AMA/Specialty RVS Update Committee
Meeting Minutes
April 24-25, 2009

I. Welcome and Call to Order

Doctor William Rich called the meeting to order on Friday, April 24, 2009, at 8:00 am. The following RUC Members were in attendance:

William Rich, MD (Chair)
Bibb Allen, MD
Michael D. Bishop, MD
James Blankenship, MD
R. Dale Blasier, MD
Joel Bradley, MD
Ronald Burd, MD
Thomas Cooper, MD
John Gage, MD
David Hitzeman, DO
Peter Hollmann, MD
Charles F. Koopmann, Jr., MD
Gregory Kwasny, MD
Walt Larimore, MD
Barbara Levy, MD
Brenda Lewis, DO
J. Leonard Lichtenfeld, MD
Lawrence Martinelli, MD
Bill Moran, Jr., MD
Gregory Przybylski, MD
Marc Raphaelson, MD
Daniel Mark Siegel, MD
Lloyd Smith, DPM
Peter Smith, MD
Samuel Smith, MD
Susan Spires, MD
Arthur Traugott, MD
James Waldorf, MD
Maurits Wiersema, MD
Allan Anderson, MD*
Sanford Archer, MD*
Dennis M. Beck, MD*
Edward Bentley, MD*
Bruce Deitchman, MD*
Emily Hill, PA-C*
William J. Mangold, Jr., MD*
Daniel McQuillen, MD*
Scott D. Oates, MD*
Julia Pillsbury, MD*
Sandra B. Reed, MD*
Chad Rubin, MD*
Steven Schlossberg, MD*
Stanley Stead, MD*
Robert Stomel, DO*
J. Allan Tucker, MD*
George Williams, MD*

*Alternate

II. Chair's Report

Doctor Rich made the following general announcements:

- Financial Disclosure Statements for each issue must be submitted to AMA staff prior to its presentation. If a form is not signed prior to the presentation, the individual will not be allowed to present.
- Presenters are expected to announce any conflicts or potential conflicts, including travel reimbursement paid by an entity other than the specialty society, at the onset of their presentation.
- Before a presentation, any RUC member with a conflict must state their conflict and recuse themselves from discussion and vote of the issue.
- RUC members or alternates sitting at the table may not present or advocate on behalf of their specialty.

- All RUC Advisors are required to sign the attestation statement and submit it with their recommendations to be incorporated into the agenda book.
- Doctor Rich welcomed the CMS staff and representatives attending the meeting, including:
    - Edith Hambrick, MD, CMS Medical Officer
    - Whitney May, Deputy Director, Division of Practitioner Services
    - Ken Simon, MD, CMS Medical Officer
- Doctor Rich welcomed the following Medicare Contractor Medical Director:
    - Charles Haley, MD
- Doctor Rich welcomed Rebecca J. Patchin, MD, Chair-Elect of AMA Board of Trustees
- Doctor Rich welcomed Iola D'Souza of the Government Accountability Office.
- Doctor Rich welcomed Kevin Hayes of the Medicare Payment Advisory Commission.
- Doctor Rich announced the members of the Facilitation Committees:

Facilitation Committee 1	Facilitation Committee 2	Facilitation Committee 3
David Hitzeman, DO (Chair)	Gregory Przybylski, MD (Chair)	Charles Koopmann, MD (Chair)
Joel Bradley, Jr., MD	James Blankenship, MD	Bibb Allen, MD
Michael Bishop, MD	John Gage, MD	Dale Blasier, MD
Gregory Kwasny, MD	Peter Hollmann, MD	Ron Burd, MD
Barbara Levy, MD	Brenda Lewis, MD	Thomas Cooper, MD
Lawrence Martinelli, MD	J. Leonard Lichtenfeld, MD	Emily Hill, PA-C
Bill Moran, MD	Arthur Traugott, MD	Walt Larimore, MD
Eileen Moynihan, MD	James Waldorf, MD	Daniel Mark Siegel, MD
Lloyd Smith, DPM	Jane White, PhD, RD	Samuel Smith, MD
Peter Smith, MD	William Mangold, Jr, MD	Susan Spires, MD
Maurits Wiersema, MD	Marc Raphaelson, MD	Robert Zwolak, MD
	Joseph Schlecht, DO	

- Doctor Rich welcomed the following individuals as observers at the January 2009 meeting:
    - Debra Abel – American Academy of Audiology
    - Margie Andreae, MD – American Academy of Pediatrics
    - Rasa Balaisyte – American Society of Neuroradiology
    - Robert Barr – American Society of Neuroradiology
    - J. Daniel Bourland, PhD – American Society for Therapeutic Radiology and Oncology
    - Darryl Bronson – American Academy of Dermatology
    - Brooks Cash – American Gastroenterological Association
    - Melissa Cinden – American Speech-Language-Hearing Association
    - Gregory DeMeo – American College of Obstetricians and Gynecologists
    - Maurine Dennis – American College of Radiology
    - Naakesh Dewan – American Psychiatric Association
    - Becky Dolan – American Academy of Pediatrics
    - Yolanda Doss – American Osteopathic Association
    - Thomas Eichler, MD – Americna Society for Therapeutic Radiology and Oncology
    - Martha Espronceda – American Society for Terapeutic Radiology and Oncology
    - Kim Fischer, MD – American College of Obstetricians and Gynecololgists
    - Jennifer Frazier - American Society for Therapeutic Radiology and Oncology

- Kim French – American College of Chest Physicians
- George Fueredi, MD – Society of Interventional Radiology
- Emily Gardner – American College of Cardiology
- Denise Garris – American College of Cardiology
- Richard Gilbert, MD – American Urological Association
- Steve Goetsch, PhD – American Society for Therapeutic Radiology and Oncology
- John Goodson – American College of Physicians Robert Hall – American Association of Hip and Knee Surgeons
- Lawrence Green, MD – American Academy of Dermatology
- Janis Gregory – American Urological Association
- Kelly Haenlein – American Academy of Dermatology
- Robert Hall, MD – American Association of Hip and Knee Surgeons
- David Halsey, MD – American Association of Hip and Knee Surgeons
- Richard Hamburger, MD – Renal Physicians Association
- Richard Hogan – American Speech-Language-Hearing Association
- Dawn Hopkins – American College of Cardiology
- Charles Hutchinson, MD – College of American Pathologists
- Jenny Jackson – American Society of Plastic Surgeons
- Chris Jones, MD – American College of Cardiology
- Lisa Kaplan, JD – American Academy of Physical Medicine and Rehabilitation
- Clifford Kavinsky, MD – American College of Cardiology
- Kristi Keil – American College of Obstetricians and Gynecologists
- Paul Knechtges – American College of Radiology
- Wayne Koch – American College of Physicians
- Carrie Kovar – American College of Cardiology
- Kevin Kovitz, MD – American College of Chest Physicians
- Rachel Kramer – Society of Interventional Radiology
- Alexander Mason, MD – North American Spine Society
- Faith McNicholas, CPC – American Academy of Dermatology
- Stephen McNutt – American Society for Therapeutic Radiology and Oncology
- Lisa Miller-Jones – American College of Surgeons
- Mary Moller – American Nurses Association
- Gerald Neidzwiecki, MD – Society of Interventional Radiology
- Dee Nikjeh – American Speech Language Hearing Association
- David O'Brien, MD – North American Spine Society
- Vinita Ollapally – American College of Surgeons
- Paul Pessis – American Speech-Language-Hearing Association
- Lisle Poulsen – American Academy of Dermatology
- John Ratliff, MD – American Association of Neurological Surgeons
- Samuel Reynolds – American Society for Gastrointestinal Endoscopy
- Christopher Saigal, MD – American Urological Association
- Matthew Sideman, MD – Society for Vascular Surgery
- Sunita Srivastava – Society for Vascular Surgery
- James Startzell, MD – American Association of Oral and Maxillofacial Surgeons
- Krista Stewart – American Association of Hip and Knee Surgeons
- Michael Sutherland – Society for Vascular Surgery
- Stuart Trembath – American Speech-Language-Hearing Association
- Edward Vates, MD – American Association of Neurological Surgeons

- Joanne Willer – American Academy of Orthopaedic Surgery
- Kadyn Williams – American Academy of Audiology
- Ayanna Wooding – College of American Pathologists

- Doctor Rich welcomed the following new members to the RUC:
  - Walter Larimore, MD – American Academy of Family Physicians (AAFP)
  - Marc Raphaelson, MD – American Academy of Neurology (AAN)
- Doctor Rich welcomed the following new alternate members to the RUC:
  - Sanford Archer, MD – American Academy of Otolaryngology – Head and Neck Surgery (AAO-HNS)
  - Terry Lee Mills, MD – American Academy of Family Physicians (AAFP)
- Doctor Rich and the entire RUC thanked Doctors Gregory Kwasny of the American Academy of Ophthalmology, Maurits Wiersema of the AGA/ASGE, Samuel Smith of the American Pediatric Surgical Association (APSA), and Dr. Katherine Bradley of the American Nurses Association (ANA) for years of service as they retire from their respective positions in the RUC process.
- Doctor Rich provided his perspectives for the RUC to consider as he departs the Committee. The presentation is attached to these minutes.

III. Director's Report

Sherry Smith made the following announcements:

- Future RUC meeting locations have been confirmed as follows:
  - October 1-4, 2009, RUC Meeting, Hyatt Regency, Chicago, IL
  - February 4-7, 2010 RUC Meeting, Hilton Bonnet Creek, Orlando, FL
  - April 28 – May 2, 2010 RUC Meeting, Renaissance Hotel, Chicago, IL
- Ms. Smith reported that the AMA Board of Trustees has appointed Doctor Barbara Levy to serve as the next chair of the RUC.

IV. Approval of Minutes for the January 29-31, 2008 RUC Meeting

The RUC approved the minutes after editorial revisions proposed by AAFP were made to the Nerve Conduction issue (Tab 18).

V. CPT Editorial Panel Update

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

- Doctor Hollmann announced that Marie Mindeman has been promoted within the AMA and will no longer be serving as the CPT Editorial Panel staff liaison to the RUC. Elizabeth Lumakovska has assumed those responsibilities and will be the new staff liaison to the RUC.
- The CPT Editorial Panel will be holding its next meeting in Rosemont, IL June 4-6, 2009. The Panel will be addressing several issues first raised by the RUC's Five Year Review Identification Workgroup.
- Doctor Hollmann also reported that the Panel has received some appeals from specialty societies following its February meeting. The changes resulting from these appeals are reflected in the materials presented to the RUC. Doctor Hollmann reminded the RUC

that an executive committee of the Panel will meet via conference call immediately after this meeting to address any requested changes.

- Lastly, Doctor Hollmann asked that the RUC and specialty societies review the descriptions of services within the Summary of Recommendation forms to ensure that the descriptions do not describe work that is ancillary to the work of the code. Any portions of work that are included as part of the sequence of events included in a service, but are separately reported should be clearly indicated.

VI. Centers for Medicare and Medicaid Services Update

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

- Doctor Simon reported that the agency is anticipating the confirmation of Governor Kathleen Sebelius as the Secretary of Health and Human Services.
- The Agency is in the midst of preparing the proposed rule for the 2010 physician payment schedule. Doctor Simon reported that once the Agency's leadership is approved, they will begin moving forward on several of the Agency's initiatives.

VII. Carrier Medical Director Update

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

- Doctor Haley reported that MAC contracts have been announced for the remaining five contracts on January 7, 2009. The losing bidders have opportunity to protest the awards, therefore the final contractors not yet finalized. The protest period will postpone the final awards for approximately two to three months.
- Three of the five contracts are under protest, which may result in corrective action, including a complete re-bidding process.

VIII. Washington Update

Kevin Hayes of MedPAC provided the following information regarding the Commission's recommendations to Congress.

- Currently, the Commission is between reports to Congress. A report was provided in March and another will be provided in June. The March report focused on physician payment, while the June report will discuss broader policy changes.
- In March, the Commission recommended a 1.1% update to Medicare conversion factor, rather than the estimated 21.5% decrease.
- The Commission also recommended an adjustment to the practice expense methodology used for equipment. The Commission recommended that the standard for use of expensive equipment be based on 45 hours per week rather than the current 25 hours per week. Expensive equipment was defined as anything that costs in excess of $1 million.
- The June report will include recommendations on topics such as self referrals, measurement of physician resource use, and establishment of Accountable Care Organizations (ACOs). The current payment system does not promote cooperation or coordination between hospitals and physicians. ACOs are designed to create incentives to coordinate services between the two and establish accountability standards based on quality and cost. ACOs would be formed out of integrated delivery systems, academic

health centers, and physician hospitals. Standards for quality and cost would be incentivized by a payment bonus or risk of lower payments.

- The report will also include information regarding the measurement of physician resource use. MedPAC first discussed this in 2005 and recommended that CMS measure resource use and share that information privately with physicians. The 2008 Medicare legislation mandated this process. June report will address some principles to guide implementation of the program. First, the Commission recommends that any process to track resource use by physician and episode of care be transparent. Second, the information should be actionable by physicians. That is, the reports should provide enough detail so that physicians may use it to improve their care and resource use.

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

- Ms. McIlrath reported that Kathleen Sebelius has been nominated to serve as the Secretary for Health and Human Services. The Senate will vote next week.
- The MedPAC recommendations are gaining traction with both public and private health policy makers and will likely play a large part in the reform of Medicare and privatized healthcare reform in the coming year.
- White House has created office of health reform, headed by Nancy-Ann DeParle, that has begun the process of developing recommendations for overall health system reform.
- Three reform summits have been held by the White House. These have resulted in a proposal to rebase the SGR, which would wipe out the current SGR deficit. The proposal includes $329 billion budgeted to do so, which would eliminate the projected 40% decrease in the conversion factor. The proposal also includes $634 billion for health system reform. The reforms are funded by Medicare cuts and higher income taxes. Of the Medicare cuts, physician payment is to be reduced by approximately $300 million.
- Senate committees have begun developing health system reform bills. Senators Baucus and Kennedy plan to develop separate bills within their respective committees and merge the bills into a unified proposal before sending them to the Senate floor.
- The House of Representatives is also working on a health system reform bill. However, the partisan divide in the House is problematic. Democrats are not including Republicans in early discussions and the Republicans are unilaterally rejecting the Democrats' proposals.
- The Senate is more likely to come up with a bi-partisan plan. It is likely going to be far more conservative and may provide enough reform to appease the more liberal House. It is expected that both the House and the Senate will develop their proposals before the August recess.
- AMA has been actively participating in the planning processes within the House, Senate, and White House. The AMA has launched a new newsletter on health system reform. Further, the AMA positions stressing that any controls on cost must address liability and anti-trust laws to be effective for physicians.
- The AMA is also working closely with specialties to create unified message to lawmakers.
- Given the present climate, it is unlikely that the projected 21.5% cut in the conversion factor will go into effect. However, in exchange for any positive update to the conversion factor or larger scale revamping of the SGR, there will likely be concessions in terms of cost and quality control measures or bundled payments demanded of physicians.

- The AMA is working to ensure that any such proposals are well-developed before implemented. The AMA has asked that any major system reform initiatives be based on demonstration projects to ensure success.

Kurt Gillis, AMA Senior Economist, provided the RUC with the following information regarding the 2008 preliminary Medicare claims data:

- The AMA has analyzed a preliminary version of the 2008 Medicare carrier claims summary file from CMS, which accounts for 97% of SGR spending, to compare estimated 2008 SGR spending to 2007 spending by type of service using CMS's BETOS categories.
- The analysis results indicate that the estimated change in SGR spending for 2008 is 2.8%. Per enrollee spending increased by 4.5%.
- Medicare physician fee schedule (MFS) spending also increased by 2.8% due to a decline in Medicare fee-for-service enrollment (-1.6% for 2008 according to CMS); a 0.9% average increase in pay for MFS services; and a 3.6% growth in volume/intensity per enrollee (similar to the rate for 2006 and 2007).
- Volume/intensity growth for imaging continued to be moderate – growth for advanced imaging was just 3%.
- Spending for SGR drugs was virtually unchanged for 2008. Spending for new drug codes was offset by reduced utilization and spending for other services.
- Dr. Gillis's presentation associated with this report is attached to these minutes.

IX. Relative Value Recommendations for CPT 2010

Adjacent Tissue Transfer (Tab 4)
Keith Brandt, MD, ASPS, Scott Collins, MD, AAD, Jane Dillon, MD, AAO-HNS, Wayne Koch, MD, AAO-HNS, Charles Mabry, MD, ACS, Christopher Senkowski, MD, ACS

CPT code 14300 *Adjacent tissue transfer or rearrangement, more than 30 sq cm, unusual or complicated, any area* was identified by the Five Year Review Identification Workgroup as potentially misvalued through its site of service anomaly screen in September 2007. The Workgroup reviewed all services that include inpatient hospital visits within their global periods, but are performed less than 50% of the time in the inpatient setting, according to recent Medicare utilization data. The RUC originally recommended a two-step action. First, the RUC removed the hospital visits from the service with no impact on the associated work RVU. Second, the RUC recommended that services be surveyed. Subsequent to being identified through the site of service anomaly screen, this code was identified through the CMS Fastest Growing Procedures Screen. The specialty societies agreed that the descriptor for this code did not accurately describe the work that is involved in the service as it did not differentiate between large and small defects therefore, the specialty society requested and the RUC agreed that the service be referred to CPT to clarify this issue. To address this concern the CPT Editorial Panel deleted CPT code 14300 and established two new codes to report adjacent tissue transfer of small and large defects.

14301 ***Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60 sq cm***
The RUC reviewed the survey times for 14301 and questioned the additional 7 minutes of time added to the pre-service time package selected. The specialty societies explained that they

added additional positioning time because these defects are occurring more frequently on difficult parts of the body including the face and hand and therefore the physician requires more time to position the particular body part to gain appropriate access to the surgical site. Based on this rationale, the RUC agreed that the additional positioning time associated with this service best reflected the pre-service time for this procedure. The RUC compared the surveyed code to its reference code 14060 *Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less* (Work RVU=9.07). The RUC noted that the surveyed code has more intra-service time as compared to the reference code, 100 minutes and 60 minutes respectively. Further, the RUC compared the surveyed code to another reference code MPC Code 58720 *Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)* (Work RVU=12.08). The RUC noted that the surveyed code has slightly more time than this reference code, 100 minutes and 90 minutes respectively. Further, the RUC compared the intensity complexity measurements of the surveyed code and the reference code and determined that the surveyed code requires more mental effort and judgment, more technical skill and physical effort to perform than the reference code. After making these comparisons, the specialty society explained that they did not have any compelling evidence to validate a higher work RVU for this service and therefore agreed that the impact of this code and 14302 need to be work neutral. Therefore based on utilization assumptions presented in the table below, the RUC agreed with the specialty societies recommended value of 12.47 work RVUs which is a value between the 25th percentile and the median. **The RUC recommends 12.47 Work RVUs for 14301.**

14302 ***Adjacent tissue transfer or rearrangement, any area; each additional 30 sq cm, or part thereof***

The RUC compared the surveyed code to its reference code 49568 *Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair)* (Work RVU=4.88). The RUC noted that the surveyed code has less intra-service time as compared to the reference code, 40 minutes and 52 minutes respectively. Further, the RUC compared the intensity complexity measurements of the surveyed code and the reference code and determined that the reference code requires more mental effort and judgment and more physical effort to perform than the surveyed code. After making these comparisons, the specialty society explained that they did not have any compelling evidence to validate a higher work RVU for this service and therefore agreed that the impact of this code and 14302 need to be work neutral. Therefore based on utilization assumptions presented in the table below, the RUC agreed with the specialty societies recommended value of 3.73 work RVUs, the survey median. **The RUC recommends 3.73 Work RVUs for 14302. The RUC requested that this code be reviewed in the future to review the volume of this service to ensure that the utilization assumptions were accurate. Therefore the RUC added the code to the New Technology List solely to review claims data to ensure only 15% of these services are reported with the add-on code.**

Work Neutrality Table

	RVW	Percentage	Utilization	Total RVUs
Current Data				
14300	13.26		14,138	**187,470 (Current RVUs)**
Projected Data				
14301 (100% of current utilization for 30-60 sq cm defects)	12.47	100.00%	14,138	176396
14302*1 (10% will be 60-90 sq cm defects)	3.73	10.00%	1,414	5273
14302*2 (4% will be 90-120 sq cm defects – requiring 14302 reported twice in addition to the base code)	7.46	4.00%	566	4219
14302*3 (1% will be 120-150 sq cm defects – requiring 14302 reported thrice in addition to the base code)	11.19	1.00%	141	1582
				187,470 (Projected RVUs)

PLI Crosswalks:
The RUC recommended that 14301 be crosswalked to the existing PLI of 14300 as they agree this is the most appropriate crosswalk.

Practice Expense:
The RUC reviewed the specialty societies' practice expense inputs for these services and with the exception of the addition of a medical supply recommend the proposed practice expense inputs which include practice expense inputs in the facility and non-facility setting for 14301 and no practice expense inputs for 14302 as it is typically performed in the facility setting.

Multi-Layer Compression System Application (Tab 5)
Charles Mabry, MD, ACS, Robb Mothershed, DPM, APMA, Gary Seabrook, MD, SVS, Christopher Senkowski, MD, ACS, Matthew Sideman, MD, SVS, Frank Spinosa, DPM, APMA, Erik Van Doorne, APTA, Robert Zwolak, MD, SVS

In February 2009, the CPT Editorial Panel created a new code to describe treatment of chronic venous insufficiency with ulceration with multi-layer compression strapping systems.

The RUC reviewed the specialty society survey data for code 29581 *Application of multi-layer venous wound compression system, below knee* and compared it to reference code 29580 *Unna boot* (work RVU = 0.55, 8 minutes pre-service time, 12 minutes intra-service time and 7 minutes immediate post-service time). The RUC determined that 29581, application of a multi-layer compression system is more intense and complex and requires more time to apply than 29580, a single layer zinc-oxide ointment containing strapping system. The multi-layer systems come with very specific instructions for use and the various layers must be applied in a bias pattern with respect to one another. The specialty society indicated and the RUC agreed that

pre-service package 5 – Non-Facility procedure without sedation/anesthesia (7 minutes) is appropriate, reflecting that the typical patient requires more complex dressings, has a larger ulcer and advanced surrounding venous skin. The survey respondents indicated an intra-service time of 15 minutes, 3 minutes more than 29580, which the specialty society and RUC agreed was appropriate to apply this multi-layer system. Additionally, the RUC agreed with the specialty society recommended immediate post-service time of 5 minutes, noting that the survey respondents indicated that this is lower than 29580 by 2 minutes even though a thorough neurovascular evaluation must be performed after application of this tight multi-layer system.

The specialty society indicated and the RUC agreed that the survey 25th percentile work RVU of 0.60 appropriately accounted for the physician work and time required to perform 29581 and placed this service in the proper rank order. The RUC also compared 29581 to a slightly more intense MPC reference code 11056 *Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 to 4 lesions* (work RVU = 0.61) to further support this work RVU. **The RUC recommends the survey 25th percentile, 0.60 work RVU for 29581.**

Practice Expense
The RUC reviewed the practice expense and made minor edits to the medical supplies for code 29581**.**

Fiducial Marker Placement (Tab 6)
Facilitation Committee #3
Paul Knechtges, MD, ACR, Kevin Kovitz, MD, ACCP, Burt Lesnick, MD, ACCP, Scott Manaker, MD, ACCP, Geraldine McGinty, MD, ACR, Gerald Niedzwiecki, MD, SIR, Alan Plummer, MD, ATS, Zeke Silva, MD, ACR, Sean Tutton, MD, SIR, Robert Vogelzang, MD, SIR

Stereotactic radiosurgery (SRS) is now performed throughout the entire body as existing technology is being utilized in an array of different permutations with variable physician and clinician collaboration models. Currently, there are CPT codes for fiducial placement for the prostate, brain, and spine, however the FDA has approved SRS to be performed for lesions, tumors and conditions anywhere in the body. Current coding schemes do not accurately reflect the components, shared work, and reality that multiple clinicians contribute to the delivery of this complex services, and thoracic and abdominal SRS have become more common over the past several years for treatment of inoperable tumors. In February 2009, the CPT Editorial Panel developed two new codes to cover fiducial placement in the thorax and abdomen and one code to describe electromagnetic navigation bronchoscopy of the pulmonary tract for the purposes of placing radiosurgical markers for SRS or for the purposes of placing dye markers for surgical assistance in video-assisted thoracic surgery (VATS) procedures.

31626 ***Bronchoscopy, rigid or flexible, including fluoroscopic guidance; with placement of fiducial markers, single or multiple***
The RUC reviewed the specialty survey results from 38 pulmonologists. The survey respondents chose CPT code 31629 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)* (Work RVU = 4.09, 000 day global) as the key reference service. Code 31626 is typically performed in the facility setting and is considered straight forward requiring sedation/anesthesia care, much like its reference service. The survey respondents indicated a median physician work relative value slightly higher than the reference code, with similar physician complexities and intensities. The survey respondents indicated that the intra-

service period is 15 minutes longer for 31626 than reference code 31629 because precision is required to inject dye markers into the soft lung tissue. The RUC agreed with the survey respondents median work relative value of 4.16 which provides for the proper work valuation and rank order for this new service in comparison to the reference code. **The RUC recommends a physician work relative value of 4.16 RVUs for new code 31626.** Moderate sedation is also required for this service and it will be displayed in appendix G for CPT 2010.

32553 ***Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-thoracic, single or multiple***

The RUC reviewed the specialty's survey results carefully and concurred that the appropriate pre-service time package for this service should reflect a straightforward patient and procedure with sedation/anesthesia care, pre-time package 1b. This change aligns the physician time and work with similar services such as new code 31626 *Bronchoscopy, rigid or flexible, including fluoroscopic guideance; with placment of fiducial markers, single or multiple* (recommended Work RVU = 4.16, 000 day global), however the RUC concurred that this new service requires less work to perform as it does not involve a bronchoscopy. The RUC also reviewed the specialties key reference service 32998 *Ablation therapy for reduction or eradication of one or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, radiofrequency, unilateral* (Work RVU = 5.68, 000 day global) in relation to new code 32553, and agreed 32998 required somewhat similar techniques; however, the service is much more complex, and intense, and required more physician time. 32998 was surveyed having 60 minutes of intra-service time whereas 32553 was indicated to have 45 minutes. In addition to the specialty's key reference service, the RUC reviewed another similar service 31628 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with transbronchial lung biopsy(s), single lobe* (Work RVU = 3.80, 000 day global, 40 minutes intra-service time) and agreed the physician work value of new code 32553 should be aligned with 31628 as the surveyed physician time, intensities, and complexities were similar. Although a value of 3.80 RVUs is below the low of the specialty's surveyed RVW results the RUC agreed it is appropriate and preserves rank order amongst other similar services. **The RUC recommends a physician relative work value of 3.80 for CPT code 32553.** To support the relativity amongst services the committee also reviewed the work, time, and intensities of codes 32550 *Insertion of indwelling tunneled pleural catheter with cuff* (Work RVU 4.17, 000 day global) and 36556 *Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older* (Work RVU = 2.50, 000 day global).

49411 ***Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-abdominal, intra-pelvic (except prostate), and/or retroperitoneum), single or multiple***

The RUC reviewed the specialties survey results carefully and concurred that the appropriate pre-service time package for this service should reflect a straightforward patient and procedure with sedation/anesthesia care, pre-time package 1b.

49411 is similar to new code 32553. Although the median survey RVW for 32553 was 5.70 RVUs and 6.00 RVUs, the surveyed intra-service time for 49410 (40 minutes) is less then 32553 (45 minutes) and the intensity and complexity measures survey results indicated 32553 was more complex. The RUC also reviewed code 31630 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with tracheal/bronchial dilation or closed reduction of fracture* (work RVU = 3.81, 45 minutes intra-service time) in relation to the new code as well. After reviewing all of the survey data in its entirety, the RUC concurred that both 32553 and 49411 should have the same work relative value. **The RUC recommends a physician work relative value of 3.80 for CPT code 49411.**

New Technology
The RUC recommends that codes 31626, 32553, and 49411 be placed on the new technology list.

Direct Practice Expense Inputs
The practice expense direct inputs recommended by the specialty were reviewed carefully, edited slightly for appropriate clinical labor time, and approved for these services.

Chemical Pleurodesis (Tab 7)
Facilitation Committee #2
Kevin Kovitz, MD, ACCP, Burt Lesnick, MD, ACCP, Scott Manaker, MD, ACCP, Keith Naunheim, MD, STS, Alan Plummer, MD, ATS

In February 2009, the CPT Editorial Panel created two new codes and revised one to describe the instillation of a fibrinolytic agent and provide further specificity to chemical pleurodesis. Chemical pleurodesis is the instillation of a chemical to get the visceral pleura of the lung to stick to the parietal pleura of the chest wall so the lung will not collapse. This revision to the definition allows the service to also be reported for fibrinolysis using a fibrinolytic agent. The revision to the descriptor also includes chemical instillation for fibrionlysis. The current code, 32560 *Chemical pleurodesis (eg, for recurrent or persistent pneumothorax)* (2009 Work RVU = 2.19) by definition is specific to chemical pleurodesis and does not include fibrinolysis or the instillation of chemicals other than those to obtain symphysis of the visceral and parietal pleural surfaces for situations such as malignant pleural effusions or pneumothorax. The instillation of the fibrinolytic chemical is similar to the instillation of a pleurodesis agent or talc, the only difference is the type of chemical that is instilled into the chest. Fibrinolytics are designed to break up debris or fibrin within the chest thus freeing up an entrapped lung.

32560 ***Instillation, via chest tube/catheter, agent for pleurodesis (eg, talc for recurrent or persistent pneumothorax)***
The specialty recommended the survey 25th percentile, 2.00 work RVUs (lower than its current value in 2009 of 2.19 work RVUs), which the RUC agreed was too high. The RUC reviewed the recommended physician time for 32560, and after clarification from the specialty, it was agreed that pre-service time package 1A (Straightforward Patient/Procedure with No Sedation/Anesthesia) was appropriate however, because of the reviews of the chest radiograph and/or chest CT which is required given the location of the chest tube, status of lung inflation and potential presence of any residual fluid or air in the chest, the RUC agreed that an additional 5 minutes of pre-service evaluation time was required. The RUC also determined that the intra-service time as described by the specialty was best reflected with the surveyed median intra-service time, 20 minutes. After establishing the accurate service physician time (pre/intra/post=25/20/20), from the straightforward patient procedure without sedation/anesthesia pre-time standard and specialty survey, the RUC made comparisons to other codes with similar service times and intensities. These reference codes included 62311 *Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast* (Work RVU=1.54 and pre/intra/post times= 35/20/15), 32421 *Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent* (Work RVU = 1.54, 000 day global, pre/intra/post times= 10/28/10) and 47525 *Change of percutaneous biliary drainage catheter* (Work RVU=1.54 and pre/intra/post times=25/20/10). **Based on these comparisons, the RUC recommends a work RVU of 1.54 for code 32560.**

32561 ***Instillation(s), via chest tube/catheter, agent for fibrinolysis (eg, fibrinolytic agent for break up of multiloculated effusion); initial day***

The specialty recommended the survey 25th percentile of 1.80 work RVUs, which the RUC agreed was too high. The RUC reviewed the recommended physician time for 32561 and determined that the intra-service time as described by the specialty was best reflected with the surveyed median intra-service time, 15 minutes. After establishing the accurate service physician time (pre/intra/post=20/15/10), from the straightforward patient procedure without sedation/anesthesia and specialty survey, the RUC determined that the intra-service work intensity for 32561 is the same as 32560. Therefore, the RUC agreed to use a building block approach to value 32561. The RUC used the intra-service work per unit of time from 32560, 0.0309, and as there is a five minute difference in intra-service physician time between 32561 and 32560, removed 0.15 RVUs (0.0309 x 5 minutes) from the recommended value for 32560. This calculation results in 1.39 RVUs. This retains the relativity of the survey medians for these two services as well. The RUC further validated this recommended RVU by comparing the surveyed code to 36580 *Replacement, complete, of a non-tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access* (Work RVU=1.31 and pre/intra/post times=25/15/10), and 27096 (Work RVU = 1.40, 000 day global, pre/intra/post times= 10/25/5), and noted the similar intensities and service times. Based on these comparisons, **the RUC recommends a physician work relative value of 1.39 for CPT code 32561.**

32562 ***Instillation(s), via chest tube/catheter, agent for fibrinolysis (eg, fibrinolytic agent for break up of multiloculated effusion); subsequent day***

The specialty recommended the survey 25th percentile, 1.50 Work RVUs, which the RUC agreed was too high. The RUC reviewed the recommended physician time for 32562 and determined that the intra-service time as described by the specialty was best reflected with the surveyed median intra-service time of 10 minutes. After establishing the accurate service physician time (pre/intra/post=20/10/10), from the straightforward patient procedure without sedation/anesthesia pre-time package and specialty survey, the RUC determined that the intra-service work intensity for 32562 is the same as 32560. Therefore, the RUC agreed to use a building block approach to value 32562. The RUC used the IWPUT of 32560, 0.0309, and as there is a 10 minute difference in intra-service physician time between 32562 and 32560, removed 0.30 RVUs (0.0309 x 10 minutes) from the recommended value for 32560. This calculation results in 1.18 RVUs (1.54 – 0.30). This retains the relativity of the survey medians for these two services as well. The RUC further validated this recommended RVU by comparing the surveyed code to 67505 *Retrobulbar injection; alcohol* (Work RVU=1.27 and pre/intra/post times=25/10/5), 27096 (Work RVU = 1.40, 000 day global, pre/intra/post times= 10/25/5), and 36516 *Therapeutic apheresis; with extracorporeal selective adsorption or selective filtration and plasma reinfusion* (Work RVU = 1.22, 000 day global, pre/intra/post times = 25/15/10) and noted the similar intensities and service times. Based on these comparisons, **the RUC recommends a physician work relative value of 1.24 for CPT code 32562.**

Practice Expense

The RUC agreed that although these services are predominately performed in the inpatient facility setting, the services may be rarely performed in the non-facility setting. The RUC reviewed the direct practice expense inputs for the non-facility setting and recommended by the specialty society and made no edits other than adjust the assist physician time to be equal to 100% of the physician intra-service work time. The RUC agreed that there are no direct practice expense inputs in the facility setting for these services.

Work Neutrality
The RUC recommendations for this issue result in a work value savings to be redistributed via the conversion factor.

Ventricular Assist Devices (Tab 8)
Facilitation Committee #2
Joseph Cleveland, MD, STS and Keith Naunheim, MD, STS

In February 2009, the CPT Editorial Panel created three new codes to describe the replacement of ventricular assist devices (VAD). With the transition of VADs to longer term uses, it has become necessary to replace the VAD pump for mechanical failure or embolization. The three new codes describe the removal and replacement of intracorporeal and extracorporeal of VADs.

33981
The specialty society requested that code 33981 *Replacement of extracorporeal ventricular assist device, single or biventricular pump(s); single or each pump* be contractor priced. The specialty society determined that the work RVU from the survey results were not representative of the work involved in this procedure. The specialty society believes that the code and vignette are representative for the procedure, but that the survey respondents took extra work/factors outside the pump replacement descriptor for the code into account when valuing the procedure (such as cannula replacement). The specialty society determined that the procedure will be properly valued if it is surveyed with the entire family of codes. The specialty society plans to submit the rest of the family of VAD codes to CPT for review at the October 2009 meeting. **The RUC agrees with the specialty society and recommends that code 33981 be contractor priced.**

33982, 33983
The RUC reviewed codes 33982 *Replacement of ventricular assist device; implantable intracorporeal, single ventricle, without cardiopulmonary bypass* and 33983 *Replacement of ventricular assist device; implantable intracorporeal, single ventricle, with cardiopulmonary bypass* and had a thorough discussion regarding the specialty survey results for these two services. The RUC determined that the low performance rate of these services, low survey response rate and other typical methods of valuation (references codes/building block) rendered inappropriate work RVUs for these services. **Therefore, the RUC recommends that codes 33982 and 33983 be contractor priced.** The specialty society indicated that they intend to review the entire family of VAD codes to determine the next steps. The VAD replacement codes will be valued with the new VAD code family or as part of the 5-year review with identified VAD codes if appropriate.

