April 2, 2014

Glenn M. Hackbarth, JD, MA
Chairman
Medicare Payment Advisory Commission (MedPAC)
425 Eye Street, NW
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Washington, DC 20001

Dr. Chairman Hackbarth:

At MedPAC's March meeting, several statements were made regarding the work of the AMA/Specialty Society RVS Update Committee (RUC) and the potential use of this work to fund a new monthly payment to primary care practitioners. As the Commission moves to finalize a recommendation on this new proposal at its April meeting, we believe it would be useful for MedPAC members to have a more complete picture of the RUC's efforts to refine and revise the current valuation of services within Medicare's physician fee schedule. Attached you will find a detailed overview of the RUC's "misvalued codes" initiative referred to at the meeting. As indicated in the summary, t**he RUC has reviewed or is scheduled to review more than 1600 codes. When Evaluation and Management (E&M) services are excluded, all but approximately 14% of the Medicare physician fee schedule will have been reviewed when this work is finished.**

Over the years, the RUC has adopted a number of refinements to improve the objectivity and accuracy of its work. These include efforts that increasingly have standardized the processes for determining the resources required for both the work and practice expense portions of the fee schedule. In many instances, RUC reviews also have led to revisions in the underlying codes for physician services. **To fully gauge the impact of the misvalued code initiative, it is therefore necessary to consider both completed and ongoing RUC reviews and to include the impact of these reviews on practice expense (pe) and coding as well as work relative values**. In addition, any comparison of Medicare payment rates for specific services or groups of services should be continually updated so as to capture the full effect of RUC recommendations and Medicare policy changes that have enhanced payment to primary care practitioners.

In discussing the misvalued code initiative last month, MedPAC staff said data used in the RUC misvalued code initiative is "highly inaccurate," and suggested that more savings could be identified and used to fund a per member per month payment for primary care practitioners. This new monthly payment is being contemplated as a replacement for the primary care bonus that expires after 2015 and for the additional care coordination codes that Medicare has said it will cover starting next year. Several points in that discussion warrant further examination. Specifically:

The studies cited to demonstrate the need and opportunity for further "misvalued code" reductions are outdated and do not reflect significant payment modifications

that have taken place over the last few years. The Urban Institute study using 2010 data predates a number of Medicare policy changes beneficial to primary care, including new or improved coverage of transitional care, the annual wellness visit, and practice expense modifications that improved payment to primary care at the expense of imaging and other services. The GAO report pointing to duplication of effort—and therefore potential overpayment—when multiple services are performed together is based on 2006 data and therefore preceded subsequent payment changes that have already addressed this duplication, including four rounds of Medicare multiple procedure payment cuts and the RUC's review (or scheduled review) of 234 pairs of services typically billed together.

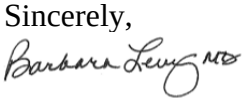
The assumption that significant additional savings can be wrung out of the misvalued codes initiative without any damage to Medicare beneficiaries' access to needed care is unrealistic. If hospital and emergency department visits are included, slightly more than 40% of all Medicare allowed charges involve evaluation and management services. As detailed in its most recent progress report (attached), the RUC has completed or initiated reviews of 1685 codes and made recommendations that have led to a redistribution of $3 billion when the impacts on work, pe and code bundling (including deletion of certain codes) all are taken into consideration. If it is assumed that no E&M codes are overvalued, then the RUC has completed or initiated reviews on services responsible for about 86% of all non-E&M spending, and any further savings would require a new round of cuts on previously-reduced services. While the RUC's recommended reductions in work values have not all fully reflected reductions in survey time, in many cases this is due to aberrations in time data collected during the early years of the fee schedule rather than a true reduction in time required to perform the service.

