AMA/Specialty RVS Update Committee
April 24-27, 1997

The Renaissance Chicago Hotel
Chicago, Illinois

I. Call to Order and Opening Remarks.

Doctor Rodkey called the meeting to order at 3:30 pm. The following RUC members were in attendance:

Grant V. Rodkey, MD
David Berland, MD
Melvin Britton, MD
Boyd Buser, DO*
Thomas P. Cooper, MD*
Robert Florin, MD
John O. Gage, MD
Tracy R. Gordy, MD
William Gee, MD
Larry P.Griffin, MD*
Kay K. Hanley, MD
Alexander Hannenberg, MD
James Hayes, MD
Richard J. Haynes, MD
Emily Hill, PA-C
David F. Hitzeman, DO
James Hoehn, MD
Alan Jensen, MD *
Dudley D. Jones, MD
Charles Koopmann Jr. MD
Barbara Levy, MD*
J. Leonard Lichtenfeld, MD
Charles D. Mabry, MD*
John Mayer, MD
David McCaffree, MD
Clay Molstad, MD*
James M. Moorefield, MD
Neil Powe, MD
William Rich, MD
Peter Sawchuk, MD*
Chester Schmidt, MD
Paul Schnur, MD*
Bruce Sigsbee, MD
John Tudor, MD
Charles Vanchiere, MD
David West, MD*
William Winters, Jr. MD

(*Indicates alternate member)

Grant Bagley, MD, Health Care Financing Administration (HCFA), also attended.

The following facilitation committees were appointed by Doctor Rodkey:

- Doctors Mayer (Chair), Hannenberg, Hayes, Lichtenfeld, Moorefield, Opelka, Tudor, and Jerilyn Kaibel, DC.

- Doctors Sigsbee (Chair), Berland, Britton, Jensen, McCaffree, Sawchuck, Vanchiere, Whitten and Eileen Sullivan-Marx, PhD.

- Doctors Haynes (Chair), Buser, Jones, Mabry, Powe, Rich, Schmidt Schnur, Winters, and Emily Hill-PA-C.

- Doctors Florin (Chair), Hanley, Haynes, Hitzeman, Jones Koopman, Molstad, and Winters.

II. Approval of February, 1997 Minutes

The minutes of the February 7-9,1997 RUC meeting were approved without revision.

III. Calendar of Meeting Dates

The RUC was informed that the minimally invasive procedures workgroup will meet July 19 in Chicago. Sandy Sherman asked the RUC if there was any interest in scheduling a meeting July 18 or 20 to discuss and/or comment on the forthcoming Proposed Rule. The RUC members indicated that they were not interested in a summer meeting.

The September 26-28 RUC meeting will be held at The Meridian in San Diego, California. The RUC expressed interest in limiting the last day (Sunday) of this meeting due to the restraints of airline schedules. Sandra Sherman assured the RUC that the September schedule will not be as heavy and may conclude Saturday or early Sunday.

Doctor Britton noted that there was a discrepancy between the dates of the May 1998 RUC meeting in the minutes and the calendar. The May 1-3,1998 meeting date printed in the minutes is correct.

V. HCFA Update

Grant Bagley,MD provided the RUC with an update on HCFA's agenda. The Spring Notice of Proposed Rule-Making (NPRM) will focus primarily on the practice expense issue. HCFA intends to meet the January 1, 1998 implementation date for resource based practice expense relative values. Doctor Bagley welcomes the RUC and any other interested parties to comment on this issue. Doctor Bagley also informed the RUC that the Proposed Rule will include the RUC's recommendation on E/M work in the global surgical period.

IV.CPT Update

Doctor Gordy reported that only a few codes will be reviewed at the May Editorial Panel meeting. Doctor Gordy also informed the RUC that a workgroup is currently addressing add-on codes.

VI. RUC Database/Rules and Procedures

Michael Beebe demonstrated the RUC database and welcomed comments on the application. All RUC participants received a copy of the RUC database along with details of the shrink-wrap agreement.

Doctors Florin, Britton and Hannenberg suggested that the RUC consider making several changes to the RUC database to make it even more useful to RUC members and specialty staff. These changes include the addition of two fields- IWPUT and Harvard time and adding a function to allow the system to sort by work RVU and global period.

A motion was made to accept the proposed revisions to the Rules and Procedures which allow for dissemination of the RUC data outside the Process with approval of the RUC.

A request was made to vote for each bullet describing proposed changes to the Rules and Procedures separately.

The first two bullets were accepted while the third was amended through a motion by Doctor Griffin. The new bullet in the Rules and Procedures is as follows:

~~Physicians' Current Procedural Terminology, Fourth Edition~~ CPT Five-digit codes, descriptions and other CPT data only are ~~is~~ copyright 1996 American Medical Association(or such other date of publication of CPT ~~as defined in the federal copyright laws~~).

The Rules and Procedures document was adopted as amended.

VII. Practice Cost Subcommittee Report

The Practice Cost subcommittee met to discuss several practice cost issues including: the accuracy of data; allocation of direct and indirect expenses, and the nature of a refinement process. The subcommittee also heard reports from Grant Bagley, MD, HCFA and from Sandy Sherman regarding the AMA's activities on this issue. A copy of these written reports are attached.

The practice cost subcommittee recommended that the AMA staff develop a strategic plan with respect to the potential RUC role in resource-based practice expense relative values and report at the September 1997 RUC Meeting. The RUC also requested that the AMA consider the additional resources and time required to engage in this activity.

Doctor Gee made a motion to accept the subcommittees recommendation.

The motion was accepted.

VIII. Research Subcommittee Report

The Research Subcommittee met on Saturday, April 26. In attendance were Doctors Rich (Chair), Britton, Florin, Gee, Gerety, Hayes, Hoehn, Koopmann, Kwass, Lichtenfeld, Moorefield, Tudor, and Sullivan-Marx, PhD. Matthew Liang, MD, a member of the Intensity Workgroup, also attended the meeting. Doctor Alicia Schoua-Glusberg from Research Support Services and Professor Benjamin Wright from the University of Chicago made presentations on the two physician work intensity research projects. The subcommittee also considered a motion by the American Urological Association to establish a rotating seat on the RUC for surgical specialties.

Doctor Schoua-Glusberg described the methods involved in conducting ethnographic interviews. She explained that this approach is often used in questionnaire design to ensure that the appropriate questions are asked to elicit the kinds of responses and thus the data researchers are looking for. It is important to look at the mental processes which go into answering a question, including subjective factors leading eventually to quantitative data. The subcommittee expressed concern that the research should be goal oriented, with the objective being a new more encompassing measure of intensity. Doctor Tudor assured the committee that the research was goal driven, but that it is important to be sure that conceptions of intensity are accurate. For example, we do not know if the current definition and categorization of intensity is correct.

