8 *Tongue Suspension (415XX)* – The Subcommittee and specialty made several modifications to the original recommendation regarding clinical labor, medical supplies, and equipment.
- Tab 9 *Laparoscopic Abdominal Wall Hernia Repair (496XX0-496XX5)* – The Subcommittee reviewed the recommended 090 day global standard inputs recommended for these facility only codes, and made a minor edit post operative office visit edit to code 496X1 before accepting all of the inputs.
- Tab 10 *Echocardiography (933XX)* – The Subcommittee reviewed the specialty society recommendation which was a sum of existing direct practice expense inputs from codes 93307, 93320, and 93325. The Subcommittee initially made minor edits to the recommended clinical

labor and medical supplies during its meeting. Concern was expressed when the PE Subcomittee realized that new equipment was recommended. The Subcommittee halted discussion at this time and referred the code for further discussion at the pre-facilitation committee meeting on Friday, September 28. However due to the fact that the code originated from the Five Year Review, where practice expense inputs were not considered part of the review process, the equipment was recommended to remain the same. This recommendation then causes the medical supplies and equipment to be the sum of the codes' parts.

- Tab 11 *Anesthesia Services (0142)* – The Subcommittee reviewed the direct practice expense inputs for this service and agreed with the clinical labor time associated.
  All of these above new and revised codes' practice expense recommendations are attached and recommended to the RUC for approval.

Existing CPT Codes - Direct Practice Expense Input Recommendations

- Tab 12 *Chemotherapy Administration (96405 – 96542)* - The Subcommittee 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 Subcommittee also reviewed recommendations submitted by the American Academy of Dermatology (96405-6), and could not evaluate the specific inputs without a more detailed spreadsheet of clinical activities. The Subcommittee asked the society to provide detailed inputs for its next meeting. The Subcommittee 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 Subcommittee meeting.
- Tab 13 *Hypothermia (99185 and 99186)* - The Subcommittee recognized that these low Medicare volume codes had never been associated with any one particular specialty society. The codes have been on various PEAC and PERC agendas and have never received specialty interest nor recommendations. The Subcommittee recommends that the codes be forwarded to CPT for possible deletion.
- Tab 14 *Dual-energy X-ray (77080)* - The Subcommittee acknowledged that a mistake had been made in the specialty society's previous recommendation. 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 Subcommittee agreed with this change and thanked the society for going through the RUC process for this change.
  All of these above existing codes' practice expense recommendations are attached and recommended to the RUC for approval.

Consideration of Practice Expense Items for Immunization Administration (Indirect vs. Direct

Steven Krug, MD and Julia Pilsbury, DO, FAAP 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. These items include a dedicated refrigeration equipment, and vaccine insurance. In addition, the cost of dedicated clinical labor staff for the management of vaccine materials, the cost of vaccine wastage was also discussed as actual costs. CMS representatives and the Subcommittee members understood that these costs are real and are new state regulations that the practice needs to adhere too. 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 vaccine wastage costs may be the result of the current drug pricing methodologies, and that each state may have different regulatory requirements. In order to consider new clinical labor costs, the Subcommittee questioned its' role in refining existing codes out of the Five Year

Review process. 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 asked the specialty to list out specific recommendations for the RUC to consider at a later date.

New and Revised RUC Recommendation Specialty Mix and Practice Expense RVUs

Doctor Charles Mick, MD from the North American Spine Society alerted the Subcommittee to a problem involving newly valued CPT codes. When the RUC makes its recommendation for physician work, the RUC's summary of recommendation form is submitted with the estimated specialty mix. The importance of recommending an accurate specialty mix was highlighted by Doctor Mick with an explanation of their society's recommendations for three total disc arthroplasty codes presented at the February 2006 RUC meeting. The recommendation resulted in a rank order anomaly for the total RVUs once implemented by CMS. In addition, CMS added to the anomaly by assigning the codes to the "all physicians'" indirect practice expense pool.

NASS and the CMS have since corrected the error which has a proposed increase in the practice expense for one of the three codes by 33% for 2008. The issue was discussed at length and the Practice Expense Subcommittee recommends the following to the RUC:

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 that 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.**

Physician Practice Information Survey

RUC Meeting – September 27, 2007

AMA

TOGETHER WE ARE STRONGER




April 2007 Launch of Survey

- Launched the survey with Gallup on April 1
- 50 physician specialties and other health care professionals included in the survey effort
- Mid-July – 7,725 sample released by this date, only 5% completed




July Re-Tool of Survey

- Re-designed materials sent to physician offices
- Eliminated many questions
- Enhanced Communications
- Practice vs. Individual data




August 2007 Survey Sample Release

- Gallup released 5,600 additional sample on August 1
- Low response rates continue
- September 25 Gallup Report:
  - 13,336 sample in field
  - 1,332 physicians completed (10%)
  - 729 financial sections completed (5%)
  - Disparate results by specialty (0 completes for Interventional Radiology; 38 completes for Colon and Rectal Surgery)




AMA/CMS September 21 Meeting

- AMA has finalized contract with CMS regarding CMS contribution to purchase data computations from survey
- AMA will pursue every option to ensure the success of the survey effort
- CMS staff flexible regarding survey project




New Timeframe

- Initial effort designed to field survey through December 2007 and submit data to CMS by March 31, 2008
- Will need to field survey throughout 2008
- Contracted with CMS to provide data no later than March 31, 2009




Response Rate/Precision Criteria/Number of Completes

- 50% response rate overly aggressive
- 20% response rate now desired
- Top priority – 100 completes per specialty
- Supplemental surveys – designed to meet CMS precision criteria, required 100 completes on average




Owner vs. Employee

- SMS and supplemental surveys – collected data for owners only
- Pilot and full survey demonstrate that practice expense data collection from employees not working
- Only 20 employee completes for practice costs to date.
- Most employees respond “0” or “don’t know” to expense questions despite prompting




Incentives

- Current incentive is $50
- Anecdotal evidence that physician community expects $200+ incentives
- Non-monetary incentives




Communication

- Specialty societies have been cooperative: websites, e-mails, newsletters, etc.
- AMA: AMAVoice; AMNews; CPT Assistant; PAHCOM; MGMA; Morning Rounds; etc.
- CMS receptive to more aggressive Call to Action Letter and Uniform Announcement




Next Steps

- AMA to complete analysis of first 600 completes to assist in decision-making
- Expect to receive revised new proposals from Gallup and other survey firms, including firms that conducted supplemental surveys
- Mid-October – AMA to make decisions regarding external survey firm
- Re-launch in late 2007.




Requests to Specialty Societies

- Continued Communication
- E-mail addresses
- Incentive concepts
- Envelopes

Members Present: Doctors James Blankenship (Chair), Michael Bishop, Ronald Burd, John Gage, Meghan Gerety, Charles Koopmann, Robert Kossman, Barbara Levy, Doug Leahy, Bernard Pfeifer, Lloyd Smith, Arthur Traugott and Richard Tuck.

