AMA/Specialty RVS Update Committee
Meeting Minutes
September 22 – September 24, 2011

I. Welcome and Call to Order

Doctor Barbara Levy called the meeting to order on Friday, September 23, 2011, at 8:00 am. The following RUC Members were in attendance:

Barbara Levy, MD (Chair)	J. Allan Tucker, MD
Bibb Allen, MD	George Williams, MD
Michael D. Bishop, MD	Allan Anderson, MD*
James Blankenship, MD	Margie Andreae, MD*
R. Dale Blasier, MD	Gregory DeMeo, DO*
Albert Bothe, MD	Jane Dillon, MD
Joel Bradley, Jr. MD	Verdi Disesa, MD*
Ronald Burd, MD	William Donovan, MD*
Scott Collins, MD	Jeffrey Paul Edelstein, MD*
William Gee, M	Brian Galinat, MD*
Anthony Hamm, DC	Burton L. Lesnick, MD*
David C. Han, MD	William J. Mangold, Jr., MD*
David F. Hitzeman, DO	Terry Mills, MD*
Charles F. Koopmann, Jr., MD	Margaret Neal*
Timothy Laing, MD	Scott D. Oates, MD*
Walt Larimore, MD	Chad Rubin, MD*
Brenda Lewis, DO	Steven Schlossberg, MD*
J. Leonard Lichtenfeld, MD	Eugene Sherman, MD*
Scott Manaker, MD, PhD	Daniel Mark Siegel, MD*
Bill Moran, Jr., MD	Stanley Stead, MD*
Gregory Przybylski, MD	Robert Stomel, DO*
Marc Raphaelson, MD	Jane White, PhD*
Sandra Reed, MD	Jennifer Wiler, MD*
Peter Smith, MD	
Arthur Traugott, MD	*Alternate

II. Director's Report

Sherry Smith made the following announcements:

- Boxes have been provided for any documents that committee members do not want to take with them. This is because of the litigation hold on all documents related to the RUC. There are also bigger boxes for binders if members do not want to take them.
- Introduction and Recognition of RUC Staff:
  - Samantha Ashley - New staff member
  - Zach Hochstetler – Promoted to Senior Policy Analyst II
  - Roseanne Fischoff – 10 years with the AMA/RUC

III. Chair's Report

- Doctor Levy welcomed everyone and recognized new RUC members:
  - Albert Bothe, MD - CPT Representative

  - Anthony Hamm, DC – HCPAC Review Board Co-Chair
  - David Han, MD, MSc, FACS – Society for Vascular Surgery
  - Timothy Laing, MD – American College of Rheumatology
  - J. Allan Tucker, MD – College of American Pathologists
- Doctor Levy announced the following new RUC Alternate Members:
  - William Donovan, MD, MPH, FACR – American College of Radiology
  - Margaret Neal, MD – College of American Pathologists
  - Jennifer Wiler, MD, MBA – American College of Emergency Physicians
  - Jane White, PhD, RD, FADA, LDN – HCPAC Review Board Alternate Co-Chair
- Doctor Levy welcomed the CMS staff and representatives attending the meeting, including:
  - Edith Hambrick, MD, CMS Medical Officer
  - Ken Simon, MD, CMS Medical Officer
  - Ryan Howe
  - Elizabeth Truong
  - Sarah Vitolo
- Doctor Levy welcomed the following Contractor Medical Director:
  - Charles Haley, MD, MS, FACP
- Doctor Levy welcomed the following MedPAC staff:
  - Ariel Winter
- Doctor Levy welcomed the following observers:
  - Arielle Rodman (filling in for Miriam Laugesen, PhD- Assistant Professor of Health Policy and Management at Columbia University).
  - Steven Stack, MD - Chair-Elect of the AMA Board of Trustees
  - Andrew Adair, Health Counsel to Congressman Jim McDermott (WA-07)
- Doctor Levy thanked Roland Goertz, MD, MBA - AAFP Chairman of the Board, for coming and answering questions for the RUC at the Administrative Subcommittee yesterday.
- Doctor Levy gave her condolences on behalf of the RUC to the family and friends of former RUC member Don Williamson, OD who passed away May 23rd after a battle with pancreatic cancer.
- A reminder that there is a confidentiality policy that needs to be signed at the registration table; nothing discussed during the meeting may be discussed outside of the meeting.
- Proceedings are recorded in order for RUC staff to create the meeting minutes.
- Before a presentation, any RUC member with a conflict will state their conflict. That RUC member will not discuss or vote on the issue.
- RUC members or alternates sitting at the table may not present or debate for their specialty.
- The RUC is an expert panel and individuals are to exercise their independent judgment and are not advocates for their specialty.
- Doctor Barbara Levy – RUC Chair; Doctor Robert Wah - AMA Board Chair; Doctor Peter Hollmann - CPT Chair; and Sherry Smith – AMA, met with Doctor Berwick – CMS Administrator; Jonathan Blum – Director Center for Medicare; and Doctor Kelman, CMS Medical Officer on July 29, 2011:
  - Met with respect to the Proposed Rule and specifically the request that RUC review all 91 E/M services in the next couple of years.

- Doctor Berwick was very straightforward about his goals of promoting primary care and supporting coordination of care and delivery reform. The group had a frank discussion of current E/M services and structure, with the RUC representatives making the point that if the committee were to review many of the E/M services it was unlikely to meet his goals. The redistribution of RVUs is unlikely to achieve the affect that Doctor Berwick is looking for in terms of determining the valuation of care coordination.
- Consensus that an alternative solution is to convene a joint RUC/CPT workgroup to determine how to meet those goals without the RUC reviewing all 91 E/M codes.
- There are many non face-to-face services which CPT has developed and RUC has reviewed, which CMS has elected not to cover such as: telephone calls, team conferences and anti-coagulation management, etc. The RUC will recommend that CMS cover these services as an interim step to help value the services that are provided in primary care practices that are not currently contained within E/M services.
- The RUC has formed the Chronic Care Coordination Workgroup (C3W) which is a joint CPT/RUC workgroup chaired by Doctor Traugott. The workgroup is intended to be a short term strategic workgroup to look at coding structure related to the needs for care coordination and prevention codes for chronic diseases. The Workgroup met yesterday and determined a set of interim short-term recommendations will be sent to CMS immediately. The letter will be circulated to all RUC members for review before it is sent to CMS.

IV. CPT Editorial Panel Update

Doctor Bothe provided the report of the CPT Editorial Panel:

- A Workgroup at CPT continues to review appendix C, which contains the clinical examples of E/M. These are being reviewed for accuracy and dispersion among all the relevant specialties.
- The CPT Editorial Panel developed strict category 3 guidelines; which states that if a category 3 code is established and does not progress to a category 1 code within 5 years it will sunset.
- The CPT code proposal application was refined with a question to the applicant about a suggested global period. Caveat that their suggestion has no binding effect on the final decision.
- Doctor Brin the chairman of joint CPT/RUC workgroup of codes that are reported together, reported to the RAW that there are 30 groups of codes that are reported together 75% of the time. 7 proposals have been requested from various specialties to correct issues identified in this screening process.
- 6 articles have been written and submitted by societies in order to clarify issues identified in previous RUC and CPT meetings and 4 have appeared this calendar year in CPT Assistant.
- AMA's public website on CPT has been updated.

V. Centers for Medicare and Medicaid Services Update

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

- The Agency is working on collating information in anticipation of the Final Rule which will be published around the 1st of November
- Thank you to RUC members and alternates for participating in the refinement panel during August-early September
- Chris Ritter has been selected as the Director of Practitioner Services replacing Carol Bazell.

VI. Contractor Medical Director Update

Doctor Charles Haley provided the contractor medical report:

- CMS near the end of their contracting reform efforts, which is to move from the multi-function contractor for each state to many single-function contractors for each region.
    - The central contractor is the Medicare Administrative Contractor (MAC) who processes the claims. There are 11 administrative contractors processing claims and each one processes about half million claims a day.
    - There are currently 4 Jurisdictions that have awarded MAC contracts. In addition jurisdiction 2 and 3 were combined, 7 and 4 were combined with an award pending and 6 and 8 have not been awarded.
- The directive of the contractors is to decrease the paid claims error rate.
    - Overall paid claims error rate is 10.5% which is $34.2 billion paid in error.
    - Part A inpatient claims error rate is 9.5% which is $11.3 billion paid in error. More effort is going to Part A inpatient claims because it accounts for a larger portion of Medicare spending.
- In 2008, CMS moved the responsibility for medical review of inpatient claims from the Quality Improvement Organization (QIO) to the A/B MAC. There are 5 contractors that could ask physicians for supporting documents related to a Medicare claim:
    - A/B MAC – TrailBlazer (Dallas)
    - Zone Program Integrity Contractor (ZPIC) – Health Integrity (Dallas/Baltimore):
    - Recovery Audit Contractor (RAC) – Connolly Consulting (Philadelphia):
    - Comprehensive Error Rate Testing (CERT) – AdvanceMed (Richmond):
    - Quality Improvement Organization (QIO)
- Other activities involved in the Medical Review process are claims reprocessing and revalidation.

VII. Washington Update

Todd Askew, AMA, provided the RUC with the following information regarding the AMA's advocacy efforts:

- January 1, 2012 Medicare payment rates will be cut by 30%. Committees are only looking at short-term extensions of current rates.
    - In 2005 repeal of the SGR would have cost $48 billion, in 2011 it would cost $300 billion to do the same. The cost of freezing rates for just one year is currently $20 billion.
    - Most members of Congress agree that SGR must be repealed but they are not willing to make it part of their agenda.
    - Because of the economic crisis there is focus in Congress on deficit reduction, which is not conducive to a repeal of the SGR

- During the debt limit debate Congress agreed to 2.2 trillion in deficit reduction. $1 trillion is obtained through caps on discretionary spending and the Supercommittee is charged with coming up with $1.2 trillion more.
    - If they fail, they will enter a process called sequestration; across the board cuts to all government spending for 1.2 trillion. Theoretically there would be 6 billion in cuts for both defense and non-defense spending, although there are many programs that cannot be cut , Medicare is limited to 2%, however this is on top of the SGR 30% cut.
    - All deficit reduction proposals that the Supercommittee is considering have called for a repeal of the SGR.
    - The President's jobs proposal includes deficit reduction measures that claim to repeal the SGR, however it is actually a baseline adjustment that looks to many savings proposals that have been proven ineffective in the past (imaging, pre-auth, etc.)

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

- The jobs bill includes language about permanently repealing the SGR
- Does not identify specific pay-fors but NYT says much of Medicare savings included in the bill will be used for this purpose. The amount of Medicare savings outlined in the bill is not enough for the SGR repeal. The health care savings outlined in the bill include:
    - Medicare: $248 billion
    - $224 billion from providers
    - $24 billion from beneficiaries
    - Medicaid: $66 billion
    - Miscellaneous: $11 billion
    - TRICARE: $20.6 billion
- Cuts for physicians and other providers include:
    - Imaging: $1.3 billion
    - Graduate Medical Education: $9 billion
    - Reduce bad debt coverage: $20 billion
    - Reduce special rural pay adjustments: $6 billion
    - Reduce post acute care pay: $42 billion
    - Drug Rebates: $135 billion
    - Waste, fraud and abuse: $2.3 billion
- Beneficiary Changes
    - Contingent on revenue increases through corporate entities and the wealthy
    - Start in 2017 & apply to new beneficiaries
    - Raise income-related premiums--$20 billion
    - Increase Part B deductible--$1 billion
    - Impose home health copayment--$400 million
    - Add surcharge for low co-pay Medigap--$2.5 billion
- MedPAC tentatively approved a proposal last week that replaces the SGR with a freeze in current payment levels for primary care and a 17% cut for all other services over three years followed by a freeze. The cuts could be implemented with a payment modifier or separate conversion factor. MedPAC estimates cuts will reduce SGR repeal cost to $200 billion. Other recommendations being considered in October are:

  - Secretary to conduct data collection from efficient practices to establish more accurate work and practice expense values to be completed within three years.
  - Data will be used by the Secretary to identify overpriced fee schedule services and reduce their RVUs. Goal is to reduce at least 1% of fee schedule spending over five consecutive years.
  - Increased shared savings opportunities for physicians who join or lead ACOs with two sided risk and determine spending benchmarks for two-sided risk ACOs.
- AMA does not support MedPAC's proposal because it is not a realistic proposal for stabilizing the program and guaranteeing continued access. The proposal will encourage physician retirement, creating shortages in many specialties and the Commission's recommended cuts would occur on top of E-Rx, PQRS and EMR penalties, which could reach 9% at the midpoint of this proposal.
- AMA will continue to advocate against this plan and point out the flaws especially with the payment accuracy proposals.

VIII. Approval of Minutes of the April 27 – May 1, 2011 RUC Meeting

The RUC approved the April 2011 RUC Meeting Minutes as submitted.

IX. Relative Value Recommendations for *CPT 2012:*

Pacemaker or Pacing Cardioverter-Defibrillator (Tab 4)
Richard Wright, MD (ACC); David Slotwiner, MD (HRS)

In February 2010, the Pacemaker and Pacing Cardioverter-Defibrillator series of CPT codes (33207, 33208, 33212, 33213, 33240 and 33249) were identified by the Relativity Assessment Workgroup through the Codes Reported Together 75% or More Screen. These insertion codes were commonly billed with the removal codes (33233, 33241 and 71090) or the device evaluation code (93641). In February 2011, the specialties submitted a code change proposal to the CPT Editorial Panel to bundle the services commonly reported together. A total of 12 codes were created or significantly revised, mandating a RUC survey in April 2011. In April 2011, the RUC reviewed the services and determined that the survey data was inconsistent both in the physician time and work values of the removal and replacement codes. In addition, a data error was noted to have caused wide variances in the survey's post-operative visit data. Given the complexity of these services, the RUC recommended interim values at the April 2011 RUC Meeting. The specialty societies resurveyed these codes and presented them to the RUC at the September 2011 RUC Meeting.

Pacemaker Services
33212 ***Insertion of pacemaker pulse generator only with existing; single lead***
The RUC reviewed the survey data for CPT code 33212 and agreed that the median physician time components accurately reflect the physician time required to perform this service. However, the survey respondents overstated the work RVU at the median level and the RUC agreed that the 25th percentile work RVU of 5.26 was appropriate for this service. To validate a work RVU of 5.26, the RUC compared 33212 to the key reference service CPT code 61885 *Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array* (work

RVU= 6.05). The Committee noted that the reference service has greater total time compared to the surveyed code, 181 minutes and 129 minutes, respectively and should be valued greater than 33212. Finally, the RUC discussed the appropriate level of post-operative visits for this service. The RUC agreed that the typical physician work related to the management of the wound requires one level three office visit (99213) and a half discharge day management service (99238). With solid survey data and the comparison to the key reference code, the RUC concurred that 33212 is appropriately valued relative to the family of services and other similar services in the RBRVS. **The RUC recommends a work RVU of 5.26 for CPT code 33212.**

33213 ***Insertion of pacemaker pulse generator only with existing; dual leads***
The RUC reviewed the survey data for CPT code 33213 and agreed that the median intra-service time accurately reflects the physician time required to perform this service. However, the post-service time was reduced from 22.5 minutes to 20 minutes to maintain continuity between the entire family of services. The RUC agreed that the survey respondents overstated the work RVU at the median level and a consistent work value was established to ensure the physician work required to insert or remove and replace each additional lead is accurate and relative to the family. Therefore, the RUC reviewed the survey data and noted that the average increase at the 25th percentile between each additional lead is 0.27 work RVUs for the entire surveyed family. The Committee applied the standard increment of 0.27 work RVUs to the base code, 33212, and agreed that a work RVU of 5.53 accurately reflects the typical physician work for 33213. To validate this work RVU, the RUC compared 33213 to reference code 61885 *Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array* (work RVU= 6.05) and noted that 61885 has greater total time at 181 minutes compared to 130 minutes and should be valued greater than the surveyed code. Finally, the RUC discussed the appropriate level of post-operative visits for this service. The RUC agreed that the typical physician work related to the management of the wound requires one level three office visit (99213) and a half discharge day management service (99238). With the comparison to the reference code, the RUC concurred that 33213 is appropriately valued relative to the family of services and other similar services in the RBRVS. **The RUC recommends a work RVU of 5.53 for CPT code 33213.**

33221 ***Insertion of pacemaker pulse generator only with existing; multiple leads***
The RUC reviewed the survey data for CPT code 33221 and agreed that the median physician time components accurately reflect the physician time required to perform this service. However, the survey respondents overstated the work RVU at the median level and the RUC applied the standard increment of 0.27 work RVUs to the insertion of dual leads code, 33213, and agreed that a work RVU of 5.80 accurately reflects the typical physician work for 33221. To validate this work RVU, the RUC noted that the recommended work RVU is almost identical to the 25th percentile survey value of 5.79. In addition, the RUC compared 33221 to reference code 61885 *Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array* (work RVU= 6.05) and noted that 61885 has greater total time at 181 minutes compared to 134 minutes and should be valued greater than the surveyed code.

The RUC discussed the appropriate level of post-operative visits for this service. The RUC agreed that the typical physician work related to the management of the wound requires one level three office visit (99213) and a half discharge day management service (99238). Finally, the Committee compared the recommended work value of 33221 compared to

33213 and agreed that the increase of 0.27 work RVUs accurately reflects the added complexity of physician work required with the insertion of more than two leads. With the comparison to the reference code, the RUC concurred that 33221 is appropriately valued relative to the family of services and other similar services in the RBRVS. **The RUC recommends a work RVU of 5.80 for CPT code 33221.**

33227 ***Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; single lead system***
The RUC reviewed the survey data for CPT code 33227 and agreed that the median physician time components accurately reflect the physician time required to perform this service. However, the survey respondents overstated the work RVU at the median level and the RUC agreed that the 25th percentile work RVU of 5.50 was appropriate for this service. To validate a work RVU of 5.50, the RUC compared 33227 to reference code 61885 *Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array* (work RVU= 6.05) and noted that 61885 has greater total time at 181 minutes compared to 129 minutes and should be valued greater than the surveyed code. In addition, the Committee reviewed 36570 *Insertion of peripherally inserted central venous access device, with subcutaneous port; younger than 5 years of age* (work RVU= 5.36) and agreed that both services have identical intra-service time, 45 minutes, and should be valued similarly. Finally, the RUC discussed the appropriate level of post-operative visits for this service. The RUC agreed that the typical physician work related to the management of the wound requires one level three office visit (99213) and a half discharge day management service (99238). With solid survey data and the comparison to two reference codes, the RUC concurred that 33227 is appropriately valued relative to the family of services and other similar services in the RBRVS. **The RUC recommends a work RVU of 5.50 for CPT code 33227.**

33228 ***Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; dual lead system***
The RUC reviewed the survey data for CPT code 33228 and agreed that the median physician time components accurately reflect the physician time required to perform this service. However, the survey respondents overstated the work RVU at the median level and the RUC established a consistent work value increment to ensure the physician work required to insert or remove and replace each additional lead is accurate and relative to the family. Therefore, the RUC reviewed the survey data and noted that the average increase at the 25th percentile between each additional lead is 0.27 work RVUs for the entire surveyed family. The Committee applied the standard increment of 0.27 work RVUs to the base code, 33227, and agreed that a work RVU of 5.77 accurately reflects the typical physician work for 33228. To validate this work RVU, the RUC noted that the recommended work RVU is almost identical to the 25th percentile survey value of 5.70. In addition, the RUC compared 33228 to reference code 61885 *Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array* (work RVU= 6.05) and noted that 61885 has greater total time at 181 minutes compared to 134 minutes and should be valued greater than the surveyed code. The Committee also reviewed 36570 *Insertion of peripherally inserted central venous access device, with subcutaneous port; younger than 5 years of age* (work RVU= 5.36) and agreed that the surveyed code should be valued higher than the reference code due to greater intra-service time, 50 minutes and 45 minutes, respectively. Finally, the RUC discussed the appropriate level of post-operative visits for this service. The RUC agreed that the typical physician work related to the management of the wound requires one level three office visit (99213) and a half discharge day management service (99238). With the

comparison to two reference codes, the RUC concurred that 33228 is appropriately valued relative to the family of services and other similar services in the RBRVS. **The RUC recommends a work RVU of 5.77 for CPT code 33228.**

33229 ***Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; multiple lead system***
The RUC reviewed the survey data for CPT code 33229 and agreed that the median physician time components accurately reflect the physician time required to perform this service. However, the survey respondents overstated the work RVU at the median level and the RUC applied the standard increment of 0.27 work RVUs to the dual removal and replacement of a dual lead system code, 33229, and agreed that a work RVU of 6.04 accurately reflects the typical physician work for 33229. To validate this work RVU, the RUC noted that the recommended work RVU is almost identical to the 25th percentile survey value of 6.00. In addition, the RUC compared 33229 to reference code 61885 *Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array* (work RVU= 6.05) and noted that 61885 has greater total time at 181 minutes compared to 144 minutes and should be valued greater than the surveyed code. The Committee also reviewed 62350 *Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy* (work RVU= 6.05) and noted that both services have identical intra-service time, 60 minutes. Therefore, 33229 and 62350 should be valued almost identically.

The RUC discussed the appropriate level of post-operative visits for this service. The RUC agreed that the typical physician work related to the management of the wound requires one level three office visit (99213) and a half discharge day management service (99238). Finally, the Committee compared the recommended work value of 33229 compared to 33228 and agreed that the increase of 0.27 work RVUs accurately reflects the added complexity of physician work required with the removal of more than two leads. With the comparison to the reference codes, the RUC concurred that 33229 is appropriately valued relative to the family of services and other similar services in the RBRVS. **The RUC recommends a work RVU of 6.04 for CPT code 33229.**

Cardioverter-Defibrillator Services
33240 ***Insertion of pacing cardioverter-defibrillator pulse generator only with existing; single lead***
The RUC reviewed the survey data for CPT code 33240 and agreed that the median physician time components accurately reflect the physician time required to perform this service. However, the survey respondents overstated the work RVU at the median level and the RUC agreed that the 25th percentile work RVU of 6.05 was appropriate for this service. To validate a work RVU of 6.05, the RUC compared 33240 to reference code 36561 *Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; age 5 years or older* (work RVU= 6.04) and noted that while the surveyed code has greater total time compared to the reference code, 140 minutes and 130 minutes, respectively, the intra-service time for both services is highly comparable with identical time of 45 minutes. Given this, the RUC agreed that the two services should be valued similarly. Finally, the RUC discussed the appropriate level of post-operative visits for this service. The RUC agreed that the typical physician work related to the management of the wound requires one level three office visit (99213) and a half discharge day management service (99238). With the comparison to the reference code, the RUC concurred that 33240

is appropriately valued relative to the family of services and other similar services in the RBRVS. **The RUC recommends a work RVU of 6.05 for CPT code 33240.**

33230 ***Insertion of pacing cardioverter-defibrillator pulse generator only with existing; dual leads***

The RUC reviewed the survey data for CPT code 33230 and agreed that the median intra-service time accurately reflects the physician time required to perform this service. However, the post-service time was reduced from 25 minutes to 20 minutes to maintain continuity between the entire family of services. The RUC agreed that the survey respondents overstated the work RVU at the median level and a consistent work value was established to ensure the physician work required to insert or remove and replace each additional lead is accurate and relative to the family. The Committee applied the standard increment of 0.27 work RVUs to the base code, 33240, and agreed that a work RVU of 6.32 accurately reflects the typical physician work for 33230. To validate this work RVU, the RUC compared 33230 to reference code 36561 *Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; age 5 years or older* (work RVU= 6.04) and noted that the surveyed code has greater intra-service time compared to the reference code, 60 minutes and 45 minutes, respectively. Therefore, 33230 should be valued greater than the reference code. In addition, the RUC compared 33230 to reference code 61885 *Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array* (work RVU= 6.05) and agreed that the surveyed code should be valued greater given its higher intra-service time compared to the reference code, 60 minutes and 45 minutes, respectively. Finally, the RUC discussed the appropriate level of post-operative visits for this service. The RUC agreed that the typical physician work related to the management of the wound requires one level three office visit (99213) and a half discharge day management service (99238). With the comparison to the reference codes, the RUC concurred that 33230 is appropriately valued relative to the family of services and other similar services in the RBRVS. **The RUC recommends a work RVU of 6.32 for CPT code 33230.**

33231 ***Insertion of pacing cardioverter-defibrillator pulse generator only with existing; multiple leads***

The RUC reviewed the survey data for CPT code 33231 and agreed that the median intra-service time accurately reflects the physician time required to perform this service. However, the post-service time was reduced from 25 minutes to 20 minutes to maintain continuity between the entire family of services. The RUC agreed that the survey respondents overstated the work RVU at the median level and a consistent work value was established to ensure the physician work required to insert or remove and replace each additional lead is accurate and relative to the family. The Committee applied the standard increment of 0.27 work RVUs to the insertion of dual leads code, 33230, and agreed that a work RVU of 6.59 accurately reflects the typical physician work for 33231. To validate this work RVU, the RUC first noted that the recommended work RVU is almost identical to the 25th percentile survey value of 6.63. In addition, the RUC compared 33231 to reference code 36561 *Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; age 5 years or older* (work RVU= 6.04) and noted that the surveyed code has greater intra-service time compared to the reference code, 60 minutes and 45 minutes, respectively. Therefore, 33231 should be valued greater than the reference code. In addition, the RUC compared 33231 to reference code 61885 *Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array* (work RVU= 6.05) and agreed that the surveyed

code should be valued greater given its higher intra-service time compared to the reference code, 60 minutes and 45 minutes, respectively.

The RUC discussed the appropriate level of post-operative visits for this service. The RUC agreed that the typical physician work related to the management of the wound requires one level three office visit (99213) and a half discharge day management service (99238). Finally, the Committee compared the recommended work value of 33231 compared to 33230 and agreed that the increase of 0.27 work RVUs accurately reflects the added complexity of physician work required with the insertion of more than two leads. With the comparison to the reference codes, the RUC concurred that 33231 is appropriately valued relative to the family of services and other similar services in the RBRVS. **The RUC recommends a work RVU of 6.59 for CPT code 33231.**

33262 ***Removal of pacing cardioverter-defibrillator pulse generator with replacement of pacing cardioverter-defibrillator pulse generator; single lead system***
The RUC reviewed the survey data for CPT code 33262 and agreed that the median physician time components accurately reflect the physician time required to perform this service. However, the survey respondents overstated the work RVU at the median level and the RUC agreed that the 25th percentile work RVU of 6.06 was appropriate for this service. To validate a work RVU of 6.06, the RUC compared 33262 to reference code 62350 *Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy* (work RVU= 6.05) and noted that both codes have identical intra-service time, 60 minutes and similar total time. Therefore, the surveyed code and reference code should be valued almost identically. Finally, the RUC discussed the appropriate level of post-operative visits for this service. The RUC agreed that the typical physician work related to the management of the wound requires one level three office visit (99213) and a half discharge day management service (99238). With solid survey data and the comparison to the reference code, the RUC concurred that 33262 is appropriately valued relative to the family of services and other similar services in the RBRVS. **The RUC recommends a work RVU of 6.06 for CPT code 33262.**

33263 ***Removal of pacing cardioverter-defibrillator pulse generator with replacement of pacing cardioverter-defibrillator pulse generator; dual lead system***
The RUC reviewed the survey data for CPT code 33263 and agreed that the median intra-service time accurately reflects the physician time required to perform this service. However, the post-service time was reduced from 25 minutes to 20 minutes to maintain continuity between the entire family of services. The RUC agreed that the survey respondents overstated the work RVU at the median level and a consistent work value was established to ensure the physician work required to insert or remove and replace each additional lead is accurate and relative to the family. The Committee applied the standard increment of 0.27 work RVUs to the base code, 33262, and agreed that a work RVU of 6.33 accurately reflects the typical physician work for 33263. To validate this work RVU, the RUC compared 33263 to reference code 36561 *Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; age 5 years or older* (work RVU= 6.04) and noted that the surveyed code has greater intra-service time compared to the reference code, 60 minutes and 45 minutes, respectively. Therefore, 33263 should be valued greater than the reference code. In addition, the RUC compared 33263 to reference code 61885 *Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array* (work RVU= 6.05) and agreed that the surveyed code should be valued greater given its higher

intra-service time compared to the reference code, 60 minutes and 45 minutes, respectively. Finally, the RUC discussed the appropriate level of post-operative visits for this service. The RUC agreed that the typical physician work related to the management of the wound requires one level three office visit (99213) and a half discharge day management service (99238). With the comparison to the reference codes, the RUC concurred that 33263 is appropriately valued relative to the family of services and other similar services in the RBRVS. **The RUC recommends a work RVU of 6.33 for CPT code 33263.**

33264 ***Removal of pacing cardioverter-defibrillator pulse generator with replacement of pacing cardioverter-defibrillator pulse generator; multiple lead system***
The RUC reviewed the survey data for CPT code 33264 and agreed that the median physician time components accurately reflect the physician time required to perform this service. However, the survey respondents overstated the work RVU at the median level and the RUC agreed that a consistent work value increment should be established to ensure the physician work required to insert or remove and replace each additional lead is accurate and relative to the family. The Committee applied the standard increment of 0.27 work RVUs to the removal and replacement of a dual lead system code, 33263, and agreed that a work RVU of 6.60 accurately reflects the typical physician work for 33264. To validate this work RVU, the RUC first noted that the recommended work RVU is almost identical to the 25th percentile survey value of 6.63. In addition, the RUC compared 33264 to reference code 36561 *Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; age 5 years or older* (work RVU= 6.04) and noted that the surveyed code has greater intra-service time compared to the reference code, 60 minutes and 45 minutes, respectively. Therefore, 33264 should be valued greater than the reference code. In addition, the RUC compared 33264 to reference code 61885 *Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array* (work RVU= 6.05) and agreed that the surveyed code should be valued greater given its higher intra-service time compared to the reference code, 60 minutes and 45 minutes, respectively.

The RUC discussed the appropriate level of post-operative visits for this service. The RUC agreed that the typical physician work related to the management of the wound requires one level three office visit (99213) and a half discharge day management service (99238). Finally, the Committee compared the recommended work value of 33264 compared to 33263 and agreed that the increase of 0.27 work RVUs accurately reflects the added complexity of physician work required with the insertion of more than two leads. With the comparison to the reference codes, the RUC concurred that 33264 is appropriately valued relative to the family of services and other similar services in the RBRVS. **The RUC recommends a work RVU of 6.60 for CPT code 33264.**

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

Practice Expense
The RUC accepted the direct practice expense inputs recommended by the specialty for these procedures performed in the facility setting at the April 2011 RUC Meeting.

Molecular Pathology-Tier 1 (Tab 5)

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The CPT Editorial Panel has developed a new coding structure to describe molecular pathology services, based on the efforts and recommendations of the Molecular Pathology Coding Workgroup convened beginning in October 2009. In October 2010 and February 2011, the Panel accepted 92 Tier 1 codes, which are a list of gene-specific and genomic analysis CPT codes for high-volume molecular pathology services. These services were previously reported with a series of "stacking codes." The RUC understands that payment for these services is currently based on a mixture of payment methodologies, including the physician fee schedule and the clinical lab fee schedule. CMS requested that the RUC review data provided by the College of American Pathologists to provide the agency with more information, as a policy is developed to determine which payment schedule is appropriate for these services. In April 2011, the RUC recommended physician work and time values for 18 Tier I codes. In September 2011, the specialty presented data on the remaining 52 services. At this time, the specialty indicated that interpretation is not typically performed by a physician for the remaining Tier I codes.

81225 CYP2C19 (cytochrome P450, family 2, subfamily C, polypeptide 19) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *8, *17)
The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81225 was 13 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that although the time associated with the key reference code 86320 *Immunoelectrophoresis; serum* (total time = 17 minutes, work RVU = 0.37) is slightly more than the surveyed code, 81225 is a more complex and intense service perform. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which requires similar physician work and time to perform. The specialty society also explained that this service keeps rank order with Tier 2 code 81401 *Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat*), which the RUC recommended at this meeting 0.40 work RVUs for 15 minutes of intra-service time. **Based on these comparisons, the RUC recommends a work RVU of 0.37, the survey's 25th percentile, for CPT code 81225**.

81245 FLT3 (fms-related tyrosine kinase 3) (eg, acute myeloid leukemia), gene analysis, internal tandem duplication (ITD) variants (ie, exons 14, 15)
The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81245 was 15 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that the key reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work RVU = 0.52) requires more time than the surveyed code.. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which requires

similar physician work and time to perform. The specialty society also explained that this service keeps rank order with Tier 2 code 81401 *Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat*), which the RUC recommended at this meeting 0.40 work RVUs for 15 minutes of intra-service time. **Based on these comparisons, the RUC recommends a work RVU of 0.37, the survey's 25th percentile, for CPT code 81245**.

81350 UGT1A1 (UDP glucuronosyltransferase 1 family, polypeptide A1) (eg, irinotecan metabolism), gene analysis, common variants (eg, *28, *36, *37)
The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81350 was 15 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that the key reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work RVU = 0.52) requires more time than the surveyed code. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which requires similar physician work and time to perform. The specialty society also explained that this service keeps rank order with Tier 2 code 81401 *Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat*), which the RUC recommended at this meeting 0.40 work RVUs for 15 minutes of intra-service time. **Based on these comparisons, the RUC recommends a work RVU of 0.37, the survey's 25th percentile, for CPT code 81350**.

81227 CYP2C9 (cytochrome P450, family 2, subfamily C, polypeptide 9) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *5, *6)
The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81227 was 14 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that although the time associated with the key reference code 86320 *Immunoelectrophoresis; serum* (total time = 17 minutes, work RVU = 0.37) is slightly more than the surveyed code, 81227 is a more complex and intense service to perform. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which requires similar physician work and time to perform. The specialty society also explained that this service keeps rank order with Tier 2 code 81401 *Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat*), which the RUC recommended at this meeting 0.40 work RVUs for 15 minutes of intra-service time. **Based on these comparisons, the RUC recommends a work RVU of 0.38, the survey's 25th percentile, for CPT code 81227**.

81355 VKORC1 (vitamin K epoxide reductase complex, subunit 1) (eg, warfarin metabolism), gene analysis, common variants (eg, -1639/3673)
The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81355 was 15 minutes. The RUC agreed that this time

accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that although the time associated with the key reference code 86320 *Immunoelectrophoresis; serum* (total time = 17 minutes, work RVU = 0.37) is slightly more than the surveyed code, 81355 is a more complex and intense service to perform. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which requires similar physician work and time to perform. The specialty society also explained that this service keeps rank order with Tier 2 code 81401 *Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat*), which the RUC recommended at this meeting 0.40 work RVUs for 15 minutes of intra-service time. **Based on these comparisons, the RUC recommends a work RVU of 0.38, the survey's 25th percentile, for CPT code 81355**.