Professor Wright presented what can be seen as the second step in the development of more encompassing measure of intensity. Once the questionnaire has been designed and the data has been collected, it must be analyzed to determine if it is linear and statistically valid. Data from Doctor Florin's neurosurgery study of intensity was analyzed using Professor Wright's Rasch

technique. The results of this analysis showed that Florin's measurement efforts produced valid data on eight out of his ten measures of intensity. The subcommittee pointed out that this research only validates Florin's study and that any new measure of intensity must apply across all specialties. Doctor Florin and Professor Wright acknowledged that this was indeed the case and suggested that the services in the Multispecialty Points of Comparison (MPC) be studied using Florin's instrument and Wright's analysis technique.

The Research Subcommittee agreed that there are methods to scale and measure intensity and that there are possibly better questions which could be asked and methods to validate the results. The subcommittee decided to continue studying the concept of intensity under the guidance of the Intensity Workgroup and asked the workgroup to make a recommendation on whether and how to study the MPC.

The Research Subcommittee discussed the AUA request to add a surgical rotating seat to the RUC. The Research Subcommittee did not make a recommendation, but suggested that the full RUC discuss the issue. After discussion at the RUC, the issue was referred to the Nominating Subcommittee Chaired by Doctor Novak and including Doctors Hitzeman, Lichtenfeld, Jones and Haynes. The committee was directed to look into the issues of: dual memberships of specialty society representatives on the RUC; the history of establishing the internal medicine subspecialty rotating seat because any surgical seat should be consistent with this rationale; and criteria of rotating seats (i.e. "specialty representation" vs. "specialty society" representation).

IX. RUC HCPAC Review Board Report

The RUC HCPAC Review Board met on Thursday to discuss several relative value recommendations as well as elect an alternate Co-chair. The Review Board elected Steve Levine, PT as alternate Co-Chair. The Board made the following recommendations:

Paring, Cutting, and Trimming of Toenails

The Review Board accepted work recommendations presented by the American Podiatric Medical Association for new codes which replace existing CPT codes 11050-11052 and HCPCS Level II code M0101. The following recommendations were based on the survey medians:

110X1	Paring or cutting of benign hyperkeratotic ; lesion (eg, corn or callus) , single lesion	.43
110X2	two to four lesions	.61
110X3	more than four lesions	.79
1172X	Trimming of nondystrophic nails, any number	.17

Endoscopic Plantar Fasciotomy

The American Podiatric Medical Association presented a work rvu recommendation of 5.10 for a new code to describe endoscopic plantar fasciotomy, which was based on their survey median. The Review Board expressed concern that this service is currently reported using code 28008 *Fasciotomy, foot and/or toe* which is valued at 4.19. After much discussion, including APMA's argument that podiatrists more typically reported code 28060, *fasciectomy, excision of plantar*

fascia; partial (separate procedure) (work rvu = 5.05), the Review Board agreed to recommend the 25th percentile of the survey median.

2989X	Endoscopic Plantar Fasciotomy	4.92

<u>Occupational and Physical Therapy Evaluation Services</u>

The CPT Editorial Panel recently added four new codes to describe physical therapy and occupational therapy evaluation services, which were crosswalked from existing HCPCS Level II codes. the HCPCS Level II codes were created by HCFA in 1993 and were assigned work rvus that were between level 2 (99202/99212) and level 3 (99203/99213) Evaluation and Management codes (or approximately 88% of 99203/99213). The American Physical Therapy Association and the American Occupational Therapy Association presented recommendations based on their survey medians. The Review Board did not accept these recommendations and will instead recommend work rvus that are consistent with the initial relativity to the Evaluation and Management codes These recommendations were also at the 25th percentile of the APTA survey data.

970X1	Physical therapy evaluation	1.20
970X2	Physical therapy re-evaluation	.60
970X3	Occupational therapy evaluation	1.20
970X4	Occupational therapy re-evaluation	.60

The RUC accepted the Review Board's report.

Doctor Haynes requested that the AAOS comment letter in support of the APMA recommendation for *2989X Endoscopic Plantar Fasciotomy* be forwarded to HCFA. Members of the RUC also expressed concern that payment policies be reviewed to specify the number of times a physical or occupational therapy re-evaluation may be reported in a given time frame.

X. Relative Value Recommendations for New or Revised Codes

Remaining Issues Referred to the CPT Editorial Panel (Tab 9)

The RUC reviewed several issues from the Five-Year Review of the RBRVS which were referred to the CPT Editorial Panel and which no action has yet been taken. The RUC received responses from several specialty societies indicating that they have submitted or are developing coding proposals for each of these codes for <u>CPT 1999</u>. The current work RVU for each of these services should be maintained in 1998.

Laparoscopy and Hysteroscopy (Tab 10), Codes 56300-56306, 56350-56356, 59150, 59151
Presenters: George Hill, MD, American Society for Reproductive Medicine and Barbara Levy, MD, American College of Obstetricians and Gynecologists

A facilitation committee Doctors Florin (Chair), Hanley, Haynes, Hitzeman, Jones Koopman, Molstad, and Winters met to review this issue.

The RUC submitted recommendations to HCFA during the Five-Year Review of the RBRVS for increases in the work relative values for codes 56300 *Laparoscopy (peritoneoscopy), diagnostic; (separate procedure)* and 56305 *...with biopsy (single or multiple)*. HCFA did not adopt these recommendations because the RUC recommendations would create rank order anomalies within

the laparoscopy and hysteroscopy family of codes. At the February 1997 RUC meeting, ACOG requested that the RUC review rank order anomalies that exist in these laparoscopic procedures. Doctor Grant Bagley recommended that the RUC review the issue and forward any comments or recommendations to HCFA.

After reaffirming their recommendations of 5.00 for 56300 and 5.30 for 56305, the RUC reviewed survey data from 125 obstetricians and gynecologists for each of these services. Establishing codes 56300 and 56305 as the base, the RUC recommends that 56301 *Laparoscopy, surgical; with fulguration of oviducts (with or without transection)* and 56302 *...with occlusion of oviducts by device (band, clip, or Falope ring)* be valued at 5.50 to account for the increased work of the additional office visit included in the 10 day global period. This recommendation is less than the survey median of 6.10.

The RUC was concerned that the survey medians for two codes, 56304 *Laparoscopy, surgical; with lysis of adhesions* and 56306 *...with aspiration (single or multiple)* were too high and recommends work rvus of 10.00 and 5.60 respectively, which approximate the 25th percentile of the survey median.

The RUC did accept the survey median for the majority of the services in this family of codes, including:

56303	*Laparoscopy, surgical; with fulguration or excision of lesions of the ovary, pelvic viscera, or peritoneal surface by any method*	10.50
56350	*Hysteroscopy, diagnostic (separate procedure)*	3.33
56351	*Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D &C*	4.75
56352	*with lysis of intrauterine adhesions (any method)*	6.17
56353	*with division or resection of intrauterine septum (any method)*	7.00
56354	*with removal of leiomyomata*	10.00
56355	*with removal of impact(ed) foreign body*	5.21
56356	*with endometrial ablation (any method)*	9.50
59150	*Laparoscopic treatment of ectopic pregnancy; without salpingectomy and/or oophorectomy*	11.20
59151	*with salpingectomy and/or oophorectomy*	11.10

The RUC agreed that these survey medians reflect an appropriate rank order between these services and codes 56300 and 56305. The survey median for code 56355 *Hysteroscopy, surgical; with removal of impact foreign body* is also equivalent to code 52315 *Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); complex* (work rvu = 5.21), which serves as an appropriate cross-specialty reference service.