93750
The RUC reviewed code 93750 *Interrogation of ventricular assist device (VAD), in person, with physician analysis of device parameters (eg, drivelines, alarms, power surges), review of device function (eg, flow and volume status, septum status, recovery), with programming, if performed, and report* and agreed with the specialty society that 93750 is comparable to reference service 95973, *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional*

30 minutes after first hour (List separately in addition to code for primary procedure) (work RVU = 0.92). However, the RUC noted that the reference service is a ZZZ global, whereas the surveyed code is a XXX global. The survey respondents indicated that 93750 does not require any pre-service or post-service time, making it similar to a ZZZ global code. As such, the RUC determined that 93750 is very similar to the reference service 95973. In addition, the two codes require identical intra-service time of 30 minutes. Therefore, the RUC agreed that the physician work and time required to perform both services is identical. **The RUC recommends a physician work RVU of 0.92 for code 93750.**

Practice Expense
The RUC reviewed and approved the direct practice expense inputs for code 93750 as recommended by the specialty society.

Arteriovenous Shunt Imaging (Tab 9)
Facilitation Committee #2
Paul Knechtges, MD, ACR, Geraldine McGinty, MD, ACR, Gerald Niedzwiecki, MD, SIR, Matthew Sideman, MD, SVS, Zeke Silva, MD, ACR, Sean Tutton, MD, SIR, Robert Vogelzang, MD, SIR, Robert Zwolak, MD, SVS

The RUC identified 36145, *Introduction of needle or intracatheter; arteriovenous shunt created for dialysis (cannula, fistula, or graft)* and 75790, *Angiography, arteriovenous shunt (eg, dialysis patient), radiological supervision and interpretation* through the Five Year Review Identification Workgroup's Codes Reported Together screen as they are reported together more than 95% of the time and referred to CPT for creation of a new bundled service. At its November 2008 meeting, the CPT Editorial Panel created three new codes to describe the work previously reported in 36145 and 75790. The Panel created: 36147, *Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report (includes access of shunt, injection(s) of contrast, and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava)* to describe the combined service; 36148, *additional access for therapeutic intervention (List separately in addition to code for primary procedure)*, an add-on service to describe instances where the practitioner requires additional access to the arteriovenous shunt; and 75791, *Angiography, arteriovenous shunt (dialysis fistula/graft), complete evaluation of dialysis access, including fluoroscopy, image documentation and report (includes injections of contrast and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava), radiological supervision and interpretation*, which describes the work previously reported with either 36147 or 75790.

36147
The specialty society presented the results of a survey of 68 vascular surgeons and interventional radiologists. Survey respondents indicated a median intra-service time of 45 minutes, which the specialty society expert panel and the RUC agreed was appropriate. In consideration of the physician time, the RUC noted that the total time of 36145 plus 75790 is 57 minutes (23 minutes and 34 minutes), though these services have never been RUC reviewed. The specialty noted that the typical patient has changed from a patient with a graft to a patient with a fistula. Fistulas are inherently more difficult to manage. Survey respondents also indicated that moderate sedation is inherent, as it is performed 73% of the time. The survey respondents indicated a median work RVU of 4.70, which the specialty expert panel noted was evidence that the typical patient had changed and is now more difficult. However, the specialty expert panel did not agree that this

was an appropriate valuation of the work, nor did they feel the survey 25th percentile work RVU was appropriate. Rather, the specialty recommended and the RUC agreed that the appropriate work RVU for 36147 is 3.72 RVUs. To calculate this value, the RUC reviewed the survey key reference service, 36558, *Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; age 5 years or older* (work RVU = 4.81, intra-service time = 30 minutes) and subtracted the value of the post-operative hospital visits within its global period. The visits include one 99212 (0.45) and one-half 99238 (0.64). 4.81 – 1.09 = 3.72. The RUC also noted that the current values of 36145 and 75790 are 2.01 and 1.84 (2.01 + 1.84 = 3.85), respectively and the correct value of 36147 should be slightly lower to account for any efficiencies by performing the procedures together. The RUC also compared the surveyed service to 36145, *Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access* (work RVU = 3.59, intra-service time = 45 minutes) and agreed that the two services are comparable, though 36147 is requires greater intensity, accounting for a slightly higher work RVU. **Therefore, the RUC recommends the new physician time as surveyed and a work RVU of 3.72 for CPT code 36147.**

36148

The specialty society presented the results of a survey of 45 vascular surgeons and interventional radiologists. The societies involved convened an expert panel as the surveyees indicated physician time which included pre and post service work for this add-on service, selected a key reference code 36558, *Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; age 5 years or older* (work RVU = 4.81), and indicated a median work RVU of 4.13 for 36148. Survey respondents also indicated that moderate sedation is inherent, as it is performed 74% of the time. The expert panel did not agree that the survey results appropriately reflected the time or work required to perform this procedure. The expert panel instead derived a work value of 1.00 for 36148 by dividing the existing work value of 36145, *Introduction of needle or intracatheter; arteriovenous shunt created for dialysis (cannula, fistula, or graft)* (work RVU = 2.01) by two. Currently, when an additional access is required, a physician will report an additional 36145, subject to a modifier 51 reduction of 50%. The new add-on code describes the same intra-service work originally reported by 36145, which was subjected to the 50% reduction. As such, the expert panel and the RUC agreed that one-half the current value is appropriate (2.01 / 2 = 1.00). The RUC also reviewed another reference service, 36620, *Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous),* (work RVU = 1.15, 7 minutes pre, 10 minutes intra, and 5 minutes post-service time). Though the specialty society agreed that the work of cannulating a poorly functioning dialysis graft or fistula is more difficult than placement of a routine arterial line, the RUC agreed that 36620 represents the most reasonable comparison. The specialties' expert panel posits that respondents may not have understood the complexities of add-on codes and modifier -51 exempt codes, which skewed the physician time and work values. The panel recommended and the RUC agreed that 15 minutes of intra-service time best reflects the time involved for 36148. **Therefore, the RUC recommends a work RVU of 1.00 and an intra-service time of 15 minutes with no pre and post service times for CPT code 36148.**

75791

The specialty society presented the results of a survey of 45 vascular surgeons and interventional radiologists. The survey respondents indicated a median intra-service time of 30 minutes. However, the specialties' expert panel agreed that this was slightly higher than required. The work involved in 75791 represents a very rare scenario. For a 75791, a patient is sent to the physician once dialysis has begun, but the fistula or graft is not functioning properly. The dialysis needle is still in place and the imaging is conducted through that access point. The specialty

commented that the overestimation of the intra-service time may also be due to the mix of specialties completing the survey. As such, the specialty recalculated the survey results between interventional radiologists and vascular surgeons based on utilization and revised their recommendations to a the median intra-service time of 25 minutes and the median work RVU of 1.71. To substantiate this recommendation, the RUC noted that the work of 75791 is very similar to that of 75790, though the intra-service time is slightly lower than the existing physician time of 34 minutes. Moreover, the existing physician work RVU of 75790 is slightly higher than the recommended work RVU, 1.84 versus 1.71, respectively. **Therefore, the RUC recommends a work RVU of 1.71 and an intra-service time of 25 minutes, with 15 minutes pre-service evaluation and 15 minutes immediate post-service time for CPT code 75791.**

Work Neutrality
The specialty society provided data to the RUC showing that the new coding structure will account for an overall decrease in work relative values for this family of services to be redistributed in the Medicare conversion factor. Currently, 36145 and 75790 are reported together approximately 95% of the time accounting for roughly 250,000 combined reporting. The specialty society estimates that 36147 will be reported approximately 188,000 times and 36148 will be reported 62,000 times. 75791 will only be reported on rare occasions (i.e., less than 1,000 per year).

Practice Expense
The RUC agreed that moderate sedation is inherent in 36147 and 36148. The supplies, equipment and clinical staff time were edited to reflect that moderate sedation is inherent.

Perforator Vein Ligation (Tab 10)
Charles Mabry, MD, ACS, Gary Seabrook, MD, SVS, Christopher Senkowski, MD, ACS, Matthew Sideman, MD, SVS, Robert Zwolak, MD, SVS

CPT code 37760 *Ligation of perforator veins, subfascial, radical (Linton type), with or without skin graft, open* was identified by the Five Year Review Identification Workgroup as potentially misvalued through its site of service anomaly screen in September 2007. The specialty societies agreed that this code was inappropriately being used to report a less extensive perforating vein operation stems therefore, the specialty society requested and the RUC agreed that the service be referred to CPT to clarify the descriptor of the existing code and create a new code to report a less extensive perforator vein ligation. To address this concern the CPT Editorial Panel editorially revised 37760 and established a new code to report 37761 which is a subfascial ligation of the perforator vein through a direct open surgical approach.

The RUC reviewed the survey data for 37761 and agreed with the specialty societies' recommendation for an additional 7 minutes of positioning time based on the need to get the patient in a position where the surgeon can target the lower extremity. The RUC compared the surveyed code to its reference code, 37500 *Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS)* (Work RVU=11.54). The RUC noted that the surveyed code has less intra-service time as compared to the reference code, 60 minutes and 90 minutes, respectively. In addition, the RUC compared the surveyed codes to another reference code, MPC code 36832 *Revision, open, arteriovenous fistula; without thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)* (Work RVU=10.50). The RUC noted that the surveyed code has less intra-service time as compared to the MPC reference code, 60 minutes and 90 minutes, respectively. Further, the RUC noted that the surveyed code required less technical skill, physical and mental effort and judgment to perform than the key reference

code. Therefore, based on these comparisons, the RUC agreed with the specialty societies' recommended 9.00 work RVUs, the survey median, for this procedure. **The RUC recommends 9.00 Work RVUs for 37761.**

CPT Recommendation:
During the presentation to the RUC, the specialty societies indicated that ultrasound guidance would be included in the work for this procedure. Therefore, the RUC recommends that a parenthetical be added following the descriptor for 37761 that indicates that ultrasound guidance should not be reported separately.

Practice Expense:
The RUC approved the practice expense inputs as recommended by the specialty societies 090 day global standards.

Work Neutrality:
The RUC recommendations for this issue will result in a work savings that should be redistributed in the Medicare conversion factor.

Pharyngeal Wall Resection with Flap (Tab 11)
Jane Dillon, MD, AAO-HNS, Wayne Koch, MD, AAO-HNS
The CPT Editorial Panel at the February 2009 Meeting revised code 42894 *Resection of pharyngeal wall requiring closure with myocutaneous or fasciocutaneous flap, or free muscle, skin or fascial flap with microvascular anastamosis* to include identification of fasciocutaneus flaps as well as pedicled flaps and use of microvascular anastomosis and requested that the parenthetic note be reconciled with the language in the listed codes to direct the user to the appropriate codes. The RUC reviewed the current service description of 42894 as it contains the sentence: "The flap is sewn to the pharyngeal defect using interrupted sutures in two layers" to ensure there is no overlap in work between 42894 and the flap repair service. The RUC determined that there is no overlap in work between 42894 and the flap repair services (15732, 17534, 15757 or 15758) and indicated that these flap repair service should be reported separately as indicated in the parenthetical. **The RUC recommends that the aforementioned sentence be removed from the intra-service description for code 42894.**

Laparoscopic Paraesophageal Hernia Repair (Tab 12)
Michael Edye, MD, SAGES, Charles Mabry, MD, ACS, Keith Naunheim, MD, STS, Charles Senkowski, MD, ACS

In February 2009, the Society of American Gastrointestinal and Endoscopic Surgeons (SAGES) requested to defer RUC review of this issue until April 2009 after the CPT Editorial Panel clarifies SAGES' October 2008 request to develop two new codes instead of one code to describe laparoscopic paraesophageal hernia repair. The CPT Editorial Panel reviewed this issue at its February 2009 meeting and created two new codes to describe the laparoscopic approach to repair of paraesophageal and diaphragmatic hernias with and without implantation of mesh.

43281
The RUC reviewed code 43281 *Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh* and compared it to key reference service 43279 *Laparoscopy, surgical, esophagomyotomy (Heller type), with fundoplasty, when*

performed (work RVU = 22.00, 80 minutes pre-time, 150 minutes intra-time and 30 minutes immediate post-time). The RUC reviewed the pre-service time and agreed with the specialty society that pre-service time package 4 – Facility Difficult patient/difficult procedure with some modifications was appropriate. The RUC agreed that an additional 12 minutes of positioning time was appropriate (15 minutes total positioning time) to reposition the patient from supine to modified lithotomy position after anesthesia is induced as well as adjust the operating room table and anesthesia lines so that the operative site is assessable for laparoscopic equipment/monitors, surgeon and assistants to visualize and perform the operation. The RUC also agreed to remove 5 minutes of scrub/dress/wait time (15 minutes total scrub/dress/wait time) as this was the median indicated by the survey respondents. The RUC determined that the intra-service time of 180 minutes and immediate post-service time of 30 minutes appropriately accounts for the physician time required to perform this service.

The RUC reviewed the survey intensity and complexity measures required for 43281 compared to key reference service 43279 and determined that 43281 is slightly more intense and complex. The specialty society indicated and the RUC agreed that the survey median work RVU of 26.50 appropriately accounts for the work required to perform this service. To provide additional support for this work RVU the specialty society indicated that code 43644 *Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)* (work RVU = 29.24) was also cited by the survey respondents as a reference service. The intensity required to perform 43644 is similar to code 43281, further 43644 has the same intra-service time but more post-operative work. If the additional 99232 visit and difference in office visits are subtracted the work RVUs for 43281 and 43644 is similar, 26.50 versus 26.85 respectively.

29.24 RVU for 43644
-1.39 one less 99232
-1.00 difference in office visit RVUs (2x99213 versus 1 each 99214, 99213, 99212
26.85

The RUC recommends the survey median work RVU of 26.50 for code 43281.

43282
The RUC reviewed code 43282 *Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh* and compared it to key reference service 43644 *Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)* (work RVU = 29.24, 75 minutes pre-time, 180 minutes intra-time and 30 minutes immediate post-time). The RUC reviewed the pre-service time and agreed with the specialty society that pre-service time package 4 - Facility Difficult patient/difficult procedure with some modifications was appropriate. The RUC agreed that an additional 12 minutes of positioning time was appropriate (15 minutes total positioning time) to reposition the patient from supine to modified lithotomy position after anesthesia is induced as well as adjust the operating room table and anesthesia lines so that the operative site is assessable for laparoscopic equipment/monitors, surgeon and assistants to visualize and perform the operation. The RUC also agreed to remove 5 minutes of scrub/dress/wait time (15 minutes total scrub/dress/wait time) as this was the median indicated by the survey respondents. The RUC determined that the intra-service time of 210 minutes and immediate post-service time of 30 minutes appropriately accounts for the physician time required to perform this service. Code 43282 requires an additional 30 minutes of intra-service time compared to key reference service 43644 and other upper GI laparoscopic bariatric procedures to account for the additional time to dissect and remove the sac, consider important components of adequate

repair, working high into the mediastinum along the esophagus in front of the aorta and in close proximity to the pleura and to sew the mesh.

The RUC reviewed the survey intensity and complexity measures required for 43282 compared to key reference service 43644 and determined that 43282 is slightly more intense and complex. The specialty society indicated and the RUC agreed that the survey median work RVU of 30.00 appropriately accounts for the work required to perform this service. Additionally, this recommendation, which is 3.50 work RVUs greater than 43281, accounts for the increased intra-operative time for mesh placement) and increased intensity for this more complex procedure. **The RUC recommends the survey median work RVU of 30.00 for 43282.**

New Technology
The RUC discussed how to ensure that 43281 and 43282 is not reported when repair of esophageal sliding hernia is performed. The specialty society indicated that they will address and provide correct coding education via a CPT Assistant article as well as the American College of Surgeons bulletin. The RUC recommends that codes 43281 and 43282 be placed on the new technology list to solely review the volume of these services in a couple years to ensure appropriate reporting..

Practice Expense
The RUC recommends the standard 090-day global direct practice expense inputs for 43281 and 43282.

Endoscopic Pancreatoscopy (Tab 13)
Joel Brill, MD, AGA, Nicholas Nickl, MD, ASGE

The CPT Executive Committee considered a request from the American College of Gastroenterology, the American Gastroenterological Association and the American Society of Gastrointestinal Endoscopy to revise the parenthetical following code 43273 to include code 43262 to the list of codes appropriately reported in addition to code 43273 *Endoscopic cannulation of papilla with direct visualization of common bile duct(s) and/or pancreatic duct(s) (List separately in addition to code(s) for primary procedure).*

The CPT Executive Committee questioned how the RUC considered sphincterotomy services and the frequency that sphincterotomy would be required for scope placement and therefore voted to reject the appeal and uphold the current position of the Panel pending determination by the RUC that sphincterotomy is not included in 43273. The RUC reviewed the background of the issue beginning with the addition of the code to CPT in February 2008 and discovered that the modifications to the parentheticals were changed by the CPT Editorial Panel after the survey initiation date. Therefore, the specialties developing recommendations for this code used the original parenthetical which included 43262 in their survey instrument. The RUC reviewed this service at its April 2008 meeting with 43262 included in the parenthetical and as a code listed in the summary of recommendation form as being a primary code for the add-on code. **Given this information, the RUC recommends that 43262 be added to the parenthetical following the descriptor for 43273 and that the intra-service description of work be modified as described below:**

After informed consent is obtained, the patient is brought to the therapeutic endoscopy suite. Sedation is administered intravenously, and the duodenoscope is introduced through the mouth with inspection of the esophagus, stomach and duodenum. Selective

cannulation of the bile duct is obtained followed by multiple views of the cholangiogram under fluoroscopy. A guidewire is passed such that the tip is in the proximal biliary tree, and a standard biliary sphincterotomy is performed, which is reported separately.

The cholangioscope is passed through the duodenoscope and into the biliary tree. Direct visualization is performed with careful inspection of the biliary and pancreatic epithelium. The mass lesion is identified and multiple biopsies are taken. The right and left intrahepatic biliary tree, common hepatic duct and common bile duct are all viewed. The cholangioscope is then withdrawn and then passed into the pancreatic duct. At the conclusion of the procedure, the cholangioscope is withdrawn and the physician proceeds with the remainder of the ERCP procedure.

Laparoscopic Longitudinal Gastrectomy (Tab 14)
Michael Edye, MD, SAGES, Charles Mabry, MD, ACS, Christopher Senkowski, MD, ACS

In October 2008, the CPT Editorial Panel created a new code to describe a complex anatomic and metabolic weight loss operation that has been increasingly used as a primary operation for morbid obesity.

The RUC reviewed code 43775 *Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy)*
and compared it to code *43771 Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only* (work RVU = 20.64, intra-service time = 120 minutes). The RUC reviewed the pre-service time and agreed with the specialty society that pre-service time package 4 FAC Difficult patient/difficult procedure with some modifications was appropriate. The RUC agreed that an additional 22 minutes of positioning time was appropriate (25 minutes total positioning time) to account for additional positioning and padding the morbidly obese patient in reverse Trendelenburg, including positioning the laparoscopic equipment/monitors so the surgeon and assistants may visualize and perform the operation. The RUC determined that the intra-service time of 120 minutes and immediate post-service time of 30 minutes appropriately accounts for the physician time required to perform this service and was identical to code 43771.

The specialty society indicated and the RUC agreed that the survey respondents over-estimated the physician work required to perform this service, as the survey median RVU would place this service out of rank order with this family of services. Therefore, the following building block was used to develop a relative value unit. Starting with code *43771 Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only* (work RVU = 20.64, intra-service time = 120 minutes), another gastric restrictive procedure with identical intra-service time but one less hospital visit, and adding one 99321 hospital visit to arrive at a work RVU of 21.40 for 43775 (20.64 + 0.76 = 21.40), which is less than the survey 25th percentile work RVU. Additionally, the specialty society indicated and the RUC agreed that one 99214 visit is necessary because the typical patient is nauseated and requires lengthy dietary and fluid balance education on the first post-operative visit. **The RUC recommends a work RVU of 21.40 for code 43775.**

The RUC also agreed with the specialty society's additional rationale comparing 43775 to survey respondents key reference service 43644 *Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)*

(work RVU = 29.24, intra-service time of 180 minutes) which has similar intensity and complexity measures. However, the survey data indicated 43775 will require 60 minutes less intra-service time and one less hospital day (99232) than 43644. By subtracting the 60 minutes less IWPUT and one less 99232 from 43644 the resulting work RVU is 21.37 (which is almost identical to the primary building block resulting RVU of 21.40).

Additional rationale:
29.24 RVU for 43644
-6.48 60 min less x 0.108 (IWPUT for 43644)
-1.39 1 less 99232
21.37

The RUC also compared 43775 to code 43330 *Esophagomyotomy (Heller type); abdominal approach* (work RVU = 22.06, 120 minutes intra-service time) which requires similar physician time and work. **The RUC recommends a work RVU of 21.40 for code 43775.**

New Technology
The RUC recommends that code 43775 be placed on the new technology list.

Practice Expense
The RUC recommends the standard 090-day global direct practice expense inputs for code 43775.

Fistula Plug (Tab 15)
Guy Orangio, MD, ASCRS

CPT converted a Category III code to a Category I code to report anal fistula repair with a fibrin plug, as this form of treatment has become more widely used.

The RUC reviewed the survey data for 46707 *Repair of anorectal fistula with plug (eg, porcine small intestine submucosa [SIS])* and agreed with the specialty society that an additional 7 minutes of positioning in the pre-service time period would be appropriate given that the patient needs to be placed in a prone jack-knife or dorsal lithotomy position and buttocks are effaced. The RUC compared the surveyed code to the key reference code 46280 *Surgical treatment of anal fistula (fistulectomy/fistulotomy); complex or multiple, with or without placement of seton* (Work RVU=6.28). The RUC noted that the surveyed code and its reference code have similar intra-service times, 40 minutes and 45 minutes, respectively. The RUC compared the intensity complexity measures of the surveyed code and reference code and noted that overall these services required equal amounts of technical skill, physical effort and mental effort to perform. However, the RUC did note that the intra-service time intensity is greater in the surveyed code as the surgeon must place a suture through the fistula track without disrupting the track integrity, attach the other end to the "plug" and then gently pull the plug through the fistula track with care until it is snug, whereas in the reference code a surgeon would place a fistula probe through the fistula track and cut the tissue above the probe and pass a seton through the fistula and tie the ends together. Based on these comparisons, the RUC agreed the specialty societies' recommended work RVUs for this procedure, 6.30 Work RVUs, the survey median. **The RUC recommends 6.30 Work RVUs for 46707.**

New Technology List:
As this service is currently being reported with a Category III code, the RUC recommended that this code be placed on the New Technology List.

Practice Expense:
The RUC approved the practice expense inputs as recommended by the specialty societies 090 day global standards.

Urodynamics Studies (Tab 16)
Facilitation Committee #1
James Giblin, MD, AUA, Richard Gilbert, MD, AUA, George Hill, MD, ACOG, Kristi Keil, MD, ACOG

In February 2008, the RUC identified 51726, 51772, 51795, and 51797 through the Codes Reported Together screen as they are reported together more than 95% of the time. The RUC referred to all four codes to CPT for creation of new bundled services and to reorganize the coding structure to reflect the typical procedures performed.

51727
The RUC reviewed the physician time for 51727 *Complex cystometrogram (ie, calibrated electronic equipment); with urethral pressure profile studies (ie, urethral closure pressure profile), any technique* and determined that an additional 13 minutes of pre-time package 5 Non-Facility Procedure without anesthesia, is necessary to capture evaluation and the placement of the foley and urodynamic cathethers. The specialty society indicated that the total pre-service time of 20 minutes, as indicated by the survey respondents is correct, but should all be captured in the pre-evaluation component. The specialty society recommended and the RUC agreed that an additional 5 minutes should be added to the survey intra-service time of 30 minutes, totaling 35 minutes, as it requires slightly more time than base code 51726 *Complex cystometrogram (eg, calibrated electronic equipment)* (work RVU = 1.71 and physician time of 25 minutes pre-, 30 minutes intra- and 15 minutes immediate post-service time) to perform the urethral pressure profile studies. The specialty society recommended and the RUC agreed that the survey immediate post-service time of 10 minutes is appropriate.

The RUC compared 51727 to 52000 *Cystourethroscopy (separate procedure)* (work RVU = 2.23 and 17 minutes pre, 15 minutes intra, and 10 minutes post time) and determined that urodynamics code 51727 is less intense. The RUC then reviewed reference code 70554 *Magnetic resonance imaging, brain, functional MRI; including test selection and administration of repetitive body part movement and/or visual stimulation, not requiring physician or psychologist administration* (work RVU = 2.11 and 15 minutes pre, 35 minutes intra, and 10 minutes immediate post-service time) and determined that 2.11 work RVUs is an appropriate crosswalk as these two services have similar service times and intensities. The RUC also, compared 51727 to 99215 *Office Visit, Established Patient* (work RVU = 2.00 and 5 minutes pre, 35 minutes intra, and 15 minutes post time). **The RUC recommends 2.11 work RVUs for 51727 and 20 minutes pre, 35 minutes intra and 10 minutes immediate post-service time.**

51728
The RUC reviewed code 51728 *Complex cystometrogram (ie, calibrated electronic equipment); with voiding pressure studies (ie, bladder voiding pressure), any technique* and determined that it requires the same physician work and physician time as 51727.

The RUC reviewed the physician time for 51728 and determined that an additional 13 minutes to pre-time package 5 Non-Facility Procedure without anesthesia, is necessary to capture evaluation and the placement of the foley and urodynamic cathethers. The specialty society indicated that the total pre-service time of 20 minutes, as indicated by the survey respondents is correct, but should all be captured in the pre-evaluation component. The specialty society recommended and the RUC agreed that an additional 5 minutes should be added to the surveyed intra-service time of 30 minutes, totaling 35 minutes, as it requires slightly more time than base code 51726 *Complex cystometrogram (eg, calibrated electronic equipment)* (work RVU = 1.71 and physician time of 25 minutes pre-, 30 minutes intra- and 15 minutes immediate post-service time) to perform the voiding pressure studies. The specialty society recommended and the RUC agreed that the survey immediate post-service time of 10 minutes is appropriate.

The RUC compared 51728 to 52000 *Cystourethroscopy (separate procedure)* (work RVU = 2.23 and 17 minutes pre, 15 minutes intra, and 10 minutes post time) and determined that urodynamics code 51727 is less intense. The RUC then reviewed reference code 70554 *Magnetic resonance imaging, brain, functional MRI; including test selection and administration of repetitive body part movement and/or visual stimulation, not requiring physician or psychologist administration* (work RVU = 2.11 and 15 minutes pre, 35 minutes intra, and 10 minutes immediate post-service time) and determined that 2.11 work RVUs is an appropriate crosswalkas these two services have similar service times and intensities. The RUC also, compared 51727 to 99215 *Office Visit, Established Patient* (work RVU = 2.00 and 5 minutes pre, 35 minutes intra, and 15 minutes post time). **The RUC recommends 2.11 work RVUs for 51728 and 20 minutes pre, 35 minutes intra and 10 minutes immediate post-service time.**

51729

The RUC reviewed the physician time for 51729 *Complex cystometrogram (ie, calibrated electronic equipment); with voiding pressure studies (ie, bladder voiding pressure), and urethral pressure profile studies (ie, urethral closure pressure profile), any technique* and determined that an additional 13 minutes to pre-time package 5 Non-Facility Procedure without anesthesia, is necessary to capture evaluation and the placement of the foley and urodynamic cathethers. The specialty society indicated that the total pre-service time of 20 minutes should all be captured in the pre-evaluation component. The specialty society recommended and the RUC agreed that an additional 10 minutes should be added to the surveyed intra-service time of 30 minutes, totaling 40 minutes, as it requires slightly more time than base code 51726 *Complex cystometrogram (eg, calibrated electronic equipment)* (work RVU = 1.71 and physician time of 25 minutes pre-, 30 minutes intra- and 15 minutes immediate post-service time) and slightly more physician time to perform than the urethral pressure studies and the voiding pressure studies alone. The specialty society recommended and the RUC agreed that the survey immediate post-service time of 15 minutes is appropriate.

The RUC reviewed the increment between the base code 51726 and the recommended work RVUs for 51727 or 51728, which was 0.40 (2.11 - 1.71 = 0.40). The RUC determined that 0.40 is an appropriate increment between 51727 or 51728 compared to 51729. The RUC added the increment and determined 2.51 work RVUs for 51729 appropriately accounts for the physician work required to perform this service (2.11 + 0.40 = 2.51). The RUC also compared 51729 to a similar service 75635 *Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU = 2.40 and 10 minutes pre, 45 minutes intra,

and 15 minutes immediate post-service time) and determined that this reference also supports a work RVU of 2.51 for code 51729. **The RUC recommends a work RVU of 2.51 for 51729 and 20 minutes pre, 40 minutes intra and 15 minutes immediate post-service time.**

Practice Expense
The RUC reviewed the clinical labor inputs for the typical patient and made minor edits regarding the intra-service time. The RUC also made adjustments to the medical supplies and equipment.

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.

Neurostimulator (Spinal) (Tab 17)
Facilitation Committee #1
Frederick Boop, MD, AANS/CNS, Fred Davis, MD, AAPM, Rodney Jones, MD, ISIS, Marc Leib, MD, ASA, Alexander Mason, MD, AANS/CNS, Charles Mick, MD, NASS

The RUC identified 63660, *Revision or removal of spinal neurostimulator electrode percutaneous array(s) or plate/paddle(s)* in its Site of Service Anomaly screen and recommended that it be referred to the CPT Editorial Panel for revision. CMS identified 63655, *Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural* through the CMS Fastest Growing Procedures screen and recommended that the RUC survey this service. At its October 2008 meeting, the CPT Editorial Panel deleted 63660 and created four new services to describe the work previously reported using 63660. The specialty societies requested a global period change for 63661, *Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed* and 63663, *Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed* from 090 day to 010 day global periods. CMS agreed with this request however, due to a late start, the specialty societies requested and RUC agreed to allow the presentation of this issue at the April 2009 RUC meeting to allow for more time to conduct the surveys and obtain an optimal number of responses.

The specialty society provided some evidence to the RUC that incorrect assumptions were made in the previous valuation of 63660, including a misleading vignette, survey and flawed crosswalk assumption. The specialty commented that code 63660 was simply too broad to be able to provide a valid measure of the work. However, the RUC did not agree that the information provided by the specialty show that the work had changed significantly. Therefore, the RUC assumes that the new family of services will be work neutral as consistent with RUC/CMS standards. The specialty also provided some evidence that the length of hospital stay for 63655 had changed since the last time is was valued and that the current value for the procedure is anomalous with other codes in the family. Specifically, the specialty stated that the current intra-service work per unit of time (IWPUT) is 0.03 whereas other similar codes have IWPUTs of roughly 0.08. The RUC did not agree that this information met the compelling evidence standards to consider increases in the work RVU of 63655. The RUC reviewed the specialty society survey data to appropriately calculate the relativity between the four new codes as well as 63655 and made the following recommendations:

63655, *Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural*
The specialty society presented the data of a survey of 42 physicians. The survey median intra-service time was 90 minutes and the median work RVU was 13.00. Additionally, the surveyees indicated that the post-operative hospital visits include a 99231 visit as well as a 99238 discharge day management service, although the surveyees indicated a typical length of stay of only one night. Due to the inconsistency of this data, the specialty did not recommend inclusion of the 99231 hospital visit. Moreover, the specialty society reduced the number of post-operative office visits from the survey data to one 99212 and two 99213 office visits. The RUC agreed with these changes to the post-operative evaluation and management services. The specialty presented a recommendation of 11.51 RVUs to the RUC. The RUC also agreed that the survey results provide some evidence that the current work RVU for 63655 of 11.43 is not too high. The RUC reviewed reference code 63030, *Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, including open and endoscopically-assisted approaches; 1 interspace, lumbar* (work RVU = 13.03) and noted that the surveyed code contains identical intra-service time as the reference code (90 minutes). However, 63030 contains more pre-service time (75 minutes vs. 63 minutes), more immediate post-service work (30 minutes vs. 20 minutes), one additional 99212, and one additional 99213 post-operative hospital visits. Given the similarities of the services and taking into account the differences in time and post-operative visits, the RUC agreed that a work RVU of 11.43 maintains proper rank order with other spine surgery procedures. **Therefore, the RUC recommends the specialty-recommended physician time and a work RVU of 11.43 for CPT code 63655.**

63661, Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed
The RUC reviewed the survey results of 64 physicians and agreed that the survey median physician intra-service time is appropriate. Additionally, the surveyees indicated that the post-operative hospital visits include a 99231 visit as well as a 99238 discharge day management service, although the surveyees indicated a patient is typically discharged the same day. Due to the inconsistency of this data, the specialty did not recommend inclusion of the 99231 hospital visit and recommended that only one-half 99238 discharge day management service be included. The RUC also agreed that the median physician work RVU of 5.30 placed 63661 in appropriate relativity within the family of 63655 and 63661 – 63664. The RUC reviewed reference code 62355, *Removal of previously implanted intrathecal or epidural catheter* (work RVU = 4.30, intra-service time = 30 minutes) and agreed that the two services are similar. However, the survey code contains a greater amount of intra-service time compared to the reference service (55 minutes and 30 minutes, respectively), which justifies a higher work RVU. The RUC applied a work neutrality adjustment to recommended work RVUs of 63661-63664, based on the current utilization and value for 63660 and 77002 (no longer reported separately), which results in a reduction the services by 5.06%. The 5.06% reduction was applied to the survey median work RVU of 5.30 and resulted in a recommended work RVU of 5.03. **Therefore, the RUC recommends the calculated work RVU for 63661 of 5.03.**

63662, Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed
The RUC reviewed the survey results of 35 physicians and agreed that the survey median physician intra-service time is appropriate. Additionally, the surveyees indicated that the post-operative hospital visits include a 99231 visit as well as a 99238 discharge day management service, although the surveyees indicated a typical length of stay of only one night. Due to the inconsistency of this data, the specialty did not recommend inclusion of the 99231 hospital visit. The RUC also agreed that the survey 25th percentile physician work RVU of 11.45 placed 63662

in appropriate relativity within the family of 63661 – 63664. The RUC reviewed reference code 63030, *Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, including open and endoscopically-assisted approaches; 1 interspace, lumbar* (work RVU = 13.03, intra-service time = 90 minutes) and agreed that the two services are similar. However, the survey code contains a smaller amount of intra-service time compared to the reference service (60 minutes and 90 minutes, respectively), the survey code also contains less pre-service time (63 minutes vs 75 minutes), and no hospital visits, whereas the reference code contains two 99231 hospital visits. These differences account for the lower recommended work RVU for 63662. The RUC applied a work neutrality adjustment to recommended work RVUs of 63661-63664, based on the current utilization and value for 63660 and 77002 (no longer reported separately), which results in a reduction the services by 5.06%. The 5.06% reduction was applied to the survey 25th percentile work RVU of 11.45 and resulted in a recommended work RVU of 10.87. **Therefore, the RUC recommends the calculated work RVU for 63662 of 10.87.**

63663, Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed

The RUC reviewed the survey results of 52 physicians and agreed that the survey median physician intra-service time is appropriate. Additionally, the surveyees indicated that the post-operative hospital visits include a 99231 visit as well as a 99238 discharge day management service, although the surveyees indicated a patient is typically discharged the same day. Due to the inconsistency of this data, the specialty did not recommend inclusion of the 99231 hospital visit and recommended that only one-half 99238 discharge day management service be included. The RUC also agreed that the median physician work RVU of 8.11 placed 63663 in appropriate relativity within the family of 63661 – 63664. The RUC reviewed reference code 63650, *Percutaneous implantation of neurostimulator electrode array, epidural* (work RVU = 7.15, intra-service time = 60 minutes) and agreed that the two services are similar. However, the survey code contains a greater amount of intra-service time compared to the reference service (90 minutes and 60 minutes, respectively), which justifies a slightly higher work RVU, maintaining rank order. The RUC applied a work neutrality adjustment to recommended work RVUs of 63661-63664, based on the current utilization and value for 63660 and 77002 (no longer reported separately), which results in a reduction the services by 5.06%. The 5.06% reduction was applied to the survey median work RVU of 8.11 and resulted in a recommended work RVU of 7.70. **Therefore, the RUC recommends the calculated work RVU for 63663 of 7.70.**

63664, Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed

The RUC reviewed the survey results of 32 physicians and agreed that the survey median physician intra-service time is appropriate. Additionally, the surveyees indicated that the post-operative hospital visits include a 99231 visit as well as a 99238 discharge day management service, although the surveyees indicated a typical length of stay of only one night. Due to the inconsistency of this data, the specialty did not recommend inclusion of the 99231 hospital visit. The RUC also agreed that the survey 25th percentile physician work RVU of 12.00 placed 63664 in appropriate relativity within the family of 63661 – 63664. The RUC reviewed reference code 62351, *Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; with laminectomy* (work RVU = 11.54, intra-service time = 90 minutes) and agreed that the two services are similar. The survey code contains an identical intra-service time compared to the reference service (90 minutes), but requires fewer post-operative hospital visits. The reference code requires a four 99233 hospital visits, whereas the survey code requires none.