81310 NPM1 (nucleophosmin) (eg, acute myeloid leukemia) gene analysis, exon 12 variants

The RUC reviewed the survey data as presented by the specialty society which indicated that the 75th percentile for time for 81310 was 19 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that the key reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work RVU = 0.52) requires more time than the surveyed code.. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which requires similar work and time to perform. The specialty society also explained that this service keeps rank order with Tier 2 code 81401 *Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat*), which the RUC recommended at this meeting 0.40 work RVUs for 15 minutes of intra-service time. **Based on these comparisons, the RUC recommends a work RVU of 0.39, the survey's 25th percentile, for CPT code 81310**.

81331 SNRPN/UBE3A (small nuclear ribonucleoprotein polypeptide N and ubiquitin protein ligase E3A) (eg, Prader-Willi syndrome and/or Angelman syndrome), methylation analysis

The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81331 was 15 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that the key reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work RVU = 0.52) requires more time than the surveyed code. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which requires similar physician work and time to perform. The specialty society also explained that this service keeps rank order with Tier 2 code 81401 *Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation*

disorder/triplet repeat), which the RUC recommended at this meeting 0.40 work RVUs for 15 minutes of intra-service time. **Based on these comparisons, the RUC recommends a work RVU of 0.39, the survey's 25th percentile, for CPT code 81331**.

81265 Comparative analysis using Short Tandem Repeat (STR) markers; patient and comparative specimen (eg, pre-transplant recipient and donor germline testing, post-transplant non-hematopoietic recipient germline [eg, buccal swab or other germline tissue sample] and donor testing, twin zygosity testing, or maternal cell contamination of fetal cells)
The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81265 was 17 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that the time associated with the key reference code 86320 *Immunoelectrophoresis; serum* (total time = 17 minutes, work RVU = 0.37) is exactly the same as the surveyed code, however, 81265 overall is a more complex and intense service to perform. Further, the RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which requires similar physician work and time to perform. The specialty society also explained that this service keeps rank order with Tier 2 code 81401 *Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat*), which the RUC recommended at this meeting 0.40 work RVUs for 15 minutes of intra-service time. **Based on these comparisons, the RUC recommends a work RVU of 0.40, the survey's 25th percentile, for CPT code 81265**.

81266 Comparative analysis using Short Tandem Repeat (STR) markers; each additional specimen (eg, additional cord blood donor, additional fetal samples from different cultures, or additional zygosity in multiple birth pregnancies)
The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81266 was 15 minutes. The RUC agreed that this time accurately reflects the amount of physician time required to perform the service. The RUC agreed with the specialty that although the time associated with the key reference code 86320 *Immunoelectrophoresis; serum* (total time = 17 minutes, work RVU = 0.37) is slightly more than the surveyed code, 81266 is overall a more intense procedure to perform. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which requires similar work and time to perform. The specialty society also explained that this service keeps rank order with Tier 2 code 81401 *Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat*), which the RUC recommended at this meeting 0.40 work RVUs for 15 minutes of intra-service time. **Based on these comparisons, the RUC recommends a work RVU of 0.41, the survey's 25th percentile, for CPT code 81266**.

81267 Chimerism (engraftment) analysis, post transplantation specimen (eg, hematopoietic stem cell), includes comparison to previously performed baseline analyses; without cell selection

The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81267 was 18 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that the key reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work RVU = 0.52) requires more time than the surveyed code. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which requires less physician work and time to perform. The specialty society also explained that this service keeps rank order with Tier 2 code 81401 *Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat*), which the RUC recommended at this meeting 0.40 work RVUs for 15 minutes of intra-service time. **Based on these comparisons, the RUC recommends a work RVU of 0.45, the survey's 25th percentile, for CPT code 81267**.

81268 Chimerism (engraftment) analysis, post-transplantation specimen (eg, hematopoietic stem cell), includes comparison to previously performed baseline analyses; with cell selection (eg, CD3, CD33), each cell type

The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81268 was 20 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that the key reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work RVU = 0.52) requires similar time to perform compared to the surveyed code, 81268. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which requires less work and time to perform. The specialty society also explained that this service keeps rank order with Tier 2 code 81401 *Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat*), which the RUC recommended at this meeting 0.40 work RVUs for 15 minutes of intra-service time. **Based on these comparisons, the RUC recommends a work RVU of 0.51, the survey's 25th percentile, for CPT code 81268**.

81226 CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *5, *6, *9, *10, *17, *19, *29, *35, *41, *1XN, *2XN, *4XN)

The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81226 was 15 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that the key reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work RVU = 0.52) requires more time to perform compared to the surveyed code, 81226. The specialty society also explained, and the RUC agreed, that this service keeps rank order with Tier 2 code 81402 *Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants 1 exon,* which the RUC recommended at this meeting 0.50

work RVUs for 20 minutes of intra-service time. **Based on these comparisons, the RUC recommends a work RVU of 0.43, the survey's 25th percentile, for CPT code 81226**.

81301 Microsatellite instability analysis (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) of markers for mismatch repair deficiency (eg, BAT25, BAT26), includes comparison of neoplastic and normal tissue, if performed
The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81301 was 20 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that the key reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work RVU = 0.52) requires similar physician time and intensity to perform compared to the surveyed code, 81301. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which requires less work and time to perform. The specialty society also explained that this service keeps rank order with Tier 2 code 81402 *Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants 1 exon,* which the RUC recommended at this meeting 0.50 work RVUs for 20 minutes of intra-service time **Based on these comparisons, the RUC recommends a work RVU of 0.50, the survey's 25th percentile, for CPT code 81301**.

81261 IGH@ (Immunoglobulin heavy chain locus) (eg, leukemias and lymphomas, B-cell), gene rearrangement analysis to detect abnormal clonal population(s); amplification methodology (eg, polymerase chain reaction)
The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81261 was 21 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that the key reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work RVU = 0.52) requires similar physician time and intensity to perform compared to the surveyed code, 81261. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which requires less work and time to perform. The specialty society also explained that this service keeps rank order with Tier 2 code 81402 *Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants 1 exon,* which the RUC recommended at this meeting 0.50 work RVUs for 20 minutes of intra-service time **Based on these comparisons, the RUC recommends a work RVU of 0.52, the survey's 25th percentile, for CPT code 81261**.

81342 TRG@ (T cell antigen receptor, gamma) (eg, leukemia and lymphoma), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)
The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81342 was 25 minutes. The RUC agreed that this time

accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that the key reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work RVU = 0.52) requires less physician time and intensity to perform compared to the surveyed code, 81342. The specialty society also explained that this service keeps rank order with Tier 2 code 81402 *Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants 1 exon,* which the RUC recommended at this meeting 0.50 work RVUs for 20 minutes of intra-service time **Based on these comparisons, the RUC recommends a work RVU of 0.57, the survey's 25th percentile, for CPT code 81342**.

81264 IGK@ (Immunoglobulin kappa light chain locus) (eg, leukemia and lymphoma, B-cell), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)

The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81264 was 22 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that although the key reference code 88182 *Flow cytometry, cell cycle or DNA analysis* (total time = 20 minutes, work RVU = 0.77) requires less time compared to the surveyed code, 81264, the reference code is overall a more intense service to perform. The RUC also compared this service to 88172 *Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site*, (Intra-time=20 minutes, Work RVU=0.60) which requires similar physician work and time to perform. The specialty society also explained that this service keeps rank order with Tier 2 code 81402 *Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants 1 exon,* which the RUC recommended at this meeting 0.50 work RVUs for 20 minutes of intra-service time **Based on these comparisons, the RUC recommends a work RVU of 0.58, the survey's 25th percentile, for CPT code 81264**.

81262 IGH@ (Immunoglobulin heavy chain locus) (eg, leukemias and lymphomas, B-cell), gene rearrangement analysis to detect abnormal clonal population(s); direct probe methodology (eg, Southern blot)

The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81262 was 20 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that although the key reference code 88182 *Flow cytometry, cell cycle or DNA analysis* (total time = 20 minutes, work RVU = 0.77) requires similar time compared to the surveyed code, 81262, the reference code is overall a more intense service to perform. The RUC also compared this service to 88172 *Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site*, (Intra-time=20 minutes, Work RVU=0.60) which requires similar physician work and time to perform. The specialty society also explained that this service keeps rank order with Tier 2 code 81402 *Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants 1 exon,* which the RUC recommended at this meeting 0.50 work RVUs for 20 minutes of

intra-service time **Based on these comparisons, the RUC recommends a work RVU of 0.61, the survey's 25th percentile, for CPT code 81262**.

81210 BRAF (v-raf murine sarcoma viral oncogene homolog B1) (eg, colon cancer), gene analysis, V600E variant
The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81210 was 15 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that the key reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work RVU = 0.52) requires more time and intensity to perform compared to the surveyed code, 81210. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which requires similar physician work and time to perform. The specialty society also explained that this service keeps rank order with Tier 2 code 81403 *Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons),* which the RUC recommended at this meeting 0.52 work RVUs for 28 minutes of intra-service time **Based on these comparisons, the RUC recommends a work RVU of 0.37, the survey's 25th percentile, for CPT code 81210**.

81263 IGH@ (Immunoglobulin heavy chain locus) (eg, leukemia and lymphoma, B-cell), variable region somatic mutation analysis
The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81263 was 23 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which requires less work and time to perform. The specialty society also explained that this service keeps rank order with Tier 2 code 81403 *Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons),* which the RUC recommended at this meeting 0.52 work RVUs for 28 minutes of intra-service time **Based on these comparisons, the RUC recommends a work RVU of 0.52, the survey's 25th percentile, for CPT code 81263**.

81332 SERPINA1 (serpin peptidase inhibitor, clade A, alpha-1 antiproteinase, antitrypsin, member 1) (eg, alpha-1-antitrypsin deficiency), gene analysis, common variants (eg, *S and *Z)
The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81332 was 15 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that the time associated with the key reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work RVU = 0.52) is more than the surveyed code. Further, the RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording,*

scanning analysis, interpretation and report (intra-time=15 minutes, work RVU=0.38), which requires similar work and time to perform. The specialty society also explained that this service keeps rank order with Tier 2 code 81401 *Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat*), which the RUC recommended at this meeting 0.40 work RVUs for 15 minutes of intra-service time. **Based on these comparisons, the RUC recommends a work RVU of 0.40, the survey's 25th percentile, for CPT code 81332**.

81257 HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis, for common deletions or variant (eg, Southeast Asian, Thai, Filipino, Mediterranean, alpha3.7, alpha4.2, alpha20.5, and Constant Spring)

The specialty society explained, and the RUC agreed, that the work RVU for this service could be best derived from crosswalking it directly to Tier 2 code 81402 *Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants 1 exon,* which the RUC recommended at this meeting 0.50 work RVUs for 20 minutes of intra-service time. The RUC agreed that 20 minutes accurately reflects the amount of time required to perform the service. The RUC also agreed with the specialty that the time associated with the key reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work RVU = 0.52) is similar compared to the surveyed code. **Based on these comparisons, the RUC recommends a work RVU of 0.50 for CPT code 81257**.

81340 TRB@ (T cell antigen receptor, beta) (eg, leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using amplification methodology (eg, polymerase chain reaction)

The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81340 was 25 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC compared the surveyed code to 88172 *Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site* (Intra-service time=20minutes, Work RVU=0.60) and noted that the surveyed code required more time to perform than the reference code. The specialty society also explained that this service keeps rank order with Tier 2 code 81402 *Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants 1 exon,* which the RUC recommended at this meeting 0.50 work RVUs for 20 minutes of intra-service time **Based on these comparisons, the RUC recommends a work RVU of 0.63, the survey's 25th percentile, for CPT code 81340.**

81293 MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants

The specialty society explained, and the RUC agreed, that the work RVU for this service could be best derived from crosswalking it directly to Tier 2 code 81403 *Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)* which the RUC recommended at this meeting 0.52 work RVUs for 28 minutes of intra-service time. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which requires much less work and time to perform. **Based on these comparisons, the RUC recommends a work RVU of 0.52 for CPT code 81293**.

81296 MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants

The specialty society explained that the work RVU for this service could be best derived from crosswalking it directly to Tier 2 code 81403 *Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)* which the RUC recommended at this meeting 0.52 work RVUs for 28 minutes of intra-service time. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which requires much less work and time to perform. **Based on these comparisons, the RUC recommends a work RVU of 0.52 for CPT code 81296**.

81299 MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants

The specialty society explained, and the RUC agreed, that the work RVU for this service could be best derived from crosswalking it directly to Tier 2 code 81403 *Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)* which the RUC recommended at this meeting 0.52 work RVUs for 28 minutes of intra-service time. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which is less complex and requires less physician work and time to perform. **Based on these comparisons, the RUC recommends a work RVU of 0.52 for CPT code 81299**.

81303 MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; known familial variant

The specialty society explained, and the RUC agreed, that the work RVU for this service could be best derived from crosswalking it directly to Tier 2 code 81403 *Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions,*

mutation scanning or duplication/deletion variants of 2-5 exons) which the RUC recommended at this meeting 0.52 work RVUs for 28 minutes of intra-service time. The RUC agreed that this time accurately reflects the amount of time required to perform the service. However, the surveyed code requires less intensity to perform than the reference code. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which is less complex and requires less physician work and time to perform. **Based on these comparisons, the RUC recommends a work RVU of 0.52 for CPT code 81303**.

81304 MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; duplication/deletion variants
The specialty society explained, and the RUC agreed, that the work RVU for this service could be best derived from crosswalking it directly to Tier 2 code 81403 *Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)* which the RUC recommended at this meeting 0.52 work RVUs for 28 minutes of intra-service time. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which is less complex and requires less physician work and time to perform. **Based on these comparisons, the RUC recommends a work RVU of 0.52 for CPT code 81304**.

81318 PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants
The specialty society explained, and the RUC agreed, that the work RVU for this service could be best derived from crosswalking it directly to Tier 2 code 81403 *Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)* which the RUC recommended at this meeting 0.52 work RVUs for 28 minutes of intra-service time. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which is less complex and requires less physician work and time to perform. **Based on these comparisons, the RUC recommends a work RVU of 0.52 for CPT code 81318.**

81300 MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants
The specialty society explained, and the RUC agreed, that the work RVU for this service could be best derived from crosswalking it directly to Tier 2 code 81404 *Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis)* which the RUC

recommended at this meeting 0.65 work RVUs for 30 minutes of intra-service time. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC also compared this service to 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (intra-time=20 minutes, work RVU=0.52), which requires less work and time to perform. The RUC also compared this code to 86077 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (Intra-time=40 minutes, work RVU=0.94) and noted that the surveyed code requires less work and time to perform. **Based on these comparisons, the RUC recommends a work RVU of 0.65 for CPT code 81300.**

81302 MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; full sequence analysis

The specialty society explained, and the RUC agreed, that the work RVU for this service could be best derived from crosswalking it directly to Tier 2 code 81404 *Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis)* which the RUC recommended at this meeting 0.65 work RVUs for 30 minutes of intra-service time. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC also compared this service to 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (intra-time=20 minutes, work RVU=0.52), which requires less work and time to perform. The RUC also compared this code to 86077 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (Intra-time=40 minutes, work RVU=0.94) and noted that the surveyed code requires less work and time to perform. **Based on these comparisons, the RUC recommends a work RVU of 0.65 for CPT code 81302.**

81294 MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants

The specialty society explained, and the RUC agreed, that the work RVU for this service could be best derived from crosswalking it directly to Tier 2 code 81405 *Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons)* which the RUC recommended at this meeting 0.80 work RVUs for 30 minutes of intra-service time. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC also compared this service to 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (intra-time=20 minutes, work RVU=0.52), which requires less work and time to perform. The RUC also compared this code to 86077 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (Intra-time=40 minutes, work RVU=0.94) and noted that the surveyed code requires less work and time to perform. **Based on these comparisons, the RUC recommends a work RVU of 0.80 for CPT code 81294.**

81297 MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants

The specialty society explained, and the RUC agreed, that the work RVU for this service could be best derived from crosswalking it directly to Tier 2 code 81405 *Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons)* which the RUC

recommended at this meeting 0.80 work RVUs for 30 minutes of intra-service time. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC also compared this service to 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (intra-time=20 minutes, work RVU=0.52), which requires less work and time to perform. The RUC also compared this code to 86077 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (Intra-time=40 minutes, work RVU=0.94) and noted that the surveyed code requires less work and time to perform. **Based on these comparisons, the RUC recommends a work RVU of 0.80 for CPT code 81297.**

81298 MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis
The specialty society explained, and the RUC agreed, that the work RVU for this service could be best derived from crosswalking it directly to Tier 2 code 81405 *Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons)* which the RUC recommended at this meeting 0.80 work RVUs for 30 minutes of intra-service time. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC also compared this service to 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (intra-time=20 minutes, work RVU=0.52), which requires less work and time to perform. The RUC also compared this code to 86077 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (Intra-time=40 minutes, work RVU=0.94) and noted that the surveyed code requires less work and time to perform. **Based on these comparisons, the RUC recommends a work RVU of 0.80 for CPT code 81298.**

81319 PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants
The specialty society explained, and the RUC agreed, that the work RVU for this service could be best derived from crosswalking it directly to Tier 2 code 81405 *Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons)* which the RUC recommended at this meeting 0.80 work RVUs for 30 minutes of intra-service time. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC also compared this service to 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (intra-time=20 minutes, work RVU=0.52), which requires less work and time to perform. The RUC also compared this code to 86077 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (Intra-time=40 minutes, work RVU=0.94) and noted that the surveyed code requires less work and time to perform. **Based on these comparisons, the RUC recommends a work RVU of 0.80 for CPT code 81319.**

81292 MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis
The specialty society explained, and the RUC agreed, that the work RVU for this service could be best derived from crosswalking it directly to Tier 2 code 81406 *Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons, cytogenomic array*

analysis for neoplasia, which the RUC recommended at this meeting 1.40 work RVUs for 60 minutes of intra-service time. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC compared this code to 96204 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (Intra-time=40 minutes, work RVU=0.94) and noted that the surveyed code requires more work and time to perform. The RUC also compared the surveyed code to 88325 *Consultation, comprehensive, with review of records and specimens, with report on referred material* (Intra-service time=80minutes, work RVU=2.50) and acknowledged that the surveyed code requires less work and time to perform. **Based on these comparisons, the RUC recommends a work RVU of 1.40 for CPT code 81292.**

81295 MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis

The specialty society explained, and the RUC agreed, that the work RVU for this service could be best derived from crosswalking it directly to Tier 2 code 81406 *Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons, cytogenomic array analysis for neoplasia,* which the RUC recommended at this meeting 1.40 work RVUs for 60 minutes of intra-service time. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC compared this code to 96204 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (Intra-time=40 minutes, work RVU=0.94) and noted that the surveyed code requires more work and time to perform. The RUC also compared the surveyed code to 88325 *Consultation, comprehensive, with review of records and specimens, with report on referred material* (Intra-service time=80minutes, work RVU=2.50) and acknowledged that the surveyed code requires less work and time to perform. **Based on these comparisons, the RUC recommends a work RVU of 1.40 for CPT code 81295.**

81317 PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis

The specialty society explained, and the RUC agreed, that the work RVU for this service could be best derived from crosswalking it directly to Tier 2 code 81406 *Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons, cytogenomic array analysis for neoplasia,* which the RUC recommended at this meeting 1.40 work RVUs for 60 minutes of intra-service time. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC compared this code to 96204 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (Intra-time=40 minutes, work RVU=0.94) and noted that the surveyed code requires more work and time to perform. The RUC also compared the surveyed code to 88325 *Consultation, comprehensive, with review of records and specimens, with report on referred material* (Intra-service time=80minutes, work RVU=2.50) and acknowledged that the surveyed code requires less work and time to perform. **Based on these comparisons, the RUC recommends a work RVU of 1.40 for CPT code 81317.**

81341 TRB@ (T cell antigen receptor, beta) (eg, leukemia and lymphoma), gene

rearrangement analysis to detect abnormal clonal population(s); using direct probe methodology (eg, Southern blot)
The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81341 was 19 minutes. The RUC agreed that this time accurately reflects the amount of physician time required to perform the service. The specialty society explained, and the RUC agreed, that the work RVU for this service could be best derived from crosswalking it directly to 88388 *Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); in conjunction with a touch imprint, intraoperative consultation, or frozen section, each tissue preparation (eg, a single lymph node)* (work RVU=0.45) The RUC agreed that this work RVU accurately reflected the amount of effort required to perform the service. The RUC compared this code to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (Intra-Service time=15 minutes, work RVU=0.38) and noted that the surveyed code requires more time and work to perform than the reference code. Further, the RUC compared the surveyed code to 95251 *Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; interpretation and report* (Intra-Service time=30 minutes, Work RVU=0.85) and noted that the surveyed code requires less work and time compared to this reference code. **Based on these comparisons, the RUC recommends 0.45 Work RVUs for 81341.**

81370 HLA Class I and II typing, low resolution (eg, antigen equivalents); HLA-A, -B, -C, -DRB1/3/4/5, and -DQB1
The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81370 was 15 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that the time associated with reference code 88172 *Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site* (total time = 20 minutes, work RVU = 0.60) is more than the surveyed code. Further, the RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which although requires similar time to perform is overall a less complex and intense service to perform in comparison to the surveyed code. **Based on these comparisons, the RUC recommends a work RVU of 0.54, the survey's 25th percentile, for CPT code 81370**.

81371 HLA Class I and II typing, low resolution (eg, antigen equivalents); HLA-A, -B, and -DRB1/3/4/5 (eg, verification typing)
The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81371 was 30 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that the time associated with reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time=20 minutes, work RVU=0.52) is less than the surveyed code and that the reference code requires less intensity to perform. Further, the RUC also compared this service to 86077 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (intra-time=40 minutes, work RVU=0.94), which requires more work and time to perform in comparison to the surveyed code. **Based on**

these comparisons, the RUC recommends a work RVU of 0.60, the survey's 25th percentile, for CPT code 81371.

81372 HLA Class I typing, low resolution (eg, antigen equivalents); complete (ie, HLA-A, -B, and -C)
The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81372 was 15 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that the time associated with reference code 88172 *Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site* (total time=20 minutes, work RVU=0.60) is more than the surveyed code and that the reference code requires more intensity to perform. Further, the RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which although it requires similar time to perform, it is a less complex and intense service to perform in comparison to the surveyed code. **Based on these comparisons, the RUC recommends a work RVU of 0.52, the survey's 25th percentile, for CPT code 81372**.

81373 HLA Class I typing, low resolution (eg, antigen equivalents); one locus (eg, HLA-A, -B, or -C), each
The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81373 was 15 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that the time associated with reference code 86320 *Immunoelectrophoresis; serum* (total time = 17 minutes, work RVU = 0.37) is similar compared to the surveyed code and that the reference code requires similar intensity to perform compared to this reference code. Further, the RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which also requires similar time and intensity to perform compared to the surveyed code. **Based on these comparisons, the RUC recommends a work RVU of 0.37, the survey's 25th percentile, for CPT code 81373**.

81374 HLA Class I typing, low resolution (eg, antigen equivalents); one antigen equivalent (eg, B*27), each
The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81374 was 13 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that the time associated with reference code 86320 *Immunoelectrophoresis; serum* (total time = 17 minutes, work RVU = 0.37) is slightly more compared to the surveyed code and that the reference code requires slightly more intensity to perform compared to this reference code. Further, the RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which also requires slightly more time to perform compared to the surveyed code. **Based on these comparisons, the RUC recommends a work RVU of 0.34, the survey's 25th percentile, for CPT code 81374**.

81375 HLA Class II typing, low resolution (eg, antigen equivalents); HLA-DRB1/3/4/5 and -DQB1
The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81375 was 15 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that the time associated with reference code 88182 *Flow cytometry, cell cycle or DNA analysis* (total time = 20 minutes, work RVU = 0.77) is more than the surveyed code and that the reference code requires more intensity to perform. Further, the RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which although it requires similar time to perform the reference code is a less complex and intense service to perform in comparison to the surveyed code. **Based on these comparisons, the RUC recommends a work RVU of 0.60, the survey's 25th percentile, for CPT code 81375**.

81376 HLA Class II typing, low resolution (eg, antigen equivalents); one locus (eg, HLA-DRB1/3/4/5, -DQB1, -DQA1, -DPB1, or -DPA1), each
The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81376 was 15 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that the time associated with reference code 88182 *Flow cytometry, cell cycle or DNA analysis* (total time = 20 minutes, work RVU = 0.77) is more than the surveyed code.. Further, the RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which although it requires similar time to perform the reference code is less complex and intense service to perform in comparison to the surveyed code. **Based on these comparisons, the RUC recommends a work RVU of 0.50, the survey's 25th percentile, for CPT code 81376**.

81377 HLA Class II typing, low resolution (eg, antigen equivalents); one antigen equivalent, each
The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81377 was 15 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC agreed with the specialty that the time associated with reference code 88172 *Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site* (total time = 20 minutes, work RVU = 0.60) is more than the surveyed code. Further, the RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which although requires similar time to perform it is a less intense service to perform in comparison to the surveyed code. **Based on these comparisons, the RUC recommends a work RVU of 0.43, the survey's 25th percentile, for CPT code 81377**.

81378 HLA Class I and II typing, high resolution (ie, alleles or allele groups), HLA-A, -B, -C, and -DRB1

The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81378 was 20 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The specialty society recommended and the RUC agreed that the best way to develop a work RVU for this service was to directly crosswalk it to 88388 *Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); in conjunction with a touch imprint, intraoperative consultation, or frozen section, each tissue preparation (eg, a single lymph node)* (work RVU=0.45). The RUC agreed with the specialty that the key reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work RVU = 0.52) requires similar time compared to the surveyed code, 81378. However, this reference code is a slightly more intense procedure to perform in comparison to the surveyed code. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which requires similar time to perform however, the surveyed code is more complex and intense to perform. **Based on these comparisons, the RUC recommends a work RVU of 0.45 for CPT code 81378**.

81379 HLA Class I typing, high resolution (ie, alleles or allele groups); complete (ie, HLA-A, -B, and -C)
The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81379 was 15 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The specialty society recommended and the RUC agreed that the best way to develop a work RVU for this service was to directly crosswalk it to 88388 *Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); in conjunction with a touch imprint, intraoperative consultation, or frozen section, each tissue preparation (eg, a single lymph node)* (work RVU=0.45). The RUC agreed with the specialty that the key reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work RVU = 0.52) requires more time compared to the surveyed code. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which requires similar time to perform however, the surveyed code is more complex and intense to perform. **Based on these comparisons, the RUC recommends a work RVU of 0.45 for CPT code 81379**.

81380 HLA Class I typing, high resolution (ie, alleles or allele groups); one locus (eg, HLA-A, -B, or -C), each
The RUC reviewed the survey data as presented by the specialty society which indicated that the median physician time for 81380 was 15 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The specialty society recommended and the RUC agreed that the best way to develop a work RVU for this service was to directly crosswalk it to 88388 *Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); in conjunction with a touch imprint, intraoperative consultation, or frozen section, each tissue preparation (eg, a single lymph node)* (work RVU=0.45). The RUC agreed with the specialty that the key reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work RVU =

0.52) requires more time compared to the surveyed code. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which requires similar time to perform however, the surveyed code requires more intensity to perform. **Based on these comparisons, the RUC recommends a work RVU of 0.45 for CPT code 81380**.

81381 HLA Class I typing, high resolution (ie, alleles or allele groups); one allele or allele group (eg, B*57:01P), each
The specialty society recommended and the RUC agreed that the best way to evaluate this service was to directly crosswalk it to 88388 *Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); in conjunction with a touch imprint, intraoperative consultation, or frozen section, each tissue preparation (eg, a single lymph node)* (Intra-service=12minutes, work RVU=0.45) as these services require the same time and intensity to perform. The RUC agreed with the specialty that the key reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work RVU = 0.52) requires more time compared to the surveyed code, 81381 and this reference code is a slightly more intense procedure to perform in comparison to the surveyed code. **Based on these comparisons, the RUC recommends a work RVU of 0.45 for CPT code 81381**.

81382 HLA Class II typing, high resolution (ie, alleles or allele groups); one locus (eg, HLA-DRB1, -DRB3,-DRB4, -DRB5, -DQB1, -DQA1, -DPB1, or -DPA1), each
The RUC reviewed the survey data as presented by the specialty society which indicated that the median physician time for 81382 was 15 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The specialty society recommended and the RUC agreed that the best way to develop a work RVU for this service was to directly crosswalk it to 88388 *Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); in conjunction with a touch imprint, intraoperative consultation, or frozen section, each tissue preparation (eg, a single lymph node)* (work RVU=0.45). The RUC agreed with the specialty that the key reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work RVU = 0.52) requires more time compared to the surveyed code, 81382 and this reference code is a slightly more intense procedure to perform in comparison to the surveyed code. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which requires similar time to perform however, the surveyed code is requires more complex and intense to perform. **Based on these comparisons, the RUC recommends a work RVU of 0.45 for CPT code 81382**.

81383 HLA Class II typing, high resolution (ie, alleles or allele groups); one allele or allele group (eg, HLA-DQB1*06:02P), each
The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81383 was 15 minutes. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The specialty society recommended and the RUC agreed that the best way to develop a work RVU for

this service was to directly crosswalk it to 88388 *Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); in conjunction with a touch imprint, intraoperative consultation, or frozen section, each tissue preparation (eg, a single lymph node)* (work RVU=0.45). The RUC agreed with the specialty that the key reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work RVU = 0.52) requires more time compared to the surveyed code, 81383 and this reference code is a slightly more intense procedure to perform in comparison to the surveyed code. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which requires similar time to perform however, the surveyed code is more complex and intense to perform. **Based on these comparisons, the RUC recommends a work RVU of 0.45 for CPT code 81383**.

Practice Expense

The specialty provided data based on assumed batch sizes and modified these batch size estimates to ensure maximum efficiency for today's practice. However the RUC agreed that the batch sizes should be re-examined when greater experience is available for these services. Further, The specialty society explained that the majority of these services are being crosswalked with minor differences to the practice expense inputs associated with the molecular pathology services that were approved at the April 2011 RUC Meeting. The remainder of the Molecular Pathology services, specifically, the HLA services, had new practice expense inputs. The PE Subcommittee reviewed all the recommended practice expense inputs over a conference call and during the PE Subcommittee meeting and made minor changes mostly pertaining to duplication in supplies and equipment, which were all subsequently approved by the RUC.

Work Neutrality

Reviewing the Medicare utilization data for 83912 *Molecular diagnostics; interpretation and report* (work RVU = 0.37) and the specialty's estimate of utilization of these individual services, the RUC understands that these recommendations will be work neutral to the family.

New Technology

The entire set of molecular pathology codes should be re-reviewed after claims data are available and there is experience with the new coding system. The physician time, work, and practice expense inputs should all be reviewed again in the future as these estimates are based on a good faith effort using available information in 2011.

Flagging in the RUC Database

The RUC recommends that all of the molecular pathology services with less than 30 survey responses should be flagged in the RUC database so that they are not used to validate the proposed work associated with any CPT codes under RUC review.

Molecular Pathology Test-Tier 2 (Tab 6)

Jonathan L. Myles, MD, FCAP (CAP); Roger D. Klein, MD, JD, FCAP (CAP); Aaron D. Bossler, MD, PhD (CAP); Thomas M. Williams, MD (CAP)

In response to payer requests, the CPT Editorial Panel developed a new coding structure to describe molecular pathology services, based on the efforts and recommendations of

the Molecular Pathology Coding Workgroup convened beginning in October 2009. In October 2010, the Panel accepted 9 Tier 2 codes, which are a list of codes to be reported when the service is not listed in the Tier 1 codes. The Tier 2 codes are arranged by the level of technical resources and interpretive professional work required. The RUC understands that these services will be rarely reported and represent tests that are established and well developed, however their low volume does not warrant characterization as Tier 1 and unlikely to be automated at this time. If increases, the RUC understands that the test will be assigned a Tier 1 code. These services were previously reported with a series of "stacking codes." The RUC understands that payment for these services is currently based on a mixture of payment methodologies, including the physician fee schedule and the clinical lab fee schedule. CMS has requested that the RUC review data provided by the College of American Pathologists to provide the agency with more information as a policy is developed to determine which payment schedule is appropriate for these services.

In April 2011, the RUC found it difficult to appropriately assign a physician work valuation to these services. The number of survey respondents for each code ranged from 11 to 26, all below the RUC's required minimum of thirty respondents. The recommendations submitted by the specialty did not reflect appropriate valuation given the corresponding time recommendations. The RUC proposed interim recommendations and the specialty society re-surveyed for the September 2011 RUC Meeting. For the September 2011 RUC meeting, the specialty society was able to garner a significantly higher response rate and thus the RUC has considerable confidence in their survey data for the following Molecular Pathology Tier 2 Tests.

81400 Molecular pathology procedure, Level 1 (eg, identification of single germline variant [eg, SNP] by techniques such as restriction enzyme digestion or melt curve analysis)

The RUC reviewed the specialty's survey data from 94 molecular pathologists who provide these services. The survey results indicated a median physician time for 81400 of 10 minutes and a work value of 0.37. The RUC agreed that the median time accurately reflects the amount of time required to perform the service. The RUC compared 81400 to the key reference code 86320 *Immunoelectrophoresis; serum* (work RVU = 0.37) and agreed that the reference code requires more time to perform than the surveyed code, 17 minutes and 10 minutes, respectively The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), and noted that the surveyed code requires less time to perform than this reference code. **Based on these comparisons, the RUC recommends a work RVU of 0.32, the survey's 25th percentile, for CPT code 81400**.

81401 Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat)

The RUC reviewed the specialty society's survey data from 59 molecular pathologists who provide these services. The survey data resulted in a median physician time for 81401 of 15 minutes and a work RVU of 0.50.. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC compared 81401 to the key reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation*

and report (work RVU = 0.52) and agreed that the reference code requires more time to perform than the surveyed code, 20 minutes and 15 minutes, respectively. Further, the RUC noted that the key reference code is a more intense service to perform as compared to the reference code. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), and noted that the surveyed code requires similar physician time to perform as compared to this reference code. **Based on these comparisons, the RUC recommends a work RVU of 0.40, the survey's 25th percentile, for CPT code 81401**.

81402 Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants 1 exon)

The RUC reviewed the specialty society's survey data from 61 molecular pathologists who provide these services. The survey data resulted in a median physician time for 81402 was 20 minutes and a work RVU of 0.52. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC compared 81402 to the key reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (work RVU = 0.52) and agreed that the reference code requires the same time to provide as compared to the surveyed code, 20 minutes. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), and noted that the surveyed code requires more time to perform as compared to this reference code. **Based on these comparisons, the RUC recommends a work RVU of 0.50, the survey's 25th percentile, for CPT code 81402**.