Hysterosonography (Tab 11), Tracking Numbers: GG1
Presentation: Carolyn Runowicz, MD, American College of Obstetricians and Gynecologists
Barbara Levy, MD, American College of Obstetricians and Gynecologists
George A. Hill, MD, American Society for Reproductive Medicine

7683X, *Hysterosonography, with or without color flow Doppler*, is a new code used to determine the presence of endometrial abnormalities such as hyperplasia, submucosal endometrial fibroids or carcinoma. Prior to imaging, a catheter is placed into the endometrial cavity and saline is injected. These services are reported using code 58340, *Catheterization and introduction of saline or contrast material for hysterosonography or hysterosalpingography*, which is separately reportable. Code 7683X was surveyed by two specialty societies with median RVUs of 0.92 and 0.78. Also, 7683X can be compared to the transvaginal ultrasound, 76830, *Echography, transvaginal* (RVU=0.69), plus 0.03 RVUs for the color Doppler. Color Doppler in echocardiography (code 93325) is equivalent to 0.07 RVUs. Based on the comparison to 76830 and 93325, the RUC recommends that 7683X should be valued at 0.72 work RVUs.

Radical Trachelectomy (Tab 12), Tracking Number: YY1
Presentation: Carolyn Runowicz, MD, American College of Obstetricians and Gynecologists
Barbara Levy, MD, American College of Obstetricians and Gynecologists

CPT code 5753X, *Radical trachelectomy with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s)*, is a new code used for the removal of the cervix and upper one third of the vagina. This service is similar to code 58210, *Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s)* (RVU=27.00), except that the new code describes an operation to remove the cervical stump which was left intact during a subtotal hysterectomy. The fact that the fundus of the uterus is not present and that the cervix is heavily scarred and inflamed, makes 5753X more difficult than 58210. Survey data from 29 obstetricians and gynecologists show a median RVU of 28.00 and a median intra-service time of 240 minutes. For code 5753X the RUC recommends the survey median, 28.00 work RVUs.

Removal of Cerclage Suture (Tab 13), Tracking Number: ZZ1
Presentation: Carolyn Runowicz, MD, American College of Obstetricians and Gynecologists
Barbara Levy, MD, American College of Obstetricians and Gynecologists

CPT code 5987X, *Removal of cerclage suture under anesthesia (other than local)*, is a new code which describes the work involved in removing a cervical suture under anesthesia. 5987X can be compared to 59320, *Cerclage of cervix, during pregnancy; vaginal* (RVU=2.48), except that 5987X requires less intra-service time and lower levels of judgment, technical skill and stress. Survey data for 5987X show a median RVU of 2.13 and a median intra-service time of 20 minutes. The RUC recommends the survey median, 2.13 work RVUs.

Repair of Non-Structural Valve Dysfunction (Tab 14), Tracking Number: BB1
Presentation: Sidney Levitsky, MD, Society of Thoracic Surgeons

CPT code 3349X, *Repair of non-structural prosthetic valve dysfunction with cardiopulmonary bypass (separate procedure)*, is a new code which describes the work involved in repairing a leak in a prosthetic valve which was installed previously. In its review the RUC discussed how the work involved in this code compares to 33405, *Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft* (RVU=28.47). They concluded that the new code has many of the same difficulties which are associated with 33405 such as; entering the chest again and working with scar tissue. Because of these issues, the RUC recommends that the value of 33530, *Reoperation, coronary artery bypass procedure or valve procedure, more than one month after original operation (list separately in addition to code for primary procedure)* (RVU=5.86), be subtracted from the specialty recommended value and that 3349X be added to the group of codes which may be reported with 33530. The specialty recommendation is based on survey data which show a median RVU of 31.50. The calculation is as follows 31.50 - 5.86 = 25.64. Thus, the RUC recommends a value of 25.64 work RVUs for 3349X.

Psychotherapy (Tab 15), Tracking Numbers: RR3 - RR26
Presentation: Ronald Shellow, MD, American Psychiatric Association
Nancy Willcockson, PhD, American Psychological Association
Mirean Coleman, National Association of Social Workers

Twenty-four new psychotherapy codes have been crosswalked from the G0071-G0094 HCPCS Level II codes developed by HCFA. The current HCPCS Level II codes have work RVUs assigned to them by HCFA. The RUC extensively discussed this issue and was concerned that survey data on these new codes were not available for all providers. The RUC recommends that the current G-code values be crosswalked to the CPT codes and remain interim until the RUC can revisit the issue after a survey has been conducted by each of the professions providing these services, including psychiatry, psychology, social work, and nursing.

Conscious Sedation (Tab 16), Tracking Numbers: NN1 and NN2
Presentation: Steven Krug, MD, American Academy of Pediatrics
Lanny Garvar, MD, American Academy of Oral Maxillofacial Surgeons

A facilitation commitee, Doctors Mayer (Chair), Hannenberg, Hayes, Lichtenfeld, Moorefield, Opelka, Tudor, and Jerilyn Kaibel, DC, met to consider this issue.

The RUC considered two new CPT codes for conscious sedation; 991X1, *Sedation with or without analgesia (conscious sedation); intravenous, intramuscular or inhalation*, and 991X2, *...oral, rectal and/or intranasal*. The RUC agreed that conscious sedation represents the lowest end of the spectrum of anesthesia services and the only comparable codes would be anesthesia codes. However, the intra service portion for the sedation alone is not as intense as an anesthesia service because the physician's attention is devoted to the principal procedure and the pre and post work for conscious sedation is more similar to an evaluation and management service.

The RUC chose to evaluate 991X1 and 991X2 by assigning what was believed to be appropriate intra-service work per-unit of time (IWPUT) for the pre-, intra-, and post-service periods. When reviewing intra-service work, the RUC recommends 50% of the accepted anesthesia intra-work intensity, .5(.017)=.0085, and 20 minutes of intra-service work. Half of the anesthesia work

intensity was selected because physicians do not spend all their time and effort on anesthesia, in that they are also involved with primary service. Twenty minutes of intra-service time is supported by the pediatric survey data and adequately distinguishes the provision of sedation from the primary procedure.

For both pre and post-service work the RUC recommends assigning an IWPUT equivalent to an evaluation and management service (0.027) and assuming 10 minutes for both pre and post time. The RUC arrived at 10 minutes of work because it is supported in the survey data which show median time in excess of 10 minutes and because it was felt that some of the pre and post-work for the primary service overlaps with work for conscious sedation. It was expressed that the survey results of 1.80 and 2.40 did not recognize the overlap of time with the primary procedure.

The resulting calculation is: 10(.027) + 20(.0085) + 10(.027) = 0.71 RVUs. The RUC viewed the value of 0.71 RVUs as a middle range. The value was adjusted up for 991X1 to 0.80 and down for 991X2 to 0.60. This adjustment compensated for the varying levels of difficulty associated with the two routes for administration of the sedation.

