

**AMA/Specialty RVS Update Committee  
April 25-April 28, 2002**

**The Sheraton Chicago Hotel  
Chicago, Illinois**

**I. Welcome and Call to Order**

Doctor Richard Whitten called the meeting to order on Thursday, April 25, 2002 at 8:00 a.m. The following RUC Members were in attendance:

James G. Hoehn, MD, Chair	Charles D. Mabry, MD*
Bibb Allen, MD*	John E. Mayer, Jr., MD
James Blankenship, MD	David L. McCaffree, MD
James P. Borgstede, MD	Bill Moran, Jr. MD
Melvin C. Britton, MD	Bernard Pfeifer, MD
Norman Cohen, MD*	Gregory Przybylski, MD
John Derr, Jr., MD	Sandra B. Reed, MD*
Lee D. Eisenberg, MD	William Rich, MD
Thomas A. Felger, MD*	Peter Sawchuck, MD*
John O. Gage, MD	J. Baldwin Smith, III, MD
William F. Gee, MD	Holly Stanley, MD*
Meghan Gerety, MD	Sheldon B. Taubman, MD
Gary Graham, MD*	Trexler Topping, MD*
James E. Hayes, MD	Arthur Traugott, MD*
Alexander Hannenberg, MD	Richard H. Tuck, MD
David F. Hitzeman, DO	Paul Waldorf, MD*
Charles F. Koopmann, Jr., MD	Paul E. Wallner, DO
M. Douglas Leahy, MD*	John Wilson, MD*
Barbara Levy, MD	Richard Whitten, MD (Vice-Chair)
J. Leonard Lichtenfeld, MD	Don E. Williamson, OD

\*Alternate

**II. Chair's Report**

Doctor Whitten welcomed the RUC members and addressed the following issues:

- Doctor Whitten reminded the RUC that this is the last meeting of the CPT/RUC cycle for CPT 2003. Any and all issues must be resolved at this meeting. Doctor Whitten noted that the RUC can assign an interim recommendation to a set of codes while requesting additional data for the September RUC meeting however, the RUC should attempt to at least make interim recommendations.
- Doctor Whitten also noted that CMS would consider all relative values for new/revised CPT 2003 codes interim for one year, regardless of the status of

the RUC recommendation. All new codes will be given an interim status for one year.

Doctor Whitten welcomed:

- Three representatives from the Korean Medical Association, Yoo-mi Chae, MD, Myung-guen Kang MD and Hee-chung Kang who are visiting us to learn more about the RUC process. Doctor Hoehn and Sherry Smith will be traveling to Seoul next week to deliver a lecture on the RUC and the RUC Process to the Korean Medical Association.
- Yasuko Ogata, PhD, RN, a research fellow at the Harvard School of Public Health, who is studying the use of RBRVS methods in home care in Japan. She is an invited guest of Eileen Sullivan-Marx, PhD, R.N.
- Frank West, an invited guest of the American Association of Vascular Surgery
- Iola Desussa and Geri Brennan, from the General Accounting Office

Doctor Whitten announced the RUC Alternates:

- Tom Felger, MD is sitting in for Neil Brooks, MD from the American Academy of Family Physicians
- Chester Schmidt, MD was not able to attend this meeting. Psychiatry was unable to send an alternate.
- Doctor Whitten addressed the Subcommittee and Workgroup meetings:
  - A number of the Subcommittees and Workgroups met via conference call to create much needed additional time at this meeting. The reports to these meetings are included in your agenda book and in the handout materials.
  - Charles Mick, MD was added to the Conscious Sedation Workgroup.
- Doctor Whitten announced that Tom Rice, PhD, a professor at UCLA is preparing a paper for a Robert Wood Johnson funded conference “Who shall lead in America Health Care in the 21st Century?” The paper describes the RUC process. In researching for the paper they contacted the AMA for a copy of the RUC meeting minutes to better understand the work of the committee. Doctor Hoehn informed the RUC that he authorized AMA staff to send the April 2002 RUC minutes to the researchers. Doctor Rice will share a copy of the paper with the RUC when it is completed.

Doctor Whitten announced the members of the three facilitation committees, as follows:

*Facilitation Committee #1*

Lee Eisenberg, MD  
Thomas Felger, MD  
John Gage, MD  
Alexander Hannenberg, MD  
Emily Hill, PA-C  
David Hitzeman, DO  
David Martin, MD  
Gregory Pzybylski, MD, Chair  
Sheldon Taubman, MD  
Arthur Traugott, MD  
Richard Tuck, MD

*Facilitation Committee #2*

James Blankenship, MD, Chair  
Richard Dickey, MD  
William Gee, MD  
James Hayes, MD  
Barbara Levy, MD  
J. Leonard Lichtenfeld, MD  
Holly Stanley, MD  
Paul Wallner, DO  
Richard Whitten, MD  
Don Williamson, OD

*Facilitation Committee #3*

James Borgstede, MD  
Melvin Britton, MD  
John Derr, MD  
Meghan Gerety, MD  
Charles Koopmann, MD  
Bill Moran, MD  
David McCaffree, MD  
Bernard Pfiefer, MD, Chair  
J. Baldwin Smith, MD  
John Mayer, MD  
William Rich, MD

**III. Director's Report**

- Sherry Smith announced that a new version of the RUC database has been created which includes 2000 frequency data and other updates including a quick search. The CD is available through Todd Klemp.
- Sherry Smith announced that plans are proceeding for the RUC Ten Year Anniversary Dinner, which will occur on Saturday, September 28<sup>th</sup>, 2002. Please expect to receive invitation in May or early June for that meeting. It is sure to be a fun event.
- The RUC should review the calendar of meeting dates. The next scheduled meeting is September, 26 – 29, 2002, in Chicago, Illinois at the Swissotel Chicago.

**IV. Approval of Minutes for the February 1, 2002 – February 3, 2002 RUC Meeting**

- An editorial change to the Research Subcommittee report was made. On page 2 of the Research Subcommittee Report, the third paragraph, third sentence regarding IWPUT should state, "Previous studies conducted for general

surgery and vascular surgery show a 90 percent correlation between survey results and the **specialty's estimates of IWPUR by Rasch analysis.**"

- Doctor McCaffree noted that the physician time recommendations attached to the February 2002 RUC minutes may be in error as there were some codes without immediate post service time. Upon AMA staff review, codes 0064X, 019X1, and 019X2 each have 10 minutes of immediate post service time that was not presented in the preliminary minutes. This information will be corrected.

## V. CPT Update

Doctor Eisenberg addressed the panel with the following issues:

- The Evaluation and Management Documentation Guidelines Workgroup will be meeting May 17<sup>th</sup> and 18<sup>th</sup>, 2002 to hear public testimony regarding the evaluation of the Evaluation and Management Documentation Guidelines.
- Questions were raised about whether the workgroup has discussed specialty specific Evaluation and Management Codes. Doctor Eisenberg stated that this subject has been addressed and considered. He continued by stating that any written comments can be submitted to Michael Beebe of CPT staff to be addressed at the May meeting.
- CPT requests that specialty societies bring forth codes they will be presenting to the RUC earlier in the CPT/RUC Cycle to ensure that all meetings have similar sized agendas.
- Questions were raised to the CPT Panel to limit that amount of submissions made to CPT and consequently the RUC Panel. Doctor Eisenberg stated that this subject has been addressed but due to the possible legal restrictions from preventing specialty societies from making submissions, it has never been enacted. He reminded the panel that the only regulating method currently employed by CPT is a deadline which specialty societies must make to have their submissions reviewed by CPT. He will raise this issue at the next CPT meeting.
- CPT requests that the RUC have a regular representative to the CPT Editorial Panel. It was suggested that this position be made on a rotating basis so that more RUC members could be exposed to the CPT Panel process. Doctor Hoehn informed the RUC that this item has been placed on the Administrative Subcommittee Agenda and asked participants to be prepared to discuss this issue during the discussion of that report.

## VI. CMS Update

CMS representatives indicated that there were no relevant updates to provide to the RUC at this meeting.

## VII. Washington Update

Sharon McIlrath, AMA, from the D.C. office reviewed several legislative and regulatory issues.

- Payment Update-
  - Current position: In addition to this year's 5.4 percent cut, CMS is predicting additional cuts of about 14% in the next three years. This amounts to a 30 percent cut when accounting for inflation. The AMA is pushing for a halt in the 2002 cut, however this task could not be completed due to time constraints and the extremely difficult legislative environment after September 11<sup>th</sup>. Members of the senate believe that this halt is still possible. With more negative years to come, it is clear there is a need to fix the formula to completely remove expenditure targets.
  - Possible Solutions: MedPAC recommended a viable solution. They recommend a 2.5 percent increase in the base for 2003 and to replace SGR with a system based largely on increases in practice costs, as measured by the Medicare Economic Index (MEI). Specifically, this system would use a smaller adjustment for productivity increases, which CMS presumes would offset part of any increase in practice costs. This would probably result in an additional increase in the update by 0.5 percent or more each year. CMS immediately branded the proposal "unrealistic," arguing that eliminating the expenditure targets will spur volume growth and destroy Medicare when the baby boomer generation reaches 65. CMS actuaries placed a \$128 billion, over 10-year cost on implementing the MedPAC proposal. The administration's position was that Congress should cut payments to the hospitals and home health to pay for improvements in physician pay. CMS has provided congressional staff with eight alternatives. These alternatives all retain SGR and all would essentially improve payments. These alternatives would result in a decrease in the conversion factors and over the ten year period, average updates for all would either be slightly worse or better than a freeze. It is important to note that a freeze would cost nearly \$40 billion. Both GAO and CBO are opposed to lifting the expenditure targets. They both share Scully's view that eliminating the targets will trigger a volume increase and that an imposition of targets will lead to slower volume growth.
  - AMA's Focus: It is the position of the AMA, to challenge the \$128 billion cost that CMS has estimated and to attack the assumption that expenditure targets control volume.
- Formation of Recommendations: Since last fall, the AMA has been working with 100 coalition groups, including non-MD groups whose payments are also tied to the physician fee schedule as well as all specialties with a Washington presence. Additional groups included group practices, AAMC and the National Rural Health Association. With the help of these groups, the AMA developed a number of recommendations for how CMS could reduce the \$128 billion cost including: changes to the productivity factor, removing drugs, fixing projection errors. In fact, Dr. Rich and AMA staff participated in a meeting with CMS actuaries and three economists who told CMS the current adjustment is too

high. Several of these recommendations were selected by a Ways and Means Committee letter that Ways and Means Chairman, Bill Thomas and Health Subcommittee Chair Nancy Johnson sent to Scully. These recommendations have resulted in the CMS actuaries refining their estimated cost of the MedPAC proposal to \$106.7 billion.

- Congress: Nancy Johnson, Health Subcommittee Chair of the Ways and Means Committee has proposed a bill similar to the MedPAC proposal however it is not a viable option unless there is a decrease in the cost estimates and Congress and the Administration are convinced that a budget neutral fix financed on the backs of other providers is not a possible solution. Meanwhile, the Congressional staff is trying to derive alternative options. Ways and Means and Energy and Commerce are supposed to be working together to create an alternative that would be part of a larger package and could go to the floor by Memorial Day. It is unclear if they will create a short or long term solution. However, there was some concern over the outcomes of the proposal, so their progress has been limited.

The AMA is requesting assistance from physicians to document how cuts will affect your practice and to tell your Congressional members that a 10-year freeze in payments is totally unacceptable.

#### **VIII. Relative Value Recommendations for CPT 2002:**

##### **Nonbiodegradable Androgen Suppression Implants (Tab 4)**

**Presenter: William F. Gee, MD, American Urological Association**

Codes 11981, 11982, and 11983 are new for CPT 2002, and were added to CPT to describe insertion, removal, and removal with reinsertion of a non-biodegradable drug delivery implant. These codes were initially created to describe a once-yearly implant containing leuprolide acetate for the treatment of prostate cancer. However, because various types of medications for various indications can be administered using this type of implant, the CPT Editorial Panel voted to keep the descriptors generic. That is why the type of drug is not listed in the descriptors of these codes.

At the April 2001 RUC meeting, the RUC recommended that CMS develop RVUs for these codes by cross-walking the RVUs from CPT codes 11975, 11976, and 11977, insertion, removal and removal with reinsertion of implantable contraceptive capsules. In April 2002, urology submitted a second letter again requesting a crosswalk to the contraceptive capsule codes. The RUC adopted this as an interim solution and requested that the specialty survey these codes for review at a future RUC meeting. During the April 2002 RUC meeting the specialty noted that the CPT descriptors for these codes do not apply specifically to a urology-related service. The RUC understands that a survey of urologists who perform this procedure for a drug specific to urology would not apply to other specialties that may use this code for other drug implants in the future.

RUC also agreed that the implant insertion would be equivalent work to the contraceptive capsule insertion and a survey is unlikely to produce different results. The RUC therefore validates its May 2001 recommendation to value 11981 identical to 11975. However, the RUC believes that the work for the removal codes may be different than the removal of multiple contraceptive capsules. Therefore, the RUC could not validate the previous recommendations for the removal codes, 11982 and 11983. The RUC recommends that the crosswalked values for 11982 and 11983 remain interim for an additional year and requests urology to survey these codes for the April 2003 RUC meeting.

**The RUC recommends that CMS accept the work RVU of the code 11981 Insertion, non-biodegradable drug delivery implant as cross-walked to 11975 Insertion, implantable contraceptive capsules (Work RVU = 1.48). In addition, the RUC recommends CMS use the interim crosswalk values of codes 11982, and 11983, to 11976, and 11977 respectively, with the understanding that the RUC’s earlier recommendations for these two codes have not been validated and a survey will be completed for the April 2003 RUC meeting. Along with the work value cross-walk, the RUC recommends the following physician time crosswalk.**

CPT Code	Cross-walk Code	Total Time
11981	11975	39
11982	11976	44
11983	11977	69

**Therapeutic Injections (Tab 5)**

**Presenter: David Martin, MD, American Academy of Orthopaedic Surgeons  
Reviewed by Facilitation Committee #2**

For CPT 2002 and 2003, the CPT Editorial Panel replaced CPT code 20550 *Injection, tendon sheath, ligament, trigger points or ganglion cyst* with an entire new family of codes that differentiates the various levels of physician work involved in providing these injections. In May 2001, the RUC submitted a recommendation to CMS that these services should all be valued at the existing value of 20550 (work rvu = 0.86) until all specialties involved in providing these services had the opportunity to survey this family of services to determine the differentiation in physician work. CMS accepted this recommendation and retained the value of 0.86 for these services, pending further review by the RUC.

In April 2002, the RUC received recommendations from a consensus group of specialties, including: neurology, orthopaedic surgery, physiatry, rheumatology, podiatry, anesthesiology, plastic surgery, hand surgery, and spine surgery. For all codes, other than the highest level 20526 *Injection, therapeutic (eg, local anesthetic, corticosteroid); carpal tunnel* service, the consensus panel of specialties recommended work relative values below the interim value of 0.86.

The RUC agreed that CPT 20550 had been overvalued in the past, but determined that the values presented by the specialty societies remained higher than the actual work performed for these services. The RUC was particularly concerned with the work relative value recommendations in relationship to the low intra-service times reported for these services.

The RUC extensively reviewed these services, with an average intra-time of 5 minutes, in comparison to other physician services with low intra-service time. The RUC compared these injection codes to other services with similar intra-service times, including:

- CPT code 67515 *Injection of medication or other substance into Tenon's capsule* (work RVU = 0.61), with an intra-time of 6 minutes.
- CPT code 64405 *Injection, anesthetic agent; greater occipital nerve* (work RVU = 1.32), with an intra-time of 12 minutes.
- CPT code 65205 *Removal of foreign body, external eye; conjunctival superficial* (work RVU = 0.71), with an intra-time of 5 minutes.
- 11950 *Subcutaneous injection of filling material (eg, collagen); 1 cc or less* (work RVU = 0.83), with an intra-service time of 15 minutes.

After considering these cross-specialty comparisons, the RUC agreed that code 20552 *Injection; single or multiple trigger point(s), one or two muscles* should be valued the same as 20600 *Arthrocentesis, aspiration and/or injection, small joint, bursa or ganglion cyst (eg, fingers or toes)* (work = 0.66). The RUC then valued 20526, 20550, and 20551 utilizing the same relativity as the survey medians for these codes. The RUC agreed that CPT code 20553 is the same work as 20550 and 20551. CPT code 20612 was deemed to be more work than 20600 and 20605 and was therefore valued at 0.70. The RUC agrees that these recommendations reflect the appropriate rank-order and relativity in this family of services.

**The RUC recommends the following relative values for these codes:**

<b>CPT 20526</b>	<b>0.94</b>
<b>CPT 20550</b>	<b>0.75</b>
<b>CPT 20551</b>	<b>0.75</b>
<b>CPT 20552</b>	<b>0.66</b>
<b>CPT 20553</b>	<b>0.75</b>
<b>CPT 20612</b>	<b>0.70</b>

The RUC recommends 20600 *Arthrocentesis, aspiration and/or injection; small joint or bursa ~~or ganglion cyst~~ (eg, fingers, toes)* (work RVU = 0.66) and 20605 *Arthrocentesis, aspiration and/or injection; intermediate joint or bursa ~~or ganglion cyst~~ (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)* (work RVU = 0.68) should be remained unchanged from 2002, as these CPT revisions are editorial in nature and the relative values are appropriate within this family of services.



### **Practice Expense**

The consensus group presented direct practice expense data with the assumption that a separate Evaluation and Management service would be typically be reported on the same date. The RUC made minor modifications to the direct practice expense inputs for these services regarding phone calls in the post-service period. These practice expense recommendations will be attached to this summary.

### **Implantation/Removal of Ventricular Assist Device (Tab 6)**

**Presenters: Sidney Levitsky, MD, and Eric Rose, MD, Society of Thoracic Surgeons**

**Reviewed By: Facilitation Committee #1**

CPT created two new codes to differentiate the insertion and removal of an implantable intracorporeal ventricular assist device, as opposed to extracorporeal. These codes were first published in CPT 2002 edition. In 2001, the specialty society was prepared to present its recommendation for CPT codes 33979 *Insertion of ventricular assist device; implantable intracorporeal, single ventricle* and 33980 *Removal of ventricular assist device; implantable intracorporeal, single ventricle*, however, upon further review of the survey responses the specialty society concluded that the survey respondents did not accurately assess the time required for these procedures due to a comparison with the reference code that had a 90-day global period. The specialty society requested to bring these codes back to the RUC when additional data from a NIH study became available. In the interim, the specialty society requested that the codes be carrier priced for 2002. The RUC agreed with the specialty society request that the codes be carrier priced for a year, and the specialty has now submitted a recommendation at the April 2002 RUC meeting.

### **33979**

The RUC began its review of the code by questioning the assignment of a XXX global period to this code. There was considerable concern that such a designation was inappropriate and the RUC discussed the possibility of valuing the code as a 000-day global period. The RUC agreed that since the code was surveyed as an XXX global period, there is insufficient data to value the code with a 000-day global period. Additionally, CMS has assigned XXX global period for the other VAD codes and valuing the code with the XXX global period would at least be consistent with other codes in the family. Therefore, the committee focused on valuing the code with a XXX global period.

The RUC compared 33979 to code 33975 *Insertion of ventricular assist device; extracorporeal, single ventricle* (work RVU = 21.00, RUC recommended value 39.00 RVU, XXX global period). This code has undergone a great deal of refinement by CMS where the initial global period of 90 days was changed to 010, and finally to XXX. The presenters were unable to describe the rationale for a XXX global period for these codes since this was assigned by CMS. The RUC

began the comparison with the RUC recommended RVU of 39.00 for code 33975 and adjusted the value to account for the differences in the code as described below. To account for the additional 80 minutes of intra service time in code 33979, the RUC assigned an IWPUT of 0.113 (same as survey estimate and similar to reference service used in survey) resulting in an additional RVU of 9.00. This IWPUT was felt to be appropriate reflection of the intensity of this procedure and was calculated by the specialty based on the survey data and their recommended RVU of 52.50. To account for the differences in post service time the RUC subtracted 2.00 RVUs for 30 minutes of critical care (33979 post-service was 30 minutes less than 33975), resulting in a final value of 46.00. This value also placed the code in the proper rank order with the other VAD codes and was similar to the survey's 25<sup>th</sup> percentile value (work RVU = 45.00).

RUC recommended value of 33975	39.00
plus 80 minutes x .113=	9.00
minus 30 minutes of critical care	<u>(2.00)</u>
<b>Total Work RVU</b>	<b>46.00</b>

**The RUC recommends a work RVU of 46.00 for code 33979.**

### **33980**

The RUC discussed the 90-day global period assigned to this code and after much discussion concluded that the recommended value of 56.25 and a global period of 90 days would be appropriate for this code. Initially, the RUC had difficulty valuing the code with a 90-day global period due to a very wide range of length of stay for this code. A RUC facilitation committee developed a building block methodology for valuing the code with a 000-day global period. However, once the RUC examined this proposal, it concluded that the building block analysis supported the original specialty society recommendation. The RUC agreed with the specialty society rationale stating that the code should have a higher value than the reference code 33863 *Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension; with aortic root replacement using composite prosthesis and coronary reconstruction* (work RVU = 45.00) since the typical patient undergoing 33863 has a life-threatening disease (aortic atherosclerosis with aneurysm and/or dissection) and may or may not have reached the stage of life-threatening criticality. He/she is frequently elderly with concomitant degenerative diseases, including diabetes, coronary artery disease, peripheral vascular disease, renal disease and/or arthritis. In comparison, the typical patient undergoing 33980 *Removal of ventricular assist device, implantable intracorporeal, single ventricle* (proposed work RVU = 56.25) is typically younger, but has undergone a challenging period of cardiac stabilization and recovery from end-stage heart failure over a period of weeks or months. He/she is healthier than before the implant but still capable of becoming very unstable after the assist device is removed, requiring several days of ICU care. Immediate postoperative stabilization is very intense and challenging and tests the surgeon's management skills. Both patients are difficult to manage following

surgery and a significant amount of critical care, intensive care, and postoperative management is required. The technical similarities between the two procedures include: a median sternotomy (in the case of the VAD patient, always a repeat sternotomy); institution of cardiopulmonary bypass; aortic cross-clamping; mobilization; exposure and surgical entry into major vessels and the heart; weaning from cardiopulmonary bypass; establishment of hemostasis; and closure of the sternotomy and abdominal incisions. In the case of the aortic graft, the surgeon must transect the aorta, graft the aneurysm, replace the native aortic valve with a prosthetic valve, and isolate and then reimplant the coronary ostia. An explantation of the VAD involves re-dissection of the heart with removal of the outflow graft, removal of the inflow cuff from the heart and the aorta, and subsequent repair of all sites. Following that, the pericardial site of the driveline connection is sutured closed, as is the interior site. Given these significant differences in work as well as a building block methodology that supported a work RVU value of 45.50 assuming a 000 day global period, the RUC concluded that the survey 75<sup>th</sup> percentile work value of 56.25 is appropriate. **The RUC recommends a work RVU of 56.25 for code 33980.**

#### **Practice Expense**

The RUC is forwarding a practice expense recommendation of zero inputs for these codes but the specialty requests to submit pre-service and intra-service time at a later date pending the outcome of IG and GAO reports that will address the topic of physicians bringing their office clinical staff to the hospital.

### **IX. Relative Value Recommendations – Requests from CMS:**

#### **Screening Mammography (Tab 7)**

**Presenter: Bibb Allen, Jr. MD, American College of Radiology**

In February 2002, the RUC extensively discussed the survey data and comparisons of CPT 76092 Screening mammography, bilateral (two view film study of each breast) with other services (with similar service times or work RVU's similar to that requested). However, the RUC found that there was a disparity between the perceived service and the information available. Based upon the information available, the specialty society had difficulty sustaining an argument for its recommended work relative value of 0.70 to the Facilitation Committee and the RUC. The Facilitation Committee could not determine a reasonable and defensible methodology for delineating a relevant work RVU. The consensus was that the information available was not fully adequate and additional information should be collected regarding physician work related to the unique quality assurance aspects of this service. The RUC recommended that 76092 be resurveyed by interested specialty societies for presentation at the April RUC meeting, and that the specialties work with AMA RUC staff regarding the survey instrument and vignette development for the service.

In April 2002, the RUC reviewed new survey data for CPT 76092, which specifically addressed and included physician work related to second readings of

the screening mammography films and issues related to the Mammography Quality Standards Act (MQSA). The RUC agreed that the use of a second review of images by a different or same physician (double reading), prior to the submission of the final report was indicative of the intensity of the procedure. The RUC also agreed that it would be inappropriate to report 76092 for a re-read, as this intensity has been factored into the work valuation of this service. The RUC reviewed the physician time related to screening mammography and compared this time to both unilateral and bilateral diagnostic mammography and agreed that the relationship in physician work and time was appropriate. The RUC also noted that the specialty recommended a work RVU below the 25th percentile of their survey data. After reviewing all of this information, the RUC agreed that the original CMS work relative value of 0.70 is appropriate.

**The RUC recommends a work relative value of 0.70 for CPT code 76092.**

**Practice Expense**

The RUC adopted the direct practice expense inputs as presented by the specialty society, with a change in the staff type to mammography technologist. The RUC understands that the radiologists may address the broader issue of adding staff activities related to MQSA to all of the mammography codes with the PEAC.

**Gastrointestinal Endoscopy Services (Tab 8)**

The CMS requested that the RUC review a number of gastrointestinal endoscopy services described by current CPT codes. The gastroenterologists did present relative values at the April 2002 RUC meeting for CPT codes 43231, 43232, 43242, 43259, 45341, and 45341, related to endoscopic ultrasound examination and ultrasound-guided needle aspiration/biopsy(s). However, the RUC referred the issue back to the specialty society for further work. A facilitation committee will be created to review the specialty society's recommendations at the September 2002 RUC meeting.

**X. Relative Value Recommendations for CPT 2003:**

**Arthroscopic Rotator Cuff Repair (Tab 9)**

**Presenters: David F. Martin, MD, and William R. Beach, MD, American Academy of Orthopedic Surgeons**

Editorial changes and a new code was created to fully capture the fact that arthroscopic rotator cuff repair has become the usual and preferred choice of surgeons performing this procedure.

**Codes 23410 and 23412**

The RUC reviewed the editorial changes to codes 23410, *Repair of ruptured musculotendinous cuff (eg rotator cuff) open; acute (for arthroscopic procedure, use 29727)*, and 23412 *Repair of ruptured musculotendinous cuff (eg rotator cuff); chronic*. The RUC agreed that these changes were editorial in nature and

do not affect the work value as these services always described the open technique. **Therefore, the RUC recommends a work relative value for 23410 of 12.45 and 23412 of 13.31.**

### **Code 29827X**

The RUC then examined the code 29827X, *Arthroscopy, shoulder, surgical; with rotator cuff repair*. After some discussion about the new technology associated with this new code and its reference code, it was determined that the RUC should use code 29806 *Arthroscopy, shoulder, surgical; capsulorrhaphy* (RVU = 14.37) as an additional reference code for 29827X. Code 29806 was previously reviewed by the RUC and has 55 minutes pre-service time, 100 minutes intra-service time, 30 minutes post service time, 0.5 discharge day and 5 office visits while code 29827X, an outpatient procedure, should have 75 minute pre-service time, 120 minutes intra-service time, 40 minutes post-service time, 0.5 discharge day and 5 office visits. The RUC removed a 99231 hospital visit (0.64RVW) from the specialty society's recommended relative work value (16.00-0.64 = 15.36). **The RUC recommends a work relative value for 29827X of 15.36**

### **Practice Expenses**

The RUC reviewed the practice expense inputs for codes 29897X3. **The RUC recommends the standard package for this 090-day global procedure.**

### **Arthroscopic Orthopaedic Procedures (Tab 10)**

**Presenters: David Martin, MD, and William R. Beach, MD, American Academy of Orthopaedic Surgeons**

Two orthopaedic arthroscopy procedure codes were created to reflect new technology now being used in performing arthroscopy.

### **Codes 25320, 27425, 27730, 27732, 27734 and 27870**

The RUC reviewed the editorial changes to codes **25320** *Capsulorrhaphy or reconstruction, wrist, open any method (eg, capsulodesis, ligament repair, tendon transfer or graft) (includes synovectomy, capsulotomy and open reduction) for carpal instability* and **27425** *Lateral retinacular release open any method*. Additionally, the RUC reviewed the editorial changes to codes **27730**, *Arrest, epiphyseal (epihysiodesis), any method open; distal tibia*, **27732**, *Arrest, epiphyseal (epihysiodesis), any method open distal fibula* and **27734**, *Arrest, epiphyseal (epihysiodesis), any method open; distal tibia and fibula*. In addition, the RUC reviewed the editorial changes to code **27870** *Arthrodesis, ankle, open any method*. The RUC agreed that these changes were editorial in nature and do not affect the work values, as these services were all initially valued assuming an open technique was utilized. **The RUC recommends a work relative value for code 25320 of 10.77, for code 27425 of 5.22 and for code 27730 of 7.41. The RUC also recommends a work relative value for code 27732 of 5.32, for code 27734 of 8.48 and for code 27870 of 13.91.**

**Code 2987X3**

Code 2987X3, *Arthroscopy, knee, surgical; with lateral release* was created to reflect new technology. It was determined by the RUC after reviewing the reference code 27425, *Lateral retinacular release, any method* (work RVU= 5.22) that the surveyed code, 2987X3 was deemed more intense and took more time than the reference code. Therefore, the RUC accepted the specialty society's median value of their survey (work RVU = 6.00), which was minimally higher than the relative work value associated with the reference code. **The RUC recommends a work relative value of 6.00 for code 2987X3.**

**Code 2989X**

CPT created code 2989X *Arthroscopy, ankle, (tibiotalar and fibulotaler joints) surgical; with ankle arthrodesis* to describe new technology. The RUC determined that the work of performing this procedure openly with code 27870, *Arthrodesis, ankle, any method* (RVU 13.91) is the same as performing the service arthroscopically. Therefore, the specialty society recommended the same relative work value for code 2989X as its reference code 27870. **The RUC recommends a work relative value of 13.91 for code 2989X**

**Practice Expense**

The RUC reviewed the practice expense inputs for codes 29897X3 and 2989X. These procedures are performed in the facility setting only. **The RUC recommends the standard packages for the 090-day global procedures.**

**Minimally Invasive Vein Harvest for CABG Procedures (Tab 11)**

**Presenter: Sidney Levitsky, MD, Society of Thoracic Surgeons**

CPT created code 3350X *Endoscopy surgical, including video-assisted harvest of vein(s) for coronary artery bypass procedure* to recognize the new technology that allows the vein conduit used for coronary artery bypasses to be harvested using a minimally invasive approach. Currently, the open method of harvesting the veins is included in the coronary artery bypass procedures (33510-33536). This new technique represents a more complicated procedure requiring additional specialized training, and requires additional intra-operative time as compared to the open procurement of the vein conduits

**3350X**

Code 3350X is an add-on code that describes the incremental work of harvesting veins for coronary artery bypass using endoscopy. The presenters stated that the 10 minutes of intra-service time only includes the additional time related to the use of an endoscope to complete a saphenous vein harvest for a CABG. The RUC agreed with the specialty's approach of assigning .31 RVUs for this code, which corresponds to 10 minutes of time at the E/M intensity of 0.031. The RUC also compared this value to a number of other add on codes such as 11001

*Debridement of extensive eczematous or infected skin; each additional 10% of the body surface (List separately in addition to code for primary procedure), with 10*

minutes intra-service time and a work RVU = .30, and concluded that the .31 RVU recommendation seemed reasonable and placed the code in proper rank order.

**The RUC recommends a work relative value of 0.31 for code 3350X.**

### **Practice Expense**

The RUC assigned zero post service time, but the specialty requests to provide pre and intra-service time after GAO/OIG reports are issued regarding various aspects of the practice expense methodology and its implementation by CMS and also after consideration of ZZZ global definition by CMS. This procedure is only performed in the facility setting and the RUC recommends zero pre-service clinical staff time.

### **Ophthalmic Endoscopy (Tab 12)**

**Presenters: Stephen Kamenetzky, MD, and Martin Uram, Technical Advisor, American Academy of Ophthalmology**

CPT code 6999X was developed to describe an endoscopic method of diagnosis, which is used in combination with many anterior and posterior segment eye procedures.

### **6999X**

The RUC reviewed the survey results for 6999X, *Use of ophthalmic endoscope*. A consensus panel was surveyed by the specialty society to obtain survey results. The consensus panel agreed that there was no pre or post service time associated with this code. The median recommended relative work value was 1.70. The RUC then reviewed the reference code, 31233 *Nasal/sinus endoscopy, diagnostic with maxillary sinusoscopy (via inferior meatus or canine fossa puncture)* (RVU = 2.18). This code was selected because it is a 0-day global with 15 minutes of pre time, 20 minutes of intra-service time and 15 minutes of post service time. Additionally, 31233, like 6999X, involves using an endoscope to inspect a cavity followed by a diagnosis. To value 6999X, the RUC removed the amount of work associated with the 30 minutes of pre and post service for 31233 (0.67) from the relative work value of this code (2.18) and obtained a value of 1.51. **The RUC recommends a work relative value of 1.51 for 6999X.**

### **Practice Expense**

Because this code is only performed out-of-office, there are no practice expense inputs associated with this code.

**Speech, Language, and Hearing Procedures (Tab 13)**

**Presenters: James Denny, III, MD, Jonathan Aviv, MD, and Dana Thompson, MD, American Academy of Otolaryngology – Head and Neck Surgery**

**Reviewed By: Facilitation Committee #2**

The new codes 926X12-926X17 were developed in order to fully capture the endoscopic work involved with swallowing and laryngeal sensory testing. The practice inputs for codes 926X1-926X9 were assessed, modified and approved by the Health Care Professional Advisory Committee (HCPAC) because there was no physician work associated with these codes.

**926X12, 926X13, 926X14, 926X15, 926X16 and 926X17**

New codes 926X12, 926X14, and 926X16 involve placement of a flexible fiberoptic endoscope into the nasal cavity to a place where videotaping of swallowing and/or sensory reflex can be recorded. New codes 926X13, 926X15, and 926X17 involve the review of these videotapes by the physician to assess and report findings and recommendations to the PCP and/or patient or caregiver (e.g., changes in diet and/or non-oral forms of alimentation).

After reviewing the survey data collected for these six codes, The RUC concluded that the relationship (i.e., relative ranking) between the procedure codes (926X12, 926X14, 926X16) and between the interpretation/report codes (926X13, 926X15, 926X17) was reasonable. However, the RUC felt that the survey respondents – using "magnitude estimation" - overestimated the RVWs.

To develop our recommendations for these codes, the RUC reviewed the new interpretation/report codes, specifically, 926X17. In comparing 926X17 with reference code 93314, the RUC noted that the intensity/complexity measures for intra-service time and for mental effort/judgment is significantly higher (see 926X17 summary form). However, clinically, the RUC believed 926X17 is slightly less *total* work than 93314 *Echo transesophageal* (RVW=1.25). We also looked at the level of physician work and decision making in relationship to E/M codes such as: 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; 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* (RVW=1.10); and 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making 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* (RVW=1.34). The RUC believes that new code 926X17 requires a level of physician judgment necessary to evaluate the (new) patient history and procedure tapes to formulate



recommendations comparable to the work of a level four established patient office visit. Based on all of these comparisons, The RUC recommends an RVW of 1.10 for 926X17. For the other two interpretation/report codes, the RUC recommends values that maintain the median survey RVW relationship between the codes, setting 926X17 at 1.10:

Survey Median RVW: 926X13=2.25 926X15=2.00 926X17=2.50  
 Ratio: 926X13=0.90 926X15=0.80 926X17=1.00  
**Recommended RVW: 926X13=0.99 926X15=0.88 926X17=1.10**

Next, the RUC considered the specialty society's recommendations for 926X12, 926X14 and 926X16. The specialty society reviewed the "total" value for the procedures and their corresponding interpretation/report. The specialty society believes that endoscopic evaluation of swallowing and interpretation/report (926X12/926X13) is the same total work as 31579 *Laryngoscopy with stroboscopy* (RVW=2.26). Using the RVW of 2.26, we subtracted 0.99 RVUs (the recommendation for 926X13) to arrive at an RVW of 1.27 for 926X12. Similar to the development of the recommendation for the three interpretation/report codes, the specialty society recommends values that maintain the median survey RVW relationship between the codes, setting 926X12 at 1.27:

Survey Median RVW: 926X12=2.50 926X14=2.71 926X16=3.70  
 Ratio: 926X12=1.00 926X14=1.08 926X16=1.48  
**Recommended RVW: 926X12=1.27 926X14=1.38 926X16=1.88**

This results in the following "total" work values for the procedure/report code pairs:

926X12/926X13 = 2.26 926X14/926X15 = 2.26 926X16/926X17 = 2.98

This relationship makes sense: 1) Compared to 926X14/926X15, 926X12/926X13 requires more time for administration of food, but is less intense. Combined, the pairs represent similar total work. 2) Pair 926X16/926X17 combines both pair 926X12/926X13 and pair 926X14/926X15, however *some* of the procedure pre/post work is the same (eg, pre-service exam or post-service discussion) and *some* of the procedure intra-service work is not doubled (eg, application of anesthetic/decongestant, insertion of endoscope). The specialty society recommends these values for 926X12, 926X14 and 926X16, however the RUC believes that the work performed in 926X12 and 926X14 is comparable and therefore should be valued the same. **The RUC recommends the following work relative values:**

Code	Work Relative Value
<b>926X12</b>	<b>1.27</b>
<b>926X13</b>	<b>0.99</b>
<b>926X14</b>	<b>1.27</b>

<b>926X15</b>	<b>0.88</b>
<b>926X16</b>	<b>1.88</b>
<b>926X17</b>	<b>1.10</b>

### **Practice Expense**

The RUC then reviewed the practice expense inputs for 926X12-926X17. The RUC questioned the time allotted for education/instruction/counseling and felt 5 minutes was appropriate for this practice expense input for codes 926X12, 926X14 and 926X16. The RUC initially proposed creating a CCI edit that would prevent billing a diagnostic service (926X12-X17) and a treatment service (92526) on the same day. In lieu of this suggestion, the RUC and the specialty society agreed with the CMS proposal to reduce the time from 15 minutes to 5 minutes and permit the billing of both services on the same date of service. Additionally, the RUC questioned the pre-service time for 926X13, 926X15 and 926X17 and felt that there was no pre-service time associated with these codes. **The RUC recommends these modified practice expense inputs for 926X12-926X17.**

### **Bone Marrow Procedures (Tab 14)**

**Presenters: James Gajewski, MD and Sam Silver, MD, American Society for Hematology and American Society for Blood and Marrow Transplant**  
**Reviewed By: Facilitation Committee #2**

Thirteen new CPT codes were added and two were deleted to provide greater granularity to code accurately the specific procedures performed for each patient receiving bone marrow or stem cell transplantation. The newer techniques used in a transplant laboratory under physician supervision are now captured in these new CPT codes. CPT codes 3821X1-3821X16 replace codes 38231 *Blood-derived peripheral stem cell harvesting for transplantation, per collection* (Work RVU = 1.50) and 86915 *Bone marrow or peripheral stem cell harvest, modification or treatment to eliminate cell type(s) (eg, T-cells, metastatic carcinoma)* (Work RVU = 0.00) to allow for different types, work, and techniques now used for different types of cell harvesting and also transplant preparation as well as the critical work and techniques involved in stem cell processing prior to a Bone Marrow Transplant. Present codes 38231 and 86915 were not designed for modern procedures in Bone Marrow transplant and have virtually no relevance to the present stem cell harvesting and processing work and procedures. The RUC understands that these services are not commonly performed on the Medicare population and very few centers perform these services (50 centers), therefore a small sample size of 22 is expected.