However, the survey code requires greater intensity and complexity, justifying a similar, though slightly lower work RVU, maintaining rank order. The RUC also noted that the physician time of 63664 is identical to the recommended survey time for 63655. The RUC applied a work neutrality adjustment to recommended work RVUs of 63661-63664, based on the current utilization and value for 63660 and 77002 (no longer reported separately), which results in a reduction the services by 5.06%. The 5.06% reduction was applied to the survey 25th percentile work RVU of 12.00 and resulted in a recommended work RVU of 11.39. **Therefore, the RUC recommends the calculated work RVU for 63664 of 11.39.**

Practice Expense
The RUC reviewed the direct practice expense inputs as recommended by the specialty and made some minor edits to the clinical labor and medical supplies to reflect the typical patient service.

Work Neutrality Calculation
In order to maintain work neutrality between the new codes created through the deletion of 63660 (and bundling of 77002), the RUC recommends the below calculation. The total work RVUs of 63660 and 77002 are 42,859. However, the total projected work RVUs based on the non-adjusted recommendations exceeds the existing work RVUs by 5.3% (45,145). To maintain budget neutrality, the RUC multiplied each work RVU by 94.94%. The resulting values reflect the RUC's recommendations and maintain budget neutrality.

New Codes					
Code	**Work RVU**	**Frequency**	**RVU Impact**	**Work Neutrality Multiplier**	**Final Work RVU**
63661	5.30	1909	10,118	94.94%	**5.03**
63662	11.45	405	4,637	94.94%	**10.87**
63663	8.11	2892	23,454	94.94%	**7.70**
63664	12.00	578	6,936	94.94%	**11.39**
Total			**45,145**		
Existing Codes					
Code	**Work RVU**	**Frequency**	**RVU Impact**		
77002	0.54	5784	3,123		
63660	6.87	5784	39,736		
Total			**42,859**		
Work Neutrality Multiplier = 42,859 / 45,145 = 94.94%					

Injection of Anesthetic Agent - Nerve (Tab 18)
Facilitation Committee #1
Frederick Boop, MD, AANS/CNS, Joseph Cleveland, MD, Fred Davis, MD, AAPM, William Donovan, MD, ASNR, Rodney Jones, MD, ISIS, Marc Leib, MD, ASA, Alexander Mason, MD, AANS/CNS, Charles Mick, MD, NASS, William Sullivan, MD, AAPMR

The RUC identified these services through its High Volume Growth screen and referred the services to CPT to devise an appropriate coding structure to report primary and additional injections. Additionally, several other services within the same family were identified through the CMS Fastest Growing Procedures screen and were recommended to be surveyed by the RUC (64415, 64445, 64447), while services that were identified through the RUC screen (64470, 64472, 64475, 64476) were recommended to be referred to CPT prior to review by the RUC. In response to the RUC's request, the CPT Editorial Panel deleted the four existing codes describing injection of anesthetic agent (64470, 64472, 64475, 64476) and replaced them with six new services. Three codes describe the work performed in injection within the cervical or thoracic area in a single injection, second injection, and all further injections and the other three codes describe the work performed in injection within the lumbar or sacral area in a single injection, second injection and all further injections.

64490, ***Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level***
The specialty society presented the survey results of 116 physicians. The median survey intra-service time was 15 minutes, which the RUC agreed was appropriate, particularly in light of the fact that the existing service, 64470, includes 20 minutes of intra-service time. The survey median work RVU was 2.00. However, the specialty noted that the key reference service selected by the respondents was 62310, *Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic* (work RVU = 1.91, intra-service time = 30 minutes). The specialty noted that the reference service does not include any fluoroscopic guidance, and that there are no other 000 global codes that describe both injection and image guidance. The RUC did not agree that the pre-service evaluation time presented by the specialties was appropriate. Rather, the RUC agreed that pre-service time package number 5, NF procedure without sedation/anesthesia, which allots 7 minutes for evaluation, was all that was required. The RUC understands that Evaluation and Management (E/M) services may be reported on the same date as these injections. Therefore, the RUC removed the additional 8 minutes from the specialty's recommendation and backed-out the associated work per minute (0.0224 x 7 = 0.18) from the survey median work RVU of 2.00, to arrive at a work RVU of 1.82 (2.00 – 0.18 = 1.82). The RUC also reviewed reference code 36569, *Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; age 5 years or older* (work RVU = 1.82, intra-time = 20 minutes) and agreed that the two services are similar. **Therefore, the RUC recommends a work RVU of 1.82 for CPT code 64490.**

64491, ***Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level***
The specialty society presented the survey results of 80 physicians for this ZZZ add-on code. The median survey intra-service time was 15 minutes, which the RUC agreed was appropriate,

particularly in light of the fact that the existing service, 64472, includes 20 minutes of intra-service time. Further, the RUC noted that the base code, 64490 also contains 15 minutes of intra-services time. However, the survey respondents indicated 10 minutes of pre-service and 5 minutes of post-service time, which the specialty and the RUC agreed was inappropriate for this add-on service. Eighty percent of the survey respondents selected 64627, *Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, each additional level (List separately in addition to code for primary procedure)* (work RVU = 1.16, intra-service = 30 minutes) as the key reference service. While the intra-service times are different between the survey code and the reference code (15 and 30 minutes, respectively), the RUC agreed that the two services are very similar. However, the reference service does not contain any imaging guidance. Further, the survey median work RVU was 1.16, which the RUC agreed was appropriate and maintains the rank and relationship between the base code and the add-on procedure. **Therefore, the RUC recommends a work RVU of 1.16 with an intra-service time of 15 minutes for 64491.**

64492*, Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any additional level(s)*

The specialty society presented the survey results of 75 physicians for this ZZZ add-on code. The median survey intra-service time was 13 minutes, which the specialty noted was inconsistent with the survey results for 64491. The specialty societies' expert panel recommended and the RUC agreed that the intra-service time for 644X2 should be identical to 64491. Therefore, the RUC agreed that 15 minutes was appropriate. Further, the RUC noted that the base code, 64490 also contains 15 minutes of intra-services time. However, the survey respondents indicated 5 minutes of pre-service and 5 minutes of post-service time, which the specialty and the RUC agreed was inappropriate for this add-on service. Eighty percent of the survey respondents selected 64627, *Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, each additional level (List separately in addition to code for primary procedure)* (work RVU = 1.16, intra-service = 30 minutes) as the key reference service. While the intra-service times are different between the survey code and the reference code (15 and 30 minutes, respectively), the RUC agreed that the two services are very similar. However, the reference service does not contain any imaging guidance. Further, the survey median work RVU was 1.10, which the RUC did not agree maintained the rank and relationship between the base code and the add-on procedure. Rather, the RUC agreed that the typical work of 64492 is identical to 64491 and should be valued identically. The RUC also reviewed reference code 36584, *Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access* (work RVU = 1.20, intra-time = 15 minutes) and agreed that the two services are similar. **Therefore, the RUC recommends a work RVU of 1.16 with an intra-service time of 15 minutes for 64492.**

64493*, Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level*

The specialty society presented the survey results of 88 physicians. The median survey intra-service time was 15 minutes, which the RUC agreed was appropriate, particularly in light of the fact that the existing service, 64470, includes 20 minutes of intra-service time. The survey median work RVU was 1.70. However, the specialty noted that the key reference service selected by the respondents was 27096, *Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid* (work RVU = 1.40, intra-service time = 25 minutes). The specialty noted that the reference service does not include any fluoroscopic guidance, and that there are

no other 000 global codes that describe both injection and image guidance. The RUC did not agree that the pre-service evaluation time presented by the specialties was appropriate. Rather, the RUC agreed that pre-service time package number 5, NF procedure without sedation/anesthesia, which allots 7 minutes for evaluation, was all that was required. The RUC understands that Evaluation and Management (E/M) services may be reported on the same date as these injections. Therefore, the RUC removed the additional 8 minutes from the specialty's recommendation and backed-out the associated work per minute (0.0224 x 7 = 0.18) from the survey median work RVU of 1.70, to arrive at a work RVU of 1.52 (1.70 – 0.18 = 1.52). The RUC also review reference code, 95865, *Needle electromyography; larynx* (work RVU = 1.57, intra-time = 15 minutes) and agreed that the two services are similar. **Therefore, the RUC recommends a work RVU of 1.52 for CPT code 64493.**

64494*, Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level*

The specialty society presented the survey results of 70 physicians for this ZZZ add-on code. The median survey intra-service time was 15 minutes, which the RUC agreed was appropriate, particularly in light of the fact that the existing service, 64475, includes 18 minutes of intra-service time. Further, the RUC noted that the base code, 64493 also contains 15 minutes of intra-services time. However, the survey respondents indicated 5 minutes of post-service time, which the specialty and the RUC agreed was inappropriate for this add-on service. Nearly 80% of the survey respondents selected 64623, *Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, each additional level (List separately in addition to code for primary procedure)* (work RVU = 0.99, intra-service = 16 minutes) as the key reference service. The RUC agreed that the two services are very similar with very similar intra-service times. However, the reference service does not contain any imaging guidance, which justifies a slightly higher work RVU for the surveyed code. The median survey work RVU was 1.10, which the RUC agreed was too high. However, the survey 25th percentile work RVU of 0.98 would create a rank order anomaly with the reference service. The specialty societies' expert panel recommended and the RUC agreed that 1.00 was appropriate and maintains the rank and relationship between the base code and the add-on procedure. The RUC also noted that the survey median work RVU of 64495 was 1.00. **Therefore, the RUC recommends a work RVU of 1.00 with an intra-service time of 15 minutes for 64494.**

64495*, Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s)*

The specialty society presented the survey results of 64 physicians for this ZZZ add-on code. The median survey intra-service time was 15 minutes, which the RUC agreed was appropriate, considering that the existing service, 64475descriptor, includes 18 minutes of intra-service time. Further, the RUC noted that the base code, 64494 also contains 15 minutes of intra-services time. However, the survey respondents indicated 5 minutes of post-service time, which the specialty and the RUC agreed was inappropriate for this add-on service. More than 80% of the survey respondents selected 64623, *Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, each additional level (List separately in addition to code for primary procedure)* (work RVU = 0.99, intra-service = 16 minutes) as the key reference service. The RUC agreed that the two services are very similar with very similar intra-service times. However, the reference service does not contain any imaging guidance, which justifies a slightly higher work RVU for the surveyed code. The median survey work RVU was 1.00, which the RUC agreed was appropriate and maintains the rank and relationship between the

base code and the add-on procedure. **Therefore, the RUC recommends a work RVU of 1.00 with an intra-service time of 15 minutes for 64495.**

Practice Expense
The RUC reviewed the direct practice expense inputs as recommended by the specialty and made some minor edits to the clinical labor and medical supplies to reflect the typical patient service.

Work Neutrality
The specialty society provided data to the RUC showing that the new coding structure will account for an overall decrease in work relative values for this family of services to be redistributed in the Medicare conversion factor. 64470, 64472, 64475, and 64476 were reported as follows in 2007, accounting for 1,929,084 work RVUs.

Code	Work RVU	2007 Frequency	Total work RVUs
64470	1.80	133,092	239,566
64472	1.29	215,038	277,399
64475	1.41	485,428	684,453
64476	0.98	742,516	727,666
Total work RVUs			**1,929,084**

The specialty society estimates that the new services will be reported as follows, which results in a reduction of 600,422 work RVUs.

Code	Work RVU	2007 Frequency	Total work RVUs
64490	1.82	133,092	242,227
64491	1.16	119,783	138,948
64492	1.16	35,935	41,685
64493	1.52	485,428	737,851
64494	1.00	36,885	36,885
64495	1.00	131,066	131,066
Total work RVUs			**1,328,662**

CT Colonography (Tab 19)
Joel Brill, MD, AGA, Brooks Cash, MD, AGA, Paul Knechtges, MD, ACR, Geraldine McGinty, MD, ACR, Nicholas Nickl, MD, ASGE, Zeke Silva, MD, ACR

The CPT Editorial Panel converted two Category III codes into three Category I codes to report diagnostic and screening computed tomographic (CT) colonography. This technology has now been in existence for over 10 years and there is enough widespread utilization of this technology to warrant the conversion of the Category III codes to Category I codes.

74261 ***Computed tomographic (CT), colonography, diagnostic, including image postprocessing; without contrast material***
The RUC reviewed the survey data for 74261 as compared to the reference code 75635 *Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (Work RVU=2.40) and noted that the intra-service times were very similar 40 minutes and 45 minutes, respectively. The RUC also removed 2 minutes of pre-service evaluation time as recommended by the specialty societies, as they agreed 5 minutes of evaluation time best reflected the service. Further, the RUC compared the surveyed code to another reference code, MPC code 78815 *Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh* (Work RVU=2.44) and noted very similar intra-service times, 40 minutes and 35 minutes respectively. In addition, the RUC compared the intensity/complexity measures of 74261 to its reference code 75635 and determined that the surveyed code required more technical skill and physical effort but less mental effort and judgment to perform than the reference code. Based on these comparisons, the RUC agreed with the specialty societies' recommended value of 2.40 RVUs which is slightly below the survey's 25th percentile, as this value appropriately places the amount of work for this code in comparison to the other CT colonography codes and other codes in the RBRVS. **The RUC recommends 2.40 Work RVUs for 74261.**

74262 ***Computed tomographic (CT), colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed***
The RUC reviewed the survey data for 74262, a very uncommonly performed service as indicated by the low Medicare utilization estimate. The RUC compared the surveyed code to the reference code 75635 *Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (Work RVU=2.40) and noted that the intra-service times were the same, 45 minutes. Further, the RUC compared the surveyed code to another reference code 75557 *Cardiac magnetic resonance imaging for morphology and function without contrast material;* (Work RVU=2.35) and noted very similar intra-service times, 45 minutes and 40 minutes respectively. Further, the RUC removed 2 minutes of pre-service evaluation time as recommended by the specialty societies, as they agreed 5 minutes of evaluation time best reflected the service. In addition, the RUC compared the intensity/complexity measures of 74262 to its reference code 75635 and determined that the surveyed code required more technical skill and physical effort, more psychological stress and was overall a more intense procedure to perform than the reference code. Based on these comparisons, the RUC agreed with the specialty societies' recommended value of 2.50 RVUs, the 25th percentile of the survey data, as this value appropriately places the amount of work for this code in comparison to the other CT colonography codes and other codes in the RBRVS. **The RUC recommends 2.50 Work RVUs for 74262.**

74263 ***Computed tomographic (CT) colonography, screening, including image postprocessing***
The RUC reviewed the survey data for 74263 as compared to the reference code 75635 *Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (Work RVU=2.40) and noted that the surveyed code has less total service time than the reference code, 51 minutes and 70.50 minutes, respectively. Further, the RUC compared the surveyed code to another reference code 75557 *Cardiac magnetic resonance imaging for morphology and function without contrast material;* (Work RVU=2.35) and noted

that the surveyed code had less total service time than this reference code, 51 minutes and 60 minutes, respectively. Further, the RUC removed 1 minutes of pre-service evaluation time as recommended by the specialty societies, as they agreed 7 minutes of evaluation time best reflected the service. In addition, the RUC compared the intensity/complexity measures of 74263 to its reference code 75635 and determined that the surveyed code required less psychological stress, mental effort and judgment to perform as compared to its reference code. Based on these comparisons, the RUC agreed with the specialty societies' recommended value of 2.28 RVUs, the 25th percentile of the survey data, as this value appropriately places the amount of work for this code in comparison to the other CT colonography codes and other codes in the RBRVS. **The RUC recommends 2.28 Work RVUs for 74263.**

New Technology List:
As these services are currently being reported with Category III codes, the RUC agreed with the specialty societies' recommendation that these codes should be placed on the New Technology List.

Practice Expense:
The RUC approved the practice expense inputs as recommended by the specialty societies.

Cardiac MR Velocity Flow (Tab 20)
Paul Knechtges, MD, ACR, James Maloney, MD, ACC, Edward Martin, MD, ACC, Geraldine McGinty, MD, ACR, Zeke Silva, MD, ACR

At the February 2007 CPT Meeting, the Editorial Panel created eight new cardiac MRI codes, which were reviewed by the RUC in April 2007. In the *Final Rule* for the 2008 Medicare Physician Payment Schedule, CMS indicated that it would not cover the four of the eight new cardiac MRI services that include flow/velocity quantification. As such, the CPT Editorial Panel, at its November 2008 meeting, created one new add-on code for velocity flow and deleted the existing four services that previously included velocity flow. Specifically, the Panel created 75565, *Cardiac magnetic resonance imaging for velocity flow mapping* and deleted 75558, *Cardiac magnetic resonance imaging for morphology and function without contrast material; with flow/velocity quantification* (work RVU = 2.60), 75560, *Cardiac magnetic resonance imaging for morphology and function without contrast material; with flow/velocity quantification and stress* (work RVU = 3.00), 75562, *Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with flow/velocity quantification* (work RVU = 2.86), and 75564, *Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with flow/velocity quantification and stress* (work RVU = 3.35).

The specialty society presented the survey results of 79 cardiologists and radiologists for 75565. Survey respondents indicated a median work RVU of 0.50, which the specialty societies' expert panel agreed was too high. Moreover, the survey 25th percentile work RVU was 0.40, which the expert panel also agreed was too high. The expert panel noted that survey respondents indicated a key reference service 93320, *Doppler echocardiography, pulsed wave and/or continuous wave with spectral display* (List separately in addition to codes for echocardiographic imaging); complete (work RVU = 0.38, intra-service = 15 minutes). Given the similarity in the intensity and complexity required to perform the surveyed code and the reference service, and the difference in intra-service time between the two (10 minutes and 15 minutes, respectively), the specialties and the RUC agreed that the work RVU for 75565 should be lower than 93320.

In addition to reviewing the survey, the RUC reviewed the differentials between those codes that included flow and those that did not that had been valued by the RUC in April 2007. The RUC looked to codes 75557, *Cardiac magnetic resonance imaging for morphology and function without contrast material* (work RVU = 2.37) and 75561, *Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences* (work RVU = 2.60). The existing differential in work RVUs between 75557 (without flow) and 75558 (with flow) is 0.25. The existing differential in work RVUs between 75561 (without flow) and 75562 (with flow) is 0.26. The survey respondents indicated a median intra-service time of 10 minutes, with significant pre-service and post-service time, inconsistent with other ZZZ global period codes. The expert panel and the RUC agreed that no pre- or post-service time is required for this add-on service. In order to substantiate the survey median intra-service time, the RUC also examined the difference in intra-service time between the codes from April 2007. The difference in intra-service time between 75557 (without flow) and 75558 (with flow) is 5 minutes and the difference between 75561 (without flow) and 75562 (with flow) is 10 minutes. Given this, the specialty and the RUC agreed that the intra-service time of 10 minutes as reported by the surveyees was appropriate. **Therefore, the RUC recommends a work RVU of 0.25 and intra-service time of 10 minutes for 75565.**

Practice Expense
The RUC approved the practice expense inputs noting a reduction in the clinical staff intra-service time to 10 minutes consistent with the physician intra-service time.

Tissue Examination for Molecular Studies (Tab 21)
Jonathan Myles, MD CAP

The CPT Editorial Panel created two CPT codes to report tissue examination and preparation procedures, which have become necessary to avoid contamination with other tissue or cell types that may cause false-positive results in certain molecular diagnostic procedures. These codes will be used to report services that need to be performed prior to ancillary diagnostic testing currently applicable to molecular studies. One example of the use of these codes is for the evaluation of sentinel lymph node biopsies requiring molecular analysis.

The RUC reviewed the surveyed data and expressed concern about the low sample size for both of these new codes. The specialty societies explained that they would consider their utilization estimate of 1,000 to be a small number of assays for a laboratory procedure. They explained that when specialized laboratory tests are performed only 1,000 to 3,000 times per year there is not a large number of laboratories doing them because most laboratories cannot afford the specialized equipment. Therefore, there is not a large number of providers for these services. The specialty society contacted all providers of this service and requested them to complete a survey. The data presented to the RUC is the data collected from these few providers. The RUC determined that based on this explanation provided by specialty society, the survey was valid.

88387 Macroscopic examination, dissection and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid – based molecular studies); each tissue preparation (eg, a single lymph node)

The RUC reviewed the survey data for 88387 as compared to the key reference code 88381 *Microdissection (ie, sample preparation of microscopically identified target); manual* (Work

RVU=1.18) and noted that the intra-service time for surveyed code was less than for the reference code, 20 minutes and 30 minutes, respectively. Further, the RUC compared the surveyed code to another reference code, MPC code 29075 *Application, cast; elbow to finger (short arm)* (Work RVU=0.77) and noted that the surveyed code has less total service time as compared to this reference code, 20 minutes and 25 minutes, respectively. In addition, the RUC compared the intensity/complexity measures of 88387 to its reference code 88381 and determined that the reference code required more technical skill and physical effort and the same mental effort and judgment to perform as compared to the surveyed code. Based on these comparisons, the RUC agreed with the specialty societies' recommended value of 0.62 RVUs which is the survey's 25th percentile. **The RUC recommends 0.62 Work RVUs for 88387.**

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)

The RUC reviewed the survey data for 88388 as compared to the reference code 88334 *Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site* (Work RVU=0.73) and noted that the intra-service time for surveyed code was less than for the reference code, 12 minutes and 20 minutes, respectively. Further, the RUC compared the surveyed code to another reference code, 77071 *Manual application of stress performed by physician for joint radiography, including contralateral joint if indicated* (Work RVU=0.41) and noted that the surveyed code has similar total service time as compared to this reference code, 12 minutes and 11 minutes, respectively. In addition, the RUC compared the intensity/complexity measures of 88388 to its reference code 88334 and determined that the reference code required more technical skill, physical and mental effort and judgment to perform as compared to the surveyed code. Based on these comparisons, the RUC agreed with the specialty societies' recommended value of 0.45 RVUs which is the 25th percentile. **The RUC recommends 0.45 Work RVUs for 88388.**

New Technology List:
As there are now so few laboratories performing this service and the number of respondents were so low, the RUC agreed with the specialty societies' recommendation that these codes should be placed on the New Technology List.

Practice Expense:
The RUC approved the practice expense inputs as recommended by the specialty societies with the substitution of an impervious gown instead of a staff lab coat.

PLI Crosswalk:
As the reference codes used for both of these surveyed codes were not similarly valued, the RUC requested a different code for the PLI crosswalk. The specialty society recommends CPT code 88329 *Pathology consultation during surgery;* (Work RVU=0.67) be the crosswalk for 88387 and 88318 *Determinative histochemistry to identify chemical components (eg, copper, zinc)* (Work RVU=0.42) be the crosswalk for 88388. The RUC agreed with these new PLI crosswalks and deemed them to be more appropriate as they were similarly valued to the recommended values of the surveyed codes.

Combined Speech-Language and Hearing Services (Tab 22)
Gregory Barkley, MD AAN, Jane Dillon, MD, AAO-HNS, Robert Fifer, PhD, ASHA, Wayne Koch, MD, AAO-HNS, Kadyn Williams, AuD, ASHA (AAA)

In February 2008, the RUC identified 92541, 92542, 92544, 92545, 92567, 92568, and 92569 through the Codes Reported Together screen as several pairings of these services are reported together more than 95% of the time. The RUC referred these codes to CPT for creation of new bundled services and to reorganize the coding structure to reflect the typical procedures performed.

92540
The RUC reviewed code 92540 *Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with recording, optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording, and oscillating tracking test, with recording* which bundles codes 92541, 92542, 92544 and 92545. Since the proposed RVUs were higher than the bundling of these four services the specialty societies were required to present compelling evidence. The RUC agreed that there was compelling evidence to warrant a higher work RVU because these services had never been RUC surveyed and audiologists' had not been included in the original Harvard study.

The RUC reviewed the survey results for 92540 comprised of 66 respondents, (51 Audiologists, 10 Otolaryngologists and 5 Neurologists). The RUC compared 92540 to reference service *92557 Comprehensive audiometry threshold evaluation and speech recognition* (work RVU = 0.60, 20 minutes intra-service) and agreed that 92540 is more than double the physician work and time than 92557. The RUC determined that the 60 minutes intra-service time for 92540 is appropriate as the health care provider performs a battery of four successive procedures, evaluation for spontaneous nystagmus, positional nystagmus testing, optokineticnystagmus testing and oscillating tracking. The RUC determined that 10 minutes of immediate post-service time is required to explain results from a functional and physiological perspective to a referring physician and the patient. The RUC agreed with the specialty society recommended physician times of pre-service time package 5 – Non-Facility Procedure without sedation/anesthesia 7 minutes, 60 minutes intra-service time and 10 minutes immediate post-service time. The RUC agreed with the survey median work RVU of 1.50, as it is representative of the audiologists' survey responses, who are the primary providers of this service. The recommended work RVU of 1.50 places this service in the proper rank order with other services provided by audiologists, as well as similar services provided by other health care professionals. For additional support the RUC compared 92540 to HCPAC MPC codes 97001 *Physical therapy evaluation* (work RVU = 1.20) and 90806 *Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient* (work RVU = 1.86). **The RUC recommends a work RVU of 1.50 for 92540.**

92570
The RUC reviewed code 92570 *Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing* which bundles codes 92567, 92568 and 92569. The specialty societies recommended a work RVU lower than these three combined services.

The RUC reviewed the survey results for 92570 in which 92 Audiologists and 6 Otolaryngologists responded. The RUC compared 92570 to reference service *92557 Comprehensive audiometry threshold evaluation and speech recognition* (work RVU = 0.60, 20

minutes intra-service) and agreed that 92570 requires approximately the same amount of physician work and time as code 92557. The RUC agreed with the specialty society recommended physician times of pre-service time package 5 – Non-Facility Procedure without sedation/anesthesia minus 4 minutes (totaling 3 minutes) as the provider is primarily setting-up the patient to perform the tests; 15 minutes intra-service time, and 3 minutes immediate post-service time. The RUC agreed that the 92 Audiologist survey respondents median work RVU of 0.55 was appropriate, as 92570 requires 5 minutes less intra-service time than 92557. The recommended work RVU places this service in the proper rank order with other services provided by audiologists, as well as similar services provided by other health care professionals. For additional support the RUC compared 92570 to HCPAC MPC codes 97530 *Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes* (work RVU = 0.44) and 97755 *Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact by provider, with written report, each 15 minutes* (work RVU = 0.62). **The RUC recommends a work RVU of 0.55 for code 92570.**

92550
The RUC reviewed code 92550 *Tympanometry and reflex threshold measurements* which bundles codes 92567 and 92568. The specialty societies recommended a work RVU lower than these two combined services.

The RUC reviewed the survey results for 92570 in which 94 Audiologists and Otolaryngologists responded. The RUC compared 92550 to reference service 92568 *Acoustic reflex testing; threshold* (work RVU = 0.29, 8 minutes intra-service) and agreed that 92550 requires approximately the same amount of physician work and time as code 92568. The RUC agreed with the specialty society recommended physician times of pre-service time package 5 – Non-Facility Procedure without sedation/anesthesia minus 4 minutes (totaling 3 minutes) as the provider is primarily setting-up the patient to perform the tests; 10 minutes intra-service time and 3 minutes immediate post-service time. The RUC agreed that survey 25th percentile work RVU of 0.35 was appropriate, as 92550 requires slightly more time to perform than 92568 alone. The recommended work RVU places this service in the proper rank order with other services provided by audiologists, as well as similar services provided by other health care professionals. **The RUC recommends the survey 25th percentile work RVU of 0.35 for code 92550.**

Practice Expense
The RUC recommends that the Audiologists' clinical labor time for codes 92541-92545 be reduced to zero, as all Audiologist time is transitioning to the work component. Additionally, the RUC recommends no clinical labor time for 92540-92550.

PLI
The RUC recommends that 92540 be crosswalked to 92620 and codes 92570 and 92550 be crosswalked to 92621.

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.

Infant Pulmonary Function Testing (Tab 23)
Kevin Kovitz, MD, ACCP, Steven Krug, MD, AAP, Burt Lesnick, MD, ACCP, Scott Manaker, MD, ACCP, Alan Plummer, MD, ATS

In February 2009, the CPT Editorial Panel created three new CPT codes to describe the infant standard pulmonary function testing (PFT) that replicates adult PFTs with sedated infants or young children.

The specialty societies performed a survey of 40 physicians performing infant PFT in the U.S. The specialty acknowledged its low response rate of 26 may have contributed to the improper rank order of survey median physician work 94012 and 94013. The RUC reviewed these three new services, which are only performed in the facility setting, in relation to survey results and specialty recommended physician time and work effort in relation to other services to develop the recommendations.

94011 Measurement of spirometric forced expiratory flows in an infant or child through 2 years of age
The RUC reviewed the specialty survey and specialty recommendations for new code 94011 and understood that the reduced pre-service time of 30 minutes (evaluation time only) from the standard package for a difficult sedated patient/straightforward procedure (33 minute evaluation time/1 minutes positioning time/5 minutes scrub, dress, wait time), appeared justified since the pediatric pulmonologists performing this test typically differs from the treating physicians (either pediatric pulmonologist or other physicians) with whom the family has a relationship established. Parents usually are shown the equipment (a clear body box that the infant is placed in, an airtight face-mask to be secured to the infant, and a pneumatic vest) as part of the informed consent process.

In support of the surveyed intra-service time (30 min), the RUC understood that infant PFTs include moderate sedation, as the physician actively performs the test. The technician calibrates the equipment, and assists in any resuscitation efforts. After the service, the physician speaks with the parents and the referring physician, and interprets the data in these difficult infants with cystic fibrosis. The RUC concurred that the correct physician time components for 94011 are 30 minutes pre-service, 30 minutes intra-service, and 20 minutes immediate post totaling 80 minutes.

The specialty recommended the survey median work RVU of 2.00 and the survey median physician time. In relation to this service, the RUC also reviewed the physician work of CPT code 99480 *Subsequent intensive care, per day, E/M of recovering infant 2501-5000g* (Work RVU = 2.40), 94002 *Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day* (Work RVU = 1.99 RVU), and 93312 *Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report* (Work RVU = 2.20), and agreed with the recommended value for 940X1 of 2.00. **The RUC recommends the survey median relative work value of 2.00 for CPT code 94011.**

94012 Measurement of spirometric forced expiratory flows before and after bronchodilator in an infant or child through 2 years of age
The specialty recommended the survey median time, but argued that the survey median was too low. The RUC reviewed the specialty survey and specialty recommendations for new code 94012 and understood that the reduced pre-service time of 30 minutes (evaluation time only)

from the standard package for a difficult sedated patient/straightforward procedure (33 minute evaluation time/1 minutes positioning time/5 minutes scrub, dress, wait time), appeared justified since the pediatric pulmonologists performing this test typically differs from the treating physicians (either pediatric pulmonologist or other physicians) with whom the family has a relationship established. Parents usually are shown the equipment (a clear body box that the infant is placed in, an airtight face-mask to be secured to the infant, and a pneumatic vest) as part of the informed consent process.

In support of the surveyed intra-service time (60 min), the RUC understood that infant PFTs include moderate sedation, and the physician actively performs the test, however in addition, the child is administered a bronchodilator after the first set of measurements, 10 minutes waiting time is necessary to permit the effect of albuterol (J code separately reported), 25 minutes additional time for making measurements. The RUC concurred that the survey respondents misunderstood this service in relation to 94011 and 94012, which provided for a disproportionately low value amongst this family of services.

The RUC developed a building block methodology to establish an appropriate work RVU. The RUC used 94011 as the base code that contains 30/30/20=80 total minutes of time and a RUC recommended value of 2.00. The survey indicated 94012 had 30 additional minutes of intra-service time above 94011. RUC took the intra-service work per unit of time (IWPUT) of 94011 (0.044) and multiplied it by the additional 20 minutes of active intra-service time for 94012, yielding 0.88 RVUs (20 x 0.044), then added the additional 10 min waiting intra-service time (10 x 0.0224 = 0.22 RVU), for a total of 1.10 RVUs (0.88+0.22 = 1.10). When added to the 2.00 RVUs from base code, 94011, this yields 3.10 work RVUs.

In relation to this service, the RUC also reviewed the physician work of CPT code 99480 *Subsequent intensive care, per day, E/M of recovering infant 2501-5000g* (Work RVU = 2.40), 96111 *Developmental testing; extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report* (Work RVU = 2.60 RVU), and 75563 *Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with stress imaging* (work RVU = 3.00). and agreed with the recommended value for 94012 of 3.10 work RVUs. **The RUC recommends a relative work value of 3.10 for CPT code 94012.**

94013 Measurement of lung volumes (ie, functional residual capacity [FRC], forced vital capacity [VVC], and expiratory reserve volume [ERV]) in an infant or child through 2 years of age

The specialty recommended that the survey results for this code were flawed, as the respondents did not understand that the service was essentially an add-on service. The RUC reviewed the specialty's survey results and understood that the work of 94013 occurs after spirometry measures are obtained with 94011 or 94012, the lungs are inflated passively, with another series of tests performed. The RUC agreed that the survey respondents did not understand the code being surveyed, and responded as if they were repeating the 94011. Therefore, the RUC removed all the pre-service time, reduced the intra-service time from the survey median of 42.5 minutes by 30 minutes to account for duplicative work performed in 94011, which left 12.5 minutes of intra-service time for 94013. The RUC also subtracted duplicative post-service time, resulting in 5 minutes of post-service time for interpretation of the data and relaying the results to the family.

The RUC used a building block methodology using 94002, *Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day* (work RVU = 1.99) as a building block base code to arrive at the value for 94013. The RUC used an IWPUT of 0.044 RVU per minute for the 12.5 minutes of intra-service work yielding 0.55 work RVUs. The 5 minutes post-service time at 0.0224 RVU per minute yields another 0.11 work RVUs to total a recommended 0.66 work RVUs for 94013. This code may be used twice if performed after both the initial testing and the post-bronchodilator study. The typical scenario is for 94013 to be used as an add-on code to 94011 or 94012, but could also be used as a stand alone code.