Observation Same Day Discharge Services (Tab 17), Tracking Numbers: OO1, OO2, and OO3
Presentation: Peter Sawchuk, MD, American College of Emergency Physicians
Steven Krug, MD, American Academy of Pediatrics

Three new codes have been developed to describe observation same day hospital discharge services: 992X1, *Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission of low severity*, 992X2, *Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission of moderate severity*, and 992X3, *Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission of high severity*. The RUC expressed concern over the time frame that these codes incorporate. They specify that the patient must be admitted and discharged on the same date. The RUC felt that a calendar day is an arbitrary cut off point. The RUC recommends that the physician work is the same when admitting a patient to hospital observation at 9:00 pm with a discharge at 9:00 am and admitting a patient to observation at 9:00 am and discharging at 9:00 pm.

The RUC recommends that 992X1, 992X2, and 992X3 should be valued based on a combination of hospital observation services, 99218, 99219, and 99220 and 99238 *Hospital discharge day management* at each of the three appropriate levels. The calculation would be as follows:

992X1 = 99218 *Observation care* (1.28) + 99238 *Hospital Discharge Day Mgt.* (1.28) =2.56
992X2 = 99219 *Observation care* (2.14) + 99238 *Hospital Discharge Day Mgt* (1.28) = 3.42
992X3 = 99220 *Observation care* (2.99) + 99238 *Hospital Discharge Day Mgt* (1.28) = 4.27

Care Plan Oversight Services (Tab 18), Tracking Numbers AE1-AE7
Presentation: Fredrica Smith, MD, American Society of Internal Medicine and David West, MD, American Academy of Family Physicians

These codes were considered by a RUC facilitation committee comprised of. Doctors Sigsbee (Chair), Berland, Britton, Jensen, McCaffree, Sawchuck, Vanchiere, Whitten and Eileen Sullivan-Marx, PhD. The current code for care plan oversight 99375 (work rvu = 1.73) has been replaced with codes that differentiate between care plan oversight services provided to patients in a number of facilities including nursing homes, hospice facilities, and home care settings. The codes represent a culmination of physician work that has occurred within a calendar month.

The RUC recommends that the codes 99375, 993X3, and 993X5, which describe more than 30 minutes of care plan oversight, be assigned the same work rvu of the existing code 99375 (1.73). The RUC recommends that the new codes for care plan oversight for 15-29 minutes be assigned a work rvu of 1.10, which incorporates the same level of intensity for an average of 20 minutes per month.

Nursing Facility Discharge (Tab 19) Tracking Numbers: AF1-AF2
Presentation: Fredrica Smith, MD, American Society of Internal Medicine and Doug Stone, MD, American Medical Directors Association

A proposal submitted by the American Academy of Internal Medicine and the American Medical Directors Association was considered at the February 1997 CPT Editorial Panel Meeting. This proposal was developed because the current discharge code inadequately describe discharge services from facilities other than the hospital and the subsequent nursing facility care codes inadequately describe the work involved with a discharge service. The Panel approved two new nursing facility discharge codes contingent upon the development of appropriate texts and cross-references.

These codes were considered by a RUC facilitation committee comprised of Doctors Sigsbee (Chair), Berland, Britton, Jensen, McCaffree, Sawchuck, Vanchiere, Whitten and Eileen Sullivan-Marx, PhD. The specialty societies reported to the committee that the nursing facility discharge day management codes are to be used to report the total duration of time spent by the physician for the final nursing facility discharge of the patient. The codes include as appropriate, final examination of the patient, discussion of the nursing facility stay, instructions for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions and referral forms. The specialty societies also reported that these codes represent a culmination of all the activities associated with the discharge of the patient.

The facilitation committee and the specialty societies agreed that RVUs based on the 25th percentile of the survey results would be a more appropriate recommendation. In addition, in order to prevent the inappropriate use of these codes (eg,. signing death certificates etc.), the RUC agreed that the time in the descriptor of CPT code 99315 be changed from “30 minutes or less” to “15 -29 minutes.”

Code	Intra-Service Time	RUC Recommendation

99315	15	1.20
99316	30	1.60

The RUC agreed with the facilitation committee that there is less physician work involved in nursing facility than hospital discharge. In addition, the RUC lowered the RVU recommendation proposed by the facilitation committee on code 99316 from 1.74 to 1.60 RVUs, the above table reflects those changes. The recommendation of 1.20 RVUs for code 99315 and 1.60 RVUs for code 99316 represents approximately 10 % less work than the RVUs for the hospital discharge codes 99238, 1.28 RVUs and 99239, 1.75 RVUs respectively.

Home Care Visits (Tab 20) Tracking Numbers: AG1-AG9
Presentation: George Talar, MD, American Academy of Home Care Physicians, David West, MD, American Academy of Family Physicians, Marc Lenet, DPM, American Podiatric Medical Association, Steven Krug, MD, American Academy of Pediatrics

At the April 1996 RUC meeting, the RUC adopted a recommendation that the entire family of home visit codes be referred to the CPT Editorial Panel to consider the following issues:

1. The highest level of service in the current new and established patient home services involves only a detailed history and a detailed examination. Therefore, there is no code to identify those home services which involve either a comprehensive history or comprehensive examination.

2. The current home services codes do not reflect the fact that physicians providing home services must often provide extensive education, counseling, and care coordination involving the patient, patient's family or caregiver.

A proposal was submitted by the American Academy of Family Physicians and the American Academy of Home Physicians which was considered at the February 1997 CPT Editorial Panel Meeting. In the proposal the specialty societies addressed the concerns of the RUC by adding new codes that require a comprehensive history and comprehensive examination as key components. In addition, a sentence was added to the descriptor of each home visit code which reads: "Education and counseling involving the patient, patient's family or caregiver is also provided." The Panel tentatively accepted three new home visit codes and the revision of existing codes 99341, 99342, 99343, 99344, 99345, 99351, 99352 and 99353 contingent on their review of the April 1997 RUC recommendations concerning typical times for these codes.

A RUC facilitation committee comprised of Doctors Sigsbee (Chair), Berland, Britton, Jensen, McCaffree, Sawchuck, Vanchiere, Whitten and Eileen Sullivan-Marx, PhD considered the Home Care Visit recommendations. The specialty societies reported to the committee that a home care service is an evaluation and management service provided to a new or established patient in the home. The level of service provided depends on the history, examination, and medical decision making involved. The presenters noted that the home care visit patient population is more complex than patients seen by physicians in the office setting. It was also reported that the home care codes were never surveyed by Harvard and that the relative value units were assigned by HCFA. In addition, the specialties noted that office visit post-service time is an inappropriate point of comparison since home health patients are only seen by the physician when they are ill.