It is important to consider any call for more "over-valued" code savings in the context of other legislative and regulatory changes that have been recommended or are underway. While Medicare's Economic Index indicates that physician costs have risen by more than 25% since 2001, updates in physician payment rates have totaled just 4.5% over that time. Current law calls for sequester cuts of 2% a year in all Medicare payments through 2023 followed by a 4% cut in the first six months of 2024. On top of these cuts, MedPAC has already recommended reductions of up to 9% in most services to offset the cost of permanent repeal of the sustainable growth rate. In addition, a recently enacted one-year SGR patch just adopted by Congress includes a misvalued code target that CBO says will remove $4 billion from Medicare physician expenditures over the next 10 years.

As you continue discussion on this and other proposals aimed at redistributing money within the physician fee schedule, we offer our assistance in the interpretation of the RUC data and recommendations. The RUC agrees that improvements are needed in the way primary care physicians are paid. To that end, the RUC responded to Medicare officials' request to identify resources needed to provide the services of a medical home and also successfully promoted Medicare coverage of new transitional care and complex chronic care coordination codes that would be used mostly by primary care physicians. In your pursuit of a similar goal, we urge MedPAC to take a measured approach that recognizes the efforts that have already taken place and to carefully weigh the relative

merits of coding changes that are well on their way to implementation versus a proposal that would require legislative action in a stalemated Congress followed by significant work on the part of CMS to design and run the new proposal. If you have any questions on the work of the RUC or its recommendations, please contact Sherry Smith at 312-464-5604 or Sherry.Smith@ama-assn.org.

Sincerely,



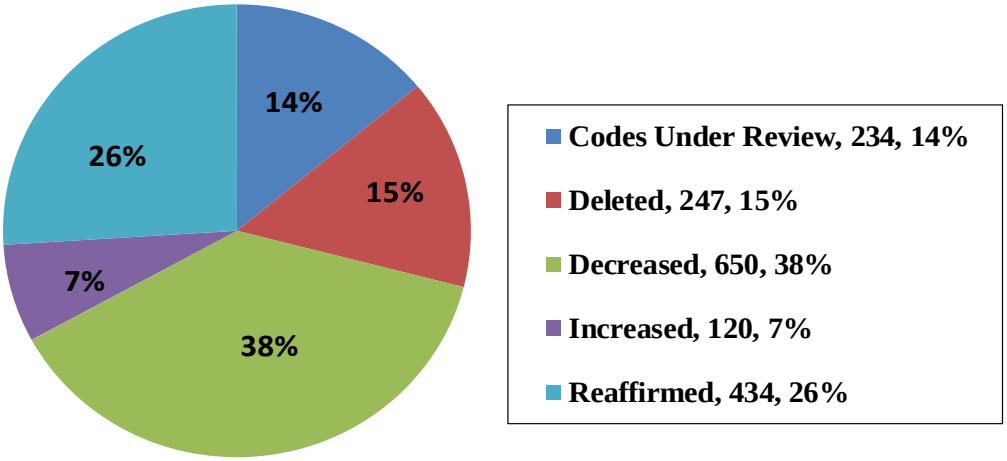
Barbara Levy, MD
Chair AMA/Specialty Society RVS Update Committee

The RUC Relativity Assessment Workgroup Progress Report

In 2006, the RUC established the Five-Year Identification Workgroup (now referred to as the Relativity Assessment Workgroup) to identify potentially misvalued services using objective mechanisms for reevaluation prior to the next Five-Year Review. Since the inception of the Relativity Assessment Workgroup, the Workgroup and CMS have identified nearly 1,700 services through 15 different screening criteria for further review by the RUC. Additionally, the RUC charged the Workgroup with maintaining the "new technology" list of services that will be re-reviewed by the RUC as reporting and cost data become available.

