

**AMA/Specialty RVS Update Committee
Meeting Minutes
January 26-28, 2012**

I. Welcome and Call to Order

Doctor Barbara Levy called the meeting to order on Friday, January 27, 2012, at 8:30 am.
The following RUC Members were in attendance:

Barbara Levy, MD (Chair)
Michael D. Bishop, MD
James Blankenship, MD
R. Dale Blasier, MD
Albert Bothe, MD
Joel Bradley, Jr. MD
Ronald Burd, MD
Scott Collins, MD
William Gee, M
Anthony Hamm, DC
David C. Han, MD
David F. Hitzeman, DO
Charles F. Koopmann, Jr., MD
Timothy Laing, MD
Walt Larimore, MD
Brenda Lewis, DO
J. Leonard Lichtenfeld, MD
Scott Manaker, MD, PhD
Bill Moran, Jr., MD
Gregory Przybylski, MD
Marc Raphaelson, MD
Sandra Reed, MD
Peter Smith, MD

Arthur Traugott, MD
J. Allan Tucker, MD
George Williams, MD
Allan Anderson, MD*
Margie Andreae, MD*
Gregory DeMeo, DO*
Jane Dillon, MD
Verdi Disesa, MD*
William Donovan, MD*
Jeffrey Paul Edelstein, MD*
Burton L. Lesnick, MD*
William J. Mangold, Jr., MD*
Terry Mills, MD*
Margaret Neal*
Scott D. Oates, MD*
Chad Rubin, MD*
Steven Schlossberg, MD*
Eugene Sherman, MD*
Daniel Mark Siegel, MD*
Robert Stomel, DO*
Jane White, PhD*
Jennifer Wiler, MD*

*Alternate

II. Chair's Report

- Doctor Levy welcomed everyone to the RUC Meeting
- Doctor Levy welcomed the following CMS staff and representatives attending the meeting:
 - John Cooper, MD – CMS Medical Officer
 - Edith Hambrick, MD – CMS Medical Officer
 - Christina Ritter, PhD – Director of the Division of Practitioner Services
 - Ryan Howe – Senior Policy Analyst
 - Sara Vitolo, MSPH – Policy Analyst
 - Ferhat Kassamali – L&M Policy Research
 - Margaret Johnson – L&M Policy Research
- Doctor Levy welcomed the following Contractor Medical Director:
 - Charles Haley, MD, MS, FACP
- Doctor Levy welcomed the following observers:
 - Robert M. Wah, MD - Chair of the AMA Board of Trustees

- Korean Medical Association
 - Hyun Kang, MD
 - Junheum Yon, MD
 - Sunwoo Kim, MD
- A reminder that there is a confidentiality policy that needs to be signed at the registration table; nothing discussed during the meeting may be discussed outside of the meeting.
- Proceedings are recorded in order for RUC staff to create the meeting minutes.
- Before a presentation, any RUC member with a conflict will state their conflict. That RUC member will not discuss or vote on the issue.
- RUC members or alternates sitting at the table may not present or debate for their specialty.
- Please share voting remotes if you step away from the table.
- The RUC is an expert panel and individuals are to exercise their independent judgment and are not advocates for their specialty.
- Doctor Hitzeman provided the Administrative Subcommittee's Financial Disclosure Review Workgroup Report
 - Two items of concern:
 - Doctor James Ulchaker, American Urological Association, initially submitted a financial disclosure form to present Cystoscopy and Treatment (52214, 52224) . However, AUA subsequently withdrew Doctor Ulchaker as a presenter so no further action was required.
 - Doctor Kovitz submitted a financial disclosure in regards to presenting Bronchial Valve Procedures (3164X1-3164X3). The Financial Disclosure Review Workgroup expressed concerns about his interests in Olympus, one of the companies that provides valves for this procedure. The Review Workgroup determined that Doctor Kovitz's involvement was minimal and that Doctor Kovitz was one of the principal investigators in this procedure.. The Review Workgroup determined, and the RUC agreed, that Doctor Kovitz may provide a brief description of how the procedure is performed. The presenter must then leave the RUC table, but may answer only technical questions from the floor limited to the procedure itself.
- Chronic Care Coordination Workgroup (C3W)
 - Doctor Levy reminded the RUC that the C3W is a joint workgroup between CPT and the RUC
 - The RUC wants to remain engaged in persuading CMS to recognize and pay for care coordination services. The Workgroup feels that this is source of a great deal of work that is uncompensated and that it would help our Primary Care colleagues who do a lot of care coordination to have their work be recognized.
 - CPT Editorial Panel has created a workgroup to review coding needs and care transition coding.
 - The Workgroup is now trying to define, perhaps with new E/M codes or bundled codes, opportunities to capture the work being provided, not only by the physician and the provider, but also by the staff and the practice to do this work. The care transition codes will describe the care that is needed during a transition from an inpatient to an outpatient facility, as well as what types of teams can provide that care.

III. Director's Report

- Sherry Smith welcomed the following new RUC staff:
 - Samantha Ashley, MS - Senior Policy Analyst I (Practice Expense Subcommittee)
 - Rosa Karbowski, MBA - Senior Policy Analyst I (Research Subcommittee)
- Due to the litigation hold we cannot discard any materials. Boxes have been distributed. Please place any RUC materials that you do not want to take with you in these boxes.

IV. Approval of Minutes of the September 22-25, 2011 RUC Meeting

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

V. CPT Editorial Panel Update

Doctor Albert Bothe provided the following report of the CPT Editorial Panel:

- Tab 3 contains two items. The first is a summary of the CPT 2013 Editorial Panel Coding Changes, to date. The RUC acted on some in September, some at this meeting and some in April. The other item summarizes the RAW material.
- We were happy to have Doctor Tucker representing the RUC at the October CPT Meeting.
- CPT is working on clarifying the definition of Qualified Health Care Provider. Historically many codes have used the word Physician, which may or may not be completely accurate or necessary, so there is a proposal to clarify how we will use standard language. Doctor Bothe clarified that there are three principles that the CPT editorial panel adopted:
 - References to a particular provider or professional will be removed when not essential.
 - There will be an effort to achieve consistency of the entire code set and if a specialty insists that the word physician should be maintained, even if not essential they will have to justify that.
 - The introductory language that was drafted last spring was affirmed at the last CPT Editorial Panel Meeting.
- CPT is going through process improvement changes. The following processes were reviewed and clarified:
 - Conflict of interest procedures
 - Panel term limits and succession
 - Appeals process
 - Workgroup structure and function codified
 - Ground rules for sunseting CPT category 3 codes
 - Dates for sunseting CPT category 3 codes verified for accuracy
 - Appendix C for specialty input and completeness
- Doctor Levy welcomed Grace Kotowicz back to the RUC

VI. Centers for Medicare and Medicaid Services Update

Doctor Edith Hambrick provided the report of the Center for Medicare and Medicaid Services (CMS):

- Doctor Donald Berwick has left the Agency and Marilyn Tavenner is the Acting Administrator
- Christina Ritter, PhD, is the Director of the Division of Practitioner Services and a new Deputy Director, Cathy Bryant has been hired.

- The agency is currently in notice of proposed rulemaking and now is the time for specialties to bring forward suggestion for items to review in the 2013 Notice of Proposed Rulemaking.
- A concern about physician owned practices increasingly being purchased by Hospital systems was brought forward to CMS. The concern was that the payment has now shifted from nonfacility to facility and may have a negative effect on the CMS' budget. CMS responded that they are aware of the issue.

VII. Contractor Medical Director Update

Doctor Charles Haley provided the contractor medical report:

- In October and November CMS made three new contract awards:
 - J6 (Wisconsin, Illinois, Minnesota) was awarded to National Government Services (NGS) and was formerly Wisconsin Physician Services (WPS) who is protesting the decision. The Government Accountability Office (GAO) will rule on the protest by February 1st.
 - J8 (Michigan and Indiana) was awarded to Wisconsin Physician Services (WPS) and was formerly National Government Services (NGS) who is protesting the decision. The Government Accountability Office (GAO) will rule on the protest by February 1st.
 - H8 (Texas, Colorado, Oklahoma, New Mexico, Arkansas, Louisiana and Mississippi) was awarded to Highmark Medicare Services and was formerly Trailblazer who is protesting the decision. The Government Accountability Office (GAO) will rule on this protest by March 1st. Immediately following the award, Highmark Medicare Services was sold to Blue Cross Blue Shield of Florida.
- Payment error rate
 - Primary focus of Contractors' medical review programs is to reduce the payment error rate.
 - The payment error rate for 2011 was 8.6%, down from the 2010 rate of 9.1%.
 - The greatest portion of the payment error rate are errors related to 2 types of inpatient services:
 - Inpatient stays less than 24 hours that should have been outpatient stays.
 - Patients whom are admitted for elective procedures and there is not sufficient documentation in the patient medical record to justify the procedure.
 - In the case of the second scenario, Contractors' believe that the records exist so they are encouraging greater sharing of records at the time of admission to try to reduce the error.
 - In November, CMS announced three new initiatives to address the payment error rate:
 - A to B Rebilling Process - 300 volunteer Hospitals nationwide will be permitted to rebill outpatient claims that are denied under Part A, as Part B claims. If the second claim goes through they will receive 90% of what they would have gotten if they had filed the claim correctly to begin with.
 - RACs Prepay Review (On hold) - RACs will be permitted to do their review before the claim is paid.
 - Prior Authorization for Qualified High Cost Durable Medical Equipment.

VIII. Patient-Centered Outcomes Research Institute (PCORI) Presentation

Robert Zwolak, MD and Christine Goertz, DC, PhD, gave the following presentation:

- PCORI is an independent, non-profit organization created by Congress in 2010.
- PCORI's mission is to fund research that will provide patients, their caregivers and clinicians with the evidence-based information needed to make better-informed health care decisions.
- PCORI is committed to continuously seeking input from a broad range of stakeholders to guide its work.
- PCORI has \$550 million dollar budget to fund research.
- Board of governors is representative of the entire health care community comprised of: patients; caregivers; physicians, nurses and providers; health services researchers; state and federal health officials; pharmaceutical, device, and diagnostic manufacturers; private payers; employers.
- PCORI's core duties are:
 - Establish national research priorities
 - Establish and carry out a research project agenda
 - Develop and update methodological standards
 - Provide a peer-review process for primary research
 - Disseminate research findings
- Draft priorities and an initial research agenda are currently posted at www.pcori.org for comment. The draft priorities and initial research agenda were developed over the last five months using the following methods:
 - Reviewed major comparative effectiveness research initiatives.
 - Reviewed previous national priority-setting processes.
 - Evaluated these against criteria laid out for PCORI in law.
 - Informally vetted draft priorities with patients, caregivers and other stakeholders through small meetings and focus groups.
- Once the initial priorities and agenda are adopted, we will work with all stakeholders to identify specific areas where PCORI's research can have the greatest impact.
- Draft National Priorities of PCORI are as follows:
 - Assessment of options for prevention, diagnosis and treatment
 - Improving healthcare systems
 - Communication & dissemination research
 - Addressing disparities
 - Accelerating PCOR and methodological research
- These priorities were then filtered through the PCORI criteria to develop the initial research agenda. PCORI criteria is as follows:
 - Impact on health of individuals and populations
 - Improvability via research
 - Inclusiveness of different sub-populations
 - Addresses current gaps in knowledge/variation in care
 - Impact on health care system performance
 - Potential to influence decision making
 - Patient-centeredness
 - Rigorous research methods
 - Efficient use of research resources
- Questions about the National Priorities and Research Agenda
 - How well do the priorities cover the research PCORI should do?
 - Are each of the priorities clearly understandable?

- What percentage of PCORI's research budget should be invested in each priority area?
- If future versions of the research agenda focus on specific conditions and diseases, how should PCORI choose which ones to target?
- What role should PCORI play in emerging public health issues?
- How could PCORI address conditions that are rare and understudied?

IX. Washington Update

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

- SGR repeal
 - Was on the table in Deficit Reduction Super Committee
 - Tied to other must-pass legislation (payroll tax/unemployment insurance)
 - House-passed version had 2-year SGR patch
 - Pay for's included:
 - Cliff financing
 - Reduced payments for hospital outpatient visits
 - Other provisions in the bill unacceptable to Senate
- SGR repeal stalemate ended with a 2-month solution
 - Averted the scheduled 27.4% conversion factor cut
 - Other 2012 fee schedule changes took effect
 - Conference committee created to develop compromise
 - Talk of one or two year patch
 - AMA continues to push for permanent repeal of the SGR
- Now SGR permanent repeal is back on the table
 - Consensus in Medicine is for a 3-pronged approach
 - Eliminate the SGR immediately
 - Provide 5 years of stable updates
 - Allow physicians to plan and invest
 - Develop & test new payment models
 - Phase-in multiple payment and delivery models
- Talk of funding SGR repeal with Overseas Contingency Operation funding (OCO)
 - OCO represents projected spending in Iraq and Afghanistan that will not occur
 - CBO baseline assumes current spending levels continue but war is ending
 - SGR is similar
 - Baseline assumes physician pay cuts, but Congress has prevented cuts in the past.
 - Clear the books; let 2 numbers cancel each other out
 - Use money that exists only on the books to cancel cuts that exist only on the books
- What the AMA is doing to support SGR repeal:
 - AMA Physicians Grassroots Network (32K)
 - AMA Very Influential Physician (VIP) Program (700K)
 - AMA Patients Grassroots Network (800K)
 - State & specialty society collaboration, sign-on letters
 - Partnerships with patient groups—AARP, Military Officers Association of America
 - Ads, editorial boards, opinion pieces
- Where do we stand with support on the SGR repeal?

- Bipartisan support for full repeal is growing
- Bipartisan support for OCO offset is growing
 - President & key Democrats back it
 - Sen. Kyl an early champion
 - Others in GOP warming to the idea
 - House physicians could be key
- Payment and Delivery System Reform
 - Bipartisan pressure for payment & delivery changes
 - AMA wants system that is physician-led & provides viable options and efforts have led to:
 - Improvements in ACO rules
 - Advanced payment option for physicians
 - Array of other demonstrations
 - ACO Improvements from Final Rule published Nov. 2
 - Provides more information on prospective patients
 - Counts specialists' primary care patients
 - Includes option without downside risk in 1st 3 years
 - Reduced required quality measures from 65 to 33
 - Removed "meaningful use" requirement
 - Centers for Medicare and Medicaid Innovation (CMMI) Initiatives
 - \$10 billion to test new payment and delivery systems
 - AMA pressing CMMI to offer more physician-friendly options
 - CMMI has responded with a number of programs, including:
 - Advanced Payment Option which provides up-front money to physician-only ACOs; money is recouped through ACOs share of any savings
 - A bundled care initiative that envisions various types of packaging care during and following a hospital admission,
 - A comprehensive Primary Care Initiative where Medicare would partner with private payers.
 - Health Care Innovation Challenge: 3-yr grants of \$1 to \$30 million for innovative projects to "drive significant healthcare improvements."
- ICD-10
 - Expands current 13,000 diagnosis codes to 68,000
 - Delayed until fiscal year 2014 which starts Oct. 1, 2013.
 - Practices already overloaded with E-Rx, PQRS, HIT, etc.
 - SGR has not kept up with practice costs
 - AMA urging Congress to halt implementation and seek stakeholder input on possible alternatives.
- Transparency Reports
 - ACA required drug & device makers to report payments and other "transfers of value" to physicians and teaching hospitals.
 - All transactions worth \$10 or more must be reported
 - Reporting begins in 2012
 - CMS must open public database in 2013
 - Proposed regulation was published December 19
 - AMA believes:
 - Correction process is inadequate

- Requirement to report “indirect” transactions will be detrimental to continuing medical education
 - AMA & specialties met with CMS earlier this week.
 - AMA is writing sign-on comment letter
- Hospital Conditions of Participation (COP)
 - New COP proposed in October; Goal is reducing hospital regulation
 - Multi-hospital systems could have single medical staff & governing body
 - Hospitals also could privilege physicians not on the medical staff.
 - Changes were sought by American Hospital Association (AHA) and Joint Commission
 - AMA believes:
 - We questioned CMS’s authority to make COP changes not related to patient safety and argued that proposals regarding hospital structure would dilute the authority of the medical staff and interfere with local decision-making.
 - Our comments were signed by 81 state and specialty societies
- AMA has been collecting comments and/or suggestions for PCORI’s draft priorities and an initial research agenda and will be submitting them. We have also notified specialties to do the same. If you have not submitted comments the AMA strongly encourages you to do so.
- Questions and Comments
 - A representative of the American Nurses Association thanked the AMA for taking such a strong leadership role on the SGR repeal.
 - Doctor Robert Wah, Chair of the AMA Board of Trustees emphasized the time element of the SGR repeal. There is a small window to press for this repeal before the March deadline. OCO is a promising option to fund the SGR repeal, and we need to press for it.
 - Doctor Gee commented that the AMA staff have done excellent work in their efforts to repeal the SGR.

X. Relative Value Recommendations for *CPT 2013*:

Shoulder Arthroplasty (Tab 4)

William Creevy, MD (AAOS); Daniel Nagle, MD (ASSH)

In June 2011, the CPT Editorial Panel created two new CPT codes for total shoulder revision, CPT code 234X1 *Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component* and CPT code 234X2 *Revision of total shoulder arthroplasty, including allograft when performed; humeral and glenoid component*. CMS requested surveys for all base and family codes. Surveys were conducted for the January 2012 RUC meeting, however due to a low rate of procedure performance and a significant amount of financial conflicts reported, the useable survey responses are not enough to make a RUC recommendation at this time. **The RUC recommends the continued collection of survey responses for review at the April 2012 RUC meeting.**

Elbow Arthroplasty and Implant Removal (Tab 5)

William Creevy, MD (AAOS); Daniel Nagle, MD (ASSH)

In June 2011, the CPT Editorial Panel created two new CPT codes for total elbow revision, CPT code 243X1 *Revision of total elbow arthroplasty, including allograft when performed;*

humeral or ulnar component and CPT code 243X2 *Revision of total elbow arthroplasty, including allograft when performed; humeral and ulnar component*. CMS requested surveys for all base and family codes. Surveys were conducted for the January 2012 RUC meeting, however due to a low rate of procedure performance and a significant amount of financial conflicts reported, the useable survey responses are not enough to make a RUC recommendation at this time. **The RUC recommends the continued collection of survey responses for review at the April 2012 RUC meeting.**

Bronchial Valve Procedures (Tab 6)

Kathrin Nicolacakis, MD (ACCP); Alan Plummer, MD (ATS); Kevin Kovitz, MD (ACCP/ATS)

At the October 2011 CPT meeting, the Panel approved three new category I codes to report bronchial valve procedures. These services were previously reported using three category III codes, 0250T, 0251T and 0252T.

3164X1 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), initial lobe*. The specialty society presented this as an add-on code to CPT code 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)* and CPT code 31634 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, with assessment of air leak, with administration of occlusive substance (eg, fibrin glue), if performed*. However, after further review and discussion, the RUC determined that the structure of the stand-alone codes and the add-on code did not accurately depict the procedures performed. The specialty society explained that the patient has a persistent air leak and a basic bronchoscopy is performed to examine the entire airway. Given that a bronchoscopy is always performed and the physician is planning to put the valve in, the code structure for this procedure should mirror the valve removal codes, 3164X2 and 3164X3. Thus, the RUC agreed that 3164X1 should be referred to the CPT Editorial Panel to be revised as a stand alone code by modifying the descriptor to include balloon occlusion for the initial lobe. Also, the Panel should create an add-on code to describe each additional lobe, to be reported in conjunction with 3164X1. **The RUC recommends that CPT code 3164X1 be referred to the CPT Editorial Panel to modify the descriptor language and create an add-on code for each additional lobe. The Panel adopted these recommendations at the February 2012 meeting. The RUC will review these two codes in April 2012.**

3164X2 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), initial lobe*. The RUC reviewed the results of 35 thoracic surgeons and recommends a work RVU of 4.20. The RUC compared 3164X2 to key reference service 31638 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with revision of tracheal or bronchial stent inserted at previous session (includes tracheal/bronchial dilation as required)* (work RVU=4.88) and determined that although the surveyed code requires less time, 45 minutes versus 60 minutes of intra service time, it is more intense to remove a valve as described in 3164X2. Furthermore, the key reference code describes the revision of a stent in which the physician goes in once whereas with the surveyed code, 3164X2, the physician is working with multiple valves in each lobe. The RUC also compared the surveyed code to 31636 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with*

placement of bronchial stent(s) (includes tracheal/bronchial dilation as required), initial bronchus (work RVU=4.30) and noted that these services both require 45 minutes of intra service time with similar intensity. Given these comparisons, the RUC agreed with the specialty that the median survey work RVU of 4.20 is an accurate measure of the physician work and intensity involved in this service. **The RUC recommends a work RVU of 4.20 for CPT 3164X2.**

3164X3 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), each additional lobe* The RUC reviewed the results of 35 thoracic surgeons and recommends a work RVU of 2.00. The RUC compared 3164X3 to key reference service 31637 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; each additional major bronchus stented* (work RVU=1.58) and noted that although the intra-service times are identical, 30 minutes, the intensity of 3164X3 is greater. The key reference service code refers to one stent per lobe versus the removal of 2-3 valves per lobe. The RUC also compared 3164X3 to CPT code 15121 *Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof* (work RVU=2.00) and noted that these services both require 30 minutes of intra service time and therefore should be similarly valued. Given these comparisons, the RUC agreed with the specialty that the median survey work RVU of 2.00 is an accurate measure of the physician work and intensity involved in this service. **The RUC recommends a work RVU of 2.00 for CPT 3164X3.**

Practice Expense:

The RUC approved the practice expense inputs as modified and submitted by the Practice Expense Subcommittee.

New Technology:

The specialty society requests and the RUC agrees that these codes should be added to the new technology list.

Stereotactic Body Radiation (Tab 7)

Keith Naunheim, MD (STS); James Levett, MD (STS)

Facilitation Committee #2

In October 2011, the CPT Editorial Panel created 327XX1 *Thoracic target(s) delineation for stereotactic body radiation therapy (SRS/SBRT), (photon or particle beam), entire course of treatment* to describe the work provided by the surgeon when they are involved in the planning of thoracic stereotactic radiosurgery (SRS) or stereotactic body radiation therapy (SRS/SBRT) for the treatment of lung lesions. Since 2010, the non-specific CPT code 32999 *Unlisted procedure, lungs and pleura* was used to report this service and the Panel agreed that a more specific code was necessary.

The RUC discussed the survey results from 36 thoracic surgeons and recommend the following physician time components: 25 minutes pre-service time, 60 minutes intra-service time and 15 minutes post-service time. The RUC then reviewed the survey respondents' estimated work RVUs and determined that the values were overestimated at the 25th percentile, 5.83 work RVUs. To determine an appropriate work value for this service, the RUC discussed the physician work involved in this service. The surgeons' work for this service is primarily performed in the initial planning phase for the patient's radiation treatment, which is only performed one time per treatment cycle. Once the CT simulations are obtained, the physician works collaboratively with the radiation

oncologist to determine the appropriate plan, including contours, dose and fractionation. The overlap of physician work with the radiation oncologist is minimal because this service is set up so that the two physicians work interchangeably throughout the planning stage in order for the treatment to be effectively administered. In addition to this work, the surgeon is also present on the first day of delivery to ensure the patient is comfortable and able to receive the treatment.

With this understanding of the physician work, the RUC compared the surveyed code 99291 *Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes* (work RVU= 4.50) and determined that a critical care procedure at 71 minutes, has more intensive, patient-focused physician work than 327XX1 (60 minutes intra-service) and should be valued slightly higher than the surveyed code. Additionally, the Committee reviewed CPT code 61781 *Stereotactic computer-assisted (navigational) procedure; cranial, intradural* (work RVU= 3.75) and agreed that while the physician work is more intense for 61781, 327XX1 has double the intra-service time, 60 minutes compared to 30 minutes, and should be valued higher. Given these work value ranges, the RUC, using magnitude estimation, determined that a work RVU of 4.18 appropriately aligns 327XX1, relative to other services. To validate this work value across the RBRVS, the RUC compared the surveyed code to CPT code 43232 *Esophagoscopy, rigid or flexible; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)* (work RVU= 4.47) and determined that while the two services have identical intra-service time, 60 minutes, 43232 is a slightly more intense service than 327XX1 and should be valued higher. Finally, the RUC agreed that the work of the thoracic surgeon in this code should be compared to similar physician work performed by a radiation oncologist. Therefore, CPT code 77301 *Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications* (work RVU= 7.99) was reviewed. The RUC noted that while the reference code has more intra-service time than the surveyed code, 131 minutes compared to 60 minutes, the recommended value of 4.18 accurately accounts for the difference in time and relative value of the physician work performed in these two procedures. **The RUC recommends a work RVU of 4.18 for CPT code 327XX1.**

Staff Note: STS has submitted a letter for appeal for RUC reconsideration of this code.

New Technology:

The specialty society requests and the RUC agrees that these three codes should be added to the new technology list.

Practice Expense:

This service is primarily performed in the facility setting and no direct practice inputs are recommended.