### ***3821X1 Management of recipient hematopoietic progenitor cell donor search and cell acquisition***

The RUC reviewed the survey results and the similarities in physician work of the reference code, 80502 *Clinical pathology consultation; comprehensive, for*

*complex diagnostic problem, with review of patient's history and medical records* (Work RVU=1.33). The RUC believed that this service was more intense than 80502 as there was zero tolerance for error. The RUC understands that this newly reported service would be billed one time per recipient. The RUC also compared this service to CPT code 99204 *Office or other outpatient visit for the evaluation and management of a new patient ... a level 4 new patient office visit representing 45 minutes of physician time* (work RVU = 2.00). The RUC agreed that the time spent on this type of per patient management reflected the specialty's recommended 25<sup>th</sup> percentile surveyed intra-service time. The RUC agreed that there was no pre- or post- service time. **The RUC recommends a relative work value of 2.00 for CPT code 3821X1.**

**3821X3 *Blood derived hematopoietic progenitor cell harvest for future transplantation per collection; allogenic***

**3821X4 *Blood derived hematopoietic progenitor cell harvest for future transplantation per collection; autologous***

These two codes were previously billed as code 38231 *Blood derived peripheral stem cell harvesting for transplantation, per collection* (Work RVU = 1.50). The specialty society recommended a value of 2.0 stating code 38231 had been undervalued. The RUC however found no compelling evidence to increase the value, and believed it had been appropriately valued by the RUC when reviewed in 1995. **The RUC recommends a relative work value of 1.50 for CPT codes 3821X3 and 3821X4.**

**3821X9 & 3821X6 – 3821X14**

The RUC reviewed CPT code 3821X9 *Transplantation preparation of hematopoietic progenitor cells; cryopreservation and storage; specific cell depletion within harvest, T-cell depletion* as an anchor code for family 3821X3 through 3821X14. The RUC first recognized that the vignette did not reflect an accurate description of the service of 3821X9, however the RUC did believe that the work involved in code 86077 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (Work RVU = 0.94) was similar. The RUC also reviewed the codes in comparison the work of evaluation and management services. The RUC was concerned regarding the accuracy of the survey data for these services. However, the RUC agreed that a repeated survey would not be appropriate, as it would have to be circulated to the same physicians/centers. The RUC recommends that a consensus panel of physicians, with the participation of one or more RUC members, review these codes again for the September 2002 RUC meeting. The RUC however, felt strongly, that these services require physician work and recommends interim work values to be assigned for 3821X6-3821X14. The RUC emphasized that these interim values should not be viewed as a “ceiling” for the future review, but serve as the best alternative until future review is completed. **Considering the similarities in work of code 86077 and 3821X9, the RUC recommends an interim value of 0.94 for code 3821X9.**

The RUC compared similarities in work and intensity of codes 86077 and 3821X9, and then agreed with the rank order established by the specialty society for the family of codes 3821X6 through 3821X14. The RUC agreed with the specialty society's recommended rank order for the family, but also understood that the values being established were interim pending future RUC review and consideration at the September 2002 meeting. **The RUC recommends the following interim work relative values for CPT codes 3821X6-3821X14:**

<b>3821X6</b>	<b>0.47</b>
<b>3821X7</b>	<b>0.56</b>
<b>3821X8</b>	<b>0.24</b>
<b>3821X9</b>	<b>0.94</b>
<b>3821X10</b>	<b>0.71</b>
<b>3821X11</b>	<b>0.47</b>
<b>3821X12</b>	<b>0.24</b>
<b>3821X13</b>	<b>0.24</b>
<b>3821X14</b>	<b>0.55</b>

***3824X Bone marrow or blood-derived peripheral stem cell transplantation; allogenic donor lymphocyte infusions***

The specialty presented a typical patient that is severely ill and in great risk. Approximately 25% of these procedures are complicated by life threatening reactions to the infusion. The RUC agreed with the specialties description of the intensity of intra-service work and 25<sup>th</sup> percentile time of 30 minutes.

The RUC also understood that this service could be compared to several other intense procedures including critical care code 99292 *Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)* (work RVU = 2.0), however, the work for this code was not quite as intense, and could be more appropriately aligned with code 99357 *Prolonged physician service in the inpatient setting, requiring direct (face-to-face) patient contact beyond the usual service (eg, maternal fetal monitoring for high risk delivery or other physiological monitoring, prolonged care of an acutely ill inpatient); each additional 30 minutes (List separately in addition to code for prolonged physician service)* (work RVU= 1.71) for its time and intensity. The RUC in addition, believed code 3824X was less intense than the reference code 38240 *Bone marrow or blood-derived peripheral stem cell transplantation; allogenic* (work RVU = 2.24, Harvard total time 53). **The RUC recommends a relative work value of 1.71 for code 3824X**, which has the approval of the specialty society.

**Practice Expense**

The RUC and the specialty society agreed that these procedures do not have any practice expense inputs and are performed exclusively in the facility setting.

**Therapeutic Apheresis (Tab 15)**

**Presenter: Samuel Silver, MD, American Society of Hematology**

**Reviewed By: Therapeutic Apheresis Workgroup**

The CPT codes 365X1-365X4 replace code 36520 *Therapeutic apheresis; plasma and/or cell exchange* (Work RVU = 1.74), and CPT codes 365X5 and 365X6 replace code 35521 *Therapeutic apheresis; with extracorporeal affinity column adsorption and plasma reinfusion* (Work RVU = 1.74) to allow reporting for the different types of therapeutic apheresis that are now performed. This provides a more accurate coding for the actual work and procedure since the different types of apheresis involve different amounts of work and technique. This also allows for better recording of the frequency of the different therapeutic apheresis procedures. Previously reported codes 36520 and 36521 were too vague to code for all the different apheresis procedures now in existence.

The specialty has tried to coordinate its survey efforts with subspecialty organizations and other specialties (eg, nephrology and rheumatology), however it has been unable to conduct a survey of the work relative values for these services. American Society of Hematology (ASH) is also in contact with the manufacturer associated with the supplies and equipment for this service to best determine the institutions that are currently performing this service. ASH will utilize this list in conducting their survey this summer.

While ASH works to complete the survey, the **RUC recommends interim values of 1.74 for each of the therapeutic apheresis services, which is the value crosswalked from current codes 36521 and 36520.** The RUC recommends that survey data be presented at the September 2002 RUC meeting. The interim values serve as a placeholder until the specialty has the opportunity to collect better data and coordinate with other relevant specialties. If data is not presented, the interim RUC recommendations will be considered “not validated.”

**Practice Expense**

The specialty had determined these services are performed more than 95% in the facility setting and the RUC agreed that they should not be priced in the non-facility setting at this time. The RUC and the specialty agreed that for these services there wouldn't be any practice expense inputs, and therefore recommends no practice expense inputs in either the facility or non-facility settings.

**Anesthesia Service for Larynx and Trachea Procedures in Children Under the Age of 1 (Tab 16)**

**Presenters: Karl E. Becker, MD, Norman A. Cohen, MD, American Society of Anesthesiologists**

CPT created code 0032X and revised 00320 to differentiate the anesthesia work in infants less than 1 year of age and patients greater than one year. The new code was created to specifically recognize the greater work, method, and risk of

anesthesia for these young patients as opposed to the typical patient currently reflected in code 00320.

0032X

The RUC focused on placing the new code 0032X in proper rank order with other ASA codes. The RUC agreed that the provision of anesthesia in children less than 1 year of age involves additional physician work. In these patients, pulmonary and cardiac reserves are significantly reduced compared to older children and healthy adults. In practice, the anesthesiologist faces a much greater probability of managing hypoxemia. Also, the work of breathing is directly proportional to airway resistance. Since the dimensions of the airway are much smaller than in the adult, even small amounts of airway edema or trauma produces dramatic increases in the work of breathing and the potential for respiratory failure. Surgical procedures involving the larynx and trachea are associated with a much higher risk of airway edema and trauma. This issue is particularly relevant to code 0032X. To account for the additional physician work, the RUC agreed that code 0032X should have one additional base unit. Therefore the resulting value of 7 base units is equal to code 00320 *Anesthesia for all procedures on esophagus, thyroid, larynx, trachea and lymphatic system of neck; not otherwise specified, age one year or older* (base unit 6), plus code 99100 *Anesthesia for patient of extreme age, under one year and over seventy (List separately in addition to code for primary anesthesia procedure)* (base unit 1), resulting in a base unit value of 7. **The RUC recommends 7 base units for code 0032X.**

**Anesthesia Services: Intrathoracic (Tab 17)**

**Presenters: Karl E. Becker, MD, Norman A. Cohen, MD, American Society of Anesthesiologists**

CPT created two new codes to better describe current clinical practice for anesthetic management of patients undergoing thoracic surgery procedures.

**00528** The specialty society requested to withdraw code 00528 so that it can be brought back to CPT for further refinement. It is the intent of the specialty to request CPT to delete the change for 2003 and return to CPT to clarify the code further and potentially create an additional code.

**00540** The recommended value of 12 base units is based on a comparison with the reference service, 00520 *Anesthesia for closed chest procedures; (including bronchoscopy) not otherwise specified* (base unit 13). Evaluation of the results of the survey intensity/complexity measures supports a base unit value the same as the base unit value for CPT code 00540 (13). However, since approximately 35-40% of procedures reported under 00540 will now be reported under 0054X1, the overall work for 00540 will decrease. The RUC agreed with the presenters that a base unit value of 12 accounts for this change and is an appropriate work neutrality adjustment. **The RUC recommends 12 base units for code 00540**

**0054X1** The RUC compared code 0054X1 to other ASA codes with base units of 15 and concluded that the results of the survey intensity/complexity measures supports a base unit value the same as the survey median of 15 base units. Also, in comparison to the reference service 00546, *Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); pulmonary resection with thoracoplasty* (base unit = 15), the RUC concluded that the two codes involve similar anesthesia work and therefore should have the same base unit value of 15 units. Additionally, to achieve proper rank order, the new code should have 2 units more than base units than CPT code 00540, *Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); not otherwise specified* (base unit = 13), which this new CPT code now enhances and defines to account for the increased work, intensity and complexity of one lung anesthesia. **The RUC recommends 15 base units for code 0054X1**

**0054X2** The RUC based its recommendation primarily by comparing the code to the reference procedure 00546 *Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); pulmonary resection with thoracoplasty* (base unit = 13), as well as the other codes in the family. The RUC concluded that to maintain proper rank order, the code should have a base unit value 3 more than the reference service base unit value, and 5 units more than the base unit value for current CPT code 00540, *Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); not otherwise specified* (base unit = 13), which this new CPT code now refines and enhances to account for the increased work, intensity and complexity measures (especially stress and technical skill required for anesthesia for tracheal-bronchial reconstruction). **The RUC recommends 18 base units for code 0054X2.**

### **Anesthesia Services for Pediatric Hernia Repair (Tab 18)**

**Presenters: Karl E. Becker, MD, Norman A. Cohen, MD, American Society of Anesthesiologists**

### **0083X1 and 0083X2**

CPT created two new codes to describe the provision of anesthesia for hernia repair of infants. The specialty stated that in due to the creation of new surgical codes stratified by age for children undergoing inguinal hernia repair, new anesthesia codes are also needed to e recognized the increased work and risk that exists in anesthetizing children for these procedures. The RUC reviewed these codes together to ensure proper relativity. The RUC felt that anesthetic management of pediatric patients under one year of age entails additional work since in these patients, pulmonary and cardiac reserve are significantly reduced compared to older children and healthy adults. In practice, the anesthesiologist faces a much greater probability of managing hypoxemia. Also, the work of breathing is directly proportional to airway resistance. The therapeutic range in which the anesthesiologist must operate is much narrower than in older children

or adults, bounded by too "light" an anesthetic in which the patient may move, develop a life-threatening laryngospasm or develop vagally-stimulated bradycardia. On the opposite side, too "deep" an anesthetic can cause severe respiratory and cardiac depression. Intravenous access is typically very difficult in children less than a year. Since this age group is often uncooperative, anesthesiologists will typically induce anesthesia with volatile anesthetics, often referred to as a "mask induction," without the benefit of intravenous access. Management of bradycardia, hypotension, or other common untoward reactions is much more difficult when the anesthesiologist is unable to administer intravenous medications. Finally, infants under one year, and particularly the premature infant at less than 50 weeks gestational age, have been shown to be in a much higher risk group for adverse respiratory and cardiovascular sequelae both under anesthesia and in the immediate post operative period and the immature renal, hepatic and nervous system in this subset of patient increases the risk of adverse drug reactions. For the above reasons, the RUC agreed that increases in basic unit value for these procedures is warranted. To account for the additional physician work, the RUC agreed that code 0083X1 should have one additional base unit. Therefore the resulting value of 5 base units is equal to code 00830 *Anesthesia for hernia repairs in lower abdomen; not otherwise specified* (base unit 4), plus code 99100 *Anesthesia for patient of extreme age, under one year and over seventy (List separately in addition to code for primary anesthesia procedure)* (base unit 1). Therefore, the new base unit value of 5 is work neutral. The RUC agreed that code 0083X2 should have 2 additional base units above the base code 00830 to maintain proper rank order. The presenters stated that this code will be provided to Medicare beneficiaries less than 100 times a year, thus no requiring any work neutrality do to the very low frequency anticipated for this code. **The RUC recommends 5 base units for code 0083X1. The RUC recommends 6 base units for code 0083X2.**

**Anesthesia Services for Arthroscopy (Tab 19)**

**Presenters: Karl E. Becker, MD, Norman A. Cohen, MD, American Society of Anesthesiologists**

**01382, 01400, 01464, 01622, 01630, 01732, and 01740**

CPT revised a series of codes to differentiate between anesthesia services for diagnostic arthroscopic procedures and open or surgical arthroscopic procedures. Since the original development of codes for anesthesia for arthroscopy more than 20 years ago, major advances in arthroscopic techniques have occurred and these changes are needed to accommodate increasingly complex arthroscopic and arthroscopically assisted joint procedures. The RUC reviewed these codes as a family. The anesthesia work for the surgical arthroscopic procedures are very similar to an open procedure as opposed to more simple diagnostic procedures. The recommended values reflect the differences in anesthesia work for these diagnostic vs. surgical arthroscopic procedures and the RUC agreed that the CPT changes did not affect the anesthesia work associated with these codes. However, the surgical arthroscopic procedures now will receive a higher base unit and the presenters justified this increase due to more complicated anesthetic management



with greater intensity as compared to the diagnostic arthroscopic procedures. The presenters clarified that when these codes were originally valued, they were valued based solely on diagnostic arthroscopy since surgical arthroscopy was not widely used. **The RUC recommends no change in base unit value for codes 01382, 01400, 01464, 01622, 01630, 01732, and 01740.**

**Anesthesia Services for Endoscopic Procedures on the Hand (Tab 20)**

**Presenters: Karl E. Becker, MD, Norman A. Cohen, MD, American Society of Anesthesiologists**

**018X1 and 01830**

CPT created a new code and revised existing code 01830 to account for new arthroscopic techniques and procedures. Arthroscopy is no longer limited to diagnostic procedures, and now surgical repairs are done using an arthroscopic approach or a combination of an open and arthroscopic approach. These CPT changes revision will bring the code descriptors in line with current practice. The RUC agreed that the changes to code 01830 did not change the value of the code and the median survey value of 3 base units supports the current value. The RUC also agreed that new code 018X1 should be valued at 3 base units since both codes involve the same amount of anesthesia work and place the codes in proper relativity with other Anesthesia codes. **The RUC recommends 3 base units for code 018X1. The RUC recommends 3 base units for code 01830.**

**Excision of Mandible/Facial Bone Tumor (Tab 21)**

**Presenter: Lanny Garvar, MD, American Association of Oral & Maxillofacial Surgeons/American Dental Association, American Society of Plastic Surgeons**

Four new codes (210X1, 210X2, 210X3 and 210X4) were developed to reflect the increased intra-operative time, the extent of surgery and the increased intensity level required to perform these services as compared to the codes currently being used, which inadequately describe the intensity of the procedures being performed.

**Codes 210X1 and 210X3**

The RUC examined codes 210X1 *Excision of benign tumor or cyst, mandible; with intra-oral osteotomy (eg, locally aggressive or destructive lesion)* and 210X3 *Excision of benign tumor or cyst of maxilla, requiring intra-oral osteotomy (eg locally aggressive or destructive lesion(s))*. The RUC agreed with the specialty societies' recommendations that these codes were needed to describe the intensity level of the service being performed. The RUC also agreed that the recommended relative work value for 210X1 and 210X3, both the survey medians, were appropriate. Both of these services are comparable in work to CPT code 21206 *Osteotomy, maxilla, segmental (eg, Wassmund or Schuchard)* (work RVU = 14.10 with a pre-service time of 75 minutes, intra-service time of 108 minutes post-service time of 57 minutes, post-op hospital time of 41 minutes and post-op office visit time of 95 minutes. Code 210X12 and 210X1 and 210X3 both had

survey time of 75 minutes for pre-service, 120 minutes of intra-service, 30 minutes of post-service 1 hospital visit, discharge day and 5 office visits. The survey respondents did indicate that 210X3 was more intense than 210X1, therefore an incremental increase is appropriate. **The RUC recommends a work relative value of 13.00 for 210X1 and 13.50 for 210X3.**

#### **Code 210X2**

The RUC considered the specialty societies' recommendation for code 210X2 *Excision of benign tumor or cyst, mandible; with extra-oral osteotomy and partial mandibulectomy (eg locally aggressive or destructive lesion)*. The RUC compared the work of 210X2 to 210X1 and agreed that the additional 120 minutes of intra-service work justified the increment of 5.75 over the base code. **The RUC recommends a work relative value of 18.75 for 210X2.**

#### **Code 210X4**

The RUC assessed the specialty societies' recommendation for code 210X4 *Excision of benign tumor or cyst, maxilla; with extra-oral osteotomy and partial maxillectomy (eg, locally aggressive or destructive lesion)*. Because of the aggressive nature of the ameloblastic fibro-odontoma, which requires radical excision to obliterate them and prevent re-occurrence, the RUC agreed with the intensity of this service. Additional justification for this recommendation included the increased intensity associated with the extra-oral approach and the higher surveyed intensity as compared to the reference code 21206 *Osteotomy, maxilla, segmental (eg Wassmund or Schuchard)* (RVU = 14.10). In addition, the total time for the surveyed code (543 minutes) far exceeded that of the reference code (348 minutes). **The RUC recommends a work relative value of 18.00 for 210X4.**

#### **Codes 21030 and 21040**

The RUC then reviewed codes 21030 *Excision of benign tumor or cyst of ~~facial bone other than mandible,~~ maxilla or zygoma, by enucleation and curettage* and 21040 *Excision of ~~benign cyst or tumor,~~ tumor or cyst of mandible, by enucleation and curettage simple*. The RUC decided to table these codes pending review of the CPT panel to clarify some language issues and the possible surveying of these codes by the specialty societies pending the CPT decision. The CPT Editorial Panel did review these codes in May 2002 and made only a minor change to "enucleation and/or curettage." The Panel commented that they viewed the original code changes as editorial.

#### **Practice Expense**

The RUC reviewed the practice expense inputs for 210X1-X4 and recommends that the standard 90-day global package would be applied to all of these codes.

**Minimally Invasive Repair of Pectus Excavatum (Tab 22)**

These codes were developed to describe a new minimally invasive technique in reconstructive repair of the pectus excavatum or carinatum.

Because the specialty society was unable to provide adequate data in time for the April meeting, the RUC recommends that these codes be carrier priced until survey data is provided at the September RUC meeting.

**Insertion/Repositioning Venous Pacing Electrode for Biventricular Pacing (Tab 23)**

**Presenters: James Maloney, MD, FACC, and Anne Curtis, MD, FACC,  
American College of Cardiology  
Facilitation Committee #3**

The CPT Editorial Panel created four new cardiac pacing codes edited two existing codes since current codes could not adequately reflect the entire procedure being performed with biventricular pacing. Originally, the CPT Editorial Panel established one new code to report the additional work of placing the left ventricular lead in the coronary sinus to achieve biventricular pacing and perform cardiac resynchronization therapy for patients with congestive heart failure. This service would be reported in addition to separately reported pacemaker or implantable cardioverter defibrillator insertion (ICD).

During the CPT Editorial Panel discussions, CMS raised the point that in approximately 10% of the cases, placing the left ventricular lead in the coronary sinus to achieve biventricular pacing is performed with an already existing pacemaker or ICD, thereby creating the need for the establishment of two codes to report this service, one as an add-on code for the initial implants, and one as a stand alone code for patients with an already established device.

Also during the CPT Editorial Panel discussions, CMS also requested the specialty to rewrite the pacemaker and ICD codes (36216 and 33217) which included the language “insertion or repositioning of a transvenous electrode...” due to a concern that in the outpatient prospective payment system, facilities were being reimbursed for the cost of a brand new lead in the case where a new lead was being repositioned and not replaced. According to CMS, this is not a physician work issue, it is simply a matter of fairness on the facility reporting side to separate out lead insertion from lead repositioning. Two new codes were created to eliminate the “insertion or repositioning language” that has been prevalent in the pacing/ICD section of the CPT book.

**3321X (AQ 1)**

This code is a separation of the previously listed code 33216 *Insertion or repositioning of a transvenous electrode (15 days or more after initial insertion); single chamber (one electrode) permanent pacemaker or single chamber pacing*

*cardioverter-defibrillator* (work RVU = 5.39) from insertion or repositioning code to insertion only. The new code is for repositioning 33221X. This code is for a right atrial or ventricular lead only and as such represent a group different from codes 3322X1, 3322X2, and 3322X3. The value carried over of 5.39 RVU was felt to be appropriate for insertion but the work of repositioning was felt to be less work and therefore the code was devalued by half the difference between the parent and a code for catheter insertion. The specialty society indicated the difference in work between insertion and repositioning of the electrode involved vascular access (already present at time of repositioning). Therefore, to adjust for the difference in intra-service time between 3321X (60 minutes) and the parent insertion code, 33216 (90 minutes), two-thirds of the RVUs for code 36491 *Placement of central venous catheter (subclavian, jugular, or other vein) (eg, for central venous pressure, hyperalimentation, hemodialysis, or chemotherapy); cutdown, over age 2* (Work RVU = 1.43) was subtracted from the parent Work RVU of 5.39. In addition, the RUC believed to maintain proper rank order between codes 33221X and code 33216 the RUC recommends a work RVU of 4.44 for 33221X. **The RUC recommends a work RVU of 4.44 for 33221X.**

#### **3322X1 (AQ 4)**

The RUC reviewed several similar procedures, and building block methodologies for this base code recommendation. The RUC believed that part of the work for this code was contained in code 33212 *Insertion or replacement of pacemaker pulse generator only; single chamber, atrial or ventricular* (Work RVU = 5.52) and code 33233 *Removal of permanent pacemaker pulse generator* (Work RVU = 3.29), and involved more work and intensity as the insertion of the pacing electrode is in the left ventricle rather than the right. The RUC discussed the code's global period and recommended a change from a 090 to a 000-day global code. The RUC believed a relative work value of 9.05 was the proper value based on subtracting out the value of the post-operative visits contained in the specialty's recommendation for a 090 day global period procedure with a the survey median work RVU of 11.00. **The RUC recommends a work RVU of 9.05 for code 3322X1, with the understanding that it be a 000-day global and the removal, insertion, and/or replacement of the generator be included in the physician work. This is a formal recommendation for a request for a CPT Editorial change.** The CPT Editorial Panel agreed in May 2002 with the CPT Executive Committee's decision to modify the descriptors of codes 3322X1 to include "(including revision of pocket, removal, insertion and/or replacement of generator)."

#### **3322X2 (AQ 5)**

The RUC reviewed and compared CPT code 3322X2 with codes 92973 *Percutaneous transluminal coronary thrombectomy (List separately in addition to code for primary procedure)* (work RVU = 3.28), 92981 *Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel (List separately in addition to code for primary procedure)* (work RVU = 4.17), 22585 *Arthrodesis, anterior*

*interbody technique, including minimal diskectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure) (work RVU= 5.53), and 22845 Anterior instrumentation; 2 to 3 vertebral segments (work RVU= 11.96).*

The specialty society and the RUC agreed that code 3322X2 was similar to the intensity and work of 92981 (Work RVU=4.17). This is a ZZZ code and the society recommendation of 10.00 work RVUs were considered high. Code 92981 has a work time of 60 minutes and the survey median time for the considered code had a survey time of 120 minutes. Therefore, by doubling the work RVU of 92981 to obtain 8.34, it was felt to be appropriate considering the similarities in intensity and work involved. This is more than some ZZZ codes considered (eg 22585 *Arthrodesis, anterior interbody technique, including minimal diskectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure) (work RVU= 5.53);* 92973 *Percutaneous transluminal coronary thrombectomy (List separately in addition to code for primary procedure) (work RVU=3.28)* less than others (22845 *Anterior instrumentation; 2 to 3 vertebral segments (work RVU= 11.96)*) and the calculated value was felt to appropriately represent the physician work. **The RUC recommends a relative work value for CPT code 3322X2 of 8.34.**

### **3322X3 (AQ 6)**

The RUC reviewed several similar procedures, and building block methodologies for this base code recommendation. The RUC believed that part of the work for this code was contained in code 33212 *Insertion or replacement of pacemaker pulse generator only; single chamber, atrial or ventricula (Work RVU = 5.52)* and code 33233 *Removal of permanent pacemaker pulse generator (Work RVU = 3.29)*, and involved more work and intensity, as the insertion of the pacing electrode is in the left ventricle rather than the right. However, the generator must be removed to have access to this lead and the nature of the lead means that to be properly replaced it must be fully removed and the sheath placed for reinsertion. In essence it is very similar to the code 3322X1 *Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, with attachment to previously-placed pacemaker or pacing cardioverter-defibrillator pulse generator (RUC recommended work RVU = 9.05)*. The RUC discussed the code's global period and recommended a change from a 090 to a 000-day global code. The RUC believed the relative work value of 8.69 was the proper value based on the subtraction of the value of the post-operative visits contained therein from the survey median work RVU of 10.64. **The RUC recommends a work RVU of 8.69 with the understanding that it be a 000 day global and the removal, insertion, and/or replacement of the generator be included in the physician work. This is a formal recommendation for a CPT Editorial change.** The CPT Editorial Panel in May 2002 agreed with the CPT Executive Committee's decision to modify the descriptors of codes 3322X1 to include “(including revision of pocket, removal, insertion and/or replacement of generator)”.

### **Practice Expense**

The standard direct practice expense input packages for 090 day global codes has been applied to code 33215. Codes 33224 and 33226 as considered by the RUC were changed to a pre-service time of 35 minutes for these codes, consistent with the pre-service time for similar to cardiac catheterization codes (93508-93533) recently adopted by the PEAC/RUC. This change was made to reflect the change in global periods for these two codes from a 090 day global to a 000 day global, resulting in the deletion of the office visit time, supplies, and equipment. The RUC also recommends code 33225 have no practice expense inputs as it is an add-on code. All of these codes are considered by the RUC as to be performed in the facility setting and therefore no practice expense inputs are recommended in the non-facility setting.

### **Open Iliac and Brachial Artery Exposure (Tab 24)**

**Presenters: Gary R. Seabrook, MD, Donna Mendes, MD, and Robert Zwolak, MD, American Association for Vascular Surgery**

Two new codes were developed to describe techniques involved in endovascular thoracic aortic aneurysm repair. The new CPT code 34833, *Open iliac artery exposure with creation of conduit for delivery of infrarenal aortic or iliac endovascular prosthesis, by abdominal or retroperitoneal incision, unilateral* includes the work of CPT code 34820, *Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral* (work RVU =9.75), plus the work involved in suturing a segment of large diameter synthetic conduit onto the iliac artery, and the work of subsequently terminating that conduit after completion of endograft deployment. The new CPT code 34834 is analogous to CPT code 34812, *Open femoral artery exposure for delivery of aortic endovascular prosthesis, by groin incision, unilateral* (work RVU= 6.75) and CPT code 34820.

### **34833**

The RUC reviewed survey time data for the open iliac exposure and determined that the median survey value of 12.00 was appropriate when compared to the reference service 34820 (RVU=9.75). Thirty-three percent more intra-service time, plus 10 percent greater intra-service intensity readily justify the increment for the new code compared to the reference. Additionally, performance of an iliac conduit (34833) includes all the work of the reference service, CPT code 34820 (RVU=9.75), plus additional mobilization of the iliac artery, performance of an anastomosis of conduit to iliac artery, and termination of the conduit after it has been used for placement of the endograft. That means that the RVW of the new service would equal the entire work of the reference plus the additional work of conduit. Survey analysis demonstrated that the intra-service portion of the new service is 33% longer (100 min vs. 75 min) and 10% more complex than the reference. Pre-service time of new and reference services are essentially the same, but post-service time for the new procedure is 15 minutes longer. In sum,

this readily accounts for the 2.25 RVU increment between established RVW of the reference service and the median survey value of the new service. The RUC agreed with the specialty societies' median work RVU and believed it was ranked appropriately with the reference service code 34820.

**The RUC recommends a work relative value of 12.00 for 34833.**

**34834**

The RUC reviewed survey time data for open brachial exposure and determined that the recommended RVU of 5.35 was appropriate when based on a comparison to key reference CPT code 34812, *Open femoral artery exposure for delivery of aortic endovascular prosthesis, by groin incision, unilateral* (work RVU =6.75). The society determined that when the pre- and the post-service work is subtracted from reference service code 34812 (work RVU=6.75), the intra-service work is approximately 3.75 RVUs. Using the survey data, the respondents indicated that the intensity in relation to the new services is 10 percent more than the reference service code 34812. In addition, survey respondents indicated that the amount of time required for the new procedure is about 33 percent less than that of the reference service. Considering these factors, when the intra-service work intensity for the RVUs is calculated, the recommended RVUs for the new service is about 2.76 RVUs. When the surveyed values for the pre- and post- service work is added to the intra-service work, recommended RVU is 5.35. An RVW of 5.35 is also justified by a building block IWPUT calculation. This value is less than the 25th percentile of survey responses.

Magnitude comparison to key reference service:

From a clinical perspective the new service, exposure of the brachial artery during endograft placement, is very similar to the key reference service CPT 34812, exposure of the femoral artery during endograft placement. The primary difference is that the brachial artery is smaller in caliber and therefore requires more painstaking dissection. In addition, the brachial artery is nearly surrounded by nerves, and extra care must be taken to avoid nerve injury during the dissection. This extra intensity is reflected in the intensity/complexity responses where intra-service intensity of the new service was rated as 4.21 compared with the key reference at 3.82.

The RUC reviewed the survey results and found that although the intensity of brachial exposure was rated 10% greater than that of femoral exposure, the survey respondents felt the intra-service time of new service was 15 minutes less than the reference, or 67% of the reference intra-time. The sum of pre- and post-service time was exactly equal for both, 105 minutes. Since this is a 0-day global, and since the pre- and post- service work in both services are similar, one may calculate the RVW of the new service based on intensity and time comparisons between new and reference services.

Reference service Intra-service work = 6.75 (RVW of reference) – 3.00 (pre + post work) = 3.75 RVUs

Intra-service work of new service = intensity relationship (10% greater) x time relationship (33% less) x intra-service work of reference = 1.10 x 0.67 x 3.75 = 2.76 RVUs

Recommended RVW of new service = Pre + Post + Intra = 2.59 + 2.76 = 5.35

**IWPUT Analysis of New Service Using Recommended RVW = 5.35**

<i>IWPUT Analysis</i>				<b>Rec. RVW</b>
				<b>5.35</b>
<b>Pre-service:</b>		<b>Time</b>	<b>Intensity</b>	(=time x intensity)
	Pre service	70	0.0224	<b>1.57</b>
<b>Post-service:</b>		<b>Time</b>	<b>Intensity</b>	
	Immediate post	17	0.0224	<b>0.38</b>
	Subsequent visits:	<b>Visit n</b>	<b>E/M RVU</b>	(=n x E/M RVU)
	ICU 99291	0.0	4.00	0.00
	99233	0.0	1.51	0.00
	99232	0.0	1.06	0.00
	99231	0.0	0.64	0.00
	Discharge 99238	0.5	1.28	0.64
<b>Post-service total:</b>				<b>1.02</b>
		<b>Time</b>	<b>IWPUT</b>	
<b>Intra-service</b>		30	<b>0.092</b>	<b>2.76</b>

**The RUC recommends a work relative value of 5.35 for 34834.**

Practice Expense

Both codes are typically performed in the facility setting and therefore have no practice expense inputs in the office setting. For codes 34833 and 34834 6 minutes of coordination of care was modified to the discharge day standard. The patient education booklet was also removed from the supply list. Attached to the recommendation are the details of the practice expense inputs.

**Endovascular Repair of Iliac Artery Aneurysm (Tab 25)**

**Presenters: Gary Seabrook, MD, and Donna Mendes, MD, American Association of Vascular Surgery, Robert Vogelzang, MD, Society for Cardiovascular and Interventional Radiology, and Bibb Allen, Jr., MD, American College of Radiology**

The existing codes for direct iliac artery aneurysm repairs do not reflect the approach or techniques involved in endovascular graft placement. For these reasons, two new codes were created and one code was revised to describe



endovascular graft placement techniques and supervision and interpretation of the graft placement.

### **34900**

The RUC reviewed the survey data and determined that an RVW of 16.38, which is midway between the two commonly chosen reference services, CPT code 34800 *Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-aortic tube prosthesis* (RVW 20.75) and CPT code 34825 *Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic aneurysm; initial vessel* (RVW 12.00) represented the proper range value for these codes. The median physician time results are very closely aligned with 34800 while the intensity values fall between 34800 and 34825. Both key reference services are 90-day globals. While a mathematical method to simultaneously account for the bimodal key reference service choice and the specialty-based distribution of survey data was not possible; the RUC agreed that a midpoint between the RVW of 34800 (20.75) and the RVW of 34825 (12.00) is the most reasonable clinical magnitude estimate for this service. The mathematical mean of these two key reference services, an RVW of 16.38. This value is less than the 25<sup>th</sup> percentile of survey responses, and it is well justified by an IWPUT analysis.

**The RUC recommends a work relative value of 16.38 for 34900.**

### **75954**

The RUC reviewed the recommendations from vascular surgery and interventional radiology. The RUC understands that a different physician (i.e. radiologist) almost always performs this service while the vascular surgeon performs the services described in 34900. Two reference services, CPT code 75952 *Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation* (RVU= 4.50) and CPT code 75953 *Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic aneurysm, radiological supervision and interpretation*, (RVU=1.36) were commonly chosen by survey respondents. The RUC agreed with the rationale that was also used for code 34900. The most reasonable clinical magnitude estimate for this service lies between the two reference services. The value of 2.93 is very close to the 25<sup>th</sup> percentile of survey responses of 2.56.

**The RUC recommends a work relative value of 2.93 for 75954.**

### **Practice Expense**

The practice expense inputs were accepted as submitted. The practice expense inputs are attached to the recommendations.

**Harvest of Femoropopliteal Vein Segment (Tab 26)**

**Presenters: Gary Seabrook, MD, Donna Mendes, MD, and Bob Zwolak, MD  
American Association of Vascular Surgery**

**Reviewed By: Facilitation Committee #1**

One new code was created for the harvest of one segment of the femoropopliteal vein, for use as a conduit during vascular reconstruction. Although CPT created three new codes for the harvest of distant site for use as a bypass conduit (35500, 35682, and 35683), none of these describes the anatomical site or encompasses the physician work involved in harvesting the femoropopliteal vein.

**35572**

The RUC determined that specialty society recommended a value based on the inclusion of pre- and post- service work, but CMS has not yet approved the addition of pre- and post- service work in high level ZZZ codes. Therefore, the RUC developed a recommendation by comparing the specialty recommendation of 7.20 work RVUs for CPT code 35572 to other vein harvest procedures, such as:

- 35500 *Harvest of the upper extremity vein, one segment, for lower extremity or coronary artery bypass procedure (List separately in addition to code for primary procedure)* (6.45 RVU) intra-service time of 60 minutes
- 35682 *Bypass graft; autogenous composite, two segments of veins from two locations (List separately in addition to code for primary procedure)* (7.20 RVU) intra-service time 60 minutes
- 35683 *Bypass graft; autogenous composite, three or more segments of vein from two or more locations (List separately in addition to code for primary procedure)* (8.50 RVU) intra service time of 90 minutes.

The RUC examined the code as a ZZZ global period with no pre-service or post-service time and determined that the intensity of the deep vein harvest procedure for the lower extremity is greater as compared to the intensity for the superficial vein harvest in the upper extremity. In order to maintain rank order, the code should be valued above CPT code 35500 (work RVU = 6.45). The RUC, however, believed that the code should be valued below the more time consuming bypass graft codes 35682 (work RVU =7.20), and 35683 (work RVU =8.50). The RUC determined that the value of 6.82 places the code in appropriate rank order with the above reference service codes.

**The RUC recommends a work relative value of 6.82 for code 35572.**

**Practice Expense**

As this is a code with a ZZZ global period, there are no practice expense inputs.

**Endoscopic Ligation Subfascial Perforator Veins (SEPS) (Tab 27)**

**Presenters: Gary Seabrook, MD, Donna Mendes, MD, and Bob Zwolak, MD  
American Association of Vascular Surgery**

**Reviewed By: Facilitation Committee #1**

One new code was developed and one existing code was revised to accurately describe what is becoming the most common method to perform subfascial perforator ligation. The endoscopic technique is completely different from the only existing code for open subfascial perforator ligation, CPT code 37760 *Ligation of perforators, subfascial, radical (Linton type), with or without skin graft*, (work RVU=10.47).

**37500**

The RUC determined that the pre-service time was excessive compared to the services for the following codes:

- 37600 *Ligation; external carotid artery* (11.25 RVU) with a 55-minute pre-service time.
- 37650 *Ligation of femoral vein* (7.80 RVU) with a 60-minute pre-service time (Harvard time)
- 37660 *Ligation of common iliac* (21.00 RVU) with a 60-minute pre-service time

The RUC considered the work of 37500 (AU1), and determined that work was more than the 37650, yet less than 37650 and 37660. The specialty and the RUC agreed that the pre-service time was excessive when compared to these services, and believed that the median pre-service time should be decreased to 60 from 90 minutes. In addition, the RUC believed that the 25<sup>th</sup> percentile of the survey respondents represented the work involved for the typical patient. The RUC also reviewed similar codes for their IWP/UT calculations and it was determined that they were consistent. The survey median and the initial specialty recommendation was for a work value of 12.00, the 25<sup>th</sup> percentile survey results and the recommendation of the RUC is for a relative value of 11.00, with a pre-service time of 60 minutes.

**The RUC recommends a work relative value of 11.00 for code 37500.**

**Practice Expense**

This procedure is only performed out-of-the-office. The practice expense inputs were approved with minor modifications. The 6 minutes for coordination of care was modified to the discharge day standards. In addition, the patient education book was removed. Details of the practice expense are attached to the recommendation.

**Endoscopic Injections and Balloon Dilation of Intestinal Strictures (Tab 28)**  
**Presenters: Marurits Wiersema, MD, Joel Brill, MD, and Thomas Browning, MD, American Society for Gastrointestinal Endoscopy, American Gastroenterological Association**

The specialty society initially presented its survey data to a pre-facilitation committee at the RUC. After extensive discussion with this small group, the specialty decided to revise its recommendations. The revised physician time and work relative values are listed below. The RUC reviewed this rationale and agreed that it was appropriate.

<b>GI Endoscopic Injection Procedure Codes</b>					<b>Revised Gastro Work RVU</b>	<b>Incremental Work Over Base Code</b>	<b>Incremental Intra Time Over Base Code</b>	<b>Conscious sedation Included?</b>
	<b>CPT Code</b>	<b>Total Pre</b>	<b>Total Intra</b>	<b>Total Post</b>				
Base	43200	12	15	27.5	1.59			
Bx	43202	12	22	27.5	1.89			
Esoph Inj	4320X	12	25	27.5	<b>2.09</b>	<b>0.5</b>	<b>10</b>	Yes
Base	43235	16	25	26.5	2.39			
Bx	43239	27	34	23.5	2.87			
EGD Inj	4332X1	27	35	23.5	<b>2.92</b>	<b>0.53</b>	<b>10</b>	Yes
Base	45330	7	15	7	0.96			
Bx	45331	7	18	10	1.15			
Flex Sig Inj	4533X1	7	23	10	<b>1.46</b>	<b>0.5</b>	<b>8</b>	No
Base	45378	20	39	31.5	3.7			
Bx	45380	45	51.5	22	4.44			
Colon Inj	4538X1	45	49	22	<b>4.30</b>	<b>0.60*</b>	<b>10</b>	Yes

\*An increase in the increment is appropriate, as an injection into the colon is more technically difficult.

<b>GI Endoscopic Dilation Procedure Codes</b>					<b>Revised Gastro Work Total RVU</b>	<b>Incremental Work Over Base Code</b>	<b>Incremental Intra Time Over Base Code</b>	<b>Conscious sedation Included?</b>
	<b>CPT Code</b>	<b>Total Pre</b>	<b>Total Intra</b>	<b>Total Post</b>				
Base	43235	16	25	26.5	2.39			
Bx	43239	27	34	23.5	2.87			
EGD Dilation	43245	27	40	23.5	<b>3.18</b>	<b>0.79</b>	<b>15</b>	Yes
Base	45330	7	15	7	0.96			
Bx	45331	7	18	10	1.15			
Flex Sig Dilation	4533X2	17	25	16	<b>1.96</b>	<b>1.00*</b>	<b>10</b>	Yes
Base	45378	20	39	31.5	3.7			
Bx	45380	45	51.5	22	4.44			
Colon Dilation	4538X2	45	54	22	<b>4.58</b>	<b>0.88</b>	<b>15</b>	Yes

\*An increase in the increment is necessary because the base does not include conscious sedation.

The physician pre- and post-service time for both the injection and the dilation codes were adjusted to be consistent with the biopsy codes for each family.