81403 Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)

The RUC reviewed the specialty's society's survey data from 47 molecular pathologists who provide these services, The survey data indicated a median time for 81403 of 28 minutes with a median physician work RVU of 0.77. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC compared 81403 to the key reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (work RVU = 0.52) and agreed that the reference code requires less time to perform as compared to the surveyed code, 20 minutes and 28 minutes, respectively. However, the specialty acknowledged, and the RUC agreed, that although the surveyed code requires more time to perform as compared to the reference code, they are similarly intense services. The RUC also compared this service to 95251 *Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; interpretation and report* (intra-time=30 minutes, work RVU=0.85), and noted that the surveyed code requires less time and is a less intense service to perform as compared to this reference code. **Based on these comparisons, the RUC recommends a work RVU of 0.52, the survey's 25th percentile, for CPT code 81403**.

81404 Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis)

The RUC reviewed the specialty society's survey data from 49 molecular pathologist who provide these services. The survey data indicated a median time for 81404 of 30 minutes with a median physician work RVU of 0.83. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC compared 81404 to the key reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (work RVU = 0.52) and agreed that the reference code requires less time to perform as compared to the surveyed code, 20 minutes and 30 minutes, respectively. Further, the specialty acknowledged ,and the RUC agreed, that the surveyed code is a more intense service to perform in comparison to the reference code. The RUC also compared this service to 86077 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (Work RVU=0.94) and noted that the reference code requires more time to perform in comparison to the surveyed code, 40 minutes and 30 minutes, respectively. **Based on these comparisons, the RUC recommends a work RVU of 0.65, the survey's 25th percentile, for CPT code 81404**.

81405 Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons)

The RUC reviewed the specialty's survey data from 31 molecular pathologists who provide these services, The survey data indicated a median time for 81405 of 30 minutes with a median physician work RVU of 0.94.. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC compared 81403 to the key reference code 88112 *Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal* (work RVU = 1.18) and agreed that the reference code requires more time to perform as compared to the surveyed code, 43 minutes and 30 minutes, respectively. The RUC also compared this service to 86077 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (Work RVU=0.94) and noted that the reference code requires more time to perform in comparison to the surveyed code, 40 minutes and 30 minutes, respectively. **Based on these comparisons, the RUC recommends a work RVU of 0.80, the survey's 25th percentile, for CPT code 81405**.

81406 Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons, cytogenomic array analysis for neoplasia)

The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81406 was 60 minutes, with a median work RVU of 1.40. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC compared 81406 to the key reference code 88323 *Consultation and report on referred material requiring preparation of slides* (work RVU = 1.83) and agreed that the reference code requires similar time to perform as compared to the surveyed code, 56 minutes and 60 minutes, respectively. However, the specialty acknowledged and the RUC agreed that although the surveyed code requires similar time to perform as compared to the reference code, the reference code is a more intense

service to perform in comparison to the surveyed code. The RUC also compared this service to 92626 *Evaluation of auditory rehabilitation status; first hour* (intra-time=60 minutes, work RVU=1.40), and noted that the surveyed code requires the same time and is a similarly intense service to perform as compared to this reference code. **Based on these comparisons, the RUC recommends a work RVU of 1.40, the survey's median, for CPT code 81406**.

81407 Molecular pathology procedure, Level 8 (eg, analysis of 26-50 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of >50 exons, sequence analysis of multiple genes on one platform)

The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81406 was 60 minutes, with a median work RVU of 1.85. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC compared 81407 to the key reference code 88309 *Level VI - Surgical pathology, gross and microscopic examination* (work RVU = 2.80) and agreed that the reference code requires more time to perform as compared to the surveyed code, 90 minutes and 60 minutes, respectively. The RUC also compared this service to 96118 *Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report* (Work RVU=1.86) and noted that this reference code requires the same time to perform in comparison to the surveyed code, 60 minutes. **Based on these comparisons, the RUC recommends a work RVU of 1.85, the survey's median percentile, for CPT code 81407**.

81408 Molecular pathology procedure, Level 9 (eg, analysis of >50 exons in a single gene by DNA sequence analysis)

The RUC reviewed the survey data as presented by the specialty society which indicated that the median time for 81408 was 80 minutes, with a median work RVU of 2.80. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC compared 81408 to the key reference code 88309 *Level VI - Surgical pathology, gross and microscopic examination* (work RVU = 2.80) and agreed that the reference code requires more time to perform as compared to the surveyed code, 90 minutes and 80 minutes, respectively. The RUC also compared this service to 88325 *Consultation, comprehensive, with review of records and specimens, with report on referred material* (Work RVU=2.50) and noted that this reference code requires the same time to perform in comparison to the surveyed code, 80 minutes. **Based on these comparisons, the RUC recommends a work RVU of 2.35, the survey's 25th percentile, for CPT code 81408**.

Practice Expense

The practice expense inputs for these services were approved at the April 2011 RUC meeting and forwarded to CMS in May 2011.

Work Neutrality

Reviewing the Medicare utilization data for 83912 *Molecular diagnostics; interpretation and report* (work RVU = 0.37) and the specialty's estimate of utilization of these individual services, the RUC understands that these recommendations will be work neutral to the family.

New Technology

The entire set of molecular pathology codes should be re-reviewed after claims data are available and there is experience with the new coding system. The time, work valuation, and practice expense inputs should all be reviewed again in the future as these estimates are based on a good faith effort using available information in 2011.

X. Relative Value Recommendations for CPT 2013

Transcath Retrieval Intravascular Foreign Body (Tab 7)
Gary Seabrook, MD (SVS); Mathew Sideman (SVS); MD, Michael Sutherland, MD (SVS); Robert Vogelzang, MD (SIR); Gerald Niedzwiecki, MD (SIR); Michael Hall, MD (SIR); Geraldine McGinty, MD (ACR); Zeke Silva, MD (ACR)
Facilitation Committee #3

In 2010, the RUC's Relativity Assessment Workgroup identified the code pair *37620 Interruption, partial or complete, of inferior vena cava by suture, ligation, plication, clip, extravascular, intravascular (umbrella device)* and 75940 *Percutaneous placement of IVC filter, radiological supervision and interpretation* and 36010 *Introduction of catheter, superior or inferior vena cava* billed together more than 75% of the time according to 2009 Medicare claims data. In February 2011, the CPT Editorial Panel created four new codes to bundle the services together. In April 2011, three new codes 37191, 37192 and 37193 were surveyed and reviewed by the RUC. However, one code 372XX1 *Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter), includes radiological supervision and interpretation, and imaging guidance (ultrasound or fluoroscopy), when performed* was held for survey for the September 2011 RUC meeting.

The RUC reviewed the survey results from 69 practicing physicians and agreed with the specialty that the survey's median physician time components as follows: pre-service time of 41 minutes, intra-service time of 60 minutes and post-service time of 20 minutes. The RUC also reviewed the survey's estimated work values and disagreed that the median work RVU of 8.00 was an accurate valuation for the typical physician work involved. The RUC did not agree that this service reflected the same work as 37183 *Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanulization/dilatation, stent placement and all associated imaging guidance and documentation)* (work RVU= 7.99). However, the RUC understands that the easier patients will be reported under the new IVC filter code 37193 *Retrieval (removal) of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed* leaving an increase in intensity of patients for 372XX1.

To find an appropriate value, the RUC compared the surveyed code to CPT code 36475 *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated* (work RVU= 6.72) and agreed that the two service have highly similar intra-service work, and identical time of 60 minutes. Given that these service are so similar, the RUC agreed that 372XX1 should be directly crosswalked to 36475. For additional reference, 372XX1 was compared to CPT code 36478 *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated* (work RVU= 6.72) and the RUC agreed that the two services should be

valued identically, due to analogous physician work and intra-service time, 55 minutes and 60 minutes, respectively. Finally, to ensure a work RVU of 6.72 is accurate, the RUC took the median survey of 8.00 work RVUs and backed out the introduction service, 36013 *Introduction of catheter, right heart or main pulmonary artery* (work RVU= 1.26), adjusted for multiple procedure reduction). The resulting work RVU of 6.74 is an accurate value for the physician work involved in 372XX1, providing an additional level of validation for the recommended work RVU of 6.72 (a direct crosswalk to 36475). **The RUC recommends a work RVU of 6.72 for CPT code 372XX1.**

Practice Expense
The RUC accepted the direct practice expense inputs recommended by the specialty and made minor modifications to the equipment to align with the revised moderate sedation equipment guidelines.

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

Biopsy of Eyelid (Tab 8)
Mark Kaufmann, MD (AAD); Brett Coldiron, MD (AAD); Fitzgeraldo Sanchez, MD (AAD); Steve Kamenetzky, MD (AAO)

CMS identified CPT code 67810 *Incisional biopsy of eyelid skin including lid margin* as part of the 4th Five-Year Review of the RBRVS as Harvard-Valued - Utilization Over 30,000. In October 2010, the RUC referred code 67810 to the CPT Editorial Panel to expand the descriptor to include the "eyelid margin" as that was the intent, as well as clarify the vignette to also include the eyelid margin.

In September 2011, the RUC reviewed the survey results from 50 dermatologists and ophthalmologists for CPT code 67810 and determined that a decrease in the current work RVU to the survey 25th percentile work RVU of 1.18 appropriately accounts for the work required to perform this service. The RUC agreed with the specialty society recommended pre-service time of 11 minutes and intra-service time of 13 minutes. The RUC acknowledged that the specialty society survey of 20 minutes and the standard of 23 minutes is too high due to the reporting of Evaluation and Management on the same date. The recommended pre-service time of 11 minutes addresses the issue. However, the RUC reduced the post-service time from 10 minutes to 5 minutes, as this service is typically performed with an Evaluation and Management service. The RUC compared 67810 to reference service 11755 *Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds) (separate procedure)* (work RVU = 1.31) and determined that the surveyed service was more intense and complex as the biopsy surrounds the eye, however requires less physician time to perform than the reference service, 13 minutes versus 25 minutes, respectively. The RUC also compared 67810 to MPC codes 31231 *Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)* (work RVU = 1.10, total time = 30 minutes) and 62270 *Spinal puncture, lumbar, diagnostic* (work RVU = 1.37, total time = 40 minutes). Therefore, the survey 25th percentile work RVU of 1.18 and total physician time of 29 minutes appropriately accounts for the physician work required to perform this service relative to similar services. **The RUC recommends a work RVU of 1.18 for CPT code 67810.**

Practice Expense:

The PE Subcommittee reviewed the direct practice expense inputs recommended by the specialty and made modifications to the medical supplies and equipment time.

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

Molecular Pathology Tier 1 (Tab 9)
Jonathan L. Myles, MD, FCAP (CAP); Roger D. Klein, MD, JD, FCAP (CAP); Jeffrey A. Kant MD PhD FCAP FAAAS (CAP); Aaron D. Bossler, MD, PhD (CAP);Thomas M. Williams, MD (CAP)

The CPT Editorial Panel has developed a new coding structure to describe molecular pathology services, based on the efforts and recommendations of the Molecular Pathology Coding Workgroup commencement in October 2009. In October 2010 and February 2011, the Panel accepted 92 Tier 1 codes, which are a list of gene-specific and genomic analysis CPT codes for high-volume molecular pathology services. These services were previously reported with a series of "stacking codes." The RUC understands that payment for these services is currently based on a mixture of payment methodologies, including the physician fee schedule and the clinical lab fee schedule. CMS requested that the RUC review data provided by the College of American Pathologists to provide the agency with more information, as a policy is developed to determine which payment schedule is appropriate for these services. In April 2011, the RUC recommended physician work and time values for 18 Tier I codes. In September 2011, the specialty presented data on the remaining services. At this time, the specialty indicated that interpretation is not typically performed by a physician for the remaining Tier I codes.

EXXX1 EGFR (epidermal growth factor receptor) (eg, non-small cell lung cancer) gene analysis, common variants (eg, exon 19 LREA deletion, L858R, T790M, G719A, G719S, L861Q)
The RUC reviewed the survey data from 49 pathologists for CPT code EXXX1 *EGFR (epidermal growth factor receptor) (eg, non-small cell lung cancer) gene analysis, common variants (eg, exon 19 LREA deletion, L858R, T790M, G719A, G719S, L861Q)* and noted that the reference code 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (work RVU=0.52) required the same amount of time to perform as the surveyed code, 20 minutes. Further, the RUC noted that reference code and the surveyed code are similarly intense and complex services to perform. In addition the, RUC compared the surveyed code to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (work RVU=0.38) and noted that the surveyed code requires more time to perform than this reference codes, 20 minutes and 15 minutes, respectively. Based on these comparisons, the RUC agreed with the specialty society's recommendation of 0.51 work RVUs for this service. **The RUC recommends 0.51, the survey's 25th percentile, for EXXX1.**

GXXX3 GJB2 (gap junction protein, beta 2, 26kDa; connexin 26) (eg, nonsyndromic hearing loss) gene analysis; full gene sequence
The specialty society explained, and the RUC agreed, that the work RVU for this service could be best derived from crosswalking it directly to Tier 2 code 81404 *Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis,*

mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis) which the RUC recommended at this meeting 0.65 work RVUs for 30 minutes of intra-service time. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC also compared this service to 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (intra-time=20 minutes, work RVU=0.52), which requires less work and time to perform. The RUC also compared this code to 86077 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (Intra-time=40 minutes, work RVU=0.94) and noted that the surveyed code requires less work and time to perform. **Based on these comparisons, the RUC recommends a work RVU of 0.65 for CPT code GXXX3.**

GXXX4 GJB2 (gap junction protein, beta 2, 26kDa; connexin 26) (eg, nonsyndromic hearing loss) gene analysis; known familial variants
The specialty society explained, and the RUC agreed, that the work RVU for this service could be best derived from crosswalking it directly to Tier 2 code 81403 *Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons),* which the RUC recommended at this meeting 0.52 work RVUs for 28 minutes of intra-service time. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which is less complex and requires less physician work and time to perform. **Based on these comparisons, the RUC recommends a work RVU of 0.52 for CPT code GXXX4.**

GXXX5 GJB6 (gap junction protein, beta 6, 30kDa, connexin 30) (eg, nonsyndromic hearing loss) gene analysis; common variants (eg, 309kb [del(GJB6-D13S1830)] and 232kb [del(GJB6-D13S1854)])
The specialty society explained, and the RUC agreed, that the work RVU for this service could be best derived from crosswalking it directly to Tier 2 code 81401 *Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat)* which the RUC recommended at this meeting 0.40 work RVUs for 15 minutes of intra-service time. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which is similarly complex and requires similar physician work and time to perform. **Based on these comparisons, the RUC recommends a work RVU of 0.40 for CPT code GXXX5.**

PXXX6 PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; full sequence analysis
The specialty society explained, and the RUC agreed, that the work RVU for this service could be best derived from crosswalking it directly to Tier 2 code 81405 *Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons)* which the RUC

recommended at this meeting 0.80 work RVUs for 30 minutes of intra-service time. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC also compared this service to 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (intra-time=20 minutes, work RVU=0.52), which requires less work and time to perform. The RUC also compared this code to 86077 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (Intra-time=40 minutes, work RVU=0.94) and noted that the surveyed code requires less work and time to perform. **Based on these comparisons, the RUC recommends a work RVU of 0.80 for CPT code PXXX6.**

PXXX7 PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; known familial variant
The specialty society explained, and the RUC agreed, that the work RVU for this service could be best derived from crosswalking it directly to Tier 2 code 81403 *Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)* which the RUC recommended at this meeting 0.52 work RVUs for 28 minutes of intra-service time. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC also compared this service to 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (intra-time=15 minutes, work RVU=0.38), which is less complex and requires less physician work and time to perform. **Based on these comparisons, the RUC recommends a work RVU of 0.52 for CPT code PXXX7.**

PXXX8 PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; duplication/deletion variant
The specialty society explained, and the RUC agreed, that the work RVU for this service could be best derived from crosswalking it directly to Tier 2 code 81404 *Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis)* which the RUC recommended at this meeting 0.65 work RVUs for 30 minutes of intra-service time. The RUC agreed that this time accurately reflects the amount of time required to perform the service. The RUC also compared this service to 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (intra-time=20 minutes, work RVU=0.52), which requires less work and time to perform. The RUC also compared this code to 86077 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (Intra-time=40 minutes, work RVU=0.94) and noted that the surveyed code requires less work and time to perform. **Based on these comparisons, the RUC recommends a work RVU of 0.65 for CPT code PXXX8.**

Practice Expense
The specialty society provided data based on assumed batch sizes and modified these batch size estimates to ensure maximum efficiency for today's practice. However the RUC agreed that the batch sizes should be re-examined when greater experience is available for these services. Further, The specialty society explained that the majority of these services are being crosswalked with minor differences to the practice expense inputs associated with the molecular pathology services that were approved at the April 2011 RUC Meeting. The PE Subcommittee reviewed all the recommended practice

expense inputs over a conference call and during the PE Subcommittee meeting and made minor changes mostly pertaining to duplication in supplies and equipment, which were all subsequently approved by the RUC.

Work Neutrality
Reviewing the Medicare utilization data for 83912 *Molecular diagnostics; interpretation and report* (work RVU = 0.37) and the specialty's estimate of utilization of these individual services, the RUC understands that these recommendations will be work neutral to the family.

New Technology
The entire set of molecular pathology codes should be re-reviewed after claims data are available and there is experience with the new coding system. The physician time, work, and practice expense inputs should all be reviewed again in the future as these estimates are based on a good faith effort using available information in 2011.

Flagging in the RUC Database
The RUC recommends that all of the molecular pathology services with less than 30 survey responses should be flagged in the RUC database so that they are not used to validate the proposed work associated with any CPT codes under RUC review.

Psychoanalysis (Tab 10)
Jeremy Musher, MD (APA); James Georgoulakis, PhD (APA-HCPAC); Doris Tomer, LCSW (NASW)

Multiple specialty societies submitted public comment to CMS to review code 90845 *Psychoanalysis* as part of the 4th Five-Year Review. In September 2010, recommendations regarding code 90845 were submitted along with 16 additional codes. During that presentation the specialties requested that the entire tab be referred to the CPT Editorial Panel to revised the code descriptors to more accurately describe these services. During the CPT review process, CPT recommended to remove psychoanalysis, as revisions to the descriptor were unnecessary because the work inherent in providing this service was the same regardless of the provider.

In September 2011, the RUC reviewed 90845 and agreed with the specialty society that there is compelling evidence that the patient population has changed and that the technique employed in psychoanalytic practice has changed. Psychoanalysis traditionally treated a wide variety of conditions which included a considerable number of high functioning patients who were treated for relatively minor psychological problems by current standards. Patients with these conditions are now often treated in a variety of newer treatment modalities rather than psychoanalysis. Given this, patients now receiving psychoanalysis are more complex and typically require a more active approach on part of the psychoanalyst due to the increased number of co-morbidities. In addition, in the past psychoanalysts tended to be silent during the treatment, intervening infrequently. Current practice emphasizes the importance of interaction between the psychoanalyst and the patient. As a result of this technical change the psychoanalyst is required to be much more intently focused on the minute to minute interaction during the session and considerably more active during the session. This substantially increases the psychoanalyst's intensity and complexity effort during the session, when compared with the earlier model.

The RUC reviewed CPT code 90845 and agreed with the specialty societies that the typical service is one hour, 5 minute pre-service, 50 minutes intra-service and 5 minutes immediate post-service time. The RUC reviewed the survey results and agreed that the median survey work RVU of 2.10 accurately values the typical physician work involved in the procedure. To justify this value, the RUC compared CPT code 90845 to key reference service 99404 *Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes* (work RVU = 1.95, total time = 60 minutes). Although the reference code has greater intra service time compared to the surveyed code, the survey respondents indicated and the RUC agreed that intensity and complexity to perform 90845 is greater in every measure compared to reference service 99404. The RUC also compared 90845 to reference code 99215 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU = 2.11, total time = 55 minutes). The respondents indicated 90845 was more intense and complex than 99215, specifically the technical skill required to perform 90845 indicated the greatest difference. Finally, the RUC compared 90845 to MPC code 99233 *Subsequent hospital care, per day, for the evaluation and management of a patient* (work RVU = 2.00, total time = 55 minutes). The RUC determined that these comparison codes coupled with the median survey results support a recommendation of 2.10 work RVUs for CPT code 90845. **The RUC recommends a work RVU of 2.10 for CPT code 90845.**

XI. CMS Requests – Harvard Valued over 30,000 Screen

Subcutaneous Removal of Foreign Body (Tab 11)
Seth Rubenstein, DPM (APMA); Tim Tillo, DPM (APMA); Thomas J. Weida, MD (AAFP)

In April 2011, the RUC identified CPT Code 10120 *Incision and removal of foreign body, subcutaneous tissues; simple* as part of the Harvard Valued – Utilization over 30,000 screen and requested that this service be surveyed.

The RUC reviewed the survey results from 45 family physicians and podiatrists for CPT code 10120 and determined that the current value of 1.25 work RVUs appropriately accounts for the work required to perform this service. The RUC determined that the survey 25th percentile work RVU of 1.22 and median work RVU of 1.30 support the current work value of 1.25. The specialty society indicated and the RUC agreed that the physician work required for this service had not changed. The RUC compared 10120 to key reference code 10060 *Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single* (work RVU = 1.22) and although the intra-service time for both services is 15 minutes, the RUC agreed with the survey respondents that code 10120 is slightly more intense and complex than 10060 due to the element of searching for the foreign body. The RUC also compared 10120 to similar service 10160 *Puncture aspiration of abscess, hematoma, bulla, or cyst* (work RVU = 1.25) and determined that maintaining the current value maintains appropriate rank order among other similar services in the RBRVS. The recommended pre-service and post-service time for this service accounts for separate reporting of an Evaluation and Management service on the same date. The RUC indicated that one 99212 office visit is appropriate to account for checking the wound, checking for signs of infection and reviewing the culture report. **The RUC recommends a work RVU of 1.25 for CPT code 10120.**

Repair of Wound or Lesion (Tab 12)
Brett Coldiron, MD (AAD); Glenn Goldman, MD (AAD); Mark Kaufmann, MD (AAD); Fitzgeraldo Sanchez, MD (AAD)

In April 2011, the RUC identified codes 13131 and 13152 as part of the Harvard Valued – Utilization Over 30,000 screen for survey at the September 2011 meeting. CPT codes 13100 and 13101 were reviewed as part of the 4th Five-Year Review. However, in the June 6, 2011 *Proposed Rule* for the 4th Five-Year Review of the RBRVS, CMS requested that the RUC review the entire family of complex wound repair codes to ensure consistency and appropriate gradation of work value. The specialty societies requested that review of codes 13131 and 13152 be postponed until after the specialty society has re-surveyed the remaining codes within this family. **The RUC recommends that the specialty society re-review /re-survey codes 13100-13152 at the January 2012 or April 2012 RUC Meeting.**

Injection for Shoulder X-Ray (Tab 13)
Geraldine McGinty, MD (ACR), Zeke Silva, MD (ACR); William Creevy, MD (AAOS)

In April 2011, the RUC identified CPT code 23350 *Injection procedure for shoulder arthrography or enhanced CT/MRI shoulder arthrography* as part of the Harvard Valued – Utilization over 30,000 screen and requested that this service be surveyed.

The RUC reviewed the survey results from 53 radiologists and orthopaedic surgeons for code 23350 and agreed with the specialty society that the work has not changed and maintaining the current work RVU of 1.00 appropriately accounts for the work required to perform this service. Further, the survey 25th percentile work RVU of 1.00 supports the current value. The RUC determined that 8 minutes pre-service time, 15 minutes intra-service time and 5 minutes immediate post-service time accurately account for the time required to perform this service. The RUC compared 23350 to key reference 62270 *Spinal puncture, lumbar, diagnostic* (work RVU = 1.37) and determined that the surveyed code requires less physician work, time, intensity and complexity to perform than code 62270, 28 minutes versus 40 minutes total time, respectively. The RUC also compared the surveyed code to MPC code 56605 *Biopsy of vulva or perineum (separate procedure); 1 lesion* (work RVU = 1.10) and determined that 56605 requires slightly more work than 23350, 35 minutes versus 28 minutes total time, respectively. **The RUC recommends a work RVU of 1.00 for CPT code 23350.**

Treatment of Humerus Fracture (Tab 14)
William Creevy, MD (AAOS); John Heiner, MD (AAOS)

In April 2011, the RUC identified CPT code 23600 *Closed treatment of proximal humeral (surgical or anatomical neck) fracture; without manipulation* as part of the Harvard Valued – Utilization over 30,000 screen and requested that this service be surveyed.

The RUC reviewed the survey results from 33 orthopaedic surgeons for code 23600 and agreed with the specialty society that decreasing the current work RVU of 3.11 to the survey 25th percentile work RVU of 3.00 appropriately accounts for the work required to perform this service. The RUC determined that 9 minutes pre-service time, 15 minutes intra-service time and 5 minutes immediate post-service time accurately account for the

time required to perform this service. The RUC noted that the pre-service time is consistent with the pre-service time for recently surveyed closed fracture without manipulation and casting/splinting services. The RUC compared 23600 to key reference 27767 *Closed treatment of posterior malleolus fracture; without manipulation* (work RVU = 2.64) and determined that while both services require 15 minutes of intra-service time, the surveyed code is more intense and complex to perform than code 27767, requiring more mental effort, technical skill and psychological stress. The RUC determined the post-operative visits, 3-99212 and 1-99213 office visits are appropriate as they are the same as the reference code and other similar upper extremity treatment codes. **The RUC recommends a work RVU of 3.00 for CPT code 23600.**

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

Treatment of Metatarsal Fracture (Tab 15)
William Creevy, MD (AAOS); John Heiner, MD (AAOS); Tye Ouzounian, MD (AOFAS); Seth Rubenstein, DPM (APMA); Timothy Tillo, DPM (APMA)

In April 2011, the RUC identified CPT Code 28470 *Closed treatment of metatarsal fracture; without manipulation, each* as part of the Harvard Valued – Utilization over 30,000 screen and requested that this service be surveyed.

The RUC reviewed the survey results from 72 orthopaedic surgeons, orthopaedic foot and ankle surgeons and podiatrists for code 28470 and agreed with the specialty society that the work has not changed and maintaining the current work RVU of 2.03 appropriately accounts for the work required to perform this service. The RUC determined that 7 minutes pre-service time, 15 minutes intra-service time and 5 minutes immediate post-service time accurately account for the time required to perform this service. The RUC noted that the pre-service time is consistent with the pre-service time for recently surveyed closed fracture without manipulation and casting/splinting services. The RUC compared 28470 to key reference 27767 *Closed treatment of posterior malleolus fracture; without manipulation* (work RVU = 2.64) and determined that the surveyed code requires less physician work, time, intensity and complexity to perform than code 27767, 77 minutes and 96 minutes total time, respectively. The RUC reviewed the post-operative visits and recommends replacing the 99213 visit with a 99212 visit to be consistent with the other distal fracture services. Therefore, the total number of visits are 3-99212 office visits. **The RUC recommends a work RVU of 2.03 for CPT code 28470.**

Application of Forearm Cast (Tab 16)
Daniel Nagle, MD (ASSH); William Creevy, MD (AAOS)

In April 2011, the RUC identified CPT code 29075 *Application, cast; elbow to finger (short arm)* as part of the Harvard Valued – Utilization over 30,000 screen and requested that this service be surveyed.

The RUC reviewed the survey results from 94 orthopaedic and hand surgeons for code 29075 and agreed with the specialty society that the work has not changed and maintaining the current work RVU of 0.77 appropriately accounts for the work required to perform this service. The RUC determined that 7 minutes pre-service time, 15 minutes

intra-service time and 5 minutes immediate post-service time accurately account for the time required to perform this service. The RUC compared 29075 to key reference 99202 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 0.93) and determined that although the surveyed code requires more physical and technical skill than the key reference service the overall intensity and complexity for 29075 is less. The RUC also compared the surveyed code to MPC codes 11000 *Debridement of extensive eczematous or infected skin; up to 10% of body surface (separate procedure); 1 lesion* (work RVU = 0.60) and 11100 *Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion* (work RVU = 0.81) and determined that 29075 at the current work RVU of 0.77 aligns appropriately with these similar services. The RUC also compared the surveyed code to similar service 29405 *Application of short leg cast (below knee to toes)* (4th Five-Year Review RUC recommended work RVU = 0.80) and determined that 29075 requires similar physician work and time, 27 minutes and 25 minutes, respectively, which further supports maintaining the current value. **The RUC recommends a work RVU of 0.77 for CPT code 29075.**

Thoracentesis with Tube Insertion (Tab 17)

In April 2011, the RUC identified CPT code 32422 as part of the Harvard Valued over 30,000 and requested that this service, and identified family, be surveyed for the September 2011 RUC meeting. In September 2011, the specialty societies indicated that there is some confusion regarding which imaging guidance codes to report when performing pneumocentesis or thoracentesis as well as 76942 *Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation* (work RVU = 0.67) is performed together more than 75% of the time with thoracentesis codes therefore possible bundling will occur. The specialty societies requested and the RUC agreed that these services should be referred to the CPT Editorial Panel to correctly describe current practice. The specialty societies intend to submit a code change proposal in the 2013 cycle. **The RUC recommends that codes 32420-32422 be referred to the CPT Editorial Panel for clarification.**

Insertion of Chest Tube (Tab 18)

In April 2011, the RUC identified CPT code 32551 as part of the Harvard Valued over 30,000 and requested that this service be surveyed for the September 2011 RUC meeting. In September 2011, the specialty societies indicated that there is some confusion regarding correct reporting as thoracostomy refers to an open procedure and there has been a recent shift in specialty utilization. The specialty societies requested and the RUC agreed that code 32551 should be referred to the CPT Editorial Panel to revise the code to correctly describe current practice. The specialty societies intend to submit a code change proposal in the 2013 cycle. **The RUC recommends that CPT code 32551 be referred to the CPT Editorial Panel for clarification.**

Introduction of Needle or Intracatheter (Tab 19)
Michael Hall, MD (SIR); William Julien, MD (SIR); Geraldine McGinty, MD (ACR) Gerald Niedzwiecki, MD (SIR); Sean Roddy, MD (SVS); Gary Seabrook, MD (SVS); Matthew Sideman, MD (SVS); Zeke Silva, MD (ACR); Michael Sutherland, MD (SVS); Sean Tutton, MD (ACR); Robert Vogelzang, MD (SIR)
Facilitation Committee #2

In April 2011, the RUC identified CPT code 36140 *Introduction of needle or intracatheter; extremity artery* as part of the Harvard Valued – Utilization over 30,000 screen and requested that this service be surveyed.

The RUC reviewed codes 36140 and agreed with the specialty societies that this service should be reviewed in two years after utilization data is available and to review what codes are being reported together. The RUC discussed that referral to the CPT Editorial Panel to either add a parenthetical or further bundle these codes may be possible options in the future. However, monitoring utilization data and reported together data first would be appropriate to analyze what is occurring prior to any code change proposals. Additionally, in the interim, the specialty societies indicated that they will work on correct coding education for these codes within their specialty societies. **The RUC recommends to refer this issue to the Relativity Assessment Workgroup for review at the October 2013 meeting after two years of utilization and codes reported together data is collected, prior to referral to the CPT Editorial Panel.**

Moderate Sedation:
The RUC agreed that moderate sedation was inherent and should be added to Appendix G of the CPT book. In October 2011, the CPT Editorial Panel agreed to add CPT code 36140 to Appendix G.

Global Period:
The RUC noted that when this service is reviewed in the future the specialty and CMS should consider whether the global period should be changed to 000. In addition, the RUC noted that the RUC survey data and Summary of Recommendation (SOR) form submitted by the specialty for this meeting will be included in the Relativity Assessment Workgroup's review of this service in October 2013.

Catheter Placement (Tab 20)

In April 2011, the RUC identified CPT code 36217 as part of the Harvard Valued over 30,000 and requested that this service be surveyed for the September 2011 RUC meeting. In September 2011, the specialty societies indicated that CPT code 36217 will be affected by the current carotid angiography code change proposal (CCP) currently being developed. **The specialty societies requested and the RUC agreed that review of this service be deferred until the CPT Editorial Panel considers the carotid angiography CCP.**

Biopsy of Lip (Tab 21)
Fitzgeraldo Sanchez, MD, FAAD (AAD); Mark Kaufman, MD, FAAD (AAD); Brett Coldiron, MD, FAAD (AAD)

In April 2011, the RUC identified CPT code 40490 *Biopsy of lip* as part of the Harvard Valued – Utilization over 30,000 screen and requested that this service be surveyed.

The RUC reviewed the survey results from 145 dermatologists and otolaryngologists for code 40490 and agreed with the specialty society that the work has not changed and maintaining the current work RVU of 1.22 appropriately accounts for the work required to perform this service. Further, the survey median work RVU of 1.25 and the survey 25th percentile work RVU of 1.18 supports the current value. The RUC determined that 8 minutes pre-evaluation time, 1 minute pre-positioning time, 5 minutes pre-

scrub/dress/wait time, 15 minutes intra-service time and 5 minutes immediate post-service time accurately account for the time required to perform this service. The specialty society indicated and the RUC agreed that 5 minutes of scrub/dress/wait time to administer anesthesia compared to other biopsy procedures is required as there is infiltration around the lesion for hemostasis as well as anesthesia plus mental nerve blocks for anesthetic reasons. The regional block (mental nerve block) does not work immediately so the physician must wait for it to work. There is, therefore, more waiting time (5 minutes).

The RUC compared 40490 to 67810 *Incisional biopsy of eyelid skin including lid margin* (RUC recommended work RVU = 1.18 and intra-service time = 13 minutes) and determined that 40490 requires 2 more minutes of intra-service time and 3 more minutes pre-scrub/dress/wait time to administer the anesthesia as described. Thus, the RUC determined maintaining the slightly higher work RVU of 1.22 accurately places this service within the RBRVS.

The RUC compared 40490 to similar services code 12013 *Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm* (work RVU = 1.22 and intra-service time = 15 minutes) and code 57500 *Biopsy of cervix, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)* (work RVU = 1.20, intra-service time = 15 minutes) and determined that these services require the same amount of physician intra-service time to perform, 15 minutes. The current value for 40490 requires slightly more pre-service time, however, the current work value of 1.22 is appropriate relative to other similar services. **The RUC recommends a work RVU of 1.22 for CPT code 40490.**

Diagnostic Sigmoidoscopy (Tab 22)
Nicholas Nickl, MD (ASGE); Edward Bentley, MD (ASGE); Jaya Agrawal, MD (AGA); Michael Edye, MD (SAGES)

In April 2011, the RUC identified CPT code 45330 Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure) as part of the Harvard Valued – Utilization over 30,000 screen and requested that this service be surveyed.