Item I. Primary Care Seat was not discussed at the full RUC.

I. Primary Care Seat

Doctor Blankenship summarized previous RUC meetings and stated that at the April 2006 meeting the RUC was notified that the 2006 MedPAC report called on CMS to request changes in the composition of the RUC to better represent primary care physicians (PCPs). Doctor Rich charged the Administrative Subcommittee with "thinking outside the box" regarding RUC composition. The RUC requested that staff poll RUC members regarding what expertise the RUC is lacking and whether codes fare better when society presenting them has seat on the RUC.

In February 2007, the Administrative Subcommittee reviewed data compiled by AMA staff and concluded that having a seat on the RUC did not affect success of specialty societies when proposing RVUs for their procedures. A poll of RUC members, alternates, and advisors was reviewed and the RUC voted to "initiate the process of adding a primary care seat to the RUC". The RUC requested specialty societies propose criteria for eligibility for the primary care seat.

In April 2007, the RUC determined the primary care seat should be a rotating seat, defined the term and election rules, eligibility of candidates, solicitation of nominations and the actual definition of primary care. The RUC requested the Administrative Subcommittee draft bylaw changes (RUC's "Structure and Functions" document) for September 2007, which would require 2/3 vote for approval by the RUC.

Primary Care Definition

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 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

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 have 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.

II. Structure and Functions

A. Primary Care Seat

The Administrative Subcommittee recommends making the following changes in the RUC Structure and Functions document 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 above modifications did not achieve a two-thirds majority vote by the RUC.

B. Practice Expense Review Committee

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 as follows:

III. ORGANIZATION AND STRUCTURE

A. RVS Update Committee

(2) Composition

The Chair of the Practice Expense ~~Review Committee~~ Subcommittee will have one (1) non-voting seat and shall be selected by the Chair of the RUC.

(6) Terms of Appointment:

(f) Chair of the Practice Expense ~~Review Committee~~ Subcommittee: The Practice Expense ~~Review Committee (PERC)~~ Subcommittee representative shall be a representative to the RUC for the same term as his or her tenure as the Chair of the Subcommittee.

(7) Voting:

(c) The representatives from the CPT Editorial Panel and the Practice Expense ~~Review Committee~~ Subcommittee shall not be entitled to vote.

E. Subcommittees and Workgroups

(2) Composition - Each Subcommittee or Workgroup will have a permanent number of seats, will be chaired by a RUC member, and be comprised of members selected from the RUC, the AC, and the HCPAC ~~and the PERC~~. Chair and members of each Subcommittee or Workgroup are to be selected by the RUC Chair.

(4) Subcommittees and Workgroups

Current Subcommittees and Workgroups include the following:

a) Administrative Subcommittee – primarily charged with the maintenance of the RUC's procedural issues

b) Five-Year Review ~~Subcommittee~~ Identification Workgroup – oversees the process of the Five-Year Review of the RBRVS and identification of potentially misvalued services

c) Multi-Specialty Points of Comparison (MPC) Workgroup – charged with maintaining the list of codes, which is used to compare relativity of codes under review to existing relative values

d) Practice Expense ~~Review Committee~~ Subcommittee – reviews direct practice expenses (clinical staff, medical supplies, medical equipment) for individual services and

~~e) Practice Expense Subcommittee~~ - examines the many broad and methodological issues relating to the development of practice expense relative values

~~f) Pre-Time Workgroup – primarily charged with developing standard pre-service physician times~~ for codes with surgical global periods (000 day, 010 day and 090 day)

~~e~~g) Professional Liability Insurance (PLI) Workgroup – reviews and suggests refinements to Medicare's PLI relative value methodology

f~~h~~) Research Subcommittee – primarily charged with development and refinement of RUC methodology

The above modifications were approved by the RUC.

III. Conflict of Interest Policy/Confidentiality Review

A. Confidentiality

The Administrative Subcommittee reviewed the current RUC confidentiality agreement. The Subcommittee understands that RUC participants may discuss their issues internally within their organizations as provided for by the RVS Update Process. A Subcommittee member noted that the current statement in the front of the agenda book needs to be clarified to apply to consultants attending the RUC meeting, who may represent multiple clients. **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

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 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

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

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

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.

The above recommendations were approved by the RUC.

AMA/Specialty Society RVS Update Committee **Tab 21**
Research Subcommittee
September 27, 2007

Members Present: Doctors Daniel Mark Siegel (Chair), Dennis Beck, Norman A. Cohen, John Derr, Emily Hill, PA-C, Eileen M. Moynihan, Greg Przybylski, J. Baldwin Smith, Peter Smith, Samuel Smith, Susan Strate, Maurits Wiersema

I. Survey Instrument and Summary of Recommendation Form - Addition of Site of Service for Moderate Sedation

At the April 2007 RUC Meeting, the RUC recommended that the Research Subcommittee review the following issue:

- The RUC noted that some services that may be performed in both the facility and non-facility setting typically deliver moderate sedation in the non-facility and general anesthesia in the facility. The RUC recommends that the Research Subcommittee consider revising the summary of recommendation questions relating to moderate sedation to identify facility versus non-facility setting in order to differentiate in such settings.

The Research Subcommittee recommends 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 <u>when performed in the Hospital/ASC setting or in the Office setting</u>?

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

The Research Subcommittee recommends that the Summary of Recommendation form be modified to read:

Is moderate sedation inherent to this procedure <u>in the Hospital/ASC setting</u>? ___
Percent of survey respondents who stated it is typical <u>in the Hospital/ASC setting</u>? ___

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? ___

Is moderate sedation inherent to this procedure <u>in the</u> <u>Office setting</u>? ___
Percent of survey respondents who stated it is typical <u>in the Office setting</u>? ___

Is moderate sedation inherent in your reference code (Office setting)? ___

The Research Subcommittee 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 recommends 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 recommends 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**.

II. RUC Surveys with a "Low" Median Service Performance Rate – Development of Policy

At the April 2007 RUC meeting, the service performance rate (i.e., number of times performed by the respondent in the last year) for three coding issues was called into question during the RUC's discussion. A few RUC members were concerned that respondents have some defined amount of experience with a service in order to complete the survey. The RUC requested that the Research Subcommittee consider implications and potential guidelines and policies regarding the validity of surveys where the "Service Performance Rate" is exceptionally low.