### **Practice Expense Inputs**

Minor revisions were made to the practice expense inputs as presented by the specialty societies to standardize the conscious sedation inputs. The clinical staff pre-service time for these services, when performed in a facility setting was made consistent with other gastrointestinal endoscopy services presented in the past to the PEAC/RUC. The revised practice expense inputs are attached to the recommendations for these services.

### **Obstetrical Ultrasound (Tab 29)**

**Presenters: George Hill, MD, American College of Obstetricians and Gynecologists, and Bibb Allen, Jr. MD, American College of Radiology**

Code 768X1-768X5 were developed to reflect the advances in ultrasound technology, which now enable physicians to evaluate and measure fetal characteristics and organ systems in much greater detail than was possible several years ago.

### **Codes 76805 and 76810**

The RUC reviewed the specialty societies' recommendations for 76805 *Ultrasound, pregnant uterus, B scan and/or real time with image documentation; complete (complete fetal and maternal evaluation), after first trimester (> or =14 weeks 0 days), transabdominal approach; single or first gestation* and 76810 *complete (complete fetal and maternal evaluation), multiple gestation, after the first trimester* each additional gestation (List separately in addition to code for primary procedure performed). The RUC agreed that the physician work for 76805 has not changed as a result. Currently, for a multiple gestation, physicians would code 76810 separately, which was valued at 1.97 RVUs. Because the descriptor of 76810 (work RVU = 1.97) once regardless of the number of gestations. Because the descriptor of 76810 has changed, for a multiple gestation, physicians would code 76805 for a single gestation and 76810 for each additional gestation. Therefore, code 76810 has been reduced to a relative work value of 0.98 (half of its original RVU = 1.97), to reflect this change in the CPT language and global period to ZZZ. **The RUC recommends a work relative value of 0.99 for 76805 and 0.98 for 76810.**

### **Codes 768X1 and 768X2**

The RUC reviewed the specialty societies' recommendations for 768X1 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (<14 weeks 0 days), transabdominal approach; single or first gestation* and 768X2 *each additional gestation (List separately in addition to code for primary procedure performed)*. These codes reflect ultrasound performed in the first trimester, which the specialties agreed was important to track. The RUC reviewed the specialty societies' survey data and the survey median relative work value of a 0.99. The RUC agreed that the work of 768X1 is identical to the work value of 76805. Code 768X1 had previously been reported under 76805. For 768X2, the RUC accepted the survey median relative work value of 0.83. The RUC understands that the work of reviewing ultrasound for multiple gestation is less in the first trimester than the 2<sup>nd</sup> or 3<sup>rd</sup> trimester (CPT code 76810, work RVU = 0.98). **The RUC recommends a work relative value of 0.99 for 768X1 and 0.83 for 768X2.**

### **Code 76815**

The RUC assessed the specialty societies' recommendation for 76815 *Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume ~~or emergency in the delivery room~~), one or more fetuses*. The RUC felt that the survey data supported the contention that this coding change was editorial and did not change the work of the service. This code is valued identical to CPT 76856 (work RVU = 0.69). **The RUC recommends a work relative value of 0.65 for 76815.**

**Code 76816**

The RUC examined the specialty societies' recommendation for 76816 *Ultrasound, pregnant uterus, real time with image documentation, follow-up or repeat (eg, re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), transabdominal approach, per fetus*. The specialty society felt that this code had been undervalued in the past because it was valued less than 76815, which is a limited scan while 76816 reflect the same services as described in 76805 (RVU = 0.99). Therefore, the RUC felt that the specialty societies' recommendation of 0.85, the survey median, was appropriate. **The RUC recommends a work relative value of 0.85 for 76816.**

**Codes 768X3 and 768X4**

The RUC examined the specialty societies recommendations for 768X3 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation and 768X4 each additional gestation (List separately in addition to code for primary procedure performed)*. The specialty societies explained that these codes reflected the work performed in 76805 *plus a detailed anatomic evaluation of the fetal brain/ventricles, face, heart/outflow tracts and chest anatomy, abdominal organ specific anatomy, number/length/architecture of limbs and detailed evaluation of the umbilical cord and placenta and other fetal anatomy as clinically indicated*. This is new work made possible by the advances in the technology of the new ultrasound machines. This service is infrequently utilized and is mostly performed by maternal-fetal specialists. Therefore, the RUC felt that the specialty societies' recommendations of 1.90 for 768X3 and 1.78 for 768X4, both the survey medians, were appropriate. A patient with a multiple pregnancy typically has had a prior ultrasound study and/or other more extensive records, which must be reviewed, adding to pre-service work. In the intra-service period, the examination of the uterus and adnexa is not repeated, but additional intra-service work other than the evaluation of the additional fetus must be performed. The chorionic membranes, amniotic membranes, and placenta must be closely examined to determine whether the pregnancy is di-chorionic or mono-chorionic and di-amniotic or mono-amniotic. Accurate determination of these factors is important to assessing risk for development of complications such twin-twin transfusion syndrome. Additional post-service work is also required – documentation is more extensive and discussion with the patient and, if applicable, her referring physician is lengthier. **The RUC recommends a work relative value of 1.9 for 768X3 and 1.78 for 768X4.**

**Code 768X5**

The RUC reviewed the specialty societies' data and recommendation for 768X5 *Ultrasound, pregnant uterus, real time with image documentation, transvaginal*. The RUC agreed with the specialty that this new service requires more time and is more intense than both codes 76856 *Ultrasound, pelvic (nonobstetric), B-scan*

and/or real time with image documentation; complete (work RVU = 0.69) and 76830 *Ultrasound, transvaginal* (work RVU=0.69) and suggests the use of the specialty society's survey 75<sup>th</sup> percentile (work RVU= 0.75) **The RUC recommends a work relative value of 0.75 for 768X5.**

### **Practice Expense**

The RUC reviewed the practice expense inputs for the obstetric ultrasound codes. The specialty society explained that these were the standard practice expense inputs for ultrasound developed by the PEAC. Questions were also raised about the ultrasound room vs. the ultrasound machine. If typically the service is performed in a radiology office or unit at the hospital, than an ultrasound room would be the appropriate equipment. If the service is typically performed in an obstetrician's office, then the ultrasound machine would be more appropriate. The specialties will indicate the typical site of service. The modified practice expense inputs are attached to these recommendations.

### **Colposcopy Procedures (Tab 30)**

**Presenters: Michael Berman, MD, FACOG, and Sandra Reed, MD, FACOG, American College of Obstetricians and Gynecologists (ACOG) and Society of Gynecological Oncologists (SGO)**

**Reviewed By: Facilitation Committee #3**

To better define the various types of colposcopy services, the CPT Editorial Panel revised three existing codes and added seven codes to differentiate between colposcopy of the vulva, entire vagina and cervix including upper/adjacent vagina.

### **56XXX1, 5746X2 and 57452**

The RUC examined the survey results for codes 56XXX1 *Colposcopy of the vulva*; 5746X2 *Colposcopy of the entire vagina; with cervix if present* and 57452 *Colposcopy (vaginosecopy) of the cervix including upper/adjacent vagina; (separate procedure)*. The RUC felt that these codes were the three base codes for the 10 proposed colposcopy codes. After much consideration of the survey data provided by the specialty society, the RUC compared these codes with their reference codes, 53600 *Dilation of urethral stricture by passage of sound or urethral dilator, male; initia* (work RVU 1.21), and code 53605 *Dilation of urethral stricture or vesical neck by passage of sound or urethral dilator, male, general or conduction (spinal) anesthesia* (work RVU 1.28), code 54050 *Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical* (work RVU 1.24). The RUC felt that the work of the colposcopy was greater than these reference codes however, was less work that code 54100 *Biopsy of penis; (separate procedure)* (work RVU 1.90). Based on a comparison to these reference codes, the RUC assigned values to these codes, to place them in rank order. **The RUC recommends a work relative value for 56XXX1 of 1.50, for 5746X2 of 1.60 and 57452 of 1.50.**



**56XXX2, 5746X3 and 57454**

Once the values of the base codes were determined, the incremental work involved with biopsy for codes 56XXX2 *Colposcopy of the vulva; with biopsy(s)*, 5746X3 *Colposcopy of the entire vagina; with cervix if present; with biopsy(s)* and 57454 *Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix and endocervical curettage* were calculated. To value 56XXX2 and 5746X3 codes, first, the RUC established that the incremental work determined by the specialty society survey was appropriate for a biopsy for all of these codes and therefore used this increment to value these codes. Consequently, to value 56XXX2, the RUC began with its recommendation of 56XXX1 (recommended work RVU 1.50) and then added the surveyed biopsy increment between 56XXX1 and 56XXX2 (0.55) to get a value of 2.05. For 5746X3, the RUC began with its recommendation for 5746X2 (recommended work RVU 1.6) and then added the surveyed biopsy increment between 5746X2 and 5746X3 (0.60) to get a value of 2.2. To value 57454, the RUC began with its recommendation for 57452 (recommended RVU of 1.50) and then added half of 57500 *Biopsy, single or multiple, or local excision of lesion, with or without fulguration, separate procedure* (RVU= 0.97) and half of 57505 *Endocervical curettage* (RVU = 1.14) minus the RVU for a 99212 office visit (RVU = 0.45). Resulting in a total value of 2.33 RVUs.

1.5 RVU	CPT code 57452, <i>Colposcopy of the cervix including upper/adjacent vagina</i> (RVU = 1.5)
+0.485 RVU	Half CPT code 57500, <i>Biopsy, single or multiple, or local excision of lesion, with or without fulguration, separate procedure</i> (RVU = 0.97)
+0.345 RVU	Half (57505 <i>Endocervical curettage</i> (RVU = 1.14) – 99212 office visit (RVU = 0.45))
<b>=2.33 RVU</b>	<b>Recommendation for 57454</b>

**Therefore, the RUC recommends a work relative value of 2.05 for 56XXX2, 2.20 for 5746X3 and 2.33 for 57454.**

**5745X1, 5745X2 and 5746X1**

A building block approach was used to calculate the recommendations for these codes. For 5745X1, *Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix*, the RUC began with the recommended work RVU of 57452 (1.50) then added half of the current relative work value for CPT code 57500, *Biopsy, single or multiple, or local excision of lesion, with or without fulguration, separate procedure* (0.49). This calculation results in an overall recommendation for 5745X1 of 1.99. For 5745X2, the RUC began with the recommended work RVU of 57452 (1.50) then added half of CPT code 57505, *Endocervical curettage* (1.14) minus the work for a 99212 office visit (0.35). This calculation results in an overall value of 1.85. For 5746X1, *Colposcopy of the cervix including upper/adjacent vagina; with loop electrode conization of the cervix*, the RUC began with recommended work RVU of 57452 (1.50) then added

half of the current relative work value for CPT code 57522 *Conization of the cervix, with or without dilation and curettage, with or without repair; loop electrode excision* (3.36) minus the work for a 99213 office visit (0.67). This calculation results in an overall recommendation for 5746X1 of 3.44. See tables below for clarification.

1.5 RVU	CPT code 57452 <i>Colposcopy of the cervix including upper/adjacent vagina</i> (RVU = 1.5)
+ 0.485 RVU	Half CPT code 57500, <i>Biopsy, single or multiple, or local excision of lesion, with or without fulguration, separate procedure</i> (RVU = 0.97)
<b>=1.99 RVU</b>	<b>Recommendation for 5745X1</b>

1.5 RVU	CPT code 57452 <i>Colposcopy of the cervix including upper/adjacent vagina</i> (RVU = 1.5)
+0.345 RVU	Half (57505 <i>Endocervical curettage</i> (RVU = 1.14) – 99212 office visit (RVU = 0.45))
<b>=1.85 RVU</b>	<b>Recommendation for 5745X2</b>

2.69 RVU	CPT code 57522 <i>Conization of the cervix, with or without dilation and curettage, with or without repair; loop electrode excision</i> (RVU = 3.36) – 99213 office visit (RVU = 0.65)
+0.75 RVU	Half CPT code 57452 <i>Colposcopy of the cervix including upper/adjacent vagina</i> (RVU = 1.5)
<b>=3.44 RVU</b>	<b>Recommendation for 5746X1</b>

**Therefore, the RUC recommends a work relative value of 1.99 for 5745X1 and 1.85 for 5745X2 and 3.44 for 5746X1.**

**57460**

For code 57460, *Colposcopy of the cervix including upper/adjacent vagina; with loop electrode biopsy of the cervix* (RVU = 2.83), the RUC agreed that this code should not have a change in value and recommend its existing value of 2.83 RVUs. **Therefore, the RUC recommends no change in the work relative value for 5746X1.**

**Practice Expense**

The specialty society utilized established PEAC methodology to when developing the practice expense for the colposcopy procedure codes. However, there were a

few minor revisions to the staff times and equipment. **Therefore, the RUC approved the practice expense inputs with necessary revisions as presented by the specialty society.**

**Vaginal Hysterectomy/Myomectomy Procedures (Tab 31)**

**Presenters: George Hill, MD, FACOG, and Sandra Reed, MD, FACOG, American College of Obstetricians and Gynecologists**

**Reviewed By: Facilitation Committee #2**

Evidence indicates that the vaginal route of surgery for hysterectomies is associated with reduced complication rates, reduced pain, absence of external scars and a shorter hospital stay. Historically, an enlarged uterus (defined as a uterus over 250 grams) has commonly been considered a contraindication to vaginal hysterectomy and was often cited as justification for the abdominal, and more recently, the laproscopic approach. In recent years practitioners have developed improved techniques in dealing with the excision of the larger uterus vaginally. Techniques employed by physicians to remove the larger uterus vaginally include bisection, morcellation, myomectomy and coring when uterine mobility and access are adequate. These techniques are generally not necessary with a uterus less than 250 grams. Employing these techniques results in a modest increase in operative time. Therefore, these codes 5814X and 5826X1-X5 were created to specifically describe vaginal hysterectomy/myomectomy procedures for enlarged uteri.

**5814X**

The RUC evaluated code 5814X *Myomectomy, excision of fibroid tumor(s) of uterus, 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams, abdominal approach*. The specialty society's survey median RVU for this code was 19.00 and the survey 25<sup>th</sup> percentile was 16.00. The RUC noted that the building block approach with an IWPUT of 0.080 – 0.088 (depending on the IWPUT used for pre and post work) supported an RVU of 19.00. The specialty society provided several cross-walk reference codes. The RUC agreed that CPT code 58200 *Total abdominal hysterectomy, including partial vaginectomy, with para-aortic and pelvic lymph node sampling, with or without removal of tube(s), with or without removal of ovary(s)* with the same intra-service time of 150 minutes and greater total RUC time (435 minutes versus 411 for 5814X) further supported the value of 19.00. The RUC noted several other cross-walk codes (43631 *Gastrectomy, partial, distal; with gastroduodenostomy* (RVU = 22.59) which has a pre-service time of 75 minutes, and intra service time of 150 minutes and a post-service time of 30 minutes and 44140 *Colectomy, partial; with anastomosis* (RVU = 21.00) with a pre-service time of 90 minutes and intra-service time of 150 minutes and a post-service time of 40 minutes) with the same intra-service times, similar intensity of procedure and work RVUs in the range on 21.00 to 23.00. **The RUC recommends a work relative value of 19.00 for 5814X.**

**5826X1**

The RUC examined the survey results for CPT code 5826X1 *Vaginal hysterectomy, for uteri greater than 250 grams*; The RUC evaluated code 5826X1. The survey median was 19.5 and the 25<sup>th</sup> percentile was 17.5. the specialty society's proposal used the building block approach with an IWPUT of 0.11 to support the survey median recommendation. The specialty society representatives expounded on the difficulty and intensity of the procedure to support the IWPUT of 0.11. Members of the RUC were not convinced that an IWPUT of 0.11 was justified and evaluated three alternative methods of evaluating the value of 5826X1. Method #1: The reference code was 58260, *Vaginal hysterectomy* (RVU = 12.98) with 60 minutes intra service time. Taking the value of 58260 (12.98) and adding to it the value of 60 intra-service minutes at an IWPUT of 0.10 yielded a value of 18.98. Method #2: The RUC also looked at several add-on codes with intra-service times of 60 minutes and noted that 22216 *Osteotomy of spine, posterior or posterolateral approach, one vertebral segment; each additional vertebral segment (List separately in addition to primary procedure)* (RVU = 6.04) was a surrogate for the 60 minutes difference in intra-service time between 5826X1 and its reference code. Adding 6.04 to the value of the reference code yields 19.02. Method #3: Using the building block approach as outlined in the specialty society's proposal but substituting an IWPUT of 0.1 yields and RVU of 18.91. Thus, three methods yielded an RVU very close to the survey median of 19. **The RUC recommends a work relative value of 19.00 for 5826X1.**

**5826X2-5826X5**

The RUC then examined 5826X2 *Vaginal hysterectomy, for uteri greater than 250 grams; with removal of tube(s) and/ or ovary(s)*, 5826X3 *Vaginal hysterectomy, for uteri greater than 250 grams; with removal of tube(s) and/or ovary(s) with repair of enterocele*, 5826X4 *Vaginal hysterectomy, for uteri greater than 250 grams; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type, with or without endoscopic control)* and 5826X5 *Vaginal hysterectomy, for uteri greater than 250 grams; vaginal hysterectomy, with repair of enterocele*. The RUC decided that these codes should be valued in relation to 5826X1 using the same incremental values as already approved for the established hysterectomy codes (58260-58270). Below is a summary of the RUC's recommendation.

CPT Code	Descriptor	RVW	Difference with 58260	RUC Survey Code	Recommendation
58260	Vaginal hysterectomy	12.98	-	5826X1	19.0
58262	Vaginal hysterectomy, with removal of tubes	14.77	1.79	5826X2	20.79
58263	Vaginal hysterectomy, with removal of tubes and/or ovary(s), with	16.06	3.08	5826X3	22.08

	repair of enterocele				
58267	Vaginal hysterectomy with colpourethrocytopexy	17.04	4.06	5826X4	23.06
58270	Vaginal hysterectomy with repair of enterocele	14.26	1.28	5826X5	20.28

**The RUC recommends a relative work value of 20.79 for 5826X2, 22.08 for 5826X3, 23.06 for 5826X4 and 20.28 for 5826X5.**

**Practice Expense**

The RUC approved the practice expense inputs for 5814X and 5826X1-5826X5. The RUC recommends that the 90- day global period standard should apply for all of these codes. Since these codes are typically performed only in the facility setting the RUC recommends no PE in the office setting. **The RUC recommends all the practice expense inputs presented by the specialty society.**

**Laparoscopic Hysterectomy/Myomectomy Procedures (Tab A)**

**Presenters: Barbara Levy, MD, and Sandra Reed, MD, American College of Obstetricians and Gynecologists**

**Reviewed By: Facilitation Committee #2**

New codes 5854X1-5854X2, 58550, and 5855X1-5855X3 were created to specifically describe vaginal hysterectomy/myomectomy procedures performed on enlarged uteri.

The specialty society stated that they would need to re-survey these codes, as the correct global period for these services should be 90 days not 10 days as stated on their survey instrument. The specialty will present survey data to the RUC at the September 2002 RUC meeting. However, in the interim, the RUC recommends that these laparoscopic codes be valued equivalent to the recommended relative work values of the open approach hysterectomy codes as follows:

New Code	Tracking Number	Crosswalk to Code	Work RVU
5854X1	BA1	58140	14.60
5854X2	BA2	5814X	19.00
58550	BA3	58550 (old code number 56308)	14.19 (no change)
5855X1	BA4	58550 (old code number	14.19

		56308)	
5855X2	BA5	5826X1	19.00
5855X3	BA6	5826X1	19.00

584X3/584X4 both compared to 58550 *Laparoscopy, surgical; with vaginal hysterectomy with or without removal of tube(s), with or without removal of ovary(s) (laparoscopic assisted vaginal hysterectomy)* (RVU = 14.19) because there is no difference in the work of removing the tube or ovaries in the laproscopic approach. The same applies to 584X51/584X6 where both are crosswalked to 5826X1 *Vaginal hysterectomy, for uteri greater than 250 grams* (recommended RVU 19.00). **Therefore, the RUC recommends interim work relative values of 14.60 for 5854X1, 19.00 for 5854X2, 14.19 for 58550 and 5855X1, 19.00 for 5855X2 and 5855X3.**

**Practice Expense**

The RUC approved the practice expense inputs for 5854X1-X6. The RUC understood that the 90- day global period standard should apply for all of these codes. **The RUC recommends all the practice expense inputs presented by the specialty society.**

**Excision of Lesions: Wide Margins (Tab B)**

**Presenters: Brett Coldiron, MD, and Daniel Siegel, MD, American Academy of Dermatology, Laura Knobel, MD, American Academy of Family Physicians, and Keith Brandt, MD, American Society of Plastic Surgeons**

CPT requested the review of 36 revised excision of benign and malignant lesion codes based on the revisions to the descriptors to include the margins of the lesions. The Dermatology, Family Physician, General Surgery and Plastic Surgery specialty societies chose not to survey these revised codes, rather they proposed increases based on the frequency that would maintain the 2002 family RVU ratio for the first 5 codes in each family remain work neutral. However, the last code in the family will remain the same. This rationale is derived from the estimation that with the inclusion of the lesion’s margins, codes that previously described larger lesion sizes will now be more appropriately coded using a higher level code. For example, the specialty societies estimated that for benign lesion types, the frequency for higher level codes would increase by 30 percent. For malignant codes, the specialty societies estimated that the frequency for code usage for the next higher level code would increase by about 50 percent. Since the description of the last code in the family is inclusive of margins at a certain level and higher, the society determined that by holding the work value for the last code in the family the same, the family will remain work neutral. The RUC agreed with this rationale. **The RUC recommends the following work relative values for codes 11400-11646:**

<b>CPT 11400</b>	<b>0.85</b>	<b>CPT 11420</b>	<b>0.98</b>	<b>CPT 11440</b>	<b>1.06</b>
<b>CPT 11401</b>	<b>1.23</b>	<b>CPT 11421</b>	<b>1.42</b>	<b>CPT 11441</b>	<b>1.48</b>

CPT 11402	1.51	CPT 11422	1.63	CPT 11442	1.72
CPT 11403	1.79	CPT 11423	2.01	CPT 14443	2.29
CPT 11404	2.06	CPT 11424	2.43	CPT 11444	3.14
CPT 11406	2.76	CPT 11426	3.78	CPT 11446	4.49
CPT 11600	1.31	CPT 11620	1.19	CPT 11640	1.35
CPT 11601	1.80	CPT 11621	1.76	CPT 11641	2.16
CPT 11602	1.95	CPT 11622	2.09	CPT 11642	2.59
CPT 11603	2.19	CPT 11623	2.61	CPT 11643	3.10
CPT 11604	2.40	CPT 11624	3.06	CPT 11644	4.03
CPT 11606	3.43	CPT 11626	4.30	CPT 11646	5.95

### **Practice Expenses**

No changes to the practice expense inputs were recommended.

### **Mohs Micrographic Surgery (Tab C)**

**Presenter: Brett Coldiron, MD, American Academy of Dermatology**

For CPT 2003, the American Academy of Dermatology recommended changes that would clarify that a biopsy and frozen pathology could be done on the same day as Mohs surgery. In addition, the specialty proposed changes to special procedures such as decalcification of the bone during Mohs surgery or specialty stains (i.e. immunostaining for melanoma). Finally, modifications to code 17310 were recommended to clarify that each specimen after the first 5 specimens in each layer is separately reimbursable. The Center's for Medicare and Medicaid recommended that the work value for 17310 be changed from 000 to ZZZ. CPT approved these changes.

Modification to codes 17304, 17305, 17306, and 17307 were considered editorial changes, and were not reviewed by the RUC. The specialty survey for code 17310 did not provide calculations that were work neutral. In addition, RUC members were unclear on the historical information regarding whether the code could be billed more than one time on the same day for greater than 5 specimens, as the interpretation from CPT differed from the interpretation put forth by CMS in 1994 letter from a CMS Chief Medical Officer. Therefore, the RUC approved a motion to let the value stand for the CPT 2003 cycle as interim. Between the April 2002 RUC Meeting and the February 2003 RUC Meeting, an ad-hoc committee would further clarify with CPT the intent of code 17310. In addition, the specialty society would revise their survey based on the agreed upon interpretation of the descriptor and the new ZZZ global period.

**The RUC recommends an interim work relative value for CPT code 17310 of 0.95.**

**Practice Expense**

The RUC referred practice expense inputs for this family of codes to the September 2002 Practice Expense Advisory Committee.

**Laser Treatment for Inflammatory Skin Diseases (Tab D)**

**Presenters: Daniel Siegel, MD and Lawrence Green, MD, American Academy of Dermatology**

**Reviewed By: Facilitation Committee #3**

Three new codes were created to more appropriately describe the use of laser treatment for skin diseases. The RUC reviewed the survey data determined that despite the specialty society's amended recommendations, the values were still too high. The RUC used the following reference service codes to assign relative work values to these proposed codes that were properly ranked:

CPT code 11402, *Excision, benign lesion except skin tag, trunk, arms, legs, 1.1 – 2.0 cm* (work RVU=1.61)

CPT code 12001, *Simple repair of superficial wounds of scalp, neck, external genitalia, 2.5 cm or less* (work RVU = 1.70)

CPT code 11406, *Excision, benign lesion, except skin tag (unless listed elsewhere), trunk, arms or legs; lesion diameter over 4.0 cm* (work RVU=2.76)

Each of these reference codes has a 010-day global period. Therefore, the RUC agreed to remove one of the office visits (CPT code 99212 with a 0.45 work RVU) from each of the reference codes and recalculate the RVU values for the new codes accordingly.

**The RUC recommends a work relative value of 1.15 RVUs for CPT code 96920.**

**The RUC recommends a work relative value of 1.17 RVUs for CPT code 96921.**

**The RUC recommends a work relative value of 2.10 RVUs for CPT code 96922.**

**Practice Expense**

The RUC reviewed the practice expenses and agreed to delete the following practice expenses: 1) Monitor patient following service/check tubes, monitors and drains; 2) Complete diagnostic forms, lab and x-ray acquisition and 3) Review/read X-ray, lab and pathology reports. This would reduce the 9 minutes from the practice expense times for each code. Lidocaine Jelly (30 mL) was removed from the list of supplies for CPT code 96920 and 96921. The Pulse Dye Laser was deleted from the list of equipment. Revised practice expense inputs are attached to the recommendations.



**Insertion of Bladder Catheters (Tab E)****Presenter: William F. Gee, MD, and Jeffery A. Dann, M.D., American Urological Association****Reviewed By: Facilitation Committee #1**

During 2001 the CPT Editorial Panel requested the review of current catheter codes with regard to the descriptor nomenclature and need to transition G0002 into a CPT code. The American Urological Association examined the current three codes; G0002, *office procedure, insertion of temporary indwelling catheter, foley type (separate procedure)* (Work RVU=0.50), 53670, *Catheterization, urethra; simple* (Work RVU=0.50), and 53675, *Catheterization, urethra; complicated (may include difficult removal of balloon catheter)* (Work RVU=1.47). From the review it became apparent that there was a potential for overlap in the nomenclature of the codes. The CPT Editorial Panel created three distinct catheterization procedures; non-indwelling catheterization, simple and indwelling catheterization, complex. The panel then deleted the existing codes and therefore eliminated overlapping nomenclature and potential confusion of the codes.

The RUC reviewed the specialty's request to crosswalk the physician work values of the existing codes to the new codes, and agreed that it would be appropriate to recommend the same values. Therefore, **the RUC recommends relative work values of 0.50, 0.50, and 1.47 for codes 5160X1, 5160X2, and 5160X3 respectively. The RUC also recommends the physician time be cross-walked as well and is as follows:**

<b>CPT Code</b>	<b>Intra Serv Time</b>	<b>Total Time</b>
<b>5160X1</b>	<b>N/A</b>	<b>33</b>
<b>5160X2</b>	<b>8</b>	<b>23</b>
<b>5160X3</b>	<b>29</b>	<b>64</b>

**Practice Expense**

The RUC reviewed in great detail the practice expense inputs in both the facility and non-facility settings for codes:

5160X1 *Insertion of non-indwelling bladder catheter (e.g., straight catheterization for residual urine)*

5160X2 *Insertion of temporary indwelling bladder catheter; simple (e.g., Foley)*

5160X3 *Insertion of temporary indwelling bladder catheter; complicated (e.g., altered anatomy, fractured catheter/balloon)*

The RUC decided to lower the clinical labor time for each of the codes from the specialty society's recommendation since the physician performs much of the work. In addition, an E/M visit is often performed on the same date. The RUC recommends the following facility and non-facility total clinical labor time:

Code	RUC Rec In office- CL Time	RUC Rec Out of office – CL Time
5160X1	18	5
5160X2	42	12
5160X3	60	18

In addition the RUC agreed to eliminate the irrigation fluid and tubing, the leg bag for 5160X1, the sterile drape, and the thermometer from the medical supplies. The revised practice expense inputs are attached to the recommendations for these codes.

**Measurement of Post-Voiding Residual Urine/Bladder Capacity (Tab F)**

**Presenter: William Gee, MD, American Urological Association**

**Reviewed By: Facilitation Committee #1**

Code 5179X represents a new code to CPT as a transition from a G code. Code G00050 *Measurement of post voiding residual urine and/or bladder capacity by ultrasound* (Work RVU=0.00) was eliminated to signify that it is no longer associated with imaging. Code 5179X was then surveyed by urology and found that it typically is performed by a urologist although no physician work was assigned to this code by CMS. Based on the median of their survey results, the specialty requested a work relative value of 0.58. The RUC reviewed the specialty's request and noted that the most appropriate reference code was code 76857 *Ultrasound, pelvic (nonobstetric), B-scan and/or real time with image documentation; limited or follow-up (e.g., for follicles)* (Work RVU=0.38) rather than code 76942 *Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation* (Work RVU=0.67). Based on the specialty society's 25<sup>th</sup> percentile survey results and the similarities in work of code 76857 and 5179X, **the RUC recommends a relative work value of 0.38, and physician time equal to the specialty society's surveyed 25<sup>th</sup> percentile.**

**Practice Expense**

The RUC reviewed in great detail the practice expense inputs in both the facility and non-facility settings for code 5179X, and agreed to lower the clinical labor time for the codes since much of the work is performed by the physician. The RUC recommends 30 minutes of clinical labor time in the office and 13 minutes in the facility setting. The RUC also recommends some basic medical supplies and equipment in the office setting, as shown in the practice expense summary form attached to the recommendation for this service.

**Renal Endoscopy (Tab G)**

**Presenters: James B. Regan, MD, and Jeffery A. Dann, MD, American Urological Association**

**Reviewed By: Facilitation Committee #1**

Renal endoscopy through an established nephrostomy or pyelostomy with transpelvic resection of tumor is a rarely performed procedure for the treatment of renal pelvic tumors. New generation endoscopes have permitted better visualization and endoscopic manipulation of the renal pelvis. Performing a renal endoscopy involves a completely different operative approach and work effort compared to performing a cystoscopic resection of a bladder tumor or a ureteroscopic resection of a ureteral tumor, and thus the need for this new code.

**5056X1**

The RUC reviewed the physician time, work, and global period status of several codes among and across specialties to properly value 5056X1. The RUC then concentrated on three relative codes:

- 43265 *Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde destruction, lithotripsy of calculus/calculi, any method* (Work RVU = 10.02), 000 day global with intra service work time of 83.5 minutes (RUC).
- 50574 *Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy* (Work RVU = 10.02), 000 day global with intra-service work time of 114 minutes (Harvard)
- 52346 *Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (e.g., balloon dilation, laser, electrocautery, and incision)* (Work RVU = 9.22), 000 day global with intra-service work time of 120 minutes (RUC).

The RUC concluded that the intensity of the work of code 5056X1 was greater than code 52346 and similar to code 43265. Using the intra-service work intensity of code 43265 for an additional 9 minutes of intra-service time, the RUC agreed that a relative value of 10.90 was appropriate. The RUC in addition discussed and agreed that code 50574 involved less work than 5056X1 and therefore agreed the code was properly rank ordered.

**The RUC recommends a relative work value of 10.90 for CPT code 5056X1.**

**Practice Expense**

The standard 90-day global practice expense inputs were used for code 5056X1 with a pre-service time of 60 minutes and a service period time of 6 minutes for a half day of discharge day management. The committee recommends no practice expense inputs in the office setting, as these procedures are typically performed in the facility setting.

**Craniotomy/Cranial Bone Flap Procedures for Trauma (Tab H)**

**Presenters: Rick Boop, MD, FACS, American Association of Neurological Surgeons, and John A. Wilson, MD, FACS, Congress of Neurological Surgeons**

**Reviewed By: Facilitation Committee #2**

Four new codes and one revised code were created to appropriately describe craniotomy/cranial bone flap procedures for trauma. The RUC reviewed the survey data from 35 neurological surgeons.

**61322 and 61323**

After review of the survey data, the RUC concluded that the survey was flawed. The reference service list did not reflect the range of services appropriate to the survey of the new services. The highest reference service on the list was CPT 61538 *Craniotomy with elevation of bone flap; for lobectomy with electrocorticography during surgery, temporal lobe* (work RVU = 26.81). The RUC thought the results of the survey suggested that the respondents did not accurately value the work involved in the codes being surveyed. Finally, adopting the survey median values would create disparities in the relative values within the family of neurosurgical codes.

The RUC determined that the survey median did not reflect the work of this procedure as compared to the key reference service 61312, *Craniectomy or craniotomy for evacuation of hematoma, supratentorial; extradural or subdural*, (work RVU = 24.57). In particular the patient population of the surveyed code is sicker than the patients represented by the reference code 61312. While the patients for 61312 recover relatively quickly from local brain trauma, the patients undergoing the surveyed procedure require more time and care for recovery from diffuse brain injury. Compared to the reference service, the intra- time was 30 minutes longer and the length of stay was 3 days longer for the code being surveyed. These factors justified recommending values higher than the survey's fiftieth percentile median values.

The RUC reviewed the new RUC MPC (approved earlier in the day) and agreed that the specialty society recommended work RVUs for both codes were consistent with similarly valued codes on the MPC list. Examples include 33533, *Coronary artery bypass, using arterial graft(s); single arterial graft*, (RVU= 30.00) and 61510, *Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma*, (RVU = 28.45). Considering

all of these factors, the RUC recommends the values proposed by the specialty society.

**The RUC recommends a work relative value of 29.50 for CPT code 61322.  
The RUC recommends a work relative value of 31.00 for CPT code 61323.**

**61316**

The specialty society revised the recommendation from 2.00 to 1.39. Upon further analysis of the survey data and the reference code of 20937, the society felt that the median survey response of 2.00 RVW did not accurately represent the work involved in the performance of this procedure. The intra-service time is 50 percent of the reference service code (20 minutes verses 40 minutes) and the measures of intensity were very similar.

Therefore, the RUC believes a value of 1.39, which is one half the value of the reference code and lies between the 25<sup>th</sup> and the 50<sup>th</sup> percentiles of the survey data, accurately represents the total work of this add-on code.

**The RUC recommends a work relative value of 1.39 for CPT code 61316.**

**62148**

The removal of the bone flap (62148) is performed electively - sometimes several months - after the original primary cranial procedure. Code 20937, *Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision)* (work RVU = 2.79), typically includes harvesting and placing a bone graft within the same operative site (i.e., exposure and closure are basically part of the primary procedure, with time necessary to fashion the graft). With 62148, re-exploration and dissection of scarred tissue is necessary to elevate the graft. As with the harvesting code 631X3, there is a separate wound that needs to be followed postoperatively. The survey median RVW of 2.00 for 62148 reflects the similarities and differences in "total" work (time/intensity), when compared with the reference code.

**The RUC recommends a work relative value of 2.00 for CPT code 62148.**

**Practice Expense**

The RUC recommends the practice expense inputs as submitted. The practice expense inputs are attached to the recommendation.

**Implantation Brain Interstitial/Intercavitary Chemotherapy (Tab I)**

**Presenter: Rick Boop, MD, FACS, American Association of Neurological Surgeons, and John A. Wilson, MD, FACS, Congress of Neurological Surgeons**

One new add-on code was approved by the CPT Editorial Panel to describe the delivery of a chemotherapeutic agent through interstitial/intercavitary implantation. The RUC reviewed survey data from 31 neurological surgeons.

The RUC compared the following reference service codes that have a ZZZ global period:

20931, *Allograft for spine surgery only; structural* (RVU = 1.81); and 64484, *Injection, anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, each additional level (List separately in addition to code for primary procedure)* (RVU = 1.33).

In comparison to 20931, which includes measuring and fashioning the bone graft, new code 61517 requires less intra-operative time because pre-sized wafers are used. New code 61517 is very similar to 64484 in terms of total work (time/intensity). The total work of 61517 reflects placement of a chemotherapeutic agent into the brain as compared with extradural injection of a non-destructive substance for 64484. The RUC believed that the survey 25<sup>th</sup> percentile – instead of the survey median – more accurately reflects the time and intensity relationships among 61517, 20931, and 64484. Based on comparison to two reference codes with the same global period (20931 and 64484), this code is also in appropriate rank order. A RUC member requested that the RUC minutes reflect that this code is an example of when addition pre- or post-service time may be appropriate for a ZZZ code.

**The RUC recommends a work relative value of 1.38 for CPT Code 61517.**

**Practice Expense**

There are no direct practice expense inputs for this code, as it has a ZZZ global period.

**Endovascular Temporary Balloon Occlusion (Tab J)**

**Presenters: Andrew Ku, MD, American Society of Interventional and Therapeutic Neuroradiology, J. Arliss Pollock, MD, American Society of Neuroradiology, and John Wilson, MD, American Association of Neurological Surgeons**

One new code was created and one code was revised to describe both temporary and permanent balloon occlusions for the assessment of a patient in order to detect cerebral ischemia. The RUC reviewed survey data from 33 neurosurgeons/neuroradiologists.

The specialty groups reviewed the survey data (12.00 RVU) and determined that the median RVU of 16.00 seemed high and that the 25<sup>th</sup> percentile of the survey data better reflected the physician work involved in performing this procedure. However, upon further review, the RUC recommends an alternate approach based on valuing the incremental components was used to determine the RVU. For CPT code 61623 the incremental components include:

<u>CPT Code/Description</u>	<u>RVU</u>
99233 <i>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</i>	1.51
36216/36217 (average) <i>Selective catheter placement, arterial system; initial second order thoracic or brachiocephalic branch, within a vascular family</i>	5.79
<i>Selective catheter placement, arterial system; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family</i>	
36218 <i>Selective catheter placement, arterial system; additional second order, third order, and beyond, thoracic or brachiocephalic branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)</i>	1.01
75898 <i>Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion</i>	1.65
<b>Total RVU</b>	<b>9.96</b>

IWPUT Calculations

<b>Pre-service time</b>	<b>Intensity</b>	<b>(= time x intensity)</b>
50	0.0224	1.2
<b>Post-service time</b>		
45	0.0224	1.01
<b>Intra-service time</b>		
90	IWPUT -0.087	7.83

Based on incremental components and IWPUT calculations the RUC recommends a relative work value of 9.96.

**The RUC recommends a work relative value of 9.96 for CPT code 61623.**

**Practice Expense**

These services are only performed in a facility. The RUC recommends a pre-service time of 15 minutes for this service, cross-walked to CPT 61626. The practice expense inputs are attached to the recommendation.

**Percutaneous Lysis of Epidural Adhesion (Tab K)**

**Karl E. Becker, MD, and Norman Cohen, MD, of American Society of Anesthesiology, and Laxmaiah Manchikanti, MD, of American Society of Interventional Pain Physicians**

**Reviewed By: Facilitation Committee #3**

CPT revised code 62263 and created a new code to allow for the reporting of percutaneous lysis of epidural adhesions using solution injections that can occur over a three day period as well as those that take place over only one day. Epidural adhesions are a common source of chronic low back pain and CPT 62263 was approved for *Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, spring-wound catheter) including radiologic localization (includes contrast when administered)* for CPT 2000. Since that time, the evolution of this technique has resulted in modification and simplification where the procedure can be performed on a one-day basis where the catheter is removed after injecting the drugs rather than leaving it in the patient.

**62263**

The RUC examined the survey results for 62263 and accepted the recommended value of 6.14. This value is the same as the current value and is supported by a survey median value of 6.10. This median value is essentially identical to the current value and the presenters stated that the CPT changes did not affect the physician work. The RUC agreed to no change in the work RVU for this code since it was originally valued by the RUC in 1999. **The RUC recommends a work relative value of 6.14 for code 62263.**

**6226X**

The RUC examined code 6226X, *Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, spring-wound catheter) including radiologic localization (includes contrast when administered) multiple adhesiolysis sessions; 1 day*, and developed a building block consistent with what was used in 1999 to value code 62263 *Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, spring-wound catheter) including radiologic localization (includes contrast when administered)* (work RVU 6.14). The RUC determined that code 6226X was equivalent to code 62319 *Injection, including catheter placement, continuous infusion or intermittent bolus, not including*



neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal) (work RVU 1.87), plus work for epidurography, injection of a neurolytic agent and half of a discharge day visit. The RUC determined that this code is typically performed on a hospital outpatient basis and developed the following recommendation as follows:

<b>CPT Code</b>	<b>Description</b>	<b>RVU</b>
62319	Insert and manipulate catheter, inject contrast/steriod	1.87
72275	Epidurography	.76
62282	Inject neurolytic agent	$\frac{1}{2}$ of 2.33= 1.16
99238	Discharge day management	$\frac{1}{2}$ of 1.28 = .64
	<b>Recommended RVU</b>	<b>4.43</b>

The RUC agreed that these building block values accurately value the procedure and placed the code in proper rank order with code 62263.