To provide Medicare with reliable data on how physician work has changed over time, the Relative Value Scale Update Committee, with more than 300 experts in medicine and research, are examining nearly 1,700 potentially misvalued services accounting for $38 billion in Medicare spending. The update committee has recommended reductions to 650 services, redistributing more than $3 billion. Here are the outcomes for the committee's review of 1,685 codes:

Potentially Misvalued Services Project



SOURCE: AMERICAN MEDICAL ASSOCIATION

New Technology

As the RUC identifies new technology services that should be re-reviewed, a list of these services is maintained and forwarded to CMS. Currently, codes are identified as new technology based on recommendations from the appropriate specialty society and consensus among RUC members at the time of the RUC review for these services. RUC members consider several factors to evaluate potential new technology services, including: recent FDA-approval, newness or novelty of the service, use of an existing service in a new or novel way, and migration of the service from a Category III to Category I CPT code. The Relativity Assessment Workgroup maintains and develops all standards and procedures associated with the list, which contains 425 services. In September 2010, the re-review cycle began and since then the RUC has recommended 14 services to be re-examined. The remaining services are rarely performed (i.e., less than 500 times per year in the Medicare population) and will not be further examined. The Workgroup will continue to review the remaining 204 services every September after three years of Medicare claims data is available for each service.

Methodology Improvements
The RUC recently announced process improvements in the area of methodology following its October 2013 meetings. The process improvements are designed to strengthen the RUC's primary mission of providing the final RVS update recommendations to the Centers for Medicare and Medicaid Services.

In the area of methodology, the RUC is continuously improving its processes to ensure that it is best utilizing reliable, extant data. At its most recent meeting, the RUC increased the minimum number of respondents required for each survey of commonly performed codes:

- For services performed more than 1 million times per year in the Medicare population, at least 75 physicians must complete the survey.
- For services performed more than 100,000 annually, at least 50 physicians will be required.

Further strengthening its methodology, The RUC also announced that specialty societies will move to a centralized online survey process, which will be coordinated by the AMA and will utilize external expertise to ensure survey and reporting improvements.

Site of Service Anomalies
The Workgroup initiated its effort by reviewing services with anomalous sites of service when compared to Medicare utilization data. Specifically, these services are performed less than 50% of the time in the inpatient setting, yet include inpatient hospital Evaluation and Management services within their global period.

The RUC identified 194 services through the site of service anomaly screen. The RUC required the specialties to resurvey 129 services to capture the appropriate physician work involved. These services were reviewed by the RUC between April 2008 and February 2011. CMS implemented 124 of these recommendations in the 2009, 2010 and 2011 Medicare Physician Payment Schedules. The RUC submitted another five recommendations as well as re-reviewed and submitted 44 recommendations to previously reviewed site-of-service identified codes to CMS for the 2012 Medicare Physician Payment Schedule.

Of the remaining 65 services that were not re-surveyed, the RUC modified the discharge day management for 46 services, maintained three codes and removed two codes from the screen as the typical patient was not a Medicare beneficiary and would be an inpatient. The CPT Editorial Panel deleted 13 codes and the RUC will re-review one service in the CPT 2016 cycle. The RUC will reassess the data each year going forward to determine if any new site of service anomalies arise.

During this review, the RUC uncovered several services that are reported in the outpatient setting, yet, according to several expert panels and survey data from physicians who performed the procedure, the service, typically requires a hospital stay of greater than 23 hours. The RUC maintains that physician work that is typically performed, such as visits on the date of service and discharge work the following day, should be included within the overall valuation. Subsequent observation day visits and discharge day management service as appropriate proxies for this work.

High Volume Growth
The Workgroup assembled a list of all services with a total Medicare utilization of 1,000 or more that have increased by at least 100% from 2004 through 2006. The query initially resulted in the identification of 81 services, but was expanded by 15 services to include the family of services, totaling 96 services. Specialty societies submitted comments to the Workgroup in April 2008 to provide feedback or explanations for the growth in reporting. Following this review, the RUC required the specialties to survey 35 services to capture the appropriate work effort and/or practice expense inputs. These services were reviewed by the RUC between February 2009 and April 2010.