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.**

III. Specialty Society Request

- Renal Physicians Association – Review of Survey Instrument for End Stage Renal Disease Codes

AMA Staff received a request from CMS regarding the ESRD codes. CMS states, "As you know, in the physician fee schedule final rule for 2007, we did not implement the RUC recommendation to apply the increases in the e/m codes to the G-codes for ESRD physician services. As we stated in the rule, we did not have the information to know what assumptions to make regarding the level of e/m visits to use as part of the building blocks for each of these services. At that time, we also indicated that we would like for the renal physicians to take these G-codes to the RUC, so that we could receive more specific recommendations on the appropriate RVUs for these services. We, therefore, request formally that the RUC review any of the ESRD G-codes that the renal physicians wish to present."

RPA stated that they would like the RUC's Research Subcommittee to review their proposed survey methodology as they plan to survey this issue for the October 2007 RUC meeting. The Research Subcommittee reviewed RPA's proposal. **The Research Subcommittee recommends**

that the specialty review the existing language associated with the temporary ESRD G-codes and submit a coding proposal to the CPT Editorial Panel defining these services and typical patients. Further, the Research Subcommittee offered to review vignettes, proposed educational materials and proposed survey instruments at its September 2007 RUC Meeting.

After several discussions with RPA, it was determined that a conference call of the Research Subcommittee should be convened prior to the September RUC Meeting. This conference call allowed the members of the Research Subcommittee the ability to give some further guidance pertaining to the proposed vignettes, description of service and modifications to the survey instrument as well as to discuss their submitted coding proposal to CPT. The report of this call and RPA's proposed vignettes and survey instruments are on pages 1162 - 1170.

The Research Subcommittee reviewed the proposed modifications to the survey instrument for the ESRD codes and made several recommendations:

1.) In the background for question one, the question will read, "How much of your own time or physician extender time is required per patient treated for the patient care related to this procedure and is not separately reportable? Indicate your time for the new/revised code on the front cover.

2.) Instructions for Completion of Table

1. Column one indicates the hypothetical days of the month for the typical patient being surveyed.
2. Column two asks for the days the patient is being dialyzed—***please indicate the days the patient is on dialysis;*** ~~***this will generally be either Monday, Wednesday and Friday or Tuesday, Thursday and Saturday for all patients.***~~
3. Column three asks for the CPT code that approximates the level of E&M service proxy provided by the physician on that day. Only fill in those days where there was either a face-to-face interaction between the physician and the patient or non-face-to-face interactions such as a telephone call or team conference—***please indicate the CPT codes for the E&M services proxies provided on those days when provided.***
4. Column four asks for the estimated RVUs associated with the service provided as indicated in Column three; the RVUs for the E&M services can be found in the attached table—***please*** ~~***indicate***~~ ***estimate the RVUs associated with this service.***
5. Column five asks for the physician time necessary to provide the E&M service proxy indicated in Column three—***please*** ~~***indicate***~~ ***estimate the time associated with this service.***
6. Column six asks for the CPT code that approximates the level of E&M service proxy provided by the physician extender on that day. Only fill in those days where there was either a face-to-face interaction between the physician extender and the patient or non-face-to-face interactions such as a telephone call or team conference—***please indicate the CPT codes for the E&M services proxies provided on those days when provided.***
7. Column seven asks for the estimated RVUs associated with the service provided as indicated in Column six; the RVUs for the E&M services can be found in the attached table—***please*** ~~***indicate***~~ ***estimate the RVUs associated with this service.***
8. Column eight asks for the physician extender time necessary to provide the E&M proxy services indicated in Column seven—***please*** ~~***indicate***~~ ***estimate the time associated with this service.***
9. ~~Column nine is intended to account for any other services not associated with a specific CPT code, such as chart review, that is associated with the care provided to this typical~~

~~patient~~ ~~***please describe other activities associated with the services provided to this typical patient.***~~

10. ~~Column ten asks for the time associated with the activities outlined in Column nine –~~ ~~***please indicate the time associated with the activities described in Column nine.***~~
11. ***Please total all of the columns in the totals line.***

Also, the Research Subcommittee made several modifications including the removal of columns nine and ten to the proposed table as follows:

Days of the Month	**□ Days of Dialysis**	**Services of Physician**			**Services of Extender (NP/PA/CNS)**			**~~Description of Other Services~~**	
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**~~9~~**	**~~10~~**
		Service Described by CPT Code	**Estimated Work RVU**	**Estimated Time**	**Service Described by CPT Code**	**Estimated Work RVU**	**Estimated Time**	**~~Activity Not Reportable by CPT Code~~**	**~~Time~~**

In addition, the Research Subcommittee discussed how this data once collected from the survey would be distributed to the RUC to evaluate these codes. RPA Staff in coordination with AMA RUC Staff will work together to modify the existing Summary of Recommendation (SOR) form to display this data. This modified SOR will be distributed to the Research Subcommittee for its approval prior to the survey period for the February 2008 RUC Meeting.

- American College of Physicians – Update on the Care Management Code

In the 2006 Tax Relief and Health Care Act, legislation was enacted to establish a Medicare medical home demonstration project. The law requires, "using the relative value scale update committee (RUC) process under such section, the Secretary shall develop a care management fee code for such payments and a value for such code." This legislation has been provided on page 1173 of the agenda book.

ACP has been working with CMS to develop the codes and descriptors for this demonstration project and would like to update the Research Subcommittee on their preparation for the survey process. 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.

IV. Pre-Service Time Follow-Up Discussion

In both March and May of 2007, the RUC requested that CMS consider a modification to the definition of physician pre-service time to be consistent with the pre-service definition utilized for the practice expense methodology. The current CMS definition of pre-service time for physicians is as follows: The pre-service period includes physician services provided from the day before the operative procedure until the time of the operative procedure. **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.** Physicians may engage in many of these pre-service activities (eg, review of records, communicating with other professionals) prior to the day before the operative procedure.

The RUC is engaged in an effort to standardize physician pre-service time. However, the RUC operates under the policies and guidelines established for the RBRVS by CMS. In order for the RUC to proceed with this project, CMS must first determine if the agency will revise the pre-service physician time definition. The RUC in its Comment Letter on the *Proposed Rule* to CMS urged CMS to consider including this proposal in the *Final Rule.* CMS informed the RUC that this recommendation is currently under consideration for the *Final Rule*.

AMA/Specialty Society RVS Update Committee
Research Subcommittee Report
August 27, 2007 – Via Conference Call

Members Present: Daniel Mark Siegel, MD (Chair), Dennis Beck, MD, Norman A. Cohen, MD, Eileen M. Moynihan, MD, Greg Przybylski, MD, Peter Smith, MD, Susan Strate, MD

I. Specialty Society Request – Renal Physicians Association – Review of Survey for End Stage Renal Disease (ESRD) Codes

AMA Staff received a request from CMS regarding the ESRD codes. CMS states, "As you know, in the physician fee schedule final rule for 2007, we did not implement the RUC recommendation to apply the increases in the e/m codes to the G-codes for ESRD physician services. As we stated in the rule, we did not have the information to know what assumptions to make regarding the level of e/m visits to use as part of the building blocks for each of these services. At that time, we also indicated that we would like for the renal physicians to take these G-codes to the RUC, so that we could receive more specific recommendations on the appropriate RVUs for these services. We, therefore, request formally that the RUC review any of the ESRD G-codes that the renal physicians wish to present."