**The RUC recommends a work relative value of 4.43 for code 6226X. The RUC also noted that since the work of epidurography is included in the recommended value, epidurography should not be separately billed in conjunction with this code and recommends that CPT add appropriate language to clarify this issue.**

#### **Practice Expense**

The RUC refined the practice expense inputs for codes 62263 to be consistent with the building blocks included in the physician work recommendations. The practice expense inputs for 6226X include pre-service time and minimal post-service time.

**Nerve Injection/Block and Daily Management of Continuous Drug Administration (Tab L)**

**Presenters: Karl E. Becker, MD, and Norm Cohen, MD American Society of Anesthesiology**

CPT revised this family of codes and created new codes to reflect new procedures to differentiate between codes describing single injections and codes for the continuous administration of local anesthetic via a catheter for post-operative pain control.

**6441X**

The RUC examined the survey data for this code and agreed that the survey median value of 3.50 accurately reflected the work involved in this code. The presenters clarified that the catheter is put in place for 72 hours and therefore 3 hospital visits involving analgesic management are typically included in the provision of this code. This also places the code in proper rank order when compared to other injection codes such as reference code 62318 *Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic* (work RVU 2.01). **The RUC recommends a work relative value of 3.50 for code 6441X.**

**644X1**

Code 6441X describes femoral nerve injections which are becoming more common for post-op pain control. The RUC reached its final conclusion after evaluation of the survey results and consideration of the similarities and dissimilarities of this procedure with the reference service. The presenters believe that the work is more difficult than reference service 64450 *Injection, anesthetic agent; other peripheral nerve or branch* (work RVU 1.27) and less than 64425 *Injection, anesthetic agent; ilioinguinal, iliohypogastric nerves* (work RVU 1.75). The intensity and complexity measures support this analysis in that these measures for 6444X1 in aggregate fall halfway between those for the key reference service. Given that the times are approximately the same for the proposed code and the key reference services, the RUC agreed that the intensity measures support a value midway between the two reference services and therefore concluded that the survey 25<sup>th</sup> percentile of 1.50 was an appropriate value for this code. **The RUC recommends a work relative value of 1.50 for code 644X1.**

**644X2**

Code 644X2 is very similar to code 6441X *brachial plexus, continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration* (RUC recommendation 3.50), except that this code should be valued slightly less since the potential complications from this

code are somewhat less and the insertion of the block is slightly easier. Therefore a value of 3.00 would place this code in proper rank order in comparison to code 6441X. this value is also the survey median value. **The RUC recommends a work relative value of 3.00 for code 644X1.**

### **644X3**

The specialties presented a building block approach in support of the survey data. The presenters stated that that a value of 3.25 accurately reflects the work involved in this procedure and it is a value in between the survey median of 2.90 and the building block value of 3.73. The presenters stated that the median value underestimated the work involved in this procedure since this 10-day global period code was compared to reference code with a 000-day global period. This value of 3.25 would also place the code in proper rank order within the family. **The RUC recommends a work relative value of 3.25 for code 644X3.**

### **64415, 64445, and 64450**

The specialty presented work neutrality calculations for these three codes based on estimated frequency, however, the resulting adjustments were of no consequence to the work RVUs for these codes. The Specialties computations are attached to the recommendation. The RUC recommends that CMS review these calculations and determine any necessary work neutrality adjustment since the RUC's intent is for these coding changes to be work neutral.

### **Practice Expense**

Since these codes are vary rarely performed in the office setting (less than 1%), the RUC agreed to assigned a status of N/A to the office setting for codes 6441X, 644X1, and 644X3. For the facility setting, zero direct inputs were assigned since these codes are always performed in conjunction with a surgery performed in the facility, and do not involve any direct expenses for the anesthesiologist.

### **Refilling of Implantable Infusion Pumps (Tab M)**

The specialty societies that were scheduled to present code 9559X *Refilling and maintenance of implantable pump or reservoir for drug delivery; spinal (intrathecal, epidural) or brain (intraventricular)*, requested that the code be presented to the RUC in September. This postponement would allow the specialties to resolve several issues with CMS prior to the RUC presentation.

### **Pediatric Intensive Care/Neonatal Intensive Care Codes (Tab N)**

**Presenters: Steven Krug, MD, FAAP, Rich Molteni, MD, FAAP and David Jaimovich, MD, FAAP, American Academy of Pediatrics**

The CPT Editorial Panel created new codes to describe pediatric critical care services. In addition, the Panel revised the existing neonatal critical care services to better define these services. The RUC reviewed survey data from more than 50 neonatologists.

The RUC reviewed the survey time data for the initial pediatric intensive care (PICU) services and determined that the total time of 240 minutes was comparable to the total time for four hours of critical care services, 99291 (work RVU = 4.00). The RUC, therefore, determined that the 25<sup>th</sup> percentile of the survey was appropriate for 99293X1 *Initial pediatric critical care, 31 days up through 24 months of age, per day, for the evaluation and management of a critically ill infant or young child*. **The RUC recommends a work relative value of 16.00 for 99293X1.**

The RUC reviewed the survey time data for the subsequent PICU services and determined that the total time of 140 minutes was comparable to two hours of critical care services, 99291 (work RVU = 4.00). Therefore, the RUC agreed that the 25<sup>th</sup> percentile of the survey was appropriate for 99294X1 *Subsequent pediatric critical care, 31 days up through 24 months of age, per day, for the evaluation and management of a critically ill infant or young child*. **The RUC recommends a work relative value of 8.00 for 99294X1.**

The RUC discussed the coding revisions made to CPT codes 99295, 99296, and 99297 and determined that additional data needed to be collected prior to the April RUC meeting, in order to appropriately value these services. These codes were referred to a facilitation committee. The facilitation committee requested that:

- The specialty society re-survey 99295 and 99296 prior to the April RUC meeting. It became clear that the survey respondents may have been confused regarding the inclusion of procedural time (ie, the respondents may have only included face-to-face critical care time in their estimates).
- The specialty society should ask the survey respondents to list the procedures typically performed, along with identification of critical care and other time spent per date of service.

The specialty society collected additional data, as requested by the RUC, and presented this data at the April 2002 RUC meeting. The survey results indicated that CPT code 99295 *Initial neonatal critical care, per day, for the evaluation and management of a critically ill neonate 30 days of age or less* typically includes 265 minutes of critical care evaluation and management physician time. The RUC agreed that this was equivalent to 1 unit of 99291 *Critical care, initial hour* (work RVU = 4.00) and 6 units of 99292 *Critical Care, each subsequent half hour* (work RVU = 2.00), for a total of 16.00 critical care work. In addition, the RUC reviewed the survey time that specifically identified the separate procedures that are included in this service and typically performed. The RUC agreed that each service and concluded that it was appropriate to add the physician time and work for procedure codes 36510 *Catheterization of umbilical vein for diagnosis or therapy; newborn* (work RVU = 1.09) and 36660 *Catheterization, umbilical artery, newborn, for diagnosis or therapy* (work RVU = 1.40). The RUC added

the critical care time and work to the procedure time and work to arrive at 18.49 work RVUs ( $16.00 + 1.09 + 1.40 = 18.49$ ) and 325 total minutes ( $265 + 30 + 30 = 325$ ). **The RUC recommends a work value of 18.49 for CPT code 99295.**

The additional specialty society data, reviewed in April, indicated that the physician critical care time related to CPT code 9929X *Subsequent neonatal critical care, per day, for the evaluation and management of a critically ill neonate 30 days of age or less* was 130 minutes. This would equate to one unit of 99291 and two units of 99292, for a total of 8.00 work related to critical care services. The specialty also indicated that it would recommend the relative value of 8.00, which does not represent a change from the current value for this service, to retain relativity between this service and new code 99294X1, which describes services performed after 30 days of age. **The RUC recommends a work value of 8.00 for CPT code 99296.**

The RUC reviewed CPT codes 99298 *Subsequent ~~neonatal~~-intensive care, per day, for the evaluation and management of the recovering very low birthweight infant (present body weight less than 1500 grams)* and 99299X1 *Subsequent intensive care, per day, for the evaluation and management of the recovering low birthweight infant (present body weight of 1500-2500 grams)*. The RUC determined that the changes made to 99298 were editorial in nature and would not reflect a change in work. The RUC reviewed survey data from 55 neonatologists and agreed that the 25<sup>th</sup> percentile of 2.50 was appropriate. **The RUC recommends a work value of 2.75 for 99298 and 2.50 for 99299X1.**

**Practice Expense Inputs:**

These services are all performed in a facility. The RUC recommends no direct practice expense inputs related to these services.

**Laparoscopic Colectomy Procedures (Tab O)**

**Presenters: Anthony Senagore, MD, and David Margolin, MD, American Society of Colon and Rectal Surgeons**

Six new laparoscopic colectomy procedure codes were created to provide the level of specificity that CPT has established for the open colectomy codes.

**442X1 – 442X6**

The RUC reviewed these new surgical laparoscopy codes independently and as a family and believed that the median survey results reflected the proper relative work values. The RUC understood that the entire family of codes displayed a tight, well surveyed group that presented itself in the proper rank order. The reference code 44204 *Laparoscopy, surgical; colectomy, partial, with anastomosis* (Work RVU = 25.08) had been recently surveyed by the RUC and served as an anchor to be used across the entire family. The RUC also compared the family across specialties by reviewing code 50545 *Laparoscopy, surgical; radical nephrectomy (includes removal of Gerota's fascia and surrounding fatty*

tissue, removal of regional lymph nodes, and adrenalectomy) (Work RVU=24.00), and believed the work was similar, however these new procedures required more pre and post service time physician work. After considering the survey results and code comparisons, the RUC regarded the values presented by the specialty were reasonable given the intensity and work involved. **The RUC recommends the following work relative values for codes 442X1 - 442X6.**

<b>442X1</b>	<b>27.00</b>
<b>442X2</b>	<b>30.00</b>
<b>442XX2</b>	<b>32.00</b>
<b>442X3</b>	<b>28.00</b>
<b>442X4</b>	<b>35.00</b>
<b>442X6</b>	<b>32.50</b>

**Practice Expense**

The RUC reviewed the practice expense inputs for this family of codes and believed at a minimum the PEAC standard 60 minutes of pre-service time was appropriate and that for some codes 442XX2, 442X3, 442X4, and 442X6 additional time for stoma education and counseling was necessary. The RUC also agreed with the presenters that code 442X1 was emergent and that the pre-service time should be only 15 minutes. The RUC agreed with the remaining practice expense components, and they are attached to the recommendations for these codes.

**Intraoperative Colonic Lavage (Tab P)**

**Presenters: Anthony Senagore, MD, and David Margolin, MD, American Society of Colon and Rectal Surgeons**

**Reviewed By: Facilitation Committee #2**

A new code was created to reflect an intra-operative colonic lavage that is gaining widespread acceptance. This procedure allows a single stage colon resection for obstructing lesions, and thus avoiding the creation of a colostomy with its associated complications. Furthermore, this procedure avoids a second major operation (colostomy closure) which is associated with a high level of morbidity.

**447XX**

The RUC reviewed the additional inter-operative work associated with this code, and understood that the lavage involved compacted stool being flushed through a large section of the colon. It was explained that much of the work involves the proper manipulation of the colon for the lavage to be successful. The RUC reviewed the survey results, and believed that the time for the lavage was lower than the survey median time of 45 minutes. The RUC believed that the specialty surveyed 25<sup>th</sup> percentile for CPT code 447XX represented the proper values for this code. **The RUC recommends the specialty society's 25<sup>th</sup> percentile survey results of a relative work value of 3.10 and an intra-service time of 35 minutes.** The specialty society concurred with this recommendation.

**Practice Expense**

The RUC recommends no practice expense inputs for this ZZZ day global code.

**Anal Fistula Glue Repair (Tab Q)**

**Presenters: Anthony Senagore, MD, and David Margolin, MD, American Society of Colon and Rectal Surgeons**

In order to provide an increased level of specificity and granularity in CPT coding for the repair of anal fistula, this code was created.

**467XX**

The RUC reviewed the survey results provided by the specialty society and believed that the specialties reference code, code 46275 *Surgical treatment of anal fistula (fistulectomy/fistulotomy); submuscular* (Work RVU= 4.56) involved much more work and intensity than code 467XX. The then RUC reviewed and compared codes 46020 *Placement of seton* (Work RVU=2.90) and 46940 *Curettage or cautery of anal fissure, including dilation of anal sphincter (separate procedure); initial* (Work RVU = 2.32). The RUC and the specialty society agreed that the specialty society's 25<sup>th</sup> percentile survey results were more representative of the work involved than the median survey results. **The RUC recommends the specialty society's 25<sup>th</sup> percentile survey results with a relative work value of 2.95 for CPT code 467XX.**

**Practice Expense**

The RUC reviewed in detail the practice expense inputs for code 467XX and agreed and recommends that the pre-service time for this facility only 010 day global code be 35 minutes. The RUC also recommends the appropriate PEAC standard office visit time, medical supply packages, and equipment as shown on the attached practice expense spreadsheet. The RUC recommends no practice expense inputs in the non-facility setting, as this service is currently provided in the facility setting only.

**XI. Practice Expense Advisory Committee (PEAC) Report (Tab R)**

Doctor Moran reported the Practice Expense Advisory Committee (PEAC) had made significant gains in refining the practice expense inputs of existing codes. He reported that the PEAC met in January and March this year concentrating on refining the inputs of families of codes and creating additional standardization among them. Doctor Moran also explained the PEAC would finish the practice expense refinement of over a thousand CPT codes this year.

**The RUC then reviewed and approved the minutes from the January and March 2002 PEAC meetings and the practice expense recommendations from those meetings.**

## **XII. Research Subcommittee Report (Tab S)**

Doctor Hayes presented the research Subcommittee report. The RUC reviewed the modified survey instrument for use by the American Psychological Association in surveying for central nervous system assessments and tests. The RUC approved the surveys with the following changes:

**Delete question 2C asking about units spent in the pre, intra and post service time period.**

**Revise question 2G so that respondents provide minutes rather than units.**

Doctor Hayes explained that the statement on critical care was approved by the research subcommittee and is presented for RUC approval so that it can be sent to CMS.

Doctor Hannenberg pointed out that the position statement stresses that the postoperative services provided by the operating surgeon to patients in the intensive care unit are not duplicative of the services that may be provided by another physician on the same day. Such a statement places too much emphasis on the surgeon providing critical care services. Doctor Hannenberg suggested changing the statement to read as follows: The RUC believes that the postoperative services provided by other physicians are not duplicative of the services that may be provided by the operating surgeon to patients in the intensive care unit on the same day. Other RUC members felt that the statement should not specifically emphasize either surgeons or other physician groups and should be more generic. The RUC agreed that the research subcommittee should review comments from specialty societies and present another draft to the RUC for approval.

**The RUC referred this recommendation back to the Research Subcommittee for further refinement and study.**

Given the inability of the RUC to develop a work relative value recommendations for the mandated on call services the RUC approved the following recommendation:

**The RUC recognizes that mandated on-call services are typically arrangements between hospitals and physicians and cover a wide range of scenarios. Therefore, the current methodology for developing relative value recommendations does not allow for valuing such services. However, the RUC is cognizant that obtaining reimbursement for mandated on-call services is an issue for some specialties.**

**The Research Subcommittee report was approved and is attached.**



### **XIII. Administrative Subcommittee Report (Tab T)**

Doctor William Gee presented the Administrative Subcommittee report. The Administrative Subcommittee Members met on Saturday, April 27, 2002, to discuss two issues related to Gastroenterology's request for a permanent seat on the RUC, and representation by a RUC member from CPT.

#### **Request from Gastroenterology for a permanent seat on the AMA/Specialty RVS Update Committee**

The RUC criteria for inclusion (in descending order) created in 1991 were:

1. The specialty is an ABMS specialty.
2. The specialty comprises 1% of physicians in practice.
3. The specialty comprises 1% of physician Medicare expenditures.
4. Medicare revenue is at least 10% of mean practice revenue for the specialty.
5. The specialty is not meaningfully represented by an umbrella organization.

Subsequent to a discussion on size, function, and composition, the Administrative Subcommittee submitted the following recommendations to the RUC:

- The RUC may wish to re-examine the size and criterion for inclusion on the RUC. A decision to do this should be discussed by the full RUC.
- The request to add Gastroenterology will be deferred until a decision on re-examination of the rules has been made.

These recommendations were discussed by the RUC along with the points that were made during the Administrative Subcommittee Meeting (see attached Subcommittee Report). Some members felt that the size of the RUC should be maintained and that the Administrative Subcommittee should not undertake re-evaluation of the committee structure. Other members of the RUC felt that the issues could be explored through the formal, already established process of the Administrative Subcommittee and required no formal action by the RUC. Upon further discussion, the following actions were made by the RUC:

**The RUC did not approve the above motions requesting re-examination of the criteria for inclusion on the RUC.**

However, the RUC did note that the RUC's criteria for inclusion of a permanent seat on the RUC were not currently included in the RUC's Structure and Functions. Accordingly, the RUC passed the following motion:

**The following RUC criteria for inclusion on the RUC should be added to the RUC's Structure and Functions Document:**

**The RUC criteria for inclusion (in descending order)**

- 1. The specialty is an ABMS specialty.**
- 2. The specialty comprises 1% of physicians in practice.**
- 3. The specialty comprises 1% of physician Medicare expenditures.**
- 4. Medicare revenue is at least 10% of mean practice revenue for the specialty.**
- 5. The specialty is not meaningfully represented by an umbrella organization.**

**The RUC did not approve the following motion that was submitted during the discussion of the Subcommittee report:**

The specialty of Gastroenterology should be granted a permanent seat on the RUC.

**RUC member attendance at the CPT Editorial Meetings**

The RUC approved the recommendation to designate one RUC member each year (May – Feb Panel Meetings) as a RUC observer and attend on behalf of the RUC. The AMA will reimburse this RUC member’s expenses.

The subcommittee suggested that any RUC member who would like to attend a CPT meeting (at the expense of their respective society) do so, as the meetings are open to RUC members.

**The Administrative Subcommittee report was approved and is attached to these minutes.**

**XIV. Practice Expense Subcommittee Report (Tab U)**

Doctor Levy presented the report of the practice expense subcommittee where inconsistencies in physician time were discussed. She explained to the RUC that the subcommittee was working at the request of the Practice Expense Advisory Committee (PEAC) to resolve inconsistencies in the number and level of E/M services in the global period for 227 non-RUC surveyed 010 and 090 day global CPT codes, and inconsistencies in the assignment of discharge day management services in the global surgical package.

At the February 2002 RUC meeting, the RUC agreed to send 227 codes for which there is no CMS post operative visit data to the specialties to ask them to address the validity of the CMS total time and submit a physician time component allocation to the subcommittee for review. Doctor Levy explained that a few specialties submitted physician time components, as requested, and the subcommittee rejected the majority of the submissions based on the fact that the physician time submitted was greater than the CMS/Harvard total time. Doctor

Levy explained that the subcommittee and the RUC believed that the physician work should not be altered during this process and that physician total time then should not be altered unless a full RUC survey was performed. Therefore, the subcommittee proposed and the RUC accepted the following 7 physician time recommendations from specialty societies out of 60 submitted:

Code	Specialty	Pre Time	Intra Time	Immed. Post	Hospital Time	Discharge Time	Office Time	Total Time	CMS/Hrwd Time
<b>92986</b>	<b>ACC</b>	<b>98</b>	<b>113</b>	<b>135</b>	<b>19</b>	<b>36</b>	<b>69</b>	<b>470</b>	<b>470</b>
<b>92990</b>	<b>ACC</b>	<b>79</b>	<b>126</b>	<b>119</b>			<b>69</b>	<b>393</b>	<b>393</b>
<b>35693</b>	<b>AAVS</b>	<b>70</b>	<b>140</b>	<b>36</b>	<b>38</b>	<b>36</b>	<b>45</b>	<b>365</b>	<b>365</b>
<b>35691</b>	<b>AAVS</b>	<b>90</b>	<b>160</b>	<b>41</b>	<b>38</b>	<b>36</b>	<b>45</b>	<b>410</b>	<b>410</b>
<b>35695*</b>	<b>AAVS</b>	<b>120</b>	<b>180</b>	<b>46</b>	<b>38</b>	<b>36</b>	<b>45</b>	<b>465</b>	<b>430</b>
<b>64612</b>	<b>AAN</b>	<b>10</b>	<b>20</b>	<b>6</b>			<b>15</b>	<b>51</b>	<b>51</b>
<b>64613</b>	<b>AAN</b>	<b>10</b>	<b>21</b>	<b>6</b>			<b>15</b>	<b>52</b>	<b>52</b>

At the February 2002 RUC meeting the RUC agreed that there can be one or one-half of a discharge day management code for any surgical procedure code when performed in the facility setting. Doctor Levy explained the data difficulties encountered in caring out this task for RUC reviewed codes, and she also explained how the subcommittee, AMA staff, and specialty societies proposed to resolve these discrepancies. Some RUC members expressed their concerns related to resolving these data difficulties, believing by doing so a redistribution of the practice expense specialty pools may occur. AMA staff and a CMS representative explained if there was any redistribution it would be minor and have little impact on reimbursement since it involves less than 20 codes. The subcommittee then proposed and the RUC accepted the following additional recommendations:

- A. For all non-RUC surveyed 10 and 90-day global codes, the Practice Expense Subcommittee recommends CMS:
 
  - 1. Reallocate existing post service time to all outpatient surgical procedure codes (typically performed in an ASC or hospital outpatient department) so that one-half of a discharge day management code time element exists in the CMS physician time database.**
  - 2. Reallocate existing post service time to all inpatient surgical procedure codes so that a full discharge day management code time element exists in the CMS physician time database.****
  
- B. For any 10 or 90-day global RUC surveyed surgical procedure without immediate post service time, specialty societies may recommend a reallocation of the code's existing total physician time, or re-survey. The results of either a reallocation or survey would then be presented to the Practice Expense Subcommittee for review.**

**The practice expense subcommittee report is attached to these minutes.**

**XV. RUC HCPAC Review Board Report (Tab V)**

Don Williamson, OD presented the RUC Health Care Professionals Advisory Committee (HCPAC) Review Board Report. Doctor Williamson informed the RUC that the practice expense inputs for the Chiropractic Manipulative Treatments Codes (98940-98943), already approved by the Practice Expense Advisory Committee (PEAC), were reviewed and approved by the HCPAC. Additionally, Doctor Williamson explained that the HCPAC reviewed, modified and approved all the practice expense inputs relating to the Speech and Language Hearing Procedures (926X1-926X11).

**The RUC HCPAC Review Board report is attached to these minutes.**

**XVI. Multi-Specialty Points of Comparison Workgroup Report (Tab W)**

Doctor Charles Koopmann presented the Multi-Specialty Points of Comparison (MPC) workgroup report and thanked the workgroup members for all of their work over the past year in preparing this draft MPC for the RUC to review. The RUC reviewed the new MPC and agreed that it should replace the current MPC.

**The RUC recommends the adoption of the new MPC list, as presented by the MPC workgroup, in lieu of the current RUC MPC list.**

**The RUC recommends that specialties should incorporate their codes from the MPC into their own specialty-specific reference service list.**

**The RUC recommends that the MPC list be reviewed (i.e., specialty societies would have the opportunity to solicit additions or deletions) on an annual basis, beginning at the September 2003 RUC meeting. The MPC list should also be reviewed after each Five-Year Review of the RBRVS.**

**XVII. Conscious Sedation Workgroup Report (Tab X)**

Doctor William Gee presented the report of the Conscious Sedation Workgroup. The workgroup developed a workplan and will continue to work on this issue at future meetings. The RUC approved the following workplan:

1. AMA staff should ask all specialty societies to consider the issue of conscious sedation again and only submit codes in which, in today's practice, the provision of conscious sedation is inherent in providing the procedure. The workgroup will review this list at the September 2002 meeting. It may be possible after these efforts to offer CPT a list of codes for which 99141 and 99142 may not also be reported. If CPT specifically stated which codes currently include conscious sedation as an inherent part of the code, it may be

easier for physicians to seek payment for codes in which conscious sedation is only administered in special circumstances (eg, pediatric cases).

2. Gastroenterology should review the results of their recent valuations at the RUC and CMS and offer the conscious sedation workgroup a workplan on how to best determine the incremental change in physician work related to conscious sedation from the early 1990s to present.
3. The Practice Expense Advisory Committee should review the direct practice expense inputs related to CPT codes 99141 and 99142 and determine appropriate standards for conscious sedation.

### **XVIII. Anesthesia Facilitation Committee Report (Tab Y)**

Doctor Mayer presented the report of the Anesthesia workgroup. Doctor Mayer summarized the work of the workgroup to date and specifically the most recent efforts at allocating anesthesia post induction time. The workgroup also determined if the surgical code and vignette were representative of all the other surgical codes covered by the particular anesthesia code. In about half of the codes, the workgroup was comfortable the results for the selected anesthesia code could be extrapolated to other codes in the family. For the remaining codes, the workgroup concluded that the results could absolutely not be extrapolated, or the results could be extrapolated but with qualifications such as to only select codes in the family.

The report generated a great deal of discussion. Some RUC members felt that the recommendation proposed by the workgroup lacked a specific recommendation regarding under or overvaluation of anesthesia codes. Specifically, it was requested that the RUC select one of the 6, five-year review recommendations. Doctor Gage pointed out that for a family of colon codes in the five-year review, the RUC workgroup did not accept the methodology presented and therefore submitted a recommendation to the RUC of maintaining the current RVUs for the family. However, the ACS had the right to go to CMS and CMS chose to take a different approach from the RUC. Doctor Mayer restated the following options available to the RUC as possible actions:

1. Adopt the recommended increase in RVUs
2. Maintain the current RVUs
3. Adopt the recommended decrease in RVUs
4. Suggest a new RVU
5. Refer the code to CPT
6. No consensus

The workgroup did not vote on one of the six options requested the RUC to select one of the options. Doctor Hannenberg explained that the workgroup was assessing anesthesia work in general and the selection of one of the six options might pigeonhole the RUC in this particular circumstance. However, Doctor

Hannenbergh felt that option 6, no consensus, would be the closest match and the workgroup recommendation is consistent with the no consensus key. This was the same action that the RUC took in October 2000 regarding the anesthesia five-year review.

Doctor Koopmann felt that the work product of the workgroup could serve as a building block for future work since in several of the codes, the families could be broken into smaller families that would allow for extrapolation after additional survey work. Since the workgroup was comfortable extrapolating the results for several of the families, the workgroup made more progress than an action key of no consensus would suggest. Alternatively, Doctor Florin addressed the RUC and stated that the data presented by ASA does not provide compelling evidence that would support extrapolation to an overall change in anesthesia work valuation. Doctor Florin felt that the workgroup should have submitted a stronger recommendation stating that the evidence supporting a change in the anesthesia conversion factor should not be supported.

Doctor Mayer stated that none of the options accurately reflect the work of the workgroup since this particular five-year review workgroup was unique. Doctor Hoehn recognized the frustration felt by the anesthesia participants as well as the workgroup members at not being able to select one of the five-year review action keys. Given that CMS representatives have attended all of the anesthesia workgroup meetings, and given the substantially different nature of the anesthesia five-year review, Doctor Hoehn did not feel that the RUC needed to select one of the six action keys. Doctor Mayer agreed that as long as the RUC was not bound to select one of the action keys, he was comfortable with the workgroup recommendation since it reflected the conclusion of the workgroup that some codes could be extrapolated and others could not.

Doctor Whitten agreed that the workgroup made substantial progress and introduced a motion to change the recommendation to reflect that the workgroup was unable to make recommendation to CMS regarding modification to the physician work valuation of anesthesia codes, rather than modification to the anesthesia conversion factor. Doctor Hannenberg clarified that such a change is appropriate technically, however, it could be characterized as a distinction without a difference since a change in the conversion factor is the ultimate outcome that would be sought after a determination of physician work is determined. However, technically the workgroup was tasked with making a determination of physician work valuation, not the conversion factor.

Doctor Gee suggested that given the progress that the workgroup has made examining this issue, that it would be appropriate for the RUC to begin examining a long term issue of placing anesthesia on the same scale as the RBRVS. Doctor Hoehn advised the RUC to continue to examine this issue and during the September RUC meeting, the RUC as whole will discuss this long term issue

again and RUC members should be prepared to present ideas for future work in this area. Also, in September the current workgroup will be dissolved.

**The RUC approved the following recommendations:**

**The RUC having carefully considered the information presented, and having a reasonable level of confidence in the data which was presented and developed by the RUC, is unable to make a recommendation to CMS regarding modification to the physician work valuation of anesthesia codes.**

**The RUC recommends forwarding to CMS the attached analysis. The RUC approved the Anesthesia Workgroup report and it is attached.**

**XIX. Services Reported with Multiple Codes Workgroup Report (Tab Z)**

Doctor Barbara Levy presented the report of the Valuing Services Reported with Multiple Codes Workgroup. Doctor Levy noted that the workgroup is waiting to receive further data from CMS and will convene and review that data when it is provided by CMS. The workgroup did draft additional questions to be added to the Summary of Recommendation form, as well as Instructions to Specialties to utilize in obtaining information on new and revised codes. The RUC approved the following changes:

**The RUC's *Summary of Recommendation* form should be amended to include the following questions:**

**Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions:**

**1. Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)**

- The surveyed code is an add-on code or a base code expected to be reported with an add-on code.**
- Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.**
- Multiple codes allow flexibility to describe exactly what components the procedure included.**
- Multiple codes are used to maintain consistency with similar codes.**
- Historical precedents.**
- Other reason (please explain) \_\_\_\_\_**

**2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction**

policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

**The *Instructions to Specialty Societies Developing Relative Value Recommendations* document should be revised to include the following directions:**

**When constructing the vignette to be surveyed, include typical other components of the procedure that would be coded separately. In the vignette, as each other component is described, clearly specify that the other component is coded and valued separately and provide the CPT code number and the work RVU of the other components in the vignette. Also, clearly differentiate the CPT codes and work relative values that bundled into the code being surveyed.**

**In the detailed description of the pre, intra, and post-service work on the RUC's *Summary of Recommendation* form (please note that this information is not included in the survey instrument), include, where appropriate, the specific CPT codes (and associated work RVUs) that are typically either bundled or typically reported separately with this code. In the *Summary of Recommendation* form, you should include a table listing the surveyed code and each additional component code included in the these detailed descriptions with the following information: CPT code, global period, work RVU, pre, intra, and post-service time, multiple procedure policy. Sum the work relative values and the time components for these CPT codes, accounting for the multiple procedure reduction, where appropriate.**

**If the surveyed code is frequently used with other component codes in combinations different than those reported in the detailed descriptions of work, provide additional tables of frequent combinations, along with the pre, intra, and post time and work RVUs as described above. It is only essential to summarize the most typical scenarios. You do not need to provide information on every potential scenario.**

**If multiple specialties typically cooperate during the procedure and use different component codes to report their work, indicate whether it is rare, common, frequent, or necessary to have both specialties performing different parts of the procedure. Indicate which physician would typically perform which components of the procedure. Indicate which services are occurring simultaneously.**

## **XX. Other Issues**

- CPT Changes

There was a RUC motion made stating, "*The RUC requests CPT to reconsider its recent practice of splitting existing codes, due to creation of problems with*



*existing code valuation (e.g. abdominal and vaginal hysterectomy codes), continuing with code splitting only where specific criteria are met (eg new technology or distinct practice changes where there is significant procedure volume).* The RUC discussed this motion and ultimately decided that it is the specialty society's responsibility to decide whether they wish to submit a coding proposal and then participate in surveying a code or a family of codes. It was noted that when specialty societies present information from the CPT proposal forms (e.g. the incidence of procedure, how the procedure was reported, how the procedure will be reported or the frequency of a particular procedure) to the CPT Editorial Panel, that information often conflicts with the information presented to the RUC. When specialty societies are completing these forms it is important to remember that these forms are used not only for the CPT process but also the RUC process.

- RUC Process

Doctor Barbara Levy outlined a suggestion to be made to the RUC process. She suggested that a template to be used for RUC discussion. Each RUC member would consider this template as they evaluate their assigned tabs. The discussion template should include the following topics: proper survey, global period, vignette, assessment of Multi-Points of Comparison (MPC), value relative to other codes of similar time and recommendation. The discussion template should also include a section to detail possible strategies to properly value the code.

- "10" Year Review Dinner

Reservations have been maintained at the Swissotel Chicago for Saturday, September 28, 2002. Invitations will be sent and there will be a cost to those who choose to attend. Seats will be held for RUC members, RUC- Alternates, former RUC members and extend open seats to advisors and specialty society staff.

- Reference Service Time

Doctor Hannenberg raised the issue regarding the collection of physician time for the reference service procedures during the survey process. He noted that the elimination of this question of the survey instrument might not be beneficial to either the survey respondent or to the RUC as it eliminates the ability for appropriate comparison with the new code. Some concern was raised by other RUC members that this data would be used for other purposes. AMA staff and CMS staff indicated that this reference service physician time data has never been included and is not intended to be include in any databases. This issue will be referred to the Research Subcommittee.

- Researching Low Relative Values

It was requested that the Research Subcommittee review the process of evaluating codes with low relative values (less than 2.00 and 3.00 RVUs). A concern was expressed a that small increase a lower value code may represent

large percentage change, and these changes may not receive the same level of scrutiny that the changes to higher RUVs receive.

- New Technology

There is some confusion about the distinction between a code being categorized as a new technology. The RUC requests that the September meeting include an information session addressing this topic coordinated with the Centers for Medicare and Medicaid Services. This would help clarify when new codes are exempt from budget neutrality adjustments. General RUC members wanted a better understanding of the criteria CMS utilizes to determine if new codes affect adjustments to the conversion factor.

**The RUC Meeting concluded at 11:00 am on Sunday, April 27<sup>th</sup>, 2002.**

**AMA/Specialty RVS Update Committee  
Practice Expense Advisory Committee**

**January 28- 30, 2002**

**Chicago, Illinois**

Bill Moran, MD (Chair)  
James Anthony, MD  
Deborah Bash, MD  
Stephen Bauer, MD  
Katherine Bradley, PhD, RN  
Manuel D. Cerqueira, MD  
Neal Cohen, MD  
Thomas A. Felger, MD  
Blair Filler, MD  
Mary Foto, OTR  
James Kelly, MD  
Gregory Kwasny, MD  
Alex G. Little, MD  
Peter McCreight, MD\*

James Metcalf, MD  
Tye Ouzounian, MD  
Dighton C. Packard, MD  
Emil Paganini, MD  
James Regan, MD  
Anthony Senagore, MD  
Daniel Mark Siegel, MD, MS  
Fredrica Smith, MD\*  
Susan Spires, MD  
Robert Stomel, DO  
J. Craig Strafford, MD  
Charles Weissman, MD  
Richard Whitten, MD\*

\*Alternate PEAC Member

PEAC Meeting Times

The PEAC began the meeting by approving the minutes of the August PEAC meeting, the PEAC then discussed the remaining meetings in 2002 and approved changing the meeting times to begin on Thursdays at 8:00 am and conclude by noon on Saturday. Since contracts have already been signed with the hotels, AMA staff will report back to the PEAC on the possibility of changing the times of the meeting. AMA staff reported that the times for the March, 2002 meeting were changed as requested and the AMA will request a change in the times for the September meeting as well.

Identification of Outliers

In August, 2001, the PEAC agreed to review, by the September meeting, all outliers to the pre-service standard times for 90 day globals as well as 000 and 10 day global periods. To allow the PEAC to plan its work, AMA staff will distribute to all PEAC participants a request for specialty societies to identify any outliers and submit a response by March 11, 2002. These lists of codes will then be reviewed by the PEAC during the March meeting and select a schedule for the review of these codes. Any 90 day global period codes not reviewed by the PEAC by the September, 2002 meeting will have 60 and 35 minutes of pre-service time assigned and the standard post-operative office visits packages would also be assigned. For 000 and 10 day global period codes, the recommendation will be for zero minutes of pre-service clinical staff time for any codes that the PEAC has not refined.

*Approved at the April 25-28, 2002 RUC Meeting.*

### Multiple Recommendations

Doctor Moran asked the PEAC to discuss how the PEAC should review multiple recommendations for a single code. This occurred for several code families scheduled for presentations at the current meeting. Representatives from the American Association of Vascular Surgeons and the American College of Radiology stated that they were working on blending their two recommendations and weighting the final times based on Medicare frequency data. The PEAC stated that such an approach appeared reasonable given the often inherent differences in costs among specialties for certain procedures. When specialties conclude that there are significant differences in the inputs among specialties for certain codes, the PEAC agreed that such a blending approach is reasonable. However, the PEAC members stressed that in most cases it should be possible for specialties to agree on a single set of inputs.

### Post operative office visits in the global package

Doctor Senagore offered a proposal to allow specialties the opportunity to change the number and level of post operative office visits to better capture the practice expense data and account for codes that may be outliers. Since the number and level of office visits was collected in the evaluation of physician work, Doctor Senagore proposed that the visit distribution may need to be different for practice expense purposes, without affecting physician work. By reviewing the current number and levels of office visits, specialties would be able to more accurately assign practice expenses. The PEAC was uncomfortable with changing its methodology for determining clinical staff time in the post-operative period for codes with 90 day global periods. The PEAC believed that the existing building block approach, that had been carefully developed should not be ignored, but instead it would be more appropriate for a specialty to make a case for either less time or more time for specific codes. In a number of the codes that Doctor Senagore presented, he had identified the need for additional staff time to care for stomas.

### Stoma Workgroup

When the ACS codes were presented to the PEAC, after incorporating the pre-facilitation committee's changes, a number of codes had an additional 7 minutes in the post service period to account for the staff time needed to care for stomas as well as an additional 15 minutes in the pre-service period for stoma education. Doctor Senagore explained that the pre-service time requirements for the identified stoma codes consisted of the patient education of the mechanics of the stoma equipment, the stoma care and understanding, as well as the pre-surgery markings. Doctor Senagore and the ACS had asked for 15 minutes of pre service time that is in addition to the pre service 60 minute standard previously addressed by the PEAC. PEAC members were concerned about the additional time and whether office staff rather than hospital staff were performing the stoma services. Some PEAC members believed that most areas of the country, stoma services were being performed by hospital staff and not by office clinical labor staff. These PEAC members believe that there has been a shift toward the clinical nursing staff in the

hospital to perform these services, and that it is has always been the responsibility of the hospital to educate and familiarize the patient with the stoma equipment.

The PEAC voted and approved an additional 7 minutes on the first post operative office visit for the extra time required to care for stomas. The PEAC's response to the additional 15 minutes was mixed. A number of members believed that for many of these codes no additional time was necessary, as any education was being captured within the 60 minute standard pre-service time period. PEAC members also questioned how often additional pre-service time was required for stoma services and the variability of this time between the different types of practices. Other PEAC members believed the 15 additional minutes was reasonable or even conservative estimates of the time required for these services. The PEAC voted and accepted that additional time was required for stoma educational services, however, the PEAC also voted separately on the additional 15 minutes for stoma services, and did not approve the 15 minutes. The PEAC members suggested the formation of a stoma workgroup to review stoma educational care across specialties and to address the extra time for this service.

#### Coordination of Care

Doctor Ouzounian discussed the previous PEAC recommendation for coordination of care. In August the PEAC recommended that certain procedures may require the assistance of office-based clinical staff to provide clinical information to hospital staff and family members during a patient's hospitalization. The PEAC agreed that based on the complexity of the clinical situation, additional coordination of care provided during the hospitalization could be defined based on the level of complexity, as follows:

1. Basic - 0 minutes
2. Moderately Complex - 3 minutes
3. Complex - 6 minutes

The PEAC developed the 3 minute intervals based on the typical phone call time, believing that for moderately complex patients, the equivalent of 1 phone call would be required, and for complex patients the equivalent of 2 phone calls would be required per hospitalization. Additionally, the PEAC agreed that since time for coordination of care is already included in the codes for management on the day of discharge, each specialty society should provide the PEAC with specific justification for the level chosen for specific codes or families of codes.

Doctor Ouzounian stated that it would be more accurate to assign specific time to the hospital E/M codes so that whenever these codes appear in the global package the PEAC approved times would be used. Some PEAC members agreed that this approach would more accurately capture the variation in coordination of care associated with differing length of stays rather than assigning either 3 or 6 minutes regardless of the typical length of stay.