The RUC recommended removing 22 services from the screen as the volume growth did not impact the resources required to provide these services. The CPT Editorial Panel deleted 21 codes and will review another two services in the CPT 2015 cycle. In September 2011, the RUC began review of services after two years of utilization data were collected. The RUC submitted an additional 11 recommendations to CMS for services for the 2012-2015 Medicare Physician Payment Schedules. The RUC will continue to review the remaining five services after additional utilization data is collected.

In April 2013, the RUC assembled a list of all services with a total Medicare utilization of 10,000 or more that have increased by at least 100% from 2006 through 2011. The query resulted in the identification of 40 services and expanded to 48 services to include the appropriate family of services. The RUC recommended removing four services from the screen as the volume growth did not impact the resources required to provide these services. The RUC recommended ten services be referred to the CPT Editorial Panel for revision, six services be reviewed again after an additional two years of utilization data is collected and the remaining 28 services be surveyed for physician work and direct practice expense inputs for the 2015 CPT cycle.

CMS Fastest Growing

In 2008, CMS developed the Fastest Growing Screen to identify all services with growth of at least 10% per year over the course of three years from 2005-2007. Through this screen, CMS identified 114 fastest growing services and the RUC added 69 services to include the family of services, totaling 183. The RUC required the specialties to survey 72 services to capture the appropriate work effort and/or practice expense inputs. These services were reviewed by the RUC from February 2008 through April 2010 and submitted to CMS for the Medicare Physician Payment Schedule.

The RUC recommended removing 51 services from the screen as the volume growth did not impact the resources required to provide the service. The CPT Editorial Panel deleted 26 codes and will review another four services in the CPT 2016 cycle. The RUC submitted 25 recommendations to CMS for the 2012 -2015 Medicare Physician Payment Schedules. The RUC will review the remaining five services after additional utilization data is available.

High IWPUT

The Workgroup assembled a list of all services with a total Medicare utilization of 1,000 or more that have an intra-service work per unit of time (IWPUT) calculation greater than 0.14, indicating an outlier intensity. The query resulted in identification of 32 services. Specialty societies submitted comments to the Workgroup in April 2008 for these services. As a result of this screen, the RUC has reviewed and submitted recommendations to CMS for 28 codes, removing four services from the screen as the IWPUT was considered appropriate. The RUC completed review of services under this screen.

Services Surveyed by One Specialty – Now Performed by a Different Specialty

In October 2009, services that were originally surveyed by one specialty, but now performed predominantly by other specialties were identified and reviewed. The RUC identified 21 services by this screen, adding 19 services to address various families of codes. The majority of these services required clarification within CPT. The CPT Editorial Panel deleted 18 codes. The RUC submitted 22 recommendations for physician work and practice expense to CMS for the 2011-2014 Medicare Physician Payment Schedules. The RUC completed review of services under this screen.

In April 2013, the RUC queried the top two dominant specialties performing services based on Medicare utilization more than 1,000 and compared it to who originally surveyed the service. Two services were identified and the RUC recommended that one be removed from the screen since the specialty societies currently performing this service indicated that the service is appropriate and recommended that the other code be referred to CPT to be revised. The RUC completed review of services under this screen.

Harvard Valued

Utilization over 1 Million

CMS requested that the RUC pay specific attention to Harvard valued codes that have a high utilization. The RUC identified nine Harvard valued services with high utilization (performed over 1 million times per year). The RUC also incorporated an additional 12 Harvard valued codes within the initial family of services identified. The CPT Editorial Panel deleted one code. The RUC submitted 20 relative value work recommendations to CMS for the 2011 and 2012 Medicare Physician Payment Schedule. The RUC completed review of services under this screen.

Utilization over 100,000

The RUC continued to review Harvard-only valued codes with significant utilization. The Relativity Assessment Workgroup expanded the review of Harvard codes to those with utilization over 100,000 which totaled 38 services. The RUC expanded this screen by 101 codes to include the family of services, totaling 139 services. The CPT Editorial Panel deleted 27 codes. The RUC submitted 112 recommendations to CMS for the 2011-2014 Medicare Physician Payment Schedules. The RUC completed review of services under this screen.