RPA stated that they would like the RUC's Research Subcommittee to review their proposed survey methodology as they plan to survey this issue for the February 2008 RUC meeting. The Research Subcommittee reviewed RPA's proposal including descriptors and vignettes. **The Subcommittee recommended the following to the specialty society:**

1.) **The vignettes for the pediatric ESRD codes (909XX1-909XX9) need to be revised to only describe the typical patient receiving the service. Additionally, it was mentioned that the descriptions of service as provided only to CPT need to be reviewed for consistency to make sure the number of visits described is consistent with the descriptor.**

2.) **As these services are bundled services, it was recommended to the society that a building block methodology would be the best manner to evaluate these codes. The Subcommittee recommended that the building block methodology be incorporated into the survey instrument by utilizing a grid that would allow survey respondents to record what services they provide to the typical patient on a daily basis over a month. This grid would allow the respondent to indicate the days in which the patient received dialysis, the additional services performed by the physician (broken down into E/M visit proxies and actual time), additional services performed by the physician extender, i.e. a nurse practitioner or physician assistant (broken down into E/M visit proxies and actual time) and other services not included in these E/M visit proxies such as record review.**

3.) **On the grid, all of the visits and times should be added by the survey respondent. Then, the visits should be multiplied by the associated E/M work RVU proxies. The resulting work RVUs for the physician extender should be multiplied by .85 to reflect the Medicare payment policy of these professionals. Finally, all work RVUs should be totaled for a recommended work RVU for the particular service being**

surveyed.

4.) **Additional language should be included on the survey instrument to instruct the survey respondent on how to complete the survey. In addition, the survey respondent will be provided a separate sheet, the Building Block Reference List, which will contain all of the services E/M proxies to be utilized in providing these services.**
5.) **The ESRD survey instrument should include all other questions from the standard survey instrument excluding questions 1,2,3,4 and 6 as these questions do not relate to the building block methodology.**

The Research Subcommittee reminded the specialty society that the deadline for the submission of their proposed survey instrument for the September 2007 RUC meeting is September 4, 2007. However, the Subcommittee stated that if they needed additional time, copies of their proposal should be brought to the meeting.

AMA/Specialty Society RVS Update Committee **Tab 22**
Extant Data Workgroup
September 28, 2007

Members Present: David Hitzeman, DO, (Chair), Bibb Allen, MD, John Derr, MD, Charles Mabry, MD, Scott Manaker, MD, Bernard Pfeifer, MD, Peter Smith, MD

The Extant Data Workgroup had a lengthy discussion about several issues pertaining to extant databases. The Workgroup discussed the specialty society recommended inclusionary/exclusionary criteria for extant database for use in the RUC Process. The Workgroup assessed all of the proposed criteria and created a proposed list of criteria including:

- 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 recommends 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.

Further, the Workgroup discussed all of the specialty society identified extant databases and determined that this identification process should continue. **Therefore, the Workgroup recommends that the specialty societies be solicited again to identify any extant databases with which they are familiar.**

Finally, the Workgroup discussed the proposed use of extant databases and ascertained whether extant databases should be a supplementary or a primary source of data in the Five-Year Review Process and/or the New/Revised Process. This discussion will continue at the Workgroup's next meeting with the anticipation of a final recommendation.

In addition, the Extant Data 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.

AMA
AMERICAN
MEDICAL
ASSOCIATION

December 20, 2007

Kerry Weems
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-FC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Subject: CMS-1385-FC Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for Calendar Year 2008

Dear Mr. Weems:

The American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) *Final Rule* on the revisions to Medicare payment policies under the Physician Payment Schedule for calendar year 2008, published in the November 27, 2007 *Federal Register*.

RUC's Recommendations to Correct Misvaluations within the RBRVS

As you are aware, the Medicare Payment Advisory Commission (MedPAC) and others have recently criticized the perceived misvaluation within the Resource-Based Relative Value Scale (RBRVS), particularly for services driven by technology. The RUC, which is sometimes unfairly assigned blame for inaccuracies within the RBRVS, has submitted several key recommendations to CMS to improve this payment system. These recommendations were fully detailed in the RUC's comment letter to CMS' *Proposed Rule*, published in the July 12, 2007, *Federal Register*. We believe that CMS has failed to seriously consider these recommendations to date. We are encouraged that more recent public statements by CMS indicate a willingness to consider the pending RUC recommendations in future rulemaking. We urge you to do so and will continue to develop data and rationale to support this effort. For nearly two decades the RUC, comprised of physicians and health care professional volunteers, has dedicated itself to the improvement of the RBRVS. We hope that we share a mutual goal to ensure that the RBRVS payment system is fair and accurate in its relativity. We must work together to make certain these improvements are appropriately considered and implemented.

A summary of the pending RUC recommendations are as follows:

- *Equipment Usage Percentage Assumptions* - The RUC has consistently recommended that the existing 50% standard utilization rate for all equipment is not an accurate measure. CMS should consider using a higher rate for all equipment, providing an opportunity to specialty societies to provide data to support lower utilization rates, if appropriate, based on clinical or geographic considerations. An increase in the utilization rate should redistribute practice expense relative values to all services within the RBRVS.

- *Equipment Interest Rate Assumptions* – The RUC's principal objection is that CMS had not reviewed the interest rate assumptions since the inception of resource-based practice expenses in 1997. The prime rate fluctuated between 4% and 9.5% in the past ten years. In addition, CMS has never provided a clear explanation of the exact method of determining the interest rates, although it appears that the Small Business Association's maximum rates have been utilized. Commenters have suggested that prime plus two percent would be appropriate. CMS merely stated that prime plus two is currently 11.5% (9.5% +2%) and compares well to the current CMS assignment of 11%, without explaining the method the agency originally used to determine the interest rate. The RUC also noted inconsistencies in the assumptions for loan cost related to equipment costs and useful life of equipment. CMS did not address the RUC comments on either of these two issues. We encourage you to review our August 27, 2007, letter again as you consider interest rate computations in future rulemaking.

- *Pricing of High Cost Disposable Medical Supplies* – The RUC has repeatedly recommended that high cost disposable medical supplies (priced at or above $200) should either be reported separately with HCPCS II codes or individually identified within the payment bundle and then re-priced on an annual basis. CMS reaction to the RUC's recommendation is particularly disappointing. CMS states that it will not review pricing as "any annual repricing of these supplies [disposable medical supplies at or above $200] would place undue burden on specific physician groups."