The facilitation committee Chair was informed that HCFA would consider a level degree of intensity for this family of codes. This was based on the revised intra-service work intensities that resulted from HCFA's review of the RUC recommendations from the 5-year review of the

evaluation and management services. As described in the May 3, 1996 NPRM; pre-service and post-service work is expressed as a percentage of intra-service work. *In order to calculate the new RVUs for the office visit codes for new and established patients, HCFA used intra-service work intensities and pre- and post-service work percentages in addition to the CPT times for each code. The intra-service work intensity of 0.031 was multiplied by the typical time of the code to determine new intra-service work values. The pre-and post-service work of this value was added to the intra-service work value to calculate the final work RVUs for these codes. The formula is total work RVUs=(intra-service work intensity)x(CPT time)x(1+pre/post percentage of intra-service work).* The pre/post percentage of intra-service work was calculated to be 43% in 1997 for the office visit codes. These assumptions were applied in developing the RUC recommendations for home visits.

Staff Note: The home visit recommendations as presented by the facilitation committee were accepted by the full RUC contingent on the CPT Editorial Panel inserting all of the RUC intra-service times into the CPT descriptors of the codes. The CPT Panel reviewed this issue at their May 2, 1997 meeting and agreed to include the intra-service times that were originally proposed by AAFP. These times were validated by combining the results of both the RUC survey and a survey of vignettes only conducted for CPT. The CPT times vary from the time presented at the RUC meeting for four codes. These intra-service times and the calculated RUC recommendations are listed in bold below:

Code	Intra-service Time	RUC Recommendation (Intra-service time x IWPUT of .031 x 1.43)
99341	20	0.89
99342	30	1.33
99343	**45**	**1.99**
99344	60	2.66
99345	**75**	**3.32**
99347	15	0.66
99348	**25**	**1.11**
99349	40	1.77
99350	**60**	**2.66**

Attendance at Delivery (Tab 21), Tracking Number: AH2
Presentation: Steven Krug, MD, American Academy of Pediatrics
David West, MD, American Academy of Family Physicians

A faciliation committee, Doctors Mayer (Chair), Hannenberg, Hayes, Lichtenfeld, Moorefield, Opelka, Tudor, and Jerilyn Kaibel, DC met to discuss this issue.

CPT code 9943X, *Attendance at delivery (when requested by delivering physician) and initial stabilization of newborn*, is a new code which describes the services of a physician who is requested by an obstetrician to attend the delivery. Attendance is not required for most deliveries and is only used for high risk deliveries such as a Caesarian section or meconium staining. A survey of 50 physicians showed a median RVU of 2.05. After considering comparisons to other evaluation and management services provided to the newborn, the RUC concluded that the specialty recommended value was too high. Code 99222, *Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components: a*

comprehensive history@ a comprehensive examination@ and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit (RVU=2.14), was viewed by the RUC as more difficult and intense than 9943X. The RUC recommends that 9943X be valued similar to 99233, *Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a detailed interval history@ a detailed examination@ medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit* (work rvu=1.51). The RUC recommends that 9943X should be valued at 1.50 RVUs.

Destruction of Lesions (Tab 22), Tracking Numbers: QQ1, QQ2, QQ3, QQ6, QQ7, QQ13, and QQ14
Presentation: James A. Zalla, MD, American Academy of Dermatology

A facilitation committee, Doctors Haynes (Chair), Buser, Jones, Mabry, Powe, Rich, Schmidt Schnur, Winters, and Emily Hill-PA-C, met to discuss this issue.

CPT code 17004,*...15 or more lesions,*is a new code which replaces several multiple lesion destruction codes. A HCPCS Level II code, G0053, is currently being used to describe the service. G0053 was assigned 3.05 work RVUs by HCFA. The survey for 17004 showed a median RVU of 3.05, but with a median intra-service time of 12 minutes. The RUC was concerned that the relatively high RVUs combined with low intra-service time resulted in a high intra-service work per-unit time (IWPUT), a constructed measure of intensity. For this reason the RUC recommends a lower work RVU for 17004. The RUC took its recommended RVU for 17000, 0.55, and its recommended RVU for 17003, 0.15, and extrapolated the values out to 15 lesions. The result is a RUC recommendation for 17004 of 2.65 RVUs.

CPT code 11200, *Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions*, has been revised to include 17200, *Electrosurgical destruction of multiple fibrocutaneous tags; up to 15 lesions*, which has been deleted. The RUC's recommendation for the revised 11200 is 0.69 RVUs which is the current value of 11200. Code 11200 is used approximately 70% more frequently than 17200 and survey data show a median RVU of 0.70.

CPT code 11201, *...each additional ten lesions*, has been revised to include 17201, *...each additional ten lesions* (RVU=0.38), which has been deleted. The RUC's recommendation for the revised 11201 is 0.35 RVUs. Survey data showed a median RVU of 0.35. The combination of a higher survey median and a higher value for 17201 persuaded the RUC that code 11201 was previously undervalued at 0.26. For these reasons the RUC recommends an increase in the work RVU of 11201 to 0.35

CPT code 17000, *Destruction by any method, including laser, with or without surgical curettement, all benign or premalignant lesions (eg, actinic keratoses) other than skin tags or*

cutaneous vascular proliferative lesions, including local anesthesia; first lesion, has been combined with 17100 which was deleted. Previously 17000 was for lesions of the face and 17100 was for lesions other than face. The RUC recommends that the new work relative value for 17000 should be 0.55 RVUs. This value is equal to 70% of the current value of 17000, 0.56 RVUs, as it was previously reported and 30% of the value of 17100, 0.53 RVUs. The percentages are based on the specialty societies estimation of the portion of the time the old codes were utilized. The value of 0.55 RVUs is also supported by survey data which showed a median RVU of 0.59 and HCFA assignment of 0.55 RVUs to G0051, the HCPCS Level II code crosswalked to 17000.

CPT code 170X1, *second through 14 lesions, each (List separately in addition to code for first lesion)*, is a new code which replaces 17001, 17002, 17101, and 17102. 170X1 is to be used as an add-on code to 17000 for work on each lesion up to 14. The codes which it replaces are currently valued at 0.19, 0.19, 0.11, and 0.11 respectively. The survey median for 170X1 is 0.19 RVUs. Based on the survey and the value of the old codes, the RUC recommends a value of 0.15 RVUs. This value is also supported by the current HCFA value of 0.18 RVUs for G0052, the HCPCS Level II code crosswalked to 170X1.

CPT code 170X2, *...15 or more lesions*, is a new code which replaces several multiple lesion destruction codes. A HCPCS Level II code, G0053, is currently being used to describe the service. G0053 was assigned 3.05 work RVUs by HCFA. The survey for 170X2 showed a median RVU of 3.05, but with a median intra-service time of 12 minutes. The RUC was concerned that the relatively high RVUs combined with low intra-service time resulted in a high intra-service work per-unit time (IWPUT), a constructed measure of intensity. For this reason the RUC recommends a lower work RVU for 170X2. The RUC took its recommended RVU for 17000, 0.55, and its recommended RVU for 170X1, 0.15, and extrapolated the values out to 15 lesions. The result is a RUC recommendation for 170X2 of 2.65 RVUs

CPT code 17110, *Destruction by any method of flat warts, molluscum contagiosum, or milia, up to and including 14 lesions*, was revised from its old description and the number of lesions treated reduced from 15. The survey median RVU was 0.67. However, the RUC was not convinced that there was compelling evidence to increase the RVUs above those established in refinement. For this reason the RUC recommends that the work RVUs should be maintained at 0.55.