Other PEAC members felt that since 6 and 9 minutes were assigned to the discharge day services, an additional 3 or 6 minutes of coordination of care was sufficient and assigning time to the hospital visit codes was not warranted. The PEAC discussed the different

utilization of office staff among specialties. A PEAC member hypothesized that proceduralists may utilize their office staff more for coordination of care activities such as phone calls since these physicians are frequently in the hospital and unavailable to perform coordination of care activities. Non-proceduralists on the other hand are more often in the office and may be more available to take phone calls and handle the coordination of care activities themselves, rather than their staff. Other PEAC members still felt that it is unlikely that office staff typically provide any significant coordination of care activities. The PEAC discussed the different utilization of office staff among specialties. A PEAC member hypothesized that proceduralists may utilize their office staff more for coordination of care activities such as phone calls since these physicians are frequently in the hospital and unavailable. Non-proceduralists on the other hand are more often in the office and may be more available to take phone calls and handle the coordination of care activities themselves, rather than their staff. Other PEAC members felt that it is unlikely that office staff typically provide any significant coordination of care activities.

Doctor Ouzounian proposed assigning 3 minutes to 99231, 6 minutes to 99232 and 9 minutes to 99233. These time reflected one, two, and three minute phone call respectively. The motion failed.

Due to the interest in examining this issue more closely, the PEAC agreed to form a workgroup to examine this issue further and determine if additional refinements to the PEAC process for assigning coordination of care can be developed.

#### Post Operative Office Visit Data

During the August 2001 PEAC meeting, several inconsistencies in the physician time databases were identified and were referred to the RUC for further review. In October, 2001 the RUC approved the AAOS request to incorporate one 99212 visit to those codes in this family that currently do not have any visits included in the global package. (Codes 29850, 29851, 29855, 29856). The AAOS stated that the absence of visit data creates inconsistencies in this family of codes since other codes do include post-operative visits. None of these 90-day global procedures missing office visits were reviewed by the RUC, so the source of the time visit data is from CMS.

The PEAC also requested the RUC to review the post operative office visits assigned to the 10-day global codes in the Destruction by Neurolytic agent family. The RUC requested NASS to present survey data to demonstrate that the codes in this family should have office visits assigned. The RUC will review this data during the February 2002 meeting.

#### Codes Extracted from ZZZ, 000, XXX Refinement Lists

During the March 2001 meeting the PEAC approved refining the facility based inputs for over 900 codes. Most of the codes did not have direct inputs assigned, and the PEAC confirmed this refinement for all but 26 codes that were extracted. The AANS has requested the PEAC to reconsider its recommendation for 40 ZZZ codes and requests the

opportunity to bring these to the PEAC for refinement. The PEAC approved the AANS request for reconsideration.

#### Request for Deferral

- The PEAC approved the request from the RPA to refine the ESDR codes in March, 2002.
- The PEAC approved the APA request to defer reviewing codes (96100- 96117) so that the APA can petition CMS to request a RUC review of physician work for these codes. The RUC or HCPAC would then perform any practice expense review of these codes.
- The STS has request to remove codes 32000 and 32002 from the top ten lists of codes. AMA staff clarified that these were not top ten codes as identified by the PEAC but were added at the request of STS, therefore the PEAC approved removing these codes form future refinement schedules.
- The PEAC approved ASHA's request to defer reviewing codes 92506, 92507, and 92536 until September. At that time either PEAC will refine the PE inputs for these codes or if there are changes in the descriptors, the HCPAC will have responsibility for reviewing these codes.
- AAPMR requested not to present two codes since it was not the major provider of these codes. The ACC volunteered to refine code 93040 and 93041 during the September PEAC meeting.
- The PEAC approved the AAN request to defer refining codes 93740 and 93770 until September so that the AAN can have more time to identify physicians who perform these services.
- The ACC requested that the 22 codes in tab 29 be deferred until March since the physician scheduled to present those codes could not attend the PEAC meeting due to a family emergency. The PEAC members felt that the ACC PEAC member could present the codes and if necessary, the scheduled presenter could be connected via speakerphone. The PEAC did not approve the request to defer refinement of these codes.

#### **Other Issues**

- When the pre-facilitation committee reviewed code 92541, *Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording*, the committee concluded that the code might inappropriately have physician work assigned. The PEAC refined the PE inputs based on an audiologist performing the test. Since an audiologist typically performs the test, the PEAC was unclear what services the physician performs. The PEAC suggested that CMS examine the code and then request the RUC to examine the work value assigned to code 92541.
- The PEAC identified three codes in the breast reconstruction family (19357, 19361, and 19366) as missing post-operative office visits. These codes only have Harvard times and have not been reviewed by the RUC. The ASPS will request that the RUC allow the specialty to add office visits to the global package for these codes since the other codes in the family do have office visits. The specialty society PEAC representative pointed out that these are all 90 day global period codes that should

have office visits as part of the global package. Once the RUC determines the number and level of office visits, the ASPS will bring the codes back to the PEAC so that the appropriate staff time and supplies are added.

- Code family 40808 and 41100 presented by ADA and AAOMS contained a number of codes without post-service office visits in the global package. The specialty societies plan on requesting the RUC to allow the specialty to add office visits to the global package for these codes since the other codes in the family do have office visits.



## Codes Refined by the PEAC January 2002

*Code Code Descriptors  
Refinement*

*Specialties involved in*

11043	DEBRIDEMENT; SKIN, SUBQ TISSUE, & MUSCLE	AAOS, APMA, ASPS
11044	DEBRIDEMENT; SKIN, SUBQ TISSUE, MUSCLE, & BONE	AAOS, APMA, ASPS
11300	SHAVING SKIN LESION, TRUNK/ARMS/LEGS; DIAMETER 0.5 CM/<	AAD
11301	SHAVING SKIN LESION, TRUNK/ARMS/LEGS; DIAMETER 0.6-1.0	AAD
11302	SHAVING SKIN LESION, TRUNK/ARMS/LEGS; DIAMETER 1.1-2.0	AAD
11303	SHAVING SKIN LESION, TRUNK/ARMS/LEGS; DIAMETER > 2.0 CM	AAD
11305	SHAVING SKIN LESION, SCALP/NECK/HANDS/FEET/GENITALIA;	AAD
11306	SHAVING SKIN LESION, SCALP/NECK/HANDS/FEET/GENITALIA;	AAD
11307	SHAVING SKIN LESION, SCALP/NECK/HANDS/FEET/GENITALIA;	AAD
11308	SHAVING SKIN LESION, SCALP/NECK/HANDS/FEET/GENITALIA;	AAD
11310	SHAVING SKIN LESION,	AAD
11311	SHAVING SKIN LESION,	AAD
11312	SHAVING SKIN LESION,	AAD
11313	SHAVING SKIN LESION,	AAD
11400	EXCISION, BENIGN SKIN LESION, EXCEPT SKIN TAG,	AAD, ASPS, ASAPS
11401	EXCISION, BENIGN SKIN LESION, EXCEPT SKIN TAG,	AAD, ASPS, ASAPS
11402	EXCISION, BENIGN SKIN LESION, EXCEPT SKIN TAG,	AAD, ASPS, ASAPS
11403	EXCISION, BENIGN SKIN LESION, EXCEPT SKIN TAG,	AAD, ASPS, ASAPS
11404	EXCISION, BENIGN SKIN LESION, EXCEPT SKIN TAG,	AAD, ASPS, ASAPS
11406	EXCISION, BENIGN SKIN LESION, EXCEPT SKIN TAG,	AAD, ASPS, ASAPS
11420	EXCISION, BENIGN SKIN LESION, EXCEPT SKIN TAG	AAD, ASPS, ASAPS
11421	EXCISION, BENIGN SKIN LESION, EXCEPT SKIN TAG,	AAD, ASPS, ASAPS
11422	EXCISION, BENIGN SKIN LESION, EXCEPT SKIN TAG,	AAD, ASPS, ASAPS
11423	EXCISION, BENIGN SKIN LESION, EXCEPT SKIN TAG,	AAD, ASPS, ASAPS
11424	EXCISION, BENIGN SKIN LESION, EXCEPT SKIN TAG,	AAD, ASPS, ASAPS
11426	EXCISION, BENIGN SKIN LESION, EXCEPT SKIN TAG,	AAD, ASPS, ASAPS
11440	EXCISION, OTHER BENIGN LESION,	AAD, ASPS, ASAPS
11441	EXCISION, OTHER BENIGN LESION,	AAD, ASPS, ASAPS
11442	EXCISION, OTHER BENIGN LESION,	AAD, ASPS, ASAPS
11443	EXCISION, OTHER BENIGN LESION,	AAD, ASPS, ASAPS
11444	EXCISION, OTHER BENIGN LESION,	AAD, ASPS, ASAPS
11446	EXCISION, OTHER BENIGN LESION,	AAD, ASPS, ASAPS
11900	INJECTION, INTRALESIONAL; UP TO & W/ 7 LESIONS	AAD
11901	INJECTION, INTRALESIONAL; > 7 LESIONS	AAD
14040	ADJACENT TISSUE TRANSFER,	AAD, ASPS, ASAPS
14041	ADJACENT TISSUE TRANSFER,	AAD, ASPS, ASAPS
14060	ADJACENT TISSUE TRANSFER/REARRANGEMENT,	AAD, ASPS, ASAPS
14061	ADJACENT TISSUE TRANSFER/REARRANGEMENT,	AAD, ASPS, ASAPS
14300	ADJACENT TISSUE TRANSFER/REARRANGEMENT, > 30 SQ CM,	AAD, ASPS, ASAPS
15100	SPLIT GRAFT, TRUNK/SCALP/EXTREMITIES; 100 SQ CM/<, 1PCT	AAD, ASPS, ASAPS
15101	SPLIT GRAFT, TRUNK/SCALP/EXTREMITIES; ADD'L 100 SQ CM/	AAD, ASPS, ASAPS
15120	SPLIT GRAFT, FACE/GENITALIA/MULTIPLE DIGITS; 100 SQ CM/<,	AAD, ASPS, ASAPS
15121	SPLIT GRAFT, FACE/GENITALIA/MULTIPLE DIGITS; ADD'L 100 SQ	AAD, ASPS, ASAPS
15260	FULL THICKNESS GRAFT, FREE, W/ CLOSURE DONOR SITE,	AAD, ASPS, ASAPS
15261	FULL THICKNESS GRAFT, FREE, NOSE/EARS/EYELIDS/LIPS;	AAD, ASPS, ASAPS
15732	MUSCLE, MYOCUTANEOUS/FASCIOCUTANEOUS FLAP; HEAD &	AAD, ASPS, ASAPS
15734	MUSCLE, MYOCUTANEOUS/FASCIOCUTANEOUS FLAP; TRUNK	AAD, ASPS, ASAPS
15736	MUSCLE, MYOCUTANEOUS/FASCIOCUTANEOUS FLAP; UPPER	AAD, ASPS, ASAPS
15738	MUSCLE, MYOCUTANEOUS/FASCIOCUTANEOUS FLAP; LOWER	AAD, ASPS, ASAPS
15820	BLEPHAROPLASTY, LOWER EYELID;	AAO, ASCRS
15821	BLEPHAROPLASTY, LOWER EYELID; W/ EXTENSIVE HERNIATED	AAO, ASCRS
15822	BLEPHAROPLASTY, UPPER EYELID;	AAO, ASCRS
15823	BLEPHAROPLASTY, UPPER EYELID; W/ EXCESSIVE SKIN WTING	AAO, ASCRS
17000	DESTRUCTION, BENIGN/PREMLIG LESIONS, EXCEPT SKIN	AAD, AAFP
17003	DESTRUCTION, BENIGN/PREMLIG LESIONS, EXCEPT SKIN	AAD, AAFP
17004	DESTRUCTION, BENIGN/PREMLIG LESIONS, EXCEPT SKIN	AAD, AAFP
19318	REDUCTION MAMMAPLASTY	AAD, APS
19357	BREAST RECONSTRUCTION W/ TISSUE EXPANDER,	AAD, APS
19361	BREAST RECONSTRUCTION W/ LATISSIMUS DORSI FLAP, W/WO	AAD, APS
19364	BREAST RECONSTRUCTION W/ FREE FLAP	AAD, APS

**Code Code Descriptors  
Refinement**

**Specialties involved in**

19366 BREAST RECONSTRUCTION W/ OTHER TECHNIQUE	AAO, APS
19367 BREAST RECONSTRUCTION W/ MYOCUTANEOUS FLAP, SINGLE	AAO, APS
19368 BREAST RECONSTRUCTION W/ MYOCUTANEOUS FLAP, SINGLE	AAO, APS
19369 BREAST RECONSTRUCTION W/ MYOCUTANEOUS FLAP, DOUBLE	AAO, APS
23470 ARTHROPLASTY, GLENOHUMERAL JOINT; HEMIARTHROPLASTY	AAOS
23472 ARTHROPLASTY, GLENOHUMERAL JOINT; TOTAL SHOULDER	AAOS
24160 IMPLANT REMOVAL; ELBOW JOINT	AAOS
24164 IMPLANT REMOVAL; RADIAL HEAD	AAOS
24360 ARTHROPLASTY, ELBOW; W/ MEMBRANE	AAOS
24361 ARTHROPLASTY, ELBOW; W/ DISTAL HUMERAL PROSTHETIC	AAOS
24362 ARTHROPLASTY, ELBOW; W/ IMPLANT & FASCIA LATA LIGAMENT	AAOS
24363 ARTHROPLASTY, ELBOW; W/ DISTAL HUMERUS/PROXIMAL	AAOS
24365 ARTHROPLASTY, RADIAL HEAD;	AAOS
24366 ARTHROPLASTY, RADIAL HEAD; W/ IMPLANT	AAOS
25250 REMOVAL, WRIST PROSTHESIS; (SEP PROC)	AAOS
25251 REMOVAL, WRIST PROSTHESIS; COMPLICATED, W/ TOTAL WRIST	AAOS
25332 ARTHROPLASTY, WRIST, W/WO INTERPOSITION/INT/EXT	AAOS
25441 ARTHROPLASTY W/ PROSTHETIC REPLACEMENT; DISTAL	AAOS
25442 ARTHROPLASTY W/ PROSTHETIC REPLACEMENT; DISTAL ULNA	AAOS
25443 ARTHROPLASTY W/ PROSTHETIC REPLACEMENT; SCAPHOID	AAOS
25444 ARTHROPLASTY W/ PROSTHETIC REPLACEMENT; LUNATE	AAOS
25445 ARTHROPLASTY W/ PROSTHETIC REPLACEMENT; TRAPEZIUM	AAOS
25446 ARTHROPLASTY W/ PROSTHETIC REPLACEMENT; DISTAL	AAOS
25447 ARTHROPLASTY, INTERPOSITION,	AAOS
25449 REVISION, ARTHROPLASTY, W/ REMOVAL, IMPLANT, WRIST	AAOS
26320 REMOVAL, IMPLANT, FINGER/HAND	AAOS
26530 ARTHROPLASTY, METACARPOPHALANGEAL JOINT; EACH JOINT	AAOS
26531 ARTHROPLASTY, METACARPOPHALANGEAL JOINT; W/	AAOS
26535 ARTHROPLASTY, IP JOINT; EACH JOINT	AAOS
26536 ARTHROPLASTY, IP JOINT; W/ PROSTHETIC IMPLANT, EACH	AAOS
27090 REMOVAL, HIP PROSTHESIS; (SEP PROC)	AAOS
27091 REMOVAL, HIP PROSTHESIS; COMPLICATED	AAOS
27120 ACETABULOPLASTY;	AAOS
27122 ACETABULOPLASTY; RESECTION, FEMORAL HEAD	AAOS
27125 HEMIARTHROPLASTY, HIP, PARTIAL	AAOS
27130 ARTHROPLASTY, ACETABULAR/PROXIMAL FEMORAL	AAOS
27132 CONVERSION, PREVIOUS HIP SURGERY TO TOTAL HIP	AAOS
27134 REVISION, TOTAL HIP ARTHROPLASTY; BOTH COMPONENTS,	AAOS
27137 REVISION, TOTAL HIP ARTHROPLASTY; ACETABULAR	AAOS
27138 REVISION, TOTAL HIP ARTHROPLASTY; FEMORAL COMPONENT	AAOS
27236 TREATMENT, OPEN, FEMORAL FX, PROXIMAL END, NECK,	AAOS
27437 ARTHROPLASTY, PATELLA; W/O PROSTHESIS	AAOS
27438 ARTHROPLASTY, PATELLA; W/ PROSTHESIS	AAOS
27440 ARTHROPLASTY, KNEE, TIBIAL PLATEAU;	AAOS
27441 ARTHROPLASTY, KNEE, TIBIAL PLATEAU; W/ DEBRIDEMENT &	AAOS
27442 ARTHROPLASTY, FEMORAL CONDYLES/TIBIAL PLATEAU(S),	AAOS
27443 ARTHROPLASTY, FEMORAL CONDYLES/TIBIAL PLATEAUS; W/	AAOS
27445 ARTHROPLASTY, KNEE, HINGE PROSTHESIS	AAOS
27446 ARTHROPLASTY, KNEE, CONDYLE & PLATEAU; MEDIAL/LATERAL	AAOS
27447 ARTHROPLASTY, KNEE/CONDYLE/PLATEAU; MEDIAL & LATERAL	AAOS
27486 REVISION, TOTAL KNEE ARTHROPLASTY, W/WO ALLOGRAFT; 1	AAOS
27487 REVISION, TOTAL KNEE ARTHROPLASTY; FEMORAL/TIBIA	AAOS
27488 REMOVAL, KNEE PROSTHESIS, W/WO SPACER INSERTION	AAOS
27700 ARTHROPLASTY, ANKLE;	AAOS
27702 ARTHROPLASTY, ANKLE; W/ IMPLANT (TOTAL ANKLE)	AAOS
27703 ARTHROPLASTY, ANKLE; REVISION, TOTAL ANKLE	AAOS
27704 REMOVAL, ANKLE IMPLANT	AAOS
28293 HALLUX VALGUS CORRECTION; W/WO SESAMOIDECTOMY;	AAOS, APMA
40800 DRAINAGE, ABSCESS, CYST, HEMATOMA, VESTIBULE, MOUTH;	AAOMS/ADA
40801 DRAINAGE, ABSCESS, CYST, HEMATOMA, VESTIBULE, MOUTH;	AAOMS/ADA
40804 REMOVAL, EMBEDDED FB, VESTIBULE, MOUTH; SIMPLE	AAOMS/ADA
40805 REMOVAL, EMBEDDED FB, VESTIBULE, MOUTH; COMPLICATED	AAOMS/ADA
40808 BX, VESTIBULE, MOUTH	AAOMS/ADA

**Code Code Descriptors  
Refinement**

**Specialties involved in**

40810	EXCISION, LESION, MUCOSA & SUBMUCOSA, VESTIBULE,	AAOMS/ADA
40812	EXCISION, LESION, MUCOSA & SUBMUCOSA, VESTIBULE,	AAOMS/ADA
40814	EXCISION, LESION, MUCOSA & SUBMUCOSA, VESTIBULE,	AAOMS/ADA
40816	EXCISION, LESION, MUCOSA & SUBMUCOSA, VESTIBULE,	AAOMS/ADA
41100	BX, TONGUE; ANTERIOR TWO-THIRDS	AAOMS/ADA
41105	BX, TONGUE; POSTERIOR ONE-THIRD	AAOMS/ADA
41108	BX, MOUTH, FLOOR	AAOMS/ADA
41110	EXCISION, LESION, TONGUE W/O CLOSURE	AAOMS/ADA
41112	EXCISION, LESION, TONGUE W/ CLOSURE; ANTERIOR	AAOMS/ADA
41113	EXCISION, LESION, TONGUE W/ CLOSURE; POSTERIOR	AAOMS/ADA
41114	EXCISION, LESION, TONGUE W/ CLOSURE; W/ LOCAL TONGUE	AAOMS/ADA
41899	UNLISTED PROC, DENTOALVEOLAR STRUCTURES	AAOMS/ADA
43235	UPPER GI ENDOSCOPY; DX (SEP PROC)	ACG, AGA, ASGE
43239	UPPER GI ENDOSCOPY; W/ BX, SINGLE/MULTIPLE	ACG, AGA, ASGE
43240	UPPER GI ENDOSCOPY; W/ TRANSMURAL DRAINAGE,	ACG, AGA, ASGE
43241	UPPER GI ENDOSCOPY; W/ TRANSENDOSCOPIC TUBE	ACG, AGA, ASGE
43242	UPPER GI ENDOSCOPY; W/ TRANSENDOSCOPIC ULTRASOUND,	ACG, AGA, ASGE
43243	UPPER GI ENDOSCOPY; W/ INJECTION, ESOPHAGEAL	ACG, AGA, ASGE
43244	UPPER GI ENDOSCOPY; W/ BAND LIGATION, ESOPHAGEAL &/OR	ACG, AGA, ASGE
43245	UPPER GI ENDOSCOPY; W/ DILATION, GASTRIC OUTLET	ACG, AGA, ASGE
43246	UPPER GI ENDOSCOPY; W/ PLACEMENT, PERCUTANEOUS	ACG, AGA, ASGE
43247	UPPER GI ENDOSCOPY; W/ REMOVAL, FB	ACG, AGA, ASGE
43248	UPPER GI ENDOSCOPY; W/ INSERTION, GUIDE WIRE/DILATION	ACG, AGA, ASGE
43249	UPPER GI ENDOSCOPY; W/ BALLOON DILATION, < 30 MM	ACG, AGA, ASGE
43250	UPPER GI ENDOSCOPY; W/ REMOVAL, LESION, HOT	ACG, AGA, ASGE
43251	UPPER GI ENDOSCOPY; W/ REMOVAL, LESION, SNARE	ACG, AGA, ASGE
43255	UPPER GI ENDOSCOPY; W/ CONTROL, BLEEDING, ANY METHOD	ACG, AGA, ASGE
43256	UPPER GI ENDOSCOPY; W/ TRANSENDOSCOPIC STENT	ACG, AGA, ASGE
43258	UPPER GI ENDOSCOPY; W/ ABLATION, LESION, NOT REMOVED	ACG, AGA, ASGE
43259	UPPER GI ENDOSCOPY; W/ ENDOSCOPIC ULTRASOUND EXAM	ACG, AGA, ASGE
43752	NASO-/ORO-GASTRIC TUBE PLACEMENT, NECESSITATING	ACEP
44140	COLECTOMY, PARTIAL; W/ ANASTOMOSIS	ACRoS, ACS
44141	COLECTOMY, PARTIAL; W/ SKIN LEVEL	ACRoS, ACS
44143	COLECTOMY, PARTIAL; W/ END COLOSTOMY & CLOSURE,	ACRoS, ACS
44144	COLECTOMY, PARTIAL; W/ RESECTION, W/	ACRoS, ACS
44145	COLECTOMY, PARTIAL; W/ COLOPROCTOSTOMY (LOW PELVIC	ACRoS, ACS
44146	COLECTOMY, PARTIAL; W/ COLOPROCTOSTOMY (LOW PELVIC	ACRoS, ACS
44147	COLECTOMY, PARTIAL; ABDOMINAL & TRANSANAL APPROACH	ACRoS, ACS
44150	COLECTOMY, TOTAL, ABDOMINAL, W/O PROCTECTOMY; W/	ACRoS, ACS
44151	COLECTOMY, TOTAL, ABDOMINAL, W/O PROCTECTOMY; W/	ACRoS, ACS
44152	COLECTOMY, TOTAL, ABD W/O PROCTECTOMY; W/ RECTAL	ACRoS, ACS
44153	COLECTOMY, TOTAL, ABD W/O PROCTECTOMY; W/ RECTAL	ACRoS, ACS
44155	COLECTOMY, TOTAL, ABDOMINAL, W/ PROCTECTOMY; W/	ACRoS, ACS
44156	COLECTOMY, TOTAL, ABDOMINAL, W/ PROCTECTOMY; W/	ACRoS, ACS
44160	COLECTOMY, PARTIAL, W/ REMOVAL, TERMINAL ILEUM &	ACRoS, ACS
44200	LAPAROSCOPY, SURGICAL; ENTEROLYSIS (SEP PROC)	ACRoS, ACS
44201	LAPAROSCOPY, SURGICAL; JEJUNOSTOMY	ACRoS, ACS
44202	LAPAROSCOPY, SURGICAL; ENTERECTOMY, INTESTINAL	ACRoS, ACS
44300	ENTEROSTOMY/CECOSTOMY, TUBE	ACRoS, ACS
44310	ILEOSTOMY/JEJUNOSTOMY, NON-TUBE (SEP PROC)	ACRoS, ACS
44312	REVISION, ILEOSTOMY; SIMPLE (RELEASE, SUPERFICIAL SCAR)	ACRoS, ACS
44314	REVISION, ILEOSTOMY; COMPLICATED (RECONSTRUCTION	ACRoS, ACS
44316	CONTINENT ILEOSTOMY (KOCK PROC) (SEP PROC)	ACRoS, ACS
44320	COLOSTOMY/SKIN LEVEL CECOSTOMY; (SEP PROC)	ACRoS, ACS
44322	COLOSTOMY/SKIN LEVEL CECOSTOMY; W/ MULTIPLE BIOPSIES	ACRoS, ACS
44340	REVISION, COLOSTOMY; SIMPLE (RELEASE, SUPERFICIAL SCAR)	ACRoS, ACS
44345	REVISION, COLOSTOMY; COMPLICATED (RECONSTRUCTION	ACRoS, ACS
44346	REVISION, COLOSTOMY; W/ REPAIR, PARACOLOSTOMY HERNIA	ACRoS, ACS
44602	SUTURE, SMALL INTESTINE; SINGLE PERFORATION	ACRoS, ACS
44603	SUTURE, SMALL INTESTINE; MULTIPLE PERFORATIONS	ACRoS, ACS
44604	SUTURE, LARGE INTESTINE; W/O COLOSTOMY	ACRoS, ACS
44605	SUTURE, LARGE INTESTINE; W/ COLOSTOMY	ACRoS, ACS
44615	INTESTINAL STRICTUROPLASTY W/WO DILATION	ACRoS, ACS

**Code Code Descriptors  
Refinement**

**Specialties involved in**

44620	CLOSURE, ENTEROSTOMY, LARGE/SMALL INTESTINE;	ACRoS, ACS
44625	CLOSURE, ENTEROSTOMY, LARGE/SMALL INTESTINE; W/	ACRoS, ACS
44626	CLOSURE, ENTEROSTOMY, LARGE/SMALL INTESTINE; W/	ACRoS, ACS
44640	CLOSURE, INTESTINAL CUTANEOUS FISTULA	ACRoS, ACS
44650	CLOSURE, ENTEROENTERIC/ENTEROCOLIC FISTULA	ACRoS, ACS
44660	CLOSURE, ENTEROVESICAL FISTULA; W/O	ACRoS, ACS
44661	CLOSURE, ENTEROVESICAL FISTULA; W/ INTESTINE &/OR	ACRoS, ACS
44680	INTESTINAL PLICATION (SEP PROC)	ACRoS, ACS
44700	EXCLUSION, SMALL INTESTINE, PELVIS,	ACRoS, ACS
44800	EXCISION, MECKEL'S DIVERTICULUM	ACRoS, ACS
44820	EXCISION, LESION, MESENTERY (SEP PROC)	ACRoS, ACS
44850	SUTURE, MESENTERY (SEP PROC)	ACRoS, ACS
44900	INCISION & DRAINAGE, APPENDICEAL ABSCESS; OPEN	ACRoS, ACS
44950	APPENDECTOMY;	ACRoS, ACS
44955	APPENDECTOMY; W/ OTHER PROC (SEP PROC)	ACRoS, ACS
44960	APPENDECTOMY; RUPTURED APPENDIX W/	ACRoS, ACS
44970	LAPAROSCOPY, SURGICAL; APPENDECTOMY	ACRoS, ACS
45000	TRANSRECTAL DRAINAGE, PELVIC ABSCESS	ACRoS, ACS
45020	INCISION & DRAINAGE, DEEP SUPRALEVATOR,	ACRoS, ACS
45100	BX, ANORECTAL WALL, ANAL APPROACH	ACRoS, ACS
45108	ANORECTAL MYOMECTOMY	ACRoS, ACS
45110	PROCTECTOMY; COMPLETE, COMBINED ABDOMINOPERINEAL,	ACRoS, ACS
45111	PROCTECTOMY; PARTIAL RESECTION, RECTUM,	ACRoS, ACS
45112	PROCTECTOMY, COMBINED ABDOMINOPERINEAL,	ACRoS, ACS
45113	PROCTECTOMY, PARTIAL, W/ RECTAL MUCOSECTOMY,	ACRoS, ACS
45114	PROCTECTOMY, PARTIAL, W/ ANASTOMOSIS; ABDOMINAL &	ACRoS, ACS
45116	PROCTECTOMY, PARTIAL, W/ ANASTOMOSIS; TRANSSACRAL	ACRoS, ACS
45119	PROCTECTOMY, COMBINED ABDOMINOPERINEAL	ACRoS, ACS
45120	PROCTECTOMY, COMPLETE, ABDOMINAL/PERINEAL APPROACH;	ACRoS, ACS
45121	PROCTECTOMY, COMPLETE, ABDOMINAL/PERINEAL APPROACH;	ACRoS, ACS
45123	PROCTECTOMY, PARTIAL, W/O ANASTOMOSIS, PERINEAL	ACRoS, ACS
45126	PELVIC EXENTERATION, W/ PROCTECTOMY/PELVIC ORGAN	ACRoS, ACS
45130	EXCISION, RECTAL PROCIDENTIA, W/ ANASTOMOSIS; PERINEAL	ACRoS, ACS
45135	EXCISION, RECTAL PROCIDENTIA, W/ ANASTOMOSIS;	ACRoS, ACS
45150	DIVISION, STRICTURE, RECTUM	ACRoS, ACS
45160	EXCISION, RECTAL TUMOR, PROCTOTOMY,	ACRoS, ACS
45170	EXCISION, RECTAL TUMOR, TRANSANAL APPROACH	ACRoS, ACS
45190	DESTRUCTION, RECTAL TUMOR, TRANSANAL APPROACH	ACRoS, ACS
52000	CYSTOURETHROSCOPY (SEP PROC)	AUA
52005	CYSTOURETHROSCOPY, W/ URETERAL CATHETERIZATION;	AUA
52007	CYSTOURETHROSCOPY, W/ URETERAL CATHETERIZATION; W/	AUA
52010	CYSTOURETHROSCOPY, W/ EJACULATORY DUCT	AUA
52204	CYSTOURETHROSCOPY, W/ BX	AUA
52214	CYSTOURETHROSCOPY, W/ FULGURATION TRIGONE/BLADDER	AUA
52224	CYSTOURETHROSCOPY, W/ FULGURATION/TREATMENT	AUA
52234	CYSTOURETHROSCOPY, W/ FULGURATION &/OR RESECTION;	AUA
52235	CYSTOURETHROSCOPY, W/ FULGURATION &/OR RESECTION;	AUA
52240	CYSTOURETHROSCOPY, W/ FULGURATION &/OR RESECTION;	AUA
52250	CYSTOURETHROSCOPY, W/ RADIOACTIVE INSERTION, W/WO	AUA
52260	CYSTOURETHROSCOPY, W/ DILATION, BLADDER, INTERSTITIAL	AUA
52265	CYSTOURETHROSCOPY, W/ DILATION, BLADDER, INTERSTITIAL	AUA
52270	CYSTOURETHROSCOPY, W/ INT URETHROTOMY; FEMALE	AUA
52275	CYSTOURETHROSCOPY, W/ INT URETHROTOMY; MALE	AUA
52276	CYSTOURETHROSCOPY, W/ DIRECT VISION INT URETHROTOMY	AUA
52277	CYSTOURETHROSCOPY, W/ RESECTION, EXT SPHINCTER	AUA
52281	CYSTOURETHROSCOPY, W/ CALIBRATION &/OR DILATION,	AUA
52282	CYSTOURETHROSCOPY, W/ INSERTION, URETHRAL STENT	AUA
52283	CYSTOURETHROSCOPY, W/ STEROID INJECTION INTO	AUA
52285	CYSTOURETHROSCOPY, TREATMENT, FEMALE URETHRAL	AUA
52290	CYSTOURETHROSCOPY; W/ URETERAL MEATOTOMY,	AUA
52300	CYSTOURETHROSCOPY; W/ RESECTION, ORTHOTOPIC	AUA
52301	CYSTOURETHROSCOPY; W/ RESECTION/FULGURATION,	AUA
52305	CYSTOURETHROSCOPY; W/ INCISION/RESECTION, ORIFICE,	AUA

**Code Code Descriptors  
Refinement**

**Specialties involved in**

52310	CYSTOURETHROSCOPY, W/ REMOVAL,	AUA
52315	CYSTOURETHROSCOPY, W/ REMOVAL,	AUA
52317	LITHOLAPAXY; SIMPLE/SMALL (< 2.5 CM)	AUA
52318	LITHOLAPAXY; COMPLICATED/LARGE (> 2.5 CM)	AUA
52320	CYSTOURETHROSCOPY; W/ REMOVAL, URETERAL CALCULUS	AUA
52325	CYSTOURETHROSCOPY; W/ FRAGMENTATION, URETERAL	AUA
52327	CYSTOURETHROSCOPY; W/ SUBURETERIC INJECTION,	AUA
52330	CYSTOURETHROSCOPY; W/ MANIPULATION, W/O REMOVAL	AUA
52332	CYSTOURETHROSCOPY; W/ INSERTION, INDWELLING	AUA
52334	CYSTOURETHROSCOPY W/ INSERTION, URETERAL GUIDE	AUA
52341	CYSTOURETHROSCOPY; W/ TREATMENT URETERAL STRICTURE	AUA
52342	CYSTOURETHROSCOPY; W/ TREATMENT URETEROPELVIC	AUA
52343	CYSTOURETHROSCOPY; W/ TREATMENT INTRA-RENAL	AUA
52344	CYSTOURETHROSCOPY W/ URETEROSCOPY; W/ TREATMENT	AUA
52345	CYSTOURETHROSCOPY W/ URETEROSCOPY; W/ TREATMENT	AUA
52346	CYSTOURETHROSCOPY W/ URETEROSCOPY; W/ TREATMENT	AUA
52351	CYSTOURETHROSCOPY W/ URETEROSCOPY &/OR	AUA
52352	CYSTOURETHROSCOPY W/ URETEROSCOPY &/OR	AUA
52353	CYSTOURETHROSCOPY W/ URETEROSCOPY &/OR	AUA
52354	CYSTOURETHROSCOPY W/ URETEROSCOPY &/OR	AUA
52355	CYSTOURETHROSCOPY W/ URETEROSCOPY &/OR	AUA
52400	CYSTOURETHROSCOPY W/	AUA
52450	TRANSURETHRAL INCISION, PROSTATE	AUA
52500	TRANSURETHRAL RESECTION, BLADDER NECK (SEP PROC)	AUA
52510	TRANSURETHRAL BALLOON DILATION, PROSTATIC URETHRA	AUA
52601	TRANSURETHRAL ELECTROSURGICAL RESECTION, PROSTATE,	AUA
52606	TRANSURETHRAL FULGURATION, POSTOPERATIVE BLEEDING	AUA
52612	TRANSURETHRAL RESECTION, PROSTATE; 1ST STAGE, 2-STAGE	AUA
52614	TRANSURETHRAL RESECTION, PROSTATE; 2ND STAGE, 2-STAGE	AUA
52620	TRANSURETHRAL RESECTION; RESIDUAL OBSTRUCTIVE TISSUE	AUA
52630	TRANSURETHRAL RESECTION; REGROWTH, OBSTRUCTIVE	AUA
52640	TRANSURETHRAL RESECTION; POSTOPERATIVE BLADDER NECK	AUA
52647	NON-CONTACT LASER COAGULATION, PROSTATE, W/ CONTROL	AUA
52648	CONTACT LASER VAPOR, W/WO TRANSURETHRAL RESECTION	AUA
52700	TRANSURETHRAL DRAINAGE, PROSTATIC ABSCESS	AUA
59400	ROUTINE OBSTETRIC CARE, ANTEPARTUM CARE, VAGINAL	ACOG, AAFP
59409	VAGINAL DELIVERY ONLY (W/WO EPISIOTOMY &/OR FORCEPS);	ACOG, AAFP
59410	VAGINAL DELIVERY ONLY (W/WO EPISIOTOMY &/OR FORCEPS);	ACOG, AAFP
59412	EXT CEPHALIC VERSION, W/WO TOCOLYSIS	ACOG, AAFP
59414	DELIVERY, PLACENTA (SEP PROC)	ACOG, AAFP
59425	ANTEPARTUM CARE ONLY; 4 TO 6 VISITS	ACOG, AAFP
59426	ANTEPARTUM CARE ONLY; 7+ VISITS	ACOG, AAFP
59430	POSTPARTUM CARE ONLY (SEP PROC)	ACOG, AAFP
59510	ROUTINE OBSTETRIC CARE W/ ANTEPARTUM CARE, CESAREAN	ACOG, AAFP
59514	CESAREAN DELIVERY ONLY;	ACOG, AAFP
59515	CESAREAN DELIVERY ONLY; W/ POSTPARTUM CARE	ACOG, AAFP
59525	SUBTOTAL/TOTAL HYSTERECTOMY AFTER CESAREAN DELIVERY	ACOG, AAFP
59610	ROUTINE OBSTETRIC CARE, VAGINAL DELIVERY, W/	ACOG, AAFP
59612	VAGINAL DELIVERY ONLY, PREVIOUS CESAREAN DELIVERY;	ACOG, AAFP
59614	VAGINAL DELIVERY ONLY, PREVIOUS CESAREAN DELIVERY; W/	ACOG, AAFP
59618	ROUTINE OB CARE, ANTE/POSTPARTUM, CESAREAN DELIVERY	ACOG, AAFP
59620	CESAREAN DELIVERY, AFTER FAILED VAGINAL DELIVERY,	ACOG, AAFP
59622	CESAREAN DELIVERY, AFTER FAILED VAGINAL DELIVERY,	ACOG, AAFP
60100	BX THYROID, PERCUTANEOUS CORE NEEDLE	AACE, ACR
66700	CILIARY BODY DESTRUCTION; DIATHERMY	AAO, ASCRS, AOA
66710	CILIARY BODY DESTRUCTION; CYCLOPHOTOCOAGULATION	AAO, ASCRS, AOA
66720	CILIARY BODY DESTRUCTION; CRYOTHERAPY	AAO, ASCRS, AOA
66740	CILIARY BODY DESTRUCTION; CYCLODIALYSIS	AAO, ASCRS, AOA
66761	IRIDOTOMY/IRIDECTOMY, LASER SURGERY (1+ SESSIONS)	AAO, ASCRS, AOA
66762	IRIDOPLASTY, PHOTOCOAGULATION	AAO, ASCRS, AOA
66770	DESTRUCTION, CYST/LESION IRIS/CILIARY BODY	AAO, ASCRS, AOA
70336	MRI, TEMPOROMANDIBULAR JOINTS	ASNR, ACR
70540	MRI, ORBIT, FACE, & NECK W/O CONTRAST MATL(S)	ASNR, ACR