Utilization over 30,000

In April 2011, the RUC continued to identify Harvard-only valued codes with utilization over 30,000, based on 2009 Medicare claims data. The RUC determined that the specialty societies should survey the remaining 36 Harvard codes with utilization over 30,000 for September 2011. The RUC expanded the screen to include the family of services, totaling 65 services. The CPT Editorial Panel deleted 12 codes. The RUC submitted recommendations for 53 services for the 2013-2014 Medicare Physician Payment Schedules. The RUC completed review of services under this screen.

Medicare Allowed Charges >$10 million

In June 2012, CMS identified 16 services that were Harvard-Valued with Annual Allowed Charges (2011 data) > $10 million. The RUC expanded this screen to 33 services to include the proper family of services. The RUC removed two services from review as the allowed charges are approximately $1 million and did not meet the screen criteria. The RUC submitted recommendations for 29 services for the 2013-2015 Medicare Physician Payment Schedules. The CPT Editorial Panel deleted one service. The RUC will review one remaining service after additional utilization data is available.

CMS/Other

Utilization over 500,000

In April 2011, the RUC identified 410 codes with a source of “CMS/Other.” CMS/Other codes are services which were not reviewed by the Harvard studies or the RUC and were either gap filled, most often via crosswalk by CMS or were part of a radiology fee schedule. “CMS/Other” source codes would not have been flagged in the Harvard only screens, therefore the RUC recommended that a list of all CMS/Other codes be developed and reviewed. The RUC established the threshold for CMS/Other source codes with Medicare utilization of 500,000 or more, which resulted in 19 codes. The RUC expanded this screen to 21 services to include the proper family of services. The CPT Editorial Panel deleted one service and will review two services for CPT 2016. The RUC submitted recommendations for 16 services for the 2013-2015 Medicare Physician Payment Schedules. The RUC removed one service from the screen and will review one service after additional utilization data is available.

Utilization over 250,000
In April 2013, the RUC lowered the threshold to the CMS/Other source codes with Medicare utilization of 250,000 or more, which resulted in 26 services and was expanded to 38 services to include the family of services. The RUC referred eight services to the CPT Editorial Panel, will submit recommendations to CMS for 22 services for the Medicare Physician Payment Schedule and will review eight services after more utilization data is available.

Bundled CPT Services
Reported 95% or More Together
The Relativity Assessment Workgroup solicited data from CMS regarding services inherently performed by the same physician on the same date of service (95% of the time) in an attempt to identify pairings of services that should be bundled together. The CPT Editorial Panel deleted 31 individual component codes and replaced them with 53 new codes that describe bundles of services. The RUC then surveyed and reviewed work and practice costs associated with these services to account for any efficiencies achieved through the bundling. The RUC completed review of all services under this screen.

Reported 75% or More Together
In February 2010, the Workgroup continued review of services provided on the same day by the same provider, this time lowering the threshold to 75% or more together. The Relativity Assessment Workgroup again analyzed the Medicare claims data and found 151 code pairs which met the threshold. The Workgroup then collected these code pairs into similar "groups" to ensure that the entire family of services would be coordinated under one code bundling proposal. The grouping effort resulted in 20 code groups, totaling 80 codes, and were sent to specialty societies to solicit action plans for consideration at the April 2010 RUC meeting. Resulting from the Relativity Assessment Workgroup review, 81 additional codes were added for review as part of the family of services to ensure duplication of work and practice expense was mitigated throughout the entire set of services. Of the 161 total codes under review, the CPT Editorial Panel deleted 33 individual component codes and replaced the component coding with 127 new and/or revised codes that described the bundles of services. The CPT Editorial Panel and the RUC are currently working on one service and expect to complete this screen for final implementation in the 2016 Medicare Physician Payment Schedule.