CPT code 171X3, *...15 or more lesions*, is a new code. Previously under the old codes removal of lesions in excess of 15 would be coded as 17110 x 2 with the second 17110 cut in half by the multiple procedure rule. The RUC chose to apply this same logic to the valuation of 171X3. If 17110 is valued at the RUC recommended 0.55, 171X3 should equal 0.55+1/2(0.55) or 0.82. The RUC's recommendation of 0.82 RVUs is less than the dermatology survey median of 1.50.

Application of Halo (Tab 23) Tracking Number: TT1
Presentation: Laura Tosi, MD, American Academy of Orthopaedic Surgeons, Steven Krug, MD, American Academy of Pediatrics

During the five-year review of the RBRVS, it was noted that although the CPT manual contained a code for the application and removal of a halo in an adult (code 20661), no such code existed for the pediatric population. Due to the fact that there is a significantly more physician work involved in this procedure in the pediatric population, the specialty societies believed that the most appropriate course of action would be to develop a new code. The services described by CPT code 2066X, *Application of halo, including removal, cranial, 6 or more pins placed, for thin skull osteology, (eg, pediatric patients, drocephalus, osteogenesis imperfecta), requiring general*

anesthesia involve pre-operative CT evaluation of the skull, multiple pin site placement, and the necessity of general anesthesia. In contrast, the adult halo application code 20661 (4.27 RVUs) does not include the pre-operative CT evaluation of the skull multiple pin site placement, and does not require general anesthesia.

This procedure is performed on non-traumatic patients with significant spinal and skeletal deformities. In children, halo application requires the use of alternate methods of anesthesia. The halo ring is applied under general anesthesia, the patient is then awakened from the general anesthesia, and to ensure proper positioning the halo pins are applied using local anesthesia at the pin sites. The actual procedure lasts approximately 330 minutes.

Physicians have termed the halo a "crown of thorns " for children. Parents are often very reluctant to consider the halo as a suitable means of treatment for their children, therefore, the physician must spend a lot of time counseling the parents. In addition, the risk of complications is much higher in the pediatric population vs. adults. These complications include: pin loosening and infection at the pin site, usually due to incorrect pin placement.

Based on a survey of over 150 orthopaedic surgeons, pediatricians, and neurosurgeons, the RUC recommended a work value 7.0 RVUs for CPT code 2066X which represents the 75th percentile of the survey data.

Arthroscopy of the Ankle (Tab 24) Tracking Numbers: VV1-VV2
Presentation: Laura Tosi, MD, American Academy of Orthopaedic Surgeons

New CPT codes were added to describe ankle arthroscopy. CPT code 298X1, *Arthroscopy, ankle, surgical; excision of osteochondral defect of talus and tibia, including drilling of the defect* involves visualization of the joint, minor synovial resection, injection and/or joint aspiration, soft tissue or invasive distraction, and abrasion arthroplasty of the defect. The typical patient presents with symptoms of ankle pain and swelling with past traumatic injury. CPT code 298X2, *Arthroscopically aided repair of large osteochondritis dissecans lesion, talar dome fracture, or tibial plafond fracture, with or without internal fixation (includes arthroscopy*) involves visualization of the joint, minor synovial resection, injection or aspiration of the joint, incidental articular shaving, removal of loose bodies, soft tissue or invasive distraction and internal fixation.

The specialty society reported that CPT code 298X1 is similar in terms of pre-and post-operative work to reference code 29898, *Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; debridement, extensive* (8.03 RVUs) although the condition that are being treated are different. Based on a survey of 51 orthopaedic surgeons, the RUC recommended an RVU of 8.60 for this procedure which represents the survey median.

CPT code 298X2 is a combination of procedures as noted above and similar in nature to reference code 29898, the work involved in 298X2 is more complex. The intra-service time for 298X2 is 90 minutes vs. 60 minutes of intra-operative time for 29898. Based on a survey of 51 orthopaedic surgeons, the RUC recommended an RVU of 8.00 for this procedure which represents the survey median.

Arthroscopy of the Hip (Tab 25) Tracking Numbers: WW1-WW4
Presentation: Laura Tosi, MD, American Academy of Orthopaedic Surgeons, Thomas Byrd, MD, Arthroscopy Association of North America

A new family of hip arthroscopy codes were added to CPT. Unlike the other arthroscopic procedures, these procedures are performed rarely, and the specialty society reported that they expect that these codes will rarely be reported. The specialty noted that unlike the other major joints including; the shoulders, knees, elbows, and ankles, the hip is a much deeper joint and is a more difficult area to work in because the surgeon must avoid soft tissue and critical nerves and blood vessels. In addition, unlike other arthroscopic procedure, hip arthroscopy is performed under x-ray which increases the amount of physician work that is involved.

Based on a survey 29 orthopaedic surgeons, the RUC recommended 7.75 RVUs for code 298X1, *Arthroscopy, hip diagnostic with or without synovial biopsy (separate procedure*), 9.00 RVUs for code 298X2, *Arthroscopy, hip, surgical; with removal of loose body or foreign body*, 9.50 RVUs for code 298X3, *Arthroscopy, hip, surgical; with debridement/shaving of articular cartilage (chondroplasty), abrasion arthroplasty, and/or resection of labrum], and 9.50 RVUs for code 298X4, Arthroscopy, hip, surgical; with synovectomy*. The recommendations for 298X1 and 298X2 represent the survey median and the recommendations for 298X3 and 298X4 represent the 25th percentile of the survey results.

Transurethral Destruction of Prostate Tissue (Tab 26), Tracking Number: J2
Presentation: Thomas J. Cooper, MD, American Urological Association

A facilitation committee, Doctors Mayer (Chair), Hannenberg, Hayes, Lichtenfeld, Moorefield, Opelka, Tudor, and Jerilyn Kaibel, DC, met to discuss this issue.

CPT code 524X2, *Transurethral destruction of prostate tissue; by radiofrequency thermotherapy*, is a new code for an emerging technology and is rarely performed in the U.S. Because this is a new technology it is difficult to make comparisons with existing procedures. The RUC felt that 524X2 could best be compared to 5246X, *Transurethral destruction of prostate tissue; by microwave thermotherapy*, another emerging technology that is seldom performed. Both codes are new approaches to treating patients with benign prostatic hyperplasia (BPH). Patients with BPH most commonly undergo a transurethral resection of the prostate which is described by CPT codes 52601, 52612, and 52614. Surveys showed a median RVU of 9.92 and an intra-service time of 57.5 minutes for 524X2 and a median RVU of 9.58 and an intra-service time of 90 minutes for 5246X. The RUC recommended a value of 9.58 RVUs for 5246X at its' February 1997 meeting and concludes that 524X2 should be valued the same. Therefore the RUC recommends that 524X2 should be valued at 9.58 RVUs.