Bundle Thrombolysis (Tab 8)

Gerladine McGinty, MD (ACR); Gary Seabrook, MD (SVS); Sean Tutton, MD (SIR)

In 2010, the Relativity Assessment Workgroup identified two codes through the 75% reported together screen: 37201 *transcatheter therapy, infusion for thrombolysis other than coronary* and 75896 *transcatheter therapy, infusion, any method (eg thrombolysis*

other than coronary), radiological supervision and interpretation. The specialty societies request deferment of this family of services due to late CPT changes that expanded the number of codes; the continued questions about CPT guideline text, descriptors, and parentheticals; and the imprecision of the 000-day global survey instrument to accurately survey these codes. The Research Subcommittee approved a modified 000-day global survey instrument to be used to survey this family at the RUC meeting in April 2012. **Given these issues, the RUC recommends to defer CPT codes 372XX1, 372XX2, 372XX3, 372XX4, 75896 and 75898 for RUC review in April 2012.**

X-ray of Cervical Spine (Tab 9)

Geraldine McGinty, M.D. (ACR); Zeke Silva, M.D. (ACR); Joshua A. Hirsch, M.D. (ASNR) and Gregory Nicola, M.D (ASNR)

In October 2010, cervical spine code 72040 was identified by the RAW as part of the CMS Low Value/High Volume screen. At the specialty societies' request, the cervical spine x-ray family of codes, CPT codes, 72040, 72050 and 72052, was referred to the CPT Editorial Panel for clarification of the descriptors and number of views. In October, 2011, the CPT Editorial Panel revised these codes to clarify the number of views for each examination. The ACR and ASNR surveyed these three codes, and convened an expert panel of physicians familiar with the services.

72040 *Radiologic examination, spine, cervical; three views or less* was surveyed for the January 2012 RUC meeting. The RUC reviewed the survey results from 43 radiologists and neuroradiologists on the expert panel and noted that the recommended RVU of 0.22, which is the current work RVU, appropriately accounts for the physician work required to perform this service. The RUC accepted the median survey times, but adjusted the pre-service time to 1 minute which is consistent with the chosen key reference code. The key reference CPT code 72100 *Radiologic examination, spine, lumbosacral; 2 or 3 views* (work RVU=0.22), 6 minutes of total time (1 min pre, 3 min intra and 2 min post) was reviewed and the RUC noted that these two services have virtually identical physician work and should be the same. **The RUC recommends a work RVU of 0.22 for CPT code 72040.**

72050 *Radiologic examination, spine, cervical; 4 or 5 views* was surveyed for the January 2012 RUC meeting. The RUC reviewed the survey results from 42 radiologists and neuroradiologists on the expert panel and noted that the recommended RVU of 0.31, which is the current work RVU, appropriately accounts for the physician work required to perform this service. The RUC accepted the median survey times, but adjusted the pre-service time to 1 minute which is consistent with the chosen key reference code. The key reference CPT code 72110 *Radiologic examination, spine, lumbosacral; minimum of 4 views* (work RVU=0.31) 8 minutes total time (1 min pre, 5 min intra, 2 min post) was reviewed and the RUC noted that these two services have virtually identical physician work and should be the same. **The RUC recommends a work RVU of 0.31 for CPT code 72050.**

72052 *Radiologic examination, spine, cervical; 6 or more views* was surveyed for the January 2012 RUC meeting. The RUC reviewed the survey results from 43 radiologists and neuroradiologists on the expert panel and noted that the recommended RVU of 0.36, which is the current work RVU, appropriately accounts for the physician work required to perform this service. The RUC accepted the median survey times, but adjusted the pre-service time to 1 minute which is consistent with the chosen key reference code. The key reference CPT code 72114 *Radiologic examination, spine, lumbosacral; complete,*

including bending views (work RVU=0.32) 8 minutes total time (1 min pre, 5 min intra, 2 min post) was reviewed and the specialty society notified the RUC that the work value for 72114 was listed incorrectly as 0.36 on the survey that respondents completed. The RUC determined that the respondents were not biased by the inaccurate information and agrees with survey respondents whom consistently indicate that cervical spine examinations are more intense than those in the lumbar spine. To further justify the recommendation it is below the 25th percentile and the median and 25th percentile survey values were all higher than the corresponding services in the lumbar spine. The difference in intensity warrants the slightly higher RVU for 72052 as compared to its reference service 72114 and maintains proper relativity for this code as compared to the lumbar region. Specifically 72052 is typically performed on a patient complaining of pain or whom has had a fall in the outpatient setting. These patients are considered trauma patients even in the outpatient setting and they have a greater possibility of rotational injuries which are not a concern in the lumbar spine. **The RUC recommends a work RVU of 0.36 for CPT code 72052.**

Practice Expense:

The Practice Expense (PE) was reviewed by Practice Expense Subcommittee and it was determined that a laser printer is an indirect expense of a physicians' office and should not be listed as a direct input for practice expense. The modification was made and the RUC approved the PE for CPT codes 72040, 72050 and 72052.

Percutaneous Coronary Intervention (Tab 10)

Richard Wright, MD (ACC); Cliff Kavinsky, MD (SCAI)

Facilitation Committee #3

In October 2010, CPT code 92980 *Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel* was identified by the MPC List screen. Since it had not been reviewed in over six years, the Relativity Assessment Workgroup (RAW) requested that the specialty societies survey this code for RUC review. Subsequently, the specialty society referred the code to the CPT Editorial Panel to revise the family of procedures to more accurately describe the current physician work involved in percutaneous coronary interventions. At the October 2011 CPT meeting, the Panel approved 13 new codes to describe these services.

The RUC had significant discussion regarding the proper reporting of a diagnostic coronary angiogram with a percutaneous coronary intervention (PCI). The specialty explained that while a diagnostic angiogram is required for an intervention procedure, these services are typically performed by different physicians. Typically, a complete diagnostic angiogram would be performed on a day prior to the PCI and would be separately reportable. However, in the event that a patient needs the intervention procedure immediately, a diagnostic exam is performed to determine the anatomy and then the intervention service is performed shortly thereafter. If these services are reported on the same day, by the same physician the standard multiple procedure reduction is applied. This policy mirrors the lower extremity revascularization codes approved by the CPT Editorial Panel and RUC in the 2011 cycle.

9298X1 Percutaneous transluminal coronary angioplasty; single major coronary artery or branch.

The RUC reviewed the survey results from 79 cardiologists and recommends the following physician time components: 39 minutes pre-service time, 60 minutes intra-service time and 30 minutes post-service time. The RUC reviewed the survey data and

agreed that the 25th percentile of 9.25 work RVUs slightly overestimated the physician work value appropriate for this service. To find a more appropriate value, the RUC compared the surveyed code to CPT code 37224 *Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty* (work RVU= 9.00). The Committee noted that while the reference code has more intra-service time compared to 9298X1, 80 minutes compared to 60 minutes, the intensity and complexity is much greater for a physician working on the heart rather than the leg. Given this, the RUC recommends a work RVU of 9.00, a direct crosswalk to 37224, for CPT code 9298X1. To ensure this value is relative, the RUC compared the surveyed code to CPT code 37220 *Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty* (work RVU= 8.15) and noted that while the intra-service times are identical, 60 minutes, the surveyed code is again a more intense procedure and should be valued higher than the reference code. **The RUC recommends a work RVU of 9.00 for CPT code 9298X1.**

9298X2 Percutaneous transluminal coronary angioplasty; each additional branch of a major coronary artery

The RUC reviewed the survey results from 80 cardiologists and recommends 30 minutes of intra-service time for this add-on code. The RUC reviewed the survey data and agreed with the specialty that the survey's 25th percentile of 4.00 work RVUs accurately values the physician work involved in the service. To justify this value the RUC compared the surveyed code to the key reference code 37232 *Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty* (work RVU= 4.00) and noted that while the reference code has more intra-service time compared to 9298X2, 40 minutes and 30 minutes, respectively, the surveyed code is a more intense procedure given the service is performed on the heart as opposed to the leg. Additionally, the Committee reviewed CPT code 34826 *Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; each additional vessel* (work RVU= 4.12) and agreed that since these two services have identical intra-service time, 30 minutes, they should be valued similarly. **The RUC recommends a work RVU of 4.00 for CPT code 9298X2.**

9298X3 Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; single major coronary artery or branch

The RUC reviewed the survey results from 73 cardiologists and recommends the following physician time components: 39 minutes pre-service time, 75 minutes intra-service time and post-service time of 30 minutes. The RUC reviewed the survey results and agreed that the survey respondents overestimated the physician work value appropriate for this service. To determine an appropriate value, the RUC compared the surveyed code to CPT code 37228 *Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty* (work RVU=11.00) and noted that while the reference code has 15 minutes more intra-service time, 9298X3 is a more intense procedure and should be valued the same. Given this comparison, the RUC agreed that a work RVU of 11.00, a direct crosswalk to 37228, is an accurate value for the surveyed code. To ensure this value is relative to the family of services, the RUC took the intra-service time of 9298X1, 60 minutes, and added half of the intra time of 9298X2, 15 minutes, to arrive at an intra-service time of 75 minutes, identical to 9298X3. Adding these times would create the same work RVU, 11.00, as is recommended for 9298X3. **The RUC recommends a work RVU of 11.00 for CPT code 9298X3.**

9298X4 Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; each additional branch of a major coronary artery

The RUC reviewed the survey results from 71 cardiologists and recommends 45 minutes of intra-service time for this add-on code. The RUC reviewed the survey data and agreed with the specialty that the survey's 25th percentile of 5.00 work RVUs accurately values the physician work involved in the service. To justify this value the RUC compared the surveyed code to CPT code 35600 *Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure* (work RVU= 4.94) and noted that the surveyed code has slightly more intra-service time, 45 minutes compared to 40 minutes, and should be valued slightly higher than the reference code. Additionally, the RUC compared 9298X4 to 9298X2 and agreed that since 9298X4 code has 15 minutes more of intra-service time compared to 9298X2, the recommended work value for 9298X4 is appropriately valued higher. **The RUC recommends a work RVU of 5.00 for CPT code 9298X4.**

9298X5 Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch

The RUC reviewed the survey results from 79 cardiologists and recommends 39 minutes pre-service time, 71 minutes intra-service time and 30 minutes post-service time. The RUC noted that survey respondents clearly underestimated the intra time to perform this service with a median of 60 minutes. This service includes the entire physician work of 9298X1 plus the additional placement of intracoronary stent(s). Given the necessary additional physician work, the RUC recommends the 75th percentile intra-service time of 71 minutes. The RUC reviewed the survey data and agreed with the specialty that the survey's 25th percentile of 10.49 work RVUs accurately values the physician work involved in the service. To justify this value the RUC compared the surveyed code to CPT code 37226 *Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed* (work RVU= 10.49) and noted that while the reference code have more intra-service time compared to 9298X5, 90 minutes and 71 minutes, respectively, the intensity of performing stent placement in the heart is much greater than a placement in the leg. Thus the recommended value is appropriately valued relative to other similar services. **The RUC recommends a work RVU of 10.49 for CPT code 9298X5.**

9298X6 Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery

The RUC reviewed the survey results from 80 cardiologists and recommends 30 minutes of intra-service time for this add-on code. The RUC reviewed the survey results and agreed that the survey respondents overestimated the physician work value appropriate for this service. To determine an appropriate value, the RUC compared the surveyed code to CPT code 33572 *Coronary endarterectomy, open, any method, of left anterior descending, circumflex, or right coronary artery performed in conjunction with coronary artery bypass graft procedure, each vessel* (work RVU= 4.44) and noted that the two service have identical intra time, 30 minutes, and should be valued identically. Thus, the RUC recommends a work RVU of 4.44, a direct crosswalk to 33572, for CPT code 9298X6. To ensure this value is relative within the family of services, the Committee compared this service to the other two add-on codes just reviewed, 9298X2 and 9298X4. It was agreed that the work value for 9298X6 should be higher than 9298X2

(recommended work RVU= 4.00) due to greater intensity and lower than 9298X4 (recommended work RVU= 5.00) due to less intra time. **The RUC recommends a work RVU of 4.44 for CPT code 9298X6.**

9298X7 Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch

The RUC reviewed the survey results from 73 cardiologists and recommends 39 minutes pre-service time, 85 minutes intra-service time and 30 minutes post-service time. The RUC reviewed the survey results and agreed that the survey respondents overestimated the physician work value appropriate for this service. To determine an appropriate value, the RUC compared the surveyed code to CPT code 61640 *Balloon dilatation of intracranial vasospasm, percutaneous; initial vessel* (work RVU= 12.32) and noted that the physician work is similar, with almost identical intra-service times, 90 minutes compared to 85 minutes. Thus, the Committee agreed that the work RVUs for code 9298X7 should be directly crosswalked to CPT code 61640. To ensure a work RVU of 12.32 is relative within the family, the RUC noted that this service requires the second highest physician time in the family, 154 minutes, and is a very intense and complex procedure to perform relative to the other services. Thus, the RUC agreed that the work RVU for this service should set the upper threshold for work values within the percutaneous coronary intervention family. **The RUC recommends a work RVU of 12.32 for CPT code 9298X7.**

9298X8 Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery

The RUC reviewed the survey results from 73 cardiologists and recommends 45 minutes of intra-service time for this add-on code. The RUC reviewed the survey data and agreed with the specialty that the survey's 25th percentile of 5.50 work RVUs accurately values the physician work involved in the service. To justify this value the RUC compared the surveyed code to the key reference service 37234 *Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed* (work RVU= 5.50) and noted that while the reference code has greater total time than 9298X8, 62 minutes compared to 45 minutes, the codes should be valued the same because the surveyed code is a much more intense procedure than 37234, as indicated by the survey respondents. Additionally, the Committee compared 9298X8 to the other similar add-on service in this family, 9298X4, and noted that while both services have identical times, 45 minutes, 9298X8 is a more intense procedure and should be valued slightly higher. **The RUC recommends a work RVU of 5.50 for CPT code 9298X8.**

9298X9 Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel

The RUC reviewed the survey results from 66 cardiologists and recommends 39 minutes pre-service time, 60 minutes intra-service time and 30 minutes post-service time. The RUC reviewed the survey results and agreed that the survey respondents overestimated the physician work value appropriate for this service. To determine an appropriate value, the RUC compared the surveyed code to 9298X5 (recommended work RVU= 10.49) and noted that while 9298X5 has slightly more total time compared to 9298X9, 140 minutes

and 129 minutes, respectively, 9298X9 is a more intense procedure and should be valued the same. To ensure a work RVU of 10.49 is relative to other similar services, the Committee reviewed CPT code 37224 *Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty* (work RVU= 9.00) and agreed that while the reference code has more total time, 158 minutes compared to 129 minutes, 9298X9 is a more intense procedure than 37224 and should be valued higher. **The RUC recommends a work RVU of 10.49 for CPT code 9298X9.**

9298X10 Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; each additional branch subtended by the bypass graft

The RUC reviewed the survey results from 67 cardiologists and recommends 60 minutes of intra-service time for this add-on code. The RUC reviewed the survey results and noted that the survey's median work RVU of 6.00 is a more appropriate value given intensity involved in the service and to maintain appropriate rank order within the family. The RUC compared 9298X10 to the similar add-on service 9298X8 (recommended work RVU= 5.50) and agreed that with 15 minutes more intra-service time, 60 minutes compared to 45 minutes, 9298X10 must be valued higher than 9298X8. In addition, the Committee compared the surveyed code to key reference service 37234 *Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed* (work RVU= 5.50) and noted that while the two service have identical intra-service time, 60 minutes, 9298X10 is a more intense procedure compared to the reference code and should be valued slightly higher. **The RUC recommends a work RVU of 6.00 for CPT code 9298X10.**

9298X11 Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel

The RUC reviewed the survey results from 67 cardiologists and recommends 39 minutes pre-service time, 70 minutes intra-service time and 40 minutes post-service time. The RUC reviewed the survey results and agreed that the survey respondents overestimated the physician work value appropriate for this service. To determine an appropriate value, the RUC compared the surveyed code to 9298X7 (recommended work RVU= 12.32) and noted that the total physician times for these two services are almost identical, 149 minutes compared to 154 minutes, and should have identical work RVUs of 12.32. The Committee also confirmed that 9298X7 sets the upper threshold for physician work and intensity in this family of services. To ensure this value aligns itself to similar services, the RUC reviewed key reference service 37231 *Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed* (work RVU= 15.00). While 9298X11 is a more intense procedure, the reference code has significantly more total time, 213 minutes compared to 149 minutes, and should be valued higher than the surveyed code. **The RUC recommends a work RVU of 12.32 for CPT code 9298X11.**

9298X12 Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; single vessel

The RUC reviewed the survey results from 65 cardiologists and recommends 39 minutes pre-service time, 90 minutes intra-service time and 30 minutes post-service time. The RUC reviewed the survey results and agreed that the survey respondents overestimated the physician work value appropriate for this service. To determine an appropriate value, the RUC compared the surveyed code to 9298X7 (recommended work RVU=12.32) and determined since both services have almost identical total times, 154 minutes and 159 minutes, respectively, the work value should be identical. . The Committee also confirmed that 9298X7 sets the upper threshold for physician work and intensity in this family of services. To ensure a work value of 12.32 is appropriate for 9298X12, the RUC reviewed the key reference service 37231 *Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed* (work RVU= 15.00). While 9298X12 is a more intense procedure, the reference code has significantly more total time, 213 minutes compared to 159 minutes, and should be valued higher than the surveyed code. **The RUC recommends a work RVU of 12.32 for CPT code 9298X12.**

9298X13

The RUC reviewed the survey results from 64 cardiologists and recommends 60 minutes of intra-service time for this add-on code. The RUC reviewed the survey data and agreed with the specialty that the survey's 25th percentile of 6.00 work RVUs accurately values the physician work involved in the service. To justify this value the RUC compared the surveyed code to the key reference service 37234 *Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed* (work RVU= 5.50) and noted that while the two service have identical intra-service time, 60 minutes, 9298X13 is a more intense procedure compared to the reference code and should be valued slightly higher. To ensure relativity within the family of service, the Committee compared 9298X13 to analogous add-on code 9298X10 (recommended work RVU= 6.00) and agreed that given the identical times and similar intensity and complexity, these two service should valued the same. **The RUC recommends a work RVU of 6.00 for CPT code 9298X13.**

CPT Discussion:

In order to clarify the correct reporting of a complete diagnostic angiography and these percutaneous coronary intervention procedures, the RUC requests that the CPT Editorial Panel, working with the specialty society, add clarifying introductory language further explaining the specific criteria for separately reporting the two services or that the services may be reported on the same day. The CPT Editorial Panel in February 2012, reviewed this request and made necessary additions to the introductory language.

Work Neutrality:

The RUC noted that under the old coding system placing a stent in a major coronary artery and one stent in one branch resulted in billing one CPT code (92980). In the new coding system, this scenario will result in billing two CPT code (9598X5 and 9298X6). While additional RVUs will be reported under this system, the subsequent reductions in work values results in a budget neutrality savings of 17% to be redistributed back into Medicare payment.

Practice Expense:

These services are primarily performed in the facility setting and no direct practice expense inputs are recommended.

Bundling EPS and Transcatheter Ablation (Tab 11)

Mark Schoenfeld, MD (HRS); Richard Wright, MD (ACC)

Facilitation Committee #1

In February 2010, the Relativity Assessment Workgroup (RAW) identified CPT codes 93651 *Intracardiac catheter ablation of arrhythmogenic focus; for treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathways, accessory atrioventricular connections or other atrial foci, singly or in combination* and 93652 *Intracardiac catheter ablation of arrhythmogenic focus; for treatment of ventricular tachycardia* as billed together more than 75% of the time with CPT code 93620 *Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording*. The specialty societies referred this issue to the CPT Editorial Panel at the October 2011 meeting and it was surveyed for the January 2012 RUC meeting.

9365X1 *Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording, His recording with intracardiac catheter ablation of arrhythmogenic focus; with treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry*

The RUC reviewed the survey results from 182 cardiologists who perform the service and recommend the following physician work time components: 39 minutes pre-service time, 180 minutes intra-service time and 30 minutes post-service time. The RUC discussed two issues related to the physician time for this service. First, the RUC discussed the time variation between the bundled 9365X1 code and the previously reported codes. It was noted that the current survey has almost 150 more survey respondents than the previous surveys. Thus, the RUC determined that these current survey data in both physician work and time are the best measure for the valuation of this service. Second, the RUC discussed the typical number of patients a practicing physician would see in a typical day. Given the large amount of time involved in these codes, the specialty society explained that two patients are typically seen by the physician per day for this service.

The RUC reviewed the robust survey data for 9365X1 and agreed that the survey 25th percentile of 15.00 work RVUs accurately accounts for the physician work involved in the service. To justify this value, the RUC compared the surveyed code to reference CPT code 33889 *Open subclavian to carotid artery transposition performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision, unilateral* (work RVU= 15.92) and agreed that since the reference code has greater total time, 298 minutes, compared to the surveyed code, 265 minutes, 33889 should be valued slightly

higher than 9365X1. Finally, the RUC reviewed CPT code 50575 *Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with endopyelotomy (includes cystoscopy, ureteroscopy, dilation of ureter and ureteral pelvic junction, incision of ureteral pelvic junction and insertion of endopyelotomy stent)* (work RVU= 13.96) and noted that while the two services have identical intra-service time of 180 minutes, 9365X1 is a more intense procedure and should be valued higher than 50575. **The RUC recommends a work RVU of 15.00 for CPT code 9365X1.**

9365X2 *Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording, His recording with intracardiac catheter ablation of arrhythmogenic focus; with treatment of ventricular tachycardia or focus of ventricular ectopy including intracardiac electrophysiologic 3-dimensional mapping, when performed and left ventricular pacing and recording, when performed*

The RUC reviewed the survey results from 179 cardiologists who perform the service and recommend the following physician work time components: 70 minutes pre-service time, 240 minutes intra-service time and 40 minutes post-service time. The RUC discussed two issues related to the physician time for this service. First, the RUC discussed the time variation between the bundled 9365X2 code and the previously reported codes. It was noted that the current survey has almost 150 more survey respondents than the previous surveys. Thus, the RUC determined that these current survey data in both physician work and time are the best measure for the valuation of this service. Second, the RUC discussed the typical number of patients a practicing physician would see in a typical day. Given the large amount of time involved in these codes, the specialty society explained that two patients are typically seen by the physician per day for this service.

The RUC reviewed the robust survey data for 9365X2 and agreed that the survey 25th percentile of 20.00 work RVUs accurately accounts for the physician work involved in the service. To justify this value, the RUC compared the surveyed code to CPT code 33891 *Bypass graft, with other than vein, transcervical retropharyngeal carotid-carotid, performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision* (work RVU= 20.00) and agreed that the two services should be valued the same given the similar physician work and total service times, 319 minutes and 323 minutes, respectively. In addition, the RUC compared 9365X2 to the base code 9365X1 and agreed that given the additional work involved in 9365X2, including the additional 3-D mapping and left ventricular pacing and recording, a work RVU of 20.00 appropriately ranks 9365X2 in relation to the base code. **The RUC recommends a work RVU of 20.00 for CPT code 9365X2.**

9365X3 *Intracardiac catheter ablation of a discrete mechanism of arrhythmia which is distinct from the primary ablated mechanism, including repeat diagnostic maneuvers, to treat a spontaneous or induced arrhythmia*

The RUC reviewed the survey results from 181 cardiologists who perform this service and recommend 90 minutes intra-service time for this add-on code. The RUC reviewed the robust survey data for 9365X3 and agreed that the survey 25th percentile of 9.00 work RVUs accurately accounts for the physician work involved in the service. The RUC

compared the surveyed code to CPT code 35306 *Thromboendarterectomy, including patch graft, if performed; each additional tibial or peroneal artery* (work RVU= 9.25) and agreed that with identical intra-service time of 90 minutes, the two codes should be valued similarly. Given this strong comparison and the strong data presented by the specialty society, the RUC agreed that a work RVU of 9.00 places 9365X3 in appropriate relativity in comparison to the family of services and across the RBRVS. **The RUC recommends a work RVU of 9.00 for CPT Code 9365X3.**

9365X4 *Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with atrial recording and pacing, when possible, right ventricular pacing and recording, His bundle recording with intracardiac catheter ablation of arrhythmogenic focus; with treatment of atrial fibrillation by ablation by pulmonary vein isolation*

The RUC reviewed the survey results from 181 cardiologists who perform the service and recommend the following physician work time components: 39 minutes pre-service time, 240 minutes intra-service time and 40 minutes post-service time. The RUC discussed two issues related to the physician time for this service. First, the RUC discussed the time variation between the bundled 9365X4 code and the previously reported codes. It was noted that the current survey has almost 150 more survey respondents than the previous surveys. Thus, the RUC determined that these current survey data in both physician work and time are the best measure for the valuation of this service. Second, the RUC discussed the typical number of patients a practicing physician would see in a typical day. Given the large amount of time involved in these codes, the specialty society explained that two patients are typically seen by the physician per day for this service.