**Code Code Descriptors  
Refinement**

**Specialties involved in**

70551 MRI, BRAIN; W/O CONTRAST	ASNR, ACR
71550 MRI, CHEST; W/O CONTRAST MATL(S)	ASNR, ACR
72141 MRI, CERVICAL SPINE; W/O CONTRAST	ASNR, ACR
72146 MRI, THORACIC SPINE; W/O CONTRAST	ASNR, ACR
72148 MRI, LUMBAR SPINE; W/O CONTRAST	ASNR, ACR
72195 MRI, PELVIS; W/O CONTRAST MATL(S)	ASNR, ACR
73218 MRI, UPPER EXTREMITY, OTHER THAN JOINT; W/O CONTRAST	ASNR, ACR
73221 MRI, ANY JOINT, UPPER EXTREMITY; W/O CONTRAST MATL(S)	ASNR, ACR
73718 MRI, LOWER EXTREMITY OTHER THAN JOINT; W/O CONTRAST	ASNR, ACR
73721 MRI, ANY JOINT, LOWER EXTREMITY; W/O CONTRAST MATL	ASNR, ACR
74181 MRI, ABDOMEN; W/O CONTRAST MATL(S)	ASNR, ACR
75552 CARDIAC MRI, MORPHOLOGY; W/O CONTRAST MATL	ASNR, ACR
75554 CARDIAC MRI, FUNCTION, W/WO MORPHOLOGY; COMPLETE	ASNR, ACR
75555 CARDIAC MRI, FUNCTION, W/WO MORPHOLOGY; LIMITED	ASNR, ACR
76075 DUAL ENERGY X-RAY ABSORPTIOMETRY, BONE DENSITY ACR	AACE, ACOG, AGS, TES,
76076 DUAL ENERGY X-RAY ABSORPTIOMETRY, BONE DENSITY ACR	AACE, ACOG, AGS, TES,
76400 MRI, BONE MARROW BLOOD SUPPLY	ASNR, ACR
78306 BONE &/OR JOINT IMAGING; WHOLE BODY	SNM, ACR
78315 BONE &/OR JOINT IMAGING; THREE PHASE STUDY	SNM, ACR
78460 MYOCARDIAL PERFUSION IMAGING; PLANAR, SINGLE STUDY,	SNM, ACC, ACR
78461 MYOCARDIAL PERFUSION IMAGING; PLANAR, MULTIPLE	SNM, ACC, ACR
78464 MYOCARDIAL PERFUSION IMAGING; SPECT, SINGLE STUDY,	SNM, ACC, ACR
78465 MYOCARDIAL PERFUSION IMAGING; SPECT, MULTIPLE STUDIES,	SNM, ACC, ACR
78478 MYOCARDIAL PERFUSION W/ WALL MOTION,	SNM, ACC, ACR
78480 RADIONUCLEAR SCAN, MYOCARDIAL PERFUSION W/ EJECTION	SNM, ACC, ACR
78580 PULMONARY PERFUSION IMAGING, PARTICULATE	SNM, ACR
91100 INTESTINAL BLEEDING TUBE, PASSAGE, POSITIONING &	ACEP
91105 GASTRIC INTUBATION & ASPIRATION/LAVAGE, TREATMENT	ACEP
92065 ORTHOPTIC &/OR PLEOPTIC TRAINING, W/ CONTINUING	AAO, ASCRS, AOA
92070 FITTING, CONTACT LENS, TREATMENT, DISEASE, W/ LENS	AAO, ASCRS, AOA
92283 COLOR VISION EXAM, EXTENDED	AAO, ASCRS, AOA
92504 BINOCULAR MICROSCOPY (SEP DX PROC)	AAO-HNS
92541 SPONTANEOUS NYSTAGMUS TEST, W/ GAZE & FIXATION	ASHA, AAO-HNS
92542 POSITIONAL NYSTAGMUS TEST, MINIMUM, 4 POSITIONS, W/	ASHA, AAO-HNS
92543 CALORIC VESTIBULAR TEST, EACH IRRIGATION, W/ RECORDING	ASHA, AAO-HNS
92544 OPTOKINETIC NYSTAGMUS TEST, BIDIRECTIONAL,	ASHA, AAO-HNS
92545 OSCILLATING TRACKING TEST, W/ RECORDING	ASHA, AAO-HNS
92546 SINUSOIDAL VERTICAL AXIS ROTATIONAL TESTING	ASHA, AAO-HNS
92552 PURE TONE AUDIOMETRY (THRESHOLD); AIR ONLY	ASHA, AAO-HNS
92553 PURE TONE AUDIOMETRY (THRESHOLD); AIR & BONE	ASHA, AAO-HNS
92555 SPEECH AUDIOMETRY THRESHOLD;	ASHA, AAO-HNS
92556 SPEECH AUDIOMETRY THRESHOLD; W/ SPEECH RECOGNITION	ASHA, AAO-HNS
92557 COMPREHENSIVE AUDIOMETRY THRESHOLD EVAL & SPEECH	ASHA, AAO-HNS
92567 TYMPANOMETRY (IMPEDANCE TESTING)	ASHA, AAO-HNS
92568 ACOUSTIC REFLEX TESTING	ASHA, AAO-HNS
92569 ACOUSTIC REFLEX DECAY TEST	ASHA, AAO-HNS
92950 CARDIOPULMONARY RESUSCITATION	ACEP
93000 ELECTROCARDIOGRAM, ROUTINE W/ AT LEAST 12 LEADS; W/ ASIM, AOA,	AACE, ACC, AAFP, ACP-
93005 ELECTROCARDIOGRAM, ROUTINE 12+ LEADS; TRACING ONLY ASIM, AOA,	AACE, ACC, AAFP, ACP-
93010 ELECTROCARDIOGRAM, ROUTINE W/ AT LEAST 12 LEADS; ASIM, AOA,	AACE, ACC, AAFP, ACP-
93015 CARDIOVASCULAR STRESS TEST W/ ECG MONITOR; W/	ACR, ACC
93016 CARDIOVASCULAR STRESS TEST W/ ECG MONITOR; PHYSICIAN	ACR, ACC
93017 CARDIOVASCULAR STRESS TEST W/ ECG MONITOR; TRACING	ACR, ACC
93018 CARDIOVASCULAR STRESS TEST W/ ECG MONITOR;	ACR, ACC
93508 CATHETER PLACEMENT, CORONARY ANGIOGRAPHY, W/O	ACC
93510 LEFT HEART CATHETERIZATION, RETROGRADE,	ACC
93511 LEFT HEART CATHETERIZATION, RETROGRADE,	ACC
93514 LEFT HEART CATHETERIZATION, LEFT VENTRICULAR	ACC
93524 COMBINED TRANSSEPTAL & RETROGRADE LEFT HEART	ACC
93526 COMBINED RIGHT HEART CATHETERIZATION & RETROGRADE	ACC
93527 COMBINED RIGHT/TRANSSEPTAL LEFT HEART	ACC
93528 COMBINED RIGHT HEART CATHETERIZATION, LEFT	ACC

93529 COMBINED RIGHT/LEFT HEART CATHETERIZATION-SEPTAL

ACC

***Code Code Descriptors  
Refinement***

***Specialties involved in***

93530 RIGHT HEART CATHETERIZATION, CONGENITAL CARDIAC	ACC
93531 COMBINED RIGHT/ RETROGRADE LEFT HEART	ACC
93532 COMBINED RIGHT/ TRANSSEPTAL LEFT HEART	ACC
93533 COMBINED RIGHT/ TRANSSEPTAL LEFT HEART	ACC
93539 INJECTION, CARDIAC CATHETERIZATION; SELECTIVE	ACC
93540 INJECTION, CARDIAC CATH; SELECTIVE OPACIFICATION	ACC
93541 INJECTION, CARDIAC CATHETERIZATION; PULMONARY	ACC
93542 INJECTION, CARDIAC CATHETERIZATION; SELECTIVE RIGHT	ACC
93543 INJECTION, CARDIAC CATHETERIZATION; SELECTIVE LEFT	ACC
93544 INJECTION, CARDIAC CATHETERIZATION; AORTOGRAPHY	ACC
93545 INJECTION, CARDIAC CATHETERIZATION;SELECTIVE	ACC
93555 IMAGING SUPERVISION, INTERPRET & REPORT, INJECTION,	ACC
93556 IMAGING SUPERVISION, INTERPRET & REPORT, INJECTION,	ACC
93733 ELECTRONIC ANALYSIS, PACEMAKER, DUAL CHAMBER,	ACC, STS
93736 ELECTRONIC ANALYSIS, PACEMAKER, SINGLE CHAMBER,	ACC, STS
93875 NON-INVASIVE EXTRACRANIAL ARTERY STUDY, COMPLETE AAVE, ACC	AAVS, ACS, AAN, ACR,
93880 DUPLEX SCAN, EXTRACRANIAL ARTERIES; COMPLETE BILAT AAVE, ACC	AAVS, ACS, AAN, ACR,
93882 DUPLEX SCAN, EXTRACRANIAL ARTERIES; UNILAT/LIMITED AAVE, ACC	AAVS, ACS, AAN, ACR,
93886 TRANSCRANIAL DOPPLER STUDY, INTRACRANIAL ARTERIES; AAVE, ACC	AAVS, ACS, AAN, ACR,
93888 TRANSCRANIAL DOPPLER STUDY, INTRACRANIAL ARTERIES; AAVE, ACC	AAVS, ACS, AAN, ACR,
93925 DUPLEX SCAN, LOWER EXTREMITY ARTERIES/ARTERIAL BYPASS AAVS, TES	ACR/ACC, AAN, ACS,
93926 DUPLEX SCAN, LOWER EXTREMITY ARTERIES/ARTERIAL BYPASS AAVS, TES	ACR/ACC, AAN, ACS,
93930 DUPLEX SCAN, UPPER EXTREMITY ARTERIES/ARTERIAL BYPASS AAVS, TES	ACR/ACC, AAN, ACS,
93931 DUPLEX SCAN, UPPER EXTREMITY ARTERIES/ARTERIAL BYPASS AAVS, TES	ACR/ACC, AAN, ACS,
93965 NON-INVASIVE VEIN STUDY, EXTREMITY, COMPLETE BILAT TES	ACC, AAN, ACS, AAVS,
93970 DUPLEX SCAN, VEINS, EXTREMITY; COMPLETE BILAT TES	ACC, AAN, ACS, AAVS,
93971 DUPLEX SCAN, VEINS, EXTREMITY; UNILAT/LIMITED TES	ACC, AAN, ACS, AAVS,
93975 DUPLEX SCAN, ARTERIAL INFLOW, VENOUS OUTFLOW, TES	ACC, AAN, ACS, AAVS,
93976 DUPLEX SCAN, ARTERIAL INFLOW, VENOUS OUTFLOW, TES	ACC, AAN, ACS, AAVS,
93978 DUPLEX SCAN, AORTA, INFERIOR VENA CAVA, ILIAC TES	ACC, AAN, ACS, AAVS,
93979 DUPLEX SCAN, AORTA, INFERIOR VENA CAVA, ILIAC TES	ACC, AAN, ACS, AAVS,
93990 DUPLEX SCAN, HEMODIALYSIS ACCESS TES	ACC, AAN, ACS, AAVS,
95807 SLEEP STUDY, ATTENDED	AASM
95808 POLYSOMNOGRAPHY; SLEEP STAGING W/ 1-3 ADD'L	AASM
95810 POLYSOMNOGRAPHY; SLEEP STAGING W/ 4+ ADD'L	AASM
95811 POLYSOMNOGRAPHY; SLEEP STAGING W/ 4+ ADD'L	AASM

**AMA/Specialty RVS Update Committee  
Practice Expense Advisory Committee**

**March 21- 22, 2002**

**Chicago, Illinois**

Bill Moran, MD (Chair)	Peter McCreight, MD*
James Anthony, MD	James Metcalf, MD
Deborah Bash, MD	Tye Ouzounian, MD
Stephen Bauer, MD	Dighton C. Packard, MD
Katherine Bradley, PhD, RN	Emil Paganini, MD
Ann Cea, MD	James Regan, MD
Manuel D. Cerqueira, MD	Sandra Reed, MD*
Neal Cohen, MD	Anthony Senagore, MD
Thomas A. Felger, MD	Daniel Mark Siegel, MD, MS
Blair Filler, MD	Fredrica Smith, MD*
Ronald Kaufman, MD	Susan Spires, MD
James Kelly, MD	Robert Stomel, DO
Gregory Kwasny, MD	Charles Weissman, MD
Alex G. Little, MD	

\*Alternate PEAC Member

**January, 2002 PEAC Minutes**

The PEAC reviewed and approved the minutes of the PEAC meeting. The PEAC did reconsider a recommendation passed during the January meeting pertaining to the in-office inputs for the upper GI code family (43235-43259). During the January, 2002 PEAC meeting, the AGA and the ASGE presented recommendations for the upper GI code family (43235-43259). The specialties presented recommendations only for the out-of-office setting and were not able to identify any physicians who perform the service in an out-of-office setting. At that time the PEAC passed a motion to assign the PEAC approved out-of-office setting inputs to the office setting until the specialties present a recommendation to the PEAC.

The PEAC discussed this previous action and determined that since a significant number of these procedures are performed in the office setting, it should be possible for the specialty societies to refine the CPEP data for these codes. The PEAC therefore concluded that rather than crosswalking the facility approved inputs to the non-facility setting, the PEAC should withdraw its previous recommendation for the non-facility setting and request that the specialties bring these codes back to the PEAC in September, 2002. The PEAC agreed to withdraw its previous recommendation regarding the in-office inputs for the upper GI code family (43235-43259). CMS will provide the specialty societies contact information for physicians that provide these services in the office setting.

*Approved at the April 25-28, 2002 RUC Meeting.*



### **PEAC Meeting Times**

The PEAC reviewed the two options for meeting dates for the March, 2003 meeting. While the PEAC did not express a preference on the date, the PEAC did recommend that the PEAC meeting be held at a location close to O'Hare airport. The PEAC will continue to utilize the current schedule of beginning on a Thursday at 8:00 am and conclude by Saturday at 12:00 noon.

### **Identification of Outliers**

During the January PEAC meeting, the PEAC discussed the approaching deadlines for refining codes that may be outliers from the pre-service standards. The PEAC agreed that specialty societies have until the September, 2002 PEAC meeting to refine any codes that are outliers from the pre-service time standards for codes with 90 day global periods. After September, the PEAC will recommend that all codes with 90 day global periods should have a pre-service clinical staff time of 60 minutes and also have the standard post operative supply packages unless the PEAC has made a recommendation differing from the standards. Additionally, the PEAC agreed that the pre-service time for all 000 and 10 day global codes should be set to zero minutes except those codes that have been reviewed by the PEAC by the September 2002 meeting.

The PEAC reviewed the 000, 10, and 90 day global period codes that specialty societies have submitted for refinement. A total of 612 codes were submitted; 292 codes with a 000 day global period, 288 with a 10 day global period, and 32 codes with a 90 day global period. Given the submission of such a large number of codes, the PEAC discussed the scheduling of these codes.

#### 90 day global period codes

Specialty societies submitted 32 codes with 90 day global periods. The PEAC agreed to refine the direct inputs for these codes during the September, 2002 PEAC meeting.

#### 000 and 10 day global period codes

The PEAC agreed that these codes that have been submitted should be considered the next series of priority codes the PEAC should refine. However, there was a concern that the codes identified may not be the high volume codes, and that the PEAC may want to once again identify high impact codes for PEAC refinement. The PEAC discussed the merits of forming another PEAC workgroup to examine the pre-service time standards of 000 and 10 day global period codes. While there was some skepticism that a new workgroup will succeed where others have failed, the PEAC voted to form a workgroup to develop standard pre-service times for the 000 and 10 day global codes. Since there were a limited number of specialty societies that identified outliers to the pre-service time standard, one approach the PEAC considered was to ask those specialties to get together and attempt to come to a consensus on a standard time or a range of times. Then, a PEAC workgroup would review the results of this group and make a recommendation to the PEAC in September. The PEAC workgroup would also make a recommendation regarding which codes will be reviewed, when they will be reviewed, and the overall review process.

The PEAC also discussed the status of codes that have been previously refined by the PEAC but are on the list of outlier codes. The PEAC felt that specialties should be given latitude to remove codes from the list if they have been previously reviewed and are not part of a family of codes. The PEAC felt it was appropriate to review codes that have been previously reviewed by the PEAC, if those codes are part of a family and would need their inputs adjusted to be consistent with the inputs of other codes in the family. The PEAC members believed that some of the codes reviewed early in the PEAC process did not have the benefit of a number of standards that were developed later in the PEAC process.

### **Coordination of Care Workgroup**

Doctor Anthony presented the report of the coordination of care workgroup. The PEAC Coordination of Care workgroup discussed various methodologies for recognizing office based clinical staff time spent in support of patients in the hospital. The workgroup reached a consensus that the office based staff do spend time on phone calls with a patient's family and with the hospital staff. These activities are in support of hospitalized patients and are necessary to provide good patient care. In particular, the workgroup focused on assigning time to the hospital visits E/M codes.

The workgroup felt that assigning coordination of care time to each hospital visit would overstate the amount of time spent on these activities. The workgroup could not agree that coordination of care activities occurred with each hospital visit or each day of hospitalization. Additionally, the work of coordination of care is currently included in the physician post-service work for these codes and assigning additional time specifically to these codes could lead to duplicate accounting of work.

The workgroup did agree that there are coordination of care activities associated with hospitalization and therefore a suitable methodology for capturing this time would be to assign 6 minutes whenever a full discharge day management code is contained in either the RUC or CMS databases. The workgroup felt that the additional six minutes sufficiently captured the time of clinical office staff to perform coordination of care activities during a hospitalization.

The PEAC approved the following two recommendations:

- 1. The workgroup recommends that the hospital E/M codes 99231, 99232, and 99233 need to be validated at this time and the workgroup proposes assigning zero direct inputs to these codes.**
- 2. The workgroup recommends assigning an additional six minutes to the discharge day management codes 99238 and 99329, bringing the total time to 12 and 15 minutes.**

Currently there are a number of anomalies in the assignment of discharge day management within the global surgical package. The RUC has reviewed this issue and

will recommend to CMS that wherever a service is typically performed in the hospital, a discharge day management code should be included in the time database. This will be a reallocation of post service physician time or total physician time without affecting physician work or total physician time. The full coordination of care report is attached to these minutes.

**I. Stoma Workgroup**

During the January 2002 PEAC meeting, the American College of Surgeons (ACS) presented a group of medical procedures involving the placement of a stoma. Doctor Senagore and the ACS had asked for 15 minutes of office clinical labor pre-service staff time that is in addition to the pre-service 60 minute standard previously addressed by the PEAC. PEAC members were concerned about the additional time and whether office clinical labor staff rather than hospital clinical labor staff were actually performing the stoma services. Some PEAC members believed that most areas of the country, stoma services were being performed by hospital clinical labor staff and not by office clinical labor staff. These other PEAC members believed that there has been a shift toward the clinical nursing staff in the hospital to perform these services, and that it is has always been the responsibility of the hospital to educate and familiarize the patient with the stoma equipment.

The PEAC voted and accepted that additional time was required for stoma educational services, however, the PEAC also voted separately on the additional 15 minutes for stoma services, and did not approve the 15 minutes. After much discussion, PEAC members suggested the formation of a stoma workgroup to address the time for this service, and review stoma educational care across specialties.

X.

Subsequent to the January 2002 PEAC meeting, a Stoma workgroup met twice, and believed that there are vast differences in medical practices however, typically office clinical staff is employed to perform and/or assist in stoma education and markings. In addition, the time spent performing these particular stoma services is above the average 90 day global standard pre-service time, and it is important for the additional time to be applied to all specialties performing these procedures. The workgroup made the following unanimous recommendations:

- 1. 5 additional minutes of pre-service clinical labor time should be applied to the specific 8 ACS identified colon and rectal codes.**
- 2. 5 additional minutes of pre-service clinical labor time should be applied to other procedures where an initial stoma is created.**

The colon & rectal codes for which the above recommendation applies are: 44141, 44144, 44150, 44151, 44155, 44156, 44316, and 45110

The workgroup also made the recommendation that the specialty societies identify any specific CPT codes where a stoma is created and additional pre-service time is necessary, then submit a list of the codes to AMA staff by June 15, 2002. AMA staff would then compile the list of stoma codes for presentation and approval by the PEAC at the

September 2002 meeting. The full Stoma workgroup minutes are attached to these minutes.

Other Issues

- For over a year the PEAC has repeatedly requested specialty societies to refine the CPEP data for codes 93740 *Temperature gradient studies*, and code 93770 *Determination of venous pressure*. Since specialties were unable to identify physicians that provide these services and present a recommendation to the PEAC, the PEAC recommends zero direct inputs for these two codes.
- For several codes the PEAC recommended a new supply item described as a needle stick safety device rather than the individual needles. Since physician offices are required to use these devices, the PEAC requested that CMS review the current inclusion of needles throughout the CPEP database and consider replacing individual needles with the needle stick safety devices where appropriate.
- The PEAC approved the STS request to remove codes 32005 and 32020 from the top ten refinement list. These codes were not originally related to a top-ten code family but were added as possible related codes. Since thoracic surgeons are not the primary provider of these services the STS requested that they be removed from refinement schedules.

*Approved at the March, 2002 PEAC meeting*

**AMA/Specialty Society RVS Update Committee  
Practice Expense Advisory Committee**

**Coordination of Care Workgroup Recommendation**

The PEAC Coordination of Care workgroup met on two occasions via conference call. The following members of the workgroup participated in the conference calls: Doctors Anthony (chair), Cerqueira, Ouzounian, Spires, Weissman, and Katherine Bradley, PhD, RN. During the second call, Carolyn Mullen, CMS participated. The workgroup discussed various methodologies for recognizing office based clinical staff time that is spent in support of patients in the hospital and attempted to better define the activities involved in coordination of care. The activities considered as coordination of care are those phone calls that office based clinical staff have with 1) family members who have clinical questions regarding care about a hospitalized patient, and 2) phone calls with hospital clinical staff to exchange clinical data between the office and the hospital. These could be calls initiated by the hospital staff or by the office staff. The workgroup reached a consensus that the office based staff do spend time on phone calls with a patient's family and with the hospital staff and these activities are in support of hospitalized patients and are necessary to provide good patient care.

The workgroup discussed various ways to capture the time spent by clinical office staff on these activities. One proposal that was discussed at length was to assign clinical staff time to the three hospital visit E/M codes (99231, 99232, 99233). Currently there are no direct inputs assigned to these codes. Under this proposal, the time would be assigned directly to the three codes and then applied to each global surgical code according to the number of times these codes appear in the global surgical package. The intent of this methodology is to assign a uniform time, apply it across all physicians who treat hospitalized patients, thus simplifying the PEAC refinement process by eliminating the need to review each code individually to determine the extent of coordination of care.

The workgroup did not agree that assigning time to the E/M codes would be appropriate because the workgroup was not convinced that such a building block methodology would lead to accurate time allocation. A building block approach worked for assigning time to the post operative office visits since there is typically contact with clinical office staff during these visits. However, the workgroup did not feel that a similar methodology is appropriate for the hospital visit codes since it was not convinced that each hospital visit also entails clinical staff coordination of coordination of care activities. The workgroup even considered using the number of hospital visits as a proxy for assigning time, but felt that there may not be a strong link between number of hospital visits and level of coordination of care activities by office staff. The workgroup also considered creating additional levels of coordination of care time beyond the current 3 and 6 minutes, but felt that such a methodology would require the PEAC to examine each code individually to validate the level of coordination of care. The workgroup concluded that it was not

*Approved at the April 25-28, 2002 RUC Meeting.*

possible to standardize the coordination of care time by allocating the time to the hospital visit codes.

However, since the PEAC is relying on a building block methodology, the workgroup felt it was important to validate the hospital E/M codes as this time while the global surgical codes are being reviewed, rather than at a later date. The workgroup agreed that zero time should be assigned due to the inability to develop a methodology to assign time to these codes.

The workgroup then discussed an alternative methodology to assign time that would allocate additional time to the discharge day management codes. The rationale is that for every code that has a full 99238 or 99239, additional time spent by office based clinical staff was necessary during the associated hospitalization. The workgroup felt that developing a single standard of 6 minutes would simplify the refinement process as well as account for a typical time spent on coordination of care activities. The time would be added to the discharge day management codes and would therefore cover the staff activities performed in support of discharge day management but also activities during the hospitalization. The intent of the workgroup is to assign the time as the PEAC refines codes so those codes that the PEAC already refined but did not receive the appropriate additional time for discharge day management, should be automatically changed, and this would be a PEAC recommendation to CMS.

The workgroup submits the following two recommendations for PEAC consideration:

3. **The workgroup recommends that the hospital E/M codes 99231, 99232, and 99233 need to be validated at this time and the workgroup proposes assigning zero direct inputs to these codes.** These codes currently have zero inputs. The workgroup felt that assigning coordination of care time to each hospital visit would overstate the amount of time spent of these activities. The workgroup could not agree that coordination of care activities occurred with each hospital visit or each day of hospitalization. Additionally, the work of coordination of care is currently included in the physician post-service work for these codes and assigning additional time specifically to these codes would lead to duplicate accounting of work.
4. **The workgroup recommends assigning an additional six minutes to the discharge day management codes 99238 and 99239, bringing the total time to 12 and 15 minutes.** The workgroup felt that there are coordination of care activities associated with hospitalization and therefore a suitable methodology for capturing this time would be to assign 6 minutes whenever a full discharge day management code is contained in either the RUC or CMS databases. The workgroup felt that the additional six minutes sufficiently captured the time of clinical office staff to perform coordination of care activities. It would also simplify the refinement process by not requiring the PEAC to verify the level of coordination of care associated with each surgical code.

*Approved at the March 2002 PEAC Meeting*

**Stoma Workgroup Recommendation  
AMA/Specialty Society RVS Update Committee**

**Background**

During the January 2002 PEAC meeting, the American College of Surgeons (ACS) presented a group of medical procedures involving the placement of a stoma. Doctor Senagore and the ACS had asked for 15 minutes of office clinical labor pre-service staff time that is in addition to the pre-service 60 minute standard previously addressed by the PEAC. PEAC members were concerned about the additional time and whether office clinical labor staff rather than hospital clinical labor staff were actually performing the stoma services. Some PEAC members believed that most areas of the country, stoma services were being performed by hospital clinical labor staff and not by office clinical labor staff. These other PEAC members believed that there has been a shift toward the clinical nursing staff in the hospital to perform these services, and that it is has always been the responsibility of the hospital to educate and familiarize the patient with the stoma equipment.

The PEAC voted and accepted that additional time was required for stoma educational services, however, the PEAC also voted separately on the additional 15 minutes for stoma services, and did not approve the 15 minutes. After much discussion, PEAC members suggested the formation of a stoma workgroup to address the time for this service, and review stoma educational care across specialties.

**Results of the Stoma Workgroup Conference Call – March 13, 2003**

The Stoma Workgroup met via conference call on March 13, 2002 to review stoma educational care across specialties and to address the time for this service. Julia Pillsbury, DO (Chair), Thomas Felger, MD, James Regan, MD, Anthony Senagore, MD, Mary Foto, OTR, and Ken Simon, MD (CMS) all participated on the call. The Stoma Workgroup met and attempted to address the following questions:

1. Is it the responsibility of the in office clinical staff or hospital clinical staff for immediate pre-service education and markings of stoma areas?
2. What amount of clinical staff time, associated with stoma education, is being performed in the 60 minute pre-service time period, of which 20 minutes is allocated to pre-service education, and how much additional time is necessary?
3. How should additional stoma educational time be applied across other codes?
  - How can additional stoma codes be identified?
  - How should any additional time be allocated?

First, Doctor Senagore explained what in-office clinical labor services were being provided in the pre-service period for stoma patients. Doctor Senagore again explained the need for extensive stoma education and markings pre-operatively. Some members of the group believed that typically these services are performed by the in-office clinical

*Approved at the April 25-28, 2002 RUC Meeting.*

labor staff, and would include discussing the use and care of the stoma appliance. Other members of the group believed that these services are performed by the surgeon and are part of physician work and/or would be performed during a typically billed E/M office consultation such as a 99245 *Office consultation for a new or established patient, 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) are of moderate to high severity. Physicians typically spend 80 minutes face-to-face with the patient and/or family.* The RUC database indicates a physician time of 108 minutes and 73 minutes of clinical labor time. It was believed by one workgroup member that at least 50 minutes of physician stoma education and consultation would be captured during this E/M office consultation. In addition, some workgroup members believed if the education and markings were being performed by clinical labor staff, that it would be the hospital clinical staff and not the office-based clinical labor staff.

The workgroup recognized that the pre-service physician work of two RUC surveyed colon and rectal surgical codes 45119 *Proctectomy, combined abdominoperineal pull-through procedure (eg, colo-anal anastomosis), with creation of colonic reservoir (eg, J-pouch), with or without proximal diverting ostomy* and 45126 *Pelvic exenteration for colorectal malignancy, with proctectomy (with or without colostomy), with removal of bladder and ureteral transplantations, and/or hysterectomy, or cervicectomy, with or without removal of tube(s), with or without removal of ovary(s), or any combination thereof* (both surveyed in May 1998), include physician time for stoma patient education and markings. A majority of the workgroup members believed that the ultimate decision on the placement of the stoma is made by the surgeon, however, typically the initial markings are made by the clinical labor staff.

Workgroup members understood that when the E/M workgroup recommended pre-service clinical labor time of 60 minutes, the time was an average that would be sufficient for those services requiring more or less time. Twenty minutes of the 60 minute pre-service time is allocated to pre-service education, and a majority of the workgroup believed that for patients requiring a stoma, 20 minutes may not be sufficient. However, the workgroup wanted to obtain specific details of the time necessary for stoma education and markings, and therefore requested an additional face-to-face meeting prior to their presentation to the PEAC.

A majority of the workgroup members believed that stoma education and markings were in office clinical labor activities and that it may require additional staff time. The majority of the workgroup recommended that 7 additional minutes of office based clinical labor pre-service time would be necessary for the 8 specific stoma codes recommended by ACS. The workgroup believed that other procedures requiring a stoma, located elsewhere on the body, would require a different set of patient education and consultation services. It was suggested that after identifying the specific time increments involved in stoma education and markings for the 8 ACS codes, the workgroup could identify incremental adjustments based on the location of the stoma that would apply



across specialties. It should be noted that ACS excluded stoma creation codes that were either revisions or emergent.

The workgroup recommended having another meeting during lunch on Thursday, March 21, 2002, and present its recommendation to the full PEAC the next day. The objectives of the next meeting are to identify the specific time elements associated with stoma education and markings associated with the 8 ACS codes and answer the three initial questions mentioned above.

### **Stoma Workgroup Recommendations**

The Stoma Workgroup met during lunch on Thursday, March 21, 2002 to continue address stoma care time, and review stoma care across specialties. Julia Pillsbury, DO (Chair), Thomas Felger, MD, James Regan, MD, Anthony Senagore, MD, James Kelly, MD, Charles Weissman, MD and Ken Simon, MD (CMS) all participated in the development of the recommendation

After an initial discussion of the workgroup's task and further discussion of stoma education and care, the workgroup reaffirmed the PEAC's initial understanding that additional office based clinical labor time was necessary for CPT codes involving the creation of an initial stoma. The workgroup understood that there are vast differences in medical practices however, typically office clinical staff is employed to perform and/or assist in stoma education and markings. In addition, the time spent performing these particular stoma services is above the average 90 day global standard pre-service time, and it is important for the additional time to be applied to all specialties performing these procedures. The workgroup made the following recommendations:

- 1. 5 additional minutes of pre-service clinical labor time should be applied to the specific 8 ACS identified colon and rectal codes (44141, 44144, 44150, 44151, 44155, 44156, 44316, and 45110)**
- 2. 5 additional minutes of pre-service clinical labor time should be applied to other procedures where an initial stoma is created.**
- 3. Specialty societies should identify any CPT codes where a stoma is created and additional pre-service time is necessary, and submit a list of the codes to AMA staff by June 15, 2002.**

AMA staff would then compile the list of stoma codes for presentation and approval by the PEAC at the September 2002 meeting.

## *Codes Refined at the March 2002 PEAC Meeting*

<i>CPT Code</i>	<i>Descriptor</i>
15000	EXCISIONAL PREP/CREATION, RECIPIENT SITE; 1ST 100 SQ CM/1PCT BODY INFANT/CHILD
15001	EXCISIONAL PREP/CREATION, RECIPIENT SITE; ADD'L 100 SQ CM/1PCT BODY INFANT/CHILD
17106	DESTRUCTION, CUTANEOUS VASCULAR PROLIFERATIVE LESIONS; < 10 SQ CM
17107	DESTRUCTION, CUTANEOUS VASCULAR PROLIFERATIVE LESIONS; 10.0-50.0 SQ CM
17108	DESTRUCTION, CUTANEOUS VASCULAR PROLIFERATIVE LESIONS; > 50.0 SQ CM
17110	DESTRUCTION, ANY METHOD, FLAT WARTS, MOLLUSCUM CONTAGIOSUM/MILIA; UP TO 14
17111	DESTRUCTION, ANY METHOD, FLAT WARTS, MOLLUSCUM CONTAGIOSUM/MILIA; 15 +
17250	CHEMICAL CAUTERIZATION, GRANULATION TISSUE (PROUD FLESH, SINUS/FISTULA)
22548	ARTHRODESIS, ANTERIOR TRANSORAL/EXTRAORAL
22554	ARTHRODESIS, ANTERIOR INTERBODY, W/ DISKECTOMY; CERVICAL BELOW C2
22556	ARTHRODESIS, ANTERIOR INTERBODY, W/ DISKECTOMY; THORACIC
22558	ARTHRODESIS, ANTERIOR INTERBODY, W/ DISKECTOMY; LUMBAR
22590	ARTHRODESIS, POSTERIOR TECHNIQUE, CRANIOCERVICAL
22595	ARTHRODESIS, POSTERIOR TECHNIQUE, ATLAS-AXIS
22600	ARTHRODESIS, POSTERIOR/POSTEROLATERAL TECHNIQUE, SINGLE LEVEL; CERVICAL
22610	ARTHRODESIS, POSTERIOR/POSTEROLATERAL, SINGLE LEVEL; THORACIC
22612	ARTHRODESIS, POSTERIOR/POSTEROLATERAL, SINGLE LEVEL; LUMBAR
22630	ARTHRODESIS, POSTERIOR INTERBODY W/ LAMINECTOMY/DISKECTOMY, SINGLE
22800	ARTHRODESIS, POSTERIOR, SPINAL DEFORMITY, W/WO CAST; UP TO 6 VERTEBRAL
22802	ARTHRODESIS, POSTERIOR, SPINAL DEFORMITY, W/WO CAST; 7 TO 12 VERTEBRAL
22804	ARTHRODESIS, POSTERIOR, SPINAL DEFORMITY; 13+ VERTEBRAL SEGMENTS
22808	ARTHRODESIS, ANTERIOR, SPINAL DEFORMITY, W/WO CAST; 2 TO 3 VERTEBRAL SEGMENTS
22810	ARTHRODESIS, ANTERIOR, SPINAL DEFORMITY, W/WO CAST; 4 TO 7 VERTEBRAL SEGMENTS
22812	ARTHRODESIS, ANTERIOR, SPINAL DEFORMITY, W/WO CAST; 8+ SEGMENTS
22818	KYPHECTOMY, 1 TO 2 VERTEBRAL SEGMENTS
22819	KYPHECTOMY, 3+ VERTEBRAL SEGMENTS
22830	EXPLORATION, SPINAL FUSION
26010	DRAINAGE, FINGER ABSCESS; SIMPLE
26011	DRAINAGE, FINGER ABSCESS; COMPLICATED
26020	DRAINAGE, TENDON SHEATH, DIGIT &/OR PALM, EACH
26025	DRAINAGE, PALMAR BURSA; SINGLE, BURSA
26030	DRAINAGE, PALMAR BURSA; MULTIPLE BURSA
26034	INCISION, BONE CORTEX, HAND/FINGER
26035	DECOMPRESSION FINGERS &/OR HAND, INJECTION INJURY
26037	DECOMPRESSIVE FASCIOTOMY, HAND (EXCLUDES 26035)
26040	FASCIOTOMY, PALMAR; PERCUTANEOUS
26045	FASCIOTOMY, PALMAR; OPEN, PARTIAL
26055	TENDON SHEATH INCISION
26060	TENOTOMY, PERCUTANEOUS, SINGLE, EACH DIGIT
26070	ARTHROTOMY, EXPLORATION/DRAINAGE/REMOVAL, LOOSE/FB; CARPOMETACARPAL JOINT
26075	ARTHROTOMY, EXPLORATION/DRAINAGE/REMOVAL, LOOSE/FB; METACARPOPHALANGEAL
26080	ARTHROTOMY, EXPLORATION/DRAINAGE/REMOVAL, LOOSE/FB; IP JOINT, EACH
26100	ARTHROTOMY W/ BX; CARPOMETACARPAL JOINT, EACH
26105	ARTHROTOMY W/ BX; METACARPOPHALANGEAL JOINT, EACH
26110	ARTHROTOMY W/ BX; IP JOINT, EACH
26115	EXCISION, TUMOR/VASCULAR MALFORMATION, HAND/FINGER; SUBQ
26116	EXCISION, TUMOR/VASCULAR MALFORMATION, HAND/FINGER; DEEP, SUBFASCIAL, IM
26117	RADICAL RESECTION, TUMOR, SOFT TISSUE, HAND/FINGER
26121	FASCIECTOMY, PALM ONLY W/WO Z-PLASTY/TISSUE REARRANGE/GRAFT
26123	FASCIECTOMY, PARTIAL PALMAR W/ RELEASE, SINGLE DIGIT, W/ PROXIMAL IP JOINT
26130	SYNOVECTOMY, CARPOMETACARPAL JOINT
26135	SYNOVECTOMY, METACARPOPHALANGEAL JOINT, W/INTRINSIC RELEASE & EXTENSOR
26140	SYNOVECTOMY, PROXIMAL IP JOINT, W/ EXTENSOR RECONSTRUCT, EACH IP JOINT
26145	SYNOVECTOMY TENDON SHEATH, RADICAL, FLEXOR/PALM/FINGER, SINGLE, EACH DIGIT
26160	EXCISION, LESION, TENDON SHEATH/CAPSULE, HAND/FINGER

<b>CPT Code</b>	<b>Descriptor</b>
26170	EXCISION, TENDON, PALM, FLEXOR, SINGLE (SEP PROC), EACH
26180	EXCISION, TENDON, FINGER, FLEXOR (SEP PROC), EACH TENDON
26185	SESAMOIDECTOMY, THUMB/FINGER (SEP PROC)
26200	EXCISION/CURETTAGE, BONE CYST/BENIGN TUMOR, METACARPAL;
26205	EXCISION/CURETTAGE, BONE CYST/BENIGN TUMOR, METACARPAL; W/ AUTOGRAFT
26210	EXCISION/CURETTAGE, BONE CYST/BENIGN TUMOR, PHALANX, FINGER
26215	EXCISION/CURETTAGE, BONE CYST/BENIGN TUMOR, PHALANX, FINGER; W/ AUTOGRAFT
26230	PARTIAL EXCISION, BONE; METACARPAL
26235	PARTIAL EXCISION, BONE; PROXIMAL/MIDDLE PHALANX, FINGER
26236	PARTIAL EXCISION, BONE; DISTAL PHALANX, FINGER
26250	RADICAL RESECTION, METACARPAL;
26255	RADICAL RESECTION, METACARPAL; W/ AUTOGRAFT (INCLUDES OBTAINING GRAFT)
26260	RADICAL RESECTION, PROXIMAL/MIDDLE PHALANX, FINGER;
26261	RADICAL RESECTION, PROXIMAL/MIDDLE PHALANX, FINGER; W/ AUTOGRAFT
26262	RADICAL RESECTION, DISTAL PHALANX, FINGER
32440	REMOVAL, LUNG, TOTAL PNEUMONECTOMY;
32442	REMOVAL, LUNG, TOTAL PNEUMONECTOMY; W/ RESECTION, BRONCHO/TRACHEAL
32445	REMOVAL, LUNG, TOTAL PNEUMONECTOMY; EXTRAPLEURAL
32480	REMOVAL, LUNG, OTHER THAN TOTAL PNEUMONECTOMY; SINGLE LOBE (LOBECTOMY)
32482	REMOVAL, LUNG, OTHER THAN TOTAL PNEUMONECTOMY; TWO LOBES (BILOBECTOMY)
32484	REMOVAL, LUNG, OTHER THAN TOTAL PNEUMONECTOMY; SINGLE SEGMENT
32486	REMOVAL, LUNG, OTHER THAN TOTAL PNEUMONECTOMY; W/ RESECTION, BRONCHUS
32488	REMOVAL, LUNG, OTHER THAN TOTAL PNEUMONECTOMY; REMAINING LUNG, FOLLOWING
32491	REMOVAL, LUNG, OTHER THAN TOTAL PNEUMONECTOMY; EXCISION-PLICATION,
32500	REMOVAL, LUNG, OTHER THAN TOTAL PNEUMONECTOMY; WEDGE RESECTION,
32501	RESECTION/REPAIR, PORTION, BRONCHUS, DURING LOBECTOMY/SEGMENTECTOMY
32520	RESECTION, LUNG; W/ RESECTION, CHEST WALL
32522	RESECTION, LUNG; W/ RECONSTRUCTION, CHEST WALL, W/O PROSTHESIS
32525	RESECTION, LUNG; W/ MAJOR RECONSTRUCTION, CHEST WALL, W/ PROSTHESIS
32540	EXTRAPLEURAL ENUCLEATION, EMPYEMA (EMPYEMECTOMY)
32650	THORACOSCOPY, SURGICAL; W/ PLEURODESIS, ANY METHOD
32651	THORACOSCOPY, SURGICAL; W/ PARTIAL PULMONARY DECORTICATION
32652	THORACOSCOPY, SURGICAL; W/ TOTAL PULMONARY DECORTICATION, W/ INTRAPLEURAL
32653	THORACOSCOPY, SURGICAL; W/ REMOVAL, INTRAPLEURAL FB/FIBRIN DEPOSIT
32654	THORACOSCOPY, SURGICAL; W/ CONTROL, TRAUMATIC HEMORRHAGE
32655	THORACOSCOPY, SURGICAL; W/ EXCISION-PLICATION, BULLAE, W/ ANY PLEURAL PROC
32656	THORACOSCOPY, SURGICAL; W/ PARIETAL PLEURECTOMY
32657	THORACOSCOPY, SURGICAL; W/ WEDGE RESECTION, LUNG, SINGLE/MULTIPLE
32658	THORACOSCOPY, SURGICAL; W/ REMOVAL, CLOT/FB, PERICARDIAL SAC
32659	THORACOSCOPY, SURGICAL; W/ CREATION, PERICARDIAL WINDOW/RESECTION SAC,
32660	THORACOSCOPY, SURGICAL; W/ TOTAL PERICARDIECTOMY
32661	THORACOSCOPY, SURGICAL; W/ EXCISION, PERICARDIAL CYST, TUMOR/MASS
32662	THORACOSCOPY, SURGICAL; W/ EXCISION, MEDIASTINAL CYST, TUMOR/MASS
32663	THORACOSCOPY, SURGICAL; W/ LOBECTOMY, TOTAL/SEGMENTAL
32664	THORACOSCOPY, SURGICAL; W/ THORACIC SYMPATHECTOMY
32665	THORACOSCOPY, SURGICAL; W/ ESOPHAGOMYOTOMY
33400	VALVULOPLASTY, AORTIC VALVE; OPEN, W/ CARDIOPULMONARY BYPASS
33401	VALVULOPLASTY, AORTIC VALVE; OPEN, W/ INFLOW OCCLUSION
33403	VALVULOPLASTY, AORTIC VALVE; USING TRANSVENTRICULAR DILATION, W/
33404	CONSTRUCTION, APICAL-AORTIC CONDUIT
33405	REPLACEMENT PROSTHETIC AORTIC VALVE W/ CARDIOPULM BYPASS; NON-HOMOGRAFT/
33406	REPLACEMENT PROSTHETIC AORTIC VALVE W/ CARDIOPULM BYPASS; HOMOGRAFT VALVE
33410	REPLACEMENT PROSTHETIC AORTIC VALVE W/ CARDIOPULMONARY BYPASS; W/ STENT<
33411	REPLACEMENT, AORTIC VALVE; W/ AORTIC ANNULUS ENLARGEMENT, NONCORONARY
33412	REPLACEMENT, AORTIC VALVE; W/ TRANSVENTRICULAR AORTIC ANNULUS ENLARGEMENT
33413	REPLACEMENT, AORTIC VALVE; TRANSLOCATION, AUTOLOGOUS PULMONARY VALVE, W/
33420	VALVOTOMY, MITRAL VALVE; CLOSED HEART
33422	VALVOTOMY, MITRAL VALVE; OPEN HEART, W/ CARDIOPULMONARY BYPASS