In relation to this service, the RUC also reviewed the physician work of CPT code 94620, *Pulmonary stress testing; simple (eg, 6-minute walk test, prolonged exercise test for bronchospasm with pre- and post-spirometry and oximetry)* (work RVU = 0.64, intra-service time = 15 minutes) and agreed that the services are similar, though 94013 requires greater intensity particularly because of the nature of the young patients. The RUC also reviewed 94070, *Bronchospasm provocation evaluation, multiple spirometric determinations as in 94010, with administered agents (eg, antigen[s], cold air, methacholine)* (work RVU = 0.60, intra-service time = 15 minutes, Harvard time), 92615, *Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing by cine or video recording; physician interpretation and report only* (work RVU = 0.63, intra-time = 10 minutes), 93279, *Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; single lead pacemaker system* (work RVU = 0.65, intra-time = 10 minutes) and 95937, *Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any one method* (work RVU = 0.65, intra-time = 12 minutes) and agreed with the recommended value for 940X3 of 0.66. **The RUC recommends a relative work value of 0.66 for CPT code 94013.**

New Technology: The RUC recommends that these services be placed on the RUC's New Technology list to be re-reviewed after 3 years of claims data are available.

Practice Expense: The RUC recommends no direct practice expense inputs for this set of codes as they are always performed in the facility setting.

Endoscopic Photodynamic Therapy Application (Tab 24)
Joel Brill, MD, AGA, Kevin Kovitz, MD, ACCP, Burt Lesnick, MD, ACCP, Scott Manaker, MD ACCP, Keith Naunheim, MD, STS, Nicholas Nickl, MD, ASGE, Alan Plummer, MD, ATS

In February 2009, the CPT Editorial Panel edited two codes that initially described photodynamic therapy by endoscopic application of light (photodynamic therapy) in two specific anatomic regions, the lungs and esophagus. The procedure described endoscopic light application to a single region (esophagus) of the gastrointestinal tract. However, other areas of the gastrointestinal tract (e.g. oral cavity, biliary tract) are also frequently treated using endoscopic application of light. The CPT Editorial Panel deleted the word "esophagus" and replaced it with "gastrointestinal tract" to include areas of the gastrointestinal tract beyond the esophagus. Since the current RUC survey results for endoscopic photodynamic therapy were nine years old, interim, and were never validated by the RUC, the specialties performed a full RUC survey.

96570 ***Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); first 30 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and gastrointestinal tract)***
The RUC reviewed the specialty societies' survey data and agreed with the specialty that the survey results overestimated the physician time and work performed. The RUC and specialties agreed that the 25th percentile survey work value survey results was too high at 1.75 RVUs, however the RUC determined that the survey 25th percentile intra-service time of 30 minutes was appropriate for this service. After reviewing the survey results, the specialties could not provide compelling evidence to warrant an increase to the current work value of 1.10 RVUs.

The RUC compared the physician work required to perform 96570 to the following other add-on services: 31620 *Endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) (List separately in addition to code for primary procedure[s])*(Work RVU = 1.40), 31632 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with transbronchial lung biopsy(s), each additional lobe (List separately in addition to code for primary procedure)* (Work RVU = 1.03), 31637 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; each additional major bronchus stented (List separately in addition to code for primary procedure)* (Work RVU = 1.58), 13102 *Repair, complex, trunk; each additional 5 cm or less (List separately in addition to code for primary procedure)* (Work RVU = 1.24). Since this service is an add on to other endoscopy or bronchoscopy procedures of the lung and gastrointestinal tract, the specialty recommended, and the RUC agreed that the service has no pre- or post-service physician time.

After reviewing these services and the survey time, the RUC determined that the current work for this service is appropriate. **The RUC recommends a relative work value of 1.10 for CPT code 96570 with physician time of 30 minutes (intra-service), with zero minutes of pre- or post service time.**

96571 ***Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); each additional 15 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and gastrointestinal tract)***
The specialty survey results for 96571 consisted of 17 respondents which the specialty societies believed provided an overvaluation of physician work and time. All of the survey respondents included pre and post physician time in their responses for this add-on code. The specialties could not identify pre and post service work of the surveyed code to explain the survey times. In addition, the specialty could not explain a median response of 40 minutes intra-service time for a surveyed procedure which is defined as taking up to 15 minutes. The specialty society and the RUC concluded that the survey respondents either included pre and/or post time associated with the broncoscopy / endoscopy procedure that is performed with the surveyed code, or that the respondents did not understand the RUC survey process. The specialty society and the RUC concurred that the survey data was flawed and unusable. The specialties agreed to use a consensus panel approach which resulted in a physician work RVU recommendation of half the value of 96570, based on half the time (30 verses 15 minutes) as defined in the CPT descriptor. The RUC agreed with the specialty societies approach to value this service and reviewed the work of 96571 in relation to 97814 *Acupuncture, 1 or more needles; with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)* (Work RVU = 0.55, ZZZ global period, 15 minutes intra-service time). The RUC concurred that the physician work intensity and complexity of 96571 is identical to 96570 and requires half the time (15 intra-service minutes). **The RUC recommends a relative work value of 0.55 for CPT code 96571 with physician time of 15 minutes (intra-service), with zero minutes pre or post service time.**

Practice Expense: The RUC recommends no direct practice expense inputs for codes 96570 and 96571 in either the non-facility or facility settings.

Remote Diabetic Retinopathy Imaging (Tab 25)
American Academy of Ophthalmology, American Optometric Association

The American Academy of Ophthalmology (AAO) requested that code 9917X *Remote retinal imaging with interpretation and report (eg, diabetic retinopathy), bilateral*, which was recently approved by the CPT Editorial Panel in February 2009, be rescinded at this time. The AAO indicated that after surveying this code to develop a relative work value, they found that the respondents identified two distinct levels in this developing service. The specialty society requests to go back to the CPT Editorial Panel with a new coding proposal separating this service into two codes in order to identify the two approaches to remote retinal imaging. **The RUC recommends that CPT rescind code 9917X and the specialty society will develop a new coding proposal. Note: The CPT Executive Committee rescinded 9917X at its May 2009 Meeting.**

X. CMS Requests

Tendon Transfer (Tab 26)
Daniel Nagle, MD ASSH

The RUC identified 26480, *Transfer or transplant of tendon, carpometacarpal area or dorsum of hand; without free graft, each tendon*, as potentially misvalued based on the recommendation of the Five Year Review Identification Workgroup. The code was referred to the Workgroup for review via the CMS Fastest Growing Screen. The RUC recommended that 26480 be surveyed.

The specialty society did not present compelling evidence regarding a change in the work RVU and, instead, provided evidence that the 26480 is correctly valued by its current work RVU of 6.76. The specialty society conducted a survey of 52 hand and orthopaedic surgeons. Survey respondents indicated a median intra-service time of 60 minutes and the specialty societies' expert panel selected pre-service time package number 3, straightforward patient/difficult procedure. The package includes 33 minutes of evaluation time, 15 minutes of scrub time, and the expert panel recommended adding 6 minutes to the 3 minutes of positioning time. The RUC agreed that a total of 9 minutes is required to position the patient's arm and hand throughout the duration of the procedure. The survey respondents indicated 15 minutes of immediate post-service time. No survey respondents indicated that 26480 is performed in the physician office setting and, therefore, one-half of a 99238 discharge day management procedure is appropriate. Survey respondents also indicated that three 99212 office visits and one 99213 office visits are typically performed post-operatively, which the RUC agreed with. The survey median work RVU for 26480 was 8.00, which the specialty and the RUC agreed was too high. Moreover, the current work RVU of 6.76 is lower than the lowest survey response of 6.85. While the survey may indicate that a higher work RVU than the current RVU is warranted, both the RUC and the specialty agreed that there is no compelling evidence beyond the survey to substantiate a change in the work since the code was valued through the Harvard studies. The RUC also looked to the survey key reference service, 25310, *Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single; each tendon* (work

RVU = 7.94), which is a very similar service. The reference service intra-service time is 60 minutes, the same as the median intra-service time for the surveyed code. However, the reference service requires slightly greater pre-service and post-service time. As such, the RUC agreed that the current work RVU of 6.76 for 26480 appropriately ranks the service within the family. **Therefore, the RUC recommends the survey physician times and post-operative office visits, and recommends maintaining the current work RVU of 6.76 for 26480.**

Fluoroscopy – PE Only (Tab 27)
Fred Davis, MD, AAPM, Rodney Jones, MD, ISIS, Paul Knechtges, MD, ACR, Marc Leib, MD, ASA, Geraldine McGinty, MD, ACR, Zeke Silva, MD, ACR, William Sullivan, MD, AAPMR

The Physician Consortium for Performance Improvement (PCPI) is developing a measure related to the use of fluoroscopy. The PCPI reviewed all services where fluoroscopy was included in the practice expense direct inputs to determine the denominator codes. The American College of Radiology suggested that seven services may not typically be performed with fluoroscopy. CMS requested that the RUC consider deleting these expenses from the inputs for these seven services. Other specialties were provided with the opportunity to review the issue and determine what room is typically used in providing the service. The RUC reviewed each service and concurred with the specialty societies that codes 64520, 64622, and 64626 provide fluoroscopy and require a radiographic-fluoroscopic room.

The RUC determined that code 64510 is performed in a examination room and services 76100 - 76102 are performed in an X-ray room. **The RUC recommends that the equipment item EL014 Room, radiographic-fluoroscopic is appropriate for 64520, 64622, and 64626 and will notify PCPI staff. The RUC also recommends the replacement of equipment item EL014 Room, radiographic-fluoroscopic to an exam table (EF023) for 64510 and a Basic Radiology Room (EL012)for CPT codes 76100, 76101, and 76102.**

Biopsy of Ear (Tab 28)
Scott Collins, MD AAD

The RUC identified 69100, *Biopsy external ear*, as potentially misvalued based on the recommendation of the Five Year Review Identification Workgroup. The code was referred to the Workgroup for review via the CMS Fastest Growing Screen. The RUC recommended that 69100 be surveyed for April 2009.

The specialty society indicated that it would pursue deletion of 69100 from CPT, as the work commonly reported under this code can be reported more efficiently by using 11100, *Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion* (work RVU = 0.81). The specialty societies were unable to complete their coding change application in time for CPT 2010, and 69100 will appear in the CPT book until CPT 2011. Subsequently, the specialty surveyed the procedure to develop an appropriate work RVU until the service is deleted from CPT. In its comments regarding deletion of 69100 and migration to use of 11100, the specialty noted that the practice expense RVU associated with 11100 is slightly lower that that of 69100. Further, the specialty noted that 69100 may be reported multiple times within the same visit on the same patient, whereas 11100 should be reported only once.

The specialty presented the results from a survey of 38 dermatologists. The surveyees indicated a median work RVU of 0.92, which is slightly higher than the current work RVU of 0.81, which was developed during the Harvard survey process and validated by the RUC during the first Five-Year Review without a survey. The specialty society expert panel reviewed the survey physician time and made minor changes to the intra-service time, reducing it by one minute to twelve minutes. The survey respondents indicated a median pre-service time of 7 minutes, which the specialty society expert panel agreed with. Survey respondents identified key reference service 11100, which is similar and often identical to the surveyed code. Because of the specialized location of the biopsy, the specialty society expert panel agreed with the survey respondents that an additional two minutes of pre-service time is required. However, the expert panel did not agree that there should be any difference in the work RVU. The RUC agreed with the specialty society presenters that the work of 69100 is identical to 11100 and should be valued the same. **Therefore, the RUC approved the amended physician time of 7 minutes pre-service evaluation, 12 minutes intra-service, and 5 minutes immediate post-service time and a physician work RVU of 0.81 for CPT code 69100, until it is deleted from CPT.**

Soft Tissue Ultrasound (Tab 29)
William Donovan, MD, ASNR, Allan Glass, MD, TES, Paul Knechtges, MD, ACR, Geraldine McGinty, MD, ACR, John Seibel, MD, AACE, Zeke Silva, MD, ACR

The RUC identified 76536, *Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation*, as potentially misvalued based on the recommendation of the Five Year Review Identification Workgroup. The code was referred to the Workgroup for review via the CMS Fastest Growing Screen. The RUC recommended that 76536 be surveyed.

The specialty society presented evidence that the work for 76536 has changed since it was first valued. The specialty noted that the typical patient has changed due to the increasing incidence and prevalence of thyroid cancer. The specialty commented that the increased incidence of thyroid cancer results in a more complex patient. However, the RUC did not agree that a rise in the recognition of certain types of cancer necessarily increases the intensity or complexity of the existing mechanisms for diagnosis of the condition. The specialty next presented evidence that the improvement in technology, including color flow and power Doppler evaluation as well as increased transducer resolution increases the complexity of the examination and the expectations of the patient. The RUC commented that the improvement in technology may increase the information available to review, but that it concurrently improves the test's accuracy and readability, affording the practitioner a more reliable and revealing test result. Lastly, the specialty noted that the code had never been reviewed by the RUC and that the original data used to value to the service may not have included the current practitioners of the service. The RUC noted that lack of RUC review is not compelling evidence to consider an increase in the RVU under the RUC rules defining the review of services identified in the Five-Year Review Process and that there is no evidence that the CMS valuation of 76536 was either inclusive or not inclusive of radiologists and endocrinologists that provide this service. Therefore, the RUC did not agree that the compelling evidence standards, required to recommend a work RVU higher than the current value, for 76536 had been met.

The specialty society presenters provided evidence that the value of 76536 should not be reduced beyond its current work RVU of 0.56. The presenters provided the survey results of 63 radiologists and endocrinologists. The median work RVU identified by the surveyees was 1.00

and the 25th percentile work RVU was 0.74. The presenters noted that the existing total physician time within the RUC database is 18 minutes, which is not allocated between pre-service, intra-service, or post-service time. The survey respondents indicated that the existing physician time is somewhat under-representative and indicated times of 5 minutes pre-service, 15 minutes intra-service and 5 minutes post-service time. However, the RUC queried and received the independent survey data of radiology vs. endocrinology. Radiologists indicated a lower intra-service time of 10 minutes, compared to 20 minutes for endocrinology.

Radiologist surveyees indicated a key reference service of 76776, *Ultrasound, transplanted kidney, real time and duplex Doppler with image documentation* (work RVU = 0.76, pre-service = 5 minutes, intra-service = 15 minutes, post-service = 5 minutes). The specialty society expert panel indicated that the appropriate physician time for 76536 should be less than 76776 as the reference service is valued slightly higher. Therefore, the specialty recommended physician times of 4 minutes pre-service, 10 minutes intra-service, and 4 minutes post-service. The RUC agreed that the work of 76776 is slightly greater than that of 76536, which justifies the difference in physician time. Further, the RUC agreed that given the survey results, the work RVU of 76536 should not be lower than its current value of 0.56 and that the current value appropriately ranks the service within its family. In further support of this recommendation, the RUC reviewed 99212, *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family,*(work RVU = 0.45, pre-service = 2, intra-service = 10, post-service = 4). The RUC agreed that the two services are very similar and that the current work RVU for 76536 of 0.56 appropriately accounts for the additional pre-service time and slightly greater intensity. **Therefore, the RUC recommends that the current work RVU for 76536 be maintained at 0.56 and that the physician time be changes to 4 minutes pre-service evaluation, 10 minutes intra-service, and 4 minutes immediate post-service.**

Radiation Treatment Delivery, Stereotactic Radiosurgery (Tab 30)
J. Daniel Bourland, PhD, ASTRO, Thomas Eichler, MD, ASTRO, Michael Kuettel, MD, ASTRO, Matthew Podgorsak, PhD, ASTRO

In the 2009 *Final Rule*, CMS received comments including one from a single free-standing non-facility provider stating that the there was a drastic difference in payment between the proposed OPPS payment $7,608 and the PFS payment $1,260. Further, the commenters stated that existing practice expense inputs are incorrect because they excluded extra clinical labor time due to Nuclear Regulatory Commission (NRC) requirements for both the physicist and the registered nurse. Because of these comments, CMS requested that practice expense inputs associated with this service be reviewed.

The RUC reviewed the direct practice expense inputs as presented by the specialty society in response to the CMS 2009 *Final Rule*. The specialty had requested an additional 99 minutes of clinical labor time to account for moderate sedation in the intra-service time. The specific recommended changes to the intra-service time were:

1. The specialty also recommended the elimination of the Registered Technician time and reassigning the remaining activities to Medical Physicist. (RUC agreed)

2. Changing several clinical labor activities from RN/LPN/MA to RN (RUC did not agree)
3. The addition of 10 minutes to the post monitoring time. (RUC agreed)
4. The addition of 45 minutes of RN assist physician time during the procedure for conscious sedation (RUC agreed)
5. Additional 44 minutes of time for miscellaneous activities (RUC did not agree)

In addition, the specialty requested minor changes to supplies and equipment. The RUC agreed with the specialty that additional time, supplies, and equipment were necessary to provide the service, however the RUC agreed to only 54 minutes of additional clinical labor time to assist in intra service and post service monitoring for moderate sedation. **The RUC recommends an additional 54 minutes of clinical labor time and other recommended medical supplies and equipment direct practice expense inputs as recommended by the specialty society for CPT code 77371. The RUC also recommends this service be placed on CPT's appendix G to indicate that Moderate Sedation is inherent to the procedure.**

Cardiac Device Monitoring (Tab 31)
James Maloney, MD, ACC, Edward Martin, MD, ACC

In the 2009 *Final Rule*, CMS stated that these services were not reviewed with the other cardiac device monitoring services, that were reviewed by the RUC in April 2008. CMS requested that these codes, as part of the family of cardiac device monitoring codes, be reviewed.

The RUC reviewed their previous recommendations for the cardiac device monitoring codes from April 2008 and determined that the wearable holter monitor codes may be not be in the proper rank order. The RUC agreed that the recently reviewed device monitoring codes relative values are based on 30 days and the wearable monitor codes, not reviewed as part of this family, are based on 24 hours of work, yet are valued the same**. The RUC recommends that the wearable cardiac monitoring family of codes, 93224-93272, that have work RVUs be referred to CPT for revision and resurvey.**

End-Stage Renal Disease – PE and Physician Time Only (Tab 32)
Eileen Brewer, MD, RPA, Richard Hamburger, MD, RPA Robert Kossmann, MD, RPA

CMS requested in the 2009 Final Rule, that the RUC review the practice expense inputs associated with the end stage renal disease (ESRD) codes to ensure that they accurately reflect the typical direct resources required to perform these services and to review the physician time for 90960 and 90961.

Practice Expense Clinical Labor Time
The specialty society convened an expert panel to review the direct practice expense clinical labor time for the adult and pediatric ESRD codes. The specialty panel agreed that 42 minutes of clinical staff time, for all of the varied and unpredictable services to a typical patient with 6 co-morbid conditions and on more than 7 drugs over the course of a month, was not sufficient to reflect the clinical staff activities performed in support of monthly dialysis care. The specialty panel determined that an additional 24 minutes of clinical staff pre-service time for the pediatric codes and 18 additional minutes for the adult codes, would accurately reflect the services provided over an entire month. The clinical activities that the expert panel believed had been under-represented were:

(1) unscheduled follow up phone calls and prescription drug review-6 minutes (12 minutes for pediatrics patients)
(2) lab and x-ray review-3 minutes
(3) evaluation of dialysis access problems-3 minutes
(4) transplant evaluation-1 minute
(5) multidisciplinary care team meetings-5 minutes

By adding these clinical labor time increments both the pediatric and adult ESRD monthly codes would have a total of 60 minutes of clinical labor time. The RUC agreed with the addition of this clinical labor time. In addition, this monthly time of 60 minutes was recommended to be applied to all of the codes in the code family, including the home dialysis codes (CPT codes 90963-90966), and proportionately to the daily dialysis codes (CPT codes 90967-90970), the values for which have been historically based on 1/30th of the monthly code value.

The RUC therefore recommends that the monthly outpatient dialysis codes (CPT codes 90951-90966), representing both in-center and home dialysis care, be assigned an additional 24 minutes of clinical staff time per code for the pediatric codes and 18 minutes of clinical staff time per code for the adult codes, and that this revision also be applied proportionately to the daily dialysis service codes (CPT codes 90967-90970) to reflect the clinical staff activities currently necessary to provide services to the typical adult and pediatric ESRD patients. Therefore, the total clinical staff time for all monthly codes should now be 60 minutes.

Physician Time for CPT code 90960 and 90961
Upon reviewing the physician time for CPT codes 90960 and 90961, the RUC concurred with CMS that for practice expense purposes, the physician time needed additional review. The specialty noted that the unit level code, 90962, was provided with 38 minutes of physician time for Care Plan Oversight (from procedure code G0182), while the services with increased physician visits and activity, 90960 and 90961, were not. The RUC agreed that even though the physician time recommendations for codes 90960 and 90961 are based on a higher number of building blocks, the degree of care plan oversight activities for these services is no less than that for the unit level code and, for practice expense purposes, were not captured by the office visit building blocks currently comprising the recommendations for these services. **The RUC recommends that CPT codes 90960 and 90961 be assigned an additional 38 minutes of physician time for practice expense purposes to reflect the care plan oversight activities currently necessary to provide services to the typical adult ESRD patient. The new total time for CPT code 90960 is 128 minutes and 113 minutes for 90961.**

XI. Practice Expense Subcommittee (Tab 33)

Doctor Moran reported that the Practice Expense Subcommittee reviewed an array of direct practice expense recommendations for new, revised, and existing CPT codes referred to the group by CMS. The RUC approved the recommendations and will forward to CMS.

The Subcommittee recommended and the RUC agreed that: A practice expense ad hoc workgroup be formed to:

1. **Obtain an understanding of the line item (review records) and what it consists of**
2. **Develop a standardized time for the item**
3. **Discussing what, if anything, should be done to adjust services reviewed previously**

The Subcommittee also recommended and the RUC agreed to the RUC **that a separate workgroup be established to review the use of less expensive equipment if appropriate, specifically the committee focused on the use of a fluoroscopic system, mobile C-Arm rather than the use of a radiographic-fluoroscopic room.**

These workgroups will convene over the summer of 2009 and report back to this Subcommittee at its next meeting.

Sherry Smith and the AMA's Division of Economic and Health Policy Research presented the overall results of the Physician Practice Information (PPI) Survey that recently was concluded with the results forwarded to the Centers for Medicare and Medicaid Services (CMS). Ms. Smith explained that the survey effort was a success and thanked the specialties for their cooperation in the survey efforts and informed the group that the AMA will provide them with specialty level reports in June 2009.

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

XII. Research Subcommittee Report (Tab 34)

Doctor Daniel Siegel delivered the Research Subcommittee Report to the RUC detailing the five items reviewed: 1.) Development of a work proxy to address 23+ hour stay services, 2.) Addition of IWPUT to the RUC Database, 3.) Review of the Reference Service List Policy, 4.) Laparoscopic Longitudinal Gastrectomy Issue and 5.) Specialty Society Requests

After a robust discussion of the current CMS policies regarding observation services, Condition Code 44 Inpatient Admission Changed to Outpatient and the Interqual program, the Research Subcommittee determined that the work proxies that are currently being used by the RUC, the hospital visit codes, are appropriate. A hospital change of a patient status from inpatient to outpatient is irrelevant to the services provided by the physician. **The Research Subcommittee recommends the following policy be created:**

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

The Research Subcommittee reviewed all of the existing RUC policy regarding IWPUT and discussed whether IWPUT should be included in the RUC database. It was clarified that the IWPUT will be in the RUC Database only and not the RBRVS Data Manager. **The Research Subcommittee recommends:**

1.) that all codes with RUC survey time display their associated IWPUT in the RUC database.

2.) that a note stating the current RUC policy regarding IWPUT be added below the CPT disclaimer in the database to read,

"IWPUT should be used only as a measure of relativity between codes or in families of

codes. IWPUT is a complimentary measure and should not be used as the sole basis for ranking or the assignment of value to a service. IWPUT may be used to validate survey data."

3.) that the IWPUT data point be included in the search function of the RUC database.

As requested by a Research Subcommittee member, the Research Subcommittee discussed constructing policy to ensure more robust review of requests from specialties to review reference service lists. **The Research Subcommittee recommends the following policy be created:**

The specialty will provide the following information to the Research Subcommittee on all codes in reference service list (in addition to the code, descriptor, work value currently provided) when submitting these requests:

1.) The year it was valued
2.) Whether the time is based on RUC, Harvard or other
3.) The MPC status
4.) The Medicare Volume
5.) The intra-service time
6.) The total service time
7.) The IWPUT calculation

On March 11th, the American Society of Metabolic and Bariatric Surgery (ASMBS) sent out an unapproved reminder email to members asking them to complete the RUC survey for the new laparoscopic longitudinal gastrectomy code. The Research Subcommittee upon review of this issue, expressed concern over how the data would be presented to the RUC and requested that the specialties provide a cover letter to their submission to the RUC explaining what occurred and provide the Research Subcommittee the data received prior and subsequent to the e-mail being sent out so that they could compare the results.

The Research Subcommittee reviewed the ASMBS e-mail and the survey results from before and after the e-mail was distributed. **The Research Subcommittee commends the specialty for how they handled this issue and would like to remind specialty societies that if they are developing primary recommendations to the RUC, they need to ensure that the materials distributed will not influence the survey respondents.**

At the Five Year Review Identification Workgroup the CAP was instructed to develop recommendations for several codes in the 88300 code family. CAP requested review of a new vignette and survey instrument for 88314 *Special stains (List separately in addition to code for primary service); histochemical staining with frozen section(s)*. This vignette and proposed survey instrument are attached to this report. **The Research Subcommittee approved the proposed vignette as submitted by the specialty society. After reviewing the proposed survey instrument, the Research Subcommittee agreed that the proposed descriptions of pre-, intra- and post-service times were too detailed and recommended that the society utilize the RUC-approved Pathology Survey Instrument.**

Also, the society is requesting to mini-survey code 88312 *Special stains (List separately in addition to code for primary service); Group I for microorganisms (eg, Gridley, acid fast, methenamine silver), each* and 88313 *Special stains (List separately in addition to code for primary service); Group II, all other (eg, iron, trichrome), except immunocytochemistry and immunoperoxidase stains, each* as the society has expressed concern that due to the multiple biopsy types and special stain types that can be reported

under a single CPT code, there could be significant differences in work. **Therefore, based on this concern, the specialty society proposes and the Research Subcommittee recommends that CAP will survey its membership to determine if there is a significant difference in work within 88312 and within 88313 and will review the results to determine if new CPT codes need to be created to clearly define the work being performed or if a RUC survey can be completed with the current CPT descriptors.**

To add more clarity to the RUC Survey process, the Research Subcommittee recommends that a text box be added to the Summary of Recommendation Form to allow the specialty societies to add to their description of survey sample type, if they desire.

February 25, 2009 Conference Call Report – Maternity Code Survey
The Conference Call Report was distributed to the Research Subcommittee members and no further discussion occurred. This Conference Call Report is in the RUC Agenda Book under the Research Subcommittee Tab. There was no discussion of this report.

The RUC approved the Research Subcommittee report and the February 25, 2009 conference call report and they are attached to these minutes.

XIII. Ad Hoc Pre-Time Workgroup Report (Tab 35)

Doctor Brenda Lewis delivered the Ad Hoc Pre-Time Workgroup Report. The Workgroup was charged with discussing new pre-service time standards proposed by specialty societies including a proposal from the spine surgeons regarding pre-service positioning time. After careful review of the specialty societies' survey data and comparisons to the pre-service positioning time of recent RUC reviewed spine codes, **the Workgroup recommends that the following positioning times for spinal surgical procedures and spinal injection procedures be incorporated into Pre-Service Time Document in the notes section:**

Positioning times for spinal surgical procedures:

Pre-Time Pkg SS1	**Anterior Neck surgery (supine) (eg ACDF)**	**15 minutes**
Pre-Time Pkg SS2	**Posterior Neck surgery (prone) (eg laminectomy)**	**25 minutes**
Pre-Time Pkg SS3	**Posterior Thoracic/Lumbar (prone) (eg laminectomy)**	**15 minutes**
Pre-Time Pkg SS4	**Lateral Thoracic/Lumbar (lateral) (eg corpectomy)**	**25 minutes**
Pre-Time Pkg SS5	**Anterior Lumbar (supine) (eg ALIF)**	**15 minutes**

Positioning times for spinal injections procedures:

Pre-Time Pkg SI1	**Anterior Neck injection (supine) (eg discogram)**	**7 minutes**

Pre-Time Pkg SI2 minutes	**Posterior Neck injection (prone) (facet)**	**5**
Pre-Time Pkg SI3 minutes	**Posterior Thoracic/Lumbar (prone) (epidural)**	**5**
Pre-Time Pkg SI4 minutes	**Lateral Thoracic/Lumbar (lateral) (eg discogram)**	**7**

The Workgroup recommends that following language be added to the instruction document:

Societies utilizing the spine pre-time packages should select a pre-service time package as directed in the instruction document and make modifications to the positioning time based on the spine pre-service time package selected. The societies should then reflect their selection of spine pre-service time package in the additional rationale section.

The RUC approved the Pre-Time Workgroup report and it is attached to these minutes.

XIV. Administrative Subcommittee Report (Tab 36)

I. Financial Disclosure Policy

Doctor Blankenship indicated that the Administrative Subcommittee reviewed the AMA General Counsel suggested revisions to the Financial Disclosure Statement for presenters. The Subcommittee determined and the RUC agreed that materially should be defined as "any" income for the past twelve months or cumulative lifetime income of at least $10,000. The Subcommittee recommends that the RUC be made aware of **any** current financial interests. The RUC modified the Financial Disclosure Statement as follows:

AMA/Specialty Society RVS Update Committee (RUC)
Financial Disclosure Statement For
Specialty Society Presenters

I certify that my personal or my family members' direct financial interest in, and my personal or my family members' affiliation with or involvement in any organization or entity with a direct financial interest in the development of relative value recommendations in which I am participating are noted below. Otherwise, my signature indicates I have no such direct financial interest or affiliation with an organization with a direct financial interest, other than providing these services in the course of patient care.

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

For purposes of this Disclosure, "direct financial interest" means:

- A financial ownership interest in an organization ** of *5%* or more; or
- A financial ownership interest in an organization ** which contributes materially* to your income; or

- Ability to exercise stock options in an organization** now or in the future ~~which contributes materially* to your income;~~ or
- A position as proprietor, director, managing partner, or key employee in an organization**; or
- Serve as a consultant, expert witness, speaker or writer for an organization**, where payment contributes materially* to your income.

* "materially" means **any** income for the past twelve months or cumulative lifetime income of at least $10,000.
** "organization" means any entity with an interest in the development of relative value recommendations.

Include only interests that relate to the specific issue that you are presenting at this RUC meeting.

Specific Disclosure (i.e., list organization)	**Explain relationship between the service(s) that you are presenting and your disclosure**	**Identify interest for the past 12 months (circle one)**	**Identify cumulative lifetime interest (circle one)**	**If disclosure relates to stock, please list number of shares owned, options or warrants**
		N/A < $10,000 ≥ $10,000	< $10,000 ≥ $10,000	
		N/A < $10,000 ≥ $10,000	< $10,000 ≥ $10,000	
		N/A < $10,000 ≥ $10,000	< $10,000 ≥ $10,000	

_____
Agenda Tab/Issue

_____ _____
Signature Date

_____ _____
Print Name Specialty Society

The Administrative Subcommittee discussed and recommends consideration of a policy whereby all RUC members and alternates will complete a financial disclosure statement. The Administrative Subcommittee will review this issue at the October 2009 Administrative Subcommittee meeting.

II. Conflict of Interest Policy and Statement

Doctor Blankenship informed the RUC that the Administrative Subcommittee reviewed the AMA General Counsel suggested revisions to the Conflict of Interest Policy and Statement and determined that the following changes be made. *All bolded and underlined*

items are additions by the Administrative Subcommittee. All items underlined are additions by the AMA General Counsel.

AMERICAN MEDICAL ASSOCIATION/SPECIALTY SOCIETY
RELATIVE VALUE SCALE UPDATE COMMITTEE ("RUC")
CONFLICT OF INTEREST POLICY

No RUC or other Committee, Subcommittee or Workgroup representative will vote or participate in any deliberation on a specific issue in the event the representative, or the representative's family member, has a direct financial interest in the outcome of the vote or deliberation other than the representative in the course of their practice performing the procedure or service at issue. Every RUC or other Committee, Subcommittee or Workgroup representative shall disclose his or her, or family member's, direct financial interest(s) prior to any vote or deliberation and shall not vote or participate in the deliberation in which he or she has a direct financial interest. **Any known disclosure should be made to the RUC chair in writing prior to the meeting.**

Any individual who is presenting or discussing relative value recommendations before the RUC shall disclose on a Financial Disclosure Form his or her direct financial interest(s) if any, prior to any presentation(s). **The Administrative Subcommittee will review financial disclosure documents in advance of the meeting. If a direct financial interest is identified on the financial disclosure form, the individual may be precluded from presenting.**

For purposes of this Policy, direct financial interest means: (i) a financial ownership interest in an organization (i.e., "organization" shall mean any entity with an interest in the development of relative value recommendations) of 5% or more; or (ii) a financial ownership interest in an organization which contributes materially (i.e., "materially" shall mean **any** income for the past twelve months or cumulative lifetime income of at least $10,000) to your income; or (iii) the ability to exercise stock options in an organization **that is related to issues at the RUC**, now or in the future ~~which contributes materially to your income;~~ or (iv) a position as proprietor, director, managing partner, or key employee in an organization; or (v) a consultant, expert witness, speaker or writer for an organization, where payment contributes materially to your income.

For purposes of the Policy "family member" means spouse, domestic partner, parent, child, brother or sister. Disclosure of a family member's interest applies to the extent known by the representative or presenter.

STATEMENT OF COMPLIANCE WITH
RELATIVE VALUE SCALE UPDATE COMMITTEE ("RUC")
CONFLICT OF INTEREST POLICY

I understand that I am expected to comply with the Conflict of Interest Policy of the RUC. To my knowledge and belief, I am in compliance with the Conflict of Interest Policy. I ~~have~~ **will** disclose any direct financial interests in specific issues considered by the RUC, or any subcommittee or workgroup of the RUC, and I ~~**have**~~ **will recuse** ~~excused~~ myself from deliberation and vote on any issue in which I or any family member have a direct financial interest. I understand that I have a continuing responsibility to

comply with the Conflict of Interest Policy, and I will promptly disclose my direct financial interests required to be disclosed under this Policy.

Date: _____ Signature: _____

Print Name: _____

III. Review of Rotating Seat Election Materials

Doctor Blankenship informed the RUC that the Administrative Subcommittee reviewed the current rotating seat election rules in light of the upcoming election at this meeting. No issues were raised.

IV. Other Issues

Referral item from Financial Disclosure Review Workgroup – Discussion on ownership of ASCs in relation to direct financial interests

The Administrative Subcommittee discussed whether physician ownership of an ASC constitutes a direct significant financial interest, outside of providing services in the course of patient care, according to the RUC financial disclosure policy. The Administrative Subcommittee indicated that ASC payment for procedures are determined by CMS and will not be impacted by work RVUs. The Administrative Subcommittee determined that physician ownership of ASCs do not have a conflict of interest, however the RUC should continue to determine financial interests on a case-by-case basis.

Subcommittee and Workgroup Vice Chairpersons

At the February 2009 meeting a RUC member requested that the RUC review the possibility of assigning an alternate for the Practice Expense Subcommittee Chair. Doctor Rich charged the Administrative Subcommittee to review this issue. **The Administrative Subcommittee determined that all Subcommittee and Workgroups should be assigned a Vice Chair in the event the Chair is not able to attend a RUC meeting. The Administrative Subcommittee recommends the following changes to the Structure and Functions Document:**

III. Organization and Structure

G. Officers

Chair – The AMA designated RUC Chair will preside at all RUC meetings. The AMA representative will be the Vice Chair and preside in the Chair's absence. Each other Committee or Subcommittee shall be chaired and **vice-chaired** by a representative of the RUC as appointed by the Chair.

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

XV. PLI Workgroup (Tab 37)

Doctor Peter Smith provided the report of the PLI Workgroup to the RUC and noted that the Workgroup reviewed the AMA staff analysis of the 2009 Medicare Physician

Payment Schedule and the RUC-recommended changes to the PLI RVU for services reviewed by the RUC that were generated through the Five-Year Review Identification Workgroup process. The Workgroup identified 38 services for which CMS has not adjusted the PLI RVU per the RUC recommendations. The data indicate that nearly $11 million in potential savings were not implemented.