The RUC reviewed the robust survey data for 9365X4 and agreed that the survey 25th percentile of 20.02 work RVUs accurately accounts for the physician work involved in the service. To justify this value, the RUC compared the surveyed code to CPT code 33891 *Bypass graft, with other than vein, transcervical retropharyngeal carotid-carotid, performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision* (work RVU= 20.00) and agreed that the two services should be valued the same given the similar physician work and total service times, 319 minutes and 323 minutes, respectively. Finally, the RUC compared 9365X4 to the family of services and agreed that this code should be valued almost identically to 9365X2 given the analogous physician time and work. **The RUC recommends a work RVU of 20.02 for CPT code 9365X4.**

9365X5 *Additional linear or focal intracardiac catheter ablation of the left or right atrium for treatment of atrial fibrillation remaining after completion of pulmonary vein isolation*

The RUC reviewed the survey results from 181 cardiologists who perform this service and recommend 90 minutes intra-service time for this add-on code. The RUC reviewed the robust survey data for 9365X5 and agreed that the survey 25th percentile of 10.00 work RVUs accurately accounts for the physician work involved in the service. The RUC compared the surveyed code to CPT code 35306 *Thromboendarterectomy, including patch graft, if performed; each additional tibial or peroneal artery* (work RVU= 9.25) and agreed that with identical intra-service time of 90 minutes, the two codes should be

valued similarly. In addition, the RUC compared 9365X5 to the other add-on service in the family 9365X3 and noted that while the times are identical, 9365X5 is a more intense service. This increased intensity is validated through the survey results which show that 9365X5 was rated as a more intense service compared to 9365X3 in every intensity/complexity measure. **The RUC recommends a work RVU of 10.00 for CPT Code 9365X5.**

CPT Discussion:

During the deliberations, the RUC questioned whether the reprogramming of the implantable cardioverter-defibrillator was inherent in these services. The specialty societies indicated that should reprogramming be required at the time of the comprehensive electrophysiologic evaluation, that work would be considered inclusive of the service. Therefore, the CPT Editorial Panel at the February 2012 meeting, included in the parenthetical notes that CPT code 93642 is a code not to be reported in conjunction with 9365X1, 9365X2 and 9365X4.

Work Neutrality

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

Practice Expense:

These services are primarily performed in the facility setting and no direct practice expense inputs are recommended

Intraoperative Neurophysiology Monitoring (Tab 12)

Marianna Spanaki, MD, PhD (AAN); Benn Smith, MD (AANEM); Marc Nuwer, MD, PhD (ACNS); Joe Zuhosky, MD (AAPMR)

Facilitation Committee #1

The CPT Editorial Panel deleted CPT code 95920 *Intraoperative neurophysiology testing, per hour* and created two new add-on codes to describe continuous intraoperative neurophysiology monitoring in the operating room and remotely due to new technology available to perform these services.

959X1 Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes

The RUC reviewed the survey results for code 959X1 and determined that the survey respondents overestimated the physician work required to perform this service, incorrectly accounting for the entire monitoring encounter not basing their response on the time increment indicated in the descriptor. Therefore, the RUC compared the 959X1 to 64566 *Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming* (work RVU = 0.60 and total time = 15 minutes) and determined these services required the same physician work, time and intensity to perform. The RUC also compared 959X1 to similar services 96571 *Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); each additional 15 minutes* (work RVU = 0.55) and 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)* (work RVU = 0.55) and determined that these services are less intense than 959X1. **The RUC recommends a work RVU of 0.60 and 15 minutes intra-service time for CPT code 959X1.**

959X2 Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour

The RUC reviewed the survey results for code 959X2 and determined that the survey respondents overestimated the physician work required to perform this service. Therefore, the RUC compared the 959X2 to 31627 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with computer-assisted, image-guided navigation* (work RVU = 2.00 and intra-time = 60 minutes) and determined these services required the same physician work, time and intensity to perform. For additional support the RUC also compared 959X2 to similar services 95957 *Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis)* (work RVU = 1.98 and intra-time = 60 minutes) and determined that these services require similar physician work and the same amount of time to perform.

The RUC noted some concern that this service may be reported for monitoring a number of patients simultaneously. The specialty society indicated that they included a question on the survey asking the typical number of patients monitored by the physician and respondents indicated that one patient is typically being monitored by the physician. Additionally, the RUC reviewed the range of add-on services with intra-service time ranging from 50-70 minutes, with work RVUs ranging from 1.00 to 5.00, and agreed that this 60 minute code at 2.00 work RVUs reported for multiple patients is in the appropriate physician work range relative to other similar services in the RBRVS. **The RUC recommends a work RVU of 2.00 for CPT code 959X2.**

Practice Expense

The RUC noted that although CPT code 959X2 is performed in the non-facility approximately 5% of the time, direct practice expense inputs for medical supplies and equipment were accepted as modified by the Practice Expense Subcommittee.

New Technology/New Services

The RUC recommends that these services be reviewed in three years to review the number of times this service is reported together by the same physician on the same day once this utilization data is available.

Work Neutrality

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

Neonatal Pediatric Transport (Tab 13)

Steve Krug, MD (AAP); Gil Martin, MD; Dan Brown, MD, PhD (SCCM)

In October 2011, the CPT Editorial Panel created CPT codes 9948X1 and 9948X2 to describe the non face-to-face services provided by physicians to supervise interfacility transport care of critically ill or critically injured pediatric patients.

9948X1 Supervision by a control physician of interfacility transport care of the critically ill or critically injured pediatric patient, 24 months of age or younger, includes two way communication with transport team before transport, at the referring facility and during the transport, including data interpretation and report; first 30 minutes

CPT code 9948X1 was surveyed for the January 2012 RUC meeting. The RUC reviewed the survey results from 84 neonatologists, pediatric intensivists, pediatric emergency physicians and pediatric transport medicine physicians and noted that the survey median work RVU of 1.50 appropriately accounts for the physician work required to perform this service. The RUC was concerned that the total service time was 7 minutes more than the key reference service CPT code 99339 *Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility); 15-29 minutes* (work RVU = 1.25). It was clarified that CPT code 99339 requires 40 minutes total time and 9948X1 requires 47 because the typical patients are critically ill or critically injured as opposed to the key reference code, which are not. The intra-service time of the code is the same as the key reference code, however it was clarified that due to the unique severity in the conditions of this subset of patients there is more planning and preparation required by the control physician in the pre-service and more documentation that the control physician must complete in the post-service, which accounts for an additional 5 minutes in the pre-service and 2 minutes in the post-service time as compared to the key reference code.

The RUC also discussed assigning 47 minutes to a code that is stated as 30 minutes in the descriptor. The CPT Editorial Panel representative clarified that according to CPT guidelines, code 9948X1 is used to report the first 16-45 minutes of direction on a given date and should only be used once even if time spent by the physician is discontinuous. Do not report services of 15 minutes or less or any time when another physician is reporting 99466-99467. Coding instructions only apply once the intra-service has begun and does not include pre- and post-service time. Once the 46th minute is reached the second code 9948X2 (add-on) should be reported. To further justify the survey median work RVU of 1.50, the RUC reviewed CPT code 99203 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU=1.42), because this also has a intra-service time of 20 minutes and although it is face-to-face, the typical patient is less critical. Only a small portion of the pediatric transports (estimated at less than 10%) should report code 9948X1 because it only applies to the most complex patients. **The RUC recommends a work RVU of 1.50 for CPT code 9948X1.**

9948X2 *Supervision by a control physician of interfacility transport care of the critically ill or critically injured pediatric patient, 24 months of age or younger, includes two way communication with transport team before transport, at the referring facility and during the transport, including data interpretation and report; each additional 30 minutes*

CPT code 9948X2 was surveyed for the January 2012 RUC meeting. The RUC reviewed the survey results from 71 neonatologists, pediatric intensivists, pediatric emergency physicians, pediatric transport medicine physicians and recommends the survey median work RVU of 1.30. The specialty society indicated and the RUC agreed that 25 minutes intra-service time appropriately accounts for the physician time required to perform this service. The specialty society explained that the intra-service time for 9948X2 is higher than the intra-service time for the base code 9948X1, 25 and 20 minutes respectively, because in order to report both codes more than 45 minutes of intra-service time is required (30 minutes threshold required to report 9948X1 and greater than 15 minutes threshold required to report 9948X2). If you add the intra-service time for 9948X1 (20 minutes) and the intra-service time for 9948X2 (25 minutes), that 45 minutes total intra-service time is achieved. The RUC determined that this time differential is appropriate. The RUC compared 9948X2 to key reference service 99340 *Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg,*

assisted living facility); 30 minutes or more (work RVU = 1.80, 30 minutes intra-service time, 60 minutes total time) and determined that although the typical patient for 9948X2 is critically ill or critically injured, the key reference service requires more physician work and time and should be valued higher. The RUC compared 9948X2 to the key MPC reference code 13102 *Repair, complex, trunk; each additional 5 cm or less* (work RVU=1.24, 25 minutes intra-service time) and determined that both codes are ZZZ globals, have the same intra-service time and should be valued similarly. Only a small portion of the pediatric transports (estimated at less than 10%) should report code 9948X2 because it only applies to the most complex patients. **The RUC recommends a work RVU of 1.30 for CPT code 9948X2.**

CPT Editorial Panel:

During discussion of the new neonatal pediatric transport codes 9948X1, 9948X2, the RUC noted that there may be overlap in reporting of the existing critical care interfacility transport codes 99466 or 99467. The RUC recommended that either the Neonatal Pediatric Transport guidelines or a parenthetical instruction be added following codes 9948X1 and 9948X2 to instruct users that it is not appropriate to report codes 9948X1 and 9948X2 in addition to codes 99466 and 99467 by the same physician. The following language was added as a parenthetical instruction: (Do not report 9948X1 or 9948X2 in conjunction with 99466, 99467 when performed by the same physician).

Practice Expense:

This service is primarily performed in a facility, so there are no direct practice expense inputs associated with this service.

XI. CMS Requests – New Technology/New Services

Computer Navigation (Tab 14)

William Creevy, MD (AAOS); John Heiner, MD (AAHKS)

In April 2007, CPT code 20985 *Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less* (work RVU=2.50) was added to the new technology list to be re-reviewed after three years of utilization data were available. In September 2011, the RAW noted that the Medicare utilization was higher than the original estimate and recommended that this service be surveyed for work and practice expense for January 2012.

The RUC reviewed the survey results from 41 orthopaedic surgeons and recommends to maintain the current work RVU of 2.50. Although the data supported the 25th percentile (work RVU=3.00), it was determined that there is no compelling evidence that the physician work has changed since the last review. The RUC noted that the current survey indicates pre-service time of 10 minutes and intra-service time of 20 minutes, which appropriately accounts for the required physician time and is identical to the current time for this service. The RUC agreed that while add-on codes typically do not have pre-service time, 20985 is unique because of the significant time and effort required to initiate and calibrate the computer equipment and review the preoperative report with the patient. The RUC compared 20985 to key reference service 61783 *Stereotactic computer-assisted (navigational) procedure; spinal* (work RVU=3.75) and determined that the surveyed code requires less physician time, 20 and 30 minutes intra-service time, respectively, and requires less technical skill and psychological stress than the reference

code. The RUC also noted that like 20985, code 61783 is an add-on service with separately identifiable pre-service time. Finally the RUC reviewed the rest of the family of computer-assisted navigational procedures, CPT codes 61781 *Stereotactic computer-assisted (navigational) procedure; cranial, intradural* (work RVU= 3.75) and 61782 *Stereotactic computer-assisted (navigational) procedure; cranial, extradural* (work RVU= 3.18) and agreed that the with similar physician work, but less total time, the current work value for 20985 maintains appropriate relativity within this family of similar services. **The RUC recommends a work RVU of 2.50 for CPT code 20985.**

Practice Expense:

The RUC approved the direct practice expense inputs as modified and submitted by the Practice Expense Subcommittee.

Arthroscopic Biceps Tenodesis (Tab 15)

William Creevy, MD (AAOS); John Heiner, MD (AANA); Louis McIntyre, MD (ASES)

In April 2007, CPT code 29828 *Arthroscopy, shoulder, surgical; biceps tenodesis* (work RVU=13.16) was identified through the New Technology/New Services List. In September 2011, the Relativity Assessment Workgroup noted that the Medicare utilization was higher than what was originally estimated and recommended that this service be surveyed for work and practice expense for January 2012.

The RUC reviewed the survey results from 38 orthopaedic surgeons and recommends to maintain the current work RVU of 13.16. The RUC reviewed the physician time components and determined that 60 minutes pre-service time, 75 minutes intra service time and 20 minutes post-service time appropriately accounts for the physician time required to perform this service. It was determined that the additional pre-service positioning time of 9 minutes appropriately accounts for the physician time required to position the patient, pad areas of the body, including the head and neck, strap the patient to equipment to ensure he/she remains in the lateral decubitus position and place the patient's hand in traction. The Committee noted that the physician time is the same as the current time, except for pre-service time which is slightly less due to the selection of the pre-service time package. The RUC compared code 29828 to key reference service 29807 *Arthroscopy, shoulder, surgical; repair of SLAP lesion* (work RVU=14.67) and two hip arthroscopic codes, 29915 *Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion)* (work RVU=15.00) and 29916 *Arthroscopy, hip, surgical; with labral repair* (work RVU=15.00) and determined that these reference services require slightly more physician time (90 minutes intra-service) and physician work to perform than the surveyed code. The RUC also reviewed the specialty society's request for 4 office visits (2-99212 and 2-99213) and agreed that these are necessary to exam and evaluate post-operative progress, assess pain and prescribe narcotics and physical therapy. **The RUC recommends a work RVU of 13.16 for CPT code 29828.**

Practice Expense:

The RUC reviewed and approved the direct practice expense inputs as modified by the Practice Expense Subcommittee.

XII. CMS Requests – Re-Review of Services

Cystoscopy and Treatment (Tab 16)

Thomas Cooper, MD (AUA); Norman Smith, MD (AUA); Martin Dineen, MD (AUA)

In February 2008, CPT code 52214 was identified by the High Volume Growth screen. CPT code 52224 was added as part of the family. The RUC recommended that a CPT Assistant article be published stating that CPT codes 52204, 52214 and 52224 should only be billed once regardless of the number of areas biopsied or fulgurated. In September 2011, the Relativity Assessment Workgroup re-reviewed these services and recommended that the specialty develop physician work and practice expense recommendations for review by RUC in January 2012.

52214 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands*

The RUC reviewed the survey results from 85 urologists and recommends the following physician time components: 29 minutes pre-service time (with the standard 4 additional minutes of time to place the patient in the dorsal lithotomy position), 30 minutes intra service time and 20 minutes post-service time. The RUC also agreed with the specialty that the median survey work RVU of 3.50 is an accurate measure of the physician work and intensity involved in this service. This value represents a lower valuation than the current work RVU of 3.70. To further justify this value, the RUC compared the surveyed code to the key reference service CPT code 52204 *Cystourethroscopy, with biopsy(s)* (work RVU= 2.59) and given that 52214 has greater total time compared to 52204, 79 minutes and 54 minutes, respectively, the RUC agreed that the surveyed code should be valued higher. Additionally, the survey respondents ranked 52214 higher in every intensity/complexity measure compared to the reference code. Finally, the RUC compared the surveyed code to MPC code 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)* (work RVU= 2.78) and noted that with greater total time, 79 minutes compared to 65 minutes, 52214 should be valued higher than 31622.

The RUC recommends a work RVU of 3.50 for CPT code 52214.

52224 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy*

The RUC first discussed the compelling evidence as presented by the specialty society. There are two primary compelling evidence standards involved in this service. First, new technology has changed the physician work. Subsequent to Harvard valuation of this service in 1988, the 120 degree deflection bi-directional third generation digital, high-definition flexible cystoscope with large working channels are now available. This has also caused a rise in physician work intensity because the patient is under local anesthesia, whereas during the previous valuation the patient was not. Second, an anomalous relationship exists between CPT codes 52224 and 52214. Currently, 52224 (work RVU= 3.14), a more difficult and intense procedure to perform, is ranked lower than 52214 (RUC recommended work RVU= 3.50). To substantiate this claim, the surveyed intensity/complexity measures for these two services were compared and 52224 ranked higher than 52214 in all but one category. The RUC agreed with the specialty society that there was overwhelming compelling evidence to change the work value of this service.

The RUC reviewed the survey results from 80 urologists and recommends the following physician time components: 32 minutes pre-service time (with additional time to position

the patient in the dorsal lithotomy position and wait for the local anesthesia to take effect), 30 minutes intra service time and 20 minutes post-service time. The RUC also agreed with the specialty that the median survey work RVU of 4.05 is an accurate measure of the physician work and intensity involved in this service. To further justify this value, the RUC compared the surveyed code to the key reference service CPT code 52204 *Cystourethroscopy, with biopsy(s)* (work RVU= 2.59) and agreed that the surveyed code should be valued substantially higher than the reference code due to greater total time, 82 minutes compared to 54 minutes. The RUC also reviewed CPT code 31629 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)* (work RVU= 4.09) and agreed that since these two services have identical intra service time, 30 minutes, and analogous total time, 82 minutes and 80 minutes, respectively, these services should have similar work values.

Finally, the RUC noted that the recommended work RVU of 4.05 results in a rise in physician work intensity for this procedure. However, there are two arguments that substantiate this work value. First, the intensity of this procedure has increased significantly since the prior valuation. The intensity of working with a flexible cystoscope increases the likelihood of multiple damages to the bladder. In addition, the inflow and outflow through the scope is small, resulting in potential obstruction of field when small amounts of bleeding occur. Second, and most importantly, the specialty presented strong survey data with a median survey work RVU of 4.05. The RUC concurred that the 25th percentile was too low and it was inappropriate to crosswalk the service to another code, given the robust survey data. **The RUC recommends a work RVU of 4.05 for CPT code 52224.**

Practice Expense:

The RUC approved the practice expense inputs as modified and submitted by the Practice Expense Subcommittee.

Cataract Surgerv (Tab 17)

Stephen A. Kamentzky, MD (AAO); Priscilla Arnold, MD (AAO)

In September 2007, CPT code 66982 was first identified by the High IWPOT and CMS Fastest Growing screens. The RUC recommended that the specialty society develop a CPT Assistant article, published in September 2009, to describe the accurate reporting of the service. Additionally, in February 2008 the RUC identified CPT code 66984 by the High IWPOT screen. In 2012, CMS identified both services via the CMS High Expenditure Procedural codes screen and the Relativity Assessment Workgroup recommended in September 2011 to have both services surveyed for the January 2012 RUC meeting.

66984 Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)

The RUC reviewed the survey results from 76 ophthalmologists and recommends the following physician time components: 22 minutes pre-service time, 21 minutes intra-service time and 7 minutes post-service time. The Committee also recommends a half-day discharge (99238), two 99212s and two 99213s, the current post-operative visits for this service. While the RUC agreed that the survey respondents accurately estimated the physician time at the median level, there was consensus that the estimated work RVU

was overestimated at the 25th percentile, 11.00 work RVUs. To determine a more appropriate work value, the RUC first discussed the high intensity of this procedure. The Committee noted that in the Third Five-Year review, the high intensity of this procedure was thoroughly discussed and the RUC was comfortable that the high IWP/UT (.211) was reasonable given the high intensity of this procedure from the initiation of the surgery until the conclusion. The Committee again affirmed that while technology has allowed physicians to perform the service faster, the intensity, and threat of complication, throughout this service has not changed. With this understanding of intensity, the RUC noted that the survey results showed minor reductions in pre and post service times and a 9 minute reduction in intra-service time, 30 minutes to 21 minutes. To account for this change in time, magnitude estimation was used to deduct 2.00 work RVUs from the current work RVU of 10.52 to arrive at a work value of 8.52.

To ensure the recommended value is appropriate, the RUC reviewed CPT code 66711 *Ciliary body destruction; cyclophotocoagulation, endoscopic* (work RVU= 7.93). While this reference code has greater intra-service compared to 66984, 30 minutes compared to 21 minutes, the surveyed code is a more intense procedure because the immediate threat of blindness is greater compared to the reference code. Additionally, 66984 is performed on an eye that is normal which increases the intensity as any error would have greater consequences. Therefore, 66984 should be valued higher than 66711. In addition, the RUC looked at 000 global period service CPT code 37191 *Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed* (work RVU= 4.71). Taking out the post-operative visits from 66984 derives a work RVU of 4.98, which given the increased intensity, accurately places the surveyed code in appropriate relativity. Finally, the RUC compared the surveyed code to MPC code 67904 *Repair of blepharoptosis; (tarso) levator resection or advancement, external approach* (work RVU= 7.97) and noted that while the MPC code has greater total time compared to 66984, 185 minutes compared to 147 minutes, the intensity is much greater for 66984. Therefore, the recommended work RVU of 8.52 appropriately aligns itself relative to this service. **The RUC recommends a work RVU of 8.52 for CPT code 66984.**

66982 Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage

The RUC reviewed the survey results from 76 ophthalmologists and recommends the following physician time components: 25 minutes pre-service time, 33 intra-service time and 10 minutes post-service time. The Committee also recommends a half-day discharge (99238), two 99212s and two 99213s. While the RUC agreed that the survey respondents accurately estimated the physician time at the median level, there was consensus that the estimated work RVU was overestimated at the 25th percentile, 13.00 work RVUs. To determine a more appropriate work value, the RUC noted that this procedure is a longer procedure compared to the base cataract surgery code, 66984, to account for the more complex nature of the patient, due to future deterioration of the eye. With roughly identical intensity for both procedure, the RUC noted that 66982 has 30% more intra-service time than 66984, 33 minutes compared to 21 minutes. Therefore, the Committee

added 30% more work RVUs to the recommended work RVU of 8.52 to arrive at a work RVU of 11.08 for code 66982.

To justify this value, the RUC first reviewed CPT code 52647 *Laser coagulation of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included if performed)* (work RVU= 11.30) and noted that while the reference code has more intra-service time, 45 minutes compared to 33 minutes, the surveyed code is a more intense procedure and should be valued slightly less. Additionally, the RUC reviewed CPT code 52400 *Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds* (work RVU= 8.69) and noted that if one 99212 and two 99213s are added to the value of this code, to match the recommended post-operative visits for 66982, the resulting work RVU is 11.11. The Committee noted again, that while 52400 has greater intra-service time, 40 minutes compared to 33 minutes, 66982 is one of the most intense procedures in the RBRVS and thus the two services should be valued similarly. **The RUC recommends a work RVU of 11.08 for CPT code 66982.**

Practice Expense:

The RUC accepted the direct practice inputs as modified by the Practice Expense Subcommittee.

Work Neutrality

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

Laser Treatment – Skin (Tab 18)

Lawrence Green, MD (AAD); Mark Kaufman, MD (AAD); Brett Coldiron, MD (AAD); Fitzgerald Sanchez, MD (AAD)

In 2002, three CPT codes were created to describe and report laser treatment for inflammatory skin diseases: 96920 *Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm*, 96921 *Laser treatment for inflammatory skin disease (psoriasis); total area 250 sq cm to 500 sq cm* and 96922 *Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm*. In February 2008, these codes were identified by the High Volume Growth and CMS Fastest growing screens. At that time the RUC recommended that these services be assessed again in two years. In October, 2011, the RAW re-reviewed these codes and recommended that the specialty society resurvey for work and practice expense for January 2012.

The RUC considered the typical patient who presents with chronic plaque psoriasis over 3-8% of their body and requires 6-8 treatments every 5-7 days. This treatment is typical performed once a year and is not reported with an Evaluation and Management code. Additionally the specialty societies indicated, and the RUC agreed that handheld UVB devices are never used for this procedure.

96920

The RUC reviewed the survey results from 49 dermatologists for CPT code 96920 and recommends to maintain the current work RVU of 1.15. The RUC compared 96920 to key reference service 11303 *Shaving of epidermal or dermal lesion, single lesion trunk, arms or legs; lesion diameter over 2.0 cm* (work RVU = 1.24) and noted that these

services require similar intra-service time, 23 minutes for 96920 and 20 minutes for 11303, but 11303 is a more intense procedure and should be valued higher. In addition, the RUC reviewed CPT code 12002 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm* (work RVU=1.14) and noted that although the more total time compared to the reference code, 35 minutes and 27 minutes, respectively, the services should be valued similarly because the intensity is greater for 12002. Therefore, maintaining the current value of 1.15 for CPT code 96920 appropriately accounts for the physician work required to perform this service relative to the reference services. **The RUC recommends a work RVU of 1.15 for CPT code 96920.**

96921

The RUC reviewed the survey results from 49 dermatologists for CPT code 96921 and recommends to increase the current work RVU from 1.15 to 1.30 which is both the survey 25th percentile and median. The specialty society presented compelling evidence and the RUC agreed that there was a significant change in physician work since the code was first surveyed. In 2002, the typical patient was 35 years old compared to 65 years old today, the introduction of new technology has increased the complexity of decision making during the physician work. Specifically, the physician is treating sensitive skin areas and must adjust laser fluence throughout the session to avoid risk of burning/blistering skin. The RUC compared 96921 to key reference service 11303 *Shaving of epidermal or dermal lesion, single lesion trunk, arms or legs; lesion diameter over 2.0 cm* (work RVU = 1.24) and determined that 96921 required more intensity and time and should be valued higher. In addition, the RUC reviewed CPT code 91022 *Duodenal motility (manometric) study* (work RVU=1.44) and noted that these services require the same intra service time of 30 minutes; however, total time for 91022 (61 minutes) is higher compared to total time for 96921 (42 minutes) and should be valued higher. The RUC also reviewed CPT code 90935 *Hemodialysis procedure with single physician evaluation* (work RVU=1.48) and noted that the intra service time for these services is similar, 30 minutes for 96921 and 25 minutes for 90935, but total time is higher for 90935 (45 minutes) compared to 96921 (42 minutes) and 90935 is a more complex procedure and should be valued higher. **The RUC recommends a work RVU of 1.30 for CPT code 96921.**

96922

The RUC reviewed the survey results from 50 dermatologists for CPT code 96922 and recommends to maintain the current work RVU of 2.10, which was also the survey 25th percentile work RVU. This is the most complex patient in this family of services, with multiple lesion sites. The RUC compared 96922 to 12015 *Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm* (work RVU=1.98) 12006 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 20.1 cm to 30.0 cm* (work RVU=2.39) and determined that these services were similar with regards to physician work, time, intensity and complexity. Therefore, maintaining the current value of 2.10 for CPT code 96922 appropriately accounts for the physician work required to perform this service relative to the key reference service. **The RUC recommends a work RVU of 2.10 for CPT 96922.**

Practice Expense:

The RUC approved the practice expense inputs as modified and submitted by the Practice Expense Subcommittee.