The RUC reviewed the survey data and survey times from 140 gastroenterologists and gastrointestinal endoscopic surgery for 45330 and agreed with the specialty societies recommended work RVU recommendation of 0.96, the current value. The specialties indicated that although the survey respondents median RVU was 1.50 and 25th percentile was 1.15, there was no compelling evidence to increase the value. The RUC compared 45330 to recently RUC reviewed code 45331 Sigmoidoscopy, flexible; with biopsy, single or multiple (work RVU= 1.15) and noted that while the surveyed code is less work, the pre-service time for 45331, 15 minutes, should be identical for 45330. This time is a 5 minutes reduction from the survey pre-service time. The total time for 45330 is 37 minutes (pre-service time= 15 minutes, intra-service time= 12 minutes, post-service time= 10 minutes). The RUC also compared the surveyed code to other reference codes including 46614 Anoscopy; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator) (work RVU=1.00, total

time=37 minutes) and 43760 Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance (work RVU=0.90, total time=32 minutes). The RUC agreed that these services have comparable physician work, with similar total times, and the recommended value ensures relativity between similar services in the RBRVS. Based on these comparisons and lack of compelling evidence, the RUC agreed with the specialty societies' recommendation that the current valuation of this service maintains rank order with these other services and is reflective of the typical physician work involved. **The RUC recommends 0.96 work RVUs for CPT code 45330.**

Cystourethroscopy and Ureteroscopy (Tab 23)
Thomas Cooper, MD (AUA); Richard Gilbert, MD (AUA); Christopher Gonzalez, MD (AUA); Norman Smith, MD (AUA); Thomas Turk, MD (AUA)

CMS identified CPT code 52235 as part of the Harvard valued over 30,000 utilization screen. The specialty added CPT codes, 52234, 52240, 52351, 52352, 52353, 52354, 52355 as part of the family to review to ensure a rank order anomaly was not created during RUC valuation.

The RUC reviewed the compelling evidence as presented by the specialty society and agreed that there has been a significant change in technology and physician work since the Harvard valuation for ureteroscopy services. During the last valuation, rigid, large scopes were used that could not evaluate the upper urinary tract and calyces. Current scopes are much smaller and flexible, allowing inspection of the surface of the ureter and entire renal pelvis. Due to these changes, physician work has become more intense as scopes must be steered through the ureter, renal pelvis and calyces.

52234 ***Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 up to 2.0 cm)***
The RUC reviewed the survey results from 73 urologists for CPT code 52234 and agreed that the physician time components were accurate at the median time (pre-service time= 29 minutes, intra-service time= 30 minutes, post-service time= 20 minutes), with four additional minutes of pre-service standard positioning time to place the patient in the dorsal lithotomy position. The RUC agreed with the specialty society that the survey respondents overestimated the physician work RVUs and agreed that the current work RVU of 4.62 is appropriate for this service. To justify a work value of 4.62, the RUC compared 52234 to reference code 52275 *Cystourethroscopy, with internal urethrotomy; male* (work RVU= 4.69) and agreed that the reference code should be valued slightly higher than the surveyed code given that the reference code has more than total time compared to 52234, 90 minutes and 79 minutes. The RUC also reviewed code 58558 *Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C* (work RVU= 4.74) and agreed that the reference code should be valued higher than 52234 due to greater total time, 90 minutes compared to 79 minutes. **The RUC recommends a work RVU of 4.62 for CPT code 52234.**

52235 ***Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; MEDIUM bladder tumor(s) (2.0 to 5.0 cm)***
The RUC reviewed the survey results from 71 urologists for CPT code 52235 and agreed that the physician time components were accurate at the median time (pre-service time= 29 minutes, intra-service time= 45 minutes, post-service time= 20 minutes), with four

additional minutes of standard pre-service positioning time to place the patient in the dorsal lithotomy position. The RUC agreed with the specialty society that the survey respondents overestimated the physician work RVUs and agreed that the current work RVU of 5.44 is appropriate for this service. To justify a work value of 5.44, the RUC compared 52235 to reference code 93458 *Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed* (work RVU= 5.85) and agreed that while the two services have identical intra-service time, 45 minutes, the reference code should be valued higher due to greater total time, 123 minutes compared to 94 minutes. Given this, the RUC agreed that the recommended work value for 52235 is accurately valued relative to other comparable services. **The RUC recommends a work RVU of 5.44 for CPT code 52235.**

52240 ***Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; LARGE bladder tumor(s)***

The RUC reviewed the survey results from 69 urologists for CPT code 52240 and agreed that the physician time components were accurate at the median time (pre-service time= 53 minutes, intra-service time=60 minutes, post-service time= 20 minutes), with two additional minutes of standard pre-service positioning time to place the patient in the dorsal lithotomy position. The RUC agreed with the specialty society that the 25th percentile work RVU of 8.75 accurately reflects the typical physician work involved in the service. To justify a work value of 8.75, the RUC compared 52240 to the key reference service 52346 *Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)* (work RVU= 8.58) and noted that the two service have identical intra-service time, 60 minutes, with similar physician work. Given this, the RUC agreed that the two services should be valued similarly. Finally, the RUC discussed the relativity between the large tumor and medium tumor services. The specialty explained that typically these services are performed on multiple lesions which are added to total greater than 5 cm. Thus the physician work is not just longer but much more intense as more lesions are addressed. **The RUC recommends a work RVU of 8.75 for CPT code 52240.**

52351 ***Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic***

The RUC reviewed the survey results from 101 urologists for CPT code 52351 and agreed that the physician time components were accurate at the median time (pre-service time= 53 minutes, intra-service time= 45 minutes, post-service time= 20 minutes), with two additional minutes of standard pre-service positioning time to place the patient in the dorsal lithotomy position. The RUC agreed with the specialty society that the 25th percentile work RVU of 5.75 accurately reflects the typical physician work involved in the service. To justify a work value of 5.75, the RUC compared 52351 to CPT code 93458 *Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed* (work RVU= 5.85) and agreed that while the two services have identical intra-service time, 45 minutes, the reference code should be valued slightly higher due to greater total time, 123 minutes compared to 118 minutes.

key reference service 52344 *Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)* (work RVU= 7.05) and noted that the reference code should be valued higher due to greater total time

compared to the surveyed code, 125 minutes and 118 minutes, respectively. The RUC also reviewed CPT code 52277 *Cystourethroscopy, with resection of external sphincter (sphincterotomy)* (work RVU= 6.16) and noted that 52277 has greater total time compared to 52351, 130 minutes compared to 118 minutes. **The RUC recommends a work RVU of 5.75 for CPT code 52351.**

52352 ***Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)***

The RUC reviewed the survey results from 93 urologists for CPT code 52352 and agreed that the physician time components were accurate at the median time (pre-service time= 53 minutes, intra-service time= 45 minutes, post-service time= 20 minutes), with two additional minutes of standard pre-service positioning time to place the patient in the dorsal lithotomy position. The RUC agreed that the survey respondents overestimated the physician work RVUs at the median time and agreed that the 25th percentile work RVU of 6.75 accurately reflects the typical physician work involved in the service. To justify a work value of 6.75, the RUC compared 52352 to the key reference service 52344 *Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)* (work RVU= 7.05) and agreed that the reference code should be value slightly higher than the surveyed code due to greater total time, 125 minutes and 118 minutes, respectively. In addition, the RUC reviewed CPT code 34812 *Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral* (work RVU= 6.74) and agreed that the two services should be valued almost identically due to equal intra-service time of 45 minutes. Finally, the RUC discussed the time differences between the Harvard survey and the current survey. The specialty explained that the physician used to spend much more time simply maneuvering the rigid scope into the ureter. Now with the flexible scope, the physician's time is much more intense because of the additional complexity of treatment involved while surveying the entire urinary tract. In addition, the new smaller, flexible scope has eliminated ramp up and down intra-service time, making the physician's work overall more intense than before. **The RUC recommends a work RVU of 6.75 for CPT code 52352.**

52353 ***Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)***

The RUC reviewed the survey results from 86 urologists for CPT code 52353 and agreed that the physician time components were accurate at the median time (pre-service time= 53 minutes, intra-service time= 60 minutes, post-service time= 20 minutes), with two additional minutes of standard pre-service positioning time to place the patient in the dorsal lithotomy position. The RUC agreed that the survey respondents accurately estimated the physician work RVU at the median time. To justify a work value of 7.88, the RUC compared 52353 to the key reference service 52345 *Cystourethroscopy with ureteroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)* (work RVU= 7.55) and agreed that while the two services have similar total times, 133 minutes and 135 minutes, respectively. In addition, the RUC reviewed CPT code 37220 *Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty* (work RVU= 8.15) and compared it to 52353, noting that both services have identical intra-service time, 60 minutes. **The RUC recommends a work RVU of 7.88 for CPT code 52353.**

52354 ***Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with biopsy and/or fulguration of ureteral or renal pelvic lesion***

The RUC reviewed the survey results from 79 urologists for CPT code 52354 and agreed that the physician time components were accurate at the survey median time (pre-service time= 53 minutes, intra-service time= 60 minutes, post-service time= 20 minutes), with two additional minutes of standard pre-service positioning time to place the patient in the dorsal lithotomy position. The RUC agreed that the survey respondents accurately estimated the physician work RVU at the median time. To justify a work value of 8.58, the RUC compared 52354 to the key reference service 52346 *Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)* (work RVU= 8.58) and noted that the two services have identical intra-service time of 60 minutes, with similar total time, and should be valued identical. Finally, the RUC discussed the time differences between the Harvard survey and the current survey. The specialty explained that the physician use to spend much more time simply maneuvering the rigid scope into the ureter. Now with the flexible scope, the physician's time is much more intense because of the additional complexity of treatment involved while surveying the entire urinary tract. In addition, the new smaller, flexible scope has eliminated ramp up and down intra-service time, making the physician's work overall more intense than before. **The RUC recommends a work RVU of 8.58 for CPT code 52354.**

52355 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with resection of ureteral or renal pelvic tumor*

The RUC reviewed the survey results from 75 urologists for CPT code 52355 and agreed that the physician time components were accurate at the median time (pre-service time= 53 minutes, intra-service time= 90 minutes, post-service time= 20 minutes), with two additional minutes of standard pre-service positioning time to place the patient in the dorsal lithotomy position. The RUC agreed that the survey respondents accurately estimated the physician work RVU at the median time. To justify a work value of 10.00, the RUC compared 52355 to CPT code 37221 *Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed* (work RVU= 10.00) and agreed that since the two service have identical intra-service time of 60 minutes, with similar total time, they should have the same value. In addition, the RUC reviewed CPT code 37210 *Uterine fibroid embolization (UFE, embolization of the uterine arteries to treat uterine fibroids, leiomyomata), percutaneous approach inclusive of vascular access, vessel selection, embolization, and all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the procedure* (work RVU= 10.60) in comparison to 52355 and agreed that the two service should be valued similarly given the identical intra-service time of 90 minutes. **The RUC recommends a work RVU of 10.00 for CPT code 52355.**

Work Neutrality

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

<u>Injection of Anesthetic Agent (Tab 24)</u>

Seth Rubenstein, DPM (APMA); Tim Tillo, DPM (APMA); Eduardo Fraifeld, MD (AAPM); Marc L. Leib, MD, JD (ASA)

The RUC identified CPT code 64450 *Injection, anesthetic agent; other peripheral nerve or branch as* part of the Harvard Valued – Utilization over 100,000 screen. In CPT 2009, codes 64455 *Injection(s), anesthetic agent and/or steroid, plantar common digital*

nerve(s) (eg, Morton's neuroma)(work RVU = 0.75) and 64632 *Destruction by neurolytic agent; plantar common digital nerve* (work RVU = 1.23) were created and it was anticipated that podiatrists would frequently use these codes instead of 64450. In the February 2010, the action plan from the specialty societies indicated that a significant drop in the frequency for 64450 was to be expected. The data from 2009 and 2010 indicated that 64450 was steadily increasing as well as additional reporting of 64455 and 64632. However, the increased reporting of 64450 was primarily from primary care. The RUC recommended that a CPT Assistant article be developed to clarify the appropriate reporting of this service and that this service should be surveyed.

In September 2011, the RUC reviewed survey results from 48 podiatrists, anesthesiologists, pain management physicians and interventional pain management physicians for code 64450 and agreed with the specialty society that the survey 25th percentile work RVU of 0.75, a decrease to the current value, appropriately accounts for the work required to perform this service. The RUC determined that 10 minutes pre-service time, 5 minutes intra-service time and 5 minutes immediate post-service time accurately account for the time required to perform this service. The RUC agreed with the adjustment of 3 additional minutes to the pre-service evaluation because this service is different from other injection services and more similar to a non-facility procedure, anesthesia with a needle stick. This is an exception because anesthesia is used as the procedure. The RUC noted that when this service is reported for injection to an upper extremity or torso that it can be for multiple nerves, it depends on the clinical situation. This service captures those injections to otherwise not specified nerves, other peripheral nerve or branch and therefore the vignette indicates injection to the posterior tibial nerve. The RUC compared 64450 to key reference 64455 *Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (eg, Morton's neuroma)* (work RVU = 0.75) and determined that these two codes require the same physician work and time to perform. The RUC also compared the surveyed code to MPC code 20551 *Injection(s); single tendon origin/insertion* (work RVU = 0.75) which also requires the same physician work and time, 20 minutes total, to perform. **The RUC recommends a work RVU of 0.75 for CPT code 64450.**

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

<u>Injection Treatment of Nerve (Tab 25)</u>
Seth Rubenstein, DPM (APMA); Tim Tillo, DPM (APMA); Eduardo Fraifeld, MD (AAPM); Marc L. Leib, MD, JD (ASA)

In April 2011, the RUC identified CPT code 64640 *Destruction by neurolytic agent; other peripheral nerve or branch* as part of the Harvard Valued – Utilization over 30,000 screen and requested that this service be surveyed.

The RUC reviewed survey results from 44 podiatrists, anesthesiologists, pain management physicians and interventional pain management physicians for code 64640 and agreed with the specialty society that the survey 25th percentile work RVU of 1.23, a decrease to the current value, appropriately accounts for the work required to perform this service. The RUC determined that 10 minutes pre-service time, 5 minutes intra-service time and 5 minutes immediate post-service time accurately account for the time required to perform this service. The RUC agreed with the adjustment of 3 additional minutes to

the pre-service evaluation because this service is different from other injection services and more similar to a non-facility procedure, anesthesia with a needle stick. This is an exception because anesthesia is used as the procedure.

The RUC compared 64640 to key reference 64632 *Destruction by neurolytic agent; plantar common digital nerve* (work RVU = 1.23) and determined that these two codes requires the same physician work and time to perform, 36 minutes. The RUC also compared the surveyed code to MPC code 20551 *Injection(s); single tendon origin/insertion* (work RVU = 0.75) which requires 20 minutes total to perform compared to 36 minutes total for code 64640. CPT code 64640 includes one 99212 *Evaluation and Management Office Visit* (work RVU = 0.48). Therefore, the RUC noted that MPC code 20551 plus the additional office visit (0.75 + 0.48 = 1.23) equals the survey 25th percentile work RVU of 1.23 and appropriately accounts for the work required to perform this service. **The RUC recommends a work RVU of 1.23 for CPT code 64640.**

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

Removal of Foreign Body (Tab 26)
Stephen A. Kamenetzky, MD (AAO) Michael Chaglasian, OD (AOA)

In April 2011, the RUC identified CPT code 65222 *Removal of foreign body, external eye; corneal, with slit lamp* as part of the Harvard Valued – Utilization over 30,000 screen and requested that this service be surveyed. Other codes that are within the family, such as CPT code 65220 *Removal of foreign body, external eye; corneal, without slit lamp* (work RVU=0.71) were not reviewed as they are not predominately performed by ophthalmologists or optometrists.

The RUC reviewed the survey data from 49 ophthalmologists and optometrists for CPT code 65222 and agreed with the specialty societies that the pre-service time was over-estimated given that this service is typically performed with an evaluation and management service. Therefore, the specialty societies recommended and the RUC agreed that the pre-service time for this procedure should be crosswalked to CPT code 12001 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less* (work RVU=0.84), as this time was deemed to be comparable. (5 minutes evaluation compared to 9 minutes from survey, 1 minute positioning due to slit lamp, and 1 minute for anesthesia.) The RUC compared this code to the key reference code 65430 *Scraping of cornea, diagnostic, for smear and/or culture* (work RVU=1.47) and noted that the surveyed code requires less time to perform in comparison to the reference code, 19 minutes and 28 minutes, respectively. Further, the RUC noted that the reference code requires more mental effort and judgment to perform in comparison to the surveyed code. In addition, the RUC compared the surveyed code to CPT code 20526 *Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel* (work RVU= 0.94) and agreed that the two services have analogous total time, 16 minutes and 19 minutes, respectively, and should be valued similarly. Based on these comparisons, the RUC agreed with the specialty society that although the survey data supports a higher work RVU, there is lack of compelling evidence to change the current value of the procedure. Therefore, the RUC recommends the current value of 65222 be maintained at 0.93 work RVUs, a value below

the surveyed 25th percentile. **The RUC recommends a work RVU of 0.93 for CPT code 65222.**

Drainage of Eye (Tab 27)

In April 2011, the RUC identified CPT code 65800 *Paracentesis of anterior chamber of eye (separate procedure); with diagnostic aspiration of aqueous* and 65805 *Paracentesis of anterior chamber of eye (separate procedure); with therapeutic release of aqueous* as part of the Harvard Valued – Utilization over 30,000 screen and requested that this service be surveyed. The American Academy of Ophthalmology (AAO) has stated that they have submitted a code change proposal for 65800 and 65805 to the CPT Editorial Panel to deleted CPT code 65805 and revise code 65800 to be reported for both diagnostic and therapeutic indications. AMA RUC Staff confirmed receipt of this coding proposal by AMA CPT Staff and it is scheduled to be presented at the October 2011 CPT Editorial Panel Meeting. The specialty will then survey the revised CPT code 65880.

Subconjunctival Injection (Tab 28)
Stephen A. Kamenetzky, MD (AAO)

In April 2011, the RUC identified CPT code 68200 *Subconjunctival injection* as part of the Harvard Valued – Utilization over 30,000 screen and requested that this service be surveyed. The specialty society indicated that although they conducted a RUC survey to value this code, they were unable to gather enough survey responses to make the survey data viable. Therefore, the specialty society convened an Expert Panel to develop recommendations. The Expert Panel agreed that the surveyed times should be crosswalked to 67515 *Injection of medication or other substance into Tenon's capsule* (work RVU=1.40; pre-service time=11 minutes, intra-service time=5 minutes and post-service time=5 minutes), however, the Expert Panel noted that the surveyed code is typically performed with an Evaluation and Management code. Therefore, the expert panel recommends and the RUC agrees that 3 minutes of pre-service time, 5 minutes of intra-service time and 5 minutes of post-service time accurately reflects the time require to perform the service. The RUC reviewed several other reference services in comparison to this surveyed code including: 11900 *Injection, intralesional; up to and including 7 lesions* (work RVU=0.52, total time=15 minutes), 64566 *Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming* (work RVU=0.60, total time=15 minutes) and 46600 *Anoscopy; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* (work RVU=0.55, total time=22 minutes). After reviewing these reference codes in comparison to the surveyed code and determining that there was no compelling evidence that the service has changed, the RUC agreed that the current value of this service is appropriate. **The RUC recommends maintaining the current work RVU of 0.49 for CPT code 68200.**

CCI Edit and CPT Assistant Article
The RUC discussed the Medicare Claims Data for this service and noted, and the specialty agreed, that it is performed inappropriately 67% of the time with CPT code 67028 *Intravitreal injection of a pharmacologic agent (separate procedure*). Therefore, the specialty society will draft a letter to request that a CCI edit be created to not allow reporting of these two services together on the same eye on the same date. The specialty will also draft a CPT Assistant Article detailing that these two services should not be reported together. However, since 67028 has much higher utilization than 68200, only

two percent of the total Medicare utilization for 67208 (1.6 million) is incorrectly reporting these services. There was concern that the CPT Assistant article may be ineffective in reaching the two percent of inappropriate billers and thus the RUC agreed to have the RAW review utilization trends for CPT code 68200 in two years.

Removal of Foreign Body (Tab 29)
Wayne Koch, MD (AAO-HNS)

In April 2011, the RUC identified CPT code 69200 *Removal foreign body from external auditory canal; without general anesthesia* as part of the Harvard Valued – Utilization over 30,000 screen and requested that this service be surveyed.

The RUC reviewed the survey results from 37 otolaryngologists for code 69200 and agreed with the specialty society that the work has not changed since the last review and maintaining the current work RVU of 0.77 appropriately accounts for the work required to perform this service. Further, the survey 25th percentile work RVU of 0.80 supports the current value. The RUC agreed with the specialty society that the patient population receiving this service is typically children and therefore was valued with a vignette for a pediatric patient. The RUC determined that 11 minutes pre-service time, 10 minutes intra-service time and 5 minutes immediate post-service time accurately account for the time required to perform this service. The RUC compared 69200 to key reference 69210 *Removal impacted cerumen (separate procedure), 1 or both ears* (work RVU = 0.61) and determined that the surveyed code requires more physician work, time, intensity and complexity to perform than code 69210, 27 minutes versus 19 minutes total time, respectively. The RUC also compared the surveyed code to MPC codes 65205 *Removal of foreign body, external eye; conjunctival superficial* (work RVU = 0.71) and determined that 69200 requires more physician work and time than 65205, 26 minutes versus 15 minutes total time, respectively. **The RUC recommends a work RVU of 0.77 for CPT code 69200.**

Typanostomy (Tab 30)
Wayne Koch, MD (AAO-HNS)

In April 2011, the RUC identified CPT code 69433 *Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia*
as part of the Harvard Valued – Utilization over 30,000 screen and requested that this service be surveyed.

The RUC reviewed the survey data from 36 otolarnygologists for 69433. The RUC agreed with the specialty society's recommended modifications to the pre-service time. The RUC agreed with the specialty society's recommended pre-service time of 19 minutes, median intra-service and post-service times, 9 minutes and 5 minutes respectively. There was significant discussion by the RUC related to the level of the recommended post-operative visit. The RUC agreed that given the tasks that the physician must perform including: a review of hearing assessment and arranging for additional testing, discuss persistent symptoms of the eustachian tube dysfunction, alternations of auditory perception, pain or discharge, and provide counseling regarding expectations and full resolution of symptoms, one 99213 office visit was appropriate. The RUC reviewed the surveyed code in comparison to two reference codes 11441 *Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.6 to 1.0 cm* (work

RVU=1.53, total service time=51 minutes) and 11422 *Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm* (work RVU=1.68, total service time=56 minutes). Based on these comparisons, the RUC agreed with the specialty society that although the survey data supports a higher work RVU, there is no compelling evidence to change the current value of the service. **Therefore, the RUC recommends to maintain the current value, a work RVU of 1.57 work RVUs for CPT code 69433.**

Global Period:
The RUC notes that if the global period is changed to a 000 in the future, the specialty should have the opportunity to re-survey the code.

Charles Koopmann, Jr., MD abstained from voting on this issue.

Contrast X-Ray Exams (Tab 31)
Geraldine McGinty, MD (ACR); Zeke Silva, MD (ACR)

In April 2011, CPT codes 74247, 74280, 74400 were identified by the Harvard Valued over 30,000 screen. The specialty surveyed the family and presented the collected data to the RUC in September 2011. For each of these services, the physician is in the room during image acquisition.

74247 ***Radiological examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon; with or without delayed films, with KUB***
The RUC reviewed the survey data from 34 radiologists and agreed with the specialty that the median survey time components (pre-service time= 5 minutes, intra-service time= 15 minutes, post-service time= 5 minutes) accurately account for the typical physician work involved in the service. The RUC also reviewed the survey work values and agreed that the current work value of 0.69, lower than the survey low, is a more accurate value for this service. To justify a work value of 0.69, the RUC compared the surveyed code to CPT code 76377 *3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; requiring image postprocessing on an independent workstation* (work RVU= 0.79) and agreed that the reference code should be valued higher due to greater total time compared to 74247, 30 minutes and 25 minutes, respectively. In addition, the RUC also reviewed CPT code 76700 *Ultrasound, abdominal, real time with image documentation; complete* (work RVU= 0.81) and agreed that while 74247 has more intra-service time compared to 76700, 15 minutes compared to 10 minutes, the physician work is less intense and thus is correctly valued relative to similar radiology services. **The RUC recommends a work RVU of 0.69 for CPT code 74247.**

74280 ***Radiologic examination, colon; air contrast with specific high density barium, with or without glucagon***
The RUC reviewed the survey data from 34 radiologists and agreed with the specialty that the median survey time components (pre-service time= 5 minutes, intra-service time= 20 minutes, post-service time= 7 minutes) accurately account for the typical physician work involved in the service. The RUC also reviewed the survey work values and agreed that the current work value of 0.99, lower than the survey 25th percentile, is a more accurate value for this service. To justify a work value of 0.99, the RUC compared the surveyed code to 76511 *Ophthalmic ultrasound, diagnostic; quantitative A-scan only*

(work RVU= 0.94) and agreed that the two services should be valued similarly given almost identical total time, 30 minutes and 32 minutes, respectively. In addition, the RUC compared 74280 to CPT code 91111 *Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus with physician interpretation and report* (work RVU= 1.00) and agreed that the service should be valued similarly due to analogous total time, 32 minutes and 35 minutes, respectively. **The RUC recommends a work RVU of 0.99 for CPT code 74280.**

74400 ***Urography (pyelography), intravenous, with or without KUB, with or without tomography***
The RUC reviewed the survey data from 34 radiologists and agreed with the specialty that the median survey time components (pre-service time= 5 minutes, intra-service time= 15 minutes, post-service time= 5 minutes) accurately account for the typical physician work involved in the service. The RUC also reviewed the survey work values and agreed that the current work value of 0.49, lower than the survey low, is a more accurate value for this service. To justify a work value of 0.49, the RUC compared 74400 to CPT code 93923 *Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, 3 or more levels* (work RVU= 0.45) and agreed that the surveyed code should be valued higher than the reference code due to greater intra-service 15 minutes compared to 10 minutes. **The RUC recommends a work RVU of 0.49 for CPT code 74400.**

Set Radiation Therapy Field (Tab 32)

In April 2011, the RUC identified CPT code 77280 *Therapeutic radiology simulation-aided field setting; simple* as part of the Harvard Valued – Utilization over 30,000 screen and requested that this service be surveyed.

At the September 2011 RUC Meeting, the specialty societies indicated that it was their understanding that 77280 had been reviewed by the RUC during the third Five-Year Review in 2005. Because of this review, the specialty society requested that the time associated with this code be designated as RUC reviewed time. The RUC reviewed its past actions regarding this code and determined that although, this code was reviewed during the third Five-Year Review and the value was maintained, the rationale specifically states, "the RUC believed that the current Harvard total and intra-time of 23 minutes of physician time was more typical and maintained the current time." The RUC interpreted this rationale to indicate that the time associated with this code remains to be Harvard time. **Therefore, the RUC did not approve the specialty society's request and recommends that the specialty society survey this code and the other codes in the family, 77285** ***Therapeutic radiology simulation-aided field setting; intermediate*****, 77290** ***Therapeutic radiology simulation-aided field setting; complex*** **and 77295** ***Therapeutic radiology simulation-aided field setting; 3-dimensional*** **for the January 2012 RUC Meeting.**

Thyroid Imaging (Tab 33)

In April 2011, the RUC identified CPT code 78007 *Thyroid imaging, with uptake; multiple determinations* as part of the Harvard Valued – Utilization over 30,000 screen and requested that this service be surveyed. The specialty societies requested and the RUC agreed that this code and its family (78000-78011) be referred to the CPT Editorial

Panel for revision and potential consolidation. **The RUC recommends that 78007 and its associated family be referred to the CPT Editorial Panel.**

Acute GI Blood Loss Imaging (Tab 34)
Geraldine McGinty, MD (ACR); Zeke Silva, MD(ACR); Gary Dillehay, MD (SNM); Scott Bartley, MD (ACNM)

In April 2011, CPT code 78278 was identified by the Harvard Valued over 30,000 screen. The specialties surveyed the code and presented the data to the RUC in September 2011.

The RUC reviewed the survey results from 259 radiologists and nuclear medicine physicians and agreed with the following physician time components: 5 minutes pre-service, 15 minutes intra-service and 10 minutes immediate post-service. The RUC also reviewed the respondents' estimated work values and agreed with the specialty that there is no compelling evidence to change the work RVU for this service. To justify maintaining the work RVU at 0.99, the RUC compared 78278 to the key reference code 78708 *Kidney imaging morphology; with vascular flow and function, single study, with pharmacological intervention (eg, angiotensin converting enzyme inhibitor and/or diuretic)* (work RVU= 1.21). The RUC noted that while the reference code has greater intra-service time compared to the surveyed code, the survey respondents rated 78278 as a more intense and complex procedure in relation to 78708. In addition, the RUC reviewed CPT code 76801 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; single or first gestation* (work RVU= 0.99) in comparison to 78278 and noted that the two services have identical intra-service time of 15 minutes and similar physician work. Given these relationships, the RUC agreed that 78278 is valued accurately relative to similar services. **The RUC recommends a work RVU of 0.99 for CPT code 78278.**

Cardiac Blood Pool Imaging (Tab 35)
Richard Wright, MD (ACC); Scott Bartley, MD (ACNM); Geraldine McGinty, MD (ACR); Zeke Silva, MD (ACR); William Van Decker, MD (SNM); Gary Dillehay, MD (SNM)

In April 2011, CPT code 78472 *Cardiac blood pool imaging, gated equilibrium; planar, single study at rest or stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without additional quantitative processing* was identified by the Harvard Valued over 30,000 screen. The specialties surveyed the code and presented the data to the RUC in September 2011.

The RUC reviewed the survey results from 227 radiologists, cardiologists, and nuclear physicians and agreed with the following physician time components: 5 minutes pre-service, 10 minutes intra-service and 5 minutes immediate post-service. The RUC also reviewed the respondents' estimated work values and agreed with the specialty that there is no compelling evidence to change the work RVU for this service. However, the survey median of 1.00 supports the current value of 0.98. To justify maintaining the work RVU at 0.98, the RUC compared 78472 to the key reference code 78453 *Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)* (work RVU= 1.00). The RUC agreed that the

two services should have similar work values due to identical physician time components and analogous physician work. The RUC also reviewed CPT code 78315 *Bone and/or joint imaging; 3 phase study* (work RVU= 1.02) in comparison to 78472 and agreed that the two service should be valued closely due to similar total time, 18 minutes and 20 minutes, respectively. **The RUC recommends a work RVU of 0.98 for CPT code 78472.**

Serial Tonometry (Tab 36)
Stephen A. Kamenetzky, MD (AAO); Michael Chaglasian, OD (AOA)

In April 2011, the RUC identified CPT code 92100 *Serial tonometry (separate procedure) with multiple measurements of intraocular pressure over an extended time period with interpretation and report, same day (eg, diurnal curve or medical treatment of acute elevation of intraocular pressure)* as part of the Harvard Valued – Utilization over 30,000 screen and requested that this service be surveyed.

The RUC reviewed the survey data from 30 ophthalmologists and optometrists for 92100. The specialty societies recommended and the RUC agreed that the survey data supports a reduction in the current valuation of this procedure. The specialty societies indicated that despite the survey time data collected, there is no pre- or post-service work as part of the typical service and therefore the pre-and post-service times were removed from the specialty societies' recommended times. This approach was approved by the RUC for other ophthalmology codes where it was felt that the report was part of the intra-service work. The specialty societies recommended and the RUC agreed that 20 minutes of intra-service time accurately reflects the performance of this service. In addition to the standard survey, the societies asked two additional questions: who does the measurement (technologist or MD/OD) and how many measurements would be done in the course of the examination. The data indicated that the MD/ODs typically performed the test and that 4 measurements were obtained during the service. The 20 minutes of total time reflect the 4 measurements that occur over several hours in the physician office.

The RUC reviewed the surveyed code in comparison to the reference code 92020 *Gonioscopy (separate procedure)* (work RVU=0.37) and noted that the reference code has less intra-service time as compared to the surveyed code, 10 minutes and 20 minutes, respectively. Further, the RUC noted that the surveyed code is an overall more intense service to perform in comparison to the reference code. Based on these comparisons, the specialty societies agreed and the RUC recommends that 0.61 work RVUs best reflects the physician work required to perform the service. **The RUC recommends 0.61 RVUs, the survey median, for 92100.**

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

Fluorescein Angiography (Tab 37)
Stephen A. Kamenetzky, MD (AAO)

In April 2011, the RUC identified CPT code 92235 *Fluorescein angiography (includes multiframe imaging) with interpretation and report* as part of the Harvard Valued – Utilization over 30,000 screen and requested that this service be surveyed.

At the September 2011 RUC Meeting, the specialty societies indicated that it was their understanding that 92235 had been reviewed by the RUC during the third Five Year Review in 2005. Because of this review, the specialty society requested that the time associated with this code be designated as RUC reviewed time. The RUC reviewed its past actions regarding this code and determined that although, this code was reviewed during the third Five Year Review and the value was maintained, the rationale specifically states, "the RUC did not accept the survey results nor any of the physician time data." The RUC interpreted this rationale to indicate that the time associated with this code remains to be Harvard time. **Therefore, the RUC did not approve the specialty society's request and recommends that the specialty society survey this code for the January 2012 RUC Meeting.**

Internal Eye Photography (Tab 38)

In April 2011, the RUC identified CPT code 92286 *Special anterior segment photography with interpretation and report; with specular endothelial microscopy and cell count* as part of the Harvard Valued – Utilization over 30,000 screen and requested that this service be surveyed. The American Academy of Ophthalmology (AAO) has stated that they have submitted a code change proposal for 92286 to the CPT Editorial Panel to modify the descriptor to more accurately describe the service being performed. **AMA RUC Staff confirmed receipt of this coding proposal by AMA CPT Staff and it is scheduled to be presented at the October 2011 CPT Editorial Panel Meeting.**

Transthoracic Echocardiography (Tab 39)

In April 2011, CPT code 93308 *Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study* was identified by the Harvard Valued over 30,000 screen. The specialties surveyed the code and presented the data to the RUC in September 2011.