The RUC approved the Workgroup recommendation that the RUC reiterate its PLI crosswalk recommendations and request that CMS accept these and implement the revised PLI crosswalks.

The Workgroup also agreed that the RUC should specifically note (in the cover letter to its annual recommendation) to CMS any changes in the PLI crosswalk for existing services that it recommends, to ensure that the recommendations are reviewed by CMS.

Doctor Smith noted that CMS has not yet shared the contractor's report regarding PLI RVUs. The Workgroup will schedule several conference call meetings to discuss the proposed changes to the CMS PLI valuation methodology once the report and Proposed Rule are available.

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

XVI. Five-Year Review Identification Workgroup (Tab 38)

Doctor Levy presented the Five-Year Review Identification issues to the RUC.

I. Reconsideration of previously identified services

a. Code 19357 - previous referral to CPT, ASPS appeal and request to remove 19357 from the site-of-service screen

The Five-Year Review Identification Workgroup reviewed CPT code 19357 *Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion* at the September 2007 RUC meeting, as identified by the site of service anomaly screen. The Workgroup agreed to refer this service to the CPT Editorial Panel because of differences in delayed and immediate breast reconstruction, which enables a bi-modal typical patient. As an interim measure the Workgroup recommended to remove the hospital visits (1-99231 and 1-99232) and reduce the discharge day management to a half day. While reviewing the Five-Year Review Identification Workgroup status report, staff discovered that the Workgroup has not readdressed this issue.

The American Society of Plastic Surgeons (ASPS) did not submit a code change proposal to the CPT Editorial Panel, instead is requesting that the RUC remove code 19357 from the site of service screen as it is typically performed in the inpatient hospital setting.

The Workgroup reviewed this issue and reaffirmed its original recommendation that this code be referred to CPT. Given its bi-modal distribution, 19357, may be separated into two separate codes to describe interval and immediate construction.

b. Code 66761 – high IWPUT screen

The Five-Year Review Identification Workgroup reviewed CPT code 66761 *Iridotomy/iridectomy by laser surgery (eg, for glaucoma) (1 or more sessions)*. This code

was in a family of codes in which one or more sessions was defined. At this April 2009 meeting, the specialty society indicated that they requested that CMS change the global period for 66761 from 090-day to 010-day. However, CMS did not accept the global period change. The specialty society indicated that typically one session is performed. **The Workgroup determined that the specialty society should clarify and re-request that CMS change 66761 to a 010-day global period. However, if the global period change is not acceptable, the specialty society should develop a coding proposal to clarify.**

c. Codes 67210, 67220 and 67228 – high IWPUT screen

Codes 67210, 67220 and 67228 were identified in February 2008 by the high IWPUT screen. At that time, the Workgroup agreed with the specialty society that the services should be changed from 090-day global periods to a 010-day global periods and after CMS concurrence referred to the CPT Editorial Panel to change the descriptor. At the October 2008 RUC meeting, American Academy of Ophthalmology (AAO) indicated that CMS informed them that they will not change the global period for these services. Therefore, AAO can not resurvey or redefine in CPT with the adjusted global periods.

At this April 2009 meeting, the specialty society indicated that 67210 is typically 1 session, 67220 is typically less than 2 sessions and 67228 is typically 2.5 sessions. **The Workgroup agreed with the specialty society that they will come back to the Five-Year Review Identification Workgroup in October 2009 with a plan on how to address codes 67210, 67220 and 67228.**

d. Definition of CT Extremity Family – Codes (73200 and 73700)

The Workgroup reviewed the March 31, 2009 letter from ACR indicating that codes 73200 and 73700 are an appropriate CT without contrast code family. **The Workgroup agreed with the specialty society that codes 73200 and 73700 will be surveyed and reviewed at the October 2009 RUC meeting. The specialty society indicated that they will develop a plan to address "with contrast" CT codes (73201, 73202, 73701, 73702, and 73706) at the October 2009 meeting.**

e. Codes 20550, 20551 and 20926: Status Update

20550

The Workgroup reviewed a letter from AAOS and agreed that code 20550 be removed from the CMS Fastest Growing screen as it has not had high volume growth and was added only added to the screen as part of this family of codes. **The Workgroup recommends that 20550 be removed from the CMS Fastest Growing screen.**

20551

The Workgroup reviewed the volume for 20550 and 20551 and determined that volume has decreased for these services combined. **The Workgroup determined code 20551 be removed from the screen and reviewed in two years.**

20926

AAOS indicated that given the significant increase in utilization and that 20926 has never been surveyed, code 20926 should be surveyed and reviewed at the October 2009 RUC meeting. **The Workgroup recommends that code 20926 should be surveyed and reviewed in October 2009.**

f. Code 88309 – CAP request to remove from screen

CAP indicated that code 88309 was added to the Top 9 Harvard Codes only because it was part of the family for 88304 and 88305. The specialty society indicated that 88309 was recently reviewed at the third Five-Year Review and should be removed from the screen. The Workgroup determined that code 88309 was thoroughly reviewed at the third Five-Year Review, however noted concern about the physician time. **The Workgroup recommends that 88309 be removed from the Top 9 Harvard screen.**

II. Items not yet submitted to CPT to be discussed

a. Referrals to the CPT Editorial Panel (55866 and 93236)

The Workgroup identified that all but two codes referred to CPT as part of the Five-Year Review Identification process have been addressed or are on the CPT Editorial Panel Agenda to address soon. Two remaining codes are 55866 and 93236.

55866

Initially the specialty society planned to develop a coding proposal to separate code 55866 into two codes to distinguish between robotic and non-robotic laparoscopic prostatectomy. The CPT Editorial Panel determined that the codes should be surveyed and describe the typical method and not separated into two codes. **The Workgroup recommends that 55866 be reviewed at the October 2009 RUC meeting. The Workgroup indicated that it is at the discretion of the society if they wish to revise the vignette and resurvey 55866 or utilize survey data from last year.**

The RUC thoroughly discussed that this issue should be surveyed to describe the typical method and presented at the October 2009 RUC meeting.

93236

The Workgroup recommended that code 93236 be removed from the high volume growth screen as it is carrier priced and does not have work or practice expense RVUs.

b. Referrals to CPT Assistant (13120-22, and 93236)

13120-22

At the February 2009 meeting the Workgroup believed that 13120, 13121, and 13122 were regularly performed at the same time as excision of lesion services and may need to be referred to CPT to create bundled services. However, the specialty society provided a robust analysis of utilization data showing that this family of codes is not typically reported by the same physician at the time of any excision codes. The Workgroup recommended that this service be reviewed again in 2 years. The Workgroup recommended that the specialty develop a CPT Assistant article to provide correct coding instructions.

Prior to this identification screen, AAD submitted a CPT Assistant article on this issue in Aug 2006. The Workgroup reviewed the 2006 article and determined that it did not sufficiently address the current issue or have any impact on Medicare utilization. **The Workgroup recommends that another CPT Assistant article be written to address this issue, specifically focusing on the second and higher volume code.**

III. Joint CPT/RUC Workgroup on Bundled Services Update – *Informational Only*

The specialty societies informed the Workgroup that coding proposals will be developed for the following issues:

a. Diskectomy and Arthrodesis (22254 and 63075)
b. Computed Tomography (72192, 72193, 72194, 74150, 74160, 74170)

IV. Small Box Technology Workgroup

The issue of small box technology arose due to the identification of practice expense issues related to 76880, *Ultrasound, lower extremity*. The availability of handheld ultrasound equipment has enabled podiatry and other specialties to perform this and other similar procedures within their offices, which is driving the increase in utilization. Previously, the Workgroup noted that value of 76880 includes the ultrasound room, which is priced significantly higher than the handheld device. The Workgroup agreed that this is an issue that may need to be addressed through either CPT changes and/or significant changes in the practice expense and possibly work. Some Workgroup members believe that there may be other services that were valued using larger, more expensive, and more sophisticated equipment where there is now smaller and more affordable equipment to perform a similar procedure. In February 2009, the RUC recommended the creation of a joint CPT and RUC workgroup to research this issue to identify similar services and develop recommendations to appropriately describe and/or address the valuation of these services.

Doctors Rich and Thorwarth subsequently created a joint CPT Workgroup and named Kenneth Brin, MD and Robert Zwolak, MD as Co-Chairs. To understand the scope of the request, Doctors Brin and Zwolak met with AMA staff and later with Ken Simon, MD of CMS to determine the best direction for a workgroup agenda.

Doctors Brin and Zwolak understand the issue presented by the identification of 76880 in the high volume growth screen and recommend that the Five-Year Review Workgroup and RUC review this code to determine if it is appropriately valued. However, the charge to expand this issue to all services utilizing ultrasound and/or technologies that have "small box" models available is less clear.

AMA staff reviewed all codes in the 70000 series of CPT to determine if other imaging codes are now predominately provided by a specialty other than radiology that may indicate some greater use of "small box" technology. It was not apparent from this review that the use of the less expensive technology has become "typical" in any other services beyond 76880.

The CPT Editorial Panel has already reviewed the issue regarding the use of hand held ultrasound, which led to the addition of the CPT guidelines.

Doctors Brin and Zwolak confirmed that CPT and CMS would be unlikely to create modifiers or separate coding to describe the same physician service, utilizing two differently priced technologies. For this reason, the Five-Year Review Workgroup should reconsider whether a joint RUC/CPT Workgroup is warranted at this time.

The Workgroup determined the RUC should review the work and practice expense inputs for 76880 the October 2009 meeting.

The Workgroup recommends that the RUC and its Practice Expense Subcommittee should consider these issues when reviewing new/revised CPT codes. This review should ensure that the technology is appropriately discussed and articulated in the recommendations to CMS. In addition, it would be important to understand when the physician is using the equipment and performing the technical component versus when staff provide the technical service.

The Workgroup recommends the dissolution of the Small Box Technology Workgroup.

V. 2010 Five-Year Review

a. Review *Guidelines for Compelling Evidence*

The Workgroup reviewed the compelling evidence standards from the last Five-Year Review. The Workgroup discussed adding a bullet point that would include "Harvard Valued code" as satisfying the standards of compelling evidence that the current valuation is not accurate. Members voiced concern that adding that compelling evidence standard would indicate that the RUC views that all Harvard codes are currently incorrectly valued. The Workgroup indicated that specialty societies may bring forth codes because they are Harvard reviewed and have never been surveyed by the RUC and typically will find that other compelling evidence standards will apply. Additionally, the Workgroup indicated that the top Harvard codes have been addressed by this Workgroup as part of the Five-Year Review Identification process. **The Workgroup reaffirmed the current compelling evidence standards from the third Five-Year Review for the 2010 Five-Year Review.**

The RUC thoroughly discussed adding a bullet point to the compelling evidence to include "Harvard valued code". Ultimately the RUC reaffirmed the current compelling evidence standards from the third Five-Year Review for the 2010 Five-Year Review. The RUC noted that specialty societies may still bring forth Harvard codes during the comment period for the 2010 Five-Year Review, but this may not be a sole basis for compelling evidence to bring forth a code.

b. Review *Procedures for the August Workgroup and Sept/Oct RUC Meetings*

The Workgroup reaffirmed the current procedures for August Workgroup and Sept/Oct RUC meetings.

c. Review feedback from specialty societies regarding scope of the Five-Year Review

AMA staff surveyed RUC participants to gather an estimate of how many codes to expect at the 2010 Five-Year Review. Over 40 specialty societies responded (all major specialties on the RUC) and over half indicated that they will not be brining forth any codes and the remaining indicated bringing forth approximately 250 codes. At this time August 26-28, 2010 has been reserved for Five-Year Review Workgroup meetings. However, if the total codes to be reviewed is approximately 250 the RUC may only be required to meet in September 2010. An additional day may be added to that meeting in lieu of the August schedule.

VI. Other Issues

A full status report of Five-Year Review Identification Workgroup and CMS Request codes was provided as an informational item.

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

XVII. HCPAC Review Board (Tab 39)

Lloyd Smith, DPM, informed the RUC that the HCPAC elected himself as the RUC HCPAC Co-Chair and Emily Hill, PA-C as the RUC HCPAC Alternate Co-Chair to serve their second two-year term, beginning September 2009 and ending in May 2011.

CMS Request: Relative Value Recommendations for *CPT 2010*:
Speech Language Pathology Services

Dr. Smith informed the RUC that at the February 2009 HCPAC meeting the HCPAC reviewed code 92526 *Treatment of swallowing dysfunction and/or oral function for feeding*, however, after a robust discussion of the intra-service work and episodes of therapy, the HCPAC recommended postponing recommending a work value for this service until additional frequency data was gathered, the length of treatment session was defined and the RUC had reviewed codes 92597 *Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech* and 92610 *Evaluation of oral and pharyngeal swallowing function.*

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

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

92611

In February 2009, the HCPAC reviewed the American Speech-Language-Hearing Association (ASHA) recommendation for 92611 *Motion fluoroscopic evaluation of swallowing function by cine or video recording.* The HCPAC recognized that since this speech language pathology service is converting from practice expense only inputs to work, survey respondents had limited reference services to identify with. The HCPAC reviewed the pre-service time and determined that 7 minutes of pre-service time appropriately accounted for the time required to review the patients medical records, review the patient history, prepare the barium liquids, prepare items of different consistencies and dress in the appropriate radiation deterrent gowns. The HCPAC reviewed the intra-service time and determined that 30 minutes appropriately accounted

for the time to feed the patient the numerous substances while watching the video fluoroscopy and make determinations on the subsequent liquid consistencies to utilize and patient posture to employ. The HCPAC reviewed the immediate post-service time survey results and recommended reducing the time from 15 minutes to 10 minutes. The HCPAC determined that 10 minutes of immediate post-operative time appropriately accounts for time required discussing findings with the patient/family, writing a report and communicating necessary information with the referring physician.

The HCPAC compared 92611 to 97001 *Physical therapy evaluation* (work RVU = 1.20, 4 minutes pre-service, 30 minutes intra-service, and 8 minute post-service time) and 92602 *Diagnostic analysis of cochlear implant, patient younger than 7 years of age; subsequent reprogramming* (work RVU = 1.30, 5 minutes pre-service, 50 minutes intra-service, and 10 minutes immediate post-service time). The HCPAC determined that 92611 is more intense than 97001 and 92602 as more management and follow-up strategy determination is required.

The HCPAC also compared 92611 to code 99203 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 1.34, pre-service time = 4 minutes, intra-service time = 20 minutes and immediate post-service time = 5 minutes), and determined that the survey 25th percentile work RVU of 1.34 is identical to 99203 and appropriately accounts for the work required to perform this service. **The HCPAC recommends a work RVU of 1.34 for code 92611.**

In April 2009, the HCPAC reexamined code 92611 to assure no rank order anomaly exists with the two codes which were reviewed at the RUC in February 2009 (92597 *Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech* (RUC recommended work RVU = 1.48) and 92610 *Evaluation of oral and pharyngeal swallowing function* (RUC recommended work RVU = 1.30). **The HCPAC reaffirmed the recommended physician work RVU of 1.34 for code 92611 which was reviewed in February 2009.**

92526

At the February 2009 HCPAC meeting the HCPAC reviewed code 92526 *Treatment of swallowing dysfunction and/or oral function for feeding.* After a robust discussion of the intra-service work and episodes of therapy, the HCPAC recommended postponing recommending a work value for this service until additional frequency data was gathered, the length of treatment session was defined and the RUC had reviewed codes 92597 *Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech* and 92610 *Evaluation of oral and pharyngeal swallowing function.*

In April 2009, the HCPAC reviewed code 92526 and determined that it is typically performed 10 times to treat dysphasia in the outpatient setting, approximately once a week. The HCPAC recognized that since this speech language pathology service is converting from practice expense only inputs to work, that survey respondents had limited reference services to identify with. The HCPAC reviewed the pre-service time and determined to decrease the surveyed pre-time to 5 minutes as it appropriately accounts for the time required to review the previous progress note and prepare the materials. The HCPAC reviewed the intra-service time and determined that 45 minutes appropriately accounted for the time to instruct a variety of oral motor and pharyngeal/laryngeal swallow exercises and assess the patient's ability to achieve criterion performance levels of a variety of therapy activities. The HCPAC reviewed the

immediate post-service time and agreed with the specialty society recommended reduction to 5 minutes. The HCPAC determined that 5 minutes appropriately accounts for time required discussing findings with the patient/family and writing a report.

The HCPAC compared 92526 to codes 97001 *Physical therapy evaluation* (work RVU = 1.20, 4 minutes pre-service, 30 minutes intra-service, and 8 minute post-service time) and 97003 *Occupational therapy evaluation* (work RVU = 1.20, 7 minutes pre-service, 45 minutes intra-service, and 5 minutes immediate post-service time). The HCPAC determined that 92526 is more intense than 97001 and 92602 as the type of patient is more fragile, typically cognitively impaired/post CVA. **The HCPAC recommends a work RVU of 1.34 for code 92526.**

Practice Expense
The HCPAC recommends removing the previous speech language pathologist's time from the practice expense inputs for codes 92526 and 92611, as well as replacing outdated recording output VHS tape with a DVD for the non-facility setting for code 92611.

PLI
The HCPAC recommends that codes 92526 and 92611 be crosswalked to 92557.

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

XVIII. Rotating Seat Elections (Tab 40)

The RUC considered the election of the internal medicine rotating seat. The following individuals were nominated:

- Robert Kossmann, MD, FACP - Renal Physicians Association
- Scott Manaker, MD, PhD, FCCP - American College of Chest Physicians / American Thoracic Society
- Eileen Moynihan, MD - American College of Rheumatology
- John A. Seibel, MD, MACE - American Association of Clinical Endocrinologists
- Samuel M. Silver, MD, PhD - American Society of Hematology

The term for the seat is two years, beginning with the September 2009 RUC meeting and ending in May 2011, with the provision of final recommendations to the Centers for Medicare and Medicaid Services.

The RUC elected Robert Kossmann, MD, representing the Renal Physicians Association.

The RUC considered the election of the "other" rotating seat. The following individuals were nominated:

- Sherry Barron-Seabrook, MD - American Academy of Child & Adolescent Psychiatry
- Scott A.B. Collins, MD - American Society for Dermatologic Surgery
- Margaret Neal, MD - American Society of Cytopathology

- Guy Orangio, MD, FACS, FASCRS - The American Society of Colon & Rectal Surgeons
- Matthew J. Sideman, MD - Society for Vascular Surgery

The term for the seat is two years, beginning with the September 2009 RUC meeting and ending in May 2011, with the provision of final recommendations to the Centers for Medicare and Medicaid Services.

The RUC elected Guy Orangio, MD, representing the American Society of Colon and Rectal Surgeons.

XIX. Other Issues

The RUC thanked Doctor Rich for his years of service to the RUC and organized medicine. Doctor Rich, in turn, thanked the RUC and welcomed the new chair, Doctor Barbara Levy by handing over the gavel.

The meeting adjourned on Saturday April 25, 2009 at 3:30 p.m.

AMA/Specialty Society RVS Update Committee
Practice Expense Subcommittee Report
Thursday, April 23, 2009

Members: *Doctors Bill Moran (Chair), Bibb Allen, Joel Brill, Manuel Cerqueira, Neal Cohen, Thomas Cooper, Walt Larimore, David Hitzeman, Peter Hollmann, William Mangold, George Williams, Tye Ouzounian, John Seibel, and Katherine Bradley, PhD, RN.*

Doctor Moran greeted the group and announced that George Williams, MD will replace Gregory Kwasny, MD on the subcommittee, and attended this meeting in his stead.

The subcommittee first discussed an item from its last meeting regarding line item "Review Charts" on its PE spreadsheet. The subcommittee has never clearly defined the line item and has no standard time. After some discussion the subcommittee recommends: **A practice expense ad hoc workgroup be formed to:**

1. **Obtain an understanding of the line item and what it consists of**
2. **Develop a standardized time for the item**
3. **Discussing what, if anything, should be done to adjust services reviewed previously**

This workgroup will convene over the summer of 2009 and report back to this subcommittee at its next meeting.

The Practice Expense Subcommittee reviewed the following new, revised, and current CPT code practice expense inputs and made the following recommendations.

Tab 4 - Adjacent Tissue Transfer (143X1 & 143X2)
To address the site of service anomaly, identified by the Five-Year Review Identification Process, the specialties deleted 14300 and created two new codes. Members discussed the practice expense inputs recommended in comparison to code 14300 and also had a robust discussion of the appropriateness of providing a non-facility recommendation of new code 143X2 *Adjacent tissue transfer each additional 30 sq cm.* The specialties hadn't agreed one set of direct PE inputs for 143X2, whereas one society provided non-facility PE inputs and the other four societies involved believed the service was only provided in the facility setting. The subcommittee agreed that since the American Academy of Dermatology hadn't expressed interest in surveying 143X2 through the level of interest process and the code had been brought forward through CPT as performed only in the hospital inpatient setting, that there should be no practice expense inputs in the non-facility setting. The subcommittee also agreed with the recommended PE inputs for code 143X1 and made one minor change in its medical supplies.

Tab 5 - Multi-Layer Compression System Application (2958X)
The subcommittee made minor reductions in the clinical staff time in the non-facility setting for this service as it is typically performed in conjunction with an evaluation and management service.

Tab 6 - Fiducial Marker Placement (3162X, 3255X, 494X2)
The subcommittee made one reduction and two increases to the clinical labor time components for new code 3162X6 from the specialty recommendation. In addition, the group made one change in post moderate sedation monitoring time, eliminated duplication in the medical supplies and equipment.

Tab 7 - Chemical Pleurodesis (3256X & 3256X1)
No changes were made to the recommended practice expense for these two codes.

Tab 8 - Ventricular Assist Devices (937XX)
No changes were made to the recommended practice expense for this code.

Tab 9 - Arteriovenous Shunt Imaging (36XXX, 361XX & 757X1)
The subcommittee reviewed the specialty submission carefully and recognized that the two codes that were replaced with the three new codes did not require moderate sedation. In addition, the specialty's CPT coding proposal indicated moderate sedation was not inherent and just over 50% of the survey respondents indicated 36XXX and 361XX moderate sedation in inherent. For code 757X1 the survey respondents indicated moderate sedation was not inherent. The specialty had recommended moderate sedation clinical labor, medical supplies, and equipment for each code. The subcommittee had a robust discussion over the inclusion of any moderate sedation PE inputs in any of the new codes and eliminated the sedation inputs for code 757X1. The subcommittee concurred that the discussion of moderate sedation for codes 36XXX and 361XX should continue at the RUC and will modify the PE inputs appropriately after that discussion.

Tab 10 - Minor Vein Perforator Ligation (3776X)
No changes were made to the recommended practice expense for this code.

Tab 12 - Laparoscopic Paraesophageal Hernia Repair (432X1 & 432X2)
No changes were made to the recommended practice expense for these two codes.

Tab 14 - Laparoscopic Longitudinal Gastrectomy (4364X)
No changes were made to the recommended practice expense for this code.

Tab 15 - Fistula Plug (467X1)
No changes were made to the recommended practice expense for this code.

Tab 16 - Urodynamics Studies (51727X, 51728X & 51729X)
The subcommittee had a lengthy discussion regarding these services and made minor modifications to the clinical labor time and eliminated duplication in medical supplies from packages and equipment.

Tab 17 Neurostimulator (Spinal) (63655, 6366X1, 6366X2, 6366X3 & 6366X4)
Several reductions to the clinical labor time were made from the specialty recommendation. In addition, the subcommittee discussed the specialty recommended need for a room, radiographic- fluoroscopic. Members believed that these codes and others may be just as well performed with a fluoroscopic system, mobile C-Arm (CMS Code ER031), which would reduce the practice expense costs.

Tab 18 Injection of Anesthetic Agent - Nerve (64XX0, 64XX1, 64XX2, 64XX3, 64XX4, 64XX5, 64415, 64445 & 64447)
Several reductions to the clinical labor time were made from the specialty recommendation. In addition, the subcommittee discussed the specialty recommended need for a room, radiographic- fluoroscopic. Members believed that these codes and others may be just as well performed with a fluoroscopic system, mobile C-Arm (CMS Code ER031), which would reduce the practice expense costs.

Tab 19 - CT Colonography (7414X1, 7414X2 & 748X2)
No changes were made to the recommended practice expense for these codes.

Tab 20 - Cardiac MR Velocity Flow (7556X1)
The subcommittee reduced the clinical labor time by 4 minutes to reflect the difference in PE time between codes 75557 and 75558, which is 10 minutes.

Tab 21 - Tissue Examination for Molecular Studies (8838X1 & 8838X2)
No changes were made to the recommended practice expense for these two codes.

Tab 22 - Combined Speech-Language and Hearing Services (926X1, 926X2 & 926X3)
No changes were made to the recommended practice expense for these two codes.

Tab 27 - Fluoroscopy – PE Only (64510, 64520, 64622, 64626, 76100, 76101 & 76102),
In the development of performance measures related to fluoroscopy, the American College of Radiology recommended that although 7 CPT codes currently include practice expense inputs for fluoroscopy, these services may not typically be performed with fluoroscopy. The subcommittee concurred with the specialty societies that codes 64520, 64622, and 64626 provide fluoroscopy. 64510 may be performed in a procedure room or office and all other services are performed in an X-ray room.

The subcommittee also recommends to the RUC that a workgroup be established to review the use of less expensive equipment if appropriate, specifically the committee focused on the use of a fluoroscopic system, mobile C-Arm rather than the use of a radiographic-fluoroscopic room.

Tab 30 - Radiation Treatment Delivery, Stereotactic Radiosurgery (SRS) (77371)
The subcommittee had provided a recommendation for the service in October 2005 however CMS requested, and the subcommittee provided, a lengthy discussion of the appropriate direct inputs for this service. The subcommittee reviewed the specialty recommendation and agreed to some of the additional clinical labor time requested and all of the minor modifications to the medical supplies and equipment needed for service.

Tab 32 - End-Stage Renal Disease – (90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, 90966)
The subcommittee agreed with the specialty presenters that 18 minutes of additional clinical staff time should be applied to all of the monthly ESRD codes (both adult and pediatric), and that it is appropriate that the PE be constant across the groupings of codes by age category, since all patients, regardless of the number of physician work/face-to-face encounters, require a similar baseline level of clinical staff support. *At the full RUC this recommendation was changed and approved whereas 18 minutes additional time was added to the adult and 24 minutes was added to the pediatric ESRD codes.*

Update on Physician Practice Information (PPI) Survey
Sherry Smith and the AMA's Department of Economic and Health Policy Research presented a background and the overall results of the Physician Practice Information (PPI) Survey that recently was concluded with the results forwarded to the Centers for Medicare and Medicaid Services (CMS). Ms. Smith explained that the survey effort was a success and thanked the specialties for their cooperation in the survey efforts and informed the group that the AMA will provide them with specialty specific survey results in June 2009. RUC members and participants asked staff to provide the components of survey that constitute the direct and indirect practice expense. These headings from the attached AMA PPI Survey submission to CMS are provided below:

Direct Practice Expense Components	**Indirect Practice Expense Components**
Clinical Payroll, Can't Bill Independently	Office Expenses (Q77)
Medical Supplies (Q80-*80a)+(Q81-Q81a))	Clerical Payroll (Q78a)
Medical Equipment (Q82)	Other Expense (Q83)

AMA
AMERICAN
MEDICAL
ASSOCIATION

March 31, 2009

Cassandra Black
Director, Division of Practitioner Services
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

Dear Ms. Black:

Enclosed is a table summarizing practice expense information by specialty from the American Medical Association's (AMA) Physician Practice Information (PPI) Survey, which was administered in 2007 and 2008. This table has been compiled per your request, with regard to the Centers for Medicare and Medicaid Services (CMS) planned revisions to the practice expense relative value units of the Medicare Resource-Based Relative Value Scale (RBRVS).

The PPI survey was designed as a nationally representative survey of physicians. The sample for the survey was drawn randomly from AMA's Physician Masterfile, which is a listing of all physicians in the United States and includes AMA members and physicians who are not AMA members. Information from the Masterfile enabled us to correct for unit nonresponse.

The survey was conducted in conjunction with national medical specialty societies and other health care professionals, representing 51 specialties and health professions. The AMA and the other participating organizations jointly funded the survey effort and distributed consistent communications to their membership to encourage accurate and complete responses.

The survey was conducted by external contractors. The Gallup Organization initiated the project in 2007. However, after lower than expected response rates, the AMA decided to transition to dmrkynetec to complete the project. Dmrkynetec, formally Doane Marketing Research, which had conducted the majority of the specialty level supplemental surveys that were implemented by CMS. We are pleased that we were able to obtain more than 7,400 respondents to this survey, with more than 100 for all but a very few specialties.

The survey was conducted via a number of different modes, including phone, facsimile, mail, and internet. Each survey respondent was first sent a worksheet to complete in advance of completing the questionnaire. Survey respondents were specifically encouraged to seek input from their practice manager or accountant to answer the practice expense questions. In

particular, we observed that dmrkynetec made every effort to re-contact respondents to address incomplete practice expense questions or to clarify responses as needed.

Respondents were encouraged to provide data based on their 2006 financial statements and tax returns. However, in a few cases, respondents chose to provide either 2005 or 2007 data In those cases, the AMA has scaled the data to 2006, utilizing changes in the total Medicare Economic Index (MEI).

Only non-federal, non-resident, patient care physicians and other health care professionals who work at least 20 hours per week in direct patient care were included in the PPI survey. The survey results do include practice expense information collected from both owners and employees. All respondents were asked to provide all practice costs attributable to their services at the individual level. If respondents were interested in participating and could not provide data at the individual level, they were allowed to provide data at the single specialty practice level or at a department level, as long as they indicated the level at which expenses were reported.

The AMA analyzed the 5,865 physician respondents and Lewin analyzed 1,538 responses from other health care professionals. We worked together to ensure that data were analyzed in a consistent manner. We have excluded the following records from the practice expense per hour computations:

- records with one or more missing expense questions. Although, we did include approximately 50 records where total expenses equaled the sum of the expenses provided and where the only missing question was medical equipment, medical supplies, or drugs;
- records where total expenses were zero;
- respondents who did not indicate the level at which they were reporting expense data;
- records for non-solo physicians with missing practice size information and those in multispecialty practices who provided data at the practice level;
- respondents practicing fewer than 26 weeks per year (including cases where weeks worked per year was missing), those reporting fewer than 20 hours of practice, and those reporting 168 hours per week providing direct patient care; and

- outlier records, utilizing three standard deviation from the natural mean of total expense per hour as the measure.

All results were weighted for unit non-response based on practice type.

Please contact us with any questions as you review these data. You may contact myself at David.Emmons@ama-assn.org or Sherry Smith, Director of Physician Payment Policy and Systems at Sherry.Smith@ama-assn.org.