XIII. CMS Requests – MPC List Screen

Diagnostic Nasal Endoscopy (Tab 19)

Wayne Koch, MD (AAOHNS)

In October 2012, CMS identified CPT code 31231 *Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)* through the MPC List screen. In September 2011, the RUC recommended that the specialty society should re-survey this service for the January 2012 RUC meeting with an improved vignette to describe the typical unilateral vs. bilateral nasal endoscopy and better define the work of the involved topical and pledgets anesthetic in the survey instrument.

In January 2012, the RUC reviewed the survey results from 135 otolaryngologists for CPT code 31231 and determined that the survey 25th percentile and current work RVU of 1.10 should be maintained. The RUC noted that this service is typically performed with an Evaluation and Management service on the same day and the specialty society confirmed that 12 minutes was specifically removed from pre-time package-6, to account for any duplication of work with the Evaluation and Management service. Therefore, 5 minutes of pre-evaluation time accounts for the time to obtain consent, move the patient, check equipment and review the CT scan, 1 minute for positioning the patient and 5 minutes of scrub/dress/wait time to administer local anesthetic and have it take effect. The RUC compared 31231 to key reference service 31575 *Laryngoscopy, flexible fiberoptic; diagnostic* (work RVU = 1.10) and noted that 31231 requires slightly less intra-service time to perform, 7 minutes and 8 minutes, respectively. The specialty society indicated and the RUC agreed that this difference in time and intensity may be because 31231 is typically performed using a rigid endoscope, whereas 31575 is performed using a flexible endoscope. The specialty society indicated that use of a flexible endoscope is easier and requires less skill. The RUC compared 31231 to similar service 30901 *Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method* (work RVU = 1.10) and noted that 31231 requires 3 minutes less intra-service time, however is more intense as the surveyed service requires the use of an endoscope. Additionally, the RUC compared 31231 to 99213 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU = 0.97 and 23 minutes total time) and determined that these services require the same total physician time to perform, however 31231 is more intense and complex because it is an invasive procedure and therefore should be valued higher.

Lastly, the RUC noted that the survey respondents indicated that the intra-time is 3 minutes less than current time but requires the same physician work, thus increasing the intensity. The RUC reviewed the comparative intrusive diagnostic services referenced by the specialty society [CPT codes 52000 *Cystourethroscopy* (work RVU = 2.23), 43250 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery* (work RVU = 3.20) and 31629 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)* (work RVU = 4.09)] and determined that a slight decrease in physician time for the surveyed code is appropriate compared to these services that combine technical skill for

insertion of a scope for the purpose of cognitive/diagnostic evaluation. The RUC agreed that services such as 31231, that have low work RVUs and do not require a significant amount of time to perform will be more effected by small valuations in time, however, the survey data and reference services support to maintain the current value. **The RUC recommends a work RVU of 1.10 for CPT code 31231.**

Practice Expense:

The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

MRI of Lower Extremity Joint (Tab 20)

Geraldine McGinty, MD (ACR); Zeke Silva, MD (ACR)

In October 2010, CPT code 73721 *Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material* was identified through the MPC List screen. This service had not been reviewed by the RUC in the last 6 years, therefore, in September 2011, the RUC recommended that the specialty societies resurvey this service for work and practice expense. CPT code 73221 *Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s)* was identified initially through the CMS Fastest Growing screen and most recently through the CMS High Expenditure Procedural Codes. CPT code 73221 was scheduled for re-review in September 2013 and had not been reviewed for work in the last 6 years, therefore the specialty society indicated it would survey for January 2012 along with 73721.

73221

The RUC reviewed the survey results of 50 radiologists for CPT code 73221 and recommends to maintain the current work RVU of 1.35, lower than the survey's 25th percentile. The specialty society recommended an increase to 1.54 work RVUs for this service, stating that the technological advancements have resulted in an increase in the number of sequences performed and slices obtained, improved capability to see smaller abnormalities and thus increased level of interpretation required. The RUC agreed that these technological advancements have occurred but have not resulted in more physician work. The RUC noted that the survey respondents indicated a median intra-service time of 20 minutes, which is the same as the current intra-service time. The RUC compared 73221 to key reference service 74177 *Computed tomography, abdomen and pelvis; with contrast material(s)* (work RVU = 1.82) and determined that the reference service requires more physician work, including contrast material, and time to perform (20 versus 25 minutes intra-service time). The RUC also compared 73221 to 99203 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 1.42) and noted that these services have almost identical time 30 and 29 minutes, respectively. Therefore, maintaining the current value of 1.35 for CPT code 73221 appropriately accounts for the physician work required to perform this service relative to the key reference service. **The RUC recommends a work RVU of 1.35 for CPT 73221.**

73721

The RUC reviewed the survey results of 51 radiologists for CPT code 73721 and recommends to maintain the current work RVU of 1.35, lower than the survey's 25th percentile. The specialty society recommended an increase to 1.54 work RVUs for this service, stating that the technological advancements have resulted in an increase in the number of sequences performed and slices obtained, improved capability to see smaller abnormalities and thus increased level of interpretation required. The RUC agreed that

these technological advancements have occurred but have not resulted in more physician work. The RUC noted that the survey respondents indicated a median intra-service time of 20 minutes, which is the same as the current intra-service time. The RUC compared 73721 to key reference service 74177 *Computed tomography, abdomen and pelvis; with contrast material(s)* (work RVU = 1.82) and determined that the reference service requires more physician work, including contrast material, and time to perform (20 versus 25 minutes intra-service time). The RUC also compared 73721 to 99203 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 1.42) and noted that these services have almost identical time 30 and 29 minutes, respectively. Therefore, maintaining the current value of 1.35 for CPT code 73721 appropriately accounts for the physician work required to perform this service relative to similar services. **The RUC recommends a work RVU of 1.35 for CPT 73721.**

Practice Expense:

The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

Fluoroscopic Guidance for Spine Injection (Tab 21)

Marc Lieb, MD (ASA); Christopher Merifield, MD (ISIS); Joe Zuhosky, MD (AAPMR); William Sullivan, MD (NASS); Eddy Fraifeld, MD (AAPM); Sean Tutton, MD (SIR); Zeke Silva, MD (ACR); David Caraway, MD (ASIPP)

In October 2012, CMS identified CPT code 77003 *Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures (epidural, subarachnoid, or sacroiliac joint), including neurolytic agent destruction* on the MPC List screen. The RUC noted that this service had not been reviewed in the past six years and requested that it be surveyed. Recently, fluoroscopic guidance was bundled into facet joint injections (codes 64490-64495) in 2010, transforminal epidural injections (codes 64479-64484) in 2011, SI joint injection (code 27096) in 2012 and paravertebral facet joint destruction (new codes 64633-64636) in 2012. The specialty societies surveyed 77003 for the September 2011 RUC meeting, however, the RUC noted many issues with the survey conducted for this service that is performed concurrently with an injection procedure. The specialties did not include the new 2012 CPT descriptor in the survey and there were issues related to the clinical vignette. The RUC urged the specialty to develop a new vignette and instructions to inform the respondent that the injection is reported separately. The Research Subcommittee reviewed the revised vignette and instructions prior to the survey for the January 2012 RUC meeting.

The specialty societies noted that the current injection codes (62310, 62311, 62318 and 62319) to be reported with 77003 do not include any pre- or post-service work duplication and will be re-surveyed and presented to the RUC in October 2012. No other injection codes are to be reported with 77003 and therefore there is no duplicative work. The specialty societies noted that the parenthetical for 77003 of the CPT book advises that injection of contrast during fluoroscopic guidance and localization is an inclusive component of these services 62310-62319 and not included in the reporting of 77003.

In January 2012, the RUC reviewed the survey responses from 122 anesthesiologists, interventional radiologists, radiologists, spine surgeons and pain medicine physicians and determined that the physician work for CPT code 77003 should be maintained at 0.60 work RVUs, lower than the survey's 25th percentile. The specialty society indicated and

the RUC agreed that there is extra positioning time in the intra-service work, which accounts for the physician repositioning the patient depending on the type of injection to be performed. The RUC noted that the survey respondents indicate a slightly decreased intra-service time, while the physician work remains the same. However, the RUC discussed that the current time for 77003 was derived from a survey in 1999 from only radiologists. In contrast, this service has a robust survey with over 120 survey respondents, completed by a diverse set of practicing physician specialties, and should be valued based upon this strong data.

The RUC compared 77003 to 77001 *Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position)* (work RVU = 0.38 and 9 minutes intra-service time) and determined that 77003 requires more physician work, time, intensity and complexity to perform than 77001. For further support the RUC compared 77003 to similar service 76881 *Ultrasound, extremity, nonvascular, real-time with image documentation; complete* (work RVU=0.63 and intra-service time = 15 minutes) and code 99241 *Office consultation for a new or established patient* (work RVU= 0.64 and intra-service time= 15 minutes) and determined that these services require similar physician work and time to perform compared to 77003. Therefore, the current work RVU of 0.60 and intra-service time of 15 minutes appropriately places this service relative to similar services. **The RUC recommends a work RVU of 0.60 for CPT code 77003.**

Practice Expense

The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

Relativity Assessment

The RUC recommends that the Relativity Assessment Workgroup review codes 77001 *Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position)* (List separately in addition to code for primary procedure) (ZZZ global period) and 77002 *Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device)* (renumbered from 76003 in CPT 2007, XXX global period), to determine if this family of services needs to be re-surveyed as well.

XIV. CMS Request – July 19th NPRM

Cholecystectomy (Tab 22)

Christopher Senkowski, MD (ACS); Don Selzer, MD (SAGES)

CMS identified CPT codes 47600 and 47605 in the Proposed Rule for 2012, stating the agency received comments regarding a potential relativity problem between these cholecystectomy codes. It appears that the visits for these services do not appropriately reflect the relativity of these two services and that 47600 should not have more time and visits association with the service than 47605. The specialty society recognized that the

value for code 47605 may be incorrect and the RUC recommended that codes 47600 and 47605 be resurveyed for physician work and practice expense for January 2012. At the January 2012 RUC meeting the specialty society requested to postpone review of these services, due to a low survey response, until April 2012 after a valid response rate could be obtained. **The RUC agreed to postpone review of 47600 and 47605 until April 2012.**

Dual-energy X-ray Absorptiometry (Tab 23)

Geraldine McGinty, MD (ACR); Zeke Silva, MD (ACR); Allan Glass, MD (TES), Afonso Bello, MD (TES); John Seibel, MD (AAACE); Howard Lando, MD (AAACE)

In the July 19, 2011, Proposed Rule, CMS indicated that for 2010 and 2011, the Affordable Care Act (ACA) modified the payment for dual x-ray absorptiometry (DXA) services described by 77080 and 77082 to an imputed value, 70 percent of the product of the CY 2006 RVUs for these services, the CY 2006 conversion factor and the geographic adjustment for the relevant payment year. The ACA also allowed for a study to be conducted by the Institute of Medicine on the ramifications of Medicare payment reductions for DXA on beneficiary access to bone mass density tests. To date, this study has not been initiated. Therefore, CMS requested that the AMA RUC review CPT codes 77080 and 77082.

The RUC understood that there was a duplicate practice expense item that CMS corrected several years ago, which led to a significant reduction in payment. However, Congress reversed this payment reduction. The Congressional correction expired on December 31, 2011. The RUC recommended that the physician work and practice expense be reviewed for January 2012.

77080 Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)

In January 2012, the RUC reviewed the survey results from 104 radiologists, endocrinologists and rheumatologists and agreed with the presenters that the previous RUC recommended work RVU of 0.20 appropriately accounts for the physician work to perform this service. The RUC agreed with the specialty societies that the typical patient has numerous previous exams and studies, therefore 2 minutes of pre-service time is appropriate to account for the physician review of the patient's history. Likewise, the post-service time of 2 minutes appropriately accounts for the physician correlating the previous studies with the current findings as well as determining use of medications and treatment for osteoporosis. The RUC compared 77080 to key reference code 77081 *Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)* (work RVU = 0.22) and determined that these services require the exact same intra-service time of 5 minutes. The RUC also compared 77080 to MPC code 93010 *Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only* (work RVU = 0.17 and 4 minutes intra-service time) and determined that these services require similar physician work and time to perform. Therefore, a work RVU of 0.20 appropriately accounts for the physician work and time required to perform 77080 relative to other services. The RUC noted that 77080 is slightly more intense and complex than 77082 due to the body sites examined and therefore should be valued slightly higher. **The RUC recommends a work RVU of 0.20 for CPT code 77080.**

77082 Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; vertebral fracture assessment

The RUC reviewed the survey results from 44 radiologists, endocrinologists and rheumatologists and agreed with the presenters that the previous RUC recommended work RVU of 0.17 appropriately accounts for the physician work to perform this service. The RUC agreed with the specialty societies that the typical patient has numerous previous exams and studies, therefore 2 minutes of pre-service time is appropriate to account for the physician review of this history. Likewise, the post-service time of 2 minutes appropriately accounts for the physician correlating the previous studies with the current findings as well as determining use of medications and treatment for osteoporosis and following up with the referring physician regarding the fracture. The RUC compared 77082 to key reference code 77081 *Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)* (work RVU = 0.22) and determined that these services require the exact same intra-service time of 5 minutes. The RUC also compared 77082 to MPC codes 93010 *Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only* (work RVU = 0.17 and 4 minutes intra-service time) and 73560 *Radiologic examination, knee; 1 or 2 views* (work RVU = 0.17 and 3 minutes intra-service time) and determined that these services require similar physician work and time to perform. Therefore, a work RVU of 0.17 appropriately accounts for the physician work and time required to perform 77082 relative to other services. The RUC noted that 77082 is slightly less intense and complex than 77082 due to the body sites examined and therefore should be valued slightly lower **The RUC recommends a work RVU of 0.17 for CPT code 77082.**

Practice Expense

The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

Pathology Consultations (Tab 24)

Joel Brill, MD (AGA); Jonathan Myles, MD (CAP); Nicholas Nickl, MD (ASGE); W. Stephen Black-Schaffer, MD (CAP); Brett Coldiron, MD (AAD)

In the CY 2012 proposed rule CMS requested a review of both the direct PE inputs and work values of CPT code 88305 in accordance with the consolidated approach to reviewing potentially misvalued codes. It was determined that a review of the work was not necessary because the most recent extensive review of the professional component was conducted by the RUC in April of 2010, and that a review of the direct PE inputs alone is appropriate.

The RUC reviewed the direct PE inputs for CPT code 88300 *Level I - Surgical pathology, gross examination only* (work RVU=0.08); CPT code 88302 *Level II - Surgical pathology, gross and microscopic examination* (work RVU=0.13); CPT code 88304 *Level III - Surgical pathology, gross and microscopic examination* (work RVU=0.22); CPT code 88305 *Level IV - Surgical pathology, gross and microscopic examination* (work RVU=0.75); CPT code 88307 *Level V - Surgical pathology, gross and microscopic examination* (work RVU=1.59) and CPT code 88309 *Level VI - Surgical pathology, gross and microscopic examination* (work RVU=2.80). **The PE Subcommittee carefully reviewed the supply inputs to ensure there is no overlap with the indirect expenses and made necessary adjustments. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

XV. CMS Request – Harvard Valued – Utilization Over 30,000

Set Radiation Therapy Field (Tab 25)

Najeeb Mohideen, MD (ASTRO)

In April 2011, the RUC identified CPT code 77280 *Therapeutic radiology simulation-aided field setting; simple* as part of the Harvard Valued – Utilization over 30,000 screen and requested that this service be surveyed. At the September 2011 RUC Meeting, the specialty societies indicated that it was their understanding that 77280 had been reviewed by the RUC during the Third Five-Year Review in 2005 and should have RUC time. The RUC reviewed its past actions regarding this code and determined that although this code was reviewed during the third Five-Year Review and the value was maintained, the rationale specifically states, “the RUC believed that the current Harvard total and intra-service time of 23 minutes of physician time was more typical and maintained the current time.” The RUC interpreted this rationale to indicate that the time associated with this code should remain the Harvard valued time. Therefore, the RUC did not approve the specialty society’s request and recommends that the specialty society survey this code and the other codes in the family, 77285, 77290 and 77295 for the January 2012 RUC Meeting.

The specialty society reviewed the process of care associated with all the codes in this simulation family and determined that there is ambiguity on how to bill for the auto simulations performed right before the treatment. The specialty also noted that there appears that the volume for the complex procedure, 77290, is too high in relation to the intermediate code, 77285. CPT language will be added to this family to address both of these issues. Finally, a 4-dimensional code is needed to describe current physician practices in this field. Altogether there will be five therapeutic radiology simulation codes for RUC review in the CPT 2014 cycle. **The RUC recommends that CPT codes 77280, 77285, 77290 and 77295 be referred to the CPT Editorial Panel for revision and RUC review in the CPT 2014 cycle.**

Fluorescein Angiography (Tab 26)

Stephen A. Kamenetzky, MD (AAO); Cameron Javid, MD (AAO)

In April 2011, CPT code 92235 *Fluorescein angiography (includes multiframe imaging) with interpretation and report* was identified through the Harvard Valued-Utilization over 30,000 screen and recently through the CMS High Expenditure Procedural Codes screen.

The RUC reviewed the survey results from 104 ophthalmologists and determined that the physician work had not changed. The RUC recommends the work RVU of 0.81 should be maintained. The RUC noted that currently, this service has a total time of 28 minutes Harvard time. It was surveyed in 2005, for the Third Five-Year Review, which yielded the same result of 15 minutes intra-service time, however the Harvard time was maintained. The RUC determined that the specialty society recommendation pre-service time of 3 minutes, intra-service time of 15 minutes and post-time of 5 minutes appropriately accounts for the physician time required to this service. The specialty society confirmed and the RUC agreed that the 3 minutes of pre-service time is not duplicative with what may occur with an Evaluation and Management service. The pre-evaluation time accounts for the physician informing the patient and reviewing the risks of anaphylactic shock each time this service is performed. Additionally, the specialty

society recommended and the RUC agreed that the immediate post-service time should be reduced from 10 minutes to 5 minutes to remove any duplication of time already accounted for in the Evaluation and Management service.

The RUC compared 92235 to key reference service 92240 *Indocyanine-green angiography (includes multiframe imaging) with interpretation and report* (work RVU=1.10) and determined that the surveyed service required less physician work, time, technical skill and physical effort than 92240. The RUC compared 92235 to similar services CPT code 99213 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU = 0.97 and 15 minutes intra-service time), 76816 *Ultrasound, pregnant uterus, real time with image documentation, follow-up (eg, re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), transabdominal approach, per fetus* (work RVU = 0.85 and 15 minutes intra-service time) and MPC code 76700 *Ultrasound, abdominal, real time with image documentation; complete* (work RVU = 0.81 and 10 minutes intra-service time) and determined that these services required similar physician work and time to perform. **The RUC recommends a work RVU of 0.81 for CPT code 92235.**

XVI. Practice Expense Subcommittee (Tab 27)

Doctor Joel Brill, Vice-Chair, provided a summary of the Practice Expense Subcommittee report. The Subcommittee reviewed the recommendations of the Ultrasound Workgroup. **The PE Subcommittee agreed that the recommendations of the Ultrasound Workgroup be submitted to CMS.**

In a related issue ACP brought a subset of the ultrasound codes to the attention of the Workgroup because they are potentially being misreported by internal medicine physicians. **The PE Subcommittee recommends that ACR and ACP work together to determine an appropriate way to handle this issue and report back to the PE Subcommittee at the April 2012 meeting.**

The PE Subcommittee reviewed the results of the PACS survey. The survey results indicate that PACS ownership is now or soon will be typical in 6 of the top 7 specialties. Obstetrics and Gynecology is the only specialty where PACS is not yet typical. **Given this more robust data, indicating that PACS are typical, the workgroup will establish the appropriate practice expense inputs for PACS and develop a plan to remove film supplies for the PE inputs. At the April 2012 meeting the workgroup will propose a timeline/workplan to modify the inputs for the Subcommittee's approval.**

Two additional issues related to migration of images from film to digital were addressed at the PE Subcommittee meeting. The Subcommittee questioned the need for a laser printer as well as equipment codes SK030, SK058, SK065 once the transition from film to digital is complete. **The workgroup was assigned to reevaluate the need for a laser printer as well as equipment codes SK030, SK058, SK065 for all codes that will transition to reporting PACS rather than film.**

The PE Subcommittee recognized that there are 000 day global codes performed primarily in the facility setting that have requested pre-service time based on comparison

codes. **The Chair will establish a workgroup to review this issue and offer recommendations to the PE Subcommittee. The workgroup will establish a consistent policy on what elements are required to substantiate pre-service time on a 000 day global service performed primarily in the facility. In addition, the workgroup will review prior RUC PE recommendations to CMS and modify if necessary.**

Finally the PE Subcommittee was concerned that the supplies included in the pack for cleaning the endoscope are not sufficient. **The Subcommittee will review the inputs in the CMS supply item SA042 and determine if additional items are required. The RUC approved the Practice Expense Subcommittee's report and it is attached to these minutes.**

XVII. Research Subcommittee (Tab 28)

Doctor Brenda Lewis, Chair, provided a summary of the Research Subcommittee report. The Subcommittee reviewed the American Speech-Language-Hearing Association scenario to demonstrate how data collected in the National Outcome Measurement System (NOMS) database would support a recommendation put forward by the specialty society. **The Research Subcommittee agreed that the NOMS database meets the RUC's extant database criteria and can be used to complement the Survey instrument and never as a source of primary data. The Research Subcommittee also recommends that ASHA create time based codes for speech therapy.**

Doctor Lewis noted to the RUC that at the February 2011 RUC Meeting, the Research Subcommittee reviewed and determined that the Society of Thoracic Surgeons (STS) database met the RUC's Inclusionary/Exclusionary criteria for extant database. At that time, the Subcommittee recommended that the specialty society develop specific criteria for when the specialty society would be required to display their extant data for a surveyed service with their RUC recommendation. **The STS will utilize the STS National Database when accurate and sufficient time data are available for specific use for existing CPT codes. The STS proposed a 95th percentile confidence interval with a +-5% variability as criteria to include STS data which was approved by the Research Subcommittee.**

Doctor Lewis explained to the RUC that Research Subcommittee continued the discussion of Mandated Activities in the Post-Service period. The Research Subcommittee solicited specialty societies for the following questions:

- 1) What types of activities are your physicians mandated by rules or regulations to complete that are not included in the work value of a service but required for the payment of that service. These non-compensated activities may include a registry or other completion of forms for 1.)a service 2.)use of a device, or 3.)drug administration protocol?
- 2) Who is the mandating body requiring this work?
 - CMS _____
 - State Agency (Please Specify) _____
 - Other Federal Agency (Please Specify) _____

3) Is the mandate time limited? Yes ____ No ____

4) Is this work part of PQRI? Yes ____ No ____

The general consensus among the Research Subcommittee members was that there may be physician work and/or practice expense related to mandated activities not currently accounted within the RBRVS. **The Research Subcommittee recommended that an ad hoc workgroup be created to review this issue and create criteria and standards for the RUC to consider at the October 2012 RUC Meeting.**

Doctor Lewis also reported that in a letter dated October 21, 2011, the American College of Surgeons (ACS) requested that the RUC collaborate with the CMS to: 1) Review the Berenson-Eggers Type of Service (BETOS) procedures categories and associated codes to make necessary changes. The classification of “major” versus “minor” procedures should be reviewed and defined; and 2) Establish an ongoing process by which new or revised codes will be assigned to the correct BETOS category and class as the codes are reviewed by the RUC. **The Research Subcommittee agreed with the ACS request and submitted a letter to CMS to offer the RUC’s expertise to review, revise and maintain BETOS as deemed necessary by the agency.**

In addition, Doctor Lewis explained to the RUC that the Research Subcommittee reviewed and discussed in length the use of panel samples in the survey process. The RUC further discussed the definition of “random sample” and confirmed that specialty societies may continue to solicit a random sample of their membership to identify survey respondents. **The Research Subcommittee recommended modifying the following definition of a panel included in the *Instructions for Specialty Societies Developing Work Value Recommendations*:**

~~As part of completing the electronic Summary of Recommendations form, you must indicate the type of survey sample conducted (i.e., random, panel, or convenience). A random sample would involve sending the survey out to a random selection of physicians in your specialty (e.g., from your membership database). A panel sample is a group of physicians that typically perform the service (e.g., attendees from a previous course on the service) or a group of your members who repeatedly complete the RUC surveys. A convenience sample would involve surveying a group of your members together in one setting (i.e., at a specialty society meeting). If the number of respondents to your survey is less than 30, you should also include an explanation for the low number of respondents (i.e., the procedure involves new technology and few physicians are performing the service at this time).~~

The RUC expects the specialty society to use a random survey to develop relative value recommendations and should disclose the process used in the rationale section of Summary of Recommendation (SOR) form. If a specialty intends to use any other survey sample method, they must request review and approval by the Research Subcommittee prior to surveying the code(s).

Lastly, Doctor Lewis reported to the RUC that the Research Subcommittee reviewed and approved a revised survey instrument for bundled thrombolysis which will be presented at the April 2012 RUC meeting. The Society for Vascular Surgery, Society of Interventional Radiology and American College of Radiology expressed the following concerns with the 000 day survey instrument: 1) the two new codes (X3 and X4) describe

continued thrombolysis treatment and/or discontinuation of thrombolysis treatment on days subsequent to the initial treatment; 2) The 000-day survey instrument describes and inquires about work on the day preceding a procedure, work that would not be included in the two subsequent day codes (372X3 and 372X4). As such, use of the 000 day global survey instrument will lead to confusion among our survey respondents and could yield inconsistent responses; and 3) The 000 day survey instrument asks about skin-to-skin work, a term which is not applicable to the intra-service work for the two additional new codes, since much of the work of these codes involves patient management.