  The RUC believes this claim is unjustifiable. After a careful analysis of the medical supplies that are priced at or above $200, the RUC determined that there are a total of 53 supply items that fall into this category. Attached is a spreadsheet that lists these 53 items, their prices, the procedure codes with which they are utilized and the top specialty that performs these procedures. After reviewing this list, it became evident that the task of reviewing and potentially re-pricing these items on an annual basis would not place an undue burden on the specialty societies as 1) the current CMS requirement to provide the cost of a supply is to provide the agency with a single invoice and 2) the specialties with the largest number of supplies on this list were diagnostic radiology (thirteen items) and urology (nine items). As such, we do not believe that it would be an undue burden placed

on these societies and the other specialty societies enumerated on this list to provide one invoice for each of their supply items on this list to CMS on an annual basis.

Further, the maintenance of this policy has other detrimental effects. In the *Final Rule*, CMS disagreed with the RUC recommendation and a clinical research study that 1 stent is utilized in transcatheter placement of stent(s) (CPT codes 37205). CMS concluded to amend the practice expense database to reflect 1.5 stents for 37205, a compromise between the RUC's recommendation, clinical research studies and other information provided by commenters that suggested 2 stents would be appropriate. The stents used in these services are currently priced at $1,645, as indicated on the aforementioned list. By not updating these costly supplies on an annual basis, not only will the supply item be potentially over-valued over time, but the supply cost will be overstated each time a single stent is used. The RUC considered this scenario when it recommended that CMS develop separate HCPCS Level II supply coding for these very high cost medical supplies. CMS has made clear, both in the *Final Rule* and in separate communications, that it will not develop separate coding. At a minimum CMS must make sure the pricing for these supplies is accurate and updated on an annual basis.

The refusal to update these supplies on an annual basis could result in distorted relative valuation for these services compared to other physician services. We believe that this action by CMS perfectly illustrates the situation that the RUC is unfortunately enduring. While the RUC has clearly put forward a significant recommendation to address and prevent potential misvaluations in the RBRVS, CMS has decided to ignore the RUC recommendation for specialty society convenience.

- *Professional Liability Insurance (PLI) RVUs* - In the July *Proposed Rule*, CMS indicated that "we would like to better understand how, and if, technicians employed by facilities purchase PLI and how their professional liability is insured. In addition, we are soliciting comments on what types of PLI are carried by facilities that perform technical services."

  In the *Final Rule,* CMS indicates that the agency will not make any changes to the technical component PLI relative values as no data are available. We are not aware that CMS received any evidence that separate professional liability insurance is typically purchased for technicians. In absence of any submitted evidence, and in receipt of a recommendation from the RUC that these policies are not typical, we are perplexed that CMS did not accept the RUC recommendation to eliminate the PLI relative values for the technical component and redistribute these PLI relative values across all physician services. This recommendation from the RUC received a unanimous vote.

CMS was required to publish resource-based PLI relative values in 2000, however the technical component PLI valuation remains charged based. It has distorted relativity in the PLI component for eight years and it is time that CMS take this component of the RBRVS seriously. Although, it is less than 5% of payment for most services, it is a significant cost for some specialties and it is CMS' responsibility to ensure that the relativity reflects these higher premiums relative to other groups with lower premiums. The example provided in our August letter illustrates the problem. It is intuitive that the PLI costs for an obstetrician performing an amniocentesis is higher than the technician's risk in an MRI of the upper extremity. Yet, CMS PLI relative values are higher for the technician.

- *Budget Neutrality/Five-Year Review Work Adjustor* - In this *Final Rule*, CMS announced that the Five-Year Review Work Adjuster will increase from -10.10% to -11.94%. The RUC strongly urges CMS to eliminate this work adjuster. Applying budget neutrality to the work RVUs to offset the improvements in E/M and other services is a step backward, and we strongly urge CMS to instead apply any necessary adjustments to the conversion factor. The RUC also recommends that CMS use unadjusted work relative values as the allocator of indirect practice expenses.

Physician Practice Information Survey Data

CMS currently utilizes practice expense data and physician hours from the 1995-1999 AMA Socioeconomic Monitoring System (SMS) survey to calculate a "practice expense per hour" estimation for each specialty. At several meetings, the RUC has recognized that these data are outdated and that there is a significant need for new survey data. On March 24, 2006, a multi-specialty sign-on letter (signed by more than 70 organizations) was sent to CMS with the following recommendation:

> *We are all in agreement, however, that moving forward, it is imperative that a multi-specialty practice expense survey be conducted to collect recent, reliable, consistent practice expense data for all specialties and health care professionals. We urge CMS to work with the AMA and other physician and health professions organizations to achieve this goal.*

The RUC appreciates that CMS has expressed support of this survey process. CMS indicated in the *Final Rule*, that "we look forward to analyzing the results of the AMA data collection efforts for possible inclusion in the resource-based practice expense methodology in future rulemaking cycles." We understand that the survey will be conducted throughout 2007 and 2008 to collect data for the 2010 Medicare Physician Payment Schedule.

Five-Year Review of Practice Expense Inputs

During the 2005 Five-Year Review process, practice expense inputs were not reviewed as it was considered that the refinement process for the costs had just been completed. Since that time, the RUC has discussed with CMS staff the timing of the next review of practice expense inputs. From these discussions, the RUC assumes that this process will be initiated in the 2009 *Final Rule* along with the initiation of the Five-Year Review Process, culminating in implementation on January 1, 2012. However, we are not confident in this assumption. In this *Final Rule*, CMS responds to several commenters seeking increases in their practice expense relative values by referring them to their specialty and the RUC. We require clarification from CMS. Is it the intention of CMS to initiate a rolling review of practice expense inputs? If this is the case, what is the mechanism to identify the codes for review?

We are also concerned that CMS has included statements in the *Final Rule* that attribute decisions to the RUC that the RUC has not made. For example, CMS discussed a comment that the RUC has failed to consider crash carts to be a direct cost, without clarifying that this was not a RUC action, but rather a decision made by CMS when the practice expense methodology was developed. We also want to clarify that at no time has the RUC attested to whether a service may or may not be safely performed in a physician's office. We want to make abundantly clear to those individuals who have reviewed your comments for transcather placement of stent(s) and arthoscopic procedures that the RUC defers to the specialty society for that determination. We mention these two items to clarify the RUC's role. The RUC process utilizes the methodology and rules developed by CMS and has no role in determining the safety or effectiveness of any medical service.

New and Revised Process: CPT 2008

CMS reviewed and accepted all of the RUC recommendations. The RUC sincerely appreciates the confidence that CMS has displayed in our process of developing work relative value recommendations. We also acknowledge the valuable contribution of your staff in attending and observing our meetings.