Sincerely,

David W. Emmons

David W. Emmons, PhD
Director, Economic & Health Policy Research

Enclosure

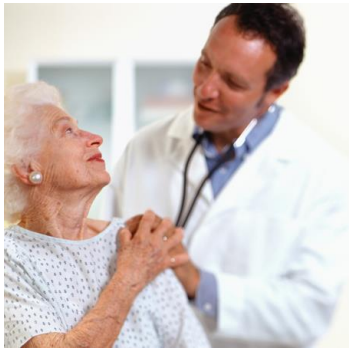
Practice Expense Per Hour- Lewin (Non-MD/DO)
2007/2008 PPI Survey

	Number of completes		Total PE/HR (less separately billable)	Office expense (Q77)	Nonphysician Payroll (Q78)	Clerical Payroll (Q78a)	Clinical Payroll, Bill Independently (Q78b)	Clinical Payroll, Can't Bill Independently (Q78c)	Medical Supplies (Q80)	Medical Supplies, Sep. Billable (Q80a)	Drugs (Q81)	Drugs, Sep. Billable (Q81a)	Medical Supplies ((Q80-Q80a)+(Q81-Q81a))	Medical Equipment (Q82)	Other Expense (Q83)
Specialty	**PPI survey**	**PE/HR**	**Mean**	**Mean**	**Mean**	**Mean**	**Mean**	**Mean**	**Mean**	**Mean**	**Mean**	**Mean**	**Computed**	**Mean**	**Mean**
Audiology	217	71	**84.84**	**39.30**	28.33	**20.86**	2.88	**4.58**	15.84	10.37			**5.28**	**2.81**	**12.01**
Chiropractor	153	120	**76.02**	**40.38**	21.94	**15.70**	1.23	**5.02**	2.77	1.21	0.02	0.01	**1.64**	**4.04**	**9.25**
Clinical Psychology	99	56	**21.52**	**14.64**	1.81	**1.65**	0.16	**0.00**	0.07	0.00			**0.07**	**1.38**	**3.78**
Clinical Social Work	185	127	**18.32**	**10.82**	4.84	**2.26**	2.37	**0.21**	0.20	0.02			**0.19**	**0.13**	**4.72**
Optometry	143	106	**114.78**	**52.35**	40.40	**23.44**	1.17	**15.79**	12.31	8.10	0.37	0.05	**4.62**	**6.35**	**12.23**
Oral Surgery (Dentist only)	115	70	**265.73**	**102.78**	94.07	**50.65**	3.09	**40.34**	32.45	3.38	5.85	0.67	**35.40**	**16.81**	**19.76**
Physical Therapy	207	76	**68.47**	**33.75**	23.77	**15.30**	1.53	**6.94**	2.19	0.50			**1.76**	**2.51**	**8.21**
Podiatry	164	99	**91.03**	**45.68**	29.13	**20.90**	1.17	**7.07**	10.33	4.70	1.22	0.26	**6.69**	**2.51**	**8.18**
Radiation Oncology (Freestanding)	111	86	**504.58**	**141.29**	204.42	**64.99**	4.70	**134.74**	19.73	5.27	49.69	38.50	**25.65**	**91.22**	**46.69**
Registered Dieticians	144	51	**22.05**	**10.39**	6.31	**3.46**	1.10	**1.76**	0.74	0.33			**0.40**	**1.44**	**4.59**
Total	1538	862													
Computed at Request of CMS:															
Radiation Oncology (Blended)	245	159	**225.91**	**65.41**	89.15	**32.72**	2.64	**53.79**	7.77	2.01	18.63	14.28	**10.11**	**35.36**	**28.53**

The freestanding to hospital based blended PE/HR for radiation oncology is based on 2005 radiation oncology physician time as 63% hospital based and 37% freestanding. Source: *Memorandum - Recommendations Regarding Practice Expense* , submitted to CMS by Lewin, September 29, 2006

Practice Expense Per Hour
2007/2008 PPI Survey

	Number of completes		**Total PE/HR (less separately billable)**	**Office expense (Q77)**	Nonphysician Payroll (Q78)	**Clerical Payroll (Q78a)**	Clinical Payroll, Bill Independently (Q78b)	**Clinical Payroll, Can't Bill Independently (Q78c)**	Medical Supplies (Q80)	Medical Supplies, Sep. Billable (Q80a)	Drugs (Q81)	Drugs, Sep. Billable (Q81a)	**Medical Supplies ((Q80-Q80a)+(Q81-Q81a))**	**Medical Equipment (Q82)**	**Other Expense (Q83)**
Specialty	**PPI survey**	**PE/HR**	**Mean**	**Mean**	**Mean**	**Mean**	**Mean**	**Mean**	**Mean**	**Mean**	**Mean**	**Mean**	**Computed**	**Mean**	**Mean**
Allergy and Immunology	164	100	**241.08**	**91.56**	112.24	**53.17**	8.50	**50.56**	15.07	2.77	20.91	11.70	**21.51**	**6.33**	**17.95**
Anesthesiology	173	81	**35.84**	**11.74**	35.45	**7.38**	22.42	**5.65**	0.34	0.07	0.23	0.10	**0.40**	**0.43**	**10.25**
Cardiology	145	55	**135.56**	**47.83**	68.93	**30.09**	7.77	**31.07**	5.66	2.03	7.96	5.97	**5.63**	**10.82**	**10.12**
Cardiothoracic Surgery	165	84	**81.40**	**33.15**	44.89	**22.00**	13.91	**8.98**	3.04	0.03	0.09	0.01	**3.09**	**1.51**	**12.68**
Colon & Rectal Surgery	151	93	**112.88**	**55.27**	40.52	**23.66**	3.49	**13.38**	5.75	0.46	2.60	1.88	**6.00**	**2.66**	**11.92**
Dermatology	152	81	**264.88**	**94.99**	127.96	**66.53**	17.23	**44.20**	22.38	1.19	6.59	3.13	**24.64**	**11.42**	**23.10**
Emergency Medicine	135	70	**40.76**	**7.73**	16.07	**8.74**	5.45	**1.88**	0.48	0.06	0.13	0.08	**0.47**	**0.05**	**21.89**
Endocrinology	155	77	**115.46**	**45.51**	61.71	**31.05**	12.35	**18.31**	7.78	1.04	2.45	1.85	**7.34**	**5.43**	**7.83**
Family Medicine	229	98	**119.19**	**54.34**	54.17	**27.46**	7.13	**19.58**	6.48	1.74	5.20	3.66	**6.27**	**3.19**	**8.35**
Gastroenterology	114	57	**128.34**	**50.68**	59.35	**35.18**	7.06	**17.11**	6.59	0.70	8.09	4.94	**9.04**	**5.42**	**10.92**
General Practice	55	30	**114.65**	**47.47**	46.25	**25.00**	4.82	**16.43**	12.51	0.65	6.79	2.40	**16.24**	**3.39**	**6.12**
General Surgery	192	92	**100.30**	**50.29**	36.32	**22.54**	3.04	**10.73**	4.24	0.58	0.32	0.03	**3.95**	**2.88**	**9.91**
Geriatrics	140	45	**73.45**	**28.42**	44.93	**21.28**	7.89	**15.76**	2.72	0.30	1.18	0.87	**2.74**	**0.80**	**4.44**
Hand Surgery	139	73	**193.08**	**73.08**	92.18	**54.47**	11.48	**26.23**	9.59	3.19	3.46	1.45	**8.42**	**9.65**	**21.23**
Internal Medicine	199	89	**110.62**	**52.37**	45.80	**25.66**	4.34	**15.80**	6.31	1.06	6.96	4.75	**7.46**	**3.34**	**6.00**
Interventional Pain Medicine	113	52	**223.91**	**78.22**	109.42	**54.89**	17.25	**37.28**	13.29	1.96	34.47	27.03	**18.77**	**11.07**	**23.68**
Interventional Radiology	115	33	**101.55**	**15.93**	40.92	**24.81**	7.08	**9.02**	4.82	0.13	1.27	0.04	**5.92**	**4.05**	**41.81**
Medical Oncology	135	50	**230.06**	**67.60**	111.92	**49.93**	10.01	**51.99**	44.25	33.53	515.27	492.60	**33.39**	**14.74**	**12.41**
Nephrology	112	39	**82.99**	**36.98**	40.84	**20.07**	12.52	**8.24**	3.16	0.15	12.97	8.58	**7.40**	**1.35**	**8.95**
Neurology	161	73	**127.21**	**64.68**	50.62	**35.95**	3.69	**10.98**	3.62	1.31	10.56	9.77	**3.10**	**2.74**	**9.76**
Neurosurgery	161	81	**132.52**	**62.69**	64.00	**41.29**	13.36	**9.35**	1.76	0.36	0.37	0.03	**1.75**	**5.66**	**11.78**
Nuclear Medicine	81	16	**52.01**	**20.89**	11.50	**7.28**	0.00	**4.23**	0.41	0.00	3.95	1.60	**2.76**	**5.23**	**11.63**
Obstetrics/Gynecology	141	72	**149.02**	**52.62**	75.82	**33.59**	9.09	**33.14**	8.52	1.68	3.78	1.67	**8.96**	**7.60**	**13.11**
Ophthalmology	160	80	**242.68**	**92.21**	107.52	**54.66**	7.16	**45.70**	9.92	4.37	15.27	7.05	**13.77**	**13.14**	**23.21**
Orthopaedic Surgery	137	66	**162.94**	**69.45**	78.50	**46.13**	11.02	**21.35**	5.93	2.03	3.75	2.38	**5.27**	**4.92**	**15.82**
Osteopathic Manipulative Therapy	54	37	**57.83**	**29.29**	15.55	**14.64**	0.65	**0.26**	1.98	0.49	1.58	0.16	**2.92**	**0.72**	**10.00**
Otolaryngology	156	72	**189.69**	**76.96**	92.83	**50.71**	11.73	**30.38**	9.45	2.20	2.31	1.74	**7.82**	**9.95**	**13.86**
Pain Medicine	106	56	**175.35**	**62.69**	110.94	**42.96**	42.15	**25.82**	11.52	1.54	11.36	6.95	**14.39**	**12.72**	**16.76**
Pathology	150	54	**101.45**	**30.65**	30.34	**14.85**	0.96	**14.53**	9.38	0.00	0.00	0.00	**9.38**	**2.56**	**29.48**
Pediatrics	192	88	**111.31**	**38.69**	53.29	**29.03**	3.92	**20.34**	7.14	2.09	23.88	16.99	**11.94**	**2.75**	**8.55**
Physical Medicine and Rehab	142	69	**130.98**	**52.82**	63.05	**46.65**	8.30	**8.11**	5.78	1.80	4.26	2.54	**5.70**	**7.05**	**10.66**
Plastic Surgery	173	95	**182.50**	**84.79**	55.13	**31.69**	4.41	**19.03**	24.41	7.16	6.10	2.31	**21.04**	**7.62**	**18.34**
Psychiatry	156	86	**32.10**	**16.11**	12.44	**8.88**	2.02	**1.54**	0.18	0.07	0.12	0.11	**0.13**	**0.34**	**5.10**
Pulmonary Disease	136	67	**74.33**	**28.99**	33.82	**17.88**	4.04	**11.90**	2.65	0.58	1.99	1.01	**3.05**	**4.11**	**8.39**
Radiation Oncology	134	71	**62.25**	**20.84**	21.44	**13.77**	1.43	**6.24**	0.74	0.10	0.40	0.05	**0.98**	**2.55**	**17.86**
Radiology	151	56	**134.84**	**30.87**	57.13	**35.71**	2.88	**18.54**	4.98	0.49	2.93	1.52	**5.90**	**14.80**	**29.02**
Reproductive Endocrinology	85	46	**350.65**	**122.51**	168.75	**60.31**	17.42	**91.02**	32.27	3.51	7.95	4.92	**31.79**	**17.17**	**27.84**
Rheumatology	146	78	**147.42**	**61.26**	57.60	**28.77**	6.32	**22.50**	8.52	3.15	110.97	96.32	**20.01**	**6.83**	**8.05**
Sleep Medicine	96	45	**155.91**	**52.43**	87.92	**38.18**	15.59	**34.16**	4.96	1.39	1.99	0.61	**4.95**	**8.12**	**18.08**
Spine Surgery	81	34	**190.94**	**83.08**	99.75	**56.81**	19.42	**23.52**	4.70	1.85	2.92	1.14	**4.62**	**11.03**	**11.88**
Urology	152	80	**133.14**	**51.20**	51.16	**30.81**	3.60	**16.75**	13.16	5.00	27.20	23.67	**11.69**	**7.69**	**15.01**
Vascular Surgery	131	74	**114.69**	**43.31**	48.33	**28.11**	4.26	**15.95**	6.72	0.67	0.69	0.20	**6.55**	**8.22**	**12.56**
All Physicians	5865	2795	**116.96**	**46.38**	53.46	**28.03**	7.08	**18.36**	6.68	1.79	14.42	11.84	**7.47**	**4.77**	**11.95**



Physician Practice Information Survey

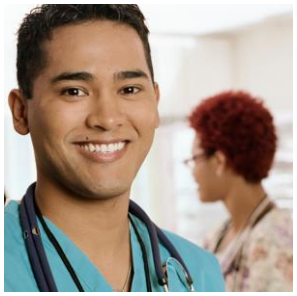
April 23, 2009

Chicago, IL

AMA

TOGETHER WE ARE STRONGER

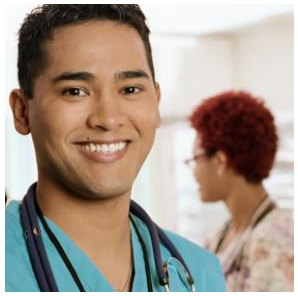


AMA Staff Introductions

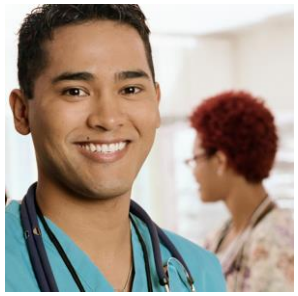
- Sherry Smith, Director, Physician Payment Policy & Systems
- David Emmons, PhD, Director, Economic & Health Policy Research
- Sara Thran, Director, Market Research & Analysis
- Sharon McIlrath, Assistant Director of Federal Affairs
- Kurt Gillis, PhD, Senior Economist II
- Carol Kane, PhD, Senior Economist II



Initiation of the PPI Survey

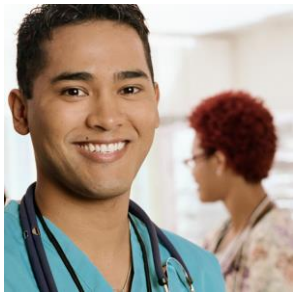
- November 2004 – RUC urged the AMA to coordinate a multi-specialty survey effort
  - Concern that the 1995-1999 SMS data no longer reflected actual physician practice costs
  - All specialties should be surveyed, using a consistent approach and timeframe



Administration of Survey

- **May 2006** - AMA coordinated the effort to finance the survey. The AMA and 70 individual specialties and health care professionals contributed. CMS purchased the resulting computations.
- **2006/2007** – Survey designed by AMA, CMS and Specialties
- **2007** – Gallup Organization survey effort
- **2008** – dmrkynetec cleaned Gallup data and continued survey effort

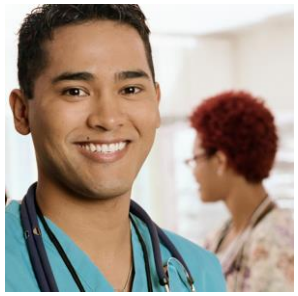


Survey Sample

- Drawn randomly from AMA's Physician Masterfile – all physicians (MDs and DOs) in United States, both members and non-members
- Lewin drew the sample for the non-MD/DOs
- Only non-federal, non-resident, patient care physicians and health professionals who work at least 20 hours per week in direct patient care were included in the PPI survey
- Employees and owners were included in the survey

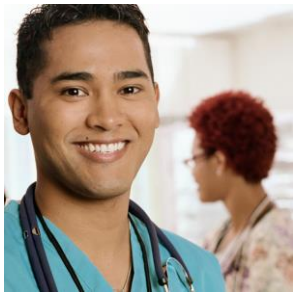


Completion of Survey

- Dmrkynetec completed the survey effort and shared data with AMA and Lewin (non-MD/Dos) in January and February
- AMA economists analyzed data and assigned weights to account for non response bias
- AMA formally submitted Practice Expense/Hour to CMS on March 31, 2009

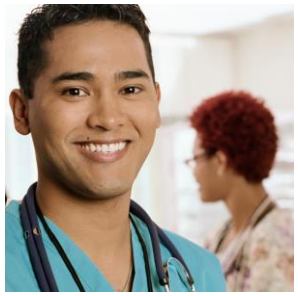


Summary of the CMS practice expense methodology to illustrate how these data may be utilized

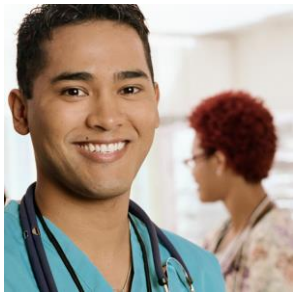
- Current Data Sources:
  - SMS Data and Supplemental Surveys to Compute Practice Expense Per Hour and Indirect to Direct Cost Ratios
  - Direct Practice Expense Inputs
  - Medicare Utilization Data
  - Physician Time
  - Work Relative Values



Current PE Methodology

- Table 1: Calculation of Practice Expense Relative Values, published in November 19, 2008 *Final Rule* (page 69735)

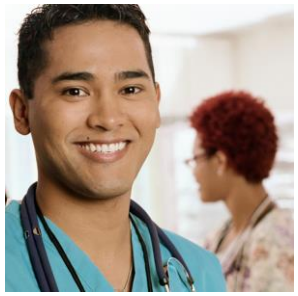


Step 1: Sum the direct costs of the clinical labor, medical supplies, and medical equipment for each service.

- **The clinical labor cost is the sum of the total cost of all the staff types associated with the service (each staff type's cost is the product of the time for each staff type and the wage rate for the staff type).**

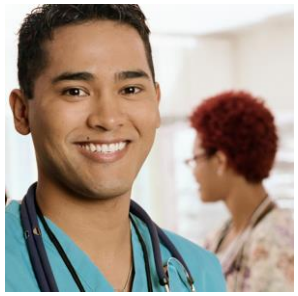
- **The medical supplies cost is the sum of the supplies associated with the service (each supplies' cost is the product of the quantity of each supply and the cost of the supply).**

- **The medical equipment cost is the sum of the equipment associated with the service (the product of the number of minutes each piece of equipment is used in the service and the equipment cost per minute.**



Step 1: 99213 as example

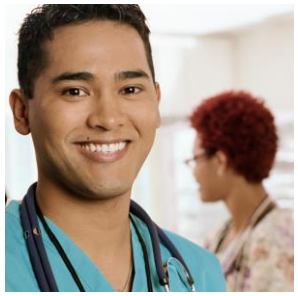
Direct Labor Cost	$13.32
Direct Supply Cost	$ 2.98
Direct Equipment Cost	$ .19
Total Direct Cost	$16.49



Step 2: Compute Current Pool of Available Direct Practice Expense RVUs

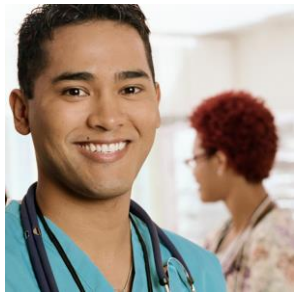
Calculate the current aggregate pool of direct PE costs by multiplying the current aggregate pool of total direct and indirect PE costs (ie, the current aggregate PE RVUs multiplied by the conversion factor) by the average direct PE percentage from the SMS and supplementary specialty survey data.

Current Direct PE Percentage is 33% - i.e., 1/3 of costs are direct, 2/3 of costs are indirect



Step 3: Compute Direct Costs from the Bottom Up Approach

Calculate the aggregate pool of direct costs summing the product of the direct costs for each service from Step 1 and the utilization data for that service.



Step 4: Using the results of Steps 2 and 3, calculate the direct adjustment and apply it to the direct costs from Step 1. For 2009, CMS has computed this direct adjustment to be 0.625. 99213 example:

Labor Cost X Direct Adjustment

$13.32 X 0.625 = $8.33

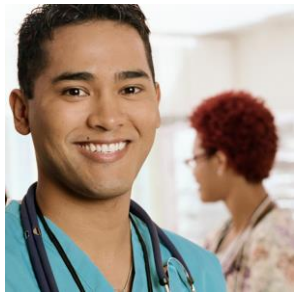
Supply Cost X Direct Adjustment

$2.98 X 0.625 = $1.87

Equipment Cost X Direct Adjustment

$0.19 X 0.625 = $0.12

CMS only recognizes 62.5% of Direct PE Inputs Due to Budget Neutrality



Step 5: Convert the products from Step 4 to an RVU by dividing them by the Medicare conversion factor and sum these RVUs to obtain the adjusted direct RVUs.

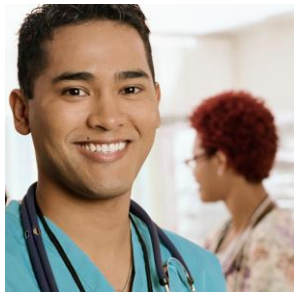
Labor RVU
$8.33 ÷ $36.0666 = 0.231 RVUs

Supply RVU
$1.87 ÷ $36.0666 = 0.052 RVUs

Equipment RVU
$0.12 ÷ $36.0666 = 0.003 RVUs

0.231 + 0.052 + 0.003 = 0.29

The computed direct PE RVU is 0.29.



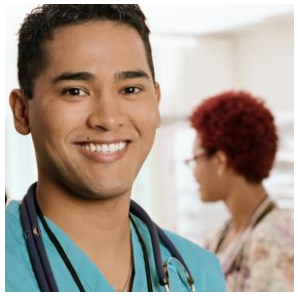
Step 6 & 7: Specialty Direct & Indirect Expense Ratios

Step 6 Based on the SMS and supplementary specialty survey data, calculate direct and indirect PE percentage for each physician specialty.

Step 7 Calculate the direct and indirect PE percentages at the service level by taking a weighted average of the results of Step 6 for the specialties that provide the service.

Note: for services with technical components and professional components, the direct and indirect PE percentages are calculated across the global component.

In 2009, the direct percentage for 99213 is 33.8% and the indirect percentage is 66.2%.



Step 8: Calculate the service level allocators for the indirect PEs based on the percentages in Step 7. The indirect PEs are allocated based on three components: the direct PE RVU, the clinical PE RVU, and the work RVU.

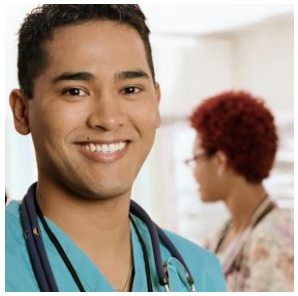
<u>For most services the formula is:</u>

Indirect Allocator = Indirect Percentage X (Direct PE RVU ÷ Direct Percentage) + Work RVU

In 2009, code 99213 is computed as:

1.48 = 0.662 X (0.29 ÷ 0.338 = 0.858) + 0.92



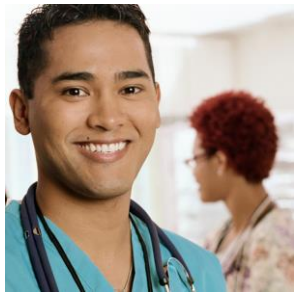



However, in two situations this formula would be altered. The first situation is when the service is a global service, then the indirect allocator is as follows:

- Indirect Percentage X (Direct PE RVU ÷ Direct Percentage) + Clinical PE RVU + Work RVU

The second situation is when the clinical labor PE RVU exceeds the work RVU; then the indirect allocator is as follows:

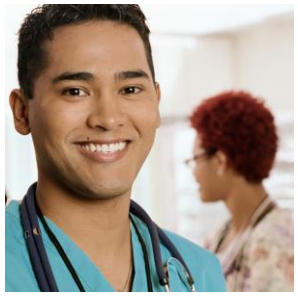
- Indirect Percentage X (Direct PE RVU ÷ Direct Percentage) + Clinical PE RVU



Step 9: Calculate the current aggregate pool of indirect PE RVUs.

By multiplying the current aggregate pool of PE RVUs by the average indirect PE percentage from the physician specialty survey data. (same as step 2 for directs – available RVUs in system)

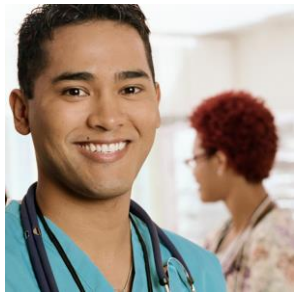


Step 10: Compute total Indirect Expense for all services

Calculate the aggregate pool of proposed indirect PE RVUs for all physician services by adding the product of the indirect PE allocators for a service from Step 8 and the utilization data for that service.

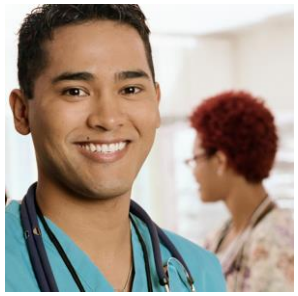


Step 11: Indirect “Neutrality”

Using the results of Steps 9 and 10, calculate an indirect PE adjustment so that the aggregate indirect allocation does not exceed the available aggregate indirect PE RVUs, and apply it to indirect allocators calculates in Step 8. For 2009, the indirect adjustment is 0.337.

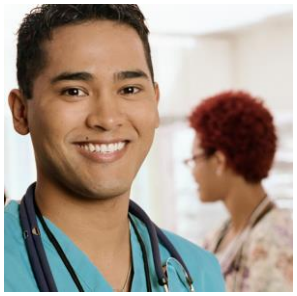
99213: 1.48 (Step 8) X 0.337 = 0.50



Step 12: Create specialty indirect cost pools

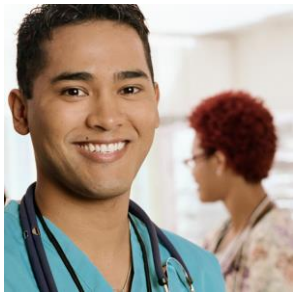
Using the results of Step 11, calculate aggregate pools of specialty-specific adjusted indirect PE allocators for all physician services for a specialty by adding the product of the adjusted indirect PE allocator for each service and the utilization data for that service.



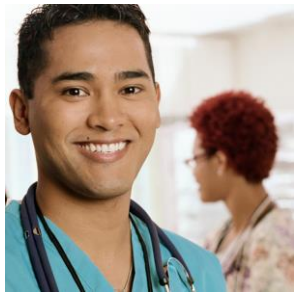
Step 13: Compute the Specialty Level Pool of Indirect Per SMS/Supplemental Survey Data

Using the specialty specific indirect PE/hour data, calculate specialty-specific aggregate pools of indirect PE for all physician fee schedule services for that specialty by adding the product of the indirect PE/hour for the specialty, the physician time for the service, and the specialty's utilization for the service.



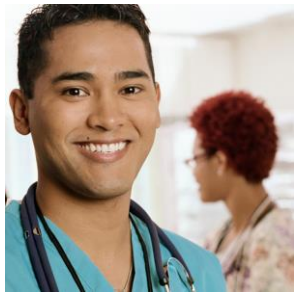
Step 14: Develop Scaling Factors

Using the results of Step 12 and Step 13, calculate the specialty specific indirect PE scaling factors as under the current methodology.



Step 15: Create Indirect Practice Cost Index Per Specialty

Using the results of Step 14, calculate an indirect practice cost index at the specialty level by dividing each specialty-specific indirect scaling factor by the average indirect scaling factor for the entire physician fee schedule.



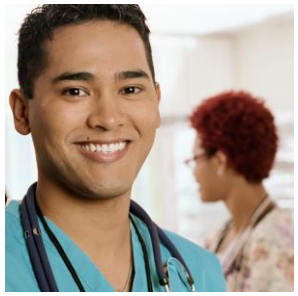
Step 16: Weight average practice cost index for all specialties that perform service.

Calculate the indirect practice cost index at the service level to ensure all of the indirect costs have been captured. Calculate a weighted average of the practice cost index values for the specialties that perform the service.

Note that for services with technical components and physician components, calculate the indirect practice cost index across the global components.

In 2009, the indirect practice cost index for 99213 is 0.973.



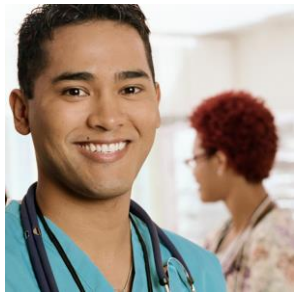



Step 17: Scale the individual service

Apply the service level indirect practice cost index calculated in Step 16 to the service level adjusted indirect allocators calculated in Step 11 to obtain the indirect PE RVUs.

99213: 0.973 X 0.50 = 0.49



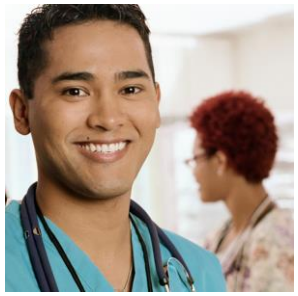



Step 18: Sum Direct and Indirect

Add the direct PE RVUs from Step 6 to the indirect PE RVUs from Step 17.

99213:

0.29 (direct pe rvu) + 0.49 (indirect pe rvu) = 0.78



Step 19: Budget Neutrality – One more time

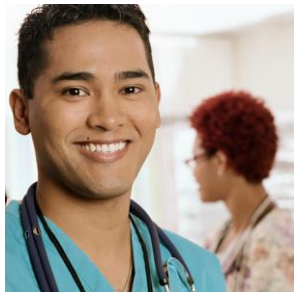
Calculate and apply the final PE budget neutrality adjustment by comparing the results of Step 18 to the current pool of PE RVUs.

This final PE budget neutrality adjustment is primarily required because certain specialties are excluded from the PE RVU calculation for rate-setting purposes, but all specialties are included for purposes of calculating the final PE budget neutrality adjustment.

In 2009, this final PE budget neutrality adjustment is 0.99575.

The fully implemented PE RVU for 99213 would be 0.78 x 0.99575) = 0.78.

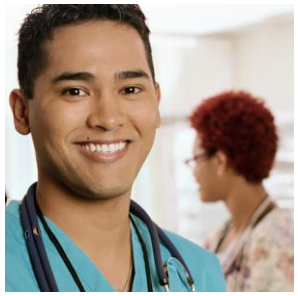


Concluding remarks regarding current methodology

It is NOT apparent how particular pe/hour computations will impact the final practice expense computations. The ratio of direct to indirect expense will be more important in some cases.

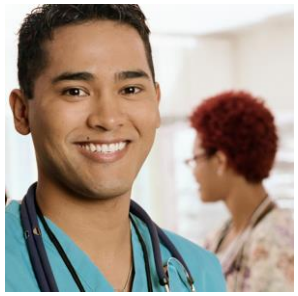
We will not know the potential impacts of the use of the new survey data until CMS releases this information (*Proposed Rule)*



PPI Survey Results

- 7,403 physicians and other health care professionals responded to the survey
- Nearly all specialties and health care professions had at least 100 respondents
- AMA analyzed 5,865 physician respondents
- Lewin analyzed 1,538 responses from other health care professionals.
- All data were reviewed in a consistent manner.



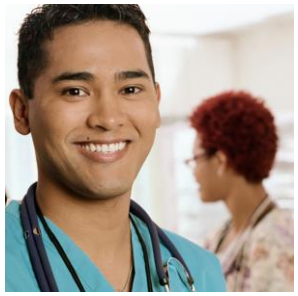



Excluded Records

We excluded the following records from the pe/hour computation:

- Records with one or more missing expense questions;
- Records where total expenses were zero;
- Respondents who did not indicate the level at which they were reporting expense data;



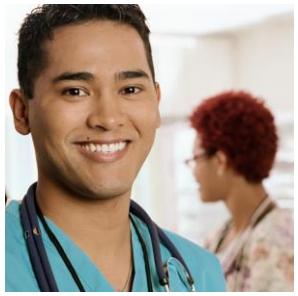



Excluded Records

We excluded the following records from the pe/hour computation:

- Records for non-solo physicians with missing practice size information and those in mutlispecialty practices who provided data at the practice level;
- Respondents who practice fewer than 26 weeks or less than 20 hours per week

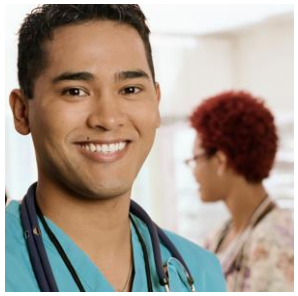


Excluded Records

We excluded the following records from the pe/hour computation:

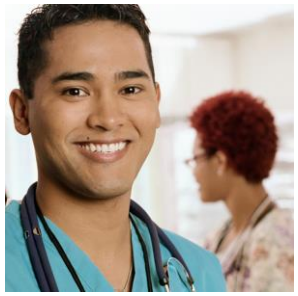
- respondents who reported working 168 hours per week; and
- outlier records, utilizing three standard deviation from the mean of total expense per hour as the measure.



Weighting

All physician results were weighted for unit non-response based on practice type.

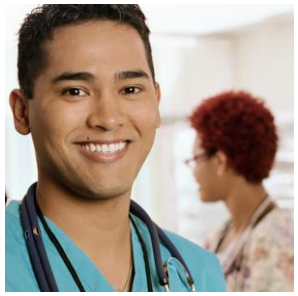
Lewin was able to weight only where information on population of health profession was available.



Respondents Used in PE/Hour Computations

- A total of 3,657 records were used in pe/hour computations:
  - 2,795 physicians
  - 862 other health care professionals

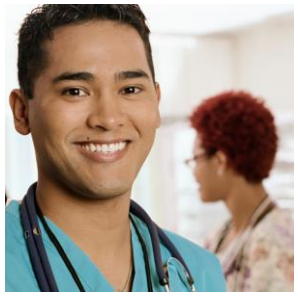


General Observations

- The all physician expense increased from $88.23 (2005 dollars) to $116.96 (2006 dollars) – with the largest increases office expense and clerical payroll.
- The indirect expense ratio for all physicians rose from 67% to 74% and is generally consistent with the increased indirect expense across most specialties.



Next Steps

- The AMA is convening a conference call on Tuesday, April 28 for specialty staff who were not in attendance at this meeting and for those with additional questions.
- A detailed report with specialty level data will be available in June 2009, in advance of the CMS Proposed Rule.
- The AMA has requested that CMS consider a town hall meeting to explain impact of utilizing new data.


AMA
AMERICAN
MEDICAL
ASSOCIATION

AMA/Specialty Society RVS Update Committee **Tab 34**
Research Subcommittee Report
Thursday, April 23, 2009

Members Present: Daniel Mark Siegel, MD (Chair), Dennis Beck, MD, Emily Hill, PA-C, Brenda Lewis, DO, Greg Przybylski, MD, Marc Raphaelson, MD, Peter Smith, MD, Samuel Smith, MD, Susan Spires, MD, James C. Waldorf, MD and Maurits Wiersema, MD

I. Development of a Work Proxy to Address 23+- Hour Stay Services

During the review of the potentially misvalued services identified through the site of service anomaly screening mechanism, the RUC uncovered several services that are reported in the Medicare claims database as typically outpatient services, but where the patient is kept overnight and, on occasion, several nights. The RUC referred to these issues as 23+ hour stay services.

Although the RUC has developed a tool to articulate the length of time the patient is in the hospital and address whether an E/M service is performed on the same date of surgery, the best E/M work proxy for this service has not been addressed. The apparent increased shift from hospital inpatient to observation status in reaction to RAC audits and proprietary software requires the RUC to ensure that appropriate proxies are developed for surgical follow-up work performed at a hospital.

After a robust discussion of the current CMS policies regarding observation services, Condition Code 44 Inpatient Admission Changed to Outpatient and the Interqual program, the Research Subcommittee determined that the work proxies that are currently being used by the RUC, the hospital visit codes, are appropriate as whether a hospital changes a patient status from inpatient to outpatient is irrelevant to the services provided by the physician. **The Research Subcommittee recommends the following policy be created:**

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

II. Addition of IWPUT to the RUC Database

A Research Subcommittee member suggested that IWPUT be added as an input to the RUC database. It was suggested that the data point should be available to assist in discussions at the RUC during specialty societies' recommendation presentations. The Research Subcommittee reviewed all of the existing RUC policy regarding IWPUT and discussed whether IWPUT should be included in the RUC database. It was clarified that the IWPUT will be in the RUC Database only and not the RBRVS Data Manager. **The Research Subcommittee recommends:**

1.) that all codes with RUC survey time display their associated IWPUT in the RUC database.

2.) that a note stating the current RUC policy regarding IWPUT be added below the CPT disclaimer in the database to read,

"IWPUT should be used only as a measure of relativity between codes or in families of codes. IWPUT is a complimentary measure and should not be used as the sole basis for ranking or the assignment of value to a service. IWPUT may be used to validate survey

data."

3.) that the IWPUT data point be included in the search function of the RUC database.

III. Review of Reference Service List Policy

As requested by a Research Subcommittee member, the Research Subcommittee discussed constructing policy to ensure more robust review of requests from specialties to review reference service lists. **The Research Subcommittee recommends the following policy be created:**

The specialty will provide the following information to the Research Subcommittee on all codes in reference service list (in addition to the code, descriptor, work value currently provided) when submitting these requests:

1.) The year it was valued
2.) Whether the time is based on RUC, Harvard or other
3.) The MPC status
4.) The Medicare Volume
5.) The intra-service time
6.) The total service time
7.) The IWPUT calculation

IV. Laparoscopic Longitudinal Gastrectomy Issue

On March 11th, the American Society of Metabolic and Bariatric Surgery (ASMBS) sent out an unapproved reminder email to members asking them to complete the RUC survey for the new laparoscopic longitudinal gastrectomy code. The RUC Advisors for Society of American Gastrointestinal and Endoscopic Physicians (SAGES) and the American College of Surgeons (ACS), apologized that this e-mail was sent. Neither ASMBS staff or surgeons discussed the email with SAGES or ACS. ASMBS has confirmed that this was the only additional emailing sent for this code after the initial email request to complete the survey was sent out. The initial e-mail is included in this agenda tab.

The specialties agreed that any survey received subsequent to the ASBMS reminder, whether the respondent saw it or not, should not be used to develop the work RVU recommendation. Prior to that email being sent, the specialties had already received 95 survey responses (as of mid-afternoon on March 10th). The specialties plan to use only these 95 responses to formulate our recommendation to the RUC.

AMA staff forwarded this information to the Research Subcommittee so that the Committee was made aware of this e-mail. The Research Subcommittee upon review of this issue, expressed concern over how the data would be presented to the RUC and requested that the specialties provide a cover letter to their submission to the RUC explaining what occurred and provide the Research Subcommittee the data received prior and subsequent to the e-mail being sent out so that they could compare the results.

The Research Subcommittee reviewed the ASMBS e-mail and the survey results from before and after the e-mail was distributed. **The Research Subcommittee commends the specialty for how they handled this issue and would like to remind specialty societies that if they are developing primary recommendations to the RUC, they need to ensure that the materials distributed will not influence the survey respondents.**

IV. Other Issues

College of American Pathologists (CAP) Proposal

At the Five Year Review Identification Workgroup the CAP was instructed to develop recommendations for several codes in the 88300 code family. CAP requested review of a new vignette and survey instrument for 88314 *Special stains (List separately in addition to code for primary service); histochemical staining with frozen section(s).* This vignette and proposed survey instrument are attached to this report. **The Research Subcommittee approved the proposed vignette as submitted by the specialty society. After reviewing the proposed survey instrument, the Research Subcommittee agreed that the proposed descriptions of pre-, intra- and post-service times were too detailed and recommended that the society utilize the RUC-approved Pathology Survey Instrument.** CAP during their presentation also stated that they had interest in including 88309 *Level VI - Surgical pathology, gross and microscopic examination Bone resection Breast, mastectomy* on the Reference Service List for 88314. The Research Subcommittee instructed the Society that if the code has been identified by the Five Year Review Identification Workgroup to be reviewed by the RUC , it should not be included on a reference service list.

Also, the society is requesting to mini-survey code 88312 *Special stains (List separately in addition to code for primary service); Group I for microorganisms (eg, Gridley, acid fast, methenamine silver), each* and 88313 *Special stains (List separately in addition to code for primary service); Group II, all other (eg, iron, trichrome), except immunocytochemistry and immunoperoxidase stains, each* as the society has expressed concern that due to the multiple biopsy types and special stain types that can be reported under a single CPT code, there could be significant differences in work. **Therefore, based on this concern, the specialty society proposes and the Research Subcommittee recommends that CAP will survey its membership to determine if there is a significant difference in work within 88312 and within 88313 and will review the results to determine if new CPT codes need to be created to clearly define the work being performed or if a RUC survey can be completed with the current CPT descriptors.**

Survey Sample Type
At the New RUC Specialty Society Advisor and Staff Meeting, a question was posed to be answered by the Research Subcommittee. The question was what type of survey sample type should be selected by the specialty society if the sample was garnered in the following manner:

A specialty society initiated an e-mail to their membership querying them if they perform a procedure. After receiving responses from this initial e-mail, a group of physicians who perform the procedure was identified. The specialty society then sends the survey instrument to the group of physicians who perform the service.