Below are the scenarios that were presented and discussed by the Research Subcommittee:

SCENARIO 1

DAY 1	
372X1 Transcatheter therapy, arterial infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, initial treatment day	Infrequent scenario where thrombolysis is started and stopped with catheter removal on the same day.
or	
372X2 Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day	

SCENARIO 2

DAY 1	Day 2 (final day of treatment)
372X1 Transcatheter therapy, arterial infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, initial treatment day	372X4 Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed, and cessation of thrombolysis including removal of catheter and vessel closure by any method
or	
372X2 Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day	

SCENARIO 3

DAY 1	Day 2, Day 3, ... Day X (continued days of treatment)	Last Day (final day of treatment)
372X1 Transcatheter therapy, arterial infusion for thrombolysis other than coronary, any method, including radiological supervision and	372X3 Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic	372X4 Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including

interpretation, initial treatment day	therapy, including follow-up catheter contrast injection, position change, or exchange, when performed	follow-up catheter contrast injection, position change, or exchange, when performed, and cessation of thrombolysis including removal of catheter and vessel closure by any method
or		
372X2 Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day		

The Research Subcommittee agreed to remove the term “skin-to-skin” in the pre-service and intra-service time period description reference in 372X3 and 372X4 and revise the term “operative” to “procedure” throughout the pre, intra and post-service time period descriptions so survey respondents will understand the continuation of service. The proposed survey, as presented, was approved.

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

XVIII. Administrative Subcommittee (Tab 29)

Doctor Dale Blasier, Chair, provided the Administrative Subcommittee discussion to the full RUC.

Composition of the RUC

The Administrative Subcommittee discussed the five recommendations and draft Structure and Function changes as determined on its November 7, 2011 conference call in response to the AAFP request to review the RUC composition.

The RUC discussed the Workgroup recommendation to add one rotating Primary Care seat and one Geriatric seat to the RUC. The RUC noted that medicine is changing and the RUC needs to change with medicine in order to maintain this important role. The RUC agreed that this change will not only add expertise in broad-based chronic disease management and preventive care, but will address outside perceptions and criticism of the RUC and political concerns.

The RUC voted and passed the recommendation to add one rotating Primary Care seat and one Geriatric seat to the RUC.

The recommended changes to the RUC structure and functions, rules and procedures, and rotating seat policies and election rules as indicated in the November 7, 2011, Administrative Subcommittee conference call report are attached to these minutes. The RUC recommends:

1. **The RUC add one rotating Primary Care seat to the RUC, consistent with the AMA definition of Primary Care and the amended Primary Care Candidate Eligibility.**

The Administrative Subcommittee specified and the RUC determined the primary care candidate eligibility as follows: The Primary Care rotating seat candidate must be in active clinical practice, with at least 50% of their professional time in direct patient care. The Primary Care rotating seat candidate must present documentation that he/she is defined as a primary care physician by Medicare (i.e., primary care bonus eligibility). The Primary Care rotating seat candidate must be a physician with significant experience and expertise in broad-based chronic disease management, comprehensive treatment plan development and management, and preventive care.

2. **The RUC add a permanent Geriatric seat.** The following exception statement will be added to the RUC Structure and Functions document:

In recognition of their expertise in caring for large, defined patient populations, and the value of such expertise to the RUC, the American Academy of Pediatrics and the American Geriatrics Society are exempt from the criteria for a permanent seat on the RUC.

3. **The RUC maintain rotating seats (two Internal Medicine subspecialty; one “Other”; and one Primary Care [new]).**
4. **The RUC recommends using its current methods for obtaining external data and does not recommend any additional “external representative” seats to the RUC.**
5. **The RUC publish the total vote count for each CPT code after publication of the Final Rule, with additional parameters that may further describe the total vote as recommended by the Administrative Subcommittee and approved by the full RUC.**

The full Administrative Subcommittee report is attached to these minutes.

XIX. Relativity Assessment Workgroup (Tab 30)

Doctor Bob Zwolak, Vice-Chair, provided a summary of the Relativity Assessment Workgroup report.

A. CMS Requests – *Final Rule* for 2012 MFS

Abdomen and Pelvis CT – 72192, 72193, 72194, 74150, 74160 & 74170

**74170 was also identified under the CMS/Other screen.*

The Workgroup reviewed the specific CMS request regarding the practice expense anomalies for the abdomen and pelvis CT codes. **The Workgroup agreed with the specialty society that the current PE RVUs are appropriate for the Abdomen and Pelvis CT codes and once the previous stand alone codes are fully transitioned for practice expense in 2013, the current PE RVU anomalies will cease to exist.**

Additionally, a CMS staff type error in the new bundled codes, which added to the anomaly, were corrected to indicate CT Technologists (L046A).

In Situ Hybridization – 88365, 88367 & 88368

CMS received comments that unlike the new FISH codes for urinary tract specimens (88120 and 88121), the existing codes (88365-88368) still allow for multiple units of each code as these codes are reported per probe. CMS stated that they have reviewed the current work and practice costs associated with 88120 and 88121 and agree at this time that they are accurate. CMS requested that the RUC review both the direct PE inputs and the work values for codes 88365, 88367 and 88368. In September 2011, the Workgroup determined that these services be tabled until January 2012 in order to review 2011 diagnosis data from CMS. **The Workgroup reviewed 2011 diagnosis claims data and the American College of Pathologists indicated that they will develop a CPT Assistant article to direct physicians to use the new FISH codes for urinary tract infections (CPT codes 88120 and 88120). The Workgroup indicated that the specialty should specify the number of probes utilized for these services in the CPT Assistant article. The Workgroup recommended that it re-review codes 88365, 88367 and 88368 in 1 year after 2012 utilization is available (January 2013).**

CMS Request to Re-Review Families of New/Revised CPT Codes

In the November 28, 2011 *Final Rule* for 2012 CMS requested that the RUC re-review specific codes in a family of services that were recently reviewed. Doctor Zwolak noted that codes indicated with an asterisk were recently reviewed by the RUC and recommendations were submitted for the 2012 Medicare Physician Payment Schedule. For whatever reason, CMS did not get involved in the LOI process to request additional codes for review as part of each family of services. AMA staff indicated that going forward, AMA staff will ask CMS to acknowledge the code families during the LOI process. **The Workgroup reviewed the CMS identified family of services and recommends:**

Trim Skin Lesions	Recommendation
11055 11056* 11057	Maintain the current work RVUs. There are no apparent rank order anomalies. CMS had the opportunity to request review of other codes during the CPT LOI process.
Thoracoscopy	
32663*, 32480, 32669*, 32670*, 32482, 32671*, 32440, 32672*, 32491, 32673*, 60520, 60521, and 60522	Request further information from CMS on why these services should be reviewed as part of a family. CMS stated in the Final Rule that it will accept the RUC recommendation for some of these thoracoscopy services pending review of the open heart surgery analogs and that the RUC look at the incremental difference in RVUs and times between the open and laparoscopic surgeries. The specialty society noted that these are not open heart surgery codes and therefore are not relevant.
CT Angiography	

74174*, 74175 and 72191	Refer to the PE Subcommittee to review in April 2012 and determine if any practice expense anomalies exist between these codes. The Workgroup determined that review of physician work is not necessary at this time.
Evoked Potentials and Reflex Studies	
95938*, 95939*, 95925, 95926, 95928, and 95929	Refer to the PE Subcommittee to review in April 2012 and determine if any practice expense anomalies exist between these codes. The Workgroup determined that review of physician work is not necessary at this time.

* RUC recommendation submitted for 2012.

- B. Review Action Plans – Table 7: CMS High Expenditure Procedural Codes Screen**
 In the July 19, 2011, Proposed Rule for 2012, CMS requests that the RUC review a list of 70 high PFS expenditure procedural codes representing services furnished by an array of specialties. CMS selected these codes based on the fact that they have not been reviewed for at least 6 years, and in many cases the last review occurred more than 10 years ago. **The Relativity Assessment Workgroup reviewed action plans for all 70 High Expenditure Procedural Codes identified and prioritized review to complete by the April 2013 RUC meeting. The Workgroup recommendations are attached to these minutes.**

Doctor Brett Coldiron, RUC Advisor from the American Academy of Dermatology Association noted that Mohs surgery codes 17311 and 17312 were identified through the CMS High Expenditure Procedural screen. In January 2012, the specialty societies indicated that shaving of epidermal or dermal lesions codes 11300-11313 should be validated for physician work prior to surveying the Mohs surgery codes. **The RUC recommended review to validate physician time for codes 11300-11313 at the April 2012 meeting.**

C. CMS/Other Screen – Review Action Plans

The Workgroup reviewed the remaining 19 action plans for the CMS/other source codes with Medicare utilization 500,000 or more and recommends the following.

CPT Code	Recommendation
73500	Refer to CPT
73550	Refer to CPT
74170**	Survey for April 2012 RUC meeting.
76645	Refer to Research Subcommittee October 2012 meeting to discuss possible crosswalk methodology after Table 7 ultrasound codes are reviewed.
76705	Refer to Research Subcommittee October 2012 meeting to discuss possible crosswalk methodology after Table 7 ultrasound codes are reviewed.
76770	Refer to Research Subcommittee October 2012 meeting to discuss possible crosswalk methodology after Table 7 ultrasound codes are reviewed.
76775	Refer to Research Subcommittee October 2012 meeting to discuss possible crosswalk methodology after Table 7 ultrasound codes are reviewed.

76856	Refer to Research Subcommittee October 2012 meeting to discuss possible crosswalk methodology after Table 7 ultrasound codes are reviewed.
76942	Action Plan due January 2013 for review by the Workgroup. Review ICD-9 diagnosis data associated with this service.
93925	Survey for April 2012.
93970	Survey for April 2012.
70450*	Reviewed action plan under Table 7 screen – Survey for April 2013
70553*	Reviewed action plan under Table 7 screen – Survey for April 2013
72148*	Reviewed action plan under Table 7 screen – Survey for April 2013
77014*	Reviewed action plan under Table 7 screen – Refer to CPT
88342*	Reviewed action plan under Table 7 screen – Refer to CPT
93880*	Reviewed action plan under Table 7 screen – Survey for Oct 2012
97150	Complete
G0127	Complete

**CMS also identified these six codes in the Final Rule for 2012, Table 7 High Expenditure Procedure Codes.*

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

- D. Joint CPT/RUC Workgroup on Codes Reported Together Frequently – Update**
 Doctor Kenneth Brin, Chair of the Joint CPT/RUC Workgroup on Codes Reported Together Frequently, provided an update of the Workgroup's progress. Doctor Brin explained that there are only two code groups not complete from the prior cycle on codes billed together 75% or more. These code groups will be addressed in CPT 2013. For the current review cycle, the Workgroup performed the data analysis on codes reported together (75% or more) on 2009 Medicare claims data and limited the number of code groups for Workgroup review to 30. Workgroup members were assigned to review these groups and, over multiple conference calls, it was determined that 17 groups will move forward to the specialty LOI for submission of Action Plans. The Joint Workgroup will then review these Action Plans and make their final recommendations. The necessary materials will be provided to the specialty societies by March 1, 2012 with requests for response by March 31, 2012. Materials related to the Joint Workgroup's efforts were included in the RAW agenda materials.

- E. Other Issues**
 The following informational items were provided: a list of CPT Editorial Panel Referrals, CPT Assistant Referrals, the progress of Relativity Assessment Workgroup of Potentially Misvalued Services and a full status report of the Relativity Assessment Workgroup (CD only).

The full Relativity Assessment Workgroup report, list of CMS High Expenditure Procedural Codes and list of codes to be reviewed by the Workgroup for CPT 2014 are attached to these minutes.

XX. Multi-Specialty Points of Comparison Workgroup (Tab 31)

Doctor Ronald Burd, Chair, presented the report of the MPC Workgroup. The Workgroup members reviewed the revised MPC list including the specialty recommendations regarding current MPC codes to either be included or excluded from the new cross-specialty MPC list. This new list consists of 223 services. In reviewing the

revised list, the Workgroup members noted that there seems to be a dearth of codes between 5.00 and 10.00 work RVUs. A query will be created by AMA staff that will obtain all RUC-reviewed codes since 2005 between 5.00 and 10.00 work RVUs and distributed to the Workgroup prior to the next meeting. The MPC Workgroup will then meet via conference call prior to the April 2012 RUC meeting to finalize and approve the MPC list. The new cross-specialty MPC list will be presented for RUC adopted at the April 2012 RUC meeting.

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

XXI. HCPAC Review Board (Tab 32)

Tony Hamm, DC, Vice-Chair, informed the RUC that the HCPAC reviewed group therapeutic procedure, CPT code 97150 and trimming of nail, CPT code 11719 and will submit the following recommendations to CMS for the 2013 Medicare Physician Payment Schedule.

Group Therapeutic Procedure (97150)

In April 2011, the Relativity Assessment Workgroup identified CPT code 97150 *Therapeutic procedure(s), group (2 or more individuals)* through the CMS/Other – Utilization over 500,000 screen and recommended it to be resurveyed. In January 2012, the HCPAC determined that there was compelling evidence that the physician work has changed for this service since the code was created and valued in 1995. This service was never surveyed by the HCPAC, however CMS staff imputed a value for this service not based off any survey results. Therefore, the HCPAC determined that incorrect assumptions were made by CMS at the time of valuation.

The HCPAC reviewed the survey results from 23 physical therapists and 11 occupational therapists and determined that the survey respondents overestimated the work required to perform this group service. The HCPAC compared 97150 to 92508 *Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals* (work RVU = 0.33 and 17 minutes intra-service time) and determined that 92508 requires more work and intensity than the surveyed code. The HCPAC compared 97150 to timed 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 97110 *Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility* (work RVU = 0.45) and determined that for a half hour of 97530 and 97110 would total 0.89 and 0.90 work RVUs which is similar to the 30 minutes total required to perform 97150. Further, if 0.89 is divided by 3, the typical number of patients in the group therapy session as confirmed by CMS claims data, the resulting value is 0.29. The HCPAC agreed that this work value is appropriate for this service. **The HCPAC recommends a work RVU of 0.29 for CPT code 97150 and 10 minutes intra-service time.**

Practice Expense:

The HCPAC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

Trimming of Nails (11719)

CPT code 11719 *Trimming of nondystrophic nails, any number* was identified by CMS through the Low Value-High Volume screen. The HCPAC noted that in September 2011, CPT code 11719 was surveyed with codes 11720 and 11721, however the American Podiatric Medical Association (APMA) indicated, and the HCPAC agreed, that the previous survey data appeared inconsistent with the service and therefore recommended a resurvey.

In January 2012, the HCPAC reviewed the survey data from 37 podiatrists for CPT code 11719 and determined that the physician work involved in the service has not changed. The HCPAC agreed 11719 is similar to 11720 *Debridement of nail(s) by any method(s); 1 to 5* (HCPAC recommended work RVU = 0.32 and 5 minutes intra-service time). However, 11720 is more intense in order to debride and reduce the size and girth of 4 nail plates compared to trimming 10 nails as described in CPT code 11719 and therefore requires more work. The HCPAC also compared 11719 to MPC code 73620 *Radiologic examination, foot; 2 views* (work RVU=0.16 and 3 minutes intra-service time) and determined these services require similar work and time to perform. For additional support the HCPAC compared 11719 to 99211 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU = 0.18 and 5 minutes intra-service time) and determined these services are also similar in work and time. The HCPAC recommends 5 minutes pre-time, 5 minutes intra-service time and 2 minutes post-service time for CPT code 11719. **The HCPAC recommends to maintain a work RVU of 0.17 for CPT code 11719.**

Practice Expense

The HCPAC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

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

XXII. Other Issues

Doctor Gee introduced a concern that including pre-service time in the RUC survey is confusing to specialty members. Doctor Gee suggested that now that pre-service time packages are established, there is little reason to ask survey participants what the pre-service time is for any given procedure. Specialties could still argue for pre-service time if it does not fit into the standard, but it would simplify the survey form, not to ask for pre-service time. The RUC referred the issue to the Research Subcommittee for review at the Fall 2012 meeting.

Doctor Waldorf introduced a concern about survey responses for intra-service time on time-based codes. Doctor Waldorf suggested that the time should be pre-populated because of the high intra-service time that are being reported through the survey. Doctor Levy clarified that the question was really how many increments the survey participants do when they perform the code. Doctor Levy further clarified that it is up to the specialty to come to the Research Subcommittee and modify the survey instrument for time-based codes.

Doctor Levy adjourned the meeting at 3:50 pm on Saturday, January 28, 2012.

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

I. Ultrasound Equipment

CMS requested that the RUC review 17 different ultrasound and ultrasound related pieces of equipment associated with 110 CPT codes varying widely in price. The Chair established a workgroup to review this issue and offer recommendations to the PE Subcommittee. The Subcommittee accepted the recommendations as submitted by the Workgroup. Significant changes from the recommendation will include changing the EL015, ultrasound room to EQ250, portable ultrasound unit for some codes and proposing a cardiovascular ultrasound room be added to the appropriate CMS ultrasound equipment codes. **The PE Subcommittee recommends that the recommendations of the Ultrasound Workgroup be submitted to CMS.**

ACP brought a subset of these codes to the attention of the Workgroup because they are potentially being misreported by internal medicine physicians. The specialty suspects the miscoding results from reporting more advanced equipment than is typically found in a general practice office today. **The PE Subcommittee recommends that ACR and ACP work together to determine an appropriate way to handle this issue and report back to the PE Subcommittee at the April 2012 meeting.**

II. Migration of Radiologic Images from Film to Digital Workgroup

In September 2011, the American College of Radiology agreed to continue to collect data and review the typical Picture Archiving and Communication Systems (PACS) environment across specialty. The specialty requested the AMA's assistance in collecting additional data on this topic. A survey was developed collaboratively and deployed by the AMA in December 2011. The survey was sent to over 100,000 practicing patient care AMA physician members with an n=700. The report focuses on the top 7 specialties with 30 or more respondents. The survey results indicate that PACS ownership is now or soon will be typical in 6 of the top 7 specialties. Obstetrics and Gynecology is the only specialty where PACS is not yet typical.

Given this more robust data, indicating that PACS are typical, the workgroup will establish the appropriate practice expense inputs for PACS and develop a plan to remove film supplies for the PE inputs. At the April 2012 meeting the workgroup will propose a timeline/workplan to modify the inputs for the Subcommittee's approval.

Several new issues relating to migration of images from film to digital were addressed at the PE Subcommittee meeting. First, the Subcommittee reviewed the direct practice

expense inputs recommended by the specialty for tabs 9 and 20 and made minor modifications to remove the equipment time for the laser printer. The workgroup was assigned to reevaluate the need for a laser printer for all codes that will transition to reporting PACS rather than film.

Second, the Subcommittee reviewed the direct practice expense inputs recommended by the specialty for tab 26. The workgroup was assigned to reevaluate the need for equipment codes SK030, SK058, SK065 once the transition from film to digital is complete. These inputs are not part of the PACS system, but should be considered by the workgroup in their deliberations.

III. Determination of Equipment Time

At the request of the Chair, Ryan Howe from CMS discussed the CMS Methodology for assigning equipment times. Since April 2010, CMS has mandated that the specialties and PE subcommittee make specific time recommendations to CMS. During the presentation, the specialties expressed concerns that the methodology is inconsistent with previous PEAC, PE Subcommittee and RUC precedents. After considerable discussion, the Chair encouraged the specialties to work with CMS on ensuring that the methodology for determining equipment times is consistent and congruent with typical patient care and workflow. CMS agreed to meet with the specialties on this issue.

IV. Pre-Service Time for 000 Day Global Codes Performed in Facility Setting

The PE Subcommittee recognized that there are 000 day global codes performed primarily in the facility setting that have requested pre-service time based on comparison codes. The PE Subcommittee noted that these codes may not be handled consistently and reviewed the RUC's previous standard that states pre-service time should not be assigned to 000 day global codes, unless the specialty can substantiate it. **The Chair will establish a workgroup to review this issue and offer recommendations to the PE Subcommittee. The workgroup will establish a consistent policy on what elements are required to substantiate pre-service time on a 000 day global service performed primarily in the facility. In addition, the workgroup will review prior RUC PE recommendations to CMS and modify if necessary.**

V. CMS Requests – MPC List Screen

Diagnostic Nasal Endoscopy (31231)

Tab 19

The PE Subcommittee reviewed the direct practice expense inputs recommended by the specialty for tab 19. The Subcommittee notes that the pack included in supplies for cleaning the endoscope, CMS supply item SA042, includes the gluteraldehyde (disinfecting/sanitizing agent), CMS supply item 52306, which was listed as a separate input. That input was removed. The specialty was concerned that a basin for the gluteraldehyde is not included in the pack. **The Subcommittee will review the inputs in the CMS supply item SA042 and determine if additional items are required.**

DESCRIPTION	Code	Unit	Item Qty	Unit price
pack, cleaning and disinfecting, endoscope	SA042	pack		15.520
gloves, non-sterile		pair	4	0.084
gown, staff, impervious		item	1	1.186
face shield, splash protection		item	1	1.706
biohazard bag		item	1	0.062
gauze, sterile 4in x 4in (10 pack uou)		item	1	0.798
alcohol isopropyl 70%		ml	60	0.002
cleaning brush, endoscope		item	1	4.992
glutaraldehyde 3.4% (Cidex, Maxicide, Wavicide)		oz	32	0.165
glutaraldehyde test strips (Cidex, Metrex)		item	1	1.012

Tab	Title	PE Input Changes (Yes or No)
6	Bronchial Valve Procedure	Yes Minor Modifications
9	X-ray of Cervical Spine	Yes Minor Modifications
12	Intraoperative Neurophysiology Monitoring	Yes Modifications/Handout
14	Computer Navigation	No
15	Arthroscopic Biceps Tenodesis	No
16	Cystoscopy and Treatment	Yes Modifications/Handout
17	Cataract Surgery	No
18	Laser Treatment	Yes Modifications/Handout
19	Diagnostic Nasal Endoscopy	Yes Modifications/Handout
20	MRI of Lower Extremity Joint	Yes Minor Modifications
21	Fluoroscopic Guidance for Spine Injection	Yes Minor Modifications

Tab	Title	PE Input Changes (Yes or No)
23	Dual-energy X-ray Absorptiometry	Yes Minor Modifications
24	Pathology Consultations	Yes Minor Modifications
26	Fluorescein Angiography	Yes Minor Modifications
32	Group Therapeutic Procedure	Yes Minor Modifications
32	Trimming of Nails	Yes Minor Modifications

Members Present

Members: Brenda Lewis, DO (Chair), Greg Przybylski, MD (Vice Chair), Sherry Barron-Seabrook, MD, Scott Collins, MD, Verdi Disesa, MD, William Donovan, MD, Anthony W. Hamm, DC, Charles Koopmann, MD, J. Leonard Lichtenfeld, MD, John Gage, MD, Marc Raphaelson, MD, and Allan Tucker, MD.

I. Research Subcommittee November 2011 Conference Call Meeting Report

The Research Subcommittee Report from the November 2011 Conference Call is included in Tab 28 of the January 2012 agenda materials for approval by the RUC.

II. Extant Data

a. Extant Database Demonstration

American Speech-Language and Hearing Association (ASHA)

The American Speech-Language and Hearing Association submitted a scenario to demonstrate how data collected in the National Outcome Measurement System (NOMS) database would support a recommendation put forward by the specialty society. The specialty made clear that the NOMS database would provide supportive/revealing insight and is not intended to replace the RUC survey process. Specifically, it would serve as a resource regarding intra-service times and provide clarification to determine the number of sessions required to show improvement or reach therapy goals.

The Research Subcommittee did note some limitations to this database as follows:

- Data is not currently audited by any third party, but third parties have access to the data to audit..
- Data is primarily collected by ICD-9 codes not CPT. The specialty noted that all services managed by speech and language therapists are cross walked to 3 untimed CPT codes: 92507 (speech therapy individual), 92508 (group) and 92526 (treatment of swallowing disorders).
- Data points are not entered into NOMS prospectively. However, clinicians record time following each session into the patient chart . This time is then entered retrospectively into NOMS and averaged for the entire treatment protocol at the end of treatment. Group time is determined using the following formula: total time divided by total number of patients.

The Research Subcommittee agreed that the NOMS database meets the RUC's extant database criteria and can be used to complement the Survey instrument and never as a source of primary data. The Research Subcommittee also recommends that ASHA create time based codes for speech therapy.

b. Extant Data Display Proposal

Society of Thoracic Surgeons

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

specific criteria (e.g. specific thresholds of survey volume and distribution) for when the specialty society would be required to display their extant data for a surveyed service with their RUC Recommendations.

The Subcommittee reviewed The STS National Adult Cardiac Database for 850,895 individual patients for procedures performed from 2006 to 2010. A comparison of the STS database to the Medicare Utilization data for 2010 indicated that more than 90% of cardiac surgical procedures are captured by the National Database. This is consistent with participation of more than 1,100 sites in the US and the STS estimate that approximately 94% of sites performing cardiac surgery are submitting data. Each site employs a third party administrator who manually enters 200-300 fields of clinical data. In addition, the database is audited. Thus, the database is considered a comprehensive and representative resource.