Laparoscopic Surgery (Tab 27)
American College of Surgeons

This issue was withdrawn by the specialty society. See Tab 10 for the RUC recommendation on CPT code 56304.

Ganciclovir Implant (Tab 28) Tracking Number: EE1
Presentation: Stephen A. Kamenetsky, MD, American Academy of Ophthalmology

A new CPT code was added for the implantation of an intravitreal drug delivery system. The most common implant is ganciclovir which is used in the treatment of CMV retinitis, a disease that is associated with AIDS patients. In the absence of a CPT code to report this service physicians have been using the unlisted procedure code 67299. The specialty society reported that due to the success of ganciclovir and its recent FDA approval, it is expected that more physicians will be reporting this procedure. The specialty society noted that the work involved in

6702X, *Implantation or replacement of intravitreal drug delivery system, include concomitant removal of vitreous (eg, ganciclovir implant*) includes concomitant removal of vitreous is less intense than vitrectomy procedures such as 67036 which has an RVU of 11.33.

Based on a survey of 40 ophthalmologists, the RUC recommended an RVU of 10.35 for code 6702X.

Bone Density Studies (Tab 29), Tracking Numbers: AB1 - AB6
Presentation: William Thorwarth, MD, American College of Radiology
Kenneth McKusick, MD, Society of Nuclear Medicine

A facilitation committee Doctors Haynes (Chair), Buser, Jones, Mabry, Powe, Rich, Schmidt Schnur, Winters, and Emily Hill-PA-C met to discuss this issue.

CPT codes 76070, 76075, 78350, and 78351 were only editorially changed. The current work relative values for these codes should be retained. Codes 760X1, *Dual energy x-ray absorptiometry (DEXA), bone density study, one or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)*, and 760X2, *Radiographic absorptiometry photodensitometry), one or more sites*, are new codes used to study bone density. The survey data showed a median RVU of 0.30 for 760X1 and a median RVU of 0.26 for 760X2. The RUC expressed concern that some portion of the work for these services is performed by a technician and as such the recommended RVUs are too high. The RUC believes that 760X1 should be compared to 71020, *Radiologic examination, chest, two views, frontal and lateral* (RVU=0.22), and recommends that the relative value should be the same. The RUC sees that the surveyed proportional relationship between 760X1 and 760X2 should be maintained. Thus, the RUC recommends that 760X1 should be valued at 0.22 RVUs and 760X2 should be valued at 0.20 RVUs.

Cervical or Vaginal Cytopathology (Tab 30) CPT Code: 88141
Presentation: George Kwass, MD, College of American Pathologists

The specialty society reported that a new code 88141, *Cytopathology, cervical or vaginal, (any reporting system; requiring interpretation by the physician* was added to CPT that will replace the work involved in the Pap smear interpretation codes 88151 and 88157, which will be deleted. The specialty noted that this change should be considered editorial and does not involve a change in physician work. The specialty recommended that the current value of the pap smear interpretation code of 0.42 RVUs be maintained for the new code 88141. The RUC agreed with the specialty society and recommend an RVU of 0.42 for CPT code 88141.

Pulmonary Artery Angioplasty (Tab 31) Tracking Numbers: XX1-XX2
Presentation: James Maloney, MD, American College of Cardiology, Steven Krug, MD, American Academy of Pediatrics

New codes were added to CPT to report the work involved in pulmonary artery angioplasties. Pulmonary artery angioplasty is used primarily to treat patients that are suffering from pulmonary artery stenosis which is caused by congenital heart disease. The specialty societies reported that these procedures are performed rarely, approximately 400 were performed in 1996. Currently, these procedures are reported using CPT code 35476 which is a percutaneous transluminal

balloon angioplasty code. The specialty societies also noted that these procedures are complex and require that the pulmonary artery be dilated at more than one stage to ensure cardiac output.

During their deliberations, the RUC believed that the specialty societies recommendations were too high for these codes, and determined that because the work of these procedures is similar, CPT codes 929X1, *Percutaneous transluminal balloon angioplasty; single vessel and 929X2, Percutaneous transluminal balloon angioplasty; each additional vessel* should have relative values more in the range of the current coronary angioplasty codes, CPT codes 92982 (10.98 RVUs) and 92984 (2.97 RVUs). The RUC recommended an RVU of 12.00 for code 929X1 and an RVU of 6.00 for code 929X2. Code 929X2 was valued as a single vessel procedure by the RUC.

Pediatric Cardiac Catheterization (Tab A) Tracking Numbers: AJ1-AJ4
Presentation: James Maloney, MD, American College of Cardiology, Walter Fried, MD, American Academy of Pediatrics

Recognizing that more of these procedures are being performed on children, new CPT codes were added for pediatric cardiac catheterization. These catheterizations are performed on patients to correct congenital anomalies. The specialty society reported that these procedures are considerably more complex, have a higher risk and require more time and expertise than similar procedures in patients with acquired heart disease. Because of the complexity of the procedure, the pre-procedure time is increased, with more time being spent in reviewing the non-invasive data and previous cardiac catheterizations. Since the vessels are smaller vascular access is more difficult in small children. In addition, the technical skill during the catheterization is increased in congenital anomalies, since the complex disease often reorients the heart, heart valves, and the ventricular septum and other structures may be in an abnormal position and location. It was also noted that children are more likely to develop complications and must be monitored more closely.

The RUC recommended an RVU of 4.23 for CPT code 935X1, *Right heart catheterization, for congenital cardiac anomalies* which was lower than the specialty society recommendation but a higher RVU than the adult right heart catheterization code 93501 which has an RVU of 3.02.

Based on a survey of approximately 40 pediatricians and cardiologists, the RUC recommended an RVU of 8.35 for code 935X2, *Combined right heart catheterization and retrograde left heart catheterization, for congenital cardiac anomalies* and 10.00 for code 935X3, *Combined right heart catheterization and transseptal left heart catheterization through intact septum with or without retrograde left heart catheterization, for congenital cardiac anomalies*. Both of these RVUs represent the survey medians.

The RUC recommended an RVU of 6.70 for CPT code 935X1, *Right heart catheterization, for congenital cardiac anomalies* which was lower than the specialty society recommendation but the same as the RVU for the adult procedure code 93529 which has an RVU of 6.50.

PET Myocardial Perfusion Imaging (Tab B)
Presentation: Kenneth McKusick, MD, Society of Nuclear Medicine and Richard Wall, MD, American College of Radiology

A facilitation committee comprised of Doctors Britton (chair), Berland, Hayes, Hoehn, Mabry, and Emily Hill PA-C considered revised RVU recommendations on PET imaging. The presenters noted that the work described by codes 787X1, *Myocardial imaging, positron emission tomography (PET), perfusion; single study at rest or stress,* and 787X2, *Myocardial imaging,*

positron emission tomography (PET), perfusion; multiple studies at rest and or stress involve PET imaging of the heart and the procedures are similar in nature to PET for myocardial evaluation, CPT code 78459 (RVU = 1.88). The presenters also noted that at the February RUC meeting, many of the members of the RUC compared PET myocardial perfusion imaging codes to CPT code 78465, *Myocardial perfusion imaging; SPECT and multiple studies*. PET myocardial perfusion imaging involves more physician than 78465. Unlike the large field of view of SPECT scanners, PET scanners have a much smaller field. In addition, due to the short half-life of the Rb-82 tracer, physician involvement in patient positioning is critical, otherwise the target may be missed. To ensure the patient is properly positioned, a test dose is given by the physician. Therefore, more physician work both pre- and intra-service work is required than for the SPECT codes.