The RUC reviewed the survey results from 87 cardiologists and agreed with the following physician time components: 5 minutes pre-service, 15 minutes intra-service and 5 minutes immediate post-service. The RUC also reviewed the respondents' estimated work values, reflecting higher work RVUs than the current, 0.53. However, the RUC agreed with the specialty that there is no compelling evidence to change the work RVU for this service. To justify maintaining the work RVU at 0.53, the RUC compared 93308 to CPT code 93224 *External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; includes recording, scanning analysis with report, physician review and interpretation* (work RVU= 0.52 and total time= 24 minutes) and agreed that these two services should have almost identical work values given they have the same intra-service time, 15 minutes, and similar total time. Given this comparison and strong survey data, the RUC agreed that the current work value accurately reflects the typical physician work involved in the surveyed code. **The RUC recommends a work RVU of 0.53 for CPT code 93308.**

Needle Electromyography (Tab 40)

In April 2011, the RUC identified CPT code 95860 *Needle electromyography; 1 extremity with or without related paraspinal areas* as part of the Harvard Valued – Utilization over 30,000 screen and requested that this service be surveyed. The specialty societies explained that this code is part of a code change proposal that is scheduled to be

reviewed at the October 2011 CPT Editorial Panel Meeting to address issues of concurrent EMG and nerve conduction studies. **The RUC recommends that 95860 be referred to the CPT Editorial Panel.**

XII. CMS Requests – MPC List Screen

Diagnostic Nasal Endoscopy (Tab 41)
Wayne Koch, MD (AAO-HNS)

In the *Final Rule* for the 2011 Medicare Physician Payment Schedule, CMS requested that the RUC review high volume services included on the RUC's Multi-Specialty Points of Comparison (MPC) List. The RUC has engaged in a more comprehensive review of the MPC, reconstructing the document to ensure that it includes true cross-specialty services. Several of the specific codes identified by CMS were scheduled for review at the September 2011 RUC meeting, with specialty society data submitted. The RUC recommended that for 31231 *Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)* the specialty society should re-survey for the January 2012 RUC meeting with improved vignette to describe the typical unilateral vs. bilateral and better define the work of the involved topical and pledgets anesthetic in the survey instrument.

Upper GI Endoscopy Biopsy (Tab 42)
Jaya Agrawal, MD (AGA); Edward Bentley, MD (ASGE); Michael Edye, MD (SAGES); Nicholas Nickl, MD (ASGE); Don Selzer, MD (SAGES)

In the *Final Rule* for the 2011 Medicare Physician Payment Schedule, CMS requested that the RUC review high volume services included on the RUC's Multi-Specialty Points of Comparison (MPC) List. The RUC has engaged in a more comprehensive review of the MPC, reconstructing the document to ensure that it includes true cross-specialty services. Several of the specific codes identified by CMS were scheduled for review at the September 2011 RUC meeting, with specialty society data submitted. The specialty societies representing gastroenterology and gastrointestinal endoscopic surgery indicated that appropriate surveys could not be conducted until after the specialty societies had an opportunity to resolve payment policy issues related to the provision of moderate sedation. The RUC understands that gastroenterology and gastrointestinal endoscopic surgery will be working with the CPT Editorial Panel and CMS to resolve this coding and payment policy question as it relates to over 100 GI endoscopy services. In the meantime, the RUC will not include any of these services on the MPC List. The specialty societies indicated that they plan to engage with the RUC on a workplan to survey this family of codes once the issues related to moderate sedation have been addressed.

Colonoscopy (Tab 43)
Jaya Agrawal, MD (AGA); Edward Bentley, MD (ASGE); Michael Edye, MD (SAGES); Nicholas Nickl, MD (ASGE); Don Selzer, MD (SAGES)

In the *Final Rule* for the 2011 Medicare Physician Payment Schedule, CMS requested that the RUC review high volume services included on the RUC's Multi-Specialty Points of Comparison (MPC) List. The RUC has engaged in a more comprehensive review of the MPC, reconstructing the document to ensure that it includes true cross-specialty services. Several of the specific codes identified by CMS were scheduled for review at the September 2011 RUC meeting, with specialty society data submitted. The specialty

societies representing gastroenterology and gastrointestinal endoscopic surgery indicated that appropriate surveys could not be conducted until after the specialty societies had an opportunity to resolve payment policy issues related to the provision of moderate sedation. The RUC understands that gastroenterology and gastrointestinal endoscopic surgery will be working with the CPT Editorial Panel and CMS to resolve this coding and payment policy question as it relates to all of over 100 GI endoscopy services. In the meantime, the RUC will not include any of these services on the MPC List. The specialty societies indicated that they plan to engage with the RUC on a workplan to survey this family of codes once the issues related to moderate sedation have been addressed.

Fluoroscopic Guidance for Spine Injection (Tab 44)
David Caraway, MD (ASIPP); William Creevy, MD (AAOS); Eddy Fraifeld, MD (AAPM); John Heiner, MD (AAOS); Marc Leib, MD (ASA); Christopher Merifield, MD (ISIS); William Sullivan, MD (NASS); Joseph Zuhosky, MD (AAPMR)

CPT code 77003 *Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, subarachnoid, or sacroiliac joint), including neurolytic agent destruction* was identified by CMS as part of the MPC List screen. In February 2011, the RUC recommended 77003 be resurveyed as it had not been reviewed in the last 6 years.

The RUC noted many issues with the survey conducted for this service, including that is performed concurrently with an injection procedure. The specialties did not include the new 2012 CPT descriptor in the survey and there were issues related to the clinical vignette. The RUC urged the specialty to develop a new vignette and instructions to inform the respondent that the injection(s) is reported separately. The Research Subcommittee will review the revised vignette and instructions prior to the survey data collection for the January 2012 RUC meeting. Additionally, the last review of RUC time in May 1999, was not a thorough review in relation to other codes and therefore the current physician time can not accurately be compared to the proposed physician time. **The RUC recommends that this service be removed from the MPC list and that the specialty societies resurvey with the correct descriptor and an appropriate vignette for January 2012.**

XIII. CMS Requests – Codes Reported 75% of More Together Screen

Shoulder Arthroscopy (Tab 45)
William Creevy, MD (AAOS); John Heiner, MD (AAOS)

In February 2010, CPT codes 29824 *Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure*, 29827 *Arthroscopy, shoulder, surgical; with rotator cuff repair* and 29828 *Arthroscopy, shoulder, surgical; biceps tenodesis* were identified in the Reported 75% or More Reported Together Screen with 29826 *Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with or without coracoacromial release*. In addition, as part of the Fourth Five-Year Review, CMS identified 29826 as a Harvard reviewed code with utilization over 30,000.

Given that 29826 is rarely performed as a stand-alone procedure (less than 1% of the time), the American Academy of Orthopaedic Surgeons requested that CMS change the

global period from a 090-day to ZZZ. CMS agreed, a revision was made to the code descriptor at the February 2011 CPT Editorial Panel, and the code was surveyed for the April 2011 RUC meeting as an add-on service. The revised code, global period, and work RVU will become effective January 1, 2012.

Review of the three 90-day global shoulder arthroscopy codes, identified in conjunction with 29826, was deferred until after revised code 29826 was reviewed in April 2011. The revised code 29826, as is the case for almost all ZZZ codes, has only intra-service work and time associated with its value. The RUC agrees that this revision in the global period as well as the elimination of pre-and post-service time eliminates all overlapping work with other procedures in the pre-operative and post-operative periods. **Therefore, the RUC affirms a work RVU of 8.82 for CPT code 29824, a work RVU of 15.59 for CPT code 29827, and a work RVU of 13.16 for CPT code 29828 as correct and not overlapping with the work RVUs for 29826, which will be an add-on code beginning January 1, 2012**.

Introduction of Catheter (Tab 46)
Michael Hall, MD (SIR); William Julien, MD (SIR); Geraldine McGinty, MD (ACR); Gerald Niedzwieki, MD (SIR); Sean Roddy, MD (SVS); Gary Seabrook, MD (SVS); Matthew Sideman, MD (SVS); Zeke Silva, MD (ACR); Michael Stherland, MD (SVS); Sean Tutton, MD (ACR); Robert Vogelzang, MD (SIR)
Facilitation Committee #2

In February 2010 CPT code 36010 *Introduction of catheter, superior or inferior vena cava* was identified with code 37620 *Interruption, partial or complete, of inferior vena cava by suture, ligation, plication, clip, extravascular, intravascular (umbrella device)* (work RVU = 11.57) as part of the Reported Together 75% or More Together screen. In February 2011, the CPT Editorial Panel deleted code 37620 and created four new codes bundling the services commonly reported together, which the RUC reviewed in April 2011.

The RUC reviewed codes 36140 *Introduction of needle or intracatheter; extremity artery* and 36010 *Introduction of catheter, superior or inferior vena cava* and agreed with the specialty society that these services should be reviewed in two years after utilization data and codes reported together data are available. The new IVC filter codes (37191-37196 and 37619) were recently bundled therefore utilization shifts will occur. The RUC discussed that referral to the CPT Editorial Panel to either add a parenthetical or further bundle these codes may be possible options in the future. However, monitoring utilization data and reported together data first would be appropriate to analyze what is occurring prior to any code change proposals. Additionally, in interim, the specialty societies indicated that they will work on correct coding education for these codes within their specialty societies. **The RUC recommends to refer this issue to the Relativity Assessment Workgroup for review at the October 2013 meeting after two years of utilization and codes reported together data is collected, prior to referral to the CPT Editorial Panel.**

Global Period:
When the code is reviewed in the future, the specialty requests a global period of 000 rather than the current XXX.

XIV. CMS Request – PE Review

Kyphoplasty (Tab 47)
Michael Hall, MD (SIR); William Julien, MD (SIR); Geraldine McGinty, MD (ACR); Gerald Niedzwieki, MD (SIR); Zeke Silva, MD (ACR); Sean Tutton, MD (ACR); Robert Vogelzang, MD (SIR)

In the July 19, 2011 *Proposed Rule* for the 2012 Medicare Physician Payment Schedule, CMS indicated that the agency received comments to establish non-facility practice expense inputs for CPT codes 22523, 22524 and 22525 kyphoplasty services. As such, CMS requested that the RUC make recommendations for the practice expense inputs for these services.

The Practice Expense Subcommittee updated the equipment for the Moderate Sedation package, specifically related to EQ212 *pulse oxymetry recording software (prolonged monitoring)* and EQ269 *blood pressure monitor, ambulatory, w-battery charger.* These two equipment items will be removed from the Moderate Sedation package as CMS indicated that EQ011 *ECG, 3-channel (with SpO2, NIBP, temp, resp)* already incorporates the functionality of these two equipment items. **The Practice Expense Subcommittee reviewed the direct practice expense inputs recommended by the specialty and removed EQ211 pulse oximeter w-printer and replaced EQ010 *ECG, 3-channel* with EQ011 to align with the revised moderate sedation equipment guidelines. The RUC recommends the modified direct practice expense inputs attached**.

XV. Practice Expense Subcommittee Report (Tab 48)

Doctor Brill, Vice-Chair, provided a summary of the Practice Expense Subcommittee report. The Subcommittee reviewed the CMS decision to eliminate two equipment items from the from the Moderate Sedation package. **The Subcommittee agreed that Equipment items EQ212 pulse oxymetry recording software (prolonged monitoring) and EQ269 blood pressure monitor, ambulatory, w-battery charger will be removed from the moderate sedation package.**

The PE Subcommittee reviewed two issues regarding services with high cost supplies billed in multiple units. **First, the PE Subcommittee reaffirms the previous RUC recommendations to CMS that high cost supplies be assigned HCPCS codes (e.g. J codes) to better monitor appropriate payment. Second, The PE Subcommittee recommends that for the Balloon Sinuplasty codes the specific sinus surgery kit be removed from the practice expense inputs for the procedure code and replaced by new HCPCS codes to describe the sinus surgery kit.**

Finally, the Subcommittee reviewed the 17 different ultrasound and ultrasound pieces of equipment with price ranges from $1,304.33 to $466,492.00. **The Chair will establish a workgroup to review this issue and offer recommendations to the Subcommittee. The workgroup will have two primary objectives: 1) review the 17 ultrasound equipment codes to determine if the level of distinction is appropriate and 2) review the list of 110 CPT codes that use the various ultrasound equipment to determine if the equipment is appropriately identified.**

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

XVI. Research Subcommittee Report (Tab 49)

Doctor Lewis informed the RUC that the Research Subcommittee discussed the potential addition of language pertaining to the completion of forms by the physician mandated by rules or regulation to all of the RUC survey instruments and expressed multiple concerns. **The Research Subcommittee agreed not to add this proposed language into the RUC survey instruments and to continue to review these types of specialty society requests on a case-by-case basis.** The language that was approved for the ACC and HRS for their survey instrument will be filed for historical purposes and recommended to specialties seeking Research Subcommittee approval of survey instruments for similar situations. In order to get a better understanding of the problem affecting physician work the Research Subcommittee will solicit the specialty societies for information on their experience with activities mandated by rules or regulation to be completed as part of the provision of a service.

Doctor Lewis explained to the RUC that the American Speech-Language and Hearing Association submitted a request to the Research Subcommittee to review the ASHA National Outcome Measurement System (NOMS) to determine if it meets the RUC's Inclusionary/ Exclusionary Criteria for Extant Databases. After their presentation, **the Research Subcommittee recommends that ASHA provide a mock demonstration of how the data collected in the NOMS data base would support a recommendation put forward by the specialty society at the upcoming February 2012 RUC meeting.**

Doctor Lewis informed the RUC that in response to a request made by the Research Subcommittee the Society of Thoracic Surgeons recommended that the extant data be displayed upon prior approval by the Research Subcommittee for codes identified by the specialty society.
The Subcommittee agreed that the specialty should review the data from the STS database and develop specific criteria (eg specific thresholds of survey volume and distribution) for when the specialty society would be required to display their extant data for a surveyed service with their RUC Recommendations.

The RUC approved the Research Subcommittee's report and it is attached to these minutes.

XVII. Administrative Subcommittee Report (Tab 50)

Doctor Blasier announced the following to the RUC:

- In May, the RUC received a request from the American Academy of Family Physicians to consider changes to the RUC composition and processes. At this meeting, the Administrative Subcommittee reviewed the following 5 requests from the AAFP:

    1. Add four additional "true" primary care seats (one each for the AAFP, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association);
    2. Eliminate the three current "rotating subspecialty seats" as the current representatives "term out;"
    3. Add a seat for Geriatrics;
    4. Add three new seats for "external representatives," such as consumers, employers, health systems, health plans; and
    5. Implement voting transparency.

- The RUC invited Doctor Roland Goertz, Chairman of the Board for the AAFP, to address the Subcommittee regarding these requests. Yesterday, the Subcommittee convened an informative hour and a half discussion with Doctor Goertz.

- The Subcommittee seemed receptive to adding 1 or more primary care seats to the RUC. There was positive discussion regarding a re-review of the 2007 Administrative Subcommittee recommendation to add a rotating primary care seat. Many of the commenting specialty societies and Subcommittee members expressed support for Geriatrics and suggestions were made to consider the expertise that the RUC may require to value care coordination and chronic disease management services.

- AMA staff will draft potential modifications to the RUC Structure and Functions document to consider these various seats for Administrative Subcommittee for a series of conference calls over the next few months. The Administrative Subcommittee will then review and formulate recommendations for the RUC at the January 2012 meeting.

- The Subcommittee did not seem receptive to eliminating the 3 current rotating seats or adding seats for "external representatives".

- The Subcommittee will continue to explore process changes to address perception regarding the transparency of the process.

The full Administrative Subcommittee minutes are attached separately to these minutes.

XVIII. Relativity Assessment Workgroup Report (Tab 51)

A. New Technology/New Services List

Doctor Larimore indicated that six years ago, the AMA RUC began the process of flagging services that represent new technology as they were presented to the Committee. The Workgroup continued this review of codes that were flagged September 2006-April 2007, with 3 years of available Medicare claims data (2008, 2009 and preliminary 2010 data).

Before examining the individual action plans, the Workgroup reviewed the original purpose of the "New Technology" designation. **The Workgroup agreed that the "New Technology" designation was intended to identify new services or codes whose use was expected to increase over time, such that as the service becomes more common and its use more diffuse, the actual work involved (time and/or intensity) or practice expenses might conceivably change (i.e., what may have seemed hard when originally valued may seem less hard now that it is more common). It was affirmed that codes showing a significant increase of utilization over time or dramatically more utilization than initially predicted by the specialty society would, in general, need to be resurveyed by the predominant specialty or specialties.**

The Workgroup recommended the following actions:

CPT Code	Recommendation
19105	Remove from list, utilization is lower than specialty estimation
20985	Resurvey for January 2012
29828	Resurvey for January 2012
33254	Remove from list, utilization is lower than specialty estimation
33255	Remove from list, utilization is lower than specialty estimation
33256	Remove from list, utilization is lower than specialty estimation
33257	Remove from list, utilization is lower than specialty estimation
33258	Remove from list, utilization is lower than specialty estimation
33259	Remove from list, utilization is as predicted by the specialty society
33265	Remove from list, utilization is lower than specialty estimation
33266	Remove from list, utilization is lower than specialty estimation
33864	Remove from list, utilization is lower than specialty estimation
34806	Remove from list, utilization is lower than specialty estimation
50593	Remove from list, utilization is lower than specialty estimation
57423	Remove from list, utilization is lower than specialty estimation
58570	Review in 2 years (Sept 2013), specialty society to identify codes and claims data for all hysterectomy procedures when re-reviewed.
58571	Review in 2 years (Sept 2013), specialty society to identify codes and claims data for all hysterectomy procedures when re-reviewed.
58572	Review in 2 years (Sept 2013), specialty society to identify codes and claims data for all hysterectomy procedures when re-reviewed..
58573	Review in 2 years (Sept 2013), specialty society to identify codes and claims data for all hysterectomy procedures when re-reviewed.
68816	Remove from list, utilization is lower than specialty estimation
75557	Remove from list, as utilization is appropriate due to shift of utilization for deleted code which included "with flow/velocity quantification", code 75558
75559	Remove from list, utilization is lower than specialty estimation
75561	Remove from list, as utilization is appropriate due to the shift of utilization of deleted code which included "with flow/velocity quantification", code 75560
75563	Remove from list, utilization is lower than specialty estimation
78811	Review in 2 years (Sept 2013) to affirm editorial nature of coding changes to remove "tumor imaging." Review migration in new technology (PET with CT scanners) and to monitor utilization related to coverage determinations. (eg, if coverage is expanded to include scans for infection).
78812	Review in 2 years (Sept 2013) to affirm editorial nature of coding changes to

	remove "tumor imaging." Review migration in new technology (PET with CT scanners) and to monitor utilization related to coverage determinations. (eg, if coverage is expanded to include scans for infection).
78813	Review in 2 years (Sept 2013) to affirm editorial nature of coding changes to remove "tumor imaging." Review migration in new technology (PET with CT scanners) and to monitor utilization related to coverage determinations. (eg, if coverage is expanded to include scans for infection).
78814	Review in 2 years (Sept 2013) to affirm editorial nature of coding changes to remove "tumor imaging." Review migration in new technology (PET with CT scanners) and to monitor utilization related to coverage determinations. (eg, if coverage is expanded to include scans for infection).
78815	Review in 2 years (Sept 2013) to affirm editorial nature of coding changes to remove "tumor imaging." Review migration in new technology (PET with CT scanners) and to monitor utilization related to coverage determinations. (eg, if coverage is expanded to include scans for infection).
78816	Review in 2 years (Sept 2013) to affirm editorial nature of coding changes to remove "tumor imaging." Review migration in new technology (PET with CT scanners) and to monitor utilization related to coverage determinations. (eg, if coverage is expanded to include scans for infection).
88380	Remove from list, utilization is lower than specialty estimation
88381	Review in 2 years (Sept 2013) to gather more data and determine if there are more efficiencies.
93982	Remove from list, utilization is lower than specialty estimation
95980	Remove from list, utilization is lower than specialty estimation
95981	Remove from list, utilization is lower than specialty estimation
95982	Remove from list, utilization is lower than specialty estimation
98966	Remove from list, not covered by Medicare
98967	Remove from list, not covered by Medicare
98968	Remove from list, not covered by Medicare
99441	Remove from list, not covered by Medicare
99442	Remove from list, not covered by Medicare
99443	Remove from list, not covered by Medicare

B. Re-Review of Services to Consider Additional Utilization Data

Doctor Larimore indicated that in 2006, the RUC began reviewing of potentially misvalued services. Throughout this process the RUC has flagged specific codes to review again to consider additional utilization data. **The Workgroup reviewed the following 32 codes and recommends:**

CPT Code	Recommendation
13120	CMS requested that the complex wound care code family be reviewed by the RUC. Resurvey for January or April 2012.
13121	CMS requested that the complex wound care code family be reviewed by the RUC. Resurvey for January or April 2012.
13122	CMS requested that the complex wound care code family be reviewed by the RUC. Resurvey for January or April 2012.
20551	Remove from screen – utilization has leveled appropriately
22214	Review in 3 years (Sept 2014) after CCI edits and CPT Assistant article have effect

22533	Remove from screen – CPT Assistant article addressed concerns, as evidence the utilization has decreased.
22849	Review in 3 years (Sept 2014) after CPT Assistant article and changes to CPT 2011 have effect.
36516	Review in 1 year (Sept 2012). Specifically review what specialties are performing compared to who originally survey, review site of service and review practice expense.
43236	Review in 2 years (Sept 2013).
43242	Review in 2 years (Sept 2013).
43259	Review in 2 years (Sept 2013).
45381	Review in 2 years (Sept 2013).
50605	Specialty society to submit CCI edits and review in 3 years (Sept 2014)
52214	Resurvey for work and practice expense for January 2012.
52224	Resurvey for work and practice expense for January 2012.
64555	Specialty to develop another CPT Assistant article and review in 3 years (Sept 2014)
65780	Add to new technology list for re-review in 3 years (Sept 2014).
66982	Resurvey for January 2012.
66984	Resurvey for January 2012.
68040	Refer to CPT to delete.
71275	Review again in 2 years (Sept 2013).
73218	Review again in 2 years (Sept 2013).
73221	Review again in 2 years (Sept 2013).
76513	Develop CPT assistant article to differentiate between the new category I code and the existing code.
77301	Review again in 2 years (Sept 2013).
77418	Remove from screen – addressed as part of the reported together 75% or more screen and utilization is appropriate.
92270	Review again in 2 years (Sept 2013).
93662	Review again in 3 years (Sept 2013) and look at what codes are being reported with 93662.
94681	Remove from screen - incorrect coding has been addressed.
96920	Resurvey for January 2012 and develop a CPT Assistant article to address the incorrect reporting when using handheld devices.
96921	Resurvey for January 2012 and develop a CPT Assistant article to address the incorrect reporting when using handheld devices.
96922	Resurvey for January 2012 and develop a CPT Assistant article to address the incorrect reporting when using handheld devices.

C. CMS Requests – NPRM for 4th Five-Year Review

Review Complex Wound Repair Codes (13100-13152)

In the June 6, 2011, Proposed Rule for the 4th Five-Year Review of the RBRVS, CMS requested that the RUC review the family of complex wound repair codes to ensure consistency and appropriate gradation of work value. The RUC has submitted 2 recommendations as part of the 4th Five-Year review, 2 codes were surveyed for RUC review at this meeting and the RUC has requested action plans for 3 other codes in this family. **The Workgroup recommends that the specialty society re-review/survey codes 13100-13152 for January or April 2012.**

- 13100 – 4th Five-Year Review
- 13101 – 4th Five-Year Review

- 13131 – surveyed for September 2011
- 13152 – surveyed for September 2011
- 13120 – survey for January 2012
- 13121 – survey for January 2012
- 13122 – survey for January 2012
- 13132 – survey for January 2012
- 13133 – survey for January 2012
- 13150 – survey for January 2012
- 13151 – survey for January 2012

Review Non-Manipulation Fracture Codes

In the June 6, 2011, Proposed Rule for the 4th Five-Year Review of the RBRVS, CMS requested that the RUC examine all the non-manipulation fracture codes to determine if positioning time was incorporated into the work RVU for the codes and if so, whether the need for positioning time was documented.

AAOS submitted a letter to the Workgroup explaining that of the 50 non-manipulation fracture codes, only 5 have been reviewed by the RUC and include only a few minutes of positioning time. Magnitude estimation was utilized in developing the work relative values for these services. The remaining 45 codes were part of the Harvard study and did not include any positioning time.

Doctor Larimore stated that the Workgroup accepted the specialty societies explanation for the pre-service work. **The Workgroup recommends that these services were valued using magnitude estimation, not via a building block method. Accordingly, any small amount of work related to positioning time should not be backed out of codes.**

D. Review Table 7 – NPRM for 2012: Select List of Procedural Codes Referred to the RUC for Review

In the July 19, 2011, Proposed Rule for 2012, CMS requests that the RUC review a list of 70 high PFS expenditure procedural codes representing services furnished by an array of specialties. CMS selected these codes based on the fact that they have not been reviewed for at least 6 years, and in many cases the last review occurred more than 10 years ago.

Of the 70 services identified, half have been reviewed by the RUC in the last 6 years. **The Workgroup reviewed these services and recommends that the specialty societies submit action plans for January 2012. If CMS determines to delete services from this list in the Final Rule, an action plan will not be necessary.**

E. CMS Requests – NPRM for 2012 MFS

In the July 19, 2011, Proposed Rule for 2012, CMS requests that the RUC review specific codes in 2012 for consideration in rulemaking for the 2013 Medicare Physician Payment Schedule.

- *Abdomen and Pelvis CT – 72192, 72193, 72194, 74150, 74160 & 74170*
  The Workgroup will address these codes again after publication of the 2012 Medicare Physician Payment Schedule, after the agency has considered the ACR comments explaining the rationale for the current rank order anomaly.

- *Tissue Pathology – 88305*

The Workgroup recommends that the RUC review the practice expense only for codes 88300-88309 at the January 2012 RUC meeting.

- *In Situ Hybridization – 88365, 88367 & 88368*
  The Workgroup determined that these services be tabled until January 2012 in order to review 2011 diagnosis data from CMS.

- *Cholecystectomy – 47600 & 47605*
  The Workgroup recommends that codes 47600 and 47605 be resurveyed for physician work and practice expense for January 2012.

- *Bone Density Tests – 77080 & 77082*
  The Workgroup recommends that the physician work and practice expense be reviewed for January 2012. These codes are currently being reviewed by the Joint CPT/RUC Workgroup. The Workgroup is requesting that these services be placed on the LOI but recognize that may be modified depending on what the Joint CPT/RUC Workgroup decides.

F. April 2010 Referred to develop CPT Assistant Articles – Review Letters

43761 *Repositioning of a naso- or oro-gastric feeding tube, through the duodenum for enteric nutrition*
The specialty requested and the Workgroup agrees that this service be removed from the referral to CPT Assistant list.

70370 *Radiologic examination; pharynx or larynx, including fluoroscopy and/or magnification technique*
The Workgroup recommends that this service be removed from the referral to CPT Assistant list.

G. CMS/Other Screen – Review Action Plans (19 codes)

At the February 2011 RUC meeting, a Relativity Assessment Workgroup member noted that any "CMS/Other" source codes would not have been flagged in the Harvard only screens, therefore the Workgroup recommended that a list of all "CMS/Other" codes be developed and reviewed at the April 2011 meeting. CMS/Other codes are services which were not reviewed by either Harvard or the RUC and were either gap filled (most likely by crosswalk) by CMS or were part of original radiology fee schedule.

The Workgroup identified 410 codes with a source of CMS/Other. The Workgroup requested that specialty societies submit an action plan that articulates how the code values and times were originally developed for CMS/Other codes with Medicare utilization 500,000 or more (19 codes) for review at the October 2011 meeting.

The Workgroup reviewed the CMS/Other codes and recommends the following actions:

CPT Code	Recommendation
70450* 70553* 72148*	The specialty society reviewed these services and present a plan to the Research Subcommittee on how to address these services (i.e., crosswalk, resurvey, or alternate approach) and report what services they will survey for April 2012. The

73500 73550 74170 76645 76705 76770 76775 76856 76942 77014* 93925 93970	* codes will be address under the Table 7 CMS screen discussed earlier in this report.
88342*	Specialty societies submit an action plan for January 2012.
93880*	Specialty societies submit an action plan for January 2012 and submit a CPT Assistant article to define the proper use of 93880.
97150	Survey for January 2012.
G0127	CMS crosswalked to 11719. Maintain, remove from screen.

**CMS also identified these six codes in the Proposed Rule for the 2012 Medicare Physician Payment Schedule and requested RUC review.*

*** CMS identified as practice expense rank order anomaly in the Proposed Rule and requested review of practice expense and work.*

Doctor Larimore noted that he expects the Workgroup will work its way through the CMS/Other designated codes by utilization, but will be sensitive regarding the timeline for the specialty societies, noting that many of these codes are radiology and anesthesiology.

Doctor Larimore thanked the Workgroup for the amount of work and pre-review that occurred in preparation for this meeting.

H. Joint CPT/RUC Workgroup on Billed Together Services

Doctor Larimore informed the RUC that Kenneth Brin, MD, Chair of the Joint Workgroup, informed the Relativity Workgroup that they are continuing to review codes reported together 75% or more. The Workgroup used the same methodology as last time, with the exception of using 2009 data. Thirty groups of code pairs were identified for further examination. The Workgroup will be reviewing these services to determine which services need to be distributed to the specialty societies for further input or creation of bundled codes. Coding change proposals will not be expected until the CPT 2014 cycle.

The RUC approved the Relativity Assessment Workgroup's report and it is attached to these minutes.

XIX. Multi-Specialty Points of Comparison Workgroup Report (Tab 52)

Doctor Burd, Chair of the MPC Workgroup, reviewed the MPC Workgroup discussion and action plans as a result from their meeting. The Workgroup noted that there are codes on the current MPC list that would have been considered multi-specialty under the new criteria, however they have not been RUC reviewed since before 2000. **The Workgroup will review these services and make a determination as to whether or not these codes will be added to the new MPC list.**

Furthermore, the Workgroup members will be seeking specialty society comments to help refine the MPC list. **First, the current MPC codes that were not determined multi-specialty should be reviewed by the dominant provider of the services to determine if individual codes are necessary for inter-specialty comparisons or not.** Second, the multi-specialty MPC list is currently heavily populated by low volume codes. **To help reduce redundancies, specialty societies will be asked to codes in a similar RVU range to determine which codes are the most important for inter-specialty valuation purposes.** The Workgroup will be working in between the January Meeting to review specialty responses and additional data before the next face-to-face meeting.

The RUC approved the Multi-Specialty Points of Comparison Workgroup's report and it is attached to these minutes.

XX. HCPAC Review Board (Tab 53)

Tony Hamm, DC, announced that the HCPAC would like to acknowledge the years of service of ASHA staff, Steven White, PhD, who will be retiring from ASHA after 30 years of service.

Relative Value Recommendations for CPT 2013:

Dr. Hamm also indicated that the HCPAC reviewed relative value recommendations for CPT 2013 for two issues Trim Skin Lesions (11056) and Debridement of Nail (11719-11721). The HCPAC reviewed the survey data for CPT code 11719 *Trimming of nondystrophic nails, any number*. The American Podiatric Medical Association (APMA) indicated that they would benefit from re-surveying this code as they agreed that the survey data was not reflective of the service. **APMA will re-survey 11719 for the January 2012 Meeting. The HCPAC recommended values for 11720 and 11721 will be interim so that they can be reviewed with 11719 to ensure appropriate relativity within the family.**

The full recommendations are attached to these minutes in the HCPAC Review Board Report.

HCPAC Reference Service List Workgroup:

Dr. Hamm indicated that after April 2011 meeting the HCPAC formed a Workgroup to review issues surrounding the development of reference service lists. The Workgroup reiterated the HCPAC's previous obstacles in developing reference service lists for some HCPAC organizations when many of the codes they typically perform are being surveyed. Several solutions were discussed including:

For specific time-based codes, articulate the number of services on the survey RSL and perform the calculation for the survey, to avoid any misinterpretation (ie, list the reference service in number of units and calculate the total work RVU for that number of units.

- 97110 Therapeutic Exercises – 15 minutes 0.45
- 97110 Therapeutic Exercises – 30 minutes 0.90
- 97110 Therapeutic Exercises – 45 minutes 1.35
- 97110 Therapeutic Exercises – 60 minutes 1.80

The HCPAC determined that they would like to refer this proposed alteration to the reference service list construct to the Research Subcommittee for their review so that all HCPAC societies can utilize this mechanism in their individual reference service lists, in instances where many of the codes being performed by the specialty are being surveyed and the surveyed code is time based.

Further, the HCPAC solicited for specialty societies to develop a proposal to address the situation of having to develop a reference service list when all of the specialty society's codes are under review. APA and NASW and any other interested societies will develop this proposal and present it at a future HCPAC meeting.

The RUC filed the HCPAC Review Board report which is attached to these minutes.

XXI. Other Issues

Doctor Chad Rubin introduced to the RUC a concept to review the Medicare Berenson-Eggers Type of Service (BETOs) classification as there have been noted errors in the specific categorization of CPT codes. Doctor Rubin suggested that the CPT Editorial Panel and RUC members could review the current classification to correct existing errors and then establish a process to submit suggestion classification categories on the RUC Summary of Recommendation form to CMS. Doctor Levy asked the American College of Surgeons to formulate a proposal to the Research Subcommittee for review.

RUC members introduced a concern rwhen reviewing the survey sample used by AAFP for an issue on this agenda. The Committee learned that the specialty society used only leadership (commission members) in conducting their survey. The RUC structure and function does allow for panels to respond to surveys. The RUC asked that the issue be referred to the Research Subcommittee for review and to specifically define a "panel sample" to ensure appropriate utilization of this sample type.

Doctor Levy adjourned the meeting at 4:11 pm on Saturday, September 25, 2011.

AMA/Specialty Society RVS Update Committee **Tab 48**
Practice Expense Subcommittee
September 22, 2011

Members Present: Doctors Bill Moran (Chair), Joel Brill (Vice-Chair), Joel Bradley, Albert Bothe, Ron Burd, Eileen Carlson, Neal Cohen, William Gee, David Han, Timothy Laing, William Mangold, Terry Mills, Guy Orangio, Tye Ouzounian, Chad Rubin, Robert Stomel

I. Migration of Radiologic Images from Film to Digital Workgroup

In April 2011, the American College of Radiology provided the PE Subcommittee with an update on their work in evaluating the migration of film acquisition to Picture Archiving and Communication Systems (PACS) through an internal ACR Workgroup. To further their evaluation, the ACR provided the PE Subcommittee with survey results from a survey conducted to determine the typical usage of PACS. The survey received 64 respondents from the AAOS, 15 respondents from the ACC and 3 respondents from the ACP. Of the 82 total respondents, 84% stated that they use PACS. The specialty also provided the typical scenario per modality. For CT, MR and interventional the use of PACS are typical. For x-ray and ultrasound PACS are not currently typical. The specialty noted, that while radiologists were not surveyed, the ACR confirmed that the above typical scenarios are accurate for the radiology community as well. The specialty and the Workgroup agreed that the ACR should continue to collect data and review the typical PACS environment across specialty and report back to the PE Subcommittee in February 2012. Staff also noted that the AMA could provide assistance to survey physicians about current PACS usage. AMA staff will work with the ACR regarding additional data collection.