Reported 75% or More Together – Part 2
In August 2011, the Joint CPT/RUC Workgroup on Codes Reported Together Frequently reconvened to perform its third cycle of analysis of code pairs reported together with 75% or greater frequency. The Workgroup reviewed 30 code pair Groups and recommended code bundling for 64 individual codes. In October 2012, the CPT Editorial Panel started review of code bundling solutions. Of the 99 total codes under review, the CPT Editorial Panel deleted 26 services and is scheduled to review 27 codes in the 2016 cycle. The RUC has submitted 46 code recommendations for the 2014-2015 Medicare Physician Payment Schedules.

Low Value/Billed in Multiple Units
CMS has requested that services with low work RVUs that are commonly billed with multiple units in a single encounter be reviewed. CMS identified services that are reported in multiples of five or more per day, with work RVUs of less than or equal to 0.50 RVUs.

In October 2010, the Workgroup reviewed 12 CMS identified services and determined that six of the codes were improperly identified as the services were either not reported in multiple units or were reported in a few units, but that was assumed in the original valuation. The RUC submitted recommendations for the remaining six services for the 2012 Medicare Physician Payment Schedule. The RUC completed review of services under this screen.

Low Value/High Volume Codes
CMS has requested that services with low work RVUs and high utilization be reviewed. CMS has requested that the RUC review 24 services that have low work RVUs (less than or equal to 0.25) and high utilization. The RUC questioned the criteria CMS used to identify these services as it appeared some codes were missing from the screen criteria indicated. The RUC identified codes with a work RVU ranging from 0.01 - 0.50 and Medicare utilization greater than one million. In February 2011, the RUC reviewed the codes identified by this criteria and added 5 codes, totaling 29. The RUC submitted 24 recommendations to CMS for the 2012 Medicare Physician Payment Schedule and five recommendations to CMS for the 2013 Medicare Physician Payment Schedule. The RUC completed review of services under this screen.

Multi-Specialty Points of Comparison List
CMS requested that services on the Multi-Specialty Points of Comparison (MPC) list should be reviewed. CMS prioritized the review of the MPC list to 33 codes, ranking the codes by allowed service units and charges based on CY 2009 claims data as well as those services reviewed by the RUC more than six years ago. The RUC expanded the list to 182 services to include additional codes as part of a family (over 100 codes of which are part of the review of GI endoscopy codes). The CPT Editorial Panel deleted 25 codes. The RUC submitted recommendations for 157 codes for the 2012-2015 Medicare Physician Payment Schedules. The RUC completed review of services under this screen.

CMS High Expenditure Procedural Codes
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 since they have not been reviewed for at least 6 years, and in many cases the last review occurred more than 10 years ago.

The RUC reviewed the 70 services identified and expanded the list to 128 services to include additional codes as part of the family. The CPT Editorial Panel deleted eight codes and will review five codes for the 2016 cycle. The RUC submitted 111 recommendations to CMS for the 2013-2015 Medicare Physician Payment Schedules will review utilization data for four services in 2015.

Services with Stand-Alone PE Procedure Time
In June 2012, CMS proposed adjustments to services with stand-alone procedure time assumptions used in developing non-facility PE RVUs. These assumptions are not based on physician time assumptions. CMS prioritized CPT codes that have annual Medicare allowed charges of $100,000 or more, include direct equipment inputs that amount to $100 or more, and have PE procedure times greater than five minutes for review. The RUC reviewed 27 services identified through this screen and expanded to 29 services to include additional codes as part of the family. The CPT Editorial Panel deleted 11 codes and will review one code for CPT 2016. The RUC submitted 17 recommendations for the 2014-2015 Medicare Physician Payment Schedules.

Pre-Time Analysis
In January 2014, the RUC reviewed codes that were RUC reviewed prior to April 2008, with pre-time greater than pre-time package 4 *Facility - Difficult Patient/Difficult Procedure* (63 minutes) for services with 2012 Medicare Utilization over 10,000. The screen identified 21 services with more pre-service time than the longest standardized pre-service package. The Relativity Assessment Workgroup reviewed these services and requests action plans from the specialty societies on how to address the pre-service time for these services. The Relativity Assessment Workgroup will review action plans at the April 2014 RUC meeting.