The society determined two relevant issues to database utilization: 1) predictive ability for each code which is related to both sample size and sample variability. The variability limit was defined as the 95th percentile confidence interval around the central tendency to reproduce results; and 2) magnitude of the 95th percentile confidence interval. It was determined that an absolute value would not be appropriate since the range of possible values is high, but rather propose that the magnitude of variability be 5% above or below the central tendency.

Using these parameters, STS analyzed 74 cohorts of patients characterized as having their procedure unequivocally and uniquely associated with a single CPT code or single CPT code/ZZZ global combinations. The cohort sample sizes ranged from 7 patients to 233,420. Since data are not normally distributed, 95th percentile confidence intervals for the intraservice time were determined from log transformed data and their values restored by calculating the antilog. The results were displayed graphically. It was evident that increasing sample size leads to higher confidence, but that single parameter is not sufficient.

For codes where values are being revised as part of a 5-year or rolling 5-year review (and now annually), the STS will utilize the STS National Database when accurate and sufficient data are available for specific use. The STS proposed a 95th percentile confidence interval with a +-5% variability as criteria to include STS data.

III. Discussion of Mandated Activities in the Post-Service Period

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

The Subcommittee made it clear that this language will *only* be added to this survey and does not constitute a general RUC policy regarding registry/report completion language. The Research Subcommittee agreed to look at this issue more globally. The Research Subcommittee heard several comments about further mandated government regulations affecting physician practices that are not paid for by any payer. In order to get a better understanding of the problem affecting physician work the Research Subcommittee solicited the specialty societies for the following questions:

- 1) What types of activities are your physicians mandated by rules or regulations to complete that are not included in the work value of a service but required for the payment of that service. These non-compensated activities may include a registry or other completion of forms for 1.)a service 2.)use of a device, or 3.)drug administration protocol?
- 2) Who is the mandating body requiring this work?
 - CMS _____
 - State Agency (Please Specify) _____
 - Other Federal Agency (Please Specify) _____
- 3) Is the mandate time limited? Yes ____ No ____
- 4) Is this work part of PQRI? Yes ____ No ____

The results of this solicitation were reviewed by the Research Subcommittee and discussed if general concepts apply. The following concerns were raised: 1) How do you avoid double payments? There is often outside funding for data collection; 2) What is significance of mandate; 3) What criteria should be developed in considering additional physician time for this activity; and 4) Are these activities covered under care coordination code?

The general consensus among the Research Subcommittee members was that there may be physician work and/or practice expense related to mandated activities (e.g. data registries/data collection) not currently accounted within the RBRVS. **The Research Subcommittee recommends that an ad hoc workgroup be created to review this issue and create criteria and standards for the RUC to consider at the October 2012 RUC Meeting.**

IV. ACS Request for CPT/RUC Review of the BETOS Classifications

In a letter dated October 21, 2011, the American College of Surgeons (ACS) requested that the RUC collaborate with the CMS to: 1) Review the Berenson-Eggers Type of Service (BETOS) procedures categories and associated codes to make necessary changes. The classification of “major” versus “minor” procedures should be reviewed and defined; and 2) Establish an ongoing process by which new or revised codes will be assigned to the correct BETOS category and class as the codes are reviewed by the RUC. Many of these classifications were established based on medical care as it was provided in 1980 and have not been updated in over 20 years.

The Research Subcommittee agreed with the ACS request and will submit a letter to CMS to offer the RUC’s expertise to review, revise and maintain BETOS as deemed necessary by the agency.

V. Use of Panel Surveys in the RUC Process

The RUC expressed concern after discovering that a specialty society used only leadership (Board members) in conducting their survey. The RUC requested that the Research Subcommittee review and define a “panel sample” to ensure appropriate utilization.

The Research Subcommittee reviewed and recommends modifying the following definition of a panel included in the *Instructions for Specialty Societies Developing Work Value Recommendations*:

~~As part of completing the electronic Summary of Recommendations form, you must indicate the type of survey sample conducted (i.e., random, panel, or convenience). A random sample would involve sending the survey out to a random selection of physicians in your specialty (e.g., from your membership database). A panel sample is a group of physicians that typically perform the service (e.g., attendees from a previous course on the service) or a group of your members who repeatedly complete the RUC surveys. A convenience sample would involve surveying a group of your members together in one setting (i.e., at a specialty society meeting). If the number of respondents to your survey is less than 30, you should also include an explanation for the low number of respondents (i.e., the procedure involves new technology and few physicians are performing the service at this time.~~

The RUC expects the specialty society to use a random survey to develop relative value recommendations and should disclose the process used in the rationale section of Summary of Recommendation (SOR) form. If a specialty intends to use any other survey sample method, they must request review and approval by the Research Subcommittee prior to surveying the code(s).

VI. Review of Revised Survey Instrument for Bundled Thrombolysis

The SVS, SIR and ACR submitted a request to revise the 000-day global survey instrument for new bundled thrombolysis codes 372X1-372X4. Thrombolytic therapy is a multi-day procedure, but is a 000 day global.

The specialties expressed the following concerns with the 000 day survey instrument: 1) the two new codes (X3 and X4) describe continued thrombolysis treatment and/or discontinuation of thrombolysis treatment on days subsequent to the initial treatment; 2) The 000-day survey instrument describes and inquires about work on the day preceding a procedure, work that would not be included in the two subsequent day codes (372X3 and 372X4). As such, use of the 000 day global survey instrument will lead to confusion among our survey respondents and could yield inconsistent responses; and 3) The 000 day survey instrument asks about skin-to-skin work, a term which is not applicable to the intra-service work for the two additional new codes, since much of the work of these codes involves patient management.

Below are the scenarios of how these codes could be billed. Each new code represents a day. There is a 24 hour period when services can be billed:

SCENARIO 1

DAY 1	
372X1 Transcatheter therapy, arterial infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, initial treatment day	Infrequent scenario where thrombolysis is started and stopped with catheter removal on the same day.
or	
372X2 Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day	

SCENARIO 2

DAY 1	Day 2 (final day of treatment)
372X1 Transcatheter therapy, arterial infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, initial treatment day	372X4 Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed, and cessation of thrombolysis including removal of catheter and vessel closure by any method
or	
372X2 Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day	

SCENARIO 3

DAY 1	Day 2, Day 3, ... Day X (continued days of treatment)	Last Day (final day of treatment)
372X1 Transcatheter therapy, arterial infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, initial treatment day	372X3 Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed	372X4 Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed, and cessation of thrombolysis including removal of catheter and vessel closure by any method
or		
372X2 Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day		

The specialty society requested and the Research Subcommittee agreed to remove the term “skin-to-skin” in the pre-service and intra-service time period description reference in 372X3 and 372X4 and revise the term “operative” to “procedure” throughout the pre, intra and post-service time period descriptions so survey respondents will understand the continuation of service. The proposed survey, as presented, was approved.



American College of Surgeons

Washington Office: 20 F Street, NW Suite 1000 • Washington, DC 20001 • 202-337-2701 • FAX 202-337-4271
e-mail: postmaster@facs.org ACS website: www.facs.org

Officers

President

L. D. Britt, MD, MPH, FACS
Norfolk, VA

President-Elect

Patricia J. Numann, MD, FACS
Syracuse, NY

First Vice-President

Richard J. Finley, MD, FACS, FRCS
Vancouver, BC

Second Vice-President

Frederick L. Greene, MD, FACS
Charlotte, NC

First Vice-President-Elect

Robert R. Bahnson, MD, FACS
Columbus, OH

Secretary

Courtney M. Townsend, Jr., MD, FACS
Galveston, TX

Treasurer

Andrew L. Warshaw, MD, FACS
Boston, MA

Executive Director

David B. Hoyt, MD, FACS
Chicago, IL

Chief Financial Officer

Gay L. Vincent, CPA
Chicago, IL

Board of Regents

Chair

Carlos A. Pellegrini, MD, FACS
Seattle, WA

Vice-Chair

Thomas V. Whalen, MD, FACS
Allentown, PA

H. Randolph Bailey, MD, FACS
Houston, TX

L. D. Britt, MD, MPH, FACS
Norfolk, VA

Bruce D. Browner, MD, FACS
Farmington, CT

Martin B. Camins, MD, FACS
New York, NY

Margaret M. Dunn, MD, FACS
Dayton, OH

Julie A. Freischlag, MD, FACS
Baltimore, MD

Barrett G. Haik, MD, FACS
Memphis, TN

Rene Lafreniere, MD, FACS, FRCS
Calgary, AB

Charles D. Mabry, MD, FACS
Pine Bluff, AR

Mark A. Malangoni, MD, FACS
Cleveland, OH

Robin S. McLeod, MD, FACS, FRCS
Toronto, ON

Raymond F. Morgan, MD, FACS
Charlottesville, VA

Leigh A. Neumayer, MD, FACS
Salt Lake City, UT

Karl C. Podratz, MD, FACS
Rochester, MN

J. David Richardson, MD, FACS
Louisville, KY

Valerie W. Rusch, MD, FACS
New York, NY

Marshall Z. Schwartz, MD, FACS
Philadelphia, PA

Howard M. Snyder III, MD, FACS
Philadelphia, PA

Mark C. Weissler, MD, FACS
Chapel Hill, NC

Michael J. Zinner, MD, FACS
Boston, MA

Board of Governors

Chair

Timothy C. Flynn, MD, FACS
Gainesville, FL

Vice-Chair

Henri R. Ford, MD, FACS
Los Angeles, CA

Secretary

Lena M. Napolitano, MD, FACS
Ann Arbor, MI

October 21, 2011

Barbara Levy, M.D.

Chair, Relative Value Scale Update Committee

American Medical Association

515 North State Street

Chicago, IL 60654

Re: Concerns Regarding the Berenson-Eggers Type of Service Procedures Category

Dear Dr. Levy:

On behalf of the more than 75,000 members of the American College of Surgeons (ACS), we write to bring to light some issues and inconsistencies regarding the Berenson-Eggers Type of Service (BETOS) procedures category. Given increased national attention to the development of new approaches to Medicare payment for physician services, it is possible that the BETOS coding system could play a larger role in physician reimbursement in the future; however, some aspects of the BETOS procedures category, as discussed below, are outdated. For example, there is currently no process for delineating whether BETOS procedures are classified as major or minor procedures.

Consequently, the ACS requests that the American Medical Association (AMA)/Specialty Society Relative Value Scale Update Committee (RUC) collaborate with the Centers for Medicare & Medicaid Services (CMS) to: (1) review the current BETOS categories and associated codes and make necessary changes; and (2) establish an ongoing process by which new or revised codes will be assigned to the correct BETOS category and class as the codes are reviewed by the RUC. This letter describes some of our concerns with the BETOS procedures category and offers initial suggestions for improvement for the RUC's consideration.

Background

The BETOS coding system is used by CMS and other researchers primarily for the purposes of tracking utilization of Medicare services and analyzing growth in Medicare expenditures. The BETOS coding system collapses the Health Care Financing Administration Common Procedure Coding System (HCPCS) procedure codes into generally agreed upon clinically meaningful groupings of procedures and

Chicago Headquarters: 633 N Saint Clair St • Chicago, IL 60611-3211 • 312-202-5000 • FAX 312-202-5001

FOUNDED BY SURGEONS OF THE UNITED STATES AND CANADA, 1913

The American College of Surgeons Is an Equal Opportunity/Affirmative Action Employer



Dr. Levy
October 21, 2011
Page 2

services. There are seven BETOS categories: 1) Evaluation and Management; 2) Procedures; 3) Imaging; 4) Tests; 5) Durable Medical Equipment; 6) Other; and 7) Exceptions/Unclassified.

The focus of this letter is the “procedures” category. Under the BETOS category of procedures, there are currently 45 BETOS classes organized into seven broad types: 1) anesthesia; 2) major procedures; 3) eye procedures; 4) ambulatory procedures; 5) minor procedures; 6) endoscopy; and 7) dialysis services.

Issue

Numerous inconsistencies exist in the current allocation of HCPCS codes into BETOS classes in the procedures category. Many of these classifications have their origins in medical care as it was provided in the 1980s. As a result, many of these classes are no longer current and have not been updated in over 20 years. These inconsistencies can open the validity of the BETOS coding system to criticism, and can even lead to inaccurate conclusions about the impact of new volume trends and payment policies. Review and revision of the procedures category of the BETOS coding system would greatly improve many of the weaknesses of the BETOS coding system overall and could make the coding system a more reliable and useful research and payment policy tool.

As such, we make two recommendations below on ways to begin to bring the procedures category of the BETOS coding system up to date.

Recommendations

1. **Classification of major vs. minor procedures:** The classification of procedures as either major or minor should be examined and revised. Below are two options for the separation of procedures into major or minor classes for the purposes of BETOS.

Option 1: Global periods – This option would classify codes as either major or minor procedures for the purposes of BETOS based on their global periods. As such, all 90-day global services would be considered BETOS major procedures and all 10- and 0-day global services would be considered minor BETOS procedures. From the start of the fee schedule in 1992, Medicare has defined “major procedures” as procedures with a 90-day global period. However, BETOS currently classifies some codes without 90-day global periods as major procedures, and classifies some 90-day global services in classes other than major procedures. We believe that Option 1 allows for a clear and straightforward delineation between major and minor procedures.



Dr. Levy
October 21, 2011
Page 3

Option 2: RVU cutoff – Alternatively, a Relative Value Unit (RVU) cutoff could be established to separate services into BETOS major or minor procedures. If an RVU cutoff approach is utilized, we recommend that a panel be convened to determine the appropriate cutoff. Under this option, any code (regardless of the global period) that is not low volume (i.e. the code has at least 1,000 claims per year), that is not an office-based procedure, and that meets the defined RVU cutoff, would be considered a BETOS major procedure. All other procedures would be considered minor for the purposes of BETOS. The classification of low volume services (less than 1000 claims per year) would be determined on a case-by-case basis.

Under this approach, most of the procedures that would be considered major would be those with 90-day globals. The RVU cutoff option would also apply to services with 10- and 0-day global periods; however, because more of these codes are performed in an office-based setting they would be less likely to meet the definition of BETOS major procedures. Office-based procedures would be excluded from being considered BETOS major procedures, even if they meet the RVU cutoff.

2. **Removal of mismatched procedures:** Some procedures located in the BETOS procedures category would be more suitable for other categories/classes. Two examples of such mismatched procedures are described below.

Anesthesia – One of the classes in the procedures category is class P0 “Anesthesia.” This classification of anesthesia is somewhat incongruous, relative to the other classes included in the BETOS category of procedures. It would be more appropriate to remove the anesthesia class and create an entirely new BETOS category for anesthesia. Because anesthesia has its own conversion factor, which is distinct from the Medicare Conversion Factor, and is paid using a different formula, it is logical to create a new BETOS category for anesthesia, separate from the BETOS procedures category.

Interventional cardiovascular and interventional radiology procedures – These two types of procedures are scattered throughout several of the major procedures classes. Many of these interventional cardiovascular and interventional radiology codes have high RVUs and 0-day global periods and are performed by non-surgeons, while the other codes in the major procedures classes are performed by surgeons the vast majority of the time. A more coherent grouping would be to create separate BETOS procedures classes for interventional cardiovascular procedures and interventional radiology procedures.



Dr. Levy
October 21, 2011
Page 4

As noted above, we request that the RUC collaborate with CMS to: (1) review the current BETOS categories and associated codes and make necessary changes; and (2) establish an ongoing process by which new or revised codes will be assigned to the correct BETOS category and class at the time of RUC review. The RUC has the required expertise and therefore is the ideal entity to conduct a comprehensive review of the BETOS coding system and to establish a process for codes to be classified appropriately going forward.

We welcome the opportunity to further discuss the benefits and limitations of each of the suggested approaches for revising the BETOS procedures category, and to share additional information and recommendations. Updating the BETOS procedures category will help maintain the validity of the BETOS coding system, will work to avoid inaccurate conclusions about the impact of new payment policies and volume trends, and could result in a more reliable and useful research and payment policy tool for the future.

We appreciate your attention to this important matter. If you have any questions about our recommendations, please contact Bob Jasak, Assistant Director for Regulatory and Quality Affairs, in the ACS Division of Advocacy and Health Policy. He may be reached at bjasak@facs.org or at (202) 672-1508.

Sincerely,

A handwritten signature in black ink that reads "David B. Hoyt". The signature is written in a cursive style with a large, stylized "H" at the end.

David B. Hoyt, MD, FACS
Executive Director

cc: Sherry L. Smith, Director, Physician Payment Policy and Systems, AMA

Members: Doctors Dale Blasier (*Chair*), David Hitzeman (*Vice-Chair*), Michael Bishop, James Blankenship, Emily Hill, PA-C, Walt Larimore, Alan Lazaroff, Scott Manaker, Sandra Reed, Arthur Traugott, James Waldorf, and George Williams

Composition of the RUC

The Administrative Subcommittee discussed the five recommendations and draft Structure and Function changes as determined on its November 7, 2011 conference call in response to the AAFP request to review the RUC composition.

- 1. The Administrative Subcommittee recommends adding one rotating Primary Care seat to the RUC consistent with the AMA definition of Primary Care and the amended Primary Care Candidate Eligibility.**
- 2. The Administrative Subcommittee recommends adding a permanent Geriatric seat to the RUC.** The following exception statement will be added to the RUC Structure and Functions document:

In recognition of their expertise in caring for large, defined patient populations, and the value of such expertise to the RUC, the American Academy of Pediatrics and the American Geriatrics Society are exempt from the criteria for a permanent seat on the RUC.
- 3. The Administrative Subcommittee recommends that the RUC maintain rotating seats (two Internal Medicine subspecialty; one “Other”; and one Primary Care [new]).**
- 4. The Administrative Subcommittee recommends using its current methods for obtaining external data and does not recommend any additional “external representative” seats to the RUC.**
- 5. The Administrative Subcommittee recommends that the RUC publish the total vote count for each CPT code after publication of the Final Rule, with additional parameters that may further describe the total vote as recommended by the Administrative Subcommittee and approved by the full RUC.**

A RUC member questioned the background information on how the Subcommittee came to the voting transparency recommendation. The Workgroup indicate the following benefits to publish the total vote count for each CPT code after publication of the Final Rule:

1. If a vote was unanimous it will provide support to those viewing from the outside that all agreed, as well as give the RUC support to defend its recommendation if CMS does not accept a recommendation.
2. Gives RUC members anonymity to vote his/her conscience because the tally will be on record, not to simply vote “yay” because it seems like the entire body will vote to pass an item.
3. Responding to the external criticism that the RUC is not transparent.

Another RUC member questioned how a Primary Care seat and Geriatric seat would benefit the RUC, what expertise would be gained from adding these seats to the RUC? The Workgroup stated that a Primary Care seat would add expertise in broad-based chronic disease management, comprehensive treatment plan development and management, and preventive care and a Geriatric seat would add expertise in care coordination and chronic disease management for the

frail/elderly. The Workgroup noted that broad expertise will be beneficial in review of many codes and the recommended additional seats will address current criticism of the RUC by MedPAC, CMS and Congress.

The Subcommittee reaffirmed the five recommendations and proposed changes to the Structure and Functions as indicated in the November 7, 2011 Administrative Subcommittee conference call report to be discussed by the full RUC.

**AMA/Specialty Society RVS Update Committee
Administrative Subcommittee Conference Call Report
November 7, 2011**

Members Present: Doctors Dale Blasier (*Chair*), David Hitzeman (*Vice-Chair*), James Blankenship, Emily Hill, PA-C, Walt Larimore, Alan Lazaroff, Scott Manaker (alternate Larry Martinelli), Sandra Reed, and James Waldorf

Barbara Levy, MD – RUC Chair
Edith Hambrick, MD – CMS Representative
Thomas Healy – AMA Assistant General Counsel

In September 2011, the Administrative Subcommittee began discussing the American Academy of Family Physicians (AAFP) requests to change the composition of the RUC. The RUC invited Doctor Roland Goertz, Chairman of the Board for the AAFP, to address the Subcommittee regarding these requests. The Administrative Subcommittee convened an informative hour and a half discussion with Doctor Goertz. The full Administrative Subcommittee discussion from the September 22, 2011, meeting is attached to this report. The Subcommittee continued review of the five AAFP requests via conference call November 7, 2011.

The Subcommittee discussed the 5 requests from AAFP:

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

In September 2011, AAP, ACP and AOA indicated that they support the addition of one primary care seat and requested that the Subcommittee re-review the 2007 discussion of adding a primary care seat to the RUC. The Subcommittee, therefore, notes that the other primary care organizations do not support a second seat for each specialty society as this does not add to specific expertise within the Committee. The Subcommittee agreed that a re-review of the earlier proposal to add a rotating seat for primary care is warranted.

The Subcommittee re-reviewed the RUC actions from 2007. In April 2007, the RUC determined the primary care seat should be a rotating seat, defined the term and election rules, eligibility of candidates, solicitation of nominations and the actual definition of primary care. The Administrative Subcommittee drafted bylaw changes (RUC’s “Structure and Functions” document) for September 2007. Although the RUC did agree on the definitions and eligibility criteria, the addition of the actual seat was not approved as it did not meet the 2/3 vote for approval required by the RUC.

In the September 2011 meeting, the Subcommittee agreed to re-review the 2007 primary care definition and candidate eligibility requirements.

On November 7, 2011, the Subcommittee reviewed the 2007 Primary Care definition, candidate eligibility, term, solicitation of nominations and election rules. The Subcommittee agreed that the 2007 definition and rules are appropriate. The Subcommittee agreed that there is compelling evidence that the expertise required by the RUC has changed since 2007. CMS is now focusing on possible different payment models for preventive care, chronic disease management and care coordination. The Administrative Subcommittee indicated that one rotating Primary Care seat is appropriate to add necessary expertise on the RUC for review of preventive and care coordination

services in the future. The Subcommittee indicated that the addition of more than one seat would not provide additional expertise.

The Subcommittee determined that verification that the physician spends at least 50% of his/her professional time in direct patient care is to be presented by the candidate via the nomination process and verbal presentation.

Following the call, one Subcommittee member expressed concern regarding whether the candidate would truly be a primary care physician in active practice without some specific verification. Additional discussion regarding this item was conducted via e-mail and the Subcommittee determined that the candidates could present documentation that they are defined as a primary care physician by Medicare (ie, primary care bonus eligibility). The Subcommittee agreed that this verification should be added to the candidate eligibility requirement.

To qualify for the (Medicare primary care) bonus (payment program), a physician must be:

(1) self-designated in a primary care specialty (general internal medicine, family practice, pediatrics, and geriatrics) and (2) a substantial portion (60 percent) of their Medicare billings (allowable charges) must be for the designated primary care services (mainly, office-and other outpatient visits) on which a bonus payment is made.

CMS will assess eligibility for the bonus by:

(1) checking a physician's specialty self-designation to ensure that they are in general internal medicine or in another primary care specialty and (2) looking back on the percentage of designated primary care services furnished by the physician during an earlier time period.

Source: Medicare Primary Care Bonus Payment Program. Bonus Payment Program Overview. http://www.acponline.org/running_practice/practice_management/payment_coding/bonus.htm

Primary Care Definition

AMA Definition of Primary Care:

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

Primary Care Candidate Eligibility

The Administrative Subcommittee recommended the candidate eligibility criteria in the Rotating Seat Policies and Election Rules be amended to read as follows:

The Primary Care rotating seat candidate must be in active clinical practice, with at least 50% of their professional time in direct patient care. The Primary Care rotating seat candidate must present documentation that he/she is defined as a primary care physician by Medicare (i.e., primary care bonus eligibility). The Primary Care rotating seat candidate must be a physician

with significant experience and expertise in broad-based chronic disease management, comprehensive treatment plan development and management, and preventive care.
(Addition shown as underline).

The Administrative Subcommittee recommends adding one rotating Primary Care seat to the RUC consistent with the AMA definition of Primary Care and the amended Primary Care Candidate Eligibility.

AMA staff drafted changes to the Structure and Functions and Rotating Seat Election Policies and Rules document specifying these changes. The RUC should review and discuss the proposed Primary Care definition, candidate eligibility, term, solicitation of nominations and election rules changes.

2. Add a seat for Geriatrics;

In September 2011, AGS, AAP, ACP, AOA and many additional commenting specialty societies expressed support for a Geriatrics seat and suggestions were made to consider the expertise that the RUC may require to value care coordination and chronic disease management services.

The Subcommittee discussed adding a Geriatric seat to the RUC, either permanent or rotating. The Subcommittee was concerned that if the RUC changed its current five criteria in order to add a permanent Geriatrics seat then the RUC would receive multiple requests for additional seats to the RUC. However, AMA staff indicated that any change may be made to the Structure and Functions (including changes to the RUC composition or changes to criteria for a RUC seat) with a 2/3 vote of the RUC and approval by the AMA.

The Subcommittee seemed receptive of adding a seat for an individual with experience in caring for the frail elderly and/or patients with chronic disease and indicated it would continue this discussion via conference call before the next meeting.

On November 7, 2011, the Administrative Subcommittee continued discussion of a Geriatric Care seat on the RUC. The Subcommittee determined that the aging population is expanding and specific expertise of those caring for the frail/elderly population is needed on the RUC. The Subcommittee noted that just as Pediatrics is included as a permanent seat on the RUC because of the specific population they serve, an exception for a permanent seat for Geriatrics would provide the appropriate expertise needed to address the arising issues in care coordination and chronic disease management for the frail/elderly.

The Administrative Subcommittee recommends adding a permanent Geriatric seat to the RUC. The Subcommittee determined that AMA staff should draft an exception statement to the five current RUC criteria for a permanent seat on the RUC to add to the Structure and Functions document.