II. Moderate Sedation Equipment

The RUC recommended to CMS updates to the Moderate Sedation package, including the addition of equipment items EQ212 and EQ269. In the Proposed Rule for the 2012 Medicare Physician Payment Schedule, CMS accepted the RUC recommendations, but eliminated these two equipment items as "EQ011 incorporates the functionality of these equipment items." The Subcommittee members reviewed the CMS recommendation and provided no further comments to CMS. These changes will be incorporated in the RUC practice expense documentation. **Equipment items EQ212 pulse oxymetry recording software (prolonged monitoring) and EQ269 blood pressure monitor, ambulatory, w-battery charger will be removed from the moderate sedation package.**

III. Services with High Cost Supplies Billed in Multiple Units

The PE Subcommittee reviewed the RUC's previous recommendation that CMS create HCPCS codes for high cost supplies so that these expenses may be monitored closely and paid appropriately. In February 2010, the Practice Expense Subcommittee reviewed Balloon Sinuplasty. The committee assumed that one unit of service would be reported in estimating practice expense. However, anecdotal reports surfaced that multiple units of service were being reported and CMS confirmed that this is typical after reviewing the first six months of claims data for 2011. The Subcommittee noted that there are two issues to be addressed: a) what is the Subcommittee's recommendation for high cost supplies and b) what is the Subcommittee's recommendation regarding the Balloon Sinuplasty services.

The PE Subcommittee reaffirms the previous RUC recommendations to CMS that high cost supplies be assigned HCPCS codes (e.g. J codes) to better monitor appropriate payment.

The PE Subcommittee recommends that for the Balloon Sinuplasty codes the specific sinus surgery kit be removed from the practice expense inputs for the procedure code and replaced by new HCPCS codes to describe the sinus surgery kit.

IV. Ultrasound Equipment

CMS received comments that there may be potential inconsistencies with the inputs and the prices related to ultrasound equipment in the direct PE database, specifically there are 17 different ultrasound and ultrasound related pieces of equipment associated with 110 CPT codes ranging in price from $1,304.33 to $466,492.00. CMS requested that the RUC review the clinical necessity of the ultrasound equipment as well as the way the equipment is described for individual codes. Staff reminded the PE Subcommittee that it is not in the Subcommittee's purview to make recommendations related to specific prices. **The Chair will establish a workgroup to review this issue and offer recommendations to the Subcommittee. The workgroup will have two primary objectives: 1) review the 17 ultrasound equipment codes to determine if the level of distinction is appropriate and 2) review the list of 110 CPT codes that use the various ultrasound equipment to determine if the equipment is appropriately identified.**

Relative Value Recommendations for CPT 2012/2013:

Molecular Pathology – Tier 1/Tier 2 (81210, 81225-81227, 81245, 81257, 81257, 81261-81268-, 81292-81304, 81310, 81317-81319, 81331, 81332, 81340-81342, 81350, 81355, 81370 & 81383, EXXX1, GXXX3, GXXX4, GXXX5, PXXX6, PXXX7 & PXXX8) Tab 5, 6 & 9

The specialty society explained that the majority of these services are being crosswalked with minor differences to the practice expense inputs associated with the MoPath services that were approved at the April 2011 RUC Meeting. The remainder of the MoPath services, specifically, the HLA services, had new practice expense inputs. The Subcommittee reviewed all the recommended practice expense inputs over a conference call and during the PE Subcommittee meeting and made minor changes mostly pertaining to duplication in supplies and equipment.

Transcath Retrieval Intravascular Foreign Body (372XX1) Tab 7

The Subcommittee reviewed the direct practice expense inputs recommended by the specialty and made minor modifications to the equipment to align with the revised moderate sedation equipment guidelines.

Biopsy of Eyelid (67810) Tab 8

The Subcommittee reviewed the direct practice expense inputs recommended by the specialty and made modifications to the medical supplies and equipment time.

CMS Request – PE Review (Price In Non-Facility)

Kyphoplasty (22523, 22524, 22525) Tab 47

The Subcommittee reviewed the direct practice expense inputs recommended by the specialty and made modifications to the equipment to align with the revised moderate sedation equipment guidelines.

AMA/Specialty Society RVS Update Committee **Tab 49**
Research Subcommittee
September 22, 2011

Members Present
Members: Brenda Lewis, DO (Chair), Greg Przybylski, MD (Vice Chair), Bibb Allen, MD, Sherry Barron-Seabrook, MD, Scott Collins, MD, Anthony W. Hamm, DC, Charles Koopmann, MD, J. Leonard Lichtenfeld, MD, Charles Mabry, MD, Marc Raphaelson, MD, Peter Smith, MD, Allan Tucker, MD

I. Research Subcommittee June 2011 Meeting Report

The Research Subcommittee Report from the June 2011 Meeting was included in this agenda for information only.

II. Discussion of Post-Service Work Description

At the June 2011 Research Subcommittee meeting which met via conference call, the Research Subcommittee discussed the American College of Cardiology (ACC) and Heart Rhythm Society (HRS) request to add specific language to include the physician work of completing registry forms in the post-service work description for the Pacemaker and Cardio-defibrillator services. The members on the conference call agreed that the physician work to complete these forms needs to be captured in the post-service work because 1.)they are mandated by CMS and this is not a time limited request from CMS, 2.) require completion by a physician, and 3.) payment is not available by any other source.

The language as approved by the members on the conference call is as follows:

Day of Procedure: Post-operative care on day of the procedure is divided into "Immediate Post-Service Time" (Question 2b), and any subsequent visit on the day of the operative procedure (Question 2d)., Immediate Post-Service Time includes "non-skin-to-skin" work in the OR, patient stabilization in the recovery room or special unit, communicating with the patient and other professionals (including written, electronic and telephone reports and orders), and completion of forms by the physician mandated by rules or regulation.

The Subcommittee made it clear that this language will *only* be added to this survey and does not constitute a general RUC policy regarding registry/report completion language. The Research Subcommittee discussed the potential addition of this language to all of the RUC survey instruments and expressed multiple concerns. **The Research Subcommittee agreed not to add this proposed language into the RUC survey instruments and to continue to review these types of specialty society requests on a case-by-case basis.** The language that was approved for the ACC and HRS for their survey instrument will be filed for historical purposes and recommended to specialties seeking Research Subcommittee approval of survey instruments for similar situations.

The Research Subcommittee heard several comments about further mandated government regulations affecting physician practices that are not paid for by any payer. In order to get a better understanding of the problem affecting physician work the Research Subcommittee will solicit the specialty societies for the following questions:

1.) What types of activities are your physicians mandated by rules or regulations to complete that are not included in the work value of a service but required for the payment of that service. These non-compensated activities may include a registry or other completion of forms for 1.)a service 2.)use of a device, or 3.)drug administration protocol?

2.) Who is the mandating body requiring this work?
   - CMS_____
   - State Agency (Please Specify)_____
   - Other Federal Agency (Please Specify)_____

3.) Is the mandate time limited? Yes____ No ____

4.) Is this work part of PQRI? Yes ___ No____

The results of this solicitation will be reviewed by the Research Subcommittee at the January 2012 meeting. Research Subcommittee will then explore ways to capture payment for this physician work i.e. via the survey process or possibly suggest CPT consider new codes to address this work.

III. Extant Data

a. Extant Database Review

American Speech-Language and Hearing Association (ASHA)

The American Speech-Language and Hearing Association submitted a request to the Research Subcommittee to review the ASHA National Outcome Measurement System (NOMS) to determine if it meets the RUC's Inclusionary/Exclusionary Criteria for Extant Databases described on page 2215 of the RUC Agenda Book.

The Research Subcommittee after hearing their presentation agreed that there are areas of this database that would be helpful in RUC deliberations but the Subcommittee would like to have a better understanding of how the database would assist in the RUC process. The Research Subcommittee did note some limitations to this database as follows:

- Data is not externally audited by any third party
- Data is primarily collected by ICD-9 codes not CPT. The specialty noted that all services managed by speech and language therapists include 3 codes and the database can be used to describe code level work
- Prospective time data is not entered in the database. Instead two data points are entered – one at the beginning of treatment and the last session. Time data is estimated by the therapist for the entire treatment protocol at the end of treatment.

Despite some limitations, the Research Subcommittee agrees that this database may meet the RUC's extant database criteria as the specialty only wishes to use this data as supplementary to the Survey instrument and never as a source of primary data. Therefore, the Research Subcommittee recommends that ASHA provide a mock demonstration of how the data collected in the NOMS data base would support a recommendation put forward by the specialty society at the upcoming February 2012 RUC meeting.

b. Extant Data Display Proposal
Society of Thoracic Surgeons

At the February 2011 RUC Meeting, the Research Subcommittee reviewed and determined that the Society of Thoracic Surgeons (STS) database met the RUC's Inclusionary/Exclusionary criteria for extant databases. The Research Subcommittee recommended that the specialty society present a proposal at the September 2011 Research Subcommittee Meeting, for when this information should be displayed with the specialty society's recommendation. The specialty society recommended that the extant data be displayed upon prior approval by the Research Subcommittee for codes identified by the specialty society.

The Research Subcommittee had concerns about this proposal from STS. **The Subcommittee agreed that the specialty should review the data from the STS database and develop specific criteria (eg specific thresholds of survey volume and distribution) for when the specialty society would be required to display their extant data for a surveyed service with their RUC Recommendations.**

AMA/Specialty Society RVS Update Committee **Tab 51**
Relativity Assessment Workgroup
September 22, 2011

Members: Doctors Walt Larimore *(Chair),* Bibb Allen, Michael Bishop, James Blankenship, Dale Blasier, Stephen Levine, PT, Brenda Lewis, William Mangold, Larry Martinelli, Marc Raphaelson, Chad Rubin, George Williams

I. New Technology/New Services List

Six years ago, the AMA RUC began the process of flagging services that represent new technology as they were presented to the Committee. The Workgroup continued this review of codes that were flagged September 2006-April 2007, with 3 years of available Medicare claims data (2008, 2009 and preliminary 2010 data).

Before examining the individual action plans, the Workgroup reviewed the original purpose of the "New Technology" designation. **The Workgroup agreed that the "New Technology" designation was intended to identify new services or codes whose use was expected to increase over time, such that as the service becomes more common and its use more diffuse, the actual work involved (time and/or intensity) or practice expenses might conceivably change (i.e., what may have seemed hard when originally valued may seem less hard now that it is more common). It was affirmed that codes showing a significant increase of utilization over time or dramatically more utilization than initially predicted by the specialty society would, in general, need to be resurveyed by the predominant specialty or specialties.**

The Workgroup recommends the following actions:

CPT Code	Recommendation
19105	Remove from list, utilization is lower than specialty estimation
20985	Resurvey for January 2012
29828	Resurvey for January 2012
33254	Remove from list, utilization is lower than specialty estimation
33255	Remove from list, utilization is lower than specialty estimation
33256	Remove from list, utilization is lower than specialty estimation
33257	Remove from list, utilization is lower than specialty estimation
33258	Remove from list, utilization is lower than specialty estimation
33259	Remove from list, utilization is as predicted by the specialty society
33265	Remove from list, utilization is lower than specialty estimation
33266	Remove from list, utilization is lower than specialty estimation
33864	Remove from list, utilization is lower than specialty estimation
34806	Remove from list, utilization is lower than specialty estimation
50593	Remove from list, utilization is lower than specialty estimation
57423	Remove from list, utilization is lower than specialty estimation
58570	Review in 2 years (Sept 2013), specialty society to identify codes and claims data for all hysterectomy procedures when re-reviewed.
58571	Review in 2 years (Sept 2013), specialty society to identify codes and claims data for all hysterectomy procedures when re-reviewed.
58572	Review in 2 years (Sept 2013), specialty society to identify codes and claims data for all hysterectomy procedures when re-reviewed..
58573	Review in 2 years (Sept 2013), specialty society to identify codes and claims data for all hysterectomy procedures when re-reviewed.

68816	Remove from list, utilization is lower than specialty estimation
75557	Remove from list, as utilization is appropriate due to shift of utilization for deleted code which included "with flow/velocity quantification", code 75558
75559	Remove from list, utilization is lower than specialty estimation
75561	Remove from list, as utilization is appropriate due to the shift of utilization of deleted code which included "with flow/velocity quantification", code 75560
75563	Remove from list, utilization is lower than specialty estimation
78811	Review in 2 years (Sept 2013) to affirm editorial nature of coding changes to remove "tumor imaging." Review migration in new technology (PET with CT scanners) and to monitor utilization related to coverage determinations. (eg, if coverage is expanded to include scans for infection).
78812	Review in 2 years (Sept 2013) to affirm editorial nature of coding changes to remove "tumor imaging." Review migration in new technology (PET with CT scanners) and to monitor utilization related to coverage determinations. (eg, if coverage is expanded to include scans for infection).
78813	Review in 2 years (Sept 2013) to affirm editorial nature of coding changes to remove "tumor imaging." Review migration in new technology (PET with CT scanners) and to monitor utilization related to coverage determinations. (eg, if coverage is expanded to include scans for infection).
78814	Review in 2 years (Sept 2013) to affirm editorial nature of coding changes to remove "tumor imaging." Review migration in new technology (PET with CT scanners) and to monitor utilization related to coverage determinations. (eg, if coverage is expanded to include scans for infection).
78815	Review in 2 years (Sept 2013) to affirm editorial nature of coding changes to remove "tumor imaging." Review migration in new technology (PET with CT scanners) and to monitor utilization related to coverage determinations. (eg, if coverage is expanded to include scans for infection).
78816	Review in 2 years (Sept 2013) to affirm editorial nature of coding changes to remove "tumor imaging." Review migration in new technology (PET with CT scanners) and to monitor utilization related to coverage determinations. (eg, if coverage is expanded to include scans for infection).
88380	Remove from list, utilization is lower than specialty estimation
88381	Review in 2 years (Sept 2013) to gather more data and determine if there are more efficiencies.
93982	Remove from list, utilization is lower than specialty estimation
95980	Remove from list, utilization is lower than specialty estimation
95981	Remove from list, utilization is lower than specialty estimation
95982	Remove from list, utilization is lower than specialty estimation
98966	Remove from list, not covered by Medicare
98967	Remove from list, not covered by Medicare
98968	Remove from list, not covered by Medicare
99441	Remove from list, not covered by Medicare
99442	Remove from list, not covered by Medicare
99443	Remove from list, not covered by Medicare

II. **Re-Review of Services to Consider Additional Utilization Data**

In 2006, the RUC began reviewing of potentially misvalued services. Throughout this process the RUC has flagged specific codes to review again to consider additional utilization data. **The Workgroup reviewed the following codes and recommends:**

CPT Code	Recommendation
13120	CMS requested that the complex wound care code family be reviewed by the RUC. Resurvey for April 2012.
13121	CMS requested that the complex wound care code family be reviewed by the RUC. Resurvey for April 2012.
13122	CMS requested that the complex wound care code family be reviewed by the RUC. Resurvey for April 2012.
20551	Remove from screen – utilization has leveled appropriately
22214	Review in 3 years (Sept 2014) after CCI edits and CPT Assistant article have effect
22533	Remove from screen – CPT Assistant article addressed concerns, as evidence the utilization has decreased.
22849	Review in 3 years (Sept 2014) after CPT Assistant article and changes to CPT 2011 have effect.
36516	Review in 1 year (Sept 2012). Specifically review what specialties are performing compared to who originally survey, review site of service and review practice expense.
43236	Review in 2 years (Sept 2013).
43242	Review in 2 years (Sept 2013).
43259	Review in 2 years (Sept 2013).
45381	Review in 2 years (Sept 2013).
50605	Specialty society to submit CCI edits and review in 3 years (Sept 2014)
52214	Resurvey for work and practice expense for January 2012.
52224	Resurvey for work and practice expense for January 2012.
64555	Specialty to develop another CPT Assistant article and review in 3 years (Sept 2014)
65780	Add to new technology list for re-review in 3 years (Sept 2014).
66982	Resurvey for January 2012.
66984	Resurvey for January 2012.
68040	Refer to CPT to delete.
71275	Review again in 2 years (Sept 2013).
73218	Review again in 2 years (Sept 2013).
73221	Review again in 2 years (Sept 2013).
76513	Develop CPT assistant article to differentiate between the new category I code and the existing code.
77301	Review again in 2 years (Sept 2013).
77418	Remove from screen – addressed as part of the reported together 75% or more screen and utilization is appropriate.
92270	Review again in 2 years (Sept 2013).
93662	Review again in 3 years (Sept 2013) and look at what codes are being reported with 93662.
94681	Remove from screen - incorrect coding has been addressed.
96920	Resurvey for January 2012 and develop a CPT Assistant article to address the incorrect reporting when using handheld devices.
96921	Resurvey for January 2012 and develop a CPT Assistant article to address the incorrect reporting when using handheld devices.
96922	Resurvey for January 2012 and develop a CPT Assistant article to address the incorrect reporting when using handheld devices.

III. CMS Requests – NPRM for 4th Five-Year Review

Review Complex Wound Repair Codes (13100-13152)

In the June 6, 2011, Proposed Rule for the 4th Five-Year Review of the RBRVS, CMS requests that the RUC review the family of complex wound repair codes to ensure consistency and appropriate gradation of work value. The RUC has submitted 2 recommendations as part of the 4th Five-Year review, 2 codes were surveyed for RUC review at this meeting and the RUC has requested action plans for 3 other codes in this family. **The Workgroup recommends that the specialty society re-review/survey codes 13100-13152 for January 2012.**

- 13100 – 4th Five-Year Review
- 13101 – 4th Five-Year Review
- 13131 – surveyed for September 2011
- 13152 – surveyed for September 2011
- 13120 – survey for January 2012
- 13121 – survey for January 2012
- 13122 – survey for January 2012
- 13132 – survey for January 2012
- 13133 – survey for January 2012
- 13150 – survey for January 2012
- 13151 – survey for January 2012
- 13152 – survey for January 2012

Review Non-Manipulation Fracture Codes

In the June 6, 2011, Proposed Rule for the 4th Five-Year Review of the RBRVS, CMS requests that the RUC examine all the non-manipulation fracture codes to determine if positioning time was incorporated into the work RVU for the codes and if so, whether the need for positioning time was documented.

AAOS submitted a letter to the Workgroup explaining that of the 50 non-manipulation fracture codes, only 5 have been reviewed by the RUC and include only a few minutes of positioning time. Magnitude estimation was utilized in developing the work relative values for these services. The remaining 45 codes were part of the Harvard study and did not include any positioning time. **The Workgroup recommends that these services were valued using magnitude estimation, not via a building block method. Accordingly, any small amount of work related to positioning time should not be backed out of codes.**

IV. Review Table 7 – NPRM for 2012: Select List of Procedural Codes Referred to the RUC for Review

In the July 19, 2011, Proposed Rule for 2012, CMS requests that the RUC review a list of 70 high PFS expenditure procedural codes representing services furnished by an array of specialties. CMS selected these codes based on the fact that they have not been reviewed for at least 6 years, and in many cases the last review occurred more than 10 years ago.

Of the 70 services identified, 20 were identified in 2005 as part of the 3rd Five-Year Review. Many of these services were identified by CMS for review and the RUC recommendation was accepted. 13 services have been reviewed in the last 6 years, 35 services were reviewed prior to 2005, 1 service was never reviewed by the RUC (CMS/Other with utilization less than 500,000) and 1 service has 0.00 work RVUs.

The Workgroup reviewed these services and recommends that the specialty societies submit action plans for January 2012. If CMS determines to delete services from this list in the Final Rule, an action plan will not be necessary.

V. CMS Requests – NPRM for 2012 MFS

In the July 19, 2011, Proposed Rule for 2012, CMS requests that the RUC review specific codes in 2012 for consideration in rulemaking for the 2013 Medicare Physician Payment Schedule.

- **Abdomen and Pelvis CT – 72192, 72193, 72194, 74150, 74160 & 74170**
  CMS received comments that the resulting PE RVUs for the new bundled codes (74176, 74177 and 78178) create a rank order anomaly in comparison to the previous stand alone codes (72192, 72193, 72194, 74150, 74160 and 74170) and requests RUC review of practice expense inputs. Also, CMS requests that the RUC review the work for these codes (72192, 72193, 72194, 74150, 74160 and 74170), which were last reviewed for CPT 2007. The RUC will discuss the CMS request, however, it is apparent that any rank order anomaly is caused by CMS data entry errors (eg, Rad Tech instead of a CT Tech for 74176, 74177 & 74178 and inconsistent room time for the new bundled codes).

  CMS requested that the RUC review both the direct PE inputs and work values for the abdomen and pelvis CT codes listed above. The Workgroup reviewed the specialty society comment letter to CMS, which agreed that there are some practice expense RVU anomalies. However, the specialty stated that once the base codes practice expense are fully transitioned, the current anomalies will be corrected. **The Workgroup will address these codes again after publication of the 2012 Medicare Physician Payment Schedule, after the agency has considered the ACR comments explaining the rationale for the current rank order anomaly.**

- **Tissue Pathology – 88305**
  CMS received comments that the direct PE inputs associated with a service are inaccurate due to an atypical vignette. As the PE for this service has not been reviewed since 1999 and in accordance with the proposed approach to review potentially misvalued codes, CMS requests the RUC to review the work and practice expense of this code.

  The Workgroup noted that this is an example of a comment received by a member of the public and CMS should require more information prior to request for re-review. The individual recognized that the supply expense was approximately $18, which is what is reflected in CMS database. The individual questions why total technical component payment is $70, implying that it is overvalued. Clearly practice expense includes other costs, such as clinical staff and indirect costs. The direct expense input data is available for public review. Comments should be directed at what may be reviewed – specific input costs. It is not appropriate for the RUC to review a service simply based on a general complaint about under or overpayment.

  The Workgroup noted that the physician work was recently reviewed in April 2010, however the practice expense had not been reviewed since 1999. **The Workgroup recommends that the RUC review the practice expense only for codes 88300-88309 at the January 2012 RUC meeting.**

- **In Situ Hybridization – 88365, 88367 & 88368**
  CMS received comments that unlike the new FISH codes for urinary tract specimens (88120 and 88121), the existing codes (88365-88368) still allow for multiple units of each code as these codes are reported per probe. CMS states that they have reviewed the current work and practice costs associated with 88120 and 88121 and agree at this time that they are accurate. However, the first 6 months of 2011 claims data have been shared with the RUC and CMS requests that additional review of these data be considered to determine if further action is warranted. CMS requested that the RUC review both the direct PE inputs and the work values

for codes 88365, 8367 and 88368. **The Workgroup determined that these services be tabled until January 2012 in order to review 2011 diagnosis data from CMS.**

- **Cholecystectomy – 47600 & 47605**
  CMS received comments regarding a potential relativity problem between two cholecystectomy codes, 47600 and 47605. It appears that the visits for these services do not appropriately reflect the relativity of these two services and that 47600 should not have more time and visits association with the service than 47605.

CPT Code	2011 Work RVU	Pre-Eval	Pre-Posit	Pre-SDW	Intra-Time	Immed Post-Time	99212	99213	99231	99232	99233	99238
47600	17.48	30	15	15	115	30	1	2	1	1	1	1
47605	15.98	90			90	30	1	1	1	1	1	1

  The specialty society recognized that the value for code 47605 may be incorrect. **The Workgroup recommends that codes 47600 and 47605 be resurveyed for physician work and practice expense for January 2012.**

- **Bone Density Tests – 77080 & 77082**
  For 2010 and 2011, the ACA modified the payment for dual X-ray absorptiometry (DXA) services described by 77080 *Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)* and 77082 *Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; vertebral fracture assessment* to 70 percent of the product of the CY 2006 RVUs for these services, the CY 2006 conversion factor and the geographic adjustment for the relevant payment year. The ACA also allows for a study to be conducted on the ramifications of Medicare payment reductions for DXA on beneficiary access to bone mass density tests. This study has not been initiated**.** Therefore, CMS requested that the AMA RUC review CPT codes 77080 and 77082.
  The Workgroup understands that there was a duplicate practice expense item that CMS corrected several years ago, which led to a significant reduction in payment. However, Congress reversed this payment reduction. The Congressional correction expires on December 31, 2011. The RUC recommendations are not to establish the payment but the correct physician work and practice expense required to perform a service. **The RUC recommends that the physician work and practice expense be reviewed for January 2012**.

VI. April 2010 Referred to develop CPT Assistant Articles – Review Letters

43761 ***Repositioning of a naso- or oro-gastric feeding tube, through the duodenum for enteric nutrition***

In April 2010, the PE Subcommittee recommended a CPT Assistant article be developed for code 43761, as this procedure is performed predominately in the facility setting in a Fluoroscopy room, assuming reporting this service in the office setting is most likely miscoding.

The 2010 Medicare data indicates that this service is performed only 3.63% in a physician's office. It appears the PE Subcommittee may have been trying to address 3% of the claims or 100 times this service is reported in the physician office. It is unlikely that a CPT Assistant article would address such a low percentage of this service being performed in the office setting. **Therefore, the specialty requested and the Workgroup agrees that this service be removed from the referral to CPT Assistant list.**

70370 ***Radiologic examination; pharynx or larynx, including fluoroscopy and/or magnification technique***

The PE Subcommittee also recommended that a CPT Assistant article be developed for code 70370, because of concern that the utilization in the non-facility is largely miscoding. The specialty societies indicate that there are different local coverage determinations and suggests that CMS first address the non-facility utilization question by standardizing the related LCDs for coverage of 70370, by establishing national coverage policy or by implementing a place of service edit. **The Workgroup recommends that this service be removed from the referral to CPT Assistant list.**

VII. CMS/Other Screen – Review Action Plans (19 codes)

At the February 2011 RUC meeting, a Relativity Assessment Workgroup member noted that any "CMS/Other" source codes would not have been flagged in the Harvard only screens, therefore the Workgroup recommended that a list of all "CMS/Other" codes be developed and reviewed at the April 2011 meeting. CMS/Other codes are services which were not reviewed by either Harvard or the RUC and were either gap filled (most likely by crosswalk) by CMS or were part of original radiology fee schedule.

The Workgroup identified 410 codes with a source of CMS/Other. The Workgroup requested that specialty societies submit an action plan that articulates how the code values and times were originally developed for CMS/Other codes with Medicare utilization 500,000 or more (19 codes) for review at the October 2011 meeting.

The Workgroup reviewed the CMS/Other codes and recommends the following actions:

CPT Code	Recommendation
70450* 70553* 72148* 73500 73550 74170 76645 76705 76770 76775 76856 76942 77014* 93925 93970	The specialty society reviewed these services and present a plan to the Research Subcommittee on how to address these services (i.e., crosswalk, resurvey, or alternate approach) and report what services they will survey for April 2012. The * codes will be address under the Table 7 CMS screen discussed earlier in this report.
88342*	Specialty societies submit an action plan for January 2012.
93880*	Specialty societies submit an action plan for January 2012 and submit a CPT Assistant article to define the proper use of 93880.
97150	Survey for January 2012.
G0127	CMS crosswalked to 11719. Maintain, remove from screen.

**CMS also identified these six codes in the Proposed Rule for the 2012 Medicare Physician Payment Schedule and requested RUC review.*

*** CMS identified as practice expense rank order anomaly in the Proposed Rule and requested review of practice expense and work.*

VIII. Joint CPT/RUC Workgroup on Billed Together Services

Kenneth Brin, MD, Chair of the Joint Workgroup, informed the Relativity Workgroup that they are continuing to review codes reported together 75% or more. The Workgroup used the same methodology as last time, with the exception of using 2009 data. Thirty groups of code pairs were identified for further examination. The Workgroup will be reviewing these services to determine which services need to be distributed to the specialty societies for further input or creation of bundled codes. Coding change proposals will not be expected until the CPT 2014 cycle.

IX. Other Issues

The following were included as informational items:

- CPT Editorial Panel Referrals
- CPT Assistant Referrals
- Progress of Relativity Assessment Workgroup of Potentially Misvalued Services
- Full status report of the Relativity Assessment Workgroup

AMA/Specialty Society RVS Update Committee **Tab 53**
Health Care Professionals Advisory Committee Review Board
September 22, 2011

Members Present
Arthur Traugott, MD (Chair), Anthony Hamm, DC (Co-Chair), Jane White, PhD, RD, FADA (Alt. Co-Chair), Eileen Carlson, RN, JD, Robert Fifer, PhD, CCC-A, Mary Foto, OTR, James Georgoulakis, PhD, Emily Hill, PA-C, Stephen Levine, PT, DPT, MSHA, William Mangold, MD, Seth Rubenstein, DPM, and Doris Tomer, LCSW

I. CMS Update

Doctor Edith Hambrick delivered the CMS Update. She informed the HCPAC that the *Proposed Rule* was released and CMS is reviewing comments they received. CMS Staff is working on drafting the Final Rule. Christine Smith-Ritter, PhD has replaced Carol Bazell, MD in the Division of Practitioner Services at CMS.

II. Relative Value Recommendations for CPT 2013:

Trim Skin Lesions (11056) - *American Podiatric Medical Association*

The HCPAC reviewed CPT code 11056 *Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 to 4 lesions*. The HCPAC reviewed the survey data and agreed it accurately reflected the service. The specialty society discussed the proposed valuation for the service, 0.61, the current value. The HCPAC expressed concern that this value was not appropriate. After a lengthy discussion, the HCPAC compared the surveyed code to reference code 99212 *Office or other outpatient visit for the evaluation and management of an established patient,* (Work RVU=0.48). The HCPAC noted that the intra-service times for these services are the same (10 minutes). Further, the HCPAC noted that these services require similar physician work to perform. In addition, the HCPAC compared the surveyed code to 29580 *Strapping; Unna boot* (work RVU=0.55). The HCPAC noted that the surveyed code has less total-service time as compared to the reference code, 19 minutes and 27 minutes, respectively. **Therefore, based on this comparison to the reference code, the HCPAC recommends 0.50 work RVUs, the survey 25th percentile, for 11056.**

Debridement of Nail (11719-11721) - *American Podiatric Medical Association*

11720
The HCPAC reviewed CPT code 11720 *Debridement of nail(s) by any method(s); 1 to 5*. The HCPAC reviewed the survey data and agreed it accurately reflected the service. The specialty society discussed the proposed valuation for the service and agreed that although the survey indicated a 25th percentile of 0.35 work RVUs, the specialty society did not have any compelling evidence to change the current value of the code. Therefore, the HCPAC agreed with the specialty society that the survey data supports the current value, 0.32 RVUs. The HCPAC compared the surveyed code to reference code 99212 *Office or other outpatient visit for the evaluation and management of an established patient,* (Work RVU=0.48). The HCPAC noted that the intra-service time for the surveyed code is less than the reference code, 5 minutes and 10 minutes, respectively. Further, the HCPAC noted that the reference code overall is a more intense service to perform in comparison to the surveyed code. **Therefore, based on this comparison to the reference code, the HCPAC recommends 0.32 work RVUs, the current work RVU for 11720.**

11721
The HCPAC reviewed CPT code 11721 *Debridement of nail(s) by any method(s); 6 or more*. The HCPAC reviewed the survey data and agreed it accurately reflected the service. The specialty society discussed the proposed valuation for the service and agreed that although the survey indicated a median value of 0.65 work RVUs, the specialty society did not have any compelling evidence to change the current value of the code. Therefore, the HCPAC agreed with the specialty society that the survey data supports the current value, 0.54 RVUs. The HCPAC compared the surveyed code to reference code 99212 *Office or other outpatient visit for the evaluation and management of an established patient,* (Work RVU=0.48). The HCPAC noted that the total-service time for the surveyed code is more than the reference code, 19 minutes and 16 minutes, respectively. Further, the HCPAC noted that the surveyed code requires more physical effort to perform in comparison to the surveyed code. **Therefore, based on this comparison to the reference code, the HCPAC recommends 0.54 work RVUs, the current work RVU for 11721.**

11719
The HCPAC reviewed the survey data for CPT code 11719 *Trimming of nondystrophic nails, any number*. The specialty society indicated that they would benefit from re-surveying this code as they agreed that the survey data was not reflective of the service. **The specialty society will re-survey this code for the February 2011 RUC Meeting. The HCPAC recommended values for 11720 and 11721 will be interim so that they can be reviewed with 11719 to ensure appropriate relativity within the family.**

III. HCPAC Reference Service List Workgroup
Jane White, PhD, RD, FADA gave the HCPAC an overview of the HCPAC Reference Service List Workgroup Report, listed on page 2616 of the RUC Agenda Book. The Workgroup reiterated the HCPAC's previous obstacles in developing reference service lists for some HCPAC organizations when many of the codes they typically perform are being surveyed. Several solutions were discussed including:

- For specific time-based codes, articulate the number of services on the survey RSL and perform the calculation for the surveyee, to avoid any misinterpretation (ie, list the reference service in number of units and calculate the total work RVU for that number of units.
    - 97110 Therapeutic Exercises – 15 minutes 0.45
    - 97110 Therapeutic Exercises – 30 minutes 0.90
    - 97110 Therapeutic Exercises – 45 minutes 1.35
    - 97110 Therapeutic Exercises – 60 minutes 1.80

The HCPAC determined that they would like to refer this proposed alteration to the reference service list construct to the Research Subcommittee for their review so that all HCPAC societies can utilize this mechanism in their individual reference service lists, in instances where many of the codes being performed by the specialty are being surveyed and the surveyed code is time based.

Further, the HCPAC solicited for specialty societies to develop a proposal to address the situation of having to develop a reference service list when all of the specialty society's codes are under review. APA and NASW and any other interested societies will develop this proposal and present it at a future HCPAC meeting.

AMA/Specialty Society RVS Update Committee
Administrative Subcommittee Meeting Discussion
September 22, 2011

Doctor Blasier, Chair of the Administrative Subcommittee began the meeting indicating that the Administrative Subcommittee will be discussing the composition of the RUC. He reiterated that the RUC is an independent body exercising its First Amendment right to petition the Federal government, it is composed of 29 members, of which 26 are voting members, it is an expert panel where individuals exercise their independent judgment and are not advocates for their specialty, it is not a political or representative committee and the RUC relies on the expertise and objectivity of its members. The RUC consistently seeks to improve its methodology and processes while relying on its core principles of magnitude estimation from the Harvard/Hsiao studies in developing work relative value recommendations.

Doctor Blasier introduced four observers attending the Administrative Subcommittee prior to beginning its discussion:

- Steven J. Stack, MD - AMA BoT Chair-Elect
- Roland Goertz, MD, MBA - AAFP Chairman of the Board
- Ariel Winter – MedPAC
- Arielle Rodman - Columbia University

In June 2011, the RUC received a request from the American Academy of Family Physicians (AAFP) to consider changes to the RUC composition and processes. At this meeting, the Administrative Subcommittee reviewed the following 5 requests from the AAFP:

1. Add four additional "true" primary care seats (one each for the AAFP, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association);
2. Eliminate the three current "rotating subspecialty seats" as the current representatives "term out;"
3. Add a seat for Geriatrics;
4. Add three new seats for "external representatives," such as consumers, employers, health systems, health plans; and
5. Implement voting transparency.