Non Face-to-Face Services:

Although, we appreciate your decision to publish the RUC recommendations for several new non face-to-face services in the *Final Rule*, we are disappointed that CMS chose to either bundle or not cover several new CPT codes describing these services. These team conferences, phone calls, and on-line communications were specifically created by CPT and valued by the RUC to exclude any duplication of pre- or post-service time from other physician services. CMS also mentions that the agency will not cover services that include conversations with parents or guardians as they are not the Medicare beneficiary. These codes were designed to also apply to pediatricians, and therefore it is critical for a parent initiated phone call to be included.

We believe that these concerns could be specifically addressed with the CPT Editorial Panel. We urge CMS to reconsider the coverage status for these services.

Fracture Treatment Procedures

As part of the 2005 Five Year Review process, the American Academy of Orthopaedic Surgery (AAOS) commented that the compelling evidence rationale for examining the work RVU for the fracture treatment codes is that there is evidence that incorrect assumptions were made in the valuation of these codes due to lack of clarity of the CPT descriptor. In particular, the CPT descriptor stated "with or without internal or external fixation." However, it is unclear whether the previous valuation for the code included the situation when internal and external fixation is applied to a fracture site. Therefore, the RUC recommended that these codes be referred to the CPT Editorial Panel first for clarification, prior to reviewing evidence of misvaluation.

At the October 2006 CPT Editorial Panel Meeting, the AAOS recommended to the CPT Editorial Panel that the identified fracture treatment codes in the musculoskeletal section of CPT, that includes the nomenclature "internal or external" fixation should be clarified to state that external fixation should be an adjunctive procedure to these procedures. The CPT Editorial Panel agreed with the specialty that these codes needed to be clarified and removed reference to external fixation from 64 CPT codes. These 64 codes were divided into four categories based on convenience of review: Shoulder/Elbow, Elbow/Hand, Hip/Knee and Foot/Ankle. At the February 2007 RUC Meeting, three of these categories were discussed: Shoulder/Elbow, Elbow/Hand and Foot/Ankle. The Hip/Knee codes were discussed at the April 2007 RUC Meeting.

Between 150 and 450 individuals participated in each of the surveys. These respondents included general orthopaedic surgeons, shoulder and elbow surgeons, orthopaedic trauma surgeons, hip and knee surgeons, podiatrists and general hand surgeons. After the results from all of these groups were tabulated, a consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, American Society for Surgery of the Hand, Arthroscopy Association of North America, American Association of Hip and Knee Surgeons, American Podiatric Medical Association and Orthopaedic Trauma Association met to discuss the survey data for the revised fracture treatment codes.

The RUC reviewed the specialties' presentation of the 25th percentile of the survey median for most services. The RUC made several modifications to the recommendations to ensure appropriate rank order and compared these services to multiple reference service codes, including many on the Multi-Specialty Points of Comparison (MPC) list. The issue was deliberated over the course of multiple meetings and hours to ensure not only appropriate intra-service work per unit of time (IWPUT), but appropriate pre- and post-service time and visit allocation. The RUC was confident that its review of these procedures was thorough and

comprehensive. To ensure that the written rationales were complete and appropriate, AMA RUC staff convened a conference call with RUC members and CMS staff prior to the formal submission in May.

In the *Final Rule*, CMS commented that "although we agree with the relationships, the increases in work RVUs re-establish the relativity of the services in these families and in doing so created budget neutrality issues. In order to retain budget neutrality within these families of codes, the work RVUs associated with each code had to be adjusted." The RUC believes that the internal/external fixation codes should not be subject to budget neutrality. The RUC carefully considered whether budget neutrality guidelines should be applied to these recommendations as the RUC operates with the initial presumption that the current values assigned to codes under review are correct. This presumption can be challenged by a society presenting a compelling argument that the existing values are no longer appropriate for the codes in question. The argument for a change in value must be substantial and meet the RUC's compelling evidence standards.

The RUC reviewed the compelling evidence offered by the specialties for these procedures. The specialty societies explained that the CPT descriptors originally contained the phrase "with or without internal or external fixation," leaving it is difficult to determine what the original Harvard survey data actually represented. Furthermore, an Abt study was performed in 1992 for RUC consideration. This study produced percentage relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. Therefore, the specialty society believes that there is little, if any, relationship between the Harvard database time and visit information and the current work RVUs. The specialty societies stated that there was a significant change in the technology for how these procedures are performed. The surgical treatments use open anatomical reduction, and internal fixation has been made more complex with the introduction of new imaging methods such as computed tomography which allows better detection of the fracture pathology and provides the basis for new surgical strategies. There are also new internal fixation devices that require more work.

Further, the patient population has changed, as women over 50 are a fast growing segment of the population. A huge percentage of these patients are osteoporatic – making fracture fixation and maintenance of fixation far more difficult. Also, for several of the identified procedures, the provider of the services has changed and was not a part of the original Harvard studies such as the American Society for Surgery of the Hand. The RUC also reviewed CPT code 20690 *Application of a uniplane (pins or wires in one plane), unilateral, external fixation system* and 20692 *Application of a multiplane (pins or wires in more than one plane), unilateral, external fixation system (eg, Ilizarov, Monticelli type)*. It is the RUC's understanding that the utilization for these two procedures will not change with this coding

change made by the CPT Editorial Panel. Therefore, given the ample amount of compelling evidence offered by the specialty societies, the RUC disagrees with CMS' determination to apply work neutrality to these services and requests that the RUC recommended relative values for these services be implemented.

However, if CMS does not implement the RUC recommended relative values for these services, the RUC requests that the budget neutrality impacts be implemented across a family of codes (i.e. the entire fracture family of codes), not across the arbitrary groupings (i.e. shoulder/elbow), that were created during their valuation process. The method employed by CMS distorted the relativity of the fracture codes.

Specialty Society Request

PE Input Correction for 43760 Change of gastrostomy tube

The RUC in coordination with the American Gastroenterological Association (AGA) and the American Society for Gastrointestinal Endoscopy (ASGE) noted an error in Table 4, *Practice Expense Supply Item Additions for CY 2008,* in the *Final Rule.* The RUC practice expense recommendation for CPT code 43760 *Change of gastrostomy tube,* included 1 low profile gastronomy replacement button and 1 stoma measuring device. As these items were new supplies, the specialty society provided an invoice and product information from the manufacturer. This information detailed that the MIC-KEY Low-Profile Gastrostomy Tube Kit included the following components: MIC-KEY low-profile device, feeding extension set, bolus extension set, one 6 ML syringe (to fill balloon), one 35 ml syringe (to check placement) and four gauze pads. The retail price of this kit was $210. The stoma measuring device had a retail price of $8.82. CMS assigned a unit price of $5 for the MIC-KEY Low-Profile Gastrostomy Tube Kit and $10 for the stoma measuring device.