<b>CPT Code</b>	<b>Descriptor</b>
33425	VALVULOPLASTY, MITRAL VALVE, W/ CARDIOPULMONARY BYPASS;
33426	VALVULOPLASTY, MITRAL VALVE, W/ CARDIOPULMONARY BYPASS; W/ PROSTHETIC RING
33427	VALVULOPLASTY, MITRAL VALVE, W/ CARDIOPULMONARY BYPASS; RADICAL
33430	REPLACEMENT, MITRAL VALVE, W/ CARDIOPULMONARY BYPASS
33510	CORONARY ARTERY BYPASS, VEIN ONLY; SINGLE CORONARY VENOUS GRAFT
33511	CORONARY ARTERY BYPASS, VEIN ONLY; 2 CORONARY VENOUS GRAFTS
33512	CORONARY ARTERY BYPASS, VEIN ONLY; 3 CORONARY VENOUS GRAFTS
33513	CORONARY ARTERY BYPASS, VEIN ONLY; 4 CORONARY VENOUS GRAFTS
33514	CORONARY ARTERY BYPASS, VEIN ONLY; 5 CORONARY VENOUS GRAFTS
33516	CORONARY ARTERY BYPASS, VEIN ONLY; 6+ CORONARY VENOUS GRAFTS
33533	CORONARY ARTERY BYPASS, USING ARTERIAL GRAFT(S); SINGLE ARTERIAL GRAFT
33534	CORONARY ARTERY BYPASS, USING ARTERIAL GRAFT(S); 2 CORONARY ARTERIAL GRAFTS
33535	CORONARY ARTERY BYPASS, USING ARTERIAL GRAFT(S); 3 CORONARY ARTERIAL GRAFTS
33536	CORONARY ARTERY BYPASS, USING ARTERIAL GRAFT(S); 4+ CORONARY ARTERIAL GRAFTS
36400	VENIPUNCTURE, < AGE 3; FEMORAL, JUGULAR/SAGITTAL SINUS
36405	VENIPUNCTURE, < AGE 3; SCALP VEIN
36406	VENIPUNCTURE, < AGE 3; OTHER VEIN
36410	VENIPUNCTURE, CHILD > AGE 3/ADULT, W/ PHYSICIAN (SEP PROC)
36415	ROUTINE VENIPUNCTURE/FINGER/HEEL/EAR STICK, COLLECTION, SPECIMEN(S)
3641X	
36540	COLLECT, BLOOD SPEC, PARTIALLY/COMPLETELY IMPLANTED VENOUS ACCESS DEVICE
36660	CATHETERIZATION, UMBILICAL ARTERY, NEWBORN, DX/THERAPY
39010	MEDIASTINOTOMY W/ EXPLORATION, DRAINAGE & REMOVAL FB/BX; TRANSTHORACIC
39200	EXCISION, MEDIASTINAL CYST
39220	EXCISION, MEDIASTINAL TUMOR
39400	MEDIASTINOSCOPY, W/WO BX
43107	TOTAL/NEAR TOTAL ESOPHAGECTOMY, W/O THORACOTOMY; W/
43112	TOTAL/NEAR TOTAL ESOPHAGECTOMY, W/ THORACOTOMY; W/
43117	PARTL ESOPHAGECTOMY, DISTAL TWO THRDS, W/ THORACOTOMY, SEP INCISIN; W/
43121	PARTL ESOPHAGECTOMY, DISTAL TWO THRDS, W/ THORACOTOMY ONLY, W/ THORACIC
43122	PARTL ESOPHAGECTOMY, THORACOABDOMINAL/ABDOMINAL APPROACH; W/
51725	SIMPLE CYSTOMETROGRAM
51726	COMPLEX CYSTOMETROGRAM
51736	SIMPLE UROFLOWMETRY
51741	COMPLEX UROFLOWMETRY
51772	URETHRAL PRESSURE PROFILE STUDIES (URETHRAL CLOSURE PRESSURE PROFILE), ANY
51784	ELECTROMYOGRAPHY STUDIES, ANAL/URETHRAL SPHINCTER, OTHER THAN NEEDLE, ANY
51785	NEEDLE ELECTROMYOGRAPHY STUDIES, ANAL &/OR URETHRAL SPHINCTER, ANY
51792	STIMULUS EVOKED RESPONSE
51795	VOIDING PRESSURE STUDIES; BLADDER VOIDING PRESSURE, ANY TECHNIQUE
51797	VOIDING PRESSURE STUDIES; INTRA-ABDOMINAL VOIDING PRESSURE
56605	BX, VULVA/PERINEUM (SEP PROC); 1 LESION
56606	BX, VULVA/PERINEUM; ADD'L LESION
56700	PARTIAL HYMENECTOMY/REVISION, HYMENAL RING
56720	HYMENOTOMY, SIMPLE INCISION
56740	EXCISION, BARTHOLIN'S GLAND/CYST
57100	BX, VAGINAL MUCOSA; SIMPLE (SEP PROC)
57105	BX, VAGINAL MUCOSA; EXTENSIVE, REQUIRING SUTURE (W/ CYSTS)
57200	COLPORRHAPHY, SUTURE, INJURY, VAGINA (NONOBSTETRICAL)
57210	COLPOPERINEORRHAPHY, SUTURE, INJURY, VAGINA &/OR PERINEUM (NONOBSTETRICAL)
57220	PLASTIC OPERATION ON URETHRAL SPHINCTER, VAGINAL APPROACH
57230	PLASTIC REPAIR, URETHROCELE
57240	ANTERIOR COLPORRHAPHY, REPAIR, CYSTOCELE W/WO REPAIR, URETHROCELE
57250	POSTERIOR COLPORRHAPHY, REPAIR, RECTOCELE W/WO PERINEORRHAPHY
57260	COMBINED ANTEROPOSTERIOR COLPORRHAPHY;
57265	COMBINED ANTEROPOSTERIOR COLPORRHAPHY; W/ ENTEROCELE REPAIR
57268	REPAIR, ENTEROCELE, VAGINAL APPROACH (SEP PROC)
57270	REPAIR, ENTEROCELE, ABDOMINAL APPROACH (SEP PROC)

<b>CPT Code</b>	<b>Descriptor</b>
57280	COLPOPEXY, ABDOMINAL APPROACH
57282	SACROSPINOUS LIGAMENT FIXATION, PROLAPSE, VAGINA
57284	PARAVAGINAL DEFECT REPAIR
57287	REMOVAL/REVISION, SLING, STRESS INCONTINENCE
57288	SLING OPERATION, STRESS INCONTINENCE
57289	PEREYRA PROC, W/ ANTERIOR COLPORRHAPHY
57291	CONSTRUCTION, ARTIFICIAL VAGINA; W/O GRAFT
57292	CONSTRUCTION, ARTIFICIAL VAGINA; W/ GRAFT
57300	CLOSURE, RECTOVAGINAL FISTULA; VAGINAL/TRANSANAL APPROACH
57305	CLOSURE, RECTOVAGINAL FISTULA; ABDOMINAL APPROACH
57307	CLOSURE, RECTOVAGINAL FISTULA; ABDOMINAL APPROACH, W/ CONCOMITANT
57308	CLOSURE, RECTOVAGINAL FISTULA; TRANSPERINEAL APPROACH, W/ RECONSTRUCTION,
57310	CLOSURE, URETHROVAGINAL FISTULA;
57311	CLOSURE, URETHROVAGINAL FISTULA; W/ BULBOCAVERNOSUS TRANSPLANT
57320	CLOSURE, VESICOVAGINAL FISTULA; VAGINAL APPROACH
57330	CLOSURE, VESICOVAGINAL FISTULA; TRANSVESICAL & VAGINAL APPROACH
57335	VAGINOPLASTY, INTERSEX STATE
57800	DILATION, CERVICAL CANAL, INSTRUMENTAL (SEP PROC)
57820	DILATION & CURETTAGE, CERVICAL STUMP
58120	DILATION & CURETTAGE, DX &/OR THERAPEUTIC (NONOBSTETRICAL)
58150	TOTAL ABDOMINAL HYSTERECTOMY W/WO REMOVAL TUBE(S)/OVARY(S);
58152	TOTAL ABDOMINAL HYSTERECTOMY W/WO REMOVAL TUBE(S)/OVARY(S); W/
58180	SUPRACERVICAL ABDOMINAL HYSTERECTOMY, W/WO REMOVAL TUBE(S)/OVARY(S)
58200	TOTAL ABDOMINAL HYSTERECTOMY, W/ PARTIAL VAGINECTOMY, W/ PELVIC LYMPH NODE
58210	RADICAL ABDOMINAL HYSTERECTOMY W/ BILAT PELVIC LYMPHADENECTOMY
58240	PELVIC EXENTERATION, GYNECOLOGIC MALIGNANCY
58555	HYSTEROSCOPY, DX (SEP PROC)
58558	HYSTEROSCOPY, SURGICAL; W/ ENDOMETRIAL BX &/OR POLYPECTOMY W/WO D&C
58559	HYSTEROSCOPY, SURGICAL; W/ LYSIS INTRAUTERINE ADHESIONS, ANY METHOD
58560	HYSTEROSCOPY, SURGICAL; W/ DIVISION/RESECTION INTRAUTERINE SEPTUM, ANY
58561	HYSTEROSCOPY, SURGICAL; W/ REMOVAL LEIOMYOMATA
58563	HYSTEROSCOPY, SURGICAL; W/ ENDOMETRIAL ABLATION, ANY METHOD
61000	SUBDURAL TAP THROUGH FONTANELLE/SUTURE, INFANT, UNILAT/BILAT; INITIAL
61001	SUBDURAL TAP THROUGH FONTANELLE/SUTURE, INFANT, UNILAT/BILAT; SUBSEQUENT
TAPS	
61020	VENTRICULAR PUNCTURE; W/O INJECTION
61026	VENTRICULAR PUNCTURE; W/ INJECTION
61050	CISTERNAL/LATERAL (C1-C2) CERVICAL PUNCTURE; W/O INJECTION (SEP PROC)
61055	CISTERNAL/LATERAL (C1-C2) CERVICAL PUNCTURE; W/ INJECTION
61070	PUNCTURE, SHUNT TUBING/RESERVOIR, ASPIRATION/INJECTION PROC
61105	TWIST DRILL HOLE, SUBDURAL/VENTRICULAR PUNCTURE;
61107	TWIST DRILL HOLE, SUBDURAL/VENTRICULAR PUNCTURE; IMPLANT VENTRIC
61108	TWIST DRILL HOLE, SUBDURAL/VENTRICULAR PUNCTURE; EVACUATION &/OR DRAINAGE,
61120	BURR HOLE, VENTRICULAR PUNCTURE W/ INJECTION
61140	BURR HOLE(S)/TREPHINE; W/ BX, BRAIN/INTRACRANIAL LESION
61150	BURR HOLE(S)/TREPHINE; W/ DRAINAGE, BRAIN ABSCESS/CYST
61151	BURR HOLE(S)/TREPHINE; W/ SUBSEQUENT TAPPING (ASPIRATION), INTRACRANIAL
61154	BURR HOLE(S) W/ EVACUATION &/OR DRAINAGE, HEMATOMA, EXTRADURAL/SUBDURAL
61156	BURR HOLE(S); W/ ASPIRATION, HEMATOMA/CYST, INTRACEREBRAL
61210	BURR HOLE(S); IMPLANTING VENTRICULAR CATHETER/RESERVOIR/ELECTRODES/DEVICE
61215	INSERTION, SUBQ RESERVOIR/PUMP/INFUSION SYSTEM, VENTRICULAR CATHETER
61250	BURR HOLE(S)/TREPHINE, SUPRATENTORIAL, EXPLORATORY, NOT FOLLOWED BY OTHER
61253	BURR HOLE(S)/TREPHINE, INFRATENTORIAL, UNILAT/BILAT
61304	CRANIECTOMY/CRANIOTOMY, EXPLORATORY; SUPRATENTORIAL
61305	CRANIECTOMY/CRANIOTOMY, EXPLORATORY; INFRATENTORIAL (POSTERIOR FOSSA)
61312	CRANIECTOMY/CRANIOTOMY, EVACUATION, HEMATOMA, SUPRATENTORIAL;
61313	CRANIECTOMY/CRANIOTOMY, EVACUATION, HEMATOMA, SUPRATENTORIAL;
61314	CRANIECTOMY/CRANIOTOMY, EVACUATION, HEMATOMA, INFRATENTORIAL;
61315	CRANIECTOMY/CRANIOTOMY, EVACUATION, HEMATOMA, INFRATENTORIAL;

<i>CPT Code</i>	<i>Descriptor</i>
61320	CRANIECTOMY/CRANIOTOMY, DRAINAGE, INTRACRANIAL ABSCESS; SUPRATENTORIAL
61321	CRANIECTOMY/CRANIOTOMY, DRAINAGE, INTRACRANIAL ABSCESS; INFRATENTORIAL
61330	DECOMPRESSION, ORBIT ONLY, TRANSCRANIAL APPROACH
61332	EXPLORATION, ORBIT (TRANSCRANIAL APPROACH); W/ BX
61333	EXPLORATION, ORBIT (TRANSCRANIAL APPROACH); W/ REMOVAL, LESION
61334	EXPLORATION, ORBIT (TRANSCRANIAL APPROACH); W/ REMOVAL, FB
61340	OTHER CRANIAL DECOMPRESSION, SUPRATENTORIAL
63001	LAMINECTOMY, W/O FACETECTOMY/FORAMINOTOMY/DISKECTOMY, 1/2 SEGMENTS;
63003	LAMINECTOMY, W/O FACETECTOMY/FORAMINOTOMY/DISKECTOMY, 1/2 SEGMENTS;
63005	LAMINECTOMY W/O FACETECTOMY/FORAMINOTOMY/DISKECTOMY, 1/2 SEGMENTS; LUMBAR
63011	LAMINECTOMY W/O FACETECTOMY/FORAMINOTOMY/DISKECTOMY, 1/2 SEGMENTS; SACRAL
63012	LAMINECTOMY W/ REMOVAL, ABNORMAL FACETS; LUMBAR
63015	LAMINECTOMY W/O FACETECTOMY/FORAMINOTOMY/DISKECTOMY, > 2 SEGMENTS;
63016	LAMINECTOMY W/O FACETECTOMY/FORAMINOTOMY/DISKECTOMY, > 2 SEGMENTS;
63017	LAMINECTOMY W/O FACETECTOMY/FORAMINOTOMY/DISKECTOMY, > 2 SEGMENTS; LUMBAR
63020	LAMINOTOMY W/ PARTIAL FACETECTOMY/FORAMINOTOMY/HERNIATED DISKECTOMY; 1
63030	LAMINOTOMY W/ PARTIAL FACETECTOMY/FORAMINOTOMY/HERNIATED DISKECTOMY; 1
63040	LAMINOTOMY W/ PARTL FACETECTMY/FORAMNOTMY/HERNIATED DISKECTMY; RE-
63042	LAMINOTOMY W/ PARTIAL FACETECTOMY/FORAMINOTOMY/HERNIATED DISKECTOMY;
63045	LAMINECTOMY, FACETECTOMY & FORAMINOTOMY, 1 SEGMENT; CERVICAL
63046	LAMINECTOMY, FACETECTOMY & FORAMINOTOMY, 1 SEGMENT; THORACIC
63047	LAMINECTOMY, FACETECTOMY & FORAMINOTOMY, 1 SEGMENT; LUMBAR
63055	TRANSPEDICULAR APPROACH, 1 SEGMENT; THORACIC
63056	TRANSPEDICULAR APPROACH, 1 SEGMENT; LUMBAR (TRANSFACET/LATERAL
63064	COSTOVERTEBRAL APPROACH, 1 SEGMENT; THORACIC
63075	DISKECTOMY, ANTERIOR; CERVICAL, 1 INTERSPACE
63077	DISKECTOMY, ANTERIOR; THORACIC, 1 INTERSPACE
63081	VERTEBRAL CORPECTOMY, ANTERIOR; CERVICAL, 1 SEGMENT
63085	VERTEBRAL CORPECTOMY, TRANSTHORACIC; THORACIC, 1 SEGMENT
63087	VERTEBRAL CORPECTOMY, THORACOLUMBAR, LOWER THORACIC/LUMBAR; 1 SEGMENT
63090	VERTEBRAL CORPECTOMY, TRANSPERITONEAL/RETROPERITONEAL, LOWER
76506	ULTRASOUND, HEAD/BRAIN
76536	ULTRASOUND, HEAD/NECK TISSUES, B-SCAN/REAL TIME W/ IMAGE DOCUMENTATION
76770	ULTRASOUND, RETROPERITONEUM, B-SCAN/REAL TIME; COMPLETE
76778	ULTRASOUND, KIDNEY TRANSPLANT, B-SCAN/REAL TIME W/WO DUPLEX DOPPLER
76818	FETAL BIOPHYSICAL PROFILE; W/ NON-STRESS TESTING
76819	FETAL BIOPHYSICAL PROFILE; W/O NON-STRESS TESTING
76825	ECHOCARDIOGRAPHY, FETAL, CARDIOVASCULAR SYSTEM, REAL TIME W/WO M-MODE;
76826	ECHOCARDIOGRAPHY, FETAL, CARDIOVASCULAR SYSTEM, REAL TIME W/WO M-MODE;
76827	ECHOCARDIOGRAPHY, FETAL, DOPPLER, CARDIOVASCULAR SYSTEM; COMPLETE
76828	ECHOCARDIOGRAPHY, FETAL, DOPPLER, CARDIOVASCULAR SYSTEM; FOLLOW-UP/REPEAT
76830	ECHOGRAPHY, TRANSVAGINAL
76831	HYSTEROSONOGRAPHY, W/WO COLOR FLOW DOPPLER
76856	ECHOGRAPHY, PELVIC (NONOBSTETRIC), B-SCAN &/OR REAL TIME W/ IMAGE
76857	ECHOGRAPHY, PELVIS, B-SCAN/REAL TIME; LIMITED/FOLLOW-UP
76870	ECHOGRAPHY, SCROTUM & CONTENTS
76872	ECHOGRAPHY, TRANSRECTAL
76873	ECHOGRAPHY, TRANSRECTAL; PROSTATE VOLUME STUDY, BRACHYTHERAPY PLANNING
76880	ECHOGRAPHY, EXTREMITY, NON-VASCULAR, B-SCAN &/OR REAL TIME W/ IMAGE
76885	ECHOGRAPHY, INFANT HIPS, REAL TIME; DYNAMIC
76942	ULTRASONIC GUIDANCE, NEEDLE PLACEMENT, RADIOLOGICAL S & I
85095	BONE MARROW; ASPIRATION ONLY
85095	BONE MARROW; ASPIRATION ONLY
85102	BONE MARROW BX, NEEDLE/TROCAR
85102	BONE MARROW BX, NEEDLE/TROCAR
88180	FLOW CYTOMETRY; EACH CELL SURFACE MARKER
88182	FLOW CYTOMETRY; CELL CYCLE/DNA ANALYSIS
88291	CYTOGENETICS & MOLECULAR CYTOGENETICS, INTERPRETATION & REPORT



<i>CPT Code</i>	<i>Descriptor</i>
88346	IMMUNOFLUORESCENT STUDY, EACH ANTIBODY; DIRECT METHOD
88347	IMMUNOFLUORESCENT STUDY, EACH ANTIBODY; INDIRECT METHOD
88362	NERVE TEASING PREPARATIONS
90471	IMMUNIZATION ADMINISTRATION; 1 SINGLE/COMBINATION VACCINE/TOXOID
90472	IMMUNIZATION ADMINISTRATION; 2+ SINGLE/COMBINATION VACCINE/TOXOID
90780	IV INFUSION THERAPY/DX, GIVEN BY/UNDER DIRECTION, PHYSICIAN; UP TO 1 HR
90781	IV INFUSION THERAPY/DX, GIVEN BY/UNDER DIRECTION, PHYSICIAN; EACH ADD'L HR, UP
90782	SUBQ/IM INJECTION, THERAPEUTIC/PROPHYLACTIC/DX
90783	THERAPEUTIC/DX INJECTION (SPECIFY MATL INJECTED); IA
90784	THERAPEUTIC/DX INJECTION (SPECIFY MATL INJECTED); IV
90788	IM INJECTION, ANTIBIOTIC (SPECIFY)
90918	ESRD SERVICES, PER MONTH; < AGE 2
90919	ESRD SERVICES, PER MONTH; AGE 2-11
90920	ESRD SERVICES, PER MONTH; AGE 12-19
90921	ESRD SERVICES, PER MONTH; AGE 20+
90922	ESRD SERVICES (< FULL MONTH), PER DAY; < AGE 2
90923	ESRD SERVICES (< FULL MONTH), PER DAY; AGE 2-11
90924	ESRD SERVICES (< FULL MONTH), PER DAY; AGE 12-19
90925	ESRD SERVICES (< FULL MONTH), PER DAY; AGE 20+
92980	TRANSCATHETER PLACEMENT INTRACORONARY STENT(S) PERCUTANEOUS; SINGLE
92981	TRANSCATHETER PLACEMENT INTRACORONARY STENT(S) PERCUTANEOUS; ADD'L VESSEL
92982	PERCUTANEOUS TRANSLUMINAL CORONARY BALLOON ANGIOPLASTY; SINGLE VESSEL
92984	PERCUTANEOUS TRANSLUMINAL CORONARY BALLOON ANGIOPLASTY; ADD'L VESSEL
92995	PERCUTANEOUS TRANSLUMINAL CORONARY ATHERECTOMY; SINGLE VESSEL
92996	PERCUTANEOUS TRANSLUMINAL CORONARY ATHERECTOMY; ADD'L VESSEL
92997	PERCUTANEOUS TRANSLUMINAL PULMONARY ARTERY BALLOON ANGIOPLASTY; SINGLE
92998	PERCUTANEOUS TRANSLUMINAL PULMONARY ANGIOPLASTY; ADD'L VESSEL
93303	TRANSTHORACIC ECHOCARDIOGRAPHY, CONGENITAL CARDIAC ANOMALIES; COMPLETE
93304	TRANSTHORACIC ECHOCARDIOGRAPHY, CONGENITAL CARDIAC ANOMALIES;
93307	ECHOCARDIOGRAPHY, TRANSTHORACIC, 2D; COMPLETE
93308	ECHOCARDIOGRAPHY, TRANSTHORACIC, 2D; FOLLOW-UP/LIMITED STUDY
93312	ECHOCARDIOGRAPHY, TRANSESOPHAGEAL, 2D; W/ PROBE, IMAGE ACQUISITION,
93314	ECHOCARDIOGRAPHY, TRANSESOPHAGEAL, 2D; W/ IMAGE ACQUISITION, INTERPRETATION
93315	ECHOCARDIOGRAPHY, TRANSESOPHAGEAL, CONGENITAL ANOMALIES; W/ PROBE, IMAGE,
93317	ECHOCARDIOGRAPHY, TRANSESOPHAGEAL, CONGENITAL ANOMALIES; W/ IMAGE,
93320	ECHOCARDIOGRAPHY; COMPLETE
93321	ECHOCARDIOGRAPHY, DOPPLER; FOLLOW-UP/LIMITED
93325	DOPPLER COLOR FLOW MAPPING
93350	ECHOCARDIOGRAPHY, TRANSTHORACIC, REAL-TIME 2D, CARDIOVASCULAR STRESS TEST,
93740	TEMPERATURE GRADIENT STUDIES
93770	DETERMINATION, VENOUS PRESSURE
96400	CHEMOTHERAPY ADMINISTRATION, SUBQ/IM, W/WO LOCAL ANESTHESIA
96408	CHEMOTHERAPY ADMINISTRATION, IV; PUSH TECHNIQUE
96410	CHEMOTHERAPY ADMINISTRATION, IV; INFUSION, UP TO 1 HR
96412	CHEMOTHERAPY, IV; INFUSION, 1-8 HR, ADD'L HR
96414	CHEMOTHERAPY, IV; INFUSION, > 8 HR W/PORTABLE/IMPLANTABLE PUMP
96420	CHEMOTHERAPY ADMINISTRATION, INTRA-ARTERIAL; PUSH TECHNIQUE
96422	CHEMOTHERAPY ADMINISTRATION, INTRA-ARTERIAL; INFUSION, UP TO 1 HR
96423	CHEMOTHERAPY ADMINISTRATION, INTRA-ARTERIAL; INFUSION, 1-8 HR, ADD'L HR
96425	CHEMOTHERAPY ADMINISTRATION, INTRA-ARTERIAL; INFUSION, > 8 HR
96520	REFILLING & MAINTENANCE, PORTABLE PUMP
96530	REFILLING & MAINTENANCE, IMPLANTABLE PUMP/RESERVOIR
98940	CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, 1-2 REGIONS
98941	CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, 3-4 REGIONS
98942	CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, 5 REGIONS
98943	CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); EXTRASPINAL, 1 OR MORE REGIONS
99195	PHLEBOTOMY, THERAPEUTIC (SEP PROC)
99431	HX & EXAM, NORMAL NEWBORN, INITIATION DX & TREATMENT PROGRAMS, PREP, HOSP

<i>CPT Code</i>	<i>Descriptor</i>
99432	NORMAL NEWBORN CARE NON-HOSPITAL W/ PHYSICAL EXAM
99433	SUBSEQUENT HOSPITAL CARE, EVALUATION & MANAGEMENT, NORMAL NEWBORN, PER
99435	HX/EXAM, NORMAL NEWBORN, ASSESSED/DISCHARGED ON SAME DAY
99436	ATTENDANCE AT DELIVERY, AT REQUEST OF DELIVERING PHYSICIAN, & STABILIZATION OF
99440	NEWBORN RESUSCITATION



**AMA/Specialty Society RVS Update Committee  
Research Subcommittee Report**

**April 9, 2002**

The following members of the research subcommittee participated in the conference call: Doctors Hayes, (chair), Blankenship, Borgstede, Britton, Derr, Mayer, Smith, Williamson, and Zwolak.

Modifications to RUC Survey

The American Psychological Association presented modified RUC surveys for six codes for central nervous system assessments and tests. Based on discussions at the February, 2002 HCPAC meeting and discussions with CMS, APA made modifications to the original RUC survey by adding questions that address the concerns raised by CMS as to whether the professional or the technician is rendering the service. By adding additional questions to the survey, the APA is attempting to determine how much time the physician or psychologist spends with the patient and how much time the clinical staff spend with the patient. Additionally the revised survey attempts to determine time spent performing the tests as opposed to time attributed to automation. The RUC agreed to the following survey modifications:

**Delete question 2C asking about units spent in the pre, intra and post service time period.**

**Revise question 2G so that respondents provide minutes rather than units.**

RUC Statement on Critical Care

At the February, 2002 RUC meeting, the RUC requested the research subcommittee to develop a RUC statement explaining the RUC's position on inclusion of critical care in the global period. This statement would then be sent to CMS. The research subcommittee discussed the statement and concluded that was consistent with previous RUC discussions regarding the issue. A subcommittee member requested a clarification so that it was clear that some of the older codes that the RUC reviewed prior to modifications to the survey may also include critical care in the surgical package. The absence of critical care listed for these older codes can be attributed to the survey instrument not including specific questions on critical care.

**The Subcommittee recommended RUC acceptance of the RUC position on inclusion of critical care in the global surgical package.**

**The RUC referred this recommendation back to the Research Subcommittee for further refinement and study.**

Mandated On-Call Services

During the February, 2002 RUC meeting, the RUC discussed two new CPT codes created to describe hospital mandated on-call services. The codes are 990X1 *Hospital mandated on call service; in-hospital, each hour* and 990X2 *out-of-hospital, each hour*. These

*Approved at the April 25-28, 2002 RUC Meeting.*

codes were created at the request of the AMA House of Delegates. Several specialties initially expressed interest in developing recommendations for these codes but eventually no specialty was prepared to develop a recommendation. Given the absence of a recommendation, the RUC referred the issue to the research subcommittee.

The subcommittee reviewed the two codes in detail and discussed possible ways to value the codes such as comparing to stand by services. There was a recognition that mandated on-call services are typically an arrangement between physicians and hospitals, and in some cases, physicians who wish to be affiliated with a trauma center, accept on call services as part of having privileges at that hospital. A comparison to stand by services was deemed to be inappropriate since the stand by services describe scenarios where the physician is preparing to provide needed services. The time a physician spends on call differs from stand by services in that the on call services may not lead to providing patient care, given that the specific arrangements of on call services are determined between hospitals and physicians, and not payers, Medicare and other public and private payers, would not be the appropriate entities to reimburse physicians for on call services. Also, given the absence of a typical patient and vignette for these codes, and the wide variety of scenarios that might be covered by these codes the subcommittee was unable to develop a methodology for creating relative values for these codes.

The RUC approved the following recommendation:

**The RUC recognizes that mandated on-call services are typically arrangements between hospitals and physicians and cover a wide range of scenarios. Therefore, the current methodology for developing relative value recommendations does not allow for valuing such services. However, the RUC is cognizant that obtaining reimbursement for mandated on-call services is an issue for some specialties.**

#### Selection of Standard IWPUT Formula

At the request of the American College of Surgeons (ACS), this issue was removed from the agenda so that it can be discussed in detail during the September, 2002 RUC meeting. At that time the ACS and AANS will make a presentation to the research subcommittee on the IWPUT methodology and suggested formula for calculating IWPUT.

**AMA/Specialty RVS Update Committee  
Administrative Subcommittee Minutes**

*Approved at the April 24-28 RUC Meeting*

The Administrative Subcommittee Members met on Saturday, April 27, 2002, to discuss two issues related to Gastroenterology's request for a permanent seat on the RUC, and representation by a RUC member from CPT. The following subcommittee members were present: Doctors William Gee (Chair), Jr., Lee Eisenberg, Alexander Hannenberg, Charles Koopman, Gregory Przybylski, Sheldon Taubman, Richard Tuck, Robert Vogelzang, Paul Wallner, Richard Whitten, and Nelda, Spyrès, LCSW.

Request from Gastroenterology for a permanent seat on the AMA/Specialty RVS Update Committee

The material related to the RUC's original criteria was discussed. The RUC criteria for inclusion (in descending order) created in 1991 were:

1. The specialty is an ABMS specialty.
2. The specialty comprises 1% of physicians in practice.
3. The specialty comprises 1% of physician Medicare expenditures.
4. Medicare revenue is at least 10% of mean practice revenue for the specialty.
5. The specialty is not meaningfully represented by an umbrella organization.

The subcommittee discussed the possibility of re-examining these original criteria with consideration of the following issues:

Size

- Should there be an assessment of the size of the RUC?
- Should there be a "cap" on the size of the RUC?
- Does the efficiency of a working body decrease with a larger group?
- Would addition of seats require evaluation of existing seats for removal?
- The RUC agenda size is increasing

Function of the RUC

- All specialties/subspecialties bring their concerns to the RUC
- RUC is an expert panel, not designed to be a representative panel
- The RUC may need changing expertise (i.e. rotating seats)
- RUC subcommittees, facilitation committees, and the ad hoc workgroups now include RUC Advisors and HCPAC members
- How can meetings be streamlined?
- The RUC may wish to consider a process where RUC alternates run facilitation committees while RUC members meet to consider initial presentations.

Composition Issues

- What is the process for responding to future requests from additional specialties seeking a seat on the RUC?
- Different balance of rotating seats versus permanent seats (The intent of the rotating seat is to provide opportunities for all specialties to participate)
- Should the RUC review the composition every 5 years?
- Term of rotating seats should be considered

*Approved at the April 25-28, 2002 RUC Meeting.*

- Compare structure of CPT to the RUC (CPT Editorial Panel is elected by the BOT)

The Administrative subcommittee submitted the following recommendations to the RUC:

- The RUC may wish to re-examine the size and criterion for inclusion on the RUC. A decision to do this should be discussed by the full RUC.
- The request to add Gastroenterology will be deferred until a decision on re-examination of the rules has been made.

**The RUC did not approve the above motions requesting re-examination of the criteria for a permanent seat on the on the RUC after the original formation.**

**The RUC passed the following motion:**

**The following RUC criteria for inclusion on the RUC should be added to the RUC's Structure and Functions Document:**

**The RUC criteria for inclusion (in descending order)**

- 1) The specialty is an ABMS specialty.**
- 2) The specialty comprises 1% of physicians in practice.**
- 3) The specialty comprises 1% of physician Medicare expenditures.**
- 4) Medicare revenue is at least 10% of mean practice revenue for the specialty.**
- 5) The specialty is not meaningfully represented by an umbrella organization.**

**The RUC did not approve the following motion that was submitted during the discussion of the Subcommittee report:**

**The specialty of Gastroenterology should be granted a permanent seat on the RUC.**

#### RUC member attendance at the CPT Editorial Meetings

**The RUC approved the recommendation to designate one RUC member each year (May – Feb Panel Meetings) as a RUC observer and attend on behalf of the RUC. The AMA will reimburse this RUC member's expenses.**

The subcommittee suggests that any RUC member who would like to attend a CPT meeting (at the expense of their respective society) do so, as the meetings are open to RUC members.

**AMA/Specialty Society RVS Update Committee  
Practice Expense Subcommittee Report – April 2002 RUC Meeting  
April 10, 2002**

The Practice Expense Subcommittee met April 10, 2002 via conference call to discuss two issues relating to physician time. Doctors Levy (Chair), Brill, Gage, Gerety, Hitzman, Lichtenfeld, McCaffree, Moran, and Rich, participated in the call.

The Practice Expense Subcommittee discussed two issues brought forth by the Practice Expense Advisory Committee (PEAC). Both issues involve the reallocation of total physician time. The first issue from the PEAC involves inconsistencies in the number and level of E/M services in the global period for 227 non-RUC surveyed 010 and 090 day global CPT codes. The second issue originating from the PEAC involves some inconsistencies in the assignment of discharge day management services in the global surgical package.

**Issue 1: Inconsistencies within CMS's Physician Time Database**

AMA staff began the conference call by explaining the history of the inconsistencies within CMS's physician time database.

Since its inception the PEAC has worked towards efficiency in the methodology by which it refines the direct practice expense inputs of procedure codes. The PEAC developed and obtained RUC approval on a methodology of refining the CPEP data associated with 90-day global codes. This methodology applies the number and level of office visits currently listed in either the RUC or CMS databases with the standard PEAC approved E/M standard packages. This approach has been used successfully for a number of codes with global periods of 10 and 90 days. Last year the PEAC began concentrating its efforts on refining the direct inputs of groups or families of procedure codes, and thus increased the significance of the accuracy of both the RUC and CMS physician time databases. During the August 2001 PEAC meeting, specialty societies identified inconsistencies in the number and level of office visits within particular families of codes. At the January 2002 PEAC meeting, AMA staff identified a large group of CMS physician time data missing post operative visit data. For these 10 and 90-day global codes, CMS does not provide a complete breakdown of the pre, intra, and post time periods, and only has total physician time. In order to resolve any future inconsistencies in the RUC database post operative visit data and to assist the PEAC in its practice expense refinement, in February 2002 the RUC approved the following recommendation by the Practice Expense Subcommittee:

*The subcommittee proposed that AMA staff send 227 codes for which there is no CMS post operative visit data to the specialty societies to ask them to address the following issues:*

*1. Do you agree that the total physician time is valid?*

*If the answer to number 1 above is yes, the RUC asks the specialty societies to allocate the total physician time into the various time components of pre-service, intra-service,*

*Approved at the April 25-28, 2002 RUC Meeting.*

and immediate post service time periods, and include the number and level of post operative hospital and office visits.

If the answer to number 1 is no, the Practice Expense Subcommittee would provide the specialty society the opportunity to survey and bring the results before the Practice Expense Subcommittee and the RUC for approval. The survey would strictly be on physician time and would have no bearing on physician work.

As a result of the above RUC action, AMA staff sent an explanatory note and request for the physician time elements by April 4, 2002, to be presented to the Practice Expense Subcommittee during its conference call April 10, 2002. Data submitted after April 4, 2002 would be presented at the following subcommittee meeting.

By April 9, 2002 AMA staff had received physician time element information from 5 specialties encompassing 42 procedure codes. The subcommittee reviewed each of the specialty society physician time recommendations and accepted 7. The subcommittee rejected 35 physician time recommendations mainly because the specialty societies did not follow the RUC's directions in making their allocations of time, resulting in a physician time that was greater than the CMS/Harvard total time without a survey to validate the additional time.

**The subcommittee accepted the following 7 physician time recommendations from specialty societies:**

Code	Specialty	Pre Time	Intra Time	Immed . Post	Hospital Time	Discharge Time	Office Time	Total Time	CMS/Hrwd Time
92986	ACC	98	113	135	19	36	69	470	470
92990	ACC	79	126	119			69	393	393
35693	AAVS	70	140	36	38	36	45	365	365
35691	AAVS	90	160	41	38	36	45	410	410
35695*	AAVS	120	180	46	38	36	45	465	430
64612	AAN	10	20	6			15	51	51
64613	AAN	10	21	6			15	52	52

Procedure code 35695 presented by AAVS was discussed at length by the subcommittee, whereas it was determined that the code's physician work had been reviewed by the RUC in the past. The subcommittee considered the current CMS/Harvard physician time to be in error for code 35695 and believed the physician time components were equivalent to CPT code 35694 *Transposition and/or reimplantation; subclavian to carotid artery*. Therefore, the subcommittee recommends a total physician time of 465 minutes for code 35695 and its time components as shown above.

The subcommittee directed AMA staff to again contact the specialties whose codes had not been accepted and provide further assistance in their recommendations, so that either the total CMS/Harvard time is correctly allocated, or a survey is conducted to develop a new time.

*Approved at the April 25-28, 2002 RUC Meeting.*

After the conference call, the subcommittee reviewed a late submission from The American Academy of Ophthalmology (AAO). AAO provided the subcommittee with a physician time allocation for 15 codes. The subcommittee reviewed the data in detail and believed the time allocations were not appropriate and possibly incomplete. Therefore, the subcommittee recommends the specialty society, in collaboration with AMA staff, review and revise their time allocations for the practice expense subcommittee to review at the following meeting.