CPT code 78459 provided the benchmark for valuing the multiple study 784X2 and the specialty societies felt that codes 784X2 and 784X1 should have the same proportionality (0.37) that exists between the single and the multiple SPECT studies (codes 78464 and 78465). The specialty societies recommended that code 784X1 have an RVU of 1.50, which is valued 20% less than code 78459 (RVU = 1.88). Using the RVU margin of (0.37) representing the incremental difference in work between the single and multiple studies.

The facilitation committee accepted the recommendation of 1.50 RVUs for 784X1 and 1.87 RVUs for 784X2 (1.87-1.50= 0.37). The RUC adopted the recommendations of the facilitation committee.

Renal Nuclear Medicine (Tab C)
Presentation: Kenneth McKusick, MD, Society of Nuclear Medicine and William Thorwarth Jr., MD, American College of Radiology

A facilitation committee comprised of Doctors Britton (chair), Berland, Hayes, Hoehn, Mabry, and Emily Hill PA-C considered revised RVU recommendations on Renal Nuclear Medicine. The presenters noted that they would like to clarify what constitutes physician work involved in the utilization of angiotensin and diuretics in renal studies. The specialty societies noted that the hydration component of procedures 787X1, *Kidney imaging with vascular flow and function; single study, with pharmacological intervention (eg, angiotensin converting enzyme inhibitor and/or diuretic* and 787X2, *Kidney imaging with vascular flow and function; multiple studies, with pharmacological intervention (eg, angiotensin converting enzyme inhibitor and/or diuretic* are very important as the physician is pharmacologically manipulating patients with diuretics. The physicians personally obtains and records blood pressure following the administration of an ACE inhibitor for renal hypertension studies.

CPT code 78707, *Kidney imaging with vascular flow and function; single study without pharmacological intervention* represents the basic kidney imaging and function study code. The specialty society recommended 0.96 RVUs for this procedure. The recommended RVU of 1.21 for CPT code 787X1 represents the basic kidney function and imaging code plus the added work of pharmacologic intervention. The recommended RVU of 1.41 RVUs for CPT code 787X2 reflects the fact that the kidney imaging study with flow and function is performed first without pharmacologic intervention and then repeated with the drugs several hours later. With regard to CPT code 787X2 the RUC was concerned that the recommended RVU for this procedure was higher than the RVU of a multiple study planar myocardial perfusion imaging (code 78461, RVU =1.23). The specialties clarified that the two study nature of code 787X2 requires more physician work. All of the RVUs that the specialties recommended to the facilitation committee were the same values that were presented at the February RUC meeting. The facilitation committee felt

that based on the clarifications that the specialty societies have made to their rationale since that time these recommendations were appropriate. The RUC accepted the recommendations of the facilitation committee.

Magnetic Resonance Spectroscopy (Tab D)
Presentation: William Thorwarth Jr., MD, American College of Radiology

A facilitation committee comprised of Doctors Britton (chair), Berland, Hayes, Hoehn, Mabry, and Emily Hill PA-C considered revised RVU recommendations on Magnetic Resonance Spectroscopy. The presenter noted that during the intra-service portion of the procedure, the physician must select the regions of study and interpret spectral images. He also noted that the interpretation of these spectral images requires more physician work than the interpretation of the images that the study produces.

Based on their survey results, the specialty society recommended the 25th percentile value of their survey which is 1.40 for code 764XX1, *Magnetic resonance spectroscopy*. The facilitation committee accepted this recommendation with the understanding that the CPT descriptor is changed so that this procedure is recognized as a stand-alone not an add-on procedure. The RUC accepted the facilitation committee recommendation.

Trichogram (Tab E)
Presentation: James Zalla, MD, American Academy of Dermatology

A facilitation committee comprised of Doctors Britton (chair), Berland, Hayes, Hoehn, Mabry, and Emily Hill PA-C considered revised RVU recommendations on Trichogram. The presenter noted that the trichogram procedure includes three components; 1) the physician selecting and obtaining the specimen; 2) preparation of the slide; and 3) interpretation of the slide.

The facilitation committee affirmed the specialty society's contention that this procedure is not part of the Evaluation and Management portion of a patient visit to evaluate hair loss. Trichogram constitutes a separate service consisting of three components described above. The comparable codes are blood smear (85060, RVUs =0.45) and crystal identification by light (89060-26, RVUs =0.37). The committee also noted that this procedure was comparable to the low level office visit (99201, RVUs =0.45). The facilitation committee accepted the 25th percentile of the specialty society survey which was 0.41 RVUs for code 969XX, *Microscopic examination of hairs plucked or clipped by the examiner (excluding hair collected by the patient) to determine telogen and anagen counts, or structural hair shaft abnormality*.

ASPRS Request for Reconsideration of Code 15880 (Tab F)
Presenters: James Hoehn, MD, American Society for Plastic and Reconstructive Surgeons and Daniel Nagle, MD,

The RUC reviewed code 15580 *Cross finger flap, including free graft to donor site* during the Five-Year Review of the RBRVS and recommended an increase from 3.40 to 9.00. HCFA accepted the RUC recommendation but indicated their concern regarding needed revisions to clarify the CPT code and/or definitions that precede the codes. The American Society for Plastic and Reconstructive Surgeons requested that the RUC reconsider its original recommendation because this service can also be reported using codes 14040 *Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feed; defect 10 sq cm or less* (work rvu = 7.18) and 15240 *Full thickness graft, free, including direct closure*

of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hand, and/or feet; 20 sq cm or less (work rvu = 8.30), which totals 11.89 when applying the multiple procedures rule.

A facilitation committee (Doctors Florin (Chair), Haynes, Jones, Molstad, Winters, Hitzeman, Hanley, and Koopmann) was assigned to review this request for reconsideration. The facilitation committee recommended that ASPRS pursue a coding proposal to address the concerns raised by HCFA. The current rvu of 8.84 should be maintained for 1998.

<u>Other Issues</u>

The April meeting was Doctor Rodkey's last meeting as RUC Chair before Doctor Hoehn assumes this position. Doctor Hanley also announced that Sandy Sherman was leaving her position as Director of the AMA's Department of Physician Payment Systems to accept a new position in the AMA's Division of Federal Affairs in Washington, and that Sherry Smith would become the new Department Director and RUC Executive Secretary. The RUC expressed its appreciation with mementos and formal toasts to Doctor Rodkey and Ms. Sherman for their outstanding contributions to the initiation and solidification of the RUC structure, function, and process.

The meeting adjourned at 12:00 pm on Sunday, April 27.