Furthermore, the specialties recognized that there was some duplicative items listed in the RUC recommendations forwarded to CMS as many of these items are included in the MIC-KEY kit. Items to be removed include: the drainage catheter, one syringe, and four gauze pads. In addition, the specialty wishes to clarify the low profile replacement button is equivalent to the MIC-KEY low profile device which is part of the MIC-KEY kit and therefore recommends that the low profile replacement button also be removed as it is part of the MIC-KEY kit. The RUC is supportive of these modification made by the AGA and ASGE and refers CMS to their letter for further information. Attached to this letter is the modified RUC practice expense recommendation for 43760, and the invoice and product information for these supplies. The RUC requests that CMS correct the pricing error by reviewing the invoices for these two supply items and incorporate the requested modifications.

Please note, however, that the RUC does not endorse any particular supply price. Cost estimates for medical supplies and equipment not listed on "CMS's Labor, Supply, and Equipment List for the Year 2007" are based on provided source(s) as noted, such as manufacturer's catalogue prices, and may not reflect the wholesale prices, quantity or cash discounts, prices for used equipment or any other factors which may alter the cost estimates.

The RUC appreciates the opportunity to offer these comments to CMS. We look forward to the work ahead to further improve the RBRVS.

Sincerely,

William L. Rich, III, MD, FACS

cc: RUC participants
Attachments

RUC Recommended Time for RUC Reviewed Codes and Site of Service Anomalies - September 2007																			
CPT Code	Pre-Evaluation Time	Pre-Positioning Time	Pre-Service Scrub, Dress, Wait Time	Median Intra Service Time	Immediate Post Service Time	99211	99212	99213	99214	99215	99231	99232	99233	99238	99239	99291	99292	Total Time	RUC Meeting Date
00142	15	0	0	38	10												0	63	September 2007
11043	45			45	20			2						.5				175	Five-Year ID WG
11044	60			90	30			3						.5				268	Five-Year ID WG
14001	34	15		105	26			4										272	Five-Year ID WG
14021	37	15		116	28			4										288	Five-Year ID WG
14041	34	15		135	27			4										303	Five-Year ID WG
14061	38	15		157	28			4.5										341.5	Five-Year ID WG
14300	44	25		102	34			4.5										308.5	Five-Year ID WG
15220	27	15		90	27		4.5							.5				250	Five-Year ID WG
15574	50			120	30	1	1	1						.5				265	Five-Year ID WG
15576	45			90	30		1	2						.5				246	Five-Year ID WG
15740	39	15		118	32			4.5						.5				326.5	Five-Year ID WG
15770	28	25		104	23			4.5						.5				302.5	Five-Year ID WG
19020	48			48	14		3											158	Five-Year ID WG
19318	60			150	30	1	2	1						.5				321	Five-Year ID WG
19357	65			105	30		5	7						.5				460	Five-Year ID WG
20000	14			19	14		1											63	Five-Year ID WG
20525	20	15		48	18		1							.5				136	Five-Year ID WG
20694	15	25		26	15		2.5							.5				140	Five-Year ID WG
21015	40			79	30		2	1						.5				223	Five-Year ID WG
21025	75			120	43	2	2	2						.5				349	Five-Year ID WG
21557	24	25		128	18		2							.5				246	Five-Year ID WG
21935	27	25		104	23		4.5							.5				270	Five-Year ID WG
22900	29	25		62	20		2.5							.5				195	Five-Year ID WG
23076	25	15	11	75	20		4.5							.5				237	Five-Year ID WG
23120	21	25		51	20		3.5							.5				192	Five-Year ID WG
23130	19	25	12	66	18		4.5							.5				231	Five-Year ID WG
23405	23	25		47	22		3.5							.5				192	Five-Year ID WG
23410	27	25		80	24		4							.5				239	Five-Year ID WG
23412	28	25		93	25		4							.5				254	Five-Year ID WG
23415	24	25		62	23		3.5							.5				209	Five-Year ID WG
23420	45			120	30			5						.5				329	Five-Year ID WG

CPT Code	Pre-Evaluation Time	Pre-Positioning Time	Pre-Service Scrub, Dress, Wait Time	Median Intra Service Time	Immediate Post Service Time	99211	99212	99213	99214	99215	99231	99232	99233	99238	99239	99291	99292	Total Time	RUC Meeting Date
23430	26	25		60	23		4							.5				217	Five-Year ID WG
23440	25	25		62	21		3.5							.5				208	Five-Year ID WG
25116	21	15		78	21		5							.5				234	Five-Year ID WG
25210	21	25		53	20		3.5							.5				194	Five-Year ID WG
25260	28	15		50	23		5							.5				215	Five-Year ID WG
25280	22	25		53	20		3.5							.5				195	Five-Year ID WG
25310	24	25		71	22		3.5							.5				217	Five-Year ID WG
26080	15	15		34	18		3.5							.5				157	Five-Year ID WG
26356	45			90	30			8						.5				368	Five-Year ID WG
27048	27	25		104	24		4							.5				263	Five-Year ID WG
27062	20	25		49	19		3							.5				180	Five-Year ID WG
27250	22	25		23	22		4.5											164	Five-Year ID WG
27267	7	0	2	15	5		4				2			1				171	September 2007
27268	7	10	2	30	5		4				2			1				196	September 2007
27269	25	15	20	125	30		3	1			2	1		1				404	September 2007
27324	18	25		41	17		3							.5				168	Five-Year ID WG
27615	30	25		150	26		4.5							.5				322	Five-Year ID WG
27619	25	15		89	23		4							.5				235	Five-Year ID WG
27650	20	25	5	68	16		4							.5				217	Five-Year ID WG
27654	27	25		108	22		4							.5				265	Five-Year ID WG
27685	17	25		55	20		4							.5				200	Five-Year ID WG
27687	21	25		59	19		3.5							.5				199	Five-Year ID WG
27690	25	25		91	21		4							.5				245	Five-Year ID WG
27691	27	25		109	22		4.5							.5				274	Five-Year ID WG
27818	19	25		54	12		4							.5				193	Five-Year ID WG
28111	18	25		44	17		3							.5				171	Five-Year ID WG
28118	21	25		56	19		3.5							.5				196	Five-Year ID WG
28120	22	25		67	21		3.5							.5				210	Five-Year ID WG
28122	18	25		51	26		5							.5				219	Five-Year ID WG
28124	17	15		34	21		4											151	Five-Year ID WG
28296	26	25		90	23		4							.5				247	Five-Year ID WG
28298	24	25		77	22		4							.5				231	Five-Year ID WG
28300	25	25		62	23		4							.5				218	Five-Year ID WG