**Issue 2: Data Difficulties with Post-Operative Discharge Day Management Physician time, for Surgical Procedures.**

During the August 2001 PEAC meeting, the PEAC identified an inconsistency in a family of codes and requested a crosswalk of post-operative discharge day management time for four codes. The practice expense subcommittee discussed the inconsistency of existing post-operative discharge day management time of surgical procedures at length and believed that for 10 and 90-day global surgical codes, some allocation of discharge day management time should be applied. In February 2002 the subcommittee and the RUC then approved the following recommendation:

- A. The RUC agrees that there can be one or one-half of a discharge day management code for any surgical procedure code when performed in the facility setting.**
- 1. The RUC should reallocate existing post service time to all outpatient surgical procedure codes (typically performed in an ASC or hospital outpatient department) so that one-half of a discharge day management code time element exists in the RUC physician time database.**
  - 2. The RUC should reallocate existing post service time to all inpatient surgical procedure codes so that a full discharge day management code time element exists in the RUC physician time database.**

When AMA staff attempted to carry out the above RUC action, they identified 4 data difficulties that prevented them from performing this reallocation of total physician time. AMA staff used 1999 Medicare utilization data to identify where the 010 and 090 day global RUC surveyed codes typically were performed. The Medicare utilization data used identified procedures typically performed over 50% of the time in an inpatient setting, and also those procedures typically performed in an outpatient hospital setting and in an ambulatory surgical center. The following are the data difficulties encountered, AMA staff sought the guidance of the Practice Expense Subcommittee as to how to resolve these issues.

1. 46 CPT codes could not be identified as performed in or out of the facility setting since they lacked Medicare utilization data.
2. 13 CPT codes identified as typically performed in the facility setting did not have sufficient post operative physician time to allocate to a full discharge day management code.

*Approved at the April 25-28, 2002 RUC Meeting.*

3. 6 CPT codes identified as typically performed in the non-facility setting did not have sufficient post operative physician time to allocate to a half discharge day management code.
4. 77 CPT codes identified as typically performed in the non-facility setting currently have a full discharge day management code and hospital visits.

The Practice Expense Subcommittee addressed each of these 4 data issues in the following manner by asking AMA staff and specialty society assistance:

***Data Issue 1:***

The subcommittee recommends AMA staff research each of the 46 CPT codes for obvious identification of the typical procedure setting. If AMA staff needs assistance, they will identify the codes and ask for the following specialty information for each code:

- A. Where is the procedure typically performed?
- B. When was the CPT code valued or surveyed?

***Data Issue 2 and 3:***

The subcommittee recommends that the specialty societies have the option to resurvey or advise the subcommittee on the appropriate physician time allocation.

***Data Issue 4:***

The subcommittee recommends the specialty societies review these 77 codes for possible errors in physician time. In addition, the subcommittee requests specialty societies to review the utilization and prepare an explanation for the need of a full discharge day management and hospital physician time elements for each code. The subcommittee will then review these explanations at the following subcommittee meeting.

**Other Recommendations from the Practice Expense Subcommittee:**

- A. **For all non-RUC surveyed 10 and 90-day global codes, the Practice Expense Subcommittee recommends CMS:**
  1. **Reallocate existing post service time to all outpatient surgical procedure codes (typically performed in an ASC or hospital outpatient department) so that one-half of a discharge day management code time element exists in the CMS physician time database.**
  2. **Reallocate existing post service time to all inpatient surgical procedure codes so that a full discharge day management code time element exists in the CMS physician time database.**

As the Practice Expense Subcommittee reviewed Issue 2 above, members questioned the RUC physician time components for 10 and 90-day surgical procedures without immediate post service time. The subcommittee made the following recommendation:



**B. For any 10 or 90-day global RUC surveyed surgical procedure without immediate post service time, specialty societies may recommend a reallocation of the code's existing total physician time, or re-survey. The results of either a reallocation or survey would then be presented to the Practice Expense Subcommittee for review.**

**RUC HCPAC Review Board Report**

The Sheraton Chicago Hotel

Chicago, Illinois

April 24, 2002

On April 24, 2002, the RUC HCPAC Board met to review issues related to the practice expenses of the Chiropractic codes reviewed by the PEAC and the Speech and Hearing Assessment Tests. The following HCPAC Review Board members participated in the discussion:

Richard Whitten, MD, Chair  
Done E. Williamson, OD, Co-Chair  
Eileen Sullivan-Marx, PhD, RN  
Mary Foto, OTR  
James Georgoulakis, PhD  
Marc D. Lenet, DPM  
Samuel M. Brown, PT  
Arthur Traugott, MD

Steven White, PhD  
Nelda Spyres, LCSW  
Emily H. Hill, PA-C  
Joe Johnson, DC  
Karen Smith, MS, RD, FADA  
Pam Smith, PhD, RD  
Walt Somoski, PhD, CCC-A

**XI. Call to Order**

Doctor Williamson called the meeting to order at 11:15 a.m.

**XII. Introduction**

Doctor Williamson introduced Joe Johnson, DC. He is the new HCPAC representative from the American Chiropractic Association.

**XIII. Chiropractic Manipulative Treatments (98940 – 98943)**

Joe Johnson, DC of the American Chiropractic Association presented the Chiropractic Manipulative Treatment codes, which were already reviewed and approved by the PEAC. These recommendations were then reviewed and approved by the HCPAC.

**XIV. Speech and Language Hearing Procedures (926X1-926X11)**

Three individual speakers presented the Speech and Language Hearing Procedures. Robert E. Fifer presented codes 926X1-926X4, Carolyn Wiles Higdon presented codes 926X5-926X9 and R. Wayne Holland, EdD presented codes 926X10 and 926X11. These codes were created to describe new evaluative tests of speech and hearing. The HCPAC listened to each set of codes being presented and used the PEAC Standardized Practice Expense Direct Inputs as a model to calculate these codes direct inputs. Once the inputs for a base code were established, a building block approach was implemented to calculate the direct inputs of the remaining codes. After much deliberation, direct input recommendations were made for each code and approved by the HCPAC. Additionally, supplies and equipment for all of the codes were assessed, modified and approved by the HCPAC.

**XV. Adjournment**

Doctor Williamson adjourned the meeting at 4:45 p.m.

*Approved at the April 25-28, 2002 RUC Meeting.*

**AMA/Specialty Society RVS Update Committee  
Multi-Specialty Points of Comparison Workgroup  
March 26, 2002**

The Multi-Specialty Points of Comparison (MPC) Workgroup met on Tuesday, March 26, 2002 via conference call to review comments by specialties regarding the proposed new MPC list. The following MPC members participated in the call: Doctors Charles Koopmann (Chair), Stephen Bauer, Joe Johnson, David McCaffree, Bernard Pfeifer, and Paul Wallner.

The MPC Workgroup solicited specialty society comments on the draft MPC list, with assigned categories, developed at their January 31, 2002 meeting. The workgroup received only three comments regarding specific changes to this draft list. The workgroup reviewed these comments and made the following revisions:

10061 <i>Drainage of skin abscess</i>	change indicator to a "B"
70496 <i>CT angiography, head</i>	add, indicator "A"
71275 <i>CT angiography, chest</i>	add, indicator "A"
72148 <i>MRI lumbar spine w/o dye</i>	delete
73721 <i>MRI joint of lower extremity</i>	add, indicator "A"
75553 <i>Heart MRI for morph w/dye</i>	add, indicator "A"
78707 <i>Kidney flow/function image</i>	add, indicator "A"
93501 <i>Right heart catheterization</i>	add, indicator "C"

- CPT codes 34802 *Endovascular abdominal repair using bifurcated prosthesis* and 78494 *Heart image, SPECT* are already included in the draft MPC. These specialty societies will be added to those requesting inclusion of these codes.
- The workgroup did not add code 36013 *Place catheter in artery* as 36489 *Insertion of catheter in vein* is already on the MPC list and the primary users of code 36013 (Anesthesiology and Thoracic Surgery) did suggest the addition of code 36013.
- The workgroup did not delete codes 35474 *Repair arterial blockage*, 70540, or 74160. Even though these services do not currently have RUC time associated with them, the workgroup agreed that the codes were important representation of services in their respective work value ranges.

The MPC workgroup has completed its review of the specialty society submissions to the new MPC and offers a list with 279 CPT codes, 188 were designated an A, 32 were designated a B, and 59 were designated a C.

The Multi-Specialty Points of Comparison Workgroup recommends adoption of the enclosed MPC list for use in lieu of the current RUC MPC list.

*Approved at the April 25-28, 2002 RUC Meeting.*

Other Issues:

- The MPC Workgroup would like to emphasize that specialties should incorporate their codes from the MPC into their own specialty-specific reference service list.
- The MPC Workgroup recommends that the MPC list be reviewed (i.e., specialty societies would have the opportunity to solicit additions or deletions) on an annual basis, beginning at the September 2003 RUC meeting. The MPC list should also be reviewed after each Five-Year Review of the RBRVS.

**AMA/Specialty Society RVS Update Committee  
Conscious Sedation Workgroup  
April 11, 2002**

The Conscious Sedation workgroup convened a conference call on Thursday, April 11 and the following members participated on the call: Doctors William Gee (Chair), John Derr, Lanny Garvar, Alexander Hannenberg, Charles Mick, Alan Plummer, J. Baldwin Smith, Maurits Wiersema, and Eileen Sullivan-Marx, PhD, RN. The workgroup reviewed the results of the solicitation of specialty societies to identify codes in which conscious sedation is either inherently included or sometimes utilized.

The workgroup reviewed previous RUC actions related to conscious sedation, including the following decisions:

1. The general approach to the conscious sedation issue should be to retain the conscious sedation as bundled into the procedure code only where it is an inherent part of the service.
2. Separate reporting and payment of conscious sedation codes 99141 and 99142 should be allowed when conscious sedation is not inherently included as a component of the physician work of the procedure code.

At the February 1-3 RUC meeting, the workgroup and RUC agreed that the next step in the process of determining appropriate payment for conscious sedation services is to identify which CPT codes describe services where conscious sedation is an inherent component of the procedure (eg, gastrointestinal endoscopy). The workgroup was also interested in identifying which codes may require conscious sedation, but for which it is not a necessary component of the service (eg, laceration repair for a child). Accordingly, AMA staff solicited specialty societies to provide those lists for review by the workgroup.

To date, the workgroup has received responses from the following specialty societies:

American Academy of Facial Plastic & Reconstructive Surgery (no codes submitted)  
American Academy of Family Physicians (no codes submitted)  
American Academy of Neurology  
American Academy of Pediatrics  
American Association of Oral and Maxillofacial Surgeons/American Dental Association  
American Clinical Neurophysiology Society  
American College of Cardiology  
American College of Chest Physicians  
American College of Radiology (no codes submitted)  
American College of Surgeons (requests extension)  
American Podiatric Medical Association  
American Psychiatric Association (no codes submitted)  
American Society for Gastrointestinal Endoscopy

*Approved at the April 25-28, 2002 RUC Meeting.*

American Society for Therapeutic Radiology and Oncology  
American Society of Hematology  
American Society for Surgery of the Hand (no codes submitted)  
American Thoracic Society  
North American Spine Society  
Society of Nuclear Medicine (no codes submitted)

*Staff Note: The workgroup also received a letter on April 12 from the American Association of Nurse Anesthetists, which is appended, to this report. The Conscious Sedation Workgroup has not yet reviewed this letter.*

In reviewing the specialty society submissions, the workgroup made the following observations:

- The workgroup agreed that the analysis of which codes in CPT may require conscious sedation (but is not typical or routine), is not beneficial. Several specialties identified numerous codes where the conscious sedation may be utilized in certain patient populations or special circumstances. The workgroup concluded that this may be applied to potentially thousands of services described in CPT and is not relevant to the current project to determine where conscious sedation is an inherent component of a service.
- Specialty societies appeared to approach this request in a number of ways. Certain specialties utilized existing data (RUC database, CPEP data) to determine which codes currently have a vignette reference or practice expense inputs related to conscious sedation. Other specialties reviewed all of their services and determined, in today's practice, which services require the provision of conscious sedation.
- Few specialties indicated that conscious sedation was inherently included in their services. A workgroup member noted that certain services should have been identified, but were not. The workgroup members discussed whether these omissions were due to a misinterpretation that only codes where the work or practice expense already specifically identifies the sedation should be identified or whether the provision of the conscious sedation is more typically administered and monitored by another provider.
- Cardiology and Pulmonary medicine each responded with a list of services that do inherently include the provision of conscious sedation. However, these specialties indicated that they do not believe that these services are inappropriately valued. This is contrary to the position of gastroenterology, which argues that the work of conscious sedation is undervalued in their codes. However, cardiology and pulmonary medicine indicate that their services have been recently evaluated. Gastroenterology contends that their services that have not been evaluated since the inception of the RBRVS are undervalued in the work related to conscious sedation.

*Approved at the April 25-28, 2002 RUC Meeting.*

**The workgroup determined that additional work and review was necessary prior to coming to any new conclusions on this topic. The workgroup recommends the following workplan related to conscious sedation:**

- 1. AMA staff should ask all specialty societies to consider the issue of conscious sedation again and only submit codes in which, in today's practice, the provision of conscious sedation is inherent in providing the procedure. The workgroup will review this list at the September 2002 meeting. It may be possible after these efforts to offer CPT a list of codes for which 99141 and 99142 may not also be reported. If CPT specifically stated which codes currently include conscious sedation as an inherent part of the code, it may be easier for physicians to seek payment for codes in which conscious sedation is only administered in special circumstances (eg, pediatric cases).**
- 2. Gastroenterology should review the results of their recent valuations at the RUC and CMS and offer the conscious sedation workgroup a workplan on how to best determine the incremental change in physician work related to conscious sedation from the early 1990s to present.**
- 3. The Practice Expense Advisory Committee should review the direct practice expense inputs related to CPT codes 99141 and 99142 and determine appropriate standards for conscious sedation.**

**AMA/Specialty Society RVS Update Committee  
Anesthesia Workgroup Report  
April, 2002**

The workgroup met to review the distribution of the post induction anesthesia time among the five intensity quintiles for the 19 anesthesia codes included in the ASA presentation. The workgroup considered the RUC approved quintile intensity levels and ASA had developed examples of the type of work represented by each quintile. The workgroup examined the surgical CPT code and the vignette chosen for each of the Anesthesia codes, and the workgroup made several determinations for each CPT procedure code and anesthesia code pairing. First, the group assessed whether the vignette of the CPT code described the typical patient for the anesthesia code. Second, the workgroup examined the time distribution among the five quintiles and made changes based on the typical patient for the code. Finally, the workgroup examined the surgical CPT code selected by ASA and made a determination as to whether it was representative of the surgical codes which would be covered by the anesthesia code. The workgroup considered the anesthesia time, the RUC or Harvard surgical intra-service times, and the representativeness of the chosen surgical CPT code to other codes covered by the particular anesthesia code. The variability of intensity and duration of the surgical procedures among other CPT surgical codes covered within the Anesthesia code family was carefully evaluated. In those families where it was determined that the proportional distribution of time among the quintiles would vary for the codes in the family, the workgroup concluded that extrapolation was not appropriate within the anesthesia code family. Also, the percentage of surgical CPT codes covered by a given anesthesia code was considered. The frequency represented by the selected surgical code was examined to determine the extent to which the code was representative of all codes which would be covered by the anesthesia code. All of these factors were considered in making a recommendation regarding whether the results of examining the anesthesia services involved in the one selected surgical code could be extrapolated to other codes in the family of surgical codes.

After the workgroup reviewed all of the 19 codes it met to develop a concluding recommendation regarding the work of the workgroup.

**The RUC approved the following recommendation:**

**The RUC having carefully considered the information presented, and having a reasonable level of confidence in the data which was presented and developed by the RUC, is unable to make a recommendation to CMS regarding modification to the physician work valuation of anesthesia codes.**

**The RUC recommends forwarding to CMS the attached analysis.**



**Review of Time Distribution within the Post Induction Anesthesia Period | Revised 4-27-02**

**ASA Code**

00142 Anesthesia for procedures on eye; lens surgery

**Surgical Code**

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

**CMS Anesthesia Time 64**

**Vignette**

A 73-year-old man with a history of adult onset diabetes, hypertension, and arthritis presents for cataract surgery (66984). He has limited range of motion in his neck and back pain due to his arthritis.

**Post Induction Anesthesia Period**

**Total post induction period 56**

<b>Level 1</b>	45.8	IWPUT .0224
<b>Level 2</b>	10.2	IWPUT .031
<b>Level 3</b>	0	IWPUT .051
<b>Level 4</b>	0	IWPUT .070
<b>Level 5</b>	0	IWPUT .085

The workgroup believed the vignette did not describe the typical patient for the surgical code 66984, since almost all patients receiving this service do not require anesthesia. However for the small percentage of these procedures that require anesthesia the workgroup believed the time allocation was reasonable.

*Approved at the April 25-28, 2002 RUC Meeting.*

The workgroup also believed that the anesthesia time could be extrapolated to the other codes in the family except for code 66821, which does not require anesthesia time.

**ASA Code**

00210 Anesthesia for intracranial procedures; not otherwise specified

**Surgical Code**

61510 Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma

**CMS Anesthesia Time 233**

**Vignette**

A 47 year old man, with a 40 pack year smoking history, presents to the emergency department with new onset seizures and mild confusion. CT demonstrates a left parietal 3 cm mass with evidence of edema. The remainder of the diagnostic evaluation is non-contributory. After initiating steroid therapy, the patient symptomatically improves. The neurosurgeon schedules the patient for craniotomy and tumor excision.

**Post Induction Anesthesia Period**

**Total post induction period** 213.1

**Level 1** 144.3 IWPUT .0224

**Level 2** 33.8 IWPUT .031

**Level 3** 29.0 IWPUT .051

**Level 4** 6.0 IWPUT .070

**Level 5** 0 IWPUT .085

The workgroup focused on the time attributed to level 4 due to the additional difficulty inherent in anesthesia for a craniectomy since the patient does not have protective reflexes during emergence. The workgroup felt that the time in level 4 should be reduced by approximately half and added to level 3. The workgroup felt the vignette was typical, however given that there are 84 codes in this family with varying levels of complexity, the workgroup had a very low level of confidence in extrapolating to other codes in the family.

**ASA Code**

00350 Anesthesia for procedures on major vessels of neck; not otherwise specified

**Surgical Code**

35301 Thromboendarterectomy, with or without patch graft; carotid, vertebral, subclavian, by neck incision

**CMS Anesthesia Time 147**

**Vignette**

A 78 year old woman with history of hypertension, stable angina and adult onset diabetes. She has smoked one pack per day for 50 years and quit six weeks prior to surgery. She complained of frequent periods of “blacking out” and was found to have critical carotid stenosis. She is scheduled for carotid thromboendarterectomy.

**Post Induction Anesthesia Period**

**Total post induction period 127.1**

**Level 1 32.8 IWPUT .0224**

**Level 2 46.3 IWPUT .031**

**Level 3 48.0 IWPUT .051**

**Level 4 0 IWPUT .070**

**Level 5 0 IWPUT .085**

The workgroup believed that the vignette presented described a scenario that is more complex than the typical patient, by stating that the typical patient has a history of hypertension, stable angina, or adult onset diabetes. The workgroup also questioned the level 4 time stating that it was not typical. The workgroup reiterated that level 4 anesthesia is for unexpected complications or events, and that this surgery typically does not have these problems. The workgroup reallocated the time out of level 4 and into levels 3 and 2. The workgroup considered these reallocated levels time could be extrapolated to the series of codes presented.

**ASA Code**

00404 Anesthesia for procedures on the integumentary system on the extremities, anterior trunk and perineum; radical or modified radical procedures on breast

**Surgical Code**

19240 Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle

**CMS Anesthesia Time 117**

**Vignette**

A 46-year-old previously healthy woman, with biopsy proven intraductal carcinoma of the right breast, presents for modified radical mastectomy.

**Post Induction Anesthesia Period**

**Total post induction period 107**

<b>Level 1</b>	87	IWPUT .0224
<b>Level 2</b>	10	IWPUT .031
<b>Level 3</b>	10	IWPUT .051
<b>Level 4</b>	0	IWPUT .070
<b>Level 5</b>	0	IWPUT .085

The workgroup agreed that the vignette described the typical patient for code 19240 and therefore the distribution of time was accurate. Additionally, since this code represents over 60% of the codes in this family, the workgroup was very comfortable that this code was representative of the family and was very comfortable with extrapolating.

**ASA Code**

00540 Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); not otherwise specified

**Surgical Code**

32480 Removal of lung, other than total pneumonectomy; single lobe (lobectomy)

**CMS Anesthesia Time 160**

**Vignette**

A 53 year old, obese male smoker presents with a 3 cm lesion in the right upper lung on CXR obtained as part of a routine biannual physical exam. He has a chronic cough productive of gray-brown sputum every morning and uses inhaled bronchodilators (Combivent) to control episodes of wheezing attributed to smoking 2 packs daily for 37 years. He is scheduled for right thoracotomy and lobectomy.

**Post Induction Anesthesia Period**

**Total post induction period 130.1**

<b>Level 1</b>	44.3	IWPUT .0224
<b>Level 2</b>	38.9	IWPUT .031
<b>Level 3</b>	22.0	IWPUT .051
<b>Level 4</b>	24.9	IWPUT .070
<b>Level 5</b>	0	IWPUT .085

The workgroup believed the vignette was close to typical except for the broncodilator phrase, and the vignette was accepted. The time allocation presented by the specialty was questioned and reallocated. While the workgroup believed the work of the anesthesiologist is intense and time

consuming, the group believed there would not be any level 5 time with the typical patient, and therefore allocated the level 5 time to level 4. In addition, the workgroup believed that more time should be allocated to level 2 time from level 3 time as it was not typical to have 27.7 minutes of level 3 service. It was found that this time could be allocated to codes in the family with single lung ventilation, such as codes 32480, 32500, and 32657. For other codes, the time could not be extrapolated in the same manner.

**ASA Code**

00562 Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator

**Surgical Code**

33533 Coronary artery bypass, using arterial graft(s); single arterial graft

**CMS Anesthesia Time 264**

**Vignette**

A 69-year-old white woman with a history of adult onset diabetes and hypertension presents with crescendo angina. Coronary angiography demonstrates diffuse disease of the circumflex coronary artery, considered by the cardiologist to not be amenable to angioplasty or stenting. The patient is scheduled for a single vessel coronary artery bypass of the circumflex artery with an internal mammary artery graft.

**Post Induction Anesthesia Period**

**Total post  
induction  
period**

238.9

<b>Level 1</b>	85	IWPUT .0224
<b>Level 2</b>	15	IWPUT .031
<b>Level 3</b>	50	IWPUT .051
<b>Level 4</b>	74	IWPUT .070
<b>Level 5</b>	15	IWPUT .085



The workgroup discussed this code in detail and was concerned with the vignette as not representative of typical cardiopulmonary bypass supported cardiac procedures, and of insufficient complexity to justify the CMS anesthesia total time. Therefore, the workgroup redistributed time based on a typical multivessel bypass patient who is not extubated in the OR (33533 and 33519). With correcting the vignette, there is confidence in extrapolating results among the family of codes only if it is assumed that the longer bypass time procedures will have almost all of the additional time on bypass allocated as level 1 time.

**ASA Code**

00630 Anesthesia for procedures in lumbar region; not otherwise specified

**Surgical Code**

63047 Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), (eg, spinal or lateral recess stenosis)), single vertebral segment; lumbar

**CMS Anesthesia Time 138**

**Vignette**

A 65-year-old retired carpenter with a 50-pack year smoking history and arthritis, presents with sciatica. Imaging reveals nerve root compression, and he presents for decompressive lumbar laminectomy.

**Post Induction Anesthesia Period**

<b>Total post induction period</b>	122.9	
<b>Level 1</b>	60.7	IWPUT .0224
<b>Level 2</b>	31.8	IWPUT .031
<b>Level 3</b>	30.4	IWPUT .051
<b>Level 4</b>	0	IWPUT .070
<b>Level 5</b>	0	IWPUT .085

The ASA presenters stated that this procedure has a more complicated emergence give the prone patient and this accounts for the inclusion of level 4

*Approved at the April 25-28, 2002 RUC Meeting.*

time. The workgroup, however felt that this code would typically not include any level 4 time and reallocated the 10.1 minutes equally between levels 2 and 3. The workgroup felt that the vignette described the typical patient. Given the wide range of codes in this family, the workgroup had a low confidence in extrapolating to the other codes in the family.

**ASA Code**

00770 Anesthesia for all procedures on major abdominal blood vessels

**Surgical Code**

**35102** Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta involving iliac vessels (common, hypogastric, external)

**RUC Surgical time used: 240**

**Vignette**

A 68 year old male smoker is found to have an asymptomatic 5 cm abdominal aortic aneurysm and is scheduled for aortobifemoral bypass graft. He is an asymptomatic smoker and is treated with a diuretic for hypertension

**Post Induction Anesthesia Period**

<b>Total post induction period</b>	220	
<b>Level 1</b>	48	IWPUT .0224
<b>Level 2</b>	57	IWPUT .031
<b>Level 3</b>	80	IWPUT .051
<b>Level 4</b>	20	IWPUT .070
<b>Level 5</b>	15	IWPUT .085

The workgroup recognized that there was a fundamental flaw in the data for this ASA code since the vignette did not accurately describe the surgical code 35081. Instead, the vignette described code 35102 *Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta involving iliac vessels (common, hypogastric, external)*. Therefore, the workgroup agreed to use the surgical intra-service time for code 35081 at 240 minutes, since the anesthesia time for this code was not available. The workgroup maintained the induction time as 20 minutes, resulting in 220 minutes to distribute among the five quintiles. The workgroup was not confident in making any extrapolation within or among the family of codes presented.

**ASA Code**

00790 Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; not otherwise specified

**Surgical Code**

47600 Cholecystectomy;

**CMS Anesthesia Time 103**

**Vignette**

A 52 year old moderately obese female with mild, untreated hypertension admitted 24 hours earlier with fever and right upper quadrant abdominal pain, is found to have an impacted cystic duct stone. With a diagnosis of acute cholecystitis, the patient is scheduled for laparoscopic, possible open cholecystectomy.

**Post Induction Anesthesia Period**

**Total post induction period 88**

<b>Level 1</b>	46.8	IWPUT .0224
<b>Level 2</b>	26.2	IWPUT .031
<b>Level 3</b>	15.0	IWPUT .051
<b>Level 4</b>	0	IWPUT .070
<b>Level 5</b>	0	IWPUT .085

The workgroup felt that the vignette was not representative of the typical patient for code 47600. Given the description of untreated hypertension the workgroup felt this was not typical and reduced the time of level 3 and redistributed 5.6 minutes to level 2. The workgroup also was not comfortable with extrapolating the results to other codes in this family due to the wide range of codes in the family with a wide range of intensities.

**ASA Code**

00830	Anesthesia for hernia repairs in lower abdomen; not otherwise specified
49505	Repair initial inguinal hernia, age 5 years or over; reducible

**CMS Anesthesia Time      99**

**Vignette**

A 7 year old boy, , presents with a bulge in the right groin. Surgical evaluation produces a diagnosis of right inguinal hernia. The general surgeon schedules the patient for an elective open right inguinal herniorrhaphy.

**Post Induction Anesthesia Period**

**Total post induction      87**  
**period**

<b>Level 1</b>	67.4	IWPUT .0224
<b>Level 2</b>	9.8	IWPUT .031
<b>Level 3</b>	9.8	IWPUT .051
<b>Level 4</b>	0	IWPUT .070
<b>Level 5</b>	0	IWPUT .085

Workgroup was comfortable with the vignette, except that the inclusion of asthma is not typical. The vignette should describe a healthy 7-year-old. However, the time distribution was not affected by the inclusion of asthma in the vignette and the workgroup was comfortable with the time distribution. The workgroup was also very comfortable with extrapolating to the other codes of the family since the surgical codes covers over 90% of the frequency for this family.

**ASA Code**

00840 Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not otherwise specified

**Surgical Code**

44140 Colectomy, partial; with anastomosis

**CMS Anesthesia Time 150**

**Vignette**

A 70 year old man is found to have a sigmoid carcinoma at screening colonoscopy and is brought for left colectomy. He has a history of arthritis and mild congestive heart failure.

**Post Induction Anesthesia Period**

**Total post induction period 132**

<b>Level 1</b>	56.1	IWPUT .0224
<b>Level 2</b>	50.9	IWPUT .031
<b>Level 3</b>	25.0	IWPUT .051
<b>Level 4</b>	0	IWPUT .070
<b>Level 5</b>	0	IWPUT .085

The workgroup examined the vignette and the distribution of time. The ASA representatives described the increased complexity inherent in this typical patient given the existence of mild congestive heart failure. The workgroup questioned whether the level four time would be typical or a complication given the high level of intensity associated with level 4. There was some concern that the inclusion of heart failure in the vignette led some respondents to add time in level 4. The workgroup therefore removed heart failure from the vignette and redistributed all level 4 time to level 2 and reduced level 3 by 4.6 minutes given the existing

definitions of the five quintiles. The workgroup was not comfortable with extrapolating to the rest of the family due to the low percentage of frequency attributed to this code.



**ASA Code**

00910 Anesthesia for transurethral procedures (including urethroscopy); not otherwise specified

**Surgical Code**

52281 Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female

**CMS Anesthesia Time 62**

**Vignette**

A healthy 35 year old man with a urethral stricture is scheduled for cystoscopy and urethral dilation.

**Post Induction Anesthesia Period**

**Total post induction period 52.1**

<b>Level 1</b>	34.1	IWPUT .0224
<b>Level 2</b>	9	IWPUT .031
<b>Level 3</b>	9	IWPUT .051
<b>Level 4</b>	0	IWPUT .070
<b>Level 5</b>	0	IWPUT .085

The workgroup believed that the vignette was appropriate for the surgical procedure. The workgroup also agreed that the anesthesia time was allocated properly and that the level 3 time was needed for awakening the patient. The workgroup understood that the time could be extrapolated to the procedures requiring anesthesia, but would exclude codes 51741, 53670, 51720, and 52000.

**ASA Code**

00914 Anesthesia for transurethral procedures (including urethroscopy); transurethral resection of prostate

**Surgical Code**

52601 Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)

**CMS Anesthesia Time 95**

**Vignette**

A 72 year old man, with obesity and hypertension controlled with an ACE inhibitor, presents to the urologist complaining of gradual onset of nocturia and urinary frequency. Prostate examination demonstrates an enlarged prostate without mass and PSA is within normal limits. The patient is scheduled for an elective transurethral resection of the prostate.

**Post Induction Anesthesia Period**

**Total post induction period 80**

<b>Level 1</b>	56.5	IWPUT .0224
<b>Level 2</b>	14.1	IWPUT .031
<b>Level 3</b>	9.4	IWPUT .051
<b>Level 4</b>	0	IWPUT .070
<b>Level 5</b>	0	IWPUT .085

The workgroup believed the vignette is typical but stating that the patient was obese is irrelevant to the procedure and anesthesia work. The time allocation was reasonable to the group and could be extrapolated to the family of codes presented except for extrapolation to code 53850, which does not require anesthesia.

**ASA Code**

00944 Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); vaginal hysterectomy

**Surgical Code**

58260 Vaginal hysterectomy;

**CMS Anesthesia Time 117**

**Vignette**

A 41 year old gravida 2 woman has suffered with severe menorrhagia not responsive to medical therapy. Vaginal examination demonstrates a normal sized uterus with moderate prolapse. She is anemic with a hemoglobin of 11 gm/dl. Her gynecologist schedules an elective vaginal hysterectomy.

**Post Induction Anesthesia Period**

**Total post induction period 102**

<b>Level 1</b>	77	IWPUT .0224
<b>Level 2</b>	15	IWPUT .031
<b>Level 3</b>	10	IWPUT .051
<b>Level 4</b>	0	IWPUT .070
<b>Level 5</b>	0	IWPUT .085

The workgroup was comfortable with the time distribution and felt that the vignette described the typical patient. Given that the time was derived from the Medicare data and represented only 21 cases, the workgroup was skeptical of the total time given the low number of cases. Additionally the 102 minutes was significantly different than the RUC surgical time of 60 minutes. The workgroup was confident in extrapolating the results given the similarity in the family of codes.

**ASA Code**

01230 Anesthesia for open procedures involving upper 2/3 of femur; not otherwise specified

**Surgical Code**

27244 Open treatment of intertrochanteric, pertrochanteric, or subtrochanteric femoral fracture; with plate/screw type implant, with or without cerclage

**CMS Anesthesia Time 110**

**Vignette**

An 82-year-old mildly demented female falls at her nursing home and sustains an intertrochanteric fracture of the femur. She is treated with beta-blockers for chronic stable angina. She is scheduled for an ORIF of the femur.

**Post Induction Anesthesia Period**

**Total post induction period 90**

<b>Level 1</b>	30	IWPUT .0224
<b>Level 2</b>	30	IWPUT .031
<b>Level 3</b>	20	IWPUT .051
<b>Level 4</b>	10	IWPUT .070
<b>Level 5</b>	0	IWPUT .085

The workgroup agreed that the typical patient for this procedure is very sick with bleeding in the hip due to the hip fracture. The level 4 time relates to sedation introduced to prevent patient motion, managing the airway, and preventing apnea and airway obstruction. The workgroup felt that the time distribution was appropriate and the vignette described the typical patient. The workgroup had a high confidence level in extrapolating to all other codes in the family since this code was representative.

**ASA Code**

01270 Anesthesia for procedures involving arteries of upper leg, including bypass graft; not otherwise specified

**Surgical Code**

35656 Bypass graft, with other than vein; femoral-popliteal

**CMS Anesthesia Time 145**

**Vignette**

A 72 year old male presents with ischemic lower extremity pain. The patient has a history of hypertension, insulin dependent diabetes, and emphysema from long standing tobacco abuse (greater than 50 pack years). He is scheduled for a femoral-popliteal bypass graft.

**Post Induction Anesthesia Period**

**Total post induction period 125**

<b>Level 1</b>	66.3	IWPUT .0224
<b>Level 2</b>	32.7	IWPUT .031
<b>Level 3</b>	26.0	IWPUT .051
<b>Level 4</b>	0	IWPUT .070
<b>Level 5</b>	0	IWPUT .085

The workgroup believed that the vignette was atypical as the patient would not be insulin dependent diabetics. The workgroup also believed that most of the time would be allocated to levels 1 and 2, and therefore reallocated time from level 4 to levels 2 and 3. The workgroup also has a very low level of comfort extrapolating and recommends no extrapolation.

**ASA Code**  
01382                      Anesthesia for arthroscopic procedures of knee joint

**Surgical Code**  
29881                      Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving)

**CMS Anesthesia Time        82**

**Vignette**

A 17-year-old boy suffered closed knee trauma during a high school football game. Physical and MRI examinations are consistent with a medial meniscal tear. The orthopedic surgeon schedules the patient for a left knee arthroscopy and meniscal debridement.

**Post Induction Anesthesia Period**

<b>Total post induction period</b>	72	
<b>Level 1</b>	55.2	IWPUT .0224
<b>Level 2</b>	9.9	IWPUT .031
<b>Level 3</b>	6.9	IWPUT .051
<b>Level 4</b>	0	IWPUT .070
<b>Level 5</b>	0	IWPUT .085

The level 2 time seemed low given the work involved in transporting the patient to the post anesthesia care unit and 5 minutes was moved from level 1 to level 2. The level 3 time for this code represents the emergence time. The typical patient does not have ADD and the workgroup changed the vignette and the workgroup had a high level of comfort with extrapolating results to other codes in the family since the other codes were similar.

**ASA Code**

01402 Anesthesia for open procedures on knee joint; total knee arthroplasty

**Surgical Code**

27447 Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)

**CMS Anesthesia Time 150**

**Vignette**

Patient background: A 71 year old 230 lb. male with a history of hypertension and end stage degenerative joint disease of his left knee presents for left total knee arthroplasty. The patient takes beta blockers and calcium channel blockers.

**Post Induction Anesthesia Period**

**Total post induction period 132.1**

<b>Level 1</b>	73.8	IWPUT .0224
<b>Level 2</b>	28.2	IWPUT .031
<b>Level 3</b>	25.1	IWPUT .051
<b>Level 4</b>	5.0	IWPUT .070
<b>Level 5</b>	0	IWPUT .085

The workgroup examined the level 4 time and was concerned that it was inflated given the typical patient described in the vignette. The workgroup therefore relocated the 4.4 minutes from level 3 to level 2. The vignette was felt to be typical and since this code represents 90% of the codes in the family and therefore the workgroup was highly comfortable with extrapolating to the remainder of the family.

**ASA Code**

01844 Anesthesia for vascular shunt, or shunt revision, any type (eg, dialysis)

**Surgical Code**

36830 Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); nonautogenous graft

**CMS Anesthesia Time 128**

**Vignette**

A 60 year old woman with polycystic kidney disease has progressive renal insufficiency and is scheduled for a Goretex arteriovenous fistula creation in the left arm in anticipation of hemodialysis. Her electrolytes are normal, she is mildly anemic and her BUN/Creatinine is 65/5.9.

**Post Induction Anesthesia Period**

**Total post induction period 110**

<b>Level 1</b>	61.4	IWPUT .0224
<b>Level 2</b>	38.4	IWPUT .031
<b>Level 3</b>	10.2	IWPUT .051
<b>Level 4</b>	0	IWPUT .070
<b>Level 5</b>	0	IWPUT .085

The workgroup agreed that the vignette was appropriate for the surgical code. The workgroup did not, however, believe any level 4 service would be provided to the typical patient and the time was reallocated from level 4 to level 2. The workgroup agreed that the results should not be extrapolated to codes 37205 and 37201, and was somewhat uncomfortable extrapolating to the remaining codes in the family.



**AMA/Specialty Society RVS Update Committee  
Valuing Services Reported with Multiple Codes Workgroup**

April 1, 2002

The Valuing Services Reported with Multiple Codes Workgroup met on Monday, April 1, 2002 via conference call to develop guidelines for specialties societies in presenting relative value recommendations for services often reported with multiple CPT codes. The following members participated on this conference call: Doctors Barbara Levy (Chair), James Borgstede, Melvin Britton, David Hitzeman, J. Baldwin Smith, and Sheldon Taubman. Doctor Blankenship was unable to attend the conference call but provided written input for discussion by the Workgroup. Doctor Paul Rudolf, Centers for Medicare and Medicaid Services, also participated on the call.

The workgroup considered a proposed set of instructions for specialties in reviewing new and revised CPT codes that may be a component of a broader service, reported typically with multiple CPT codes. The workgroup recommends that the following language should be added to the *Instructions to Specialty Societies Developing Work Relative Value Recommendations* document and the *Summary of Recommendation* form, where appropriate.

**The RUC's *Summary of Recommendation* form should be amended to include the following questions:**

**Services Reported with Multiple Codes**

**Is this new/revised code typically reported on the same date with other CPT codes?  
If yes, please respond to the following questions:**

**1. Why is the procedure reported using multiple codes instead of just one code?  
(Check all that apply.)**

- The surveyed code is an add-on code or a base code expected to be reported with an add-on code.**
- Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.**
- Multiple codes allow flexibility to describe exactly what components the procedure included.**
- Multiple codes are used to maintain consistency with similar codes.**
- Historical precedents.**
- Other reason (please explain)\_\_\_\_\_**

**2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one**

**physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.**

**The *Instructions to Specialty Societies Developing Relative Value Recommendations* document should be revised to include the following directions:**

**When constructing the vignette to be surveyed, include typical other components of the procedure that would be coded separately. In the vignette, as each other component is described, clearly specify that the other component is coded and valued separately and provide the CPT code number and the work RVU of the other components in the vignette. Also, clearly differentiate the CPT codes and work relative values that bundled into the code being surveyed.**

**In the detailed description of the pre, intra, and post-service work on the RUC's *Summary of Recommendation* form (please note that this information is not included in the survey instrument), include, where appropriate, the specific CPT codes (and associated work RVUs) that are typically either bundled or typically reported separately with this code. In the *Summary of Recommendation* form, you should include a table listing the surveyed code and each additional component code included in the these detailed descriptions with the following information: CPT code, global period, work RVU, pre, intra, and post-service time, multiple procedure policy. Sum the work relative values and the time components for these CPT codes, accounting for the multiple procedure reduction, where appropriate.**

**If the surveyed code is frequently used with other component codes in combinations different than those reported in the detailed descriptions of work, provide additional tables of frequent combinations, along with the pre, intra, and post time and work RVUs as described above. It is only essential to summarize the most typical scenarios. You do not need to provide information on every potential scenario.**

**If multiple specialties typically cooperate during the procedure and use different component codes to report their work, indicate whether it is rare, common, frequent, or necessary to have both specialties performing different parts of the procedure. Indicate which physician would typically perform which components of the procedure. Indicate which services are occurring simultaneously.**

The workgroup also discussed what the RUC's responsibility would be if during a review of a service reported with multiple CPT codes, it became apparent that an existing CPT code (ie, one that was not under review as a new or revised code) was mis-valued. AMA staff clarified that the RUC reviews new and revised codes, as well as codes referred to the RUC by CMS to review (most often during the Five-Year Review process). A workgroup member suggested that the RUC might wish to identify these codes and solicit CMS to refer the specific codes to the RUC for later review. The workgroup determined that this topic should be discussed by the entire RUC.

The workgroup continues to be interested in obtaining information from CMS on groups of codes that are frequently reported on the same date by the same physician to explore further the special issues relating to services reported with multiple codes.