Post-Operative Visits

010-Day Global Codes

In January 2014, the RUC reviewed all 477, 010-day global codes to determine any outliers. Many 010-day global period services only include 1 post-operative office visit. The Relativity Assessment Workgroup pared down the list to 19 services with >1.5 office visits and 2012 Medicare utilization > 1,000. The Workgroup reviewed the 19 services and requests action plans from the specialty societies to address/explain the office visits associated with these services. The Relativity Assessment Workgroup will review action plans at the April 2014 RUC meeting.

090-Day Global Codes

In January 2014, the RUC reviewed all 3788, 090-day global codes to determine any outliers. Based on 2012 Medicare utilization data, 10 services were identified, that were reported at least 1,000 times per year and included more than six office visits. The Relativity Assessment Workgroup reviewed the 10 services and requests action plans from the specialty societies to address/explain the office visits associated with these services. The Relativity Assessment Workgroup will review action plans at the April 2014 RUC meeting.

Public Comment Requests

In 2011, CMS announced that due to the ongoing identification of potentially misvalued services by CMS and the RUC, the Agency will no longer conduct a separate Five-Year Review. CMS will now call for public comments on an annual basis as part of the comment process on the Final Rule each year.

Final Rule for 2013

In the Final Rule for the 2013 Medicare Physician Payment Schedule, the public and CMS identified 35 potentially misvalued services. The RUC reviewed these services and referred three services to the CPT Editorial Panel for revision. The RUC indicated they did not provide a recommendation for one service because it lacked specialty society interest. The RUC submitted recommendations for 20 services for the 2014 Medicare Physician Payment Schedule and will submit the remaining 11 recommendations for the 2015 cycle.

Final Rule for 2014

CMS did not receive any publicly nominated potentially misvalued codes for inclusion in the Proposed Rule for 2014. However, to broaden participation in the process of identifying potentially misvalued codes, CMS sought the input of Medicare contractor medical directors (CMDs). The CMDs have identified over a dozen services in which CMS is proposing as potentially misvalued. The RUC reviewed these services and appropriate families at the October 2013 RUC meeting and noted that two services identified were recently reviewed and recommendations were submitted for the 2014 Medicare Payment Schedule. The RUC recommended no further action for 10 services, deletion of one service, referral to the CPT Editorial Panel for eight services and to survey four services for the 2015 Medicare Payment Schedule.

Other Issues

In addition to the above screening criteria, the Relativity Assessment Workgroup performed an exhaustive search of the RUC database for services indicated by the RUC to be re-reviewed at a later date. Three codes were found that had not yet been re-reviewed. The RUC recommended a work RVU decrease for two codes and to maintain the work RVU for another code.

CMS also identified 72 services that required further practice expense review. The RUC submitted practice expense recommendations on 67 services and the CPT Editorial Panel deleted 5 services. The RUC also reviewed special requests for 19 audiology and speech-language pathology services. The RUC submitted recommendations for 10 services for the 2010 Medicare Physician Payment Schedule and the remaining nine services for the 2011 Medicare Physician Payment Schedule.

CMS Requests and RUC Relativity Assessment Workgroup Code Status	
Total Number of Codes Identified*	**1,685**
Codes Completed	**1,451**
Work and PE Maintained	434
Work Increased	120
Work Decreased	531
Direct Practice Expense Revised (beyond work changes)	119
Deleted from CPT	247
Codes Under Review	**234**
Referred to CPT	55
RUC to Review April 2014	140
RUC future review after additional data obtained	39

**The total number of codes identified will not equal the number of codes from each screen as some codes have been identified in more than one screen.*

The RUC's efforts for 2009-2014 have resulted in $3 billion in redistribution within the Medicare Physician Payment Schedule.