CPT Code	Pre-Evaluation Time	Pre-Positioning Time	Pre-Service Scrub, Dress, Wait Time	Median Intra Service Time	Immediate Post Service Time	99211	99212	99213	99214	99215	99231	99232	99233	99238	99239	99291	99292	Total Time	RUC Meeting Date
28310	19	15		46	18		3							.5				165	Five-Year ID WG
28730	60			120	30			5						.5				344	Five-Year ID WG
28740	45			80	30			4						.5				266	Five-Year ID WG
29888	26	15		127	22		4							.5				273	Five-Year ID WG
30465	30			120	30		2	2						.5				277	Five-Year ID WG
31571	45			40	25									.5				129	Five-Year ID WG
31611	19	25		43	18		2.5							.5				164	Five-Year ID WG
32421	10			28	10													48	Five-Year ID WG
32422	15	15		31	14													75	Five-Year ID WG
32550	15	15	10	30	20													90	Five-Year ID WG
32551	14	25	7	24	25													95	Five-Year ID WG
32560	15	15		39	16													85	Five-Year ID WG
36820	81			90	23		1	1						.5				252	Five-Year ID WG
36821	29	25		75	28		2.5							.5				216	Five-Year ID WG
36825	23	25	8	81	22		2.5							.5				218	Five-Year ID WG
36834	30			73	15		1	1						.5				176	Five-Year ID WG
36870	20			60	15		1							.5				130	Five-Year ID WG
37609	45			30	20		1							.5				130	Five-Year ID WG
37760	30	25	8	133	23		3							.5				286	Five-Year ID WG
37785	21	25		63	17		2							.5				177	Five-Year ID WG
38542	21	25		73	19		3							.5				205	Five-Year ID WG
42145	60			60	30			3						.5				238	Five-Year ID WG
42415	30	25		156	37			3.5						.5				347.5	Five-Year ID WG
42420	32	25		182	22			3.5						.5				360.5	Five-Year ID WG
42440	22	25		71	19		1.5							.5				180	Five-Year ID WG
45170	80			30	45		1	2						.5				236	Five-Year ID WG
46200	21	25		31	19		3.5							.5				171	Five-Year ID WG
48102	20	15		41	17		0.5							.5				120	Five-Year ID WG
49421	20	25		41	15		2							.5				152	Five-Year ID WG
49440	35	5	8	38	20						1							126	September 2007
49441	35	5	8	45	20						1							133	September 2007
49442	35	5	8	30	20						1							118	September 2007
49446	25	8	5	40	15													93	September 2007

CPT Code	Pre-Evaluation Time	Pre-Positioning Time	Pre-Service Scrub, Dress, Wait Time	Median Intra Service Time	Immediate Post Service Time	99211	99212	99213	99214	99215	99231	99232	99233	99238	99239	99291	99292	Total Time	RUC Meeting Date
49450	20	5	5	10	10													50	September 2007
49451	20	5	5	15	10													55	September 2007
49452	20	5	5	20	10													60	September 2007
49460	20	5	5	15	10													55	September 2007
49465	5	5	5	10	10													35	September 2007
49521	45			90	30		1	1						.5				223	Five-Year ID WG
49587	45			60	30		1	1						.5				193	Five-Year ID WG
51040	16	25		33	14		2							.5				139	Five-Year ID WG
51100	10			13	10													33	Five-Year ID WG
51101	12	15		18	12													57	Five-Year ID WG
51102	33			30	20			1						.5				125	Five-Year ID WG
52400	90			60	30			1						.5				222	Five-Year ID WG
52500	40			45	35			3						.5				208	Five-Year ID WG
52640	25	25		39	17		2							.5				157	Five-Year ID WG
53445	50	25		126	24			3						.5				313	Five-Year ID WG
54405	33	25		115	23			2.5						.5				272.5	Five-Year ID WG
54410	50			145	30			2	1					.5				330	Five-Year ID WG
54520	21	25		40	15		1.5							.5				144	Five-Year ID WG
54530	33	25		58	17			2.5						.5				209.5	Five-Year ID WG
56515	50			45	20			1						.5				157	Five-Year ID WG
56620	26	25		66	29			2.5						.5				222.5	Five-Year ID WG
57155	47.5			55	20		1	1						.5				180.5	Five-Year ID WG
57287	45			70	30		1	2						.5				226	Five-Year ID WG
58660	47.5			90	30			1						.5				209.5	Five-Year ID WG
58661	55			90	30			1						.5				217	Five-Year ID WG
60220	62.5			90	25		1	1						.5				235.5	Five-Year ID WG
60300	20			15	15													50	Five-Year ID WG
61793	85			120	18			2						.5				288	Five-Year ID WG
61885	50			60	25			4						.5				246	Five-Year ID WG
62263	40			30	20		2							.5				141	Five-Year ID WG
62281	50			40	30													120	Five-Year ID WG
62287	70			60	30			3						.5				248	Five-Year ID WG
62350	70			60	25		4							.5				332	Five-Year ID WG

CPT Code	Pre-Evaluation Time	Pre-Positioning Time	Pre-Service Scrub, Dress, Wait Time	Median Intra Service Time	Immediate Post Service Time	99211	99212	99213	99214	99215	99231	99232	99233	99238	99239	99291	99292	Total Time	RUC Meeting Date
62355	60			40	20		3							.5				187	Five-Year ID WG
62362	75			90	30		4							.5				278	Five-Year ID WG
62365	60			45	20		3							.5				192	Five-Year ID WG
63650	26	25	5	74	19			2						.5				214	Five-Year ID WG
63660	24	25		64	18			2						.5				196	Five-Year ID WG
63685	28	25		62	18			2						.5				198	Five-Year ID WG
63688	23	25		59	17			2						.5				189	Five-Year ID WG
64416	30			30	20													80	Five-Year ID WG
64573	65			90	20			2						.5				240	Five-Year ID WG
64581	60			120	30				1					.5				269	Five-Year ID WG
64640	20			31	18		1											85	Five-Year ID WG
64708	21	25		76	18		2.5							.5				199	Five-Year ID WG
64712	25	25		109	19		3							.5				245	Five-Year ID WG
64831	25	25		74	21			2.5						.5				221.5	Five-Year ID WG
65105	24	25		77	21			4.5						.5				269.5	Five-Year ID WG
65285	37	15		79	32			5.5						.5				308.5	Five-Year ID WG
66982	40			60	15			5						.5				249	Five-Year ID WG
67039	30	25		88	28			7						.5				351	Five-Year ID WG
67040	36	25		105	30			7.5						.5				387.5	Five-Year ID WG
67107	27	25		107	31				4.5					.5				389	Five-Year ID WG
67108	40	25		191	34				5					.5				509	Five-Year ID WG
67110	24	25		41	25			4.5										218.5	Five-Year ID WG
68810	20			15	15			1	1									113	Five-Year ID WG
69801	21	25		61	17		3											172	Five-Year ID WG
69930	120			180	30		1		2					.5				445	Five-Year ID WG