Draft Exception Statement:

In recognition of their expertise in caring for large, defined patient populations, and the value of such expertise to the RUC, the American Academy of Pediatrics and the American Geriatrics Society are exempt from the criteria for a permanent seat on the RUC.

3. Eliminate the three current “rotating subspecialty seats” as the current representatives “term out;”

In September 2011, the Subcommittee was not receptive to eliminate the three current rotating seats. It was noted that the current rotating seats allow for additional expertise from subspecialties. The perspective from these specialty societies has been important to the RUC. In November 2011, the Subcommittee confirmed its previous discussion. **The Administrative Subcommittee recommends that the RUC maintain rotating seats (two Internal Medicine subspecialty; one “Other”; and one Primary Care [new]).**

4. Add three new seats for “external representatives,” such as consumers, employers, health systems, health plans; and

In September 2011, the Subcommittee discussed the addition of external representatives and was generally opposed to adding any additional seats. The Subcommittee determined that the RUC already has access to external information and data that is available through specialty society extant databases and other external sources such as Medical Group Management Association (MGMA). Therefore, the Subcommittee indicated that no expertise would be gained by adding external representatives and did not seem receptive to adding external representatives. In November 2011, the Subcommittee confirmed its previous discussion.

The Administrative Subcommittee recommends using its current methods for obtaining external data and does not recommend any additional “external representative” seats to the RUC.

5. Implement voting transparency.

In September 2011, the Subcommittee discussed the voting transparency as indicated by AAFP’s request. AAFP indicated that the purpose of more transparency was to defeat the perception that specialties vote in blocks (proceduralists vote in favor of procedural codes). Therefore, the only form of transparency that would seem acceptable to AAFP would be to publish individual votes.

The Subcommittee noted that disclosing individual votes could have the opposite effect intended by AAFP. Specialties would then have more pressure to simply vote in favor of their specialty instead of currently, where a RUC member analyzes the data presented and makes an informed decision in favor or against one’s own specialty societies recommendations. The Subcommittee indicated that individual votes should not be reported per member. This would lead to additional pressure on RUC members by outside manufacturers and lobbyists and well as pressure from their own specialty societies.

The Administrative Subcommittee noted further:

- The charge of the RUC is for multi-specialty physicians to use their expert judgment irrespective of the specialty they practice to develop recommendations exercising their First Amendment Right to petition the government.
- Publication of RUC recommendations is prohibited until after CMS publication.
- There is a lack of outside understanding of high standard of 2/3 require to pass a recommendation.
- No requests for outside observation of RUC meetings have ever been turned down.

One Subcommittee member suggested that the RUC total vote count (28-0 to 19-9) be published for each CPT code following the publication of the Final Rule. In November 2011, the Subcommittee continued discussing this method of voting transparency. The Subcommittee agreed that publishing the total vote count per code would provide transparency without jeopardizing the independent judgment of each RUC member.

The Administrative Subcommittee recommends that the RUC publish the total vote count for each CPT code after publication of the Final Rule.

Members: Doctors Walt Larimore (*Chair*), Robert Zwolak (*Vice-Chair*), Michael Bishop, James Blankenship, Dale Blasier, William Donovan, John Gage, Stephen Levine, PT, Brenda Lewis, William Mangold, Larry Martinelli, Marc Raphaelson, George Williams

I. CMS Requests – *Final Rule* for 2012 MFS

Abdomen and Pelvis CT – 72192, 72193, 72194, 74150, 74160 & 74170

**74170 was also identified under the CMS/Other screen.*

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

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

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

CMS indicated in the November 28, 2011 Final Rule that the agency continues to believe that the direct PE inputs of the component codes should be reviewed and maintains their initial request that the RUC review the component codes for work and PE.

The Workgroup agreed with the specialty society that the current PE RVUs are appropriate for the Abdomen and Pelvis CT codes and once the previous stand alone codes are fully transitioned for practice expense in 2013, the current PE RVU anomalies will cease to exist. Additionally, a staff type error in the new bundled codes were corrected to indicate CT Technologists (L046A) which added to the anomaly.

In Situ Hybridization – 88365, 88367 & 88368

CMS received comments that unlike the new FISH codes for urinary tract specimens (88120 and 88121), the existing codes (88365-88368) still allow for multiple units of each code as these codes are reported per probe. CMS stated that they have reviewed the current work and practice costs associated with 88120 and 88121 and agree at this time that they are accurate. CMS requested that the RUC review both the direct PE inputs and the work values for codes 88365, 88367 and 88368. In September 2011, the Workgroup determined that these services be tabled until January 2012 in order to review 2011 diagnosis data from CMS.

The Workgroup reviewed 2011 diagnosis claims data and the American College of Pathologists indicated that they will develop a CPT Assistant article to direct physicians to use the new FISH codes for urinary tract infections (CPT codes 88120 and 88120). The Workgroup indicated that the specialty should specify the number of probes utilized for these services in the CPT Assistant article. The Workgroup recommended that it re-review codes 88365, 88367 and 88368 in 1 year after 2012 utilization is available (January 2013).

CMS Request to Re-Review Families of New/Revised CPT Codes

In the November 28, 2011 *Final Rule* for 2012 CMS requested that the RUC re-review specific codes in a family of services that were recently reviewed.

The Workgroup noted that in the recent review of these services, CMS had the opportunity to add CPT codes to each of these family of services prior to the survey and RUC review processes. AMA staff indicated that going forward, AMA staff will ask CMS to acknowledge the code families during the LOI process. **The Workgroup reviewed the CMS identified family of services and recommends:**

Trim Skin Lesions	Recommendation
11055 11056* 11057	Maintain the current work RVUs. There are no apparent rank order anomalies. CMS had the opportunity to request review of other codes during the CPT LOI process.
Thoracoscopy	
32663*, 32480, 32669*, 32670*, 32482, 32671*, 32440, 32672*, 32491, 32673*, 60520, 60521, and 60522	Request further information from CMS on why these services should be reviewed as part of a family. CMS stated in the Final Rule that it will accept the RUC recommendation for some of these thoracoscopy services pending review of the open heart surgery analogs and that the RUC look at the incremental difference in RVUs and times between the open and laparoscopic surgeries. The specialty society noted that these are not open heart surgery codes and therefore are not relevant.
CT Angiography	
74174*, 74175 and 72191	Refer to the PE Subcommittee to review in April 2012 and determine if any practice expense anomalies exist between these codes. The Workgroup determined that review of physician work is not necessary at this time.
Evoked Potentials and Reflex Studies	
95938*, 95939*, 95925, 95926, 95928, and 95929	Refer to the PE Subcommittee to review in April 2012 and determine if any practice expense anomalies exist between these codes. The Workgroup determined that review of physician work is not necessary at this time.

* RUC recommendation submitted for 2012.

II. Review Action Plans – Table 7: CMS High Expenditure Procedural Codes Screen

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

CMS did not revise the original list of 70 services in the November 1, 2011 Final Rule, requesting all codes be surveyed for physician work and practice expense (if it has not been reviewed for physician work and practice expense in the last 6 years). **The Relativity Assessment Workgroup reviewed action plans for all 70 High Expenditure Procedural Codes identified and prioritized review to complete by the April 2013 RUC meeting. The Workgroup recommendations are in the attached spreadsheet.**

III. CMS/Other Screen – Review Action Plans

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

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

In September 2011, following review of the 19 action plans for these CMS/Other source codes, the Workgroup determined that 1 code would be surveyed for January 2012, 1 G-code is a CMS crosswalk and should be removed from this screen, 6 codes were also identified on by CMS through Table 7: High Expenditure Procedural Codes screen and the Workgroup will review action plans to address these services under that screen in January 2012, and the Workgroup reviewed the action plans for 11 radiology services and the specialty indicated they would present a plan to the Research Subcommittee on how to address these services via crosswalk, resurvey or another alternate approach in January 2012. However, the specialty societies decided not to submit a proposal to the Research Subcommittee and instead submitted action plans for the remaining 11 CMS/Other codes. **The Relativity Assessment Workgroup reviewed the remaining CMS/Other action plans and recommends the following:**

CPT Code	Recommendation
73500	Refer to CPT
73550	Refer to CPT
74170**	Survey for April 2012 RUC meeting.
76645	Refer to Research Subcommittee October 2012 meeting to discuss possible crosswalk methodology after Table 7 ultrasound codes are reviewed.
76705	Refer to Research Subcommittee October 2012 meeting to discuss possible crosswalk methodology after Table 7 ultrasound codes are reviewed.
76770	Refer to Research Subcommittee October 2012 meeting to discuss possible crosswalk methodology after Table 7 ultrasound codes are reviewed.
76775	Refer to Research Subcommittee October 2012 meeting to discuss possible crosswalk methodology after Table 7 ultrasound codes are reviewed.
76856	Refer to Research Subcommittee October 2012 meeting to discuss possible crosswalk methodology after Table 7 ultrasound codes are reviewed.
76942	Action Plan due January 2013 for review by the Workgroup. Review ICD-9 diagnosis data associated with this service.
93925	Survey for April 2012.
93970	Survey for April 2012.
70450*	Reviewed action plan under Table 7 screen – Survey for April 2013
70553*	Reviewed action plan under Table 7 screen – Survey for April 2013
72148*	Reviewed action plan under Table 7 screen – Survey for April 2013
77014*	Reviewed action plan under Table 7 screen – Refer to CPT
88342*	Reviewed action plan under Table 7 screen – Refer to CPT
93880*	Reviewed action plan under Table 7 screen – Survey for Oct 2012
97150	Complete
G0127	Complete

*CMS also identified these six codes in the Final Rule for 2012, Table 7 High Expenditure Procedure Codes.

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

IV. Joint CPT/RUC Workgroup on Codes Reported Together Frequently – Update

Doctor Kenneth Brin, Chair of the Joint CPT/RUC Workgroup on Codes Reported Together Frequently, provided an update of the Workgroup's progress. Doctor Brin explained that there are only two code groups not complete from the prior cycle on codes billed together 75% or more. These code groups will be addressed in CPT 2013. For the current review cycle, the Workgroup performed the data analysis on codes reported together (75% or more) on 2009 Medicare claims data and limited the number of code groups for Workgroup review to 30. Workgroup members were assigned to review these groups and, over multiple conference calls, it was determined that 17 groups will move forward to the specialty LOI for submission of Action Plans. The Joint Workgroup will then review these Action Plans and make their final recommendations. The necessary materials will be provided to the specialty societies by March 1, 2012 with requests for response by March 31, 2012. Materials related to the Joint Workgroup's efforts were included in the RAW agenda materials.

V. Other Issues

The following informational items were provided: a list of CPT Editorial Panel Referrals, CPT Assistant Referrals, the progress of Relativity Assessment Workgroup of Potentially Misvalued Services and a full status report of the Relativity Assessment Workgroup (CD only).

TABLE 7: SELECT LIST OF PROCEDURAL CODES REFERRED FOR AMA RUC REVIEW

CPT Code	Long Descriptor	RUC Surveyed	RAW Screen	Notes	SS Submitting Action Plan	RAW Recommendation	Code Family	Date of Review Rec
47562	Laparoscopy, surgical; cholecystectomy	Sep 2005		CMS identified this service as part of the 3rd Five-Year Review and accepted the RUC recommendation.	ACS, SAGES	No action/RUC recommendation reaffirmed. This service has been surveyed and RUC reviewed 3 times. Codes 47563 and 47564 were recently reviewed in Oct 2010 and 47562 was used as a stable reference service. The RAW determined that this service has not changed and resurveying would not produce a different result.		complete
47563	Laparoscopy, surgical; cholecystectomy with cholangiography	Oct 2010	4th Five-Year Review	CMS identified this service as part of the 4th Five-Year Review. The RUC recommendation is currently under review by CMS.	ACS, SAGES	RUC work RVU and PE recommendation reaffirmed.		complete
49505	Repair initial inguinal hernia, age 5 years or older; reducible	Sep 2005		CMS identified this service as part of the 3rd Five-Year Review and accepted the RUC recommendation.	ACS, SAGES	No action/RUC recommendation reaffirmed. This service has been surveyed and RUC reviewed 4 times. The RAW determined that this service has not changed and resurveying would not produce a different result.		complete
66982	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine	Feb 2000	High IWPUT / CMS Fastest Growing, Site of Service Anomaly (99238-Only)	Review September 2011. CPT Assistant article published; Apr 2008, reduced to 2x99213 & 3x99212	AAO	Surveyed January 2012 - issue complete.		complete
67028	Intravitreal injection of a pharmacologic agent (separate procedure)	Oct 2009	High Volume Growth / CMS Fastest Growing, Harvard Valued - Utilization over 100,000	Reviewed in Oct 2009 for CPT 2010. RUC recommended lower RVU than specialty, AAO appealed, RUC continued with recommendation to CMS. AAO requested refinement, CMS refinement panel recommended RUC rec, CMS rejected refinement panel recommendation.	AAO	No action/Feb 2009 RUC recommendation reaffirmed. This code was surveyed for work and PE for 2010. CMS rejected RUC recommendation.		complete
73221	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s)	Apr 2001	CMS Fastest Growing	This code was scheduled for re-review Sept 2013, however will need to be addressed before then.	ACR	Surveyed January 2012 - issue complete.		complete
88312	Special stains; Group I for microorganisms (eg, Gridley, acid fast, methenamine silver), including interpretation and report, each	Feb 2011	Top 9 Harvard		CAP	No action/Feb 2011 RUC recommendation reaffirmed. This code was recently surveyed for work and PE for 2012 and accepted by CMS.		complete

TABLE 7: SELECT LIST OF PROCEDURAL CODES REFERRED FOR AMA RUC REVIEW

CPT Code	Long Descriptor	RUC Surveyed	RAW Screen	Notes	SS Submitting Action Plan	RAW Recommendation	Code Family	Date of Review Rec
92235	Fluorescein angiography (includes multiframe imaging) with interpretation and report	Sep 2005	Harvard Valued - Utilization over 30,000	CMS identified this service as part of the 3rd Five-Year Review and accepted the RUC recommendation. The RUC will be reviewing this service at the September 2011 meeting.	AAO	Surveyed January 2012 - issue complete.		complete
94240	Functional residual capacity or residual volume: helium method, nitrogen open circuit method, or other method	Aug 1995	Codes Reported Together 75% or More	Deleted from CPT 2012		Deleted from CPT 2012, no action required.		complete
94720	Carbon monoxide diffusing capacity (eg, single breath, steady state)	Aug 1995	Codes Reported Together 75% or More	Deleted from CPT 2012		Deleted from CPT 2012, no action required.		complete
43235	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	Sep 2005	MPC List	CMS identified this service as part of the 3rd Five-Year Review and accepted the RUC recommendation. In 2010, CMS indicated that one of the rationale for review of MPC services was that the code was not reviewed by the RUC in the last 6 years. This code was reviewed by the RUC in the last 6 years, therefore RUC reaffirmed its previous recommendation.	AGA, ASGE, SAGES	Refer to CPT, specialty intends on revising entire GI endoscopy family.		Refer to CPT
45378	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)	Sep 2005		CMS identified this service as part of the 3rd Five-Year Review and accepted the RUC recommendation.	AGA, ASGE, ASCRS, SAGES	Refer to CPT, specialty intends on revising entire GI endoscopy family.		Refer to CPT
69210	Removal impacted cerumen (separate procedure), 1 or both ears	Sep 2005		CMS identified this service as part of the 3rd Five-Year Review and accepted the RUC recommendation.	AAO-HNS	Survey work and PE for April 2013 RUC meeting.		Refer to CPT
77014	Computed tomography guidance for placement of radiation therapy fields	Aug 1995	CMS Request - Practice Expense Review / CMS-Other - Utilization over 500,000	Review September 2011 Action Plan	ACR, ASTRO	Refer to CPT		Refer to CPT
77421	Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy	Apr 2005	Codes Reported Together 75% or More	New PE Inputs	ACR, ASTRO	Refer to CPT		Refer to CPT
88112	Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal	Apr 2003			CAP	Refer to CPT.		Refer to CPT
88342	Immunohistochemistry (including tissue immunoperoxidase), each antibody	Apr 2003	CMS-Other - Utilization over 500,000	Review September 2011 Action Plan	CAP	Refer to CPT.		Refer to CPT

TABLE 7: SELECT LIST OF PROCEDURAL CODES REFERRED FOR AMA RUC REVIEW

CPT Code	Long Descriptor	RUC Surveyed	RAW Screen	Notes	SS Submitting Action Plan	RAW Recommendation	Code Family	Date of Review Rec
90801	Psychiatric diagnostic interview examination	Oct 2010	4th Five-Year Review	Referred to CPT	APA, APA(HCPAC), AACAP, NASW	Referred to CPT reviewing Feb 2012.		Refer to CPT
90805	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services	Oct 2010	4th Five-Year Review	Referred to CPT	APA, APA(HCPAC), AACAP	Referred to CPT reviewing Feb 2012.		Refer to CPT
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;	Oct 2010	4th Five-Year Review	Referred to CPT	APA, APA(HCPAC), NASW	Referred to CPT reviewing Feb 2012.		Refer to CPT
90808	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient;	Oct 2010	4th Five-Year Review	Referred to CPT	APA, APA(HCPAC), NASW	Referred to CPT reviewing Feb 2012.		Refer to CPT
90818	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient;	Oct 2010	4th Five-Year Review	Referred to CPT	APA, APA(HCPAC), NASW	Referred to CPT reviewing Feb 2012.		Refer to CPT
90862	Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy	Oct 2010	4th Five-Year Review	Referred to CPT	APA, AACAP	Referred to CPT reviewing Feb 2012.		Refer to CPT
95861	Needle electromyography; 2 extremities with or without related paraspinal areas	Sep 2005	Codes Reported Together 75% or More	CMS identified this service as part of the 3rd Five-Year Review and accepted the RUC recommendation. In April 2011, the RUC recommended that this service be referred to CPT to develop a more comprehensive coding solution which bundles services commonly performed together.	AAN	Referred to CPT Feb 2012		Refer to CPT
95903	Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study	Apr 1995			AAN	Referred to CPT Feb 2012		Refer to CPT
97001	Physical therapy evaluation	Apr 1997			APTA	Refer to CPT.		Refer to CPT
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities	May 1994			APTA	Refer to CPT.		Refer to CPT

TABLE 7: SELECT LIST OF PROCEDURAL CODES REFERRED FOR AMA RUC REVIEW

CPT Code	Long Descriptor	RUC Surveyed	RAW Screen	Notes	SS Submitting Action Plan	RAW Recommendation	Code Family	Date of Review Rec
97140	Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes	May 1998			APTA	Refer to CPT.		Refer to CPT
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes	May 1994			APTA	Refer to CPT.		Refer to CPT
20610	Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)	Oct 2010	Harvard Valued - Utilization over 100,000 / MPC List	This service was brought forward as part of the family of 20605. MPC List screen, RUC reaffirmed the RUC recommendation as this service was recently reviewed under another screen.	AAOS, ACRh	Review PE only at April 2012 meeting. Survey for work was completed recently (Oct 2010). RUC recommendation reaffirmed.		2012 Apr
33405	Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve	Sep 2005		The specialty societies identified this service in the 3rd Five-Year Review and CMS accepted the RUC recommendation.	STS	Review at April 2012 RUC meeting. STS to submit updated inputs.		2012 Apr
33430	Replacement, mitral valve, with cardiopulmonary bypass	Sep 2005	High IWPOT	The specialty societies identified this service in the 3rd Five-Year Review and CMS accepted the RUC recommendation. In Feb 2008 the RUC removed this service from the screen since it was recently reviewed at the 3rd Five-Year Review.	STS	Review at April 2012 RUC meeting. STS to submit updated inputs.		2012 Apr
33533	Coronary artery bypass, using arterial graft(s); single arterial graft	Sep 2005		The specialty societies identified this service in the 3rd Five-Year Review and CMS accepted the RUC recommendation.	STS	Review at April 2012 RUC meeting. STS to submit updated inputs.		2012 Apr
35475	Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel	Aug 1995			ACC, ACR, SIR, SVS	Survey for work and PE for April 2012.		2012 Apr
35476	Transluminal balloon angioplasty, percutaneous; venous	Aug 1995			ACR, SIR, SVS	Survey for work and PE for April 2012.		2012 Apr
50590	Lithotripsy, extracorporeal shock wave	Sep 2005		CMS identified this service as part of the 3rd Five-Year Review and accepted the RUC recommendation.	AUA	Survey for work and PE for April 2012.		2012 Apr
53850	Transurethral destruction of prostate tissue; by microwave thermotherapy	Feb 1997			AUA	Survey for work and PE for April 2012.		2012 Apr
76830	Ultrasound, transvaginal	Sep 2005		CMS identified this service as part of the 3rd Five-Year Review and accepted the RUC recommendation.	ACR, ACOG	Survey for work and PE for April 2012.		2012 Apr
76872	Ultrasound, transrectal	N/A			ACR, AUA	Survey for work and PE for April 2012.		2012 Apr

TABLE 7: SELECT LIST OF PROCEDURAL CODES REFERRED FOR AMA RUC REVIEW

CPT Code	Long Descriptor	RUC Surveyed	RAW Screen	Notes	SS Submitting Action Plan	RAW Recommendation	Code Family	Date of Review Rec
77301	Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications	Apr 2001	CMS Fastest Growing / CMS Request - Practice Expense Review	This code was scheduled for re-review September 2012, however will need to be addressed before then.	ASTRO	Survey for work and PE for April 2012.		2012 Apr
92083	Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degrees, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)	Sep 2005	MPC List	CMS indicated that one of the rationale for review of MPC services was that the code was not reviewed by the RUC in the last 6 years. This code was reviewed by the RUC in the last 6 years, therefore RUC reaffirmed its previous recommendation.	AAO, AOA(HCPAC)	Survey for work and PE for April 2012.		2012 Apr
93015	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report	Sep 2005	Codes Reported Together 75% or More	CMS identified this service as part of the 3rd Five-Year Review and accepted the RUC recommendation. In April 2010 the RUC recommended that a CPT Assistant article be developed to educate correct coding practices.	ACC	Survey for work and PE for April 2012.	93016, 93017, 93018	2012 Apr
95117	Professional services for allergen immunotherapy not including provision of allergenic extracts; 2 or more injections	N/A, 0.00 work RVUs			AAAAI, ACAAI	Review PE for 95115 and 95117 in April 2012.	95115	2012 Apr
95819	Electroencephalogram (EEG); including recording awake and asleep	Aug 2005		CMS identified this service as part of the 3rd Five-Year Review and accepted the RUC recommendation.	AAN, ACNS	Survey for April 2012 or October 2012.	95822	2012 Apr
22851	Application of intervertebral biomechanical device(s) (eg, synthetic cage(s), methylmethacrylate) to vertebral defect or interspace (List separately in addition to code for primary procedure)	Apr 1995	CMS Fastest Growing	This code was scheduled for re-review Oct 2012.	NASS	Review utilization data at the RAW in Oct 2012 as part of the re-review of this service under the CMS Fastest Growing screen.		2012 Oct RAW
27236	Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement	Sep 2005		CMS identified this service as part of the 3rd Five-Year Review and accepted the RUC recommendation.	AAOS	Survey for work and PE for Oct 2012 RUC meeting.		2012 Oct
62311	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; lumbar, sacral (caudal)	May 1999			AAPMR, ASA, ISIS, NASS	Survey for work and PE for Oct 2012 RUC meeting.	62310, 62318, 62319	2012 Oct

TABLE 7: SELECT LIST OF PROCEDURAL CODES REFERRED FOR AMA RUC REVIEW

CPT Code	Long Descriptor	RUC Surveyed	RAW Screen	Notes	SS Submitting Action Plan	RAW Recommendation	Code Family	Date of Review Rec
63047	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar	Sep 2005		CMS identified this service as part of the 3rd Five-Year Review and accepted the RUC recommendation.	AAOS, NASS, AANS/CNS	Survey work for Jan 2013 RUC meeting. (Facility Only)	63048	2012 Oct
93000	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report	Aug 1995			ACC	Survey for work and PE for Oct 2012 RUC meeting.	93005, 93010	2012 Oct
93880	Duplex scan of extracranial arteries; complete bilateral study	Aug 1995	Codes Reported Together 75% or More / CMS-Other - Utilization over 500,000	Review September 2011 Action Plan	ACC, ACR, SIR, SVS	Survey for work and PE for Oct 2012 RUC meeting.	93882	2012 Oct
98940	Chiropractic manipulative treatment (CMT); spinal, 1-2 regions	Apr 1996			ACA	Survey 98940-98943 for October 2012.	98940-98943	2012 Oct
98941	Chiropractic manipulative treatment (CMT); spinal, 3-4 regions	Apr 1996			ACA	Survey 98940-98943 for October 2012.	98940-98943	2012 Oct
98942	Chiropractic manipulative treatment (CMT); spinal, 5 regions	Apr 1996			ACA	Survey 98940-98943 for October 2012.	98940-98943	2012 Oct
17004	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses), 15 or more lesions	Feb 2006		This service was identified by the RUC as a rank order anomaly as part of the 3rd Five-Year Review. CMS did not accept the RUC recommendation, but established a lower work RVU.	AAD	Survey work and PE for January 2013 RUC meeting.	17000, 17003	2013 Jan
22612	Arthrodesis, posterior or posterolateral technique, single level; lumbar (with or without lateral transverse technique)	Sep 2005	Codes Reported Together 75% or More	This service was identified by CMS in the 3rd Five-Year Review. CMS did not accept the RUC recommendation at that time, but assigned a lower work RVU of 21.79. Additionally, in Feb 2011 - Referred to CPT and a new code was created to describe the physician work when the services are performed together on the same date of service by the same physician. Additionally, a parenthetical was created to indicate that the separate services (22630 and 22612) are not to be reported together. The change to code 22612 was Editorial, no change in work RVU.	AAOS, NASS, AANS/CNS	Review 3/4 2012 utilization data at the RAW in Jan 2013. The specialty societies ability to survey will change as surgeons are able to understand correct coding.		2013 Jan RAW
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft	Sep 2005		CMS identified this service as part of the 3rd Five-Year Review and accepted the RUC recommendation.	AAOS	Survey work and PE for Jan 2013 RUC meeting.		2013 Jan