After reviewing this example, the Research Subcommittee determined that this survey sample type would be a Panel sample, a group of physicians that typically perform the service. The Research Subcommittee reminds the specialty societies that these definitions of survey sample type are in the instruction document. **However, to add more clarity to the process, the Research Subcommittee recommends that a text box be added to the Summary of Recommendation Form to allow the specialty societies to add to their description of survey sample type, if they desire.**

February 25, 2009 Conference Call Report – Maternity Code Survey

The Conference Call Report was distributed to the Research Subcommittee members and no further discussion occurred. This Conference Call Report is in the RUC Agenda Book under the Research Subcommittee Tab.

AMA/Specialty Society RVS Update Committee
Research Subcommittee Report
Wednesday, February 25, 2009 – Conference Call

Members Present: Daniel Mark Siegel, MD (Chair), Emily Hill, PA-C, Brenda Lewis, DO, Eileen M. Moynihan, MD, Marc Raphaelson, MD, Susan Spires, MD and James C. Waldorf, MD

I. Specialty Society Request

American College of Obstetricians and Gynecologists (ACOG) and American Academy of Family Physicians (AAFP) – Review of a MMM Global Survey Instrument

As requested by the Research Subcommittee at the January/February 2009 RUC Meeting, the specialty societies revised their survey instrument and cover letter per the specifications made by the Subcommittee and developed their vignettes and SORs for review. At the January/February 2009 RUC Meeting, the Research Subcommittee commented that the Summary of Recommendation Form (SOR) should have two tables, one table should display the survey data and the other table should display the societies' recommendations. The specialty society complied with this recommendation and has submitted several documents for review.

The Research Subcommittee reviewed all of the documents as provided by the specialty societies and had lengthy discussions including: more descriptive vignettes and critical care time. The Research Subcommittee agreed that the vignettes as developed by the specialties need to be more descriptive to allow for accurate survey results. **The Research Subcommittee recommends the following modifications to the proposed vignettes:**

59400 Vaginal Delivery Global
A 26 year old G2 P1 presents to you 7 weeks and 4 days from the first day of her last menstrual period with a confirmed positive pregnancy test to initiate prenatal care.

Admission to labor and delivery:
This patient presents to labor and delivery at 39 weeks and 3 days gestation with regular contractions every 3 minutes for the past 3 hours. She denies ROM but has had slight spotting. Her cervix is 3cm/ 90% effaced and -1 station. Over the course of an hour she changes her cervix to 4cm/100% effaced and still -1 station. She progresses through labor and has a vaginal delivery.

59510 Cesarean Section Global
A 20 year old G1 P0 presents to you 6 weeks and 5 days from the first day of her last menstrual period with a confirmed positive pregnancy test to initiate prenatal care.

Admission to labor and delivery:
This patient presents to labor and delivery at 40 weeks and 3 days gestation with spontaneous rupture of membranes having irregular contractions. She is in active labor which ultimately does not progress and requires a cesarean section.

59610 VBAC Global
A 28 year old G2 P1 presents to you 7 weeks and 2 days from the first day of her last menstrual period to initiate prenatal care with a known positive pregnancy test. Her first pregnancy resulted in a cesarean section for breech presentation. If possible she desires to have a vaginal delivery.

Admission to labor and delivery:
She presents to labor and delivery at 39 weeks 6 days gestation after 1 hour of regular contractions timed every 5 minutes. She is having regular contractions and her cervix is 2cm/100% effaced and -1 station. She progresses through labor and has a vaginal delivery.

59618 Cesarean Section after VBAC attempt
A 20 year old G2 P1 presents to you at 7 weeks and 2 days from the first day of her last menstrual period to initiate prenatal care with a known positive pregnancy test. Her first pregnancy resulted in a cesarean section for breech presentation. If possible she desires to have a vaginal delivery.

Admission to labor and delivery:
She presents to labor and delivery at 39 weeks 6 days gestation after 1 hour of regular contractions timed every 5 minutes. She is having regular contractions and her cervix is 2cm/100% effaced and -1 station. She has a trial of labor which does not progress requiring a cesarean section.

The Research Subcommittee reviewed the revised survey instrument and had a vigorous discussion about the Management of Typical Labor portion of the survey instrument. The discussion was centered around whether or not critical care time is associated with this service. The specialty societies explained that given the intensive measures that they sometimes must undertake including the placement of various types of invasive monitoring devices that the critical care time should be a part of the survey instrument. **The Research Subcommittee agreed with this logic and recommends the following changes to the survey instrument:**

- **Addition of the following language be added into the background for question #3**

  Critical care is the direct delivery of medical care for a critically ill patient. The physician must devote full attention to the patient and therefore cannot provide services to any other patient during the same time period. The time that can be reported as critical care is the time spent engaged in work directly related to the patient's care, whether that time was spent at the immediate bedside or elsewhere on the floor or unit. For example, time spent at the nursing station on the floor reviewing test results or imaging studies, discussing the critically ill patient's care with other medical staff, or documenting critical care services in the medical record would be reported as critical care.

- **Question #3a should read: Please identify how much time is spent providing care to the patient during each encounter of management of typical labor**

- **Question #3b should be added to read: What percent of this time is critical care time?**

- **The term, "time" should be replaced with the term, "minutes" in the table**

The specialty societies explained that they would take the median surveyed critical and non-critical times and use hospital evaluation and management codes or critical care codes as proxies for this work to derive an RVU for this component of the service.

Further recommended modifications to the revised survey instrument include:

- **Background for Question 9 should read, "Question 9 ~~10~~ addresses only routine postpartum care within 42 days *after the day of delivery*, including hospital and office visits**

- **Question 9 should read, "Please select the single most appropriate hospital or office visit code for each day beginning with the first day after delivery?"**

The Research Subcommittee reviewed the Revised Summary of Recommendation form and to ensure comparability with the survey instrument **recommends the following revisions:**

- **In the Survey Data Table – The inputs should read, "Median total antepartum time as estimated by respondents" and "Median total time for management of labor as estimated by survey respondents"**

- **In the Survey Data Table – An additional input should be added – "Median percent of time that is critical care time as estimated by survey respondents"**

- **In the Specialty Society Recommended Data Table – the input should read, "Total critical time for management of labor"**

- **In the Specialty Society Recommended Data Table an additional input should be added – "Total non-critical time for management of labor"**

- **In the Specialty Society Recommended Data Table a column should be added to reflect specialty society recommended Work RVUs for associated with each of these inputs**

- **In the Specialty Society Recommended Data Table a row should be added to reflect specialty society recommended Total Work RVUs and Total Minutes**

The Research Subcommittee stated that the Additional Rationale section would be the appropriate place to explain any additional information to support their recommendation and information on how the work proxies for the management of typical labor time were determined.

The Research Subcommittee reviewed the revised cover letter from the specialty societies and **recommend the following revision to ensure no coding bias:**

- **The last sentence should read, "However, your input is ~~desperately~~ extremely needed so that maternity care services can be accurately and fairly valued"**

The specialty societies plan to have several education sessions for potential survey respondents which will be staffed by AMA staff and one representative from the Research Subcommittee. The specialty societies plan to present their recommendations for the MMM codes at the October 2009 RUC Meeting.

AMA/Specialty Society RVS Update Committee **Tab 35**
Ad Hoc Pre-Time Workgroup Report
Thursday, April 23, 2009

Members Present: Brenda Lewis, DO (Chair), John Gage, MD, Emily Hill, PA-C, Walt Larimore, MD, Gregory Przybylski, MD, Peter Smith, MD, Sam Smith, MD and Maurits Wiersema, MD

I. Survey Results – Pre-Service Positioning Time Standards

North American Spine Society, American Academy of Orthopaedic Surgeons, American Academy of Pain Medicine, American Academy of Physical Medicine and Rehabilitation, American Association of Neurological Surgeons/Congress of Neurological Surgeons, American Society of Anesthesiologists and International Spine Intervention Society

At the October 2008 RUC Meeting, the Research Subcommittee recommended that the Ad Hoc Pre-Service Time Workgroup be formed to further refine the pre-service time packages. The Workgroup was also to discuss new pre-service time standards proposed by specialty societies including the proposal from NASS.

The NASS proposal was to develop a survey instrument and collect data from a large number of spine surgeons and spine proceduralists on the time it takes to position patients for several categories of spinal procedures. Once their survey instrument was approved by the Workgroup and subsequently the Research Subcommittee and the RUC, NASS initiated their survey and has collected data supporting their recommendations for new pre-service time standards for spine procedures. Their survey instrument and data distribution is included in Ad Hoc Pre-Service Time Workgroup tab.

After careful review of the specialty societies' survey data and comparisons to the pre-service positioning time of recent RUC reviewed spine codes, **the Workgroup recommends that the following positioning times for spinal surgical procedures and spinal injection procedures be incorporated into Pre-Service Time Document in the notes section:**

Positioning times for spinal surgical procedures:

Pre-Time Pkg SS1	**Anterior Neck surgery (supine) (eg ACDF)**	**15 minutes**
Pre-Time Pkg SS2	**Posterior Neck surgery (prone) (eg laminectomy)**	**25 minutes**
Pre-Time Pkg SS3	**Posterior Thoracic/Lumbar (prone) (eg laminectomy)**	**15 minutes**
Pre-Time Pkg SS4	**Lateral Thoracic/Lumbar (lateral) (eg corpectomy)**	**25 minutes**
Pre-Time Pkg SS5	**Anterior Lumbar (supine) (eg ALIF)**	**15 minutes**

Positioning times for spinal injections procedures:

Pre-Time Pkg SI1	**Anterior Neck injection (supine) (eg discogram)**	**7 minutes**
Pre-Time Pkg SI2	**Posterior Neck injection (prone) (facet)**	**5 minutes**
Pre-Time Pkg SI3	**Posterior Thoracic/Lumbar (prone) (epidural)**	**5 minutes**
Pre-Time Pkg SI4	**Lateral Thoracic/Lumbar (lateral) (eg discogram)**	**7 minutes**

The Workgroup recommends that following language be added to the instruction document:

Societies utilizing the spine pre-time packages should select a pre-service time package as directed in the instruction document and make modifications to the positioning time based on the spine pre-service time package selected. The societies should then reflect their selection of spine pre-service time package in the additional rationale section.

AMA/Specialty Society RVS Update Committee **Tab 36**
Administrative Subcommittee Report
April 23, 2009

Members: Doctors James Blankenship (Chair), Michael Bishop, Dale Blasier, Ronald Burd, John Gage, Charles Koopmann, Robert Kossman, Barbara Levy, Len Lichtenfeld, Lawrence Martinelli, Lloyd Smith and Arthur Traugott.

I. Financial Disclosure Policy

The Administrative Subcommittee reviewed the AMA General Counsel suggested revisions to the Financial Disclosure Statement for presenters. The Subcommittee determined that materially should be defined as "any" income for the past twelve months or cumulative lifetime income of at least $10,000. The Subcommittee recommends that the RUC be made aware of **any** current financial interests. The Administrative Subcommittee modified the Financial Disclosure Statement as follows:

AMA/Specialty Society RVS Update Committee (RUC)
Financial Disclosure Statement For
Specialty Society Presenters

I certify that my personal or my family members' direct financial interest in, and my personal or my family members' affiliation with or involvement in any organization or entity with a direct financial interest in the development of relative value recommendations in which I am participating are noted below. Otherwise, my signature indicates I have no such direct financial interest or affiliation with an organization with a direct financial interest, other than providing these services in the course of patient care.

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

For purposes of this Disclosure, "direct financial interest" means:

- A financial ownership interest in an organization ** of *5%* or more; or
- A financial ownership interest in an organization ** which contributes materially* to your income; or
- Ability to exercise stock options in an organization** now or in the future ~~which contributes materially* to your income;~~ or
- A position as proprietor, director, managing partner, or key employee in an organization**; or
- Serve as a consultant, expert witness, speaker or writer for an organization**, where payment contributes materially* to your income.

* "materially" means **any** income for the past twelve months or cumulative lifetime income of at least $10,000.
** "organization" means any entity with an interest in the development of relative value recommendations.

Include only interests that relate to the specific issue that you are presenting at this RUC meeting.

Specific Disclosure (i.e., list organization)	**Explain relationship between the service(s) that you are presenting and your disclosure**	**Identify interest for the past 12 months (circle one)**	**Identify cumulative lifetime interest (circle one)**	**If disclosure relates to stock, please list number of shares owned, options or warrants**
		N/A < $10,000 ≥ $10,000	< $10,000 ≥ $10,000	
		N/A < $10,000 ≥ $10,000	< $10,000 ≥ $10,000	
		N/A < $10,000 ≥ $10,000	< $10,000 ≥ $10,000	

_____
Agenda Tab/Issue

_____ _____
Signature Date

_____ _____
Print Name Specialty Society

The Administrative Subcommittee discussed and recommends consideration of a policy whereby all RUC members and alternates will complete a financial disclosure statement. The Administrative Subcommittee will review this issue at the October 2009 Administrative Subcommittee meeting.

II. Conflict of Interest Policy and Statement

The Administrative Subcommittee reviewed the AMA General Counsel suggested revisions to the Conflict of Interest Policy and Statement and determined that the following changes be made. *All bolded and underlined items are additions by the Administrative Subcommittee. All items underlined are additions by the AMA General Counsel.*

AMERICAN MEDICAL ASSOCIATION/SPECIALTY SOCIETY
RELATIVE VALUE SCALE UPDATE COMMITTEE ("RUC")
CONFLICT OF INTEREST POLICY

No RUC or other Committee, Subcommittee or Workgroup representative will vote or participate in any deliberation on a specific issue in the event the representative, or the representative's family member, has a direct financial interest in the outcome of the vote or deliberation other than the representative in the course of their practice performing the procedure or service at issue. Every RUC or other Committee, Subcommittee or Workgroup representative shall disclose his or her, or family member's, direct financial interest(s) prior to any vote or deliberation and shall not vote or participate in the deliberation in which he or she has a direct financial interest. **Any known disclosure should be made to the RUC chair in writing prior to the meeting.**

Any individual who is presenting or discussing relative value recommendations before the RUC shall disclose on a Financial Disclosure Form his or her direct financial interest(s) if any, prior to any presentation(s). **The Administrative Subcommittee will review financial disclosure documents in advance of the meeting. If a direct financial interest is identified on the financial disclosure form, the individual may be precluded from presenting.**

For purposes of this Policy, direct financial interest means: (i) a financial ownership interest in an organization (i.e., "organization" shall mean any entity with an interest in the development of relative value recommendations) of 5% or more; or (ii) a financial ownership interest in an organization which contributes materially (i.e., "materially" shall mean **any** income for the past twelve months or cumulative lifetime income of at least $10,000) to your income; or (iii) the ability to exercise stock options in an organization **that is related to issues at the RUC**, now or in the future ~~which contributes materially to your income;~~ or (iv) a position as proprietor, director, managing partner, or key employee in an organization; or (v) a consultant, expert witness, speaker or writer for an organization, where payment contributes materially to your income.

For purposes of the Policy "family member" means spouse, domestic partner, parent, child, brother or sister. Disclosure of a family member's interest applies to the extent known by the representative or presenter.

STATEMENT OF COMPLIANCE WITH
RELATIVE VALUE SCALE UPDATE COMMITTEE ("RUC")
CONFLICT OF INTEREST POLICY

I understand that I am expected to comply with the Conflict of Interest Policy of the RUC. To my knowledge and belief, I am in compliance with the Conflict of Interest Policy. I ~~have~~ **will** disclose any direct financial interests in specific issues considered by the RUC, or any subcommittee or workgroup of the RUC, and I ~~**have**~~ **will recuse** ~~excused~~ myself from deliberation and vote on any issue in which I or any family member have a direct financial interest. I understand that I have a continuing responsibility to comply with the Conflict of Interest Policy, and I will promptly disclose my direct financial interests required to be disclosed under this Policy.

Date: _____ Signature: _____

Print Name: _____

III. Review of Rotating Seat Election Materials

The Administrative Subcommittee reviewed the current rotating seat election rules in light of the upcoming election at this meeting. No issues were raised.

IV. Other Issues

Referral item from Financial Disclosure Review Workgroup – Discussion on ownership of ASCs in relation to direct financial interests

The Administrative Subcommittee discussed whether physician ownership of an ASC constitutes a direct significant financial interest, outside of providing services in the course of patient care, according to the RUC financial disclosure policy. The Administrative Subcommittee indicated that ASC payment for procedures are determined by CMS and will not be impacted by work RVUs. The Administrative Subcommittee determined that physician ownership of ASCs do not have a conflict of interest, however the RUC should continue to determine financial interests on a case-by-case basis.

Subcommittee and Workgroup Vice Chairpersons

At the February 2009 meeting a RUC member requested that the RUC review the possibility of assigning an alternate for the Practice Expense Subcommittee Chair. Doctor Rich charged the Administrative Subcommittee to review this issue. **The Administrative Subcommittee determined that all Subcommittee and Workgroups should be assigned a Vice Chair in the event the Chair is not able to attend a RUC meeting. The Administrative Subcommittee recommends the following changes to the Structure and Functions Document:**

III. Organization and Structure
G. Officers

Chair – The AMA designated RUC Chair will preside at all RUC meetings. The AMA representative will be the Vice Chair and preside in the Chair's absence. Each other Committee or Subcommittee shall be chaired and **vice-chaired** by a representative of the RUC as appointed by the Chair.

AMA/Specialty Society RVS Update Committee **Tab 37**
Professional Liability Insurance Workgroup
April 23, 2009

Members Present: Peter Smith, MD (Chair), Ron Burd, MD, John Gage, MD, David Hitzeman, DO, Stephen Kamenetzky, MD, Charles Koopmann, MD, Charles Mick, MD, Gregory Przybylski, MD, Sandra Reed, MD, Daniel Mark Siegel, MD

I. Discussion of PLI Analysis of Recommendations to CMS for Crosswalks Not Implemented

The Workgroup reviewed the AMA staff analysis of the 2009 Medicare Physician Payment Schedule and the RUC-recommended changes to the PLI RVU for services reviewed by the RUC that were generated through the Five-Year Review Identification Workgroup process. The Workgroup identified 38 services for which CMS has not adjusted the PLI RVU per the RUC recommendations. The data indicate that nearly $11 million in potential savings were not implemented. The Workgroup noted that CMS has been notified of the issue.

The Workgroup recommends that the RUC reiterate its PLI crosswalk recommendations and request that CMS accept these and implement the revised PLI crosswalks.

Going forward, the Workgroup agreed that the RUC should specifically note (in the cover letter to its annual recommendation) to CMS any changes in the PLI crosswalk for existing services that it recommends, to ensure that the recommendations are reviewed by CMS.

II. Other Issues

The Centers for Medicare and Medicaid Services have not yet shared the contractor's report regarding professional liability insurance RVUs. Staff expects CMS to share this information soon as it will be used in the development of the *Proposed Rule* for the 2010 Physician Payment Schedule. As such, the Workgroup will schedule several conference call meetings to discuss the proposed changes to the CMS PLI valuation methodology once the report and *Proposed Rule* are available for review.

AMA/Specialty Society RVS Update Committee **Tab 38**
Five-Year Review Identification Workgroup
April 23, 2009

Members: *Barbara Levy, MD (Chair), Michael Bishop, MD, James Blankenship, MD, Dale Blasier, MD, Walter Larimore, MD, Brenda Lewis, DO, William J. Mangold, Jr., MD, Lawrence Martinelli, MD, Geraldine McGinty, MD, Marc Raphaelson, MD, Maurits Wiersema, MD, George Williams, MD, and Robert Zwolak, MD*

I. Reconsideration of previously identified services

a. Code 19357 - previous referral to CPT, ASPS appeal and request to remove 19357 from the site-of-service screen

The Five-Year Review Identification Workgroup reviewed CPT code 19357 *Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion* at the September 2007 RUC meeting, as identified by the site of service anomaly screen. The Workgroup agreed to refer this service to the CPT Editorial Panel because of differences in delayed and immediate breast reconstruction, which enables a bi-modal typical patient. As an interim measure the Workgroup recommended to remove the hospital visits (1-99231 and 1-99232) and reduce the discharge day management to a half day. While reviewing the Five-Year Review Identification Workgroup status report, staff discovered that the Workgroup has not readdressed this issue.

The American Society of Plastic Surgeons (ASPS) did not submit a code change proposal to the CPT Editorial Panel, instead is requesting that the RUC remove code 19357 from the site of service screen as it is typically performed in the inpatient hospital setting.

The Workgroup reviewed this issue and reaffirmed its original recommendation that this code be referred to CPT. Given its bi-modal distribution, 19357, may be separated into two separate codes to describe interval and immediate construction.

b. Code 66761 – high IWPUT screen

The Five-Year Review Identification Workgroup reviewed CPT code 66761 *Iridotomy/iridectomy by laser surgery (eg, for glaucoma) (1 or more sessions)* at the February 2008 RUC meeting. The Workgroup determined that the RUC recently reviewed this service at the 2005 Five-Year Review and determined it required further analysis, specifically addressing changes in visits, before any definitive action be taken. Staff was to review the original summary of recommendation form to determine if the discharge work was removed from the valuation when the time was reduced, and the Workgroup was to review in April 2008. While reviewing the Five-Year Review Identification Workgroup status report, staff discovered that the Workgroup has not readdressed this issue.

At this April 2009 meeting, the specialty society indicated that they requested that CMS change the global period for 66761 from 090-day to 010-day. However, CMS did not accept the global period change. The specialty society indicated that typically one session is performed. **The Workgroup determined that the specialty society should clarify and re-request that CMS change 66761 to a 010-day global period. However, if the global period change is not acceptable, the specialty society should develop a coding proposal to clarify.**

c. Codes 67210, 67220 and 67228 – high IWPUT screen

Codes 67210, 67220 and 67228 were identified in February 2008 by the high IWPUT screen. At that time, the Workgroup agreed with the specialty society that the services should be changed from 090-day global periods to a 010-day global periods and after CMS concurrence referred to the CPT Editorial Panel to change the descriptor.

At the October 2008 RUC meeting, American Academy of Ophthalmology (AAO) indicated that CMS informed them that they will not change the global period for these services. Therefore, AAO can not resurvey or redefine in CPT with the adjusted global periods.

At this April 2009 meeting, the specialty society indicated that 67210 is typically 1 session, 67220 is typically less than 2 sessions and 67228 is typically 2.5 sessions. **The Workgroup agreed with the specialty society that they will come back to the Five-Year Review Identification Workgroup in October 2009 with a plan on how to address codes 67210, 67220 and 67228.**

d. Definition of CT Extremity Family – Codes (73200 and 73700)

The Workgroup reviewed the March 31, 2009 letter from ACR indicating that codes 73200 and 73700 are an appropriate CT without contrast code family. **The Workgroup agreed with the specialty society that codes 73200 and 73700 will be surveyed and reviewed at the October 2009 RUC meeting. The specialty society indicated that they will develop a plan to address "with contrast" CT codes (73201, 73202, 73701, 73702, 73703, 73704, 73705 and 73706) at the October 2009 meeting.**

e. Codes 20550, 20551 and 20926: Status Update

20550

AAOS requested that code 20550 be removed from the CMS Fastest Growing screen as it has not had high volume growth and was added only added to the screen as part of this family of codes. **The Workgroup recommends that 20550 be removed from the CMS Fastest Growing screen.**

20551

AAOS requested more information from CMS regarding who is providing this service and what types of conditions this procedure is currently being used to treat. To date, no data was received from CMS. However, the utilization data indicates a dramatic change in scope and a wide variety of providers are performing this service, primarily Family Practice. The Workgroup reviewed the volume for 20550 and 20551 and determined that volume has decreased for these services combined. **The Workgroup determined code 20551 be removed from the screen and reviewed in two years.**

20926

AAOS indicated that given the significant increase in utilization and that 20926 has never been surveyed, code 20926 should be surveyed and reviewed at the October 2009 RUC meeting. **The Workgroup recommends that code 20926 should be surveyed and reviewed in October 2009.**

***f.* Code 88309 – CAP request to remove from screen**

CAP indicated that code 88309 was added to the Top 9 Harvard Codes only because it was part of the family for 88304 and 88305. The specialty society indicated that 88309 was recently reviewed at the third Five-Year Review and should be removed from the screen. The Workgroup

determined that code 88309 was thoroughly reviewed at the third Five-Year Review, however noted concern about the physician time. **The Workgroup recommends that 88309 be removed from the Top 9 Harvard screen.**

II. Items not yet submitted to CPT to be discussed

a. Referrals to the CPT Editorial Panel (55866 and 93236)

The Workgroup identified that all but two codes referred to CPT as part of the Five-Year Review Identification process have been addressed or are on the CPT Editorial Panel Agenda to address soon. Two remaining codes are 55866 and 93236.

55866

In February 2008 the Five-Year Review Identification Workgroup recommended that the specialty society develop a coding proposal to separate code 55866 into two codes to distinguish between robotic and non-robotic laparoscopic prostatectomy. The CPT Editorial Panel determined that the codes should be surveyed and describe the typical method and not separated into two codes. **The Workgroup recommends that 55866 be reviewed at the October 2009 RUC meeting. The Workgroup indicated that it is at the discretion of the society if they wish to revise the vignette and resurvey 55866 or utilize survey data from last year.**

93236

The Workgroup recommended that code 93236 be removed from the high volume growth screen as it is carrier priced and does not have work or practice expense RVUs.

b. Referrals to CPT Assistant (13120-22, and 93236)

13120-22

At the February 2009 meeting the Workgroup believed that 13120, 13121, and 13122 were regularly performed at the same time as excision of lesion services and may need to be referred to CPT to create bundled services. However, the specialty society provided a robust analysis of utilization data showing that this family of codes is not typically reported by the same physician at the time of any excision codes. The Workgroup recommended that this service be reviewed again in 2 years. The Workgroup recommended that the specialty develop a CPT Assistant article to provide correct coding instructions.

Prior to this identification screen, AAD submitted a CPT Assistant article on this issue in Aug 2006. The Workgroup reviewed the 2006 article and determined that it did not sufficiently address the current issue or have any impact on Medicare utilization. **The Workgroup recommends that another CPT Assistant article be written to address this issue, specifically focusing on the second and higher volume code.**

III. Joint CPT/RUC Workgroup on Bundled Services Update – *Informational Only*

The specialty societies informed the Workgroup that coding proposals will be developed for the following issues:

a. Diskectomy and Arthrodesis (22254 and 63075)
b. Computed Tomography (72192, 72193, 72194, 74150, 74160, 74170)

IV. Small Box Technology Workgroup

At the October 2008 RUC Meeting, the RUC approved the recommendation of the American Podiatric Medical Association to survey 76880, *Ultrasound, lower extremity*. APMA indicated a level 1 interest in the code. However, the APMA later notified the RUC that it rescinded its level of interest to survey 76880, as it is not the dominant specialty. Specifically, the APMA noted that the physician work component of 76880 is more commonly performed by Diagnostic Radiology.

According to the 2007 Medicare utilization data. Podiatry is the dominant provider of this service in the non-facility setting.

The American College of Radiology indicated its willingness to take interest in the service. The availability of handheld ultrasound equipment has enabled podiatry and other specialties to perform this and other similar procedures within their offices, which is driving the increase in utilization. The Workgroup noted that value of 76880 includes the ultrasound room, which is priced significantly higher than the handheld device. The Workgroup agreed that this is an issue that may need to be addressed through either CPT changes and/or significant changes in the practice expense and possibly work. Some Workgroup members believe that there may be other services that were valued using larger, more expensive, and more sophisticated equipment where there is now smaller and more affordable equipment to perform a similar procedure. In February 2009, the RUC recommended the creation of a joint CPT and RUC workgroup to research this issue to identify similar services and develop recommendations to appropriately describe and/or address the valuation of these services.

Doctors Rich and Thorwarth subsequently created a joint CPT Workgroup and named Kenneth Brin, MD and Robert Zwolak, MD as Co-Chairs. To understand the scope of the request, Doctors Brin and Zwolak met with AMA staff and later with Ken Simon, MD of CMS to determine the best direction for a workgroup agenda.

Doctors Brin and Zwolak understand the issue presented by the identification of 76880 in the high volume growth screen and recommend that the Five-Year Review Workgroup and RUC review this code to determine if it is appropriately valued. However, the charge to expand this issue to all services utilizing ultrasound and/or technologies that have "small box" models available is less clear.

AMA staff reviewed all codes in the 70000 series of CPT to determine if other imaging codes are now predominately provided by a specialty other than radiology that may indicate some greater use of "small box" technology. It was not apparent from this review that the use of the less expensive technology has become "typical" in any other services beyond 76880.

The CPT Editorial Panel has already reviewed the issue regarding the use of hand held ultrasound, which led to the addition of the CPT guidelines.

Doctors Brin and Zwolak confirmed that CPT and CMS would be unlikely to create modifiers or separate coding to describe the same physician service, utilizing two differently priced technologies. For this reason, the Five-Year Review Workgroup should reconsider whether a joint RUC/CPT Workgroup is warranted at this time.

The Workgroup determined the RUC should review the work and practice expense inputs for 76880 the October 2009 meeting.

The Workgroup recommends that the RUC and its Practice Expense Subcommittee should consider these issues when reviewing new/revised CPT codes. This review should ensure that the technology is appropriately discussed and articulated in the recommendations to CMS. In addition, it would be important to understand when the physician is using the equipment and performing the technical component versus when staff provide the technical service.

The Workgroup recommends the dissolution of the Small Box Technology Workgroup.

V. 2010 Five-Year Review

a. Review *Guidelines for Compelling Evidence*

The Workgroup reviewed the compelling evidence standards from the last Five-Year Review. The Workgroup discussed adding a bullet point that would include "Harvard Valued code" as satisfying the standards of compelling evidence that the current valuation is not accurate. Members voiced concern that adding that compelling evidence standard would indicate that the RUC views that all Harvard codes are currently incorrectly valued. The Workgroup indicated that specialty societies may bring forth codes because they are Harvard reviewed and have never been surveyed by the RUC and typically will find that other compelling evidence standards will apply. Additionally, the Workgroup indicated that the top Harvard codes have been addressed by this Workgroup as part of the Five-Year Review Identification process. **The Workgroup reaffirmed the current compelling evidence standards from the third Five-Year Review for the 2010 Five-Year Review.**

b. Review *Procedures for the August Workgroup and Sept/Oct RUC Meetings*

The Workgroup reaffirmed the current procedures for August Workgroup and Sept/Oct RUC meetings.

c. Review feedback from specialty societies regarding scope of the Five-Year Review

AMA staff surveyed RUC participants to gather an estimate of how many codes to expect at the 2010 Five-Year Review. Over 40 specialty societies responded (all major specialties on the RUC) and over half indicated that they will not be brining forth any codes and the remaining indicated bringing forth approximately 250 codes. At this time August 26-28, 2010 has been reserved for Five-Year Review Workgroup meetings. However, if the total codes to be reviewed is approximately 250 the RUC may only be required to meet in September 2010. An additional day may be added to that meeting in lieu of the August schedule.

VI. Other Issues

A full status report of Five-Year Review Identification Workgroup and CMS Request codes was provided as an informational item.

AMA/Specialty Society RVS Update Committee **Tab 39**
RUC HCPAC Review Board Meeting
April 23, 2009

Members Present:

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

I. HCPAC Co-Chair and Alternate Co-Chair Elections

The HCPAC elected Lloyd Smith, DPM as the RUC HCPAC Co-Chair and Emily Hill, PA-C as the RUC HCPAC Alternate Co-Chair to serve their second two-year term, beginning September 2009 and ending in May 2011.

II. CMS Request: Relative Value Recommendations for *CPT 2010*:

Speech Language Pathology Services

At the February 2009 HCPAC meeting the HCPAC reviewed code 92526 *Treatment of swallowing dysfunction and/or oral function for feeding.* After a robust discussion of the intra-service work and episodes of therapy, the HCPAC recommended postponing recommending a work value for this service until additional frequency data was gathered, the length of treatment session was defined and the RUC had reviewed codes 92597 *Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech* and 92610 *Evaluation of oral and pharyngeal swallowing function.*

In April 2009 the HCPAC reviewed code 92526 and determined that it is typically performed 10 times to treat dysphagia in the outpatient setting, approximately once a week. The HCPAC recognized that since this speech language pathology service is converting from practice expense only inputs to work, that survey respondents had limited reference services to identify with. The HCPAC reviewed the pre-service time and determined to decrease the surveyed pre-time to 5 minutes as it appropriately accounts for the time required to review the previous progress note and prepare the materials. The HCPAC reviewed the intra-service time and determined that 45 minutes appropriately accounted for the time to instruct a variety of oral motor and pharyngeal/laryngeal swallow exercises and assess the patient's ability to achieve criterion performance levels of a variety of therapy activities. The HCPAC reviewed the immediate post-service time and agreed with the specialty society recommended reduction to 5 minutes. The HCPAC determined that 5 minutes appropriately accounts for time required discussing findings with the patient/family and writing a report.

The HCPAC compared 92526 to codes 97001 *Physical therapy evaluation* (work RVU = 1.20, 4 minutes pre-service, 30 minutes intra-service, and 8 minute post-service time) and 97003 *Occupational therapy evaluation* (work RVU = 1.20, 7 minutes pre-service, 45 minutes intra-service, and 5 minutes immediate post-service time). The HCPAC determined that 92526 is more intense than 97001 and 92602 as the type of patient is more fragile, typically cognitively impaired/post CVA. **The HCPAC recommends a work RVU of 1.34, 5 minutes per-service time, 45 minutes intra-service time, and 5 minutes immediate post-service time for code 92526.**

92611

The HCPAC reexamined code 92611 to assure no rank order anomaly exists with the two codes which were reviewed at the RUC in February 2009 (92597 *Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech* (RUC recommended work RVU = 1.48) and 92610 *Evaluation of oral and pharyngeal swallowing function* (RUC recommended work RVU = 1.30). The HCPAC reaffirmed the recommended physician work RVU of 1.34 for code 92611 which was reviewed in February 2009. The HCPAC recommended 7 minutes pre-service time, 30 minutes intra-service time and 10 minutes immediate post-service time. **The HCPAC recommends a work RVU of 1.34 for 92611.**

RUC Chairman's Report

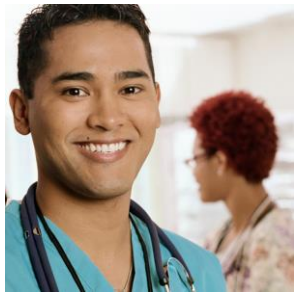
April 23-26, 2009

Chicago, IL

AMA

TOGETHER WE ARE STRONGER



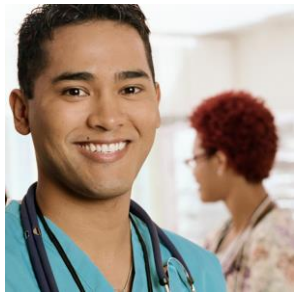



Procedural Issues

Advisors:

- Financial Disclosure Forms-must be on file prior to presentation – no forms are accepted at the meeting.
- Attestations of Survey data should be signed with or after the submission of the SOR. AMA had received statements from Advisors prior to submission of any recommendations
- Before the presentation of a new code, the Chairman will ask presenters to declare any conflicts

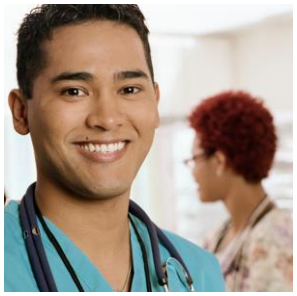


Procedural Issues

- October 2006 – The RUC reaffirmed that RUC advisors and presenters verbally disclose financial conflicts prior to presenting relative value recommendations
- The RUC also recommended that the RUC Chair ask RUC advisors and presenters to verbally disclose any travel expenses for the RUC meeting paid by an entity other than the specialty society



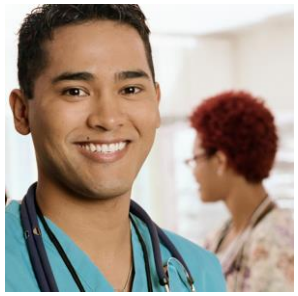



Procedural Issues

RUC Members:

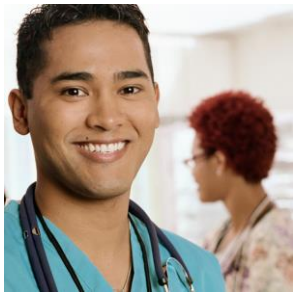
- Before a presentation, any RUC member with a conflict will state their conflict and the Chair will rule on recusal.
- RUC members or alternates sitting at the table may not present or debate for their society



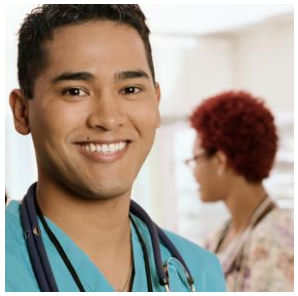
Procedural Issues

- For **new** codes, the Chairman will inquire if there is any discrepancy between submitted PE inputs and PE Subcommittee recommendations or PEAC standards.
- If the society has not accepted PE Subcommittee recommendations or PEAC conventions, the tab will be immediately referred to a Facilitation Committee before any WRVU discussion.