Doctor Blasier indicated that these are major suggested changes to the RUC composition and the Administrative Subcommittee should discuss each of these composition suggestions thoroughly.

Doctor Blasier indicated that the Subcommittee will begin the proceedings with Doctor Goertz who will explain the AAFP request and speak for as long as he wants. After, the presentation, Subcommittee members may ask questions and make comments, additionally the microphones will be open to members on the floor.

9:03am – Testimony of Doctor Roland Goertz, Chairman of Board, American Academy of Family Physicians

Doctor Roland Goertz, conveyed his appreciation to Doctor Levy and Doctor Blasier for the opportunity to be able to address the RUC and recognized the RUC members for the hours of work it takes to do the job related to complete its charge as well as the members dedication to the profession. Doctor Goertz stated he has the utmost respect for the hours and time it takes to do this job the right way. He indicated he wants to make it clear that none of what he present is

pointed at any one member or members of the RUC, nor even the technical evaluation process you follow. It is intended to address what AAFP believes are very serious unintended consequences of the system currently used to evaluate primary care services and to address significant perceptions, whether right or wrong, about the way the RUC operates. The overall goal is to have an even better RUC, with an improved system that is above any misguided perceptions. Other work the AAFP is doing is certainly intended to change the value basis for family medicine and other primary care services, but the recommendations we made to you are separate from that effort. I want to begin by addressing three issues directly.

1. AAFP is in no way seeking to create an alternative to the majority of what the RUC does. In fact, even if AAFP is successful with its expert group to reassess the value of primary care, the RUC will need to continue its work. However, there will be a well researched and defined alternative for CMS to value the primary care services I have mentioned.

2. AAFP acknowledges that the RUC has made a number of recommendations that has been favorable to the work and payment of family medicine and primary care and CMS has not always accepted those recommendations. However, when reviewing the overall impact of payment of primary care physicians compared to non-primary care physicians over the last 20 years, a period that is virtually congruent with the work period of the RUC, the outcome of overall payment processes are inescapably obvious and virtually impossible to refute, the gap has doubled. This doubling of payment gap is directly related to the valuation process used by the RUC and not just implemented by CMS but by most private payers. This has created enormous issues in recruitment of adequate numbers of family physicians and has lead many medical students to choose higher paying non-primary care careers. Today only 10% of allopathic medical students choose family medicine and fewer are selecting general internal medicine and general pediatrics. I know many who wanted to choose primary care careers but could not ignore the debt load and projections of making 1/3 of what non-primary care physicians would make over their life-time.

3. Not just AAFP members, but others have a perception that there is a specialty bias on how the RUC does its work. I expect you will immediately dismiss this comment as untrue. I ask you to consider that your work is being devalued and less trusted by a growing number because of this perception and it is in your best interest to address it directly. Perceptions are reality for those who hold them, and this perception is not uncommon among primary care physicians and others, even one Congress person seems to hold it. Our recommendations are for concrete suggestions to counter these perceptions and improve the process that you follow.

Doctor Goertz began discussing the June 10, 2011, AAFP request to the RUC.

1. The four additional seats: As noted there is strong belief and now growing research that primary care services are undervalued by the RBRVS process. And a growing number of family physicians attribute that to a lack of true primary care perspective on the RUC. AAFP defines primary care physicians as including family physicians, general internists, and general pediatricians. While AAP, ACP and AOA include primary care physicians among their membership, nothing ensures that any of these organizations will appoint a primary care physician from their ranks as their RUC representative. Given the growing volume of research and outcomes data that shows the value of primary care to the health care system, we believe it is important that the RUC ensure that it has primary care

expertise beyond just a single family physician. Thus, we are advocating for the addition of 4 true primary care seats.

2. Eliminate the three current rotating subspecialty seats as their terms "term out": AAFP recognizes that group dynamics make it increasingly difficult to manage the RUC process as the size of the RUC increases. Thus, to counter balance the addition of 4 new primary care seats, AAFP proposes eliminating the current rotating seats as the current representatives term out. Subspecialties are already represented by umbrella organizations that have permanent seats on the RUC and through the RUC Advisory Committee.

3. Add three new seats for "external representatives," such as consumers, employers, health systems, health plans: The objective of this request for consideration, is that there are many other experts beyond physicians on payment models. There are sets of extant data that we believe will be very beneficial to the RUC to have access to through these external representatives. So AAFP have found that the inclusion of others beyond physicians in discussions related to issues such as these, very beneficial to the Academy in the past. That is the core of the recommendation to have external seats.

4. Add a seat for geriatrics: Historically the primary beneficiary of the RUC's deliberations has been the Medicare program. Medicare is primarily a program for the aged. Thus, the RUC would benefit from the expertise that Geriatrics could bring to the table.

5. Greater voting transparency: From AAFP's perspective the RUC functions much like a public advisory committee. As such its vote should be transparent and open to public scrutiny. The RUC has been criticized in the past for potential and present conflicts of interest and we note that there has been commendable strides in recent years to ensure that conflicts of interest are avoided in the process of conducting RUC business. We see some form of increased voting transparency as another critical action in this direction that would easily and immediately dispel any perceptions of such conflicts. In summary, AAFP's recommendations are made with the hope that they will accomplish two things. Add important credible voices to the RUC and to dispel strongly held perceptions, whether true or untrue, on how the RUC works. At this time when our health care system is struggling under issues of quality, access and cost, we suggest that the recommendations we have made will result in a better RUC with improved confidence in it by all physicians and the public. Thank you for your time and I am happy to address any questions.

Ended 9:15am

Doctor Blasier opened up the microphones for the Administrative Subcommittee members to ask questions or make comments.

Doctor Blankenship: Regarding the transparency issues, I am personally sympathetic towards voting transparency, because I generally think that we should have nothing to hide. But I noted that in the responses from other specialty societies that there was almost unanimous opinion that that was not a good idea. My question is regarding your reasoning that there should be transparency. In your letter I did not understand what the rationale for it was. There is avoiding the appearance of conflict of interest, but I am not quite sure what that apparent conflict of interest is. What is the conflict of interest that this will serve to dispel and the other question is the argument regarding what the relationship with the AAFP BOT, their voting is not transparent but

somehow we are different from them. Another argument said that we have some sort of fiduciary responsibility and if we did it for the entire CMS budget, that did not make sense to me. Could you explain those two points.

Doctor Goertz: There are variations of voting transparency that one could discuss, whether it is not a vote, but not single vote transparency. And other variations of that. The bottom line for the request is to offer an option to make sure that there is no bias and no conflict in a sequential consistent way in the votes that RUC conducts. Nothing more and nothing less.

Doctor Blankenship: It is an exaggeration to say that we have fiduciary duty for the CMS Medicare Fee Schedule Part B budget.

Doctor Goertz: You are referring to the August 31st letter and the responses. The point in the letter is that we are not comparing apples to apples or oranges to oranges. The RUC process is significantly different in our opinion than the membership representative process and fiduciary responsibility that we as a Board for representing our members conduct.

Doctor Williams: Could you develop further the concept that the complexity of Evaluation Management services provided by primary care physicians today is different and likely more intense than the same service provided by other specialties?

Doctor Goertz: There has been a growing body of research specifically one published article recently, that over the past 20 years the evolution of what the primary care physician is expected to do with interfacing with the patient and the complexity of the system is not currently valued appropriately with the current methodology.

Doctor Williams: Wouldn't other specialists have the same issues as they try to deliver care?

Doctor Goertz: The current information would indicate that the intensity of the primary care's interface across the breath of medicine would be different than a specialist with a specific subset of medicine interfacing with the patient.

Doctor Manaker: Are there any other reasons to eliminate the three rotating seats, other than merely the size of the committee?

Doctor Goertz: AAFP was silent of the total number of what the RUC might be, that is in your purview and we were trying to consistently establish a core primary care representative piece within the RUC, with you making the true and right decisions about how large the RUC should be, because I am clearly aware that others have requested seats in addition to what we have requested.

Doctor Blankenship: I would like to go back to the conflict of interest question. I am puzzling over what would constitute the apparent conflict of interest. If I am a cardiologist and I always vote yes for cardiology issues? Beyond that is it to see if procedural specialties always vote for procedural codes, is that the conflict you are thinking about? What is the appearance of conflict interest that we are trying to dispel?

Doctor Goertz: The latter description that you are mentioning is the one that has been discussed the most.

Doctor Blasier: In your narrative you referred to a "specialty bias" and I think each of us are sensitive to that and feels a strong commitment to objectivity and fairness. What did you mean?

Doctor Goertz: It is really embodied in the previous question. If there is a perception that the votes always go along the procedural lines or along the specialty lines. Particularly non-primary care versus primary care. AAFP feels strongly that that perception has to be dispelled some way. There is, whether I like it or not, a strong perception of that specialty bias, by a significant number of our members. Therefore, we are asking for the RUC to try and address that to try and dispel it.

Doctor Blankenship: I would like to clarify your recommendation for the extra representation. It wasn't clear, are you suggesting that the RUC actually add a seat at this table for a member of the insurance industry and another seat for a hospital organization and so on for as many external representations as we think would be appropriate?

Doctor Goertz: The request is for consideration for three external seats, selecting appropriately and carefully, who those three may be. AAFP suggests those groups as areas where you may find those three expert members that could be added. AAFP does not say there should be one from each, but there should be three external seats that would be added to the RUC.

Doctor Traugott: Could you please clarify that more. Here at the RUC we do not decide on payment policy. We are bound by a very strict set of rules of which we evaluate physician work and practice expense. I am having questions how these external people on the RUC would advance the process that we are trying to accomplish.

Doctor Goertz: I fully appreciate the technical nature of what you do and the legislative boundaries that you work within. Our suggestion is intended to offer to you an expertise set and possibly access to extant data sets that you currently do not have access to in development to these seats that might be added. Currently you have access to certain sets of data and other sets of data that might help you in your deliberations. Whether or not those could be accessed without an additional seat from an external member that is a non-physician to RUC or not, I do not know the answer. But AAFP believes the presence of those around the table in a formal way will give more credence to the work you do.

Doctor Bishop: I am curious and would appreciate if you would elaborate, as the RUC expands is the AAFP proposal an order to add more votes for primary care or is it to add more expertise for primary care or both?

Doctor Goertz: It would be both, but the latter would be the most significant issue, adding a larger number of expertise in primary care to the RUC itself.

Doctor Hitzeman: Besides extant data from these outside individuals, what else would you expect them to participate in the RUC process? We review the physician work and the practice expense components. It has been our problem in the past, this is proprietary data that the private payers have. What makes you think that they would share that data? Secondly, our work here is for CMS and the RBRVS, it is not for the private payers. We are responding to the RBRVS system which is run and directed by CMS. It would be a change in how we do things and the information we get because we are determining values for the Medicare Fee Schedule.

Doctor Goertz: I completely understand the comment, my response is that the relative value of primary care to the overall system might be enhanced with a discussion of external members that

are at the table. The technical discussions and the technical work that you do, you are bound to the system that you have we clearly understand that. It is hopeful that those voices would then land more thought about how the relative value across the processes work is positioned instead of the technical values that you work on.

Doctor Hitzeman: You are talking about the end point and that is reimbursement. We do not deal with reimbursement. We deal with code values and the relativity within the Schedule. As you know the last two times Evaluation and Management services have been reviewed the RUC has recommended significant increases. But because of the system outside of our control the amounts of increases were reduced. Adding new members and expertise is not going to change those external forces. To get at the ultimate goal AAFP is looking to get increased reimbursement. How do you address that?

Doctor Goertz: We address that by not avoiding the issue that CMS is really the process that needs to be changed. We have been very clear in our interactions with CMS with the problems that have occurred with the current system and our desire to have a different relative value for primary care services versus non-primary care services in a rational way. The purpose of the external seats is not just a technical process, its an issue of image to the outside also. That's more the crux of the request than it is the technical issues that you are asking about.

Doctor Lewis: Whether the RUC votes to add external seats or not, I would like to point out that there is a mechanism now to look at any data from any external source. We have sent multiple requests to every specialty to solicit any information and knowledge of databases that may help the RUC do their job in valuing any service for any specialty. We have actually gotten very little back. If there is extant data out there that would be helpful, no one has identified it or presented it. Whether there are seats or not we have been very open in soliciting and evaluating any such information and using it if it meets our criteria.

Doctor Blankenship: The American College of Cardiology in response, proposed the idea of changing the current rotating seats as they are now designated to a rotating seat that would be specified as to have expertise in chronic care management and coordination of care a second rotating seat for a person with expertise in geriatric care and a third rotating seat for someone with expertise in inpatient care. The value of that is you would be guaranteed to add a person to the RUC with specific expertise in those areas, without making the size of the RUC unmanageable. Further, it would guarantee we would add expertise to the RUC. Whereas if we designate 4 primary care seats, we may not get any additional unique perspective. To what extent would that proposal satisfy your goals?

Doctor Goertz: It sounds reasonable, but I would really position our situation, our board and a process. Consider our requests, let us know what the RUC is willing to consider and then our Board will do a due deliberation of that. So I can not specifically answer whether that is acceptable or not. Once we receive the RUC's response we will have a serious and deliberate response considering all the issues and possibilities, including the one you mentioned if indeed you send that forward.

Doctor Senkowski: Could you expand on Doctor Williams question as to the changes in the intensity and complexity for your specialty as compared to others. I am a general surgeon in Georgia and clearly the increase in the elderly with multiple problems has hit my practice as well. I am also thinking of the medical specialists who also see an increase in complexity in intensity. How is it different?

Doctor Goertz: You are asking a technical question that I simply do not have all the information about. The issue is not necessarily the technical issues that you will enably ask about, the issue is the 20 year trend that has created aberrations in the process who selects in a medical school setting what they are going to do for the rest of their lives. The data that is coming out lately, particularly about the intensity about what a primary care physician evaluates in their office, is from a child to an adult with the interface with the insurance companies with the coordination of care that is unpaid for by specific codes is really at the heart of what I mentioned. I fully accept that all specialties have been confronted with increased intensity and complexity with these issues, but often do not confront the breadth of those that a primary care physician does.

Doctor Williams: Could you summarize the current status of primary care education, what it takes to become a member of your Academy and what the Board and your specialty involves?

Doctor Goertz: Three years of training post MD/DO degree, the American Board of Family Medicine follows the ABMS criteria for boarding, CME process as most other Boards do now also. For a member of the Academy there are 150 hours of CME required every 3 years for continued membership and have to have a license in good standing in the state you are in. There are other side issues related but those are the basic criteria. They are moving from a 7 year to a 10 year Maintenance of Certification (MOC).

Doctor Traugott: I think almost everyone here would agree that the disparity that you are describing to us is an unintended consequence of the RBRVS system and I am still grasping for an understanding how any modifications we make at the RUC will correct this unintended consequence of our current system.

Doctor Goertz: I personally believe you are right in the statement you made, that is why the Academy has invested a significant amount of money in that specialty task force to look at the revaluation for the process of primary care. We see the future as a blended set of issues related that come together in a payment model that is different. We have discussed this at length at the Board and believe there will be a maintenance of the FFS element that is embedded or carried forward that you represent in the work you do. And there will be an additional component that will center around quality. How that will be rewarded or paid threshold levels once the appropriate quality measures are approved. A third element would be some aspect of payment related to coordination activities that are currently not easily subjectible to code creation. What we are asking of the RUC is not going to solve the entire dilemma. What we are asking of the RUC is to add expertise and voice and that in turn lends stronger credibility to the work you do, so that we are not having, particularly in a member framework, dealing with the strong sentiment about what the RUC is doing, but move toward a payment model that revalues the system in a better way in our opinion.

Doctor Mabry: The College of Surgeons has the Health Policy Research Institute that has been tasked with the question of workforce issues across the whole surgical and medical spectrum. What we found out is that the numbers of general surgeons are dropping at a dramatic rate and ACS thinks it has nothing to do with payment, but the same token, I think Family Physicians has been variable, but has not dropped at the rate of certain surgical specialties. I raise the caution that while it may be true that certain specialties are paid at different rates there may not be an effect that of that payment on those that go into certain specialties, there may be other factors involved.

Doctor Goertz: Fully accept that, we have done a number of studies that show that there are other impacts. But unfortunately over that last 3-4 years the payment issues is at the top of issues that is driving the process.

Doctor Manaker: I appreciated your comments about the evolution of health care payment reform right now, and recognizing what we do here is a fairly narrow technical aspect. The call for changing the composition really hinges on expertise and valuing primary care, particularly non-face to face services. Yet historically the RUC does not do payment policy and we have valued many of those non-face to face services, telephone calls, care plan oversight, tiered values of patient centered medical homes, and anticoagulant management. In your specialty society's estimation, were there problems with those values suggesting that our expertise was inadequate?

Doctor Goertz: The patient centered medical home recommendations, we very much appreciated what the RUC did. Of course the end point as I mentioned earlier, that CMS does not accept everything that you recommend. We do not and have not taken a position that you incorrectly have done those valuations, that is not the point of our request.

Doctor Blankenship: Has your specialty actually queried graduating medical students, kind of like a sensitivity analysis to say if salaries increase by 20% when you go into family medicine or increase by X%, do you have any assessment on how much it would take? Secondly, is it in the realm of possibility, say the RUC decides to double the value for E/M code would that make a difference to convince people to go into family medicine?

Doctor Goertz: There has been research done by others that has asked that question. The point seems to be somewhere around 50%. If you could bring up the value of family and primary care to no less than 50-60% of non-primary care income, you would be moving in the right direction. Now, that is external survey data. So that seems to be the point that most people refer to and that has been adopted by a number of primary care groups where they believe the tide will turn in medical students selection.

Doctor Raphaelson: What is the rationale for adding extra primary care seats to the RUC, other than expertise? Why not talk about adding voting representation for primary care and what is the primary reason at the RUC. My understanding that RUC was originally constituted that every certified specialty got a seat, is that the right rationale going forward, should it be based on the number of physicians in specialties or based on policy. I do not think the expertise issue is a major one for RUC right now.

Doctor Goertz: That is an excellent observation and one our Board has discussed and we chose to remain silent on that, it is up to RUC on how to make a decision on adequate and appropriate representation. The purpose of the request is to make sure that at least our membership and others in primary car feel confident that they have more than an a singular voice around the RUC table that can be definitely told to them represents and is the expertise of primary care at the table. The other questions you ask are bigger and broader than what we have commented on and are in the purview of the RUC itself to decide.

Doctor Raphaelson: Another question is regarding the openness of meetings, what is AAFP's specific request? You would like the vote open and tallied by the member and projected at the meeting and did you request that the meetings be more generally open? What are your concerns about the transparency of the RUC processes?

Doctor Goertz: We are requesting that there be a movement towards more transparency voting and that is exactly it. To offer more suggestions about that would take away the rich discussion that I hope the RUC will have later. We are simply asking the RUC consider moving towards more transparency on how the RUC operates and how the votes are taken.

Doctor Blasier: The AAFP has been open about its intention to create a task force to look at different ways to value the services provided by primary care physicians and they have also made these requests for changes to the RUC. What is the relationship with what the RUC does with your requests and the functions of the task force? Will our proceedings change what the task force does, where are you going with this?

Doctor Goertz: It's also an issue that we have discussed in length with the Board. As has been mentioned around the table, we now understand clearly that you are restricted in how you conduct your work on how it is related to the RBRVS process. The work of the task force in our view is in addition to what we are asking of the RUC. The task force, and I can not predict what exactly their outcome will be (with an outcome hopefully by March 2012), will indicate how to revalue primary care services within the scheme of overall payment. It is separate and viewed as in addition to, and not to replace what the RUC already does.

Doctor Glass: As we have been told numerous times, the RUC is an expert panel exercising its First Amendment right, it can presumably do whatever it chooses to do, which currently is using resource inputs to set relative values for services. Are you asking that, or would approve of, the RUC in its independent capacity do more than that and go beyond, just than determining the relative value inputs. For example, a 99213 based on the resource inputs comes out to 0.92, but we would like to add that we think in this case the resource values underestimate the amount of work. Do you want the RUC to expand what it does?

Doctor Goertz: We have not had that discussion relative to what the RUC does. My personal answer, is that I do not see that we are asking the RUC to go beyond the process and methodology of the technical assessing of relative values that you are currently using. But we are asking that you allow us to look at other methodologies outside, via our taskforce, to see if there can be additive processes, to add to what you are doing but mainly for CMS not the RUC. If the RUC in its deliberations determines it is wise to move in the direction you are indicating I am sure we would support that, but that is not what we are asking at this time.

Doctor Williams: I have no problem with your task force and it would seem to me that you have the same opportunity that the RUC has to petition CMS. So I think if your arguments are compelling they will win and you should move forward with whatever mechanism of alternative valuation that you this is most appropriate, submit that to CMS and let them decide and that is exactly what we do. We do our best to value procedures and submit to CMS.

Doctor Goertz: It is exactly our intention to make sure that we are very clear to the RUC and to all of the other member organizations about what we are trying to do. We unfortunately, as most of you have, the situation where we could be viewed at odds with what the RUC is doing. Therefore, at our view we want to be clear on what we are trying to do with the taskforce, which is not to obviate or replace what the RUC is doing, but to look at payment systems in a different way that will hopefully have different outcomes that is desperately needed by the people of this country. I am appreciative of your comment because I am always concerned that will be misperceptions of our intent.

Doctor Manaker: Could we go back to the issue of transparency? I appreciate and understand the call for transparency and would like to explore how we try and respond to your request. If the issue is really transparency of the voting members, our self appointed charge is to put on our RUC hat and not represent our native specialty. Would the call of transparency be satisfied by the public voting of the members, so that our votes were recorded and known? Because then it would

go beyond the closed confidential room in which we deliberate. Or would it be satisfied by allowing the room to be open, but the voting members' specific votes remain confidential?

Doctor Goertz: I think that either of those two processes would show a movement in the direction that is requested. I can not individually tell you that that would "pass the standard" of what we are asking. That would take a Board deliberation once the RUC has made a decision.

Doctor Oates: The external source members that would be added, would they be voting members?

Doctor Goertz: That is an interesting question, because the request to you is to add them to RUC it is silent whether they would be full voting members or not. From our discussion, it was that they would be voting members.

Doctor Oates: When you formulated the make up of these external sources, your categories are fairly general. Did you give any thought at all how these individuals would be chosen to represent the various specialties.

Doctor Goertz: Our intent was to give you suggested areas to look at but leave it up to the RUC as the rational important decision to who might add that value to you.

Emily Hill, PA-C: We have had a lengthy discussion and to me it falls in three areas. 1) There is discussion about things for which we have no control that the RUC can not impact in terms of reimbursement, such as people going into a specific specialty or primary care. 2) Perception. 3) What is this body needs to have in order to appropriately fulfill its function and charge. Perhaps we need to start looking at the latter, because that is something the RUC needs to consider. What expertise does the RUC need to fulfill its charge as it currently exists? Some of the things we can not influence.

Doctor Lazaroff: Regardless of your individual position about the merits of the specific proposal AAFP has made, I think there are general agreement that those changes in itself would not correct the inequities that seem to exist. Geriatricians believe that the cognitive work that geriatricians do is substantially different from the cognitive work that many specialists do. The work that I do can not be appropriately valued by the RUC because there is not an E/M code that appropriately describes that work. I know this is not directly in the purview of the RUC, but the RUC can not be accurate in its valuations if the code definitions and accompanying documentation requirements do not reflect the actual work. Geriatricians will be seeing 3-4 chronic conditions and addressing each differently along with possible counseling, etc. You can never say there is a self-contained issue, therefore documentation requirements are irrelevant to the work done. My plea is changing the structure may have some merit, but we need to look much more deeply at the whole system to get to the root cause.

Doctor Levy: There is a Joint CPT/RUC Workgroup specifically addressing those issues as we speak. That is in process and please join us this afternoon at our meeting.

Doctor Schlecht: I would like to comment from the AOA. In 2007, primary care came to this body and recommended the addition of 1 primary care rotating seat, I think that still maintains merit and we ought to look at that. AOA supports the addition of geriatric seat to accomplish the issues that have been addressed. I think it would be a shame if the RUC was challenged for 2 or 3 seats, when the real issue has already been discussed, which is the AAFP task force and the Joint CPT/RUC task force that will come out with the real solution to these issues. I would hope that

the AAFP is not set on concrete, if we do not accomplish certain numbers that has been talked about.

Doctor Martinelli: The ACP continues to support the process of the RUC and has been a participant since the beginning. We do support a seat for geriatrics feeling that they do bring an expertise and focus on the elderly population as well as the ability for chronic and longitudinal care that most other specialties do not focus on to the extent that they do. We would also like to encourage the RUC to look at the current survey instrument and its value, accuracy and validity as we value E/M and chronic care codes. As we have seen as some of our recent meetings some of the data we have presented is challenging to use the cognitive mind set with surveys that are to some extent designed to value procedures. We would recommend revisiting the rotating seat for primary care as we did in 2007. Also, the opposition that we have to the elimination of the rotating seats. Those seats give the smaller specialties a chance to be represented at the table and also bring their own particular expertise to the process. As we go forward with the Chronic Care Coordination Workgroup (C3W). We encourage the panel to look at the development and valuation of the patient-centered medical home and its model for chronic care coordination. In terms of expertise at the table, we again would reiterate our support for pulmonary, gastroenterology and hematology/oncology to have the opportunity to be considered at the table before the full RUC in their effort to obtain permanent seats. Regarding transparency, we have a couple issues for discussion/clarification. 1) If we were to open the meeting to the media, would the media be bound by the same non-disclosure agreement that the attendees are now, not to discuss the valuations and the discussion prior to the publication of the full values by CMS as we currently do. 2) Now that the RUC is an expert panel would changing it to a representative panel raise antitrust concerns, because then it does become a representative panel.

Doctor Goertz thanked the RUC for the opportunity to address the group and assured the RUC that AAFP's efforts are to try and make the future better, it is not to attack the process you follow in any way, but to try and correct the unintended consequences in the best we have in the recommendations that we have made.

10:03 am
Doctor Blasier thanked Doctor Goertz for addressing the RUC today. The Subcommittee continued with the discussion of the current RUC composition and the five AAFP requests.

1. **Add four additional "true" primary care seats (one each for the AAFP, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association)**

The Subcommittee indicated that it discussed adding a rotating primary care seat in 2007, which failed at the full RUC by one vote. The Subcommittee seemed in favor of the addition of a primary care seat, but adding 3 more in addition may not add to the current process. It seems that clear with all that has been discussed, the change in reimbursement, perception and new payment models that are coming out, the RUC needs more expertise in the primary care area. In 2007, the RUC also set out the qualifications for that member, which was a significant document that needs very little change and we should consider that again in our approach.

The Subcommittee discussed if the RUC does add any primary care seats, it may want a more specific categorization of a family medicine or primary care seat. The RUC should specify exactly what expertise we want to get from the person for that seat. For example, it could be a medical home seat, an inpatient hospitalist seat, or coordination of care seat, etc.

The Subcommittee seemed favorable with the addition of a seat in primary care but before adding just a "primary care" seat the Subcommittee discussed looking other areas of expertise that are lacking from the RUC. A Subcommittee member noted that one of the issues that has come up on the Joint CPT/ RUC Workgroup on Chronic Care Coordination (C3W), is the lack of representation of chronic care on the RUC.

Many of the Subcommittee members supported the notion that this Committee should bring the question of a dedicated rotating primary care seat to the full RUC. The RUC should use this opportunity to consider what other areas and changes we may be amenable to. To be clear, the Subcommittee should bring to the full RUC for discussion the addition of a new rotating voting seat dedicated to primary care in accord with the previous deliberation from 2007.

AMA staff noted that for those members that were not here in 2007, the RUC actually did approve the primary care definition and the candidate eligibility outlined on page 223. The RUC approved that by 2/3 vote, it was the vote on actual changes to the Structure and Functions to implement it, which was defeated by one vote.

The Subcommittee agreed that it needs to consider what expertise the RUC needs. AMA staff confirmed that the RUC will review any specific recommendations from the Administrative Subcommittee. The Subcommittee agreed it had a robust discussion a couple years ago, where the RUC looked at all of the top aspects the RUC needs as well as definitions. Whether an additional seat is called primary care or comprehensive care coordination is up for discussion. Additionally, the Subcommittee, in review of the specialty society responses, discussed that adding 4 additional seats may be too many and would not add to the level of expertise needed. The other primary care specialties did not request an additional seat for their respective organization.

The Subcommittee indicated that they agreed the full RUC should discuss defining the additional seat needed at this time, whether it be primary care or chronic care coordination, etc. However, the Subcommittee should first review all the definitions and criteria from the primary care seat discussion laid out in 2007, re-examine and re-define, then send on any recommendations to the RUC.

2. Eliminate the three current "rotating subspecialty seats" as the current representatives "term out;"

Doctor Blasier indicated that the vast majority of specialty societies commented that they were not in favor of eliminating the current rotating seats. Doctor Manaker expressed his confidence in Doctor Levy and her successors, that she and later Chairs would be able to manage the Committee at a size of up to 40. However, the Subcommittee was not in favor of eliminating the three rotating seats. It was noted that this allows for additional expertise from subspecialties. The perspectives from these individual societies have been important to the RUC.

3. Add a seat for Geriatrics

The Subcommittee discussed the fact that Geriatrics currently meets 1 of the 5 criterion to have a permanent seat on the RUC, that "Medicare revenue is at least 10 percent of mean practice revenue for that specialty." However, based on the responses from the specialty societies, seven supported the addition of a Geriatric seat and none opposed. The Subcommittee was supportive that the expertise of Geriatrics is needed on the RUC. Geriatrics would bring a different view that is very important in the evolution on how health care is changing could provide a unique perspective to the RUC and contribute to the process.

The Subcommittee was concerned that if the RUC changed its current criteria in order to add a permanent Geriatrics seat or made an exception to add a permanent Geriatric seat then the RUC would receive multiple requests for additional seats to the RUC. AMA staff indicated that any change to the Structure and Functions (change to criteria for a RUC seat) will require a 2/3 vote of the RUC and approval by the AMA.

The Subcommittee determined that adding a rotating seat for chronic care may be the best route to add the appropriate expertise needed on the RUC. The Subcommittee requested that AMA staff develop draft language to amend the Structure and Functions to include a rotating seat for care coordination and chronic disease management services in the interim and bring back to this Subcommittee.

1. Add three new seats for "external representatives," such as consumers, employers, health systems, health plans;

The Subcommittee discussed the addition of external representatives and was generally opposed to adding any additional seats. The Subcommittee determined that the RUC already has access to external information and data that is available through specialty society extant databases and other external sources such as Medical Group Management Association (MGMA). Therefore, the Subcommittee indicated that no expertise would be gained by adding external representatives and did not seem receptive to adding external representatives.

2. Implement voting transparency

The Subcommittee discussed the voting transparency as indicated by AAFP's request and some members were still unclear on what AAFP means by more transparency. AAFP indicated that the purpose of more transparency was to defeat the perception that specialties vote in blocks (proceduralists vote in favor of procedural codes). Therefore, the only form of transparency that would seem acceptable to AAFP would be to publish individual votes.

The Subcommittee noted that there may not be a good understanding outside of the RUC process, that RUC requires a high standard for a recommendation to pass, a 2/3 vote. Therefore, the range of possibilities if votes are published are 26-0 to 18-8. What exactly that would mean for the Committee is unclear. If published would CMS look at the 18-8 differently than the 26-0 recommendations? The Subcommittee also did not see the clear benefit to publishing a vote, when discussions about issues at the RUC are prohibited until CMS publishes the final values.

Subcommittee members indicated that disclosing individual votes will have the opposite effect intended by AAFP. Specialties would then have more pressure to simply vote in favor of their specialty instead of currently, where a RUC member analyzes the data presented and makes an informed decision in favor or against one's own specialty societies recommendations. The Subcommittee indicated that individual votes should not be reported per member and indicating the vote numbers per issue would serve no purpose. All would lead to additional pressure on RUC members by outside manufacturers and lobbyists and well as pressure from their own specialty societies.

The Subcommittee discussed allowing outside people to more easily observe the RUC to improve perception regarding transparency. It was noted the RUC has always allowed individuals to attend a RUC meeting, either at the invitation of a national medical specialty society or by the Chair of the RUC. The Subcommittee noted that the RUC may not be able to do much about perception

when individuals do not want to be persuaded by fact. Nevertheless, the Subcommittee will continue to explore process changes to address perception regarding the transparency of the process.

A Subcommittee member questioned if publishing individual votes would take the RUC out of the protection of *Noerr-Pennington* and create another set of potential difficulties that would complicate the RUC's activities. Thomas Healy, AMA Office of General Counsel, indicated if you create an opportunity for lobbying there will be lobbying. However, he would be happy to answer any specific questions of the RUC members. The Administrative Subcommittee, including all RUC members and alternates present, entered an executive session to preserve attorney client/privilege for Thomas Healy from the AMA Office of General Counsel to address the concerns of the RUC.

Summary:

- The Subcommittee seemed receptive to adding 1 or more primary care seats to the RUC. There was positive discussion regarding a re-review of the 2007 Administrative Subcommittee recommendation to add a rotating primary care seat.
- Many of the commenting specialty societies and Subcommittee members expressed support for Geriatrics and suggestions were made to consider the expertise that the RUC may require to value care coordination and chronic disease management services.
- AMA staff will draft potential modifications to the RUC Structure and Functions document to consider these various seats for Administrative Subcommittee for a series of conference calls over the next few months. The Administrative Subcommittee will then review and formulate recommendations for the RUC at the January 2012 meeting.
- The Subcommittee did not seem receptive to eliminating the 3 current rotating seats or adding seats for "external representatives".
- The Subcommittee will continue to explore process changes to address perception regarding the transparency of the process.