TABLE 7: SELECT LIST OF PROCEDURAL CODES REFERRED FOR AMA RUC REVIEW

CPT Code	Long Descriptor	RUC Surveyed	RAW Screen	Notes	SS Submitting Action Plan	RAW Recommendation	Code Family	Date of Review Rec
27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)	Sep 2005		CMS identified this service as part of the 3rd Five-Year Review and accepted the RUC recommendation.	AAOS	Survey work and PE for Jan 2013 RUC meeting.		2013 Jan
35301	Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision	Aug 1995			SVS	Survey for work and PE for Jan 2013.		2013 Jan
36870	Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)	Apr 2000	Site of Service Anomaly (99238-Only)	Sep 2007, reduced 99238 to 0.5	ACR, SIR, SVS	Survey for work and PE for Jan 2013.		2013 Jan
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Oct 2004			ACRrh, AGA, ASGE, ASCO	Survey work and PE for January 2013 RUC meeting.	96366	2013 Jan
96367	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion, up to 1 hour (List separately in addition to code for primary procedure)	Oct 2004			ACRrh, AGA, ASGE, ASCO	Survey work and PE for January 2013 RUC meeting.	96368	2013 Jan
96413	Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug	Oct 2004	Codes Reported Together 75% or More	Oct 2010 New PE Inputs	ACRrh, AGA, ASGE, ASCO	Survey work and PE for January 2013 RUC meeting.	96415, 96417	2013 Jan
17311 * See foot note	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; first stage, up to 5 tissue blocks	Apr 2006			AAD	Survey work and PE for April 2013 RUC meeting.	17313, 17314, 17315	2013 Apr

TABLE 7: SELECT LIST OF PROCEDURAL CODES REFERRED FOR AMA RUC REVIEW

CPT Code	Long Descriptor	RUC Surveyed	RAW Screen	Notes	SS Submitting Action Plan	RAW Recommendation	Code Family	Date of Review Rec
17312 * See foot note	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; each additional stage after the first stage, up to 5 tissue blocks (List separately in addition to code for primary procedure)	Apr 2006			AAD	Survey work and PE for April 2013 RUC meeting.	17313, 17314, 17315	2013 Apr
31237	Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)	Jun 1993			AAO-HNS	Survey work and PE for April 2013 RUC meeting.	31238, 31239, 31240	2013 Apr
70450	Computed tomography, head or brain; without contrast material	Aug 1995	CMS-Other - Utilization over 500,000	Review September 2011 Action Plan	ACR, ASNR	Survey work and PE for April 2013 RUC meeting.	70460	2013 Apr
70551	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material	Aug 1995			ACR, ASNR	Survey work and PE for April 2013 RUC meeting.		2013 Apr
70553	Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences	Aug 1995	CMS-Other - Utilization over 500,000	Review September 2011 Action Plan	ACR, ASNR	Survey work and PE for April 2013 RUC meeting.		2013 Apr
72141	Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material	Apr 2001			ACR, ASNR	Survey work and PE for April 2013 RUC meeting.		2013 Apr
72148	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material	Aug 1995	CMS-Other - Utilization over 500,000	Review September 2011 Action Plan	ACR, ASNR	Survey work and PE for April 2013 RUC meeting.		2013 Apr

* Shaving of Epidermal or Dermal Lesions codes 11300-11313 should be validated for physician work at the April 2012 meeting.

Members Present: Ron Burd, MD (Chair), Albert Bothe, MD, Scott Collins, MD, Mary Foto, OTR, David Han, MD, J Leonard Lichtenfeld, MD, Scott Manaker, MD, PhD, Eileen Moynihan, MD, Guy Orangio, MD, Arthur Traugott, MD, J Allan Tucker, MD

I. Review of Multi-specialty MPC Codes- Specialty Feedback

Doctor Burd reviewed the work of the MPC Workgroup. The Workgroup has had several initiatives completed since the September 2012 RUC Meeting. The Chair noted that the MPC Workgroup sent out two sets of code groups for specialty society review in November 2011. The first code group contained codes that the Workgroup obtained through several screening criteria focused on capturing services performed by multiple specialties. These services were heavily weighted towards lower RVU services (below 5.00 work RVUs). The second code group contained codes that are currently on the MPC list above 5.00 work RVUs. Staff collected the specialties' responses and populated the new MPC list, containing 223 services.

The MPC Workgroup reviewed the new MPC list of 223 services and analyzed any gaps in both work RVU ranges and specialty representation. The Workgroup noted that there is a dearth of services between 5.00 and 10.00 work RVUs. (Only 8 codes are currently in that range.) In order to obtain services in this range, Workgroup members first looked at the list of codes that are currently MPC codes above 5.00 work RVUs, but were disapproved by the specialty societies. The Workgroup reviewed 11 codes in the appropriate range and agreed to add one code 33212 because it has high volume and is recently RUC reviewed. The Workgroup also discussed potential screens to obtain a list of codes to potentially add to the new MPC list. A query will be set up to obtain all RUC-reviewed codes since 2005 between 5.00 and 10.00 work RVUs. The Workgroup will work with this list to filter out a subset of codes that will fill in the observed RVU gap.

II. Next Steps

The new multi-specialty MPC list will be complete and submitted to the RUC for approval at the April 2012 RUC Meeting. In order to achieve this goal, the Workgroup will analyze the requested code data over email and a conference call prior to the April 2012 meeting to establish the final list of codes for the new MPC list.



RUC Chair Report



January 26-28, 2012

Tucson, AZ

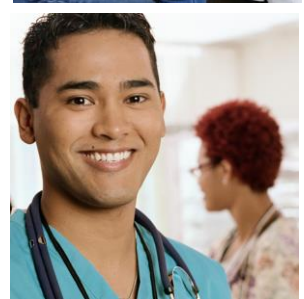
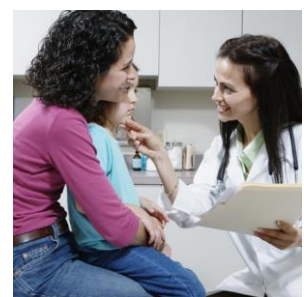


CMS Representatives

- John Cooper, MD – CMS Medical Officer
- Edith Hambrick, MD – CMS Medical Officer
- Christina Ritter, PhD – Director of the Division of Practitioner Services
- Ryan Howe – Senior Policy Analyst
- Sara Vitolo, MSPH – Policy Analyst
- Ferhat Kassamali – L&M Policy Research
- Margaret Johnson – L&M Policy Research

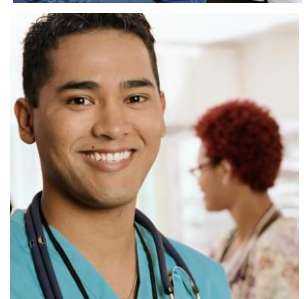
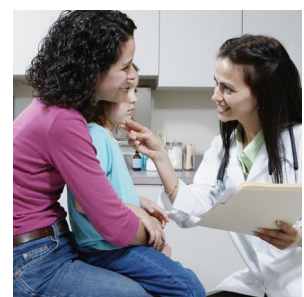
Contractor Medical Director

- Charles Haley, MD,MS, FACP



AMA Board of Trustees

- Robert M. Wah, MD
Chair of the AMA Board of Trustees



Korean Medical Association

- Hyun Kang, MD
- Junheum Yon, MD
- Sunwoo Kim, MD

AMA RUC Staff



- Samantha Ashley, MS
 - Senior Policy Analyst I
 - Practice Expense Subcommittee
- Rosa Karbowskiak, MBA
 - Senior Policy Analyst I
 - Research Subcommittee

Confidentiality

- All RUC attendees/participants are obligated to adhere to the RUC confidentiality policy. (All signed an agreement at the registration desk)

Record Keeping

- Please note that all meetings are recorded for staff to summarize recommendations to CMS.





Procedural Issues

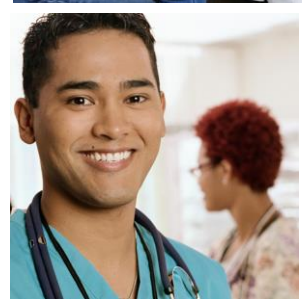
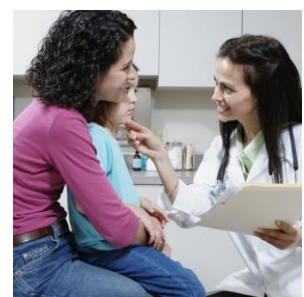


RUC Members:

- 
- Before a presentation, any RUC member with a conflict will state their conflict. That RUC member will not discuss or vote on the issue and it will be reflected in the minutes
 - RUC members or alternates sitting at the table may not present or debate for their society
 - Please share voting remotes if you step away from the table
- 

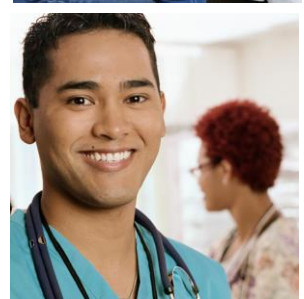
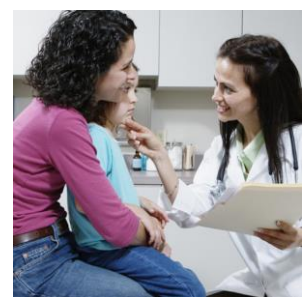
The RUC is an Expert Panel

- Individuals exercise their independent judgment and are not advocates for their specialty



Financial Disclosure Review Workgroup Report

- Doctor Blasier – to provide report (handout packet for tab 29 Administrative Subcommittee)



Chronic Care Coordination Workgroup

- CMS Discussions and C3W follow up – we want to remain engaged in persuading CMS to recognize and pay for care coordination services
- CPT Editorial Panel has created a workgroup to begin review coding needs
- Care transition coding to be addressed by the new CPT Workgroup





American Medical Association

515 N. State Street
Chicago, Illinois 60654

ama-assn.org
312.464.5000

March 8, 2012

Marilyn Tavenner
Acting Administrator
Chief Operating Officer
Center for Medicare
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Subject: RUC Recommendations

Dear Ms. Tavenner:

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

January 2012 RUC Recommendations

The enclosed recommendations result from the RUC's review of physicians' services from the January 26-28, 2012 meeting and address a number of screens, many specifically mentioned in the Affordable Care Act legislation including:

- New Technology/New Services
- High Intrасervice Work Per Unit of Time (IWPUT)
- CMS Fastest Growing
- Multi-Specialty Points of Comparison (MPC) List
- CMS High Expenditure Procedural Codes
- High Volume Growth Screen.
- Harvard Valued, Utilization greater than 30,000 Screen
- CMS Requests – Final Rule for 2012 MFS

Update on Progress of the Relativity Assessment Workgroup

The RUC has reviewed nearly 1,000 physician services identified under one or more objective screens as potentially mis-valued. The implementation of these RUC recommendations to improve the relativity within the RBRVS began in 2009, with significant impact in 2011. The cumulative impact of the three years of effort is \$1.5 billion in redistribution. The practice and professional liability redistribution occurs within the relative values, while the work value redistribution was implemented with minor increases to the Medicare conversion factor in 2009-2012.

The significance of the RUC's work should not be underestimated. This work would not be possible without the contributions of the volunteer physicians on the RUC and the medical specialty societies.

Many specialty societies have shepherded coding changes, surveys, and relative value recommendations that ultimately result in payment reductions for their members. The individuals in this process have done so as organized medicine understands that ensuring the relativity within the RBRVS is important. This volunteer effort should be recognized by CMS and other policymakers, not only in descriptions within rulemaking, but also in methods of implementation and expectations regarding ongoing review. This effort should also be considered when CMS supersedes the RUC process by implementing questionable broad based policies across the entire Medicare Physician Payment Schedule such as the recent application of the multiple procedure payment reduction to the professional component of imaging services.

In addition to the specific recommendations included in this submission, the RUC offers CMS the following additional information:

- *CMS High Expenditure Procedural Codes* - In rulemaking for the 2012 Medicare Physician Payment Schedule, CMS requested an additional screen to identify mis-valued services, a list of 70 high expenditure procedural codes representing services furnished by an array of specialties. CMS selected these codes based on the fact that they have not been reviewed for at least 6 years, and in many cases the last review occurred more than 10 years ago. In January 2012, the Relativity Assessment Workgroup reviewed action plans for all 70 High Expenditure Procedural Codes identified and prioritized review to complete by the April 2013 RUC meeting. **Several specific code recommendations identified through this screen are included in this submission and a timeline for review of the remaining services is attached.**
- *CMS Requests – Proposed and Final Rule for 2012 MFS* - In rulemaking for 2012, CMS requested that the RUC review specific codes in 2012 for consideration in rulemaking for the 2013 Medicare Physician Payment Schedule.

Abdomen and Pelvis CT – 72192, 72193, 72194, 74150, 74160 & 74170

CMS received comments that the resulting practice expense RVUs for the new bundled codes (74176, 74177 and 78178) create a rank order anomaly in comparison to the previous stand alone codes (72192, 72193, 72194, 74150, 74160 and 74170) and requested RUC review of practice expense inputs. Also, CMS requested that the RUC review the work for these codes (72192, 72193, 72194, 74150, 74160 and 74170), which were last reviewed for CPT 2007. The RUC indicated that it would review the CMS request at the September, 2011 RUC meeting however, it is apparent that any rank order anomaly is caused by CMS data entry errors (eg, Radiology Technician instead of a CT Technician for 74176, 74177 & 74178 and inconsistent room time for the new bundled codes).

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

CMS indicated in the November 28, 2011 Final Rule that the agency continues to believe that the direct practice expense inputs of the component codes should be reviewed and maintains their initial request that the RUC review the component codes for work and Practice Expense.

The RUC reviewed these services in January 2012 and agreed with the specialty society that the current practice expense RVUs are appropriate for the Abdomen and Pelvis CT codes and once the previous stand alone codes are fully transitioned for practice expense in 2013, the current practice expense RVU anomalies will cease to exist. Additionally, an error that added to the anomaly in the new bundled codes was corrected to indicate CT Technologists (L046A) as the allocated staff type.

In Situ Hybridization – 88365, 88367 & 88368

CMS received comments that unlike the new FISH codes for urinary tract specimens (88120 and 88121), the existing codes (88365-88368) still allow for multiple units of each code as these codes are reported per probe. CMS stated that they have reviewed the current work and practice costs associated with 88120 and 88121 and agree at this time that they are accurate. CMS requested that the RUC review both the direct practice expense inputs and the work values for codes 88365, 88367 and 88368. In September 2011, the Workgroup recommended that these services be tabled until January 2012 in order to review 2011 diagnosis data from CMS.

In January 2012, the RUC reviewed 2011 diagnosis claims data and the American College of Pathologists indicated that they will develop a CPT Assistant article to direct urologists to use the new FISH codes for urinary tract infections (CPT codes 88120 and 88120). The RUC indicated that the specialty should specify the number of probes utilized for these services in the CPT Assistant article. **The RUC recommended that codes 88365, 88367 and 88368 be reviewed one year after 2012 utilization data are available (January 2013).**

CMS Request to Re-Review Families of New/Revised CPT Codes

In the November 28, 2011 *Final Rule* for 2012 CMS requested that the RUC re-review specific codes in a family of services that were recently reviewed.

The RUC noted that in the recent review of these services, CMS had the opportunity to add CPT codes to each of these families of services prior to the survey and RUC review processes. AMA staff indicated that going forward, AMA staff will ask CMS to acknowledge the code families during the LOI process.

The RUC reviewed the CMS identified family of services and recommends:

Trim Skin Lesions	Recommendation
11055 11056* 11057	Maintain the current work RVUs. There are no apparent rank order anomalies. CMS had the opportunity to request review of other codes during the CPT LOI process.
Thoracoscopy	
32663*, 32480, 32669*, 32670*, 32482, 32671*, 32440, 32672*, 32491, 32673*, 60520, 60521, and 60522	The RUC requests further information from CMS on why these services should be reviewed as part of a family. CMS stated in the Final Rule that it will accept the RUC recommendation for some of these thoracoscopy services pending review of the open heart surgery analogs and that the RUC look at the incremental difference in RVUs and times between the open and laparoscopic surgeries. The specialty society noted that these are not open heart surgery codes and therefore are not relevant.
CT Angiography	
74174*, 74175 and 72191	The RUC referred these services to the Practice Expense Subcommittee to review in April 2012 and determine if any

	practice expense anomalies exist between these codes.
Evoked Potentials and Reflex Studies	
95938*, 95939*, 95925, 95926, 95928, and 95929	The RUC referred these services to the Practice Expense Subcommittee to review in April 2012 and determine if any practice expense anomalies exist between these codes.

** RUC recommendation submitted for 2012.*

Ultrasound Equipment

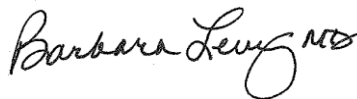
CMS requested that the RUC review 17 different ultrasound related equipment items (including ultrasound rooms) associated with 110 CPT codes ranging in price from \$1,304.33 to \$466,492.00. CMS requested that the RUC review the clinical necessity of the ultrasound equipment as well as the way the equipment is described for individual codes. A Workgroup was created to review this issue and offer recommendations to the Practice Expense Subcommittee and the RUC. The recommendations of the Workgroup were reviewed and accepted by the Practice Expense Subcommittee at the January 2012 RUC Meeting. The recommendations are included in this submission.

Berenson-Eggers Type of Service (BETOS)

In a letter dated, October 21, 2011 (attached), the American College of Surgeons (ACS) requested that the RUC collaborate with the CMS to: 1) Review the Berenson-Eggers Type of Service (BETOS) procedures categories and associated codes to make necessary changes. For example, the classification of “major” versus “minor” procedures should be reviewed and defined; and 2) Establish an ongoing process by which new or revised codes will be assigned to the correct BETOS category and class as the codes are reviewed by the RUC. Many of these classifications were established based on medical care as it was provided in 1980 and have not been updated in over 20 years. The RUC agreed with the ACS request to offer CMS the RUC’s expertise and recommendations to review, revise and maintain BETOS as deemed necessary by the agency. We ask that your staff begin a dialogue with RUC staff regarding this potential project.

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

Sincerely,



Barbara S. Levy, MD

cc: John Cooper, MD
Edith Hambrick, MD
Ryan Howe
Christina Ritter
Sara Vitolo
RUC Participants

RUC Recommended Physician Time for CPT 2013 - March 2012 Submission

[illegible]

**AMA/Specialty Society RVS Update Committee
Ad Hoc Committee – STS Appeal of Stereotactic Body Radiation
March 08, 2012**

Ad Hoc Committee Members Present: Chad Rubin, MD (Chair); James Blankenship, MD; Scott Collins, MD; William Gee, MD; David Hitzeman, MD; Emily Hill; Timothy Laing, MD; Scott Manaker, MD

Specialty Representatives: James Levett, MD; Julie Painter

On February 22, 2012, the RUC received a formal appeal from the Society of Thoracic Surgeons (STS) regarding the RUC's recommended work value for CPT code 327XX1 *Thoracic target(s) delineation for stereotactic body radiation therapy (SRS/SBRT), (photon or particle beam), entire course of treatment*. In response to this appeal, Doctor Levy formed an Ad Hoc Committee as laid out in the RUC's Rules and Procedures for appeals for reconsideration of RUC recommendations. The Ad Hoc Committee met via conference call on March 8, 2012 to hear arguments from the specialty society and consider whether or not the RUC should reconsider the recommended work value for CPT code 327XX1 made at the January 2012 RUC meeting.

The specialty society presented a work value of 5.83, the survey's 25th percentile, at the January 2012 RUC meeting. The RUC agreed that this value was too high and facilitated this code over lunch. The facilitation committee discussed numerous methods for deriving an appropriate physician work value for this code. The work of the facilitation committee is attached and was approved by the RUC. The specialty appealed the decision for two primary reasons: 1) the specialty notes that there was general consensus during the facilitation committee meeting that a work value of 4.44 was supported and 2) the specialty was notified just prior to the presentation of the facilitation committee report to the full RUC that the resulting building block methodology created a lower work RVU than what was generally discussed at the facilitation committee meeting.

The Chair reminded the members that there are two purposes of the Committee: 1) to vote to reconsider the RUC recommended value and 2) if approved to recommend a revised work value to the RUC in April. Therefore, the Ad Hoc Committee discussed the RUC recommendation, including reviewing the original facilitation committee report to gain a better understanding of the original circumstances regarding valuation. The Ad Hoc Committee agreed that the language of the RUC rationale could be strengthened to point out that the facilitation committee used this specific approach in order to equate the work of the thoracic surgeon to the work of a radiation oncologist.

After discussion, the Ad Hoc Committee voted and the request for reconsideration of the RUC recommended work RVU of 4.18 for CPT code 327XX1 failed.

Therefore, the Ad Hoc Committee does not recommend that the RUC should reconsider its previous recommendation.

February 22, 2012

Barbara Levy, MD
Chair, AMA Relative Value Update Committee
515 State Street
Chicago, IL 60045

RE: Appeal RUC decision on Tab 7, Stereotactic Body Radiation Therapy (SBRT), code 327XX1 made by the RUC at the January, 2012 meeting

Dear Dr. Levy

The Society of Thoracic Surgeons (STS) would like to appeal the decision made by the RUC on the recommended work value for Tab 7, Stereotactic Body Radiation Therapy (SBRT), code 327XX1 at the January 2012 RUC meeting.

The specialty society achieved consensus with the facilitation committee on a value of 4.44, and a supporting rationale. However after the meeting, the deliberations of the specialty society and the facilitation committee were modified without input from the specialty and presented at the RUC, which voted on a value of 4.18.

The STS would like appeal the RUC decision on this code and has provided reference codes and a rationale in the table below with codes that support the original facilitation committee recommendation of 4.44 as a value for code 327XX1. The codes in the table were identified based on the similar type of work involved as that for thoracic SBRT and then the value calculated so that it would be comparable to the time (pre, intra, and post) of the SBRT code with 60 minutes of intra time and the selected pre-time package 2a (difficult patient/ straight forward procedure (no anesthesia) with 18 minutes of evaluation time, 1 minute of positioning time and 6 minutes for scrub, dress and wait time.

CPT Code	glob	long descriptor	Time Source	RUC Year	MPC	RVW	Intra Time	Intra Work	Intra Work for 60 Mins	SBRT Pre and Post Work	Comparable Total RVW
73219	XXX	Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; with contrast material(s)	RUC	2001	No	1.62	20	1.17	3.52	0.8102	4.33
73719	XXX	Magnetic resonance (eg, proton) imaging, lower extremity other than joint; with contrast material(s)	RUC	2001	No	1.62	20	1.17	3.52	0.8102	4.33
99355	ZZZ	Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service; each additional 30 minutes (List separately in addition to code for prolonged physician	RUC	1993	No	1.77	30	1.77	3.54	0.8102	4.35

CPT Code	glob	long descriptor	Time Source	RUC Year	MPC	RVW	Intra Time	Intra Work	Intra Work for 60 Mins	SBRT Pre and Post Work	Comparable Total RVW
		service)									
99283	XXX	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components:	RUC	2005	No	1.34	18	1.07	3.57	0.8102	4.38
73722	XXX	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; with contrast material(s)	RUC	2001	No	1.62	20	1.21	3.62	0.8102	4.43
72198	XXX	Magnetic resonance angiography, pelvis, with or without contrast material(s)	RUC	1993	No	1.80	25	1.51	3.62	0.8102	4.43
74183	XXX	Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s), followed by with contrast material(s) and further sequences	RUC	2001	No	2.26	30	1.81	3.62	0.8102	4.43
327XX1	000	Thoracic target(s) delineation for stereotactic body radiation therapy (SRS/SBRT), (photon or particle beam), entire course of treatment	Survey /RUC Approved	2012	No	4.44	60	3.63	3.63	0.8102	4.44
37209	000	Exchange of a previously placed intravascular catheter during thrombolytic therapy	RUC	1994	No	2.27	30	1.82	3.64	0.8102	4.45
72196	XXX	Magnetic resonance (eg, proton) imaging, pelvis; with contrast material(s)	RUC	2001	No	1.73	20	1.23	3.68	0.8102	4.49

CPT Code	glob	long descriptor	Time Source	RUC Year	MPC	RVW	Intra Time	Intra Work	Intra Work for 60 Mins	SBRT Pre and Post Work	Comparable Total RVW
99244	XXX	Office consultation for a new or established patient, which requires these 3 key components	RUC	2006	Yes-A	3.02	40	2.46	3.69	0.8102	4.50
78451	XXX	Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)	RUC	2009	No	1.40	15	0.95	3.81	0.8102	4.62

The STS requests that the RUC consider radiation oncology and neurosurgery to be related specialties with respect to this code and therefore to rule their involvement in this appeal to be a conflict of interest.

Please contact Julie Painter (jpainter@physiciancoding.com) or James Levett, MD (jmlevett@hotmail.com) with any questions related to this issue.

Sincerely,



James M. Levett, MD
STS RUC Advisor