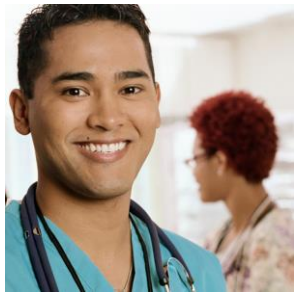
RUC Meeting

- **Cell phones!!!**



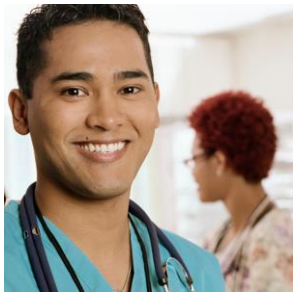
CMS Representatives

- Edith Hambrick, MD – CMS Medical Officer
- Whitney May – Deputy Director, Division of Practitioner Services
- Ken Simon, MD – CMS Medical Officer



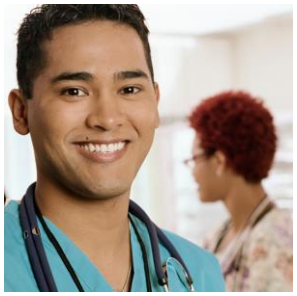
AMA Board of Trustees

- Rebecca J. Patchin, MD, Chair-Elect of AMA Board of Trustees



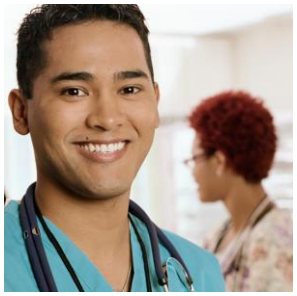
US Government Accountability Office (GAO)

- Iola D’Souza



Medicare Payment Advisory Commission (MedPAC)

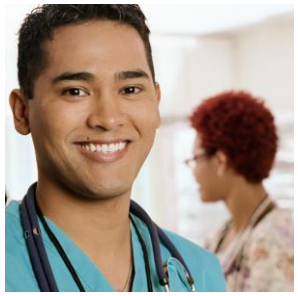
- Kevin Hayes



Medicare Contractor Medical Directors

- Charles Haley, MD



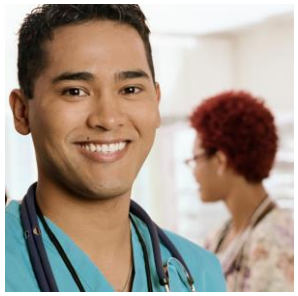



Facilitation Committee #1

Arteriovenous Shunt Imaging Pre-Facilitation
Friday, April 24, 7:00-8:00 am
Soft Tissue Ultrasound Pre-Facilitation
Saturday, April 25, 7:00-8:00 am

- David Hitzeman, DO (Chair)
- Joel Bradley, Jr., MD
- Michael Bishop, MD
- Gregory Kwasny, MD
- Barbara Levy, MD
- Lawrence Martinelli, MD
- Bill Moran, MD
- Eileen Moynihan, MD
- Lloyd Smith, DPM
- Peter Smith, MD
- Maurits Wiersema, MD



Facilitation Committee #2

CT Colonography Pre-Facilitation

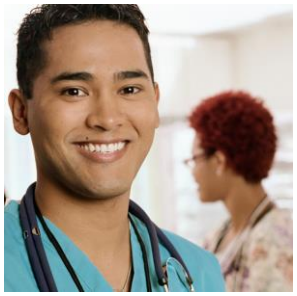
Friday April 24, Noon

Tissue Examination for Molecular Studies Pre-Facilitation

Saturday, April 25, 7:00-8:00 am

- *Gregory Przybylski, MD (Chair)*
- *James Blankenship, MD*
- *John Gage, MD*
- *Peter Hollmann, MD*
- *Brenda Lewis, MD*
- *J. Leonard Lichtenfeld, MD*
- Arthur Traugott, MD
- James Waldorf, MD
- Jane White, PhD, RD
  William Mangold, Jr, MD
- Marc Raphaelson, MD
- Joseph Schlecht, DO



Facilitation Committee #3

Infant Pulmonary Function Testing: Pre-Facilitation

Friday, April 24, 7:00-8:00 am

- Charles Koopmann, MD (Chair)
- Bibb Allen, MD
- Dale Blasier, MD
- Ron Burd, MD
- Thomas Cooper, MD
- Emily Hill, PA-C
- Walt Larimore, MD
- Daniel Mark Siegel, MD
- Samuel Smith, MD
- Susan Spires, MD
- Robert Zwolak, MD
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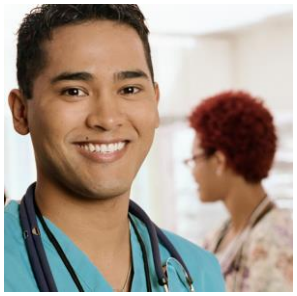
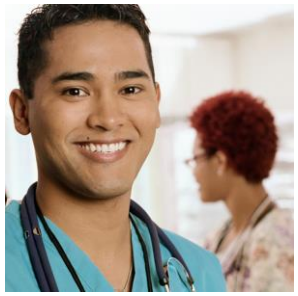


RUC Observers

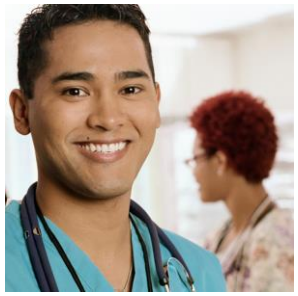
- Debra Abel – American Academy of Audiology
- Margie Andreae, MD – American Academy of Pediatrics
- Sandford Archer, MD – American Academy of Otolaryngology-Head and Neck Surgery
- Rasa Balaisyte – American Society of Neuroradiology
- Robert Barr – American Society of Neuroradiology
- J. Daniel Bourland, PhD – American Society for Therapeutic Radiology and Oncology
- Darryl Bronson – American Academy of Dermatology



RUC Observers

- Brooks Cash – American Gastroenterological Association
- Melissa Cinden – American Speech-Language-Hearing Association
- Gregory DeMeo – American College of Obstetricians and Gynecologists
- Maurine Dennis – American College of Radiology
- Naakesh Dewan – American Psychiatric Association
- Becky Dolan – American Academy of Pediatrics
- Yolanda Doss – American Osteopathic Association
- Thomas Eichler, MD – Americna Society for Therapeutic Radiology and Oncology

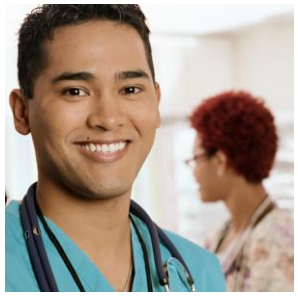


RUC Observers

- Martha Espronceda – American Society for Terapeutic Radiology and Oncology
- Kim Fischer, MD – American College of Obstetricians and Gynecololgists
- Jennifer Frazier - American Society for Therapeutic Radiology and Oncology
- Kim French – American College of Chest Physicians
- George Fueredi, MD – Society of Interventional Radiology
- Emily Gardner – American College of Cardiology
- Denise Garris – American College of Cardiology
- Richard Gilbert, MD – American Urological Association

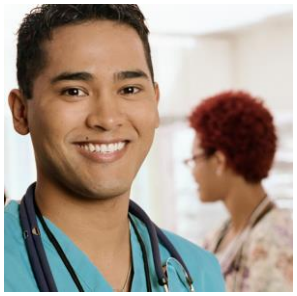


RUC Observers

- Steve Goetsch, PhD – American Society for Therapeutic Radiology and Oncology
- John Goodson – American College of Physicians Robert Hall – American Association of Hip and Knee Surgeons
- Lawrence Green, MD – American Academy of Dermatology
- Janis Gregory – American Urological Association
- Kelly Haenlein – American Academy of Dermatology
- Robert Hall, MD – American Association of Hip and Knee Surgeons

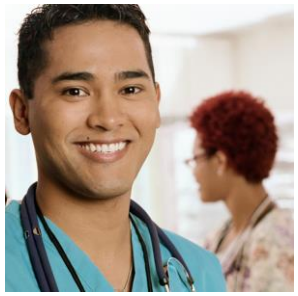


RUC Observers

- David Halsey, MD – American Association of Hip and Knee Surgeons
- Richard Hamburger, MD – Renal Physicians Association
- Richard Hogan – American Speech-Language-Hearing Association
- Dawn Hopkins – American College of Cardiology
- Charles Hutchinson, MD – College of American Pathologists
- Jenny Jackson – Americna Society of Plastic Surgeons
- Chris Jones, MD – American College of Cardiology

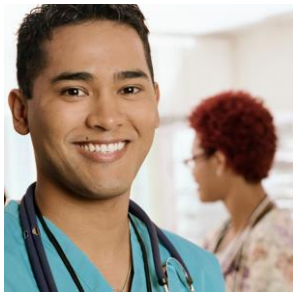


RUC Observers

- Lisa Kaplan, JD – American Academy of Physical Medicine and Rehabilitation
- Clifford Kavinsky, MD – American College of Cardiology
- Kristi Keil – American College of Obstetricians and Gynecologists
- Paul Knechtges – American College of Radiology
- Wayne Koch – Americna College of Physicians
- Carrie Kovar – American College of Cardiology
- Kevin Kovitz, MD – American College of Chest Physicians
- Rachel Kramer – Society of Interventional Radiology

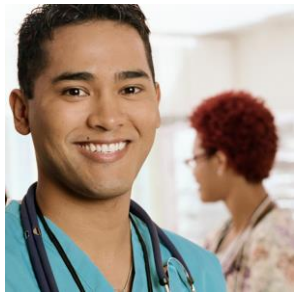


RUC Observers

- Alexander Mason, MD – North American Spine Society
- Faith McNicholas, CPC – American Academy of Dermatology
- Stephen McNutt – American Society for Therapeutic Radiology and Oncology
- Lisa Miller-Jones – American College of Surgeons
- Mary Moller – American Nurses Association
- Gerald Neidzwiecki, MD – Society of Interventional Radiology
- Dee Nikjeh – American Speech Language Hearing Association
- David O'Brien, MD – North American Spine Society

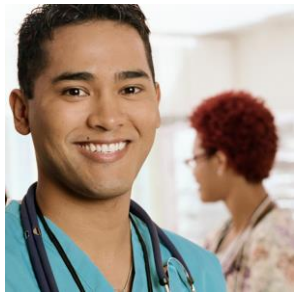


RUC Observers

- Vinita Ollapally – American College of Surgeons
- Paul Pessis – American Speech-Language-Hearing Association
- Lisle Poulsen – American Academy of Dermatology
- John Ratliff, MD – American Association of Neurological Surgeons
- Samuel Reynolds – American Society for Gastrointestinal Endoscopy
- Christopher Saigal, MD – American Urological Association
- Matthew Sideman, MD – Society for Vascular Surgery

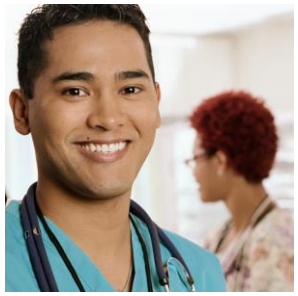


RUC Observers

- Sunita Srivastava – Society for Vascular Surgery
- James Startzell, MD – American Association of Oral and Maxillofacial Surgeons
- Krista Stewart – American Association of Hip and Knee Surgeons
- Michael Sutherland – Society for Vascular Surgery
- Stuart Trembath – American Speech-Language-Hearing Association
- Edward Vates, MD – American Association of Neurological Surgeons
- Joanne Willer – American Academy of Orthopaedic Surgery
- Kadyn Williams – American Academy of Audiology
- Ayanna Wooding – College of American Pathologists

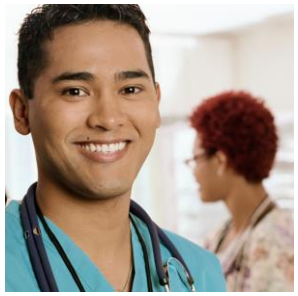


Welcome New RUC Members

- Walter Larimore, MD – American Academy of Family Physicians (AAFP)
- Marc Raphaelson, MD – American Academy of Neurology (AAN)

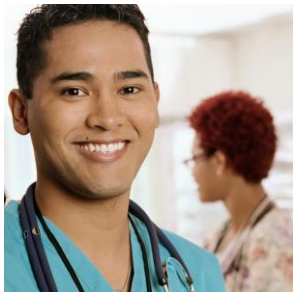


Welcome New RUC Alternates

- Sanford Archer, MD – American Academy of Otolaryngology – Head and Neck Surgery (AAO-HNS)
- Terry Lee Mills, MD – American Academy of Family Physicians (AAFP)

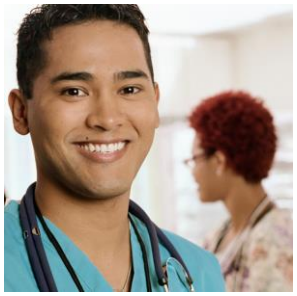


Departing RUC Members

- Gregory Kwasny, MD – American Academy of Ophthalmology
- Maurits Wiersema, MD – AGA/ASGE
- Samuel Smith, MD - American Pediatric Surgical Association (APSA)
- Katherine Bradley, PhD, RN – American Nurses Association (ANA)
  - Served on PE Subcommittee and HCPAC



Financial Disclosure Review Workgroup Report

- RUC review and approve now prior to meeting


AMA
AMERICAN
MEDICAL
ASSOCIATION

The State of the RUC: April 24, 2009

William L. Rich III, MD, FACS
Chair AMA RUC

RBRVS

- History
- Goals
- What is the RUC?
- Impact of RUC decisions
- To do list

History RBRVS

Medicare

- Medicare passes in 1963 and implemented in 1964
- To encourage MD participation, Congress allowed use of established fiscal intermediaries to administer claims and payment was based on the lower of the local UCR or the actual MD charge.
- Sweet!
- MD Medicare spending grew rapidly in the ensuing years.
- Congress tried several methods to distribute health care dollars: price freeze, Medicare HMOs, etc-all failed

Legislative milestones

- 1989, OBRA passage enables RBRVS-Resource Based Relative Value Scale
- RUC meets in 1991
- Implemented 1992
- Congress mandates CMS “update” the WRVUS at least every five years

Goals of RBRVS

- Pay for services based on a rational analysis of the inputs needed to provide the services- *relative value units (RVUs)*
- Shift revenue from proceduralists to primary care to influence manpower decisions.
- **Slow the rate of growth using spending targets**

Goals of RBRVS

- The goal of shifting revenues from hospital based procedures to outpatient diagnostic and office visit codes was successful.
- In 1995, ophthalmology received 65% of revenue from surgery and 35% from EM and office testing. In 2005, the ratio is reversed.

Goals of RBRVS

- Did these shifts in revenues increase applications to primary care or slow the rate of growth of services?-NO

History

- RUC meets in 1991 and submits WRVUS for new and revised codes
- 2/3 required for adoption of WRVUS
- Completed three Five Year Reviews: 1997, 2002, & 2007
- Practice expenses inputs developed for 6500 codes by PEAC from 1999-2004. Functions them assumed by PERRC and PE Subcommittee.
- RUC submits PLI cross walks
- CMS accepts 94% of RUC recommendations

What the RUC is and is not

What is the RUC?

- RUC is an independent group exercising its First Amendment Right to petition the federal government.
- RUC is not an advisory committee to the Centers for Medicare and Medicaid Services (CMS). CMS is entirely responsible for the RBRVS. **All** modifications to the RBRVS are made through rulemaking and open to public comment.

The RUC-

is comprised of 29 members, 26 voting members (14 of these 26 voting members are from specialties whose Medicare allowed charges are primarily derived from the provision of E/M* services).

The RUC is-

not dominated by proceduralists who do not understand the challenges faced by primary care physicians. Nearly all physician specialties report E/M services and understand the work involved. The RUC has recommended substantial increases to E/M each time the codes have been submitted for review.

The RUC-

- is a a committee responsible for many recommendations to improve Medicare payment for primary care services, including:

-significant increases to E/M services in 1997 and 2007. The work relative value for 99213, for example, increased 59%

-improvements in immunization administration; telephone calls, team conferences, anticoagulant management, and patient education

- a fair application of budget neutrality to ensure that primary care retained the full benefit of the E/M increases

-development of a payment model for the new Medicare Medical Home Demonstration Project

The RUC--

- Is not responsible for decisions that resulted in no or stalled Medicare payment improvements for primary care, including:

  -refusal to fully implement the RUC recommended E/M increases in 1997.

  -delay in implementing the immunization administration payment increases and refusal to provide separate payment for telephone calls, team conferences, anticoagulant management, and patient education

-implementation of an unfair work adjuster, to be corrected on January 1, 2009, only after Congressional action following RUC advocacy.

-delay in implementation of the Medicare Medical Home Demo until late 2009, despite the efficient

The RUC is--

- Is an expert panel. Individuals exercise their independent judgment and are not advocates for their specialty.

The RUC is not--

a representative committee. The RUC relies on socioeconomic expertise and objectivity. A common misperception is that members of the RUC vote en bloc. **This is not true.** The RUC requires a 2/3 vote (18 out of 26) to submit a recommendation to CMS. These votes are confidential and reviewed only by AMA staff. RUC members have voted against their own specialty's recommendations when they thought those recommendations were inappropriate. The AMA staff (who can see how individual RUC members vote) observe that voting does not usually align in blocs, and that voting often is contrary to the apparent self-interest of individual RUC members.

The RUC-

is supported by an Advisory Committee of 100 specialty societies and health care professional organizations who collect data and formally present recommendations to the RUC. Advisory Committee members, not individual RUC members, are the advocates for their specialties

The RUC-

is not a closed process. The RUC Chairman accepts requests for attendance at each meeting, including MedPAC staff, GAO staff, and international delegations. However, the RUC has a strict conflict of interest policy and does not want the influences of industry involved in the process. The RUC looks to each specialty society to provide accurate time and survey data. An attestation statement of accuracy and potential conflict of interest is now required of each advisor presenting to the RUC.

The RUC -

is involved in reviewing direct practice expense inputs and submitting these recommendations to CMS. The RUC has reviewed 7,000 CPT codes and estimated the clinical staff (typically nursing) time, supplies, and equipment used in the provision of these services. CMS has only begun to transition the full impact of these recommendations into the RBRVS.

The RUC --

is not even able to recalculate the CMS practice expense relative value units, let alone establish them. The RUC submits recommendations on clinical staff (type and time); medical supplies (type and number of units); and medical equipment (type). All other elements of the data and the actual methodology have been developed by CMS. CMS prices the wages, supplies, and equipment. CMS has accepted supplemental overall practice expense data directly from specialties. The RUC's recommendations to improve both the practice expense and professional liability insurance (PLI) methodology have not yet been adopted.

The RUC--

is supported by the AMA and 100 specialty societies and health care professional organizations. Each society provides not only an advisor, but also staff representatives. The societies typically have one staff employed to collect survey data and provide other analysis for both the CPT and RUC processes, among other responsibilities. The AMA provides the meeting forum and a professional staff of five, all master degree level individuals

The RUC--

is not free to organized medicine, but it is free to the federal government. The RUC activity provides the Medicare program with the ability to issue timely updates to the Medicare Physician Payment Schedule, at almost no cost to the government. A very conservative estimate of the annual cost to the AMA, specialty societies, and health care professional organizations is $7 million per year in staff salaries, survey expense, meeting and travel expense, and lost wages of RUC volunteer physicians.

The RUC--

- does evaluate the work, practice expense inputs and professional liability cross walk for new and revised CPT codes for the MFS
- does not have a role to play in adjusting income targets or devising manpower policy

Impact of RUC On Primary Care

- Improved valuation for primary care services
- Changes in allowed charges
- Improved payment for preventive services
- Valuation of Medical Home and Coordination of Care
- Identification of mis-valued services

Myths:

- RUC has allowed the EM share of WRVUS to be diluted

Total WRVUs ‘92 vs ’07(millions), utilizing 2005 Medicare Claims

CPT Cat	1992 WRVUS	2007 WRVU	% increase
Surgery	163	177	9%
EM	374	543	45%
Radiology	77	66	-6%
Pathology	17	18	6%
“medicine”	79	90	14%

Myth:

- RUC pays much more for a a segment of professional time for specialists than primary care.

Physician Work RVUs to time (units in millions), utilizing 2007 Medicare Claims

CPT Cat.	MFS mins '09	Mins. % of total	Work RVUS '09	WRVUS % of total	WRVU/ min
Surgery	5,882	19.46%	234	21.01%	**.0398**
E/M	15,072	49.86%	590	52.96%	**.0391**
Pathology	794	2.63%	22	1.97%	.0277
Radiology	2,021	7.28%	87	7.87	.0395
Medicine (tests)	6,219	20.57%	173	15.53%	.0278

Improved RUC valuation of primary care

- EM WRVUS from ‘92 to ‘07 increased 45%
- Surgical WRVUs increased 9%
- Tests and therapy increased 14%
- Pathology 6%
- Radiology WRVUS decreased 6%

Changes in payment 1993-2002

- Payments for new office visits increased 73%
- Established visits increased 67%
- Consults increased 32%
- Standard imaging increased 3%

Changes in payment ‘93-’02

- Decreases of 8% for major procedures: 24% for CV, 26% for eye and 24% for endoscopy
- ***Since ’93-’07, cataract, CABG and joint replacement surgery decreased 43% in ‘93 dollars.***

Coordination of care and medical home

- After the Federal contractor (Mathematica) was unable to value the Medical Home, the RUC did so in three months and approved the work group product with a unanimous vote. The monthly PPM payments would allow robust increases in primary care payment of over $150,000/yr/MD.
- The RUC has valued and proposed separate payment for care coordination, team conferences, patient education, and telephone calls.

Mis-valuation of services

- RUC has made repeated appeals for CMS to re-consider their equipment utilization assumptions and cost of capital for high end imaging which result in over payment of practice expenses.
- RUC has recently identified over 400 services for review and CMS adoption has lead to an overall increase in the conversion factor and $200 million in practice expense savings. Recommendations from the January ‘09 meeting will redistribute $70 million

To do list

Eliminate specialty “caucuses”

Address mis-valued services

Don’t expand the RUC for political reasons

Work with CMS and MedPac to clean up BETOS

Aid CMS’ office of Value Based Purchasing in evaluating the use of commercial grouper software to establish efficiency measures.

“Caucuses”

My attendance at two surgical meetings shortened my life span fifteen years!

“Caucuses”

The meetings of the Surgical and Cognitive Caucuses during the Third Five Year Review of Work Values caused me irreparable mental harm!

Cognitive caucus

- The creation of surgical and cognitive groups lead to a stale mate and pointless animosity preventing adoption of a recommendation for increases in EM services.
- Shut out many specialties who received over 50% of their income from EM services
- The votes to get to a 2/3 majority came from the same surgical specialties originally excluded from the "cognitive caucus"

Percentage of specialty Medicare charges from EM

- Psychiatry-98%
- Geriatrics-93%
- ED-91%
- Family practice-85%
- Internal medicine 82%
- Rheumatology-64%
- Neuology-62%

- Hematology-54%
- GI-45%
- Dermatology-38%
- Cardiology-35%

- Ophthalmology-64%
- Ob-gyn-56%
- ENT-52%
- Hand, Plastics, GS-50%
- CV/Thoracic-44%
- Ortho-43%

Mis-valued services

- Testing growing at 14%/beneficiary/yr
- Economists assume rapid growth and marketing imply mis-valuation
- Congress/CMS have moved aggressively in the past to lower payments outside the RUC process and will do so in the future.

Remember the sage words of John Gage!!

Mis-valued services

- RUC should continue to evaluate services where technology has created efficiencies.

Possible approaches if we don't:

- All fast growing services arbitrarily cut 20%
- "mis-valued services put in a spending pool with a separate conversion factor which would lead to 34% cuts in payment within eight years!
- Set up panel of economists, insurers, and consumers to assign payment

RUC expansion

- Do societies sitting on the RUC have a greater chance of having codes approved at the societies recommendation?

- NO!

Percentage of WRVUS accepted at initial recommendation.

- For societies sitting on the RUC in the rotating seat, there was a 42% acceptance rate for 260 new codes. The rate of acceptance was 62% for 440 codes when these societies were ***not*** on the RUC.
- There is no evidence that a specialty benefits from a full time seat on the RUC.
- There is no need to further expand the RUC for political reason which could limit effective decision making and impair efficiency.

Value based purchasing

- CMS' Office of Value Based Purchasing is mandated by Congress to assess methods of measuring value
- Grouper software is currently used to measure efficiency of care in commercial insurance plans and being evaluated by CMS
- These proprietary products, Thomson Reuters and Ingenix, are now available on their websites.
- An AAO analysis of the algorithms revealed glaring flaws
- The RUC should approach Dr. Valuck of CMS and offer to evaluate the assumptions used in the grouper software.

What is the current status of the RUC?

- The RUC is a organization that has matured and grown over the last eighteen years. It has a broader work load , a robust COI policy, responds to new health policy issues affecting the MFS, is staffed by superb professionals, and peopled with the brightest, hardest working physicians I have met.

One additional piece of advice--

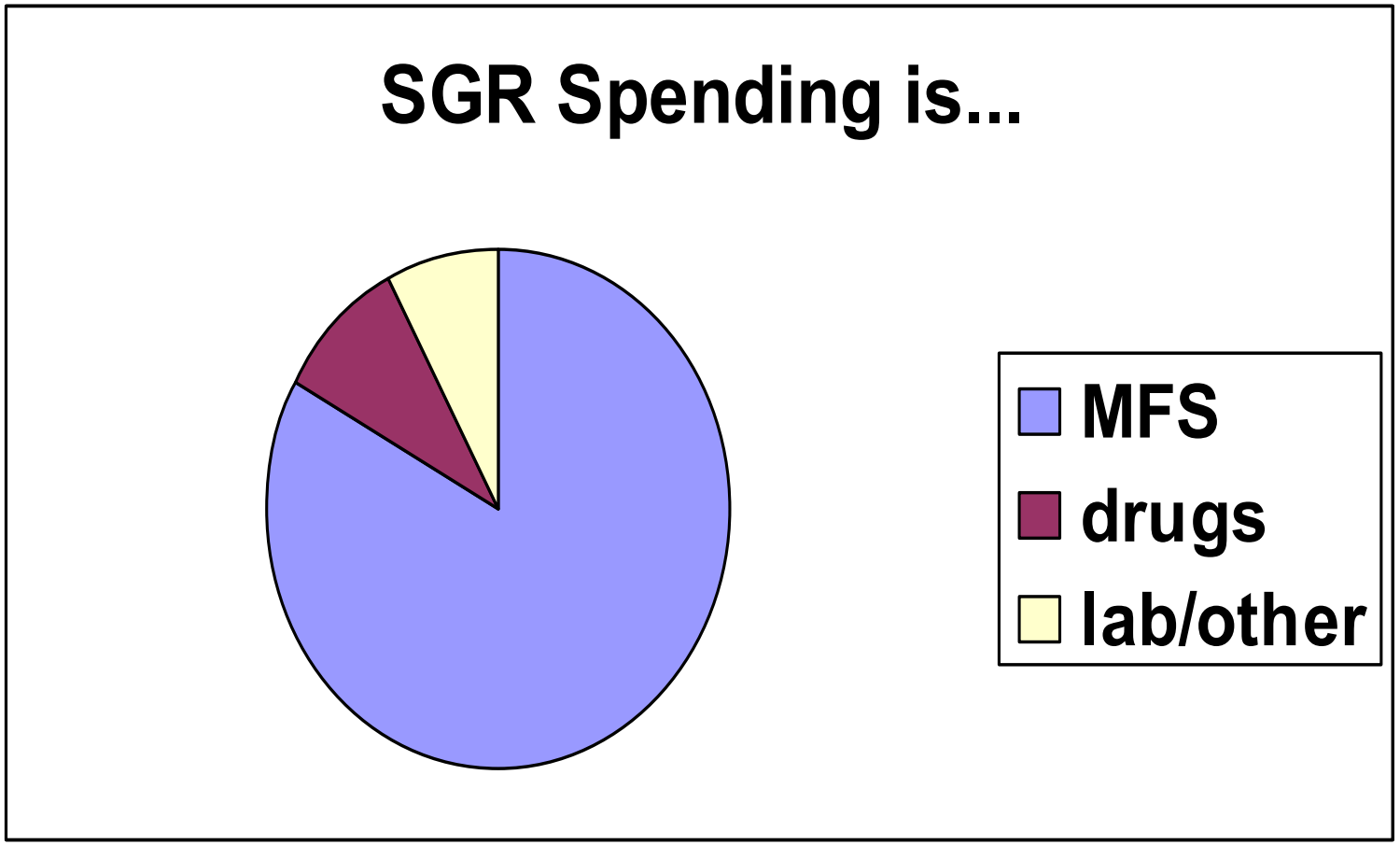
Wear your RUC hat and-

--just do the right thing!

SGR Spending and Utilization Growth for 2008

Estimates based on claims processed through Dec 31, 2008

Background



Background

- V/i growth has been below average for
  - E&M
  - Major Procedures
  - Anesthesia
- V/i growth has been above average for
  - Advanced Imaging
  - Tests
  - Minor Procedures
  - Drugs

Results for 2008 - Overall

- SGR spending is up 2.8%
- MFS spending also up 2.8%

- Change in MFS spending was due to:
  - Decline in FFS enrollment (-1.6%)
  - Increase in MFS pay (0.9%)
  - V/i growth of 3.6%

Results for 2008 - Imaging

- Continued decline in utilization growth

- 3% v/i growth for advanced imaging
- 4% v/i growth for echography

- V/i growth for imaging is similar to that for all services

Results for 2008 - Imaging

- v/i growth for:
  - Nuclear Medicine was 0%
  - MRI Brain was -1%
  - MRI Other was 3%

  - Standard Imaging/Breast increase of 60% is due to increased use of G0202, G0204, G0206. Use of 77055-77077 went down (standard imaging/chest).

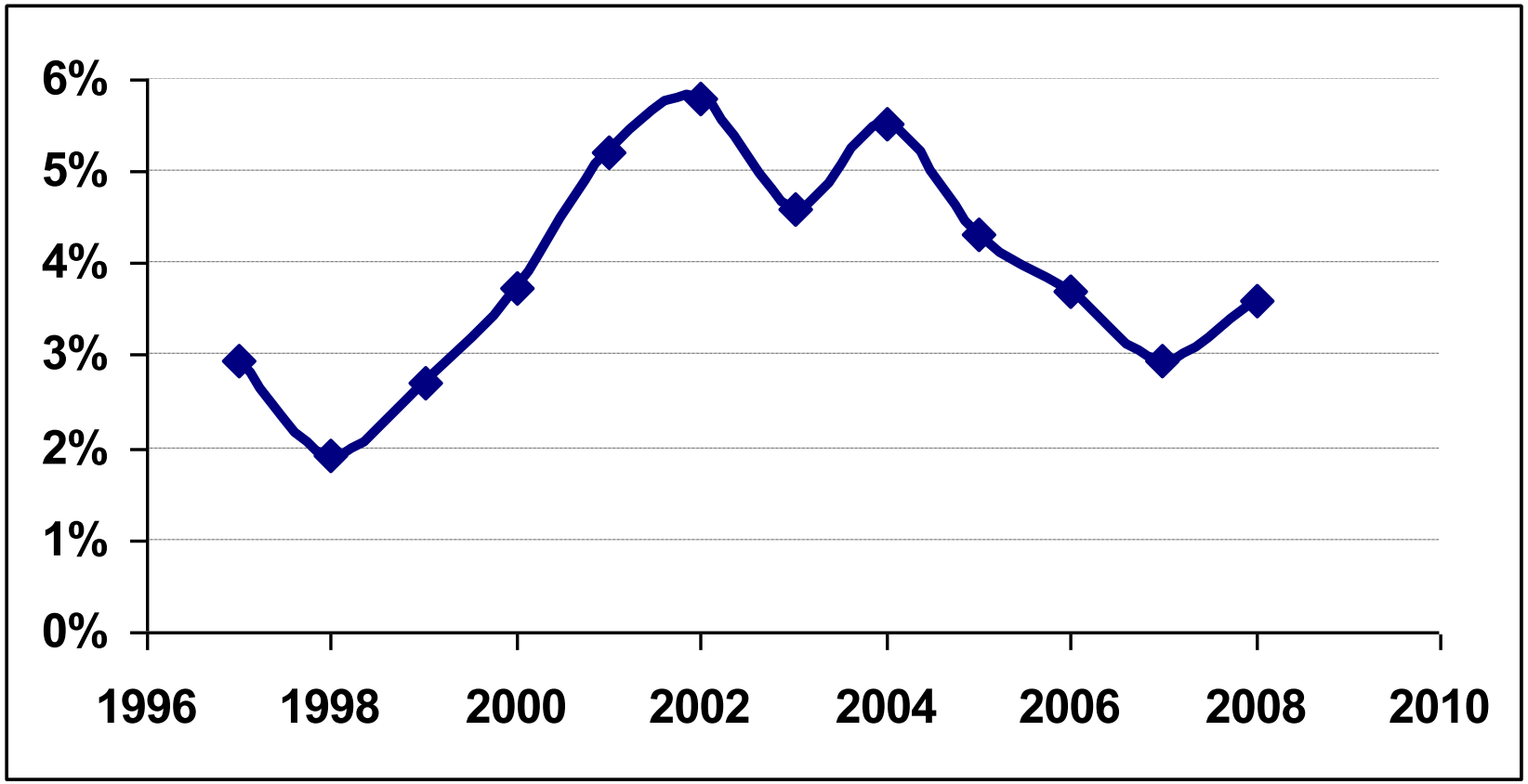
Results for 2008 – E&M

- V/i growth for E&M went up
- Office, hospital, ER visit volume/intensity growth all up slightly
- Critical care utilization up 12%

Other Results for 2008

- Continued low growth in utilization of major procedures
- Continued above average growth in v/i for minor procedures (physical therapy) and lab tests
- Just 2% growth in spending for drugs
- Utilization of Darbepoetin and Epoetin again down sharply (-33% per enrollee)

Overall MFS v/i growth



Key Results

- Overall MFS v/i growth has stabilized
- v/i growth for imaging is down again
- No growth in drug utilization (again)
- v/i growth for E&M is up

- Uniform growth in utilization across type of service categories