Medicare Update

September 23, 2011

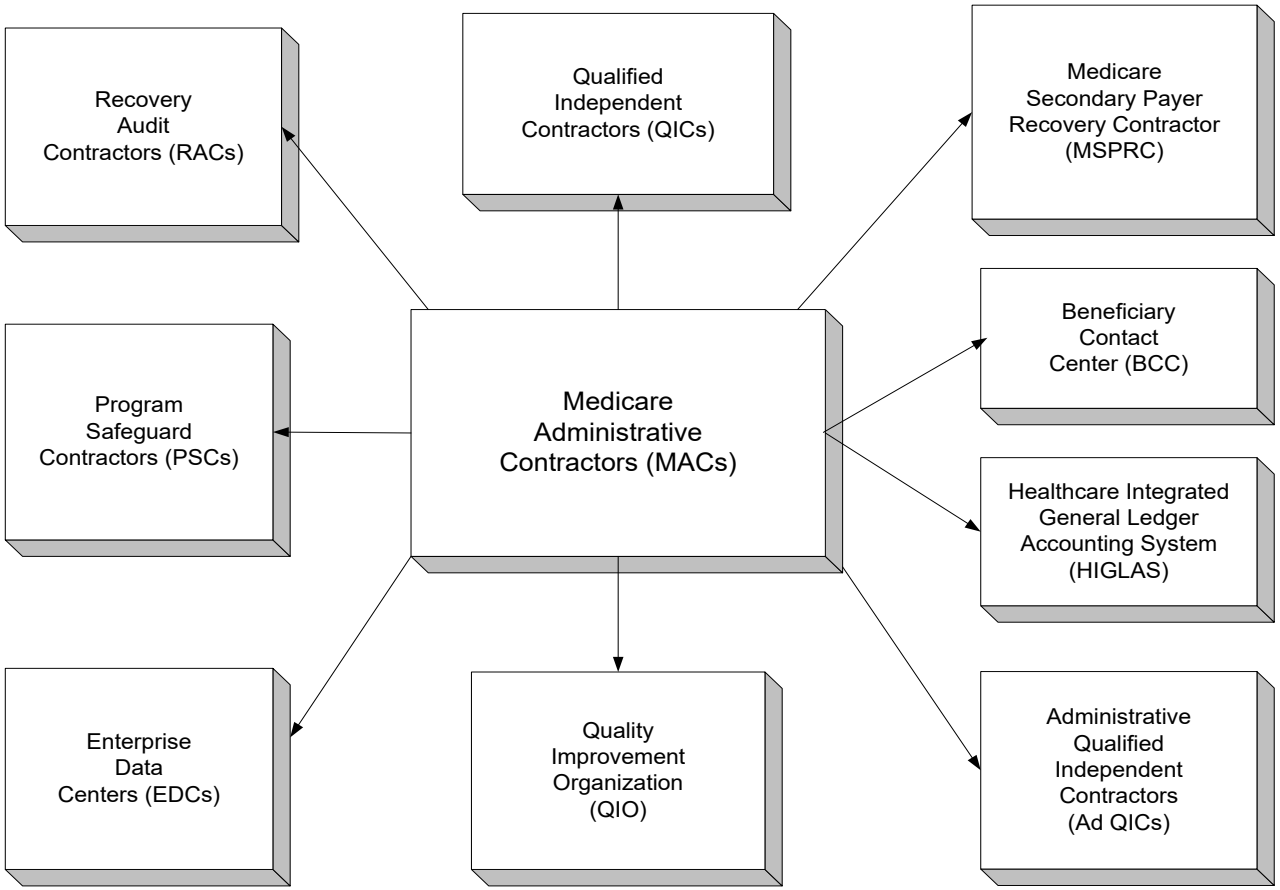
Charles E. Haley, MD
TrailBlazer Health Enterprises, LLC

Published May 2011

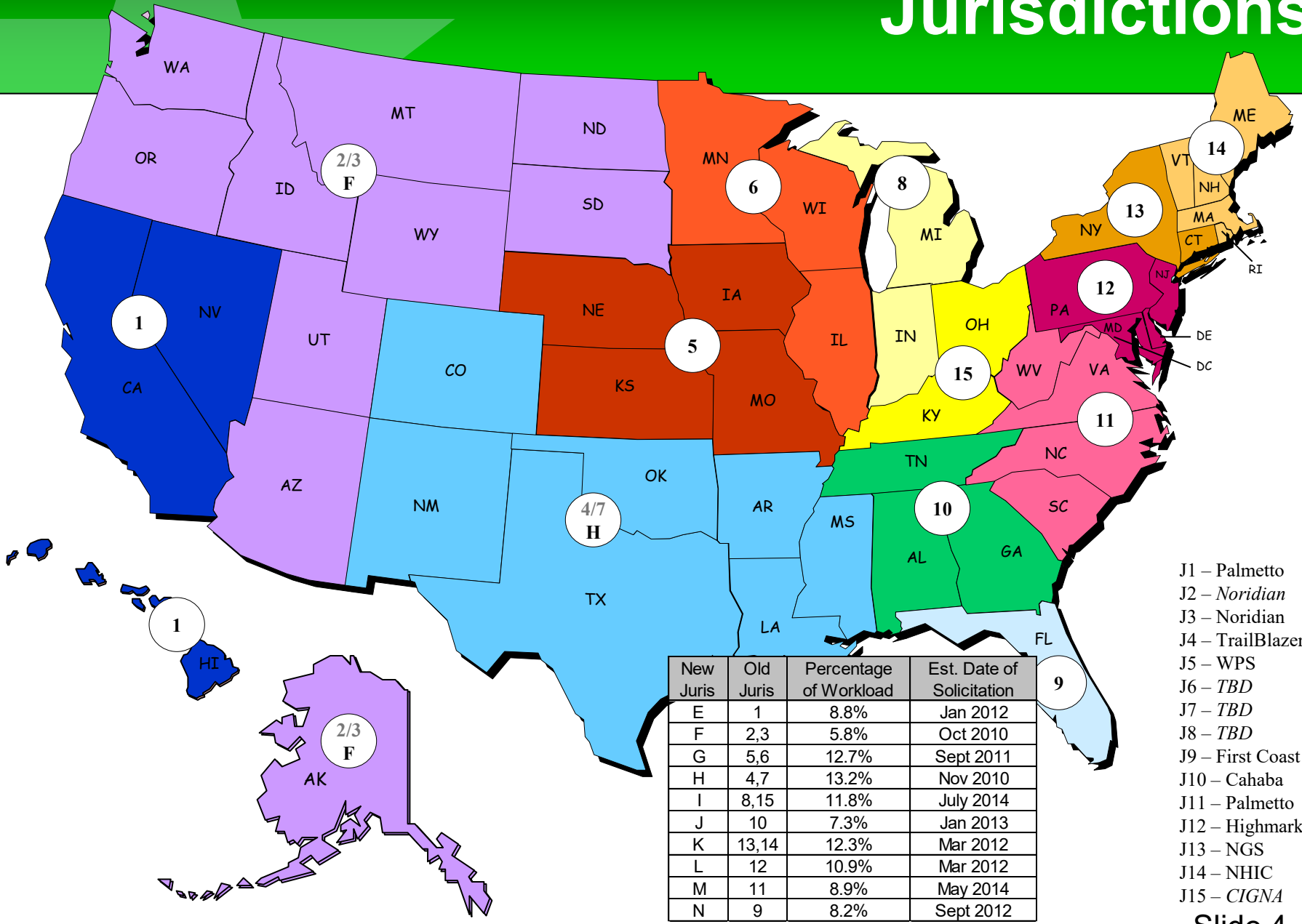
Contracting Reform

The Centers for Medicare & Medicaid Services (CMS) is moving away from a multi-function contractor for each state to many single-function contractors for each region.

Medicare Functional Environment



Jurisdictions



New Juris	Old Juris	Percentage of Workload	Est. Date of Solicitation
E	1	8.8%	Jan 2012
F	2,3	5.8%	Oct 2010
G	5,6	12.7%	Sept 2011
H	4,7	13.2%	Nov 2010
I	8,15	11.8%	July 2014
J	10	7.3%	Jan 2013
K	13,14	12.3%	Mar 2012
L	12	10.9%	Mar 2012
M	11	8.9%	May 2014
N	9	8.2%	Sept 2012

J1 – Palmetto
J2 – *Noridian*
J3 – Noridian
J4 – TrailBlazer
J5 – WPS
J6 – *TBD*
J7 – *TBD*
J8 – *TBD*
J9 – First Coast
J10 – Cahaba
J11 – Palmetto
J12 – Highmark
J13 – NGS
J14 – NHIC
J15 – *CIGNA*

Payment Accuracy

Several federal laws and executive orders require that the government measure and attempt to reduce the payment error rates in federal programs.

http://www.paymentaccuracy.gov/

Role of A/B MAC MR

Prime directive for A/B MAC MR:

- The contractor shall decrease the paid claims error rate and address MR-related coverage, coding and billing errors in accordance with Internet-Only Manual (IOM) Pub. 100-08.

2010 CERT Paid Claims Error Rate

Type of Contractor	Paid Claims Error Rate	Projected Dollars Paid in Error
Overall	10.5%	$34,268,664,880
Part B	12.9%	$10,939,319,559
DME MAC	73.8%	$ 7,251,392,747
Part A (excluding inpatient)	4.2%	$ 4,745,626,984
Part A (Inpatient PPS)	9.5%	$11,332,325,591

2012 CERT Paid Claims Error Goal

Type of Contractor	Paid Claims Error Rate	2010 Dollars Paid in Error	2012 Goal	Est. $ Reduction
Overall	10.5%	$34.2 B	6.2%	~ $14 B
Part B	12.9%	$10.9 B		
DME MAC	73.8%	$ 7.2 B		
Part A (excluding inpatient)	4.2%	$ 4.7 B		
Part A (Inpatient PPS)	9.5%	$11.3 B		

Update on Medical Review

In 2008, CMS moved the responsibility for review of inpatient claims from the QIO to the A/B MAC

Medical Review

Three main contractors for Medical Review (MR):

- A/B MAC – TrailBlazer (Dallas):
  - Coverage, coding and payment accuracy.
- Zone Program Integrity Contractor (ZPIC) – Health Integrity (Dallas/Baltimore):
  - Fraud.
- Recovery Audit Contractor (RAC) – Connolly Consulting (Philadelphia):
  - Recovery of incorrect payments.

Smaller role in MR:

- Comprehensive Error Rate Testing (CERT) – AdvanceMed (Richmond):
  - Nationwide error rate calculation.
- Quality Improvement Organization (QIO) – varies by state:
  - Quality reviews.

Fun Activities for Fall and Winter

- Claims Reprocessing
  - Required by Affordable Care Act
  - About 75% complete
  - Will be “mostly” complete by 12/31
- Revalidation
  - Required by Affordable Care Act
  - Must be complete by March 2013
  - Contractors hiring staff
  - First: Those not already in PECOS

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October 3, 2011

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Baltimore, MD 21244-1850

Subject: Additional RUC Recommendations for Consideration for Final Rule on the 2012 Medicare Physician Payment Schedule

The American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC) met September 22-24, 2011 to review specialty society data and develop relative value recommendations for individual physician services. A significant portion of the agenda was devoted to issues that relate to CPT 2013 or newly identified potentially misvalued services. These items will be submitted to CMS in the future. However, given the immediate urgency for items related to 2012, we submit these recommendations to you at this time. In addition, the RUC recommends immediate consideration of certain methodological and policy changes for 2012. The RUC submission includes the following issues for consideration by the Centers for Medicare and Medicaid Services (CMS):

- Chronic Care Coordination Workgroup Implementation and Initial Recommendations
- Separate Payment for High Cost Medical Supplies (Balloon Sinuplasty for 2012)
- Kyphoplasty – Non-Facility Practice Expense Input Recommendations
- Molecular Pathology – CPT 2012 Tier 1 and Tier II Recommendations
- Pacemaker or Pacing Cardioverter-Defibrillator – 2012 Bundled CPT Code Recommendations
- Psychoanalysis – 4th Five-Year Review Recommendation
- Update on Review of RUC's Multi-Specialty Points of Comparison (MPC) Codes
- Positioning Time in Non-Manipulation Fracture Codes

Chronic Care Coordination Workgroup – Implementation and Initial Recommendations

Immediately following our meeting with you on July 29, 2011, the AMA worked to create a joint workgroup of CPT Editorial Panel and RUC members to consider specific alternatives to a re-review of the valuation of 91 Evaluation and Management (E/M) services. The workgroup, named the Chronic Care Coordination Workgroup (C3W), will provide strategic direction to the CPT and RUC in response to the CMS request to address the adequacy of coding and valuation of care coordination services and management of chronic diseases. The following individuals will participate on the C3W:

Name	CPT/RUC	Position within Committee	Specialty
Al Bothe, MD	CPT & RUC	CPT Liaison to the RUC	General Surgery
Katherine Bradley, RN, PhD	HCPAC	Former HCPAC Member	Nursing
Kenneth Brin, MD	CPT	Vice Chairman	Cardiology
Jane Dillon, MD	RUC	Alternate Member	Otolaryngology
Richard Duszak, MD	CPT	Member	Radiology
David Ellington, MD	CPT	Member	Family Medicine
David Hitzeman, DO	RUC	Member, Vice Chair of Administrative Subcommittee	Osteopathic Medicine
Peter Hollmann, MD	CPT	Chairperson	Geriatrics
Doug Leahy, MD	RUC	Alternate Member	Internal Medicine
Barbara Levy, MD	RUC	Chairperson	Gynecology
Chad Rubin, MD	RUC	Alternate Member	General Surgery
Peter Smith, MD	RUC	Member	Thoracic Surgery
Arthur Traugott, MD	RUC	Vice Chairman	Psychiatry
Ken Simon, MD Edith Hambrick, MD		CMS Observers (Doctor Simon is a voting member of CPT Editorial Panel)	

The C3W has convened several conference calls and convened one face-to-face meeting. We were particularly pleased that CMS staff and medical officers participated in these meetings. It is imperative that the Workgroup understand the limitations and obstacles that preclude the Agency from recognizing separate payment for existing care coordination CPT codes, particularly those already assigned values and ready for immediate implementation. An immediate solution to incentivize care coordination is required, and it is, therefore, critical that medicine and CMS work closely together to ensure consensus and effective implementation.

We are pleased to announce that the C3W has reached consensus that the CPT Editorial Panel and the RUC should work toward coding and payment solutions that promote care coordination and team based care. The Workgroup also recognizes that a number of services, already described in CPT and valued by the RUC, provide a short-term opportunity to begin payment for better care coordination. The RUC does not fully understand all of the CMS rationale precluding payment

for these services in the past. However, if costs were of concern, CMS should consider the current environment in a reassessment. Not only will payment for these services save Medicare money in unnecessary office and emergency room visits, potential savings in Medicare Parts A and D will also offset upfront payment for non-face-to-face-services. In addition, the RUC's work on misvalued codes provides an opportunity to offset the costs, negating any impact to the Medicare conversion factor.

The RUC urges CMS to consider immediate implementation of the previous RUC recommendations for the following services on January 1, 2012:

Anticoagulant Management (CPT Codes 99363 and 99364)

In 2007, the CPT Editorial Panel created the following CPT codes to describe anticoagulant management:

99363 *Anticoagulant management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; initial 90 days of therapy (must include a minimum of 8 INR measurements)*

99364 *Anticoagulant management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; each subsequent 90 days of therapy (must include a minimum of 3 INR measurements)*

CMS has published relative values for these codes, based on information provided by the RUC, which would result in nominal payment ($41 per month for initial 90 days and $14 per month for subsequent 90 days of management). However, CMS has to date considered these services "bundled" into E/M and not separately paid.

Immediate implementation of CPT codes 99363 and 99364 *Anticoagulant management* would signal that CMS is serious about providing incentives for care coordination. These services are also cost effective, eliminating unnecessary face-to-face physician services which are required as a substitute to a more common sense strategy to pay for the management of these patients. As stated in our earlier recommendations (and included in the attachments):

> *In 2001, the Centers for Medicare and Medicaid Services (CMS) stated that the standard of care for anticoagulant services was suboptimal and the current payment policy requires the physician to have the beneficiary schedule an office visit to discuss prothrombin time tests results and necessary adjustments to receive separate payment. Although it is clinically optimal for a physician to discuss results with a patient and make an adjustment during a face-to-face encounter under some circumstances, physicians often engage in these activities outside of a face-to-face encounter with the patient. The CPT Editorial Panel agreed with the specialty that bundling this post service time into the payment for the visit is unfair when physicians are managing patients on long-term anticoagulants. In addition, the Panel believed that CMS policy provides inadequate avenues for physicians to be paid for managing patients on long term anticoagulant and may contribute to the problem of underutilization of anticoagulant drugs that has adverse effects on the health of patients. Failure to*

> *receive anticoagulant drugs when indicated can increase patient risk of thrombosis and embolism, and under or over anticoagulation can increase patient risk of bleeding. The CPT Editorial Panel discussed the issue at its February 2006 meeting and created two new codes to allow the reporting of anticoagulant management services. To ensure appropriate utilization of these codes, the Panel added minimum International Normalized Ratio (INR) measurements, eight for the initial anticoagulant management and three for subsequent therapy, and stated that this service cannot also be reported with another Evaluation and Management (E/M) code.*

While unfortunate that CMS elected to deny separate payment of this important bundled service in the past, there is a new opportunity to consider implementation. In their comments related to the July 19 Proposed Rule on the 2012 Medicare Physician Payment Schedule, specialty societies ranging from primary care (American College of Physicians, American Academy of Family Physicians and American Geriatrics Society) to internal medicine subspecialties (Infectious Disease Society of America) to surgery (American College of Surgeons and American Academy of Otolaryngology – Head and Neck Surgery) united in their support of separate payment for anticoagulant management.

This proposal has the support of multiple specialty societies, and has many features that are completely aligned with the stated goals of CMS as it transforms the payment system into a vehicle for quality improvement and cost savings. There is ample evidence that better anticoagulation management can reduce thromboembolic and bleeding events that are devastating to Medicare Beneficiaries and add cost to health care. These anticipated outcomes would be an **easily measurable** expectation of implementing the anticoagulation codes.

This proposal would identify a discrete population of patients with a chronic condition that would have historical Medicare utilization data regarding Part A, B and D services. Upon initiation of funding, this patient population would be identified and ongoing health care utilization collected for comparison to this historical baseline. Additional comparisons could be made to Medicare Beneficiaries with similar conditions, but who are either not managed with the anticoagulation codes or who are being treated with newer, more expensive direct thrombin inhibitors whose cost effectiveness and outcome measures rely on limited clinical trial evidence.

Should these codes be funded, the RUC would be eager to participate in exploring the cost and quality measurement aspects of implementation with CMS, as the results may be generalizable to other planned interventions to link payment policy to anticipated positive outcomes. This highly feasible immediate implementation would also provide real experience to practicing physicians, organized medicine, and CMS in working toward other similar bundled care coordination codes. **The RUC recommends that CMS implement separate payment for CPT codes 99363 and 99364 *Anticoagulant Management* beginning January 1, 2012.**

Education and Training for Patient Self-Management (CPT Codes 98960-98962)

In 2006, the CPT Editorial Panel implemented three codes to describe patient education and training. CMS accepted direct practice expense inputs submitted by the RUC, however, the Agency implemented the codes as bundled within E/M services. These services are clearly separate and distinct from E/M, requiring 30 minutes of education provided by non-physician clinical staff.

98960 *Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient*

98961 *2-4 patients*

98962 5-8 patients

The vignette for 98960 is as follows and describes the patient that would benefit from care coordination and team based care:

> *A 60 year-old man with a symptomatic established illness or disease, e.g. diabetes or asthma, or the desire to delay disease co-morbidities, e.g. cardiovascular co-morbidities, is referred by a physician to a qualified, non-physician health care professional, e.g. RD or RN, for education/training.*

The estimated national payment for these services, based on CMS published relative values, range from $10-$26, dependent upon the number of patients in the education session. **Immediate implementation of the education and training services (CPT codes 98960-98962) is recommended to recognize the costs associated with team based service.**

Medical Team Conference (CPT Codes 99366-99368)

Another service that would be included in a medical home or global payment in the long-term, but could be implemented short-term to recognize team based care is the medical team conference (CPT Codes 99366-99368). When a physician is involved in a team conference with the patient and other health care professionals, an E/M service may be reported. However, if the patient is not present (CPT 99367), no separate reporting is allowed by Medicare. Non-physicians, such as dieticians, physical and occupational therapists, are not allowed to separately report the time that they spend in team conferences, whether the patient is present (CPT 99366) or not (CPT 99368). Similar to the education and training codes described above, these time-based team codes are important in capturing real costs to a physician's practice. **Immediate implementation of the medical team conferences (CPT codes 99366-99368) is recommended to recognize the costs associated with team based care.**

Telephone Services (CPT Codes 99441-99443 and 98966-98969)

While technical issues related to audit standards and appropriateness may have precluded CMS from considering separate payment for telephone service in the past, the CPT Editorial Panel's revisions for *CPT 2008* and the enclosed RUC's recommendations illustrate that there is a path forward to appropriately pay for these services. Documentation for these services is required and the instructions are clear:

> Telephone services are non-face-to-face evaluation and management (E/M) services provided by a physician to a patient using the telephone. These codes are used to report episodes of care by the physician initiated by an established patient or guardian of an established patient. If the telephone service ends with a decision to see the patient within 24 hours or next available urgent visit appointment, the code is not reported; rather the encounter is considered part of the preservice work of the subsequent E/M service, procedure, and visit.

Likewise, if the telephone call refers to an E/M service performed and reported by the physician within the previous seven days (either physician requested or unsolicited patient follow-up) or within the postoperative period of the previously completed procedure, then the service(s) are considered part of that previous E/M service or procedure. (Do not report 99441-99443, if reporting 99441-99444 performed in the previous seven days.)

99441 *Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion*

99442 *11-20 minutes of medical discussion*

99443 *21-30 minutes of medical discussion*

(For telephone services provided by a qualified nonphysician health care professional, see 98966-98968)

(Do not report 99441-99443 when using 99339-99340, 99374-99380 for the same call (s))

(Do not report 99441-99443 for anticoagulation management when reporting 99363-99364)

Relative values are already developed and published by CMS for these services. The CPT Editorial Panel would welcome the opportunity to clarify language to provide the assurance that CMS may require to consider implementation of these codes. CMS may also consider a modest roll-out of these services to beneficiary groups who may benefit the most from such care coordination. Another alternative is to cap the number of phone calls per beneficiary per month (eg, two calls per month). The concerns about misuse of phone calls should be alleviated in part by the ease of understanding by the Medicare patient of the involved service. Medicare beneficiaries will easily understand an Explanation of Benefits (EOB) statement that describes telephone calls and determine whether or not a call had been convened for the time stated clearly in the CPT short description (eg, 99441 *Phone E/M by Phys 5-10 minutes).*

The RUC recommends that CMS implement separate payment for Telephone Services (CPT Codes 99441-99443 and 98966-98969) beginning January 1, 2012.

Medical Home

We recognize that the recommendation to identify and pay for individual, fragmented CPT codes describing only components of overall care coordination may not be consistent with a systematic move to more global payment models. However, immediate needs require that such an approach be implemented while a more comprehensive approach is developed. One such comprehensive approach was the RUC's recommendations related to medical home (see attached). The descriptors for the medical home demonstration incorporated all of the individual care coordination tasks discussed in the above recommendations.

In May 2008, CMS applauded the RUC for its work on medical home. Yet, the demonstration project was never implemented and organized medicine has never received an explanation regarding the impediments to implementing this specific proposal. On September 26, 2011, CMS announced a new Comprehensive Primary Care Initiative, where partnering with private and other public payors, CMS proposes to implement a medical home payment model in 5-7 geographic locations in 2012. Unlike the demonstration project previously envisioned that allowed physicians to with various practice capabilities to participate, this new initiative is directed only at advanced primary care practices and payment amounts will be dependent on the complexity of the patient.

We are pleased that CMS is moving this issue forward in the new initiative. Great effort and expense has already been undertaken by many practices and organizations across our nation to work toward practice improvement through patient centered medical home. We believe that if CMS builds upon both these efforts, and the work that the RUC has already done in valuing the Patient Centered Medical Home, the outcome will lead to greater acceptance and success of this critical project. The Chronic Care Coordination Workgroup would benefit from a new conversation with CMS to better understand the concerns regarding the previously considered model and the decision-making that led to the structure of the new initiative. These discussions would also be helpful to the CPT Editorial Panel in considering how best to describe this model of team-based coordinated care.

CMS will note than in comments to the Proposed Rule on the 2012 Medicare Physician Payment Schedule, a wide range of specialties supported the RUC's efforts on medical home and proposed that this model be considered in lieu of a review of E/M valuation. We applaud CMS for moving in the direction of recognizing payment for medical home care coordination. However, a broader implementation is warranted. **We urge CMS to immediately engage with the CPT Editorial Panel and the RUC to clarify and resolve any issues that impede a broad and expedient implementation.**

The Chronic Care Coordination Workgroup will continue to convene over the coming months to provide strategic leadership to the CPT Editorial Panel and the RUC in addressing the coding and valuation of coordination of care and the prevention and management of chronic disease. **We urge CMS to immediately implement separate payment for anticoagulant management and other non face-to-face services to demonstrate that CMS is prepared to incentivize care coordination and foster delivery reform.**

Separate Payment for High Cost Medical Supplies (Balloon Sinuplasty for 2012)

The RUC has repeatedly requested that CMS create J codes for high cost supplies so that these expenses may be monitored closely and paid appropriately. The RUC submitted the following comment to CMS on August 24, 2011:

> ***Distinct Reporting for High Cost Disposable Supplies***
>
> The RUC has repeatedly called on CMS to separately identify and pay for high cost disposable supplies using distinct J codes, rather than bundle into the service described by CPT. There are approximately 20 supply items that CMS has priced in excess of $1,000, for example. **The RUC urges CMS to consider the**

establishment of J codes for high cost supplies. The pricing of these supplies should be based on a transparent process, where items are annually reviewed and updated.

CMS provided the RUC with the attached 2011 claims data for the CPT codes that include a supply item identified as costing more than $1,000 per unit. While the mean, mode, and median for each CPT code indicate that typically only one unit of service is billed, additional analysis was conducted on one specific family of services, balloon sinuplasty (CPT codes 31295-31297).

Balloon sinuplasty was reviewed by the Practice Expense Subcommittee and the RUC in February 2010. The committees assumed that one unit of service would be reported in estimating practice expense inputs. The RUC recommended one kit (either SA106 or SA107) per CPT code. CMS priced these kits at $2600 and $1295, respectively. Following implementation of the codes on January 1, 2011, anecdotal reports surfaced that multiple units of services were being reported and the corresponding number of kits were not utilized. CMS reviewed the first six months of claims data for 2011 and determined that the typical claim does include multiple units of service, as follows:

Code	billed in more than one unit	billed in more than 2 units
31295	57%	24%
31296	54%	21%
31297	74%	48%

The RUC again urges CMS to implement new policy that high cost supplies be assigned HCPCS codes (e.g. J codes) to better monitor appropriate payment. Further, the RUC recommends that CMS immediately remove the sinus surgery kit (SA106 and SA107) from the direct practice expense inputs for the procedure codes 31295-31297. CMS should instead create two new HCPCS codes to describe these sinus surgery kits to ensure that appropriate payment is made relative to the price of these supplies.

Kyphoplasty – Non-Facility Practice Expense Input Recommendations

In the July 19, 2011 Proposed Rule on the 2012 Medicare Physician Payment Schedule, CMS stated that stakeholders had requested the CPT codes 22523-22525 *Percutaneous Kyphoplasty* be priced in the non-facility setting. CMS suggested that the RUC might assess whether non-facility pricing is appropriate. The RUC does not believe that it is within the Committee's expertise to determine whether or not a service can be performed in the office setting safely or effectively. The RUC did solicit specialty societies to provide an opportunity for data collection and submission. The American College of Radiology and the Society for Interventional Radiology submitted direct practice expenses for the non-facility setting for these CPT codes. The RUC reviewed this information and the recommended practice costs are included in the attached submission.

Molecular Pathology – CPT 2012 Tier 1 and Tier II Recommendations

The RUC understands that CMS is currently reviewing the new molecular pathology section for *CPT 2012* to determine which services will be paid on the Medicare Physician Payment Schedule versus the Clinical Lab Fee Schedule. Throughout 2011, CMS has urged the specialty and the RUC to provide data to help CMS make an informed decision. While the RUC does not make recommendations regarding the assignment of a service to a particular payment schedule, the Committee did review a significant volume of data presented by the College of American Pathologists. Recommendations for the Tier I and Tier II Molecular Pathology services to be described in *CPT 2012* are included in the attached submission. The RUC considers all of these codes to be new technology.

Pacemaker or Pacing Cardioverter-Defibrillator – 2012 Bundled CPT Code Recommendations

As part of the RUC's efforts to recommend code bundling for services reported by the same physician on the same date of service, the CPT Editorial Panel created a new code structure for pacemaker and cardioverter defibrillators for *CPT 2012*. The RUC submitted interim recommendations to CMS for these services in May 2011. At the September 22-24 RUC meeting, the Committee reviewed new survey data from cardiologists and has formulated revised recommendations. The revised RUC recommendations for new CPT codes 33212-33231 are included in the attached submission.

Psychoanalysis – 4th Five-Year Review Recommendation

CMS referred 90845 *Psychoanalysis* to the RUC as part of the 4th Five-Year Review of the RBRVS. In October 2010, the RUC referred the entire psychiatry section to the CPT Editorial Panel for further review. The Editorial Panel and the specialties involved all agreed that no further revision is needed for psychoanalysis. Therefore, the specialty presented their data for this service to the RUC. The RUC recommendations for CPT code 90845 are included in the attached submission.

Update on Review of RUC's Multi-Specialty Points of Comparison (MPC) Codes

In the *Final Rule* for the 2011 Medicare Physician Payment Schedule, CMS requested that the RUC review high volume services included on the RUC's Multi-Specialty Points of Comparison (MPC). The RUC has engaged in a more comprehensive review of the MPC, reconstructing the document to ensure that it includes true cross-specialty services. Several of the specific codes identified by CMS were scheduled for review at the September 2011 RUC meeting, with specialty society data submitted. Review of each of the following codes, however, led to significant concerns with the survey data, and in some cases, coding and payment policy for the individual codes. The RUC recommended the following course of actions for these services.

31231 *Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)* – Re-survey for the February 2012 RUC meeting with improved vignette to describe the typical unilateral vs. bilateral and better define the work of the involved local anesthetic in the survey instrument.

43239, 45380, 45385 *GI Endoscopy Services* – The specialty societies representing gastroenterology presented that appropriate surveys could not be conducted until after the specialty had an opportunity to resolve payment policy issues related to the provision of moderate

sedation. The RUC understands that gastroenterology will be working with the CPT Editorial Panel and CMS to resolve this coding and payment policy question as it relates to all of GI endoscopy services (120+ services). In the meantime, the RUC will remove all such services from the MPC. The specialty societies indicated that they plan to engage with the RUC on a workplan to survey all 120+ codes once the issues related to moderate sedation have been addressed.

77003 *Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, subarachnoid)* – The RUC noted many issues with the survey conducted for this service that is performed concurrently with an injection procedure. The specialties did not include the new 2012 CPT descriptor in the survey and there were issues related to the clinical vignette. The RUC urged the specialty to develop a new vignette and instructions to inform the respondent that the injection is reported separately. The Research Subcommittee will review the revised vignette and instructions prior to the survey data collection for the February 2012 RUC meeting.

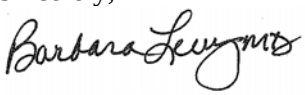
Positioning Time in Non-Manipulation Fracture Codes

In the June 6, 2011, *Proposed Rule* for the 4th Five-Year Review of the RBRVS, CMS requests that the RUC examine all the non-manipulation fracture codes to determine if positioning time was incorporated into the work RVU for the codes and if so, whether the need for positioning time was documented.

The American Academy of Orthopaedic Surgeons (AAOS) submitted a letter to the RUC explaining that of the 50 non-manipulation fracture codes, only 5 have been reviewed by the RUC and most included 2 minutes of positioning time. The time was documented in the service descriptions. Magnitude estimation was utilized in developing the work relative values for these services. The remaining 45 codes were part of the Harvard study and did not include any positioning time. **The RUC agrees with the AAOS assessment included in this submission, recognizing that the services were valued using magnitude estimation, not via a building block method. The two minutes of positioning time was documented in the service descriptions for the few individual services reviewed by the RUC.**

The RUC appreciates the opportunity to provide comment and recommendations related to the 2012 Medicare Physician Payment Schedule. If you have any questions regarding this submission, I would welcome the opportunity to speak to you personally, in particular related to our continuing work on care coordination. Of course, your staff may also contact Sherry Smith at the AMA for clarification regarding these recommendations.

Sincerely,



Barbara S. Levy, MD

cc: RUC Participants

Attachments

AMA
AMERICAN MEDICAL ASSOCIATION

American Medical Association
515 N. State Street
Chicago, Illinois 60654

ama-assn.org
312.464.5000

October 27, 2011

Donald Berwick, MD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1524-P
Mail Stop C4-26-05
7500 Security Blvd
Baltimore, MD 21244-1850

Subject: RUC Recommendations for Consideration for CMS Requests

Dear Doctor Berwick:

The American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC) submits the enclosed recommendations for work and direct practice expense inputs to the Centers for Medicare and Medicaid Services (CMS). The RUC is a committee of physician volunteers exercising its first amendment right to petition CMS to consider a number of improvements to the Resource-Based Relative Value Scale (RBRVS). These recommendations are a component of the RUC's consideration of services that were identified as potentially misvalued. The RUC is fully committed to this ongoing effort to improve relativity in the work, practice expense, and professional liability insurance values.

The enclosed recommendations result from the RUC's review of physicians' services from the September 22-25, 2011 meeting and include:

- *Harvard Valued, Utilization greater than 30,000* – The RUC submits recommendations for 43 high volume services that were previously reviewed under the Harvard research in the 1980s.

- *Multi-Specialty Points of Comparison (MPC) List* – In the *Final Rule* for the 2011 Medicare Physician Payment Schedule, CMS requested that the RUC review high volume services included on the RUC's Multi-Specialty Points of Comparison (MPC). The RUC has engaged in a more comprehensive review of the MPC, reconstructing the document to ensure that it includes true cross-specialty services. Several of the specific codes identified by CMS were scheduled for review at the September 2011 RUC meeting, with specialty society data submitted. Review of each of the following codes, however, led to significant concerns with the survey data, and in some cases, coding and payment policy for the individual codes. The RUC recommended the following course of actions for these services.

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- *Codes Reported 75% or More Together Screen* –The RUC submits recommendations on four codes that were identified through the Codes Reported 75% or more Together Screen. This submission includes recommendations on:

    - Shoulder Arthroscopy (29824, 29827 and 29828) – the RUC affirmed the current work RVUs for these codes as the work does not overlap with CPT code 29826 which will be an add-on code beginning January 1, 2012

    - Introduction of Catheter (36010) – Due to the utilization shifts which will occur because of the creation of the new IVC filter codes (37191-37196 and 37619) which were recently bundled, the RUC reviewed codes 36140 *Introduction of needle or intracatheter; extremity artery* and 36010 *Introduction of catheter, superior or inferior vena cava* and agreed with the specialty society that these services should be reviewed in two years after utilization data and codes reported together data are available.

Thank you for your careful consideration of the RUC's recommendations. We look forward to continued opportunities to offer recommendations to improve the RBRVS.

Sincerely,

Barbara S. Levy, MD

cc: Edith Hambrick, MD
Ryan Howe
Christina Ritter
Ken Simon, MD
Elizabeth Truong
Sara Vitolo
RUC Participants